

Robert Wood Johnson Foundation Payment Reform Evaluation Project
Washington State Multi-Payer Medical Home Reimbursement Pilot
Puget Sound Health Alliance / Health Care Authority

Executive Summary: Autumn 2012 Site Report

Context

The Washington State Multi-Payer Medical Home Reimbursement Pilot is the second of two initiatives authorized by the Washington State Legislature to promote the growth of patient-centered medical homes (PCMHs). During its early years, this project was supported by the Aligning Forces for Quality Payment Reform Development Fund. Primary care clinics with medical homes and/or medical organizations that participated in an earlier initiative (the Washington Patient Centered Medical Home Collaborative) were invited to participate in the Pilot. The Pilot was launched by its sponsor, the Washington State Health Care Authority (HCA), a public purchaser and payer. The Pilot is a joint demonstration of the HCA and the Puget Sound Health Alliance (Alliance), with support from the Governor's health policy office, all of which are charged with convening and facilitating multiple stakeholders to implement the Pilot.

The Pilot's implementation and early results are affected by local and national events. Locally, the growth in the number of free-standing emergency rooms has very likely countered the Pilot's efforts to reduce emergency department (ED) visits. At the national level, with the Affordable Care Act (ACA) upheld, stakeholders are focusing their energy on being well-positioned for full implementation of the Act in 2014. This leaves less bandwidth for participation in the Pilot.

Objective

The Pilot's objective is to design and implement a per-member-per-month (PMPM) payment structure in PCMHs that creates incentives for improving primary care and reducing avoidable hospitalizations and unnecessary ED visits, ultimately producing cost savings. Another objective is to identify the necessary implementation features for reducing preventable hospital admissions and ED visits.

Approach

Recruitment of Medical Groups. A multi-stakeholder group was formed and developed eligibility criteria that medical groups must satisfy to participate in the Pilot. A central criterion was evidence of medical home readiness: the core capabilities to implement the PCMH, and the ability to implement changes at the beginning of the Pilot. Medical groups also had to meet other criteria and commit to a specific action plan. Ultimately, eight medical groups with 12 clinics met the criteria and agreed to participate; seven of the 12 clinics were also PCMH Collaborative participants. All medical groups have chosen to reduce avoidable ED visits, but only one group is reducing avoidable hospitalizations.

Payment Reform. The multiple payers in the Pilot provide "new money" to medical groups in the form of supplemental PMPM payments based on the number of plan members attributed to each medical group. The design calls for practices to receive \$2.50 PMPM during the first 8 months, and \$2.00 each of the next two years. Cost savings due to reductions in avoidable hospitalizations and/or avoidable ED visits are shared equally between medical groups and health plans, contingent on the medical group satisfying clinical quality metrics. Medical groups also face a financial risk of repaying part of the supplemental payments if the medical group fails to meet targets for utilization reductions.

Implementation. To foster collaboration among stakeholders, the HCA and the Alliance convene quarterly steering committee meetings where stakeholders identify issues and find solutions. This process has built a sense of “ownership” of the Pilot and created relationships among stakeholders that did not exist previously. Clinics have flexibility and can choose the interventions to reduce preventable ED visits and hospital admissions that they think will work for their patient populations. The Pilot supports the clinics’ practice transformation by setting up webinars where experts discuss different approaches, such as care coordination, increasing access to primary care and health insurance, and building relationships with local emergency departments. Payers also support the Pilot and the clinics by providing data.

Modified risk. The Pilot originally set out to share both savings and losses between plans and practices. The implementation phase was much more complex and as a result pilot outcome data were not available to practices until early in the third and final year of the Pilot. Both plans and practices agreed to modify the risks and penalties for the first two years since practices did not have sufficient data to inform their activities.

Early Results. Commercial members’ utilization rates for preventable ED visits increased 3.9 percent, but Medicaid members’ utilization rates for preventable ED visits decreased 27 percent in the first eight months of the pilot. One medical group achieved its 2011 target reduction by decreasing avoidable inpatient events. In the same period, two medical groups are on track with matching their performance targets. One clinic reached its target with reductions in avoidable ED visits alone, the other with reductions in avoidable inpatient events alone

Logic Model

The Pilot has multiple payers, rather than a single payer, to increase the percentage of patients in the medical groups participating in the pilot so that PMPM payments will be of sufficient size to motivate structural changes in the medical group and provider behavior, which in turn drive changes in clinical care processes. The multi-payer approach promotes a ‘practice wide approach’ to coordinate patient care, rather than fulfill the separate and potentially conflicting goals from multiple plans. The alignment of PMPM payments with the medical home will cause medical groups to integrate the continuum of care and deliver proactive coordinated care, which will introduce greater efficiency in the allocation of health care resources. The downstream effects will be cost-savings from reduced avoidable emergency room visits and hospitalizations and improved outcomes.

Facilitators and Barriers

Facilitators:

- Context: The Alliance’s history of fostering collaboration among stakeholders, the Legislature’s mandate to implement the Pilot, and medical groups’ experience with a medical home collaborative.
- New forms of collaboration have emerged to address common problems.
- Leadership: HCA and Alliance’s role as conveners, and medical leadership in support of practice transformation
- RWJF Conference provided an opportunity for leadership across payment reform projects to share best practices with each other and explore solutions to overcoming challenges.

Barriers:

- Turnover in HCA leadership.
- Competition, rather than collaboration, among health plans.
- Limited funds contributed to an understaffed Pilot for managing this complex undertaking.
- Information- and data-related barriers:
 - Health plans had flexibility in data reporting to reduce the burdens of their voluntary participation in the Pilot, but this resulted in data discrepancies and delays, and the lack of a uniform data set across plans.
 - Limited information about ED visits and hospitalizations slowed design and start-up of the Pilot.
 - Medical groups have limited, real-time information about their patients' utilization of the emergency room and hospital, which limits their ability to be proactive in coordinating care.
- Hospitals are not participating in the Pilot, which may have limited the real-time sharing of information about ED visits.
- Pilot's patient population was smaller than expected and therefore did not represent the majority of a practice population, making it hard to ascertain whether the pilot results accurately reflect the experience of the clinics as a whole.
- The risk of financial losses faced by practices creates an incentive to target limited resources to the smaller pilot population rather than the greater practice population.
- Plans that provide administrative services only generally do not control the expenses of self-insured employers, and PMPM payments may require employer approval.
- Difficulty of accurately attributing patients to plans as they change insurance.
- Not all high risk patients want to be in a medical home and receive highly coordinated care, and the habits of visiting EDs are hard to change.
- Size of PMPM payment may be insufficient to cover the medical groups' costs of reforms.
- Increased marketing by free standing emergency rooms and hospitals to seek care in the ER rather than a primary care doctor's office likely influences patient choice for treatment location.

Evaluation and Sustainability

A limited evaluation is planned, mainly because the Pilot lacks funding and data to do an in-depth evaluation. The Pilot ends in December 2013, and sustainability will depend on the final results.

Lessons Learned

A legislative mandate is no guarantee that implementation will be timely, low-cost, and with few difficulties. Having multiple payers increases complexity. A major barrier is the lack of sufficient funds for implementation and management, particularly to achieve timely, accurate, and uniform data reporting from all the health plans. Context matters: payers are focusing their energy toward ACA reforms, and the growth of free-standing EDs may have undermined the Pilot's efforts to reduce preventable ED visits. The payment scheme, designed for medium and large medical groups, may not be suitable for solo physician practices and small medical groups.