Final Report to the Legislature

Payment Options and Learning Collaborative Work In Support of Primary Care Medical Homes

As Required by Engrossed Second Substitute House Bill 2549

December 15, 2008

From:

Department of Social and Health Services,
Health Care Authority,
Department of Health

Report to the Legislature
Payment Options and Learning Collaborative Work in Support of Primary Care Medical Homes, As Required by E2SHB 2549
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EXECUTIVE SUMMARY

In March/April 2008 the Washington State Legislature passed Engrossed Second Substitute House Bill 2549 (E2SHB 2549), which was signed by the Governor and enacted as chapter 295, Laws of 2008. The bill included a provision for the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) to assess opportunities for changing payment practices, for themselves as well as other payers, in ways that would better support development and maintenance of primary care medical homes. The bill also directed the Department of Health (DOH) to develop a medical home learning collaborative to promote adoption of medical homes in a variety of primary care practice settings. This report summarizes the Agencies' work to-date on both initiatives: focusing first on the payment assignment (Sections I-IV) and then on the DOH Collaborative (Section V).

"Now is the time to act. It's time to rethink our reimbursement philosophy; it's time to refocus our efforts on coordinated, integrated, quality care."

G.P. Poulsen, The Third Path: Systemic Change Will Focus on Returning Value, *Modern Healthcare* and The Commonwealth Fund, April 2008.

The goal of the report is to provide information for future discussion and development of multi-payer pilots of alternative payment approaches, and for support of primary care peer learning. The Washington Primary Care Coalition and discussions with various payers, providers, purchasers, and other experts helped shape the report and its recommendations.

DSHS AND HCA PAYMENT ASSIGNMENT

The report assumes that *any future pilot program of payment change will be a multi-payer effort involving more than one practice setting*. Thus, the report looks at an array of payment options that hold promise for a broad coalition of payers, providers and patients.

As a precursor to the payment discussion, medical home principles and operational definitions are presented. This material lays the groundwork for a multi-payer group to adopt its own medical home principles and operational standards, so it can quickly move to discussing specific measures by which to judge practices' medical home development.

Payment Options and Analysis

Drawing on the literature, as well as existing or proposed initiatives, the report presents four basic payment options. Each option traces back to one of two broad classes of payment: Fee-for-Service "Plus" or Payment Re-Engineering.

- *Fee-for-Service "Plus"* encompasses two general payment options, one based on the current coding system and the other involving an add-on payment that is separate from coding-based reimbursement.
- *Payment Re-Engineering* also covers two general payment options: Bundled Fixed Payment (of various forms) and Full-Risk Capitation. Three examples of "bundled fixed payment" are presented which include payments aggregated around visits and/or conditions (e.g., acute episode such as a broken hip, chronic illness such as diabetes, or the basic 'preventive and wellness' needs of a general primary care practice population).

Three approaches are used to address the question posed in E2SHB 2549 regarding options that might have greatest applicability across multiple payers: pros/cons analysis, criteria ratings[1], and payment strategy (i.e., payment option groupings).

The results of these three analyses suggest the following:

- The *Fee-for-Service "Plus"* options are relatively easy to implement for both providers and payers, and apply equally well to providers with different characteristics. However, they are not likely to lead to desired, sustainable, systemic change; will likely require additional funding at implementation (i.e., not be budget neutral); and, will only marginally help sustain primary care as financially and professionally viable (although these options clearly have value as transition tools, and for partially addressing the current financial instability of some primary care practices).

- The *Payment Re-engineering* options can be more challenging to implement (especially the options with which there is little practical experience), and are less applicable to certain types of practices (e.g., solo and rural providers). However, they are more likely to achieve the long-term goal of a high-performing system, have *potential* for budget neutral implementation, and provide greater opportunity for practices to afford to be 21st century medical homes – although many practices may never be able to operate at a level to accept payment using some of these approaches.

- A *two-path payment strategy* that parallels these two broad classes of payment should be part of any multi-payer pilot, and primary care practices should be recruited to allow both paths to be pursued simultaneously.

    - ➔ The Path 1 strategy applies mainly to primary care practices less evolved in terms of medical home stage or less likely to be part of organized networks. Payment has three parts: (1) increased reimbursement for selected codes that specifically address important medical home components (with the potential for higher payments to practices achieving a more advanced stage of development); (2) a monthly, risk-adjusted, care coordination and infrastructure support payment (with the potential for a higher monthly amount to practices that participate in networks); and (3) performance/accountability incentives.[2]

    - ➔ The Path 2 strategy is for primary care practices that are ready and able to handle a completely revamped payment approach that cuts across provider types and care settings, and fully trades volume for value. Varying levels of *bundled and risk-adjusted payment* are used (likely paid on a monthly basis); the final level being full-risk capitation in which the practice accepts all insurance and performance risk for all providers, settings, and services.[3] Performance/accountability incentives are involved that put some percent of payment at risk, offer the opportunity for shared savings and include agreements by the practice to address errors and avoidable complications without additional payment (within reason).

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[1] Five rating criteria were used: operational feasibility; applicability to primary care practices with different characteristics; likelihood of leading to, and sustaining, systemic changes; ability to implement in a budget neutral manner; and, likelihood of positive impact on primary care as a profession.

[2] The performance/accountability incentives should (a) hold teams as well as individuals accountable, (b) enable and push improvement in clinical and service outcomes, and in infrastructure elements, and (c) use a combination of "positives and negatives", i.e., bonuses, penalties, shared savings.

[3] The key to implementing the Payment Re-Engineering options is not to repeat the problems of the 1990s when practices accepted insurance and performance risk unaligned with their capabilities. The early capitation models were not adjusted for health risk (illness burden and comorbidities), and in certain full-risk capitation arrangements (e.g., percent of premium), practices were expected to bear insurance (underwriting) risk in addition to the costs of hospital and selected subspecialty services well beyond their immediate scope of control. These earlier full-risk models also did not build a "risk premium" into payments to compensate for bearing economic risk. These shortcomings should be remedied in future pilots using bundled payment.

Given this two-path approach, each of the four payment options discussed in the report has a potential role to play in supporting the medical home model. Thus, in answer to E2SHB 2549's directive to assess options potentially applicable across payers: no options should be off the table at this point except the "do nothing" option.

Next Steps and Recommendations

With respect to design issues, the report recommends that a multi-payer pilot program should:

- Encompass the two payment strategy paths, as recommended above;
- Not focus solely on provider payment change to the exclusion of other critical issues that support medical home transformation, such as consumer incentives;
- Require a minimal level of "readiness to change" on the part of participating primary care practices;
- Ensure that the final pilot design provides an environment in which providers can afford to offer a medical home and be rewarded and held accountable for efficiency and outcomes;
- Use the expertise of early-implementers by including them in design efforts;
- Address consistency between the Medical Home Collaborative and payment pilot definitions and measures of a medical home;
- Have an explicit plan for evaluating the payment pilots; developed in parallel with the design and implementation details.
- Be developed as quickly as possible by reaching agreement in early 2009 among payers to move forward, completing design work by the end of 2009, and targeting implementation for mid 2010 (allowing the 2010 Legislative session to consider legislative or funding issues needed to support state program involvement).

The report also suggests several design-related topics to use as a starting place for early consensus among potential pilot partners. In addition to the issue raised earlier of defining what is and is not a medical home, these include the following:

➔ Topics about which there is *substantial agreement* among policy analysts, evaluators, and early implementers include:

- Take a phased approach—examples of phasing include how a practice is paid initially and over time, the degree of accountability to which a practice is held, and who participates in the pilot.
- Focus on a few priority elements of a medical home—examples of elements around which there is considerable agreement are care coordination, health information technology for coordination and decision support, virtual or physical organizational structures (i.e., relationships and mechanisms for working across providers and settings), and patient activation as care partners and quality improvement participants.
- Include performance accountability that focuses on:
  - Enhanced access via non-traditional means including new options for provider-patient communication, open scheduling, and expanded hours;
  - Improved patient satisfaction with the care experience;
  - Fewer unnecessary emergency room visits;
  - Reduced preventable hospital admissions and readmissions;
  - Decreased urgent and emergency hospitalizations for chronic illnesses; and/or
  - Referral care that is steered to high-quality specialists who have uniformly adopted evidence-based intervention practices.

➔ Topics about which there is *considerably less agreement* include:

- Whether practices should be required to meet certification or accreditation standards to receive improved payment, and
- Whether to focus on all consumers or those who use large amounts of health care resources.

Last, the report urges several actions related to moving forward as quickly as possible. These include:

- Find a neutral, respected convener to bring affected groups together and get commitments to implement a multi-payer pilot program within a reasonable time period;
- Ensure links not only to state-sponsored initiatives such as the DOH Collaborative, but to other medical home initiatives that may provide opportunity for a much richer pilot design;

- Provide state resources (at least in part) for (a) pilot design and development, project implementation and operational oversight, and evaluation; (b) the DOH Collaborative as a training and technology support center; and, (c) state programs to the degree needed to participate in a pilot (as purchasers and payers); and
- Start identifying legal and procedural limits that state agencies and/or a collaborative effort in general might face, for example, related to federal Medicaid policies, anti-trust limits on payers, and provider restrictions regarding financial arrangements with each other.

DOH MEDICAL HOME COLLABORATIVE ASSIGNMENT: PROGRESS REPORT[4]

The Department of Health (DOH) has offered training for primary care providers, using the Collaborative methodology, since 1999. In E2SHB 2549, the department was asked to continue that work by developing and implementing the Patient-Centered Medical Home (PCMH) Collaborative. Progress to begin enrolling practices in the Collaborative by March 2009 is on schedule, although progress could be delayed due to the state's current budget situation.

Progress To-Date

The Washington State Collaborative Advisory Committee, which guided development of previous collaboratives, was used to create the initial PCMH Collaborative structure and will continue to advise on its development.

The recommended structure is based on the nationally recognized Chronic Care Model developed at Group Health Cooperative's Center for Health Studies. A "change package" based on the model's six elements is being developed that defines the specific changes that clinical practices need to make to demonstrate they are medical homes. It also defines the data needed to measure those changes. An expert panel met in October 2008 to develop the initial change package; several focus groups have reviewed the draft and suggested refinements. Additional focus groups are scheduled for early 2009, after which the change package will be finalized.

Next Steps

Enrollment in the PCMH Collaborative is scheduled for March through May 2009. Important tasks prior to May 2009 include developing marketing materials, hiring the coach and coordination staff positions, training the coaches, and contracting with enrolled teams. Initial site visits with enrolled teams are scheduled for June 2009, with the first in-person learning session scheduled for September 2009.

Recommendations

It is important to integrate fully the PCMH Collaborative and medical home payment-change efforts. Toward that end, the department recommends the following:

- Allow clinical practices enrolled in the PCMH Collaborative to opt-into any reimbursement pilots created for medical homes;
- Report clinical practice changes resulting from implementing the PCMH Collaborative through the Puget Sound Health Alliance's *Community Check-Up* reports;
- For enrolled practices, have health plans track and report financial outcomes recommended in the change package; and
- Identify resources outside of the state general fund to expand evaluation design and reduce the reporting burden of the enrolled clinical practices.

[4] This is the first of three progress reports due January 1 of 2009, 2010, and 2011. The final report is due December 31, 2011.

Payment Options and Learning Collaborative Work In Support of Primary Care Medical Homes

SECTION I: INTRODUCTION

In March/April 2008 the Washington State Legislature passed Engrossed Second Substitute House Bill 2549 (E2SHB 2549), which was signed by the Governor and enacted as chapter 295, Laws of 2008. The bill included a provision for the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) to assess opportunities for changing payment practices, for themselves as well as other payers, in ways that would better support development and maintenance of primary care medical homes. The bill also directed the Department of Health (DOH) to develop a medical home learning collaborative to promote adoption of medical homes in a variety of primary care practice settings. This report summarizes the Agencies' work to-date on both initiatives; it is submitted to the Legislature as required by E2SHB 2549.

"Now is the time to act. It's time to rethink our reimbursement philosophy; it's time to refocus our efforts on coordinated, integrated, quality care."

G.P. Poulsen, The Third Path: Systemic Change Will Focus on Returning Value, *Modern Healthcare* and The Commonwealth Fund, April 2008.

Sections I through IV of the report focus on the payment assignment given to DSHS and HCA.

- Section I introduces the payment assignment and provides context;
- Section II discusses medical home principles and definitions;
- Section III identifies a range of payment options; and,
- Section IV provides suggestions for next steps.

The last section of the report, Section V, is a status report on development of the DOH medical home learning collaborative, including next steps and recommendations.[5]

The goal of the report is to provide information for future discussions and development of multi-payer pilots of alternative payment approaches, and for support of primary care peer learning opportunities.

A. PAYMENT ASSIGNMENT

The remainder of Section I, through Section IV, focuses on DSHS's and HCA's medical home payment assignment. Although medical home history in Washington goes back many years, legislative and executive branch interest in altering payment to support medical homes became a major focus during discussions of the 2006-07 Blue Ribbon Commission on Health Care Costs and Access (The Commission).[6]

The Commission's work resulted in two actions specific to payment change. First, in 2007 Engrossed Second Substitute Senate Bill 5930 (E2SSB 5930) was enacted. Section 1 required DSHS and HCA to develop a five-year plan to change reimbursement ***within their health care programs***.[7] The legislation specified five goals that the reimbursement changes were to accomplish including:

> " … (f) Better support primary care and provide a medical home to all enrollees through reimbursement policies that create incentives for providers to enter and remain in primary

[5] The status of the Collaborative is reported in a separate section to make it easy to find. Although DSHS, HCA, and DOH are working together, timing issues may preclude complete alignment of thinking between the report's payment sections and Collaborative section. As a result, there may be areas of inconsistency.

[6] Washington State Blue Ribbon Commission on Health Care Costs and Access, *Final Report*, January 2007. Although many of the recommendations touch on elements relevant to primary care medical home development and sustainability, see in particular Recommendations 1, 2, 4, 5, 12, and 16.

[7] See Washington State Health Care Authority and Department of Social and Health Services, *State Purchasing to Improve Health Care Quality – A Five-Year Plan*, September 2007.

care practice and that address disparities in payment between specialty procedures and primary care services; …"

Second, in 2008 the Legislature reiterated its interest in payment change through passage of E2SHB 2549, noting that:

> "… Development and maintenance of medical homes require changes in the reimbursement of primary care providers in medical home practices. There is a critical need to identify reimbursement strategies to appropriately finance this model of delivering medical care."

In E2SHB 2549, the Legislature asked DSHS and HCA to extend their thinking beyond their own health care programs, and to consider payment changes that might be ***applicable to other payers*** as well. In general, DSHS and/or HCA were asked to:

1. develop strategies for primary care reimbursement that support adoption of medical homes and have *potential applicability* to payers other than HCA and DSHS;
2. collaborate with the Puget Sound Health Alliance on any work it does in the areas of primary care reimbursement and performance measurement in support of medical homes; and
3. for providers participating in the medical home collaborative program, develop reimbursement approaches that support improved patient outcomes and system efficiencies in (at least) five areas specified in the bill (see Figure I-1).

Figure I-1: Engrossed Second Substitute House Bill 2549, Section 3
(Language specific to payment; complete text of E2SHB 2549 is in Appendix I-1)

"(1) As part of the five-year plan to change reimbursement required under section 1, chapter 259, Laws of 2007, the health care authority and department of social and health services must expand their assessment on changing reimbursement for primary care to support adoption of medical homes to include medicare, other federal and state payors, and third-party payors, including health carriers under Title 48 RCW and other self-funded payors.

(2) The health care authority shall also collaborate with the Puget Sound health alliance, if that organization pursues a project on medical home reimbursement. The goal of the collaboration is to identify appropriate medical home reimbursement strategies and provider performance measurements for all payors, such as providing greater reimbursement rates for primary care physicians, and to garner support among payors and providers to adopt payment strategies that support medical home adoption and use.

(3) The health care authority shall work with providers to develop reimbursement mechanisms that would reward primary care providers participating in the medical home collaborative program that demonstrate improved patient outcomes and provide activities including, but not limited to, the following:

(a) Ensuring that all patients have access to and know how to use a nurse consultant;
(b) Encouraging female patients to have a mammogram on the evidence-based recommended schedule;
(c) Effectively implementing strategies designed to reduce patients' use of emergency room care in cases that are not emergencies;
(d) Communicating with patients through electronic means; and
(e) Effectively managing blood sugar levels of patients with diabetes."

Figure I-1 contains the exact bill language related to payment; the text of the entire bill is in Appendix I-1.

B. E2SHB 2549 IN CONTEXT

E2SHB 2549 complements an array of on-going public and private initiatives related to medical home ideals. Although not a comprehensive list, the following examples give perspective to the wealth of transformation activity that is occurring and to which payment reform might be applicable.

Cross-Agency:

- *Governor's Health Care Team*: Looking at ways to strengthen state agencies' chronic care efforts by focusing on reimbursement reform to pay for outcomes. In development.
- *Medical Home Partnership Committee*: A group of state agencies and community/advocacy organizations (e.g., Medical Home Leadership Network, Health Coalition for Children and Youth) whose purpose is "to serve as a forum until 2010 for the Department of Health and other public and private partners to assure coordinated and collaborative efforts to develop, implement, and promote Medical Homes for all people in Washington State." [8]

Department of Health (DOH):

- *Washington State Collaborative to Improve Health*: The 2008-2009 learning collaborative addresses five topics. Clinical practices select one of the five topics for their quality improvement work related to implementing the Chronic Care Model. Seven of the 31 enrolled practices are addressing "Medical Home for Children with Special Health Care Needs". This experience is informing the development of the Patient-Centered Medical Home Collaborative created in E2SHB 2549 (see Section V of the report).
- *Children With Special Health Care Needs (CSHCN) and the Medical Home Leadership Network*: Long-standing, multi-faceted, work springing from the DOH's collaboration with other state agencies, the University of Washington, pediatric and primary care practices, public health departments, advocacy and community groups, payers, and professional organizations. CSHCN initiatives emphasize coordinated, continuous, comprehensive care within a medical home; their work provides an impressive launching pad and lessons for medical home provision to other populations. One example is the vision of a medical home presented in Figure II-1 (Section II of the report), which has been adopted as applicable for all populations (not solely CSHCN).[9]

Health Care Authority (HCA):

- *Health Record Bank Pilot Program*: In conjunction with the Health Information Infrastructure Advisory Board, provided grants to three Washington communities to test the potential impact of consumer-managed health record banks as tools for providers and consumers who want to improve patient care coordination. Awards in 2008 for 2009 implementation.
- *Washington Health Information Collaborative (public/private partnership)*: As a contributing sponsor, HCA provides grants to small hospitals, clinics, and medical practices to implement, expand, and upgrade technology related to improving patient care (e.g., electronic medical records and patient registries). Latest round of awards was 2008.
- *Patient Decision Aids/Shared Decision Making Demonstration*: Develop tools to improve patient-provider joint decision making and better align care with patient's needs, goals and values. In development.
- *Uniform Medical Plan Initiatives*: Programs to support self-management of chronic conditions (e.g., provide over-the-phone nurse coaches); provide financial incentives to consumers for healthy behaviors; and promote use of personal health records to improve patient-provider communication and disease self-management.

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[8] This group was initially started in 2006 by the Department of Health to help develop Governor Gregoire's prevention agenda; in June 2008 the group renamed itself and drafted a new purpose statement (noted above).

[9] Directly relevant to the reimbursement focus of this report is the financing goal established in the CSHCN's June 2006 strategic plan, i.e., "financing for medical homes is adequate." Among the six objectives related to the financing goal are: "(1) Reimbursement for health care services is sufficient to allow quality, comprehensive, linguistically and culturally appropriate, coordinated care within a medical home, and (2) Public and private financing is sufficient to allow health care providers to coordinate care." Source: Department of Health, Children with Special Health Care Needs Program, *Medical Homes for Children and Youth with Special Health Care Needs – Making It Happen in Washington State, 2006-2010: A Strategic Plan to Achieve Medical Homes for All Children and Youth with Special Health Care Needs by 2010*, June 2006. For additional information, including the Medical Home Leadership Network, see www.medicalhome.org.

Department of Social and Health Services (DSHS):

- *Children's Health Improvement System (CHIS)*: Five-year plan (2009-2013) to tie reimbursement for medical providers to quality improvement measures related to providers' medical home level and use of evidence-based practices.[10] Steering committee recommendation is to integrate CHIS into medical home pilot projects, November 2008.
- *Chronic Care Management Program*: E2SSB 5930 directs DSHS to design and implement medical homes for its aged, blind and disabled clients in conjunction with chronic care management programs to improve health outcomes, access and cost-effectiveness. DSHS is revamping the existing Chronic Care Management Program to focus on "Rethinking Care", an initiative supported by the Center for Health Care Strategies focusing on clients who are aged, blind or disabled with chronic physical illness and co-existing mental illness or chemical dependency. Enrollment is slated for January 2009.
- *General Assistance/Unemployable Pilot*: Managed care pilot program that integrates medical and mental health delivery systems to serve persons with temporary incapacities and to provide a medical home while on DSHS grant assistance. Managed care started December 2004; mental health component started January 2008.
- *Health Navigators Pilot*: Implements a model that links racial and ethnic populations at risk of chronic conditions with navigators who guide them through the health care system by addressing language or cultural barriers to health care services. Projects implemented in three pilot sites January 2008.
- *Foster Care Health Pilot*: Uses regional centers to link children to medical homes, provide primary care provider education, and make referrals to specialty care. Projects implemented in three pilot sites September 2008.
- *Emergency Room Diversion Grant*: Among other goals, improve the ability of community health clinics to be effective medical homes and alternate emergency care providers in order to reduce unnecessary emergency room visits. Four pilot sites begin implementation by February 2009.

Non-State-Agency: Although it is impossible to do justice to the breadth of activity occurring, the following are a few examples.

- *Washington Primary Care Coalition*: An advocacy, education, and information-sharing group with a focus on sustaining primary care as a cornerstone of a patient-centered, high quality, efficient delivery system. The Medical Home Coordination Group (MHCG), a subcommittee of the Coalition, is a forum to share learning from Washington state medical home projects. They have developed a template to collect standardized development, implementation, and evaluation information on a wide range of provider, clinic, employer, and community-specific initiatives, as they become known.
- *Puget Sound Health Alliance (PSHA)*: The 2008 Puget Sound Community Check-Up report and recommendations from PSHA clinical improvement teams reflect an interest in promoting and measuring medical home characteristics.[11]
- *Washington Health Foundation*: The 2008 Healthiest State Report Card includes a "health home" measure that ranks Washington 25th in the nation and indicates that disparities exist among groups' medical home access.
- *Safety Net Medical Home Initiative*: Two Washington-based organizations, Qualis Health and Group Health Cooperative's MacColl Institute for Health Care Innovation, have teamed up with The Commonwealth Fund to lead a five-year national program in which regional coordinating centers will help transform 50 safety net clinics nationwide into patient-centered medical homes.
- *Improving Performance in Practice (IPIP):* This national program, funded by the Robert Wood Johnson Foundation and sponsored by several primary care specialty societies, awarded a grant

[10] The Children's Health Improvement System (CHIS) was developed as a result of the 2007 child health care act, Second Substitute Senate Bill 5093 (2SSB 5093). The workgroup developed three model components (clinical, service, and infrastructure), each with several domains and recommendations for changes. It also recommended a set of structural, process, and outcome performance measures for evaluating the success of the CHIS. The framework used by the workgroup may prove helpful in designing a multi-payer medical home payment pilot. Additional details of the CHIS model are in Department of Social and Health Services, *Children's Healthcare Improvement System, Report to the Legislature*, November 30, 2007.

[11] See: Puget Sound Health Alliance, *Puget Sound Community Checkup: A Report to the Community on Health Care Performance across the Region*, November 13, 2008. Puget Sound Health Alliance, *Asthma Clinical Improvement Team Final Report*, undated. (Other PSHA clinical improvement team reports include depression, diabetes, heart disease, low back pain, prescription drugs, and prevention.) All reports are available at www.pugetsoundhealthalliance.org.

to the Washington Academy of Family Physicians to help practices provide better care for patients with chronic conditions.[12]

C. CONSULTATION WITH OTHERS

To shape this report, DSHS and HCA staff spoke with a variety of interest groups representing providers, payers, and purchasers, including the Washington Primary Care Coalition, Washington Health Insurance Plans, the CEO Forum (representing employers), and representatives of individual clinic and primary care practice groups. In addition, the Washington Primary Care Coalition served as a focal point for sharing ideas and concerns.

As one of nine competitively selected states, staff had access to technical assistance from national experts through The Commonwealth Fund/AcademyHealth "State Quality Improvement Institute" (QI).[13] Washington's core team for the QI program is a public/private partnership of state agencies and representatives from the Puget Sound Health Alliance and Group Health Cooperative. An example of QI-funded assistance to Washington is a presentation to the Washington Primary Care Coalition (with open invitation to a variety of interested parties) by an expert on medical home reimbursement models in use across the country. (See Section III and Appendix III-2.)

D. REPORT CONTENTS

With the exception of Section V (Collaborative status update), this report focuses on payment alternatives to support the development and sustainability of primary care medical homes. It assumes that any future pilot program of payment change will be a multi-payer effort involving more than one practice setting. It provides an array of payment options for a broad coalition of payers in Washington State and that have applicability to practices of differing characteristics (e.g., medical home stage, size, geographic location, nature of integration/organization) serving various populations (e.g., pediatric, adolescent, adult, chronically ill). Sample medical home principles and operational definitions are presented; however, the report is not a broad review or analysis of the medical home literature, either in terms of medical home impact on patient care and outcomes, or effect on revitalizing the primary care profession.

[12] Quality improvement coaches and learning collaboratives will focus on five key areas: (1) registry to identify patients with diabetes/asthma prior to the visit, (2) condition-specific decision support tools, (3) customized flow diagrams and protocols to standardize the care process, (4) monitoring of protocol usage, and (5) assignment of care team roles.

[13] Implementing patient-centered care through medical homes was the focus of Washington's application to the Quality Institute. Technical assistance was sought in three areas: (1) expansion of patient-centered medical homes to improve quality, access, and affordability, (2) reimbursement changes tied to provider participation in medical homes, and (3) communication strategies to mobilize consumer-provider partnerships for improving quality.

SECTION II: MEDICAL HOME PRINCIPLES AND DEFINITIONS

Changing payment in support of medical homes involves two issues. One issue is payment itself – the specific payment options and how they are best blended. The other issue concerns what the payment is for, that is, what the payment is intended to motivate, support, or enable.

Although this report is primarily about payment options, Section II lays the groundwork by briefly addressing the "payment for what" issue – first by providing some context for the medical home concept in general, and then by looking at currently used medical home principles and operational definitions.

A. MEDICAL HOME CONTEXT

The abundant and growing amount of information around the medical home model of care delivery covers the gamut from

- History (where it began; where it is today)
- Principles (conceptual underpinnings, vision)
- Operational definitions and standards (specific components)
- Measures (quantification of components)
- Impacts on quality and efficiency (better health, better outcomes, better care for the same or less cost)
- Effects on the profession of primary care (revitalizing a delivery system)
- Useful payment models (that enable and support transformation and accountability)[14]

Although it is beyond the scope of this report to summarize this vast body of work, the following points provide a useful frame of reference.

What is a Medical Home? "A Medical Home is an approach to delivering primary health care through a 'team partnership' that ensures health care services are provided in a high quality and comprehensive manner."[15]

What is the Evidence? "Care delivered by primary care physicians in a Patient-Centered Medical Home is consistently associated with better outcomes, reduced mortality, fewer preventable hospital admissions for patients with chronic diseases, lower utilization, improved patient compliance with recommended care, and lower Medicare spending."[16]

What is the Risk? "…many of those supporting application of the [medical home] concept do so realizing that there is a risk [that the model will not deliver superior performance]… These purchasers and payers, however, find the merits of the concept to be sufficiently compelling to warrant an investment in pilots or phased implementations that will be subject to formal assessment and evaluation for effectiveness." [17]

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[14] Sample references covering this range of topics are in Appendix II-1.

[15] University of Washington Medical Home Leadership Network and state Department of Health, *Washington State Medical Home Fact Sheet*, July 2007. (www.medicalhome.org/about/medhomeplan.cfm)

[16] Patient-Centered Primary Care Collaborative, *Patient-Centered Medical Home: Building Evidence and Momentum, A Compilation of PCMH Pilot and Demonstration Projects*, 2008, pp 53. See also www.pcpcc.net.

[17] Patient-Centered Primary Care Collaborative, *The Patient-Centered Medical Home: A Purchaser Guide, Understanding the Model and Taking Action*, 2008. pp 10. See also www.pcpcc.net.

What is the Status of Transformation? Adoption of the model *as a set of complementary components* is a work in progress, for example:

- "Our data on the infrastructure components of the PCMH [Patient-Centered Medical Home] model demonstrate that the model has a long way to go to achieve widespread implementation."[18]

- "Only 27 percent of adults ages 18-64 reported having all four indicators of a medical home: a regular doctor or source of care; no difficulty contacting their provider by telephone; no difficulty getting care or medical advice on weekends or evenings; and doctors' visits that are well organized and running on time."[19]

What Is Needed to Move from Good Idea to Evidence-Based Idea? There is growing agreement among policy analysts and researchers that:[20]

- Comparisons of effectiveness across initiatives are severely limited by the array of different, but overlapping, definitions of medical home; nonetheless, a balance should be maintained between standardization and flexibility-to-innovate (at least in the short-run);

- Rigorous designs are needed:
    - To determine which *combinations of medical home attributes* are most important for improving population health; most significantly improve patients' care experiences; and reduce total health care costs per person.
    - To isolate the impacts of medical home implementation, and supporting payment changes, from other general trends or program influences occurring simultaneously.

- It may take longer than some are willing to wait to fully measure the impacts of care redesign and payment changes; identification of "leading indicators" of beneficial changes (e.g., time to first ambulatory visit after hospitalization) may prevent the model from being prematurely judged as to its effectiveness, particularly in terms of living up to high expectations. The challenge is to provide sufficient time to rigorously test the model, but not so much time as to have it be "outstripped by events in a 24/7 world."[21]

There is ample evidence regarding the value of the *attributes of primary care* to a high performing health care system.[22] A nationwide shortage of primary care providers has been described, as has the burdensome primary care work environment and current payment system that reinforces quantity of care over quality of care. Medical homes and reimbursement changes to support them offer hope for changing this paradigm. An important early step in this direction is that of clinical practice redesign, for which primary care practices require financial support and technical assistance to change the way primary care is delivered.

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[18] Rittenhouse, D.R., Casalino, L.P., Gillies, R.R., Shortell, S.M., and Lau, B., Measuring the Medical Home Infrastructure in Large Medical Groups, *Health Affairs*, Volume 27(5), September/October 2008, pp 1246-1258 (quote from p 1257). The study measured four of seven components of the Joint Principles of the Patient-Centered Medical Home (PCMH) including: physician-directed medical practice, care coordination / integration, quality and safety, and enhanced access. Not included were measures of the PCMH components of personal physician, whole-person orientation, or payment reforms. See Figure II-2 for a list of the Joint Principles.

[19] Beal, A.C., Doty, M.M., Hernandez, S.E., Shea, K.K. and Davis, K., *Closing the Divide: How Medical Homes Promote Equity in Health Care*. The Commonwealth Fund, June 2007. (quote from Executive Summary, p x)

[20] See for example: Saultz, J., *A Scientific Foundation for the 21st Century Medical Home,* Presentation to The Medical Home: Exploring Northwest Initiatives Conference, The Trust for Healthcare Excellence, July 14, 2008. Rosenthal, M.B., *Evaluation of Patient Centered Medical Home (PCMH) Initiatives*. Presentation, National Academy for State Health Policy (NASHP) Web Seminar Series on State Roles in Multi-Payer Medical Home Pilots, a joint offering of NASHP and the Patient-Centered Primary Care Collaborative, with support from The Commonwealth Fund, November 12, 2008.

[21] Dentzer, S., Innovations: 'Medical Home' or Medical Motel 6? *Health Affairs*, Volume 27(5), September/October 2008, p 1217.

[22] For example see: Starfield, B., Shi, L. and Macinko, J., Contribution of Primary Care to Health Systems and Health, *The Milbank Quarterly*, Volume 83(3), 2005, pp 457-502.

The report now turns to the main topic of this section, that is, "payment for what". The framework in the box at the right is a simple graphic that shows the process of defining a concept based on increasing levels of specificity. The flow is: Principles/Vision give rise to Operational Definitions/Standards, which in turn give rise to specific Measures – where measures represent the level of specificity needed to appropriately attribute impacts or outcomes to an intervention. This report addresses the first two levels of the graphic but not the third. An early task of a multi-payer collaborative will be the third level—agreeing on the specific measures to use in judging whether practices are or are not medical homes.[24]

Three Levels of Specificity	Example[23]
Principles / Vision	Evidence-based medicine and clinical decision-support tools guide decision-making
↓	↓
Operational Definitions / Standards (i.e., elements of interest)	When seeing patients, the practice uses a tracking system with guideline-based preventive service clinician reminders
↓	↓
Measures (of an element)	Guideline-based reminders are used for at least 2 of the following 4: • Age-appropriate screening tests • Age-appropriate immunizations (e.g., influenza, pediatric) • Age-appropriate risk assessments (e.g., smoking, diet, depression) • Counseling (e.g., smoking cessation)

B. MEDICAL HOME PRINCIPLES/VISION

Washington State's vision of a medical home served as the starting point for this report. Collaboration among various stakeholder groups, led by the University of Washington Medical Home Leadership Network and state Department of Health, developed the core principles of the vision shown in Figure II-1. The vision emphasizes accessibility and continuity, coordination and comprehensiveness, and patient-family-community centeredness.

Figure II-1: Washington State's Vision: Core Principles of a Medical Home

A Medical Home is an approach to delivering primary health care through a 'team partnership' that ensures health care services are provided in a high quality and comprehensive manner.

Accessible and Continuous
- Care is provided in the community
- Changes in insurance providers or carriers are accommodated by the medical home practice

Coordinated and Comprehensive
- Preventive, acute care, specialty care, and hospital care needs are addressed
- When needed, a plan of care is developed with the patient, family, and other involved care providers and agencies
- Care is accessible 24 hours a day, 7 days a week
- The patient's medical record is accessible, but confidentiality is maintained

Family-Centered
- Families and individual clients are involved at all levels of decision-making

Compassionate and Culturally Effective
- The patient's and family's cultural needs are recognized, valued, respected, and incorporated into the care provided
- Efforts are made to understand and empathize with the patient's and family's feelings and perspectives

University of Washington Medical Home Leadership Network and state Department of Health, ***Washington State Medical Home Fact Sheet***, July 2007. (www.medicalhome.org/about/medhomeplan.cfm)

[23] Examples are based on the Joint Principles of the Patient-Centered Medical Home and the Physician Practice Connections® - Patient-Centered Medical Home (PPC-PCMH™) standards. The Joint Principles and PPC-PCMH™ are discussed later in this section of the report.

[24] There are two types of measures to consider: Measures used to assess the presence or absence of a medical home and measures used to evaluate the effects of a medical home in terms of impacts on quality and efficiency. This discussion focuses on the former, not the latter.

There are, however, other medical home principles/visions with a prominent place in national medical home thinking. Notable among these are the Joint Principles shown in Figure II-2. Four medical societies developed these principles, which were subsequently endorsed by thirteen specialty societies, adopted by the Patient-Centered Primary Care Collaborative, and are the basis for the patient-centered medical home (PCC-PCMH™) standards developed by the National Committee for Quality Assurance, and discussed throughout this report.[25]

Additional principles developed by America's Health Insurance Plans (AHIP) and principles associated with two concepts closely aligned with medical home thinking—Ideal Medical Practice and Chronic Care Management— were also reviewed for this report and are in Appendix II-2.[26]

Taken together these five sets of principles provide a robust, all-encompassing, relatively consistent vision for primary care medical homes. A multi-payer collaborative intending to implement and evaluate payment change that supports primary care medical homes will need to decide which of these visions, or blends of them, it will use as a starting point.[27]

[25] The four medical societies that developed the Joint Principles are the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA). The thirteen organizations newly endorsing the principles are: The American Academy of Chest Physicians, The American Academy of Hospice and Palliative Medicine, The American Academy of Neurology, The American College of Cardiology, The American College of Osteopathic Family Physicians, The American College of Osteopathic Internists, The American Geriatrics Society, The American Medical Directors Association, The American Society of Addiction Medicine, The American Society of Clinical Oncology, The Society for Adolescent Medicine, The Society of Critical Care Medicine, and The Society of General Internal Medicine. The Patient-Centered-Primary Care Collaborative is a national coalition of major purchasers, payers, provider organizations, and consumer groups actively working to drive a shared vision of a transformed, high-value health care system. (see www.pcpcc.net)

[26] For Ideal Medical Practice see: Moore, L.G. and Wasson, J.H., The Ideal Medical Practice Model: Improving Efficiency, Quality and the Doctor-Patient Relationship, *Family Practice Management*, September 2007; and www.aafp.org/fmp and www.HowsYourHealth.org. For chronic care management see: Wagner, E.H., Chronic Disease Management: What Will it Take to Improve Care for Chronic Illness? *Effective Clinical Practice*, Volume 1(1), 1998, pp 2-4 and www.improvingchroniccare.org.

[27] Two distinctions between Washington's medical home vision and the visions or principles of many other organizations are important. First, discussions of Washington's vision emphasized the more inclusive term "primary care provider" rather than the more specific term "physician". Second, to be consistent with national terminology, this report uses the term "patient-centered", although the intent is to reflect Washington's vision of the more inclusive term of "family-centered".

Figure II-2: *Joint Principles* of the Patient-Centered Medical Home*

Personal physician. Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice. The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation. The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision-making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers and community resources.
- It should support adoption and use of health information technology for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits.)
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

*Principles jointly agreed to by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA). Supported by numerous specialty societies and endorsed by the Patient-Centered-Primary Care Collaborative, a national coalition of major purchasers, payers, provider organizations, and consumer groups.

Source: National Committee for Quality Assurance, *Standards and Guidelines for Physician Practice Connections® - Patient-Centered Medical Home (PPC-PCMH™)*, 2008, Appendix 1.

C. MEDICAL HOME OPERATIONAL DEFINITIONS

Less consistent than the principles are the observable standards or operational definitions used in implementation. Medical home standards are evolving, elements of a medical home that contribute to high-value continue to be tested, payers' choices of components to implement hinge on values, preferences, resources, market environment, business models, prior initiatives, and populations served. As pilots, demonstrations, and transformations come on-line and are evaluated, evidence will build regarding medical home attributes, and blends of attributes, of highest value. In the meantime, it seems prudent to keep in mind that a one-size-fits all operational definition may be unrealistic for practices of varying characteristics and books of business. One approach that balances flexibility with standardization is to specify standard components of the medical home, with an ordering that suggests different tiers (levels) of medical home development.

Several recent compilations of medical home initiatives give a sense of the range of definitions in use; these summaries include:

- Patient-Centered Primary Care Collaborative (PCPCC), *Patient-Centered Medical Home, Building Evidence and Momentum: A Compilation of PCMH Pilot and Demonstration Projects, 2008*. Available at www.pcppc.net. The Center for Multi-Stakeholder Demonstrations, one of four collaborative centers of the PCPCC, maintains an on-line listing as well, available at www.pcpcc.net.[28]

- National Partnership for Women and Families, *Side-by-Side Summary of State Medical Home Programs, Updated September 26, 2008*. Available at www.nationalpartnership.org.

- National Academy for State Health Policy, *Results of State Medical Home Scan, October 2008*. Available at www.nashp.org.

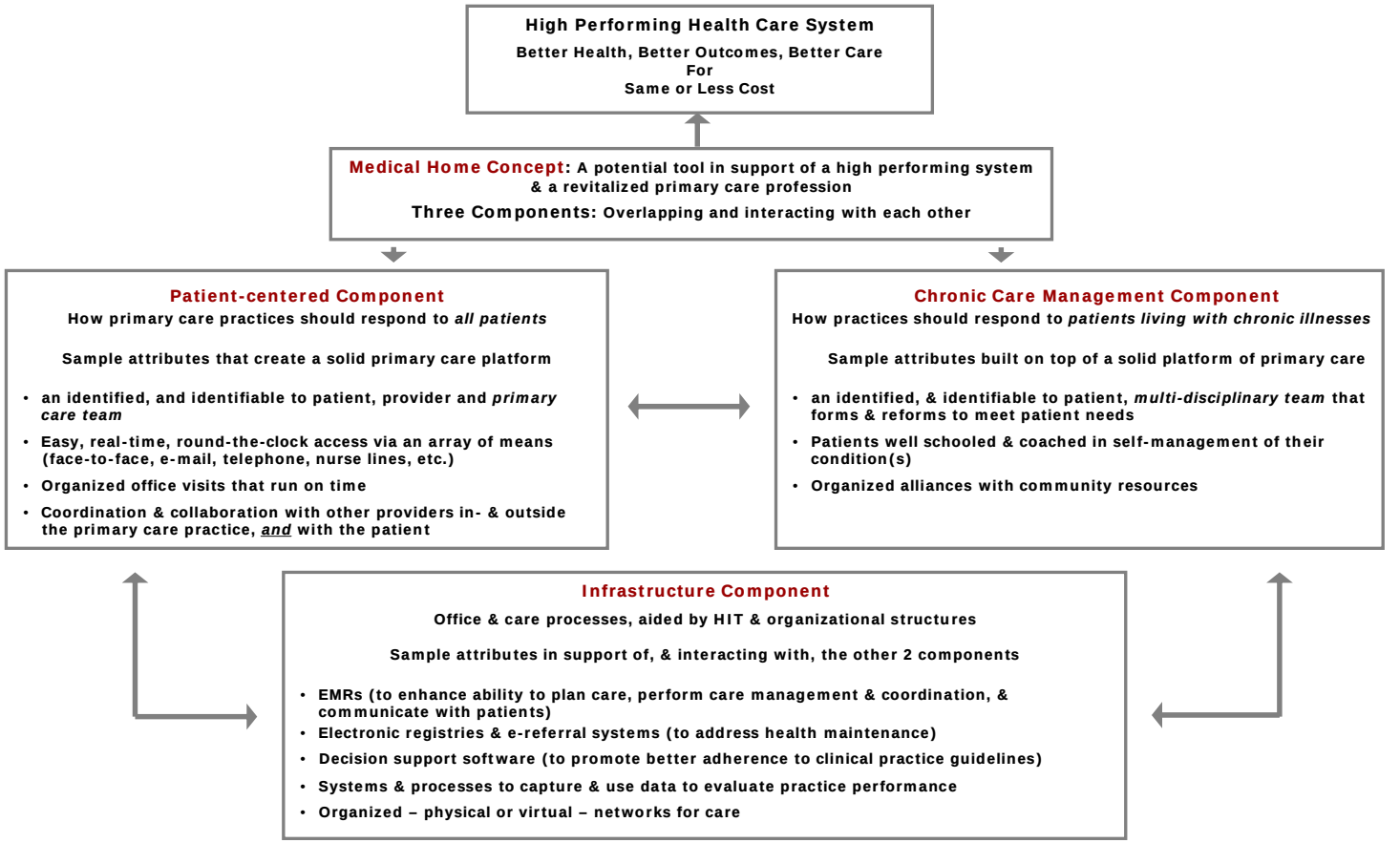
The report does not attempt to summarize all existing definitions. Rather, it provides a model for operationally recognizing a medical home and then offers two relatively standardized frameworks for evaluating the presence or absence of a medical home.

Recognizing a Medical Home. Figure II-3 provides an at-a-glance model of the medical home construct. In the graphic, the model is anchored at the top and bottom, respectively, by showing its relationship to a high performing health care system and to desired outcomes (e.g., fewer unnecessary emergency room visits). The three overlapping and interacting components, that is, patient-centered, chronic care management, and infrastructure, represent the core of a medical home and are presented in the graphic with sample attributes.[29]

[28] A sample of state-specific initiatives is also included in PCPCC's publication *The Patient-Centered Medical Home: A Purchaser Guide, Understanding the Model and Taking Action, 2008*.

[29] The graphic is a representation built from many different sources but draws most heavily from the writings of L.G. Moore and J.H. Wasson on the ideal medical practice, from E.H. Wagner et al on the chronic care model, and from delivery system theme articles in the September/October issue of *Health Affairs*. Sample sources include: Moore, L.G. and Wasson, J.H., The Ideal Medical Practice Model: Improving Efficiency, Quality and the Doctor-Patient Relationship, *Family Practice Management*, September 2007. www.aafp.org/fmp and www.HowsYourHealth.org; Wagner, E.H., Chronic Disease Management: What Will it Take to Improve Care for Chronic Illness? *Effective Clinical Practice,* Volume 1(1), 1998, pp 2-4, and Wagner, E.H., Austin, B.T., Davis, C., Hindmarsh, M., Schaefer, J., and Bonomi, A., Improving Chronic Illness Care: Translating Evidence into Action, *Health Affairs*, Volume 20(6), November/December 2001, pp 64-78. www.improvingchroniccare.org; Berenson, R.A., Hammons, T., Gans, D.N., Zuckerman, S., Merrell, K., Underwood, W.S., and Williams, A.F., A House Is Not a Home: Keeping Patients at the Center of Practice Redesign, *Health Affairs*, Volume 27(5), September/October 2008, pp 1219-1230; and, *Today's Care vs. Medical Home Care*, PowerPoint slide by F.D. Duffy, MD, School of Community Medicine, University of Oklahoma, 2008, available at www.pcpcc.net.

Medical Home Reimbursement Project
Figure II-3: Recognizing a Medical Home



To What End?
- Enhance access via non-traditional means
- Improve satisfaction with care experience
- Decrease unnecessary emergency room visits
- Reduce preventable hospital admissions & readmissions
- Prevent urgent & emergent hospitalizations for chronic illnesses
- Steer referral care to high-quality medical specialists sparing in their use of "supply-sensitive" services

The graphic is a representation built from many different sources but draws heavily on the writings of L.G. Moore and J.H. Wasson on the ideal medical practice, from E.H. Wagner et al on the chronic care model, and from delivery system theme articles in the September/October 2008 issue of *Health Affairs.*

Setting Medical Home Standards. Two of the more standardized and predominant approaches to operationally defining a primary care medical home are (a) Physician Practice Connections® - Patient-Centered Medical Home (PPC-PCMH™) and (b) Bridges to Excellence Medical Home Recognition.

- **Physician Practice Connections® - Patient-Centered Medical Home (PPC-PCMH™)** The nine standards, encompassing 30 different elements and about 170 separate measures, included in the PPC-PCMH™ are the result of collaboration between several physician groups and the National Committee for Quality Assurance (NCQA); building on initial work of pediatricians caring for children with special health care needs. They reflect implementation of the Joint Principles referenced earlier. A limited review of initiatives across the country, including efforts aimed at Medicare, Medicaid, and/or commercial populations, indicates that the PPC-PCMH™ is becoming the baseline of choice for new initiatives. The basics of the approach are in Figure II-4; details are available at www.pcpcc.net.[30]

- **Bridges to Excellence Medical Home Recognition (BTE)** The BTE model reflects the same foundation as PPC-PCMH™ but is slightly more prescriptive regarding condition-specific standards. Designed as a recognition and reward program[31], it provides a useful framework for assessing practices' adoption of value-added systems and processes of care and use of those systems to deliver improved results, especially for patients with chronic conditions. Simply put, it blends recognition for good systems and processes with recognition for good outcomes. A summary is in Figure II-5; details are available at www.bridgestoexcellence.org.

For purposes of operationally defining a medical home, an important characteristic of both of these approaches is that they "tier" their definitions. Each tier requires a progressively more advanced level of medical home. The tiers can be used to determine a baseline level of performance for receipt of enhanced medical home payments, as well as for linking improvement to payment (e.g., higher tier recognition results in higher enhanced payment).

This report does not advocate for adoption of either approach "as is", nor to the exclusion of other approaches. Rather, these two provide a reasonable starting point for discussions by any multi-payer collaborative of "payment for what". For example, a multi-payer group could use the "laundry list" of standards encompassed in PPC-PCMH™ and BTE to select specific medical home elements that fit Washington's needs and delivery system environment.[32] In fact, when coupled with elements defined by other models, for example, chronic care management, ideal medical practice, children with special health care needs, guided care, the result is a robust universe from which to select.[33]

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[30] The four physician societies that worked closely with NCQA are the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA). See National Committee for Quality Assurance, *Standards and Guidelines for Physician Practice Connections® - Patient-Centered Medical Home (PPC-PCMH™)*, 2008.

[31] The BTE medical home program is designed to provide participating employers with a recognition and reward tool. BTE suggests that doctors can receive an annual bonus payment of $125 for each patient covered by a participating employer, with a yearly maximum incentive of $100,000.

[32] For example, Medicare's medical home demonstration project modifies the PPC-PCMH™ approach to fit its high-need elderly population, and uses two tiers (rather three) of medical home development. Section 204 of the Tax Relief and Health Care Act of 2006 established Medicare's 3-year medical home demonstration. Recruitment for demonstration practice sites occurs in Spring 2009, following completion in late 2008 of the program design.

[33] For example:
- Medical Home Index (MHI) and Medical Home Family Index (MHFI) for Children with Special Health Care Needs. The MHI consists of six domains, each with two to seven elements scored at four levels. The MHFI is a 25-item questionnaire used in conjunction with the MHI to provide patient/family perspective. See www.medicalhomeimprovement.org.
- Assessment of Chronic Illness Care (ACIC) and Patient Assessment of Chronic Illness Care (PACIC) for the Chronic Care Model. The ACIC (version 3.5) consists of seven domains – six domains correspond to the six components of the Chronic Care Model; the seventh domain addresses how well the six components are integrated. Each domain consists of three to six elements scored at four levels. The PACIC is a 20-item questionnaire used in conjunction with the ACIC to provide patient perspective. See www.improvingchroniccare.org.
- HowsYourHealth is part of the Ideal Medical Practice model and includes a family of four surveys (child, adolescent, adult, geriatric) designed to "place clinicians and patients 'on the same page' for issues that matter to the patients" and "help patients become better at managing concerns that are important to them". The adult survey, for example, consists of three domains; each domain has two to six elements measured by a set of questions that vary in number based on the element. See www.HowsYourHealth.org.

Medical Home Reimbursement Project
Figure II-4: Physician Practice Connections® - Patient-Centered Medical Home (PPC-PCMH™) Standards

Standard 1: Access and Communication
- **A. Has written standards for patient access and patient communication****
- **B. Uses data to show it meets its standards for patient access and communication****

Standard 2: Patient Tracking and Registry Functions
- A. Uses data system for basic patient information (mostly non-clinical data)
- B. Has clinical data system with clinical data in searchable data fields
- C. Uses the clinical data system
- **D. Uses paper or electronic-based charting tools to organize clinical information****
- **E. Uses data to identify important diagnoses and conditions in practice****
- F. Generates lists of patients and reminds patients and clinicians of services needed (population management)

Standard 3: Care Management
- **A. Adopts and implements evidence-based guidelines for three conditions ****
- B. Generates reminders about preventive services for clinicians
- C. Uses non-physician staff to manage patient care
- D. Conducts care management, including care plans, assessing progress, addressing barriers
- E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities

Standard 4: Patient Self-Management Support
- A. Assesses language preference and other communication barriers
- **B. Actively supports patient self-management****

Standard 5: Electronic Prescribing
- A. Uses electronic system to write prescriptions
- B. Has electronic prescription writer with safety checks
- C. Has electronic prescription writer with cost checks

Standard 6: Test Tracking
- **A. Tracks tests and identifies abnormal results systematically****
- B. Uses electronic systems to order and retrieve tests and flag duplicate tests

Standard 7: Referral Tracking
- **A. Tracks referrals using paper-based or electronic system****

Standard 8: Performance Reporting and Improvement
- **A. Measures clinical and/or service performance by physician or across the practice****
- B. Survey of patients' care experience
- **C. Reports performance across the practice or by physician ****
- D. Sets goals and takes action to improve performance
- E. Produces reports using standardized measures
- F. Transmits reports with standardized measures electronically to external entities

Standard 9: Advanced Electronic Communications
- A. Availability of Interactive Website
- B. Electronic Patient Identification
- C. Electronic Care Management Support

**** = must pass elements**

Nine standards include thirty elements, 10 of which are "must pass" (defined as scoring at least 50% of the points for that element). Most elements consist of several factors used in the scoring (i.e., "measurable" versions of the elements, for a total of around 170 measures). Each element has a level of information technology (IT) associated with it and plays a role in scoring. (Basic IT = electronic practice management system; Intermediate IT = Basic plus additional IT such as EHR or e-prescribing capability; Advanced IT = interoperable IT capabilities such as ability to electronically transmit and receive data between the practice and other entities)

Three levels of achievement are possible:

Level 1 Medical Home: pass 5 of the 10 "must pass" elements with performance of at least 50% and receive 25-49 total points
Level 2 Medical Home: pass 10 of the 10 "must pass" elements with performance of at least 50% and receive 50-74 total points
Level 3 Medical Home: pass 10 of the 10 "must pass" elements with performance of at least 50% and receive 75-100 total points
(if "must pass" scoring and total points indicate different levels of recognition, the lower level is awarded)

Source: National Committee for Quality Assurance, *Standards and Guidelines for Physician Practice Connections® - Patient-Centered Medical Home (PPC-PCMH™)*, 2008.

Medical Home Reimbursement Project
Figure II-5: Bridges to Excellence (BTE) Recognition as a Medical Home

Recognition as a BTE medical home requires achieving …
- **Level II or III in Physician Office Link, *and***
- **Level II or III in at least 2 of the 3 current condition-specific programs (diabetes, cardiac, back pain)**

For condition-specific programs:

- Level I: Thresholds focus on above average performance, at about the 50th national percentile
- Level II: Thresholds focus on really good performance, at about the 75th national percentile
- Level III: Thresholds focus on very top performance, at about the 90th national percentile

(in some cases there are "must pass" elements)

Physician Office Link	Diabetes Care	Cardiovascular and Stroke Care	Back Pain Care
Level I: Evidence-based care and tracking Elements assess … • Use of evidence-based standards of care • Maintenance of patient registries to identify and follow-up with at-risk patients • Provision of educational resources to patients **Level II: Electronic systems** Elements assess whether electronic systems are used to … • Maintain patient records • Provide decision support • Enter orders for prescriptions and lab tests • Provide patient reminders **Level III: Interconnected / integrated electronic systems** Elements assess if electronic systems … • Are interconnected within a practice • Are interoperable (can talk to) other systems • Use nationally accepted medical code sets • Can automatically send, receive, and integrate data such as lab results and medical histories from other organizations' systems.	Level (I, II, or III) of practice performance is assessed based on meeting thresholds for: • HbA1c control • Blood pressure control • LDL control • Eye exams • Foot exams • Nephropathy assessments • Smoking status and cessation advice or treatment	Level (I, II, or III) of practice performance is assessed based on meeting thresholds for: • Blood pressure control (BP result) • Complete lipid profiles • Cholesterol control (LDL result) • Use of aspirin or another antithrombotic • Smoking status and cessation advice or treatment	Level (I, II, or III) of practice performance is assessment based on clinical thresholds and structural standards for … • Clinical Measures 1. initial visit 2. physical exam (must pass) 3. mental health assessment 4. appropriate imaging for acute back pain 5. repeat imaging studies 6. medical assistance with smoking cessation 7. advice for normal activities 8. advice against bed rest 9. recommendation for exercise 10. appropriate use of epidural steroid injections 11. surgical timing 12. patient reassessment 13. shared decision making (about surgery and its alternatives) • Structural Standards 14. patient education 15. post-surgical outcomes (must pass) 16. evaluation of patient experience

Source: www.bridgestoexcellence.org

Payment Options and Learning Collaborative Work In Support of Primary Care Medical Homes

SECTION III: POTENTIAL PAYMENT OPTIONS AND STRATEGY

Organizations' medical home principles/visions often include statements specific to payment. The Joint Principles of the Patient-Centered Medical Home listed in Section II of the report (Figure II-2) and the principles developed by America's Health Insurance Plans (Appendix II-2) are examples.[34] More locally, the Washington State Primary Care Coalition developed the set of payment-specific principles shown in Figure III-1.

Although the wording and breadth of each set of payment principles differs, at their root each emphasizes payment reform that is value-driven, focusing simultaneously on high quality care and controlled costs, with assurances that all patients, regardless of illness burden, have access to needed care.

Figures III-1: Washington State Primary Care Coalition, Payment Principles

Principles to support high quality primary care consistent with the patient-centered medical home:

- Promote ongoing innovation in care delivery
- Include payment for health promotion in addition to disease management
- Empower patients
- Be risk adjusted in a clinically meaningful way
- Be holistic in orientation
- Support both small rural practices and large multi-specialty groups
- Have inherent simplicity
- Tie payment to interactions between patients and providers
- Align incentives for the provider to deliver quality care
- Nurture foundational elements of medical home in practices
- Encourage transparency and accountability for quality
- Encourage partnerships between primary and specialty care
- Reward successful practices
- Be aligned with insurance benefits

Source: Payment Subcommittee of the Washington State Primary Care Coalition, May 22, 2008 Meeting Summary and May 29, 2008 Meeting Agenda.

A. PAYMENT OPTIONS

Drawing on the literature, as well as existing or proposed initiatives, the report presents four basic payment options; each option traces back to one of two broad classes of payment as shown in Figure III-2.[35]

The two broad classes of payment are **Fee-for-Service (FFS) "Plus"** and **Payment Re-Engineering**.

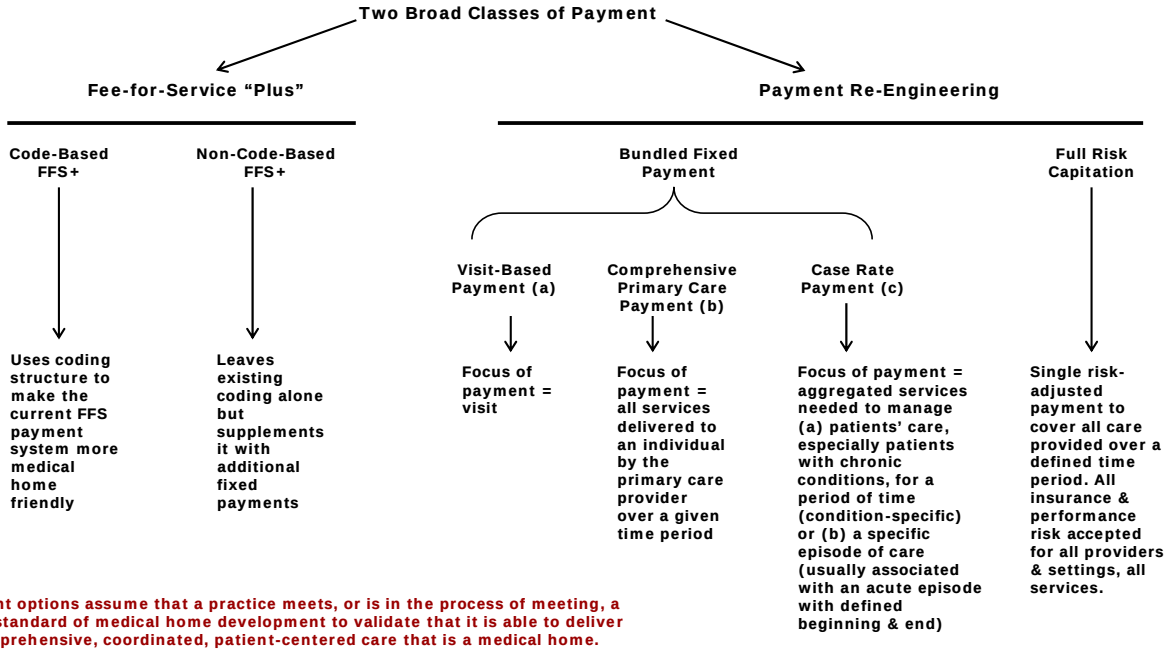
- Fee-for-Service "Plus" encompasses two general payment options, one based on the current coding system and the other involving an add-on payment that is separate from coding-based reimbursement.

- Payment Re-Engineering also covers two general payment options: Bundled Fixed Payment (of various forms) and Full-Risk Capitation. Three examples of "bundled fixed payment" are presented which include payments aggregated around visits and/or conditions (e.g., acute episode such as a broken hip, chronic illness such as diabetes, or the basic 'preventive and wellness' needs of a general primary care practice population.)

[34] Two other helpful examples of payment reform principles that support value-based health care and competition are in Appendix II-3. One example comes from recommendations of the 2007 payment reform summit of the Network for Regional Healthcare Improvement, see Miller, H.D., *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*, The Commonwealth Fund, September 2007; and Jewish Healthcare Foundation and the Pittsburgh Regional Health Initiative, *Incentives for Excellence: Rebuilding the Healthcare System from the Ground Up*, 2007. The second example is based on Porter, M.E. and Teisberg, E.O., *Redefining Health Care: Creating Value-Based Competition on Results*, Harvard Business School Press, Boston, MA, 2006.

[35] Different authors, and medical home initiatives, describe the options with varying degrees of specificity but in general all variations seem to ultimately boil down to one of these four options.

Medical Home Reimbursement Project
Figure III-2: Payment Options in Support of Medical Home Transformation and Sustainability



All payment options assume that a practice meets, or is in the process of meeting, a minimum standard of medical home development to validate that it is able to deliver the comprehensive, coordinated, patient-centered care that is a medical home.

(a) as discussed in Goldfield, N., Averill, R., Vertrees, J., Fuller, R., Mesches, D., Moore, G., Wasson, J., & Kelly, W., Reforming the Primary Care Physician Payment System, Eliminating E&M Codes and Creating the Financial Incentives for an "Advanced Medical Home", *Journal of Ambulatory Care Management*, 31(1), 2008, pp 24-31.

(b) as discussed in Goroll, A.H., Berenson, R.A., Schoenbaum, S.C., & Gardner, L.B., Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care, *Journal of General Internal Medicine*, 22, 2007, pp 410-415.

(c) as discussed in Miller, H.D., *From Concept to Reality: Implementing Fundamental Reforms in Health Care Payment Systems to Support Value-Driven Health Care, Working Draft*, Network for Regional Healthcare Improvement, Healthcare Payment Reform Series, Discussion draft for 2008 NRHI Healthcare Payment Reform Summit, Version 2.0, July 21, 2008. Miller, H.D., *From Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs,* Network for Regional Healthcare Improvement, Healthcare Payment Reform Series, Recommendations of the 2008 NRHI Healthcare Payment Reform Summit, 2008. de Brantes, F. & Camillus, J.A., *Evidence-Informed Case Rates: A New Health Care Payment Model,* The Commonwealth Fund, April 2007.

Although the Fee-for-Service "Plus" options are relatively straightforward and familiar, the following brief descriptions provide a common frame-of-understanding for this report.

FEE-FOR-SERVICE (FFS) "PLUS" OPTIONS[36]

FFS "Plus", Code Based Option: This option expands on the "business-as-usual" visit-based, fee-for-service system by doing one or both of the following:

Initiate new reimbursement:

- Reimburse medical home service-related *codes not currently in use* (i.e., the codes exist but are not used or accepted for payment)

Modify reimbursement:

- Increase reimbursement for *currently used* medical home-related codes (e.g., office-based E&M, consultation, counseling)
- Pay progressively higher amounts for meeting higher medical home levels
- Make modifications to accommodate medical home activities, e.g., pay 95% of CPT office visit fee for a "virtual" office visit (e.g., phone visit)

FFS "Plus", Non-Code-Based: In addition to usual fee-for-service payments, this option includes a "lump sum" amount designed to cover specific medical-home-related activities. For example,

A fixed payment is pre-determined that …

- Is based on a pmpm count (entire patient panel or a subpopulation)
- Is based on clinician FTEs in the practice
- Reflects specific practice infrastructure costs independent of any particular count

Where the payment is …

- Paid monthly, quarterly, or one-time (payments may be upfront, paid only for the short-term, paid later in the development process, may include bonuses or grants)
- Sometimes split among an individual provider, the practice, and/or the broader network
- Often involving some form adjustment (case mix, risk, needs, efficiency, outcomes)

And is often for …

- Care coordination/care management outside usual office visits
- Installing infrastructure support and care process redesign, including health information technology (registries, electronic health records)
- Stimulating virtual network development (e.g., self-created regional networks)
- Supporting shared resources among practices
- Offsetting revenue losses due to transformation activities
- Covering services/approaches not currently billable, at practice's discretion
- Achieving cost savings, efficiencies, better outcomes from better care management

With the exception of full-risk capitation, the Payment Re-Engineering options are less familiar. Full-risk capitation represents the final step in bundled payment – a practice accepts all insurance and performance risk for all providers, settings, and services for a fixed time-period. Not many (although some) practices can accept this extreme form of aggregated payment; a larger share of primary care practices, however, may be ready to accept a less comprehensive version of capitation. Examples of less comprehensive approaches, i.e., "bundled fixed payment options" are summarized below – although other variations are possible, these examples demonstrate the range of current thinking.

[36] Abbreviations used in the descriptions are: E&M = Evaluation and Management; CPT = Current Procedural Terminology; PMPM = per member per month; FTE = full time equivalent

BUNDLED FIXED PAYMENT OPTIONS

Visit-Based Payment System: [37]
Phase 1: Visit-based payment that pays on the basis of the patient's condition (all office services directly provided by the primary care provider are aggregated into the visit payment, using Ambulatory Patient Groups)

Phase 2: Adjust the visit amount based on the patient's overall burden of illness (e.g., using Clinical Risk Groups), and based on the primary care provider's historical ordering efficiency (in terms of ordering services delivered by other providers) and resource-based quality of care outcomes. Adjustment factors are prospectively applied but retrospectively established.

The efficiency/outcome adjustment is directly related to the level of risk selected by the primary care practice (i.e., its scope of services)—ranging from primary care services for a single visit to all health care resources except hospital care. The primary care provider is not responsible for paying for other providers' services but is accountable for relative efficiency. Payment = APG payment (times) patient burden of illness adjustment (times) efficiency adjustment based on level of risk chosen by provider.

Comprehensive Primary Care Payment: [38]
Monthly risk- and needs-adjusted* comprehensive payment for any primary care practice that qualifies as an "advanced medical home". Substantial part of the payment, e.g., 15%-25%, is performance/outcomes based and paid as a bonus for achieving valued outcomes. Performance/outcome goals used for the bonus are risk- and needs-adjusted as well.

Comprehensive payment is not based on aggregating current fee schedule-based payments but rather covers all practice expenses and salaries related to operating an advanced medical home, including dollars for essential infrastructure and systems, especially interoperable electronic health records with decision support. ("Formula" or mechanism to calculate the comprehensive payment is unclear.)

*Risk-adjustment would account for diagnoses, i.e., patient illness burden; needs-adjustment would account for behaviors, psychosocial factors, and social environment.

Case Rate Payment: [39]
- **Condition-specific**

Periodic payment to a group of providers to cover all care management, preventive care, and minor acute services (i.e., all outpatient services) associated with their patients' care, especially *patients with chronic illness(es), over a pre-defined period of time*. Payment varies based on patient characteristics—conditions they have and other factors affecting the care they need. Bonuses and penalties to the provider group are based on health outcomes, patient satisfaction, and patient use of major acute care services. Payment is made to the primary care provider who has relationships with other providers likely needed based on a pre-defined set of services for the condition; primary care provider pays for other services out of the condition-specific payment. Includes the use of "warranties", i.e., providers agree to address errors or preventable complications without additional payment.

- **Episode of Care**

Similar to condition-specific except (a) the payment covers all services needed by a patient during a pre-defined episode of care for a *patient's acute condition* (e.g., heart attack, broken hip). The provider group includes all hospital, physician, other facility providers, etc. involved in the patient's care. As with condition-specific, payment varies based patient's characteristics; bonuses and penalties apply; one party receives payment and apportions it to the others; envisions use of warranties.

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[37] As described in Goldfield, N., Averill, R., Vertrees, J., Fuller, R., Mesches, D., Moore, G., Wasson, J., and Kelly, W., Reforming the Primary Care Physician Payment System, Eliminating E&M Codes and Creating the Financial Incentives for an "Advanced Medical Home", *Journal of Ambulatory Care Management*, 31(1), 2008, pp 24-31.

[38] As described in Goroll, A.H., Berenson, R.A., Schoenbaum, S.C., and Gardner, L.B., Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care, *Journal of General Internal Medicine*, 22, 2007, pp 410-415.

[39] As described in Miller, H.D., *From Concept to Reality: Implementing Fundamental Reforms in Health Care Payment Systems to Support Value-Driven Health Care, Working Draft*, Network for Regional Healthcare Improvement, Healthcare Payment Reform Series, Discussion draft for 2008 NRHI Healthcare Payment Reform Summit, Version 2.0, July 21, 2008; Miller, H.D., *From Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs,* Network for Regional Healthcare Improvement, Healthcare Payment Reform Series, Recommendations of the 2008 NRHI Healthcare Payment Reform Summit, 2008; de Brantes, F. and Camillus, J.A., *Evidence-Informed Case Rates: A New Health Care Payment Model*, The Commonwealth Fund, April 2007.

B. ASSESSING OPTIONS

Given the array of options, the question arises as to whether any of them are more or less viable candidates for inclusion in a Washington state multi-payer medical home payment pilot. As a start for answering that question, Figures III-3 and III-3a provide high-level summaries of the pros and cons of the options vis-à-vis supporting the development and sustainability of primary care medical homes.

Figure III-4 follows the pro/con analysis and provides a rating of each option based on five broad criteria of interest:

- operational feasibility;
- applicability to primary care practices with different characteristics;
- likelihood of leading to, and sustaining, systemic changes;[40]
- ability to implement in a budget neutral manner; and,
- likelihood of positive impact on primary care as a profession.

Figure III-4 also notes other issues not addressed or rated at this time but nonetheless important considerations for any multi-payer payment pilot.[41]

Our interpretation, synthesis, and analysis of the literature and current payment-reform initiatives suggest the following:

- The Fee-for-Service "Plus" options are relatively easy to implement for both providers and payers, and apply equally well to providers with different characteristics. However, they are not likely to lead to desired, sustainable, systemic change; will likely require additional funding at implementation (i.e., not be budget neutral); and, will only help marginally in sustaining primary care as financially and professionally viable (although these options clearly have value as transition tools and for partially addressing the current financial instability of some primary care practices).

- The Payment Re-Engineering options can be more challenging to implement (especially the options with which there is little practical experience), and are less applicable to certain types of practices (e.g., solo and rural providers). However, they are more likely to achieve the long-term goal of a high-performing system, have *potential* for a budget neutral implementation, and provide greater opportunity for practices to afford to be 21st century medical homes – although many practices may never be able to operate at a level to accept payment via some of these approaches.[42]

[40] Desired systemic changes include improvements in health outcomes, reductions in health care costs per person, and improvements in the process of care (e.g., fewer errors of omission and commission, achieved in part by emphasizing "appropriate" care).

[41] It is likely that after a multi-payer group has organized and adopted a set of payment principles, they would use a more extensive rating scheme than is presented here (e.g., payment options rated against each of their principles).

[42] The key to implementing the Payment Re-Engineering options is not to repeat the problems of the 1990s when practices accepted insurance and performance risk unaligned with their capabilities. The early capitation models were not adjusted for health risk (illness burden and comorbidities), and in certain full-risk capitation arrangements (e.g., percent of premium), practices were expected to bear insurance (underwriting) risk in addition to the costs of hospital and selected subspecialty services well beyond their immediate scope of control. These earlier full-risk models also did not build a "risk premium" into payments to compensate for bearing economic risk. These shortcomings should be remedied in future pilots using bundled payment.

It should be noted that the pros/cons analysis and rating summary are high level and examine each option as if it occurred by itself, in a vacuum, uninfluenced by surrounding context. The true value of a payment option, however, can only be assessed (1) when placed in the context of an overall payment/incentive strategy (e.g., how it blends with other financial and non-financial incentives), (2) when its operational details are defined (e.g., the amount of an add-on payment), (3) when it is specifically tied to payment "for what" (e.g., care coordination or a registry system), and (4) by its linkage to accountability for improved efficiency, patient experience, and health outcomes. A multi-payer collaborative interested in pilot testing and evaluating impacts of alternative payment options will need to address these four issues -- the information presented here provides sufficient background to get started.

Medical Home Reimbursement Project Figure III-3: Pros and Cons of Payment Options in Support of Primary Care Medical Homes			
Option	**Why this option would support the medical home model[43]**	**Pros**	**Cons**
Existing fee-for-service	It does not.	It exists.	It is the antithesis of aligning payment with support of patient-centered, primary care medical homes. It rewards providing *more* care, not *better* care.
FFS Plus: Code-based (adds or modifies payment for existing codes)	Conveys message that certain codes associated with medical home characteristics are important enough to warrant special reimbursement recognition.	Easiest change to make operationally, especially if focuses on higher reimbursement for codes we already have but do not currently pay for. Likely to require minimal system changes, either for providers or payers. Many examples from other state/payer initiatives to draw from. Applicable to any primary care practice, using any business model, at any stage of development or size. Maintains incentive to see patients in office setting when appropriate. Provides additional revenue to practices.	Does little to alter the underlying disincentives of rewarding volume and inefficiency, and penalizing quality. Incentives still strong for high-cost intensive procedures compared to high-value preventive care and chronic illness management. Does little to foster overall accountability for efficiency and outcomes across all settings and providers. May be hard to set up in budget neutral manner, i.e., likely to require new dollars at least in the short term.
FFS Plus: Non-Code-Based (adds a pre-determined fixed payment that is not code-dependent)	Recognizes that certain elements of medical homes, and the systemic changes needed to support them, do not lend themselves well to "code-based" reimbursement, i.e., a different form of payment is needed. This is especially true in the areas of care coordination/care management, process/office redesign, enhanced access through non-traditional means (e.g., open scheduling, expanded hours, new options for communication, group visits), leadership for change, and health information technology (e.g., registries, decision support tools) needed to support medical home activities.	Relatively easy to do (although may be slightly more difficult for some payers, e.g., Medicaid due to federal restrictions). Starts moving system away from sole emphasis on volume; potential to promote greater efficiency (depending on what payment is for); recognizes upfront costs to transform and sustain transformation. Significant flexibility in design—payer can be specific about what the payment is to be used for or can define desired outcomes and let practice determine how best to achieve the goals. Equally applicable to primary care practices at various stages of medical home development and size.	Raises need for some kind of case-mix adjustment (risk-based, needs-based, peer grouping) of add-on payment, which is inherently more complex to do. Only marginally better than "FFS Plus: Code-Based" option at getting to underlying disincentive problems. Focuses payment on a subset of medical home characteristics rather than creating a payment design aligned with the medical home concept as a whole. May be difficult to set up in budget neutral manner, at least initially (payers may be reluctant to pay upfront transformation amounts—costs today in exchange for *possible* future savings may be a hard sell).

[43] Medical home = "an approach to delivering primary health care through a 'team partnership' that ensures health care services are provided in a high quality and comprehensive manner – accessible and continuous, coordinated and comprehensive, family-centered, compassionate and culturally effective". University of Washington Medical Home Leadership Network and state Department of Health, *Washington State Medical Home Fact Sheet*, July 2007. (www.medicalhome.org/about/medhomeplan.cfm).

Medical Home Reimbursement Project Figure III-3: Pros and Cons of Payment Options in Support of Primary Care Medical Homes			
Option	**Why this option would support the medical home model[43]**	**Pros**	**Cons**
Bundled Fixed Payment Options, considered as a group (options just short of full-risk capitation), e.g., a. Visit-based payment system (e.g., Goldfield, et al) b. Comprehensive primary care payment (e.g., Goroll, et al) c. Case rate payment: Condition-specific and episode of care (e.g., Miller; de Brantes, et al) See Figure III-3a for pros and cons specific to each of the three bundled examples listed above.	Does much better job than any of the "FFS Plus" options in aligning payment with more advanced levels of medical home activity – patient-centered, coordinated, efficient care that results in better outcomes. Provides environment in which primary care providers can afford to provide a medical home and be rewarded and held accountable for efficiency and outcomes.	Assuming a good design and effective implementation: the more bundled the payment the higher the incentive for more efficient and higher quality care; higher percents of payment can be tied to performance/outcomes putting the emphasis where it should be. Motivates need for systems and processes to support coordination and management. Allows provider flexibility to use best combination of services, providers, facilities for maximum value. Encourages organized care systems—whether among primary care providers alone or across provider types and settings. May be more amenable than "FFS Plus" options to an initial design that is budget neutral, with ability to put dollars at risk and to implement shared savings.	Likely to take more work than "FFS Plus" options to get bundled payment "implementation ready", for both providers and payers—little practical experience with these options to-date in primary care (some experience with surgical care bundling). Some versions of bundled payment are harder to do (depending on episode, condition, or provider type emphasis). Clear need for risk- and/or needs adjustment; and for understanding separation/integration of insurance risk and provider performance risk. Bundling across provider types and settings may be most effective but is also beyond the focus on primary care practices. Raises question of what provider is linked to which aspects of performance. Less feasible for practices of all sizes and stages of development, i.e., requires a more advanced stage of medical home development and organization.
Full-risk (insurance and performance) population capitation, i.e., single payment to cover the full continuum of services of a given patient population for a given period of time (The final step in bundled payment.)	The final step in bundled payment, it provides a strong incentive for implementing the breadth of characteristics associated with advanced medical homes, and holding providers accountable for quality and efficiency outcomes. By definition, this level of bundling cuts across all provider and facility types; includes full insurance and performance risk.	Same as with bundled payment above, only more so -- stimulates organization of care and spurs optimal care and efficiency over the continuum of services.	Many of the same concerns as with bundled payments. Works best within a highly integrated, organized care delivery system that includes all parts of the care spectrum (primary, specialty, facility), so is not applicable to many primary care practices. Level of financial risk involved is not realistic for most primary care practices; administrative challenges for aggregating all services may be impractical. Need to be clear on why earlier versions of this in 1990s did not work well (e.g., lack of risk/needs adjustment, full transfer of insurance risk to practices not able to accept it, lack of emphasis on performance risk to guard against under-service, insufficient recognition of costs of infrastructure and effective processes).

Note: Eligibility for any of these options assumes a practice meets, or is well positioned and in the process of meeting, a baseline level of being a medical home.

Medical Home Reimbursement Project Figure III-3a: Pros and Cons for Three Variations of "Bundled" Payment Options Shown in Figure III-3		
Bundled Payment Option	**Pros**	**Cons**
Visit-based payment system (Goldfield, et al)	Payment approach *builds-in* adjustments for patient burden of illness and for motivating efficiency and quality outcomes. Accommodates practices based on the level of risk (scope of services) a practice wants to accept (and an insurer wants to transfer) for coordinating care. Does not increase administrative burden on providers – submit claims as currently do. Insurers have all the information needed to develop the adjustment factors. Budget neutral implementation may be possible—but uncertain (not tested out). Fewer design issues than other "bundled" options (many of component pieces have been in use, e.g., Ambulatory Patient Groups to bundle services).	Insurers have to develop and update the adjustment factors (e.g., annually for patient burden of illness and every 6 months for efficiency and resource-based quality-of-care outcomes), but they have all the information needed to do so. May be less explicit in recognizing need for, and upfront costs of, infrastructure changes needed to support advanced care coordination and management activities (process redesign, information and decision support systems, leadership activities).
Comprehensive primary care payment (Goroll, et al)	Payment is built from bottom-up to recognize all resources (people and systems) needed to run advanced medical home. Payment is risk/needs adjusted so burden of illness is explicitly recognized. Addresses clinical and financial accountability at practice level – (a) substantial portion of payment, 15-25%, is performance and outcomes based, (b) practice has to work within a global monthly budget so some financial accountability is built-in. Eliminates claims billing. Focus is strictly on primary care practice scope of services so fewer issues re financial risk for services delivered by other providers (alternatively, this may make it less applicable to some larger, more integrated practices).	Much less clear how this would work at a practical level – many complicated design and implementation issues to address and test. Eliminating claims billing is problematic; claims data are used to assess process and outcome measures, and for reassessment of payment over time. Budget neutrality in short run is unlikely. (Net increase in total practice revenue is likely; over 2/3 to teams and systems essential for improving care). Potential for abuses may require audit activities. May be unintended consequence of practice downsizing.
Case rate payment: Condition-specific or episode of care (Miller; de Brantes, et al) Condition-specific: focus is case rate for specific patients with chronic conditions for specific time periods; can be structured to apply to "wellness condition" so is applicable to entire patient population Episode of care: focus is case rate for acute episodes (with identifiable beginning and end)	Case rates are negotiated between provider group and payer; however, an external entity determines services/costs included in the case rate so there is uniformity in baseline definitions. Single payment is made to group of providers (group defined by who needs to provide services for a given condition or episode), so strong incentive for efficient coordination and use of services. Condition-specific option may fit better in terms of primary care taking the lead (acute episode group goes well beyond primary care to include all hospital, physician, home health agencies, etc. involved in patient's care for that episode). Payment amount varies based on patient characteristics. Lends itself well to "warranties", i.e., no adjustment to payment to cover adverse events. Payment is determined prospectively; opportunity for up or down retrospective adjustment based on level of outcomes achieved.	Same "implementation ready" concerns as with comprehensive primary care payment, i.e., not clear how this would work at practical level. Clear need for mechanism to accept and divide payment up among provider groups (all bundled options face this "attribution" issue but it is especially strong here). Similar attribution issues arise around performance accountability (e.g., who takes responsibility for a preventable hospital readmission?). May risk creating an incentive for a fragmented view of patient care (i.e., condition by condition).

Medical Home Reimbursement Project Figure III-4: Relative Rating of Payment Options Against Five Criteria				
* = rates lower on the criterion *** = rates higher on the criterion	**FFS Plus: Code-Based**	**FFS Plus: Non-Code Based**	**Bundled (3 variations combined)[44]**	**Full-Risk Capitation**
Operationally feasible (systems and processes) to implement in short-term for both providers and payers	***	***	* (a)	**
Equally applicable to provider practices at different stages of medical home development, different levels of integration, and different sizes and locations	***	***	* (b)	*
Likely to lead to desired systemic changes that are sustainable (including resulting efficiency and quality outcomes)[45]	*	* (plus) (d)	** (c)	***
Easier (relative to other options) to implement in a budget neutral manner	*	*	**	***
More likely to have positive impact on revitalizing primary care as a desirable specialty and making it possible to afford to function as a medical home	*	**	***	***

(a) Visit-based version is much more "operationally ready and feasible" than other bundled versions; probably would rate ** on its own.

(b) Visit-based version is more adaptable (than other bundled versions) to practices across a range of "risk assumption" capability (based on scope of services a practice wants, and is able, to assume responsibility for); probably would rate ** on its own.

(c) Visit-based version by itself would rate *** because of built-in adjustments for motivating efficiency and quality outcome improvements.

(d) Plus = Not very effective at leading to systemic changes, but more so than code-based FFS Plus.

Other important issues that cannot be rated at this time:

- Critical mass of payers and providers (and thus patients) is willing to develop and test the option
- Special considerations are needed for applying the payment option in a managed care compared to fee-for-service/self-insured environment
- Positive return-on-investment (for payers and providers) is observable within short-term; within long-term. (Highly dependent on the specifics of what is implemented: how it blends with other components of overall payment strategy, operational details (e.g., the amount of an add-on payment), tied to "for what" (e.g., care coordination or a registry system), and linkage to accountability for improved efficiency, patient experience, and health outcomes.)

[44] Rating for bundled options is across all three variations (visit-based, comprehensive primary care, case rate). Where variations might differ substantially on a criterion it is noted in the figure.

[45] For example, improvements in health outcomes, reduced health care costs per person, and improvements in the process of care (e.g., fewer errors of omission and commission, achieved in part by emphasizing "appropriate" care).

C. PAYMENT STRATEGY

The previous discussion took a narrow view of payment options – considering each as if it existed in a vacuum. Payment strategy, the focus of this section, is less about stand-alone options and more about effective grouping of the options. Keeping in mind the assumption of a multi-payer pilot, the following three suggestions are made for initiating a broader audience discussion on payment strategy.

***First*,** a limited review of current and proposed initiatives across the country indicates considerable agreement on several points: phasing, defined medical home characteristics, and accountability.[46] These points provide a starting place for developing consensus among potential partners around implementation focus.[47]

The first area of agreement is on "phasing". A phased approach, based on a practice's stage of medical home development is recommended. Examples of phasing include how a practice is paid (e.g., starting with FFS "plus" options and moving to more comprehensive payment) and the degree of accountability to which a practice is held. Pilot programs may also phase-in who participates, starting with those who meet a baseline of readiness for change, are most interested, or are most capable of providing a "test" of the viability of a new payment approach. The national Patient-Centered Primary Care Collaborative (PCPCC)[48] summarizes a two-phase strategy: phase one promotes transformation objectives and phase two pushes for improvement among transformed practices (often by putting dollars at risk and/or sharing savings). The goals are first to ensure that practices are able to meet a basic platform of care and subsequently to push for continued improvement and value.

There also is substantial agreement around the need for four specific elements of a medical home:

1. improved care coordination (across providers, settings, and patients and their families),
2. medical home related health information technologies (notably registries, electronic health records, and decision support tools),
3. some form of organization/integration in support of the first two elements (i.e., networks or other established relationships and mechanisms for working across providers and settings)[49], and
4. activation of patients as partners in their care and participants in quality improvement (e.g., via patient experience feedback).

[46] There are two notable issues for which there is less agreement. One issue is whether practices should be required to meet certification or accreditation standards (e.g., PPC-PCMH™ developed by NCQA, see Section II) to receive improved payment. The argument is that establishing strict standards is premature until more is known about which specific medical home processes and structures, and combinations of them, produce better outcomes. The second issue is whether a payment pilot program should focus on all consumers or those who use large amounts of health care resources. A reasonable compromise is "Pilot projects should support care changes that can benefit large numbers of patients but should focus on specific patients and conditions with significant potential for improvements in value." (Miller, H.D., *From Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs*, Network for Regional Healthcare Improvement, Healthcare Payment Reform Series, Recommendations of the 2008 NRHI Healthcare Payment Reform Summit, 2008, see recommendations 1.1 and 5.2.)

[47] A set of framing questions was used with the Agencies to facilitate discussion around scope, scale, and issues of interest and agreement. With some refinements, this tool could also be used with a broader group of potential partners. (In using the tool with state agencies it was clear that some items were less useful than others and a few important questions were left out.) Appendix III-1 contains the (unrefined) set of questions.

[48] See www.pcpcc.net

[49] For alternative ways of organizing providers see Shih, A., Davis, K., Schoenbaum, S.C., Gauthier, A., Nuzum, R., and McCarthy, D., *Organizing the U.S. Health Care Delivery System for High Performance*, Commission on a High Performance Health System, The Commonwealth Fund, August 2008.

Finally, there is near universal agreement that payment reform must include accountability for improvements in efficiency, quality, patient experience, and health outcomes. In the final analysis, support of medical homes must contribute to:

- Enhancing access to primary care through non-traditional means such as open scheduling, expanded hours, and new options for provider-patient communication,
- Improving patient satisfaction with the care experience,
- Decreasing unnecessary emergency room visits,
- Reducing preventable hospital admissions and readmissions,
- Preventing urgent and emergency hospitalizations for chronic illnesses, and/or
- Steering referral care to high-quality specialists who have uniformly adopted evidence-based intervention practices and sparingly use "supply sensitive" services[50],

Second, a two-path strategy is recommended as a place to start discussions on a multi-payer medical home payment pilot. Figure III-5 outlines two paths, which by intent parallel the two broad classes of payment described earlier – Fee-for-Service "Plus" and Payment Re-Engineering.

- The Path 1 strategy applies mainly to primary care practices less evolved in terms of medical home stage or less likely to be part of organized networks. Payment has three parts: (1) increased reimbursement for selected codes that specifically address important medical home components (with the potential for higher payments to practices achieving a more advanced stage of development); (2) a monthly, risk-adjusted, care coordination and technology support payment (with the potential for a higher monthly amount to practices that participate in virtually or physically organized networks); and (3) performance/accountability incentives.[51]

- The Path 2 strategy is for primary care practices that are ready and able to handle a completely revamped payment approach that cuts across provider types and care settings, and fully trades volume for value. Varying levels of *bundled and risk-adjusted payment* are used (likely paid on a monthly basis); the final level being full-risk capitation in which the practice accepts all insurance and performance risk for all providers, settings, and services. Performance/accountability incentives are involved that put some percent of payment at risk, offer the opportunity for shared savings, and include agreements by the practice to address errors and avoidable complications without additional payment (within reason).

If a multi-payer payment pilot does occur, practices should be recruited that allow both paths to be pursued simultaneously. *Given this two-path approach, each of the four payment options discussed earlier has a potential role to play in supporting the medical home model.* Thus, in answer to the directive in E2SHB 2549 to assess options with applicability across payers: no options should be off the table at this point except the "do nothing" option. (However, some variations of "bundled payment" may be more immediately viable than others, e.g., Goldfield's visit-based approach compared to Goroll's comprehensive payment approach.)

Proposed Path 1 is by far the more common strategy among on-going or proposed initiatives. It closely parallels the three-part model recommended by the PCPCC.[52] This is the path most likely in-sync with the majority of primary care practices that might participate in the DOH medical home collaborative, for which E2SHB 2549 requests development of supportive payment approaches.[53]

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[50] "Supply sensitive" services are services where utilization is strongly associated with the local supply of health care resources, i.e., more supply results in higher utilization and costs independent of what the evidence might show in terms of effectiveness. Examples of "supply sensitive" services are tests and imaging procedures, and use of the hospital as a site of care.

[51] The performance/accountability incentives should (a) hold teams as well as individuals accountable, (b) enable and push improvement in clinical and service outcomes, and in infrastructure elements, and (c) use a combination of "positives and negatives", i.e., bonuses, penalties, shared savings.

[52] The PCPCC model includes: (1) a fee-for-service component to recognize visit-based services currently paid under the present system, (2) a monthly care coordination payment for work that falls outside of face-to-face visits and for health information technologies to achieve better outcomes, and (3) a performance-based component that recognizes achievement of quality and efficiency goals. See www.pcpcc.net. (Above language is a close but not exact quote from PCPCC's May 2007 release of *Proposed Hybrid Blended Reimbursement Model.*)

[53] E2SHB 2549 requests that payment approaches be determined for use in the Collaborative that would be applicable to at least the following outcomes and medical home activities:

Proposed Path 2 is less common but is an important strategy to pursue. As noted by the Commonwealth Fund program on a high performing health system, "we recommend that payers move away from fee-for-service toward bundled payment systems that reward coordinated, high-value care".[54] Initial discussions with Washington primary care practices indicate that some feel ready to move in this direction.

Third, to help inform any multi-payer discussions, Figure III-6 provides a select sample of how payment strategies do/could play out in real life. These represent only a handful of the many good models; they were selected because of the range of factors they encompass – local/non-local, levels of system integration, types of incentive programs including shared savings, fee-for-service/bundled payments, transitional payments, use of tiering, target populations, payment adjustments based on patient characteristics, and multi-payer involvement. Consistent with the characteristics of most primary care practices, it is not surprising that "Path 1" variations dominate the landscape. With the exception of Group Health and Swedish/Ballard, all examples are variants of the "Path 1" strategy. Other than listing these two examples last and non-local efforts first, the examples in Figure III-6 are in no particular order; and, the descriptions focus solely on payment strategy, not other important components of the programs.

Additional examples of "medical home support" payment options are in Appendix III-2. The information, from a September 2008 presentation to the Washington Primary Care Coalition, provides useful details about payment models *and* payment amounts being used in those models.[55]

- Ensure all patients have access to and know how to use a nurse consultant,
- Encourage female patients to have a mammogram on the evidence-based recommended schedule,
- Effectively implement strategies to reduce patients' use of emergency room care in cases that are not emergencies,
- Communicate electronically with patients, and
- Effectively manage blood sugar levels of patients with diabetes.

[54] Shih, A., Davis, K., Schoenbaum, S.C., Gauthier, A., Nuzum, R., and McCarthy, D., *Organizing the U.S. Health Care Delivery System for High Performance*, Commission on a High Performance Health System, The Commonwealth Fund, August 2008.

[55] Bailit, M., *National Reimbursement Models and Alignment with Washington State Initiatives*, Bailit Health Purchasing, September 15, 2008; prepared for Washington State as a participant in the State Quality Improvement Institute program, sponsored by The Commonwealth Fund and AcademyHealth.

Medical Home Reimbursement Project
Figure III-5: Potential Payment Strategy – A Two Path Approach

	Proposed Path 1	Proposed Path 2
Practices Targeted:	Primary care practices less evolved in terms of medical home stage (by choice or circumstance), or less likely to be part of organized networks and/or fully integrated systems	Primary care practices ready and able to handle a completely revamped payment approach that cuts across provider types and care settings, and fully trades volume for value (accepting certain levels of insurance risk as well as performance risk).
Pay How:	Variation on PCPCC three-part model, to likely include: • Increased reimbursement on selected codes that specifically address important medical home components; *with higher payment to practices achieving a higher index of medical home* (may also require activation of some codes not currently reimbursed) • Monthly, risk-adjusted, care coordination and technology support payment. Consider higher monthly amount if practice is part of an organized network, with some amount of payment going to network as well as individual practice. • Performance/accountability incentives, noting that (a) teams as well as individuals should be held accountable for performance, (b) improvements need to be enabled and pushed in 3 areas—clinical and service outcomes, and infrastructure elements, and (c) combinations of bonuses, penalties, shared savings, and incentive pools should be considered.[56]	Risk-adjusted, needs-adjusted, bundled or fully capitated payment, depending on level of primary care practice integration across provider types and settings. Includes performance/accountability incentives that put some percent of payment at risk and offer opportunity for shared savings resulting from better outcomes and increased efficiencies (including full or partial warranties in which providers agree to address errors and avoidable complications without additional payment, within reason).
Relative Emphasis of Payment:	Initially: support the costs of transforming, including learning and leadership Increasingly: greater and greater emphasis on performance-based payment and less on payment in support of transformation	Continuous improvement: motivate and reward achievement of continuously higher quality and increased efficiency

PCPCC = Patient-Centered Primary Care Collaborative

[56] The performance/accountability component is often termed pay-for-performance. As defined by the Institute of Medicine, pay-for-performance is entirely consistent with medical home transformation efforts, i.e., "Pay for performance is not simply a mechanism to reward those who perform well; rather, its purpose is to encourage redesign and transformation of the health care system to ensure high-quality care for all. In such a system, all participants, providers, purchasers, and beneficiaries can potentially benefit." Institute of Medicine, *Rewarding Provider Performance: Aligning Incentives in Medicare*, National Academies Press, August 2006.

	Medical Home Reimbursement Project **Figure III-6: Sample Payment Implementation Models[57]** **(see Appendix III-2 for additional examples)**
Medicare Demonstration	• FFS for Medicare covered services continues • Monthly care management fee to physicians for medical home services • Incentive payment for the medical home practice based on shared savings (shared savings are reduced by amount of care management fees) • Payments tied to level of medical home recognition based on NCQA PPC-PCMH™ (2 tiers)
New York - Mid Hudson	• FFS continues • Structural component – determined by achieving Level 2 recognition based on NCQA PPC-PCMH™ • Outcomes component – based on process and outcomes HEDIS measures derived from aggregated administrative data received from participating health plans
New York - Emblem Health	• FFS continues • Care management payment – equal to a maximum of 7% of the average physician's revenue from the covered patients adjusted for the severity of risk of the physician's panel and the practice's level of Medical Home recognition (based on NCQA PPC-PCMH™ plus some home-grown questions) • Performance based payment – equal to a maximum of 7% of the average physician's revenue from covered patients based upon results on performance measures related to clinical quality, efficiency and patient experience
North Carolina	• FFS continues • Fixed pmpm to providers for working together to create a medical home and for giving data to the state • Fixed pmpm to local networks (in which provider participates) to support shared, local case and disease management staff and activities
Oklahoma	• FFS visit-based component continues with coverage of new codes (e.g., after hours) • Monthly case management/care coordination fee, varies by peer group based on type of panel (children only, adults and children, adults only) and practice capabilities defined by 3 tiers based on NCQA PPC-PCMH™ • Pay-for-excellence incentive payments made quarterly, tied to specific quality indicators/activities • Transitional payments in first year to smooth dramatic financial changes to a practice (paid quarterly)
Pennsylvania - Southeastern	• FFS continues • Medical home and care management supplemental payment – based on documented level of NCQA PPC-PCMH™ recognition (with financial help to get to Level 1 within 12 months) • Performance based payment – with expectations related to practice redesign, patient registry or electronic medical record use
Pennsylvania - Geisinger	• Per physician per month amount to recognize expanded scope of practice as a medical home • Per enrollee (Medicare count) per month amount as transformation stipend to finance practice infrastructure changes • Incentive pool based on difference between actual and expected total cost of care for medical home enrollees (tied to meeting quality performance indicators; amounts prorated based on percent of targets met; incentive payments are split between individual providers and the practice to encourage team-based care and support)
Vermont-Blue Cross/Blue Shield	• FFS continues with increased rates (6% fee enhancement) to qualifying practices for certain codes – office-based E&M, consultations, preventive medicine, and counseling (applies to all patients, not just those with chronic conditions)

[57] Some of the examples are working models; others are in design or proposal phase, or are simply suggested ways of proceeding. The *summaries focus solely on payment strategy* and do not attempt to capture other important and complementary program components (e.g. non-financial incentives such as public reporting).

	Medical Home Reimbursement Project **Figure III-6: Sample Payment Implementation Models[57]** **(see Appendix III-2 for additional examples)**
Vermont-Blueprint Medical Home Pilot	• FFS continues • Sliding scale pmpm incentive payment based on level of medical home development using NCQA PPC-PCMH™ standards • Insurers pay .19% tax to establish HIT systems for practices to track patients' care and progress, receive information on evidence-based care, and identify at-risk patients
WA – Medicaid (Children's Health Improvement System-5 year plan, 2009-2013)	• Enhanced payment for active billing codes, and activation of other codes, related to care management and other medical home characteristics • Changes to policies so existing codes can be reimbursed more frequently (e.g., well child visits for adolescents) • Incentive payments for delivery of certain services (e.g., preventive dental, after-hours care) • Potential grant funding for health information technology to small and mid-sized clinics • Performance incentives
WA – Puget Sound Health Alliance (recommendation of Asthma Clinical Improvement Team)	• Tier 1: additional reimbursement for meeting qualification standards for a patient-centered medical home • Tier 2: Tier 1, plus pay for performance for meeting designated targets for process of care or outcome measures
WA – Northwest Physician Network	Flat fee paid at each of 5 tiers to encourage and support behavior change and to reward sustained efforts and leadership
WA – Orthopedic and Neurological Surgeon Quality Pilot	Not a medical home related pilot but uses a strategy that could be transferable 3-tier incentive payment model: incentive payments based on meeting thresholds for 6 quality indicators representing 3 tiers of performance; incentive payments are progressively higher for higher tiers; evaluation of tier placement every 6 months
WA – Boeing (Ambulatory Intensive Care Pilot)	FFS continues PMPM amount is paid for care management (e.g., practice-embedded nurse case manager)
WA – Group Health (Access Initiative)	• Primary care provider is guaranteed 80% of base salary plus variable compensation up to 120% of the base salary • Variable compensation component is based on individual physician productivity and attainment of objectives for service quality and coding accuracy (with monetary incentive to respond to patient e-mails)
WA – Swedish/Ballard Clinic proposal	• Risk-adjusted, value-based capitated payment (per member per month or per year) • Percentage of payment (up to 20%) tied to specific metrics • Gain-share bonus program for system savings

E&M = Evaluation and Management
FFS = fee-for-service
HIT = Health Information Technology
NCQA PPC-PCMH™ = National Committee for Quality Assurance, Physician Practice Connections® - Patient-Centered Medical Home Standards
HEDIS = Healthcare Effectiveness Data and Information Set
PMPM = per member per month

SECTION IV: SUGGESTIONS AND NEXT STEPS

Section IV is specific to the "payment change" assignment of E2SHB 2549. It includes Agency suggestions for moving forward to change primary care reimbursement in support of a medical home approach to delivering care. Section V, Progress of the Medical Home Collaborative Program, follows and likewise includes "next step" suggestions for the collaborative.

With respect to the payment assignment, DSHS and HCA were asked to consider alternatives for changing primary care reimbursement that might have applicability beyond state programs and that would be feasible and of interest to other payers such as "Medicare, other federal and state payors, and third-party payors, including health carriers under Title 48 RCW and other self-funded payors."[58]

This language, in combination with lessons from early-implementers of medical home reimbursement projects, means*: any payment change program needs to be piloted as a multi-payer effort.*[59]

A: NEXT STEPS FOR MOVING TO A PILOT PROGRAM

- **Convene**: A neutral, respected convener is needed to bring affected groups together and get commitments for action to develop a pilot program within a reasonable time period. Large efforts such as this, particularly when outlays of money might be involved, need a respected champion and taskmaster with statewide presence and credibility. No single payer, purchaser, provider group, consumer or advocacy organization can play that role. Although other options exist, Pennsylvania offers an effective model: their multi-payer effort was initiated by a Governor-established commission (the Chronic Care Commission); championed by the Governor; and, had convening, organizing, and staffing support from the Governor's Office of Health Care Reform. An initial meeting with Washington payers indicates enthusiastic support for moving forward collectively, under the aegis of a neutral convener, to pilot reimbursement changes in support of primary care medical homes. On behalf of providers, the Washington Primary Care Coalition is equally ready to move forward on care and payment transformation.

- **Maximize Effect**: Links, where possible, to other medical home efforts should be considered in development and design work, allowing for a much richer pilot design. Examples of this include:
    - The DOH Medical Home Collaborative: Continued funding for the Collaborative (beyond what is currently in budget) could provide learning, information technology, and coaching support to potential pilot practices. Practices whose level of medical home sophistication exceeds Collaborative scope could serve as coaches to less developed practices within the Collaborative. Peer leadership is an important element for disseminating change – a leadership "award" (similar to the "spread leadership award" used by Northwest Physicians Network) could be offered.
    - Medicare Medical Home Demonstration Project and the Safety Net Medical Home Initiative (funded by the Commonwealth Fund and offered by Qualis Health and the MacColl Institute for Health Care Innovation): Imagine the potential to test payment changes if there were a multi-payer payment pilot that included practices participating in the Medicare and safety net initiatives, that also served state payer and commercial populations. Selection of practice sites for both initiatives occurs in early 2009 and bears watching.

[58] See Figure I-1, Section I, of this report: E2SHB 2549, Section 3(1).

[59] Payers, purchasers and providers all need to work together to ensure a critical mass of consumers is covered in any pilot program. A single payer's market share may not be sufficient to motivate and measure change. Likewise, payers' incentives must align so the incentives do not work against each other, and do not create burdensome and unrealistic expectations for providers' practice of their profession.

- **Provide Continued Funding**: In the 2009 session, the Legislature could provide, at a minimum, resources for design and development, project implementation and operational oversight, and pilot evaluation. Continued funding of the DOH Collaborative as a training and technology support center is also needed, as is funding to allow state programs (as purchasers and payers) to participate in any future pilot.[60]

- **Identify Legal and Procedural Limits**: State agencies (DSHS and HCA) could begin now to explore legal or procedural issues that might arise given any of the possible payment options discussed in this report. For example, Medicaid may need permission from the Centers for Medicare and Medicaid Services (CMS) to implement a monthly care coordination payment for primary care practices in its managed care program (similar to Arizona). Also, a multi-payer pilot needs to be aware of anti-trust limitations that arise when payers collaborate with one another. And, with respect to bundled payment, there is the issue of how providers can arrange for, and divide, the payment without violating current law (e.g., the Stark Law).[61] The point is to get started earlier, rather than later, on understanding the legal and procedural limits in design and collaboration.

B: PARTING THOUGHTS: A PILOT PROGRAM SHOULD…

- Encompass the two payment strategy paths outlined in Section III. A multi-payer initiative provides an opportunity to test payment options, and combinations of options, within both paths – allowing evaluation of payment change impacts across practices with varied characteristics and levels of medical home development.[62]

- Not focus solely on provider payment change. This report does not address all of the components, other than provider payment, needed for successful medical home transformation and sustainability. The design of an effective pilot program does not have that luxury. For example, designers of a pilot program may want to consider the use of consumer incentives. This could involve incentives to use higher-value providers (when available), treatment options, and preventive services; as well as incentives to adhere to effective care processes and self-management.

- Require a minimal level of "readiness to change" as part of its criteria for participation (e.g., senior manager support, cohesive team, high quality communication patterns).

- Ensure that implementation designs provide an environment in which providers can afford to offer a medical home and be rewarded and held accountable for efficiency and outcomes.

- Use the expertise of early-implementers by inviting their participation in design and evaluation phases.

[60] Although it is hoped that medical home payment-change programs can be implemented in a budget neutral manner, it is likely that in the short-run they will cost money. However, it is reasonable to expect a return on that investment, in terms of reduced total health care costs per person, after two to three years, depending on the care and payment changes adopted.

[61] The Stark Law impacts the Medicaid and Medicare programs. It prohibits physicians from making referrals to facilities/providers in which the physician has a financial stake.

[62] It clearly allows for testing the impacts of specific care changes as well. However, for purposes of this report the focus is on payment.

- Consider several points of agreement listed in Section III around which to build early consensus:
    - Take a phased approach—examples of phasing include how a practice is paid initially and over time, the degree of accountability to which a practice is held, and who participates in the pilot.
    - Focus on a few priority elements of a medical home—examples of elements around which there is considerable agreement are care coordination, health information technology for coordination and decision support, virtual or physical organizational structures (i.e., relationships and mechanisms for working across providers and settings), and patient activation as care partners and participants in quality improvement.
    - Include performance accountability that focuses on:
        - Enhanced access via non-traditional means including new options for provider-patient communication, open scheduling, and expanded hours;
        - Improved patient satisfaction with the care experience;
        - Fewer unnecessary emergency room visits;
        - Reduced preventable hospital admissions and readmissions;
        - Decreased urgent and emergency hospitalizations for chronic illnesses; and/or
        - Referral care that is steered to high-quality specialists who have uniformly adopted evidence-based intervention practices.

- Pay early attention to two issues around which there is less agreement among stakeholders:
    - Whether practices should be required to meet certification or accreditation standards to receive improved payment, and
    - Whether to focus on all consumers or those who use large amounts of health care resources.

- Address consistency between the Medical Home Collaborative and the payment pilot definitions and measures of a medical home.

- Have an explicit plan for evaluating the payment pilots; developed in parallel with the design and implementation details. The evaluation would compare and contrast the process of implementation, and the impacts on efficiency, quality, patient experience, and health care cost per capita, of the different payment options.

- Be developed quickly, putting the need to identify a convener front and center. Only after there is agreement among the parties (purchasers, payers, providers) can a multi-payer initiative move forward and a specific design and implementation timeline be developed. An agreement, *by early 2009*, among payers to move forward collectively will allow completion of major design work by the end of the year. Implementation *in mid 2010* allows the 2010 Legislative session to consider any additional legislative or funding issues needed to support state program involvement.

SECTION V: PROGRESS ON DEVELOPMENT OF THE PATIENT-CENTERED MEDICAL HOME COLLABORATIVE

The Department of Health was charged by E2SHB 2549 to "offer primary care practices an opportunity to participate in a medical home collaborative." (See Figure V-1) This section of the report identifies the progress made to develop the Patient-Centered Medical Home (PCMH) Collaborative, since the Legislature awarded funding and staffing on July 1, 2008. "Patient-centered" has been added to the formal name of the Collaborative to more clearly define the focus, and align it with other national medical home efforts.

Figure V-1: Engrossed Second Substitute House Bill 2549, Section 2

NEW SECTION. Sec. 2. (1) Within funds appropriated for this purpose, and with the goal of catalyzing and providing financial incentives for the rapid expansion of primary care practices that use the medical home model, the department of health shall offer primary care practices an opportunity to participate in a medical home collaborative program, as authorized under RCW 43.70.533. Qualifying primary care practices must be willing and able to adopt and maintain medical home models, as defined by the department of social and health services in its November 2007 report to the legislature concerning implementation of chapter 5, Laws of 2007.

(2) The collaborative program shall be structured to promote adoption of medical homes in a variety of primary care practice settings throughout the state and consider different populations, geographic locations, including at least one location that would agree to operate extended hours, which could include nights or weekends, and other factors to allow a broad application of medical home adoption, including rural communities and areas that are medically underserved. The collaborative program shall assist primary care practices to implement the medical home requirements and provide the full complement of primary care services as established by the medical home definition in this section. Key goals of the collaborative program are to:

(a) Develop common and minimal core components to promote a reasonable level of consistency among medical homes in the state;

(b) Allow for standard measurement of outcomes; and

(c) Promote adoption, and use of the latest techniques in effective and cost-efficient patient-centered integrated health care.

Medical home collaborative participants must agree to provide data on patients' experience with the program and health outcome measures. The department of health shall consult with the Puget Sound health alliance and other interested organizations when selecting specific measures to be used by primary care providers participating in the medical home collaborative.

(3) The medical home collaborative shall be coordinated with the Washington health information collaborative, the health information infrastructure advisory board, and other efforts directed by RCW 41.05.035. If the health care authority makes grants to primary care practices for implementation of health information technology during state fiscal year 2009, it shall make an effort to make these grants to primary care providers participating in the medical home collaborative.

(4) The department of health shall issue an annual report to the health care committees of the legislature on the progress and outcome of the medical home collaborative. The reports shall include:

(a) Effectiveness of the collaborative in promoting medical homes and associated health information technology, including an assessment of the rate at which the medical home model is being adopted throughout the state;

(b) Identification of best practices; an assessment of how the collaborative participants have affected health outcomes, quality of care, utilization of services, cost-efficiencies, and patient satisfaction;

(c) An assessment of how the pilots improve primary care provider satisfaction and retention; and

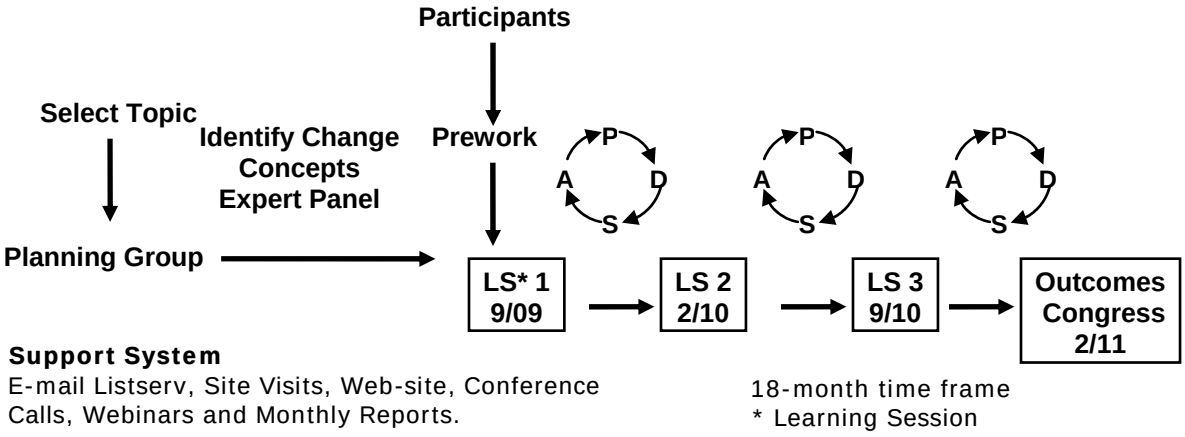
(d) Any additional legislative action that would promote further medical home adoption in primary care settings.

The first annual report shall be submitted to the legislature by January 1, 2009, with the final report due to the legislature by December 31, 2011.

A. BACKGROUND ON COLLABORATIVE METHODOLOGY

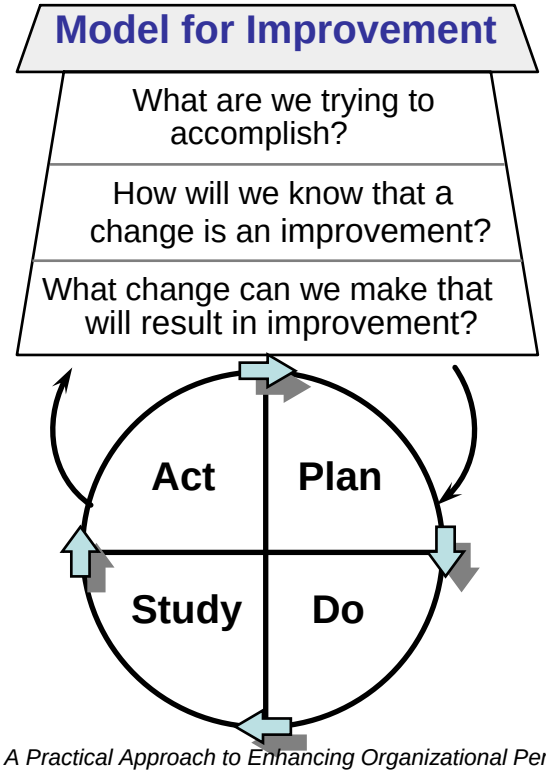
The department has offered training for primary care providers, using the Collaborative methodology, since 1999. Developed by Don Berwick, M.D., president of the Institute for Healthcare Improvement, the Collaborative is a proven method to change health care processes and outcomes. It requires health care teams, i.e., people associated with the medical practice, to share their successes and failures to move toward sustained change. (See Figure V-2)

Figure V-2: Collaborative Process for Patient-Centered Medical Homes



The Model for Improvement is essential to the Collaborative's success; it is shown in Figure V-3. This process breaks change into small, quantifiable steps designed to overcome human resistance to change.

Figure V-3: Model for Improvement



The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. G. Langley, K. Nolan, T. Nolan, C. Norman, L. Provost. Jossey-Bass Publishers., San Francisco, 1996.

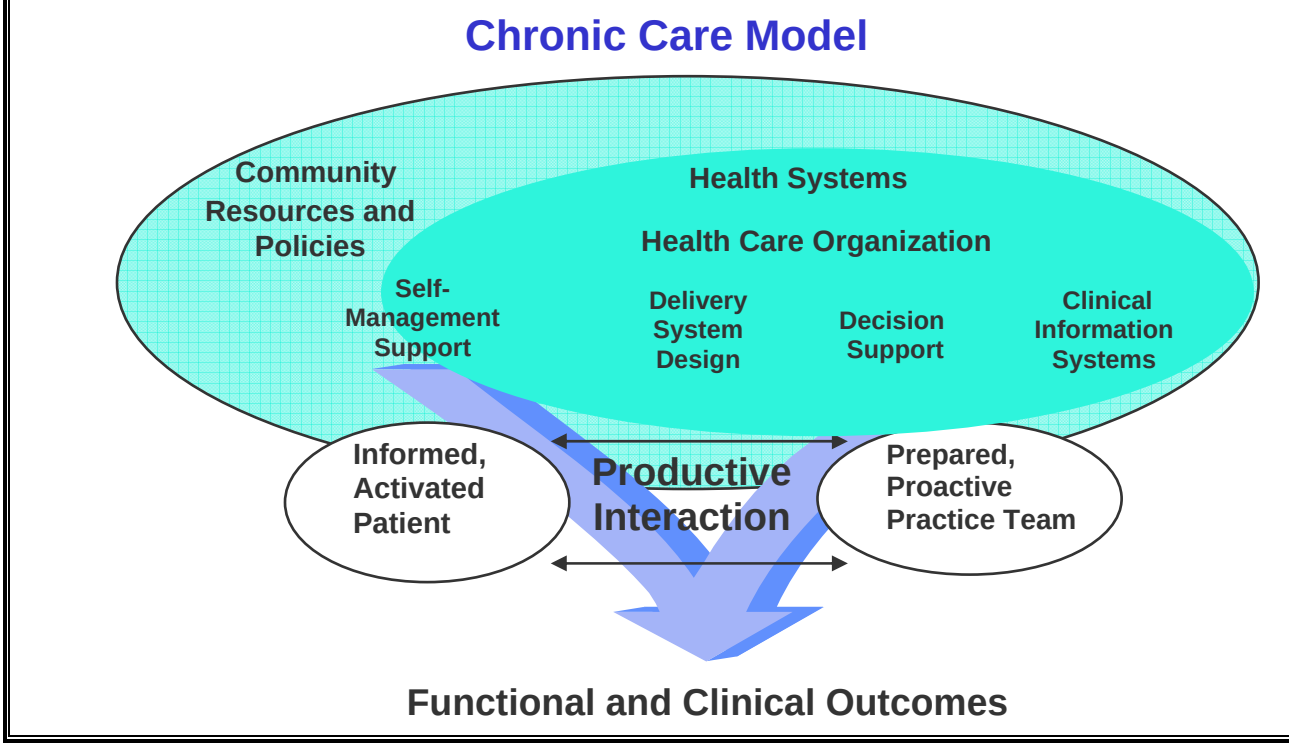
Most Collaborative cycles last about a year, however, the PCMH Collaborative spans 18 months (September 2009 – February 2011) because the practice changes will take more time. To date, the department has offered five Collaboratives and is in the middle of a sixth training cycle, as shown in Figure V-4 and described more fully at www.doh.wa.gov/cfh/wsc.

Figure V-4: Washington State Collaborative History

Collaborative Cycle	Date	Topics	Number of Clinical Practices
1	Oct 1999 – Nov 2000	Diabetes	17
2	Feb 2001 – Mar 2002	Diabetes	26
3	Nov 2002 – Oct 2003	Diabetes – Adult Preventative Services	29
4	Jun 2004 – Jun 2005	Diabetes – Heart Disease	37
5	Feb 2006 – Mar 2007	Diabetes – Heart Disease Prevention	25
6	May 2008 – May 2009 (Collaborative to Improve Health)	Diabetes - Asthma - Hypertension - Childhood Obesity - Medical Home for Children with Special Healthcare Needs	31

With Qualis Health and Group Health Cooperative's Center for Health Studies as partners, the department has trained 165 primary care practices using the Collaborative methodology. The Collaborative teaches practices to implement the Chronic Care Model. This model was developed by Dr. Ed Wagner, director of the Center for Health Studies, through a grant from the Robert Wood Johnson Foundation on Improving Chronic Illness Care. The Chronic Care Model is nationally recognized for driving health care to shift to prevention-focused chronic care and is described in Figure V-5. The model guides the primary care practice changes; when fully implemented the changes are sustainable.

Figure V-5: Chronic Care Model



B. INTERNAL AND EXTERNAL STAKEHOLDERS

A work group at the department has met biweekly since July 2008 to guide development of the PCMH Collaborative. This work group reports to the Office of Community Wellness and Prevention within the Division of Community and Family Health. Departmental programs that participate in the work group include Asthma, Diabetes Prevention and Control, Heart Disease and Stroke Prevention Program, Children with Special Healthcare Needs, Rural Health, Tobacco Prevention and Control, and Cancer Prevention and Control.

The Washington State Collaborative Advisory Committee, made up of state health agencies, health care providers, professional associations, health plans, and insurance companies, has met quarterly for the past two years to guide development of the current Washington State Collaborative to Improve Health, which includes a medical home option (see Figure V-4).[63] This advisory committee will continue and is advising on the development of the PCMH Collaborative. Members of the committee are listed in Appendix V-1.

C. CHRONIC CARE MODEL GUIDES IMPLEMENTATION

The Chronic Care Model guides all clinical practice changes of the Washington State Collaborative program. When these practice changes are made, the results are closely aligned with the characteristics of a medical home. (See Figure II-1). Therefore, the Chronic Care Model will also be used for the PCMH Collaborative.

Using the Chronic Care Model framework, an expert panel meeting was held October 29, 2008, at the Puget Sound Health Alliance, to identify changes that clinical practices need to make to demonstrate that they are medical homes. Conducting an expert panel meeting is the first step when developing new topics for a Collaborative as outlined in the Collaborative process. (See Figure V-2) Facilitated by Dr. Ed Wagner, the expert panel created a change package. See Appendix V-2 for the list of Expert Panel Members.

The PCMH Collaborative Change Package includes:

1. The changes a clinical practice needs to make to be a patient-centered medical home.
2. The pilot population the practice will focus these changes on.
3. The data needed to measure changes in the practice.

The key changes providers need to make are organized by the six elements of the Chronic Care Model: health care organization, clinical information systems, decision support, delivery system design, self-management support, and community resources and policies. The draft change package is in Appendix V-3.

At the conclusion of this one-day meeting, several areas of refinement were identified. The change package is being reviewed by focus groups made up of stakeholders to continue the refinement process.

D. REFINING THE PCMH COLLABORATIVE CHANGE PACKAGE

Three focus groups have provided insight to refine the change package. Meetings were held November 5, 2008, with enrolled practices and faculty of the currently running Washington State Collaborative to Improve Health; November 10 and December 1, with the Washington Primary Care Coalition; and

[63] The ongoing Collaborative to Improve Health has 31 enrolled clinical practices. It targets practices with five or fewer providers and has (1) reduced the time away from the office for the practice teams from eight days to three, (2) assigned a coach to each team, (3) opened enrollment to pediatric and adult practices with a choice of five clinical topics, (4) added three to four months of preparation for the clinical practices to establish a pilot population and gather baseline data on mandatory reporting measures, (5) conducted three site visits, and (6) added monetary incentives for achievement of key processes and clinical changes. In February 2009, the advisory committee will evaluate how these changes affected enrollment and outcomes.

November 14, with the Washington State Collaborative Advisory Committee. As a result, the following refinements will be made:

1. The changes will be prioritized.
2. The changes will be labeled by the concepts of a medical home they exemplify.
3. The pilot population will be removed.
4. Discussions will be scheduled with the health plans to assist with gathering the data on changes in cost and utilization.

Four additional focus groups with primary care providers in Aberdeen, Federal Way, Moses Lake and Ferndale are planned in January 2009. When focus groups are completed, their recommendations will inform final revision of the change package.

E. STAFFING

Four positions were funded to create, implement, and evaluate the PCMH Collaborative. The 1.0 FTE manager and .5 FTE epidemiologist have been selected, but do not start work until January 2009 because of budget restrictions. The 1.0 FTE practice coach and .5 FTE coordinator positions have not been approved due to budget restrictions.

F. NEXT STEPS

Next steps for developing the PCMH Collaborative include:

- Complete the focus group process.
- Refine the change package.
- Develop marketing materials.
- Launch enrollment of clinical practices.
- Hire the coach and the coordinator positions.
- Train the coaches.
- Set up contracts with the enrolled teams.
- Close enrollment by May 2009.
- Begin site visits by coaches in June 2009.
- Plan first face-to-face learning session for practices in September 2009.

A detailed timeline is in Appendix V-4.

G. RECOMMENDATIONS

The Department of Health recommends the following to ensure the integration of the PCMH Collaborative with the medical home reimbursement discussions:

- Allow clinical practices enrolled in the PCMH Collaborative to opt-into any reimbursement pilots created for medical homes;
- Report clinical practice changes resulting from implementing the PCMH Collaborative through the Puget Sound Health Alliance's *Community Check-Up* reports;
- For enrolled practices, have health plans track and report financial outcomes recommended in the change package; and
- Identify resources outside of the state general fund to expand evaluation design and reduce the reporting burden of the enrolled clinical practices.

Payment Options and Learning Collaborative Work In Support of Primary Care Medical Homes

REPORT APPENDICES

December 15, 2008

CERTIFICATION OF ENROLLMENT

ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2549

Chapter 295, Laws of 2008

60th Legislature
2008 Regular Session

PRIMARY CARE--PILOT PROJECTS

EFFECTIVE DATE: 06/12/08

Passed by the House March 8, 2008
Yeas 93 Nays 0

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate March 5, 2008
Yeas 47 Nays 0

BRAD OWEN

President of the Senate

Approved April 1, 2008, 2:55 p.m.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2549** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BARBARA BAKER

Chief Clerk

FILED

April 2, 2008

Secretary of State
State of Washington

ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2549

AS AMENDED BY THE SENATE

Passed Legislature - 2008 Regular Session

State of Washington 60th Legislature 2008 Regular Session

By House Appropriations (originally sponsored by Representatives Seaquist, Lantz, Morrell, Liias, Barlow, and Green)

READ FIRST TIME 02/13/08.

AN ACT Relating to establishing patient-centered primary care pilot projects; creating new sections; and providing an expiration date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The legislature finds that our primary care system is severely faltering and the number of people choosing primary care as a profession is decreasing dramatically. Primary care providers include family medicine and general internal medicine physicians, pediatricians, naturopathic physicians, advanced registered nurse practitioners, and physician assistants. A strong primary care system has been shown to improve health outcomes and quality and to reduce overall health system costs. To improve the health and well-being of the people in the state of Washington; enhance the recruitment, retention, performance, and satisfaction of primary providers; and control costs, our statewide system of primary care providers needs to be rapidly expanded, improved, and supported, in line with current research and professional innovations.

The legislature further finds that a medical home can best deliver the patient-centered approach that can manage chronic diseases, address acute illnesses, and provide effective prevention. A medical home is

a place where health care is accessible and compassionate. It is built on evidence-based strategies with a team approach. Each patient receives medically necessary acute, chronic, prevention, and wellness services, as well as other medically appropriate dental and behavioral services, and community support services, all which are tailored to the individual needs of the patient. Development and maintenance of medical homes require changes in the reimbursement of primary care providers in medical home practices. There is a critical need to identify reimbursement strategies to appropriately finance this model of delivering medical care.

NEW SECTION. **Sec. 2.** (1) Within funds appropriated for this purpose, and with the goal of catalyzing and providing financial incentives for the rapid expansion of primary care practices that use the medical home model, the department of health shall offer primary care practices an opportunity to participate in a medical home collaborative program, as authorized under RCW 43.70.533. Qualifying primary care practices must be willing and able to adopt and maintain medical home models, as defined by the department of social and health services in its November 2007 report to the legislature concerning implementation of chapter 5, Laws of 2007.

(2) The collaborative program shall be structured to promote adoption of medical homes in a variety of primary care practice settings throughout the state and consider different populations, geographic locations, including at least one location that would agree to operate extended hours, which could include nights or weekends, and other factors to allow a broad application of medical home adoption, including rural communities and areas that are medically underserved. The collaborative program shall assist primary care practices to implement the medical home requirements and provide the full complement of primary care services as established by the medical home definition in this section. Key goals of the collaborative program are to:

(a) Develop common and minimal core components to promote a reasonable level of consistency among medical homes in the state;

(b) Allow for standard measurement of outcomes; and

(c) Promote adoption, and use of the latest techniques in effective and cost-efficient patient-centered integrated health care.

Medical home collaborative participants must agree to provide data on patients' experience with the program and health outcome measures. The department of health shall consult with the Puget Sound health alliance and other interested organizations when selecting specific measures to be used by primary care providers participating in the medical home collaborative.

(3) The medical home collaborative shall be coordinated with the Washington health information collaborative, the health information infrastructure advisory board, and other efforts directed by RCW 41.05.035. If the health care authority makes grants to primary care practices for implementation of health information technology during state fiscal year 2009, it shall make an effort to make these grants to primary care providers participating in the medical home collaborative.

(4) The department of health shall issue an annual report to the health care committees of the legislature on the progress and outcome of the medical home collaborative. The reports shall include:

(a) Effectiveness of the collaborative in promoting medical homes and associated health information technology, including an assessment of the rate at which the medical home model is being adopted throughout the state;

(b) Identification of best practices; an assessment of how the collaborative participants have affected health outcomes, quality of care, utilization of services, cost-efficiencies, and patient satisfaction;

(c) An assessment of how the pilots improve primary care provider satisfaction and retention; and

(d) Any additional legislative action that would promote further medical home adoption in primary care settings.

The first annual report shall be submitted to the legislature by January 1, 2009, with the final report due to the legislature by December 31, 2011.

NEW SECTION. **Sec. 3.** (1) As part of the five-year plan to change reimbursement required under section 1, chapter 259, Laws of 2007, the health care authority and department of social and health services must expand their assessment on changing reimbursement for primary care to support adoption of medical homes to include medicare, other federal

and state payors, and third-party payors, including health carriers under Title 48 RCW and other self-funded payors.

(2) The health care authority shall also collaborate with the Puget Sound health alliance, if that organization pursues a project on medical home reimbursement. The goal of the collaboration is to identify appropriate medical home reimbursement strategies and provider performance measurements for all payors, such as providing greater reimbursement rates for primary care physicians, and to garner support among payors and providers to adopt payment strategies that support medical home adoption and use.

(3) The health care authority shall work with providers to develop reimbursement mechanisms that would reward primary care providers participating in the medical home collaborative program that demonstrate improved patient outcomes and provide activities including, but not limited to, the following:

(a) Ensuring that all patients have access to and know how to use a nurse consultant;

(b) Encouraging female patients to have a mammogram on the evidence-based recommended schedule;

(c) Effectively implementing strategies designed to reduce patients' use of emergency room care in cases that are not emergencies;

(d) Communicating with patients through electronic means; and

(e) Effectively managing blood sugar levels of patients with diabetes.

(4) The health care authority and the department of social and health services shall report their findings to the health care committees of the legislature by January 1, 2009, with a recommended timeline for adoption of payment and provider performance strategies and recommended legislative changes should legislative action be necessary.

NEW SECTION. **Sec. 4.** This act expires December 31, 2011.

NEW SECTION. **Sec. 5.** If specific funding for the purposes of this act, referencing this act by bill or chapter number, is not provided by June 30, 2008, in the omnibus appropriations act, this act is null and

1 void.

Passed by the House March 8, 2008.
Passed by the Senate March 5, 2008.
Approved by the Governor April 1, 2008.
Filed in Office of Secretary of State April 2, 2008.

The following is a selection of references used to inform development of the payment-change portion of the report.

- Allen, D., *Calculating the Cost of Care Coordination: A Quick and Dirty Guide to Estimation*. PowerPoint Presentation, Catalyst Center, Boston University School of Public Health. Undated.
- America's Health Insurance Plans, *Board of Directors Statement on Core Principles Integral to the Development of the Patient-Centered Medical Home*, Approved by Board of Directors on June 18, 2008.
- American Academy of Pediatrics Policy Statement, The Medical Home, *Pediatrics*, Volume 110, 2002, pp 184-186. (Reaffirmed May 2008)
- American College of Physicians, Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries. *Annals of Internal Medicine*, Volume 148, 2008, pp 55-75.
- American College of Physicians, *The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care*, Policy Monograph, January 22, 2006.
- Assessment of Chronic Illness Care (ACIC) and Patient Assessment of Chronic Illness Care (PACIC) for the Chronic Care Model, www.improvingchroniccare.org.
- Bailit, M., Hughes, C., Beesla, R., and White, D., *The Patient-Centered Medical Home: A Purchaser Guide*, National Business Coalition on Health and Patient-Centered Primary Care Collaborative, 2008.
- Bailit, M., *National Reimbursement Models and Alignment with Washington State Initiatives*, Bailit Health Purchasing, September 15, 2008; prepared for Washington State as a participant in the State Quality Improvement Institute program, sponsored by The Commonwealth Fund and AcademyHealth.
- Beal, A.C., Doty, M.M., Hernandez, S.E., Shea, K.K. and Davis, K., *Closing the Divide: How Medical Homes Promote Equity in Health Care*, The Commonwealth Fund, June 2007.
- Beesla, R. and Kaye, N., *Supporting the Patient Centered Medical Home in Medicaid and SCHIP: Savings and Reimbursement,* State Health Policy Briefing, Volume 2, Issue 8, National Academy for State Health Policy, April 2008.
- Berenson, R.A., Hammons, T., Gans, D.N., Zuckerman, S., Merrell, K., Underwood, W.S., and Williams, A.F., A House Is Not a Home: Keeping Patients at the Center of Practice Redesign, *Health Affairs*, Volume 27(5), September/October 2008, pp 1219-1230.
- Berwick, D., Preface, *The Journal of Ambulatory Care Management*, Volume 29(3), July-September 2006.
- Bodenheimer, T. Coordinating Care – A Perilous Journey through the Health Care System. *The New England Journal of Medicine*, Volume 358, 2008, pp 1064-1071.
- Bohmer, R.M.J. and Lawrence, D.M., Perspective: Care Platforms: A Basic Building Block for Care Delivery, *Health Affairs*, Volume 27(5), September/October 2008, pp 1336-1340.
- Conrad, D., Fishman, P., Grembowski, D., Ralston, J., Reid, R., Martin, D., Larson, E., and Anderson, M., Access Intervention in an Integrated, Prepaid Group Practice: Effects on Primary Care Physician Productivity, *Health Services Research*, Volume 43(5), 2008 (Part II), pp 1888-1905.
- Cooley, W.C. and McAllister, J. W., Building Medical Homes: Improvement Strategies in Primary Care for Children with Special Health Care Needs, *Pediatrics*, Volume 113(5), 2004, pp 1499-1506.
- Davis, K., Schoenbaum, S.C., and Audet, A., A 2020 Vision of Patient-Centered Primary Care. *Journal of General Internal Medicine*, Volume 20, 2005, pp 953-957.
- de Brantes, F. and Camillus, J.A., *Evidence-Informed Case Rates: A New Health Care Payment Model*, The Commonwealth Fund, April 2007.
- Dentzer, S., Innovations: 'Medical Home' or Medical Motel 6? *Health Affairs*, Volume 27(5), September/October 2008, p 1217.
- Department of Health, Children with Special Health Care Needs Program, *Medical Homes for Children and Youth with Special Health Care Needs – Making It Happen in Washington State, 2006-2010: A Strategic Plan to Achieve Medical Homes for All Children and Youth with Special Health Care Needs by 2010*, June 2006.
- Department of Social and Health Services, *Children's Healthcare Improvement System, Report to the Legislature*, November 30, 2007.
- Dowling, W., *Continuum of Medical Home Payment Methods and Alternative Medical Home Payment Methods*, Presentation to Rural Health Steering Committee, Association of Washington Public Health Districts, 2008.
- Dudley, R.A. and Rosenthal, M.B., *Pay for Performance: A Decision Guide for Purchasers*. Agency for Healthcare Research and Quality, Publication No. 06-0047, April 2006.
- Fiscella, K. and Epstein, R.M., So Much To Do, So Little Time: Care for the Socially Disadvantaged and the 15-Minute Visit, *Archives of Internal Medicine*, Volume 168(17), September 22, 2008, pp 1843-1852.
- Fisher, E.S., Perspective: Building a Medical Neighborhood for the Medical Home. *The New England Journal of Medicine*, Volume 359, 2008 pp 1202-1205.
- Folsom, A., Demchak. C., and Arnold, S.B., *Rewarding Results Pay-for-Performance: Lessons for Medicare*, AcademyHealth, Changes in Health Care Financing and Organization Program of the Robert Wood Johnson Foundation, Volume XI(1), March 2008.
- Goldfield, N., Averill, R., Vertrees, J., Fuller, R., Mesches, D., Moore, G., Wasson, J., and Kelly, W., Reforming the Primary Care Physician Payment System, Eliminating E&M Codes and Creating the Financial Incentives for an "Advanced Medical Home", *Journal of Ambulatory Care Management*, Volume 31(1), 2008, pp 24-31.
- Goroll, A.H., Berenson, R.A., Schoenbaum, S.C., and Gardner, L.B., Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care, *Journal of General Internal Medicine*, Volume 22, 2007, pp 410-415.

- Guinn, N. and Moore, L.G., Practice Measurement: A New Approach for Demonstrating the Worth of Your Work. *Family Practice Management*, February 2008, pp 19-22.
- Hamblin, A. *Using ROI Forecasting to Maximize the Value of Medicaid Investments*, Center for Health Care Strategies, Inc., Issue Brief, April 2008.
- Health Affairs, *Issue Theme: Overhauling the Delivery System*, Volume 27(5), September/October 2008.
- Higashi, T., Wenger, N.S., Adams, J.L., Fung, C., Roland, M., McGlynn, E.A., Reeves, D., Asch, S.M., Kerr, E.A., and Shekelle, P.G., Relationship between Number of Medical Conditions and Quality of Care, New England Journal of Medicine, Volume 356(24), 2007, pp 2496-2504.
- Homer, C.J., Klatka, K., Romm, D., Kuhlthau, K., Bloom, S., Newacheck, P., Van Cleave, J., and Perrin, J.M., A Review of the Evidence for the Medical Home for Children with Special Health Care Needs. *Pediatrics*, Volume 122, 2008, pp e922-e937.
- HowsYourHealth, www.HowsYourHealth.org.
- Hung, D.Y., Glasgow, R.E., Dickinson, L.M., Froshaug, D.B., Fernald, D.H., Balasubramanian, B.A., and Green, L.A., The Chronic Care Model and Relationships to Patient Health Status and Health-Related Quality of Life, *American Journal of Preventive Medicine*, Volume 35(5), Supplement, November 2008, pp S398-S406.
- Hwang, J. and Christensen, C.M., Perspective: Disruptive Innovation in Health Care Delivery: A Framework for Business-Model Innovation, *Health Affairs*, Volume 27(5), September/October 2008, pp 1329-1335.
- Iglehart, J. K., Perspective: No Place Like Home-Testing a New Model of Care Delivery. *The New England Journal of Medicine*, Volume 359, 2008, pp 1200-1202.
- Institute of Medicine, *Rewarding Provider Performance: Aligning Incentives in Medicare*, National Academies Press, August 2006.
- Integrated Healthcare Association, *Advancing Quality Through Collaboration: The California Pay for Performance Program, A Report on the First Five Years and a Strategic Plan for the Next Five Years,* February 2006.
- Jewish Healthcare Foundation and the Pittsburgh Regional Health Initiative, *Incentives for Excellence: Rebuilding the Healthcare System from the Ground Up*, 2007.
- Johnson, B., Abraham, A., Conway J., Simmons, L., Edgman-Levitan, S., Sodomka, P., Schlucter, J., and Ford, D., *Partnering with Patients and Families to Design a Patient and Family-Centered Health Care System: Recommendations and Promising Practices*, The California HealthCare Foundation, Institute for Family-Centered Care, and Institute for Healthcare Improvement, April 2008.
- Kilo, C.M., *The Medical Home and Primary Care Redesign: A Historical Perspective*, Presentation, The Medical Home: Exploring Northwest Initiatives Conference, The Trust for Healthcare Excellence, July 14, 2008.
- Lee. P.V. and Lansky, D., Perspective: Making Space for Disruption: Putting Patients at the Center of Health Care, *Health Affairs*, Volume 27(5), September/October 2008, pp 1345-1348.
- Llanos, K., Rothstein, J., Dyer, M.B., and Bailit, M., *Physician Pay-for-Performance in Medicaid: A Guide for States*, Center for Health Care Strategies, Inc., March 2007.
- MacColl Institute for Healthcare Innovation (Group Health), RAND, and the California Health Care Safety Net Institute, *Integrating Chronic Care and Business Strategies in the Safety Net*, Agency for Healthcare Research and Quality, Rockville, MD, Publication No. 08-0104-EF, September 2008.
- Medical Home Index (MHI) and Medical Home Family Index (MHFI) for Children with Special Health Care Needs, www.medicalhomeimprovement.org.
- Medicare Medical Home Demonstration, Section 204 of the Tax Relief and Health Care Act of 2006.
- Miller, H.D., *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*, The Commonwealth Fund, September 2007.
- Miller, H.D., *From Concept to Reality: Implementing Fundamental Reforms in Health Care Payment Systems to Support Value-Driven Health Care, Working Draft*, Network for Regional Healthcare Improvement, Healthcare Payment Reform Series, Discussion draft for 2008 NRHI Healthcare Payment Reform Summit, Version 2.0, July 21, 2008.
- Miller, H.D., *From Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs*, Network for Regional Healthcare Improvement, Healthcare Payment Reform Series, Recommendations of the 2008 NRHI Healthcare Payment Reform Summit, 2008.
- Moore, L.G. and Wasson, J.H., An Introduction to Technology for Patient-Centered, Collaborative Care, *Journal of Ambulatory Care Management*, Volume 29(3), July-September 2006, pp 195-198.
- Moore, L.G. and Wasson, J.H., The Ideal Medical Practice Model: Improving Efficiency, Quality and the Doctor-Patient Relationship, *Family Practice Management*, September 2007.
- National Committee for Quality Assurance, *Standards and Guidelines for Physician Practice Connections® - Patient-Centered Medical Home (PPC-PCMH™)*, 2008.
- National Committee for Quality Assurance, *Integrated Healthcare Association California Pay for Performance Program: Measurement Year 2009 Draft P4P Manual*, September 2, 2008.
- Patient Centered Primary Care Collaborative, *Patient-Centered Medical Home: Building Evidence and Momentum: A Compilation of PCMH Pilot and Demonstration Projects*, 2008.
- Patient-Centered Primary Care Collaborative, *Employer Perspective—The Patient Centered Medical Home (PCMH): A More Cost Effective and Efficient Model of Health Care*, www.pcpcc.net, accessed October 2008.
- Patient-Centered Primary Care Collaborative, *Evidence of Quality: Evidence on the Effectiveness of the Patient-Centered Medical Home on Quality and Cost*, www.pcpcc.net, accessed October 2008.
- Patient-Centered Primary Care Collaborative, *Proposed Hybrid Blended Reimbursement Model*, May 2007, at www.pcpcc.net.

- Patient-Centered Primary Care Collaborative, *The Patient-Centered Medical Home: A Purchaser Guide, Understanding the Model and Taking Action, 2008*.
- Paulus, R.A., Davis, K., and Steele, G.D., Continuous Innovation in Health Care: Implications of the Geisinger Experience, *Health Affairs*, Volume 27(5), September/October 2008, pp 1235-1245.
- Payment Subcommittee of the Washington State Primary Care Coalition, Payment Principles, May 22, 2008 Meeting Summary and May 29, 2008 Meeting Agenda.
- Porter, M.E. and Teisberg, E.O., *Redefining Health Care: Creating Value-Based Competition on Results*, Harvard Business School Press, Boston, MA, 2006.
- Puget Sound Health Alliance, *Asthma Clinical Improvement Team Final Report*, undated. Accessed October 2008.
- Puget Sound Health Alliance, *Puget Sound Community Checkup: A Report to the Community on Health Care Performance across the Region*, November 13, 2008.
- RAND, *Improving Chronic Illness Care Evaluation: Evaluation of the Effectiveness of the Chronic Care Model and the IHI Breakthrough Series Collaborative*, Series of Reports and Articles, The Robert Wood Johnson Foundation. See www.rand.org/health/projects/icice.
- Redling, B. and Moore, P. The Patient-Centered Primary Care Practice: Focus on Diabetes, *Physicians Practice*, Complementary CME Series on Practice Management, Medical Education Solutions Group, 2006.
- Rittenhouse, D.R., Casalino, L.P., Gillies, R.R., Shortell, S.M., and Lau, B., Measuring the Medical Home Infrastructure in Large Medical Groups, *Health Affairs*, Volume 27(5), September/October 2008, pp 1246-1258.
- Robert Graham Center, *The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change*, Policy Studies in Family Medicine and Primary Care, November 2007.
- Rosenthal, M.B., *Evaluation of Patient Centered Medical Home (PCMH) Initiatives*. Presentation, National Academy for State Health Policy (NASHP) Web Seminar Series on State Roles in Multi-Payer Medical Home Pilots, a joint offering of NASHP and the Patient-Centered Primary Care Collaborative, with support from The Commonwealth Fund, November 12, 2008.
- Rosenthal, M.B., Perspective: Beyond Pay for Performance – Emerging Models of Provider-Payment Reform. *The New England Journal of Medicine*, Volume 359, 2008, pp 1197-1200.
- Rosenthal, T.C., The Medical Home: Growing Evidence to Support a New Approach to Primary Care, *Journal of the American Board of Family Medicine*, Volume 21(5), September/October 2008, pp 427-440.
- Saultz, J., *A Scientific Foundation for the 21st Century Medical Home*, Presentation to The Medical Home: Exploring Northwest Initiatives Conference, The Trust for Healthcare Excellence, July 14, 2008.
- Sepúlveda, M.J., Bodenheimer, T., and Grundy, P., Primary Care: Can It Solve Employers' Health Care Dilemma?, *Health Affairs*, Volume 27(1), January/February 2008, pp 151-158.
- Sepúlveda, M.J., *The Medical Home, Round Two: Building on a Solid Foundation*, The Commonwealth Fund, April 2008.
- Shih, A., Davis, K., Schoenbaum, S.C., Gauthier, A., Nuzum, R., and McCarthy, D., *Organizing the U.S. Health Care Delivery System for High Performance*, Commission on a High Performance Health System, The Commonwealth Fund, August 2008.
- Shortell, S.M. and Casalino, L.P., Health Care Reform Requires Accountable Care Systems, *Journal of the American Medical Association*, Volume 300(1), July 2, 2008, pp 95-97.
- Sia, C., Tonniges, T.J., Osterhus, E., and Taba, S., History of the Medical Home Concept, *Pediatrics*, Volume 113(5), May 2004, pp 1473-1478.
- Sidorov, J.E., Perspective: The Patient-Centered Medical Home for Chronic Illness: Is It Ready for Prime Time?, *Health Affairs*, Volume 27(5), September/October 2008, pp 1231-1234.
- Silva, T.J., Sofis, L.A., and Palfrey, J.S., *Practicing Comprehensive Care: A Physician's Operations Manual for Implementing a Medical Home for Children with Special Health Care Needs*, undated.
- Spann, S.J., Task Force Report 6: Report on Financing the New Model of Family Medicine, *Annals of Family Medicine*, Volume 2(Supplement 3), 2004, pp S1-21.
- Starfield, B., and Shi L., The Medical Home, Access to Care, and Insurance: A Review of Evidence, *Pediatrics*, Volume 113(Supplement 5), May 2004, pp 1493-1498.
- Starfield, B., Shi, L. and Macinko, J., Contribution of Primary Care to Health Systems and Health, *The Milbank Quarterly*, Volume 83(3), 2005, pp 457-502.
- Stille, C.J., Jerant, A., Bell, D., Meltzer, D., and Elmore, J.G., Coordinating Care Across Diseases, Settings, and Clinicians: A Key Role for the Generalist in Practice. *Annals of Internal Medicine*, Volume 142, 2005, pp 700-708.
- Takach, M., Kaye, N., and Beesla, R., *Strategies States Can Use to Support the Infrastructure of a Medical Home*, State Health Policy Briefing, Volume 2, Issue 9, National Academy for State Health Policy, May 2008.
- *Today's Care vs. Medical Home Care*, PowerPoint slide by F.D. Duffy, MD, School of Community Medicine, University of Oklahoma, 2008, available at www.pcpcc.net.
- Tollen, L., *Physician Organization in Relation to Quality and Efficiency of Care: A Synthesis of Recent Literature*, The Commonwealth Fund, April 2008.
- University of Washington Medical Home Leadership Network and state Department of Health, *Washington State Medical Home Fact Sheet*, July 2007.
- Wagner, E.H., Austin, B.T., Davis, C., Hindmarsh, M., Schaefer, J., and Bonomi, A., Improving Chronic Illness Care: Translating Evidence into Action, *Health Affairs*, Volume 20(6), November/December 2001, pp 64-78.
- Wagner, E.H., Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness? *Effective Clinical Practice*, Volume 1(1), 1998, pp 2-4.
- Washington Primary Care Coalition, *Recommendations on Medical Home Reimbursement*, July 8, 2008.

- Washington State Blue Ribbon Commission on Health Care Costs and Access, *Final Report,* January 2007.
- Washington State Health Care Authority and Department of Social and Health Services, State *Purchasing to Improve Health Care Quality – A Five-Year Plan*, September 2007.
- Wasson, J. and Benjamin, R., *How's Your Health?*, 4th Edition, FNX Corporation, ©1998-2009. (See www.HowsYourHealth.org or www.HowsYourHealth.com)
- Williams, C.H. and Christianson, J.B., *Paying for Quality: Understanding and Assessing Physician Pay-for-Performance Initiatives*, The Synthesis Project of the Robert Wood Johnson Foundation, Policy Brief No. 13, December 2007.

Helpful web sites include:

www.aafp.org
www.bridgestoexcellence.org
www.HowsYourHealth.org or www.HowsYourHealth.com
www.iha.org
www.improvingchroniccare.org
www.medicalhome.org
www.medicalhomeimprovement.org
www.nashp.org
www.nationalpartnership.org
www.pcpcc.net
www.pugetsoundhealthalliance.org

America's Health Insurance Plans (AHIP)
Core Principles Integral to the Development of the Patient-Centered Medical Home*

1. Care should emphasize providing comprehensive care to meet patients' individual needs.

The medical home is not a concept designed to provide one standard process of care for everyone regardless of need or complexity of health problem. At its core, it is about practice redesign so the care delivered is responsive to the diverse range of patients' individual needs and preferences, while delivering high-quality evidence-based treatment. This includes preventive health services as well as management of chronic health care conditions.

2. Care coordination, a core component of the medical home, should be tailored to engage all patients as partners in their care so they can maintain or improve their overall health status.

Structuring successful care coordination activities should include clear criteria for patient participation, and different strategies for particular populations of patients in order to integrate care across the full spectrum of the delivery system.

3. Health information technology, such as registries, decision support tools, non-traditional methods of communication (e-mail) and e-prescribing, should be used to help ensure care delivery based on the latest medical evidence, and to facilitate care coordination across a range of health care providers.

For the patient-centered medical home to be successful, physicians will need to work together, which will require the appropriate technological tools, facilitators, and evidentiary support. Learning collaboratives, both physical and virtual, should be encouraged as a way to share early successes and useful treatments and approaches.

4. Clinicians who practice in a medical home environment should commit to being accountable for improving clinical outcomes and patient experience, appropriate utilization of health care services, and ensuring transparency of reliable clinician performance data.

It is important to link quality and cost of care information and to make reliable, useful information available to consumers, purchasers, and physicians that help guide decision-making.

5. Physician practices that incorporate the patient-centered medical home model will require new capabilities and infrastructure, and objective assessment will be necessary to determine if a clinician's practice meets the core criteria and has the capabilities and infrastructure to serve as a medical home.

The clinician practice should demonstrate its capability to manage the level of care and illness for the populations served in the medical home. Outcomes should be measured over time including overall clinical quality, cost effectiveness and both patient and physician experience.

6. The benefits of a medical home only will be realized if both clinical practice and consumer behavior evolves, therefore, educating consumes will be a critical element in this evolution.

Information provided to consumers about medical homes should be relevant, useful, actionable, and understandable so that consumers can make educated and informed decisions about their health care and choice of providers.

7. Payment methods should encourage the development of both a clinical practice infrastructure and processes that can provide a more efficient, coordinated and patient-centered care experience.

The payment structure for the medical home concept needs to support high-quality coordinate of care for patients with differing needs and preferences. Payment should be aligned with efforts to improve access and communication, to establish patient-centered programs for education and empowerment in self-management, to ensure the timely delivery of evidence-based care, and to reflect the level of management required for the population served. The payment system should encourage efficient as well as effective care, and measurable improvements in clinical quality, access, and satisfaction.

8. Pilot testing of structural requirements, appropriate measurement, and reporting methods should be completed before the patient-centered medical home concept is broadly implemented to determine which approaches are most effective.

Research is necessary to determine a sustainable framework for improving clinical outcomes, ways to ensure long term affordability for patients, and the best methods for implementation to ensure a stable infrastructure that prioritizes improved health outcomes.

***Source:** America's Health Insurance Plans (AHIP), *Board of Directors Statement on Core Principles Integral to the Development of the Patient-Centered Medical Home*, Approved by AHIP Board of Directors on June 18, 2008. Accessed at www.ahip.org, November 2008.

[1] Principles presented in this appendix supplement those discussed in the main body of the report.

Chronic Care Model: Change Concepts for Six Model Elements*

Health System: Create a culture, organization and mechanisms that promote safe, high quality care

- Visibly support improvement at all levels of the organization, beginning with the senior leader
- Promote effective improvement strategies aimed at comprehensive system change
- Encourage open and systematic handling of errors and quality problems to improve care
- Provide incentives based on quality of care
- Develop agreements that facilitate care coordination within and across organizations

Clinical Information Systems: Organize patient and population data to facilitate efficient and effective care

- Provide timely reminders for providers and patients
- Identify relevant subpopulations for proactive care
- Facilitate individual patient care planning
- Share information with patients and providers to coordinate care
- Monitor performance of practice team and care system

Delivery System Design: Assure the delivery of effective, efficient clinical care and self-management support

- Define roles and distribute tasks among team members
- Use planned interactions to support evidence-based care
- Provide clinical case management services for complex patients
- Ensure regular follow-up by the care team
- Give care that patients understand and that fits with their cultural background

Self-Management Support: Empower and prepare patients to manage their health and health care

- Emphasize the patient's central role in managing their health
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
- Organize internal and community resources to provide ongoing self-management support to patients

Decision Support: Promote clinical care that is consistent with scientific evidence and patient preferences

- Embed evidence-based guidelines into daily clinical practice
- Share evidence-based guidelines and information with patients to encourage their participation
- Use proven provider education methods
- Integrate specialist expertise and primary care

The Community: Mobilize community resources to meet needs of patients

- Encourage patients to participate in effective community programs
- Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
- Advocate for policies to improve patient care

***Source**: From www.improvingchroniccare.org, accessed November 2008. See Wagner, E.H., Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness? *Effective Clinical Practice*, 1(1), 1998, pp 2-4; Wagner, E.H., Austin, B.T., Davis, C., Hindmarsh, M., Schaefer, J., and Bonomi, A., Improving Chronic Illness Care: Translating Evidence into Action, *Health Affairs*, 20(6), November/December 2001, pp 64-78.

Ideal Medical Practice (IMP): Key Principles**

"Patient-centered, collaborative care" is healthcare jargon. But underlying the jargon is the *principle* that a patient who receives such care strongly agrees that '**I receive exactly the healthcare I want and need exactly when and how I want and need it**'."

- **High quality, patient-centered, collaborative care**
  - Quality measurement is built into all patient interactions using a few key measures taken continuously
  - Standardized and monitored referrals to, and follow-up by, other specialists
  - Patients know their provider/care team and vice-versa
  - Patient access to excellent information from which to make good decisions about their health (instilled with confidence to make good decisions)
- **Unfettered access and continuity**
  - Same day appointments
  - Practices are readily available to patients by phone or e-mail
- **Extreme efficiency and lower overhead**
  - Wise use of technology and improved workflow
  - Reduced staffing needs
  - Patient and provider time is not wasted

****Source for IMP quote:** Moore, L.G. and Wasson, J.H., An Introduction to Technology for Patient-Centered, Collaborative Care, *Journal of Ambulatory Care Management*, 29(3), July-September 2006, pp 195-198.

Sources for other IMP key principles: Adapted from Moore, L.G. and Wasson, J.H., The Ideal Medical Practice Model: Improving Efficiency, Quality and the Doctor-Patient Relationship, *Family Practice Management*, September 2007, and materials from www.aafp.org, www.idealmedicalpractices.org, www.idealmedicalhome.org, and www.idealhealth.wiki-spaces.

[1] Principles presented in this appendix supplement those discussed in the main body of the report.

Medical Home Reimbursement Project
Appendix II-3: Payment Principles in Support of Medical Homes [1]

2007 Network for Regional Healthcare Improvement Summit, Recommended Goals for Improved Healthcare Payment Systems*	**M.E. Porter and E.O. Teisberg Principles of Value-Based Competition***
In order to address the current problems with healthcare payment systems and to avoid the concerns about existing Pay-for-Performance systems, the following are twelve goals that revised payment systems should seek to achieve: 1. Payment systems should enable and encourage providers to deliver accepted procedures of care to patients in a high-quality, efficient, and patient-centered manner. 2. Payment systems should support and encourage investments, innovations, and other actions by providers that lead to improvements in efficiency, quality, and patient outcomes and/or reduced costs. 3. Payment systems should not encourage or reward over-treatment, use of unnecessarily expensive services, unnecessary hospitalization or re-hospitalization, provision of services with poor patient outcomes, inefficient service delivery, or choices about preference-sensitive services that are not compatible with patient desires. 4. Payment systems should not reward providers for under-treatment of patients or for the exclusion of patients with serious conditions or multiple risk factors. 5. Payment systems should not reward provider errors or adverse events. 6. Payment systems should make providers responsible for quality and costs within their control, but not for quality or costs outside of their control. 7. Payment systems should support and encourage coordination of care among multiple providers, and should discourage providers from shifting costs to other providers without explicit agreements to do so. 8. Payment systems should encourage involvement of patients in decision-making, and encourage patient choices that improve adherence to recommended care processes, improve outcomes, and reduce the costs of care. 9. Payment systems should not reward short-term cost reductions at the expense of long-term cost reductions, and should not increase indirect costs in order to reduce direct costs. 10. Payment systems should not encourage providers to reduce costs for one payer by increasing costs for other payers, unless the changes bring payments more in line with costs for both payers. 11. Payment systems should minimize the administrative costs for providers in complying with payment system requirements. 12. Different payers should align their standards and methods of payment in order to avoid unnecessary differences in incentives for providers. In addition, an overarching goal is to have improved payment systems maintain or reduce healthcare costs, rather than increase them.	Payment system implications of value-based competition = • Associate reward with specific medical conditions • Reward results, not process • Reward excellence with more patients (versus paying a little bit more) • Move to single prices for episodes and ultimately cycles of care, combining hospital and all physician charges • Eventually move to providers setting prices (rather than payer-set-reimbursement) – only achievable in a re-engineered value-based competition system. The "principles of value-based competition" that drive the above payment system implications are: • The focus should be on value for patients, not just lowering costs. • Competition must be based on results. • Competition should center on medical conditions over the full cycle of care. • High-quality care should be less costly. • Value must be driven by provider experience, scale, and learning at the medical condition level. • Competition should be regional and national, not just local. • Results information to support value-based competition must be widely available. • Innovations that increase value must be strongly rewarded.
***Sources:** Jewish Healthcare Foundation and the Pittsburgh Regional Health Initiative, *Incentives for Excellence: Rebuilding the Healthcare System from the Ground Up*, 2007. Also see: Miller, H.D., *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*, The Commonwealth Fund, September 2007, pages vii-viii and 27-28.	*__Source:__ Porter, M.E. and Teisberg, E.O., *Redefining Health Care: Creating Value-Based Competition on Results*, Harvard Business School Press, Boston, MA, 2006. (See page 98 for Principles; implications are a summary based primarily on Chapter 8, Health Care Policy and Value-Based Competition.)

[1] Payment principles presented in this appendix supplement those discussed in the main body of the report.

Medical Home Reimbursement Project
Appendix III-1: Framing-Scoping Questions for Agency Discussion

Appendix Explanation: The following questions were used with state agencies to facilitate discussion around scope, scale, and issues of interest and agreement. With some refinements, this tool could be used with a broader group of potential partners. (In using the tool with state agencies it was clear that some items were less useful than others and a few important questions were left out.)

Framing –Scoping Questions

Directions to State Agencies: In the 5-year purchasing plan, the Agencies were asked to look at "changing reimbursement for primary care to support adoption of medical homes". They now need to look at the same issue, **expanded *to include all other payers.*** So, the question is:

	In a discussion with other payers/purchasers, where would you position yourself in terms of initial steps? **Following are 14 either/or questions: for each question pick one alternative and think about why you lean in that direction.**	**Why?**
Big Picture	☐ Assume the medical home concept is ***on-target*** and worth basing payment changes on ☐ Discuss whether it ***diverts attention*** from value-based purchasing	
	☐ Focus on smaller, incremental, potentially ***less disruptive payment and structure change*** ☐ Push the envelope with ***"constructive disruption"*** (e.g., risk-based capitation with shared savings)	
On Whom to Focus	☐ Support medical-home-like changes to improve care ***for all consumers*** of primary care ☐ Support medical-home-like changes to improve care ***for subsets of consumers*** (e.g., those with specific chronic conditions, in outcome areas where care quality is low and/or cost is high)	
	☐ Foster **new efforts** (e.g., focus on primary care practices not yet in transition or very early in readiness-to-change) ☐ Support **existing efforts** already in progress where change is already happening	
	☐ Target ***patient volume*** – that is, focus on large practices where the majority of patients are ☐ Target ***practice volume*** – that is, focus on small practices that make up the majority of practices	
	☐ Encourage practices to be part of "actual or virtual" organized, collaborative, ***integrated structures*** ☐ Not worry about whether practices are ***"stand alone"***	
	☐ Focus on practices that ***already meet*** some established medical home-like criteria (e.g., NCQA, BTE, IMP, CCM) ☐ Welcome ***any*** primary care practice with a desire and commitment to medical home practice redesign	
Time Horizon	☐ Push efforts with **near-term results** (2 years or less) (noting implications for design) ☐ Advocate for time-to-results tolerance (i.e., the need for a ***longer horizon***)	

Medical Home Reimbursement Project
Appendix III-1: Framing-Scoping Questions for Agency Discussion

	In a discussion with other payers/purchasers, where would you position yourself in terms of initial steps? **Following are 14 either/or questions: for each question pick one alternative and think about why you lean in that direction.**	**Why?**
Payment / Financial Support	☐ Provide ***upfront or short-term transitional funding*** for needed medical home infrastructure (e.g., redesigning care processes, EMRs, patient registries, offsetting revenue losses for time engaged in quality improvement) ☐ Provide ***incentive payments*** for meeting specific clinical outcome, quality improvement, or efficiency goals	
	☐ Focus payment changes on ***individual practices*** ☐ Have payment changes that apply to both individual ***practices and networks*** of practices	
	☐ Focus payment / financial changes on **providers only** ☐ Focus payment / financial changes on both ***providers and consumers*** / patients	
	☐ Target changes that improve the ***existing FFS system*** (e.g., pay for codes for services not traditionally reimbursed) ☐ Target changes that create care management / coordination "***add-ons"*** ☐ Target changes ***tied to specific*** clinical outcome, quality improvement, or efficiency goals	
The What	☐ Focus on improving the ***patient-centered component*** of medical-homeness ☐ Focus on improving the ***"systemness" component*** of medical-homeness (aided by HIT and organizational structures) ☐ Focus on improving the ***chronic care management component*** of medical-homeness	
	Focus on primary care providers' services … ☐ With the largest impact ***based on numbers of patients impacted*** ☐ With the largest impact ***based on resource consumption*** ☐ With the greatest amount of ***unjustified variation*** ☐ With ***evidence-based*** or consensus-driven best-practices ***and readily available outcome metrics*** ☐ With the ***most interest*** from providers and / or consumers ☐ With observed outcomes ***fartherest from expected*** performance	

National Reimbursement Models and Alignment with Washington State Initiatives

September 15, 2008

Presented by Michael Bailit
to the Washington Primary Care Coalition

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Presentation Objectives

1. Set the context for a discussion of PCMH reimbursement models
2. Review the range of PCMH reimbursement models being utilized nationally, who is using them, and experience to date
3. Discuss the Washington Primary Care Coalition recommendations
4. Consider two additional questions:
   a. how to motivate practices to participate
   b. whether to use "patient-centered" as an organizing tool

Setting the Context

- All of the existing and emerging PCMH initiatives across the U.S. include payment reform as a core component.
- The Joint Principles of the AAP, ACP, and AAFP call for "payment [that] appropriately recognizes the added value provided to patients who have a PCMH", with additional specifications.
- Most of the PCMH initiatives across the U.S. do not strictly adhere to the Joint Principles' specifications for payment.

Setting the Context

Two cited rationales for payment reform for medical homes:

1. infrastructure support: Several have modeled the costs to a practice to deliver PCMH care and have identified the need for additional resources in the practice setting to cover costs including: increased time commitment for non-billable activities, case management/care support, HIT, and space and equipment.
2. incentive alignment: FFS payment drives how practices deliver primary care. Many believe that only changes to the payment system that motivate and support the PCMH will generate practice transformation.

Seven National PCMH Payment Models

1. FFS with discrete new codes
2. FFS with higher payment levels
3. FFS with supplemental lump sum payments
4. FFS with PMPM fee
5. FFS with PMPM fee and with P4P
6. FFS with PMPY payment
7. Comprehensive Payment with P4P

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PCMH Payment Models

Model #1: FFS with new codes for PCMH

Case examples:

- BCBSMI: pays T-Codes for practice-based care management
- Horizon BCBS of NJ: pays for traditionally non-reimbursed care management services

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PCMH Payment Models

Model #2: FFS with higher payment levels

Case examples:

- BCBSVT: pays enhanced rates (+6%) to qualifying practices for office-based E&M, consultations, preventive medicine, and counseling codes
- BCBSMI: plans to pay 10% higher E&M code rates to qualifying practices beginning mid-2009

PCMH Payment Models

Model #3: FFS with lump sum payments

Case example:

- PA Chronic Care Initiative (SE Region): six participating insurers pay periodic lump sum payments to qualifying practices per clinician FTE based on documented level of NCQA PPC-PCMH achievement – insurers include three Medicaid MCOs
  - Other PA regions (SC, SW, NE) will probably take different approaches when they begin in early 2009

PCMH Payment Models

Model #4: FFS with PMPM payment

Case examples (both Medicaid):

- Community Care of NC: FFS with PMPM payment to PCP and another PMPM payment to regional PCP networks for care management and pharmaceutical consultation
  - Began in 1998 with Medicaid women and children only
  - Expansion to elderly and persons with disabilities in 2008
- Connect Care Choice (RI): FFS with PMPM for enrolled chronically ill adults

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PCMH Payment Models

Model #4: FFS with PMPM payment

Case example (non-Medicaid):

- Vermont Blueprint: three insurers and Medicaid pay FFS with sliding scale PMPM based on level of achievement against NCQA PPC-PCMH standards
  - Unlike most models using NCQA recognition, the payment scale is continuous rather than tiered

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PCMH Payment Models

Model #5: FFS with PMPM fee and with P4P

- The model endorsed by the PCPCC.
- PMPM fee referred to by the PCPCC as a "monthly care coordination payment".

Case examples:

- Emblem Health (NY): FFS, case mix-adjusted PMPM care management payment, and P4P (measures of clinical quality, efficiency and patient experience)
- THINC RHIO (NY): FFS with enhanced PMPM payment for PCMH structural measures and for performance on 10 HEDIS measures

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PCMH Payment Models

Model #6: FFS with PMPY payment

- This is the Bridges to Excellence medical home model.
- Practices must be Level 2-certified for BTE's Physician Office Link (= NCQA PPC) and any two of the BTE Diabetes, Cardiac Care and Spine Care Link programs.
- Shared savings model: $250/pt split between physician and purchaser/payer. Savings amount informed by BTE ROI analysis.

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PCMH Payment Models

Model #7: Comprehensive Payment with P4P

- This is a risk-adjusted PMPM comprehensive payment covering all primary care services.
- Unlike traditional primary care capitation, the payments would support an investment in medical home systems to improve care.
- 15-20% of annual payments would be performance-based and paid as a bonus.

Case examples:

- Capital District Health Plan (NY) will pilot starting 1/09.
- Separate small pilot in MA w/o true comprehensive payment.

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Payment Amounts

- Supplemental payments reflect both estimates of what the medical home might cost, and the availability of funds.
- Most current models typically range between $.50 PMPM and $5.50 PMPM in added spending.
- Medicare's AMA/Specialty Society Relative Value Scale Update Committee ("the RUC") has estimated $25, $35, and $50 PMPM per chronically ill patient based on level of PCMH status for the forthcoming Medicare Medical Home pilot.
  - CMS plans to introduce in 2009 with some form of case mix adjustment

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Estimated Practice Costs

Source	Enhancement in PMPM terms	What's included for the payment	Comments
Deloitte Center for Health Solutions	$8.66 PMPM	PCP added annual $100K payment for care coordination Health coach salary plus fringe Health coach tools (data collection, telephones, IT) Data manager (.33 FTE with salary of $65K and fringe)	EMR purchase cost of $80-120K, with $20K for installation, and then $5K annually. Also, $20K at risk for annual perf. bonus.
Rhode Island Chronic Care Sustainability Initiative (a)	$4.78 PMPM	Case manager salary plus fringe Office staff (.5 FTE with annual salary plus fringe) Office space Office equipment Patient educational collateral materials	Assumes a three-physician practice with one NP.
Rhode Island Chronic Care Sustainability Initiative (b)	$7.34 PMPM	All of the above, plus PCP added annual payment for alt. communication (optional)	PCP added payment is for e-mail and telephone calls, including after hours and on weekends.
Rhode Island Chronic Care Sustainability Initiative (c)	$3.00 PMPM	Not decided as of 3-08.	The $3.00 limit was set when one insurer stated that it would pay no more than $3.00.

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Estimated Practice Costs

Source	Enhancement in PMPM terms	What's included	Comments
Richard Baron for PA SE Regional Rollout, 9-07	$3.78 - $5.04 PMPM	PCP added annual payment for lost revenue Nurse Practitioner (.3 FTE) Medical assistant (.3 FTE) Health educator (.1 FTE) Social worker (.1 FTE)	EMR purchase cost of $78K. Lost revenue due to PCP time on project management.
Allan Goroll et. al	$5.83-$9.38 PMPM	Nurse Practitioner (.5 to 1 FTE) Data manager (.85 to 1 FTE) Nutritionist (0 to .5 FTE) Social worker (0 to .5 FTE) (Latter two would be excluded in smaller practices.)	EMR and quality monitoring system: $35K annually. Also, $35-$50K annual bonus for meeting mutually est. goals.

Miscellaneous Notes:

- United HealthCare estimated the additional reimbursement to a primary care practice for implementing a Patient-Centered Medical Home at 20% above baseline reimbursement.

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Examples of Other CCM/PCMH Programs

Source	Enhancement PMPM	What's required	Comments
Community Care of North Carolina	$5.50 PMPM	▪The payment is <u>not</u> based on an assessment of practice costs. Requirements include: 1.Create a medical home. 2.Give data to the state. 3.Address four quality improvement program areas: disease management; high-risk and high cost patients; pharmacy management; and emergency department utilization. 4.Use local network funds to support local case and disease management activities and staff for putting resources into the community (e.g., initially case managers, then clinical pharmacists).	$2.50 is paid to the PCP, while $3.00 goes to the network.
Blue Cross Blue Shield of Michigan (prior approach)	$0.17 PMPM	▪The payment is not based on an assessment of practice costs. ▪The payment is made to local physician organizations or networks and is used to purchase shared resources.	"A meaningful amount was estimated to be $3000 per physician, under the assumption that…this would be enough catalyze commitment, leadership and change. Our experience to date has proved this calculus to be correct." BCBSMI will move to a fee schedule enhancement in 2009.

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Examples of Other CCM/PCMH Programs

Source	Enhancement in PMPM terms	What's required	Comments
Blue Cross Blue Shield of Vermont	6% fee enhancement	The payment is not based on an assessment of practice costs. BCBSVT expects the following in return: 1. Patient registry and reminder system. 2. Use of evidence-based clinical guidelines. 3. Evidence that the practice team is "prepared" for the patient visit – *"Care Plan"*. 4. On-site nurse educators or easy access to nurse educators. 5. Patient access to self-management tools. 6. Tracking and reporting of outcomes. 7. Patient satisfaction survey/measures. 8. Evidence of office staff training on the scheduling and coding implications of chronic disease management.	"We weren't necessarily aiming to offset the costs and we didn't have an anticipated ROI." "We landed on 6% as a starting point. Our anticipated ceiling is 12%."
Health Disparities Collaboratives of the Health Resources and Services Administration (HRSA)	$0 However, health centers routinely experienced financial losses.	▪ Participation in collaboratives to improve the care of patients with diabetes, asthma, or cardiovascular disease	There were significant improvements in the measures of prevention and screening. There was no improvement, however, in any of the intermediate outcomes assessed.

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Sources of Funding

- A tough issue. Because ROI is uncertain, most payers are "taking a flyer" based on research supporting the model. Approaches taken to date:
  - Reallocation of budgeted physician P4P funds
  - Reallocation of budgeted fee increase
  - Reallocation of DM/care management funding
  - New expenditure
- Idea discussed for the future:
  - Rebalancing of the physician fee schedule – reducing specialist fees to fund increase for primary care

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Summary of Discussion of National Models

- There are a few different payment models that have emerged so far.
- Even within those that have emerged so far there is variation.
- We don't know what works best yet, so don't feel bound by what others have elected to do.

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Considering Two Additional Questions

1. How to motivate practices to participate

- Practices choose to participate for either or both of the following reasons:
  - They seek a better way to operate their practice and deliver care. Many have heard of the PCMH and are intrigued by it. These are the "early adopters."
  - They seek a means to obtain additional revenue for their practice.
- If starting with a pilot, involvement of the primary care associations and of primary care practices in the planning process should yield sufficient numbers of interested practices.

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Considering Two Additional Questions

1. How to use "patient-centered" as an organizing tool

- It is unclear whether the concept of "patient-centeredness" resonates sufficiently with physicians to use it as an organizing tool.
- Also, note that the PCMH is a collection of concepts, of which patient-centeredness is one.

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Making Your Decision

- How to decide which model?
  - Other efforts across the country typically seem to be decided based on a) what are others doing, and b) the particular individuals involved in the design process and their values and philosophies.
- Resource for Information on Models
  - "The Patient-Centered Medical Home – A Purchaser Guide"
  - Available at www.pcpcc.net

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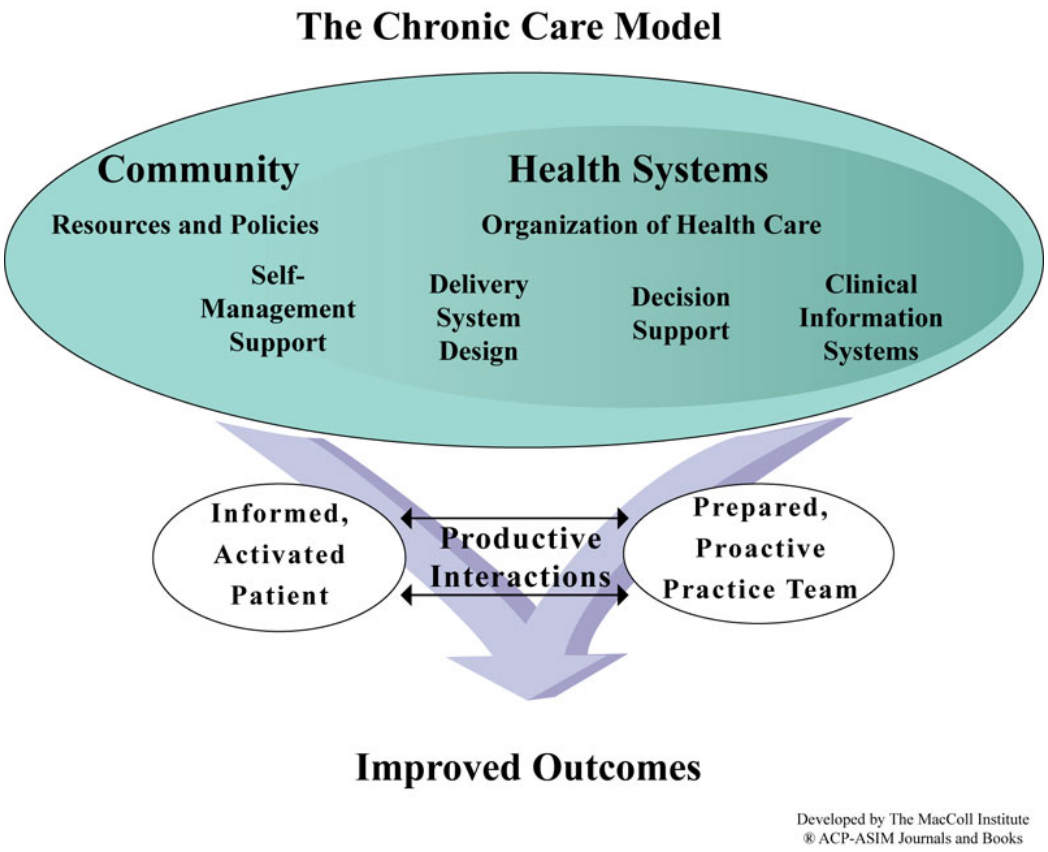
Proposed Patient-Centered Medical Home Change Package
Drafted by Expert Panel, October 29, 2008



Organization of Health Care

- Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality.
- Establish a QI team that meets regularly and guides the effort.
- Ensure that providers and other care team members have protected time and a method to proactively manage at-risk patient populations as well as contact, educate and track individual patients with complex needs.
- Build the practice's values on creating a medical home for patients into staff hiring and training processes.
- Choose and use a formal model for quality improvement.
- Clearly establish and monitor metrics to evaluate improvement efforts and outcomes; ensure that all team members understand the metrics for success.
- Balance the patient load across the providers in the office.

Self Management Support

- Respect patient/family values and expressed needs.
- Communicate effectively with patients/family in a culturally appropriate manner, with a language and at a level that the patient/family understands.
- Encourage patients/family to expand their role in decision-making, health-related behaviors and self-management.
- Provide self-management support at every visit through goal setting, action planning and follow-up.

Delivery System Design

- Obtain feedback from patients/family about their healthcare experience and use information for quality improvement.
- Conduct planned care visits for complex patients with one or more chronic diseases.
- Prepare for productive interactions by ensuring up-to-date information is available at the time of each visit.
- Assure that patients are able to see their provider whenever possible and their care team in every circumstance.
- Promote and expand access; assure established patients have 24/7 continuous access to their care teams via phone, email, or in-person visits.
- Scheduling options are patient- and family-centered and accessible to all patients, regardless of physical ability.
- Test results and care plans are communicated to patients/families.

Decision Support

- Include all key team members – including patients/family and providers – in the quality improvement team to enable workflow re-organization.
- Clearly link each patient to a provider and care team so that both patient and provider/care team know and recognize each other as partners in care.
- Clearly define roles and distribute tasks among care team members to reflect the skills, abilities and credentials of team members.
- Cross-train care team members to maximize flexibility and assure that patients needs are met.
- The practice is following evidence-based care guidelines

Clinical Information Systems

- Optimize use of health information technology to
    - Schedule appointments and monitor access to care on a continual basis.
    - Understand and define your patient population, including language, race/ethnicity, and disabilities
    - Define and track care for individual patients and subpopulations, including referrals and abnormal lab/imaging results.
    - Provide patient-specific educational materials and reminders
- Use point-of-care reminders based on clinical guidelines.
- Define and understand which patients are part of the medical home

Community Resources and Policies

- Link patients with community resources to facilitate referrals and respond to social service needs.
- Integrate specialty and mental and behavioral health into care protocols; have referral protocols in place with an array of specialists to meet patients' needs.
- Proactively track and support patients as they go to and from specialty care, the hospital, the emergency department
- Follow-up with patients within a few days of an emergency room visit or hospital discharge.

Update per focus group input - Bullets to be prioritized and labeled by what medical home concept they support.

Proposed Pilot Population

Adults: People between 18 and 75 with 2 or more chronic diseases who have been seen in the practice twice in the past 2 years.

Asthma
Chronic Kidney Disease
Chronic Obstructive Pulmonary Disease
Congestive Heart Failure
Diabetes
Hypertension
Low Back Pain or Chronic Pain
Mental Illness
Substance Abuse

Children: Children between 0 and 18 who have been seen in the practice twice in the past two years.

Update per focus groups input – Pilot population to be omitted.

Proposed Measures

1. One measure to capture the degree to which practices have implemented a medical home.
2. 2 to 3 clinical measures that are shared by all the patients in the pilot population

    - Adults: blood pressure level (outcome)
      tobacco cessation (process)
      PHQ9 (process)
    - Children: measure not yet determined
      measure not yet determined

3. Patient/family experience – Propose to gather from GHC tool tested in the Medical Home Model for Primary Care in Factoria
4. Provider experience – Propose to gather from GHC instrument to measure burnout. Appropriate for all levels of staff.
5. Cost and Utilization – Propose to gather from health plans for the clinics that are enrolled
    - Emergency room use
    - Hospital admissions
    - Specialty care costs
    - Pharmacy cost

Patient Centered Medical Home Collaborative Timeline

	2008						2009												2010											2011										
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Hire Staff (HSC4, HSC1, HSC3 & EPI 1)																																								
Planning Activities																																								
Commonwealth Consultation																																								
Expert Panel																																								
Provider Focus Group																																								
Advisory Committee Mtgs																																								
Internal Healthcare wrk-group																																								
Measures in Registry																																								
Reimbursement Model Dev.																																								
Marketing and Enrollment																																								
Develop Marketing Materials																																								
Launch Enrollment																																								
Market to Key Providers																																								
Develop Prework Materials																																								
Train Coaches																																								
Enrollment Closes																																								
Collaborative																																								
Collaborative Prework																																								
Registry Support																																								
Coaching Visits																																								
Learning Sessions															LS 1					LS 2							LS 3					OC									
Legislative Reports																																								

PROGRESS TOWARD KEY OUTCOMES:

Hire Staff: 1.0 HSC 4 (manager) and .5 Epi 1 approved to hire. Staff selected, start date January 2009. Budget reductions will not allow the 1.0 HSC 3 (coach) and .5 HSC 1 (coordinator) to be hired.

Academy Health & Commonwealth Consultation: DOH actively participating in State Quality Improvement Initiative. Attended late June meeting to consult with medical home experts. September 15th Primary Care Coalition addressed reimbursement models using technical assistance from Academy Health.

Expert Panel: This group decides what outcome measures clinical teams will report on to demonstrate that they have implemented a medical home. These will be in accordance with Section 2(2) of 2SHB 2549.

Provider Focus Groups: Focus Groups will test outcome measures with primary care providers to determine feasibility of practices implementing the process and outcome measures recommended by the Expert Panel.

Advisory Committee: Community-based advisory committee reviews and advises DOH on the planning, implementation and evaluation of the Washington State Collabortive on Medical Home.

Internal Healthcare Workgroup: DOH planning group formed in July 2008 to advise planning and implementation of the Washington State Collaborative on Medical Home. Members include staff from CWP, MCH, HSQA, and UW.

Measures in Registry: The Chronic Disease Electronic Measurment System (CDEMS) was designed by DOH to assist clinical practices to guide and track clinical outcomes. This registry will need to be retooled to collect data elements determined by expert panel and provider focus groups. Current contract with registry consultant and programmer in place to add new measures once they are determined through expert panel and focus group process.

Reimbursement Model Development: DOH works with DSHS and HCA on proposed models for designing reimbursement to providers for demonstrating implementation of a medical home.

Marketing Materials: Design materials to market Patient Centered Medical Home Collaborative to practices; use advisory committee to distribute marketing/enrollment materials. Communications plan to be developed.

Prework Materials: This is a handbook for all enrolled practices that provides all details about Collaborative involvement. Template from current Washington State Collaborative to Improve Health will be used.

Coaching Visits: Provide instructions on participation, begin baseline assessment, assess progress, teach chronic care model, and install registry.

Learning Sessions (LS): Face to face meetings between faculty and primary care practices on medical home model (OC = Outcome Congress).