

Washington State Health Care Authority

Report to the Legislature

Primary Care Health Homes-Chronic Care Management

Engrossed Substitute Senate Bill 5394
Chapter 316, Laws of 2011

December 1, 2012

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Executive Summary

Section 7 of Engrossed Substitute Senate Bill 5394 (the Act), enacted as Chapter 316, Laws of 2011 directs the Health Care Authority (HCA) to coordinate a discussion with carriers to learn from successful chronic care management models and develop principles for effective reimbursement methods to align incentives in support of patient-centered chronic care health homes. The section further directs the authority to submit a report to the appropriate committees of the legislature by December 1, 2012, describing the principles developed from the discussion and any steps taken by the Public Employees Benefits Board or carriers in Washington State to implement the principles through their payment methodologies.

Section 2 of the Act defines primary care health homes and chronic care management. Section 1 states the legislative findings that chronic care management in the health home setting can improve care quality while curtailing costs, and that realizing the full potential of this approach to care is impeded by the current fee-for-service (FFS) payment system. This section further states the legislative intent to promote the adoption of health homes and advance the practice of chronic care management to improve health outcomes and reduce cost.

Section 4 of the Act specifies that after January 1, 2012, contracts with managed health care systems under Chapter 74.09 RCW will provide for provider reimbursement methods that incentivize chronic care management within health homes and reward health homes that reduce emergency department and inpatient use. Section 5 applies the same requirements to managed care plans contracted after January 1, 2012, under Chapter 70.47 RCW, and Section 6 applies them to managed care plan and the self-insured plan or plans contracted under Chapter 41.05 RCW, effective January 1, 2013.

HCA conducted the discussion with carriers specified in Section 7 on May 22, 2012, and compiled a record of the main themes and principles that emerged from that discussion. Subsequent discussions with the managed care plans and carrier for the self-funded Public Employee Benefits program provided information on how they intended to comply with the provisions of the Act.

Engrossed Substitute Senate Bill 5394, Chapter 316 Laws of 2011

Major Provisions of the Act

This legislation seeks to address the rapid increase in the cost of publicly sponsored health care by promoting primary care health homes and providing incentives for more effective care of individuals with chronic conditions.

The Act defines a primary care health home as coordinated care provided by a licensed primary care provider coordinating all medical care services, and a multidisciplinary team comprised of clinical and nonclinical staff. Primary care services may include, in addition to those health home services defined at USC Section 1396w-4:

- Comprehensive care management including but not limited to chronic care treatment and management;
- Extended hours of service;
- Multiple ways for patients to communicate with the team including electronically and by phone;
- Education of patients on self-care, prevention and health promotion, including the use of patient decision aids;
- Coordinating and assuring smooth transitions and follow-up from inpatient to other settings;
- Individual and family support including authorized representatives;
- The use of information technology to link services, track tests, generate patient registries and provide clinical data; and
- Ongoing performance reporting and quality improvement.

Chronic care management is defined in the Act as health care management in a health home of persons identified with or at risk for one or more chronic conditions. Effective chronic care management includes:

- Actively assisting patients to acquire self-care skills;
- Employing evidence-based clinical practices;
- Coordinating care across health care settings and providers, including tracking referrals;

- Providing ready access to behavioral health services that are, to the extent possible, integrated with primary care;
- Using appropriate community resources to support individual patients and families in managing chronic conditions.

A chronic condition is defined as a prolonged condition, including but not limited to:

- A mental health condition;
- A substance use disorder;
- Asthma;
- Diabetes;
- Heart disease;
- Being overweight, with a body mass index over 25.

Further, the Act requires that managed health care delivery systems and self-insured plans contracting with the Health Care Authority (HCA) under Chapter 74.09 RCW, Chapter 74.47 RCW and Chapter 41.05 RCW include provider reimbursement methods that incent chronic care management within health homes; and reward health homes that by using chronic care management, reduce emergency department and inpatient use. Contracts that include these provisions must not exceed the rates that would be paid in the absence of the provisions.

Primary Care Health Homes-Chronic Care Management

Principles of Successful Chronic Care Management Models

The Act directs HCA to conduct a discussion with carriers to learn from successful models and develop principles for effective reimbursement methods to align incentives in support of patient centered chronic care health homes. This discussion was convened May 22, 2012, by Richard Onizuka, then Assistant Director for Health Care Policy. Representatives of Group Health, Premera, Regence, Aetna, Molina, Community Health Plan and CIGNA participated. The dominant principles that emerged from the conversation, reflecting the broadly agreed views of participants, were:

- 1. The fee-for service (FFS) reimbursement model is unsustainable.** The currently dominant reimbursement model promotes uncontrolled cost escalation through increased capacity, increased unit volume to utilize available capacity and increased charge master unit prices. It also encourages utilization of procedures, medications and devices that are not as safe or therapeutically effective as less expensive alternatives. Some parallel considerations include:

- A. Many providers operating under the FFS model are not in a position to assume the risk of abandoning it abruptly, in the sense that their business model is firmly based on it. In the short term at least, they don't have an effective alternative for wholesale change. While some large or integrated delivery systems can thrive under capitation or bundled payment, smaller or more independent hospitals and medical practices are less able to do so.
 - B. While FFS is not sustainable, it will be the provider's as well as the payer's responsibility to change its business model to support emerging reimbursement models.
 - C. There is wide diversity among providers in their ability to adapt their business models to a change in reimbursement. A capitated, integrated delivery system can gauge capacity needs from enrollment, but a FFS-based provider develops capacity to attract revenue and then develops utilization/pricing to support that capacity—a top-line rather than bottom-line orientation to return on investment.
- 2. The transition from FFS to value-based reimbursement is a long-term process.** For the reasons outlined above, it will not be feasible for providers to modify their business plans to adapt to new reimbursement models quickly; it may take as long as a decade for statewide transformation. As part of this process, provider incentives are evolving—e.g. from early models based on diagnosis related groups (DRG) toward shared savings and to benchmarking against control groups, the consumer price index (CPI) or similar standards.
- 3. Diversity among providers creates differing responses to a given incentive.** For example, incentives to reduce emergency department utilization may be effective with a freestanding primary care medical practice, but less so with an integrated delivery system that owns both the medical practice and the hospital that will experience reduced emergency department utilization. Incentives must be designed and implemented in such a way that they do not achieve savings at one point by increasing cost or jeopardizing quality at another, such as reducing length of acute inpatient stay that has the effect of increasing readmissions or skilled nursing admissions/length of stay.
- 4. There are both commonalities and differences among the current approaches to incentives.** In the discussion of current activities, the most common themes were:
- A. Shared savings: Although savings calculation methods vary, providers are incented by the opportunity to share in savings generated by their practice-transformation efforts. Examples include Molina's partial capitation of certain medical groups and

- the Boeing/Regence Intensive Outpatient Care Program (IOC), which calculates savings against control group cost experience and shares gains with participating clinics. National carriers Aetna and CIGNA operate pay-for-performance medical home initiatives in other states. The general trend is toward calculating savings against total per capita expenditure across all care modalities.
- B.** Quality thresholds: Provider eligibility to share in savings or receive other incentives is contingent on maintaining or improving clinical quality, usually as measured by HEDIS or HEDIS-like process quality indicators. Another approach utilizes certification by the National Committee for Quality Assurance (NCQA) as a Patient Centered Medical Home (PCMH) as a marker for clinical and process quality.
 - C.** Medical management/care coordination: The primary mechanism for achieving savings by incentive programs is promotion of care management and care coordination, as in HCA's multipayer reimbursement pilot, either at the provider or payer level. This activity is focused on reducing high-cost services like preventable emergency department events, ambulatory-sensitive inpatient admissions and redundant imaging and laboratory tests.
 - D.** With few exceptions, the payer initiatives of Washington carriers are single-payer rather than multi-payer efforts. Examples include the Group Health Cooperative medical home pilot, the Premera Blue Cross statewide medical home program with Providence Health Services and global outcomes contracts with 12 medical groups, and the Regence/Boeing Intensive Outpatient Care program (IOCP). However, multipayer approaches have been promoted by legislatively based, state-payer and community initiatives. In addition to the multipayer reimbursement pilot mentioned above, examples include the Department of Health Primary Care Collaborative, the public-private partnership on best practices for reducing non-emergent ED utilization, the Dr. Robert Bree Collaborative and the Community Checkup reporting initiative of the Puget Sound Health Alliance.
 - E.** There are conscious efforts to avoid reinventing the wheel. Process elements like HEDIS quality metrics and patient attribution algorithms are copied from one carrier's initiative to another's.
 - F.** Most payer initiatives focus on large, integrated delivery systems rather than small, independent provider entities.

The major differences among approaches were:

- A.** Some payers' initiatives focus on intensive patients while others are practice-wide. The intensive approaches, such as the IOCP, are more feasible to implement for larger provider entities than for smaller ones which cannot administratively support multiple care management models.

- B.** Some, like the Regence IOCP and the statewide multipayer reimbursement pilot, offer prospective care management support while others do not. The trend has been increasingly to tie prospective support to utilization/cost performance.
- C.** Some, like the multipayer reimbursement pilot, expose providers to negative risk but at this point, most payer initiatives do not. A common form of negative risk is a withhold of some portion of contractually agreed reimbursement unless/until performance targets are met.
- D.** Some emphasize patient engagement, while others do not. However, even where this is not a criterion for incentive payment some providers are pursuing patient engagement as a part of their patient management strategy. At a minimum, this includes efforts like a “call us first” patient information campaign to reduce preventable ED utilization.

While results data are still sparse, what information is available tends to be positive. Reductions in preventable emergency department utilization tend to be in the range of 13-15% with a return of investment of approximately 1.5. As greater experience is gained over longer periods and greater segments of the enrollee population, more meaningful indicators will emerge.

Implications for Incentive Design

The discussion also elicited some important considerations for designing and implementing incentive programs. These points reflect the views of the discussion participants and do not necessarily reflect State policy.

- 1. It is important to ensure that carriers are purchasing value.** Initiatives should incent not only the right units of service at the right unit price, but also the right *kinds* of services. Evidence-based medicine must be integrated directly into the incentive structure, with appropriate liability protections for providers.
- 2. Incentives must accommodate the diversity of providers.** One provider or delivery system may optimize by shifting resources from one level of service to another, while a different entity may achieve savings by reducing capacity or redirecting patients. Providers will need to learn how to increase net revenue while reducing gross revenue and incentives must support these changes in provider behavior.
- 3. Medical management/care coordination is moving toward a community-based approach.** Especially for payers serving the Medicaid population, care management is evolving toward the community-based models associated with health homes, opening opportunities for improved coordination with behavioral health and long term care services. For example, since the HCA-health plan meeting, HCA has proposed to the Centers for Medicare and Medicaid Services (CMS) a Medicaid Health Homes initiative

under Section 2703 of the Affordable Care Act which will organize health homes under regional, community based organizations.

4. Standardized metrics and processes will make incentive programs more effective.

The building blocks of medical homes—items like patient attribution models and quality indicators—are becoming increasingly common and statewide standardization would reduce the burden of participation for both providers and payers.

5. Regulatory relief would facilitate broader participation and faster implementation.

Compliance with stringent regulations, particularly in the areas of antitrust and privacy/security, is a major obstacle to getting incentive programs to the operational stage and encouraging provider participation. More importantly, it also restricts multi-payer collaboration which is essential to reaching a critical mass of patients included.

Public Employee Benefits (PEB) Contracting Managed Care and Self-Insured Plans

The Act directs HCA to report to the legislative health committees on the principles developed from the discussion with managed care plans and insurance carriers, and on any steps taken by PEB or carriers to implement the principles through their payment methodologies.

Fully insured coverage for PEB beneficiaries is provided by Group Health and Kaiser Health Plan; self-funded coverage is administered by Regence. Each of these entities has established policies and initiatives in the area of primary care health homes consistent with the requirements of the Act, as well as with the structural characteristics of its delivery system and provider reimbursement model.

- 1. Group Health.** Group Health operates under two delivery models, an integrated system and a network of community providers. The integrated system owns and operates 25 medical centers employing 357 primary care physicians. It holds Level 3 National Committee for Quality Assurance (NCQA) medical home recognition covering all 25 medical centers.

Group Health initiated its first primary care medical home project at its Factoria medical center in 2006 and has since implemented the model at all 25 owned and operated sites. The Factoria experience indicated a reduction of 29% in emergency department utilization and a 6% reduction in hospital days. The Emergency Department Hospital Inpatient (EDHI) initiative was begun in 2009 to improve care transitions among emergency departments, hospitals home health and skilled nursing facilities. This includes promotion of 24-hour urgent care in three medical centers, consulting nurses with emergency department physician backup, extended observation in the urgent care centers and the placement of hospitalist physicians 7 hospitals to co-manage decisions on admission from the emergency department. Hospital Transition Management (HTM) is a

complementary cross-functional improvement effort involving hospital staff, care management, skilled nursing and home care to reduce readmissions, focusing on high-risk patients.

Within this system performance appraisals for physicians include both medical home and chronic condition management requirements. Compensation includes incentives paid on group performance, and no modifications are deemed necessary.

The PEB community network includes over 1000 primary care physicians. Incentives are under development for development of medical homes, based on NCQA recognition or medical home attributes such as extended service hours, use of decision tools and multiple ways to communicate with patients. This incentive program will be in place by January 1, 2013. Group Health is also in process of implementing the internally developed Provider Index with physicians in the contracted network. It will provide a monitoring and reporting mechanism for providers at the clinic level, to improve team performance in quality and cost effectiveness. Measures include a set of HEDIS clinical process indicators, patient experience survey and claims analysis. The latter includes data on emergency department and inpatient cost and utilization.

- 2. Kaiser Foundation Health Plan.** Kaiser serves PEB beneficiaries in Southwest Washington as an integrated staff-model delivery system similar to the integrated model for Group Health. It operates under a medical home model at all locations, using a primary care team consisting of primary care physicians, nurse care managers, pharmacists and support staff. The team provides integrated care, including support tools for self-management and prevention, and relies on extensive use of Kaiser's electronic health record. Kaiser is currently in process of enhancing its medical home capabilities, reducing physician panel size at some locations, adding clinical pharmacists and care managers and simplifying internal procedures. Evidence over the past year indicates reduced emergency department and inpatient utilization, specialty referrals and pharmacy utilization.

Because Kaiser physicians are salaried, incentive payment is by peer-determined bonus based on clinical quality and patient satisfaction. It is not specifically tied to reduced emergency department or inpatient utilization.

- 3. Regence Blue Shield.** Regence administers the Uniform Medical Plan (UMP), PEBB's self-funded plan, and currently includes approximately 250 UMP enrollees in its Intensive Outpatient Care Program (IOCP). This program is a health home approach to chronic care management available to 5-15% of attributed enrollees with the highest risk of utilization, based on claims experience. They include persons with multiple chronic conditions who agree to participate, and are intensively managed with a strong emphasis on patient and family engagement. The initial test of the model with a subset of 276

Boeing employees produced savings of approximately 20%* in total per capita spending, primarily from reduced emergency department and inpatient utilization.

The incentive payment includes a per member per month (PMPM) care coordination fee and up to 50% of net savings in total per capita expenditures. Savings are calculated by comparing improvement between the attributed population and a control group, from a baseline to an observation period. Of the 50% shared savings for which the provider is potentially eligible, 30% is earned from reduced cost and 20% from quality performance.

* *The Commonwealth Fund Newsletter*, March 25, 2011.

Medicaid Contracting Health Plans

In addition to the PEB contracting entities, the managed health care systems that contract to serve the Medicaid Healthy Options, Basic Health and SSI blind/disabled populations are required to offer intensive care coordination services to high risk/high cost consumers. Beginning in 2011, plans are now required to ensure that the primary care provider (PCP) is responsible for the provision, coordination and supervision of health care to meet the needs of each enrollee. The plan is required to provide support to the PCP for care coordination if it does not provide care coordination directly. For the first time, managed care contracts now require coordination with community-based services like First Steps Maternity Services, transportation, Regional Support Networks and developmental disabilities services.

As a result of ESSB 5394, Healthy Options contracts now include a section on care coordination, including continuity of care, transitional care, coordination of care and intensive care management for enrollees with special health care needs.

In addition, as noted above HCA has developed and submitted a draft State Plan Amendment (SPA) in support of the funding opportunities in Section 2703 of the Patient Protection and Affordable Care Act (ACA). Under the draft SPA, contracting health plans would be required to provide health home services either by qualifying as a health home or contracting with a qualified health home. In the FFS model, a portion of the monthly payment for health home services is withheld subject to payment if performance criteria in the areas of preventable Emergency Department and hospital inpatient utilization as well as readmissions. HCA is also working in collaboration with the health plans to ensure that health home models for both managed care and fee-for-service enrollees are structured similarly to promote fidelity between the programs and reduce the need for extensive resources while avoiding unnecessary duplication.

Examples of payers' Medicaid initiatives include:

- 1. Molina Healthcare.** Molina currently offers a Patient Centered Medical Home Incentive to its strategic primary care provider partners who are accredited as PCMHs by either

NCQA or a third- party accreditation program, or non-accredited providers who agree to demonstrate compliance with performance requirements in electronic medical records, patient tracking and registry functions, test tracking, referral tracing, e-prescribing and performance reporting and improvement. Molina also maintains a Shared Savings and quality Program with offers strategic provider partners the opportunity to share in gains from reducing total medical care costs for assigned members, while meeting or exceeding defined quality targets. The Accountable Care Entity (ACE) program allows providers who reduce total health care cost relative to a utilization and cost benchmark to participate in shared savings.

- 2. Community Health Plan of Washington (CHPW).** CHPW developed the Mental health Integration Program (MHIP) in collaboration with their community health center partners. They developed a model of care to serve populations with special health care needs, starting with the Disability Lifeline population and adapted recently to care for all high-risk Medicaid enrollees. This innovative mental health integration model has already resulted in significant savings in hospital care. The incorporation of a payment innovation has been shown to reduce the time to improved depression scores in half, by requiring care coordinators to have met quality indicators.
- 3. Amerigroup Washington.** Amerigroup Washington is pursuing negotiated, value-based provider contracts with integrated systems and primary care practices, with priority emphasis on recruiting federally qualified health centers (FQHC). Its Provider Relations Department has implemented Enhanced Payment programs with MultiCare Health Systems and International Community Health Services. These programs are designed to provide supplemental reimbursement for primary care coordination and management while generating utilization data for the development of a Provider Quality Improvement Program to follow after the Enhanced Payment program.
- 4. UnitedHealthcare Community Plan.** United is in process of implementing accountable care communities (ACC), essentially virtual ACOs as defined by the Affordable Care Act. The ACC model gives providers access to real-time ED and inpatient data allowing for smooth transitions and patient education leading to improved outcomes measured in terms of ED visits, readmissions and avoidable admissions. Shared-savings contracts allow for value-based purchasing and resultant practice transformation with data and consultative inputs from the health plan.

Application of Chronic Care Health Home Principles

The various approaches to promoting health home services in publicly sponsored programs reflect the distinct approaches of their sponsors as well as several commonalities. Among the most important of these characteristics:

- Payment and delivery reform are interdependent—neither is successful without the other, and models are increasingly designed to link decision-making authority with accountability for performance. In particular, models which place primary care providers in control of care management also focus incentives—positive or negative--on those providers.
- Incentive payments are built on or adapted from payers’ existing medical home/health home models, most of which have been in development for some time.
- Incentive payments do not replace FFS wholesale. Rather, they add a care coordination fee and/or add a sharing of savings. Within integrated systems, payment is generally not FFS-based and performance incentives are integrated into the payment structure. In some integrated systems, incentives are paid at the group level to encourage teamwork.
- Some incentive payment structures specifically target clinical services like emergency department, imaging, pharmacy and inpatient utilization, while others are based on per capita costs.
- Incentive payment arrangements are generally not prescriptive as to how a provider should achieve savings, allowing the provider to determine specific approaches to practice transformation that fit the dynamics of the practice and patient panel.
- Incentives are designed to promote utilization savings, but also include a quality component either as a performance target in its own right or as a threshold for receiving an incentive payment.