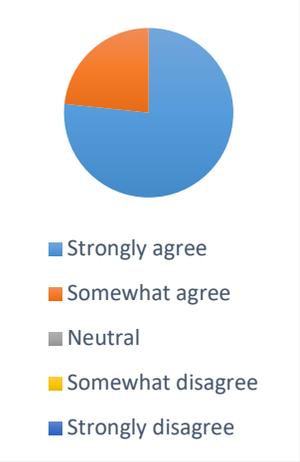
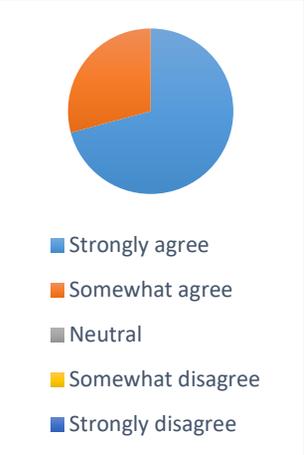
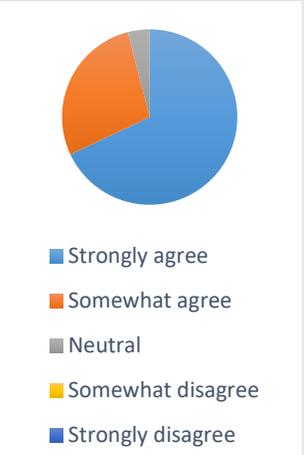


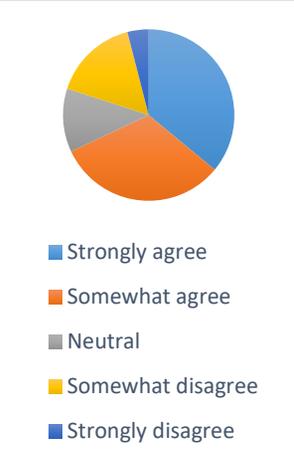
Straw Plan Components Based on Combined Priorities from Primary Care Providers and Payers

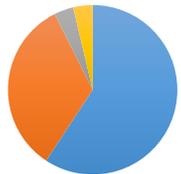
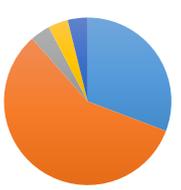
Element	Working Description	Key Webinar Concepts (5+ participants)
<p>Primary care as integrated whole-person care, including behavioral and preventive services</p> <p>Level of “agree” from webinar: 100%</p>  <p>Legend:</p> <ul style="list-style-type: none"> ■ Strongly agree ■ Somewhat agree ■ Neutral ■ Somewhat disagree ■ Strongly disagree 	<p>Goal: <i>A care team, using a range of settings or modalities to ensure access, is responsible for a patient’s physical and behavioral health care using a single unified care approach that includes evidence-based prevention and wellness, acute care, chronic care, and referral to specialty and community support as needed.</i></p> <p>Description: A care team, using a range of settings or modalities, is responsible for a patient’s physical and behavioral health care using a single unified care approach that includes evidence-based prevention and wellness, acute care, chronic care, and referral to specialty and community support as needed. The care team:</p> <ul style="list-style-type: none"> • Documents and communicates all types of needs; • Trains and assigns team members to support patient and family self-management, self-efficacy, shared decision making, and behavior change; • Includes behavioral health providers (using coordinated, co-located, or integrated models); • Is trained to connect vulnerable populations with appropriate evidence-based care (including oral health), and engages patients and families in their own care and behavioral change; • Engages patients; • about its processes for 1) integrating physical and behavioral health; 2) developing integrated care plans; and 3) providing self-management agreement support and behavior change; and • Uses a range of settings, as appropriate, to ensure access, including but not limited to office settings, home visits, digital modalities, and community locations. 	<p>Evidence-based (7)</p> <p>Patient and family centered (6)</p>

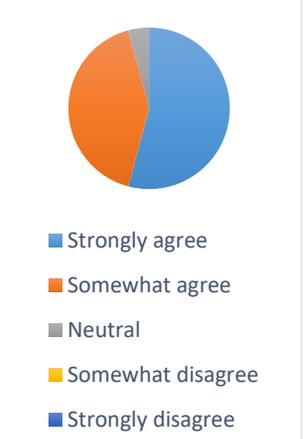
Element	Working Description	Key Webinar Concepts (5+ participants)
<p>Shared understanding of care coordination and providers in that continuum</p> <p>Level of “agree” from webinar: 100%</p> 	<p>Goal: <i>Patients are assigned to care teams based on level of need, stressing the importance of managing chronic disease, behavioral health, oral health, social support needs, and patient/family goals.</i></p> <p>Description: All empaneled or attributed patients are assigned to high-functioning care teams based on their goals and level of need, stressing the importance of managing chronic disease, behavioral health, oral health, and social support needs. The care team addresses the needs and goals of the individual and family by efficiently organizing and coordinating care across all elements of the broader health system including hospitals, specialty care, health plans, home and community-based services, and community resources. Effective coordination by the care team includes:</p> <ul style="list-style-type: none"> • Adequate health information to coordinate transitions of care among providers, plans, and other organizations; • Agreements or contracts among providers, plans, and other organizations to coordinate transitions including emergency department and inpatient visits, residential and partial treatment facility stays, stays at substance abuse treatment facilities, and community resources; • Tracking referrals, following up on over-due responses and closing care gaps; • Explicit approaches to integrate physical and behavioral health care; and • Complete and correct coding, where necessary, for service accuracy and billing. <p>Potential roles:</p> <ul style="list-style-type: none"> • <i>Primary care providers</i> deliver integrated whole-person care (as described above), using a single unified care approach, and coordinating/following all referrals using effective communication and agreements with providers, plans and other organizations in the health system. 	<p>Patient choice, goals and level of need (16)</p> <p>Defined, high-functioning care team (7)</p>

Element	Working Description	Key Webinar Concepts (5+ participants)
	<ul style="list-style-type: none"> • <i>Specialty providers</i> deliver specialty care and effectively communicate with primary care provider teams through care coordination agreements and formal/informal relationship building. • <i>Behavioral health (SUD and mental health providers)</i> 1) participate on care teams as part of integrated, whole person care and 2) serve as specialty providers for those with more intense levels of behavioral health needs. • <i>ACHs</i> 1) increase community capacity, 2) develop awareness of and facilitate connections to community services necessary for whole-person wellness, and 3) support providers in the transformation to integrated whole-person primary care as defined above. • <i>Payers, including MCOs</i> 1) support the development of whole-person care as defined above, 2) provide payment and incentives as described below, and 3) support providers to fulfill care coordination and case management roles. • <i>HCA</i> 1) provides unified vision of transformation and transformation support, 2) holds MCOs and contracted payers accountable for their role described above, 3) provides and/or seeks (as necessary) policy support for provision whole person care, and 4) sets standards for interoperability and information exchange. • <i>Community-based providers</i> 1) work with ACHs to assess (and increase as needed) capacity, 2) participate with primary care teams as part of unified care approach, and 3) utilize communication and data sharing mechanisms necessary to participate in unified care approach. • <i>State agencies</i> work in collaboration with HCA to establish consistent standards for data sharing, integrated care delivery expectations, and payment approaches. 	
Aligned payment and incentives across payers to support model	<p>Goal: <i>Plans will align payment approaches, which will be tied to measurable value metrics and may include a combination of care management fees, office visit fees, and performance-based incentive payments.</i></p>	Simple, easy to measure & report (7)

Element	Working Description	Key Webinar Concepts (5+ participants)
<p>Level of “agree” from webinar: 96%</p>  <p>Legend:</p> <ul style="list-style-type: none"> ■ Strongly agree ■ Somewhat agree ■ Neutral ■ Somewhat disagree ■ Strongly disagree 	<p>Description:</p> <p>Plans will align payment approaches, tied to measurable value metrics, using three braided approaches:</p> <ol style="list-style-type: none"> 1. Monthly care management fee for non-visit-based care management strategies, including minimum expectation for meaningful annual engagement with each attributed or enrolled patient using a range of modalities. Monthly care management fee will be increased over time, while office visit fees will be reduced. 2. Office visits paid by FFS and/or comprehensive primary care payment. 3. Performance incentive paid prospectively on an annual basis according to a tiered PMPM formula. Performance measures based on: a) evidence-driven clinical quality measures; and b) utilization measures that drive total cost of care (such as ED utilization or hospitalizations, appropriate site of service, and access). Recoup if population performance, utilization and quality thresholds are not met. 	<p>Evidence-based (7)</p>
<p>Application of actionable analytics (clinical, financial, and social supports)</p>	<p>Goal:</p> <p><i>Payers and providers together use cost and utilization data that is interoperable with and across EHR systems to develop, implement, and document interventions to improve performance.</i></p> <p>Description:</p> <p>Payers and providers together use data that is interoperable with and across EHR systems to develop, implement, and document interventions to improve performance, and share information at the individual clinician and practice level.</p> <p>Payers work together to aggregate cost and utilization data and deliver to providers in a manner that is interoperable with EHR systems. These data will:</p> <ul style="list-style-type: none"> • Be based upon an agreed upon attribution methodology • Be delivered at the care team level and be incorporated into work flow • Hold the care team accountable for performance, and incentivize those that perform 	<p>Interoperability (6)</p>

Element	Working Description	Key Webinar Concepts (5+ participants)
<p>Level of “agree” from webinar: 68%</p>  <ul style="list-style-type: none"> ■ Strongly agree ■ Somewhat agree ■ Neutral ■ Somewhat disagree ■ Strongly disagree 	<p>Providers use cost and utilization data to:</p> <ul style="list-style-type: none"> • Analyze and identify whole person needs at a population level and develop processes to meet those needs; • Systematically identify referral patterns and adjust to improve patient outcomes and reduce cost and unnecessary care; • Coordinate and manage referrals; • Identify hospitals and EDs responsible for the majority of patients’ hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer; • Enhance quality and evaluate effectiveness over time; • Identify and implement behavioral health integration processes; and • Identify opportunities to work with ACHs to improve community supports. 	
<p>Improved provider capacity and access</p> <p>Level of “agree” from webinar: 92%</p>	<p>Goal: <i>Patients are empaneled or attributed to high-functioning care teams to coordinate and provide care, and patients receive meaningful annual engagement using a range of modalities.</i></p> <p>Description: At least 90% of patients, allocated by insurers to a practice, are empaneled or attributed to high-functioning care teams to coordinate and provide care. At a minimum, 90% of patients receive meaningful annual engagement using a range of modalities.</p> <p>Care teams skilled in addressing physical AND behavioral health are available during office hours and extended hours. Same day appointments, 24/7 e-health, telephonic access, and communication through IT innovations are offered and integrated into care modalities. Technology-driven modalities and innovations are integrated with electronic health record. Behavioral and physical health advice/care (including clinical advice, test results, medication refills and appointment reminders) is documented for the patient through accessible, secure electronic means.</p>	<p>Use of telehealth (7)</p> <p>Resources (6)</p>

Element	Working Description	Key Webinar Concepts (5+ participants)
 <ul style="list-style-type: none"> ■ Strongly agree ■ Somewhat agree ■ Neutral ■ Somewhat disagree ■ Strongly disagree 		
<p>Aligned measurement of “value” from the model</p> <p>Level of “agree” from webinar: 88%</p>  <ul style="list-style-type: none"> ■ Strongly agree ■ Somewhat agree ■ Neutral ■ Somewhat disagree ■ Strongly disagree 	<p>Goal: <i>Primary care is defined as integrated whole-person care, including evidence-based behavioral and preventive services as described above. Payers agree to use a core set of measures that measure increased quality of care, improved health for patients, and reduced cost.</i></p> <p>Description: Primary care is defined as integrated whole-person care, including evidence-based behavioral and preventive services as described above. Payers agree to use a core set of measures that:</p> <ul style="list-style-type: none"> • Demonstrate transformation to this definition of primary care over a 3-year period; • Measure increased quality of care, improved health for empaneled patients, and reduced cost; • Define a core set of no more than ten (10) measures that demonstrate improved patient satisfaction and affordability; and • Reduce administrative burden to the extent possible. 	<p>Evidence-based (8)</p>

Element	Working Description	Key Webinar Concepts (5+ participants)
<p>Financing</p> <p>Level of “agree” from webinar: 96%</p>  <p>■ Strongly agree ■ Somewhat agree ■ Neutral ■ Somewhat disagree ■ Strongly disagree</p>	<p>Goal: <i>Payers agree to an incremental and defined percent (%) of spend on primary care as a proportion of total cost of care, not including labs and prescription drug costs, and considering a range of practitioners and multi-disciplinary teams. Percent of spend may be tiered, based on achievement of specified measures of transformation, increased quality, improved health and reduction in total cost of care.</i></p> <p>Description: Payers agree to an incremental and defined percent (%) of spend on primary care as a proportion of total cost of care, not including labs and prescription drug costs, <i>and considering a range of practitioners and multi-disciplinary teams.</i></p> <p>Percent of spend may be tiered, based on achievement of specified measures of transformation, increased quality, improved health and reduction in total cost of care.</p>	<p>Equity (9)</p>

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Discussion Reference: Principles for Quality Measure Selection

Criteria for addition of new measures to the WA Statewide Core Measures Set¹

- 1) Measures should be based on **readily available** health care insurance claims, clinical data and/or survey data.
- 2) Preference should be given to **nationally-vetted measures** (e.g., NQF-endorsed) and other measures currently used by public agencies. Measures should be **aligned** with national measure sets and other measure sets commonly used in Washington, whenever possible.
- 3) Measures should have significant potential to **improve health system performance** in a way that will positively impact quality of care, safety and health outcomes (including morbidity, disability, mortality, health equity, and quality of life) and reduce costs.
- 4) Measures should have a **sufficient numerator and denominator size** for each measure to produce valid and reliable results.
- 5) Measures should be **amenable to the influence of health care providers** if results are expected to be reported at the provider level.
- 6) The measure set should be **aligned**, to the extent possible with the Governor's performance management system measures and common measures specific to the Medicaid program.
- 7) The measure set should be **useable by multiple parties** (purchasers, payers, providers, hospitals, health systems, public health and communities) and take into consideration **different populations**.
- 8) Where appropriate, measures have potential to affect causality, **preventing a health condition** from occurring in the first place.

AAFP Principles for Measure Selection²

- 1) Measures should be focused on improving processes and outcomes of care in terms that matter to patients.
- 2) Measures should be based on best evidence and reflect variations in care consistent with appropriate professional judgment.
- 3) Measures should be practical given variations of systems and resources available across practice settings.
- 4) Measures should not separately evaluate cost of care from quality and appropriateness.
- 5) Measures should take into account the burden of data collection, particularly in the aggregation of multiple measures.

CMS Core Measure Collaborative³

The guiding principles used by the Collaborative in developing the core measure sets are that they be meaningful to patients, consumers, and physicians while reducing variability in measure selection, collection burden, and cost.

¹ Plan for the Ongoing Evolution and Evaluation of the Statewide Core Measures Set, <https://www.hca.wa.gov/about-hca/healthier-washington/performance-measures>

² Source: AAFP principles for Administrative Simplification <https://www.aafp.org/about/policies/all/principles-adminsimplification.html>

³ Source: CMS core measure collaborative <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures>