

PROPOSED

Washington Multi-payer Primary Care Transformation Model

Introduction

Primary care is the foundation of our health care system and essential to better health outcomes, lower costs and healthier families and communities. Evidence shows greater use of primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality.¹

Primary care offices are in the best position to reduce demand in other parts of the health care system and keep patients out of the hospital, raising fears about increasing costs and related complications if patients must seek care in other parts of the system. For at least a decade, healthcare experts have been calling for a transformation in primary care, including:

- Revising how traditional office visits have been defined;
- Providing whole-person care (primary care and behavioral health) in primary care settings;
- Expanding the use of telehealth; and
- Halting the longstanding system of paying clinicians for each service they provide (fee-for-service or FFS).

There is also widespread agreement primary care is underfunded, burnout is high among primary care providers, and the proportion spent on primary care is insufficient, despite current high levels of healthcare spending in the United States and robust evidence that health systems with a primary care focus have superior patient outcomes, fewer inequities, and lower costs. On average, the United States spends 5-7 percent on primary care as a percentage of total health care spending, compared to 14 percent spend on primary care in Organization for Economic Co-operation and Development (OECD) countries.² In 2018, Washington State, as reflected by spending by both public and private payers, spent only 4.4 to 5.6 percent.³ Primary care spending in Washington State used to be higher, due to a 2010 Affordable Care Act provision mandating a two-year increase (in 2012 and 2013) in primary care in Apple Health (Medicaid).

States that have introduced/passed legislation or issued executive orders to measure, and eventually increase, primary care investment without growing overall health care spending have seen positive results. For example, Rhode Island, an early leader in primary care spend measurement and investment, measured and increased its primary care spending from 5.7

¹ Patient-Centered Primary Care Collaborative and the Robert Graham Center. Investing in Primary Care: a State-Level Analysis. July 2019.

² Ibid.

³ Washington State Office of Financial Management. Primary Care Expenditures: Summary of current primary care expenditures and investment in Washington, a Report to the Legislature, Nov 22, 2019.

percent in 2008 to 9.1 percent in 2012. Over this same period, total health care expenditures fell by 14 percent. Rhode Island achieved its target of 10.7 percent by 2014.⁴

In Washington's Apple Health (Medicaid) program, the primary care rate is equal to 65 percent of Medicare reimbursement rates for primary care, making Washington State the 32nd lowest paying state for Medicaid primary care rates (Medicaid primary care rates nationwide range from 33 percent to 127 percent of Medicare).⁵ Apple Health has heard from primary care providers in Washington they provide primary care services to Washington's Apple Health patients at a loss. Washington State's primary care rate has not been increased since 2014.

Washington State Health Care Authority's Efforts to Strengthen Primary Care and Whole Person Care through Value-based Payments and Alternative Payment Models

The Washington State Health Care Authority (HCA), the largest purchaser in Washington providing care to 2.5 million Medicaid recipients, public and school employees, was directed by the Legislature (ESSB 2572) in 2014 to increase alternative payment arrangements and value-based payment strategies. As a result, HCA has implemented various strategies to advance whole person and primary care including:

- Financial integration of physical and behavioral health into Medicaid Managed Care Organizations by 2020;
- A primary care model with select Federally Qualified Health Centers on moving Medicaid payments away from encounter-based payments to payments based on value;
- Free primary care visits for enrollees and primary care medical home requirements for clinical integrated networks under the Accountable Care Organization program offered to public and school employees;
- Accountable Communities of Health work on bi-directional integration of physical and behavioral health transformation through care transformation under the Medicaid Transformation Program;
- A contract requirement for all Medicaid and public and school employee health plan partners to report total expenditures spent on primary care; and,
- Minimum primary care spending threshold requirements for Public Option plans offered on the Washington Health Benefit Exchange in 2021.

The Washington Legislature has also taken steps to increase Washington Apple Health's primary care reimbursement rates, most recently through the passage of SSB 6676, which was not enacted due to financial impact of COVID-19 on Washington State's budget.

⁴ Patient-Centered Primary Care Collaborative and the Robert Graham Center. Investing in Primary Care: a State-Level Analysis. July 2019.

⁵ Medicaid-to-Medicare Fee Index 2016; State Health Facts, Kaiser Family Foundation (www.kff.org/medicaid).

The recent COVID-19 pandemic has further threatened primary care practice solvency and the viability of our already fragile primary care system, increasing the risk of practice acquisition and consolidation and affordability concerns. According to the Quick COVID-19 Primary Care Survey administered by the Larry A. Green Center (June 12-15, 2020), primary care clinicians continue to struggle to keep their businesses running. Nationally, in the last four weeks, 5 percent report their practice is now (temporarily or permanently) closed; 25 percent of clinician have skipped or deferred their salaries; and 39 percent have needed to layoff or furlough clinicians or staff; and 1 in 5 have limited patient volume as a result, causing a major impact on access to care. Washington State survey results mirror national results; over 60 percent of primary care clinicians report that COVID-19 has moderately or severely impacted their practices. The survey results underscores that, without immediate private and public payer action to stabilize (short-term) and strengthen (long-term) primary care, primary care will not readily survive the next wave of the pandemic.

The proposed multi-payer primary care transformation model builds upon and will accelerate HCA's current primary care and transformation efforts, as listed above, and will be closely aligned and synergistic with future HCA programs and efforts including pediatric alternative payment models, the next phase of Medicaid MCO behavioral health integration, rural sustainability, Cascade Care/Public Option and efforts to address the social determinants of health. Even with existing efforts, there's widespread agreement from primary care providers, Washington State's health plans and stakeholders that a more comprehensive transformation model centered on primary care that is supported and implemented by all health plans is critical to better health outcomes for Washington State residents.

During the second half of 2020, HCA will work with its health plan partners to implement the model in state in state-financed programs (Apple Health, public employees and school employees) through budget-neutral mechanisms. HCA will also work with interested employers through the Washington Health Alliance and Pacific Business Group on Health to spread and scale the model throughout Washington State.

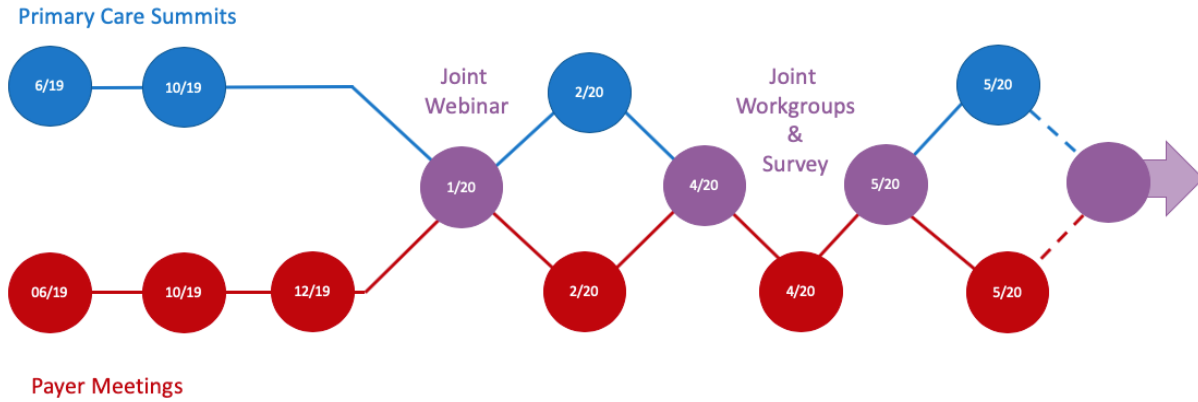
Multi-payer Primary Care Transformation Model Development

HCA has been working over the last year to develop the proposed new multi-payer primary care transformation model outlined below, in collaboration with Washington State's payers and primary care provider community, as well as employers and other stakeholders interesting in advancing whole-person care. Figure 1 provides an overview of the process to date that has culminated in this proposed primary care transformation model.

HCA has been impressed by the level of alignment and support that has emerged from both the payer and provider communities as well as employers to support the proposed whole-person, coordinated model of care for Washingtonians. Through the meetings outlined below, both payers and providers have expressed support for implementation of the model across all HCA

programs (Apple Health, public employees and school employees), as well as privately insured lives to the extent possible.

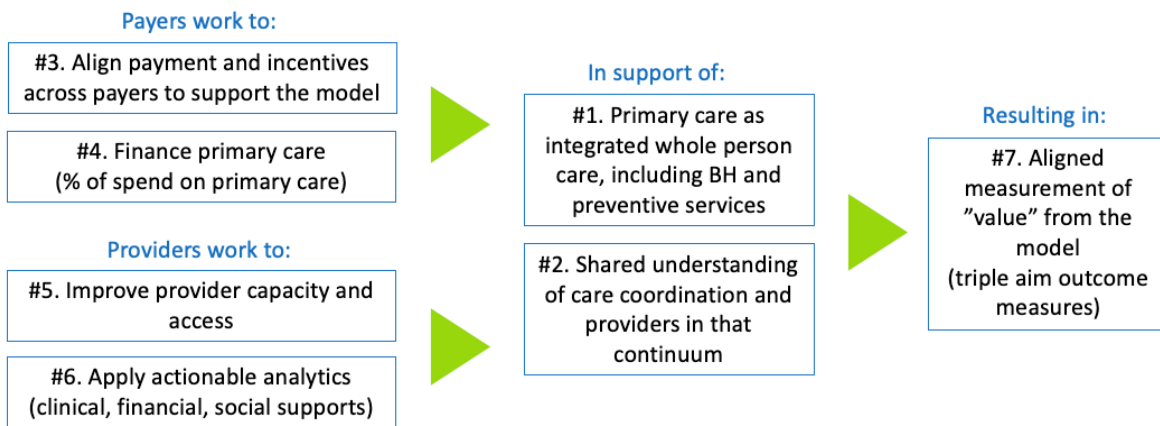
Figure 1: Building Consensus on Primary Care in WA in 2019/2020



Proposed Multi-payer Primary Care Transformation Model: Key Components for a Whole-person Care, Integrated Primary Care Model for Washington

The proposed model is intended to be multi-payer to provide a consistent framework for integrated primary care payment across providers and payers. Figure 2 provides an overview of the proposed seven components of the model and the components are discussed below.

Figure 2: Primary Care Transformation Proposed Components



Component 1: Primary care as integrated whole-person care, including behavioral and preventive services

Goal: 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.

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:

- 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, non-traditional person-to-person modalities and community locations.

Component 2: Shared understanding of care coordination and providers in that continuum

Goal: 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 the goals of the patient, family, and caregiver.

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, community resources, and end-of-life care. Effective coordination by the care team includes:

- 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.

Potential roles:

- *Primary care providers* 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.
- *Specialty providers* deliver specialty care and effectively communicate with primary care provider teams through care coordination agreements and formal/informal relationship building.
- *Behavioral health (SUD and mental health providers)* 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.
- *ACHs* 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.
- *Payers, including MCOs* 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.
- *HCA* 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.
- *Community-based providers* 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.
- *State agencies* work in collaboration with HCA to establish consistent standards for data sharing, integrated care delivery expectations, and payment approaches.

Component 3: Aligned payment and incentives across payers to support model

Goal: Plans will align payment approaches, which will be tied to measurable value metrics and may include a combination of transformation of care fees, comprehensive payments, and performance-based incentive payments.

Description: The payment model will be comprised of three components:

1. *Transformation of Care Fee (TCF)*. A TCF will be paid to support the transformation of care to a coordinated delivery model that integrates behavioral and physical health care, as well as transition to care provided in a range of settings to ensure access, including but not limited to office settings, home visits, digital modalities, non-traditional person-to-person modalities and community locations. In order to receive TCFs, practices will be required to agree to make transformation progress as defined by specified transformation measures. The TCF will be provided up to three years before transitioning to performance incentive payments (PIPs). The transition period from TCFs to PIPs within the three years may vary based on individual practices' progress on the transformation outcome measures.
2. *Comprehensive Primary Care Payment (CPCP)*. A fixed, monthly PMPM payment will be made to provide comprehensive high-quality and high-value primary care services including physical and behavioral health, evidence-based prevention and wellness, acute care, chronic care, and referral to specialty and community support, regardless of modalities used, delivered to a patient population over a period of time. The goal of CPCP is to give providers the freedom to deliver the care that best meets the needs of their patients and move away from the fee-for-service model.
3. *Performance Incentive Payment (PIP)*. An incentive payment prospectively on a quarterly basis according to a tiered PMPM formula based on performance, moving away from the fee-for-service model. Full or partial payment will be recouped in subsequent years if population performance, utilization and quality thresholds are not met. Performance will be measured through evidence-driven clinical quality measures; and utilization measures that drive total cost of care (such as ED utilization or hospitalizations, access measures).

The CPCP is intended to provide payment certainty for integrated primary care services as defined in the delivery model section of this paper. The TCF provides up to three years of support for practices to transition to the integrated care delivery model and to make changes in infrastructure, staffing and business processes to support the model. By three years, the revenue of the TCF will transition to a performance incentive payment designed to induce further efficiency and quality of care. The transition period will vary across providers recognizing that some providers have been already investing in transformation.

Component 4: Financing

Goal: 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, multi-disciplinary teams, and care modalities including telehealth and other non-traditional person-to-person modalities. 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.

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, and considering a range of practitioners, multi-disciplinary teams, and care modalities including telehealth and other non-traditional person-to-person modalities.

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.

Component 5: Improved provider capacity and access

Goal: 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.

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, including telehealth and other non-traditional person-to-person modalities.

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, non-traditional person-to-person modalities 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.

Component 6: Application of actionable analytics (clinical, financial, and social supports)

Goal: 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.

Description:

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.

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:

- 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

Providers use cost and utilization data to:

- 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.

Component 7: Aligned measurement of “value” from the model

Goal: 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 outcome measures of increased quality of care, improved health for patients, and reduced cost, and process measures that reflect progress toward those care transformation goals

Description:

Primary care is defined as integrated whole-person care, including evidence-based behavioral and preventive services as described above. Payers will use a core focused set of measures that:

- 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; and
- Reduce administrative burden to the extent possible.

Proposed Transformation Measures

The measures in Table 1 are recommended to gauge progress toward whole-person, integrated care model over a three-year period. These measures would remain constant, but measurement of them (or metrics) would be designed to demonstrate progress. While each of these is used by transformation efforts at the federal level or in other states, the HCA may need to ensure or develop mechanisms to measure them.

Table 1: Proposed Transformation of Care Measures

Focus Area	Transformation Measure
Access	Same day appointments, 24/7 e-health, telephonic access, and communication through IT innovations are offered for both physical AND behavioral health and integrated into care modalities.
	Practice regularly offers at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours in early mornings, evenings, and weekends.
Care Coordination	Practice has and uses a documented strategy to identify care gaps and prioritize high-risk patients and families, AND proactively manages care gaps and documents outcomes, for example, using and documenting care plans.
	Practice consistently implements team-based care strategies (huddles, care mgmt. meetings, high risk patient panel review)
Whole Person Care	Practice uses an evidence-based tool to screen for behavioral health issues, AND has a documented process for connecting patients/families with behavioral health resources following screening, including standing orders, and protocols for follow up
	Practice has and uses a documented risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs.
	Ensure patients' goals, preferences, and needs are integrated into care through advance care planning.
Application of Actionable Analytics	Capacity to query and use data to support clinical and business decisions.

Proposed Clinical Quality Measures:

The measures in Table 2 are recommended as a core set to gauge the clinical quality delivered by an integrated, whole-person care model. Except where otherwise noted, all measures are recommended using HEDIS measurement standards (metrics).

Table 2: Proposed Clinical Quality Measures

Contraceptive Care – Most & Moderately Effective Methods (using NQF 2903)
Childhood Immunization Status (CIS) (Combo 10)
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)
Adolescent Well Child Visits (AWC) (12-21 years of age)
Percent of patients who receive annual BH screening in primary care (using NQF 0418)
Depression Remission and Response for adolescents and adults
Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (CDCŃ)
Controlling High Blood Pressure (CBP)
Medication Management for People with Asthma (MMA) Medication Compliance 75%
Screening for colorectal cancer
Reduction in Emergency Room utilization
Total Cost of Care Metrics