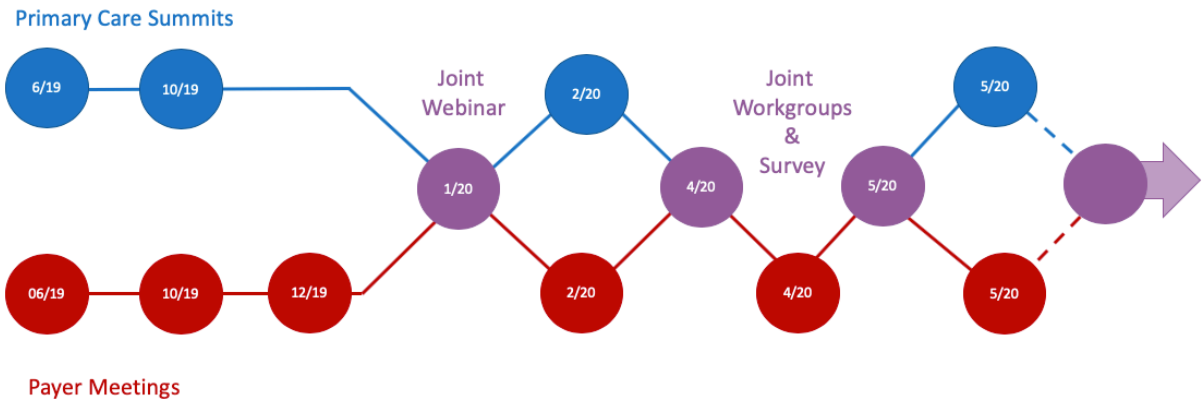
MEMORANDUM OF UNDERSTANDING AMONG WASHINGTON STATE HEALTH PLANS IN SUPPORT OF MULTI-PAYER COLLABORATIVE PRIMARY CARE REFORM WORK

Background

The Washington Health Care Authority has been working over the last year to develop a proposed new primary care model, in collaboration with the state's payers and primary care provider community. Figure 1 provides an overview of the process to date that has culminated in the WA Primary Care Transformation Initiative. HCA has been impressed by the level of alignment and support that has emerged from both the payer and provider communities to support a new whole-person, coordinated model of care for Washingtonians.

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



Purpose and Scope

The purpose of this Memorandum of Understanding (MOU) among Washington state health plans (Payers) is to outline a multi-payer initiative that strengthens primary care through an integrated whole-person approach that includes behavioral and preventive services, under the umbrella of the Washington Primary Care Transformation Initiative. The initiative will improve primary care through:

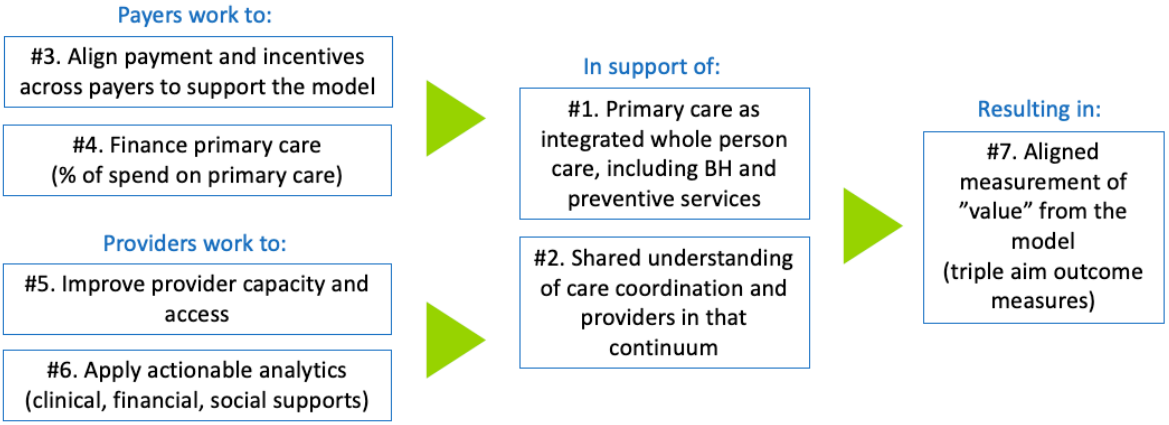
- Shared understanding of integrated whole person care;
- Shared understanding of care coordination and the roles necessary to achieve it;
- Improved access;
- Application of actionable analytics;
- Aligned models of payment, including practice incentives; and
- Common measurement of quality (for both practice transformation and clinical quality).

Health plans participating in this initiative believe that while there are many paths towards a better health care system, all successful paths are based on a foundation of strong and advanced primary care. Recognizing that the impact of any one payer alone is limited, the payers in this initiative have collaboratively committed to a good faith effort to coordinate with the HCA to transform the way in which primary care is delivered and financially supported in the practices participating this initiative.

Over the next three years, the WA Primary Care Transformation Initiative will evaluate the impact of value-based payment models and aligned metrics on the integration of whole person care, as well as the impact to population health. Payers will use good faith efforts to contract with the practices participating in this initiative, and practices will be held accountable for meeting transformation and clinical quality metrics.

This Memorandum of Understanding serves to memorialize the HCA's and the Payers' respective commitments in a public, transparent fashion. This Memorandum of Understanding is non-binding, but each participating Payer is committed to this multi-payer initiative and will make good faith efforts to implement it, and comply with all components of the MOU for the success of the WA Primary Care Transformation Initiative. Each payer will use good faith efforts to build the framework of commitments that meet the WA Primary Care Transformation Initiative goals and requirements. The MOU itself will be a public document. Thus, to achieve this vision of integrated whole person care, the Payers and the HCA enter into this Memorandum of Understanding committing to the following model components.

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.

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.

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.

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.

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.

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.

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

Proposed transformation and quality measures are included in Appendices B-D.

Washington Multi-Payer Collaborative organizations agreeing to this MOU

x 8/26/2020
Leanne Berge
Chief Executive Officer
Community Health Plan of WA

x
Craig Smith
President & CEO
Amerigroup Washington

x
Emily Leigh-Pitstick
Network Vice President
United Healthcare

x
Ken Chandler
SVP, National Accounts
Premera Blue Cross

x
Joseph E. Smith
Vice President, Sales & Business Development
Kaiser Foundation Health Plan of Washington

x
Andrew Nelson
VP, Network Management
Molina Healthcare

Tim Lieb
President
Regence BlueShield

x
Beth Johnson
President and CEO
Coordinated Care

x
Susan E. Birch
Director
Washington State Health Care Authority

x
Name
Title
Payer organization

Appendix A: WA Primary Care Transformation Initiative 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.

3. *Performance Incentive Payment (PIP).* An incentive payment prospectively on a quarterly basis according to a tiered PMPM formula based on performance. 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.

Appendix B: Proposed Transformation Measures

The following measures 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.

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.

Appendix C: Proposed Clinical Quality Measures

The following measures 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).

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%) (CDCÑ)
Controlling High Blood Pressure (CBP)
Asthma Medication Ratio: 0.50 or greater
Screening for colorectal cancer
Reduction in Emergency Room utilization

Appendix D: Proposed System Measures

Measures to be determined to gauge system performance in an integrated, whole-person care model.