Washington Primary Care Model Update

OCH VBP Action Group

July 12, 2022

Washington State Health Care Authority

Building a new multi-payer primary care model for WA

- Goals:
  - Align payment, incentives, and metrics across payers and providers
  - Promote and incentivize integrated, whole-person and team-based care that includes primary care, physical and behavioral health care, and preventive services
  - Improve provider capacity and access
  - Increase primary care expenditures while decreasing total health spending
  - Work with interested public and private employers to spread and scale the model throughout Washington State

Primary Care Transformation (PCT) components

Payers work to:

Align payment and incentives across payers to support the model

Finance primary care (% of spend on primary care)

Providers work to:

Improve provider capacity and access

Apply actionable analytics (clinical, financial, social supports)

In support of:

Primary care as integrated whole person care, including BH and preventive services

Shared understanding of care coordination and providers in that continuum

Resulting in:

Aligned measurement of "value" from the model (quadruple aim outcome measures)

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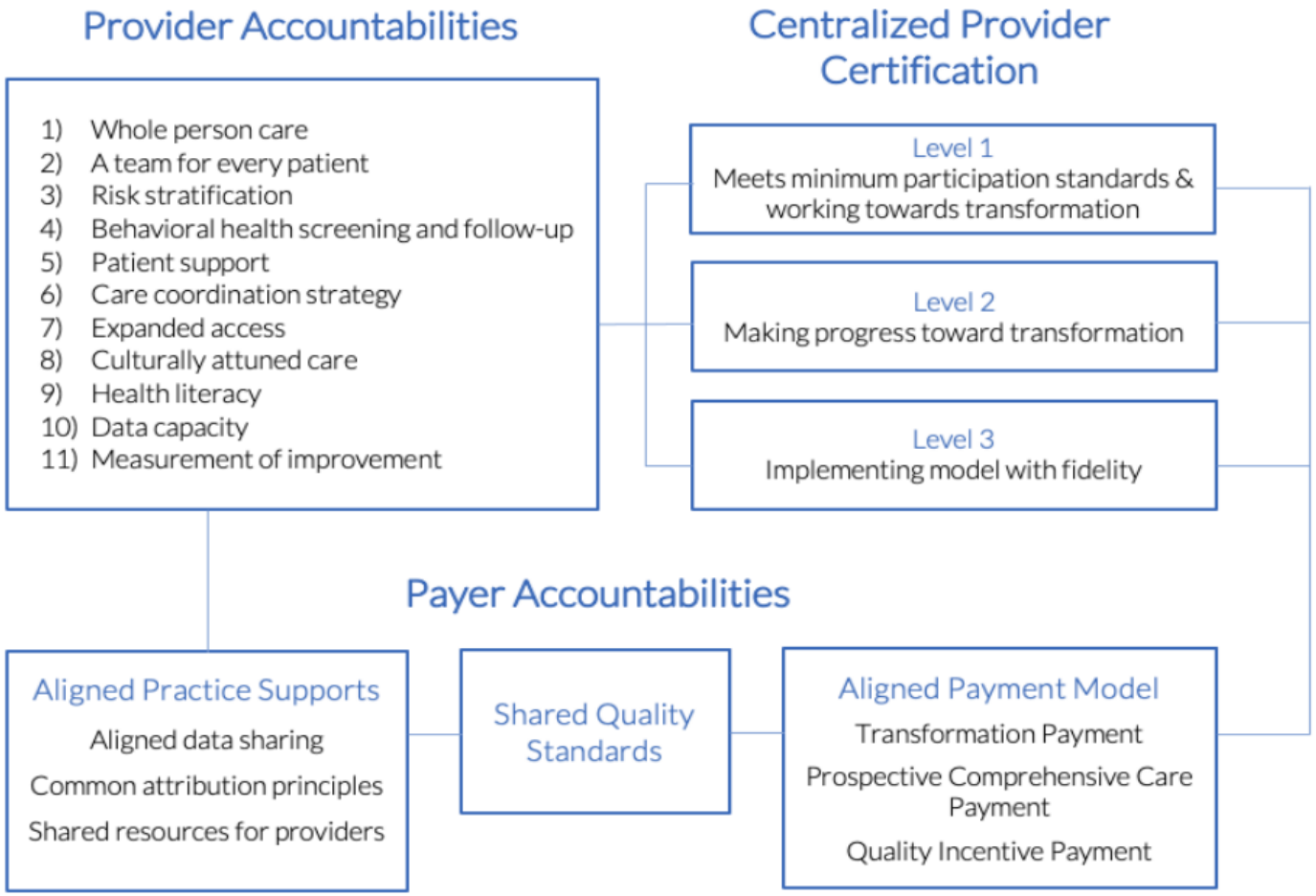
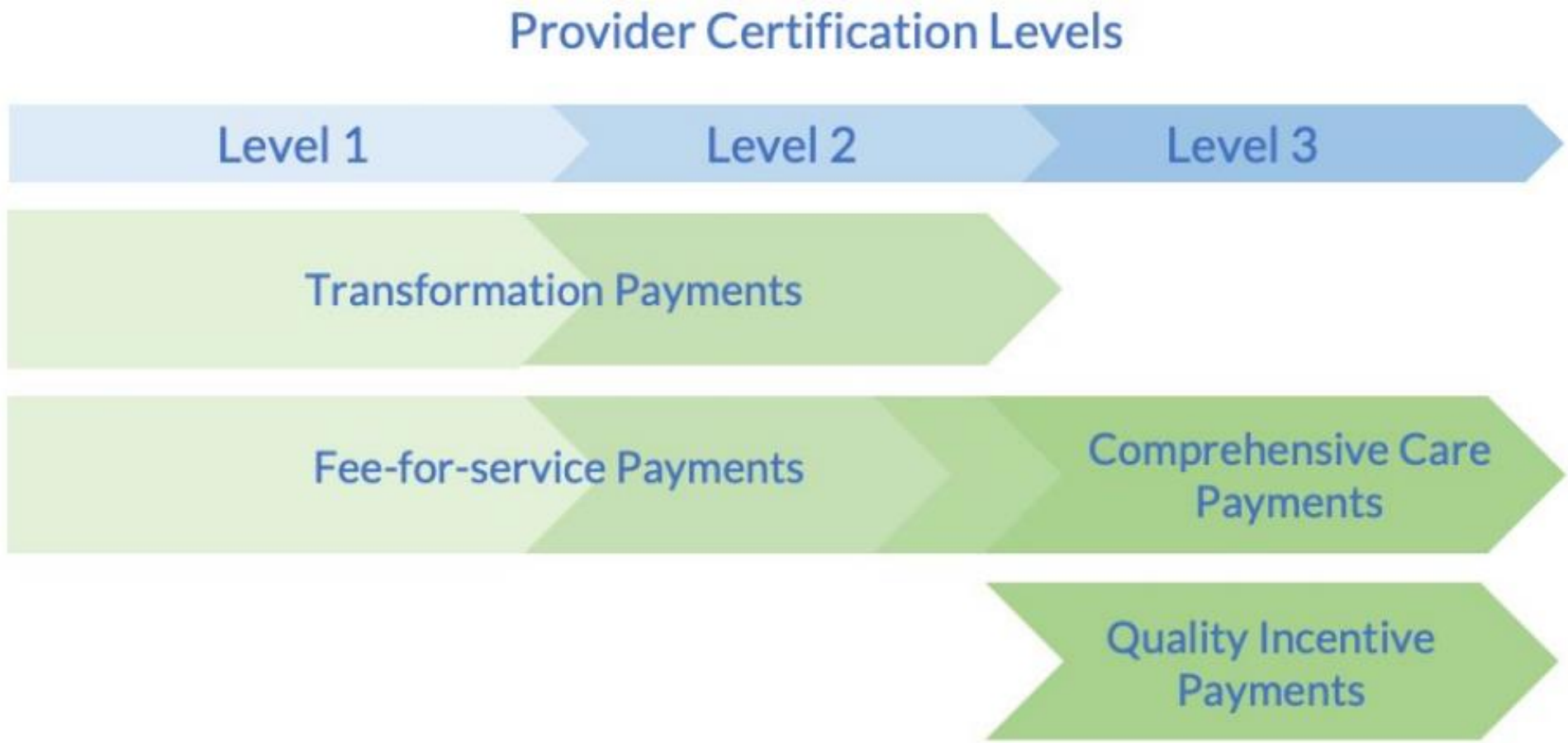
PCT model key implementation elements



Proposed payment model

- The payment model will be comprised of three components:
  - 1) a **transformation of care fee (TCF)** paid to support the transformation to a coordinated delivery model that integrates behavioral and physical health care provided in a range of settings to ensure access;
  - 2) a prospective PMPM **comprehensive primary care payment (CPCP)** to cover costs of basic primary care services; and,
  - 3) **performance incentives** available after three years with performance measured according to a combination of quality of clinical care and utilization measures.
- To begin to receive TCFs, practices will be required to agree to make progress toward transformation as defined by specified transformation measures.
- TCF will be provided up to three years before transitioning to PIPs
  - The transition period within the three years may vary based on individual practices' progress on transformation measures

Proposed payment mode (cont.)



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Provider supports – stakeholder input

- Data & Technology
  - Regular actionable claims & utilization data for attributed patients
  - Common tool to provide patient data across payers
  - Common referral resource
  - Expanded care notification and coordination mechanisms across range of providers and settings
  - Transparent attribution process and timely accurate data
- Common Tools & Training
  - BH screening
  - Models of BH integration & coordination
  - Addressing bias & removing cultural barriers to care
  - Incorporating patient feedback, shared decision making, & patient self-management into care practices
  - Designing & implementing team-oriented care

Quality alignment: clinical quality measures

1. Child and Adolescent Well-Care Visit (WCV)
2. Childhood Immunization Status (CIS) (Combo 10)
3. Screening for Colorectal Cancer (COL)
4. Breast Cancer Screening (BCS)
5. Cervical Cancer Screening (CCS)
6. Depression Screening and Follow up for Adolescents and Adults (DSF-E): Screening submeasure only (Note: inclusion not yet finalized by PMCC)
7. Controlling High Blood Pressure (CBP)
8. Asthma Medication Ratio (AMR)
9. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (CDCÑ)
10. Antidepressant Medication Management (AMM)
11. Follow-up after ED visit for Alcohol and Other Drug Abuse of Dependence (FUA)
12. Ambulatory Care - Emergency Department (ED) Visits per 1,000 (AMB) (Medicaid only in HEDIS, but will adapt for use across populations)

Linkage to Paying for Value survey findings

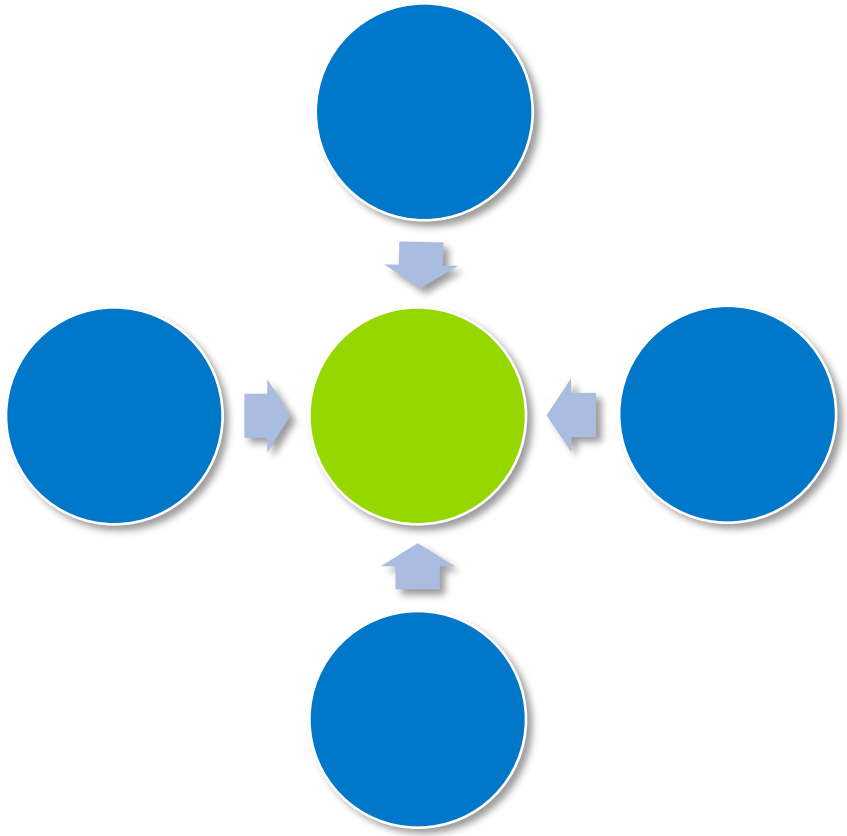
For both providers and payers, these factors are **enablers to VBP adoption when present** and **barriers when absent**:

Aligned incentives/contract requirements	Aligned quality measures/definitions	Interoperable data systems/access to comprehensive data on patient populations

Cross-system alignment and interoperability are key to VBP success

Centralized provider certification

- All plans use the same set of standards for providers
- Single process (HCA or delegate) to evaluate provider's achievement of standards (certification)
- Less burden on practices and less burden on payers
- Increases consistency/reduces different interpretation of performance across payers



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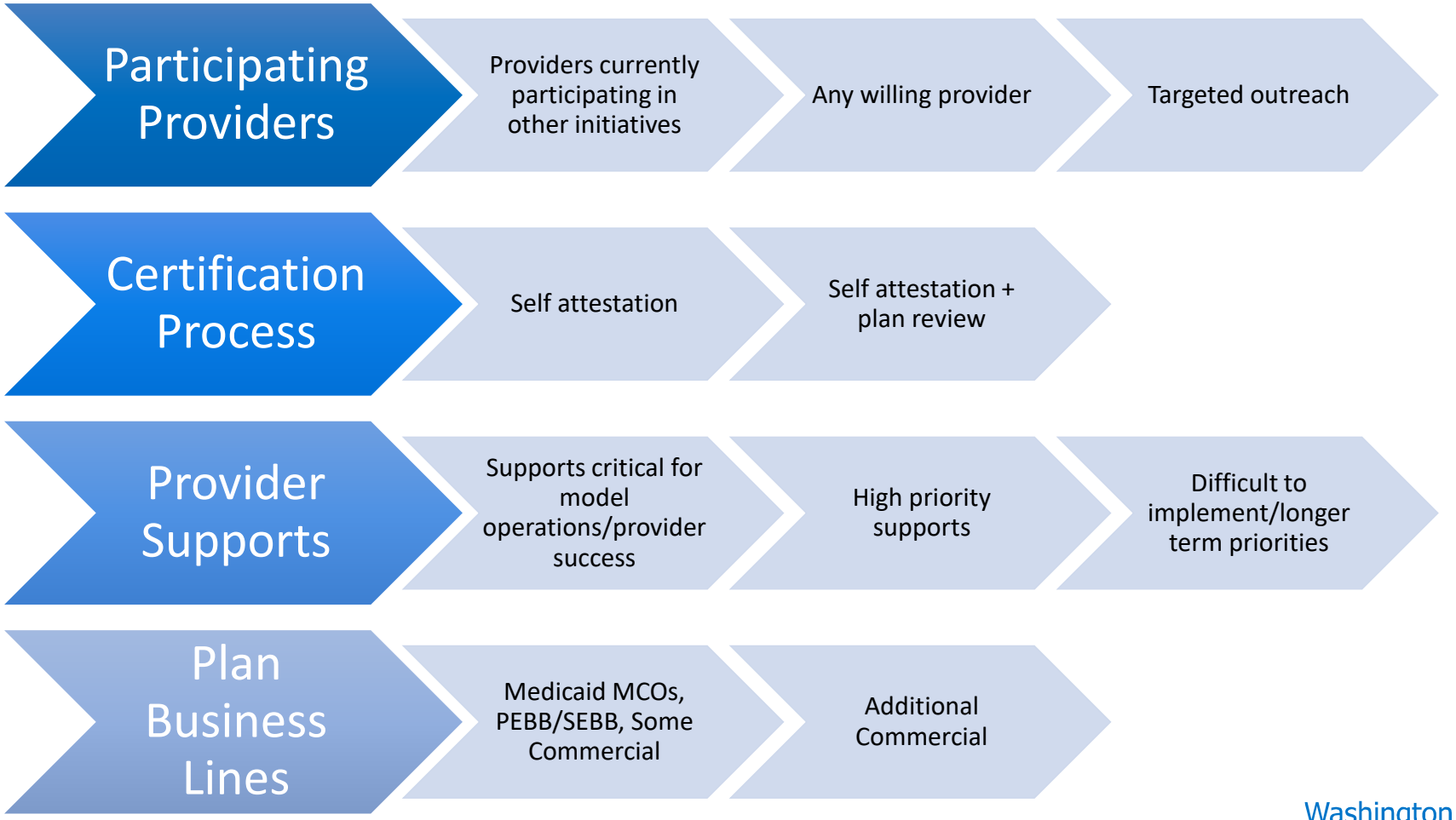
Certification example: care coordination

- Care Coordination Strategy. 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.
- Level 1
  - Practice demonstrates basic ability to track referrals to consulting specialty providers
  - Practice contacts of 90% of patients within 72 hours of hospitalization or ED visit, including medication reconciliation
- Level 2
  - Practice builds out capacity and documentation for care coordination strategies with team and with external health and social supports
  - Practice routinely reviews all available cost data to identify utilization and cost drivers for majority of empaneled patients
  - Practice has a QI/Operations team that documents, implements, and track improvements to reduce total cost of care, and appropriate utilization
- Level 3
  - Practice has a documented care plan for 90% of high-risk patients (the top quartile of patients based on the risk stratification methodology) and families reflected in EHR

Phased implementation – Jan 2023



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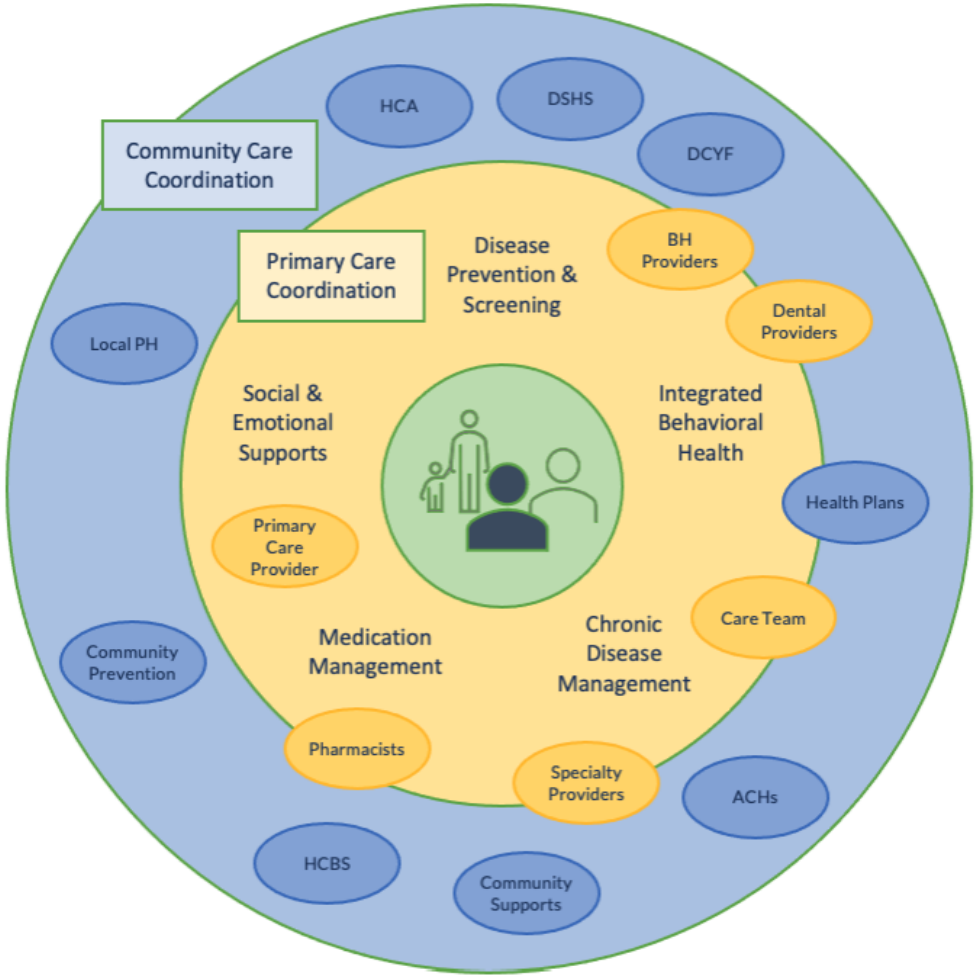
Potential roles for partners in care coordination



Questions?

- https://www.hca.wa.gov/about-hca/value-based-purchasing/multi-payer-primary-care-transformation-model
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