Washington State Health Care Authority

WA Multi-payer Primary Care Transformation Model (PCTM)

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This document outlines the framework for the Washington Multi-payer Primary Care Transformation Model (PCTM). The Health Care Authority (HCA) is working with payers, providers, and other primary care stakeholders, as well as tribes, to operationalize the model for implementation beginning in 2023.

For more information on the PCTM, please visit the HCA website.

Overview of the WA Multi-payer Primary Care Transformation Model (PCTM)

Purpose

Primary care is the foundation of the health care delivery system; an effective primary care system can drive quality outcomes at an efficient cost. Recognizing this, the Washington State Health Care Authority (HCA), in collaboration with the state's payers and primary care provider community, has been working to develop a new primary care model for the state.

This model is a key component of HCA's value-based purchasing (VBP) journey. By 2021, HCA aims to move 90 percent of its purchasing spend into Categories 2C-4B of the Centers for Medicare and Medicaid Services (CMS) Learning Action Network (LAN) Framework. This model fits category 4 of the LAN framework, the highest level of VBP. As a result of implementing this model, primary care will advance significantly further along the VBP continuum, and help HCA achieve our purchasing goals.

Through this model payers will align standards, provide practice supports, and offer payment models that balance provider flexibility with accountability. This new paradigm will reduce administrative burden for both payers and providers and will allow clinicians to focus on whole-person care for patients.

Discussions to date have revealed an impressive level of alignment and support from both the payer and provider communities to support a new whole-person, coordinated model of care for Washingtonians. In August 2020, 8 payers jointly developed and signed a memorandum of understanding (MOU) outlining 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 Model (PCTM).

The MOU and the initial briefing paper, released for public comment in July 2020, can be found on the HCA website. This document builds on previous work by outlining key elements of the model developed over the past year in collaboration with payers and primary care stakeholders. A month- long stakeholder input period was held in November 2021 to gather implementation advice. A high-level summary of the ideas and reactions gathered is posted with the PCTM model framework at the link above. HCA will incorporate this input in its expanding efforts to engage a broad range of primary care stakeholders and tribes in the implementation of the PCTM.

The model is ambitious in its goals and will require continuous systemwide improvements that will need to be staged over time. The goal is to move into a first phase of implementation in January 2023. Successful and sustained implementation requires HCA, payers, and providers, policymakers, Tribal partners, and other stakeholders to closely collaborate to make this model a reality, delivering the whole-person primary care system Washingtonians deserve.

Goals of the Model

The overarching goal of Washington's health care transformation efforts is to achieve the quadruple aim of enhancing patient experience, improving population health (i.e., health outcomes), reducing costs, and improving the work life of health care providers, including clinicians and staff.[1] The PCTM will support the quadruple aim through:

- Promote and incentivize integrated, whole-person and team-based care. This includes primary physical and behavioral health care services for acute, chronic, and preventive needs.
- Improve primary care provider capacity and access.
- Increase investment in a transformed primary care system while better managing total cost of care over time.
- Align payment incentives as well as quality metrics across payers and providers.
- Work with interested public and private employers to spread and scale the model throughout Washington State.

Key Components of the Multi-payer PCTM

The WA Multi-payer Primary Care Transformation Model (PCTM) is intended to be a consistent framework for integrated primary care payment across providers and payers in the state in support of the quadruple aim. Figure 1 below provides an overview of the seven key components of the PCTM.

#1. Primary care as integrated whole-person care. Primary care includes a comprehensive array of appropriate, evidence-informed services; this array of services is coordinated by the accountable primary care provider but may exist in multiple care settings or be delivered in a variety of modes.

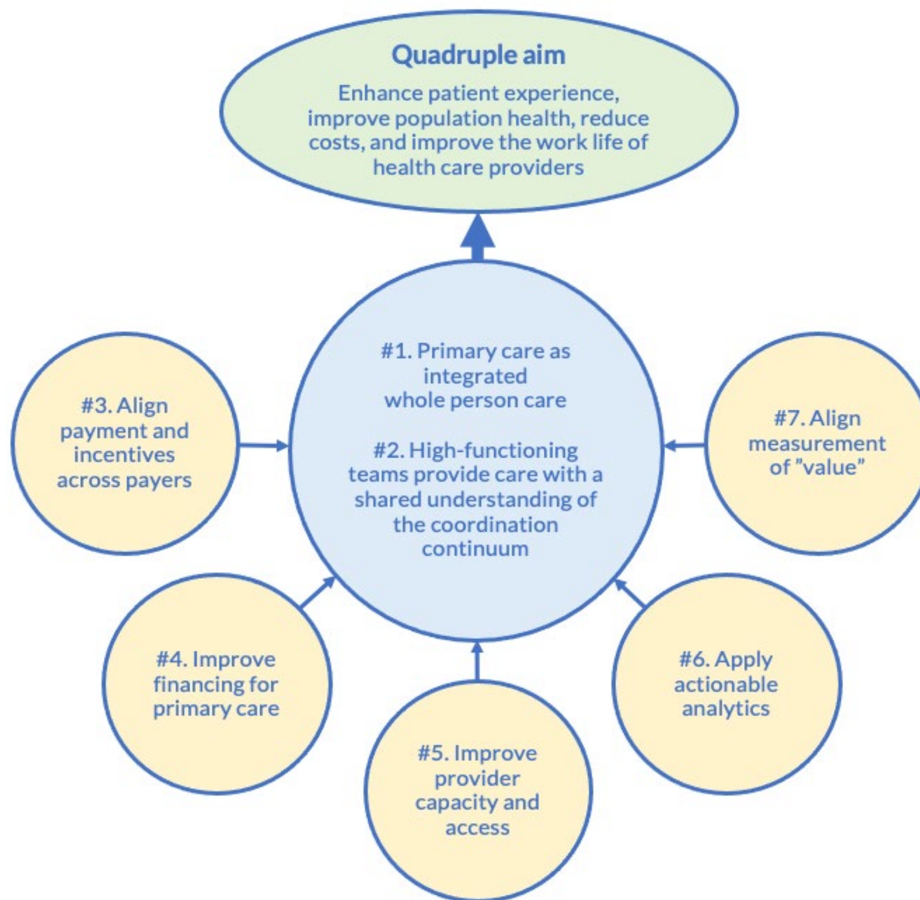
Key service components of primary care include:

- Care coordination of primary and specialty care at the provider level
- Integrated behavioral health (coordinated, co-located, or integrated models)
- Disease prevention and screening
- Chronic condition management

[1] https://digital.ahrq.gov/acts/quadruple-aim

- Medication management
- Health promotion
- Person-centered care that considers physical, emotional, and social needs, including referral to community supports as needed.

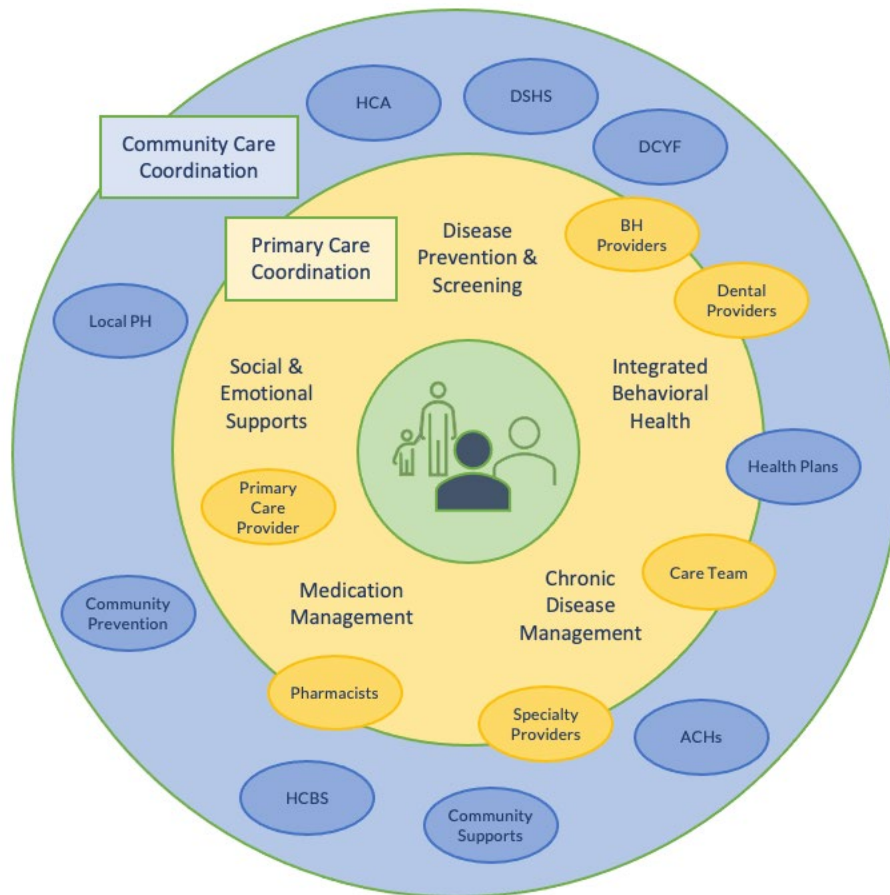
Figure 1. Primary Care Transformation Model Components



Note: Information on the Quadruple Aim can be found at https://digital.ahrq.gov/acts/quadruple-aim .

#2. High-functioning teams provide care with a shared and inclusive understanding of the continuum of coordination. Providers assign patients to high-functioning care teams, led by an accountable provider based on patient, caregiver, and family goals and level of need, including chronic disease management, behavioral health, oral health, and social support needs. The care team addresses the goals and needs of the individual and family by efficiently organizing and coordinating care across the range of broader health system partners including hospitals, specialty care, health plans, home and community-based services, community care coordination resources, and end-of-life care (Figure 2).

Figure 2. Potential roles of Partners in Continuum of Patient-centered Care Coordination



Notes: DCYF = WA Department of Children, Youth, and Families; DSHS = WA Department of Social and Health Services; HCA = WA Health Care Authority; HCBS = home and community-based services; BH = behavioral health; PH = public health

#3. Aligned payment and incentives across payers. Health 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.

#4. Improved financing for primary care. Washington's Office of Financial Management released a first analysis of annual primary care medical expenditures in December 2019 at the direction of the Legislature.[2] Additionally, HCA has required Medicaid MCO and

[2] Washington Office of Financial Management. *Primary Care Expenditures: Summary of current primary care expenditures and investment in Washington*, Report to the Legislature. December 2019. https://ofm.wa.gov/pubs-reports/primary-care-expenditures-report-legislature

ERB payers to measure and report primary care spend since 2020, with the intent that all payers in Washington over time will track and be held accountable for a minimum spend on primary care.

#5. Improved provider capacity and access. Patients have access to meaningful engagement from high-functioning care teams to coordinate and provide both physical and behavioral health care using a range of modalities including telehealth and other non-traditional person-to-person modalities. Translation services are available for languages common among the patient population.

#6. Application of actionable analytics (clinical, financial, and social supports). 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. Providers use data to analyze and identify whole person needs at a population level and individual level to enhance quality and evaluate effectiveness of primary care delivered.

#7. Aligned measurement of "value" from the model. 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.

Implementation of the WA Multi-payer Primary Care Transformation Model (PCTM)

This section outlines initial PCTM implementation components, highlighting where additional work is needed. HCA is working across payers, providers, and other stakeholders to ensure that PCTM implementation is timely and responsive while recognizing that expectations will need to be phased in over time to ensure Washington's health system collectively transforms under the model. Figure 3 provides an overview of the key implementation elements of the model identified by HCA, payers, providers, and other stakeholders.

Scope of Services

Payment for the services component of the primary care model will cover a defined set of services guided by this document and the work of the Bree Collaborative

recommendations,[3] and the Office of Financial Management's Primary Care Expenditures Report to the Legislature.[4]

Provider Accountabilities

Provider accountabilities are key capacities or competencies required to provide whole-person care. These accountabilities (outlined in Table 1) were developed from payer, primary care provider, and other stakeholder input. Each accountability is broken into levels with Level 1 reflecting capacities or competencies for practices that are just beginning their transformation journey and Level 3 reflecting capacities or competencies of a more advanced practice. Where providers fall within these levels, which would be defined by a centralized certification process discussed below, informs which type of payments they receive from payers.

The accountabilities are designed to ensure participating providers are those who are responsible to provide or coordinate a full range of primary care services to attributed patients at least at the Level 1 level. The provider does not have to provide the full range of services directly but must be accountable for ensuring patients have access to the full range outlined in the accountabilities through documented care compacts and referral policies. The primary care team may or may not reside in the same physical setting and does not need to have the same organizational affiliation to act as a team.

Centralized Provider Certification

The currently proposed process includes centralized provider certification administered by HCA. Through this process providers are assigned a certification level from Level 1 to Level 3 based on their ability to perform provider accountabilities.

The certification process would provide a common measuring stick for gauging provider progression under the model and determining which financial arrangement the provider is eligible to receive.

HCA will convene a multi-stakeholder committee this winter to develop the first phase of the provider certification process. HCA anticipates that there will be an ongoing multi-stakeholder process for developing, reviewing, and updating the certification process as the model progresses, as well as adjustments to the provider accountabilities as the model gains momentum and lessons learned from implementation can be incorporated.

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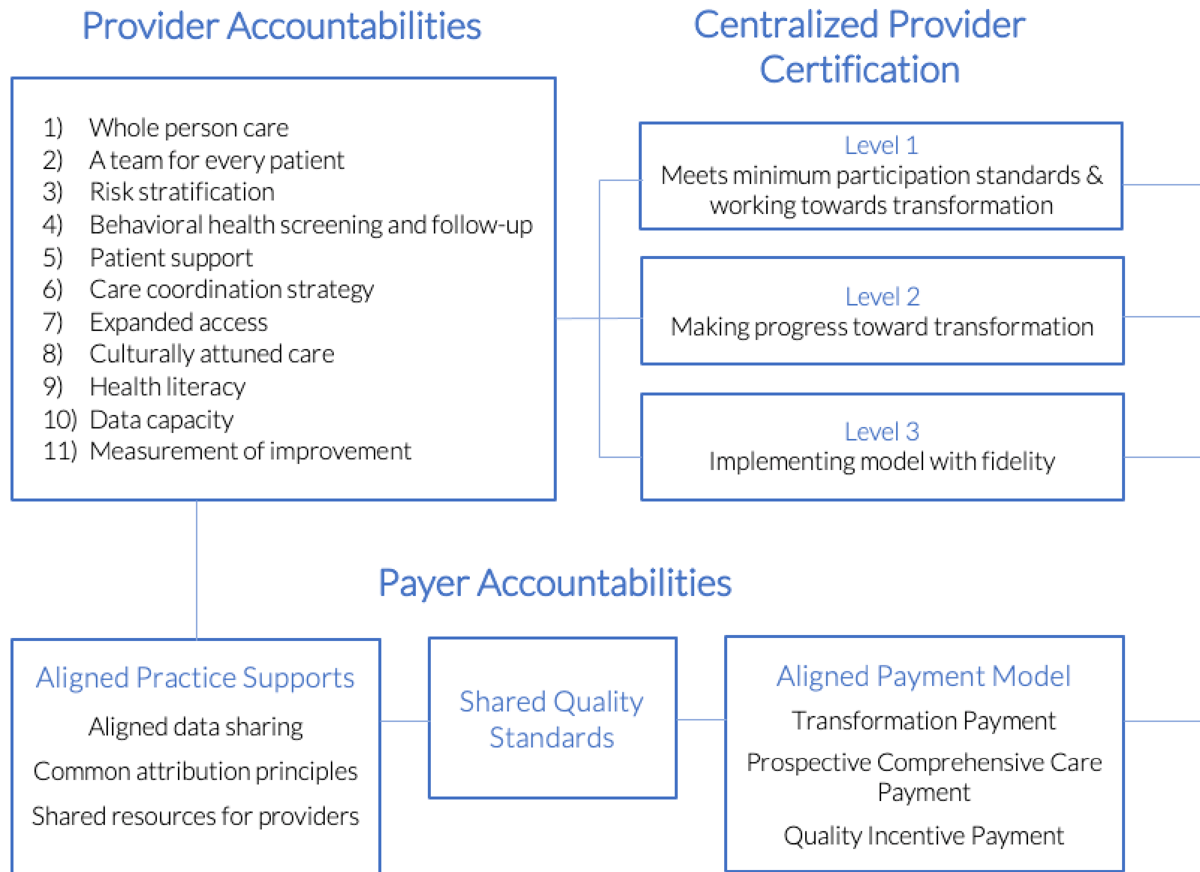
[3] Dr. Robert Bree Collaborative. *Primary Care Report and Recommendations*. 2020. https://www.qualityhealth.org/bree/topic-areas/previous-topics/primary-care/

[4] Washington Office of Financial Management, *Primary Care Expenditures*, December 2019.

Figure 3. WA Multi-payer Primary Care Model Key Implementation Elements



Payer Accountabilities

Similar to providers, payers have a number of accountabilities under PCTM that will develop over the course of implementation. These include aligning overall payment approaches, implementing shared quality standards, and aligning actionable data and other efforts to support provider transformation.

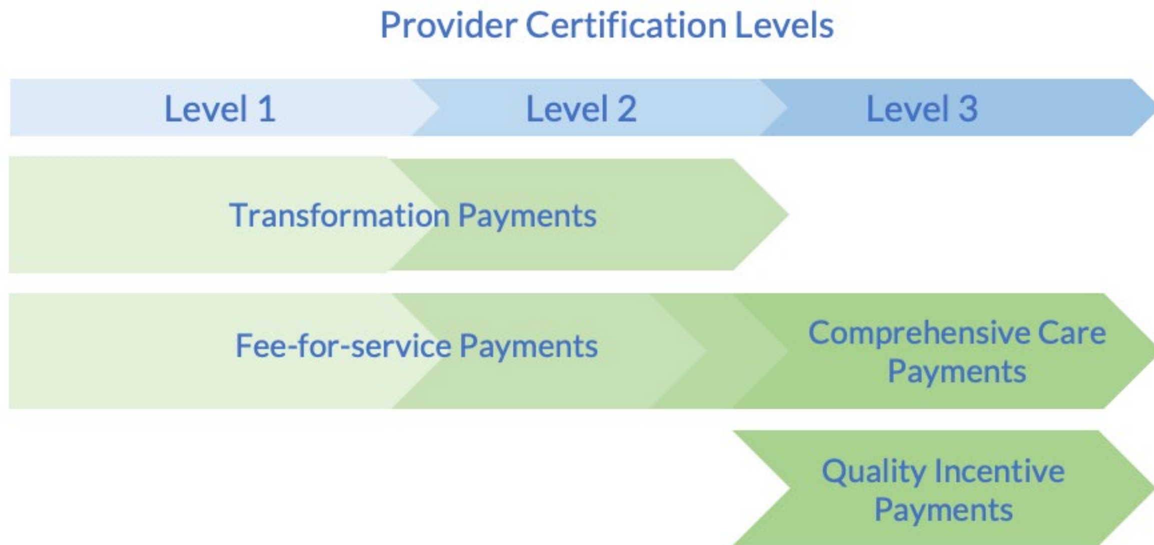
1) Aligned Payment Approaches

Payers will work to align overarching payment approaches to support providers according to their certification level and measurable clinic quality metrics, that move away from traditional fee-for-service payments.

Figure 4 provides an overview of the proposed three components of the model: a transformation payment for eligible practices early in their practice transformation journey, a service payment that moves primary care practices from fee-for-service to a

comprehensive care payment, and a quality payment for practices that are further along with practice transformation. The provider certification level will inform which payments the providers receive.

Figure 4. Overview of Multi-payer Payment Approach



2) *Aligned Quality Measurement*

Aligning quality measurement has the potential to reduce administrative burden for both providers and payers. It also increases the likelihood of success on the most important measures by reducing focus fragmentation.

The following have been approved by the HCA Primary Care Measure Set Workgroup as a core set to gauge the clinical quality delivered by an integrated, whole-person care model. Measurement is aligned with the participation level agreed to by payer and provider (NPI, practice site, etc.) Except where otherwise noted, all measures are recommended using HEDIS measurement standards (metrics). All measures are part of the Washington Common Measure Set.

1. Child and Adolescent Well-Care Visit (WCV)
2. Childhood Immunization Status (CIS) (Combo 10)
3. Breast Cancer Screening (BCS)
4. Cervical Cancer Screening (CCS)
5. Colorectal Cancer Screening (COL)
6. Depression Screening and Follow up for Adolescents and Adults (DSF-E)
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)

3) Aligned Provider Supports

Successful implementation of a multi-payer primary care model requires a combination of practices supports, payment innovation, and delivery system alignment. Participating payers are exploring options to further reduce administrative burden for both providers and payers by collaborating on key providers supports (Table 2). For example, payers could support one single comprehensive resource library for providers vs. each payer providing a separate set of resources. In cases where provider supports cannot be centralized to reduce the number of entities engaging with providers, payers will leverage common standards and practices to streamline processes for providers.

Payers have prioritized alignment of data sharing and operational standards that support care coordination, quality improvement, and attribution for initial phases of implementation.

Phased Implementation Planning

Phased implementation is slated to begin January 2023 based on the incremental development and execution of these key model elements. The goal is that, over time, all public and private payers will align their primary care payment models with the proposed Model.

Figure 5 provides an overview of just a selection of the collaboration that needs to occur between now and January 2023. HCA will be convening a range of meetings and input avenues throughout the year including:

- Monthly meetings of the Multi-payer Collaborative (MPC)
- A multi-stakeholder committee to plan the centralized certification process
- Stakeholder summits throughout the year to review and provide input on developing model elements
- Regular meetings with employer representatives to maintain broad purchaser support for the model

Figure 5. Collaborative Implementation Approach

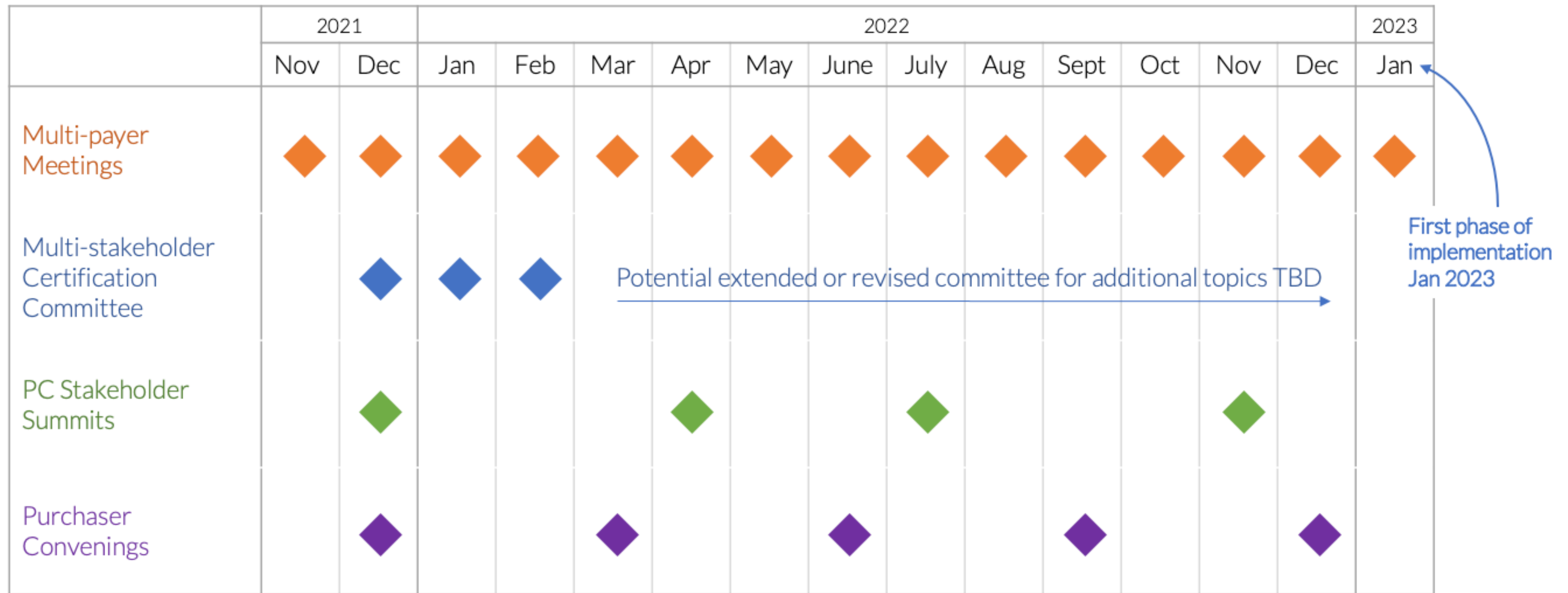


Table 1. Provider Accountabilities and Certification Levels

<table>
<tr><th colspan="2">Whole-person care. Provider is accountable for providing or coordinating a full range of primary care services to attributed patients</th></tr>
<tr><td>Level 1</td><td>Practice routinely offers all the following categories of services:
• acute care for minor illnesses and injuries
• ongoing management of chronic diseases including coordination of care
• office-based procedures and diagnostic tests
• preventive services including recommended immunizations
• patient education and self-management support</td></tr>
<tr><td>Level 2</td><td>• Practice has integrated care and/or has established care compacts as necessary with specialists, medical, behavioral health, and community support resources
• Members of the care team know how to use, and document use of, those care management agreements to ensure prompt access to care</td></tr>
<tr><td>Level 3</td><td>• Practice systematically measures and tracks patient physical and behavioral health outcomes at an individual and population level
• Practice provides comprehensive care, and a process for coordination of care, has led to measurable changes in quality and/or cost of care over time and in comparison, to providers operating in Levels 1 & 2</td></tr>
<tr><td colspan="2">A team for every patient: Active patients are empaneled to a primary care team for advanced clinical judgment. The primary care team may or may not reside in the same physical setting and does not need to have the same organizational affiliation to act as a team.</td></tr>
<tr><td>Level 1</td><td>• Care is organized by teams responsible for specific patient panels
• Practice reports the percentage of patients empaneled to a high-functioning care team to provide and coordinate care
• Teams utilize written job descriptions including defined roles and responsibilities for all members of the care team</td></tr>
<tr><td>Level 2</td><td>• Practice achieves goal of 95% of patients empaneled to a high-functioning care team to provide and coordinate care
• Care teams consistently implement team-based care strategies (huddles, care management meetings, high risk patient panel review, etc.).</td></tr>
</table>

Level 3	• Practice achieves goal of 95% of patients empaneled to a high-functioning care team to provide and coordinate care • Care teams consistently address physical AND behavioral health needs using shared operations, workflows, and formal protocols • Practice policies support empanelment including definitions, changing PCPs, assigning new patients, and ensuring continuous coverage
Risk Stratification. Practice has and uses a documented risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs	
Level 1	• Practice has a documented risk stratification strategy
Level 2	• Practice has and uses a documented strategy to identify care gaps and prioritize high-risk patients and families
Level 3	• Stratifies 95% of its patient population according to health risk such as special health care needs or health behavior
Behavioral Health Screening and Follow-up: Practices 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	
Level 1	• Has evaluated and identified behavioral health resources for patients/families • Conducts targeted screening for behavioral health conditions for populations identified as high risk
Level 2	• Actively uses an evidence-based screening tool for behavioral health concerns (including depression, maternal depression, developmental delays, substance use disorders, tobacco use, and other unhealthy behaviors) • Has documented process for connecting patients/families with behavioral health resources following screening, including standing orders, and protocols for follow up • Practice screens and follows up as needed with at least 50% of patients/families for substance use disorder and/or other behavioral health needs.
Level 3	• Practice screens and follows up as needed with at least 90% of patients/families for substance use disorder and/or other behavioral health needs.
Patient Support. Ensure patients' goals, preferences, and needs are integrated into care through advance care planning	
Level 1	• Practice has assessed capability and plan for support of patients' self-management

	• Has identified mechanisms for patients and caregivers to provide input and feedback, including on transformation activities and progress, such as patient focus groups • Practice has identified how to document patient feedback, review on a quarterly basis, and used to improve care
Level 2	• Practice has established mechanisms for patients and caregivers to provide input and feedback, including on transformation activities and progress • Practice identifies subpopulation(s) of patients and caregivers for engagement in advance care planning based on risk stratification methodology • Teams engage in shared decision making with patients that respects their personal goals
Level 3	• Practice has established workflows and protocols for shared decision-making including use of patient decision aids and self-management support tools • Practice convenes focus groups of patients and families at least 2 times per year • Practice engages subpopulations of patients in advance care planning
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 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
Expanded access. Same day appointments, 24/7 clinical advice, 24/7 e-health, telephonic access, and communication through IT innovations are offered for both physical AND behavioral health and integrated into care modalities.	
Level 1	• Practice provides basic capacity includes access (directly or through team partners) to at least 50% of expanded access strategies listed above are in place for both physical and behavioral health care

Level 2	• At least 75% of expanded access strategies listed above are in place for both physical and behavioral health
Level 3	• Practice has expanded access capabilities fully in place for both physical and behavioral health
Culturally attuned care. Provides access to care that is culturally supportive in location, translation services, and demographic composition. 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.	
Level 1	• Practice has real-time translation services for top 3 languages common among the patient population are available
Level 2	• Practice has at least one alternative to traditional office visits is available on a limited basis
Level 3	• Provider team composition reflects patient panel composition • Practice provides multiple alternatives to traditional office visits are regularly available
Health Literacy. Patient-facing forms and information: • Are readable at an 8th grade reading level • Are available in languages that reflect the patient population • Are available in accessible formats (e.g., braille, large print, audio) • Use inclusive, non-stigmatizing language • Reaffirm the confidentiality of information	
Level 1	• Practice utilizes patient-facing forms and information are written at the appropriate level and are available in languages that reflect the patient population consistent with published guidelines
Level 2	• Practice's patient-facing forms adhere to all standards and are available in several accessible formats
Level 3	• Practice's patient-facing forms adhere to all standards and are available in all accessible formats
Data capacity. Build capacity to query and use data to support clinical, population health, and business decisions.	
Level 1	Practice has capacity to: • Incorporate data-informed process changes • Review data at least quarterly and conducts regular QI activities • Send and receive data to plans
Level 2	Practice has capacity to: • Incorporate analytic tools into team workflows

	• Process for quality improvement using data according to an identified model • Ensure accurate and up to date provider data to payers for overall network monitoring • Use EHR clinical quality measures to provide regular panel reports on measures
Level 3	Practice has the capacity to: • Demonstrate bidirectional data exchange capabilities with plans and other data sources • Use data to inform practice strategy and interventions • Connect to HIE and receives alerts • Use available resources including payer claims data to drive quality improvement processes and sustain outcomes. • Apply data-driven quality improvement processes for all patients and all providers (e.g., not limited to identifying gaps in care and closing them one patient at a time)
Measure improvement. Use aligned metrics to measure value	
Level 1	• Practice has a documented plan to systematically measure and track physical health outcomes as specified for the Model • Practice has a documented continuous quality improvement strategy in place
Level 2	• Practice has a documented plan to systematically measure and track both physical and behavioral patient outcomes as specified for the Model • Systematically measures and tracks patient physical and behavioral health outcomes at individual level
Level 3	• Provide timely metric data to show progress from investment • Systematically measures and tracks patient physical and behavioral health outcomes at an individual and population level • Practice can document measurable changes in quality and cost of care

Table 2. Model Supports and Potential Payer Accountabilities

The current working list of proposed payer accountabilities to support provider success under the model are provided in the table below. As with other aspects of the model, the different payer accountabilities will likely be phased in over time based on how critical the specific accountability is for provider success or the resources and time required to implement.

Supported Provider Accountability	Payer Accountabilities Currently Under Consideration
Primary Care Model Operations	
Team for Every Patient	Assign patients to providers through a transparent attribution process; provide timely and accurate attribution information to providers.
Data Capacity	Send summary of claims and utilization data to providers on a quarterly basis for attributed members.
Aligned Payment Policy	
Whole Person Care	Create shared (multi-payer) incentives for specialists and PCPs to communicate and coordinate.
Whole Person Care	Pay for e-consults and other avenues to support access to specialty care where needed.
Whole Person Care	Alignment of nonprimary care payment methodologies to support primary care. (inpatient/outpatient/specialty)
BH Screening and Follow up	Ensure depression screening is a compensable service included in the model.
Data Capacity	Align metric specifications for quality care and care transformation, with input from providers, for both physical and behavioral health.
Whole Person Care	Align hospital payment incentives to encourage post discharge coordination and medication reconciliations with primary care.
Whole Person Care; BH Screening and Follow up	Ensure payment models support integration of physical and behavioral health.
Direct Payer-to-member Support and Engagement	
Team for Every Patient	Provide members with information about the value of primary care, how to access primary care within the network, and otherwise encourage members to select a primary care provider/team at enrollment.

Team for Every Patient	Share provider performance information with members to help them select a provider that best meets their needs.
Network Management	
Care Coordination Strategy	Ensure provider network adequacy to support comprehensive care coordination strategies; work together across plans to increase community capacity where needed.
Culturally Attuned Care	Explore partnerships with the University of Washington and other medical, nursing and other clinical care schools to increase diversity of providers throughout the state.
Whole Person Care and BH Screening and Follow up	Work across payers, and with others (e.g., CBOs and ACHs) to increase community based behavioral health capacity.
Practice Support	
BH Screening and Follow up	Provide a common tool for behavioral health screening.
BH Screening and Follow up	Provide training and other tools regarding models of behavioral integration and coordination including primary care integration into behavioral health settings.
Capacity and Access	Conduct provider assessment related to technology and capacity needed for expanded access.
Capacity and Access	Explore options for shared resource model for afterhours to get economies of scale (especially for smaller practices and rural communities)
Capacity and Access	Utilize shared provider credentialing for behavioral health and social supports.
Care Coordination Strategy	Develop common mechanisms to notify and encourage coordination, including medication reconciliation, among primary care provider(s) and hospitals.
Care Coordination Strategy	Expand hospital/primary care notification and coordination mechanisms to include specialty, BH and social support providers.
Care Coordination Strategy	Provide common clarification of data sharing allowed under 42 CFR part 2
Care Coordination Strategy	Provide care compact templates/guides/application training.
Care Coordination Strategy; Data Capacity	Develop and support robust, interoperable HIE.
Culturally Attuned Care	Provide common tools and training in addressing bias and removing cultural barriers to care.
Culturally Attuned Care	Invest in common translation service(s).
Culturally Attuned Care	Provide training and resources regarding best practices for developing workforce reflective of patient population.

Data Capacity	Health plans meet regularly with providers and practices to share relevant information including cost (e.g., services, medication), and to collaborate on data solutions.
Data Capacity	Use common method/tool to provide claims-based data, including cost and utilization, to enable visibility and accountability across the medical neighborhood and the training to use it successfully.
Health Literacy	Develop common library of health literacy and culturally attuned care delivery strategies, include samples of accessible formats, non-stigmatizing language, and 8th grade reading level.
Patient Supports	Offer common training and assistance for incorporating patient feedback, shared decision making, and patient self-management into care and business processes.
Patient Supports	Provide common tools for discussing care transformation and whole-person care with patients.
Patient Supports	Offer assistance and/or training in methods for common patient engagement methods that can be used across partners in the medical neighborhood.
Risk Stratification	Identify and provide support in the implementation of a common, validated risk-stratification methodology and tool in clinical and business operations, including embedding it in EHRs.
Team for every patient	Provide practices with training and other resources regarding designing and implementing team-oriented care.
Whole person care	Provide common referral tracking tools for practices, focused on specialty providers and community-based organizations.