Washington
MULTI-PAYER COLLABORATIVE
Better Quality, Less Hassle.

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

July 8, 2024

Purpose and Scope

The purpose of this memorandum of understanding (MOU) among health plans (payers) is to outline individual and collective payer efforts to strengthen and support primary care in the state of Washington through an integrated whole-person approach that advances the health of Washingtonians and includes behavioral and preventive services.

Participating payers believe that while there are many paths towards a better health care system, all paths that are successful in improving the health of Washingtonians 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 align with each other to transform the way in which primary care is delivered and supported in participating practices. As a result, payers individually and collectively are committed to the following actions in support of the Primary Care Transformation Initiative (which includes the initiatives known as Primary Care Transformation Model and Making Care Primary Model) including:

1) Ongoing and active participation in the Washington Multi-payer Collaborative to foster collaborative support strategies for primary care.
2) Adherence to the Washington Multi-payer Collaborative's Alternative Payment Policies for Primary Care (see Attachment 1).
3) Use of the Washington Primary Care Practice Recognition Program to inform provider partnership and contracting strategies.[1]

This MOU memorializes the payers' commitments in a public, transparent fashion. This MOU 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 Primary Care Transformation Initiative (PCTI). This MOU is a public document.

[1] Primary Care Transformation | Washington State Health Care Authority

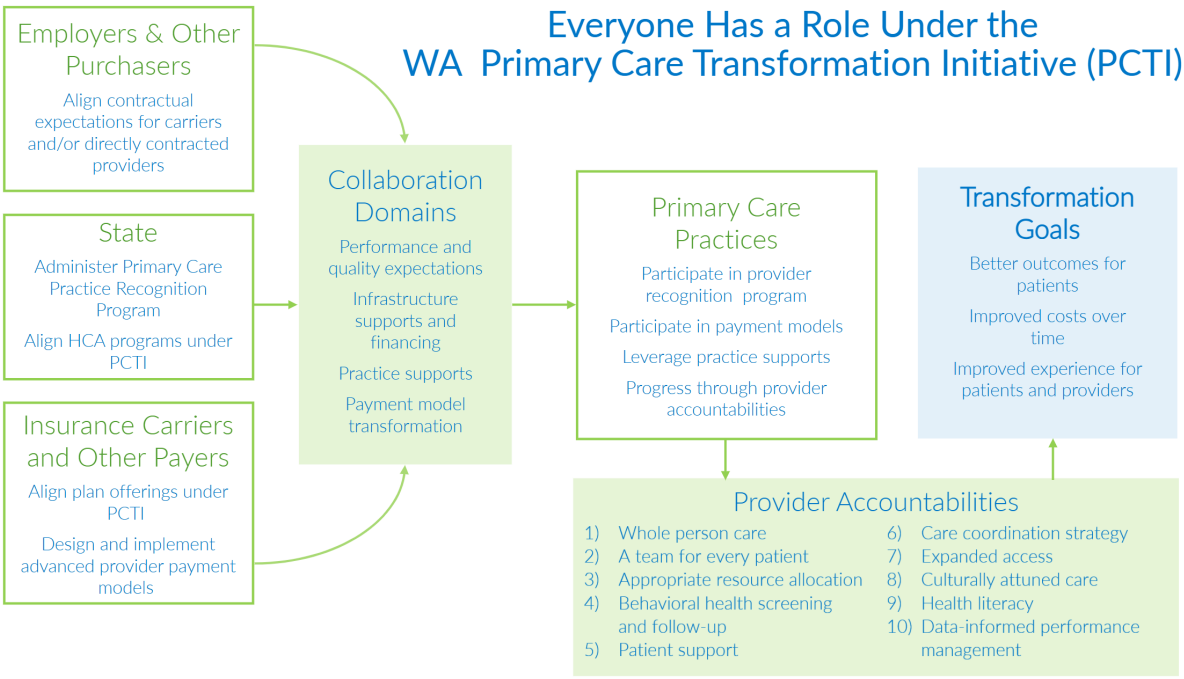
There is significant variation in how health plans are financed and administrated. Accountable actors for each model element will vary across purchasers and health plans. Roles may evolve as the PCTI matures (see Attachment 1).

To ensure compliance with anti-trust laws, payer collaboration is guided by an anti-trust statement to ensure no financial or other competitively sensitive information is exchanged.

Background

Washington payers, the Health Care Authority (HCA), the Center for Medicare and Medicaid Innovation, the primary care provider community, and Washington employers have been working together to develop a new approach to delivering, supporting, and paying for primary care. The initial approach was called the Primary Care Transformation Model, and it was an effort to create systemwide alignment in support of primary care across payment models, practice supports, quality standards, and operational considerations. The Primary Care Transformation Initiative (PCTI) represents Washington's statewide effort to align that model with other primary care improvement efforts including Making Care Primary. The PCTI is designed to focus on whole-person, integrated care and result in improved patient care and population outcomes across the state. The initiative is represented by the components outlined in Figure 1.

Figure 1: Primary Care Transformation Initiative Framework [2]



[2] Managed care organizations are considered payers in this framework.

The PCTI supports primary care's movement towards an integrated whole-person approach that includes behavioral and preventive services by meeting providers where they are in their individual transformation journey. Providers that participate in the *Washington Primary Care Practice Recognition Program*, administered by the Health Care Authority (HCA), will be recognized at one of three levels depending on the practice's capabilities as defined by an accountability framework.

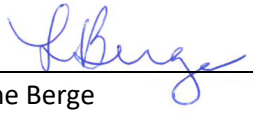
The accountability framework is comprised of transformation and clinical quality metrics tied to 10 core accountabilities outlined in Figure 1 above and detailed at Primary Care Transformation | Washington State Health Care Authority. The Health Care Authority will stratify practices into three Recognition Levels:

- Recognition Level 1: practices meeting minimum standards and working towards transformation,
- Recognition Level 2: practices making active progress towards transformation, and
- Recognition Level 3: practices able to provide most or all of the accountabilities.

To achieve this vision of integrated whole person care, the payers enter this memorandum of understanding; payers will collectively support practices through aligned strategies designed by the Washington Multi-payer Collaborative and will individually use one or more of the alternative payment options included in Attachment 1 to support providers that meet accountabilities of the initiative and with whom they contract.

To provide greater insight into what providers can expect by participating in the PCTI, payers will leverage a shared, publicly available resource to communicate plan-specific information related to implementation of the PCTI.

Washington Multi-payer Collaborative organizations agreeing to this Memorandum of Understanding

x 

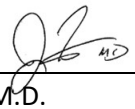
Leanne Berge
Chief Executive Officer
Community Health Plan of WA

x 

Staici West
Vice President, Network Development
Coordinated Care

x 

Angela M. Dowling
President
Kaiser Permanente Washington

x 

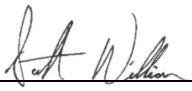
Jay Fathi, M.D.
Plan President and CEO
Molina Healthcare of Washington, Inc

x 

Jennifer Sanders
VP, Provider Strategy & Solutions
Premera Blue Cross

x 

Claire Verity
Market President
Regence BlueShield

x 

Scott Williams
Vice President, Network Management
UnitedHealthcare

x 

Susan E. Birch
Director
WA State Health Care Authority

x 

Lisa Bogard
President & CEO
Wellpoint Washington, Inc.

Attachment 1: Washington Multi-payer Collaborative Alternative Payment Policies for Primary Care

Approved Policies as of February 6, 2024

Introduction

Members of the Washington Multi-payer Collaborative are committed to working together to elevate the health status of Washingtonians by increasing the quality of primary care and reducing the hassles that stand in the way of providers delivering that care. To accomplish this goal, collaborative members will work together to align implementation of alternative payment models (APMs) to support the ability of primary care providers to deliver advanced, high quality, whole person care.

This document outlines guiding policies for multi-payer implementation of the Primary Care Transformation Initiative (PCTI). These policies attempt to balance alignment (a key component of the value proposition of the initiative), with sufficient flexibility to address organization and provider-specific constraints. As guiding policies, there may be some policy deviation driven by operational constraints, but participating plans are committed to maximizing the possible alignment under this framework.

It will take time for both payers and providers to grow the capacity to offer and participate in APMs. Payers may need to phase in payment models aligned with the Washington PCTI due to resource or capacity constraints. However, participating payers commit to a good faith effort to offer aligned payment models consistent with the policies outlined here.

Exceptions to Offering Washington Primary Care Transformation Initiative Payment Models (APMs)

Payers will not be expected to offer the payment models aligned with the Washington Primary Care Transformation Initiative (PCTI) to a provider under the following circumstances:

- Practice volume of assigned or attributed patients is insufficient, as determined by payer.
- Payer is not contracted with provider.
- Participation is not supported by the purchaser.
- Participation would result in the plans no longer being actuarially sound.
- Provider chooses not to participate.
- Provider is not in the cohort being offered APMs based on the current payer implementation phase (see implementation phase policies below).
- Purchaser, provider, and payer are mutually satisfied with current contract model
- Implementing an alternative payment model that adheres to these policies would result in movement back to a payment model that is tied more closely to fee-for-service, as determined by payer (see the HCPLAN APM framework for an example continuum for alternative payment).[3]
- Provider is not satisfying minimum Washington PCTI participation requirements per provider's contract.
- Prohibited by state or federal law.

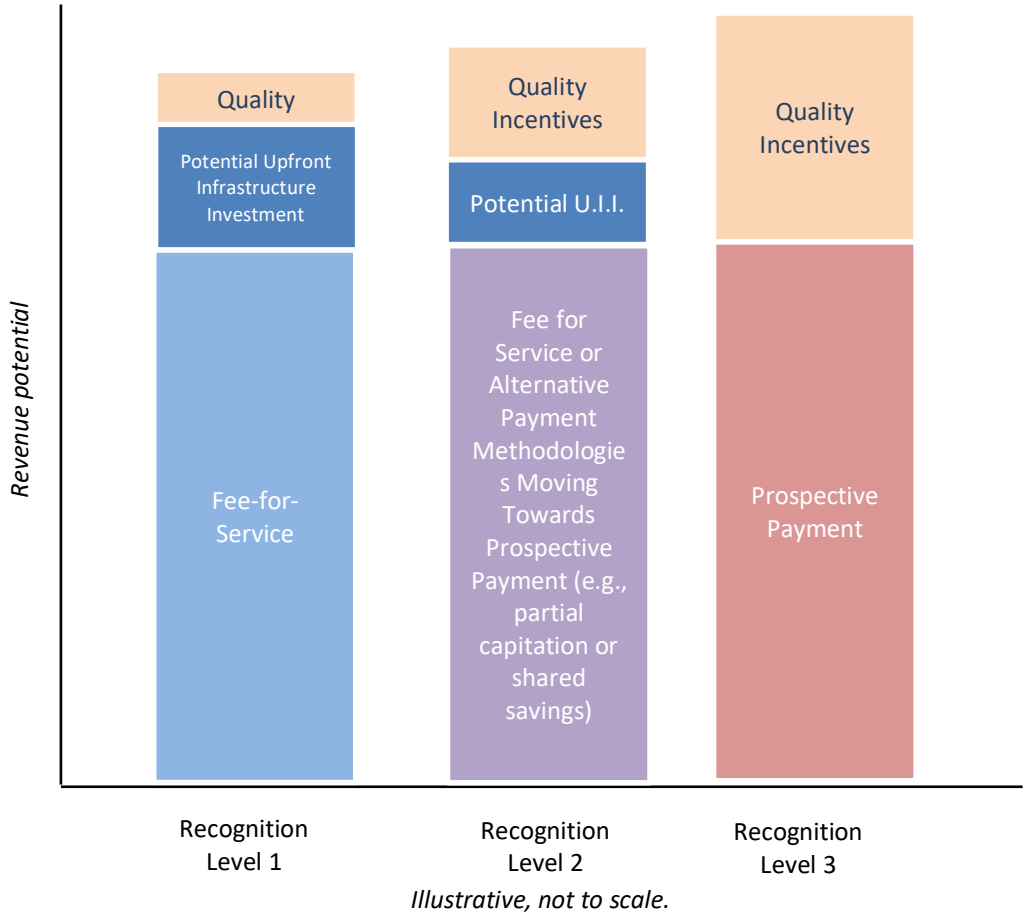
[3] https://hcp-lan.org/apm-framework/

Alternative Payment Policies for Primary Care

Payment Framework

At a minimum, payers will offer alternative payment methodologies directionally aligned with the general framework shown below in Figure 2 and consistent with the policies described in this document. Payers retain the flexibility to design payment model parameters consistent with purchaser, provider, and payer needs.

Figure 2: Payment Model Components by Provider Recognition Level



The four primary payment types include the following:

- **Fee-for-Service:** traditional fee-for-service payments where a provider bills for services individually and receives payment for each billable service rendered.
- **Upfront Infrastructure Investment (UII):** In addition to service revenue, UII is designed to assist providers in developing or expanding capabilities in service delivery and business acumen needed to operate under new funding and business models. It is based on the premise that new or expanded capabilities are needed in order to successfully transition away from fee-for-service models of care and business, toward models centered on value and outcomes.

"Value based" models are increasingly required by purchasers and payers, and in some cases, UII payments may be made directly to practices by purchasers or payers, or practices may receive UII support through state infrastructure avenues.

- **Quality Incentives:** funding in addition to service revenue that is designed to reward practices for delivering high quality care as demonstrated through performance measurement.
- **Prospective Payment:** service funding that is paid on a monthly basis for each attributed life independent of each individual's actual service utilization.

Program Onboarding

1) **Transition timing to Washington PCTI payment approaches:**
   a) If a provider is both interested in receiving prospective payment and quality payments, and is certified at Recognition Level 3, payers will work with the provider in transitioning to prospective payments with the goal of provider participation in the payment model within 2 years of recognition.
   b) Payers will work collaboratively with providers to develop mutual capacity to transition to prospective payment while considering relevant factors such as total cost of care improvement and member outcomes.
2) **Transition decision making:** Payer and provider will use the contract renewal process, which includes review of performance (see Quality Measure section), as the mechanism to advance into the quality incentive component of the Washington Primary Care Transformation Initiative design.
3) **Provider quality program participation:** Quality program participation will be available to providers of all Recognition Levels (subject to exceptions outlined in this document) payers will work toward a structure with increasing incentive amounts for each progressive Recognition Level, subject to payer budget constraints and negotiated rates. This can include total cost of care management incentives.

Quality Measure and Reporting Alignment

Alignment on quality measures is key to reducing provider administrative burden and creating actionable focus. The following quality measures represent the Washington Primary Care Core Measure Set that the Multi-payer Collaborative members will include in payment models offered to PCTI participating practices when appropriate as described in policies 4) – 8) in this section. Note this is an initial list that is being revised for maximum alignment across different payer and purchaser initiatives through an HCA-facilitated committee.

- Colorectal Cancer Screening (NQF 0034)
- Breast Cancer Screening (NQF 2372)
- Cervical Cancer Screening (NQF 0032)
- Child and Adolescent Well Child Visits (WCV) Ages 3-11 (NQF 1516)
- Childhood Immunization Status Combo 10 (NQF 0038)
- Depression Screening and Follow up for Adolescents and Adults (DSF-E)
- Antidepressant Medication Management (Acute & Continuation Phases) (NQF 0105)
- Follow up after Emergency Department Visit for Substance Use (FUA)(30 day, total) (NQF 3489)
- Ambulatory Care – ED Visits per 1000)
- Total Cost of Care

4) **Measure selection considerations:** Payer measure selection will balance addressing purchaser priorities, incentivizing high performance, and driving further improvement in patient outcomes. Potential exceptions to measure selection requirements may apply to practices' unique panel

composition for which the standard measure set would not incentivize meaningful improvements in quality.

5) **Aligned measures to monitor and report:** Payers will make best efforts to work with providers to at least monitor and report the Washington Primary Care Core Measure Set, using NCQA standards, and any remaining Making Care Primary metrics not captured in the Washington Primary Care Core Measure Set (for Making Care Primary participants only), unless the focus is not relevant to a specific provider's patient population. (e.g. pediatrics).
6) **Aligned measures for payment:**
    a. Payers and providers will jointly agree on which measures from the core primary care measure set are tied to payment, with the goal of including all applicable core primary care measures, as well as additional measures appropriate to their agreement. For CMS Innovation Center's Making Care Primary Model provider participants, this would include all required measures.[4]
    b. Level 2 and 3 providers may include measurement of performance on total cost of care for use in incentive calculation.
7) **Standardized quality reporting:** Multi-payer Collaborative payers will work to develop the capacity to provide standardized (e.g., core content and data definitions) quality reports and data in support of providers. Payers may continue to provide specialized support to providers, as well as in complement**.**
8) **Interpretation of measures and performance**
    a) Participating payers will define provider success on any given measure as meeting the benchmark established for that measure.
    b) The Washington Multi-payer Collaborative will establish benchmarks across the Washington Primary Care Core Measure Set, employing NCQA percentiles where appropriate.
    c) Performance of at least the 50th percentile for any given measure, or other appropriate publicly published benchmarks, as measured for the specific covered population (e.g., commercial, Medicaid, Medicare), is required to be eligible for quality incentives. Note that the CMS Innovation Center's Making Care Primary Model has additional benchmark reference groups and thresholds to be eligible for quality incentives.

Quality Incentive Payments

9) **Quality payment approach:** Payers and providers will retain the flexibility to negotiate the financial terms of the quality payments, but payers will offer incentive payments above and beyond service reimbursement. While the goal is to offer payments to all participants, budgetary and other constraints may limit the availability of these arrangements during early implementation stages.
10) **Threshold for quality payment:** Preferred payment designs include that for each quality measure where the provider's performance during the Performance Period meets or exceeds the applicable target, the provider will earn compensation (i.e., specified dollar amount per measure) as outlined in each provider payer agreement.
11) **Quality payment timing:** Payers will make standalone quality payments or make prospective adjustments to a provider's contracted rate schedule, based on quality performance no later than 12 months after the end of a performance period; both parties may agree on a more accelerated process.

[4] https://www.cms.gov/priorities/innovation/innovation-models/making-care-primary

Primary Care Scope of Services

12) **Scope of Services included in Prospective Payment:** Payment for the services component of the primary care payment model will cover a defined set of services guided by the definition developed by Washington's Primary Care Advisory Committee of the Health Care Cost and Transparency Board. (Note: The recognition process will serve as an additional constraint on the scope of services as only providers that can provide comprehensive primary care will be certified at the minimum program participation level, Recognition Level 1.)

Implementation Phase 1 Scope

13) **Timing and cohort definition:** Washington Multi-payer Collaborative members will begin the implementation process to offer payment models consistent with Multi-payer Collaborative policies to the CMS Innovation Center's Making Care Primary model participants beginning July 1, 2024. This applies to all lines of business that are relevant under Multi-payer Collaborative policies. (This does not necessarily mean that payment models will be implemented by July 1, 2024.)

14) **Application of payment models:** Payer-provided upfront infrastructure investment is not required as a minimum multi-payer participation standard, but payers may opt to support practices with upfront infrastructure investment at their discretion.

15) **Level determination:** For the purposes of determining which minimum Multi-payer Collaborative payment policies apply, the CMS Innovation Center's Making Care Primary (MCP) program Track will apply to practices participating in the CMS MCP program instead of the Washington Primary Care Practice Recognition Program Recognition Level, subject to commercial population considerations as programs evolve and mature.

Stakeholder Engagement and Provider Communications

The relationships each plan has with contracted primary care providers is a key channel for provider communication. The Washington Multi-payer Collaborative will build common messaging for providers that individual plans will use to educate and promote interest in the Washington PCTI. Ideally through aligned messaging, more providers will gain understanding of the PCTI and the messages they hear are the same, or similar, from each of the plans they contract with to provide care.

16) **Development of common payer Washington PCTI communication messages for providers:** The Multi-payer Collaborative will develop and approve common communication messages and talking points on Washington PCTI intent, policies, and implementation status for clear messaging and engagement of providers.

17) **Payer outreach to providers for the Washington PCTI:** Multi-payer Collaborative members agree to use finalized common messages in their communications with providers where possible. Additionally, Multi-payer Collaborative members agree to individually reach out to contracted primary care providers at key Washington PCTI implementation moments as agreed to by the Multi-payer Collaborative.