Paying for Value Survey Questions and Answers		
#	**Respondent Question**	**HCA Answer**
1.	On Attachment D, Part B, #3, a, vi: Can HCA confirm if Column D should be Column M in this instruction?	Clarification: There are two columns in which you may enter a notice of the inclusion of "Proprietary Information" on the response templates - Sheet 1 – Column D - Sheet 2 – Column M We will update Attachment D on the website.
2.	On Attachment D, Part B, #3, c, i: Can HCA confirm if cells E34-G42 should be cells E36-G44 and cells E33, F33, and G33 should be E35, F35, and G35 in this instruction?	HCA confirms this error, and we will update Attachment D on the website.
3.	Will HCA please provide additional detail regarding the purpose and ultimate use of the data collected through the survey, particularly as it relates to the Apple Health program?	HCA will use data submitted to inform its VBP roadmap and purchasing strategies.
4.	The Survey Instructions identify that the purpose of the survey is to collect a "snap shot in time." Please confirm that data current as of January 1, 2016 may be used as the "snap shot" time period in response to this survey.	Confirmed: Response data current as of January 1, 2016 is acceptable for the purposes of this survey.

5.	On Sheet 1 - Payers of Attachment C: Response Template for Payers, please confirm that for the purposes of Question 5.4, the term "purchasers" refers to HCA or CMS with regards to Apple Health or Medicare contracts.	Confirmed: For the purposes of Question 5.4 of Sheet 1-Payers on Attachment C: Response Template for Payers, the term "purchasers" may refer to HCA or CMS with regard to Apple Health and Medicare contracts, respectively.
6.	On Sheet 2 – APM Breakdown of Attachment C: Response Template for Payers, please confirm that for columns E-H, "providers" should be calculated at the practice level.	Please list number of FTE providers. For example, if two clinics with 10 and 20 providers, respectively, are in 2B Medicaid arrangements, please input '30' in Column 'E'.
7.	Within the Health Care Payment and Learning Action Network Alternative Payment Methodology continuum, there are two gray boxes within Category 3 and 4, 3N: Risk Based Payment not Tied to Quality and 4N: Capitated Payment not tied to Quality. If there are payment methodologies that fall within these categories, where should they be represented in the survey?	HCA will add Categories 3N and 4N to both response templates and post the updated versions to the website. HCA's VBP definition includes Categories 2C through 4B but excludes 3N or 4N.
8.	If there are multiple payment models per category, how do you recommend labeling and completing the survey?	For multiple payment models per category, HCA recommends a concise response detailing each payment model, to the responder's best ability. Each model may be identified numerically or separated into distinct paragraphs (by holding ALT and pressing ENTER).
9.	The survey requests attribution of lives by payment models, some payment models might be for a specific element of care for an individual, how would you attribute this to an individual, so the individual lives are not counted multiple times?	HCA understands that individuals may receive care from multiple providers who may each be reimbursed under different payment models. HCA is most interested in a rough estimate of attributed lives, so please make a note where number of lives may be counted multiple times.
10.	Can you further clarify question 2.4 or provide some examples? *How does your organization ensure benefit design recommendations support and align with delivery*	Benefit design needs to align with delivery system reforms to maximize health system transformation. HCA is interested in learning more about payers' and providers' experience and expertise in working with

	system reforms?	purchasers to ensure benefit design incentivizes patients to seek the right care at the right time, in the most appropriate setting, and complements delivery system reforms.
11.	If ultimately Medicaid rates are validated by encounters we submit, can we truly have any Medicaid payments fall within Category 4?	HCA believes there are actuarial processes available to support all categories of APM.
12.	Where would HCA place elements of the PEB Accountable Care Program? Would HCA be able to simulate this on the webinar or provide a written example?	HCA's PEBB Accountable Care Program falls within Category 3B, as it involves a global financial target for a defined population, downside risk, and upside gain-sharing. HCA will detail this example on the webinar.
13.	Related to question 11, if CMS is utilizing the HCPLAN continuum, do we know if they are committed to adapting how rates are validated to ensure ability to truly do population health based payments and is HCA equipped to do this as well?	HCA continues to engage CMS on this question.
14.	Has HCA thought about how this survey may indicate regional status of value based payment? If so, can you indicate what questions (if any) request attribution by region/location?	If current value based payments are attributed to specific regions in your network, please indicate where they are implemented on Sheet 2 – APM Breakdown in the Payment Model Example column. In the future, HCA will be interested in the regional breakdown of VBP attainment.
15.	Can HCA describe how they will utilize the data collected? Are there plans to validate the submissions?	HCA will use the information and data collected to serve as a proxy towards understanding the stated goal of seeing 80% of state-financed health care, and 50% of commercially-financed health care, in VBPs/APMs by 2019. HCA may also use the data and information collected to inform future initiatives, programmatic changes, and

		purchasing strategies. HCA understands that responses are self-reported and non-binding. As such, there are no plans to validate submissions. Nevertheless, with the possibility of pursuing strategies informed by responses, it is HCA's expectation that responses be, to the extent possible, true and accurate.
16.	The RFI aims to identify barriers impeding desired progress, how might potential barriers be addressed?	It is known payers and providers may face a multitude of barriers toward progress with adopting VBPs and APMs. While each case may require a unique effort to address specific barrier, survey responses will inform other Healthier Washington efforts aimed at assisting providers with the transition to value, such as the Practice Transformation Hub and Medicaid 1115 waiver.
17.	Will there be an opportunity for respondents to engage with HCA after submission to discuss answers and further review next steps?	HCA is open to pursuing dialogue with organizations interested in pursuing VBPs and APMs and will conduct follow-up conversations with interested respondents.
18.	What has HCA done to engage behavioral health providers and Behavioral Health Organizations to complete the survey?	BHOs and behavioral health providers have received an initial distribution of the survey and will be further engaged.
19.	Does HCA know when elements of the APM continuum will be incorporated as expectations within the Medicaid contracts?	HCA will rely on the HCP-LAN APM Framework to inform VBP components of its contracts as soon as 2017. Specific elements are still under review.
20.	Does HCA have plans to form a work group or committee to accelerate this work forward and facilitate alignment across purchasers, payers and providers?	HCA will continue to accelerate the transition to value-based payments and to facilitate alignment through existing Healthier Washington channels as well as the 1115 Medicaid waiver. HCA intends to leverage existing forums for this conversation.