Medicaid Value-based Purchasing Action Team

January 18, 2018

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2017 MVP Action Team Highlights

- Examined VBP landscape and HCA expectations
- Explored provider capabilities needed for VBP (governance/organization; provider engagement; care coordination/management; population health management; links to SDOH)
- Supported/advanced provider survey
  - Identified key enablers and barriers to VBP adoption
- Examined role of ACHs in advancing VBP (convener; educator; regional strategy developer; driver of sustainable reforms; advocate/champion)

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MVP Action Team Survey: Key takeaways

- Keep large/small group format but allocate/manage time effectively
- Use case studies and concrete examples
- Be action-oriented in supporting and guiding ACHs

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Value-based Roadmap and Rural Multi-payer Model

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January 18, 2018

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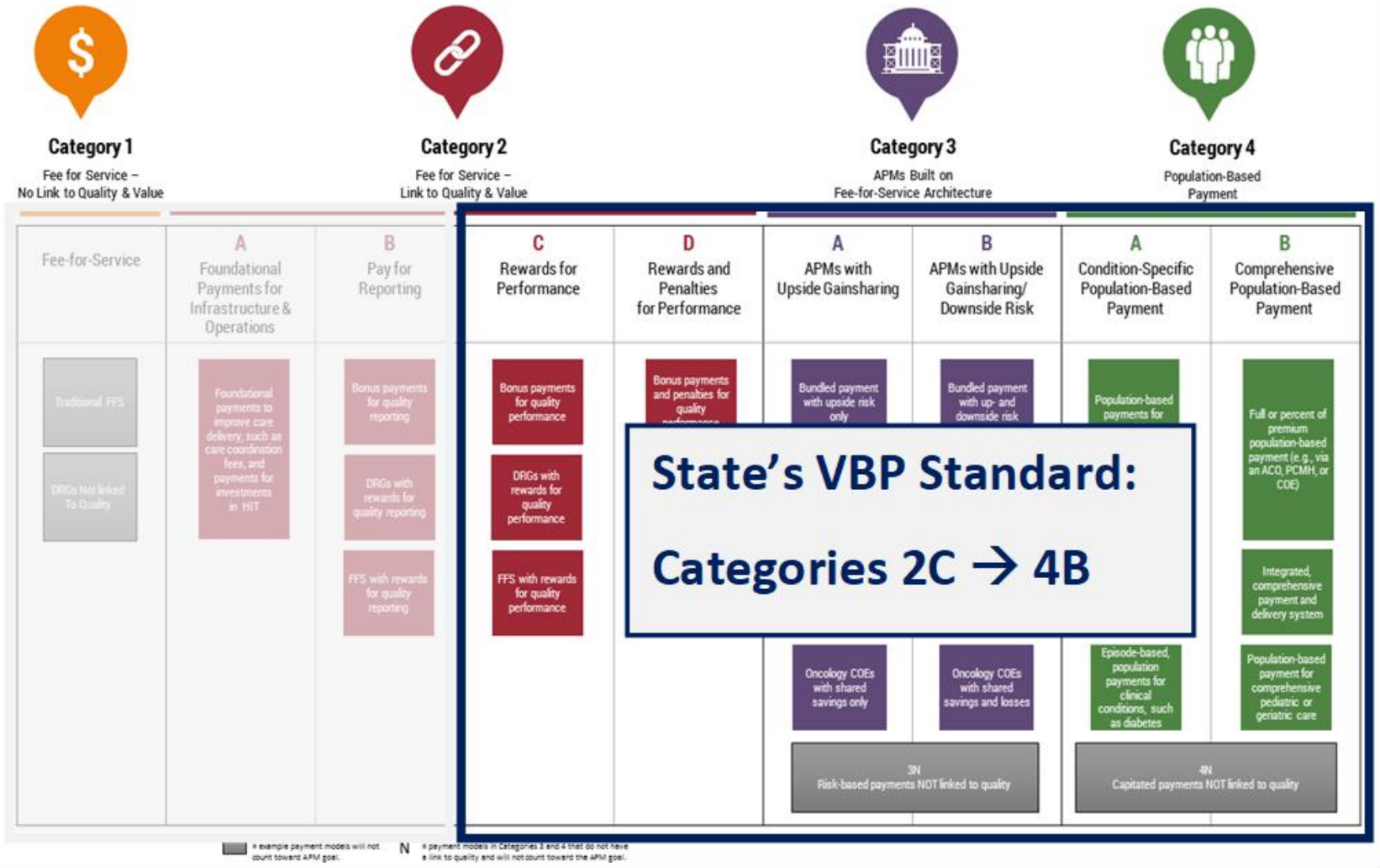
Alignment with CMS Alternative Payment Models framework



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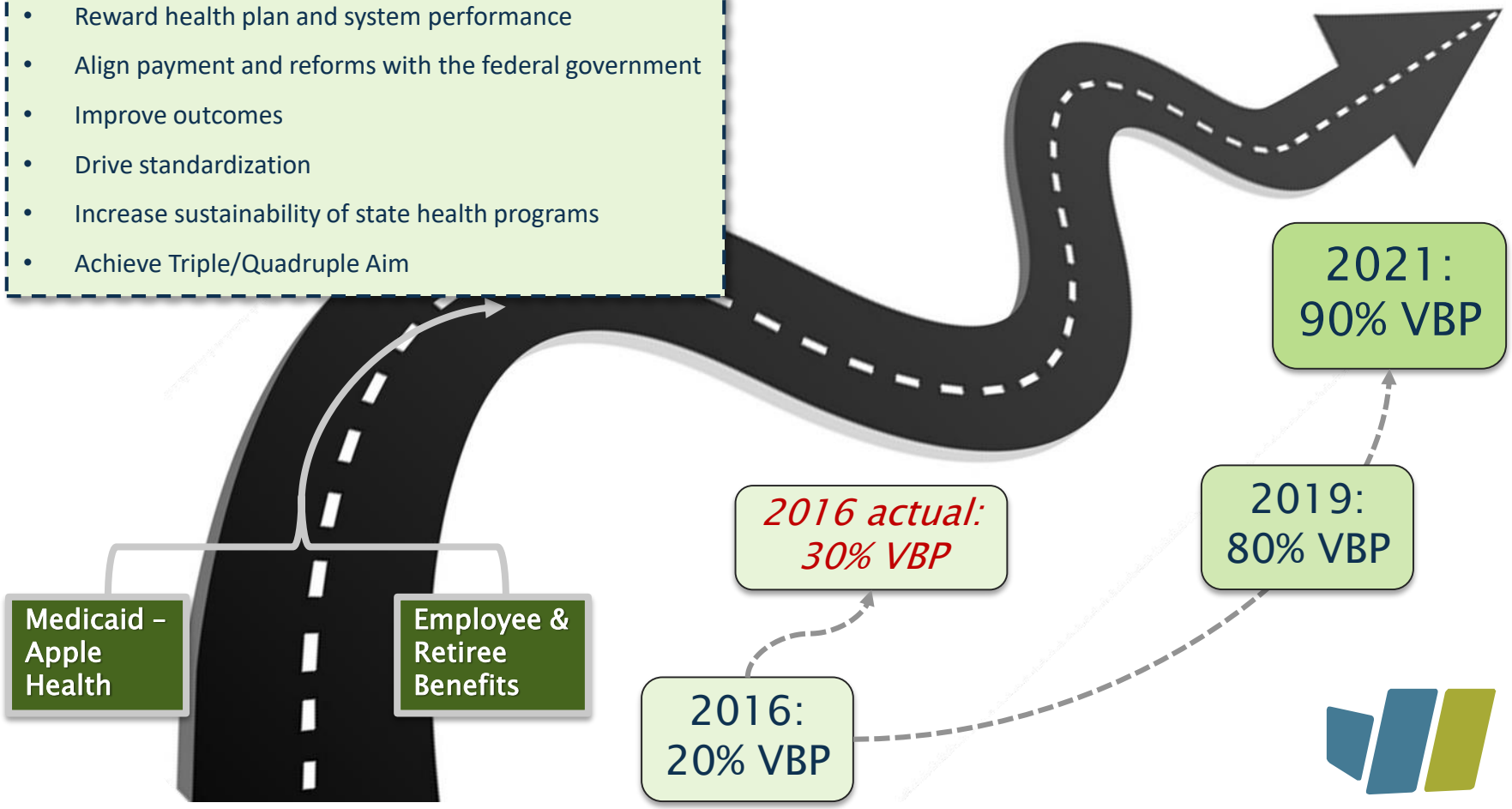
HCA Value-based Roadmap

- Reward patient-centered, high quality care
- Reward health plan and system performance
- Align payment and reforms with the federal government
- Improve outcomes
- Drive standardization
- Increase sustainability of state health programs
- Achieve Triple/Quadruple Aim



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Apple Health appendix

- Reflects specific initiatives and changes pertaining to the Apple Health program, in alignment with HCA's Value-based Roadmap
- Required under STCs 40 and 41 under the demonstration, as well as contractual obligations in Managed Care contracts
- Deliverable to CMS

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Employees and Retirees Benefits (ERB) appendix

- Reflects specific initiatives and changes pertaining to the ERB program, in alignment with HCA's Value-based Roadmap
- Demonstrates how HCA is driving common elements through its ERB programs to pay for value
- Signals HCA's vision for expansion of current programs and development of new programs and initiatives

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Status

- Value-based Roadmap
  - Published January 2018
- Employees and Retirees Benefits appendix
  - Published January 2018
- Apple Health appendix
  - Published/submitted to CMS fall 2017

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Rural Multi-payer Model (exploration)

Challenges providers face

- Recruitment and retention
- Sicker, older populations
- Low operating margins
- Relationships with larger systems have not benefited rural providers

Low utilization and challenges faced under cost-based reimbursement will be exacerbated as the system moves to value-based purchasing.

Is there a better way?

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Opportunity for rural health systems

HCA is exploring ways to transform the rural health delivery system.

Under a new model, collectively, we can ***collaborate*** and ***transform*** the delivery system to leverage:

- Budgeted payment approaches
- Practice transformation

Rural multi-payer model

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Rural multi-payer model

Goals:

- Value-based payment reform
- Sustainable solutions for maintaining and increasing access
- Delivery system transformation
- Patient engagement

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Timeline

December 2017 - January 2018:

- Individual meetings with payers for input and review
  - Discuss the model
  - Identify concerns
  - Provide additional details
- Presentation and engagement with providers

February 2018:

- Feb. 1: Meeting with MCOs, commercial payers and providers on the model
  - Background and overview
  - Discussion on the vision
  - Potential models
  - Timeline and continued engagement
- Feb 28: Webinar

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Questions?

More Information:

https://www.hca.wa.gov/about-hca/healthier-washington/paying-value

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Value-based Payment for Children's Health Care

Medicaid Value-Based Purchasing Action Team Meeting

January 2018

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2021 Vision: 90% of Provider Payments Under State-Financed Health Care Will be Linked to Quality and Value

VBP Goals (consistent with HCP-LAN Framework)					
	DY1	**DY2**	**DY3**	**DY4**	**DY5**
HCP LAN Category 2C-4B	30%	50%	75%	85%	90%
Subset of goal above: HCP LAN Category 3A-4B	-	10%	20%	30%	50%

Source: Washington HCA

National and State VBP Focus is on Adults

- Discussions about VBP in Washington, and across the country, have largely focused on VBP with adult patients in mind.
- This is because adults, especially sick adults, make up a huge percentage of health care spending.
- Many adult-focused VBP models encourage providers to seek quick savings which are achieved through the reduction of high-cost services such as hospitalizations and emergency department visits.

Pediatric Primary Care Provider VBP Models are Critical to Meeting State's Goals

- 45% of Apple Health enrollees are children; they account for roughly 15% of the spending.
- HCA and MCOs will need to develop child-focused VBP models in order to meet the VBP goals by 2022.

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Pediatric Primary Care Provider VBP Models must Define Value Differently than Adult-focused Models

- VBP models for children's health care need to be different than adult-focused models because "**value**" in children's health care is about addressing issues that affect children **into and throughout** their adult lives – not about reducing hospital usage or managing expensive chronic conditions.

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Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Source: Kaiser Family Foundation

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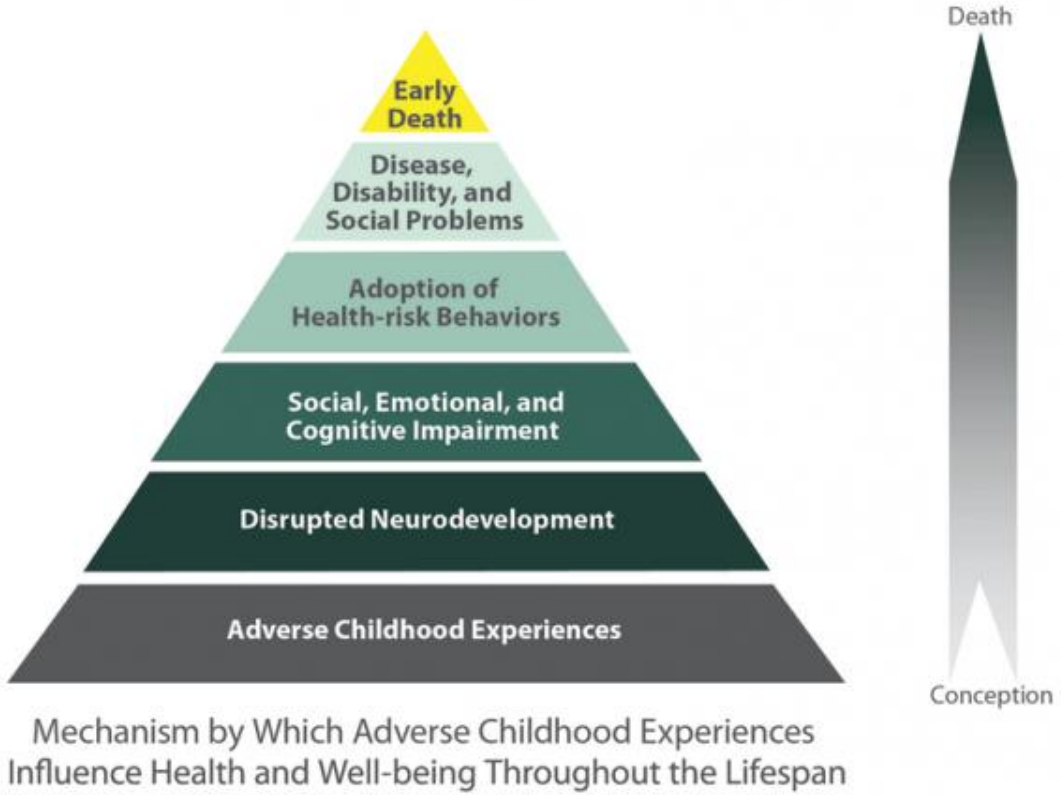
Adverse Childhood Experiences



Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Intimate partner violence
- Mother treated violently
- Substance misuse within household
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

Source: Centers for Disease Control and SAMHSA

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Challenges in Designing VBP models for Children's Health Care

- Most children generate little medical expense and because of that, total cost of care models won't work well, as patterns of medical expenditure tend to be more sensitive to random events.

- There are very few children with high medical needs, and those with such needs are not all alike, making it difficult to apply commonly used adult-focused payment methodologies (e.g., total cost of care models, episode budgets).
    - Except to regional tertiary referral centers that see a large volume of kids with complex care needs.

- Present and future health status is largely defined by factors not under the control of clinicians. As previously noted, there are strong associations between the social determinants of health and adverse childhood events, that intersect with, but are largely addressed outside of the health care system.

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WCAAP's Recommendations for Two Child-Focused VBP Models

1. Pediatric Primary Care Advanced Payment Model
2. Population health model for Children with Medical Complexity

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Pediatric Primary Care Advanced Payment Model

This payment model is designed for primary care pediatric providers not to place financial risk but to:

1. Adequately fund traditional and non-tradition value-based care
2. Provide delivery service flexibility
3. Encourage appropriateness of care and setting
4. Provide Incentives to Continually Improve

- There are four elements to the VBP model:
  1. A bundled pediatric primary care payment;
  2. care coordination fees;
  3. targeted fee-for-service, and
  4. performance bonus opportunity

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Bundled pediatric primary care payment

- A prospectively paid per-patient-per month risk-adjusted rate based on historical costs with upward adjustment to account for:
  - Care described in the Bright Futures guidelines
  - Time for telephone calls with families, schools, etc.
  - Costs associated with providing integrated behavioral health care services
- A downward adjustment can be made for practices that have higher-than-expected use of ED, urgent care and specialty services.
- Specialty and tertiary care services should be excluded

Targeted Fee-for-Service Payments

- Some services should be excluded from the bundled pediatric primary care payment in order to incentivize their delivery
  - Immunizations
  - Screening for social determinants of health (including parental depression)
  - Services delivered by some, but not most, practices (e.g., suturing)

Care Coordination Fees

- In addition to the bundled payment, a care coordination fee would cover Care Coordinators to focus on children who have medical and social risk factors, and specifically to…
  - Coordinate specialist referrals
  - Track test results
  - Follow-up with patients
  - Refer and coordinate with community-based social service agencies
- Like the bundled payment, the care coordination payment should also be risk-adjusted, and combined with the bundled payment for ease of administration (i.e., one payment).

Performance Bonus Opportunity

- It is important that there be an explicit incentive and reward for the delivery of high quality and efficient care. WCAAP therefore recommends an opportunity for practices to earn a bonus based on performance.
- Research suggests the potential rewards should approach 10% of compensation to provide sufficient motivation.
- Rewards should recognize excellence and improvement on evidence-based performance measures from state or national measure sets.

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Advanced Payment Model for Children with Medical Complexity

- A total cost of care model where the provider organization receives a budget for the total care *for a sufficiently large population*.
  - Provider organizations most able to participate in this model would be tertiary referral centers – like Seattle Children's hospital and Children's University Medical Group, perhaps.
- The model should evolve from shared savings to shared risk, but should not become full-risk due to the impact high-cost outliers
- Eligibility for distribution of any earned savings should be based on quality performance
  - Quality measures would need to be relevant to the health status of the population
- A care coordination payment should also be coupled with this model

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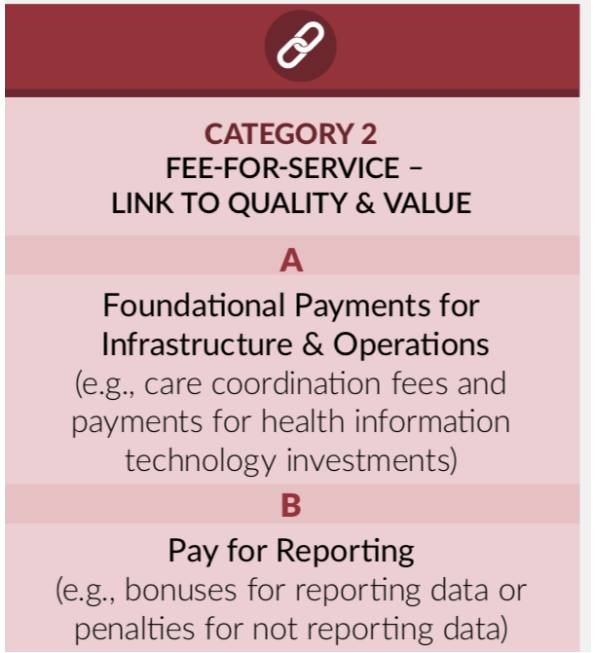
Challenges

- Costs for care at the beginning of life will necessarily go up because:
  - FFS Medical care for pediatric patients has been underfunded by public payers (2/3 Medicare rates; ½ costs of delivery)
  - Investments will be needed (HCP-LAN Category 2A payments)
    - Pediatric care redesign elements/infrastructure less well established – risk-adjustment; care coordination; care management; performance measures; IT investment; Provider Engagement; Governance and Organization
  - Care essential for improved lifetime health outcomes is not currently reimbursed (SDH screening/coordination)



Implementing VBP for Children's Health Care

- Because there are no VBP models for children's health care in place at present, there is a tremendous opportunity to work together to design and implement one, allowing us to work together to build a common approach across payers.

- Aligned value-based payment models are a win-win-win.
  - Pediatric providers would have an aligned set of incentives and resources to maximize value (e.g., connecting families with community resources to address SDOH)
  - Health plans would likely see improved care for their members and have help meeting HCA's challenging VBP targets
  - HCA would meet its goals and improve the cost and quality of children's health care today, and the future health and social service expenditures

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Questions and Discussion

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VBP in the context of MCO-provider relationship

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HCA's 2022 Vision

90 percent of provider payments under State-financed health care must be linked to quality and value by the end of 2021

VBP Goals (consistent with HCP-LAN Framework)*					
	DY1	DY2	DY3	DY4	DY5
HCP LAN Category 2C – 4B	30%	50%	75%	85%	90%
Subset of goal above: HCP LAN Category 3A-4B	-	10%	20%	30%	50%
Payments in Advanced APMs			TBD*	TBD*	TBD*

By 2022, 90% of payments must be in an arrangement that is *higher than 2B*

By 2022, 50% of payments must be in a *Category 3 or 4* arrangement

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Role of the MVP Action Team

- **Think about what is and isn't working:**
  - How is your ACH currently supporting VBP advancement through the Medicaid Transformation efforts?
  - How is the ACH approaching alignment and non-duplication?
  - What else could the ACH be doing to align with and advance VBP?
- **Guiding principles to frame the ACH role to support VBP within the Medicaid Transformation Project.**
- **Recommended practical application**

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Guiding principles as identified by ACHs

- Delivery System Reform (DSRIP) activities are meant to catalyze the transition from a system that rewards volume to one that rewards value.
- DSRIP alone is not enough and alignment with other value-based efforts is imperative.
  - The ACH must set expectations and criteria for performance (as it relates to DSRIP) in line with MCO needs and plans, but also with the expectations of other payers such as Medicare and commercial plans, to avoid burdening providers with non-aligned expectations
  - Must focus on metrics across payers (Medicare, Medicaid and Commercial)
- ACHs do not interfere with MCO-provider contracting but can address barriers and promote enablers.
- Care is taken to avoid collusion; establish shared understanding of boundaries.
- DSRIP activities must support sustainable transformation, clinical integration, and increased VBP attainment over time.
- Support partnering providers in the development of their capabilities to embrace alternative payment methodologies without increasing overall system calls
- Must work with and support Behavioral Health providers in the VBP transition

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Practical application as identified by ACHs

- Provide funds to offset upfront costs
- Assess current state (and any gaps) of partnering provider capabilities and readiness
- Integrate VBP elements in ACH contracts with partnering providers
- Leverage regional workgroups or cohorts to align activities and strategies to create opportunities for shared learnings and grow the relationships among partnering providers.
  - Providers can be grouped in cohorts based upon their capabilities and goals
  - A role of a workgroup will be to educate providers on what resources are available for them to transition to VBP contracts and develop a regional strategy
- Support the development of provider change plans; monitor change plan progress
- Provide VBP education and share best practices with partners. Offer workshops, webinars, and technical training, summits
- Continued partnership and dialogue with MCOs
- Develop ongoing assessment mechanism in partnership with MCOs

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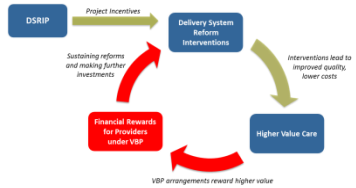
Additional background materials

VBP rewarding *and* sustaining higher value care



VBP is about providers assuming more accountability for the quality and cost of care, incentivizing higher-value care. Generally, VBP can take one of two forms:

1. **Providers receiving bonus payments or paying penalties** for meeting or not meeting quality or cost metrics (e.g., pay-for-performance, quality incentive bonuses, withholds) that then help the payer meet their related quality or cost goals
2. **Providers taking on risk themselves** for a population, subset of benefits, or episode of care and retain the reward or penalty associated with cost and quality (e.g., global capitation, bundled payment arrangement)

DSRIP projects are intended to help providers develop the population health management and workforce capabilities that can drive improvements in quality and costs and, as a result, be rewarded under either form of VBP.

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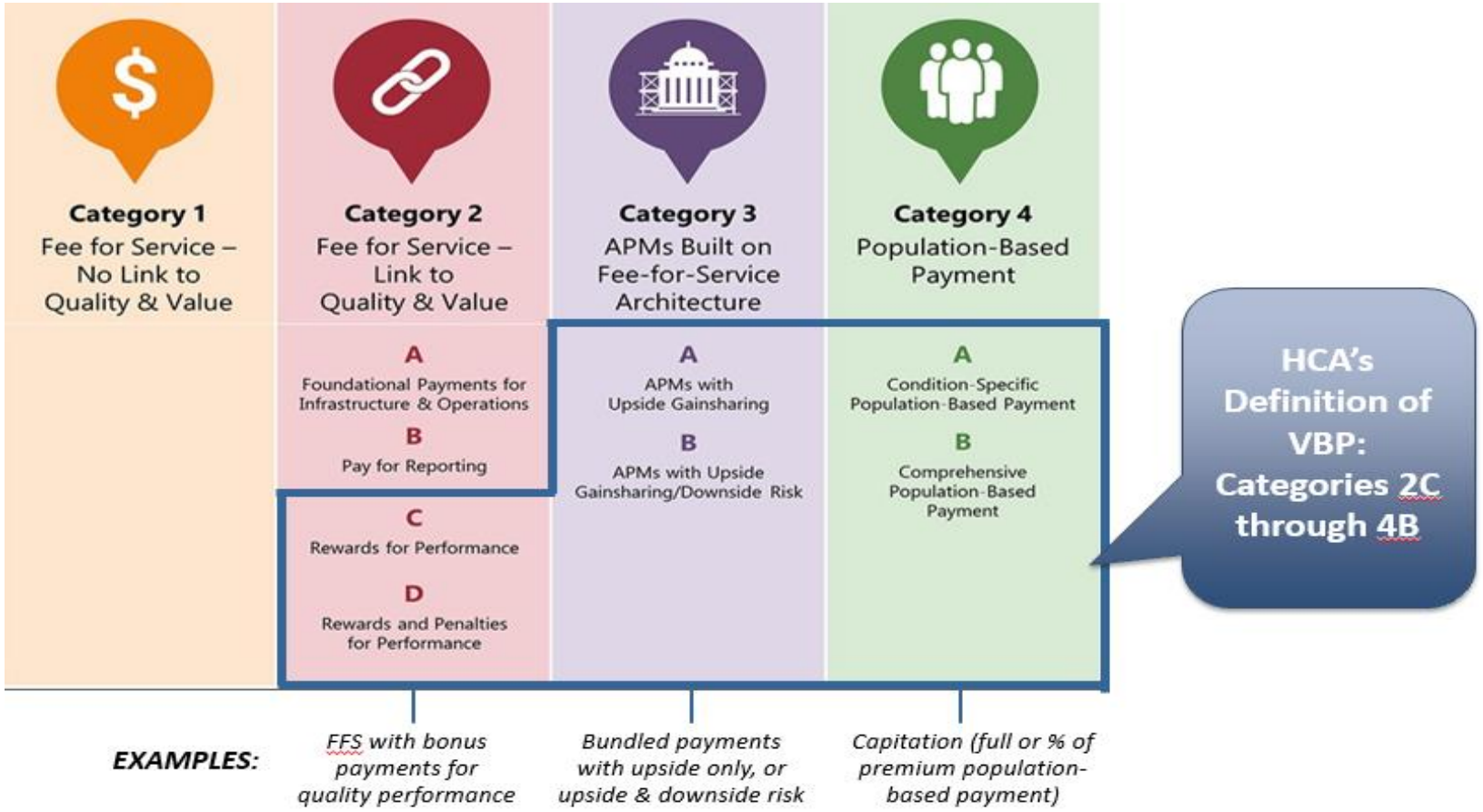
Defining VBP



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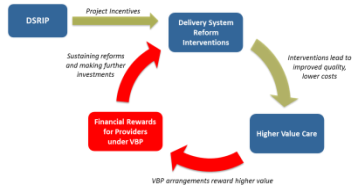
Role of ACHs in advancing VBP



ACHs can play a variety of different roles to advance VBP in their regions

Convener

- **Partner and communicate regularly with all relevant parties, including MCOs, providers, CBOs, etc.**
- **Connect providers with one another and/or with non-physician organizations**, like CBOs, counties, etc.
- **Facilitate ongoing communication among** stakeholder groups

Regional Strategy Developer

- **Assess current state** and **monitor progress** in conjunction with HCA and MVP AT
- **Identify regional provider needs**
- **Determine feasibility of regional "solution"**
- **Develop strategies to address needs** leveraging existing resources (e.g., MCO programs to support providers)
- **Leverage DSRIP** and other programmatic resources to support regional effort

Driver of *Sustainable* Reforms

- **Support approaches to provider capability development** that do not add to overall system costs and are in line with MCOs' VBP efforts
- **Advocate for initiatives that are in line with MCO contract requirements** (e.g., HEDIS measure performance)
- **Work with providers and MCOs** to define new projects

Educator

- Educate providers on **VBP targets and models**
- Support **access to resources and information** on VBP readiness
- Educate provider and non-provider partners on required **VBP capabilities** and **stakeholder roles**
- HCA, MCOs, others will provide support to ACHs in these education efforts

Advocate "Practice Transformation Champion"

- **Provide support and advocate** on behalf of providers and other partners as they work on developing VBP capabilities

Supported by HCA and MVP Action Team

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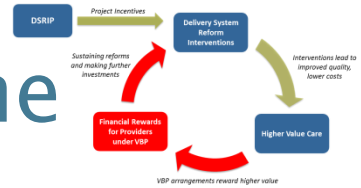
ACH engagement with VBP over time



	Year 1	Year 2	Year 3	Year 4	Year 5
Domain 1 Annual VBP Targets					
HCP-LAN Category 2C-4B	30%	50%	75%	85%	90%
HCP-LAN Category 3A-3B	-	10%	20%	30%	50%
Select ACH VBP Milestones					
	Project Plan ★	★ Regional VBP Transition Plans			
	Engagement, capacity assessment	Convening to develop Plan; securing provider LOIs	Transition Plan implementation; Report on progress; Ongoing engagement with providers, plans and MVP Action Team		
Potential ACH Roles					
Convener					
Educator					
Regional Strategy Developer					
Sustainable Reforms Driver					
Advocate					

Source: *Healthier Washington Medicaid Transformation Approved Project Toolkit, June 2017*

Glossary of Acronyms

- **ACH:** Accountable Communities of Health
  - See more at https://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach
- **APM:** Alternative payment models
  - See more at https://hcp-lan.org/groups/apm-refresh-white-paper/
- **CBO:** Community-based organization
- **DSRIP:** Delivery System Reform Incentive Payment demonstration
  - See more at https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation, https://www.hca.wa.gov/assets/program/Medicaid-demonstration-terms-conditions.pdf or http://www.kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/
- **FFS:** Fee-for-service (traditional payment model for provider reimbursement, where providers are paid a set amount of each service provided to a patient)
- **HCA:** Washington State Health Care Authority (the State Medicaid Agency)
- **HCP LAN:** Health Care Payment Learning & Action Network
  - See more at https://hcp-lan.org/
- **MCO:** Medicaid Managed Care Organization
- **VBP:** Value-based payment (model for paying providers that ties payment with outcomes through rewards for high quality and/or cost-effectiveness; defined by HCA as Categories 2C and higher in the HCP LAN APM framework
  - See https://www.hca.wa.gov/assets/program/vbp_roadmapw-ah.pdf

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