Value-based Purchasing Roadmap

2019–2021 and beyond
Contents

Introduction .................................................................................................................................................. 4

Background .................................................................................................................................................. 4

HCA’s foundational principles .................................................................................................................... 4

HCA’s purchasing goals .............................................................................................................................. 5

Chart 1: moving toward HCA’s 90 percent VBP adoption goal .............................................................. 6
Chart 2: LAN APM framework for VBP or APMs .................................................................................. 7
Chart 3: Washington State’s VBP standard .............................................................................................. 8

The rearview mirror .................................................................................................................................. 8

Paying for value surveys ............................................................................................................................ 8
Table 1: top three barriers and enablers to VBP adoption ....................................................................... 9

Successes .................................................................................................................................................. 9
Table 2: Medicaid, PEBB, and SEBB success and milestones ................................................................. 9

Challenges .............................................................................................................................................. 10

The road ahead ......................................................................................................................................... 11

Sustainability ........................................................................................................................................... 11

Priorities ................................................................................................................................................ 11

Rural communities ................................................................................................................................. 12

Cascade Care/public option ....................................................................................................................... 12

Integrated Care for Kids .......................................................................................................................... 13

Partner and community engagement ...................................................................................................... 13

Roles in VBP across the health system .................................................................................................... 13

Appendix A: Vehicles of Transformation .................................................................................................. 15
Introduction

Health Care Authority's (HCA's) goal is to achieve a healthier Washington by containing costs while improving outcomes, patient and provider experience, and equity through innovative, value-based purchasing (VBP) strategies. This is the 2019 update to the HCA Value-based Purchasing Roadmap since its original publication in June 2016.

The roadmap describes HCA's VBP goals, purchasing and delivery system transformation strategies, innovation successes to date, and future plans to accelerate transition into value-based payment models. Specifically, this roadmap highlights HCA's successes in delivery system transformation, as well as upcoming projects and priorities to drive positive results across the state for years to come.

Background

In 2016, Centers for Medicare & Medicaid Services (CMS), the largest health care purchaser in the United States, led a national effort to move from traditional volume-based health care payments to payments based on value. Medicare declared its commitment to value and quality, and announced its own purchasing goals. CMS remains committed to robust participation in innovative delivery system transformation models and has made substantial progress in meeting its goals.

The Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015 rewards providers through higher Medicare reimbursement rates for participation in advanced value-based payments or alternative payment models (APMs). To date, CMS has signaled its continued commitment to APMs by announcing new priorities, including strengthening patient engagement and reducing provider burdens, such as regulations. Like CMS, HCA is transforming the way we purchase health care. As directed by state legislation passed in 2014, and as an agency strategy, HCA intends to link 90 percent of provider payments under state-financed health care programs by the end of 2021. This encompasses Washington Apple Health (Medicaid), Public Employees Benefits Board (PEBB), and School Employees Benefits Board (SEBB) programs.

On January 9, 2017, Washington State and CMS reached agreement on a groundbreaking five-year Medicaid Transformation project. This work allows the state to invest in comprehensive Medicaid delivery and payment reform through a Delivery System Reform Incentive Payment (DSRIP) program.

This agreement presents an opportunity to leverage state-purchased programs to accelerate payment and delivery service reforms and reward regionally based care redesign approaches that promote clinical and community linkages.

HCA’s foundational principles

The roadmap lays out how HCA is changing the way health care is delivered by implementing new payment models that encourage population-based care. This roadmap braids major components of payment redesign model tests, Statewide Common Measure Set, Accountable Communities of Health (ACHs), Medicaid

---

1 For more information on roadmap activities and paying for value strategy, visit hca.wa.gov/about-hca/healthier-washington/paying-value. If you have questions or would like a copy of the first edition of HCA’s VBP Roadmap, please contact J.D. Fischer at jd.fischer@hca.wa.gov.

2 For more information on CMS’ value-based programs, visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html.

3 For more information on CMS’ communications, visit https://www.cms.gov/newsroom.
Transformation, and the Dr. Robert Bree Collaborative care transformation recommendations and bundled payment models. HCA built the roadmap upon the following foundational principles:

1. Continually strive for smarter spending, better outcomes, and better consumer and provider experience.
2. Reward the delivery of person- and family-centered, high-value care.
3. Reward improved performance of HCA’s Medicaid, PEBB, and SEBB programs and their contracted health systems.
4. Align payment and delivery reform approaches with other purchasers and payers, where appropriate, for greatest impact and to simplify implementation for providers.
5. Drive standardization and care transformation based on evidence.
6. Increase the long-term financial sustainability of state health programs.

HCA’s purchasing goals

A primary strategy in achieving HCA’s goal is capitalizing on the state’s authority and purchasing power to advance VBP.

As the largest health care purchaser in Washington State, HCA purchases care for more than two million Washingtonians through the Apple Health (Medicaid) and PEBB programs. In January 2020, HCA will purchase care for the SEBB program, which is expected to have more than 140,000 members. Annually, HCA will spend more than $12 billion between these three programs. This gives HCA the market power to drive transformation as a convener and innovator.

HCA’s vision for a healthier Washington in 2021 is that:

- All HCA programs implement VBP according to an aligned purchasing philosophy.
- Accountable delivery system networks and plan partners comprise most of HCA’s purchasing business.
- HCA exercises significant oversight and quality assurance over its contracting partners, and implements corrective action as necessary.

By 2021, HCA will tie 90 percent of payments made to providers for service delivery to quality, ensuring shared accountability for each patient’s well-being and total cost of care. This requires thoughtful, evidence-based, collaborative management of physical, behavioral, and social determinants of health needs.

The chart below shows HCA’s interim purchasing goals and VBP milestones along the path to 90 percent adoption in 2021.
To move away from fee-for-service, HCA adopted the framework created by CMS through the Health Care Payment and Learning Action Network (LAN). The LAN framework defines payment arrangements or APMs. (See chart on next page.)
Chart 2: LAN APM framework for VBP or APMs

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service – No Link to Quality &amp; Value</td>
<td>Fee for Service – Link to Quality &amp; Value</td>
<td>APMS Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
</tr>
</tbody>
</table>

### Fee-for-Service

#### A. Foundational Payments for Infrastructure & Operations
- Traditional FFS
- DRGs Not Linked to Quality

#### B. Pay for Performance
- Bonus payments for quality reporting
- DRGs with rewards for quality performance
- FFS with rewards for quality reporting

#### C. Rewards and Penalties for Performance
- Bonus payments for quality performance
- DRGs with rewards and penalties for quality performance
- FFS with rewards and penalties for quality performance

#### D. APMS with Upside Gainsharing/Downside Risk
- Bundled payment with upside risk only
- Episode-based payments for ambulatory-based clinical encounters with shared savings and losses
- Oncology COE with shared savings only
- SN Risk-based payments NOT linked to quality

### APMS Built on Fee-for-Service Architecture

#### A. APMS with Upside Gainsharing
- Bundled payment with up and downside risk
- Episode-based payments for post-discharge clinical encounters with shared savings and losses
- Oncology COE with shared savings and losses

#### B. APMS with Upside Gainsharing/Downside Risk
- Bundled payment with up and downside risk
- Episode-based payments for post-discharge clinical encounters with shared savings and losses
- Oncology COE with shared savings and losses

### Population-Based Payment

#### A. Condition-Specific Population-Based Payment
- Population-based payments for specialty conditions and facility specific care (e.g. via an ACO, POCM, or Care)
- Primary care PCMH with shared savings and losses
- Oncology COEs with shared savings and losses
- SN Capitated payments NOT linked to quality

#### B. Comprehensive Population-Based Payment
- Full or partial payment for primary care (e.g. via an ACO, POCM, or Care)
- Partial population-based payments for primary care
- Episode-based payments for clinical conditions, such as diabetes
- Drug payments for comprehensive pediatric or genetic care
HCA aims to have 90 percent of state-financed health care payments to providers in APM categories 2C-4B by 2021.

The rearview mirror

Paying for value surveys

Each year, HCA surveys health plans and providers to measure VBP adoption and related barriers and enablers. HCA uses these surveys to track progress toward its VBP goals, continually improve current programs, and develop future initiatives.

For calendar year 2017, health plans reported having 50 percent Medicaid, 56 percent commercial, and 64 percent Medicare provider payments in payment arrangements in APM categories 2C and higher. In calculating payments through Medicaid Managed Care and PEBB, HCA reported achieving 43 percent of payments to providers (in calendar year 2017) in APM categories 2C and higher. This outpaces HCA’s 2017 goal of 30 percent.

The table below highlights the top three barriers and enablers to VBP adoption as reported by health plans and providers.
Table 1: top three barriers and enablers to VBP adoption

<table>
<thead>
<tr>
<th>Health plans</th>
<th>Top barriers to VBP adoption</th>
<th>Top enablers to VBP adoption</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Payment model uncertainty disparate incentives and/or contract requirements</td>
<td>• Trusted partnerships and collaboration</td>
</tr>
<tr>
<td></td>
<td>• Attribution</td>
<td>• Interoperable data systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Aligned incentives and contract requirements</td>
</tr>
<tr>
<td>Providers</td>
<td>• Lack of interoperable data systems</td>
<td>• Aligned quality measures and definitions</td>
</tr>
<tr>
<td></td>
<td>• Misaligned incentives and/or contract requirements</td>
<td>• Trust partnerships and collaboration with payers</td>
</tr>
<tr>
<td></td>
<td>• Insufficient access to comprehensive data on patient populations</td>
<td>• Development of a medical home culture with engaged providers</td>
</tr>
</tbody>
</table>

HCA will publish additional results from the 2019 paying for value survey later this year.

**Successes**

HCA's programs—Medicaid and PEBB—accomplished much over the last year. Overall, as “one” agency, HCA made strides toward its goal of aligning purchasing strategies, as applicable, across all books of businesses. Accomplishments include:

- Expanded PEBB’s Centers of Excellence program from one to two episodes, adding spinal fusion (in addition to total knee and hip replacements), which identifies facilities that adopt and demonstrate their use of Bree Collaborative-endorsed best practices pertaining to surgeries and health conditions. PEBB then incentivizes eligible members to use those Centers of Excellence.
- Completed procurements for statewide implementation of Medicaid integrated managed care (physical and behavioral health managed by Medicaid managed care organizations).
- Selected Regence as the Uniform Medical Plan third-party administrator in PEBB.
- Brought together all health plans operating in Washington during five convenings to explore multipayer opportunities in primary care and/or rural health models.
- Held a Primary Care Summit with providers throughout Washington State to discuss ways to advance primary value-based care models and strategies.
- Submitted a draft concept paper on a rural multipayer transformation model to the Center for Medicare and Medicaid Innovation.
- Increased enrollment in the PEBB Accountable Care Program to 30,000.

The following table highlights a few successes and milestones across Medicaid, PEBB, and SEBB over the last year.

Table 2: Medicaid, PEBB, and SEBB success and milestones

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>PEBB</th>
<th>SEBB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed procurement for mid-adopter and on-time-adopter regions for integrated managed care</td>
<td>Selected Capital Medical Center and Virginia Mason as Centers of Excellence for spine care bundles</td>
<td>Completed procurement for fully insured health insurance benefits options, including a new value-based payment strategy tying</td>
</tr>
<tr>
<td>Action</td>
<td>Outcome</td>
<td>Reason</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Increased the percent withheld tied to quality and value-based payments in managed care organization contracts to 1.5%</td>
<td>Increased enrollment in the Accountable Care Program to 30,000 members</td>
<td>Completed procurement for standalone vision benefits options</td>
</tr>
<tr>
<td>Began exploring a value-based pediatric primary care payment model</td>
<td>Implemented Regence as the third-party administrator for the Uniform Medical Plan, HCA’s self-funded health insurance option, beginning in 2020 to include additional VBP options</td>
<td>Completed procurement for dental and life insurance benefits options</td>
</tr>
<tr>
<td>Facilitated the certification of one of Community Health Plan of Washington’s provider payment models as an Other Payer Advanced Alternative Payment Model under the MACRA Quality Payment Program</td>
<td>Developed plan for multi-year implementation of additional bundled payment programs including additional Centers of Excellence and additional episodes of care.</td>
<td>Expected to enroll 200,000 + school employees into a consolidated purchasing program, extending VBP benefits to a new population (occurs January 2020).</td>
</tr>
<tr>
<td>Completed the Behavioral Health VBP Practice Transformation Academy, in partnership with the Healthier Washington Collaboration Portal and the Washington Council for Behavioral Health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HCA continues to collaborate with the Washington Health Alliance, Dr. Robert Bree Collaborative, and Pacific Business Group on Health to share best practices. In addition to local and regional organizations, HCA is closely following and working with the Health Care Transformation Task Force and LAN to advance national health systems transformation.

**Challenges**

The transition to value poses varied challenges, especially the timely, accurate, and effective sharing of actionable data. Health information technology (HIT) is necessary to successfully transition health care payment and delivery. HCA officially launched the Clinical Data Repository in 2018 to support providers in sharing critical clinical data. In addition, HCA developed an HIT Strategic Roadmap to identify activities that advance the use of interoperable HIT and health information exchange. In following this roadmap, HCA aims to support robust data exchange across the care continuum in support of Medicaid Transformation, and a State Medicaid Health IT Plan. This will allow HCA to provide statewide leadership and bring infrastructure and tools to state agencies that can benefit the larger care community.

Achieving incremental progress as we near 90 percent will come with its own set of challenges. Refining and expanding current programs while innovating through new initiatives will ensure HCA achieves its goals. HCA also wants to work with and help other purchasers and employers implement value-based strategies to

---

4 For more information on HCA’s HIT strategy and initiatives, visit [hca.wa.gov/about-hca/health-information-technology/what-were-working#washington-smhp](http://hca.wa.gov/about-hca/health-information-technology/what-were-working#washington-smhp).
accelerate transformation more broadly. This spread-and-scale effort includes promoting the Purchaser Toolkit\(^5\) and the Statewide Common Measure Set,\(^6\) as well as seeking opportunities to engage additional providers, payers, and purchasers in transformation.

**The road ahead**

**Sustainability**
Achieving true transformation requires significant, multisector, system-wide collaboration, and individual commitments to improve how we pay for services. This approach requires that care is equitable, focused on the whole person, and supports healthier and engaged communities.

After the State Innovation Models grant ended in January 2019, HCA developed a sustainability framework to help us consider each project and investment as it relates to HCA’s operational programs. The framework illustrates levers for sustaining transformed relationships among people, institutions, funding sources, and governments to ensure a holistic approach to sustainability.

The sustainability framework also highlights four business processes: capacity and infrastructure, strategic partnerships, inclusion and equity, and communication and storytelling.

Chart 4: HCA’s sustainability framework

---

**Priorities**
HCA will continue to align with CMS and monitor health systems transformation at the federal level, particularly MACRA and the Quality Payment Program. HCA participated in those public comment periods and expects to align state-financed health care programs with federal APMs, to the extent possible. When CMS allows, we will seek certification as Other Payer Advanced APMs for Medicaid, PEBB, and SEBB VBP models.

Long-term priorities for HCA include:

---

\(^5\) For more information on HCA’s VBP strategies, including the Purchaser’s Toolkit, visit hca.wa.gov/about-hca/value-based-purchasing.

\(^6\) For more information on the Statewide Common Measure Set, visit hca.wa.gov/about-hca/healthier-washington/performance-measures.
• Launching a Washington State Primary Care Program with provider and health plan stakeholders to strengthen primary care and advance primary care value-based care models.
• Integrating behavioral and physical health payment and delivery statewide.
• Building provider and health plan accountability for social determinants of health.
• Addressing the opioid crisis.
• Advancing health equity.
• Eliminating hepatitis C.
• Continuing to invest in HIT and supporting critical infrastructure, such as the Clinical Data Repository.

HCA is implementing a “one HCA” purchasing philosophy across Medicaid, PEBB, and SEBB programs. This philosophy will ensure we are holding our business partners and servicing providers accountable to consistent standards, building on successes, and learning from challenges across agency programs.

In addition, HCA is exploring building on the Centers of Excellence program and implementing a bundled payment approach for select episodes of care in Medicaid. HCA is also supporting the Dr. Robert Bree Collaborative’s Maternity Bundle Payment workgroup to develop recommendations for a bundled payment model. We will integrate the final recommendations into a new approach to maternity care across all HCA programs.

**Rural communities**

HCA is collaborating with providers, health plans, CMS, and others to explore a new payment model to drive delivery system transformation in rural communities. This multi-payer approach centers on a global budget concept for rural hospitals and foundational primary care incentives. Washington State will ensure rural residents achieve greater health and well-being, and can readily access care at the right time, in the right care setting. HCA can accomplish this goal by:

• Redesigning rural health system financing.
• Enhancing population health management.
• Addressing the health care workforce.
• Leveraging HIT.

**Cascade Care/public option**

HCA is partnering with the Washington State Health Benefit Exchange and Office of the Insurance Commissioner to implement a new public option health insurance plan. The purpose of this new plan is to increase the availability of quality, affordable health coverage on the Washington State individual market. Cascade Care (Senate Bill 5526) aims to create more affordable and value-based benefit plans (through standardized and public option plans) through the Health Benefit Exchange.

Under this new program, public option plans will be required to adhere to affordability standards linked to Medicare and evidence-based, high-value care protocols, including the Bree Collaborative and the Health Technology Assessment program. These elements are already successfully embedded in HCA’s PEBB and SEBB plan options.
Integrated Care for Kids

HCA submitted a grant application to CMS to participate in the Integrated Care for Kids (InCK) grant opportunity to test a regional strategy of coordinating clinical care and social services for children and youth in Medicaid. If awarded this seven-year grant, HCA will—in partnership with Coordinated Care, the Better Health Together ACH, and community and tribal health providers—develop and implement an innovative payment model focusing on Medicaid-covered children and youth in the Spokane County region.

The InCK model aims to empower states to:

1. Improve performance on priority measures of child health, including rates of substance and opiate use.
2. Reduce avoidable inpatient hospitalizations and out-of-home placements resulting from issues like family instability driven by substance use.
3. Create sustainable APMs that ensure provider accountability for cost and quality outcomes.

Partner and community engagement

Addressing social determinants of health and health equity are critical for achieving a healthier Washington. HCA is engaging community partners and tribal governments in addressing these complex challenges. We are exploring how to leverage clinical and nonclinical interventions to achieve improved clinical and nonclinical outcomes (i.e. helping Washingtonians reach the middle class by middle age) throughout the different stages of life (i.e., birth, early childhood, adulthood, end of life).

HCA is partnering with Community Health Plan of Washington and Community Health Network of Washington in the Advancing Health Equity Learning Collaborative (AHE). Through AHE, a national program funded by the Robert Wood Johnson Foundation, HCA will collaborate with and learn from partners and other states to better understand effective strategies of reducing and eliminating health and health care quality and access disparities.

Through social impact bonds, philanthropic investments, and broadened community partnerships, HCA is committed to reducing inequities in our state. Building on the state of Colorado’s opportunity framework, HCA will address indicators throughout each life stage, integrate social determinants into all our purchasing strategies, and bring value-based concepts into long-term services and supports.

Roles in VBP across the health system

Realizing the vision of a transformed health system will require significant, multisector, system-wide collaboration, and individual commitments to take action to improve how we collectively pay for services. HCA is maximizing stakeholder strengths in defining, delivering, measuring, and reinforcing VBP. We are engaged in ongoing work with stakeholders and partners to identify respective roles in advancing VBP.

The table below serves as a starting point and a living documentation of the ongoing roles of various stakeholders and partners in the shift to value. This table is not exhaustive, and is best used as a reference-point and conversation starter.

HCA’s goal is for all parties to excel in their strengths and receive sufficient support to do so, to add clarity to discussions and work streams focused on VBP and health systems transformation.

7 For more information on InCK, visit https://innovation.cms.gov/initiatives/integrated-care-for-kids-model/.
8 For more information on the Advancing Health Equity Learning Collaborative, visit https://www.chcs.org/project/advancing-health-equity-leading-care-payment-and-systems-transformation/.
## Table 3: ongoing roles of VBP stakeholders and partners

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Defining VBP</th>
<th>Delivering VBP</th>
<th>Measuring VBP</th>
<th>Reinforcing VBP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State</strong></td>
<td>Define VBP vision, targets &amp; expectations of stakeholders</td>
<td>Enable VBP through MCO contracting &amp; direct purchasing</td>
<td>Issue and compile results from annual VBP surveys</td>
<td>Incorporate MCO contract incentives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guide and support aligned investments for VBP enabling platforms</td>
<td>Define key metrics</td>
<td>Allocate MCO &amp; ACH DSRIP VBP</td>
</tr>
<tr>
<td></td>
<td><strong>MCOs / PEBB/SEBB contractors</strong></td>
<td>Contract with providers through APMs</td>
<td>Provide VBP adoption data through annual MCO survey</td>
<td>Incentives</td>
</tr>
<tr>
<td></td>
<td>Define provider contract options</td>
<td>Provide timely and actionable data to providers</td>
<td>Provide qualitative report in quarterly meetings</td>
<td>Oversee ACHs &amp; contractors</td>
</tr>
<tr>
<td><strong>ACHs</strong></td>
<td>Articulate business case for DSRIP projects in VBP terms</td>
<td>Support VBP-enabling clinical practice transformation</td>
<td><strong>Encourage provider survey participation</strong></td>
<td>Expand VBP adoption based on lessons learned, across lines of business</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facilitate VBP-enabling population health partnerships &amp; investments</td>
<td></td>
<td>Deliver VBP contract training and support to providers</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
<td>Define clinical practice value in VBP terms</td>
<td>Deliver high-value care</td>
<td>Participate in provider survey</td>
<td>Allocate DSRIP funds to support and/or reward VBP adoption</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assess/develop readiness</td>
<td></td>
<td>Implement DSRIP projects consistent with VBP readiness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enter into APMs with MCOs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reporting &amp; quality improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Engage patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Primary Role* | *Secondary Role*
Appendix A: Vehicles of Transformation

HCA is working across programs, which include Medicaid, PEBB, and SEBB, to transform the statewide health system. The following Vehicles of Transformation provide overviews of initiatives where HCA is focusing its resources. Successful development, implementation, and sustainability of these initiatives will help us reach our goal of a healthier Washington.

The below Vehicles of Transformation are available in this appendix:

- Accountable Communities of Health
- Accountable Care Program
- Alternative payment methodology 4
- Clinical Data Repository
- Centers of Excellence
- Eliminating hepatitis C
- Innovation Accelerator Program
- Integrated managed care
- Medicare Advantage Plus prescription drug procurement
- Managed care organization premium withhold
- Medicaid Transformation
- Patient attribution
- Performance measures
- Pharmacy program
- Public option/Cascade Care
- Rural health system transformation
- School Employees Benefits Board
- State Innovation Models grant
- Workforce and practice transformation
ACCOUNTABLE COMMUNITIES OF HEALTH

THE BIG IDEA

Accountable Communities of Health (ACHs) bring together leaders from multiple sectors across the state to improve health and health equity. ACHs align resources and activities to support wellness and a system that delivers care for the whole person. There are nine ACHs and their boundaries align with Washington’s Medicaid regional service areas.

GOAL

ACHs support health system transformation by connecting partners and aligning activities across multiple communities and sectors that share a common interest in achieving whole-person health and wellness.

DESIRED OUTCOMES

Health system transformation depends on coordination and integration between health care, community services, social services, and public health. ACHs provide the necessary links and supportive environments to address the needs of the whole person.

HOW IT WORKS
DESCRIPTION

ACHs address health issues through local collaboration on shared goals. They align resources and activities to improve whole-person health and wellness, and support local and statewide initiatives, such as Medicaid Transformation. ACHs convene and connect partners to support clinical-community linkages, recognizing that VBP promotes population health that extends beyond clinical quality improvement.

THE CHALLENGE

Health and wellness involves many factors beyond clinical health care. There is a need for partners to identify new ways to integrate care and create connections between clinical care and community supports. This is a challenge because it involves multiple sectors, communities, and organizations that may not traditionally coordinate on shared approaches, workflows, or investments.

HOW WE GET THERE

As part of Medicaid Transformation, each ACH region is pursuing projects aimed at transforming the Medicaid delivery system. ACHs are responsible for implementing regional strategies and investing resources within the following focus areas:

- **Health systems and community capacity building.** Supporting provider adoption of a value-based payment system, developing the health care workforce, and making improvements in population health management. This includes enhanced data collection and analytic capacity.
- **Care delivery redesign.** Supporting integration of physical and behavioral health care, improving care coordination to ensure better transitions between services and settings, and improving diversion interventions (helping people access the most appropriate service or facility for their needs).
- **Prevention and health promotion.** Focusing on opioid use, maternal and child health, access to oral health services, and chronic disease prevention and management.

RESULTS

ACHs are positioned to:

- Promote health equity throughout the state.
- Establish new partnerships that bridge the gap between clinical care and community supports.
- Increase community health and wellness, including whole-person care.
THE BIG IDEA
Integrate quality of care with financial incentives to drive improved member experience and health outcomes.

GOAL
To achieve smarter spending, better outcomes, and better consumer and provider experience for all members.

DESIRED OUTCOMES
- Healthy Washington residents through coordinated, integrated care.
- Providers compared against established national and community standards with a focus toward quality improvement.
- Improve health care quality and cost through unique partnerships with provider networks.
- Achieve member savings by paying for value.

HOW IT WORKS

Core network: PSHVN or UW Medicine ACN
- Primary care providers
- Specialty providers
- Ancillary providers within the ACN (PSHVN or UW Medicine ACN)

Support network: All ancillary providers from the PPO network

Out-of-network (includes some Regence providers)
DESCRIPTION

Each Accountable Care Program (ACP) network delivers integrated physical, mental health, and substance use disorder services, and assumes financial and clinical accountability for a population of members. An ACP network is paid fee-for-service throughout the year, then HCA reconciles the annual payment based on an ACP network's quality and financial performance. If the network improves care delivery and outcomes while containing costs, they share in savings. If the network overspends or underperforms in care delivery, they share in deficits.

Quality results determine the percentage of savings/deficits shared. HCA collaborates with the Puget Sound High Value Network and the UW Medicine Accountable Care Network. Each ACP network is comprised of several major health care systems encompassing the Puget Sound area, Yakima, and Spokane.

THE CHALLENGE

HCA's challenge is to implement incentives that enable providers to accept financial risk and respond with better care at lower costs. HCA invested in developing, administering, and modifying a system to assess the performance of an accountable care network and adopt standards of care that improve the lives of people and providers in Washington.

HOW WE GET THERE

Creating a network where it is possible to perform high-quality care is our goal. Equally important is what our primary goal is not: to save money. We are focused on delivering coordinated care and achieving better outcomes, not finding a way to pay smaller fees. HCA provided incentives to perform high-quality care, in part, by adopting local and national standards and by challenging and supporting a network of accountable providers to reach those standards. Ongoing collaboration with our ACP partners will allow us to expand provider networks while increasing member engagement and enrollment.

RESULTS

- Enrollment started strong and increased. Roughly 10,000 people selected UMP Plus in the first year (2016), and enrollment grew to 30,000+ over the following three years.
- Each network achieved the maximum quality score in the first three years.
- The ACP networks started in five counties (King, Kitsap, Pierce, Snohomish, and Thurston). An additional three counties (Skagit, Spokane, and Yakima) are now part of the ACP program, with each network increasing provider participation each year.
- The ACP program will be offered to school employees when the School Employees Benefits Board program begins in 2020.
Multipayer alignment

ALTERNATIVE PAYMENT METHODOLOGY 4

THE BIG IDEA

Alternative payment methodology 4 (APM4) supports federally qualified health centers (FQHCs) in the transition from an encounter-based reimbursement methodology to a value-based alternative payment methodology that rewards for quality of care provided to Medicaid managed care enrollees.

GOAL

APM4 provides additional flexibility in delivering primary care services, expands primary care capacity, and creates financial incentives for improved health care outcomes while meeting federal requirements. This methodology allows participating providers to enhance their capacity for managing population health.

DESIZED OUTCOMES

- Improve and maintain access to care by focusing on efficient service delivery.
- Enhance team-based care coordination among doctors, mid-level practitioners, pharmacists, and patient navigators.
- Expand primary care teams and improve quality.
DESCRIPTION

With strong support from these clinics, the state introduced a value-based alternative payment methodology in Medicaid for FQHCs and rural health centers. The model tests how increased financial flexibility can support promising models that expand care delivery. On July 1, 2017, 16 clinics began using a new alternative payment methodology for Medicaid managed care enrollees. The new model provides flexibility in delivering primary care services, expands primary care capacity, and creates financial incentives for improved health care outcomes while meeting federal requirements.

THE CHALLENGE

Primary care providers offer some of the most innovative and integrated delivery models in the state, yet their reimbursement structure stifles further innovation. Face-to-face, encounter-based payments currently drive reimbursement for FQHCs, resulting in a system that creates an incentive to deliver care based on volume over value. While these statutory and regulatory requirements help to maintain access, these regulatory requirements make changes to payment especially difficult.

HOW WE GET THERE

APM4 applies only to Medicaid managed care enrollees and does not include current managed care organization contractual arrangements or flow of payments. APM4 converts the entire encounter-based rate into a baseline per member per month rate, which is adjusted prospectively for trend and according to quality performance. Financial conversion is based on calendar year 2015 reconciliation.

Within this basic framework, clinics will continue to perform annual reconciliation to ensure that federal reimbursement requirements are met. However, instead of resolving underpayments or
overpayments through a settlement process, APM4 will prospectively adjust payments based on a clinic’s performance on quality measures. Given its experimental nature, APM4 is not mandated for all clinics and maintains an opt-in/opt-out approach.

RESULTS

APM4 will allow clinics to improve access to care by focusing on improvement against specific quality measures and allowing clinicians to work at the top of their license. This payment methodology provides flexibility for primary care providers to have a larger member panel without the burden of increasing the number of face-to-face patient encounters, thus expanding primary care capacity in medically underserved areas. APM4 also incentivizes alternatives to face-to-face visits and allows clinics to offer convenient access to primary care services.
The Clinical Data Repository (CDR) supports health systems transformation by connecting all providers in an Apple Health (Medicaid) client’s network of care.

**GOAL**

The CDR is a cloud database that providers use to securely share clinical and services information about the Apple Health (Medicaid) clients they see. It is standards-based and vendor-neutral, so providers are able to share this information in a compatible form, regardless of the electronic health records system (EHR) they use.

**DESIRED OUTCOMES**

- The CDR complements VBP efforts with historical data showing how care impacts health outcomes over time. Most importantly, this capability is available to all Apple Health providers.
- The CDR is a common platform improving health outcomes by giving providers a clear picture of their clients’ care history.
- The CDR improves client and provider experiences while maximizing resources.

**HOW IT WORKS**
DESCRIPTION

HCA is the designated Medicaid agency for Washington State. It purchases care for more than two million Washington residents through Apple Health and Public Employee Benefits Board Program. In 2020, HCA will purchase care for school employees through the School Employee Benefits Board Program.

HCA’s multiple, independent managed care organizations (MCOs) provide physical and behavioral health care for Washington’s Apple Health population. The CDR is meant to improve client and provider experiences while maximizing resources.

THE CHALLENGE

It has been difficult for Apple Health providers to access the data to gain a more comprehensive understanding of their patients’ medical history. In 2011, EHR adoption among providers began, but without much regard for interoperability. Disparate health record systems that didn’t connect led to lack of information about treatment, health conditions, and prescriptions as clients saw different providers over time.

APPROACH

In 2009, OneHealthPort began hosting Washington State’s health information exchange (HIE). They since created and now manage the CDR for HCA. OneHealthPort has operated in the healthcare space since 2002. HCA used its purchasing power to incentivize MCOs to ensure participating providers submit electronic care summaries to the CDR after each encounter with Apple Health clients. HCA’s HIT team facilitates dialogue with providers, OneHealthPort, ACHs, MCOs, and Tribes.

OUTCOME

The CDR view-only web portal launched in the summer of 2017. Providers submitted over 10 million electronic care summaries since 2016 to the CDR covering Apple Health clients. This means many clients have multiple care summaries associated to their records. Opportunities for meaningful, historical observations from independent sources will increase as more care summaries are added.
THE BIG IDEA
The Centers of Excellence (COE) Program identifies facilities that adopt and demonstrate their use of Bree best practices pertaining to surgeries and health conditions. The Public Employees Benefits Board then incentivizes eligible members to use those Centers of Excellence.

GOAL
The goal of the COE Program is to optimize health care outcomes for members while containing health care costs. Second, Health Care Authority (HCA) anticipates the COE Program will highlight the results achieved through evidence-based clinical best practices and improve the quality of care across providers.

DESIRED OUTCOMES
- Optimal clinical outcomes (reduced surgical complications, revisions, readmissions).
- Cost neutrality or savings.
- Improve statewide access to affordable, quality health care.

HOW IT WORKS
- HCA procures COEs, requiring facilities to adopt the Bree Criteria and maintain documented evidence of their clinical outcomes about the specific surgery or procedure.
- HCA designs a “bundled” set of services that typically characterize the episode of care, and enter into contracts with COEs to provide the medical services that are part of the bundle.
- A third-party administrator, Premera Blue Cross, ushers members through the program, prepare referrals for the COE, and arrange travel logistics for the member. They facilitate the member’s journey from start to finish.
• Low to no out-of-pocket expense incentivizes members to use the COE.

**APPROACH**

We have made a great effort to let our members know this program exists and how it can benefit them. As a result, participation is increasing: in the first two years, nearly 15 percent of Uniform Medical Plan (UMP) Classic and Consumer-Directed Health Plan members seeking a Total Joint Replacement (TJR) used the COE for that procedure.

As the third-party administrator, Premera has done an excellent job ushering our members through this serious life event, from initial interest to post-operative return to their home provider.

**THE CHALLENGE**

The COE program is important for our members because, surprisingly, clinical practices can vary widely between facilities and surgeons. The COE Program requires the adoption of standardized best practices developed by the Bree Collaborative, which have been proven to result in optimal clinical outcomes. Identifying COEs and incentivizing our members to use them enhances the quality of care available.

**OUTCOME**

• Our first bundle, TJR, went live January 2017. In the first two years, 166 surgeries were performed at Virginia Mason, the COE for TJR. To date, there have been no surgical revisions, complications, or readmissions.
• In addition to these outstanding clinical outcomes, UMP and the persons using the benefit saved money. Members have also had positive experiences with the program.
• Expanding our success, in January 2019, HCA implemented a second bundle, Spine Care, which offers comprehensive evaluations to member participants and—if appropriate—lumbar fusion. In the first seven months of the bundle, three fusions and 20 evaluations have been performed.
**THE BIG IDEA**

In collaboration with other state agencies, HCA established an innovative purchasing strategy that includes outreach support through a competitive procurement for the drugs used to cure the hepatitis C virus (HCV).

**GOAL**

- Eliminate HCV in Washington State by 2030 through combined public health efforts and a negotiated lower cost for medication.
- Elimination to where HCV is no longer a public health threat and those few who become infected with HCV learn their status quickly and access curative treatment without delay, preventing the forward spread of the virus.

**DESIRED OUTCOMES**

- Ensure cost control through a modified subscription model.
- Simultaneously increase the potential to treat as many patients as possible.
- Outreach support services from AbbVie done in collaboration with “Hep C Free Washington” plan.
HOW IT WORKS

In September 2018, Gov. Jay Inslee unveiled a first-in-nation approach to eliminating HCV in Washington by 2030. Directive 18-13 directs HCA to initiate an innovative strategy to purchase drugs used to cure HCV and ensure timely access for Washingtonians living with HCV. About 30,000 people living with HCV in Washington are covered by state-purchased health care insurance and programs, including Apple Health (Medicaid), the Public Employees Benefits Board Program, and the departments of Corrections, Labor & Industries, and Social & Health Services (state hospitals).

Effective July 1, 2019, HCA contracted with AbbVie, a research-based global biopharmaceutical company as the result of competitive procurement.

THE CHALLENGE

HCV is the most common blood borne disease in the United States. Between 75 and 85 percent of people infected develop chronic HCV—a lifelong condition that can cause severe scarring (cirrhosis) of the liver, liver cancer, the need for a liver transplant, and even death. From 2010 to 2016, the number of reports of new infections (acute cases) rose by more than 280 percent in Washington, with most occurring among young persons who inject drugs. The death toll from HCV continues to rise, tied to the opioid epidemic and the rise in drug injection.

APPROACH

HCA and AbbVie entered into two agreements. One is a traditional drug rebate arrangement for those in state-run facilities and public and school employees. The second is a modified subscription model for Apple Health (Medicaid). AbbVie will coordinate with HCA and Department of Health to implement the “Hep C Free Washington” plan to:
• Find individuals who are not yet treated.
• Educate the health care workforce about screening and curative HCV treatment.
• Address barriers to care, and connect patients to HCV prescribers.

OUTCOME

• In June 2019, Washington became the fourth state to gain federal approval to negotiate a deal with drug manufacturers to link payment for prescription drugs to the value delivered from Centers for Medicare & Medicaid Services.
• Washington’s first use of this approval will be for purchasing hepatitis C drugs under the agreement with AbbVie.
• The average per-client cost to treat HCV infection has been reduced to about 40 percent of what clients enrolled in state agency health care plans were paying before.
THE BIG IDEA

A program funded by the Center for Medicare & Medicaid Innovation, in collaboration with the Center for Medicaid and Children’s Health Insurance Program Services providing targeted technical support to states to build capacity for ongoing innovation in Medicaid.

GOAL

Washington received technical support through the Value-Based Payment and Financial Simulations (VBPF) functional area in the Innovation Accelerator Program (IAP). Washington’s participation focused on exploring an alternative payment model (APM) that addresses asthma exacerbation, furthering Washington’s knowledge of innovative payment approaches to address social determinants of health (SDOH), and enhancing the state’s efforts to support regional and provider engagement in APMs.

DESIRED OUTCOMES

- An environmental scan of payment models that incorporate elements to address SDOH.
- Guidance and recommendations to enhance stakeholder outreach and support related to payment reform.
- A financial simulation of a potential bundled payment model for asthma exacerbation in Medicaid.

HOW IT WORKS
DESCRIPTION

IAP collaborated with states interested in designing, developing, or implementing VBP approaches (i.e. payment models that range from rewarding for performance in fee-for-service to capitation, including APMs and comprehensive population-based payments) and support to conduct financial simulations and forecasts that analyze the financial impact of these payment and delivery strategies.

THE CHALLENGE

IAP represents CMS’s unique commitment to support state Medicaid agency efforts toward system-wide payment reform and delivery system innovation. The VBPFS functional area began in September 2016. IAP is also working with states on other health care payment delivery system reform efforts to build and strengthen state data analytic capacity and advance state performance improvement efforts and quality measurement.

APPROACH

Beginning in August 2018, IAP supported nine Medicaid agencies for a 12-month period, providing intensive, hands-on technical support to help these agencies advance VBP approaches. As part of IAP participation, Washington received tailored VBP policy documents, such as:

- Environmental scans, options memos, and stakeholder engagement assessments.
- Financial simulation results to help forecast the impact of specific VBP approaches.
- Access to peer-to-peer calls and discussions groups.
- Access to subject matter experts from the Office of the National Coordinator.

OUTCOME

IAP provided Washington with examples of other bundled payment programs from across the country, as well as key questions and considerations for selection and prioritization of bundled payment models. Washington received a financial simulation of an acute asthma exacerbation bundled payment model using Washington’s Medicaid claims data, based largely on Tennessee’s bundled payment framework. IAP also provided support on strengthening stakeholder engagement and provider readiness for VBP within the state’s Accountable Communities of Health.

The state also received support in addressing SDOH within VBP arrangements, including an environmental scan of other states’ approaches to addressing SDOH within their Medicaid managed care programs, and options for how HCA could consider incorporating SDOH initiatives within their planned or existing VBP programs.
THE BIG IDEA
Having a single payer be responsible for an individual’s whole-person health (physical health and behavioral health) allows for better care and, in turn, better outcomes.

GOAL
To set the foundation that will lead to more integrated care at the clinical level, leading to lower costs and improved health outcomes for Washington residents.

DESIRED OUTCOMES
• Increase access to needed behavioral health services.
• Reduce potentially avoidable utilization of emergency departments, psychiatric inpatient, and crisis services.
• Improve quality and coordination of physical health and behavioral health.

HOW IT WORKS
DESCRIPTION

HCA, supported by legislation, will implement integrated managed care (IMC) in all regions across the state by January 1, 2020. In IMC regions, managed care organizations (MCOs) become responsible for the full continuum of physical and behavioral health services for Apple Health (Medicaid) clients.

Services include specialty behavioral health services, outlined in the Medicaid (Title XIX) State Plan, that were previously covered by behavioral health organizations (BHOs). In the three regions that have not yet implemented IMC, these specialty behavioral health services are still covered by the BHOs. A behavioral health administrative services organization (BH-ASO) is identified in each region to administer crisis services and non-Medicaid funded services source.

THE CHALLENGE

Within the non-integrated managed care system, behavioral health services are separated. No single entity is accountable for an individual's health, nor are data and information available to manage the whole person, leading to missed opportunities and poorer health outcomes for clients. The IMC approach seeks to close this gap.

HOW WE GET THERE

The transition takes place in phases: April 1, 2016 (one region), January 1, 2018 (one region), January 2019 (four regions), July 1, 2019 (one region), and January 1, 2020 (three regions).

HCA used a request for proposals (RFP) process to select the MCOs for each region. Plan selections and the number of plans per region were determined based on population and region size, network adequacy, and responses provided in the bids. New IMC contracts were developed inclusive of both the physical health benefits and behavioral health benefits.

BH-ASOs were procured using the RFP process, or have been identified using legislative direction that provides county authorities the right of first refusal to transition their BHO to the BH-ASO. HCA contracts with a BH-ASO in each IMC region.

RESULTS

As of October 2019, the state has implemented IMC in seven of the 10 regions across the state. The remaining three regions will transition on January 1, 2020. Preliminary data show encouraging results in the first year of IMC in Southwest Washington, our first integrated region.
Supplement the current Public Employees Benefits Board (PEBB) Program Medicare portfolio, which serves state and school retirees, through a procurement of one or more fully insured group Medicare Advantage plus prescription drug (MA-PD) plan(s).

GOAL

Transition to a more sustainable and affordable health benefits portfolio for PEBB Medicare retirees that maximizes federal funding and leverages value-based initiatives. HCA is early in the procurement process, but intends to offer new plan(s) under PEBB, effective January 1, 2021.

DESIRED OUTCOMES

- Equitable access and affordability, including broad network coverage and competitive member premiums.
- Comprehensive benefits designed to encourage value over volume.
- Plan participation in value-based payment arrangements, independently and/or in participation with federal initiatives.

HOW IT WORKS

MA-PDs are private insurance plans that cover all Medicare benefits, including Part D drug benefits. The Centers for Medicare & Medicaid Services (CMS) pays MA-PD insurers a per-member per-month subsidy for medical benefits covered by Medicare (Medicare Parts A & B, also called “Original Medicare”). In addition, MA-PD plans receive subsidies from CMS that cover at least 74.5 percent of the cost of Part D drug benefits. Drug manufacturer discounts are also available to Part D plans under the Patient Protection and Affordable Care Act (ACA) to help keep premiums low.
As private plans that must compete for every enrollee, Medicare Advantage Organizations (MAOs) are strongly incentivized to provide the highest quality benefits at the lowest cost. Risk-based provider contracts help them achieve this goal, and CMS has been creating new opportunities for MAOs to participate in value-based initiatives formerly reserved for Original Medicare. MAOs can help attract providers by offering value-based contracts that help providers meet CMS quality benchmarks and improve outcomes for Medicare beneficiaries.

THE CHALLENGE

Increasing prescription drug spending, particularly for UMP Classic Medicare, is driving up member premiums and compromising the affordability and sustainability of PEBB Medicare retiree benefits. Additionally, the state’s annual expenditures on retiree subsidies already greatly exceeds the level of federal funds received for offering qualifying Medicare Part D coverage.

A large portion (60 percent in 2018) of the per member per month bid rate each year for UMP Classic Medicare is attributed to prescription drug benefits, and this portion has been steadily growing. At the same time, the cost attributed to medical services has remained relatively stable. This suggests that as the drug market becomes more volatile, and the specialty drug trend continues, premiums are likely to increase.

In addition, the PEBB retiree population is growing at a faster pace than the PEBB employee population. This is partly attributable to normal retirement trend, which has remained steady for the past five years, but is likely supplemented by the continued wave of baby boomers aging into Medicare. By 2030, one in five Americans will be retirement age, and the population over age 65 will outnumber children for the first time in history.

APPROACH

HCA analyzed numerous policy solutions to provide better value in PEBB Medicare coverage. Based on this work, we recommended to the PEB Board a procurement for one or more fully insured group MA-PD plan(s), at least one of which offers national PPO coverage. These plans would be offered in addition to options under the current PEBB Medicare retiree portfolio. HCA intends to incorporate value-based components into its contract(s) with apparently successful bidder(s).

OUTCOME

After a competitive procurement, HCA selected Regence BlueShield and UnitedHealthcare as apparently successful bidders and will announce awarded contracts later in 2019.
THE BIG IDEA
HCA designed and implemented a value-based contracting arrangement, where HCA withholds a percentage of the monthly per-member-per-month (PMPM) premium to each managed care organization (MCO) which they may earn back through the achievement of VBP and quality targets.

GOAL
Incentivize MCOs to shift from volume to value by allowing them to earn back a portion of withheld capitated premium payments. MCOs demonstrate increased value-based contracting with providers and quality performance improvement. Medicaid managed care represents a large majority of HCA’s health care purchasing, and this incentive structure will help HCA achieve its goal of 90 percent VBP by 2021.

DESIRED OUTCOMES
- Increased value-based contracting to reach 90 percent goal by 2021
- Increased provider incentives
- Improved quality performance
HOW IT WORK

Prior to 2017

• HCA pays "capitated" premium for each Medicaid beneficiary.
• MCO pays provider, primarily on fee-for-service basis, using monthly premium from HCA.
• Provider performs services, often without incentives to prioritize value over volume.

Present & future

• HCA pays MCOs "capitated" premium for each Medicaid beneficiary.
• HCA withholds a percentage of capitated premium, which MCOs can earn back by implementing VBP with providers.
• MCOs work with providers to enter into value-based contracts meeting the criteria of the HCP-LAN APM framework.
• Under VBP, providers take on greater accountability to deliver higher value care to Medicaid beneficiaries.

DESCRIPTION

HCA pays MCOs a PMPM premium rate that covers all of a client’s care. The MCOs pay providers with the premiums to perform services for Apple Health clients. To connect payment to quality of care and to value, HCA withholds 1.5 percent of an MCO’s monthly premium (increasing to 2.0 percent starting January 1, 2020), to be returned based on performance in the following areas:

• VBP arrangements with providers
• Qualifying provider incentives
• Achieving quality improvement targets

Over time, the withhold amount and benchmarks for each performance area may increase.

THE CHALLENGE

HCA has set a target for 90 percent of provider payments under state-financed health care to be linked to quality and value by 2021. This includes Washington Apple Health (Medicaid), through which HCA purchases health care for approximately 1.8 million Washingtonians. Implementing value-based contracts with the five Apple Health MCOs is imperative to the state’s ability to achieve its purchasing goals by 2021.

HOW WE GET THERE

HCA has adopted the Health Care Payment Learning and Action Network (HCP-LAN) Framework created by the Centers for Medicaid & Medicare Services to define value-based payment. To meet HCA targets, at least one percent of premium payments must be incentives and disincentives in LAN category 2C or higher. Provider incentives are additional payments or withholds based on provider performance.
Additionally, an MCO needs to pay at least 50 percent of provider payments in the form of VBP arrangements in LAN category 2C or higher, which is HCA’s definition of VBP. A third party reviews and validates the self-reported (by each MCO) provider incentive payments and VBP arrangements. Finally, MCOs must achieve the top national Medicaid quartile or demonstrate statistically significant improvement on select quality measures.

RESULTS
THE BIG IDEA

The Medicaid Transformation Project is the result of a Section 1115 waiver that removes certain Medicaid requirements and allows Washington to use Medicaid funds for innovative infrastructure, projects, activities, and services that would not otherwise be allowed.

GOAL

The Medicaid Transformation Project improves population health and supports the delivery of whole-person care, including new linkages between clinical and community-based services.

DESIRED OUTCOMES

- Integrate physical and behavioral health purchasing and service delivery.
- Convert 90 percent of Medicaid provider payments to reward outcomes.
- Support provider capacity to adopt new payment and care models.

HOW IT WORKS

<table>
<thead>
<tr>
<th>Transformation through Accountable Communities of Health</th>
<th>Long-term services &amp; supports</th>
<th>Foundational Community Supports</th>
<th>SUD Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional approach</td>
<td>Caring for our aging population</td>
<td>Housing and employment</td>
<td>Treatment Services</td>
</tr>
<tr>
<td>Up to $1.1 billion</td>
<td>$175 million</td>
<td>$200 million</td>
<td></td>
</tr>
</tbody>
</table>
DESCRIPTION

Under a five-year agreement with the Centers for Medicare & Medicaid Services, the state will address the goals of the Medicaid Transformation Project through several core initiatives:

- Transformation through Accountable Communities of Health (ACHs) and Delivery System Reform Incentive Payment (DSRIP) program.
- Long-term Services and Supports (LTSS)
- Foundational Community Supports (FCS)
- Substance use disorder (SUD) program – treatment services, including short-term services provided in residential and inpatient treatment setting that qualify as an IMD.

THE CHALLENGE

Washington Apple Health (Medicaid) covers more than 1.8 million individuals, amounting for nearly one in four Washingtonians. The federal government and several states recognize the best way to control costs and improve health is to transform the delivery model to reward providers and health plans for better health.

Transformation investments allow the state to spend Medicaid dollars in different ways to reward providers and health plans based on the quality of care, rather than the number of procedures and services provided.

HOW WE GET THERE

- **Transformation through ACHs** recognizes that health is local and that achieving health and wellness goals requires collaboration across multiple communities and sectors. Each region is pursuing transformation projects tailored to the needs of their communities and partners.
- **LTSS** allow the state to offer services for older adults and the people who care for them, helping people stay at home and delay or avoid the need for more intensive care.
- **FCS** helps our most vulnerable people to get and keep housing and jobs.
- **The SUD program** allows the state to receive federal funding for SUD treatment services, including short-term services provided in some residential and inpatient treatment settings.

RESULTS

The state aims to:

- Reduce avoidable use of intensive services and settings.
- Improve population health by focusing on prevention.
- Accelerate the transition to value-based payment and ensure Medicaid cost growth is below national trends.
Multipayer alignment

PATIENT ATTRIBUTION

THE BIG IDEA

Patient attribution is foundational to incentivize provider payment for value. A patient attribution methodology is critical for VBP success because it is the basis for holding providers and provider groups accountable for meeting VBP targets, and decision-making on payment for quality patient care.

GOAL

HCA will have a consistent methodology for Medicaid, Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) for identifying provider-patient relationships. A standard reliable attribution model across payers will align providers and provider groups so they have the information needed to proactively engage patients in prevention, and managing acute and chronic health conditions.

DESIRED OUTCOMES

- Improvement in contracted quality performance measurement targets (will achieve more direct relationships).
- Improved patient satisfaction with care provided.
- Alignment of patient attribution methodology across Medicaid, PEBB and SEBB programs.

HOW IT WORKS

Source: HCP-LAN white paper on patient attribution, 2016
DESCRIPTION
A patient attribution methodology is a means to attribute patients to providers for accountable care and VBP models over the course of VBP arrangement. It is a foundational element of both individual care and population-based care management. Providers need a means to know which patients they are accountable for managing prevention, routine care, and chronic conditions. The simple concept is that providers need to be accountable for managing and coordinating the full continuum of care across the patient life span, from prevention to end-of-life care, and everything in between.

THE CHALLENGE
HCA currently lacks a standard, accurate attribution methodology for patient attribution to providers. For example, the Accountable Care Program leverages Regence’s attribution methodology. MCOs use client assignment as a means of compiling patient rosters for providers and tracking and ensuring patient access. However, this methodology is insufficient to achieve accurate attribution for the purpose of value-based payments. Also, many of the VBP arrangements are over a longer periods than typical MCO assignment of patients to providers (can change monthly).

APPROACH
In 2019, the HCA began assembling an internal work group to explore and identify recommendations adopting a standardized patient attribution model across Medicaid, PEBB and SEBB. Initial research effort examined national literature and other attribution models from states similar to Washington. Initial model exploration has begun.

A review of the methodology that was applied for the State Innovation Models grant is under exploration to see if that approach can be scaled for a broader statewide approach for assigning patients to providers. We are also evaluating model based on provider providing “key” primary care services as the attributed provider and approach of looking at longer time periods to identify who provided patient care.

OUTCOME
The desired outcome is HCA having a consistent, standardized methodology for patient-provider attribution across the Medicaid, PEBB, and SEBB programs. This consistent approach will support a “One HCA” approach for providers to proactively engage their attributed client populations. In turn, clients of all state-paid programs will be more proactively engaged and informed about managing their own health care. These efforts will collectively support the ultimate VBP goal of better health, better care, and lower cost.
THE BIG IDEA

Washington State is reducing provider burden and advancing value-based payment arrangements in its purchasing contracts by using performance measures from common measure sets.

GOAL

By using measures from the Statewide Common Measure Set and Service Coordination Organization Measure Set to drive toward quality and value in purchasing contracts, HCA can align efforts around a core set of priorities and reduce measurement and reporting fatigue.

DESIRED OUTCOMES

- Measures are aligned and tied to VBP across agency purchasing contracts.
- Measures in agency purchasing contracts are aligned with national reporting requirements.

HOW IT WORKS

Alignment of Common Measures Across Value-Based Payment (VBP) Contracts

Apple Health (Medicaid Managed Care) 7

Accountable Care Program 15

Integrated Managed Care 11

Encounter to Value (APM) 7

Apple Health & APM 4 Contracts

- Adult BMI Assessment
- Breast Cancer Screening
- Childhood Lead Screening
- Cholesterol Screening in Women Ages 18-64
- Colon Cancer Screening
- Comprehensive Diabetes Care
- Diabetes: Poor Control
- Diabetes: High Blood Pressure
- Life Expectancy

BHC Contracts

- Adult BMI Assessment
- Breast Cancer Screening
- Childhood Lead Screening
- Cholesterol Screening in Women Ages 18-64
- Colon Cancer Screening
- Comprehensive Diabetes Care
- Diabetes: Poor Control
- Diabetes: High Blood Pressure
- Life Expectancy
DESCRIPTION

Per legislation, in 2013-14, there were two state-led and stakeholder-developed state measure sets. The Governor-appointed Performance Measures Coordinating Committee developed the Statewide Common Measure Set to inform health care purchasing. HCA has taken the lead in incorporating measures from the Common Measure Set into state contracts.

Additionally, the Service Coordination Organization Measure Set was developed by Department of Social and Health Services with input from community stakeholders to address those with behavioral health needs. These two measure sets are the foundation for how we select and align performance measures for state purchasing contracts, including measures that are included in pay-for-performance arrangements.

THE CHALLENGE

Providers may be required to report on up to 150 clinical quality metrics at any given time, through their contractual agreements with health plans. HCA wants to support providers in their efforts to ensure high quality care and better manage the health of their patients. Monitoring the health of their patient population through a set of clinical quality metrics can assist us in these efforts.

By aligning performance measures in state purchasing contracts, as well as tying pay-for-performance arrangements on only a few priority areas, ultimately we can reduce the reporting burden for providers.

HOW WE GET THERE

HCA developed a multi-agency stakeholder process to identify appropriate measures for annual purchasing contracts, including those tied to VBP. The Quality Measurement, Monitoring and Improvement (QMMI) process uses a multi-workgroup structure to select and produce timely, reliable, and valid clinical performance measures, and to organize activities to promote clinical quality. With this structure in place, the state can address gaps in care by actively identifying, prioritizing, and monitoring clinical quality measures.

RESULTS

There are currently 25 performance measures tied to VBP in all state purchasing contracts. Of those 25 measures, five are common across all contracts. For the Medicaid contracts, seven measures are common across all contracts, with the exception of the Foster Care contract. That contract addresses the needs of a specific population, and has measures that do not align.

As much as we may try to align fully across all contracts, we also understand are situations where we need to ensure the appropriate quality measures are included to address the priorities of those populations.
THE BIG IDEA

HCA leverages an evidence-based preferred drug selection process for the Washington Preferred Drug List (PDL) and pooled purchasing through the Northwest Prescription Drug Consortium to bring high value pharmaceutical coverage to state-financed health care programs.

GOAL

Through evidence-based drug selection and proactive monitoring of the prescription drug pipeline, HCA aims to ensure affordability to consumers, effectively manage cost trends, and incentivize sufficient access and appropriate utilization of essential pharmaceutical drugs.

DESired OUTCOMES

- Manageable cost trend
- Establish clinical policies that effectively manage emerging drugs and ensure appropriate utilization of drugs
- Evidence-based affordable cures for curable conditions

DESCRIPTION

HCA contracts with Moda Health to manage the pharmacy benefit for Uniform Medical Plan (UMP). HCA reimburses pharmacies for dispensing drugs to members. Moda negotiates after-the-fact rebates with manufacturers and reimbursement rates with pharmacies. Additionally, HCA manages a single PDL for the five contracted Medicaid managed care organizations and the fee-for-service (FFS) program to drive the highest value for Apple Health clients.
THE CHALLENGE

Highly expensive breakthrough therapies continue to come to market for orphan diseases (i.e. diseases affecting less than 200,000 individuals nationwide). For regular everyday pharmaceuticals, prices continue to rise, even on older generic drugs.

APPROACH

Apple Health has a single preferred drug list across five MCOs and the FFS program to drive the lowest net cost to the state. A single PDL allows all Apple Health programs to benefit from proprietary federal rebates to which MCOs do not have access. Rebate transparency helps HCA drive to the lowest cost while maintaining access to essential drugs. Further, a single PDL removes member uncertainty about pharmaceutical coverage changes when changing managed care plans.

HCA manages a PDL for UMP, separate from the Apple Health PDL. HCA aligns clinical policies (i.e. opioid utilization and hepatitis C) where possible. Moda manages negotiations and PDL management for UMP. Preferred drugs with a clear evidence base have fewer restrictions for providers, removing barriers inhibiting their usage.

RESULTS

- HCA launched the single PDL for Apple Health January 1, 2018.
- HCA implemented a new opioid policy in November 2017 and January 2018 for Apple Health and UMP, respectively.
- HCA is developing a hepatitis C elimination strategy with Department of Health, potentially revolving around a revenue-based purchasing strategy with drug manufacturers, to eliminate this disease strategically and efficiently.
THE BIG IDEA

Increase the availability of quality, affordable health coverage on the individual market.

GOAL

Cascade Care (Senate Bill 5526) creates more affordable and value-based benefit plans (through standard and public option plans) on the individual market through the Health Benefit Exchange (HBE). HBE will implement Cascade Care in partnership with HCA and Office of the Insurance Commissioner. The new coverage options will be available for coverage effective January 1, 2021.

DESIRED OUTCOMES

• More affordable, more understandable health plan options for consumers.
• Decrease in consumer out-of-pocket costs (since prices will be linked to Medicare), i.e., reduce deductibles, provide predictable cost sharing, maximize subsidies, limit adverse premium impacts.

Under this new program, public option plans will be required to adhere to affordability standards linked to Medicare and evidence-based, high-value care protocols, including the Bree Collaborative and the Health Technology Assessment program—elements already successfully embedded in HCA’s Public Employees Benefits Board and School Employees Benefits Board plan options.

THE CHALLENGE

Right now, health plan options offered through HBE have minimal benefit, quality, and cost containment requirements or standards, which do not incentivize high-value care. Plus, the cost of the current health plan options on HBE continues to increase year over year.
APPROACH

HBE is developing standards plans, which are qualified health plans that have a standard benefit design across carriers. HCA is working with HBE and other implementation partners to procure public option plans that will be available through Washington Healthplanfinder. Public option plans are qualified health plans that have a standard benefit design and meet additional quality and value requirements.

OUTCOME

The cross-agency workgroup has begun the work, and outcomes are yet to be determined.
Multipayer alignment

RURAL HEALTH SYSTEM TRANSFORMATION

THE BIG IDEA

By redesigning rural health through new financing and focusing on rural health system transformation at the community level, HCA will ensure rural residents achieve greater health and wellbeing, and have sustainable access care.

GOAL

The rural health system transformation model will bolster VBP goals, help rural providers become ready for new models of care, and remove barriers to health transformation.

DESired outcomes

- Sustainability of the rural health delivery system.
- Redesigned rural health delivery system that supports new infrastructure and practice transformation.
- Improved outcomes for people based on quality performance measures.

HOW IT WORKS

<table>
<thead>
<tr>
<th>Fixed annual revenue</th>
<th>Care transformation support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed annual payment paid out to monthly, providing a stable stream of revenue</td>
<td>Tailored assistance at no cost to the rural community</td>
</tr>
<tr>
<td>Stabilize cash flow, so rural providers can invest in care quality and sustainability</td>
<td>The objective of support is to minimize the burden of making transformation-related changes</td>
</tr>
<tr>
<td>Based on historic data adjusted for transformation-related service changes</td>
<td>Support across all transformation phases: data collection, plan creation, and implementation</td>
</tr>
</tbody>
</table>
DESCRIPTION

The rural health system transformation model brings together payers and providers on an aligned payment approach, with incentives that focus on improving the health and wellbeing of beneficiaries in rural communities. The model seeks to achieve this through a predictable budget for rural hospitals, primary care providers, and other key provider groups. This enables rural providers to invest in practice transformation without being penalized for declining utilization. It also builds upon investments already in place, such as Medicaid Transformation.

THE CHALLENGE

In the current system, access to care is limited in rural regions, and rural populations tend to have higher risks of morbidity and mortality. Rural providers face thin margins and underutilization. Providers face recruitment and retention challenges, and relationships with larger systems have not benefited rural providers. Fundamental transformation is required to sustain the rural health care delivery system.

HOW WE GET THERE

By its nature, this model is being developed by many stakeholders. A new rural payment model requires Medicare participation and state investments in rural health delivery system transformation. The state is engaging with rural providers, payers, community advocates, associations, legislators, and the Governor’s Office to shape this new payment approach and coordinate desired outcomes.

RESULTS

- Transformed health delivery in rural communities.
- Improved health status of rural Washingtonians.
- Health care services that match the needs of the community.
**THE BIG IDEA**

Adopting quality of care and financial incentives to provide best-in-class member experience and healthy outcomes into fully insured health plan contracts.

**GOAL**

Incorporating value-based strategies into the SEBB medical contracts will serve as a mechanism for ensuring that health plans and providers are financially accountable for delivering high-quality and high-value care to plan members. By redesigning the way we pay for care—rewarding value over volume—the VBP model represents an overall commitment toward better health, better care, and lower costs.

**DESIRED OUTCOMES**

- Improved health status of Washington State residents through incentives to perform coordinated high-quality care.
- Providers accountable for quality care from the Statewide Common Measure Set.
- Achieve savings for both the state and plan members by paying for value.

**DESCRIPTION**

Starting January 1, 2020, benefits offered by SEBB will be available to eligible school employees throughout the state. To ensure SEBB plan members are afforded high-quality and high-value health care services, HCA aims to adopt VBP strategies in a manner that drives clinical and financial accountability for its plan carriers.

A VBP approach rewards carriers for holding contracted provider to a high standard of care (i.e. paying providers for the delivery of high-quality care and reducing payments for those that provide unnecessary or low-quality care). By incorporating a value-based component into SEBB
plans, carriers and providers will be financially accountable for delivering high-quality, high-value care and a satisfactory patient experience—resulting in lower health care costs and greater financial sustainability for the program.

THE CHALLENGE

In spite of rising health care spending in the current health care environment, there is often little-to-no correlation between how much people pay for health care services and the quality of care they receive. The integration of VBP into medical contracts will facilitate a shift away from this dynamic by allowing HCA to measure the quality of health care services and ensure that plans and providers are paid according to quality of the services being provided.

APPROACH

Recently, the HCA has incorporated a variety of different payment redesign models into existing contracts, with the aim of accelerating market transformation in a direction that fundamentally changes the way health care is provided and paid for throughout the state. HCA will be working closely with carriers, during the SEBB contract negotiation process, to explore various value-based payment models and determine which would be the most effective and appropriate to adopt for SEBB. The value-based payment model HCA intends to integrate into its SEBB medical contracts will be built on the principles of:

- Improving cost, quality, and health outcomes for patients and populations.
- Rewarding the delivery of high quality, patient-centered care.
- Rewarding performance of health plans and their contracted health care systems for increased adoption of value-based payment method.
- Aligning payment and delivery reform approaches with the Centers for Medicare & Medicaid Services for the greatest impact and to simply expectations for health care delivery systems.
- Consistent utilization of Statewide Common Measure Set to support continuous performance improvement.

OUTCOME

- Continuously improving health outcomes—for eligible school employees and dependents enrolled in the program—through a focus on rewarding high-quality, evidence-based care.
- Long-term financial sustainability of the SEBB program.
THE BIG IDEA

In early 2019, Washington State completed the grant period on its State Innovation Models (SIM) cooperative agreement. Washington received nearly $65 million from the Center for Medicare and Medicaid Innovation to implement and test its State Health Care Innovation Plan.

GOAL

Transform the health system to achieve better population health, reward high-quality care, and spend limited resources in better ways. This work represents a collaborative approach among providers, payers, purchasers, community advocates, and state agencies, working together to improve the lives of Washingtonians.

DESIRED OUTCOMES

- Improve how we pay for services.
- Ensure health care focuses on the whole person.
- Build healthier communities through a collaborative, regional approach.

HOW IT WORKS
DESCRIPTION

Specific focus areas of the SIM grant include:

- Supporting Accountable Communities of Health (ACHs).
- Building payment reform test models.
- Supporting clinicians through the Healthier Washington Collaboration Portal.
- Strengthening person and family engagement.
- Addressing the workforce.
- Investing in data and analytics.

THE CHALLENGE

In the absence of a comprehensive and aligned approach to transformation, the health system is inconsistent, with weak linkages between clinical and community interventions.

To achieve HCA’s goal of better health, better care, smarter spending, and improved provider experience, the system must address:

- Lack of incentives and support to coordinate care.
- Financial and administrative barriers to integrated care.
- Disparate performance measures.
- Slow adoption of VBP strategies.
- Lack of meaningful data and analytics.

HOW WE GET THERE

Sustainability. The SIM grant ended on January 31, 2019. Sustainability strategies for the multiple work streams under SIM were implemented, and most all of the initiatives were sustained, either through agency operations, community partners, or continued innovation funding. The state’s efforts established strategic partnerships among state agencies, tribal governments, public and private sector partners, community based organizations, ACHs, and others.

RESULTS

In the final SIM evaluations led by the University of Washington, evidence showed that our work resulted in increased capacity for health system change in the coming decades. Our work continues through our three foundational strategies: paying for value, whole-person care, and strong clinical-community linkages. This future also includes a climate of partnership, engagement, and mutual support among the state, communities, providers, and the market.
Workforce and Practice Transformation

The Big Idea

Practice transformation and workforce development are the foundations for preparing the health care workforce for innovation and successful transition to integrated, team-based care and value-based payment arrangements.

Goal

Physical and behavioral health providers:

- Adopt person-centered, integrated care supported by population health management tools.
- Develop clinical-community partnerships to address social determinants of health.
- Receive support and technical assistance to implement strategies to move toward value-based care.

Desired Outcomes

- Providers and their teams design and implement new workflows and team roles that improve their readiness and capacity for team-based care and value-based payment arrangements.
- Accountable Communities of Health (ACHs), providers, and workforce partners coordinate resources to address common needs, gaps, and barriers to delivery system transformation and value-based payment.
- Opportunities are available to train and deploy new paraprofessional roles, including community health workers and behavioral health paraprofessionals, that expand clinical and community capacity to address social determinants of health.
HOW IT WORKS

DESCRIPTION

• ACHs coordinate with providers and clinics to identify training and support needs.
• ACHs develop partnerships with education, practice transformation, and statewide or regional workforce development resources, such as community colleges, employers, and health industry experts to address evolving workforce needs through education, training and retraining for existing workers, and innovation that supports new paraprofessional roles.
• ACHs coordinate with state agencies, providers, the health sector, and workforce experts to identify and address regulatory barriers to team-based, bidirectional, integrated care.

THE CHALLENGE

Achieving our goals requires building a sustainable and transformed workforce that has the ability and capacity to make community-clinical linkages to address social determinants of health.

Transforming the workforce enhances the role of all team members and integrates new roles for paraprofessionals, such as community health workers and behavioral health specialists. The team members help build capacity to provide the right services to the right person, at the right time in the right setting.

Building a sustainable workforce strategy requires engagement of ACHs, physical and behavioral health providers, workforce and education partners, and health sector experts. Together, they create and sustain innovative career pathways that offer opportunities for career growth in a transformed delivery system.
HOW WE GET THERE

Hands-on training, coaching, and technical assistance through practice transformation support providers and clinics to address gaps and barriers to team-based, integrated care and support value-based payment arrangements. ACHs will also create workforce development strategies and partnerships to address their specific needs and community resources.

RESULTS

- ACHs began coordinating with the Health Workforce Council to support shared workforce development goals.
- ACHs submitted implementation plans, outlining the scope of their Medicaid Transformation projects, including workforce development partnerships, activities, and goals.
- The Practice Transformation Support Hub, now named the Healthier Washington Collaboration Portal, offered intensive coaching services for 133 primary care and behavioral health agencies to enhance readiness for VBP contracts and arrangements throughout 2018.
- The Hub offered training, technical assistance, and coaching tailored to behavioral health agencies transitioning to integrated managed care and entering into VBP arrangements, including the VBP Academy.
- The Hub continued through 2018 to host Hub-created materials, tools, training and other resources for practices preparing for VBP.