# HCA Value-based Roadmap

## Apple Health Appendix

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# Purpose

The Apple Health Appendix reflects specific initiatives and changes pertaining to the Apple Health (Medicaid) program, in alignment with the Health Care Authority's (HCA) Value-based Roadmap.[1] This document describes how managed care is transforming in alignment with the Medicaid Transformation Project, and establishes targets for Value-based Payment (VBP) attainment and related incentives under the Delivery System Reform Incentive Payment (DSRIP) program for Managed Care Organizations (MCO) and Accountable Communities of Health (ACH).

This document addresses the following topics:

- Identified VBP targets and approach for measuring, categorizing and validating progress towards regional ACH and statewide MCO attainment of VBP goals.
- Alternative payment models deployed between MCOs and providers to reward performance consistent with DSRIP objectives and measures.
- Use of DSRIP measures and objectives by the state in its contracting strategy approach for managed care plans.
- Measurement of MCOs based on utilization and quality in a manner consistent with DSRIP objectives and measures.
- Inclusion of DSRIP objectives and measures reporting in MCO contract amendments.
- Evolution toward further alignment with the Medicare & CHIP Reauthorization Act (MACRA) and other advanced Alternative Payment Models (APM).
- Approaches that MCOs and the state will use with providers to encourage practices consistent with DSRIP objectives, metrics, and VBP targets.

In accordance with the Special Terms and Conditions (STCs) of the demonstration, the Appendix will be updated annually to ensure best practices and lessons learned are captured and incorporated into HCA's overall vision of delivery system reform.[2] The Appendix will remain a living document throughout the duration of Medicaid Transformation; subject to change and adjustment to ensure that Washington State is able to achieve its purchasing goals.

# Introduction

## Apple Health and VBP Reform

To reach the goals defined in the Value-based Roadmap, including driving and sustaining delivery system transformation by shifting 90% of state-financed health care to VBP by 2021, Apple Health must play a leading role. On January 9, 2017, Washington State and the Centers for Medicare and Medicaid Services (CMS) reached agreement on a groundbreaking five-year project that allows the state to invest in comprehensive Medicaid delivery and payment reform efforts through DSRIP.

[1] For more information on HCA's Roadmap activities and Paying for Value strategy, visit: www.hca.wa.gov/about-hca/healthier-washington/paying-value. If you would like a copy of the first edition of HCA's Value-based Roadmap, please contact J.D. Fischer at jd.fischer@hca.wa.gov.

[2] Link: https://www.hca.wa.gov/assets/program/Medicaid-demonstration-terms-conditions.pdf

VBP strategies are foundational to Medicaid Transformation and serve as key sustainability vehicles of delivery system reform activities. HCA's commitment to value-based purchasing extends beyond Medicaid Transformation as well. These additional efforts will be discussed throughout this document, along with those required under the Transformation's STCs.

As Washington transitions to a new health care purchasing system for Apple Health, HCA recognizes that a comprehensive and successful transformation requires a multilayered approach that can address the needs of MCOs, individual providers, and Medicaid beneficiaries. Initiatives under Medicaid Transformation, including community-led delivery system reform strategies, play a crucial role in promoting overall system transformation.

### Alignment and Health Care Payment & Learning Action Network (HCP-LAN)

HCA strives to align its efforts with the perspectives of MCOs and providers who are integral to implementing new purchasing methodologies. As HCA implements VBP strategies for the Medicaid program, Medicare is making significant strides in implementing similar VBP reforms. Likewise, multiple commercial payers in the state are building VBP into their contracting strategies. Providers must frequently navigate all of these systems, presenting significant opportunities to align value-based purchasing methodologies across payer markets. Alignment requires that, while HCA assesses the individualized requirements of different stakeholders in the Medicaid system, it works to ensure that system reforms support and reinforce each other without leading to unnecessary burden. Apple Health will play a leadership role in driving toward VBP in the state, while also aligning where feasible with other payers for greatest impact and to simplify implementation for providers.

A primary mechanism for alignment across payer markets is the use of the HCP-LAN Framework, as discussed in the Roadmap.[3] These categories will form a framework for the implementation of VBP in Washington by defining payment models subject to incentives and penalties, aligned with Healthier Washington's broader delivery system goals. The HCP-LAN Framework recognizes a variety of approaches that can advance value-based care, and thereby provide flexibility to providers to participate in value-based payment models based on their capabilities, addressing the circumstances of the services they provide and the communities they serve. By adopting a national framework, Washington ensures that providers do not face conflicting guidance on how payment models will be classified. This uniformity with national standards is intended to enhance provider engagement and reduce the administrative burden for providers in learning to operate under VBP methodologies.

## Advancing towards Washington State's Apple Health VBP goals

Key levers and strategies underway that support statewide VBP adoption among Apple Health providers in Washington include:

- Apple Health (Medicaid) MCO contract requirements
- Medicaid Transformation and the DSRIP program
- The state's role as a convener
- VBP strategies for FQHCs and in rural communities

[3] For purposes of alignment, this appendix leverages the version of HCP-LAN framework that was available in January of 2017 when CMS approved the state's Medicaid Transformation Project. See *Attachment A: HCP-LAN APM Framework & HCA's VBP Standard.* Attachment A: HCP-LAN APM Framework & HCA's VBP Standard

A central component of implementing VBP in Washington is incentivizing MCOs to adopt VBP with network providers through HCA's contract with the MCO. MCOs are incentivized to meet value-based targets (related to quality, value-based payment adoption level, and the portion of contractor payments that are directly tied to incentives within VBP arrangements) through HCA-MCO contractual arrangements. Through the MCO withhold program, a portion of the MCO's monthly premium is withheld by HCA and can be earned back for achievement of defined targets, as detailed in the HCA-MCO contracts.

However, the shift from fee for service (FFS) to VBP also requires delivery system changes. Time-limited DSRIP funds available through Medicaid Transformation allow providers to make these changes through initial investment in the health system transformation process, and build provider capability to succeed in VBP arrangements. In turn, VBP adoption can reinforce and sustain DSRIP-funded delivery system transformation investments. This can occur through longer-term payer, provider, member, and community partnerships, as well as investments in population health management capabilities. The end goal is a transformed system of health and wellness, bolstered by VBP.

Outside of DSRIP, the state is pursuing several different strategies. On July 1, 2017, HCA converted 16 Federally Qualified Health Centers (FQHCs) to a value-based payment methodology. Under this payment methodology, FQHCs are incentivized to manage the health of their population according select quality metrics, and will be held accountable to their performance on these measures. While implementation and sustainability improvements are being implemented, the ultimate goal is to grow this program over time.

HCA is also exploring VBP in rural settings. Currently, 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. The state is seeking a Rural Multi-Payer Model to transform health care in Washington's rural regions to:

- Ensure care focuses on whole-person health
- Build healthier communities through regional and collaborative approaches
- Ensure sustainable access to health care in rural areas.

By leading with the way providers are paid, and aligning with incentives to transform the delivery system, Washington will build sustainable solutions for payers and providers that increase health access across rural communities.

Through these strategies, as described in more detail in the subsequent sections, MCOs and providers are supported and rewarded for advancing VBP during Medicaid Transformation and beyond.

## MCO contract requirements: VBP withhold program

A primary driver to advance state VBP goals is through Apple Health MCO contract requirements. HCA currently contracts with five MCOs, paying them a per member per month (PMPM) premium to deliver Medicaid services to the majority of the state's Medicaid beneficiaries. Through HCA's contractual arrangements with each MCO, MCOs are incentivized to negotiate VBP arrangements with network providers.

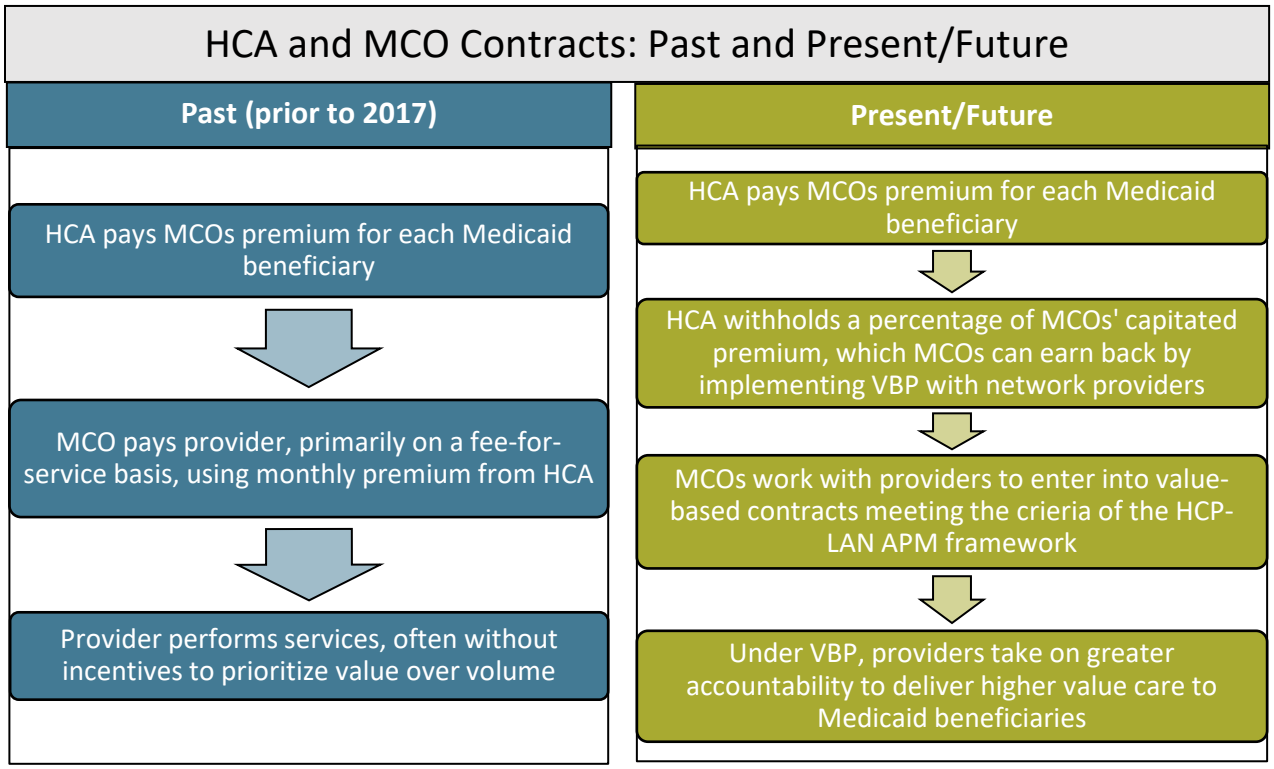
The structure of the MCO withhold program reinforces the links to quality that are emphasized by both CMS and Medicaid Transformation. It specifically incentivizes the adoption of VBP methodologies between the MCOs and providers, with a focus on the breadth and depth of these methodologies, and an additional emphasis on quality improvement. By incentivizing VBP in the MCO contracts through the withhold program, along with the other efforts described in this Appendix, HCA expects value-based payment to expand and continue well beyond the five years of Medicaid Transformation.

Consistent with federal requirements defined under 42 CFR 438.6(b), HCA ensures that the VBP withhold, in conjunction with MCO performance that is reasonably achievable, results in MCO rates that are actuarially sound. HCA's contracted actuaries include confirmation of the soundness of the rates in the rate certification provided to CMS.

### *MCO contract withhold program framework*

To incentivize VBP adoption, HCA implemented a program, under which a percentage of each MCOs' monthly per member per month premium is withheld pending achievement of certain targets.

*Figure 1. HCA and MCO Contracts: Past and Present/Future*




The total percentage withhold is established each year, and began with performance year 2017 as one percent (1%) of monthly capitation rates. For performance year 2018 and continuing for 2019 the percentage withhold has been set to be 1.5% of monthly capitation rates. The amount withheld may be earned back in three ways, each of which seeks to advance value-based purchasing:

- **VBP portion (12.5%):** The VBP portion of the withhold focuses on the percent of an MCO's total payments to providers that is within a recognized value-based purchasing arrangement. The

target for this element will increase from 30% to 90% by 2021. Qualifying VBP arrangements must meet the definition of Category 2C or higher within the HCP-LAN categorization.

- **Provider incentives portion (12.5%):** The provider incentives portion of the withhold focuses on the percent of funding, within recognized VBP arrangements, that is directly conditioned on meeting quality and financial metrics. Up to 12.5% of the provider incentives portion of the withhold may be earned back by linking qualifying provider incentive payments to quality and financial attainment or losses. The target was set at 0.75% of assessed payments in 2017 and increased to 1% for 2018 and 2019.

- **Quality Improvement Score (QIS) portion (75%)**: The QIS portion of the withhold may be earned back by demonstrating quality improvement and attainment on HEDIS clinical performance measures as calculated under HCA's QIS model. Following receipt of HEDIS scores, on or before July 1 following the performance year, HCA shall determine the percentage of the withhold earned back by the MCO based on the MCO's achieving Quality Improvement Score (QIS) targets. Up to 75% of the withhold may be earned by achieving quality improvement targets. The threshold for earning back the entire QIS portion of the withhold in the QIS model is set at a score of 0.2.

These three components of HCA's withhold program, as well as the annual target percentages that must be met in order for MCOs to receive the full withhold amount, are outlined in the table below and described in detail in MCO contracts.[4]

*Table 1. MCO Contract Withhold Components*

**MCO Contract Withhold Components**

*Percentage Targets by Year*

| VBP Share: 12.5% | |
|---|---|
| Performance Year | Target Percentage |
| 2017 | 30% |
| 2018 | 50% |
| 2019 | 75% |
| 2020 | 85% |
| 2021 | 90% |

| Provider Incentives Share: 12.5% | |
|---|---|
| Performance Year | Target Percentage |
| 2017 | .75% |
| 2018 | 1% |
| 2019 | 1% |
| 2020 | TBD |
| 2021 | TBD |

| QIS Share: 75% | |
|---|---|
| Performance Year | Target Score |
| 2017 | 0.2 |
| 2018 | 0.2 |
| 2019 | 0.2 |
| 2020 | 0.2 |
| 2021 | 0.2 |

Below is an example of the measures and benchmarks used in the QIS portion of the withhold program.[5]

[4] See model managed care contracts for more information. Link: https://www.hca.wa.gov/billers-providers/programs-and-services/modelmanaged-care-contracts

[5] The Integrated Managed Care and Foster Care contracts use the measures in Table 2. Quality Measures, as well as additional measures particular to the populations covered under those contracts.

*Table 2. Quality Measures*

| | NQF | Quality Measures Description | Target | Mean |
|---|---|---|---|---|
| Adult Measures | 0059 | Comprehensive Diabetes Care - Poor HbA1c Control (>9%) | NCQA Quality Compass Medicaid HMO 90th percentile values | NCQA Quality Compass Medicaid HMO average values |
| | 0061 | Comprehensive Diabetes Care - Blood Pressure Control (<140/90) | | |
| | 0018 | Controlling High Blood Pressure (<140/90) | | |
| | 0105 | Antidepressant Medication Management – Effective Acute Phase Treatment | | |
| | 0105 | Antidepressant Medication Management - Effective Continuation Phase Treatment (6 Months) | | |
| Pediatric Measures | 0038 | Childhood Immunization Status - Combo 10 | | |
| | 1516 | Well-child visits in the 3rd, 4th, 5th and 6th years of life | | |
| | 1799 | Medication Management for people with Asthma: Medication Compliance 75% (Ages 5-11) | | |

### *MCO VBP data submission: report requirements*

In order to assess MCO performance against the MCO contract withhold components, MCOs are required to provide VBP performance data that is defined in a Value-Based Purchasing Exhibit to the MCO contracts.[6] The reporting covers data pertaining to the adoption and intensity of value-based payment methodologies by the MCO. Data are submitted under other sections of the MCO contracts are incorporated in assessing performance under the Value-Based Purchasing Exhibit. The primary data for each portion of the Withhold is as follows:

**Medicaid VBP adoption is calculated based on the share of MCO payments to providers that are made through VBP arrangements in HCP-LAN Category 2C or higher, for the purposes of:**

- *The state's MCO withhold program*
- *MCO DSRIP VBP Incentives*
- *ACH DSRIP VBP Incentives; and*
- *Statewide accountability for DSRIP VBP targets.*

- **VBP portion:** MCOs report the dollar amounts of regional and statewide payments to providers under value-based arrangements in each category of APMs as defined under the HCP-LAN framework.
- **Provider incentives portion**: MCOs report on the extent of regional and statewide Payment Incentives and Payment Disincentives represented in their VBP contracts with providers, as a share of total provider payments.
- **QIS portion**: The QIS portion of the withhold relies on provisions in the MCO contracts, related to the submission of clinical quality data.

### Validation of VBP data contained in MCO report

HCA contracted with an Independent Assessor that is responsible for validating data submitted by the MCOs for the VBP portion and provider incentives portion of the withhold.

[6] See model MCO contract: https://www.hca.wa.gov/assets/billers-and-providers/model_contract_ahmc.pdf

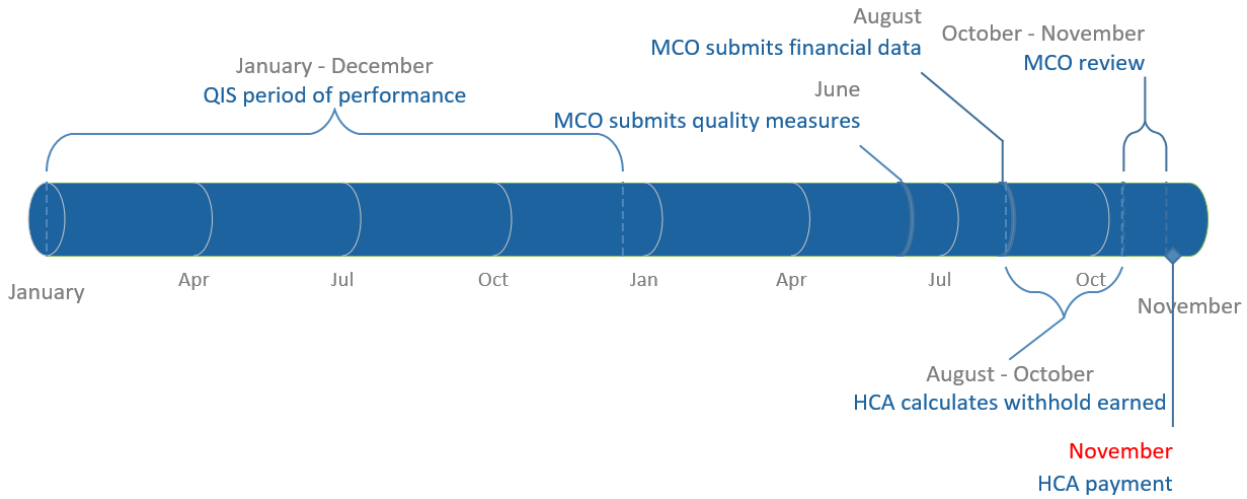
For 2018, measuring calendar 2017 VBP adoption levels, MCOs were required to provide the Independent Assessor the following:

- **VBP performance data**. VBP performance data relating to the VBP portion and provider incentives portion of the withhold are submitted by each MCO to the Independent Assessor on a template provided by HCA.
- **Supplemental packet**. MCOs were required to provide documentary support for a sample of 30 providers identified by the Independent Assessor. The MCO had to identify how contracts with each provider were categorized on the VBP Data Entry Tables, as well as documentation from the provider contract to support HCP-LAN categorization and qualifying incentives.

### *Timeline for MCO VBP data submission, assessment and payment*

A high-level timeline for the MCO withhold program is outlined below.

*Figure 2. Timeline for VBP data submission, validation and payment*




The two-year performance and review period continues on a rolling basis as shown, so that the subsequent performance year begins while data for the prior performance year is submitted to and reviewed by HCA. For example, MCOs will report on 2018 data in August 2019. The validation process is conducted, with the process completed and payment of the percentage of the withhold earned back to be scheduled within HCA's payment systems by November 30, 2019.

## Supporting VBP advancement through Medicaid Transformation

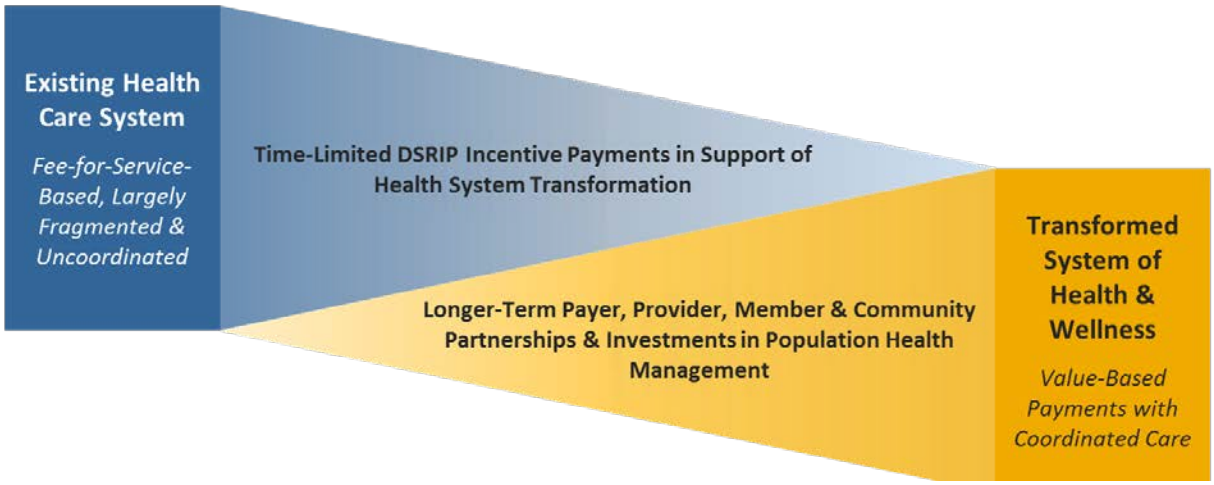
Under Medicaid Transformation, the DSRIP program provides resources to providers to move along the VBP continuum. Investment in foundational strategies that promote provider readiness for VBP is necessary to ensure the sustainability of Medicaid Transformation initiatives.

To encourage MCOs and providers to pursue VBP arrangements, DSRIP incentives are available for MCO and ACH achievement of VBP adoption targets as defined in the STCs.[7] VBP adoption targets under Medicaid Transformation are based on the percentage of payments to providers that fall into categories 2C through 4B of the HCP-LAN APM Framework, starting in demonstration year (DY) 1, with progressive targets throughout the transformation. Ultimately, DSRIP funds allow providers to make delivery system

[7] See Special Terms and Conditions, subpart 41: https://www.hca.wa.gov/assets/program/Medicaid-demonstration-terms-conditions.pdf

changes required for the implementation of VBP strategies, while VBP contracts can help sustain these changes by financially rewarding their outcomes.

*Figure 3. DSRIP program and VBP*




Advancing the shift toward VBP arrangements in place of traditional fee for service models is a primary component of DSRIP accountability during Medicaid Transformation, as highlighted below for the following entities:

- Washington State is accountable for the advancement of quality outcomes and VBP adoption goals. In DY 3-5, a portion of DSRIP incentives will be at risk depending on:
    - Statewide demonstration of physical and behavioral health integration in managed care;
    - Statewide improvement and attainment of quality targets across a set of quality metrics; and
    - Statewide improvement and attainment of defined statewide VBP targets.[8]
- MCOs are eligible to earn DSRIP VBP incentives for reporting data required to assess MCO and ACH VBP adoption levels (per MCO contract requirements) and achievement and improvement toward annual VBP adoption targets.
    - MCOs have the opportunity to earn incentives for VBP adoption through DSRIP. This is distinct, but complimentary, to the contractual expectations set forth between HCA and MCOs through the quality withhold program (described above in section *MCO contract requirements: VBP withhold program*).
- ACHs can also earn DSRIP VBP incentives through reporting of regional efforts to advance VBP, as well as achievement and improvement toward annual VBP adoption targets.

Detailed parameters for how VBP incentive funds are earned and distributed to qualifying entities are outlined in subsequent sections. For more detail about the DSRIP accountability framework, see the DSRIP Measurement Guide.[9]

[8] For more information, see: https://www.hca.wa.gov/assets/statewide-accountability-model-slides.pdf
[9] Link: https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf

## Statewide accountability for VBP advancement

Beginning in 2019 (DY 3), a portion of statewide DSRIP funding will be at risk depending on the state's advancement of VBP adoption and performance on a set of quality metrics. If the state does not achieve its targets, available DSRIP funding will be reduced in accordance with the STCs.

By the end of 2021 (DY 5), 90% of total Medicaid MCO payments to providers must be made through designated VBP arrangements in order for the state to secure maximum available DSRIP incentives. The VBP component constitutes 20% of the annual statewide DSRIP withhold, beginning in DY3.

*Definition of Achievement*: Statewide VBP adoption targets are consistent with HCP LAN Category 2C-4B VBP arrangements.[10] VBP adoption performance is measured by two factors: improvement toward and achievement of the annual target. If the VBP adoption target is achieved, then the full VBP portion of the statewide accountability withhold is earned. If the target is not achieved, a portion of the withhold can still be earned based on the state's improvement in VBP adoption from the prior year.

*Table 3. Annual statewide VBP adoption target and scoring weights*

| | VBP adoption target (HCP LAN 2C-4B) | Scoring weights | |
|---|---|---|---|
| | | Improvement Score | Achievement Score |
| **DY 3** | 75% | 50% | 50% |
| **DY 4** | 85% | 45% | 55% |
| **DY 5** | 90% | 40% | 60% |

*Table 4. Statewide accountability VBP adoption - measurement years*

| DY | Performance year | Baseline year |
|---|---|---|
| 3 | 2019 | 2018 |
| 4 | 2020 | 2019 |
| 5 | 2021 | 2020 |

*Data source:* HCA will use the data on VBP adoption levels reported by MCOs consistent with the contract requirements described above and validated by the Independent Assessor to calculate VBP adoption levels. The statewide accountability VBP baseline year is the year prior to the performance year, in alignment with MCO VBP adoption assessment per the contractual agreement with HCA.

Payments to providers are defined as total Medicaid payments to providers (in dollars) for services, including inpatient, outpatient, physician/professional, and other health services, excluding any pass-through payments or other services carved out from MCO contracts. This amount excludes payments related to case payments, administrative dollars, Washington State Health Insurance Pool (WSHIP), premium tax, Safety Net Assessment Fund (SNAF), Provider Access Payment (PAP) or Trauma funding.[11]

[10] See *Attachment A: HCP-LAN APM Framework & HCA's VBP Standard.* Attachment A: HCP-LAN APM Framework & HCA's VBP Standard

[11] Note: for Calendar Year 2017 (CY2017), HCA included payments for pharmacy service in both the numerator and denominator when calculating the level of VBP adoption. However, starting in 2018, pharmacy has been removed

*Calculating the level of VBP adoption:* VBP adoption is calculated based on the share of MCO payments to providers that are made through VBP arrangements in HCP-LAN Category 2C or higher.[12]

*Equation 1. Level of VBP adoption (%)*

$$\text{Level of VBP adoption (\%)} = \frac{\text{MCO payments to providers (in \$) made through VBP arrangements at or above Category 2C}}{\text{Total MCO payments to providers (in \$)}}$$

The state is measured on achievement of VBP adoption targets, as well as improvement over the state's prior year VBP adoption level. If the state has reached or exceeded the HCP-LAN 2C-4B VBP adoption target for the performance year, then the achievement score will be 100%. If not, the achievement score is 0%. If the state has met the VBP adoption target for the performance year, then the improvement score is 100%.

If the state has not met the VBP adoption target for the performance year, then the improvement score is calculated as the percent change from the baseline year to the performance year.

*Equation 2. VBP improvement score*

$$\text{Improvement Score} = \frac{\text{Performance Year VBP Adoption (\%)} - \text{Baseline Year VBP Adoption (\%)}}{\text{Baseline Year VBP Adoption (\%)}}$$

Where the calculation of the *improvement score* produces a negative percentage, the *improvement score* is 0%. The *improvement score* is capped at 100%.

The overall VBP performance score is calculated by first finding the achievement score and the improvement score for the performance period, and then multiplying each score by the relevant scoring weights defined in *Table 3. Annual statewide VBP adoption target and scoring weights*. To illustrate, see example below.

*Table 5. Example calculation of statewide accountability - VBP Adoption Score – DY 3 assessment*

| DY 3 VBP Adoption Assessment | Value | Calculation |
|---|---|---|
| DY 3 VBP target | 75% | |
| DY 3 Performance | 70% | |

from the MCO per member per month (PMPM). Therefore, for CY2018, HCA will be excluding all such payments in both the numerator and denominator when calculating the level of VBP adoption. See model managed care contracts for more information. Link: https://www.hca.wa.gov/billers-providers/programs-and-services/model-managed-care-contracts

[12] Payments for behavioral health services are included when they are paid by a MCO, including integrated MCOs. Payments for behavioral health services paid by BHOs prior to integration are not included.

| | | |
|---|---|---|
| DY 2 (baseline) | 50% | |
| **Achievement Score** | 0% | |
| **Improvement Score** | 40% | *(0.7 – 0.5) / 0.5* |
| **Overall VBP Score** | 40% | *(0 * 0.5) + (0.4 * 0.5)* |
| **Percent contribution of VBP Adoption Score to Statewide accountability composite score** | 20% | |
| ***Earned share of funds for statewide VBP adoption*** | 80% | *0.2 * 0.4* |

For more information about the overall statewide accountability approach and components, see the DSRIP Measurement Guide.[13]

## DSRIP Incentives for MCO VBP achievement

MCOs are critical partners in delivery system reform efforts, particularly to ensure the state is successful in meeting its value-based payment goals. As stated in the MTP STCs, MCOs are expected to serve in leadership or supportive capacity in every regional ACH. This ensures that delivery system reform efforts are coordinated across all necessary sectors – those providing payment, those delivering services, and those providing critical, community-based supports.

In support of Medicaid Transformation, MCOs are accountable for demonstrating improvement toward and achievement of the state's VBP targets, and will play a critical role in the success and sustainability of Washington's DSRIP program.

### *Available incentives*

MCOs are expected to participate in delivery system reform efforts as a matter of business interest and contractual obligation to the state. For this reason, they do not receive incentive payments for participation in ACH-led transformation projects. However, MCOs are eligible to earn MCO DSRIP VBP Incentives (through the "Challenge Pool") for achieving annual MCO VBP targets.[14] The amount of incentives available to an individual MCO is determined by the attributed statewide managed care member months under signed Apple Health contracts for the year.[15]

*Table 6. Annual DSRIP funding available for MCO DSRIP VBP incentives*

| DY 1 | DY 2 | DY 3 | DY 4 | DY 5 |
|---|---|---|---|---|
| *N/A* | $8,000,000 | $8,000,000 | $8,000,000 | $8,000,000 |

MCO DSRIP VBP Incentives are earned according to Pay for Reporting (P4R) and Pay for Performance (P4P) expectations. Each year, MCOs have a defined portion of incentives available for achieving P4R

[13] See DSRIP Measurement Guide, Chapter 2: https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf

[14] See "Exhibit: Challenge Pool Value-based Purchasing Incentives" in model managed care contracts: https://www.hca.wa.gov/billers-providers/programs-and-services/model-managed-care-contracts

[15] Annual DSRIP incentives are based on best available information, and subject to change. In MCO contracts, these incentives are referred to as Base Earnable Funds (BEF). See "Exhibit: Challenge Pool Value-based Purchasing Incentives" in model managed care contracts for definitions: https://www.hca.wa.gov/billers-providers/programs-and-services/model-managed-care-contracts

criteria and P4P targets. The percent of available incentives split between P4R and P4P is defined in MTP STCs.

*Table 7. Annual percent of potential earnable MCO DSRIP VBP Incentives, by P4R and P4P*

| MCO DSRIP VBP Incentives | DY 2 | DY 3 | DY 4 | DY 5 |
|---|---|---|---|---|
| Pay for Reporting (P4R) | 50% | 25% | 0% | 0% |
| Pay for Performance (P4P) | 50% | 75% | 100% | 100% |

The managed care contracts, including HCA's Apple Health Managed Care, Apple Health Integrated Managed Care, and Apple Health Foster Care, further specify how the incentives are distributed. If more than one of these contracts is effective between HCA and the MCO, the incentives earned are calculated as a single payment based on data aggregated from each of MCO's applicable Apple Health contract(s).[16]

### *Assessment of progress and performance*

The performance year for determining whether MCOs have completed milestones in support of advancing VBP and achieved VBP targets is aligned with a given demonstration year. The assessment period will occur during fall (October-December) subsequent to the performance year.

### Pay for Reporting

MCOs are eligible to earn MCO DSRIP VBP Incentives for P4R in DY 2 and DY 3 only (as no VBP Incentive funds were available in DY 1). These incentives are available to the MCOs for the complete and timely reporting of data required to assess the MCO progress toward meeting VBP adoption targets. The required data and timeline for submission is specified in the contractual agreement between HCA and the MCO.[17]

### Pay for Performance

For DY 2 through DY 5, the P4P portion of MCO DSRIP VBP Incentives are available for successful achievement of and improvement toward specified VBP adoption targets. Each MCO will be measured based on MCO-provided data (validated by the Independent Assessor), and must meet performance expectations for the given year. Performance targets, as well as improvement and achievement weighting for MCO VBP score determination, are outlined below.

*Table 8. MCO VBP adoption targets*

| Year | Performance targets | |
|---|---|---|
| | HCP LAN 2C-4B Performance target | HCP LAN 3A-4B Performance subtarget |
| DY 1 | 30% | N/A |
| DY 2 | 50% | 10% |
| DY 3 | 75% | 20% |
| DY 4 | 85% | 30% |

[16] See model managed care contracts https://www.hca.wa.gov/billers-providers/programs-and-services/model-managed-care-contracts

[17] See model managed care contracts https://www.hca.wa.gov/billers-providers/programs-and-services/model-managed-care-contracts

| | | |
|---|---|---|
| DY 5 | 90% | 50% |

MCO improvement and achievement are weighted differently throughout the transformation. MCO improvement toward VBP adoption targets is more heavily weighted in the early years, while credit for full achievement of those targets is increasingly weighted in the later years.

*Table 9. MCO VBP P4P score weights*

| Year | Calculation Weight | | |
|---|---|---|---|
| | Achievement score | Achievement subset score | Improvement score |
| DY 1 | 40% | 0% | 60% |
| DY 2 | 35% | 5% | 60% |
| DY 3 | 45% | 5% | 50% |
| DY 4 | 50% | 5% | 45% |
| DY 5 | 55% | 5% | 40% |

The amount of MCO VBP P4P Incentives earned by the MCO on the basis of performance will reflect the following components:

1) Achievement of MCO VBP adoption target (HCP-LAN 2C-4B *performance target*)
2) Achievement of defined subset criteria
3) Improvement from prior year VBP adoption
4) Minimum threshold for MCO DSRIP VBP Incentives (HCP LAN 3A-4B *performance subtarget*)

Based on its performance, the MCO is eligible to earn all or part of the available MCO DSRIP VBP Incentives. The state and Independent Assessor will leverage data the MCOs are contractually required to submit for purposes of identifying the following:

1. *Achievement score:* An achievement score for each MCO is calculated annually. If the MCO has reached or exceeded the HCP-LAN 2C-4B *performance target* for the performance year, then the *achievement score* will be 100%. If not, the *achievement score* is 0%.

2. *Achievement subset score:* In demonstration years 2, 3, 4, and 5, the state will assess whether the MCO has met the annual *achievement subset* criteria. If the *achievement subset* criteria have been met, then the *achievement subset score* will be 100%, and if the achievement subset criteria have not been met, then the *achievement subset score* will be 0%.

    a. In DY 2, the *achievement subset* criteria required that the MCOs have at least one VBP contract in HCP-LAN Category 3B or above.
    b. For DY 3 – 5, the *achievement subset* criteria will be defined according to the following parameters:

i. Year 3: At least one VBP contract as a MACRA A-APM. Washington secured CMS approval for several Medicaid payment models to be considered A-APMs for performance year 2019. These contracts will qualify in 2019.[18]
ii. Year 4 and Year 5: At least one VBP contract in Category 3B or above and including at least one of the following features:
    - More than nominal risk for shared losses[19]
    - Payments tied to provider improvement or attainment on metrics from the statewide common measure set using HCA quality improvement model or similar tool
    - Care transformation requirements including state-level best practices
    - Use of certified EHR technology in support of VBP methods

3. *Improvement score:* An *improvement score* for each MCO is calculated annually. If the MCO has met the *performance target* for the demonstration year, then the *improvement score* is 100%. If the MCO has not met the *performance target* for the performance year, then the *improvement score* is calculated as the percent change from the baseline year to the performance year. See *Equation 2. VBP improvement score*.

   The *improvement score* is capped at 100%. Where the prior calculation produces a negative percentage, the *improvement score* is 0%.

4. Eligibility for MCO DSRIP VBP Incentives *(performance subtarget)*: In addition, MCOs must also meet a minimum threshold of VBP adoption in Category 3A and above (*performance subtarget*) to earn any MCO DSRIP VBP Incentives in DY 4 and 5. The *performance subtarget* is also applied as a threshold for *distribution of remaining funds only* in DY 2 and 3 (as described in section below: *Distribution of remaining incentives*).

*Table 10. Annual HCP-LAN 3A-4B subtarget threshold for MCO DSRIP VBP Incentives*

| | DY 1 | DY 2 | DY 3 | DY 4 | DY 5 |
|---|---|---|---|---|---|
| **HCP-LAN 3A – 4B performance subtarget** | *N/A* | Eligibility: Remaining funds<br><br>Target = 10% | Eligibility: Remaining funds<br><br>Target = 20% | Eligibility: All funds<br><br>Target = 30% | Eligibility: All funds<br><br>Target = 50% |

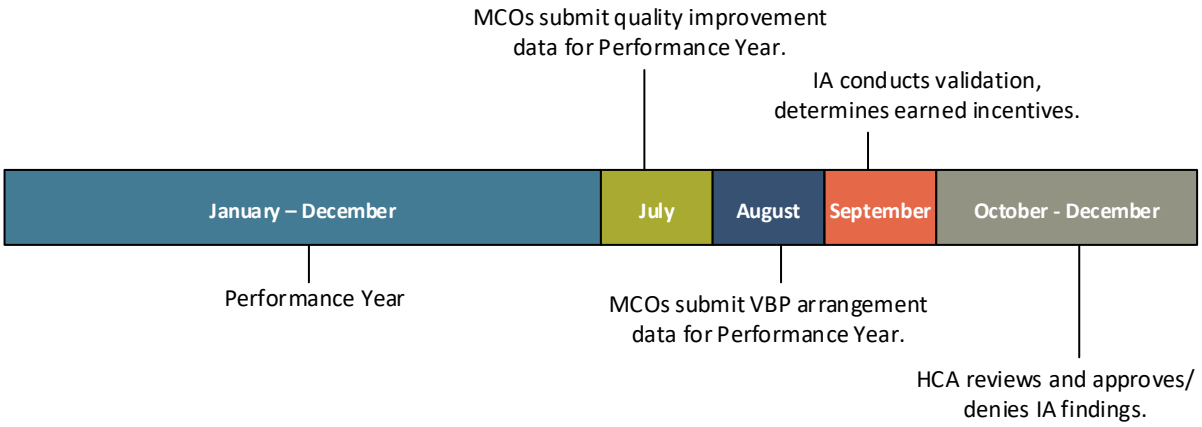
### *Incentive payment determination*

For the purpose of the DSRIP program, the Independent Assessor is responsible for determining whether reporting and performance expectations have been met.

[18] See Medicaid Other Payer Advanced APMs in the Quality Payment Program for Performance Year 2019: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Medicaid-Other-Payer-Advanced-APM-determination-list.pdf

[19] Per the MACRA definition for advanced alternative payment models. See 42 CFR § 414.1420(d)(3).

*Figure 4. Assessment timeline for MCO DSRIP VBP Incentives*




### *Distribution of remaining incentives*

If there are any remaining MCO DSRIP VBP Incentives for a given performance year after initial allocation, then a secondary process is initiated to allocate the unearned incentives. Each MCO is eligible to earn a share of any remaining incentives based on achievement of the factors defined below.

*Table 11. MCO eligibility to earn remaining MCO DSRIP VBP Incentives*

| 1) HCP-LAN 3A-4B performance subtarget | 2) Relative quality improvement composite score (QIS) |
|---|---|
| The MCO must meet the HCP LAN 3A-4B *performance subtarget* for the performance year set out in *Table 11.*<br>- If the MCO *has not* met the annual *performance subtarget*, it will not be eligible for any of the remaining incentives.<br>- If the MCO *has met* the annual *performance subtarget*, it is eligible for a percentage of incentives based on its relative Quality improvement composite score (QIS).<br><br>*Important:* MCOs must meet the HCP-LAN 3A-3B *performance subtarget* during DY 4 and DY 5 to be eligible for <u>any</u> MCO DSRIP VBP Incentives as part of the primary VBP adoption assessment, in addition to any remaining incentives as part of the secondary process. | - If the MCO has met the HCP LAN 3A-4B *performance subtarget*, the MCO will receive a percentage of remaining MCO DSRIP VBP Incentives.<br>- This percentage is determined by the MCO's relative performance on the set of quality measures (as defined in MCO contracts for the associated performance year), represented by a QIS.<br>- MCO QIS results are calculated in accordance with Washington Apple Health Managed Care Contracts.[20]<br>- The state and Independent Assessor will leverage the QIS results to determine the amount of remaining incentives earned for eligible MCOs by calculating the MCO's QIS score as a percent of total qualifying MCO QIS scores. |

[20] MCO performance on quality outcomes and QI Model/QI Composite Score (referred to in MCO contracts as "QIS") methodology are further specified in the *Exhibit: Challenge Pool – Value Based Purchasing Incentives* of the managed care contracts. Link: https://www.hca.wa.gov/billers-providers/programs-and-services/model-managed-care-contracts

## DSRIP Incentives for ACH VBP achievement

Provider readiness for VBP models and contracts will be critical to meet statewide and regional VBP targets, as well as other state VBP goals. ACHs serve in a supportive role to help assess and support provider VBP readiness and practice transformation and to connect providers to relevant training and resources. ACH regions are awarded incentives for demonstrated improvement and achievement of VBP adoption targets in the ACH region. During DSRIP, ACHs are accountable for investing resources to support partnering providers. For example, ACHs should be distributing earned incentives to support their partnering provider needs in moving along the VBP continuum.

Under DSRIP, transformation efforts will be driven by ACHs and coalitions of partnering providers as they select and implement a set of strategies from the Medicaid Transformation Project Toolkit to address regional health needs. To be successful, ACHs must integrate foundational cross-cutting health system and community capacity building elements that address workforce, systems for population health management, and financial sustainability through VBP.

Across the project stages, providers partnering with their ACH may be eligible to receive incentive payments by contributing to the completion of project milestones and regional improvement on clinical and population health measures. The incentive funds earned by providers allow them to make the investments necessary to be successful in the project, as well as promote efforts to scale and sustain strategies that prove to have positive health and wellness impacts in their communities. In order to be financially sustainable, however, other sources of funding must be identified to sustain these strategies, which could come through success in VBP contracts.

While VBP arrangements vary in complexity and provider risk, all require that providers have the ability to effectively measure and influence the quality and cost of care provided. The presence and maturity of a number of underlying capabilities influence whether providers succeed under their VBP arrangements. ACHs will undertake efforts to understand the current state of VBP capabilities among their provider partners, and how the ACHs can leverage DSRIP funds to support development of capabilities moving forward. ACHs determine the allocation methodology for earned VBP Incentive DSRIP funds among partnering providers in their region.

### *Available incentives*

ACHs are eligible to earn VBP Incentives through reporting on the completion of VBP milestones (P4R) and improvement toward VBP adoption targets (P4P) by the MCOs in their respective regions. With regard to VBP adoption, ACHs will be rewarded on progress in the early years, and increasingly on full attainment of targets in later years. The table below indicates the percentage distribution of VBP Incentives available to ACHs for reporting and performance throughout Medicaid Transformation, per the MTP STCs.

*Table 12. Annual percent of potential earnable ACH DSRIP VBP Incentives, by P4R and P4P*

| ACH DSRIP VBP Incentives | DY 1 | DY 2 | DY 3 | DY 4 | DY 5 |
|---|---|---|---|---|---|
| Pay for Reporting (P4R) | 100% | 75% | 50% | 25% | 0% |
| Pay for Performance (P4P) | 0% | 25% | 50% | 75% | 100% |

*Assessment of progress and performance*

*Pay for Reporting*

ACHs report on VBP P4R milestones as part of their semi-annual reports. ACH DSRIP VBP Incentives for P4R are earned by providing complete and timely evidence of milestone completion for the annual reporting period. ACH VBP P4R milestones evolve as the transformation progresses. The table below outlines the milestones for each demonstration year.

*Table 13. ACH VBP P4R milestones*

| Milestone | Reflective of activities that occurred during: |
|---|---|
| • N/A (None; no DSRIP funding allocated to VBP Incentives in DY 1) | DY 1 (2017) |
| • Inform providers of VBP readiness tools to assist their move toward value-based care.<br>• Connect providers to training and/or technical assistance (TA) offered through HCA, the Practice Transformation Support Hub, MCOs, and/or the ACH.<br>• Support assessments of regional VBP attainment by encouraging / incentivizing completion of the state provider survey.<br>• Support providers to develop strategies to move toward value-based care. | DY 2 (2018) |
| • Identification and support of providers struggling to implement practice transformation and move toward value-based care.<br>• Support providers to implement strategies to move toward value-based care.<br>• Continued support of regional VBP attainment assessments by encouraging / incentivizing completion of the state provider survey. | DY 3 (2019) |
| • Continued support of regional VBP attainment assessments by encouraging / incentivizing completion of the state provider survey.<br>• Continued identification and support of providers struggling to implement practice transformation and move toward value-based care. | DY 4 (2020) |
| • N/A (All VBP Incentives reward performance; no incentives for reporting) | DY 5 (2021) |

### Incentive payment determination

The achievement of ACH VBP P4R milestones is assessed by the Independent Assessor. Each VBP P4R milestone is associated with one (1.0) achievement value (AV); the percentage of P4R funds earned for the demonstration year is equal to the percent of P4R AVs earned out of the total possible number of AVs. ACHs attest to milestones and provide evidence of completion (e.g. narrative responses, lists of activities), which are assessed on a binary complete/incomplete scale. The time period for achieving P4R milestones is the corresponding demonstration year. Earned incentives are distributed annually to ACHs, aligned with the timing of P4P payment cycles for both ACH VBP and ACH Project incentive payments.

*Pay for Performance*

The state calculates VBP adoption by ACH region annually each year for the prior measurement based on data provided by MCOs. Data used to calculate regional ACH VBP achievement is obtained by the state through annual MCO reporting on VBP adoption by region and LAN category. The resulting data are validated by the Independent Assessor and aggregated across all MCOs by region and LAN category. It is important to note that ACH achievement of regional VBP adoption targets is contingent on MCO

VBP adoption performance. ACHs are expected to engage with MCOs and providers in their region to encourage VBP adoption, but are not expected to be parties to VBP contracts themselves.

ACH VBP P4P Incentives are associated with VBP adoption targets, as required by the STCs. Regional VBP adoption is calculated based on the share of MCO payments to providers that are made through VBP arrangements in the HCP-LAN Category 2C or higher.

*Table 14. ACH VBP adoption targets*

| Year | Performance targets | |
|---|---|---|
| | HCP LAN 2C-4B Adoption target | HCP LAN 3A-4B Adoption subtarget |
| DY 1 | 30% | N/A |
| DY 2 | 50% | 10% |
| DY 3 | 75% | 20% |
| DY 4 | 85% | 30% |
| DY 5 | 90% | 50% |

Achievement of annual ACH VBP P4P outcomes will take into account not only full achievement of VBP adoption targets, but also improvement from prior year performance toward VBP adoption targets.

*Table 15. ACH VBP P4P score weights*

| Year | Calculation Weight | | |
|---|---|---|---|
| | Achievement score | Achievement subset score | Improvement score |
| DY 1 | N/A | N/A | N/A |
| DY 2 | 35% | 5% | 60% |
| DY 3 | 45% | 5% | 50% |
| DY 4 | 50% | 5% | 45% |
| DY 5 | 55% | 5% | 40% |

The amount of ACH VBP P4P Incentives earned by the ACH on the basis of performance will reflect the following components:

1) Achievement of ACH VBP adoption target (HCP-LAN 2C-4B *performance target*)
2) Achievement of defined subset criteria
3) Improvement from prior year VBP adoption
4) Minimum threshold for ACH DSRIP VBP Incentives (HCP LAN 3A-4B *performance subtarget*)

Based on the region's performance, an ACH is eligible to earn all or part of the available incentives for ACH VBP P4P. The state and Independent Assessor will leverage data the MCOs are contractually required to submit for purposes of identifying the following:

1. *Achievement score:* An *achievement score* for each ACH region is calculated annually. If the ACH region has reached or exceeded the HCP-LAN 2C-4B *performance target* for the performance year, then the *achievement score* will be 100%. If not, the *achievement score* is 0%.

2. *Achievement subset score:* In demonstration years 2, 3, 4, and 5, the state will assess whether the ACH region has met the annual Achievement Subset criteria. If the Achievement Subset criteria have been met, then the *achievement subset score* will be 100%, and if the Achievement Subset criteria have not been met, then the *achievement subset score* will be 0%.

    a. In DY 2, the Achievement Subset criteria requires that the ACH region have at least one MCO with at least one VBP contract in HCP-LAN Category 3B or above.
    a. For DY 3 – 5, the *achievement subset* criteria will be defined according to the following parameters:
        i. Year 3: At least one VBP contract as a MACRA A-APM. Washington secured CMS approval for several Medicaid payment models to be considered A-APMs for performance year 2019. These contracts will qualify in 2019.[21] Year 4 and Year 5: At least one VBP contract in Category 3B or above and including at least one of the following features:
            - More than nominal risk for shared losses[22]
            - Payments tied to provider improvement or attainment on metrics from the statewide common measure set using HCA quality improvement model or similar tool
            - Care transformation requirements including state-level best practices
            - Use of certified EHR technology in support of VBP methods

3. *Improvement score:* An *improvement score* for each ACH region is calculated annually. If the ACH region has met the *performance target* for the demonstration year, then the *improvement score* is 100%. If the ACH region has not met the *performance target* for the performance year, then the *improvement score* is calculated as the percent change from baseline year to the performance year. See *Figure 5. VBP Improvement Score Formula.*

   The *improvement score* is capped at 100%. Where the prior calculation produces a negative percentage, the *improvement score* is 0%.

4. In addition, ACHs must also meet a minimum threshold of VBP adoption in Category 3A and above (*performance subtarget*) to earn any ACH DSRIP VBP Incentives in DY 4 and 5.

*Table 16. Annual HCP-LAN 3A-4B subtarget threshold for ACH DSRIP VBP Incentives*

| | DY 1 | DY 2 | DY 3 | DY 4 | DY 5 |
|---|---|---|---|---|---|
| **HCP-LAN 3A – 4B Subtarget** | N/A | None | None | 30% | 50% |

[21] See Medicaid Other Payer Advanced APMs in the Quality Payment Program for Performance Year 2019: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Medicaid-Other-Payer-Advanced-APM-determination-list.pdf

[22] Per the MACRA definition for advanced alternative payment models. See 42 CFR § 414.1420(d)(3).

### Incentive payment determination

The Independent Assessor calculates the final ACH VBP P4P score by adding the weighted scores for improvement, performance target and performance subset target achievement. The final score across all components will determine the proportion of potential ACH VBP P4P incentives earned by an ACH for a given performance year. Full credit is earned by meeting or exceeding the defined target for the associated year. It is not possible for an ACH to earn additional incentives if improvement or performance expectations are exceeded. Examples of ACH VBP Incentive calculation and payment timing are found in the DSRIP Measurement Guide.[23]

#### *Distribution of remaining incentives*

Should a region not meet full progress (P4R) or performance (P4P) expectations, the ACH's unearned VBP Incentives are used to fund ACH High Performance Incentives.[24]

## State role as convener: Medicaid Value-based Payment (MVP) Action Team

The Medicaid Value-based Payment (MVP) Action Team was created to serve as a learning collaborative to support ACHs, MCOs, and providers to attain VBP targets. It has provided a forum to facilitate provider preparation for value-based contract arrangements and to provide guidance on HCA's VBP standards. Similarly, the MVP Action Team has promoted provider participation in VBP assessments, including the state's provider VBP survey.

The MVP Action Team is comprised of health care leaders from around Washington with significant experience with Medicaid and payment transformation efforts. The MVP Action Team includes state, regional and local partners representing physical and behavioral healthcare providers, hospitals, clinics, Indian health care providers, community-based organizations, MCOs, public health providers and others. To ensure balanced membership representing varying perspectives, each MCO and ACH nominated a representative to serve on the MVP Action Team.

The MVP Action Team has served as a source of information and advice for HCA in its development of strategies and guidance for VBP advancement. MVP Action Team members have also advised and interacted with ACH staff and partnering providers in their pursuit of VBP goals. The MVP Action Team continues to represent an important sounding board as HCA and ACHs strategize how paying for value efforts can best meet the needs and capacity of each region.

## State role as convener: Medicaid Transformation Learning Symposium

Convening stakeholders and partners to share learnings and collaborate on shared priorities is critical for managing change, advancing equity, and achieving broad health systems transformation. Accordingly, and in agreement with the MTP STCs, the state is hosts an annual Medicaid Transformation Learning Symposium for Accountable Communities of Health (ACHs) and their partner organizations working to advance community and health systems change. This year's Symposium will occur in late October, with a key session focusing on defining roles and relationships in VBP. The state specifically tailored the full-day Symposium to bring together health care influencers from across the state to foster learning, inspiration, and innovation.

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[23] Link: https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf

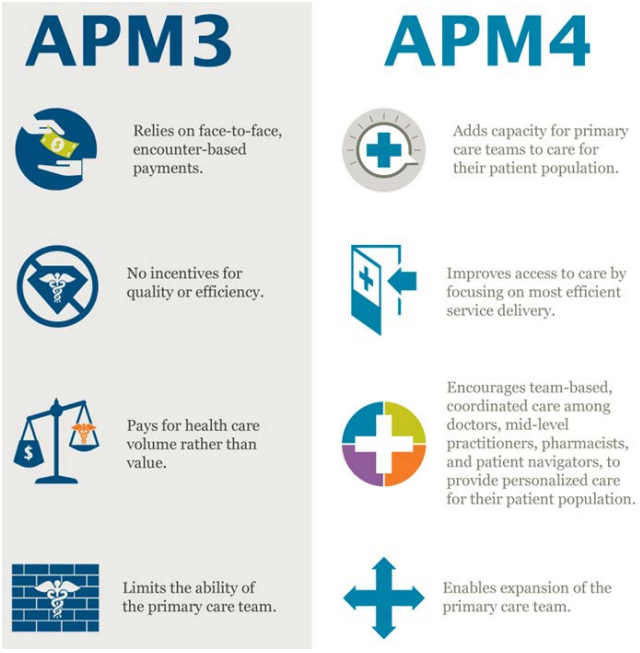
[24] See DSRIP Measurement Guide, Chapter 8 for more information: https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf

## Advancement of VBP for FQHCs and in Rural Communities

Since 2000, Medicare and Medicaid reimbursement for FQHCs and Rural Health Clinics (RHCs) occurs through what is known as Prospective Payment System (PPS). These providers qualify for cost-based reimbursement from Medicare and Medicaid for the delivery of comprehensive health care services, typically to an underserved area or population. While they offer some of the most innovative and integrated delivery models in the state, their reimbursement structure stifles further care delivery innovation. The PPS system has gone through several iterations in Washington, where the first iteration was known as APM1.[25] At the outset of 2017, APM3 was limited to face-to-face, encounter-based payments.

On July 1, 2017, 16 FQHCs in Washington began using a new alternative payment methodology (APM4) for Medicaid managed care enrollees that 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.[26] APM4 converts encounter-based payments to an equivalent PMPM rate that is prospectively adjusted based on quality performance

*Figure 5. Summary of APM3 and APM4*




HCA will determine prospective quality adjustment percentages annually based on the FQHC's achieving quality improvement score targets. FQHCs that demonstrate quality improvement and attainment year over year will continue to receive their full PMPM rate. FQHCs that do not demonstrate quality

[25] The APM1 through APM4 designations for FQHCs and RHCs are independent from the APM categories delineated under the HCP-LAN framework and discussed earlier in this document. The numbering in APM3 and APM4 reflects that they are distinct iterations of the PPS model that is particular to FQHCs and RHCs, while the HCP-LAN framework has broader scope and uses categories one through four to delineate payment methodologies by type.

[26] See APM4 Fact Sheet: https://www.hca.wa.gov/assets/program/APM4-fact-sheet.pdf

improvement and attainment will be subject to downward adjustment of their PMPM rate, with the guarantee that once quality targets are met the FQHC is restored to the full benefit of the baseline PMPM rate (as trended by the Medicare Economic Index (MEI)) in future years.

Each clinic will be measured by seven quality measures from the Statewide Common Measure Set, consistent with the MCO contracts and the state's Public Employee Benefits Board (PEBB) Accountable Care Program (ACP).[27] The goal of APM4 is to 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.

The APM4 payment methodology provides flexibility for primary care providers to serve a larger member panel while maintaining an appropriate level of face-to-face patient encounters, thus expanding primary care capacity in medically underserved areas. APM4 is also intended to incentivize alternatives to face-to-face visits and allow the clinics to offer more convenient access to primary care services.

In rural communities, under the Rural Multi-Payer Model, HCA has engaged with rural providers, commercial payers and MCOs to develop a new model of payment.[28] The Rural Multi-Payer Model seeks to transform health care in Washington's rural regions to ensure that care focuses on whole-person health, build healthier communities through regional and collaborative approaches, and ensure sustainable access to health care in rural areas. By leading with the way providers are paid, and aligning with incentives to transform the delivery system, Washington can build sustainable solutions for payers and providers that increase health access across rural communities.

Currently, 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 always benefited rural providers. The Rural Multi-Payer Model seeks to address these issues through fundamental transformation of the rural health delivery system. The state's goal is to improve the health of rural Washingtonians and preserve access to care in rural areas in a manner that is sustainable and better serves the health needs of local populations.

To reach this goal, Washington's rural model includes the following components:

- *Prospective, population-based alternative payment*, that includes behavioral health and long-term care services, aimed at rewarding value and efficiency over volume.
- *Health delivery redesign strategy*, to ensure the payment model incentivizes hospitals' investment in essential services that meet the needs of their communities most efficiently, including leveraging technology.
- *High-quality, patient-centered care* that is incentivized so the most optimal care is delivered at the right time and linked appropriately to social and environmental factors.

[27] More information about the Statewide Common Measure Set can be found here: https://www.hca.wa.gov/about-hca/healthier-washington/performance-measures

[28] See Rural Multi-Payer Model Fact Sheet: https://www.hca.wa.gov/assets/program/rural-multi-payer-model-fact-sheet.pdf

- *Health information and data infrastructure investments,* to support coordinated care and population health management strategies.
- *Incentives for clinical/community linkages* to incentivize rural providers and communities to partner with their local Accountable Community of Health to impact population health outcomes, access and quality.

## Understanding payer and provider experience in the transition to VBP

Understanding the payer and provider experience with VBP is crucial to monitor the progression along the VBP continuum. On an annual basis, HCA issues two value-based payment (VBP) surveys to Washington State payers and providers. Core objectives of the surveys are to track both health plan and provider experience in moving towards the state's goal of paying for value, and to identify explanatory factors, such as enablers and barriers, that may promote or impede desired progress. HCA is responsible for performing analysis of data collected from provider survey respondents. Individual organization responses are not shared publicly. The survey instruments can be found on HCA's Paying for Value webpage.[29]

In particular, for Medicaid Transformation to be successful, an in-depth understanding of the provider perspective is critical for the work undertaken by ACHs. Provider feedback informed transformation project plan design in the planning stage, and can inform transformation activities throughout the implementation and scale/sustain stages. In their role as convener, ACHs are in a position to support statewide assessment of provider experience in moving to VBP arrangements by encouraging and incentivizing completion of the provider survey among their partnering providers.

### Results

Over 90 unique provider entities responded to the 2018 VBP provider survey, compared to 80 provider respondents in 2017. This is in large part due to the collaborative outreach efforts of statewide associations and ACHs. Results are publicly available in aggregate form on HCA's Paying for Value webpage.[30]

## Next Steps

### Annual update

HCA will update this document on an annual basis. Upcoming editions will include more information on progress made towards achieving state and Medicaid Transformation VBP adoption targets, as well as the state's role in assuring alignment with MACRA and other advanced alternative payment model updates.

## Additional resources

For more information on HCA's Roadmap activities and Paying for Value strategy, visit: www.hca.wa.gov/about-hca/healthier-washington/paying-value

For more information about Washington's Medicaid Transformation, visit:

[29] Link: https://www.hca.wa.gov/assets/provider-vbp-survey-template.xlsx
[30] Link: https://www.hca.wa.gov/about-hca/healthier-washington/paying-value

https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation.

To be notified of Medicaid Transformation developments, join the Healthier Washington listserv. Instructions are available at:
https://public.govdelivery.com/accounts/WAHCA/subscriber/new?topic_id=WAHCA_237%27%3E

Washington State Health Care Authority

# Attachment A: HCP-LAN APM Framework & HCA's VBP Standard

*Figure 6. HCP-LAN APM Framework for Value-based Purchasing or Alternative Payment Models*

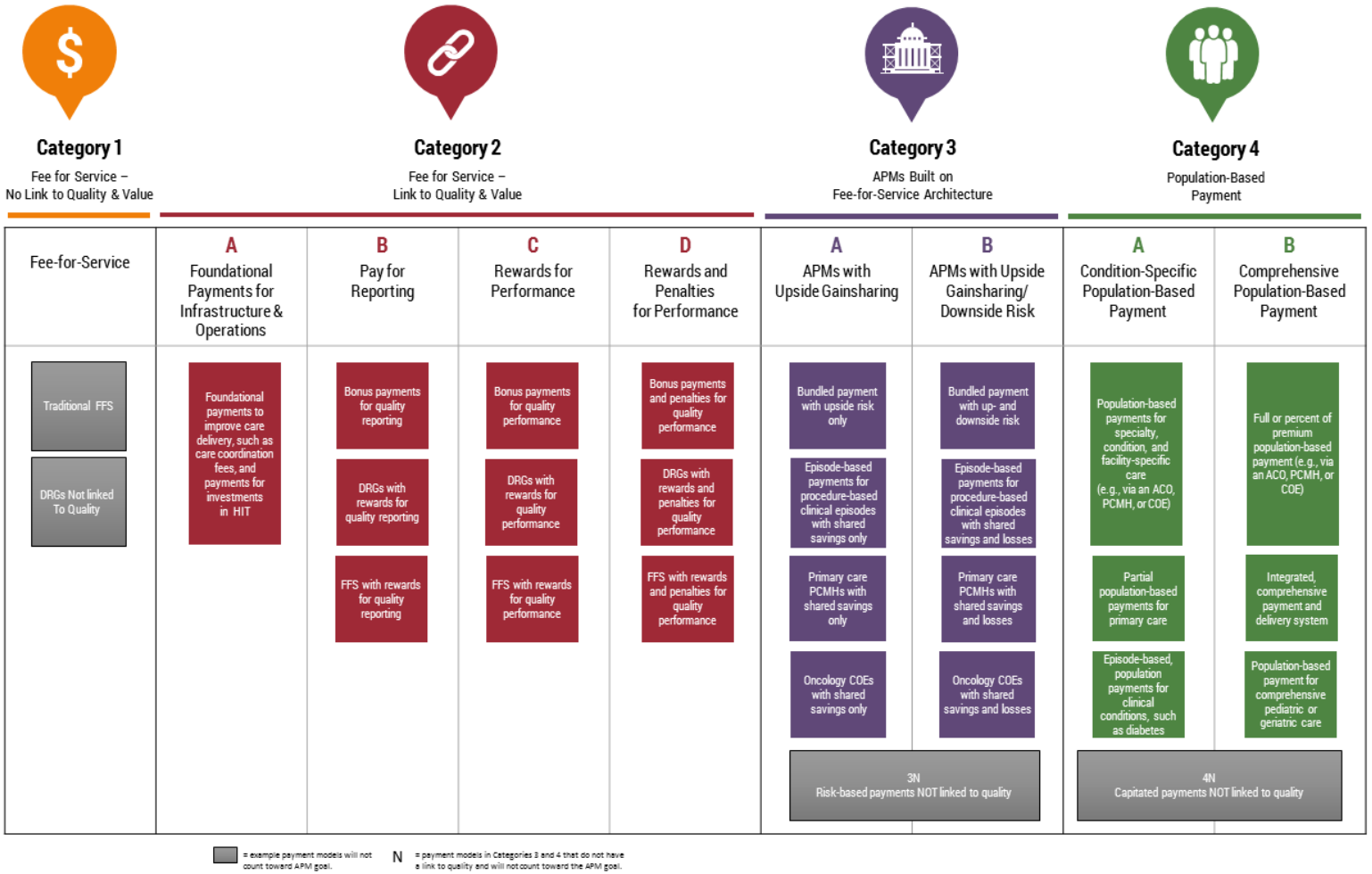


*Figure 7. Washington State's Value-based Purchasing Standard*