Value-based Purchasing (VBP) Roadmap Apple Health Appendix

2022 update

Table of contents

Purpose

The Apple Health Appendix reflects specific initiatives and changes pertaining to the Medicaid (Apple Health) program, in alignment with the Health Care Authority's (HCA's) VBP Roadmap.[1] In Washington State, Apple Health is the name for Medicaid. When referencing Washington's Medicaid program in this document, it will be referred to as Apple Health.

This document describes how Apple Health is changing, with the support of the Medicaid Transformation Project (MTP), the targets for VBP attainment, and the related incentives under the Delivery System Reform Incentive Payment (DSRIP) program. (The DSRIP program is for managed care organizations (MCOs) and Accountable Communities of Health (ACHs).

This document addresses the following topics:

- Identified VBP targets and approach for measuring, categorizing, and validating progress toward regional ACH and statewide MCO attainment of VBP goals.
- Alternative payment models (APMs) deployed between MCOs and health care providers to reward performance consistent with DSRIP objectives and measures.
- Use of DSRIP measures and objectives by HCA in its contracting strategy approach for managed care plans.
- Measurement of MCOs based on utilization and quality that is consistent with DSRIP objectives and measures.
- Inclusion of DSRIP objectives and measures reporting in MCO contract amendments.
- Evolution toward further alignment with the Medicare and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) and other advanced APMs.
- Approaches that MCOs and HCA will use with providers to encourage practices consistent with DSRIP objectives, measures, and VBP targets.

In accordance with the special terms and conditions (STCs) of Washington's Section 1115 Medicaid demonstration waiver (called MTP), HCA will update the Apple Health Appendix annually to capture best practices and incorporate lessons learned into HCA's overall vision for delivery system reform. The appendix is a living document throughout the duration of MTP. It is subject to change and adjustment to ensure that Washington State can achieve its VBP goals.

[1] Learn more about HCA's roadmap activities and paying for health and value strategy on the HCA website. If you would like a copy of the first edition of HCA's VBP Roadmap, please contact Kahlie Dufresne.

Introduction

Apple Health and VBP reform

To reach the goals defined in the VBP Roadmap (different than the Apple Health Appendix), Apple Health must play a leading role. One main goal for HCA is to drive and sustain delivery system transformation by shifting 90 percent of state-financed health care into value-based arrangements by the end of 2021.

On January 9, 2017, Washington State and the Centers for Medicare & Medicaid Services (CMS) reached agreement on a groundbreaking, five-year (extended one year due to COVID-19 impacts) project that allows the state to invest in comprehensive Medicaid delivery and payment reform efforts through DSRIP.

VBP strategies are foundational to MTP and serve as a vehicle for delivery system reform activities. HCA's commitment to advancing VBP strategies extends beyond MTP. This document covers efforts to increase adoption of VBP models statewide, along with those required under MTP's STCs.

As Washington continues to transition the health care purchasing strategy for Apple Health, HCA recognizes that a comprehensive and successful transformation requires a multi-layered approach that addresses the needs of MCOs, individual providers, and Medicaid beneficiaries. Initiatives under MTP, including community led delivery system reform strategies, play a crucial role in promoting overall system transformation.

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

HCA strives to align its efforts with the perspectives of MCOs and providers. These partners are integral to implementing new purchasing methodologies. As HCA implements VBP strategies, Medicare is making significant strides in implementing similar VBP reforms. Likewise, HCA—through the Public Employees Benefits Board (PUBB) and School Employees Benefits Board (SEBB) and multiple commercial payers in the state—is building VBP into its contracting strategies.

Providers must frequently navigate all these systems, which presents significant opportunities to align VBP methodologies across payer markets. This requires that HCA leverage purchasing power through Apple Health, PEBB, and SEBB to ensure that system reforms support and reinforce each other without leading to unnecessary burden for providers. Aligning the transition to VBP with other payers, where feasible, simplifies implementation for providers and allows them to achieve the greatest impact for their clinicians and patients.

The primary tool for multi-payer alignment is the use of the Refreshed HCP-LAN APM Framework[2] across all of HCA's books of businesses. These categories form the framework for the implementation of VBP in Washington by defining payment models subject to incentives and penalties, aligned with HCA's delivery system transformation goals. This framework recognizes a variety of approaches that can advance value-based care and provide flexibility to providers to participate in value-based payment models. The framework also addresses the circumstances of the services providers give and the communities they serve.

By adopting a national framework, Washington ensures that providers do not face conflicting guidance on how to classify payment models. This uniformity with national standards will enhance provider engagement and reduce administrative burden for providers learning to operate under VBP methodologies.

Advancing Washington State's Apple Health VBP goals

Key levers and strategies that drive and support VBP adoption among Apple Health providers include:

- Apple Health MCO contract requirements

[2] Learn more about the HCP-LAN APM Framework refresh.

- MTP and the DSRIP program
- The state's role as a convener
- VBP strategies for rural communities

A central component of implementing VBP is incentivizing MCOs to adopt VBP with network providers through their contract with HCA. One way to do this is an MCO withhold, where HCA withholds a portion of the MCO's monthly premium. MCOs may earn the withheld funds by achieving defined targets for quality, VBP adoption, and provider incentive payments.

The shift from fee-for-service (FFS) to VBP also requires delivery system changes. Time-limited DSRIP funds available through MTP allow providers to make these changes through investment in the delivery system transformation process and build provider capacity and infrastructure to succeed in VBP arrangements.

In turn, VBP adoption can reinforce and sustain DSRIP-funded delivery system transformation investments. This occurs through longer-term payer, provider, member, and community partnerships, as well as investments in population health management capabilities. The goal is a transformed system that improves the health and well-being of Washington communities.

HCA is also pursuing targeted strategies for specific provider entities and settings. For example, 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 to select quality metrics and are held accountable for performance on these measures.

Rural transformation efforts

On September 10, 2021, CMS announced that Washington State was one of four state awardees for the Community Health Access and Rural Transformation (CHART) Model grant.[3] HCA is the lead agency for the CHART Model, which tests whether an aligned all-payer capitated APM and a community designed transformation plan will improve access to whole-person care, decrease population health disparities, and reduce costs. HCA is in the pre-implementation stage of this model in the North Central region of Washington State, which includes Chelan, Douglas, Grant, and Okanogan counties.

Under the CHART Model, HCA will partner with potential Participant Hospitals (PHs), the North Central Accountable Community of Health and other community and Tribal leaders, payers, and the CHART Advisory Council to build a Community Transformation Plan (CTP) that meets North Central community's needs. The CTP features evidence-informed strategies to improve access to care, equity, quality of care, and health outcomes for all North Central residents.

The COVID-19 pandemic further underscores the need for more predictably financing of services that prioritize value and population health. This model will support appropriate care, meet community needs, and support rural providers though the health system transformation process. Focus areas in the seven-year grant include:

- Redesigning rural health system financing
- Enhancing population health management
- Addressing the rural health care workforce
- Leveraging digital health, telehealth, and secure information exchange

By changing 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 strategies such as CHART and others like it, MCOs and providers are supported and rewarded for advancing VBP during MTP and beyond.

MTP - statewide accountability

The STCs outlines the requirements for Washington State pertaining to VBP withhold amounts based on statewide advancement of VBP adoption and quality metric goals.

---

[3] Learn more about the CHART Model on the CMS website.

- **What this means:** if Washington State does not achieve the targets within the statewide accountability framework, the maximum available DSRIP funds will not be earned. The amount at risk is five percent in demonstration year (DY) 3, ten percent for DY4, and increases to 20 percent in DY5 and DY6.
    - Statewide performance across the 10 quality measures determines 80 percent of the funding "at risk."
    - Attainment of statewide VBP targets determines 20 percent of the funding "at risk."

MCO contract requirements: VBP withhold

A primary way 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 many of the state's Medicaid beneficiaries. According to HCA's contractual arrangement, each MCO must negotiate VBP arrangements with network providers. To ensure accountability, HCA withholds a percentage of each MCO's PMPM premium. MCOs may earn back the withheld funds by demonstrating quality improvement and implementing VBP arrangements with providers.

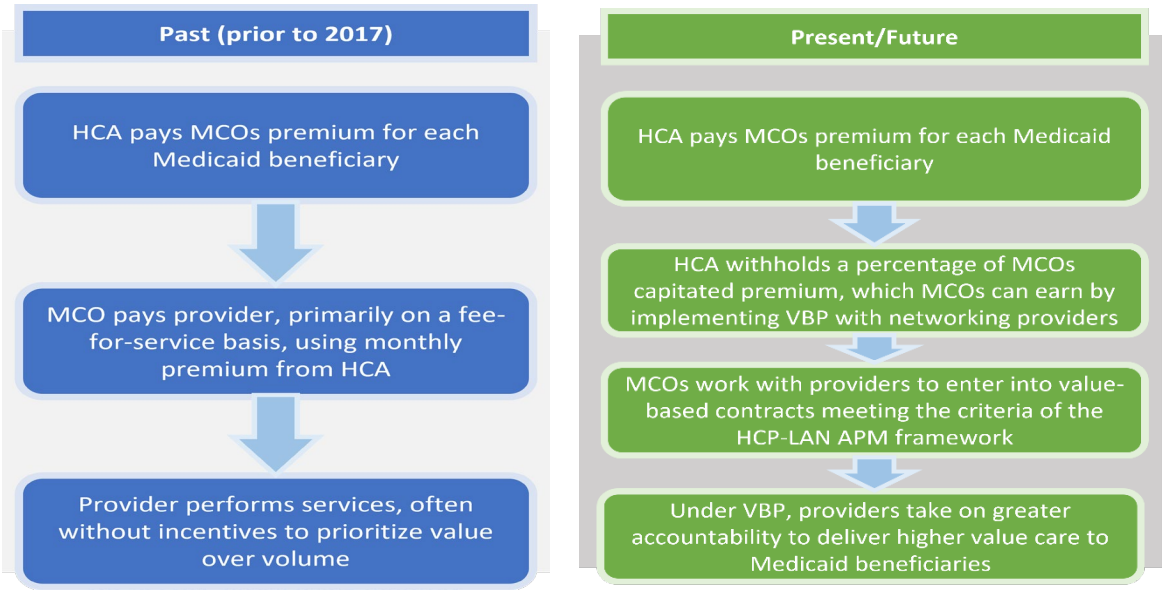
The structure of the MCO withhold reinforces the quality emphasized by CMS and MTP. It incentivizes the adoption of VBP methodologies between the MCOs and providers, with a focus on regional VBP adoption and provider accountability, and an additional emphasis on quality improvement. By incentivizing VBP in the MCO contracts through the withhold program, along with the other efforts described in this document, HCA expects VBP adoption to expand and continue well beyond MTP.

Consistent with federal requirements defined under 42 CFR 438.6(b), HCA ensures that through the VBP withhold, MCO performance is reasonably achievable. This results in actuarially sound MCO rates so that rates appropriately cover all reasonable and expected costs for each MCO. HCA's contracted actuaries include confirmation of the soundness of the rates in the rate certification provided to CMS.

MCO contract withhold framework

Under the withhold, a percentage of each MCOs' monthly PMPM premium is withheld, pending achievement of certain targets.

Figure 1: HCA and MCO contracts: past, present, future



The total percentage withhold is established each year (table below). The amount withheld may be earned back in three ways, each of which seeks to advance VBP:

- **VBP adoption (10.0 percent):** the VBP portion of the withhold focuses on the percent of an MCO's total payments to providers within a recognized VBP arrangement. Qualifying VBP arrangements must meet the definition of Category 2C or higher within the HCP-LAN categorization.
    - *This metric is weighted at 12.5 percent in the Integrated Foster Care (IFC) contract.*

- **Advanced VBP adoption (5.0 percent):** the advanced VBP portion of the withhold focuses on the percent of an MCO's total payments to providers within a recognized VBP arrangement that includes downside risk. Qualifying VBP arrangements must meet the definition of Category 3B or higher within the HCP-LAN categorization.
  - *This target is only included in the Integrated Managed Care (IMC) contract.*
- **Provider incentives (10.0 percent):** the provider incentives portion of the withhold focuses on the percent of payments to providers that is directly conditioned on meeting quality and financial metrics. See table 1 for more details.
  - *This metric is weighted at 12.5 percent in the IFC contract.*
- **Quality improvement (75 percent):** House Bill 1109 (2019) required changes to the quality improvement portion of the withhold. Beginning in 2020, the quality improvement portion of the withhold may be earned back by achieving top national Medicaid quartile scores or demonstrating statistically significant improvement, as determined by an external quality review organization.

Following receipt of quality performance metric results, on or before July 1 after the performance year, HCA will determine the percentage of the withhold earned back by the MCO, based on the MCO's achieving quality improvement targets. Up to 75 percent of the withhold may be earned by achieving quality improvement targets. The amount of the withhold earned back is based on the proportion of measures for which the MCO achieved either top national Medicaid quartile or statistically significant improvement.[4]

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

Table 1: MCO contract withhold targets: VBP adoption, provider incentives, and quality improvement

VBP adoption & Advanced VBP adoption		
Year	2C+ Target	3B+ Target[5]
2017	30%	N/A
2018	50%	N/A
2019	75%	N/A
2020	85%	N/A
2021	85%	N/A
2022	90%	N/A
2023	90%	15%

Provider incentives	
Year	Target
2017	.75%
2018	1%
2019	1%
2020	1.25%
2021	1.25%
2022	1.25%
2023	2.00%

Quality improvement	
Year	Target
2017	0.2
2018	0.2
2019	0.2
2020	100%
2021	100%
2022	100%
2023	100%

MCO VBP data submission requirements

To assess MCO performance against the MCO contract withhold components, MCOs are required to provide VBP performance data as outlined in Exhibit D: VBP of the MCO contracts. The reporting covers data pertaining to the adoption and intensity of value-based payment methodologies by the MCO. They submit data to an external third-party independent assessor (IA) to validate performance under the VBP exhibit. The data for each component of the withhold is as follows:

- **VBP adoption:** 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:** 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.

[4] The measures are under review for contract year 2021. They were not available at the time of this update (October 1).

[5] The 3B+ target is only for the IMC contracts, and now the IFC contract. Because of COVID-19, the percentage of total VBP adoption target in DY5 is downgraded from 90 percent to 85 percent as of August 14, 2020. This means the target will not change from 2020 to 2021.

- **Quality improvement:** the quality improvement portion of the withhold relies on provisions in the MCO contracts, related to the submission of clinical quality data.

Validation of MCO VBP data

This IA is responsible for validating data submitted by the MCOs for the VBP adoption and provider incentives portions of the withhold. For 2022, measuring calendar 2021 VBP adoption, MCOs were required to submit to the IA:

- **VBP performance data:** MCOs complete a template provided by HCA with VBP performance data relating to the VBP adoption and provider incentives.
- **Supplemental packet:** MCOs provide documentary support for a sample of 45 providers identified by the IA. The MCO identifies the categorization of each provider contract according to the HCP-LAN Framework, with supporting documentation from the provider contract to illustrate the categorization and qualifying incentives.

The table on the next page is an example of how MCOs report their payments to providers by ACH region and APM category.

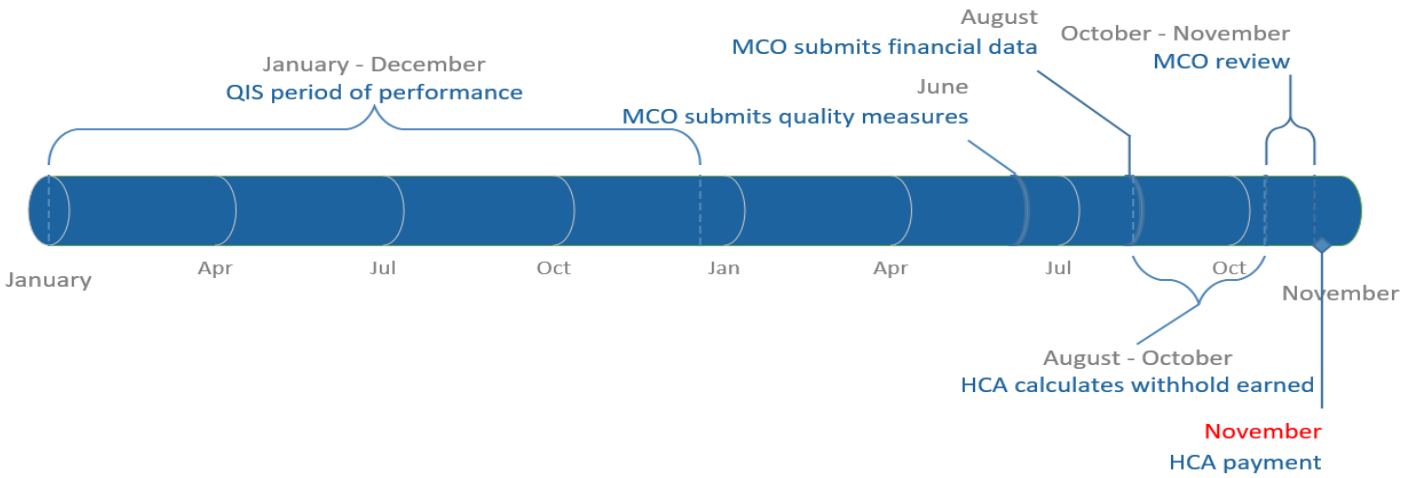
Table 2: MCO VBP performance data template

Medicaid total assessed payments by APM category													
Category			Region: Accountable Communities of Health										
APM category	APM Sub-category	Strategy	Better Health Together	Cascade Pacific Alliance	Greater Health Now	HealthierHere	North Central	North Sound	Olympic	Elevate Health	SWACH	Out-of-State	All
1 FFS - no link to quality	1	Fee-for-service											
2 FFS - link to quality	2A	Foundational payments for infrastructure & operations											
	2B	Pay-for-reporting											
	2C	Rewards for performance											
3 APMs built on FFS architecture	3A	APMs with upside gainsharing											
	3B	APMs with upside gainsharing and downside risk											
	3N	Risk-based payments - no link to quality											
4 Population-based payment	4A	Condition-specific, population-based payment											
	4B	Comprehensive population-based payment											
	4C	Integrated finance & delivery systems											
	4N	Capitated payments - no link to quality											
Total annual payments													

Timeline

To allow time for MCOs to gather and report the required data, the assessment of performance occurs from August through November of the year after performance year. The two-year performance and review period continues on a rolling basis as shown, so the following performance year begins while HCA reviews the data for the prior performance year.

Figure 3: timeline for MCO VBP data submission, validation, and payment



For example, MCOs will report on 2022 data in August 2023. The validation process is conducted, with the process completed and payment of the percentage of the withhold earned to be scheduled within HCA's payment systems by November 30, 2023.

Supporting VBP advancement through MTP

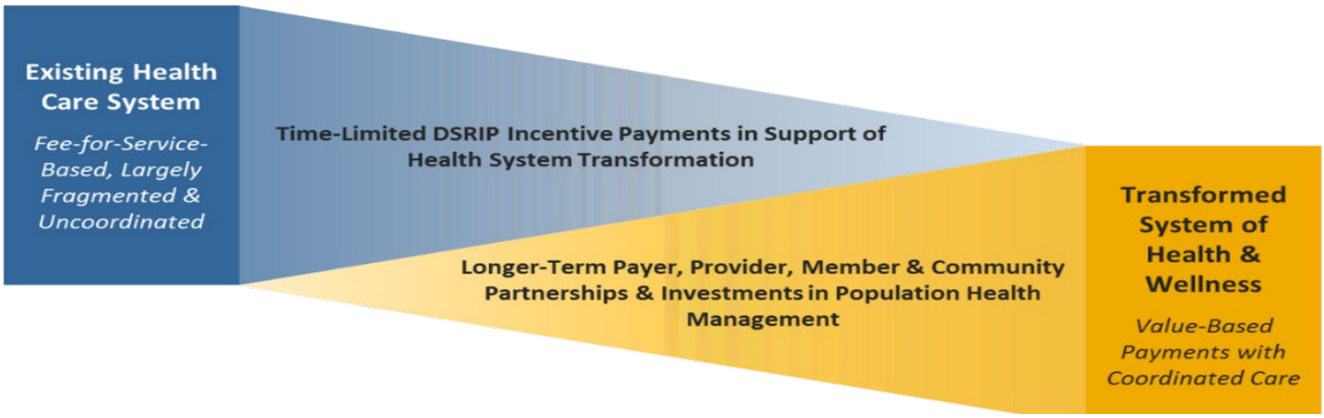
VBP advancement overview

Under MTP, 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 MTP.

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. VBP adoption targets under MTP are based on the percentage of payments to providers that fall into Categories 2C of the HCP-LAN Framework, starting in DY1, with progressive targets through DY6.

Ultimately, DSRIP funds allow providers to make delivery system changes required for the implementation of VBP strategies, while VBP contracts can help sustain these changes by financially rewarding their outcomes.

Figure 4: DSRIP program and VBP



Advancing the shift toward VBP arrangements in place of traditional FFS models is a primary component of DSRIP accountability during MTP. This is highlighted below for the following entities:

- Washington is accountable for advancing quality outcomes and VBP adoption goals. In DY3-5, a portion of DSRIP incentives are at risk, depending on statewide performance in the following:
    - Demonstration of physical and behavioral health integration in managed care.
    - Improvement and attainment of quality targets across a set of quality metrics.
    - Improvement and attainment of defined statewide VBP targets.
- 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 can earn incentives for VBP adoption through DSRIP, like their contractual expectations.
- 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.

For more details about the DSRIP accountability framework, see the DSRIP Measurement Guide.

Statewide accountability for VBP advancement

Beginning in 2019 (DY3), a portion of statewide DSRIP funding is at risk,[6] 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 2022 (DY6), 90 percent of total Medicaid MCO payments to providers must be made through designated VBP arrangements for the state to secure maximum available DSRIP incentives.

Definition of achievement: statewide VBP adoption targets are consistent with HCP-LAN Category 2C or higher VBP arrangements. VBP adoption 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 using the improvement scoring methodology as presented in equation 2.

The remainder of this section describes how a portion of the withhold is earned and calculated when the VBP adoption target is not met.

Table 3: annual statewide VBP adoption target and scoring weights

	VBP adoption target (HCP-LAN 2C or higher)	Scoring weights	
		Improvement	Achievement
DY3	75%	50%	50%
DY4	85%	45%	55%
DY5	90[7]%	75[8]%	25%
DY6	90%	75%	25%

[6] Because of COVID 19, statewide accountability for DY4 has been waived. This eliminated at-risk loss of dollars from 10 percent to zero (0), effective June 8, 2020.
[7] HCA submitted a revision to CMS to maintain the target score of 85 percent from DY4 through DY5 and DY6. This is pending approval.
[8] In February 2022, CMS approved a scoring weight update to better incentivize improvement toward VBP goals. This approval also included an updated methodology for improvement score calculation as outlined in Equation 2 on page 11.

Table 4: statewide accountability VBP adoption - measurement years

DY	Performance year	Baseline year
3	2019	2018
4	Waived	Waived
5	2021	2020
6	2022	2021

Data source: according to their contract requirements with HCA, MCOs must attest to their VBP adoption levels annually by reporting total payments in each HCP-LAN category. The IA will calculate and validate statewide performance according to this annual data source. The statewide accountability VBP baseline year is the year prior to the performance year. This timeline aligns with MCO VBP adoption assessment according to 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, premium tax, Safety Net Assessment Fund, provider access payment, or trauma funding.[9]

Calculating the level of VBP adoption: VBP adoption is calculated based on the share of MCO payments to providers made through VBP arrangements in HCP-LAN Category 2C or higher.[10]

Equation 1: level of VBP adoption (percentage)

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

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 meets the VBP adoption target for the performance year, then the improvement score is 100 percent. If the state does not meet 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). The weighted improvement score is measured by rewarding improvement over the baseline up to 100 percent of the improvement weight, which for DY4 would equal a maximum of 45 percent of the at-risk dollars as presented in Table 3.

Equation 2: VBP improvement score

$$\text{Improvement Score} = \frac{\text{PY VBP adoption actual} - \text{Baseline}}{\text{PY VBP adoption target} - \text{Baseline}}$$

Where the calculation of the **improvement score** produces a negative percentage, the improvement score is zero (0) percent. The improvement score is capped at 100 percent.

The overall VBP performance score is calculated by first finding the VBP adoption target score and the VBP adoption actual score for the performance period, and then multiplying each score by the relevant scoring weights defined in Table 3.

[9] For calendar year (CY) 2017, HCA included payments for pharmacy service in the numerator and denominator when calculating the level of VBP adoption. In 2018, pharmacy was removed from the MCO PMPM, so as of 2018, all such payments are excluded when calculating the level of VBP adoption.

[10] Payments for behavioral health services are included when paid by an MCO, including integrated MCOs. Payments for behavioral health services paid by behavioral health organizations prior to integration are not included.

The example below illustrates the portion of funds associated with VBP adoption earned by the state with an overall performance score of 84 percent. This performance would earn the state 39 percent of the 20 percent of overall dollars at-risk for statewide performance.

Table 5: example calculation of statewide accountability VBP adoption

DY4 VBP adoption assessment (DY5 VBP target = 90%)	Value/score	Calculation
DY4 performance	88%	
DY3 (baseline)	82%	
Adoption target	90%	
Improvement score	76%	Based on "equation 2" graphic above (0.88 – 0.82) / (0.90 - 0.82)
Overall VBP score	57%	(Achievement Score * Weight) + (Improvement Score * Weight) = (0 * 25%) + (76% * 75%) 0% + 57%

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

DSRIP incentives for MCO VBP achievement

Washington's MCOs are critical partners in delivery system reform efforts, particularly to ensure the state's success in meeting its VBP goals. As stated in the STCs, MCOs are expected to serve in a leadership or supportive capacity in every ACH. This ensures delivery system reform efforts are coordinated across all necessary sectors—those providing payment, delivering services, and providing critical, community-based supports.

In support of MTP, MCOs will demonstrate 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 VBP incentives (through the challenge pool) for achieving annual MCO VBP targets. 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 performance year.[11]

Table 6: annual DSRIP funding available for MCO DSRIP VBP incentives

DY1	DY2	DY3	DY4	DY5	DY6[12]
N/A	$8,000,000	$8,000,000	$8,000,000	$8,000,000	$0

MCO 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 criteria and P4P targets. The percent of available incentives split between P4R and P4P is defined by the STCs.

[11] 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.

[12] In DY6 the state will no longer provide regional ACH incentives and statewide MCO incentives. This change was made due to the limited total funding available in DY6 and the significant advancement made DY1-DY5 surrounding VBP. Learn more about this update.

Table 7: annual percent of potential earnable MCO DSRIP VBP incentives, by P4R and P4P

MCO DSRIP VBP incentives	DY2	DY3	DY4	DY5	DY6
P4R	50%	25%	0%	0%	N/A%
P4P	50%	75%	100%	100%	N/A%

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 will not be calculated separately for each contract. Instead, the incentives are calculated as a single payment, based on data aggregated from each of MCO's applicable Apple Health contract(s).

Assessment of progress and performance

The performance year for determining whether MCOs completed milestones in support of advancing VBP and achieved VBP targets is aligned with a given DY. The assessment period will occur during fall (October–December), following the performance year.

P4R

MCOs are eligible to earn MCO VBP incentives for P4R in DY2 and DY3 only (no VBP incentives were available in DY1). 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 is specified in contract between HCA and the MCO.

P4P

For DY2-5, the P4P portion of MCO VBP incentives are available for successful achievement of and improvement toward specified VBP adoption targets. Each MCO is measured based on MCO-provided data (validated by the IA) and must meet performance expectations for the given year.

Performance targets, as well as improvement and achievement weighting for MCO VCP score determination, are outlined below.

Table 8: MCO VBP adoption targets

Year	Performance targets	
	HCP-LAN 2C or higher performance target	**HCP-LAN 3A-4B performance subtarget**
DY1	30%	N/A
DY2	50%	10%
DY3	75%	20%
DY4	85%	30%
DY5	90%[13]	50%
DY6	N/A	N/A

MCO improvement and achievement are weighted differently throughout MTP. 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.

[13] HCA submitted a revision to CMS to maintain the target score of 85 percent from DY4 through DY5 and DY6. This is pending approval.

Table 9: MCO VBP P4P score weights

Year	Calculation weight		
	Achievement score	Achievement subset score	Improvement score
DY1	40%	0%	60%
DY2	35%	5%	60%
DY3	45%	5%	50%
DY4	20%	5%	75%
DY5[14]	20%	5%	75%
DY6	N/A	N/A	N/A

Based on its performance, the MCO is eligible to earn all or part of the available MCO VBP incentives. HCA and the IA will use data, which the MCOs are contractually required to submit, to identify the following:

- **Achievement score:** an achievement score for each MCO is calculated annually. If the MCO has reached or exceeded the HCP-LAN 2C or higher performance target for the performance year, then the achievement score will be 100 percent. If not, the achievement score is zero (0) percent.
- **Achievement subset score:** in DY2-5, HCA will assess whether the MCO has met the annual achievement subset criteria. In DY3, the achievement subset criteria requires that the MCOs have at least one VBP contract as a MACRA APM. In DY4 and 5, the achievement subset criteria requires that the MCOs have 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
    - Payments tied to provider improvement or attainment on metrics from the Washington Statewide Common Measure Set using HCA quality improvement model or similar tool
    - Care transformation requirements, including state-level best practices
    - Use of certified electronic health record (EHR) technology in support of VBP methods
- **Improvement score:** an improvement score for each MCO is calculated annually. If the MCO has met the performance target for the DY, the improvement score is 100 percent. If the MCO has not met the performance target for the performance year, the improvement score is calculated as the percent change from the baseline year to the performance year. See Table 5 for more information.
  The improvement score is capped at 100 percent. Where the prior calculation produces a negative percentage, the improvement score is zero (0) percent.
- **Eligibility for MCO VBP incentives (performance subtarget):** MCOs must also meet a minimum threshold of VBP adoption in Category 3A and above (performance subtarget) to earn any MCO VBP incentives in DY4 and 5. The performance subtarget is also applied as a threshold for distribution of remaining funds only in DY2 and 3. This is described in the secondary process below.

Table 10: annual HCP-LAN 3A-4B subtarget threshold for MCO DSRIP VBP incentives

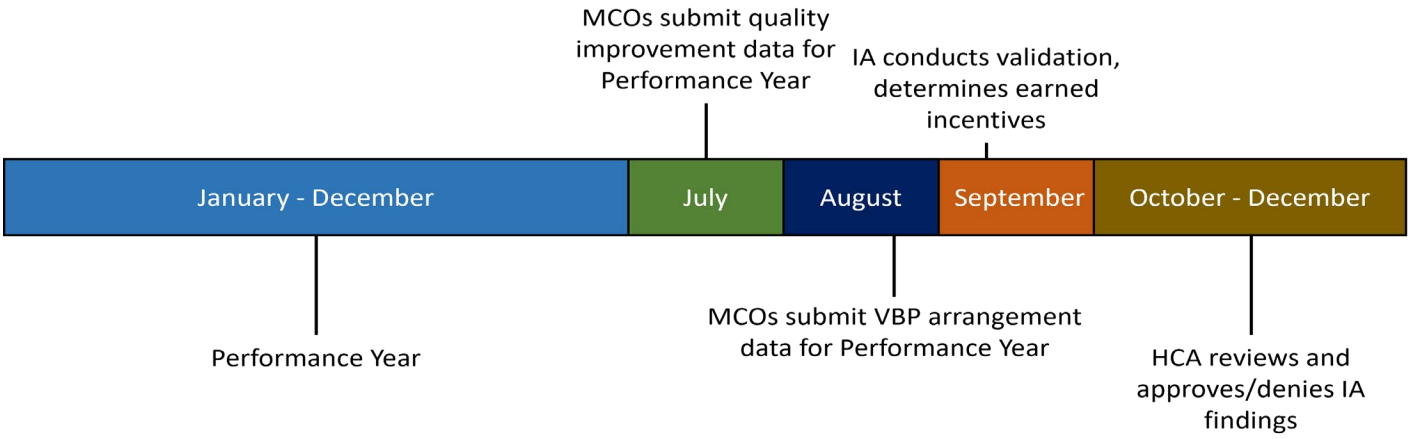
	DY1	DY2	DY3	DY4	DY5
HCP-LAN 3A–4B performance subtarget	N/A	Eligibility: remaining funds Target= 10%	Eligibility: remaining funds Target= 20%	Eligibility: all funds Target= 30%	Eligibility: all funds Target= 50%

[14] CMS approved on February 2022, of a scoring weight update to provide better incentive for improvement toward VBP contract goals for DY 4,5 and 6.

Incentive payment determination

The IA is responsible for determining whether reporting and performance expectations have been met.

Figure 5: assessment timeline for MCO VBP incentives



Distribution of remaining incentives

If there are any remaining MCO VBP incentives for a given performance year after initial allocation, 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

HCP-LAN 3A-4B performance subtarget	Relative quality improvement performance
The MCO must meet the HCP-LAN 3A-4C performance subtarget for the performance year. • If the MCO has not met the annual performance subtarget, they will not be eligible for any of the remaining incentives. • If the MCO has met the annual performance subtarget, they are eligible for a percentage of remaining incentives.	If the MCO meets the HCP-LAN 3A-4C **performance subtarget**, the MCO will receive a percentage of remaining MCO VBP incentives. This percentage is determined by the MCO's relative performance on the set of quality measures, as defined in MCO contracts with HCA. The state and IA will use the quality metric results to determine the amount of remaining incentives earned for eligible MCOs.

Important: MCOs must meet the HCP-LAN 3A-4C **performance subtarget** during DY4 and 5 to be eligible for any MCO VBP incentives, as part of the primary VBP adoption assessment. This is in addition to any remaining incentives, as part of the secondary process.

DSRIP incentives for ACH VBP achievement

Provider readiness for VBP models and contracts are 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. ACHs 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 are driven by ACHs and coalitions of partnering providers as they select and implement a set of strategies from the MTP 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 are eligible to receive incentive payments by contributing to the completion of project milestones and regional improvement on quality and outcome measures. The incentives 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 improve whole-person health of their communities. 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 can effectively measure and influence the quality and cost of care provided. The presence and maturity of many underlying capabilities influence whether providers succeed under their VBP arrangements. ACHs have made efforts to understand the current state of VBP capabilities among their provider partners, and how 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

ACH can earn VBP incentives for P4R and P4P. ACH VBP incentives are funded through the reinvestment pool. Potential earnable ACH VBP incentives are distributed evenly across all nine ACHs. However, ACHs will earn incentives based on VBP performance outcomes. All unearned incentives will be redirected to the high-performance pool. Annual DSRIP incentives are based on best available information, and subject to change.

Table 12: annual DSRIP funding available for ACH VBP incentives

DY1	DY2	DY3	DY4	DY5	DY6[15]
N/A	$3,600,000	$4,500,000	$5,400,000	$6,300,000	$0

Note: both ACH VBP and integration incentives are funded through the reinvestment pool. Earned incentives for ACHs that achieve key integration milestones may affect the amount of ACH VBP incentives available for a given year.

ACHs are eligible to earn VBP incentives through reported progress on VBP milestones (P4R), and improvement toward and achievement of VBP adoption targets (P4P) in their regions. With VBP adoption, ACHs are rewarded on reported progress in the early years and rewarded more on full attainment of targets in later years. The table below indicates the percent of VBP incentives available to ACHs for P4R and P4P throughout the transformation.

Table 13: annual percent of potential earnable ACH VBP incentives, by P4R and P4P

ACH VBP incentives	DY1	DY2	DY3	DY4	DY5	DY6
Pay-for-reporting (P4R)	100%	75%	50%	25%	0%	N/A
Pay-for-performance (P4P)	0%	25%	50%	75%	100%	N/A

Assessment of progress and performance

P4R

ACHs report on VBP P4R milestones as part of their semi-annual reports. ACH 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

[15] In DY6 the state will no longer provide regional ACH incentives and statewide MCO incentives. This change was made due to the limited total funding available in DY6 and the significant advancement made DY1-DY5 surrounding VBP. This update can be found in the planning protocol.

transformation progresses. Note that P4R milestones phase out as accountability transitions to demonstrating performance against VBP targets in the later years.

Table 14: ACH VBP P4R milestones

Milestone	Reflective of activities that occurred during:
• N/A (none; no DSRIP funding allocated to VBP incentives for DY1).	DY1 (2017)
• Inform providers of VBP readiness tools to assist their move toward value-based care. • Connect providers to training and/or technical assistance (TA) offered through HCA, the Healthier Washington Collaboration Portal, MCOs, and/or the ACH. • Support assessments of regional VBP attainment by encouraging/incentivizing completion of the state provider survey. • Support providers to develop strategies to move toward value-based care.	DY2 (2018)
• Identification and support of providers struggling to implement practice transformation and move toward value-based care. • Support providers to implement strategies to move toward value-based care. • Continued support of regional VBP attainment assessments by encouraging/incentivizing completion of the state provider survey.	DY3 (2019)
• Continued support of regional VBP attainment assessments by encouraging/incentivizing completion of the state provider survey. • Continued identification and support of providers struggling to implement practice transformation and move toward value-based care.	DY4 (2020)
• N/A (all incentives reward performance; no incentives for reporting)	DY5 (2021)
• **N/A no incentives for performance or reporting**	DY6 (2022)

P4P

The IA calculates VBP adoption by ACH region each year for the prior measurement year. The calculation is based on data provided by MCOs. HCA and IA obtain the data used to calculate regional ACH VBP achievement from annual MCO reporting on VBP adoption, both by region and by HCP-LAN category.

The resulting data is validated by the IA and aggregated across all MCOs by region and HCP-LAN category. 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 directly involved in 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 15: ACH VBP adoption targets

Year	Performance targets	
	HCP-LAN 2C or higher adoption target	**HCP-LAN 3A-4B adoption subtarget**
DY1	30%	N/A
DY2	50%	10%
DY3	75%	20%
DY4	85%	30%
DY5	90%	50%
DY6	N/A	N/A

Achievement of annual ACH VBP P4P outcomes will consider full achievement of VBP adoption targets and improvement from prior year performance toward VBP adoption targets.

Table 16: ACH VBP P4P score weights

Year	Calculation weight		
	Achievement score	Achievement subset score	Improvement score
DY1	N/A	N/A	N/A
DY2	35%	5%	60%
DY3	45%	5%	50%
DY4[16]	20%	5%	75%
DY5	20%	5%	75%
DY6	N/A	N/A	N/A

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

- Achievement of ACH VBP adoption target (HCP-LAN 2C or higher performance target)
- Achievement of defined subset criteria
- Improvement from prior year VBP adoption
- Minimum threshold for ACH VBP incentives (HCP-LAN 3A-4C performance subtarget)

Based on its performance, an ACH is eligible to earn all or part of the available incentives for ACH VBP P4P. HCA and IA will use data the MCOs are contractually required to identify the following:

- **Achievement score:** an achievement score for each ACH region is calculated annually. If the ACH region has reached or exceeded the HCP-LAN 2C-4C performance target for the performance year, the achievement score will be 100 percent. If not, the achievement score is zero (0) percent.
    - **Achievement subset score:** in DY2-5, HCA will assess whether the ACH region has met the annual achievement subset criteria. If the achievement subset criteria have been met, the achievement subset score will be 100 percent. If the achievement subset criteria have not been met, the achievement subset score will be zero (0) percent.
- **Improvement score:** an improvement score for each ACH region is calculated annually. If the ACH region has met the performance target for the DY, then the improvement score is 100 percent. 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.

  The improvement score is capped at 100 percent. Where the prior calculation produces a negative percentage, the improvement score is zero (0) percent. See Figure 5 for more information. ACHs must also meet a minimum threshold of VBP adoption in Category 3A and above (performance subtarget) to earn any ACH VBP incentives in DY4 and 5.

Table 17: annual HCP-LAN 3A-4B subtarget threshold for ACH VBP incentives

	DY1	DY2	DY3	DY4	DY5	DY6
HCP-LAN 3A – 4B Subtarget	N/A	None	None	30%	50%	N/A

Incentive payment determination

[16] CMS approved on February 2022, of a scoring weight update to provide better incentive for improvement toward VBP contract goals for DY 4,5 and 6.

P4R

The achievement of ACH VBP P4R milestones is assessed by the IA. Each VBP P4R milestone is associated with one (1.0) achievement value (AV). The percentage of VBP P4R funds earned for the year is equal to the percent of VBP 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 period for achieving P4R milestones is during the same DY.

Table 1: schedule of ACH VBP P4R milestone AVs

ACH VBP P4R milestones	DY2 Quarter (Q)1-Q4	DY3 Q1-Q4	DY4 Q1-Q4
Inform providers of VBP readiness tools to assist their move toward value-based care.	1.0	-	-
Connect providers to training and/or TA offered through HCA, the Healthier Washington Collaboration Portal, MCOs, and/or the ACH.	1.0	-	-
Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.	1.0	1.0	1.0
Support providers to develop strategies to move toward value-based care.	1.0	-	-
Identification and support of providers struggling to implement practice transformation and move toward value-based care.	-	1.0	-
Support providers to implement strategies to move toward value-based care.	-	1.0	-
Continued identification and support of providers struggling to implement practice transformation and move toward value-based care.	-	-	1.0
	4.0	**3.0**	**2.0**

To identify the earned VBP P4R incentives for each ACH, the average AV for all P4R milestones that apply in the year (the percent AV completion) is multiplied by the ACH VBP incentives associated with P4R in the measurement year. In the example below, an ACH that earns three out of four possible AVs for the reporting period would earn 75 percent of available ACH VBP incentives associated with P4R. Refer to the **DSRIP Measurement Guide** for details.

Table 19: example ACH VBP P4R AV calculation (for reporting period DY2)

ACH VBP P4R milestones for reporting period DY2 Q1–Q4	Earned AV	Possible AV
Inform providers of VBP readiness tools to assist their move toward value-based care.	0.0	1.00
Connect providers to training and/or TA offered through HCA, the Healthier Washington Collaboration Portal, MCOs, and/or the ACH.	1.0	1.00
Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.	1.0	1.00
Support providers to develop strategies to move toward value-based care.	1.0	1.00
Total achievement value (TAV)	**3.0**	4.0
Percentage achievement value (PAV)	(3.0 / 4.0) = 75%	100%

Earned incentives are distributed annually to ACHs, aligned with the timing of payment cycles for ACH project incentive payments.

P4P

The IA calculates the final ACH VBP P4P score by adding the weighted scores for improvement, performance target, and performance subset target achievement. The final score for 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. ACHs do not earn additional incentives for exceeding improvement or performance expectations. Examples of ACH VBP incentive calculations are available in the DSRIP Measurement Guide.

ACHs earn VBP P4P incentives on an annual basis. Earned incentives are distributed in alignment with earned project P4P and VBP P4R incentive payments. Because of the data compilation and validation process, there is an approximate 18-month lag between the end of the performance year and when ACH VBP P4P incentives are paid.

Distribution of remaining incentives

If a region does not meet progress (P4R) or performance (P4P) expectations, the ACH's unearned VBP incentives will be used to fund ACH high-performance incentives.

State role as connector

Recognizing the importance of alignment between VBP strategies and delivery system reform efforts, HCA continues to play a connector role between ACHs and MCOs. Priorities include preparing partners for VBP readiness and ensuring delivery system reform investments and efforts align with and advance contractual and payment strategies. HCA facilitates monthly sessions with MCOs and launched a work group that includes MCOs and ACHs. HCA's goal with this work group is to help promote information sharing and alignment surrounding contractual expectations, payment, and support being offered to partners.

ACH/HCA Learning Symposium

As part of the STCs, ACHs and HCA host an annual Learning Symposium, which encourages cross-collaboration and information sharing between HCA, ACHs, partners, and others. Like last year, ACHs played a larger role in developing and putting on the event. The event took place virtually on October 11–12, 2022, with sessions focused on:

- Social determinants of health
- COVID-19 impacts
- Tribal partnerships
- Youth-focused initiatives
- The future of ACHs
- Washington's MTP waiver renewal

The Learning Symposium supports advancement of MTP objectives with a focus on statewide collaboration.

Understanding the payer and provider experience

Understanding the payer and provider experience with VBP is crucial to monitor progress along the VBP continuum. Every year, HCA issues Paying for Value surveys to Washington State plans/payers and providers. Core objectives of the surveys are to:

- Track both health plan and provider experience in moving toward the state's goal of paying for health and value.
- Identify explanatory factors, such as enablers and barriers, which may promote or block desired progress.

HCA is responsible for performing analysis of data collected from provider survey respondents. Individual organization responses are not shared publicly. HCA summarizes a few key findings from the Paying for Value surveys in the VBP Roadmap. The surveys are available on HCA's Tracking success page. Results from the 2021 Paying for Value surveys will be available in the fall of 2021.

For MTP to be successful, an in-depth understanding of the provider perspective is necessary. Provider feedback informs 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 positioned 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.

Annual update

HCA updates this document on an annual basis. Upcoming editions will include more information on progress made toward achieving state and MTP VBP adoption targets, as well as the state's role in assuring alignment with MACRA and other advanced APM updates.

Resources

- Learn more about VBP, roadmap activities, and HCA's paying for health and value strategy on the HCA website.
- Learn more about Washington's MTP.
- Sign up to receive announcements about VBP or MTP.

Attachments

The next page shows Attachment A: the HCP-LAN APM Framework and HCA's VBP standard.

Attachment A: HCP-LAN APM Framework and HCA's VBP standard

Figure 6: refreshed HCP-LAN APM Framework for VBP or APMs

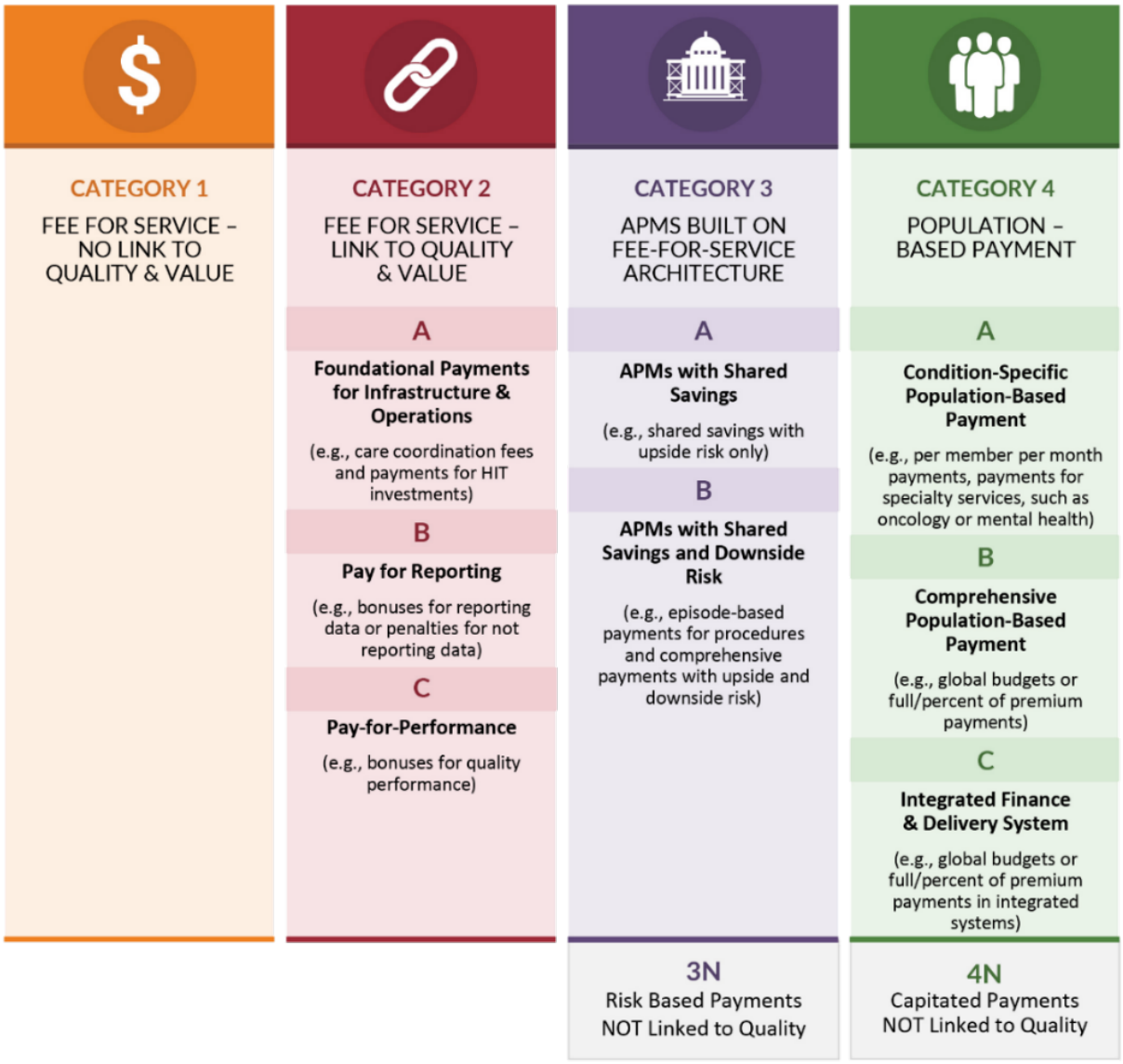


Figure 7: Washington State's VBP standard