HCA's Value-based Roadmap 2018-2021 & Beyond

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Introduction

HCA's ultimate goal is to achieve a healthier Washington – consistent with the Quadruple Aim – by containing costs while improving outcomes, patient and provider experience, and equity through innovative value-based purchasing (VBP) strategies. This is the third version of the Health Care Authority's (HCA) Value-based Roadmap (Roadmap)[1] since the original Roadmap's June 2016 publication.

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

Background

In 2016, the Centers for Medicare and Medicaid Services (CMS), the largest health care purchaser in the United States, led a national imperative to move away from traditional volume-based health care payments to payments based on value. [2] Medicare declared its own commitment to value and quality and announced its own purchasing goals. While CMS has altered its approach regarding mandated payment models, CMS remains committed to voluntary participation and has made substantial progress in meeting its goals.

Additionally, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 rewards providers through higher Medicare reimbursement rates for participation in advanced value-based payments (VBPs) or alternative payment models (APMs) beginning in 2019. To date, the federal government has signaled its continued commitment to APMs. It has announced new priorities, including strengthening patient engagement and reducing provider burdens, such as regulations.[3]

Like Medicare, HCA is transforming the way it purchases health care, transitioning from volume-based payment models. As directed by state legislation passed in 2014, and as a strategy under Healthier Washington, HCA has pledged that 90 percent of HCA provider payments under state-financed health care programs will be linked to quality and value by 2021. This encompasses Washington Apple Health (Medicaid) and the Employees and Retirees Benefits (ERB) programs (comprising the Public Employees Benefits Board [PEBB] and School Employees Benefits Board [SEBB] programs). HCA's goal is that Washington's annual health care cost growth will be less than the national health expenditure trend.

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

[3] For more information on CMS' communications, visit https://www.cms.gov/newsroom.

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

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

HCA's foundational principles

The Roadmap lays out how HCA is fundamentally changing the way that health care is delivered by implementing new payment models that encourage population-based care. This Roadmap braids major components of Healthier Washington (payment redesign model tests, the Statewide Common Measure Set, and Accountable Communities of Health [ACHs], for example), Medicaid Transformation, and the Dr. Robert Bree Collaborative care transformation recommendations and bundled payment models. HCA built the Roadmap upon the following foundational principles:

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

HCA's purchasing goals

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

As the largest health care purchaser in Washington State, HCA purchases care for more than 2 million Washingtonians through the Apple Health and the public employee benefits programs. Annually, HCA spends more than $12 billion between the two programs. This gives HCA the market power to drive transformation as a convener and innovator.

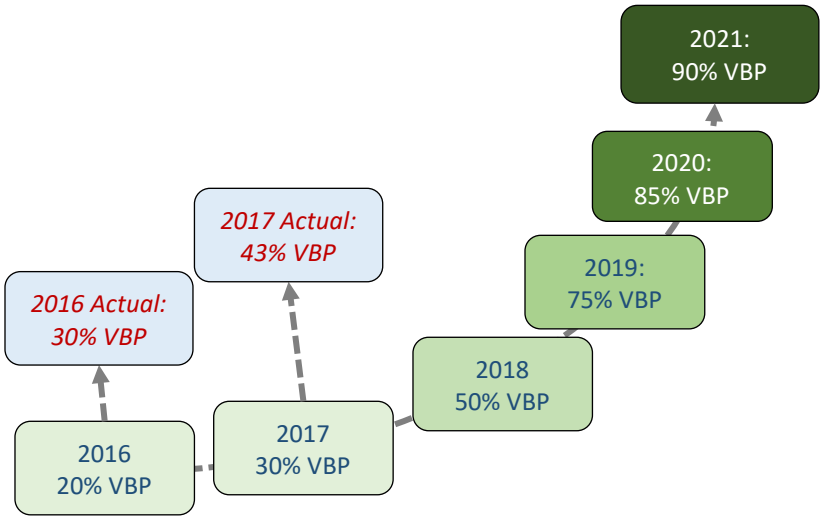
HCA's ultimate goal is to achieve a Healthier Washington – consistent with the Quadruple Aim – by containing costs while improving outcomes and both patient and provider experience

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

- All HCA programs implement VBP according to an **aligned purchasing philosophy.**

- **Accountable delivery system networks and plan partners** comprise most of HCA's purchasing business.
- HCA exercises **significant oversight and quality assurance** over its contracting partners and implements corrective action as necessary.
- Washington's **annual health care cost growth will be less than the national health expenditure trend**.

By 2021, HCA will tie 90 percent of payments made to providers for service delivery to quality and value and ensure shared accountability for each patient's well-being and total cost of care. This requires thoughtful, evidence-based, collaborative management of physical, behavioral, and social determinants of health needs. The graphic below shows HCA's interim purchasing goals and VBP milestones along the path to 90 percent adoption in 2021:



To guide this movement away from fee-for-service, HCA has adopted the framework created by CMS, via the Health Care Payment & Learning Action Network (HCP-LAN), to define payment arrangements, or APMs (see Chart 1, next page).

Chart 1: HCP-LAN APM Framework for Value-based Purchasing or Alternative Payment Models

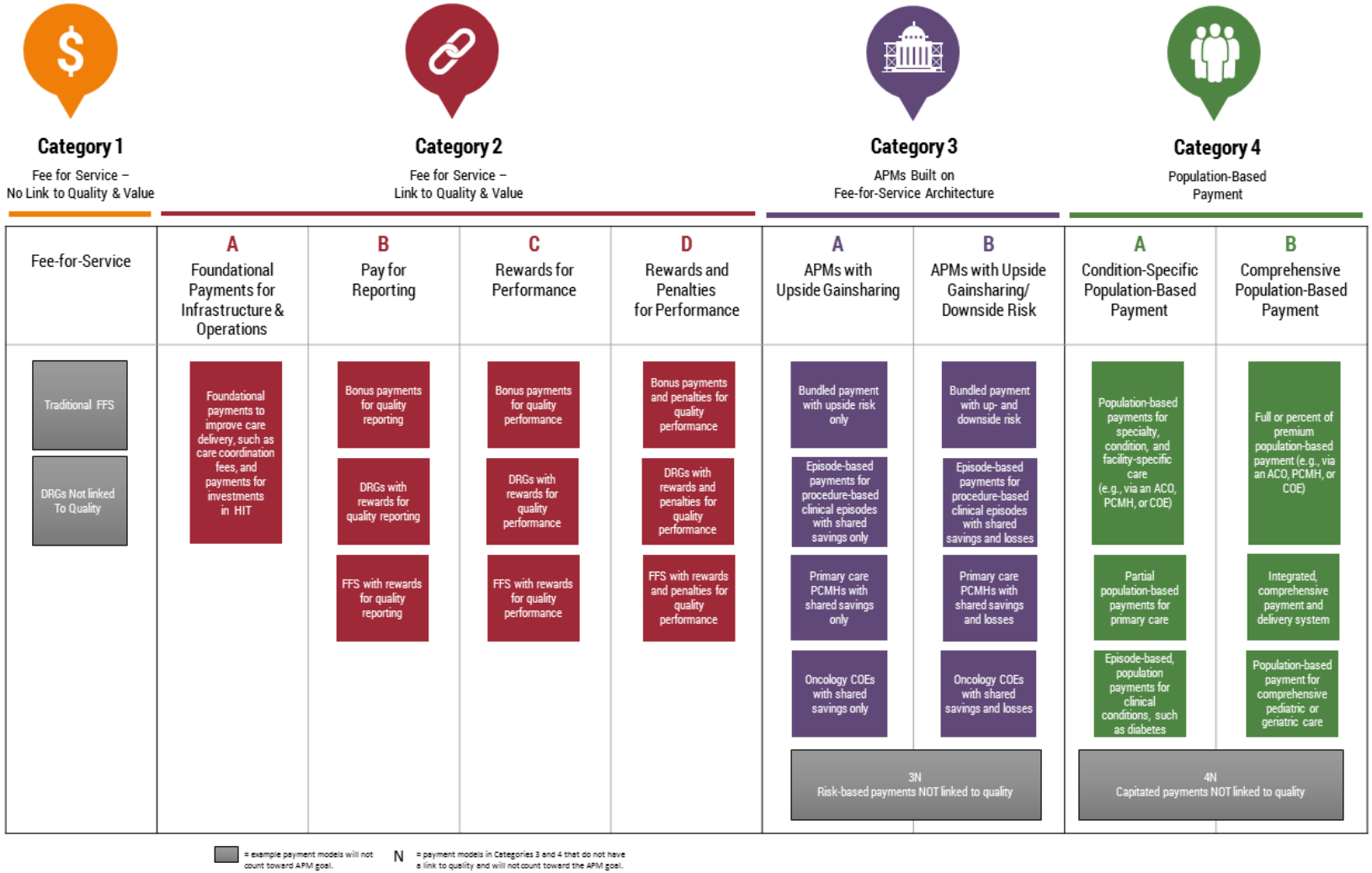
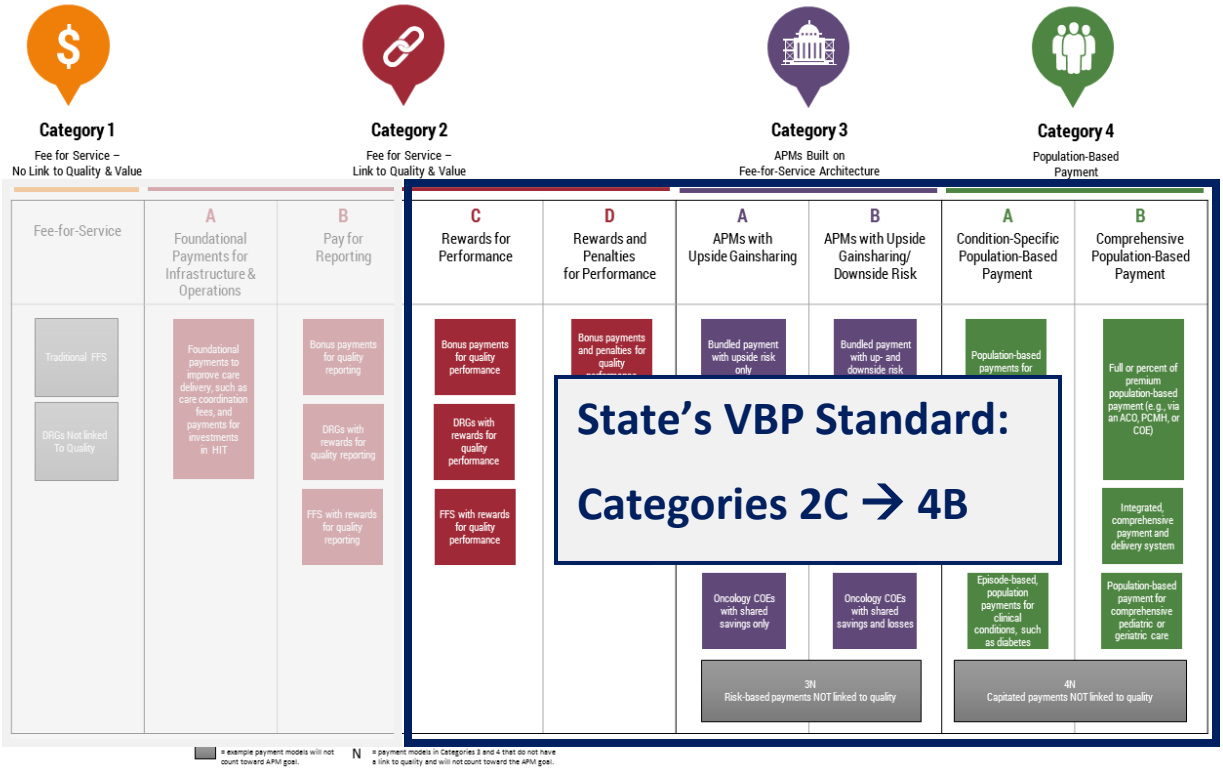


Chart 2: Washington State's Value-based Purchasing Standard



HCA aims to have 90 percent of state-financed health care payments to providers in APM Categories 2C-4B by 2021.

The rearview mirror

Value-based purchasing surveys

Each year, HCA surveys health plans and providers throughout the state to measure VBP adoption and associated barriers and enablers. HCA uses these surveys to track progress toward its VBP goals, continually improve current programs, and develop future initiatives. In 2017, health plans reported having 28 percent (Medicaid), 39 percent (commercial), and 44 percent (Medicare) of payments to providers (in calendar year 2016) in payment arrangements in APM Categories 2C and higher. In calculating payments through Medicaid Managed Care and the Public Employee Benefits programs, HCA reported achieving 30 percent of payments to providers (in calendar year 2016) in APM Categories 2C and higher, outpacing the 2016 goal of 20 percent. The table below highlights the top three barriers and enablers to VBP adoption as reported by health plans and providers, respectively:

HCA's 2017 Value-based Survey: Barriers and enablers of VBP adoption		
	Top barriers to VBP adoption	Top enablers to VBP adoption
Health plans	• Disparate incentives and/or contract requirements • Lack of interoperable data systems	• Trusted partnerships and collaboration

	• Payment model uncertainty	• Aligned incentives and contract requirements • Aligned quality measures and definitions
Providers	• Lack of interoperable data systems • Lack of timely cost data to assist with financial management • Insufficient access to comprehensive data on patient populations	• Aligned incentives and/or contract requirements • Trust partnerships and collaboration with payers • Aligned quality measures and definitions

HCA will publish results from the 2018 Value-based Purchasing Survey later this year.

Successes

Among myriad accomplishments over the last year, HCA has expanded the Centers of Excellence program to include spinal fusion, completed procurements for statewide implementation of integrated managed care, selected Regence as the Uniform Medical Plan third party administrator, made progress toward a Rural Multipayer model, and increased enrollment in the Accountable Care Program to 25,000.

For additional information on these initiatives and others, see the Vehicles of Transformation appendices at the end of this document. The following table highlights a few successes and milestones across Medicaid, PEBB, and SEBB over the last year:

Medicaid	PEBB	SEBB
Completed procurement for mid-adopter and on-time-adopter regions for integrated managed care (IMC)	Selected Capital Medical Center and Virginia Mason as Centers of Excellence for spinal fusion bundles	Began procurement for fully insured health insurance benefits options – including a new value-based payment strategy tying health plans' medical loss ratio (MLR) to value
Increased the percent withhold tied to quality and value-based payments in managed care organization contracts to 1.5%	Increased enrollment in the Accountable Care Program to 25,000	Began procurement for standalone vision benefits options
Began exploring a value-based pediatric primary care payment model	Selected Regence as the third party administrator for the Uniform Medical Plan, HCA's self-funded health insurance option, beginning in 2020	Began procurement for dental and life insurance benefits options
Facilitated the certification of one of Community Health Plan of Washington's provider payment models as an Other	Began exploring additional bundled payment procurement options	

Payer Advanced Alternative Payment Model under the MACRA Quality Payment Program		
Completed the Behavioral Health VBP Practice Transformation Academy, in partnership with the Practice Transformation Support Hub and the Washington Council for Behavioral Health		

Challenges

The transition to value poses varied challenges, not least among them the timely, accurate, and effective sharing of actionable data. HCA is in the second year of a multipayer data aggregation pilot, Payment Model 4, focused on supporting providers to access and utilize data across payers and providers. Further, HCA officially launched the Clinical Data Repository (CDR) earlier this year to support providers in sharing critical clinical data.

Health Information Technology (HIT) is as necessary as it is complex to successfully transition health care payment and delivery.[4] HCA developed an HIT Strategic Roadmap to identify activities that advance the use of interoperable HIT and Health Information Exchange (HIE) across the care continuum in support of Medicaid Transformation, and a State Medicaid Health IT Plan (SMHP) to provide statewide leadership and bring infrastructure and tools to state agencies that can benefit the larger care community.

More generally, achieving incremental progress as we near 90 percent, and successfully crossing the so-called "last mile," will come with its own set of challenges. Refining and expanding current programs while innovating via new initiatives will ensure HCA achieves its goals. HCA also wants to work with and help other purchasers and employers implement value-based strategies to accelerate transformation more broadly. This spread-and-scale effort includes promoting the Purchaser Toolkit[5] and the Statewide Common Measure Set,[6] as well as seeking opportunities to engage additional providers, payers, and purchasers in transformation. Further, HCA will continue collaborating with the Washington Health Alliance, Dr. Robert Bree Collaborative, and Pacific Business Group on Health to share best practices. In addition to local and regional organizations, HCA is closely following and working with the Health Care Transformation Task Force and Health Care Payment & Learning Action Network to advance national health systems transformation.

[4] For more information on HCA's HIT strategy and initiatives, visit: https://www.hca.wa.gov/about-hca/health-information-technology/what-were-working#washington-smhp
[5] For more information on HCA's value-based purchasing strategies, including the Purchaser's Toolkit, visit https://www.hca.wa.gov/about-hca/value-based-purchasing
[6] For more information on the Statewide Common Measure Set, visit https://www.hca.wa.gov/about-hca/healthier-washington/performance-measures

The road ahead

Sustainability is critical if Washington is to realize true health systems transformation. The State Innovation Models (SIM) test grant and Medicaid Transformation are lynchpins to sustaining success. However, achieving true transformation will require significant, multi-sector, systemwide collaboration, and individual commitments to improve how we pay for services. This approach requires that care is equitable, focuses on the whole person, and supports the development of healthier and activated communities. HCA will continue to invest heavily in HIT, including supporting critical infrastructure such as the Clinical Data Repository and All Payer Claims Database. Such investments are essential for effective population health management.

HCA has reviewed its purchasing strategies in order to implement a "One HCA" purchasing philosophy across Medicaid, PEBB, and SEBB programs. This philosophy will ensure we are holding our business partners and servicing providers accountable to consistent standards, building on successes, and learning from challenges across programs. Accordingly, HCA is exploring building on the PEBB Center of Excellence program and implementing a bundled payment approach for select episodes of care in Medicaid. Further, HCA will support the Dr. Robert Bree Collaborative to develop recommendations for a maternity care bundled payment model in 2019.

HCA continues to align with the federal government and monitor health systems transformation at the federal level, particularly MACRA and the Quality Payment Program (QPP). HCA participated in the public comment processes for the annual proposed rules to the program and expects to align state-financed health care programs with federal APMs, to the extent possible, and will seek certification as Other Payer Advanced APMs for Medicaid, PEBB, and SEBB VBP models.

VBP Spotlight

HCA worked closely with Community Health Plan of Washington, one of Washington's Medicaid managed care organizations (MCOs), to submit one of their APMs for certification as an Other Payer Advanced Alternative Payment Model (Advanced APM). In September, CMS approved CHPW's submission as a State Medicaid Other Payer Advanced APM, allowing participating providers to qualify for associated bonus payments under the Advanced APM track of QPP. CHPW's Advanced APM is one of four qualifying models in the entire country.

Long-term priorities for HCA include strengthening primary care, integrating behavioral and physical health payment and delivery statewide, taking aggressive measures to address social determinants of health, addressing the opioid crisis, advancing health equity, and eliminating Hepatitis-C.

We will continue to participate in new and expanded innovations led by the CMS. To that end, HCA has been collaborating with providers, health plans, CMS, and others to explore a new payment model to drive delivery system transformation in rural communities. This multi-payer approach centers around broad engagement on a global budget for rural hospitals and aligned primary care incentives. By redesigning rural health system financing, enhancing population health management, addressing the

health care workforce, and leveraging health information technology, Washington State will ensure rural residents achieve greater health and wellbeing, and can readily access care at the right time, in the right care setting. HCA aims to reach preliminary agreement with CMS on a model in 2019.

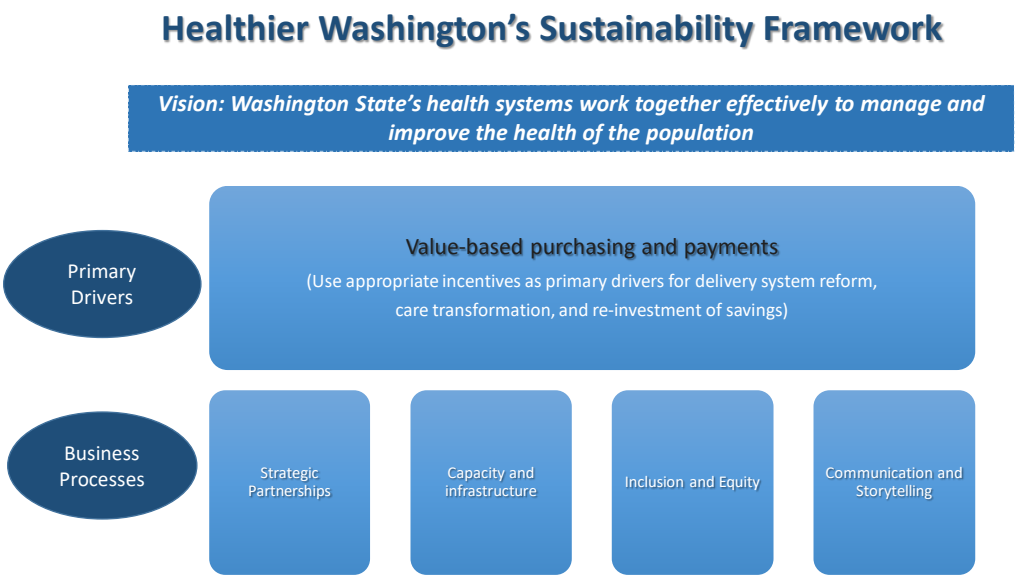
Addressing social determinants of health and health equity are critical for achieving a healthier Washington. Accordingly, HCA is engaging community partners and tribal governments in addressing these complex challenges. We are exploring how to leverage clinical and non-clinical interventions to achieve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

Through social impact bonds, philanthropic investments, and broadened community partnerships, HCA is committed to reducing inequities in our state. Building on Colorado's Opportunity Framework,[7] HCA will address indicators throughout each life stage, integrate social determinants into all of our purchasing strategies, and bring value-based concepts into long-term services and supports.

In preparation for the Healthier Washington State Innovation Model (SIM) program's end on January 31, 2019, HCA has considered sustainability in the context of the health system at large rather than its component parts. Consequently, we developed a Sustainability Framework to guide our thinking beyond the SIM investment, to help us consider each program and investment as it relates to the whole. The Sustainability Framework considers levers for sustaining transformed relationships among people, institutions, funding sources, and governments, in order to ensure a holistic approach to sustainability.

Using the primary driver of paying for value, the sustainability framework also highlights four business processes: capacity and infrastructure, strategic partnerships, inclusion and equity, and communication and storytelling.

Figure 1: Healthier Washington's Sustainability Framework



[7] For more information on Colorodao's Opportunity Framework, visit https://colorado.gov/pacific/hcpf/colorado-opportunity-framework

Roles in VBP across the health system

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

HCA's goal is for all parties to do their best, and receive sufficient support to do so, adding clarity to discussions and work streams focused on VBP and health systems transformation.

	Defining VBP	Delivering VBP	Measuring VBP	Reinforcing VBP
State/other government				
MCOs / PEBB & SEBB Contractors				
ACHs				
Providers				
Community Based Organizations				

Appendix 1: Vehicles of Transformation

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

Topic 1: Federal initiatives & waivers

Topic 2: Accountable plan partners

Topic 3: Bundled payments and episodes of care

Topic 4: Multipayer alignment

Topic 5: Delivery system transformation

Topic 6: Pharmacy

Federal initiatives & waivers

HEALTHIER WASHINGTON MEDICAID TRANSFORMATION

SYNOPSIS

The Healthier Washington Medicaid Transformation is the result of a Section 1115 waiver, a contract between federal and state governments that waives certain Medicaid requirements, under which Washington has committed to use Medicaid funds for innovative projects, activities, and services that would not otherwise be allowed.

GOAL

Medicaid Transformation aims to improve the health system by addressing local health priorities, improve population health, reward cost-effective care that treats the whole person, and create sustainable linkages between clinical and community-based services.

DESIRED OUTCOMES

- Integrate physical and behavioral health purchasing and service delivery
- Convert 90 percent of Medicaid provider payments to reward outcomes
- Support provider capacity to adopt new payment and care models
- Implement population health strategies that improve health equity
- Provide new targeted services that address the needs of the state's aging populations and address key determinants of health

HOW IT WORKS

Transformation through Accountable Communities of Health	Long-term services & supports	Foundational Community Supports
Regional approach	Caring for our aging population	Housing and employment
Up to $1.1 billion	$175 million	$200 million

THE CHALLENGE

Washington Apple Health (Medicaid) covers more than 1.8 million individuals, amounting to nearly one in four Washingtonians. The federal government and several states recognize the best way to control costs and improve health is to transform the delivery model to reward providers and health plans for better health. Transformation investments allow the state to spend Medicaid dollars in different ways to reward providers and health plans based on the quality of care rather than the number of procedures and services provided. Medicaid Transformation focuses largely on supporting providers and plans as they switch to these new delivery and payment systems.

DESCRIPTION

Under a five-year agreement with the Centers for Medicare and Medicaid Services (CMS), the state will address the aims of the Medicaid Transformation project through three core initiatives:

- Transformation through Accountable Communities of Health (ACHs) and Delivery System Reform Incentive Payment (DSRIP) program
- Long-term Services and Supports (LTSS)—Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)
- Foundational Community Supports (FCS)—Targeted Home and Community-based Services (HCBS) for eligible individuals

HOW WE GET THERE

Transformation through ACHs and the DSRIP program respond to the fact that our health, and the health services we receive, are often shaped by where we live. Improving health care for all Washington's residents requires regional understanding, experience, and advocacy. The nine regionally based ACHs are the hubs for this work and each region is pursuing transformation projects that are tailored to their specific needs.

Federal funding is dependent upon the achievement of transformation targets. This means that payments are earned when these targets, such as value-based payment adoption and quality outcomes, are met.

Long-term Services and Supports (LTSS) allow the state to offer services for older adults and the people who care for them, through two new eligibility categories: Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA). These services help people stay at home and delay or avoid the need for more intensive care.

Foundational Community Supports (FCS) include targeted Home and Community-based Services (HCBS) for our most vulnerable people to get and keep housing and jobs. These new services embrace the reality that without stable housing and income, it is extremely difficult for people and their families to be healthy and stay healthy.

RESULTS

The state aims to reduce avoidable use of intensive services and settings such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional long-term services and supports, and jails; improve population health by focusing on prevention; accelerate the transition to value-based payment; and ensure Medicaid cost growth is below national trends.

Federal initiatives & waivers

STATE INNOVATION MODELS (SIM) GRANT

SYNOPSIS

In 2014, Washington State received nearly $65 million to implement and test its State Health Care Innovation Plan. The award from the Center for Medicare & Medicaid Innovation (CMMI) enabled the state to develop the multi-stakeholder Healthier Washington initiative.

GOAL

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

DESIRED OUTCOMES

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

HOW IT WORKS

THE CHALLENGE

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

In order to achieve the Quadruple Aim of better health, better care, smarter spending, and provider joy, the system must address:

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

DESCRIPTION

While health systems transformation and innovation began in Washington State before SIM resources were available, the grant set in motion efforts to address challenges to the health system. By design, there is significant overlap in strategies, allowing for a systems approach to transformation. Specific focus areas of the SIM grant include:

- **Supporting Accountable Communities of Health (ACHs).** The nine regional ACHs are drivers of health systems transformation, bringing together public and private community partners to advance shared regional health goals.
- **Building payment reform test models.** Washington is testing payment redesign models to advance value-based payment.
- **Supporting clinicians through the Practice Transformation Support Hub.** Dedicated support for primary and behavioral health providers as they integrate care and adopt value-based systems.
- **Strengthening person and family engagement.** Shared decision making is focused on ensuring providers and consumers have meaningful conversations that help people make care choices that are right for them and their families.
- **Addressing the workforce.** Washington State is exploring ways to ensure the system has the right people delivering the right care at the right place and time.
- **Investing in data and analytics.** A mature data and analytic infrastructure provides a foundation for moving to whole-person care and improving population health.

HOW WE GET THERE

Although the SIM grant ends on January 31, 2019, Healthier Washington efforts have established strategic partnerships among state agencies, tribal governments, public and private sector partners, community based organizations, ACHs, and others. Inclusion and equity is a foundation of this work as we strive to reduce health disparities, address social determinants, and focus on wellness.

RESULTS

Our vision for a transformed health system that endures beyond the life of the SIM grant is one where our three foundational strategies of paying for value, whole-person care, and strong clinical-community linkages are embedded in the health system. This future also includes a climate of partnership, engagement, and mutual support among the state, communities, providers, and the market.

Accountable plan partners

INTEGRATED MANAGED CARE

SYNOPSIS

Having a single payer be responsible for an individual's whole person health (physical health and behavioral health) allows for better care and, in turn, better outcomes.

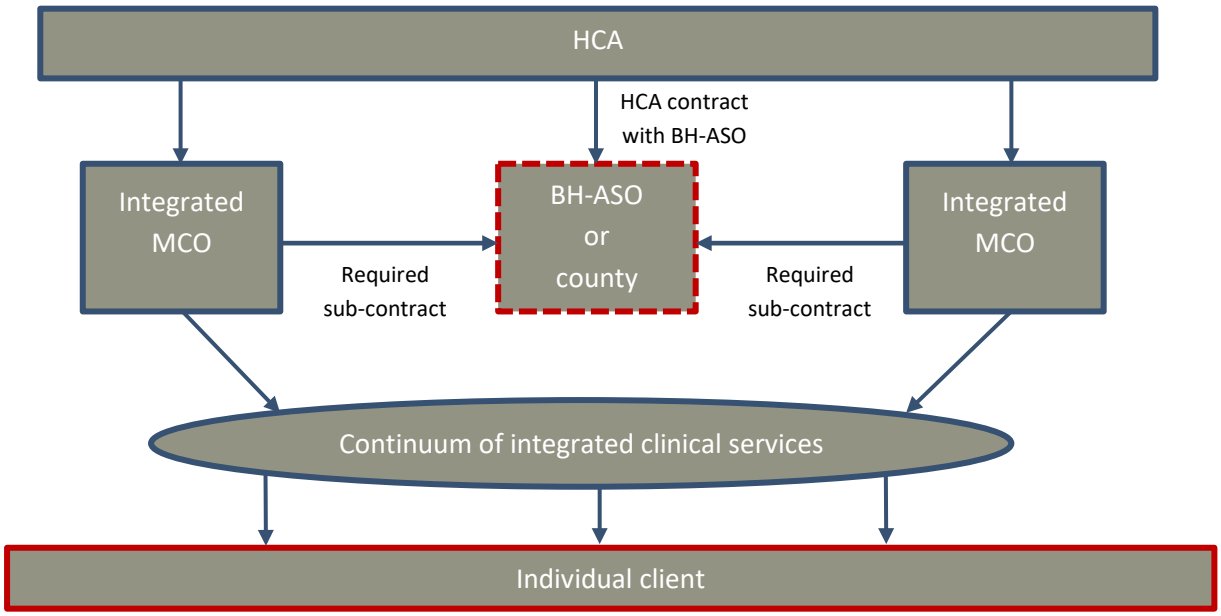
GOAL

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

DESIRED OUTCOMES

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

HOW IT WORKS



THE CHALLENGE

Within the current system, behavioral health services are bifurcated. No single entity is accountable for an individuals' health, nor are data and information available to manage the whole person, leading to missed opportunities and poorer health outcomes for clients. In particular, research shows that individuals needing treatment for more than one condition of mind and body die on average 25 years earlier than those without. The integrated managed care approach seeks to close this gap.

DESCRIPTION

The Washington State Health Care Authority (HCA), supported by legislation, will implement integrated managed care in all regions across the state by January 1, 2020. In integrated managed care regions, MCOs will become responsible for the full continuum of physical and behavioral health services for Apple Health (Medicaid) clients. Services will include specialty behavioral health services, outlined in the Medicaid (Title XIX) State Plan, that are currently covered by Behavioral Health Organizations (BHO). A Behavioral Health Administrative Services Organization (BH-ASO) will be identified in each region to administer crisis services and non-Medicaid funding source.

HOW WE GET THERE

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

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

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

RESULTS

As of October 2018, the state has implemented integrated managed care in two of the 10 regions across the state. An additional five regions will transition on January 1, 2019. The remaining three regions will transition on January 1, 2020. Preliminary data show encouraging results in the first year of integrated managed care in Southwest Washington, our first integrated region.

Accountable plan partners

MANAGED CARE ORGANIZATION PREMIUM WITHHOLD

SYNOPSIS

The Washington State Health Care Authority (HCA) has designed and implemented a value-based contracting arrangement, whereby HCA withholds a percentage of the monthly per-member-per-month (PMPM) premium to each managed care organization (MCO) which they may earn back through the achievement of VBP and quality targets.

THE GOAL

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

DESIRED OUTCOMES

- Increased value-based contracting; 90 percent by 2021
- Increased provider incentives
- Improved quality performance

HOW IT WORKS

Prior to 2017

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

Present & future

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

DESCRIPTION

THE CHALLENGE

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

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

- Value-based purchasing arrangements with providers
- Qualifying provider incentives
- Achieving quality improvement targets

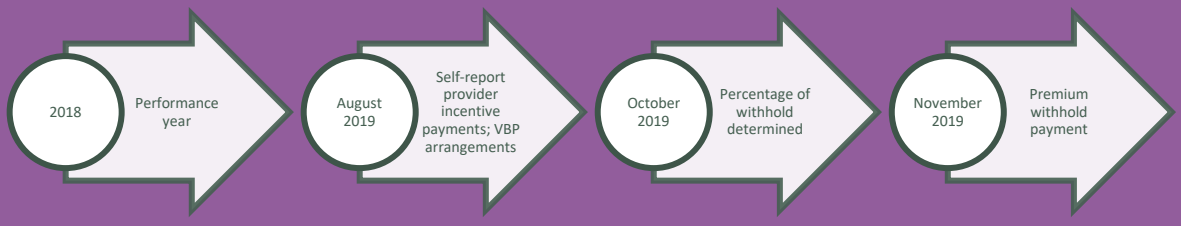
Over time, the withhold amount and benchmarks for each performance area may increase.

HOW WE GET THERE

HCA has adopted the Health Care Payment Learning and Action Network (HCP-LAN) framework created by the Centers for Medicaid and Medicare Services (CMS) to define value-based payment. To meet HCA targets, at least 1 percent of premium payments must be incentives and disincentives in LAN Category 2c or higher. Provider incentives are additional payments or withholds based on provider performance. Additionally, an MCO needs to pay at least 50 percent of provider payments in the form of VBP arrangements in LAN Category 2c or higher, which is HCA's definition of VBP. A third party reviews and validates the self-reported (by each MCO) provider incentive payments and VBP arrangements. HCA uses its homegrown Quality Improvement Score (QIS) model to evaluate performance on seven quality measures from the Statewide Common Measure Set.

RESULTS

Reconciliation, validation, and determination of the whithhold follows this timeline:



Accountable plan partners

SCHOOL EMPLOYEES BENEFITS BOARD (SEBB) PROGRAM

SYNOPSIS

Adopting quality of care and financial incentives to provide best-in-class member experience and healthy outcomes into medical plan contracts for school employees

GOAL

Incorporating value-based strategies into the SEBB medical contracts will ensure that health plans and providers are financially accountable for delivering high quality and high value care to plan members. By redesigning the way we pay for care—rewarding value over volume—the VBP model represents an overall commitment toward the Quadruple Aim of better health, better care, smarter spending, and provider joy.

DESIRED OUTCOMES

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

HOW IT WORKS

All school employees into a single risk pool

Encompasses 295 school districts, 9 educational service districts, and 10 charter schools

Board designs plans & establishes criteria based on evidence & cost effectiveness

HCA administers the program as the single state agent for purchasing health care services

DESCRIPTION

THE CHALLENGE

Despite rising spending in the current health care environment, there is often little to no correlation between how much people pay for health care services and the quality of care they receive. One of the primary challenges that HCA faces will be moving SEBB carriers toward a value-based payment model, which controls cost and incentivizes quality services while ensuring that carriers are afforded the flexibility to meet the needs of providers and stakeholders.

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

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

HOW WE GET THERE

HCA will work with carriers during the SEBB contract negotiation process to explore value-based payment models and determine which would be the most effective and appropriate to adopt for the SEBB program. This model will be built on the principles of:

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

RESULTS

By adopting value-based reimbursement and alternative payment strategies into SEBB medical contracts, HCA hopes to see:

- Continuously improving health outcomes for eligible school employees and dependents enrolled in the program
- A greater focus on rewarding high quality, evidence based care
- Long-term financial sustainability of the SEBB program

Bundled payments & episodes of care

CENTERS OF EXCELLENCE PROGRAM

SYNOPSIS

The Centers of Excellence (COE) Program identifies facilities that have adopted use best practices set forth by the Dr. Robert Bree Collaborative pertaining to surgeries and health conditions, and then incentivizes eligible Public Employee Benefits (PEB) members to use those COEs.

GOAL

To optimize health outcomes for PEB members while controlling health care costs. To highlight clinical best practices and improve the quality of care across the spectrum.

DESIRED OUTCOMES

- Optimal clinical outcomes (surgical complications, revisions, readmissions)
- Cost neutrality, if not cost savings
- Improve statewide access to affordable, quality health care

HOW IT WORKS

Customer Journey Map: Health Care Authority Center of Excellence

	I HAVE CHRONIC JOINT PAIN.	I WANT TO LEARN MORE.	I AM QUALIFIED FOR REFERRAL.	I AM APPROVED FOR SURGERY.	I AM HAVING SURGERY.	I AM HOME.
MEMBER EXPERIENCE	• I am in pain. • I am taking medication to manage my pain. • I seek treatment for my pain. • I might benefit from a joint replacement.	• I am curious about the program. • My doctor recommends surgery. • I need more info to make an informed decision.	• I understand the requirements and next steps. • I have help to gather data, tests, and records. • Premera refers me to Virginia Mason.	• I know what to expect. • My care companion is ready to help me. • I know my surgery date, and travel and lodging are arranged.	• I am comfortable. • I know what to expect when I get home. • My care companion is prepared. • My surgery was successful.	• I am recovering. • I manage my pain. • I define my new normal. • I provide my feedback.
TOUCH POINTS	• Outreach letters • Benefit Fair interactions • Communications	• Concierge service team • Communications	• Concierge service team • Health care services team • Welcome packet	• Concierge service team • Health care services team • Journey booklet	• Health care services team	• Health care services team • Survey
	NO MEMBERS SLIP THROUGH THE CRACKS	LEARNING IS SIMPLE AND EASY	I AM MOVING FORWARD QUICKLY	I HAVE EVERYTHING I NEED	I AM TAKEN CARE OF	YOU TOOK GREAT CARE OF ME
PHASE	IDENTIFICATION	EDUCATION	QUALIFICATION	ASSESSMENT & APPROVAL	RESTORATION	RECOVERY & RESOLUTION

Adapted from Premera Blue Cross

THE CHALLENGE

Traditionally, fee-for-service payments drive most surgeries, with reimbursement tied to volume of services. This contributes to wide variation in care quality and cost, depending on where a patient receives surgery. New payment paradigms like bundled payments—which specify evidence-based practices, quality standards and pre-established prices—are necessary to rein in unnecessary variation and reduce unintended outcomes like readmissions and hospital-borne infections.

DESCRIPTION

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

- HCA procures COEs, which requires them to have adopted Bree Collaborative criteria and documented evidence of their clinical outcomes with regard to the specific surgery or procedure.
- HCA designs a "bundled" set of services that typically characterize the episode of care, and enter into contracts with COEs to provide the medical services that are part of the bundle.
- A third party administrator—Premera Blue Cross—ushers members through the program, prepares referrals for the COE, and arranges travel and other logistics for the member to facilitate their journey, start to finish.

HOW WE GET THERE

The state has made a great effort to let PEB members know about this program and how they can benefit from it. As a result, in the first year, 15 percent of those seeking a total joint replacement have used the COE for that procedure. As the third party administrator, Premera has done an excellent job escorting PEB members through a serious life event—from initial interest to post-operative return to their home.

RESULTS

Our first bundle, total joint replacement, went live in January 2017. In the first year, 95 surgeries were performed at Virginia Mason, the COE for total joint replacement. To date, there have been no surgical revisions, complications, or readmissions. In addition, Uniform Medical Plan and the people using the benefit have saved money. PEB members have been highly satisfied with their experience. The state will implement a second bundle—lumbar spinal fusion—in January 2019.

Multi-payer alignment

ALTERNATIVE PAYMENT METHODOLOGY 4

SYNOPSIS

Engaging federally qualified health centers (FQHCs) in an alternative payment methodology that transitions reimbursement from an encounter-based system to a value-based system for services provided to Medicaid managed care enrollees.

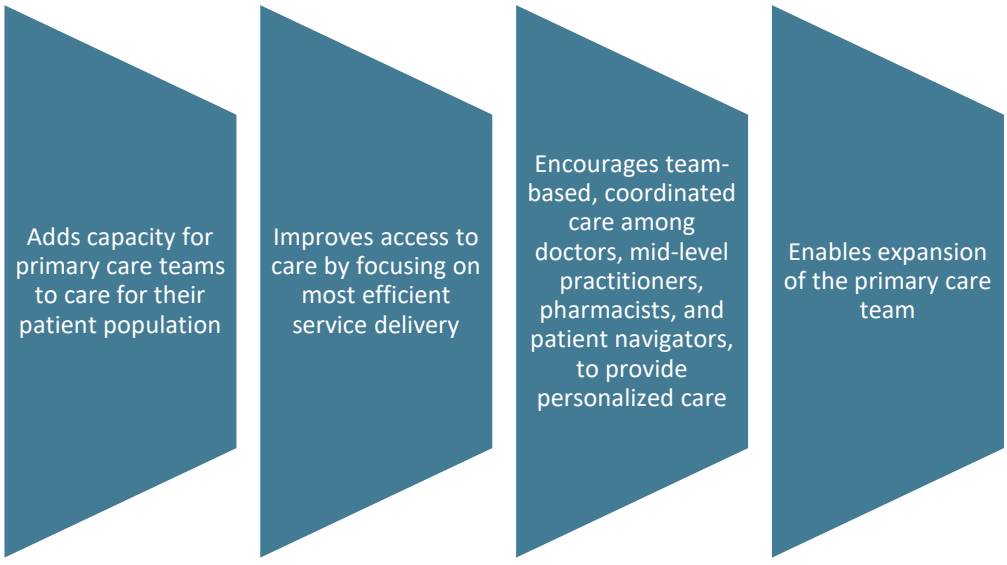
GOAL

Alternative Payment Methodology 4 provides additional flexibility in delivering primary care services, expands primary care capacity, and creates financial incentives for improved health care outcomes while meeting federal requirements. This methodology allows participating providers to enhance their capacity for managing population health.

DESIRED OUTCOMES

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

HOW IT WORKS



THE CHALLENGE

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

DESCRIPTION

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

HOW WE GET THERE

APM4 applies only to Medicaid managed care enrollees and does not include current MCO contractual arrangements or flow of payments. APM4 converts the entire encounter-based rate into a baseline per member per month (PMPM) rate, which is adjusted prospectively according to quality performance. Financial conversion is based on calendar year 2015 reconciliation. Within this basic framework, clinics will continue to perform annual reconciliation to ensure that federal reimbursement requirements are met. However, instead of resolving underpayments or overpayments through a settlement process, APM4 will prospectively adjust payments based on a clinic's performance on quality measures. Given its experimental nature, APM4 is not mandated for all clinics and maintains an opt-in/opt-out approach.

RESULTS

APM4 will allow clinics to improve access to care by focusing on improvement against specific quality measures and allowing clinicians to work at the top of their license. This payment methodology provides flexibility for primary care providers to have a larger member panel without the burden of increasing the number of face-to-face patient encounters, thus expanding primary care capacity in medically underserved areas. APM4 also incentivizes alternatives to face-to-face visits and allows clinics to offer convenient access to primary care services.

Multi-payer alignment

PERFORMANCE MEASURES

SYNOPSIS

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

GOAL

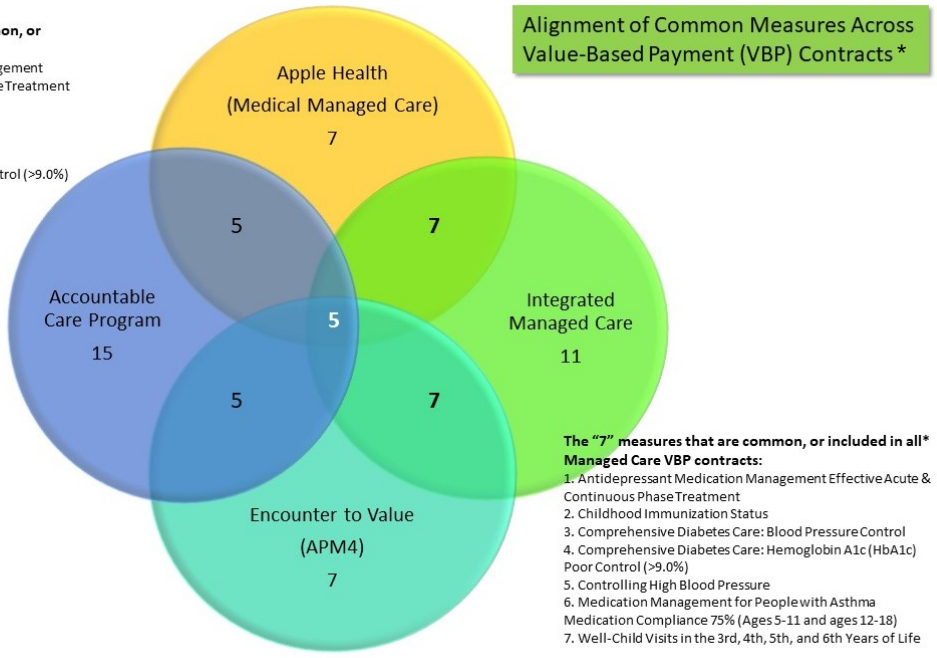
By using measures from the Statewide Common Measure Set and Service Coordination Organization Measure Set to drive toward quality and value in purchasing contracts, Washington State can align efforts around a core set of priorities and reduce measurement and reporting fatigue.

DESIRED OUTCOMES

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

HOW IT WORKS

The "5" measures that are common, or included in all VBP contracts:
1. Antidepressant Medication Management Effective Acute & Continuous Phase Treatment
2. Childhood Immunization Status
3. Comprehensive Diabetes Care: Blood Pressure Control
4. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
5. Controlling High Blood Pressure



The "7" measures that are common, or included in all* Managed Care VBP contracts:
1. Antidepressant Medication Management Effective Acute & Continuous Phase Treatment
2. Childhood Immunization Status
3. Comprehensive Diabetes Care: Blood Pressure Control
4. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
5. Controlling High Blood Pressure
6. Medication Management for People with Asthma Medication Compliance 75% (Ages 5-11 and ages 12-18)
7. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

*With the exception of the Foster Care Contract

THE CHALLENGE

Providers may be required to report on up to 150 clinical quality metrics at any given time, through their contractual agreements with health plans.

Washington State wants to support providers in their efforts to ensure high quality care and better manage the health of their patients. Monitoring the health of their patient population through a set of clinical quality metrics can assist them in these efforts.

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

DESCRIPTION

Per legislation, in 2013-14 there were two state-led and stakeholder-developed state measure sets. The Governor-appointed Performance Measures Coordinating Committee (PMCC) developed the Statewide Common Measure Set to inform health care purchasing. Washington State has taken the lead in incorporating measures from the Common Measure Set into state contracts. Additionally, the Service Coordination Organization Measure Set was developed by the Washington State Department of Social and Health Services (DSHS) with input from community stakeholders to address those with behavioral health needs. These two measure sets are the foundation for how we select and align performance measures for state purchasing contracts, including measures that are included in pay-for-performance arrangements.

HOW WE GET THERE

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

RESULTS

There are currently 25 performance measures tied to VBP in all state purchasing contracts. Of those 25 measures, five are common across all contracts. For the Medicaid contracts, seven measures are common across all contracts, with the exception of the Foster Care Contract. That contract addresses the needs of a specific population and therefore has measures that do not align. As much as we may try to align fully across all contracts, we also understand there are situations where we need to ensure the appropriate quality measures are included to address the priorities of those populations.

Multi-payer alignment

PAYMENT MODEL 4: MULTIPAYER DATA AGGREGATION PILOT

SYNOPSIS

The Washington State Health Care Authority (HCA) provides resources and claims data from state-financed health care programs to participating providers to test whether increasing providers' access to patient utilization data accelerates providers' willingness to engage in value-based payment arrangements.

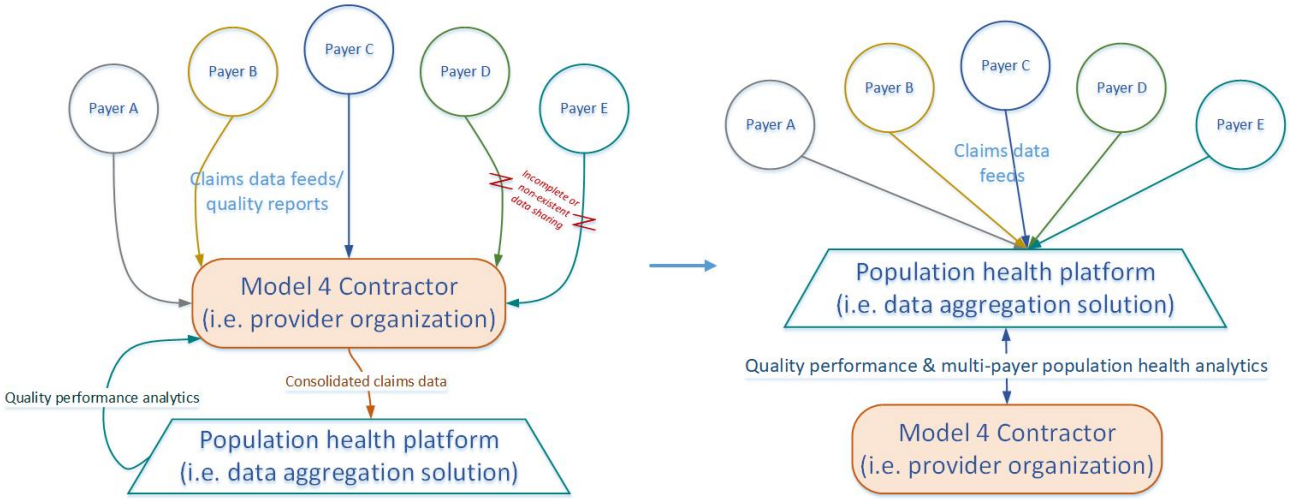
GOAL

Facilitate and accelerate the adoption of value-based payments by increasing providers' access to patient data across multiple payers and aligning quality measures to assess provider performance.

DESIRED OUTCOMES

- Improved population health management by participating providers
- Increased payer participation
- Increased participation in value-based payment arrangements

HOW IT WORKS



Current state

Future state

THE CHALLENGE

Providers need new and expanded sets of patient-level data in order to take on financial and clinical accountability, improve care coordination practices, and better manage population health. Without comprehensive access to patient data, many providers will struggle to adopt value-based payment arrangements.

DESCRIPTION

HCA has contracted with two provider organizations, Northwest Physicians Network (NPN) and Summit Pacific Medical Center (Summit), to lead an urban and rural pilot, respectively, of this multipayer data aggregation strategy. Each organization is using a shareable data aggregation solution to support their partners in better managing patient populations, measure quality performance, and adopt value-based payment arrangements. In turn, HCA is sharing attributable medical and pharmacy claims data extracts from the Uniform Medical Plan and Apple Health (Medicaid) managed care plans on a monthly basis. NPN and Summit submit semi-annual progress reports to HCA detailing progress toward implementing the shared data aggregation solution, engaging providers in population health management, engaging additional payers, and adopting value-based payment models. Further, both organizations submit annual quality reports to HCA on their performance against select quality measures from the Statewide Common Measure Set.

HOW WE GET THERE

The monthly process comprises the following components:

- NPN and Summit submit provider rosters to the Washington State Health Care Authority (HCA).
- Participating managed care organizations submit Apple Health client assignment files to HCA.
- For Apple Health managed care data, HCA identifies attributed claims data based on the provider rosters and associated assignment files.
- For Uniform Medical Plan (UMP) data, HCA identifies attributed claims data based on a third party administrator's attribution methodology and associated provider rosters.
- HCA transmits attributable claims data for Apple Health managed care and UMP to NPN and Summit through a secure file transfer protocol.
- Other participating payers submit attributable claims data to each provider through a similar process.
- NPN and Summit leverage a sharable data aggregation solution to populate provider dashboards, quality reports, and care coordination support strategies for their providers.

RESULTS

Both NPN and Summit have dedicated staff to support the pilot and help providers better understand and use multipayer data to manage patient populations. NPN is in the process of integrating data from four additional commercial health plan partners. Summit has improved their capacity to identify gaps in care and target specific quality initiatives to improve care.

Multipayer alignment

RURAL MULTIPAYER MODEL

SYNOPSIS

By redesigning rural health through new financing, population health management, addressing the health care workforce, and using health information technology, Washington State will ensure rural residents achieve greater health and wellbeing and can readily access care.

GOAL

The Rural Multipayer Model will bolster value-based purchasing goals, help practices become ready for new models of care, and remove barriers to health transformation.

DESIRED OUTCOMES

- New infrastructure to support practice transformation
- Improved outcomes for people based on quality performance measures
- Sustainability of the rural health delivery system

HOW IT WORKS

Quality Performance

Total cost of care pool	
Hospital Services (IP/OP, including ER, observation, ancillary, swing beds)	• Baseline budget – Total patient revenue • Trending of the budget • Payer allocation of the budget • Retrospective adjustments and reconciliation of the budget • Prospective adjustments of the budget • Encounter-based payments
Primary Care (RHCs and PCP related services)	• Per-member-per-month • Prospective quality adjustments • Encounter-based payments

THE CHALLENGE

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

DESCRIPTION

The Rural Multipayer Model brings together payers and providers on an aligned payment approach, with incentives that focus on improving the health and wellbeing of beneficiaries in rural communities. The model does this through a global budget for rural hospitals and common primary care incentives. This enables rural providers to invest in practice transformation without being penalized for declining utilization. It also builds upon investments already in place, such as the Healthier Washington Medicaid Transformation.

HOW WE GET THERE

By its nature, this model is being developed by many stakeholders. A new rural payment model requires Medicare participation and state investments in rural health delivery system transformation. The state is engaging with rural providers, payers, community advocates, associations, legislators, and the Governor's office to shape this new payment approach and coordinate desired outcomes. We are targeting early agreements with the Centers for Medicare & Medicaid Services (CMS) starting in 2019.

RESULTS

- Transformed health delivery in rural communities
- Improved health status of rural Washingtonians
- Health care services that match the needs of the community

Delivery system transformation

ACCOUNTABLE COMMUNITIES OF HEALTH (ACHs)

SYNOPSIS

Accountable Communities of Health (ACHs) bring together leaders from multiple sectors around the state with a common interest in improving health and health equity. As ACHs better align resources and activities, they support wellness and a system that delivers care for the whole person. There are nine ACHs. Their boundaries align with Washington's Medicaid regional service areas.

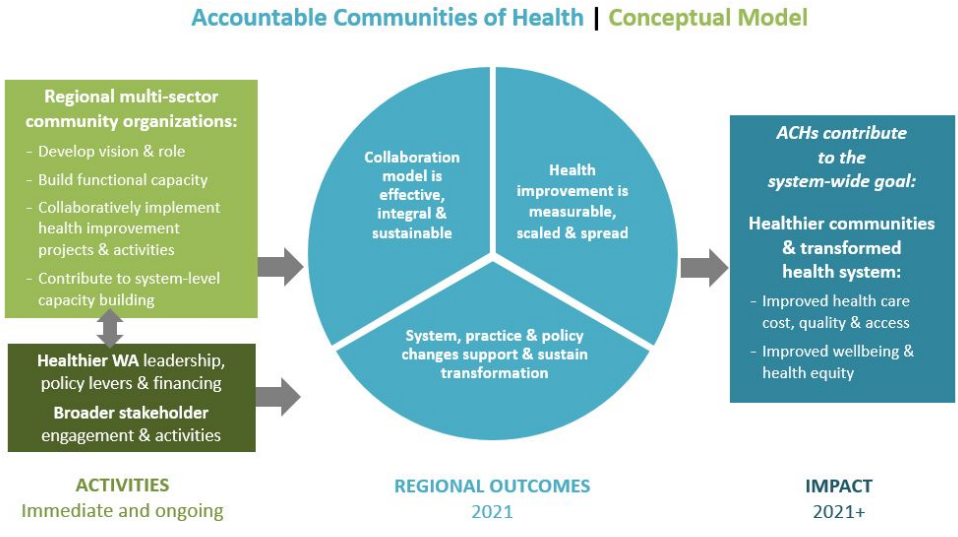
GOAL

ACHs support health systems transformation, including providers transitioning to value-based payment arrangements, by connecting partners and aligning activities across multiple sectors with a common interest in achieving whole person health and wellness.

DESIRED OUTCOMES

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

HOW IT WORKS



THE CHALLENGE

Recognizing that VBP ultimately supports population health management and extends beyond clinical quality improvement, there is a need for partners to identify new ways to integrate care and create connections between clinical care and community supports. This is a challenge as it involves multiple sectors, communities and organizations that may not traditionally coordinate on shared approaches, workflows, or investments.

DESCRIPTION

ACHs address health issues through local collaboration on shared goals. They can help align resources and activities that improve whole person health and wellness, and support local and statewide initiatives such as Healthier Washington Medicaid Transformation, practice transformation, and value-based purchasing. Further, ACHs convene and connect partners to support clinical-community linkages, recognizing that VBP supports population health management and extends beyond clinical quality improvement.

HOW WE GET THERE

As part of Medicaid Transformation, each ACH region is pursuing projects aimed at transforming the Medicaid delivery system. Transformation projects focus on:

Health systems and community capacity building. Adopting a value-based payment system, developing the health care workforce, and making improvements in population health management, including enhanced data collection and analytic capacity.

Care delivery redesign. Supporting integration of physical and behavioral health care, improving care coordination, making better transitions between services and settings, and improving diversion interventions (helping people access the most appropriate service or facility for their needs).

Prevention and health promotion. Focusing on opioid use, maternal and child health, access to oral health services, and chronic disease prevention and management.

Within Medicaid Transformation, ACHs are accountable for investing resources to support providers in moving along the VBP continuum. Medicaid Transformation activities and investments support increased use of VBP arrangements that reward providers for quality of care rather than the volume of services provided. ACHs play an important role in supporting the delivery of person- and family-centered care to meet the needs of their communities.

RESULTS

ACHs are positioned to:

- Promote health equity throughout the state.
- Create, support, and collaborate on local health improvement plans.
- Support local and statewide initiatives such as Medicaid Transformation, practice transformation, and value-based purchasing.
- Align resources and activities that improve whole-person health and wellness.

Delivery system transformation

ACCOUNTABLE CARE PROGRAM

SYNOPSIS

Integrate the quality of care with financial incentives to provide best-in-class member experience, leading to healthy people.

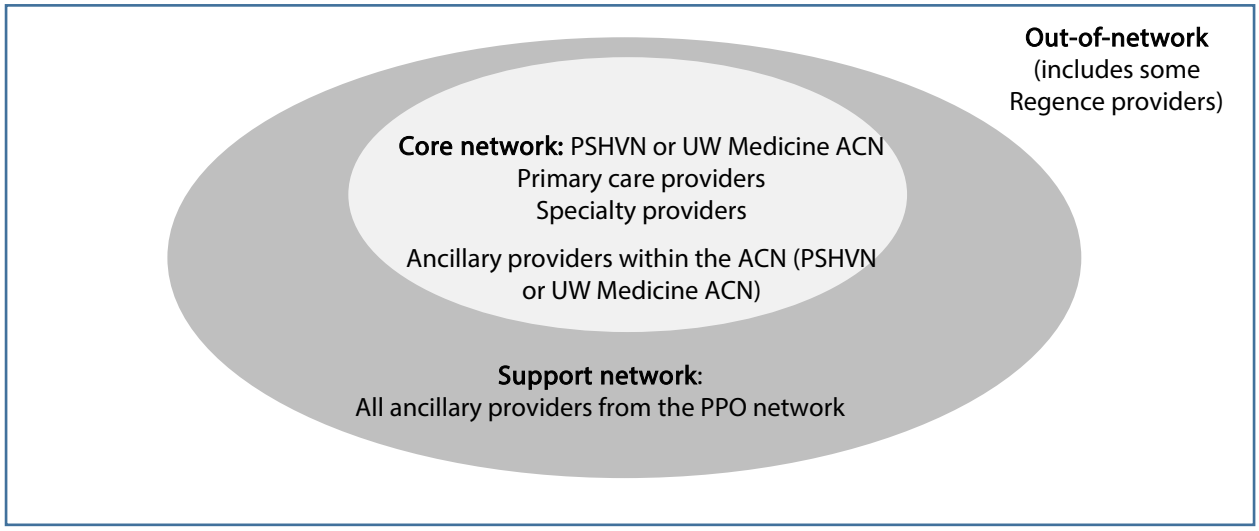
GOAL

High-quality care. Accountable Care Program: Come for the cost, stay for the quality.

DESIRED OUTCOMES

- Healthy Washington residents through incentives to providers who perform coordinated, high-quality care
- Providers compete within established community standards
- Achieve member savings by paying for value

HOW IT WORKS



THE CHALLENGE

The challenge to the Washington State Health Care Authority (HCA) is to implement incentives that permit providers to accept financial risk and respond with better care at lower costs.

HCA invested in developing, administering, and modifying how to assess the performance of an accountable care network and adopt standards of care that improve the lives of the people and providers of Washington State.

DESCRIPTION

Each Accountable Care Program (ACP) network delivers integrated physical, mental health, and substance use disorder services, and assumes financial and clinical accountability for a population of members. An ACP network is paid fee-for-service throughout the year, and then HCA reconciles the annual payment based on an ACP network's quality and financial performance. An ACP network is rewarded for delivering quality care, improving the patient experience, and keeping people healthy.

HCA collaborates with the Puget Sound High Value Network and the UW Medicine Accountable Care Network to provide care in an accountable delivery and payment model. Each ACP network is comprised of eight major health care systems. They provide access to high quality and timely service at a lower cost through this network structure.

HOW WE GET THERE

Creating a network where it is possible to perform high-quality care is our goal. Equally important is what our goal is not: to save money. We are focused on delivering coordinated care, not finding a way to pay smaller fees. HCA has provided incentives to perform high-quality care, in part, by adopting local and national standards and by challenging and supporting a network of accountable providers to reach those standards.

RESULTS

- Enrollment started strong and increased. Roughly 10,000 people selected UMP Plus in the first year (2016), and enrollment grew to 15,000 and 25,000 the following two years.
- Each network achieved the maximum quality score in the first two years. Metrics for preventive care and cancer screening, chronic illness, member experience, and maternity care are combined in an overall quality score.
- The ACP networks started in five counties. An additional three counties and three more major health systems are now in the Accountable Care Program.

Delivery system transformation

UNIFORM MEDICAL PLAN

SYNOPSIS

Comprising customized, quality-focused benefit options, the Uniform Medical Plan (UMP), administered by Regence BlueShield, is HCA's self-funded health plan available to nearly 200,000 members enrolled in the Public Employees Benefits Board (PEBB) and, beginning January 1, 2020, School Employees Benefits Board (SEBB) programs.

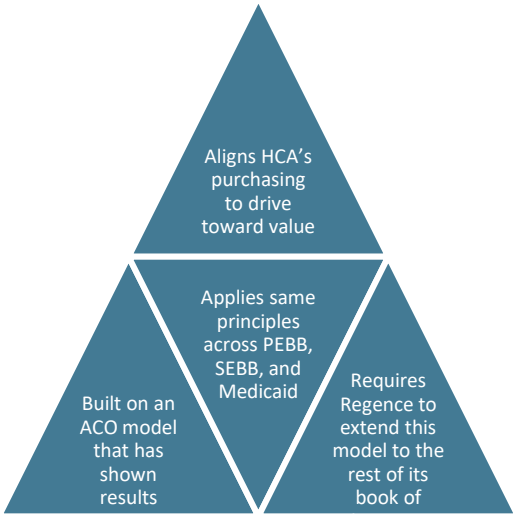
GOAL

Offer competitive and high-value health benefits to public employees and serve as a catalyst to influence the Washington State health insurance market. Continue transforming the health system to one that provides better care and better health at a lower cost. Reward providers for quality improvement. Ensure that payments to providers are tied to cost and quality performance.

DESIRED OUTCOMES

- Improved clinical outcomes
- Enhanced patient and member experience
- Increased adoption of value-based payment models across Washington

HOW IT WORKS



THE CHALLENGE

Flexibility and the ability to innovate on the design of health benefits are critical for HCA to tailor health plan options available to members, particularly as a large, statewide employer. Self-funding through UMP gives HCA this capacity and opportunity to customize clinical policies, payment and contract policies. HCA can drive the way VBP is constructed and have more oversight of how our health care dollars are being spent (stewarding public funds), and helps us transform the broader marketplace.

DESCRIPTION

HCA's new contract with Regence to serve as the UMP Third Party Administrator (TPA), effective January 1, 2020, includes myriad enhancements to the previous TPA contract. These included improved care quality and website user experience, and requirements that Regence participate in various multi-payer initiatives and offer an accountable care organization (ACO) type offering, a la HCA's Accountable Care Program, to its other customers in Washington's health insurance market.

As a self-funded health care plan, HCA assumes the direct risk for the payment of claims for health benefits under UMP. While HCA takes on the financial risk and responsibility to design and implement benefits, Regence provides access to their provider network and associated negotiated rates, claims adjudication and payment, and other services such as customer service. HCA uses Regence's clinical policies and utilization and case management policies as a baseline for UMP policies.

HOW WE GET THERE

HCA added a handful of new innovative performance guarantees to the UMP TPA contract. Accordingly, 4 percent of administrative fees paid to Regence are tied to a value-based performance guarantee, which includes all UMP plans, and requires Regence to demonstrate increased VBP adoption across its book of business from 2020 through 2023 (when the target plateaus at 85%). Further, 7 percent of annual administrative fees paid to Regence are tied to clinical outcomes (15 quality compass measures) held at 90th percentile of preferred provider organizations.

RESULTS

The new third-party administrator contract for UMP will start providing benefits for members on January 1, 2020. Prior to launch, Regence will develop a roadmap for member experience and VBP to guide implementation of programs and strategies designed to meet performance goals.

Delivery system transformation

VALUE-BASED PAYMENT PRACTICE TRANSFORMATION ACADEMY

SYNOPSIS

In 2017, the Value-based Payment Practice Transformation Academy offered technical assistance to community behavioral health providers throughout the state to increase their engagement in VBP arrangements.

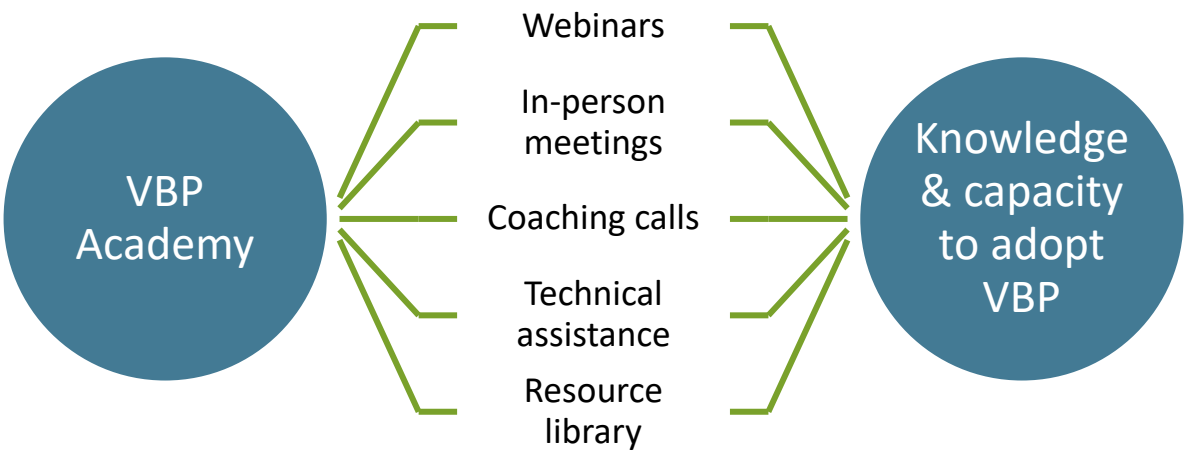
GOAL

To help participating organizations meet the Healthier Washington goal of having 90 percent of state payments tied to value by 2021.

OUTCOMES

- Academy participants report increased understanding of and comfort with entering into VBP arrangements.
- Behavioral health providers increased their participation in VBP arrangements.
- Participants were able to identify and better understand barriers to entering into VBP arrangements.

HOW IT WORKED



THE CHALLENGE

The State is transitioning to a new health care purchasing system for Apple Health (Medicaid) to shift 90 percent of state-financed health care to VBP by 2021. To achieve this, health care providers need to increase their adoption of VBP arrangements. However, providers may not have the tools, resources, or knowledge to participate in such arrangements. This is particularly true for community behavioral health providers, many of whom do not have experience working in a managed care environment or are not as advanced in health information technology as many physical health providers.

DESCRIPTION

In 2017, the Washington Council for Behavioral Health partnered with the Healthier Washington Practice Transformation Support Hub and the National Council for Behavioral Health to develop the VBP Academy, a 10-month learning academy for licensed community behavioral health agencies.

The Academy, which ran from October 2017 to July 2018, included 20 behavioral health agencies currently providing outpatient mental health and/or substance use disorder services in Washington State. The VBP Academy was designed to:

- Cultivate internal champions to plan for and enact steps to succeed in VBP arrangements
- Increase understanding of value-based principles and models in behavioral health consistent with the HCA's Value-based Road Map and Apple Health managed care contracts
- Provide comprehensive technical assistance to build organizational capacity to adopt VBP arrangements in Washington State.

HOW WE GET THERE

Through a combination of in-person meetings, practice coaching calls, and monthly technical assistance webinars, the VBP Academy fostered the fundamental principles organizations need to demonstrate readiness for VBP arrangements.

Phase 1 of the VBP Academy, which ran from October 2017 to January 2018, focused on building a foundation of VBP readiness. Participating organizations improved their VBP literacy as well as their understanding of organizational readiness assessments, population health management, and continuous quality improvement. In Phase 2, which ran from February 2018 to August 2018, each participating agency carried out a stretch project focused on quality improvement related to a health measure identified in the Medicaid Transformation Project Toolkit. Activities were structured in a manner that tied the selected "value measures" to specific Medicaid transformation projects. Practice Transformation Support Hub Coaches also provided assistance and feedback throughout the project.

RESULTS

Participants gained a better understanding of VBP models in behavioral health, quality improvement, data collection, and alignment of clinical delivery and payment systems. Because of their participation, organizations experience measurable outcomes, including:

- A comprehensive quality improvement and project management strategy
- Cultivating buy-in among internal stakeholders
- Developing a committee structure to operationalize transformation
- Creating a concrete work plan that prioritizes organizational transformation efforts

Delivery system transformation

WORKFORCE AND PRACTICE TRANSFORMATION

SYNOPSIS

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

GOAL

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

DESIRED OUTCOMES

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

HOW IT WORKS

Statewide
- Convene, coordinate
- Resource repository
- Facilitation, technical assistance
- Communication
- Partner with state experts

→

ACH/Regional
- Coordinate common needs, programs & best practices
- Design workforce plan
- Develop partnerships
- Communication

→

ACH/Project
- Identify local needs
- Implement plans
- Work with state partners on regulatory barriers
- Address workforce gaps

→

Local
- Implement workforce plan
- Innovations like employer based training & support
- Practice transformation support
- Educational programs & resources

THE CHALLENGE

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

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

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

DESCRIPTION

ACHs coordinate with providers and clinics to identify training and support needs.

ACHs develop partnerships with education, practice transformation, and statewide or regional workforce development resources, such as community colleges, employers, and health industry experts to address evolving workforce needs through education, training and re-training for existing workers, and innovation that supports new paraprofessional roles.

ACHs coordinate with state agencies, providers, health sector, and workforce experts to identify and address regulatory barriers to team-based, bidirectional, integrated care.

HOW WE GET THERE

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

RESULTS

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

Pharmacy

PRESCRIPTION DRUG PROGRAM

SYNOPSIS

The Washington State Health Care Authority (HCA) uses an evidence-based selection process for managing preferred drugs on the Washington Preferred Drug List (PDL) and uses pooled purchasing through the Northwest Prescription Drug Consortium to deliver high value prescription drug benefits to state-financed health care programs.

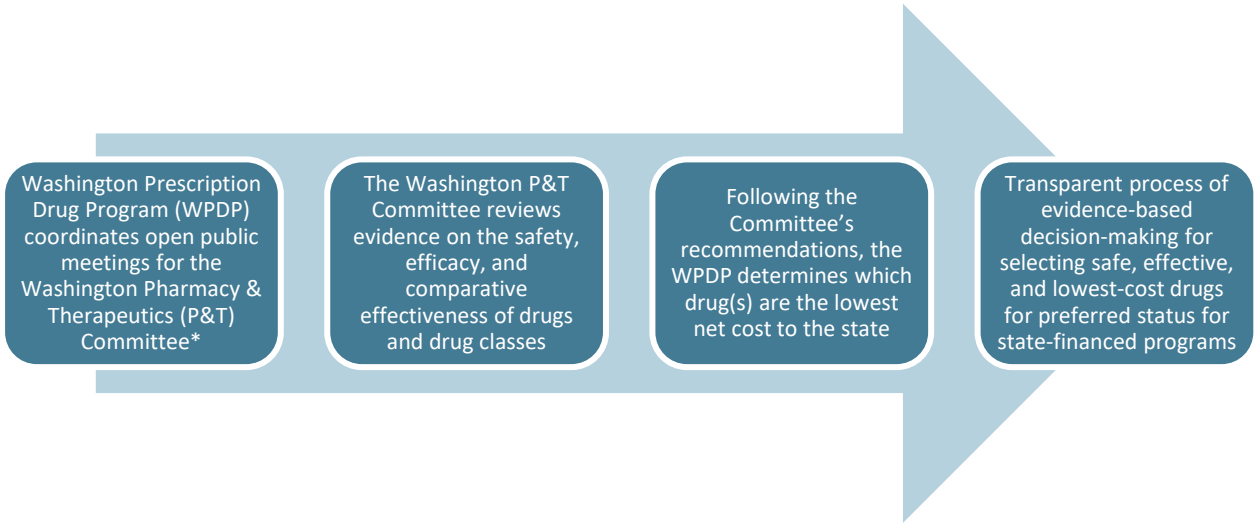
GOAL

The Prescription Drug Program designs and delivers high quality, evidence-based pharmacy programs by exploring collaborative and innovative prescription drug purchasing strategies.

DESIRED OUTCOMES

- Manageable and sustainable pharmacy and overall cost trends
- Clinical policies for new medications to ensure appropriate utilization
- Improved health outcomes through access to medications

HOW IT WORKS



*The Washington State Pharmacy & Therapeutics Committee is made up of 10 practicing physicians, pharmacists, and other clinicians.

THE CHALLENGE

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

DESCRIPTION

HCA administers two state-financed health programs: Washington State Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB). It will also administer the School Employee Benefits Board (SEBB) program beginning in 2020.

For PEBB, HCA contracts with Moda Health to manage the pharmacy benefit for the Uniform Medical Plan (UMP), the state's self-insured health plan. Moda and its partners contract with manufacturers for drug rebates and they negotiate reimbursement rates with pharmacies to pay for medications dispensed to members.

For Medicaid, HCA manages a single PDL for the five contracted Medicaid managed care organizations (MCOs) and the fee-for-service (FFS) program. The goal of the single PDL is to direct Apple Health clients to the high value drugs.

HOW WE GET THERE

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

Separate from the Apple Health PDL, HCA manages the Washington Preferred Drug List (WA-PDL), used by UMP and comprising approximately 35 drug classes. Moda manages the PDL for UMP for those drug classes not on the WA-PDL. HCA aligns clinical policies across all programs (i.e., opioid use and Hepatitis C treatment) whenever possible.

Typically, preferred drugs with a clear evidence-base have fewer restrictions for providers, improving access to high value drugs.

RESULTS

- HCA launched the single PDL for Apple Health on January 1, 2018.
- HCA implemented a new opioid policy in November 2017 and January 2018 for Apple Health and UMP, respectively.
- Washington State has launched a Hepatitis C elimination strategy with HCA, the Department of Health, and other partners.