

HCA VALUE-BASED ROAD MAP, 2017-2021

INTRODUCTION

There is a national imperative led by Medicare, the biggest payer in the U.S., to move away from traditional volume-based health care payments to payments based on value. Over the past year this movement has gained significant traction since Medicare declared its own commitment to value and quality, announced its own purchasing goals (similar to HCA), and made substantial progress in meeting its goals. At the same time, federal legislation—the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, supports Medicare’s acceleration of value-based purchasing by rewarding providers through higher Medicare reimbursement rates for participation in advanced value-based payments (VBPs) or Alternative Payment Models (APMs) starting in 2019.

Like Medicare, the Washington State Health Care Authority (HCA) is transforming the way it purchases health care. As directed by the Legislature in statute, and as a key strategy under Healthier Washington, HCA has pledged that 80 percent of HCA provider payments under State-financed health care programs—Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) program—will be linked to quality and value by 2019. HCA’s ultimate goal is that, by 2019, Washington’s annual health care cost growth will be 2 percent less than the national health expenditure trend.

To further align with the Centers for Medicare and Medicaid Services (CMS) payment reform efforts and accelerate the transition to value-based payment, HCA is currently in negotiations with CMS for an 1115 Medicaid transformation waiver. If approved, the waiver presents a unique opportunity to accelerate payment and delivery service reforms and reward regionally-based care redesign approaches that promote clinical and community linkages through State-purchased programs. Moreover, if the waiver is approved, HCA commits that 90 percent of its provider payments under state-financed health care will be linked to quality and value by 2021.

PURPOSE AND GOALS

The HCA Value-based Road Map lays out how HCA will fundamentally change how health care is provided by implementing new models of care that drive toward population-based care. This HCA VBP Road Map braids together major components of Healthier Washington (Payment Redesign Model Tests, Statewide Common Measure Set and Accountable Communities of Health (ACHs), for example), the Medicaid transformation waiver, and the Bree Collaborative care transformation recommendations and bundled payment models. The Road Map is built on the following principles:

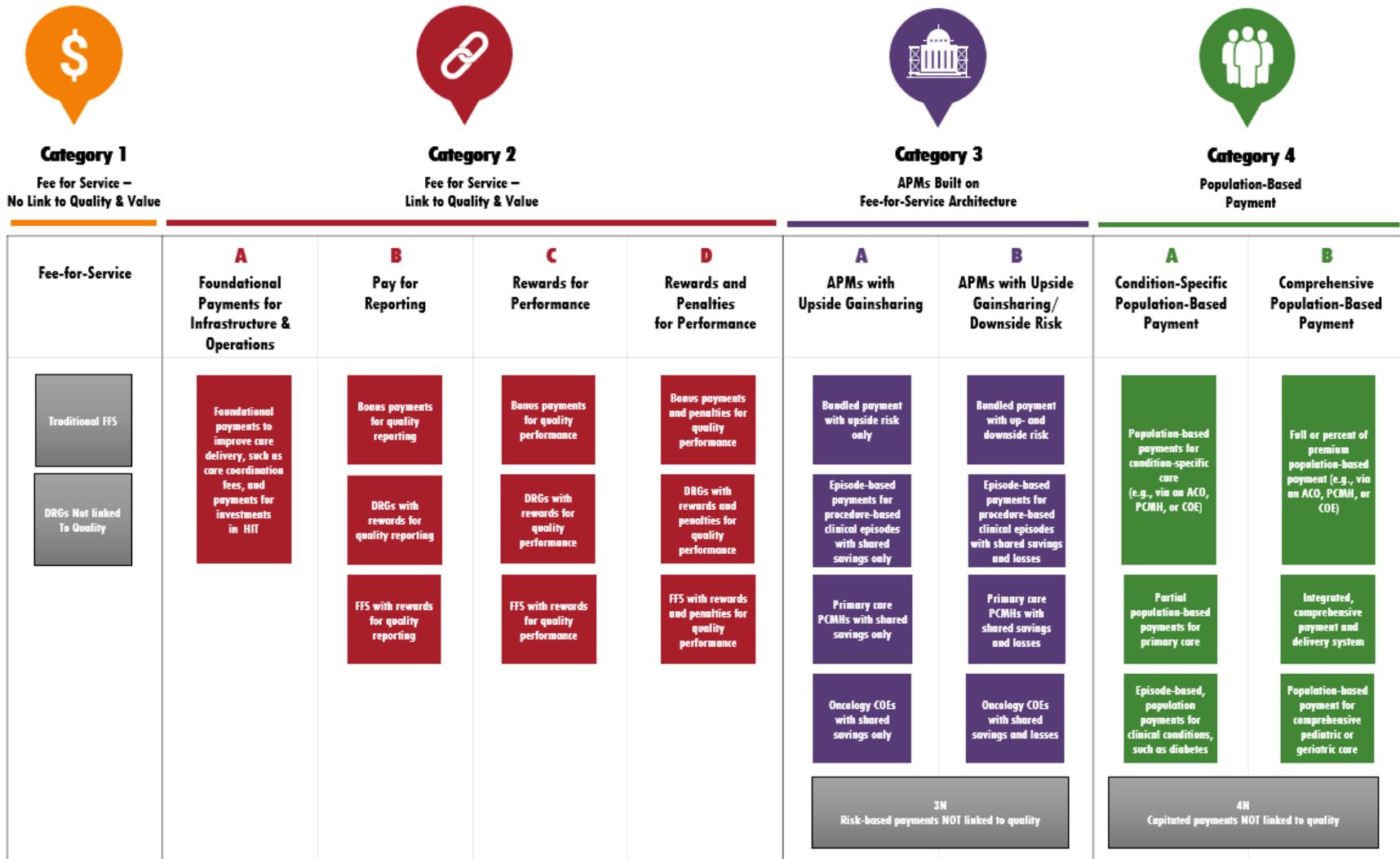
- Reward the delivery of patient-centered, high value care and increased quality improvement;
- Reward performance of HCA's Medicaid and PEBB Program health plans and their contracted health systems;
- Align payment and delivery reform approaches with CMS for greatest impact and to simplify implementation for providers;
- Improve outcomes for patients and populations;
- Drive standardization based on evidence;
- Increase long-term financial sustainability of state health programs; and
- Continually strive for the Triple Aim of better care, smarter spending and healthier people.

HCA'S FRAMEWORK AND PURCHASING GOALS

As the largest purchaser in Washington State, HCA purchases care for over 2.2 million Washingtonians through Apple Health and PEBB. Annually, HCA spends 10 billion dollars between the two programs. As a purchaser and state agency, HCA has market power to drive transformation using different levers and relationships.

As stated in the HCA Paying for Value survey released in March 2016, HCA has adopted the framework created by CMS to define VBPs, or APMs (see Chart 1, next page).

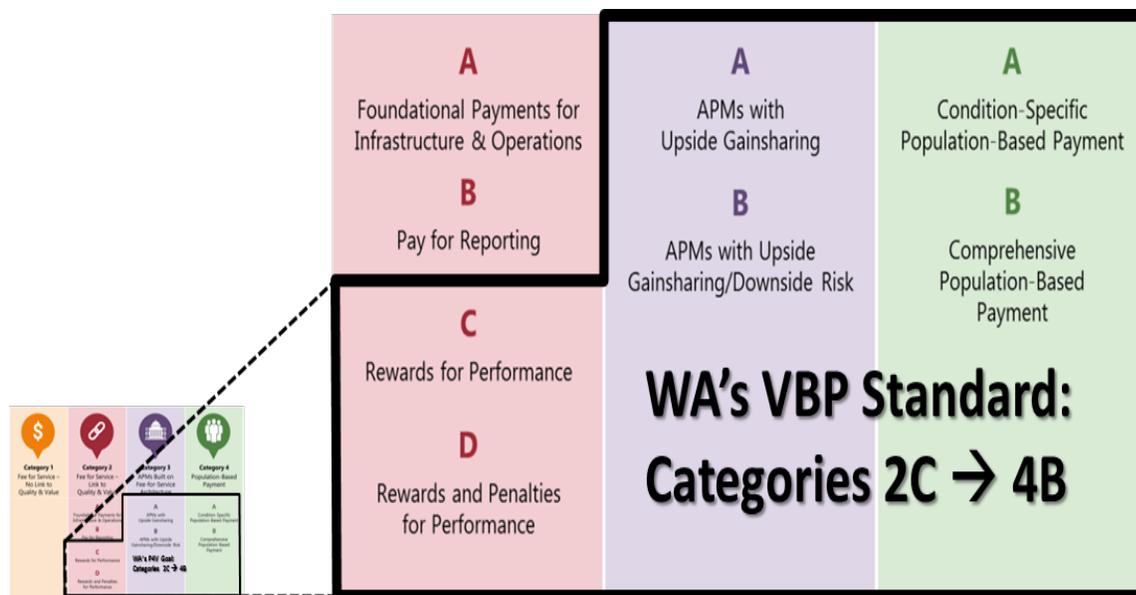
Chart 1: CMS Framework for Value-based Payments or Alternative Payment Models



■ = example payment models will not count toward APM goal. N = payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

HCA's implementation of the CMS framework is shown below in Chart 2.

Chart 2: Washington State's Value-based Payment Framework



To reach its purchasing goal, HCA expects 90 percent of state-financed health care payments to providers will be in CMS' categories 2c-4b by 2021. HCA's ultimate vision for 2021 is:

- HCA programs implement VBPs according to an aligned purchasing philosophy.
- Nearly 100% of HCA's purchasing business is entrusted to accountable delivery system networks and plan partners.
- HCA exercises significant oversight and quality assurance over its contracting partners and implements corrective action as necessary.

HCA's interim purchasing goals and key VBP milestones along the path to 90 percent in 2021 are shown below.

- 2016: 20% in VBP
- 2017: 30%
- 2018: 50%
- 2019: 80%
- 2020: 85%
- 2021: 90%

APPENDIX

CHANGES TO APPLE HEALTH CONTRACTS STARTING IN 2017

This document reflects specific, imminent changes pertaining to the Apple Health program, in alignment with HCA's VBP Roadmap. This document is not all-inclusive of expected long-term changes to the Apple Health program.

Consistent with HCA's VBP targets, there will be significant changes to Apple Health contracts starting in January 2017. MCO contracts will require that a growing portion of premiums be used to fund direct provider incentives tied to attainment of quality. To ensure quality and performance thresholds are being met, HCA will withhold an increasing percentage of plan premiums, to be returned based on achieving a core subset of metrics from the statewide common measure set. HCA will use the same measures in all provider VBP arrangements.

In addition, through use of time-limited funding under the Medicaid transformation waiver, MCOs will be able to earn financial incentives for achieving annual VBP targets (described further in the visual below). In 2018 and each year thereafter, the MCOs' accountability for each of these new contract components will grow progressively.

Finally, the Apple Health program changes include the creation of a "challenge pool" to reward exceptional managed care performance and a "reinvestment pool" to provide similar regional incentives for exceptional performance attributable to the broader participants in an ACH¹.

A description of the approaches as well as the parties to each approach is described in further detail below. A visual summary of funds flow and a table that provides additional detail on how the new incentive structures would work are included at the end of this document.

APPROACHES

TIME-LIMITED INCENTIVES FOR MCOs AND ACHs

HCA-MCO AND HCA-ACH

VBP INCENTIVES

MCOs will earn incentives funded through Initiative 1 of the Medicaid transformation waiver for exceeding VBP target thresholds, starting with 30 percent in 2017. These incentives will be in place for the five years of the waiver, but will not extend beyond the waiver period. Performance will be measured consistent with the approach taken in HCA's Paying for Value RFI, by looking at the

¹ This document refers to the ACH role broadly, recognizing ACH participants include MCOs and providers, for which specific roles are also highlighted.

proportion of payments tied to value-based arrangements (as defined in the HCP-LAN framework). Through the waiver, ACHs will also be able to structure incentive programs regionally to reward providers who are undertaking new VBP arrangements, these will be tied to the same VBP targets.

PROVIDER INCENTIVES UNDER MANAGED CARE

MCO-PROVIDER

MANAGED CARE ORGANIZATION (MCO) INCENTIVES

Value-based payment strategies require risk sharing and other financial arrangements between providers and plans that reward value outside of a fee-for-service model. To ensure that providers are being adequately incentivized in these arrangements, HCA will establish a percentage of premium threshold that each MCO must meet as part of its contractual obligations. Beginning in 2017, MCOs must ensure that at least 0.75 percent of their premium is going to providers in the form of incentives that help ensure that value-based arrangements are adequately rewarding and incentivizing providers to achieve quality and improved patient experience.

QUALITY WITHHOLD

HCA-MCO

MANAGED CARE ORGANIZATION (MCO) INCENTIVES

HCA will withhold a progressively increasing percentage of premiums paid to MCOs on the basis of quality improvement and patient experience measures. MCOs will need to demonstrate quality improvement against a standard set of metrics to earn back the withheld premium amount. Today, HCA utilizes a 1 percent withhold related to the quality of data submissions from MCOs to HCA. This approach broadens the quality standards being measured and increases the percentage of withhold gradually each year, until it reaches 3 percent in 2021.

COMMON MEASURES

HCA-MCO-ACH-PROVIDERS

HCA has committed to using standard measures of performance across its purchasing activity, consistent with the statewide common measure set. In addition, these measures will drive the evaluation and incentive payments under the Medicaid transformation waiver. Specifically, HCA anticipates a core subset of common measures to be used in its contracts with MCOs around the quality withhold and also expects to see this same core set of measures used in VBP arrangements between plans and providers. A good example of how the common measure set is already being used in HCA purchasing efforts can be found [here](#).

CHALLENGE POOL

HCA-MCO

CHALLENGE POOL

Washington State has embraced the value of a competitive managed care model for delivering Medicaid services. HCA's approach to VBP seeks to reward exceptional performance of MCOs through use of a "challenge pool." Unearned VBP incentives from the waiver and uncollected withhold payments from managed care premiums will be made available in a challenge pool that rewards plans that meet an exceptional standard of quality and patient experience, based on a core subset of measures.

REINVESTMENT POOL

HCA-MCO-ACH-PROVIDERS

REINVESTMENT POOL

The value-based payment structure for Medicaid also provides a reinvestment pool, funded similarly to the "challenge pool," which would use unearned ACH VBP incentives and a share of unearned MCO incentives to provide meaningful reinvestment in regional health transformation activities, based on performance against a core subset of measures. This provides a continuing incentive for multi-sector contributions to health transformation and rewards the delivery system and supporting organizations for achieving quality and improved patient experience.

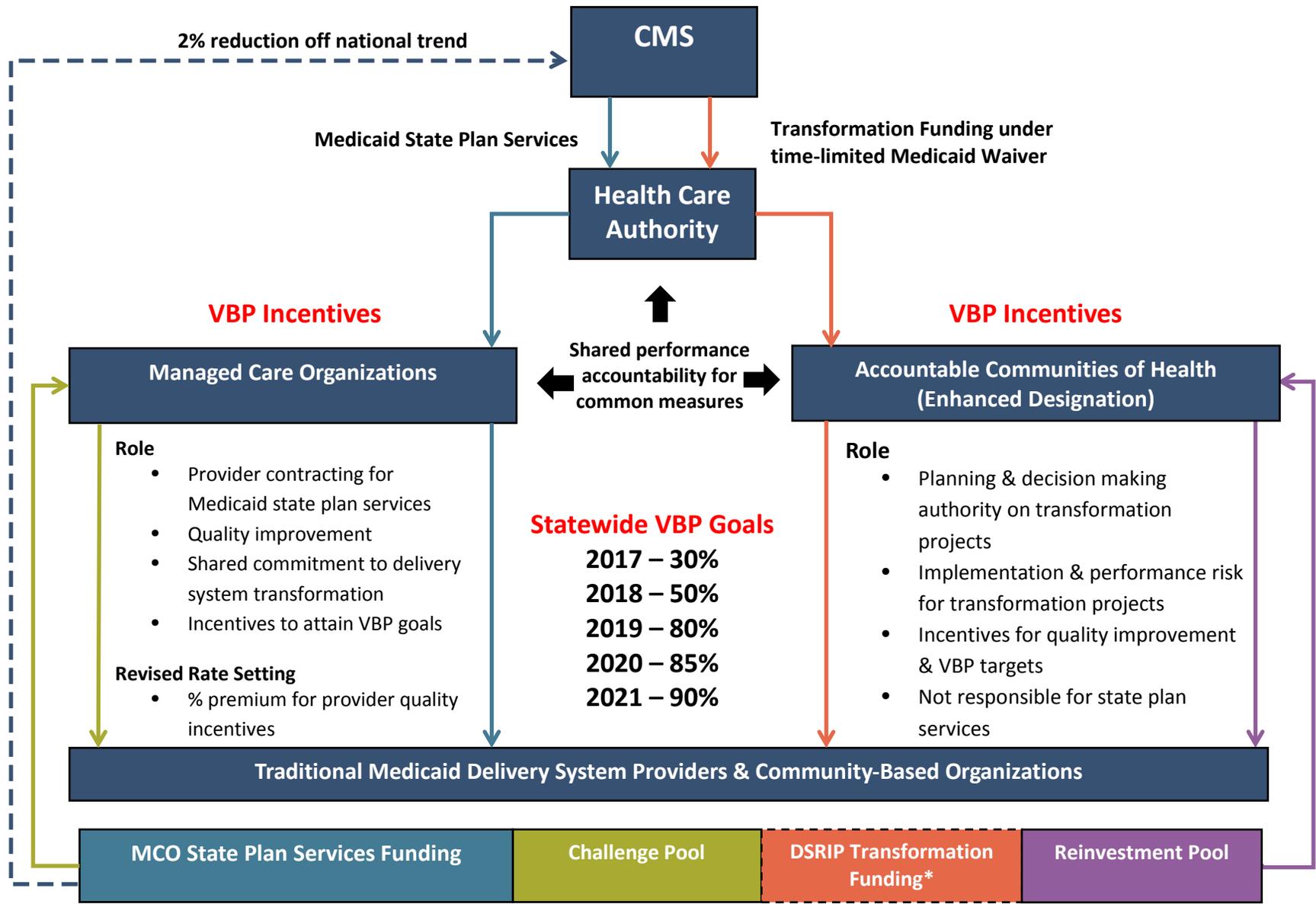
VALIDATING VBP ATTAINMENT IN MANAGED CARE PROVIDER CONTRACTING

To adequately measure the status of payer-provider arrangements under Medicaid that are proprietary in nature, HCA will use a third-party assessment organization to review and validate detailed plan submissions. A similar model is used today through the federally required External Quality Review Organization that provides annual reports on the performance of each MCO.

SUMMARY

Taken together, these components reflect a phased incentive approach that emphasizes more equal weight being placed on ACHs and statewide managed care organizations (payer and provider networks) in achieving the state's roadmap to value-based payment over the next five years. They also show how contractual and financial levers are used to sustain community reinvestment and sustainable incentive structures that can last well beyond the waiver. This approach ensures mutual accountability for the performance of the health system in service of whole-person health outcomes and quality improvement.

Washington State Value-Based Purchasing Framework: Apple Health Program Changes



*Time Limited – 5 years

Apple Health Value Based Payment - Overview and Sample Scenario

CALENDAR YEAR	VBP INCENTIVES			MANAGED CARE ORGANIZATION (MCO) INCENTIVES		CHALLENGE POOL	REINVESTMENT POOL
	Managed Care Organization (MCO specific)	Accountable Communities of Health (ACH Specific)	STATE VBP Target	Managed Care Organization (MCO specific)	Managed Care Organization (MCO specific)	Managed Care Organization (MCO specific)	Accountable Communities of Health (ACH Specific)
	VBP Target Incentive ¹ % of each incremental % point of premium over/under VBP target ²	Region Specific VBP Target Incentive ¹ \$ tied to each 1% over State VBP Target ³		Provider Incentives % premium for provider quality incentives	Quality Withhold % premium at Risk for performance ⁴	Unearned VBP Incentives ^{5,6} % of unearned MCO Incentives and withhold	Unearned ACH VBP Incentives ^{5,6} % of unearned ACH VBP and a share of unearned MCO incentives
<i>Pre</i>	-	-	20%	-	-	-	-
2017	(+/-) 2%	\$200k for each 1%	30%	0.75%	1.0%	(up to) 1%	
2018	(+/-) 1.5%	\$300k for each 1%	50%	1.0%	1.5%	(up to) 1%	
2019	(+/-) 1%	\$666k for each 1%	75%	1.5%	2.0%	(up to) 1%	
2020	(+/-) 0.75%	\$1m for each 1%	85%	2.0%	2.5%	(up to) 1%	

2021	(+/-) 0.5%	\$1.2m for each 1%	90%	2.5%	3.0%	(up to) 1%	
<i>Post</i>	Not extended beyond the five year waiver period		90%+	3.0%	2.5%	0.25% + 25% of remaining withhold ⁷	0.25% + 75% of remaining withhold ⁷

SAMPLE SCENARIO							
2017	<p>MCO "A" with \$1B of premiums exceeds VBP target statewide by 20% in year 1 and earns \$4M.</p> <p>MCO "B" with \$1B of premiums is short in meeting the VBP targets statewide by 10% in year 1 and pays \$2M out of its premium withhold.</p>	<p>ACH "A" exceeds VBP regional target by 10% in year 1 and earns \$2M of DSRIP incentive.</p> <p>ACH "B" is short in meeting the VBP regional target by 10% in year 1 and does not earn a DSRIP incentive.</p>	30%	<p>MCO "A" is contractually obligated to allocate at least 0.75% of its premium to providers in the form of incentives that help ensure value-based arrangements are adequately rewarding and incentivizing providers to achieve quality and improved patient experience.</p>	<p>MCO "A" demonstrates quality improvement against common measures and earns back 1% withheld premium amount.</p> <p>To earn back the 1% premium withhold, MCO "A" must also achieve the state VBP target and pass at least the required % premium for provider quality incentives.</p>	<p>MCO "A" exceeds quality improvement target by 5 basis points—earns back complete premium withhold and is eligible for challenge pool, not to exceed 1% of premium.</p>	<p>ACH "A" meets quality improvement target and is now eligible for its share of the reinvestment pool.</p>

¹ Challenge and reinvestment pools funded by unearned MCO VBP incentives and ACH VBP incentives (under DSRIP) as well as any unpaid premium withhold for quality

² Not to exceed 1% of managed care organization's total premium payment, with a \$20m annual aggregate maximum across all MCO VBP Incentives

³ Not to exceed \$7.5M for any region in any year, with a \$20M annual aggregate maximum across all ACH VBP incentives

⁴ Or 75% of year to year trend increase (averaged across eligibility groups), whichever is lower, but not below 1%

⁵ Dollars accrued for reinvestment and challenge pools are split equally between MCO and ACHs.

⁶ Total combined value of challenge and reinvestment pools will not exceed \$25M on an annualized basis.

⁷ Post waiver period, challenge pool is composed of 0.25% of all MCO premiums and 25% of any unearned withhold - the reinvestment pool is funded similarly with 75% of remaining withhold.

Example for MCO "A" 2017

Experience	Calculation	Result
Total premium		1,000,000,000
Quality improvement withhold	1% of premium	(10,000,000)
Achieves 50% VBP vs. 30% target	2% incentive x 20% excess x \$1B premium	4,000,000
Amount for provider incentives	0.75% of premium	(7,500,000)
Demonstrates quality improvement	1% of premium	10,000,000
Meets exceptional performance standard	Up to 1% of premium, depending on amount in pool	<u>5,000,000</u>
Total premium plus incentives		1,001,500,000