Value-based purchasing survey results

Washington providers and health plans report 2017 VBP experiences
Background

HCA’s roles and our value-based roadmap
What we do at HCA

State’s largest health care purchaser
- Medicaid (Apple Health)
  - 1.9 million people
- Public Employees Benefits
  - 370,000 people
- School Employees Benefits (2020)
  - 144,000 more covered lives coming

Driving change through incentives
- Reward patient-centered, high-quality care
- Reward health plan and system performance
- Drive standardization

We purchase care for 1 in 3 non-Medicare Washington residents with an annual spend over $12B
HCA purchasing goals

By 2021:

- 90 percent of state-financed health care and 50 percent of commercial health care will be in value-based payment arrangements (measured at the provider/practice level).
- Washington’s annual health care cost growth will be below the national health expenditure trend.

Tools to accelerate VBP and health care transformation:
- 2014 legislation directing HCA to implement VBP strategies
- SIM round 2 grant, 2015-2019
- Healthier Washington Medicaid Transformation 2017-2021
HCA’s ultimate goal is to achieve a healthier Washington – consistent with the quadruple aim – by containing cost growth while improving outcomes and both consumer and provider experience.

HCA’s vision for 2021 is to drive toward a healthier Washington by using the State’s authority and purchasing power to advance VBP.

- All HCA programs implement VBP according to an aligned purchasing philosophy.
- Plan partners and accountable delivery system networks comprise most of HCA’s purchasing business.
- HCA exercises significant oversight and quality assurance over its contracting partners, implementing corrective action as necessary.
- Washington’s annual health care cost growth will be less than the national health expenditure trend.

Source: HCA, “HCA Value-based Roadmap 2017-2021,” January 2018
HCA’s VBP Guiding Principles:

1) Continually strive for the quadruple aim of lower costs, 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 feasible, for greatest impact and to simplify implementation for providers;

5) Drive standardization and care transformation based on evidence; and

6) Increase the long-term financial sustainability of state health programs.

Value-based purchasing roadmap

2016:
20% VBP

2017:
43% VBP

2018:
50% VBP

2019:
75% VBP

2020:
85% VBP

2021:
90% VBP
Alignment with CMS Alternative Payment Models (APM) framework

State’s VBP Standard: Categories 2C → 4B
## VBP accountability – MCO contracts

### MCO Contract Withhold Components

**VBP Share: 12.5%**

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Target Percentage</th>
</tr>
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<tbody>
<tr>
<td>2017</td>
<td>30%</td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
</tr>
<tr>
<td>2019</td>
<td>75%</td>
</tr>
<tr>
<td>2020</td>
<td>85%</td>
</tr>
<tr>
<td>2021</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Provider Incentives Share: 12.5%**

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Target Percentage</th>
</tr>
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<tbody>
<tr>
<td>2017</td>
<td>.75%</td>
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<tr>
<td>2018</td>
<td>1%</td>
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<tr>
<td>2019</td>
<td>1%</td>
</tr>
<tr>
<td>2020</td>
<td>TBD</td>
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<tr>
<td>2021</td>
<td>TBD</td>
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</table>

**QIS Share: 75%**

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Target Score</th>
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<tbody>
<tr>
<td>2017</td>
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<td>2018</td>
<td>0.2</td>
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<td>2019</td>
<td>0.2</td>
</tr>
<tr>
<td>2020</td>
<td>0.2</td>
</tr>
<tr>
<td>2021</td>
<td>0.2</td>
</tr>
</tbody>
</table>
# VBP accountability - MTP

### Statewide accountability

**Percentage Targets by Year**

<table>
<thead>
<tr>
<th>VBP adoption target (HCP LAN 2C-4B)</th>
<th>Scoring weights</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improvement Score</td>
<td>Achievement Score</td>
<td></td>
</tr>
<tr>
<td>DY 3</td>
<td>75%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>DY 4</td>
<td>85%</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>DY 5</td>
<td>90%</td>
<td>40%</td>
<td>60%</td>
</tr>
</tbody>
</table>

### Pay for Performance MCO DSRIP VBP incentives

**Percentage Targets by Year**

<table>
<thead>
<tr>
<th>Performance targets</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HCP LAN 2C-4B Performance target</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCP LAN 3A-4B Performance subtarget</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DY 1</td>
<td>30%</td>
<td>N/A</td>
</tr>
<tr>
<td>DY 2</td>
<td>50%</td>
<td>10%</td>
</tr>
<tr>
<td>DY 3</td>
<td>75%</td>
<td>20%</td>
</tr>
<tr>
<td>DY 4</td>
<td>85%</td>
<td>30%</td>
</tr>
<tr>
<td>DY 5</td>
<td>90%</td>
<td>50%</td>
</tr>
</tbody>
</table>
HCA’s value-based purchasing survey

Tracking progress in calendar year 2017

Informing current and future strategy
Overview

Three surveys: MCO, commercial health plan, provider

Purpose: track progress towards VBP goals

Issued to all Washington State health plans (including five MCOs) and to provider organizations

MCO and provider surveys add regional information and context

Intended to be completed by administrators
Health plan VBP survey
Health plan VBP survey respondents

MCOs (n=5):
- Amerigroup
- Community Health Plan of Washington
- Coordinated Care
- Molina
- United

Medicare & commercial health plans (n=7):
- Aetna
- Amerigroup*
- Community Health Plan of Washington*
- Coordinated Care*
- Kaiser Permanente*
- Premera*
- Regence*

*Current HCA contractor
NCACH provider VBP survey respondents

 Providers giving HCA permission to share responses (n=23):
  - American Behavioral Health Systems, Inc.
  - Assured Independence
  - Catholic Charities - Serving Central Washington
  - Catholic Charities of Central Washington
  - Catholic Charities of Eastern Washington
  - Chelan county Public Hospital District No. 1 DBA Cascade Medical Center
  - Children’s Home Society of Washington
  - Columbia Basin Health Association
  - Columbia Valley Community Health
  - Confluence Health

 Providers (continued):
  - Coulee Medical Center
  - Family Health Centers
  - Grant Integrated Services
  - Lake Chelan Community Hospital and Clinics
  - Mid Valley Hospital/Mid Valley Medical Group
  - Moses Lake Community Health Center
  - North Valley Hospital
  - Okanogan Behavioral Healthcare
  - Parkview Medical Group
  - Samaritan Hospital
  - Sundown M Ranch
  - The Center for Alcohol and Drug Treatment
  - Three Rivers Hospital
Quantitative data results

Health plan VBP survey
Health plan VBP surveys (cont.)

Payments by APM category

**Medicaid** Payments by APM Category

- n=5
- Total payments = $4.62B
- VBP = $2.30B (49.7%)

**Medicare** Payments by APM Category

- n=6
- Total payments = $1.61B
- VBP = $1.03B (64.1%)

**Commercial** Payments by APM Category

- n=5
- Total payments = $10.72B
- VBP = $6.04B (56.4%)

Statewide VBP = $9.37B (55%)

2017 survey results = 37%
2016 survey results = 30%
MCO VBP by Accountable Community of Health

- Olympic Community of Health: 47%
- North Sound ACH: 46%
- HealthierHere: 50%
- Cascade Pacific Action Alliance: 47%
- Pierce County ACH: 56%
- SWACH: 54%
- North Central ACH: 62%
- Greater Columbia ACH: 47%
- SWACH: 54%
- Better Health Together: 50%
Payments by APM category

**Medicaid Payments by APM Category**
- FFS: 50%
- 2A/2B: 1%
- 2C/2D: 4%
- 3A/3B: 42%
- 4A/4B: 4%

**NCACH Medicaid Payments by APM Category**
- FFS: 38%
- 2A/2B: 0%
- 2C/2D: 40%
- 3A/3B: 22%
- 4A/4B: 4%

**Note:** Confluence Health has indicated they will revert to full FFS

MCO reported payments: $236M
Confluence reported revenue: $73M
(31% of total MCO payments)

*If all Confluence revenue was FFS in 2017, regional VBP would be 48% (down from 62%)*

n=5
Total payments = $4.62B
VBP = $2.30B (49.7%)

n=5
Total payments = $236M
VBP = $146M (61.9%)
Provider VBP survey
Provider VBP survey

Respondent organization type

(multiple selections per respondent possible)

Statewide

<table>
<thead>
<tr>
<th>Organization Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not-for-profit</td>
<td>11</td>
</tr>
<tr>
<td>Critical Access Hospital</td>
<td>20</td>
</tr>
<tr>
<td>Rural Health Clinic</td>
<td>17</td>
</tr>
<tr>
<td>Federally Qualified Health Center</td>
<td>16</td>
</tr>
<tr>
<td>Hospital</td>
<td>13</td>
</tr>
<tr>
<td>Outpatient clinic/facility</td>
<td>4</td>
</tr>
<tr>
<td>Inpatient clinic/facility</td>
<td>29</td>
</tr>
<tr>
<td>Behavioral health provider</td>
<td>4</td>
</tr>
<tr>
<td>Multi-specialty practice</td>
<td>18</td>
</tr>
<tr>
<td>Independent, multi-provider...</td>
<td>7</td>
</tr>
<tr>
<td>Tribal health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Single-provider practice</td>
<td>1</td>
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</tbody>
</table>

n=95

NCACH

<table>
<thead>
<tr>
<th>Organization Type</th>
<th>Count</th>
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<tbody>
<tr>
<td>Not-for-profit</td>
<td>2</td>
</tr>
<tr>
<td>Critical Access Hospital</td>
<td>5</td>
</tr>
<tr>
<td>Rural Health Clinic</td>
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<tr>
<td>Federally Qualified Health Center</td>
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</tr>
<tr>
<td>Hospital</td>
<td>6</td>
</tr>
<tr>
<td>Outpatient clinic/facility</td>
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</tr>
<tr>
<td>Inpatient clinic/facility</td>
<td>9</td>
</tr>
<tr>
<td>Behavioral health provider</td>
<td>1</td>
</tr>
<tr>
<td>Multi-specialty practice</td>
<td>4</td>
</tr>
<tr>
<td>Independent, multi-provider single...</td>
<td>2</td>
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<tr>
<td>Tribal health care provider</td>
<td>1</td>
</tr>
<tr>
<td>Single-provider practice</td>
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</tbody>
</table>

n=23
Quantitative data results

Provider VBP survey
Provider VBP survey (cont.)

Respondents’ number of clinicians

**Statewide**

- n=95

**NCACH**

- n=23
Provider VBP survey (cont.)

Total revenue by sector: North Central Accountable Community of Health

NCACH: Revenue by Sector

<table>
<thead>
<tr>
<th></th>
<th>Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$171</td>
</tr>
<tr>
<td>Medicare</td>
<td>$367</td>
</tr>
<tr>
<td>Commercial</td>
<td>$385</td>
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</table>

n=18
Qualitative data results

Provider VBP survey
Respondents’ experience with VBP

Statewide:
- Very positive: 4
- Somewhat positive: 16
- Neutral: 15
- Somewhat negative: 3
- Very negative: 3
- N/A: 42

NCACH:
- Very positive: 0
- Somewhat positive: 2
- Neutral: 1
- Somewhat negative: 1
- Very negative: 2
- N/A: 12

n=83

n=18
### Summary: top three enablers and barriers to VBP adoption  
(from most often cited to least)

<table>
<thead>
<tr>
<th>Enablers</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statewide</strong></td>
<td></td>
</tr>
<tr>
<td>Aligned quality measurements and definitions (26)</td>
<td>Lack of interoperable data systems (61)</td>
</tr>
<tr>
<td>Development of medical home culture with engaged providers (23)</td>
<td>Lack of timely cost data to assist with financial management (53)</td>
</tr>
<tr>
<td>Ability to understand and analyze payment modes (21)</td>
<td>Lack of access to comprehensive data on patient populations (48)</td>
</tr>
<tr>
<td><strong>NCACH</strong></td>
<td></td>
</tr>
<tr>
<td>Common clinical protocols and/or guidelines (4)</td>
<td>Lack of interoperable data systems (12)</td>
</tr>
<tr>
<td>Aligned quality measurements and definitions (4)</td>
<td>Insufficient patient volume by payer to take on clinical risk (10)</td>
</tr>
<tr>
<td>Sufficient patient volume by payer to take on clinical risk (3) – tied with three others (medical home culture; regulatory changes; aligned incentives)</td>
<td>Lack of timely cost data to assist with financial management (9) – tied with ‘lack of consumer engagement’</td>
</tr>
</tbody>
</table>
Provider VBP survey (cont.)

Respondents’ experience over the last year relative to barriers

Statewide

- Improved: 25
- Worsened: 9
- Stayed the same: 53

NCACH

- Improved: 3
- Worsened: 2
- Stayed the same: 16
### Health equity

<table>
<thead>
<tr>
<th>Statewide</th>
<th># of Providers responding “Yes” to collecting the following data</th>
<th># of Providers responding “Yes” to assessing performance by the following data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td>86</td>
<td>13</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>81</td>
<td>13</td>
</tr>
<tr>
<td>Language</td>
<td>80</td>
<td>11</td>
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</table>

<table>
<thead>
<tr>
<th>NCACH</th>
<th># of Providers responding “Yes” to collecting the following data</th>
<th># of Providers responding “Yes” to assessing performance by the following data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td>22</td>
<td>5</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>Language</td>
<td>22</td>
<td>4</td>
</tr>
</tbody>
</table>
Integration: respondents’ reported level of SAMHSA’s “Six Levels of Collaboration/Integration”

- **Statewide**
  - Level 6: Full Collaboration in a Transformed/Merged Integrated Practice: 6 providers
  - Level 5: Close Collaboration Approaching an Integrated Practice: 13 providers
  - Level 4: Close Collaboration Onsite with Some System Integration: 14 providers
  - Level 3: Basic Collaboration Onsite: 15 providers
  - Level 2: Basic Collaboration at a Distance: 14 providers
  - Level 1: Minimal Collaboration: 33 providers

- **NCACH**
  - Level 6: Full Collaboration in a Transformed/Merged Integrated Practice: 1 provider
  - Level 5: Close Collaboration Approaching an Integrated Practice: 4 providers
  - Level 4: Close Collaboration Onsite with Some System Integration: 3 providers
  - Level 3: Basic Collaboration Onsite: 2 providers
  - Level 2: Basic Collaboration at a Distance: 10 providers
  - Level 1: Minimal Collaboration: 3 providers

- 70 providers intend to move to a higher level in the next year
- 18 providers intend to move to a higher level in the next year
Provider VBP survey (cont.)

Technical support: types of technical support received

- Value-based reimbursement
- Behavioral/physical health integration
- Practice transformation

Statewide

NCACH

Value-based reimbursement: 50
Behavioral/physical health integration: 48
Practice transformation: 36

Value-based reimbursement: 10
Behavioral/physical health integration: 13
Practice transformation: 16
Technical support: type of technical support that would be the most helpful moving forward

- Value-based reimbursement
- Behavioral/physical health integration
- Practice transformation
Provider VBP survey (cont.)

Respondents’ future plans for VBP

Statewide

- Increase by more than 50%: 61
- Increase by 25-50%: 15
- Increase by 10-24%: 16
- Increase by up to 10%: 25
- Stay the same: 23
- Decrease by up to 10%: 1
- Decrease by 10-24%: 1
- Decrease by 25-50%: 1
- Decrease by >50%: 1

NCACH

- Increase by more than 50%: 1
- Increase by 25-50%: 3
- Increase by 10-24%: 3
- Increase by up to 10%: 4
- Stay the same: 9
- Decrease by up to 10%: 1
- Decrease by 10-24%: 1
- Decrease by 25-50%: 1
- Decrease by >50%: 1
VBP Toolkit

- Manatt conducting interviews with ACHs, providers, and MCOs
  - Which VBP TA tools and resources are most valuable?
  - ACH role in facilitating access to and use of TA tools and resources
  - ACH training needs to support TA role

- Preliminary interview findings:
  - Must target VBP resource development and delivery in the most high-value areas
  - Coordination across stakeholders (ACHs, MCOs, provider associations, HCA) to provide the necessary suite of support services to help providers transition to VBP
  - VBP roles need to be clearly defined and communicated

- Aim to publish/release final toolkit/compendium in May
Summary findings

Provider and health plan VBP surveys
Summary findings – VBP is accelerating

- Health plans’ VBP adoption increased from previous year, outpacing targets.
- Providers’ experience with VBP has been generally positive among those providers with some degree of VBP participation.
- Providers generally plan to increase VBP participation and desire technical support.
- Responding providers generally report lower levels of VBP adoption than health plans.
- Lack of interoperable data systems remains the top-rated barrier.
- To facilitate the acceleration:
  - Improve timeliness and comprehensiveness of data shared to providers (multi-payer)
  - Align quality measures and incentives
  - Foster collaborative and trusting relationships
  - Invest in inter-operability
  - Support small to medium sized providers
Overview of Rural Transformation Model & how it fits into broader Healthier Washington Transformation journey
### Rural Stakeholder Perspectives – Why Rural Transformation

<table>
<thead>
<tr>
<th>Rural Health Systems</th>
<th>WA HCA (Medicaid and PEBB/SEBB)</th>
<th>Medicare/CMMI</th>
<th>Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Financial solvency under FFS (e.g., low volume)</td>
<td>• Stewards of tax payer money to leverage purchasing power to pay for high-quality, high-value care across for rural WA</td>
<td>• Same as HCA</td>
<td>• Unit costs higher in rural areas</td>
</tr>
<tr>
<td>• Sicker, older and population changes</td>
<td>• VBP and population health TCOC goals</td>
<td>• Rural providers traditionally left out of Medicare VBP efforts</td>
<td>• Are already supporting rural health system transformation on an individual hospital basis</td>
</tr>
<tr>
<td>• Lack of resources to invest in value-based care</td>
<td>• Build on transformation efforts (e.g., Accountable Communities of Health)</td>
<td>• Interest in partnering with states with novel rural transformation approaches that improve health outcomes and reduce costs</td>
<td>• Some services provided by some rural health systems may not meet the needs of their individual communities</td>
</tr>
<tr>
<td>• Workforce issues, recruitment and retention</td>
<td>• Consolidation</td>
<td>• Consolidation</td>
<td>• Consolidation</td>
</tr>
<tr>
<td>• Consolidation</td>
<td></td>
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</tr>
</tbody>
</table>
Rural Transformation Journey - Background
Where we’ve been, where we are, and where we want to go

- Healthier Washington's Payment Model 2: Encounter to Value
- Health Innovation Leadership Network: Rural Health Innovation Accelerator Committee

2015
Early engagement to develop a new rural model:
- Commercial payers, MCOs, providers, and key stakeholder
- Medicare

2017

2018
Exploratory development of a Rural Multi-Payer Model
Washington Rural Health Access Preservation (WRHAP) Project

• WRHAP group created in 2014 by DOH and Washington State Hospital Association, following New Blue “H” Report
• Workgroup's mission: assist WRHAP Critical Access Hospitals (CAHs) on brink of closure with preparing for value-based purchasing, alternative payment models
• 13 of smallest and most remote Critical Access Hospitals are WRHAP members:
  – Cascade Medical Center
  – Columbia Basin
  – Dayton
  – East Adams
  – Ferry County
  – Forks
  – Garfield
  – Mid Valley
  – Morton
  – North Valley
  – Odessa
  – Three Rivers
  – Willapa
WRHAP Legislation

• ESHB 2450 (2016)
  – Established WRHAP pilot
  – Allowed designated Critical Access Hospitals (CAHs) that dropped their CAH licensure to participate in WRHAP and resume CAH payment

• SHB 1520 (2017)
  – Expanded ESHB 2450
  – Directed HCA to create WRHAP pilot “to develop an alternative service and payment system for CAHs” and encourage additional payers to use the adopted payment methodology
  – $2.1 million transition funding in 2018 and 2019 for WRHAP pilot
SHB 1520 Implementation

- HCA, DOH, and Washington State Hospital Association (WSHA) worked with WRHAP hospitals (summer/fall 2017) to use transition funding to:
  - Build capacity of behavioral health services or care coordination services
  - Link quality performance to implementation of those services
- HCA worked with CMS to match funding (approved July 2018)
- Transitional funding through MCO contracts with TA support from WSHA (July 2018)
- Progress report to Legislature (submitted December 2018)

- With CMS approval, transitional payments are active
  - WRHAP hospitals have until December 2018 to submit their first performance report
Broader Rural Transformation Efforts Timeline

- **WRHAP created (2014)**
- **ESHB 2450 (2016)**
- **SHB 1520 & CMS approval of transition funds (2018)**
- **Work with CMMI* to secure Medicare participation (2019)**

- **CAH* & Rural Health Center Payment Model, State Innovation Model Grant (2014)**
- **Updated Medicare participation guidance (2017)**
- **Blueprint for rural transformation for all rural hospitals (Sept. 2018)**

*CAH = Critical Access Hospital; CMMI = Center for Medicare and Medicaid Innovation*
Primary Goal: Sustain access to essential care in rural communities

Secondary Goals:
• Improve health outcomes and quality of care for rural residents
• Incentivize rural health systems to provide services that meet the needs of their communities (in partnership with the state, federal gov’t and payers)
• Improve the financial state of participating rural hospitals by re-aligning incentives and through care coordination
• Reduce the growth of hospital expenditures across payers

Proposed Approach – 3 components:
1) Alternative Payment Model (Budget) for all rural hospitals (52 eligible)
2) Delivery system transformation strategy (detailed care transformation plans, annually)
3) Quality metrics

Justification for approach:
• Broad accountability for a population as condition of Medicare participation (vs. regional)
• Budget approach brings stability and predictability for rural health systems
• Allows for customized approach for each community (created by each community)
• Opportunity to address state and federal regulatory barriers, e.g., workforce, scope of practice
• Opportunity to synchronize with transformation efforts already underway (e.g., ACHs)
## Alignment of transformation goals: Achieving the Triple Aim

<table>
<thead>
<tr>
<th>SIM Grant</th>
<th>Medicaid Transformation Initiative</th>
<th>Proposed Rural Transformation Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% of WA residents and their communities will be healthier (through improving the way we pay for care)</td>
<td>Accelerate the transition to value-based care (90% by 2021)</td>
<td>Same – by sustaining access to equitable and essential care in rural communities</td>
</tr>
<tr>
<td>All people with physical and behavioral (mental health and substance use disorder) will receive high quality care</td>
<td>Improve population health</td>
<td>Same – by promoting coordination of services like primary care, specialty care and behavioral health</td>
</tr>
<tr>
<td>Washington’s annual health care cost growth will be 2% less than the national health expenditure trend</td>
<td>Ensure that Medicaid per-capita cost growth is below national trends</td>
<td>Reduce the growth of hospital expenditures across payers</td>
</tr>
<tr>
<td></td>
<td>Reduce avoidable use of intensive services and settings</td>
<td></td>
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## SIM Medicaid Transformation Initiative Proposed Rural Transformation Model

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<th>SIM</th>
<th>Medicaid Transformation Initiative</th>
<th>Proposed Rural Transformation Model</th>
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| VBP (4 payment models) | VBP (existing Medicaid VBP, VBP targets for MCOs and ACHs)  
In 2020: 85% (LAN 2C-4B); 30% (LAN 3A-4B)  
In 2021: 90% (LAN 2C-4B); 50% (LAN 3A-4B) | VBP (budget approach), LAN 4B |
| Care transformation strategy (various) | Care transformation strategy (toolkit) | Care transformation strategy (annual plans) |
| Providers, PEBB, commercial and MCO plans, employers, ACHs | Providers, MCOs, ACHs | Providers, PEBB and SEBB, commercial and MCOs, ACHs, multi-payer, employers, Medicare |

### Foundational Transformational Core Strategies

- Accountable Communities of Health
- Integrating physical and behavioral health care
- Performance measures
- Practice transformation support
- Health workforce innovation
A new payment approach and care transformation support are the two main pillars of the model.

### Fixed annual revenue
- Fixed annual payment paid out to hospitals monthly, providing a stable stream of revenue
- Stabilize cash flow, so hospitals can invest in care quality and sustainability
- Based on historic data adjusted for transformation-related service changes

### Care transformation support
- Tailored assistance at no cost to the hospital
- The objective of support is to minimize the burden of making transformation-related changes
- Support across all transformation phases: data collection, plan creation, and implementation
52 Eligible Hospitals (CAH or in an OFM rural county)
The proposed model will open to 52 rural hospitals and all health plans

Requirements for model participation

- Defined as a rural hospital by HCA (i.e., hospital is within a OFM-designated rural county or 39 critical access hospitals)
- Have a significant proportion (TBD, although likely greater than ~70%) of the hospital’s net patient revenue would be from insurer participants in the model
- Demonstrate interest and commitment to transformation
Hospitals can transform care, improve quality, and become financially stable under the model

How can providers succeed by adopting global budgets?

- **Reduce costs**
  - Generate optimal revenue (e.g., by increasing appropriate outpatient and inpatient volume) from service lines and community programs that align with hospital and population needs and improve the patient care experience

- **Improve quality**
  - Reduce hospital care (e.g., reduce # of readmissions, # hospitalizations, length of stay) that is unplanned and can be prevented through improved quality, care management, coordination and clinical operations

- **Improve operational efficiency**
  - Improve hospital’s ability to provide care in the most cost-effective manner (e.g., reduce operating expenses per admission) by optimizing processes and capabilities

- **Optimize service profile**
  - Generate optimal revenue (e.g., by increasing appropriate outpatient and inpatient volume) from service lines and community programs that align with hospital and population needs and improve the patient care experience
Inclusions in the baseline are based on type of facility and type of service

**What facilities/services and included in the NPR?**

**Included facilities in Year 1:**
- Acute care hospitals
- Critical access hospitals (CAH)
- Hospital-owned long-term care
- Hospital-owned behavioral health services
- Hospital-owned and operated clinics
- Hospital-employed PCPs

**Included services in Year 1:**
- Inpatient hospital services
- Outpatient hospital services (e.g., ED, Lab, Imaging, E&M services, Same day surgery, Other OP services)
- Hospital-owned primary care
- Hospital-owned long-term care
- Hospital-owned behavioral health
- CAH swing beds
- Professional services

**Excluded facilities in Year 1:**
- Post-acute care institutions (e.g., skilled nursing facility)
- Dialysis facility
- Ambulatory surgery centers or other special facilities

**Excluded services in Year 1:**
- Dental services
- Durable medical equipment
- Home health services
- All others

The global budget excludes operating revenue outside of NPR such as existing earned quality, value-based payments, or other supplemental payments (e.g., legislative programs, DSH)
In discussions with CMMI and other stakeholders, HCA is still working through some elements of the model.

Elements under consideration for the rural multi-payer model:

- How employed PCPs, including those in owned FQHCs and RHCs, will be incorporated into the model
- Administrative feasibility of incorporating professional fees
- Guardrails to be included in the model
- Glide path for hospitals joining the model
- Care transformation investment support options
- Elements and structure of transformation plans
- How quality metrics will be harmonized between the rural multi-payer model and other state programs

HCA will continue to build out these aspects and incorporate input and suggestions.
### Rural Health Systems
- Voluntary
- Phased approach, e.g., 8-10 in Year 1
- 52 hospitals eligible (if in a OFM-rural designed county)
- Participating rural health systems will:
  - Have a set budget
  - Agree to submit care transformation plans
  - Will receive data and analytic support

### Medicare/CMMI
- Model engagement with WA under SIM
- Continued engagement through Spring to show value of model to Medicare

### Payers
- Voluntary
- Phased approach, starting with Medicaid, PEBB and SEBB
- ASO BOB at payers’ discretion, with TA assistance from HCA
- Prospective payment to participating rural health systems based on % of revenue
Participating hospitals would embark on a journey to ensure preparedness and readiness for care design under a new budget

### Community & provider assessment
- Internal or external benchmarking on operational performance, access, and quality
- Understanding community needs by leveraging material (e.g., CHNA) and interviews

### Exploration
- Determine possibility with transformation areas/levers/interventions
- Model the impact of provider and insurer participation
- Produce examples of how to identify potential strategic priorities

### Evaluation
- Prioritization of strategic priorities
- Develop initiatives to help define year 1 expectations and interventions
- Consult with experts and communities for best practice sharing

### Plan
- Develop board-level briefing materials
- Develop transformation plan, including:
  - Community needs
  - Capabilities assessment
  - Strategic priorities (w/ targets, financial plan etc.)
  - High-level action plan
- Consult with experts and communities for best practice sharing

### Launch
- Launch global budget model
- Consider change management approach
- Provide guidance on detailed action plan and execution to organization
Proposed Governance Approach

- A public/private board made up of providers, payers, national rural/payment experts
- Authority to approve and amend budgets within parameters set in state/federal agreement and provider and payer MOUs
- Potential models to emulate/learn from:
  - Maryland Health Services Cost Review Commission
  - Pennsylvania legislation
  - Bree Collaborative
Proposed Timeline

- Multi-year (5-7 year model)
- Budget starts for participating hospitals: Mid 2020 or Jan 1, 2021
- Pre-implementation phase starts when Medicare agreement finalized: Fall 2019/Jan 1, 2020
- Formal commitments from “early adopter” hospitals and payers: Summer 2019/Fall 2019
### Detailed roadmap broader Rural Multi-payer Model

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<td>▪ Determine technical model parameters and high-level design</td>
<td>▪ Engage CMMI to refine model components and develop State Agreement if approved</td>
<td>▪ Complete transformation plans</td>
<td>▪ Go-live with Year 1 of model for payers and first wave of participating providers</td>
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<td>▪ Engage providers for feedback</td>
<td>▪ Develop quality goals and relationship to existing measure sets</td>
<td>▪ Use simulation tool to determine value creation opportunity</td>
<td>▪ Launch governance structure</td>
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<td>▪ Create concept paper for CMMI feedback</td>
<td>▪ Develop governance approach and required structures</td>
<td>▪ Finalize list of Wave 1 providers and insurers participating in the model with formal agreements</td>
<td>▪ Determine next wave of hospital and provider participation</td>
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<td>▪ Engage interested stakeholders to specifically quantify value of participation / provide board communication materials</td>
<td>▪ Determine technical requirements for data intake and reporting</td>
<td>▪ New payment model would start mid-2020 or January 2021</td>
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<td>▪ Begin to collect data from providers and insurers</td>
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Questions & discussion

Thank you!
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