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Initiative #1 Statewide Accountability Approach

April 2018

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Acronym Glossary

- **A-APM** – Advanced Alternative Payment Model
- **DSRIP** – Delivery System Reform Incentive Payment
- **DY** – demonstration year (January 1 – December 31)
- **FFP** – Federal financial participation
- **HCP-LAN framework** – the Health Care Payment Learning & Action Network framework for alternative payment models
- **MTP** – Healthier Washington Medicaid Transformation project
- **P4P** – Pay for performance
- **P4R** – Pay for reporting
- **STC** – Special Terms & Conditions
- **QIS** – Quality improvement score
- **VBP** – Value-based purchasing

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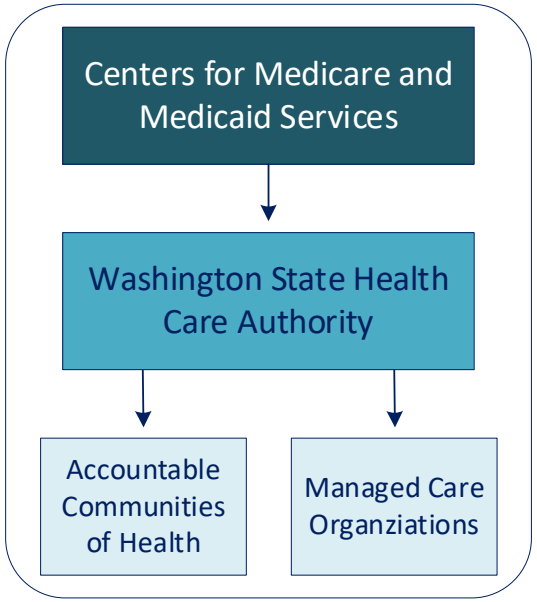
Introduction

The Healthier Washington Medicaid Transformation aims to transform the health care delivery system to address local health priorities, deliver high-quality, provide cost-effective care that treats the whole person, and create sustainable linkages between clinical and community-based services.

As part of the Transformation, the Delivery System Reform Incentive Payment (DSRIP) program provides resources for regional, collaborative activities coordinated by the state's nine Accountable Communities of Health (ACHs).

Overall progress under the DSRIP program will be monitored, assessed, and incentivized for Washington State overall, at the level of the ACH region, and the Medicaid managed care organization (MCO).



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Introduction

The purpose of this slide deck is to provide an overview of the statewide accountability framework for the Healthier Washington Medicaid Transformation.

Statewide Accountability Components

- 100% of total DSRIP funding is at risk if the state fails to demonstrate statewide integration of physical and behavioral health managed care by January 2020.
- In Medicaid Transformation Years 3-5, a portion of DSRIP funding will be at-risk depending on the state's advancement of quality and VBP goals, including:
  - Improvement and attainment of quality targets across a set of quality metrics; and,
  - Improvement and attainment of defined statewide VBP targets.

If overall DSRIP funding is reduced on account of underperformance for statewide targets, DSRIP Project Incentives to ACHs and partnering providers will be reduced accordingly.

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Statewide Accountability Framework

STC Requirements

In DY 3-5, a portion of DSRIP funding will be at-risk depending on the state's advancement of VBP adoption and quality goals.*

Percent of DSRIP Funding At Risk for Performance

DY 1	DY 2	DY 3	DY 4	DY 5
0%	0%	5%	10%	20%

Statewide Accountability Components

Quality Measures (10)

- All-Cause Emergency Department Visits per 1,000 Member Months
- Antidepressant Medication Management (acute/continuation phase)
- Comprehensive Diabetes Care: Blood Pressure Control
- Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9%)
- Controlling High Blood Pressure (<140/90)
- Medication Management for People with Asthma: Medication Compliance 75%
- Mental Health Treatment Penetration (Broad)
- Plan All-Cause Readmission Rate (30 days)
- Substance Use Disorder Treatment Penetration
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

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Statewide VBP Adoption Targets

(% of payments at or above HCP LAN 2C)

DY 3	75%
DY 4	85%
DY 5	90%

**** The percentages for DY 4 and DY 5 assume the state demonstrates statewide integration of physical and behavioral health managed care by January 2020.***

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Managed Care Integration

STC Requirements

100% of total DSRIP funding is at risk if the state fails to demonstrate statewide integration of physical and behavioral health managed care by January 2020.

Measurement Approach

Definition of Achievement	At least two contracts for integrated managed care in each purchasing region must be effective and beneficiary enrollment initiated as of January 1, 2020.
Data Source	HCA will track and report on achievement of the metric based on effective dates of integrated managed care contracts for each region.

Managed care integration is a foundational goal for Medicaid Transformation and is characterized as a "statewide accountability metric" because all DSRIP funds are at risk if statewide integration of physical and behavioral health does not occur by the 2020 deadline.

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Quality Improvement

The ten statewide accountability quality metrics were selected to align with other state measure sets and contracts including the managed care contracts, statewide common measure set, and P4P measures included in the ACH projects that can be accurately calculated at the regional level. HCA will adapt the Quality Improvement (QI) model to determine statewide performance.

Measurement Approach

Definition of Achievement	The threshold QI-score (QIS) to receive full credit for statewide performance is 0.2. This is the same threshold applied in the context of the QI-model used for the MCO withhold.
Data Source	Performance results will be calculated from ProviderOne Medicaid claims and enrollment data. Measures that require medical record data will be generated from MCO performance results reported per contract agreements with HCA.

How the QI Model works:

- The **QI Model** generates an overall QI Score based on the weighted average of the set of quality measures.
- The **QI Score** for each measure is blended between state improvement from prior performance and movement toward achieving the target score.
- The individual QI Scores are then combined with their weights into **one overall QI Score (QIS)**.

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Quality Improvement

Measurement Approach

Each quality measure receives an equal weight in the QI Model to mitigate the influence that regional project selections have on statewide performance measurement.

Quality Measures	QI Model Parameters		
	Quality Score *How Performance Year result compares to the range defined by the Measure Target and Measure Mean*		**Improvement Score** *How Performance Year result compares to the range defined by the Improvement Baseline Year result and the Measure Target*
	Measure Target (upper bound of range)	**Measure Mean (lower bound of range)**	
All-Cause Emergency Department Visits per 1,000 Member Months	Statewide mean - 1 percentage point	Statewide mean	Performance Year and Improvement Baseline Year correspond to the ACH pay-for-performance measurement years.
Antidepressant Medication Management (acute/continuation phase)	National Medicaid 90th Percentile	National Medicaid Mean	
Comprehensive Diabetes Care: Blood Pressure Control	National Medicaid 90th Percentile	National Medicaid Mean	
Comprehensive Diabetes Care: Hemoglobin A1c Poor Control	National Medicaid 90th Percentile	National Medicaid Mean	
Controlling High Blood Pressure	National Medicaid 90th Percentile	National Medicaid Mean	
Medication Management for People with Asthma (5 – 64 Years)	National Medicaid 90th Percentile	National Medicaid Mean	
Mental Health Treatment Penetration	Statewide mean + 1 percentage point	Statewide mean	
Plan All-Cause Readmission Rate (30 days)	Statewide mean - 1 percentage point	Statewide mean	
Substance Use Disorder Treatment Penetration	Statewide mean + 1 percentage point	Statewide mean	
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	National Medicaid 90th Percentile	National Medicaid Mean	

DY	Performance Year	Improvement Baseline Year
3	2019	2017
4	2020	2018
5	2021	2019

VBP Adoption

STC Requirements

By the end of 2021, 90% of all Medicaid MCO payments to providers must be made through designated VBP arrangements in order for the state to secure maximum available DSRIP funds.

Measurement Approach

Definition of Achievement	Statewide VBP adoption goals are limited to HCP LAN 2C-4B VBP arrangements.
Data Source	Per their contract requirements with HCA, MCOs must attest to their VBP adoption annually by reporting total payments in each HCP-LAN category. *Note: VBP baseline year is the year prior to the measurement year.*

Statewide Accountability VBP Goals

	Target Goal (HCP LAN 2C-4B)	Scoring Weights*	
		Improvement	Achievement
DY 3	75%	50%	50%
DY 4	85%	45%	55%
DY 5	90%	40%	60%

VBP adoption performance is measured by two factors: improvement and achievement of the target goal. If the VBP target is achieved, then the full VBP portion of the statewide accountability withhold is earned. If the goal is not achieved, a portion of the withhold can still be earned based on the state's improvement in VBP adoption from the prior year.

Note: Regional VBP P4R and P4P reporting requirements will remain in place, while statewide performance will be measured on a P4P basis.

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Calculating Level of VBP Adoption

Approach

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

Calculation Methodology

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

Data source: annual MCO data collection

Note: Payments for services covered by Behavioral Health Organizations (BHOs) will only be included in DSRIP VBP adoption calculations after integration with MCOs, starting at the time of integration.

* Specifically defined as total MCO payments to providers for services, including pharmacy, inpatient, outpatient, physician/professional, and other health services, excluding any pass-through payments or other services carved out from MCO contracts. This amount excludes payments related to case payments, administrative dollars, WA State Health Insurance Pool (WSHIP), premium tax, Safety Net Assessment Fund (SNAF) Provider Access Payment (PAP) or Trauma funding. *Source: MCO Model Contract, Section 3.4.1.2.*

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Statewide Accountability Composite Score

Each of the ten quality measures contributes equal weight to the Quality Improvement QIS (totaling 80%). VBP adoption is weighted at 20% in recognition of its importance in the overall Medicaid Transformation effort and statewide value-based roadmap.

The example illustrates the DSRIP funds lost in DY 3 if the state achieves full credit for Quality Improvement (QIS), but achieves only 50% credit for demonstrating improvement towards (but not attainment of) the state VBP adoption target.

Statewide Accountability Components (DY 3-5)	Weight	Example Statewide Withhold Scenario (5% of DSRIP Funding At Risk in DY 3: $11,795,000)			
		Percent Earned	Dollars At Risk*	Dollars Lost	Dollars Earned
Quality Improvement (Composite QI-Score)	80%	100%	$9,436,000	$0	$9,436,000
Value-Based Payment Adoption Score	20%	50%	$2,359,000		$1,179,500
Total	100%		$11,795,000	$1,179,500	$10,615,500

Recall that 100% of total DSRIP funding is at risk if the state fails to demonstrate statewide integration of physical and behavioral health managed care by January 2020.

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Statewide Accountability Withhold Approach

Funding & Mechanics Protocol Requirements

The state will submit the statewide accountability report and supporting documentation to CMS for review and approval. CMS will have 90 calendar days to review and approve the statewide accountability report. Once CMS approves the report, the state can access the earned funds, according to the statewide accountability composite score.

Withhold Approach

Validating Statewide Accountability Scores & Annual Withhold Amounts*
(Annual Process: DY 3-5)

Starting in DY 3:
Total available DSRIP funds to draw down from CMS will be limited by at-risk portion.

- DY 3: 5%
- DY 4: 10%
- DY 5: 20%

January-September (following DYs 3-5):
Quality performance and VBP adoption data are aggregated and validated.

In September, HCA prepares a statewide accountability report for CMS that includes the quality QIS and VBP scores for the prior measurement year, and resulting statewide accountability composite score.

September following Withhold Year (e.g., September DY 4):
HCA submits the statewide accountability report to CMS.

CMS has 90 days to review and approve statewide accountability report, and confirm share of withheld funds earned.

End of every December to Q2 (following DYs 3-5):
HCA draws down any earned at-risk funding for distribution.

Any funds lost will be applied to the portion of DSRIP funds associated with P4P project incentives, proportionally across ACHs.

P4P project incentive funds, including any earned withheld funds, become available by Q2.

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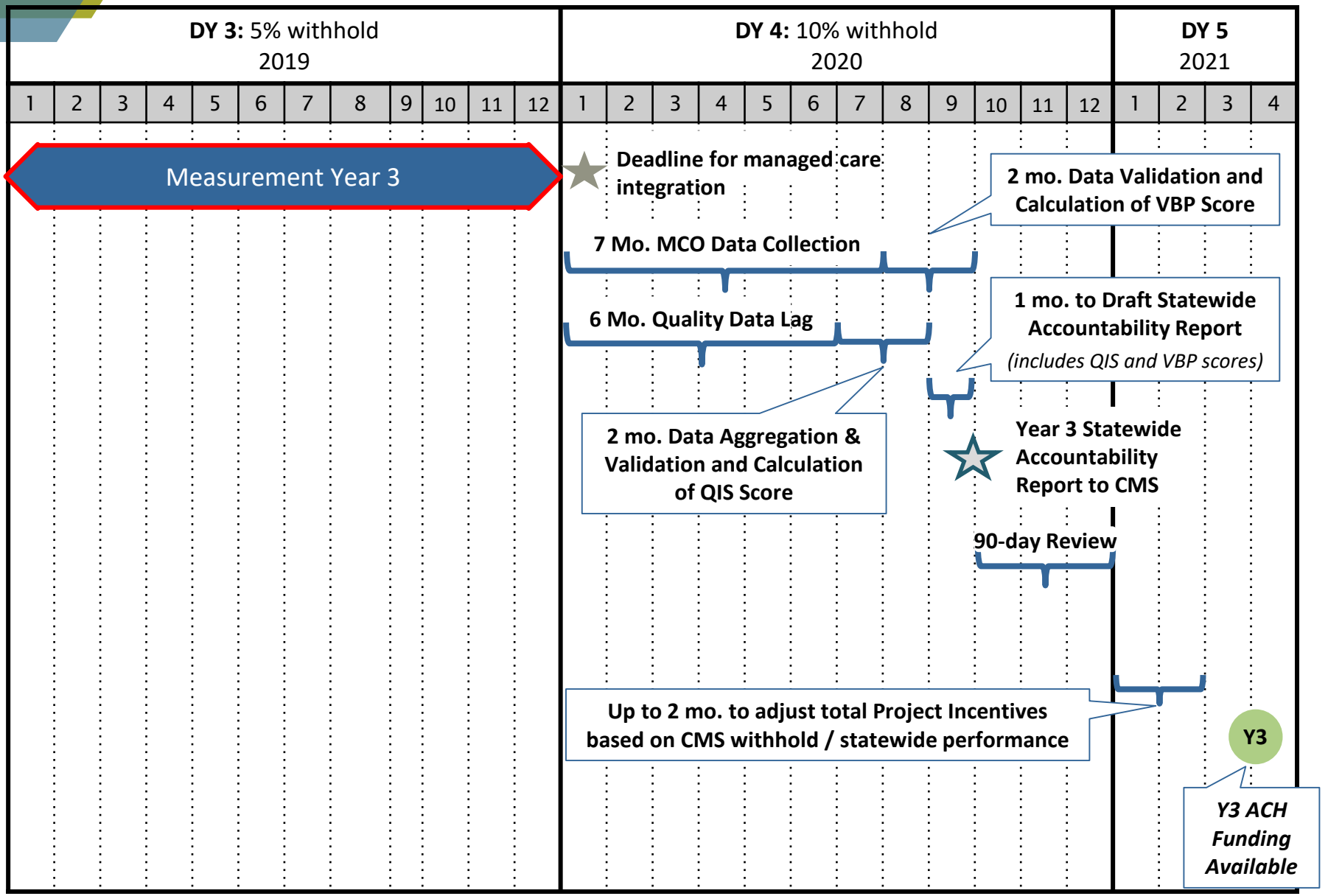
See the next slide for withhold process and timeline

Statewide Accountability Withhold Process & Timing

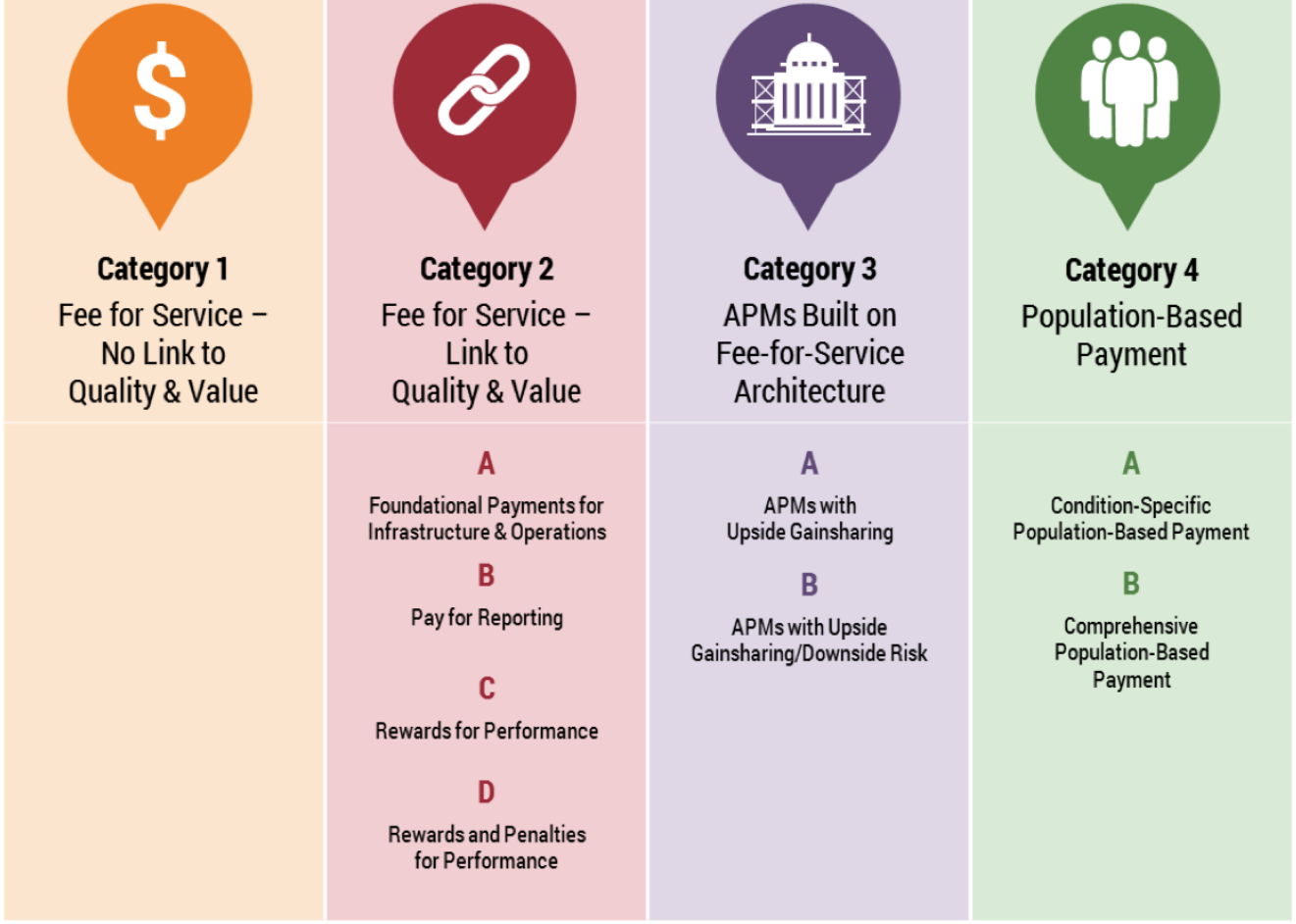


Appendix: Statewide Accountability Measures

Measures	Description
VBP Measure	
VBP Adoption	Statewide VBP adoption targets will be limited to HCP LAN 2C-4B VBP arrangements: DY 3 (75%); DY 4 (85%); DY 5 (90%).
Quality Measures	
All-Cause Emergency Department Visits per 1,000 Member Months	The rate of Medicaid enrollee visits to the emergency department per 1000 member months, including visits related to mental health and chemical dependency.
Antidepressant Medication Management (acute/continuation)	The percentage of Medicaid enrollees 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment.
Comprehensive Diabetes Care: Blood Pressure Control*	The percentage of Medicaid enrollees 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading is <140/90 mm Hg.
Comprehensive Diabetes Care: HbA1c Poor Control (> 9%)*	The percentage of Medicaid enrollees 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control).
Controlling High Blood Pressure (<140/90)*	The percentage of Medicaid enrollees 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90).
Medication Management for People with Asthma: Medication Compliance 75%	The percentage of Medicaid enrollees 5-64 years of age identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.
Mental Health Treatment Penetration (Broad)	The percentage of Medicaid enrollees 6 years of age and older with a mental health service need who received at least one qualifying service during the measurement year.
Plan All-Cause Readmission Rate (30 days)	The proportion of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days among Medicaid enrollees ages 18-64 years old.
Substance Use Disorder Treatment Penetration	The percentage of Medicaid enrollees 12 years of age and older with a substance use disorder treatment need who received substance use disorder treatment in the measurement year.
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	The percentage of Medicaid-covered children 3-6 years of age who had one or more well-child visits with a primary care provider during the measurement year.

Statewide measures only

Appendix: HCP-LAN Framework



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