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State Demonstrations Group

MaryAnne Lindeblad
Medicaid Director
Washington State Health Care Authority
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Olympia, Washington 98504-5502

JUN 2 8 2018

Dear Ms. Lindeblad:

This letter is to inform you that Washington State's submission of the Value-Based Payment (VBP) Roadmap and Health Information Technology (HIT) Protocol have been approved. These protocols have been found to be in accordance with the Special Terms and Conditions (STC) of the state's section 1115 demonstration, entitled "Medicaid Transformation Project" (MTP) (No. 11-W-00304/0). These protocols are approved for the period starting with the date of this approval letter through December 31, 2021—and are hereby incorporated into the STCs as Attachments E and M, respectively.

Your project officer for this demonstration is Mr. Eli Greenfield. He is available to answer any questions concerning your section 1115 demonstration. Mr. Greenfield's contact information is as follows:

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Official communications regarding program matters should be sent simultaneously to Mr. Greenfield and to Mr. David Meacham, Associate Regional Administrator in our Seattle Regional Office. Mr. Meacham's contact information is as follows:

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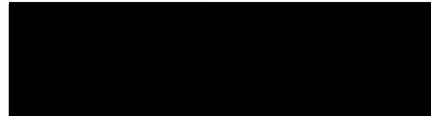
We look forward to working closely with the Health Care Authority to monitor progress along the way.

Sincerely,



Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: David Meacham, Associate Regional Administrator, Seattle Regional Office

HCA VALUE-BASED ROADMAP
Apple Health Appendix

Table of Contents

Purpose ... 2

Introduction ... 2

Apple Health and VBP Reform ... 2

Alignment and Health Care Payment & Learning Action Network (HCP-LAN) ... 3

Strategies in Support of VBP ... 3

DSRIP Project Toolkit and the ACHs ... 4

Medicaid Value-based Payment (MVP) Action Team ... 5

Role and Purpose ... 5

Membership ... 5

A Look Ahead ... 6

VBP: Targets and Incentives ... 6

VBP Incentives: MCO Improvement and Attainment of VBP Targets ... 7

VBP Incentives: ACH Regional Improvement and Attainment of VBP Targets ... 9

VBP in MCO Contracts ... 11

VBP in Rural Settings ... 15

Measuring VBP in Washington: VBP Surveys ... 16

MCO Survey ... 16

Objective ... 16

Method ... 17

Provider Surveys ... 18

Objective ... 18

Method ... 19

Survey Results ... 20

Progress to Date ... 21

Annual Update ... 21

Next Steps ... 21

Lessons Learned ... 21

Additional Resources ... 21

Purpose

The Apple Health Appendix reflects specific initiatives and changes pertaining to the Apple Health (Medicaid) program, in alignment with the Health Care Authority's (HCA) Value-based Roadmap. This document describes how managed care is transforming in alignment with the Medicaid Transformation Project (demonstration), and establishes targets for Value-based Payment (VBP) attainment and related incentives under the Delivery System Reform Incentive Payment (DSRIP) program for Managed Care Organizations (MCO) and Accountable Communities of Health (ACH).

This document addresses the following topics:

- Identified VBP targets and approach for measuring, categorizing and validating progress towards regional ACH and statewide MCO attainment of said VBP goals.
- Alternative payment models deployed between MCOs and providers to reward performance consistent with DSRIP objectives and measures.
- Use of DSRIP measures and objectives by the state in their contracting strategy approach for managed care plans.
- Measurement of MCOs based on utilization and quality in a manner consistent with DSRIP objectives and measures.
- Inclusion of DSRIP objectives and measures reporting in MCO contract amendments.
- Evolution toward further alignment with the Medicare & CHIP Reauthorization Act (MACRA) and other advanced Alternative Payment Models (APM).
- Approaches that MCOs and the state will use with providers to encourage practices consistent with DSRIP objectives, metrics, and VBP targets.

In accordance with the Special Terms and Conditions (STCs) of the demonstration, the Appendix will be updated annually to ensure best practices and lessons learned are captured and incorporated into HCA's overall vision of delivery system reform. The Appendix will remain a living document throughout the duration of the demonstration; subject to change and adjustment to ensure that Washington State is able to achieve its purchasing goals.

Introduction

Apple Health and VBP Reform

To reach the goals defined in the Value-based Roadmap, including shifting 90% of state-financed health care to VBP by 2021, Apple Health must play a leading role in transforming Washington's health care payment system. On January 9, 2017, Washington State and the Centers for Medicare and Medicaid Services (CMS) reached agreement on a groundbreaking five-year demonstration that allows the state to invest in comprehensive Medicaid delivery and payment reform efforts through a DSRIP program.

As Washington transitions to a new health care purchasing system for Apple Health, HCA recognizes that a comprehensive and successful transformation requires a multilayered approach that can address the needs of MCOs, individual providers, and Medicaid beneficiaries. Initiatives

under the demonstration, including community-led delivery system reform strategies, play a major role in assisting the overall system transformation.

HCA strives to align its efforts with the perspectives of MCOs and providers who bear the administrative burden of implementing new purchasing methodologies. Alignment requires that, while HCA assesses the individualized requirements of different stakeholders in the Medicaid system, it works to ensure that system reforms support and reinforce each other without leading to unnecessary administrative burden. As HCA implements VBP strategies for the Medicaid program, Medicare is making significant strides in implementing similar VBP reforms. Likewise, multiple commercial payers in the state are building VBP into their contracting strategies. Providers must frequently navigate all of these systems, presenting significant opportunities to align value-based methodologies across payer markets.

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

VBP strategies are built into the fabric of the demonstration by their inclusion as a foundational element of delivery system reform activities. Yet, HCA's commitment to value-based purchasing extends beyond the demonstration. Within Medicaid, HCA has changed MCO contracts in ways that align with the demonstration's goals. These efforts will be discussed throughout this document, along with those required under the demonstration STCs.

A primary mechanism for alignment across payer markets is the use of the HCP-LAN Framework,[1] as discussed in the Roadmap. These categories will form a framework for the implementation of VBP in Washington by defining payment models subject to incentives and penalties, aligned with Healthier Washington's broader delivery system goals. The HCP-LAN Framework recognizes a variety of approaches that can advance value-based purchasing, and thereby provide flexibility to providers to address the circumstances of the services they provide and the communities in which they provide them.

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

Strategies in Support of VBP

The shift from fee for service (FFS) to VBP requires delivery system changes. Time-limited DSRIP funds allow providers to make these changes through initial investment in the health system transformation process, and build provider capability as it relates to VBP. In turn, VBP adoption can reinforce and sustain DSRIP investments. This can occur through the longer-term payer, provider, member, and community partnerships, as well as investments in population health management. The end goal is a transformed system of health and wellness, bolstered by VBP.

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[1] For purposes of alignment, this appendix leverages the version of HCP-LAN framework that was available in January of 2017 when CMS approved the state's Medicaid Transformation demonstration.

DSRIP Project Toolkit and the ACHs

DSRIP provides the opportunity for delivery system reform that will promote improved health outcomes, and provide resources to providers to move along the VBP continuum. Under DSRIP, transformation efforts will be driven by ACHs and coalitions of partnering providers as they select and implement a set of strategies from the Project Toolkit to address regional health needs. To be successful, ACHs must integrate foundational cross-cutting health system and community capacity building elements that address workforce, systems for population health management, and financial sustainability through VBP.

Key milestones associated with project implementation require ACHs to demonstrate how they have considered financial sustainability of project efforts beyond the years of the demonstration. Key milestones during the project planning stage include: identification of strategies to support regional attainment of statewide VBP targets; a defined path toward VBP adoption reflecting current state and implementation of DSRIP projects; as well as a plan for encouraging annual VBP survey participation. A milestone for each DSRIP project requires the identification of strategies that will support financial sustainability of project activities, signaling the importance of ensuring that investments are lasting. In later years of the demonstration, ACHs are expected to identify and document the adoption of payment models that support integrated care approaches and the transition to value based payment for services by partnering providers.

The Project Toolkit specifies metrics that will be assessed for performance. Metrics were prioritized for inclusion in the Toolkit based on the relevancy to project strategies, their link to state and demonstration priority areas, and to ensure consistency and alignment with measures in MCO contracts, cross-system outcome measures for adults enrolled in Medicaid per House Bill 1519, and the State Common Measure Set.

Provider readiness for VBP models and contracts will be critical to meet statewide and regional DSRIP VBP payment arrangement targets, as well as other state VBP goals. Across the project stages, providers partnering with their ACH may be eligible to receive incentive payments by contributing to the completion of project milestones and regional improvement on clinical and population health measures. The incentive funds earned by providers allow them to make the investments necessary to be successful in the project, as well as promote efforts to scale and sustain strategies that prove to have positive health and wellness impacts in their communities. In order to be financially sustainable, however, other sources of funding must be identified to sustain these strategies, which could come through success in VBP contracts.

While VBP arrangements vary in complexity and provider risk, success in any requires providers to be able to effectively measure and influence the quality and/or cost of care provided. The presence and maturity of a number of underlying capabilities influence whether providers will perform well in their VBP contracts. ACHs will undertake efforts to understand the current state of VBP capabilities among their provider partners, and how they can leverage DSRIP funds to support development of capabilities moving forward.

Medicaid Value-based Payment (MVP) Action Team

Role and Purpose

The Medicaid Value-based Payment (MVP) Action Team serves as a learning collaborative to support ACHs, MCOs, and providers to attain VBP targets. It serves as a forum to facilitate provider preparation for value-based contract arrangements and to provide guidance on HCA's VBP standards. The Action Team promotes provider participation in VBP assessments, including the state's Medicaid VBP survey, and helps facilitate value-based contract arrangements by providing support and making recommendations to ACHs. To date, meetings have focused on topics such as: the role of ACHs in implementing VBP, required capabilities for providers to successfully implement and sustain VBP strategies, and strategies for engaging providers with little to no VBP experience.

The MVP Action Team has also assisted HCA in designing and fielding VBP surveys of MCOs and providers to capture a baseline of VBP levels. Additional assessments will be conducted annually to monitor progress from the baseline.

Moving forward and building from existing work when applicable, the MVP Action Team will:

- Assist HCA in deploying surveys or other assessments of VBP adoption to understand the current types of VBP arrangements across the industry.
- Review and communicate the level of VBP arrangements as a percentage of total payments across the region to determine current VBP baseline.
- Support ACHs as they perform assessments of VBP readiness across regional provider systems, and help ACHs develop strategies for advancing VBP.
- Develop recommendations to improve VBP readiness across the industry.

Implementing value-based purchasing throughout Medicaid requires a dedicated effort from diverse stakeholders, and the MVP Action Team plays a central role in bringing these stakeholder groups together. The MVP Action Team serves as an advisory board and a learning collaborative to both engage with HCA on VBP guidance and decisions, and create an environment where regional approaches can be shared and best practices cataloged. The MVP Action Team identifies enablers and challenges to VBP implementation and develops recommendations to improve the readiness of MCOs, providers, and ACHs.

Membership

The MVP Action Team is comprised of health care leaders from around Washington with significant experience with Medicaid and payment transformation efforts. The MVP Action Team includes state, regional and local level stakeholders, and tribal government partners representing: physical and behavioral healthcare providers, hospitals, clinics, Indian health care providers, community-based organizations, MCOs, public health providers and others. To ensure balanced membership representing varying perspectives, each MCO and ACH nominated a representative to serve on the MVP Action Team.

A Look Ahead

The MVP Action Team will meet on a quarterly basis throughout the demonstration to support ACHs, MCOs, and providers as they strive to implement VBP strategies and sustain them after the demonstration. The MVP Action team will be engaged in the annual updates to this document to ensure it aligns with the current state of VBP in Washington and reflects challenges faced by Washington providers. The MVP Action Team will continue to weigh in on MCO and provider surveys to communicate a VBP baseline for each ACH and help them to strategize and implement VBP that will best meet the needs and capacity of their region. The MVP Action Team will continue to serve as a source of guidance for ACHs and HCA during the demonstration.

VBP: Targets and Incentives

Beyond promoting the investment in foundational strategies that promote provider readiness for VBP, paying for value across the continuum of care is necessary to ensure the sustainability of the transformation projects undertaken through the demonstration. HCA and CMS agreed upon targets for VBP adoption under the demonstration (see Table A) based on the percentage of payments to providers that fall into categories 2C through 4B of the HCP-LAN APM Framework, starting in Demonstration Year (DY) 1, with progressive targets throughout the demonstration.

Table A: Annual VBP Goals for DSRIP

Annual VBP Goals for MCOs and ACH Regions (STC 41)					
	DY 1	DY 2	DY 3	DY 4	DY 5
HCP LAN 2C – 4B	30%	50%	75%	85%	90%
Subset: HCP LAN 3A – 4B	n/a	10%	20%	30%	50%
Subset: MACRA A-APMs	n/a	n/a	TBD*	TBD	TBD

**To be defined in future updates to this document.*

To encourage MCOs and providers to pursue VBP arrangements, DSRIP funds are available to incentivize MCO and ACH regional progress towards VBP targets as defined by the state in STC 41. These incentives can be earned as follows:

1. Incentives to reward **MCO** reporting, attainment and improvement towards annual VBP goals (in addition to those incentive embedded in the MCO contract, outlined below).

2. Incentives to reward regional **ACH** reporting, attainment and improvement towards annual VBP goals.

Funds will be distributed to MCOs through the Challenge Pool, based on percentage of Medicaid lives. Funds will be distributed evenly across the nine ACHs through the Reinvestment Pool.

Detailed parameters for how VBP incentive funds are earned and distributed to qualifying entities are outlined in subsequent sections of this document. The following parameters apply to both MCO and ACH VBP Incentives:

- MCOs and ACHs will earn VBP Incentives based on pay-for-reporting (P4R) and pay-for-performance (P4P), with the portion associated with P4P increasing year-over-year, per Table B.
- MCOs will report data on the status of VBP contracting levels annually, which will provide the basis for VBP adoption assessment for both the MCOs and ACHs, and thus is the data source for determining P4P VBP Incentives for both ACHs and MCOs. Results will be reviewed by a third party validator; the review methodology is under development.
- VBP Incentives (P4R and P4P) will be calculated and paid once per year.
- Unearned VBP Incentives are redirected to reward MCOs/ACHs based on their performance on quality metrics.
- Total potential VBP Incentive funding is set each year by HCA, taking into account any remaining VBP-designated funds after Integration Incentives have been distributed. Given the anticipated volume of Integration Incentives in DYs 1 and 3, VBP Incentives may be lower in those years.

Table B: VBP Milestone Categories, by Demonstration Year

Annual VBP Incentives: P4R and P4P (Planning Protocol)										
	DY 1		DY 2		DY 3		DY 4		DY 5	
	P4R	P4P	P4R	P4P	P4R	P4P	P4R	P4P	P4R	P4P
MCO VBP Incentives	75%	25%	50%	50%	25%	75%	0%	100%	0%	100%
ACH VBP Incentives	100%	0%	75%	25%	50%	50%	25%	75%	0%	100%

VBP Incentives: MCO Improvement and Attainment of VBP Targets

MCO improvement and attainment of VBP targets are key to the success and sustainability of Washington's DSRIP program. The following describes the MCO eligibility for earning incentives, earnable funds, reporting requirements, and measurement of MCO VBP attainment:

Eligibility: MCOs are eligible for VBP Incentives based on P4R and P4P, with P4P increasing year-over-year, as outlined in Table B [DSRIP Planning Protocol, section IV, Table 3].

Threshold for Years 4 and 5: As indicated in Table C below, no MCO VBP Incentives (P4R or P4P) can be earned if the MCO does not achieve the thresholds of 30% and 50% of provider payments in HCP-LAN categories 3A and above in Years 4 and 5, respectively.

Potential Earnable Funds: For a given demonstration year, the maximum potential VBP Incentives per MCO will be based on the MCO's share of total Apple Health Managed Care member months for that year. The available funds are earned through the DSRIP Challenge Pool. Available funds in each year are split between P4R and P4P, which are separately earned as outlined below.

MCO P4R VBP Requirements: P4R for MCOs is entirely based on timely and complete annual submission of MCO VBP data, by HCP-LAN APM category and region, via the standard VBP survey template. Completion of the required VBP survey template is being integrated as a requirement in

MCO contracts. P4R for MCOs has an "all or nothing" standard; if an MCO does not submit the required data in a timely and complete fashion, zero percent of earnable P4R funds are earned that year. MCOs may earn 100% of earnable funds if the required data is submitted in a timely and complete fashion.

Measurement of MCO VBP Attainment (P4P): MCO VBP adoption levels will be measured based on MCO-provided data. MCOs will complete an annual quantitative report on VBP adoption by region and by LAN category.

VBP P4P will be based on a model that incorporates attainment of the target and improvement over prior year performance, with achievement increasing in weight over time (see Table C).

Table C: Weighting of Improvement and Achievement of Annual MCO VBP Targets

	Y1	**Y2**	**Y3**	**Y4**	**Y5**
Improvement Over Self *(from Previous Year)*	60%	60%	50%	45%	40%
Achievement of Annual VBP Target (Overall / Subset Target Attainment)	40%	35% / 5%	45% / 5%	50% / 5%	55% / 5%
Requirement to Meet 3A–4B Attainment Threshold for Any VBP Funds	N	N	N	Y – 30%	Y – 50%

Subset Attainment Target: Each year, up to 5% of MCO P4P VBP Incentive funds will be based on achieving certain additional VBP adoption criteria outlined in STC 41:

- Year 2: At least one VBP contract in category 3B or above
- Year 3: At least one VBP contract as a MACRA A-APM (to be defined)
- Year 4 and Year 5: At least one VBP contract in category 3B or above and including at least one of the following features:
  - More than nominal risk for shared losses
  - Payments tied to provider improvement or attainment on metrics from the statewide common measure set using HCA quality improvement model or similar tool
  - Care transformation requirements including state-level best practices
  - Use of certified EHR technology in support of VBP methods

QIS – Assessing Achievement: Achievement requires VBP adoption at or above the VBP target goal in the STCs, per Table A. Credit is only earned for meeting or exceeding the defined target for the applicable demonstration year.

QIS – Measuring Improvement:
If the MCO did not achieve the VBP goal for the year:

- Improvement will be measured as the percent change in VBP adoption relative to the prior year performance.
- Improvement values are capped at 100%.

If the MCO has achieved the VBP goal for the year:

- Any incremental additional improvement over prior performance will secure a 100% improvement score.

QIS –Final Score and Distribution of Earned Funds: The weighted scores for improvement, overall achievement and subset-achievement are added together to arrive at a final MCO VBP P4P QIS. The final results from the MCO QIS assessment will determine the proportion of maximum potential P4P VBP incentives earned by an MCO in a given year.

Unearned funds from Challenge Pool: Funds that remain unearned from the Challenge Pool are redirected to reward MCO performance on a standard set of clinical quality measures.

VBP Incentives: ACH Regional Improvement and Attainment of VBP Targets

The success and sustainability of the state's DSRIP program is largely dependent on moving along the VBP continuum as a state and at the regional level. The STCs of the demonstration put forward annual VBP targets that the state and the ACHs are accountable for reaching. Furthermore, if VBP benchmarks for statewide VBP attainment are not met, a percentage of statewide DSRIP funding will be at risk beginning DY3.

Eligibility: ACHs can earn VBP Incentives based on P4R and P4P, with P4P increasing year-over-year, as outlined in Table B [DSRIP Planning Protocol, section IV, Table 3].

Threshold for Years 4 and 5: As indicated in Table D below, no ACH VBP Incentives (P4R or P4P) can be earned if the ACH region does not achieve the thresholds of 30% and 50% of provider payments from MCOs in HCP-LAN categories 3A and above in Years 4 and 5, respectively.

Potential Earnable Funds: Statewide ACH VBP Incentives will be evenly split across all ACHs to identify the maximum potential VBP Incentives per ACH in a given year. The available funds are earned through the DSRIP Reinvestment Pool. Available funds in each year are split between P4R and P4P, which are separately earned as outlined below.

ACH VBP P4R Requirements: Requirements for VBP P4R for ACHs will change as the demonstration progresses. ACHs will report on VBP milestones as part of their semi-annual reports. P4R achievement will be based on providing evidence of completion of each milestone per year. Each milestone will receive a value of 0% (not reported, or not completed) or 100% (reported and evidence of completion).

Each year's P4R achievement will be the average of the P4R milestone scores attained, with ACHs earning the proportion of p4R associated VBP incentives equivalent to the total P4R score.

Table D: ACH VBP P4R Milestones

ACH P4R Milestones	
Year 1 (2017)	• Documented outreach to provider partners to support HCA-administered VBP Provider Survey participation.
Year 2 (2018)	• Documented completion of Domain 1 VBP milestones from the Project Toolkit: o Inform providers of VBP readiness tools and resources. o Connect providers to training and TA from HCA and the MVP Action Team. o Support VBP assessments to help the MVP Action Team substantiate reporting accuracy. o Disseminate MVP Action Team and other state / regional VBP implementation efforts' learnings to providers. o Develop a regional VBP transition plan.
Year 3 (2019)/ Year 4 (2020)	• Report on progress on implementing the Regional VBP Transition Plan. • Engagement and contribution to the MVP Action Team.

Measurement of ACH VBP Attainment (P4P): ACH VBP adoption levels will be measured based on MCO-provided data. MCOs will complete an annual quantitative report on VBP adoption by region and by LAN category. The resulting data will be aggregated across all MCOs by region and LAN category, prior to distribution to ACHs.

VBP P4P will be based on a model that incorporates attainment of the target and improvement over prior year performance, with achievement increasing in weight over time (see Table E).

Table E: Weighting of Improvement and Achievement of Annual ACH VBP Targets

	Y1	Y2	Y3	Y4	Y5
Improvement Over Self *(from Previous Year)*	*n/a*	60%	50%	45%	40%
Achievement of Annual VBP Target (Overall / Subset Target Attainment)	*n/a*	35% / 5%	45% / 5%	50% / 5%	55% / 5%
Requirement to Meet 3A–4B Attainment Threshold for Any VBP Funds	*n/a*	N	N	Y – 30%	Y – 50%

Subset Attainment Target: Each year, up to 5% of P4P ACH VBP incentive funds will be based on achieving certain additional VBP adoption criteria outlined in STC 41:

- Year 2: At least one VBP contract in category 3B or above.
- Year 3: At least one VBP contract as a MACRA A-APM (to be defined).
- Year 4 and Year 5: At least one VBP contract in category 3B or above and including at least one of the following features:
    - More than nominal risk for shared losses.

- Payments tied to provider improvement or attainment on statewide common measure set using HCA quality improvement model or similar tool.
- Care transformation requirements including state-level best practices.
- Use of certified EHR technology in support of VBP methods.

QIS – Assessing Achievement: Achievement requires VBP adoption at or above the VBP target goal in the STCs, per Table A. Credit is only earned for meeting or exceeding the defined target for the applicable demonstration year.

QIS – Measuring Improvement:
If the ACH did not achieve the VBP goal for the year:

- Improvement will be measured as the percent change in VBP adoption relative to the prior year.
- Improvement values are capped at 100%.

If the ACH has achieved the VBP goal for the year:

- Any incremental additional improvement will secure a 100% improvement score.

QIS – Final Score and Distribution of Earned Funds: The weighted scores for improvement, overall achievement and subset-achievement are added together to arrive at a final ACH VBP P4P QIS score. The final results from the ACH QIS assessment will determine the proportion of maximum potential VBP Incentives earned by an ACH for a given year.

Unearned funds from Reinvestment Pool: Unearned ACH VBP Incentive funds from the Reinvestment Pool are distributed to reward ACH quality performance. ACHs are eligible to earn incentives by demonstrating high performance on the following measures as determined by a separate QIS for DSRIP high performance:

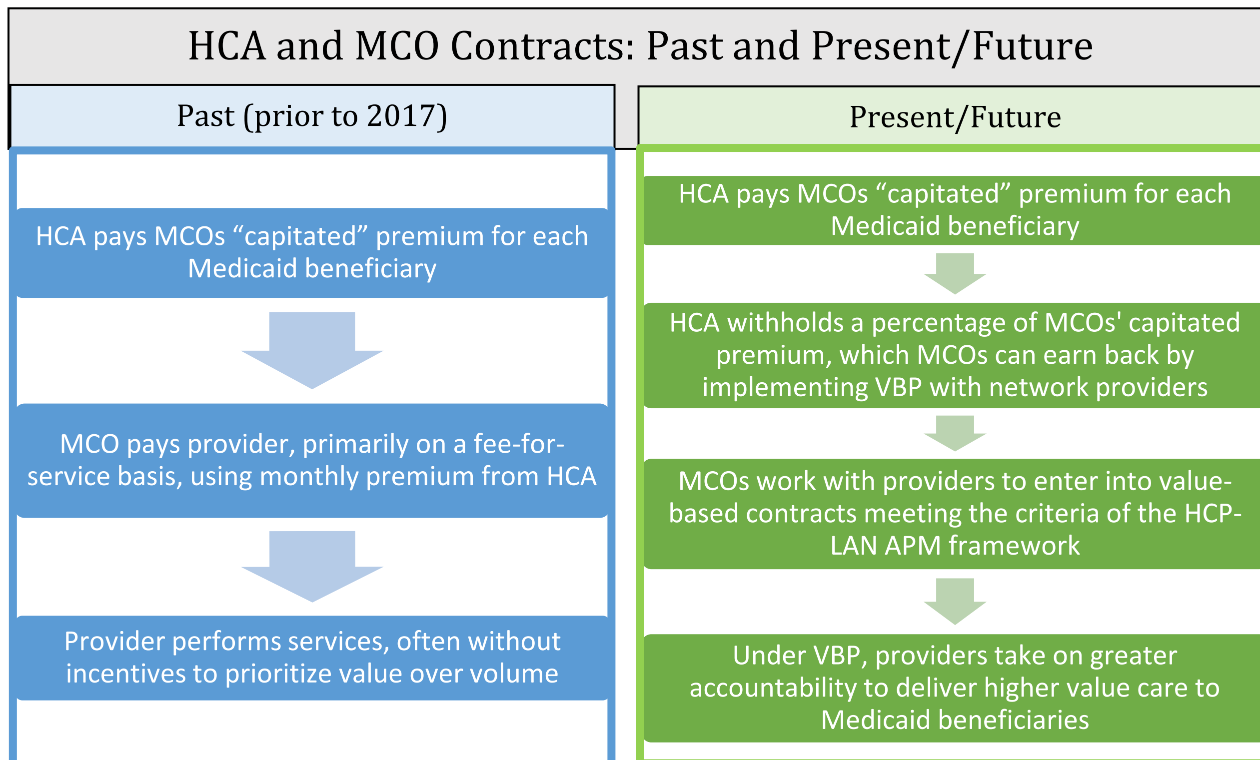
1. Mental Health Treatment Penetration
2. Substance Use Disorder Treatment Penetration
3. Outpatient Emergency Department Visits per 1000 Member Months
4. Plan All-Cause Readmission Rate (30 days)
5. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
6. Antidepressant Medication Management
7. Medication Management for People with Asthma (5 – 64 Years)

VBP in MCO Contracts

A central component of implementing VBP in Washington is incentivizing MCOs to adopt VBP with network providers through HCA's contract with the MCO. HCA currently contracts with five MCOs, paying them a per member per month (or "capitated") premium to deliver Medicaid services to the majority of the state's Medicaid beneficiaries. By incentivizing VBP in the MCO contracts, along with the other efforts described in this Appendix, HCA expects value-based purchasing to expand and continue well beyond the five years of the demonstration.

To incentivize VBP adoption, HCA has designed and implemented a withhold program, under which a percentage of each MCOs' monthly per member per month premium is withheld pending achievement of certain targets, as shown in the figure below.

Figure 1: HCA and MCO Contracts: Past and Present/Future



The total percentage withhold is set to increase incrementally (0.5 percent per year) from one percent in 2017 to three percent in 2021. The amount withheld from each MCO's premiums may be earned in three ways, each of which seeks to advance value-based purchasing:

- **VBP Portion (12.5%):** The VBP Portion of the withhold focuses on the percent of an MCO's total purchasing that is within a recognized value based purchasing arrangement. The target for this element will increase from 30% to 90% by 2021. Qualifying VBP arrangements must meet the definition of Category 2C or higher within the HCP-LAN categorization.
- **Provider Incentives Portion (12.5%):** The Provider Incentives Portion of the withhold focuses on the percent of funding, within recognized VBP arrangements, that is directly conditioned on meeting quality metrics. Up to 12.5 percent of the Provider Incentives portion of the withhold may be earned back by making qualifying provider incentive payments tied to quality and financial attainment or losses. The target for this element will increase from .75% to 2.5% by 2021.
- **QIS Portion (75%)**: The QIS Portion of the withhold may be earned back by demonstrating quality improvement and attainment on HEDIS clinical performance measures as calculated under HCA's QIS model. Following receipt of HEDIS scores, on or before July 1 following the performance year, HCA shall determine the percentage of the contract withhold earned back by the Contractor based on the Contractor's achieving Quality Improvement Score

(QIS) targets. Up to 75 percent of the withhold may be earned by achieving quality improvement targets. The target for this element will increase from 0.75% to 2.5% by 2021.

These three components of HCA's withhold program, as well as the annual target percentages that must be met in order for MCOs to receive the full withhold amount, are shown in Figure 2 below.

Figure 2: MCO Contract Withhold Components

MCO Contract Withhold Components
Percentage Targets by Year

VBP Share: 12.5%	
Performance Year	Target
2017	30%
2018	50%
2019	80%
2020	85%
2021	90%

Provider Incentives Share: 12.5%	
Performance Year	Target
2017	.75%
2018	1%
2019	1.5%
2020	2.0%
2021	2.5%

QIS Share: 12.5%	
Performance Year	Target
2017	.75%
2018	1%
2019	1.5%
2020	2.0%
2021	2.5%

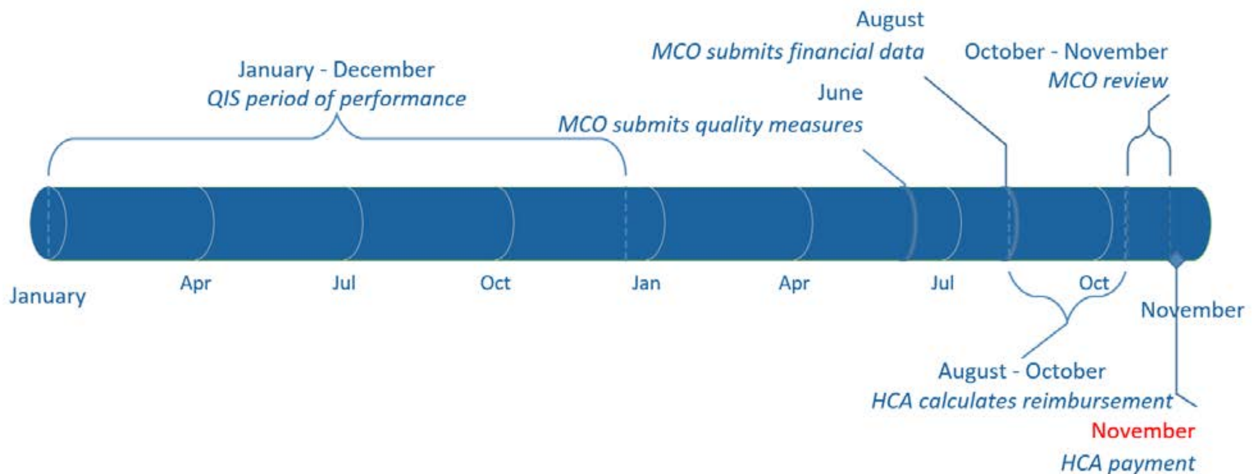
An example of the measures and benchmarks used in the QIS model is shown below (Table F) for the Managed Care contracts. The Integrated Managed Care and Foster Care contracts use the measures below, as well as additional measures particular to the populations covered under those contracts.

Table F: Quality Measures

	Quality Measure	Quality Measures Description	Measure Weight	Target	Mean
Adult Measures	NQF 0059	Comprehensive Diabetes Care - Poor HbA1c Control (>9%)	Equally weighted	NCQA Quality Compass Medicaid HMO 90th percentile values	NCQA Quality Compass Medicaid HMO average values
	NQF 0061	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)			
	NQF 0018	Controlling High Blood Pressure (<140/90)			
	NQF 0105	Antidepressant Medication Management – Effective Acute Phase Treatment			
	NQF 0105	Antidepressant Medication Management - Effective Continuation Phase Treatment (6 Months)			
Pediatric Measures	NQF 0038	Childhood Immunization Status - Combo 10			
	NQF 1516	Well-child visits in the 3rd, 4th, 5th and 6th years of life			
	NQF 1799	Medication Management for people with Asthma: Medication Compliance 75% (Ages 5-11)			
	NQF 1799	Medication Management for people with Asthma: Medication Compliance 75% (Ages 12-18)			

An overview of the timeline for annual performance, data submission, and HCA's review process before issuing payment is shown in Figure 3 below. The two-year performance and review period continues on a rolling basis as shown, so that the subsequent performance year begins while data for the prior performance year is submitted to and reviewed by HCA.

Figure 3: Timeline for annual performance, data submission, and HCA's review process.



The structure of the MCO withhold program reinforces the links to quality that are emphasized by both CMS and the demonstration. It specifically ties incentive payments to the presence and use of value-based payment strategies, value-based purchasing strategies, and quality improvement.

VBP in Rural Settings

HCA is also turning its focus towards health systems transformation in rural health settings. More than 41% of current Medicaid beneficiaries and 1 in 10 Washingtonians are served in a federally qualified health center (FQHC) or a rural health clinic (RHC) for primary care. Most of rural Washington is served by federally designated critical access hospitals (CAH). These providers offer some of the most innovative and integrated delivery models in the state, yet their reimbursement structure is tied to each encounter with a client, which stifles care delivery innovation. In these settings, payment changes are especially difficult given statutory and regulatory barriers and business models that rely on encounter-driven, cost-based reimbursement.

With strong support from these clinics and hospitals, the state has introduced a value-based alternative payment methodology, or Alternative Payment Methodology 4 (APM4), in Medicaid for FQHCs and RHCs and is pursuing flexibility in delivery and financial incentives for participating CAHs. The model will test how increased financial flexibility can support promising models that expand care delivery.

HCA will determine prospective adjustment percentages annually based on the clinics achieving quality improvement score targets. Clinics that demonstrate quality improvement and attainment against their baseline will continue to receive their full PMPM rate. Clinics that do not demonstrate quality improvement and attainment will be subject to downward adjustment of their PMPM rate. In total dollars, downward adjustment of the PMPM rate will never go below APM3 equivalent

payment amounts. After being adjusted downward, clinics that meet quality improvement targets can earn back the full benefit of the baseline PMPM rate (as trended by the MEI) in future years.

Each clinic will be measured by seven quality measures from the Statewide Common Measure Set, consistent with the MCO contracts and PEBB ACP. The goal of APM4 is to 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 is also intended to incentivize alternatives to face-to-face visits and allow the clinics to offer more convenient access to primary care services.

Measuring VBP in Washington: VBP Surveys

During the summer of 2017, HCA surveyed MCOs and provider organizations to assess progress towards VBP goals. In order to understand the state's movement toward its demonstration goals, provider surveys will be administered on an annual basis. MCO surveys have transitioned into an annual reporting requirement in MCO contracts.

MCO Survey

In accordance with STCs, the state is required to monitor attainment of HCP-LAN category-specific VBP thresholds at both a statewide and regional level (see STC 40-41). Prior to 2017, the state did not have a data source to measure volume of qualifying provider payments in VBP arrangements by MCO and by region. To measure progress towards VBP by MCOs at the state and regional levels, MCOs were asked to report on levels of VBP adoption with providers. The 2017 MCO report, using calendar year 2016 levels of VBP adoption, will be leveraged to provide a statewide historical baseline from which VBP progress can be measured over the course of the demonstration.

Objective

The purpose surveying MCO data is to collect information on payments that MCOs make to providers through VBP arrangements (as defined by Categories 2C through 4B of the HCP-LAN APM framework) and to understand the MCO perspective on enablers and challenges of VBP adoption. The 2017 MCO report serves multiple objectives:

- To establish a historical measure of VBP attainment for MCOs and the state.
- To inform payments made through the state's withhold arrangement program, described above.
- With the integration of the VBP survey into the MCO contracts, VBP adoption data will be available at state and regional (ACH) levels for 2017 (from 2018 data reporting) and on.

In the future, MCO surveys will be incorporated into MCO contracts as required reporting. Future year MCO reporting will be used to establish annual statewide and regional VBP attainment under the demonstration, in order to assess eligibility for VBP Incentives.

Method

Survey administration. HCA released the VBP survey to all five MCOs in Washington State on June 2, 2017. The survey window was open from June 2, 2017 to July 19, 2017. The survey was administered via email, and on June 9, 2017, HCA published formal answers to questions received by June 7, 2017. MCOs were asked to respond to the survey using a standardized survey response template, provided in Excel. MCOs were instructed to submit one response per organization.

Survey Instrument. To measure the level of VBP attainment, MCOs were instructed to report on total payments[2] made to providers during the calendar year, as well as total Managed Care enrollees by HCP-LAN category. MCOs were asked to report their payments by HCP-LAN APM category (1 through 4B). The framework was included as a reference in the survey template. Regions were defined according to ACH boundaries, outlined in the DSRIP Funding and Mechanics protocol (Section I). To account for providers that have locations or deliver services in multiple regions, the following formula was applied to approximate the regional breakdown:

Dollars attributed to a provider for a region = Total dollars for APM subcategory across all provider locations x [number of billing providers in region / total number of providers contributing to APM subcategory]

HCA understands that individuals may receive care from multiple providers who may be reimbursed under different payment models. In this survey, a member month may be attributed to more than one APM subcategory. This is a limitation of the survey, and may result in double, or multi-counting in some instances. However, HCA sees value in collecting an estimate of covered lives, and understands that this will be inexact.

MCO's were asked to complete the following sections:

- Total Medicaid Payments: the total annual payments made through each type of payment arrangement, by geographic region. This calculation is at the level of the provider group, summing all the corresponding amounts.
- Total Covered Lives: the total number of member months attributed to each type of payment arrangement, by geographic region.
- Provider Incentives: the total amount of Medicaid paid incentives and paid disincentives, as well as a request for examples of most common incentive structures by associated APM subcategory. Reporting for statewide Medicaid paid incentives and disincentives is mandatory. However, further breakdown to the regional level is preferred, but not required. Provider Incentives are defined as follows:

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[2] Total Payments were defined as the total Medicaid payments made to providers, excluding any case payments, administrative dollars, Washington State Health Insurance Pool (WSHIP), premium tax, Safety Net Assessment Fund (SNAF), Provider Access Payment (PAP) or Trauma funding, from January 1, 2016 through December 31, 2016. Total payments include pharmacy, inpatient, outpatient, physician/professional, and other health services, excluding any pass-through payments.

- *Paid Incentives* means payments paid exclusively to providers in a value-based payment arrangement, as defined by Category 2C or higher of the HCP-LAN APM Framework White Paper, such as bonus payments and shared savings arrangements that offer financial rewards to providers who meet, exceed, or improve their performance on specified quality measure targets.

In addition, MCO's were encouraged to respond to the following sections; however, completion was not mandatory:

- Non-Medicaid Payments: the total annual non-Medicaid payments made through each type of payment arrangement, by type of insurance product (i.e., Medicare or Commercial).
- Non-Medicaid Covered Lives: the total number of member months attributed to each type of payment arrangement, by type of insurance product (i.e., Medicare or Commercial).
- Qualitative Questions: Key domains include:
    - Barriers and Enablers to VBP Adoption.
    - Quality Metrics Applied to Current VBP Contracts: Alignment of Quality Measures Used to Assess Provider Performance in Current VBP Contracts.
    - Traditional MCO Functions: The degree to which MCOs may shift traditionally MCO-based functions onto contracted providers under certain VBP arrangements.

Analysis and Reporting of Results. HCA will perform initial data analysis for MCO survey data. Results will be publicly available in aggregate form on HCA's webpage. Individual MCO responses will not be shared publicly.

Provider Surveys

While assessments and reports have been conducted on the national level and in other contexts, understanding the Washington provider experience with VBP is crucial to inform the progression along the VBP continuum. Additionally, an in depth understanding of the provider landscape is a crucial component of the work undertaken by ACHs. Provider feedback will promote robust project plan design, improved implementation and the foundation for successful plan for project sustainability. For these reasons, HCA developed a provider-facing VBP survey in 2017 to assess adoption levels, barriers and enablers of VBP amongst providers. While provider survey completion is not mandatory, ACHs are requested and incentivized to encourage survey participation, particularly among large provider groups in their regions.

Objective

The goal of the provider survey is to understand the level of VBP attainment, as defined by the percentage of total revenue in key VBP categories, and to identify key barriers and enablers to entering into VBP arrangements among Washington State providers.

Method

Survey administration. HCA released the provider survey to provider organizations in Washington on June 2, 2017. The survey window was open from July 10, 2017 to September 8, 2017. The survey was administered via email, and HCA sent email reminders to potential respondents in advance of the survey submission deadline in coordination with the MVP Action Team and ACH leadership. The survey response template was provided in Excel, in an effort to standardize with concurrent survey efforts in the state. The survey tool required about 30 minutes to complete, based on results of survey pre-testing. Provider organizations were instructed to submit one response per provider organization. Due to the content of the survey, HCA provided the recommendation that the survey be completed by an administrative lead (with consultation by clinical leadership as needed). Results will be publicly available in aggregate form, and will not be shared at the individual provider organization level. If he provider consents, individual results will be shared with the ACH.

Survey instrument. To provide context for the scope of care the survey response represents, all providers were instructed to identify:

- Type of provider organization they represent.
- Number of full time clinician equivalents (FTEs) employed with the organization.
- Counties served by the organization.

To measure the level of VBP attainment, providers were instructed to report on payments received during the calendar year. Payments were reported by payer type (e.g., Medicaid, Medicare, commercial insurance) and further categorized according to HCP-LAN APM Framework definitions. The detailed survey instrument can be found on the HCA webpage.

To learn about provider experience in transitioning to a value-based system of care, providers were asked the following:

- *If you are receiving VBP from any payer, how has your overall experience with VBP been?*
- *If you are receiving VBP from any payer, what has enabled your participation in VBP?*
- *What are the greatest barriers for engaging in value-based payment arrangements?*
- *Realistically, how do you expect your participation in VPB to change over the next 12 months?*

Categorical response options were provided, with an opportunity to provide a response not captured in the list of enablers and barriers to participation.

Analysis and Reporting of Results. HCA is responsible for performing analysis of data collected from provider survey responses. Results will be publicly available in aggregate form on HCA's webpage. Individual organization responses will not be shared publicly.

Survey Results

Key results from the MCO survey (n=5) include the following:

MCOs reported that in calendar year 2016, 28% of their payments to providers are in VBP arrangements as defined by HCP-LAN Framework Categories 2C through 4B. The top five enablers facilitating the adoption of VBP arrangements were (in order of significance):

- Trusted partnerships and collaboration
- Aligned incentives and/or contract requirements
- Payment model technical assistance
- Interoperable data systems
- Aligned quality measurements and definitions

The top five barriers impeding the adoption of VBP arrangements were (in order of significance):

- Disparate incentives and/or contract requirements
- Lack of interoperable data systems
- Lack of collaboration
- Lack of consumer engagement
- Disparate quality measures and definitions

Key results from the provider survey (n=80) include:

More than 75% of responding providers receive at least some revenue in HCP-LAN Framework Categories 2C-4B. Approximately 65% of responding providers (who reported their experience with VBP) reported having had a positive experience with VBP. The top five enablers impeding the adoption of VBP arrangements were (in order of most-referenced):

- Trusted partnerships and collaboration with payers
- Aligned quality measures and definitions
- Aligned incentives and/or contract requirements
- Ability to understand and analyze payment models
- Access to comprehensive data on patient populations

The top five barriers impeding the adoption of VBP arrangements were (in order of most-referenced):

- Lack of interoperable data systems
- Lack of timely patient population cost data
- Insufficient access to comprehensive data on patient populations
- Inability to adequately understand and analyze payment models
- Misaligned quality measures and definitions

Additional survey results and reporting will be discussed in future updates to this document.

Progress to Date

Annual Update

This document will undergo updates annually. Upcoming editions will include more information on progress made towards achieving state and demonstration VBP targets, as well as the state's evolution in seeking continued alignment with MACRA and other advanced alternative payment model updates.

Next Steps

Beginning in calendar year 2017 the MCO survey will transition to a contractual reporting requirement in MCO contracts. HCA will identify a third-party validator to review MCO-reported payments by HCP-LAN category. HCA is developing a methodology for validating reported payment data, which will be shared with MCOs and ACHs for public comment. The validation methodology will be incorporated in the next VBP withhold.

Lessons Learned

Additional information will be provided in future updates to this document.

Additional Resources

More information about Washington's demonstration is available at:
https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation.

Interested parties can sign up to be notified of demonstration developments, release of new materials, and opportunities for public comment through the Healthier Washington listserv. Instructions are available at:
https://public.govdelivery.com/accounts/WAHCA/subscriber/new?topic_id=WAHCA_237%27%3E

Medicaid Transformation Demonstration Project
Health Information Technology Strategic Roadmap

Introduction

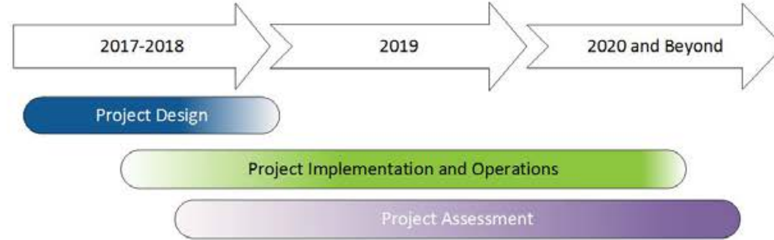
The Washington State Medicaid Transformation Demonstration is a five-year agreement between the state and the federal government that provides up to $1.1 billion in federal investment for regional and statewide health system transformation projects that benefit Apple Health (Medicaid) Clients. Achieving health system transformation for Washington State will require the use of interoperable health information technology (Health IT) and health information exchange (HIE). Interoperable Health IT[1] and HIE[2] have the potential to improve the quality, continuity, coordination, and safety of patient care, while at the same time reducing unnecessary and costly services. Furthermore, the use of these technologies will help facilitate the State's broader goals of moving toward value-based purchasing.

This Health IT Strategic Roadmap identifies activities necessary to advance the use of interoperable Health IT and HIE across the care continuum in support of the programmatic objectives of the Demonstration. The Roadmap divides efforts into the three phases of the Demonstration: Project Design, Project Implementation and Operations, and Project Assessment, and articulates the role the State, Medicaid Managed Care Organizations, providers and Accountable Communities of Health (ACH) have in advancing Health IT and HIE. In addition to this Roadmap, the State has created an Operational Plan that details the first 16 months (remainder of 2017 and 2018) of activities that provide actionable steps to advance Health IT and HIE in support of the Demonstration. The Operational Plan is appended to this document and will be revised quarterly to reflect progress and document next steps. The Operational Plan will be updated in 2018 to provide the details for 2019 and annually mid-year for the details of the following year. The following diagram highlights the key elements of the strategic roadmap and operational plan:

[1] Health Information Technology is the range of technologies to store, share, and analyze health information, including clinical and claims related data

[2] Health information exchange is the electronic exchange of health information to facilitate delivery system and payment transformation, care coordination and improved health outcomes

Washington Health IT/HIE Roadmap



Governance

- Guidance on roles and data governance: including MPI and Provider Directory
- Data Governance and data-sharing framework
- Expand provider types in CDR
- DSAs for Health IT and HIT Organizations
- Health IT Infrastructure
- Select Assessor Contractor

Policy

- Planning and guidance for acquiring and use of Health IT
- TA: Planned resources
- Provide TA to ACHs, MCOs and providers to advance critical Health IT infrastructure
- Evaluate options for new data/service for OHP/ CDR (including public health)
- Guidance on how Health IT could be used to support ACH projects, service delivery and payment transformation
- Determine financial needs for State, MCOs, ACH and providers
- Operational Plan Implementation and Update
- Exchanging sensitive information
- Evaluate options for quality measurement
- Monitor efforts of ACHs, MCOs and providers for quality measurement
- Support Health IT Infrastructure
- Develop Methodology for Assessment, including use of clinical and claims data
- Assess progress toward meeting VBP penetration targets

Technology

- Identify existing Health IT infrastructure to support Demonstration and gaps an barriers
- Plan for Mater Patient Index
- Implement Master Patient Index
- Plan for Provider Director
- Implement Provider Directory
- Implement recommendations for quality measurement
- Health IT Infrastructure: Launch CDR Provider Portal
- Assess overall Health IT infrastructure
- Assess provider adoption and use of population health management systems

Finance

- Identify opportunities for shared HIT/ HIE financing/investments
- Determine appropriate funding source for each Health IT task
- Update and submit Medicaid Health IT IAPD and state budget requests to support Health IT
- Assess progress toward meeting VBP penetration targets

Background

Washington State understands the role of and need for interoperable Health IT and HIE to enable the efficient exchange and use of health information, a foundational requirement to achieving the triple aim. In 2009, the Washington State Legislature passed Substitute Senate Bill 5501 to accelerate the secure electronic exchange of high-value health information within the state. This legislation resulted in the designation of OneHealthPort as the lead HIE organization. Subsequently, a clinical data repository (CDR) was created to address some of the challenges with interoperability.

Purpose and Goals

Washington State is undertaking an innovative and ambitious agenda through the Demonstration to advance coordination of care and improve patient outcomes that will be supported, in part, through its use of the CDR and additional activities identified in this Roadmap. The purpose of the Roadmap is to identify the broad goals of how Health IT and HIE will support the Demonstration, recognizing that the more detailed tasks are identified, expanded upon, and tracked in the accompanying operational plan. The Roadmap is built on the following goals:

- Develop policies and procedures to advance the widespread use of interoperable Health IT and HIE across the care continuum;

- Coordinate at the regional and statewide level to ensure that interoperable Health IT and HIE efforts are shared and identified best practices are shared throughout the state;

- Improve coordination and integration among behavioral health, physical health, and Home and Community Based Services (HCBS) providers, as well as community-level collaborators;

- Support the acquisition and implementation of interoperable Health IT particularly for providers who are ineligible for the Electronic Health Record (EHR) incentive program;

- Encourage use of clinical and claims data by the State, ACHs, payers, and others to support a variety of health improvement activities as represented by ACH project plans;

- Develop or expand the critical infrastructure needed to facilitate population health management, including prescription drug monitoring, disease registries and electronic lab reporting;

- Support the electronic exchange of interoperable clinical health information, using standards identified in Interoperability Standards Advisory (ISA);

- Support the development and use of a Medicaid enterprise master patient index and comprehensive provider directory strategy to facilitate more efficient information exchange;

- Align with the Washington State Health IT & HIE Strategy; and

- Ensure the roadmap provides guidance & alignment throughout the duration of the Demonstration, as well as beyond the Demonstration's end date.

Demonstration Health IT Framework

The work of the Health IT Strategic Roadmap is intended to align with the Demonstration's three phases of work: design, implementation and operations, and assessment. These phases are cyclical, with project assessment feeding into future project design. Activities described in this document require work by the State and the ACHs to assemble the infrastructure, develop policies and procedures, and implement incentives to advance the use of Health IT and HIE in support of broader Demonstration activities. As described in this document, these phases support, and are consistent with, the three project stages (design, implementation and operations, and assessment) in the State's approved DSRIP Planning Protocol. This framework recognizes the varying levels of interoperability that exist among regions and providers in the state, allowing regional efforts to advance Health IT and HIE in coordination with the broader statewide approach.

Project Design

Initial phase August to December 2017

During the project design phase, the State will engage and collaborate with ACHs, providers, payers, OneHealthPort, and other stakeholders to develop and disseminate the tasks and deliverables (which will inform the Operational Plan) to advance the use of Health IT for population health management.

This phase will identify the gaps and opportunities to advance in the Health IT and HIE infrastructure, policies and procedures, and incentives necessary to facilitate population health management. ACHs will be expected to identify payers (including Medicaid MCO payers) and providers (e.g., physical health, behavioral health, long-term services and supports, and other community-based services/providers) to collaborate with the State and other stakeholders to assist in and inform the development of the Operational Plan.

The State will provide guidance to the ACHs on how Health IT and HIE elements will be required for incorporation in the ACH project plans and what resources will be made available to support project implementation. ACHs will incorporate this guidance into their project plans to be submitted in November.

Task	Additional Description	Proposed Due Date
The State will engage and collaborate with ACHs, providers, payers (including Medicaid MCOs), OneHealthPort, and other stakeholders to develop and disseminate an Operational Plan	The Operational Plan will address the following topics: Governance: • Roles of stakeholders • Data governance • Health IT governance Policy: • Shared policies and technical standards for secure Health IT and HIE systems • Performance measures related to the adoption and use of Health IT and HIE Technology: • Types of and how population health management systems that could be used to support: ACH projects, service delivery and payment transformation, and quality and performance management • Gaps and barriers Finance • Determine financial needs for State, MCOs, ACHs and providers • Determine appropriate funding source, including role of Medicaid Financing (IAPDU-SPA-Waiver)	2017
The State will develop and disseminate guidance for planning, acquisition and use of Health IT and HIE	Policy: • This guidance will include interoperable HIT and HIE to support ACH activities Finance: • Opportunities for shared HIT/HIE financing/investments	2017 -2018
The State will identify technical assistance needs to assist in the acquisition, adoption, implementation, and use of Health IT and HIE. The State will notify ACHs of these planned resources.	Policy: • State will develop and make available to ACHs TA resources for HIT/HIE activities in support of Demonstration activities. TA resources may include assistance related to: o Billing IT and HIT applications; o Vendor evaluation and selection criteria; o Workflow considerations; and o Use of the CDR	2017 – 2018 (initially and ongoing through 2020)
The State will determine the need, and if so how and when, to integrate key Medical, clinical, and public	Policy: This data will potentially include: • Assessment and care plan data; and • Public Health data such as:	2017-2018

health data with the Clinical Data Repository	○ Immunizations ○ Prescription drug monitoring	

Project Implementation and Operations

Initial phase January 2018-

The project implementation phase will consist of implementing the Operational Plan, collaboratively addressing the Health IT and HIE gaps, aligning statewide initiatives, and positioning the ACHs and state for success in their programmatic objectives.

The Operational Plan will seek to identify and address gaps in Health IT and HIE, prioritizing the most important elements to support Health IT and HIE and ACH-proposed projects. The State will focus on several elements, including data governance and data sharing frameworks, facilitating HIE across multiple provider types, and developing a master patient index and statewide provider directory.

The State is also committed to ongoing alignment among all Health IT- and HIE-related activities within the state, including State Innovation Model efforts, Medicaid Health IT Plan, and Health IT Implementation Advanced Planning Document (IAPD).

During the project implementation phase, ACHs will assist the State in identifying critical gaps and will collaborate with providers, payers, and other stakeholders to develop and support the use of best practices in leveraging Health IT and HIE to support their transformation efforts.

Task	Additional Description	Proposed Due Date
The State will implement, review, update, and disseminate the Operational Plan	Policy: The State, in collaboration with stakeholders, will: • Annually update the Operational Plan and implement Accordingly • Identify and share emerging best practices • Identify and assist in resolving emerging issues; and • Provide quarterly updates on progress on implementing the Operational Plan to CMS/ONC	2017, 2018, 2019, 2020
State will support and advance critical HIT/HIE infrastructure	The State will support several activities needed to advance the HIT/HIE infrastructure, including: Governance: • The State will develop and disseminate guidance to the ACHs, payers and providers related to exchange of information, including data governance and data sharing framework	2018

Task	Additional Description	Proposed Due Date
	• The State will develop and disseminate guidance to the ACHs, payers and providers related to onboarding and registration of additional provider types, including expanding the provider types sending and receiving content from the CDR • The State will develop and disseminate guidance to the ACHs, payers and providers related to establishing electronic health information sharing agreements with HIT/HIE organizations Policy: This includes developing and disseminating guidance and providing TA to the ACHs, payers, providers, and other stakeholders on the activities, including the following: • Supporting the onboarding of additional providers to the CDR • Use of Consolidated Clinical Document Architecture (C-CDA) in electronic health information exchange activities • The State will develop and disseminate guidance to the ACHs, payers, providers, and other stakeholders related to exchanging sensitive information (e.g. SUD data) Technology: • Launching of the CDR provider portal • Develop and/or purchase other technology as identified and needed	
The State will disseminate information on efforts to streamline Behavioral Health reporting	Policy: State will seek to align reporting requirements to support and align with HIE/HIT standards and support data use State will disseminate information on the results of the alignment effort, including requirements	2018
The State will determine and implement the most appropriate method for the creation and management of the Master Patient Index	Policy: • Document gaps and barriers in existing State infrastructure • Identify work plan for developing a Master Patient Index for use across information systems (e.g. MMIS, OHP) Technology:	2018-2019

Task	Additional Description	Proposed Due Date
	• Acquire /implement technology solution based on work plan	
The State will determine and implement the most appropriate method for the creation and management of the Provider Directory	Policy: • Document gaps and barriers in existing State infrastructure • Identify work plan for developing a Provider Directory for use across information systems (e.g. MMIS, OHP) Technology: • Acquire/implement technology solution based on work plan	2018-2019
The State will evaluate options and draft recommendations for leveraging clinical and claims data to support needed quality measurement/analytic activities of the state, MCOs, ACHs, providers and payers.	Policy: • The state with stakeholder input will evaluate options for leveraging clinical and claims data to support needed quality measurement/analytic activities of the state, MCOs, ACHs, providers and payers. • Based on the evaluation of options, the state will draft recommendations for leveraging clinical and claims data to support needed quality measurement/analytic activities of the state, MCOs, ACHs, providers and payers.	2018
State will implement approved recommendations for leveraging clinical and claims data to support quality measurement/analytic activities of the state and will oversee the efforts of the Medicaid MCOs, ACHs and providers	Technology: • The State will implement approved recommendations for leveraging clinical and claims data to support quality measurement/analytic activities of the state	

The State will use the HIT/HIE Strategic Roadmap and Operational Plan to update and align key documents and activities	Policy:
	• Based on the completion of the OP for 2017-2018, the state will update as needed
	  • SIM HIT documents;
	  • State Medicaid HIT plan;
	  • Health IT IAPD; and
	  • Medicaid EHR Incentive Program State initiated MACRA Advanced Alternative Payment models.
		2017 for 2017 and 2018

Task	Additional Description	Proposed Due Date
	• Based on the updated OP for 2019, the state will update as needed the same documents. • Based on the updated OP for 2020, the state will update as needed the same documents.	2018 for 2019 2019 for 2020
The state will update and submit Medicaid Health IT IAPD and state budget requests to support implementation of Health IT, including interoperable HIE and services	Finance: • Prepare Implementation Advance Planning Document Update • Prepare state budget requests	As required

Project Assessment

Initial phase beginning January 2019

The project assessment phase will focus on assessing the direction of the Health IT and HIE in ACH projects and their utility in achieving the goals of the Demonstration. The assessment for each project will be tailored to the specifics of the project and will be conducted by an independent, external evaluator. Assessments will include a mix of qualitative and quantitative analysis, using a variety of data types including clinical, administration, and survey data.

Information obtained through these assessments will be made available to future project planning efforts to ensure any identified shortcomings are not repeated.

Task	Additional Description	Proposed Due Date
The State will contract with and support an independent external evaluator	This evaluator will perform the following: • Develop a methodology to qualitatively and quantitatively assess the impact of the Demonstration on delivery systems, clinical care, health outcomes, and costs; • Assess overall Medicaid system performance under the DSRIP program; • Assess overall Health IT infrastructure; • Assess progress toward meeting VBP penetration targets; • The State will oversee the efforts of the Medicaid MCOs, ACHs and providers;	2019

	• Assess progress toward meeting VBP penetration targets; and • Assess impact of the Demonstration on provider adoption and use of population health management systems, including the use of interoperable HIT and HIE.	

It is understood that the Health IT and HIE needs of the State and the ACHs are evolving, which will require both the Roadmap and the Operational Plan to be updated regularly. HCA will provide annual updates to the Health IT Roadmap to document changes in priorities and highlight progress made during the duration of the Demonstration. HCA will also provide reports and updated Operational Plan quarterly to document the progress towards completing activities identified in the Health IT Strategic Roadmap.