Washington State Health Care Authority

HCA Update – Health Innovation for Washington

Presented to the Joint Select Committee on Health Care Oversight

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Today's Meeting Agenda

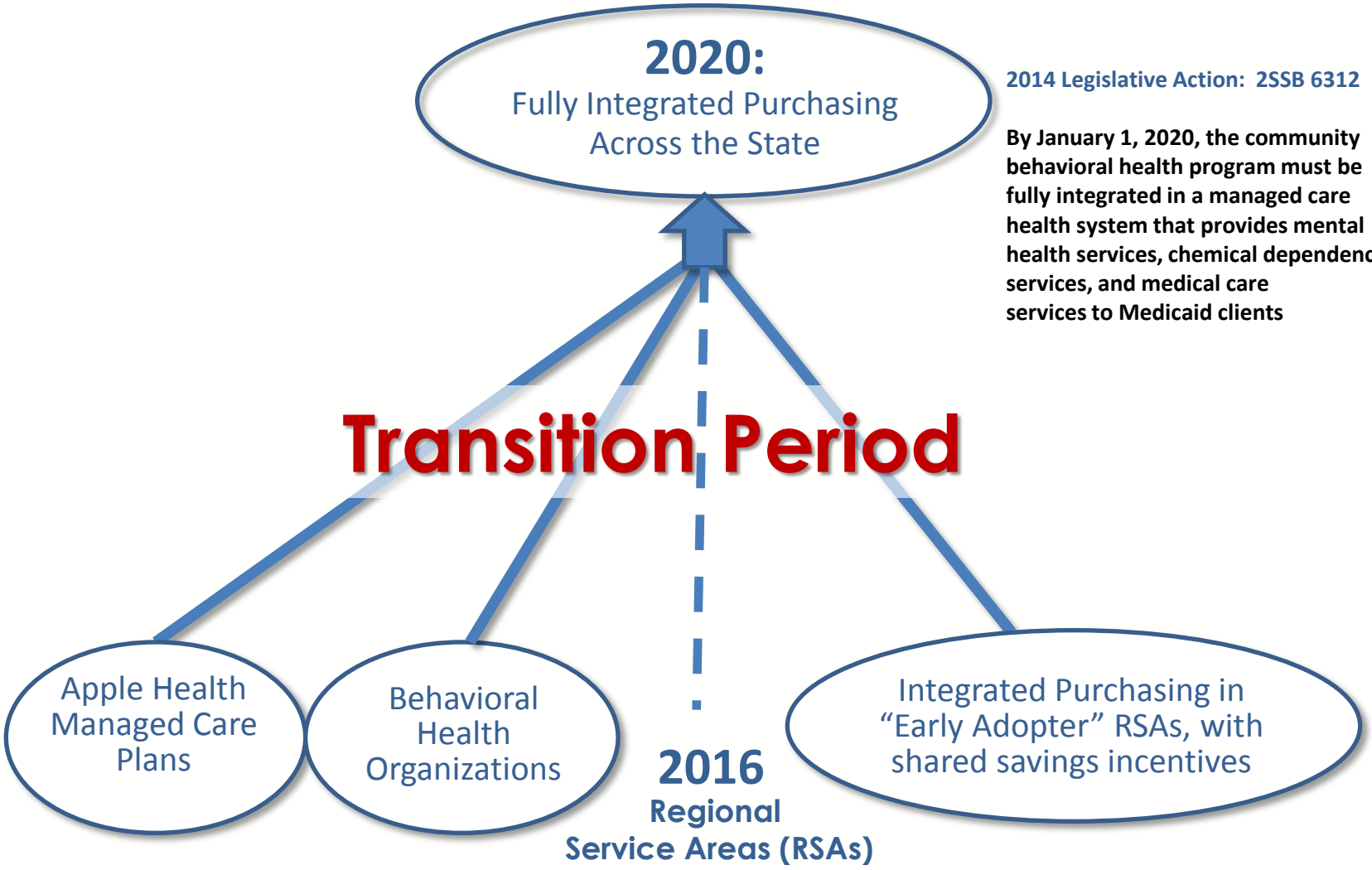
- Integrated Purchasing Timelines / Early Adopters
- Performance Measures Update
- Managed Care Contract Management

Integrated Purchasing Timelines / Early Adopters

Potential Payment Redesign Opportunities

- **MODEL TEST 1:** *Early Adopter of Medicaid Integration*
  Test how integrated Medicaid financing for physical and behavioral health accelerates integrated delivery of whole-person care
- **MODEL TEST 2:** *Encounter-based to Value-based*
  Test a value-based alternative payment methodology in Medicaid for federally-qualified health centers and rural health clinics and pursue new flexibility in delivery and financial incentives for participating Critical Access Hospitals
- **MODEL TEST 3:** *Puget Sound PEB and Multi-Purchaser*
  Through existing PEB partners & volunteering purchasers, test new accountable network, benefit design and payment approaches
- **MODEL TEST 4:** *Greater Washington Multi-Payer*
  Test integrated finance and delivery through a multi-payer network with a capacity to coordinate, share risk and engage a sizeable population

Parallel Paths to Purchasing Transformation



2014 Legislative Action: 2SSB 6312

By January 1, 2020, the community behavioral health program must be fully integrated in a managed care health system that provides mental health services, chemical dependency services, and medical care services to Medicaid clients

2016 Medicaid Purchasing Context

- **"Early adopter" regional service areas**
  - Fully Integrated managed care plans contract for full physical and behavioral health risk

- **"Other" regional service areas**
  - Managed care plans contract for physical health for all and mental health for individuals who do not meet access-to-care standards
    AND
  - Behavioral health organizations provide substance use disorder services for all and mental health for individuals who do meet access-to-care standards

Purchasing in "Early Adopter" RSAs

- Standards developed jointly by the HCA and DSHS
- Agreement by county authorities in a regional service area
- Compliance with Medicaid and State managed care contracting requirements
- Shared savings incentives
  - Payments targeted at 10% of savings realized by the State
  - Based on outcome and performance measures
  - Available for up to 6 years or until fully integrated purchasing occurs statewide
- Models continuing to be discussed broadly

Early Adopter Regions: Fully Integrated Physical & Behavioral Health Purchasing
Basic Managed Care Arrangements

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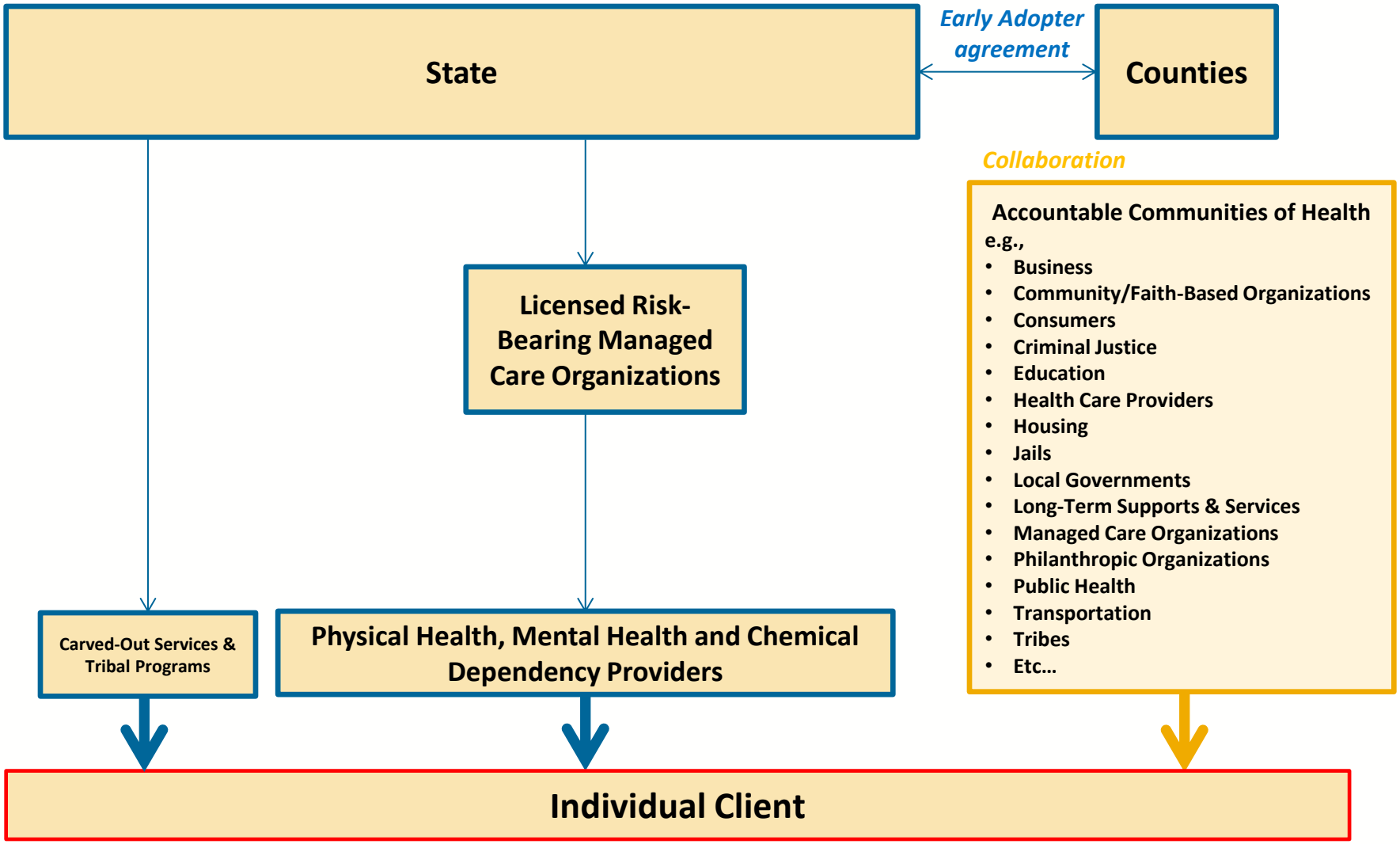

Other Regions: Physical & Behavioral Health Purchasing

Separate Managed Care Arrangements

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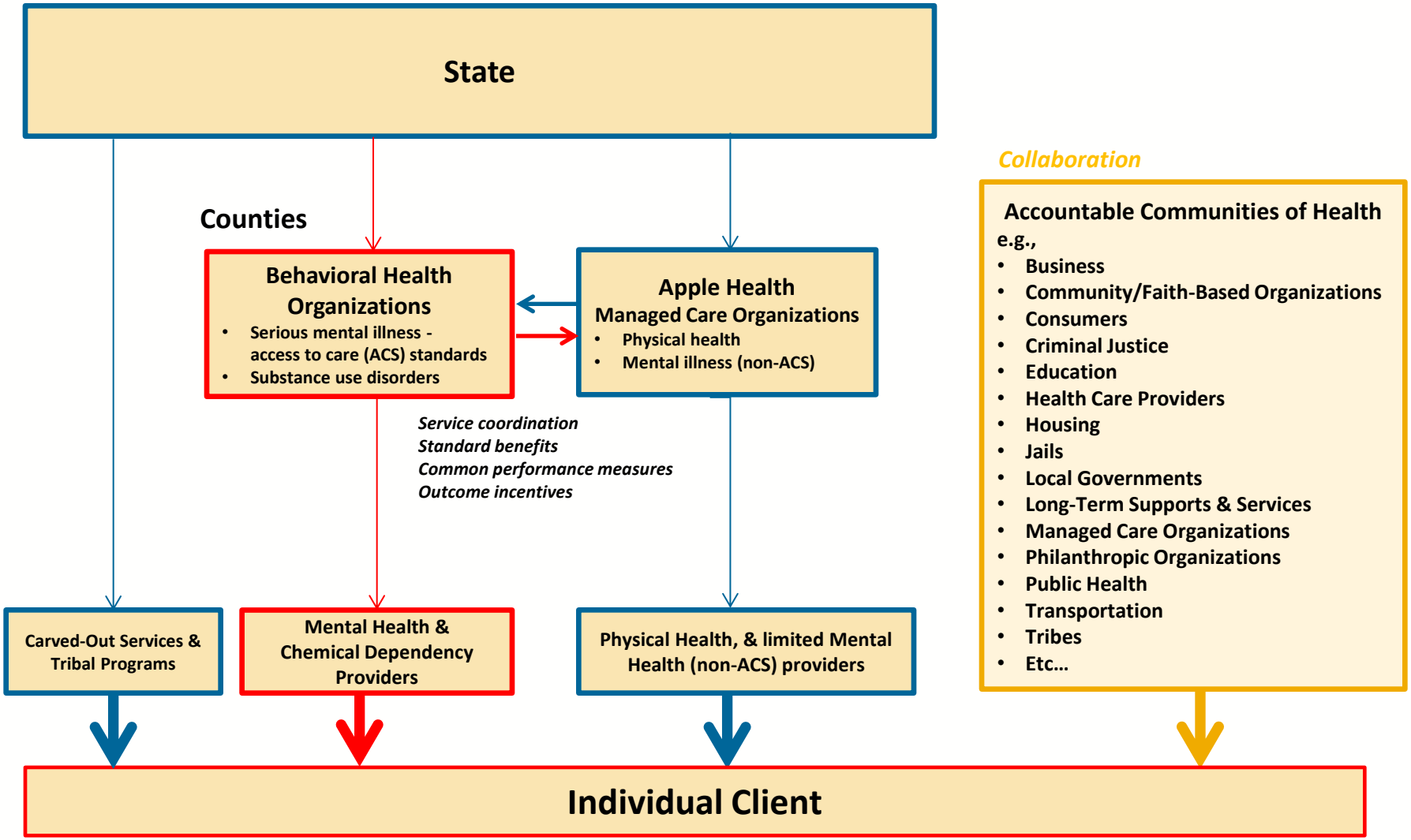
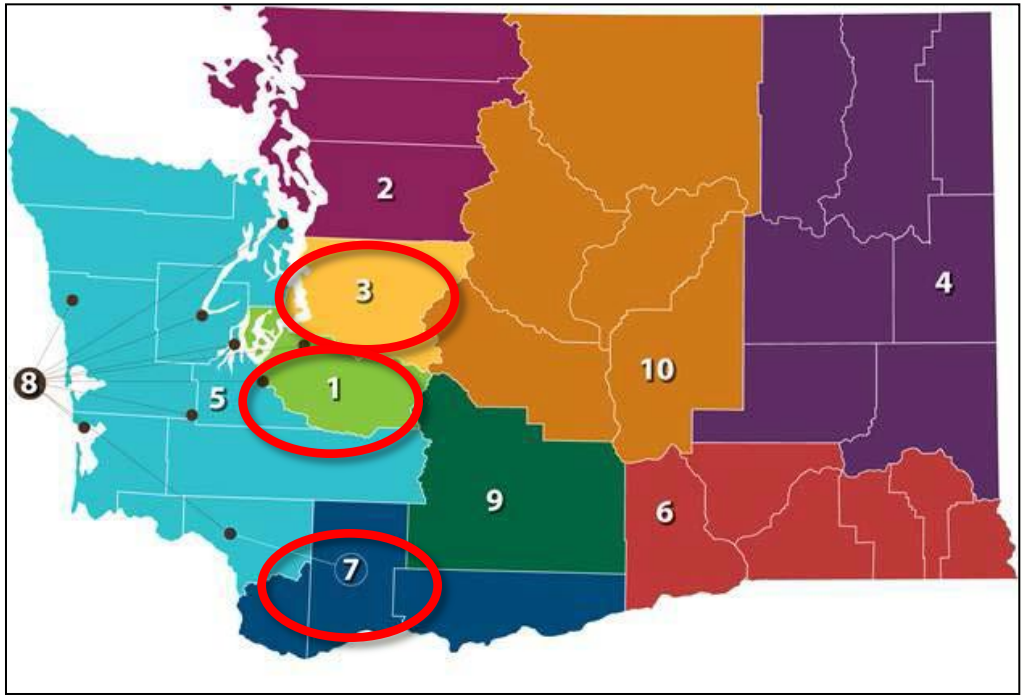


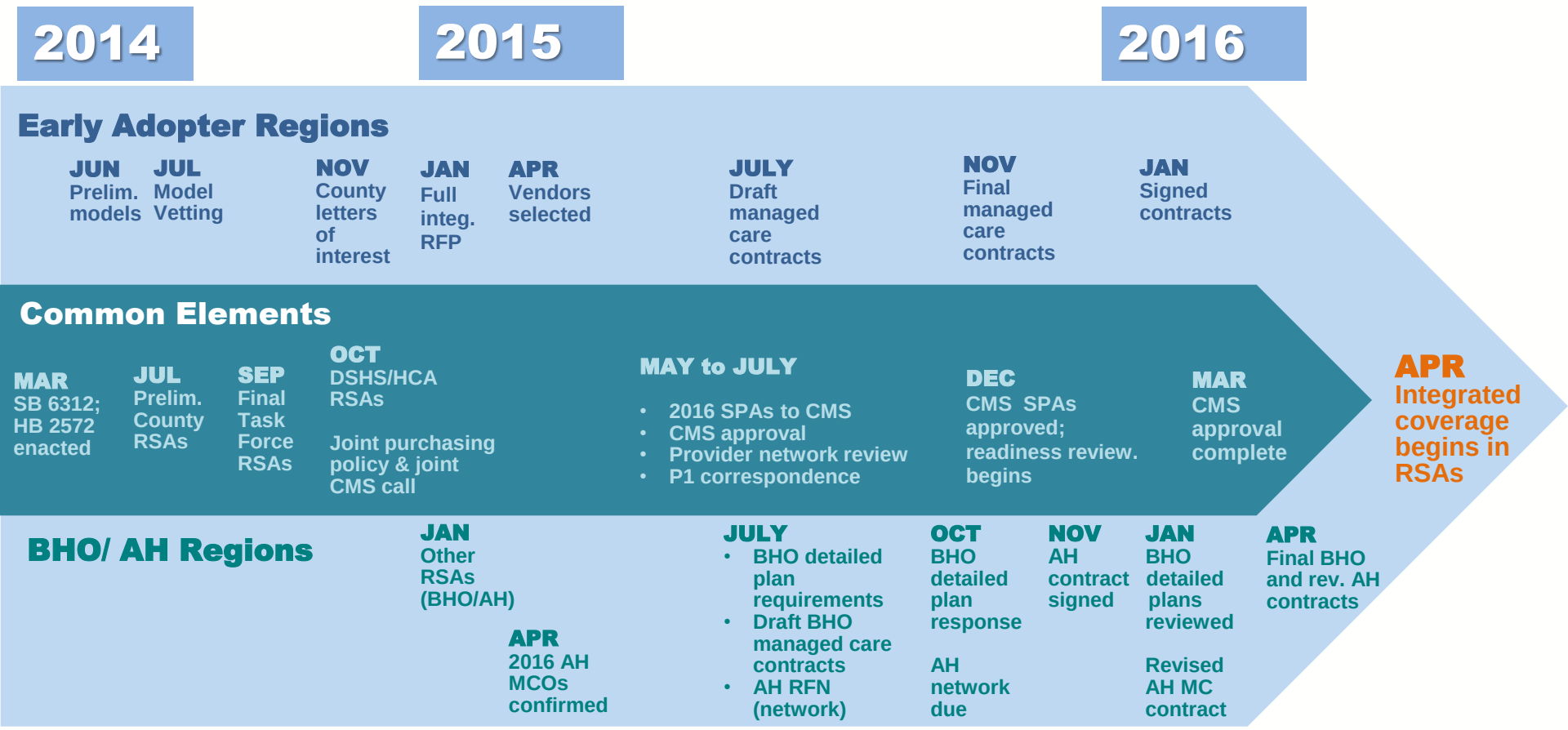
“Early Adopters”: Community Planning Interest



Community of Health Planning Regions

1. Pierce County Health Innovation Partnership
2. North Sound Accountable Community of Health
3. King County
4. Better Health Together
5. CHOICE Regional Health Network
6. Benton-Franklin Community Health Alliance
7. Southwest Washington Regional Health Alliance
8. South Puget Intertribal Planning Agency
9. Yakima County Accountable Community of Health
10. North Central Health Partnership

Medicaid Integration Timeline



RSA – Regional service areas
MCO – Managed Care Organization
BHO – Behavioral Health Organization
AH – Apple Health (medical managed care)
SPA – Medicaid State Plan amendment
CMS – Centers for Medicare and Medicaid Services
Early Adopter Regions: Fully integrated purchasing
BHO/AH Regions: Separate managed care arrangements for physical and behavioral health care

Performance Measures Update

Key Strategy in WA Innovation Plan

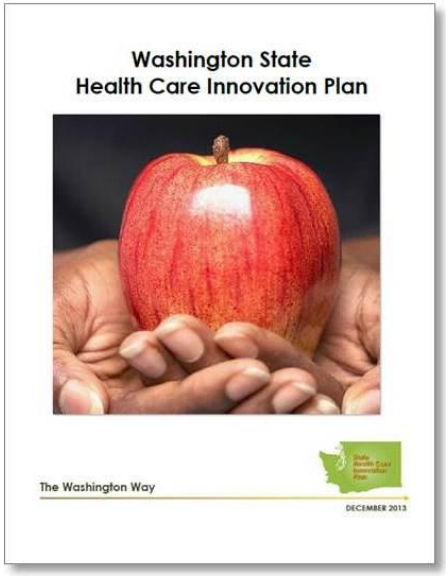
WA Innovation Plan:

Better Health, Better Care, Better Value

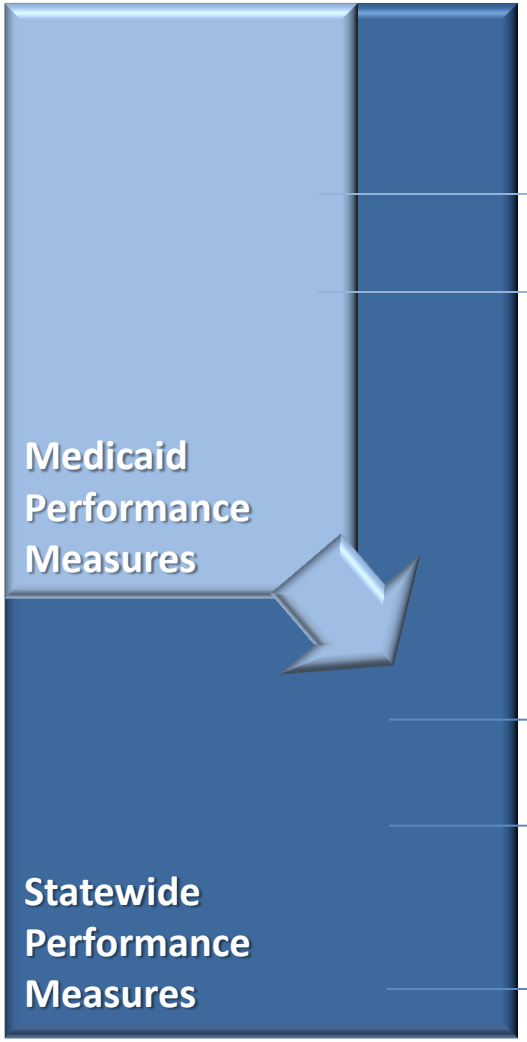
Build a Culture of Robust Transparency:

a Foundational Building Block

- Develop a statewide measure set
- Collect and report statewide data
- Make quality and cost of providers and services transparent for all



Performance Measures: Evolution of Common Measure Sets in WA



- **Medicaid Adult Quality Measures:** CMS grant supporting use of Medicaid core measure set for WA adults.
- **2SSB 5732/2SHB 1519 Requirements for Performance Measures.** Cross-System Steering Committee and work groups develop measures for state agencies contracting with RSNs, county chemical dependency coordinators, Area Agencies on Aging and managed health care plans.
- **E2SHB 2572 in Support of the State Health Care Innovation Plan.** Statewide "health performance" measures by Jan. 1, 2015
- **Performance Measures Coordinating Committee (PMCC) and Workgroups Formed:** Led by HCA and Washington Health Alliance; 29 health care leaders plus state agency representatives. Four meetings through Dec. 17, 2014
- **Final PMCC Recommendations:** Due to HCA by January 1, 2015.

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Legislative Language: ESHB 2572, Section 6

- **Under ESHB 2572,** HCA is charged with facilitation of the Performance Measurement Committee
  - *Committee charged with recommending standard statewide measures of "health performance" by January 1, 2015.*
  - *Committee's measures recommendation submitted to HCA Director*

Role of Performance Measurement Committee

- **Committee responsibilities:**
  - Set overall direction for developing recommendations, including:
    - *Scope of measurement*
    - *Measure selection process*
    - *Potential measure stratifications*
  - Ensure a transparent process and ample opportunity for public comment
  - Review and recommend final measure set to HCA
  - Recommend ongoing process to evaluate and modify measure set

Role of the Technical Work Groups

- **Three technical work groups:**
  - *Prevention*
  - *Acute Care*
  - *Chronic Illness*
- **Each work group will:**
  - be responsible for reviewing and recommending up to 15 measures, *based on measurement selection criteria approved by the PMCC*
  - consider and propose if and how to stratify selected measures by population
  - develop a "parking lot" of high priority measures for potential future use

High Priority* Topics by Workgroup

PREVENTION	ACUTE CARE	CHRONIC ILLNESS
Adult Screening(s)	Avoidance of Overuse	Asthma
Behavioral Health/Depression	Behavioral Health	Care Coordination
Childhood: early and adolescents	Cardiac	Depression
Immunizations	Cost and Utilization	Diabetes
Nutrition/ Physical Activity/ Obesity	Readmissions/Care Transitions	Drug and Alcohol Use
Obstetrics	Obstetrics	Functional Status
Oral Health	Patient Experience	Hypertension and Cardiovascular Disease
Safety/Accident Prevention	Patient Safety	Medications
Tobacco Cessation	Pediatric	
Utilization	Potentially Avoidable Care	
	Stroke	

*Not listed in any particular priority order.

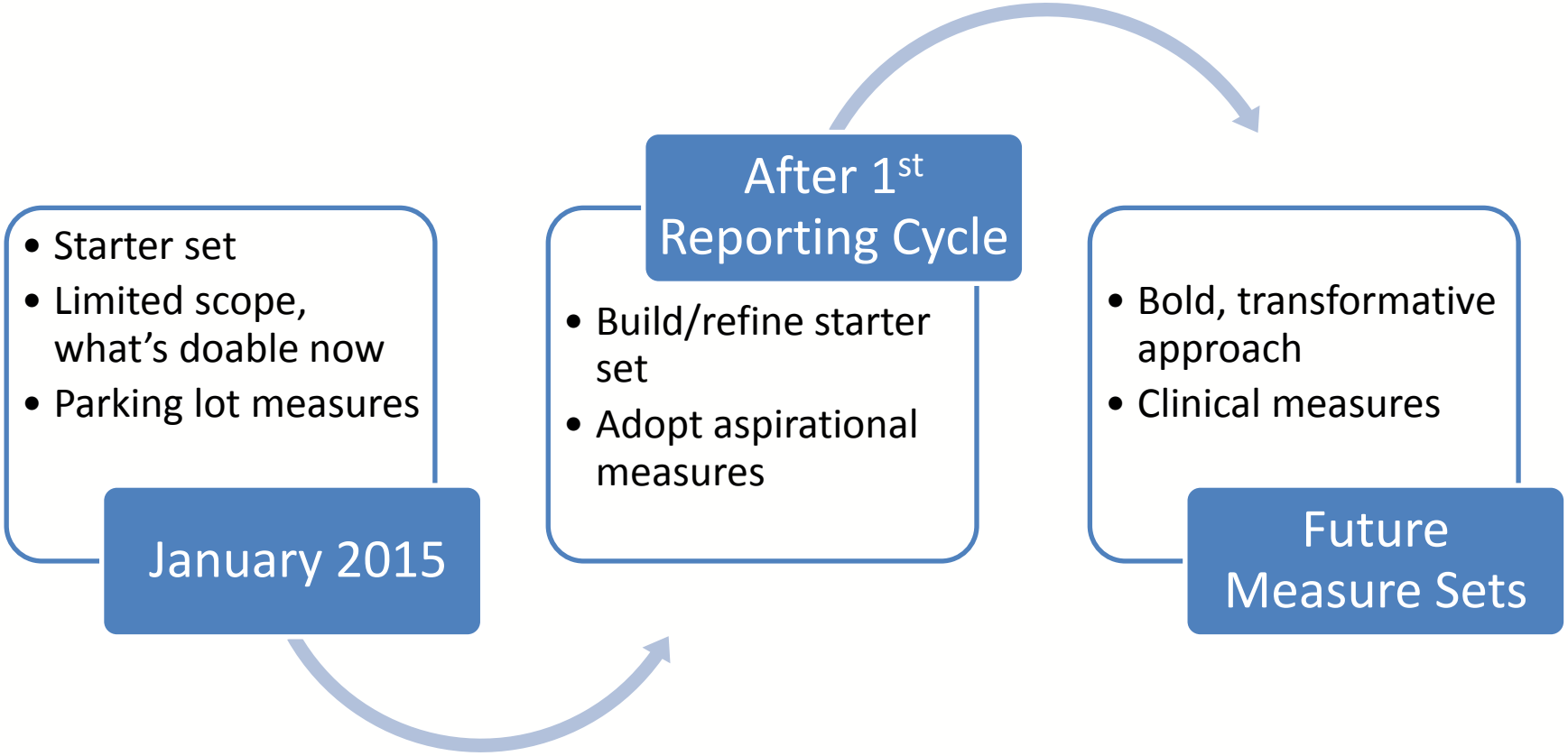
Object of Measurement:

- **The measure set may be used to assess** hospitals and medical groups (including integrated health systems), health plans, or geographic regions (counties, ACH).
  - *Some measures can apply to both providers and health plans, while some may only be applicable to one or the other.*
  - *Health plan measures applied to providers may not yield the exact same result.*
- **The measure set will use common measures wherever possible across payer types,** minimizing exceptions. Measure set may include separate measures for commercial and Medicaid populations on a limited basis.

Final Recommendations May Include:

1. **Recommended "Starter Set" Measures**
   - For each measure:
     - Measure definition
     - Measure Owner/Steward
     - Type of data required for measurement
     - Recommended source of data in Washington
     - Unit(s) of analysis (i.e., target(s) of measurement)
     - Whether and how the measure should be stratified
2. **Recommendations for future consideration**
   - Include topics or specific measures considered to be high priority for the future (not measureable in near term)

Evolution of Core Measure Set Development



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Timeframe

- Technical work groups to meet on bi-weekly basis through September
- Recommendations to Performance Measurement Committee presented at October meeting
- Refinements to recommendations based on feedback
- Performance Measurement Committee finalizes recommendations at December meeting
- Recommendations due to HCA by January 1, 2015

Managed Care Contract Management

What is managed care in Medicaid?

- **Since early 1990s: Medicaid transitioning beneficiaries to health plans** – non-FFS requires CMS approval
- **Today: Over 90% of full-benefit eligibles** are served through managed care plans
- **State sends PMPM (per-member, per-month) to 5 plans** with defined set of benefits for defined population—each plan is fully at risk for the care of their respective population
- **Goals of managed care:** Control costs, improve coordination and quality, improve population health:
  - *Improved quality*
  - *Access, care coordination*
  - *Predictable costs*

Medical/non-Access-to-Care[1] Mental Health Services Delivered through Managed Care

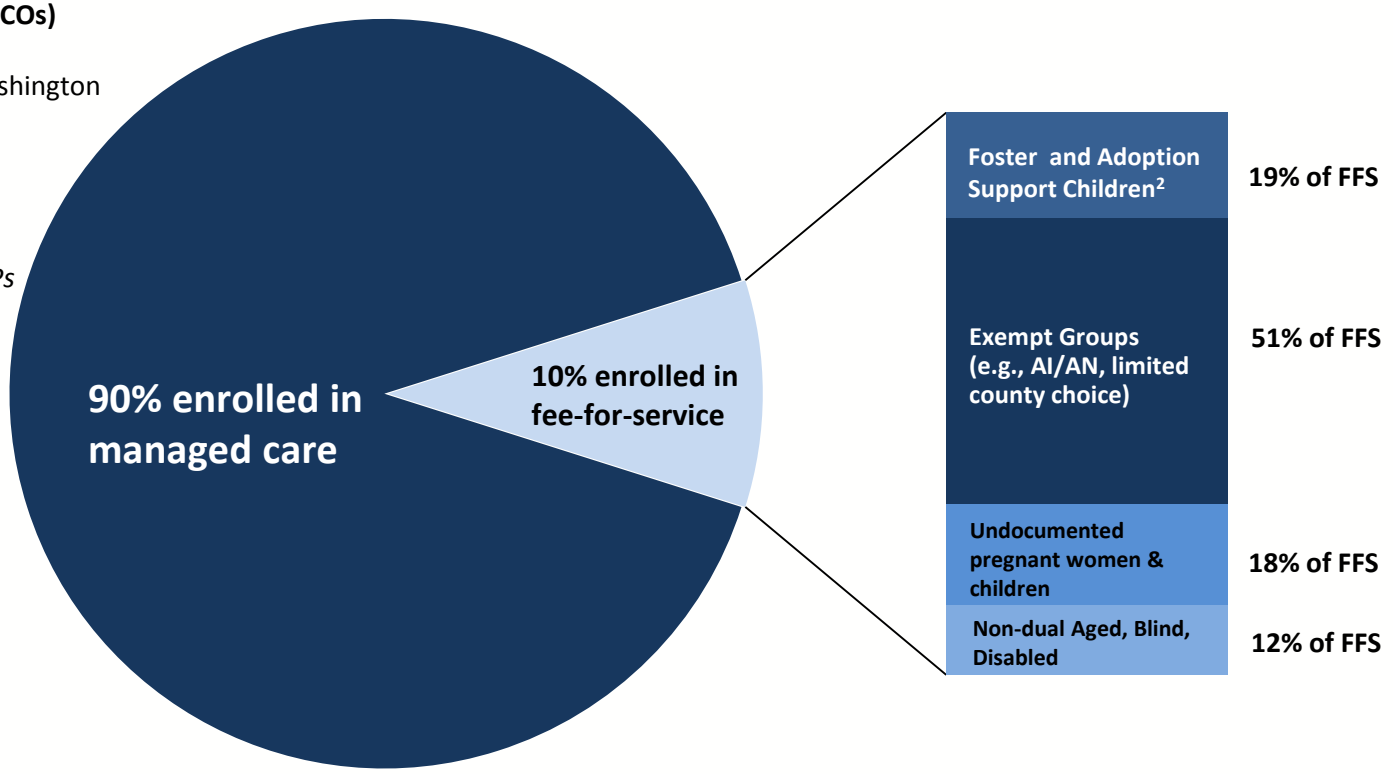
Approx. 1.3 million individuals receive their <u>full</u> health benefits coverage from Medicaid/CHIP

(excludes duals, partial duals, family planning-only and alien emergency medical.)

2014 – 5 managed care organizations (MCOs)

- Amerigroup
- Community Health Plan of Washington
- Coordinated Care
- Molina Healthcare
- UnitedHealth

- *Offers QHPs in Exchange*
- *Additional proposed 2015 QHPs*



[1] **Unique to WA – "Access to Care" standards define level of mental health impairment**

[2] **Currently planned to move to managed care in 2015**

Source: HCA Quarterly Enrollment Reports

How do we select managed care plans?

- **In 2012, HCA launched new procurement:**
  Two incumbent plans (CHPW & Molina) and three new plans awarded contracts (Amerigroup, UnitedHealthcare, Coordinated Care)
- **Between procurements:** State provides opportunities for new plans to apply; HCA decides whether new plans are offered
- **In response to 2SSB 6312** ***(RSAs for Medicaid & Early Adopters for full integration)*****:** HCA determining next steps for April 2016 in collaboration with DSHS

Rate Setting

- **State works with an actuary** to ensure that capitated rates reflect the population characteristics, benefits and service delivery expectations placed on health plans
- **CMS requires actuarial soundness & must approve the rates**
- **State process** for building rates:
  - *Historical snapshot of utilization*
  - *Examine policy, benefit, eligibility and other changes*
  - *Examine trends: Medical inflation, utilization patterns, new drugs, new technologies, changes in health care practice, etc.*
  - *Based on research, assumptions made about plan performance and the impact of care coordination on overall health care spending*
  - *Rates set with clear communication among HCA, OFM, Legislative fiscal staff and the state's contracted actuary*
  - *Rates paid out monthly to plans reflecting their enrolled population.*
  - *Rates adjusted to control for demographic differences and health risk characteristics of enrollees served. Adjustment is cost-neutral to state.*

Paid to Plans in July 2014

- **Number of Plans:** **Five**
- **Number of Managed Care Enrollees:** **1.26 million**
- **Total Paid to Plans:** **$437.5 million**

How much do we pay plans?

APPLE HEALTH MANAGED CARE PROGRAMS *September 2014*		
Population	*Avg. PMPM*	*Admin. Rate*
Children and Families	$ 151.01	13.5%
New Adults	$ 634.37	12.5%
Blind/Disabled	$ 798.40	9.4%

- **By law, HCA required to provide actuarially sound rates.**
- **Year-to-year trend for managed care contracts** determined on the basis of: Medical inflation, utilization changes and policy changes

How are managed care plans held accountable?

- **Plans have the full financial risk** for 1.26M clients – they must deliver the care on-time and on budget or face losses
- **State controls the plans' margins for administration and profit.** "Medical Loss Ratio:" Proportion of premium applied to delivery of services set in contract.
- **Administrative performance measures:** HCA monitors plans' customer service, benefit management, network adequacy
- **Quality monitoring:** TeaMonitor, federal EQRO requirement, plans measured annually on basis of HEDIS scores, NCQA accreditation, enrollment based on performance
- **Encounter Data:** Plans share data with HCA , providing info on each medical encounter (allows comparison of plan performance, etc.)

How are managed care plans held accountable?

- **Sanctions if performance is lacking**:
  - Withholding up to 5% of schedule premium payments if the contract fails to meet one or more obligations under the contract
  - Immediate sanctions can be imposed by the state (HCA) or federal government (CMS, OIG) for failure to provide medically necessary services

What was the effect of moving Blind and Disabled clients to Managed Care?

- **Recent evaluation :** Independent assessment required by CMS and completed by Mathematica Research showed:
  - *Total capitation payments in year 1 were smaller than projected expenditures by about $60.8 million*
  - *Enrollees reported adequate access to care*
  - *Appropriate utilization improved:*
    - *Emergency Department use fell*
    - *Outpatient and prescription drug use increased*
  - *Quality of care not compromised*

KEY TAKE-AWAYS

- **By transferring risk for 90% of Apple Health enrollment,** there is greater certainty in budgeting and some protection from adverse health claims experience
- **Rate setting is a collaborative process** that ensures actual utilization, trends and enrollee risk are taken into account in determining how much the state pays its plans
- **Plan performance is closely monitored,** and insufficient performance from plans is penalized
- **Patient care and care coordination** generally improved through a partnership with managed care plans

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