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

2020: Fully Integrated Purchasing Across the State

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.

Transition Period

Apple Health Managed Care Plans
Behavioral Health Organizations
Integrated Purchasing in “Early Adopter” RSAs, with shared savings incentives

2016 Regional Service Areas (RSAs)
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

- State
- Counties

Early Adopter Agreement

Licensed Risk-Bearing Managed Care Organizations

- Carved-Out Services & Tribal Programs
- Physical Health, Mental Health and Chemical Dependency Providers

Collaboration

Accountable Communities of Health
e.g.,
- Business
- Community/Faith-Based Organizations
- Consumers
- Criminal Justice
- Education
- Health Care Providers
- Housing
- Jails
- Local Governments
- Long-Term Supports & Services
- Managed Care Organizations
- Philanthropic Organizations
- Public Health
- Transportation
- Tribes
- Etc…

Individual Client

DRAFT

8-8-14
Other Regions: Physical & Behavioral Health Purchasing
Separate Managed Care Arrangements

State

Counties

Behavioral Health Organizations
- Serious mental illness - access to care (ACS) standards
- Substance use disorders

Apple Health Managed Care Organizations
- Physical health
- Mental illness (non-ACS)

Service coordination
Standard benefits
Common performance measures
Outcome incentives

Carved-Out Services & Tribal Programs

Mental Health & Chemical Dependency Providers

Physical Health, & limited Mental Health (non-ACS) providers

Accountable Communities of Health
- Business
- Community/Faith-Based Organizations
- Consumers
- Criminal Justice
- Education
- Health Care Providers
- Housing
- Jails
- Local Governments
- Long-Term Supports & Services
- Managed Care Organizations
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- Etc...

Individual Client
“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

9-18-14
Medicaid Integration Timeline

**Early Adopter Regions**
- **JUN** Prelim. models
- **JUL** Model Vetting
- **NOV** County letters of interest
- **JAN** Full integ. RFP
- **AUG** Vendors selected
- **JUL** Draft managed care contracts
- **NOV** Final managed care contracts
- **JAN** Signed contracts

**Common Elements**
- **MAR** SB 6312; HB 2572 enacted
- **JUL** Prelim. County RSAs
- **SEP** Final Task Force RSAs
- **OCT** DSHS/HCA RSAs
- **JAN** Full integ. RFP
- **SEP** Final Performance measures
- **MAY to JULY**
  - 2016 SPAs to CMS
  - CMS approval
  - Provider network review
  - P1 correspondence
- **DEC** CMS approved; readiness review begins
- **MAR** CMS approval complete

**BHO/ AH Regions**
- **JAN** Other RSAs (BHO/AH)
- **APR** 2016 AH MCOs confirmed
- **JUL**
  - BHO detailed plan requirements
  - Draft BHO managed care contracts
  - AH RFN (network)
- **OCT**
  - BHO detailed plan response
  - AH network due
- **NOV**
  - AH contract signed
  - Revised AH MC contract
- **JAN**
  - BHO detailed plans reviewed
  - AH contract detailed signed
  - AH contract detailed confirmed
  - AH BHO detailed plans reviewed
  - AH BHO and rev. AH contracts

**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

September 15, 2014
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
Statewide Performance Measures

- **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.


- **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.
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

<table>
<thead>
<tr>
<th>PREVENTION</th>
<th>ACUTE CARE</th>
<th>CHRONIC ILLNESS</th>
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<tbody>
<tr>
<td>Adult Screening(s)</td>
<td>Avoidance of Overuse</td>
<td>Asthma</td>
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<tr>
<td>Behavioral Health/Depression</td>
<td>Behavioral Health</td>
<td>Care Coordination</td>
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<td>Childhood: early and adolescents</td>
<td>Cardiac</td>
<td>Depression</td>
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<td>Immunizations</td>
<td>Cost and Utilization</td>
<td>Diabetes</td>
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<td>Readmissions/Care Transitions</td>
<td>Drug and Alcohol Use</td>
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<td>Functional Status</td>
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<td>Oral Health</td>
<td>Patient Experience</td>
<td>Hypertension and Cardiovascular Disease</td>
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<td>Safety/Accident Prevention</td>
<td>Patient Safety</td>
<td>Medications</td>
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<td>Pediatric</td>
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<td>Utilization</td>
<td>Potentially Avoidable Care</td>
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<td>Stroke</td>
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*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

- **January 2015**
  - Starter set
  - Limited scope, what’s doable now
  - Parking lot measures

**After 1st Reporting Cycle**

- Build/refine starter set
- Adopt aspirational measures

**Future Measure Sets**

- Bold, transformative approach
- Clinical measures
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 full 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

90% enrolled in managed care
10% enrolled in fee-for-service

Foster and Adoption Support Children\(^2\)
19% of FFS

Exempt Groups (e.g., AI/AN, limited county choice)
51% of FFS

Undocumented pregnant women & children
18% of FFS

Non-dual Aged, Blind, Disabled
12% of FFS

\(^1\) 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
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
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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