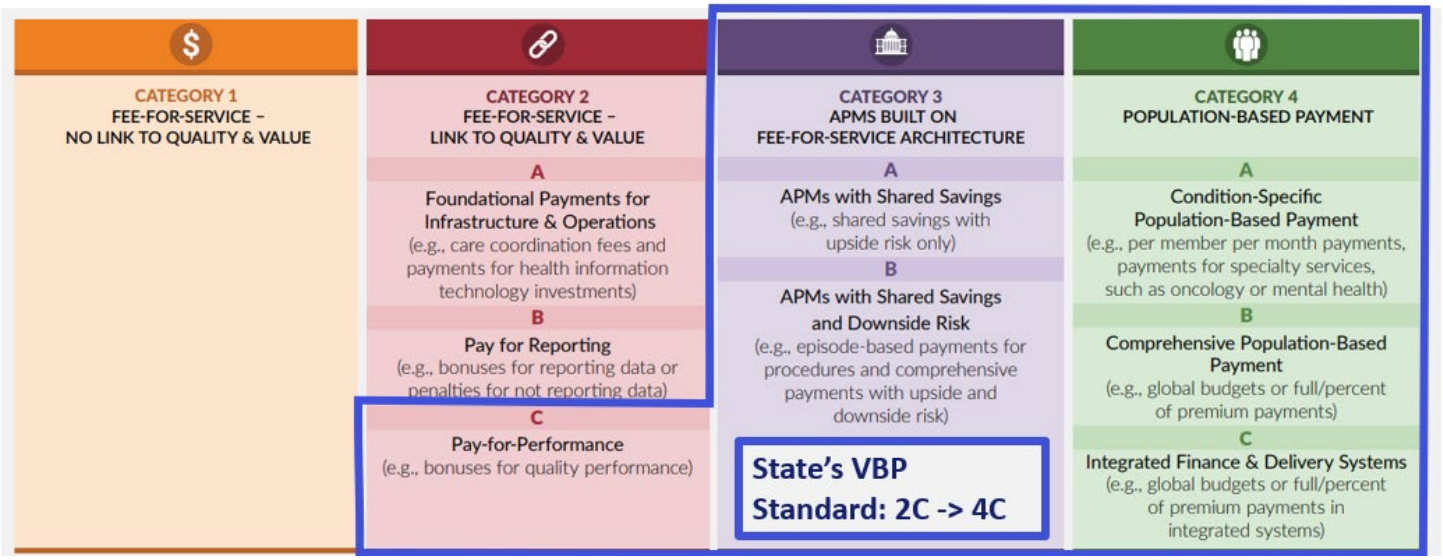
2021 Paying for Value survey results

Executive summary

Background

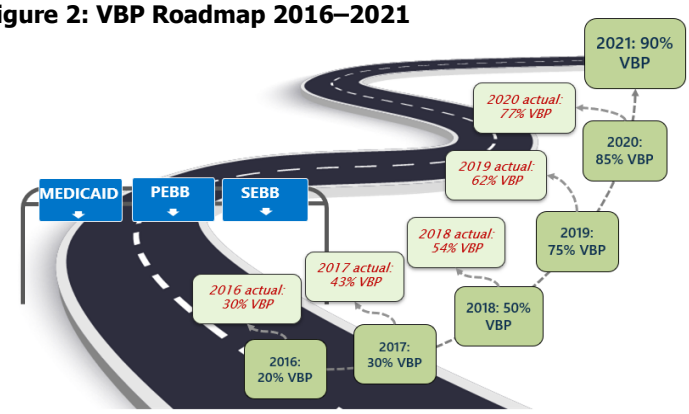
Value-based purchasing (VBP) describes a range of innovative payment strategies intended to contain costs while improving outcomes by tying payment to care quality. Different types of VBP arrangements, also known as alternative payment models (APMs), are categorized according to the Health Care Payment Learning & Action Network's (HCP-LAN) Alternative Payment Model (APM) Framework below.

Figure 1: HCP-LAN APM Framework



HCA spends over $12 billion on health care each year and covers over 2.5 million Washington residents. In 2016, HCA established a goal of achieving 90 percent of state-financed health care (i.e., Medicaid Managed Care and Public and School Employee Benefits Board (PEBB and SEBB) health care) payments in VBP arrangements by the end of 2021 (Figure 2). For the purposes of this goal, HCA defines "VBP" as APMs in Categories 2C and above.

Figure 2: VBP Roadmap 2016–2021



Every year, HCA distributes the Paying for Value Survey to health care payers (plans) and providers to gather information about participation in and experience with VBP. The survey includes questions relating to barriers and enablers to VBP adoption, health equity, practice transformation efforts, participation in the Medicaid Transformation Project (MTP), workforce needs, and impacts of the COVID-19 pandemic. The 2021 survey asked respondents to report on calendar year 2020.

HCA uses survey results to generate data for accountability metrics through MTP and other programs, including incentive payments for managed care organizations (MCOs) and Accountable Communities of Health (ACHs), state earnings of at-risk funds, and performance guarantees for PEBB and SEBB health carriers.

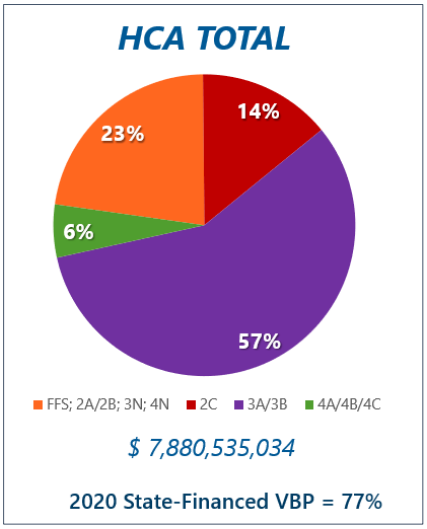
HCA issues surveys to all payers (MCOs and commercial/Medicare Advantage plans) and providers across the state. In 2021, HCA received responses from 64 providers in 31 counties. This is a significantly decreased response rate from previous surveys (170 in 2020 and 148 in 2019). This may be a result of COVID-19 burnout, survey fatigue, or other factors.

Participation in VBP

Payers

HCA purchases value-based care in two sectors: Medicaid Managed Care and PEBB and SEBB. Figure 3 shows the proportion of payments in each APM category in all state-financed care.

Figure 3: state financed VBP by APM



Within Medicaid Managed Care, about three-quarters of Category 3 payments fall into 3A, which allows providers to share in savings without taking financial responsibility ("downside risk") if care is too expensive.

Table 1 displays the changes in VBP attainment in each insurance sector over time. State-financed health care is the care that HCA pays for; statewide health care is all insured care in the state of Washington. Medicaid Managed Care and Medicare are typically very strong in VBP attainment. State-financed commercial insurance plans (PEBB & SEBB) have higher rates of VBP than the commercial sector as a whole. In 2020, state financed VBP surpassed statewide VBP for the first time.

Table 1: percentage of health care spending in VBP arrangements over time

	State-financed health care spending			Statewide health care spending			
	Medicaid MC	PEBB/SEBB	Total	Medicaid	Medicare	Commercial	Total
2020	82%	71%	**77%**	82%	80%	59%	**68%**
2019	77%	38%	**62%**	73%	63%	56%	**64%**
2018	66%	29%	**54%**	66%	64%	55%	**58%**
2017	50%	38%	**43%**	50%	64%	56%	**55%**
2016	28%	13%	**30%**	28%	44%	39%	**37%**

Providers

The largest share of provider reported VBP revenue came from Medicaid, followed by Medicare, commercial, other government, and self-pay (self-insured employers). Forty-three percent of responding providers rated themselves as mostly or very "ready and capable" to engage in VBP, with an additional 32 percent rating themselves as "somewhat ready and capable." Ninety-four percent said they expected their participation in VBP to increase or stay the same during the next 12 months.

According to payers, the most common provider types engaged in VBP are primary care providers, followed by community health centers. Dentists, long-term care facilities, nurse-midwives, and OBGYNs are among the least common provider types in VBP arrangements.

Experience with VBP

Payer experience is shaped by varying goals and definitions of success for APMs. Payer-reported measures of success include financial outcomes, patient satisfaction, and clinical quality ratings.

Most providers characterized their experience with VBP as "neutral" or "positive" from both the clinician and organizational perspectives. Barriers to VBP adoption for both payers and providers remain similar year over year.

Table 2: barriers and enablers to VBP adoption for payers and providers

	Barriers	Enablers
Payers	• Lack of interoperable data systems* • Payment model uncertainty* • Attribution* • Disparate incentives/contract requirements* • Disparate quality measures/definitions	• Interoperable data systems* • Cost transparency • Trusted partnerships and collaborations* • Aligned incentives/contract requirements* • Aligned quality measures/definitions*
Providers	• Misaligned incentives and/or contract requirements* • Lack of timely cost data to assist with financial management* • Lack of access to comprehensive data on patient populations* • Lack of interoperable data systems* • Insufficient patient volume by payer to take on clinical risk*	• Development of medical home culture • Ability to understand and analyze payment models • Access to comprehensive data on patient populations* • Common clinical protocols and/or guidelines associated with training for providers • Sufficient patient volume by payer to take on clinical risk

* Consistent with 2020 survey responses

Health equity

Both payers and providers reported broad commitments to health equity. About half of responding providers reported receiving technical support for addressing health inequities and social determinants of health in the previous year. The same share said they would like to receive technical support on these topics in the future. Collection and disaggregation of patient data by race, ethnicity, language, and disability status is increasing year over year for both payers and providers. This represents an important step toward addressing racial and ethnic health disparities.

However, payers emphasize that demographic data is difficult to capture and are not always high quality. Individuals may not identify with the standard Offices of Management and Budget (OMB) categories or may be reluctant to self-report due to concerns about how the information will be used. Several payers are in the process of improving data collection methods and data integrity.

Although VBP has great potential to improve health equity, purchasers and payers are still in the early stages of determining how to use health care payment to address non-medical social needs (NMSNs). Current barriers to addressing NMSNs include data challenges, lack of alignment across social systems, duplication with community-based resources, gaps in availability of critical services, difficulty in measuring the effectiveness of non-medical supports, and the ongoing COVID-19 pandemic.

Summary and conclusions

HCA is making progress toward VBP goals

As of 2020, 77 percent of state-financed health care is in VBP arrangements, falling short of the benchmark of 85 percent for 2020 (see Figure 2). This represents significant progress from 2019. Additionally, 59 percent of commercial health care and 80 percent of Medicare Advantage health care are in VBP arrangements as of 2020.

Alignment is critical

For both payers and providers, these factors are critical to VBP adoption and expansion: 1) aligned incentives and contract requirements; 2) aligned quality measures and definitions; and 3) interoperable data systems and access to comprehensive patient population data. **Cross-system alignment and interoperability are key to VBP success.**

Role clarity needs improvement

Fewer than 10 percent of surveyed providers describe the role clarity among HCA, payers, ACHs, and providers as "very clear" or "extremely clear." An additional 40 percent describe it as "not so clear" or "not at all clear." **Improving role clarity between various actors in the VBP landscape is an important area of work.**

COVID-19 complicates the VBP landscape

Providers in fee-for-service arrangements suffered during the pandemic because of the decrease in overall health care utilization. This shed a light on the importance of VBP strategies and may have increased the appetite for VBP contracting. At the same time, providers may have less capacity to invest in the transformation to VBP while the pandemic continues. **Minimizing the amount of effort and resources needed to engage in VBP arrangements will enable greater VBP expansion.**

Health equity

Addressing health equity through VBP is in its early stages. Stakeholders at every level are working to address equity, but there are still significant challenges to overcome before VBP can effectively support health equity. **Coordination among payers, providers, and purchasers will be necessary for VBP to reach its full potential as a health equity tool.**