2021 Paying for Value survey results

Washington State providers and health plans report on their value-based purchasing experiences

February 15, 2022

Washington State Health Care Authority

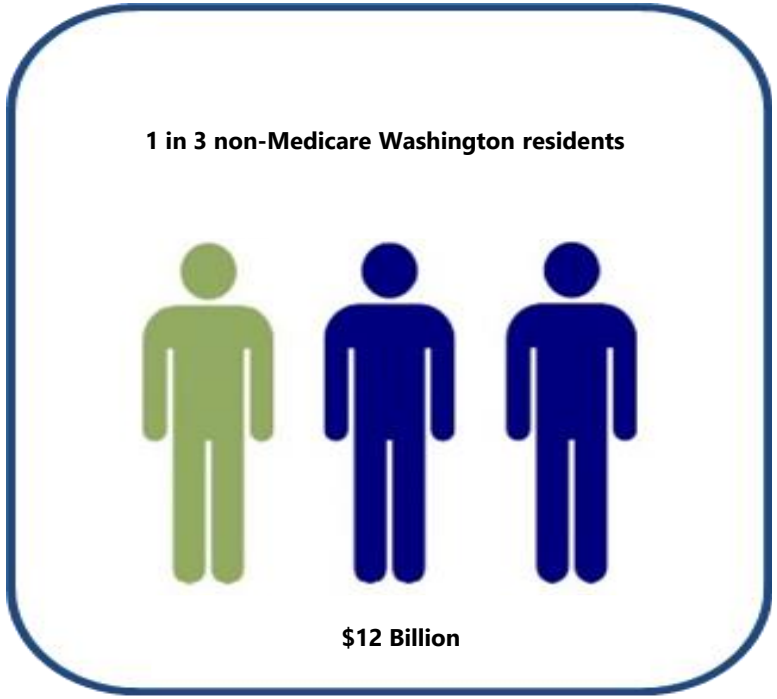
Background

Health Care Authority (HCA) roles and the Value-based Purchasing (VBP) Roadmap

Washington State Health Care Authority

HCA: purchaser, convener, innovator

- Medicaid (Apple Health)
  - 2 million covered lives
  - Five managed care organizations (MCOs): Amerigroup, Community Health Plan of Washington, Coordinated Care, Molina, and United Healthcare
- Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB)
  - PEBB: 380,000 covered lives, including statewide and internationally
  - SEBB: about 250,000 covered lives, beginning January 1, 2020
- Innovation
  - Medicaid Transformation Project (MTP)
  - State Innovation Models (SIM)
  - Centers of Excellence for Total Joint Replacement and Spinal Fusion



HCA strategic plan 2022–2025

hca.wa.gov/about-hca/our-mission-vision-and-values

HCA purchasing goals

- By the end of 2021*:
  - 90 percent of state-financed health care and 50 percent of commercial health care will be in VBP arrangements

Tools to accelerate VBP and health care transformation:
- 2014 legislation directing HCA to implement VBP strategies
- SIM Round 2 grant, 2015-2019
- MTP, 2017-2022

*HCA will calculate 2021 VBP adoption in the fall of 2022. HCA is currently developing revised purchasing goals for 2022-2025.

Alignment with Alternative Payment Models (APM) Framework

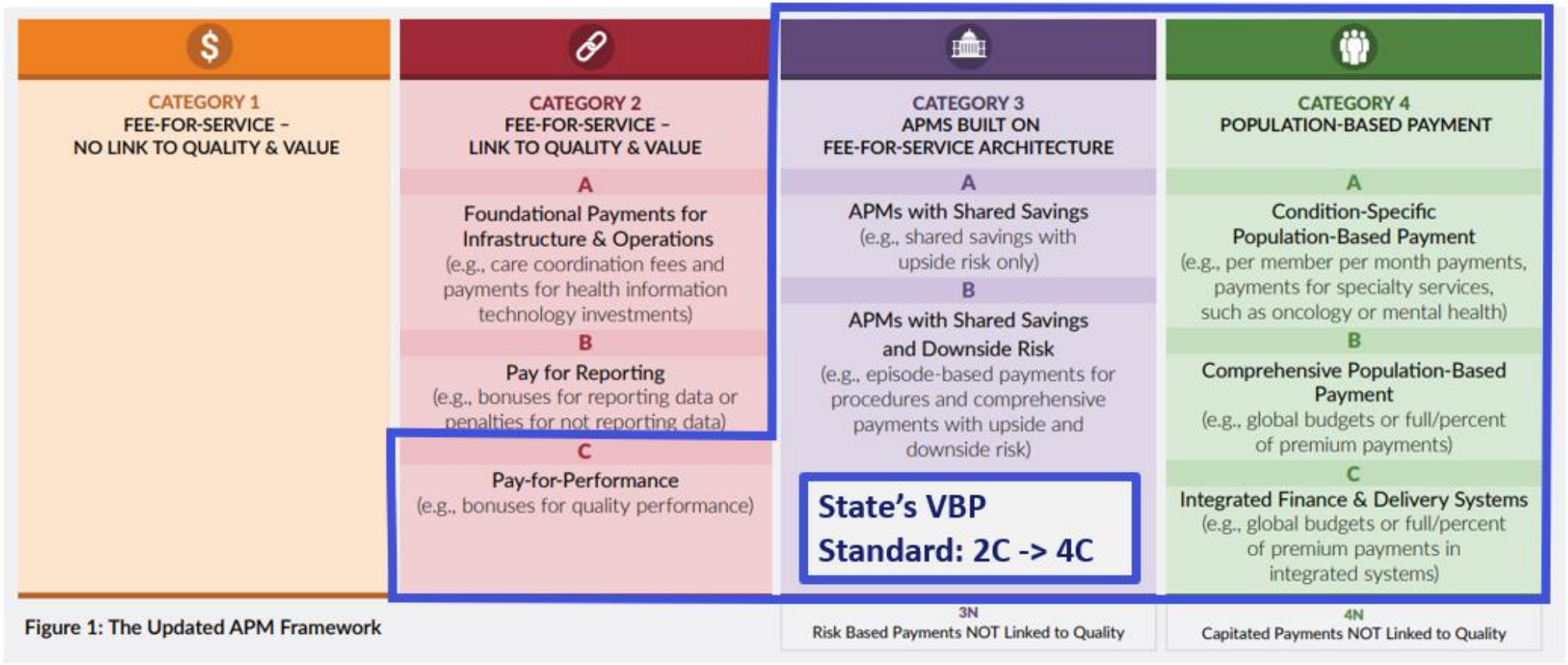


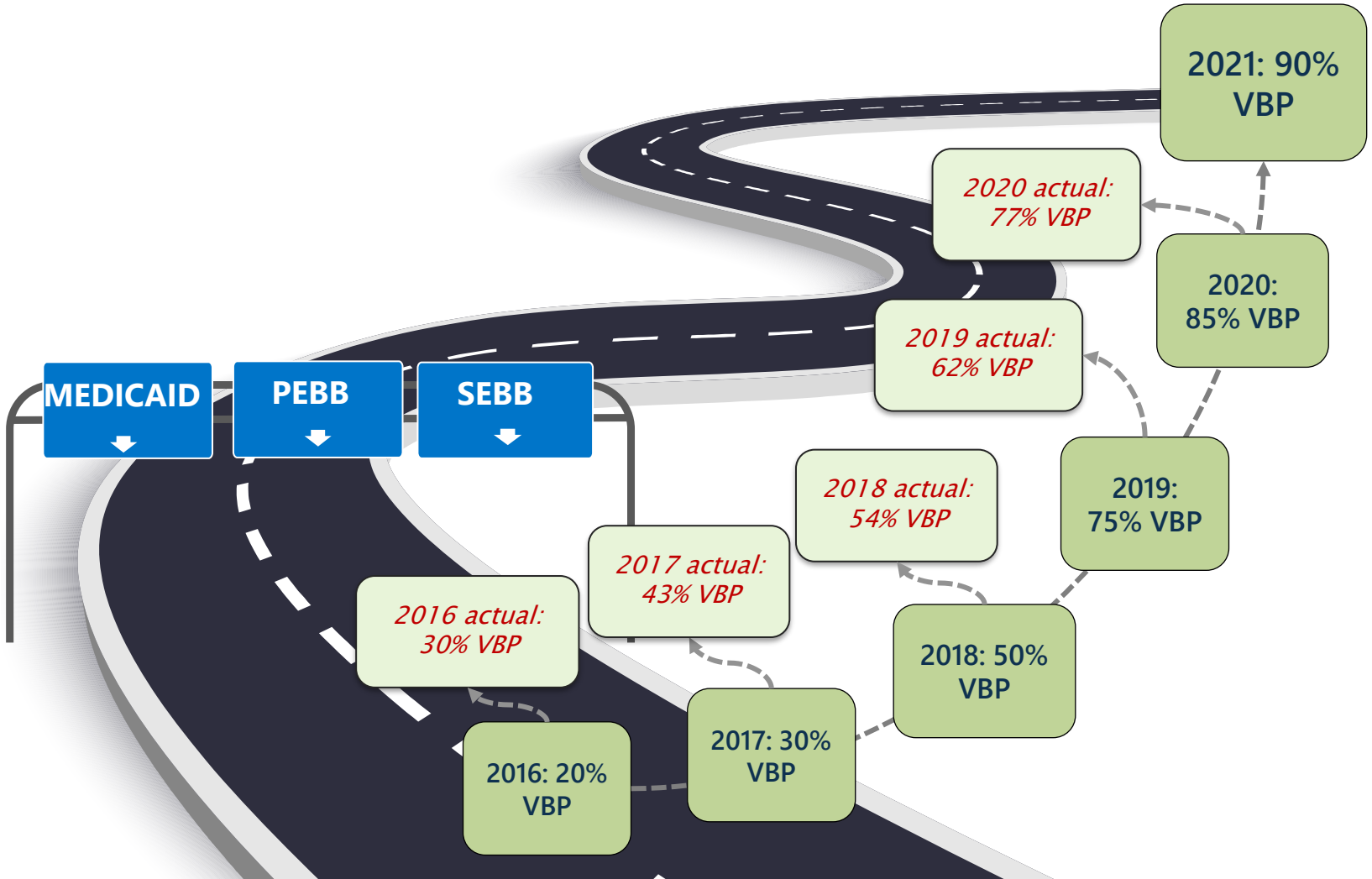
Figure 1: The Updated APM Framework

VBP Roadmap

HCA's vision is to achieve a healthier Washington by:

- Aligning all HCA programs according to a "One HCA" purchasing philosophy.
- Holding plan partners and delivery system networks accountable for quality and value.
- Exercising significant oversight and quality assurance over contracting partners and implementing corrective actions as necessary.

VBP Roadmap


MEDICAID
PEBB
SEBB
2016 actual: 30% VBP
2017 actual: 43% VBP
2018 actual: 54% VBP
2019 actual: 62% VBP
2020 actual: 77% VBP
2016: 20% VBP
2017: 30% VBP
2018: 50% VBP
2019: 75% VBP
2020: 85% VBP
2021: 90% VBP

HCA's Paying for Value survey

Tracking progress in calendar year 2020
and informing current and future strategy

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Overview

- Three surveys: MCO, commercial/Medicare health plan, and provider
- Purpose: track progress toward VBP goals in 2020
- Issued to all Washington State health plans (including five MCOs) and provider organizations
  - MCO and provider surveys add regional information and context
  - Intended to be completed by administrators
  - Provider survey through ServiceNow

Tying survey data to accountability

- The MCO and provider surveys generate data for several accountability metrics relating to VBP attainment:
  - MCO Paying for Value survey:
    - Medicaid Managed Care capitation withhold
    - Determines the MCO's earn-back of the VBP portion of the withhold
  - MTP
    - Determines the state's earned Delivery System Reform Incentive Payment (DSRIP) program funding from the amount of at-risk funds (statewide accountability)
    - Determines earned DSRIP VBP incentives for MCOs and Accountable Communities of Health (ACHs)

Tying survey data to accountability (continued)

- **Provider** Paying for Value survey:
  - Some ACHs provide incentives to organizations that complete the survey
- **Payer** Paying for Value survey:
  - Public and school employee health plan performance incentives

Survey responses

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Payer survey respondents

- Medicare and commercial health plans:
  - Amerigroup*
  - Community Health Plan of Washington*
  - Coordinated Care*
  - Kaiser Permanente Northwest*
  - Kaiser Permanente Washington*
  - Molina*
  - Premera*
  - Regence*
  - United Healthcare*

*Current HCA contractor

- Medicaid MCOs
  - Amerigroup
  - Community Health Plan of Washington
  - Coordinated Care
  - Molina
  - United Healthcare

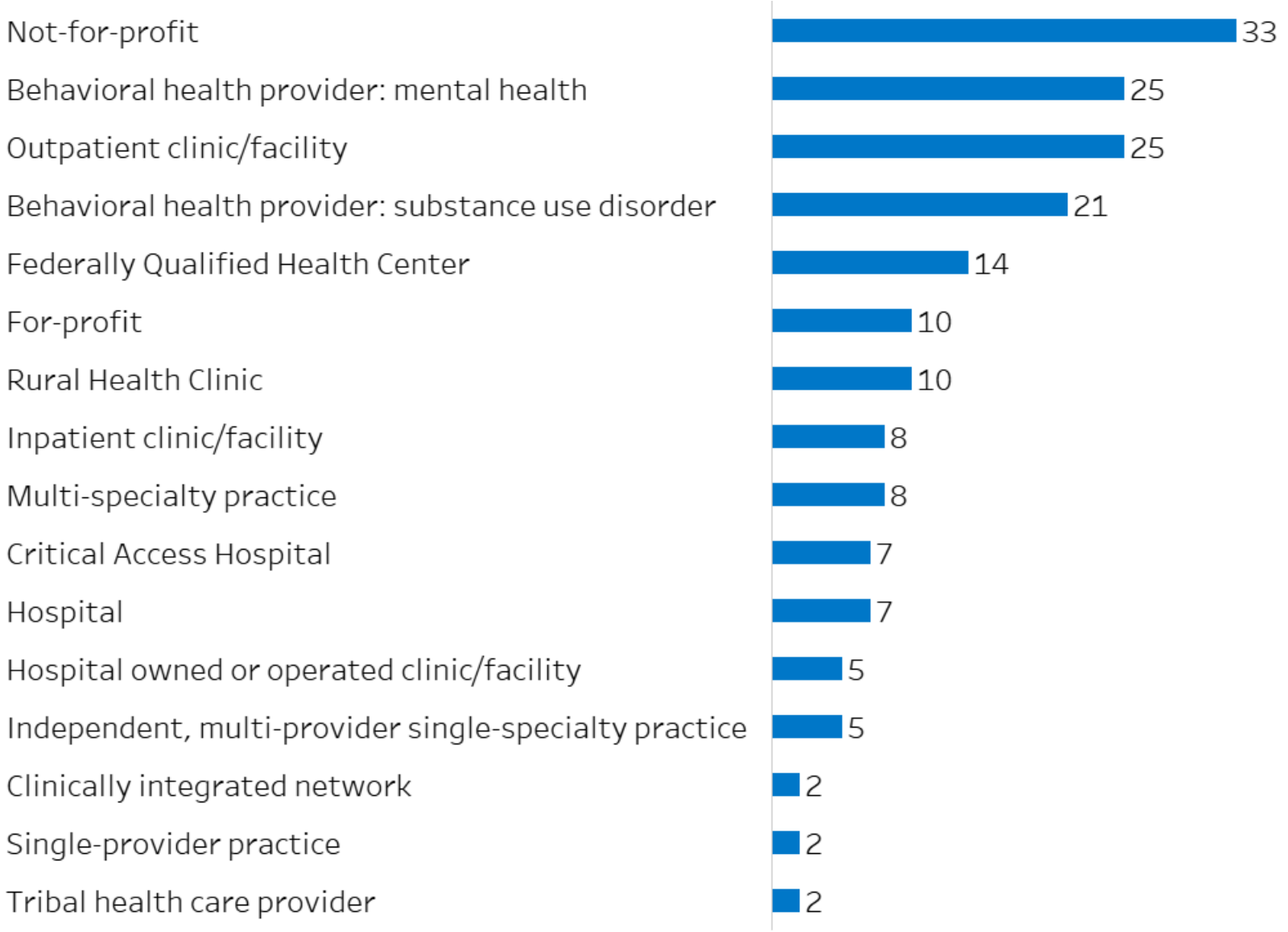
Provider survey respondents

- 64 responses from providers in 31 counties across Washington
- Decreased response rate (from 170 in 2020 and 148 in 2019)
  - COVID-19 burnout?
  - Survey fatigue?

Provider facility type (provider survey)

Multiple selections per respondent possible

n=61



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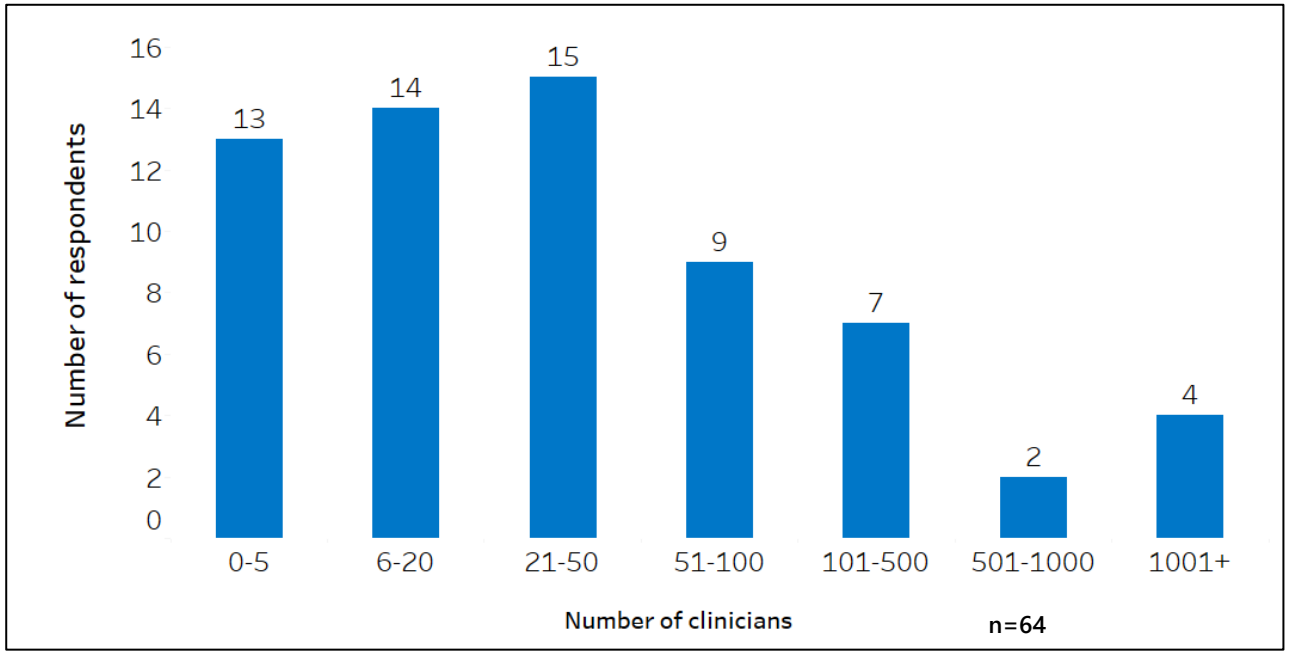
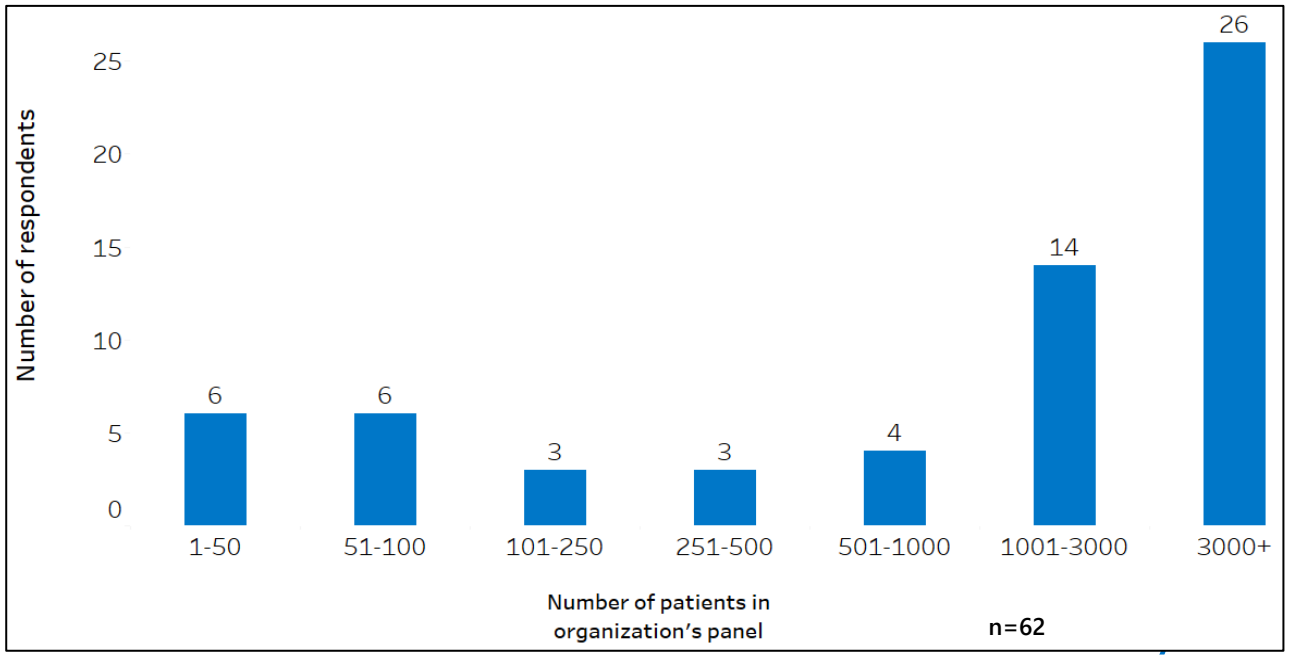
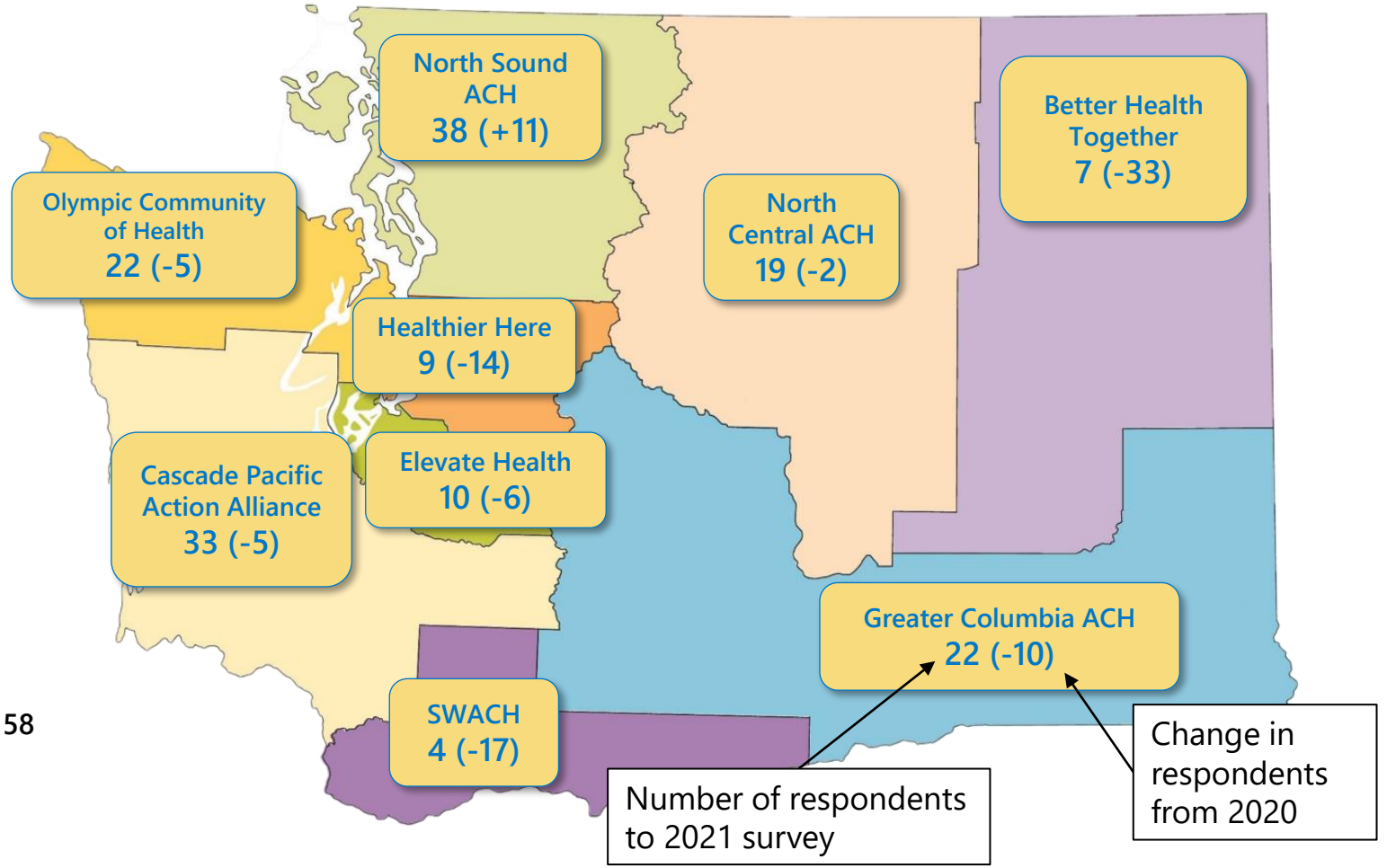
Number of clinicians and size of patient panel (provider survey)





Provider service area by ACH (provider survey)

- Multiple regions per respondent possible
- Counties without respondents:
  - Adams
  - Ferry
  - Garfield
  - Pacific
  - Pend Oreille
  - Skamania
  - Wahkiakum
  - Whitman



n=58

Participation in VBP

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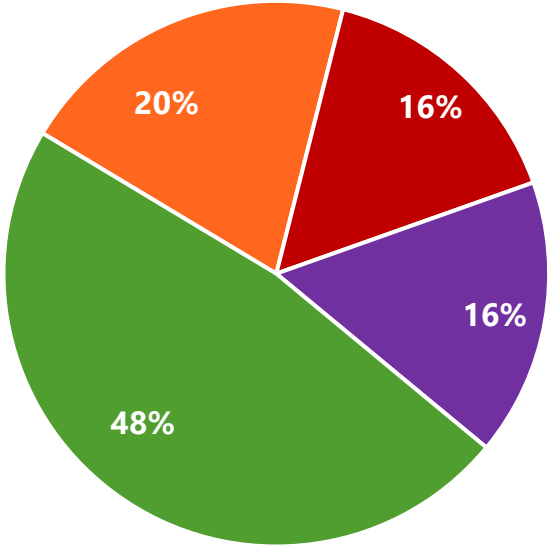
Medicare Advantage payments in VBP by APM Category

CATEGORY 1 – 2B: FEE-FOR-SERVICE - NO LINK TO QUALITY		
1 Fee-for-service	**2A** Foundational Payments for Infrastructure & Operation	**2B** Pay-for-Reporting
20%	0%	0%



CATEGORY 3N & 4N – NO LINK TO QUALITY		**CATEGORY 2C:** FEE-FOR-SERVICE - LINK TO QUALITY
3N Risk-based payments NOT linked to quality	**4N** Capitated payments NOT linked to quality	**2C** Pay-for-Performance
0%	0%	16%

CATEGORY 4A – 4C: POPULATION-BASED PAYMENT		
4A Condition-specific population-based payment	**4B** Comprehensive population-based payment	**4C** Integrated finance and delivery systems
0.5%	6%	41%

$4,326,794,647
18% of all health plan payments in WA

CATEGORY 3A – 3B: APMs BUILT ON FFS ARCHITECTURE	
3A APMs with upside gainsharing	**3B** APMs with upside gainsharing and downside risk
12%	4%

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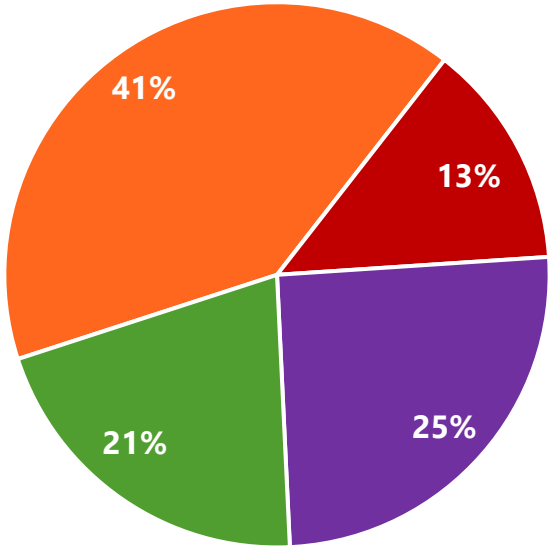
Commercial payments in VBP by APM Category

CATEGORY 1 – 2B: FEE-FOR-SERVICE - NO LINK TO QUALITY		
1 Fee-for-service	**2A** Foundational Payments for Infrastructure & Operation	**2B** Pay-for-Reporting
40%	0%	0%



CATEGORY 3N & 4N – NO LINK TO QUALITY		**CATEGORY 2C:** FEE-FOR-SERVICE - LINK TO QUALITY
3N Risk-based payments NOT linked to quality	**4N** Capitated payments NOT linked to quality	**2C** Pay-for-Performance
0%	0%	13%

CATEGORY 4A – 4C: POPULATION-BASED PAYMENT		
4A Condition-specific population-based payment	**4B** Comprehensive population-based payment	**4C** Integrated finance and delivery systems
0%	0%	20%

- FFS; 2A/2B; 3N; 4N
- 2C
- 3A/3B
- 4A/4B/4C

$12,997,090,031
59% of all health plan payments in WA

CATEGORY 3A – 3B: APMs BUILT ON FFS ARCHITECTURE	
3A APMs with upside gainsharing	**3B** APMs with upside gainsharing and downside risk
8%	17%

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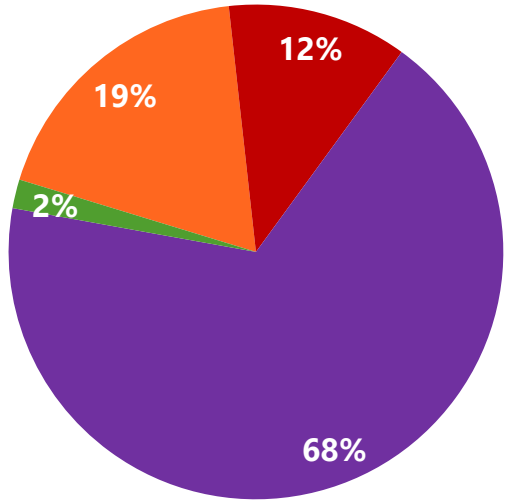
Medicaid payments in VBP by APM Category

CATEGORY 1 – 2B: FEE-FOR-SERVICE - NO LINK TO QUALITY		
1 Fee-for-service	2A Foundational Payments for Infrastructure & Operation	2B Pay-for-Reporting
18%	0%	0%



CATEGORY 3N & 4N – NO LINK TO QUALITY		**CATEGORY 2C:** FEE-FOR-SERVICE - LINK TO QUALITY
3N Risk-based payments NOT linked to quality	4N Capitated payments NOT linked to quality	2C Pay-for-Performance
0%	0%	12%

CATEGORY 4A – 4C: POPULATION-BASED PAYMENT		
4A Condition-specific population-based payment	4B Comprehensive population-based payment	4C Integrated finance and delivery systems
0%	2%	0%

$4,561,989,886
21% of all health plan payments in WA

CATEGORY 3A – 3B: APMs BUILT ON FFS ARCHITECTURE	
3A APMs with upside gainsharing	3B APMs with upside gainsharing and downside risk
49%	19%

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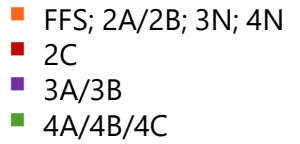
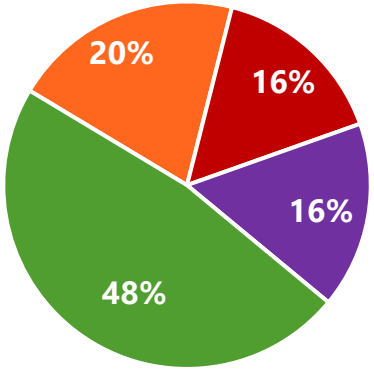
Summary: all payments in VBP by APM and sector

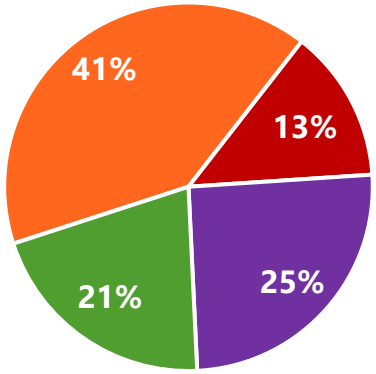


Medicare Advantage



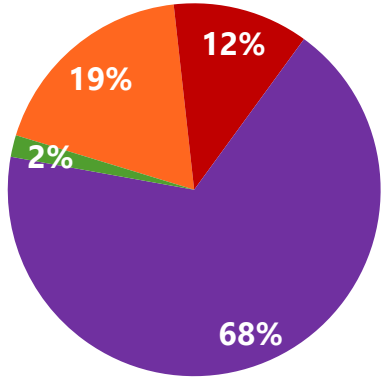
n=9
Total payments = $4.3B
(18% of all health plan payments)
VBP = $3.4B
(80% of Medicare Advantage payments)

Commercial



n=7
Total payments = $13B
(59% of all health plan payments)
VBP = $7.7B
(59% of all commercial payments)

Medicaid

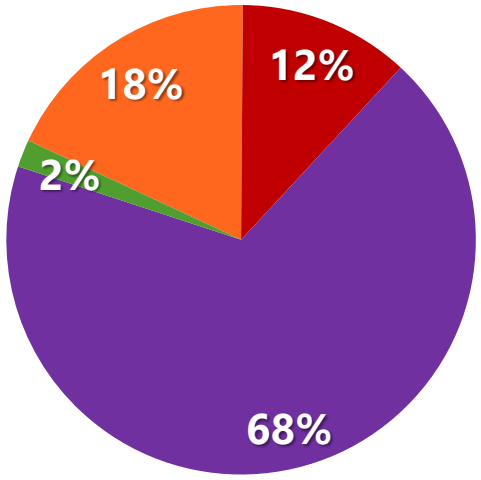


n=6
Total payments = $4.6B
(21% of all health plan payments)
VBP = $3.7B
(82% of all MCO payments)

2020 statewide VBP = 68%
2019 = 64%
2018 = 62%
2017 = 54%
2016 = 43%

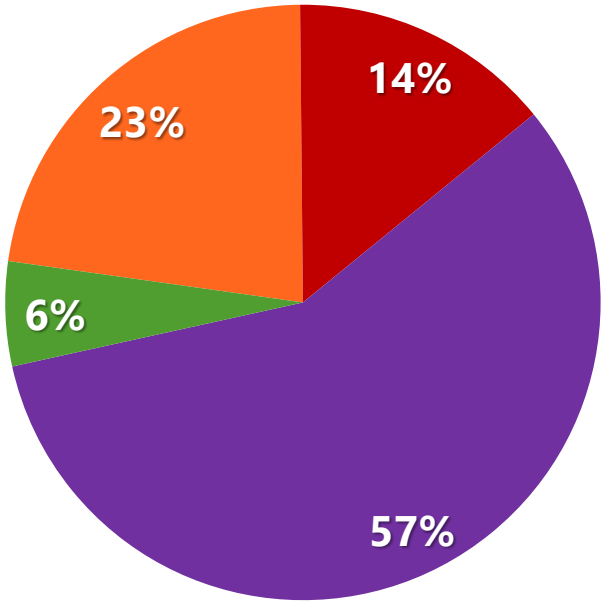
Summary: state-financed payments in VBP by APM and sector

Medicaid Managed Care



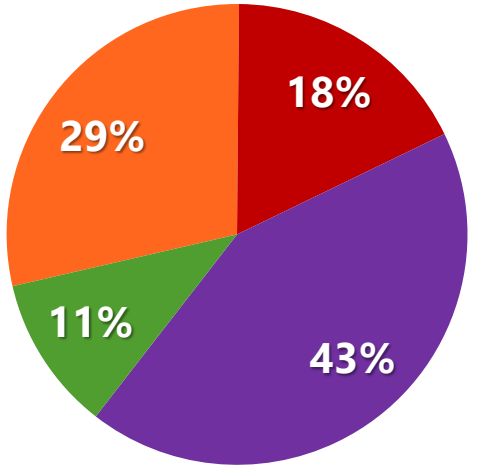
$ 4,561,989,886

HCA TOTAL



$ 7,880,535,034

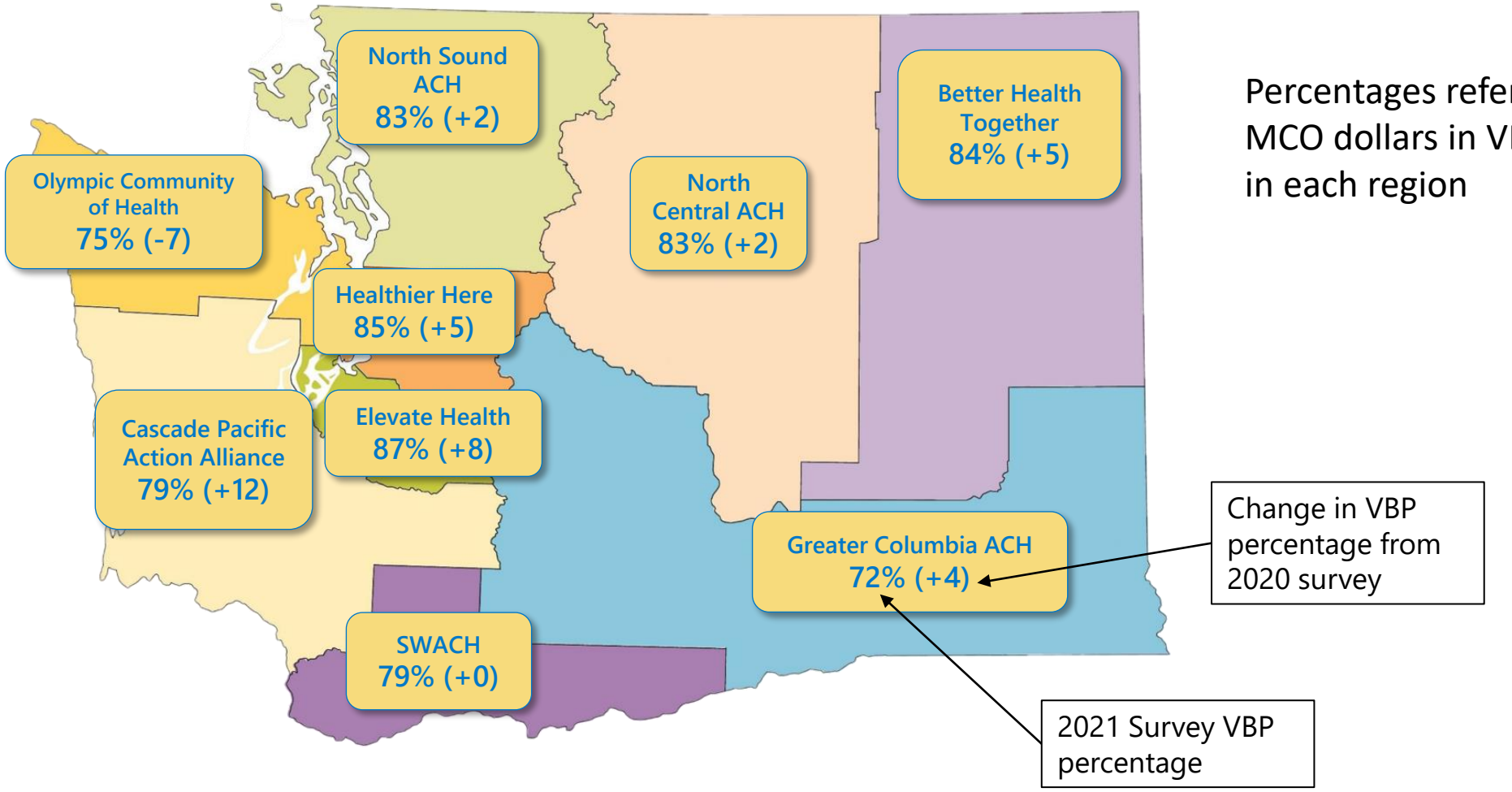
PEBB & SEBB



$ 3,318,545,148

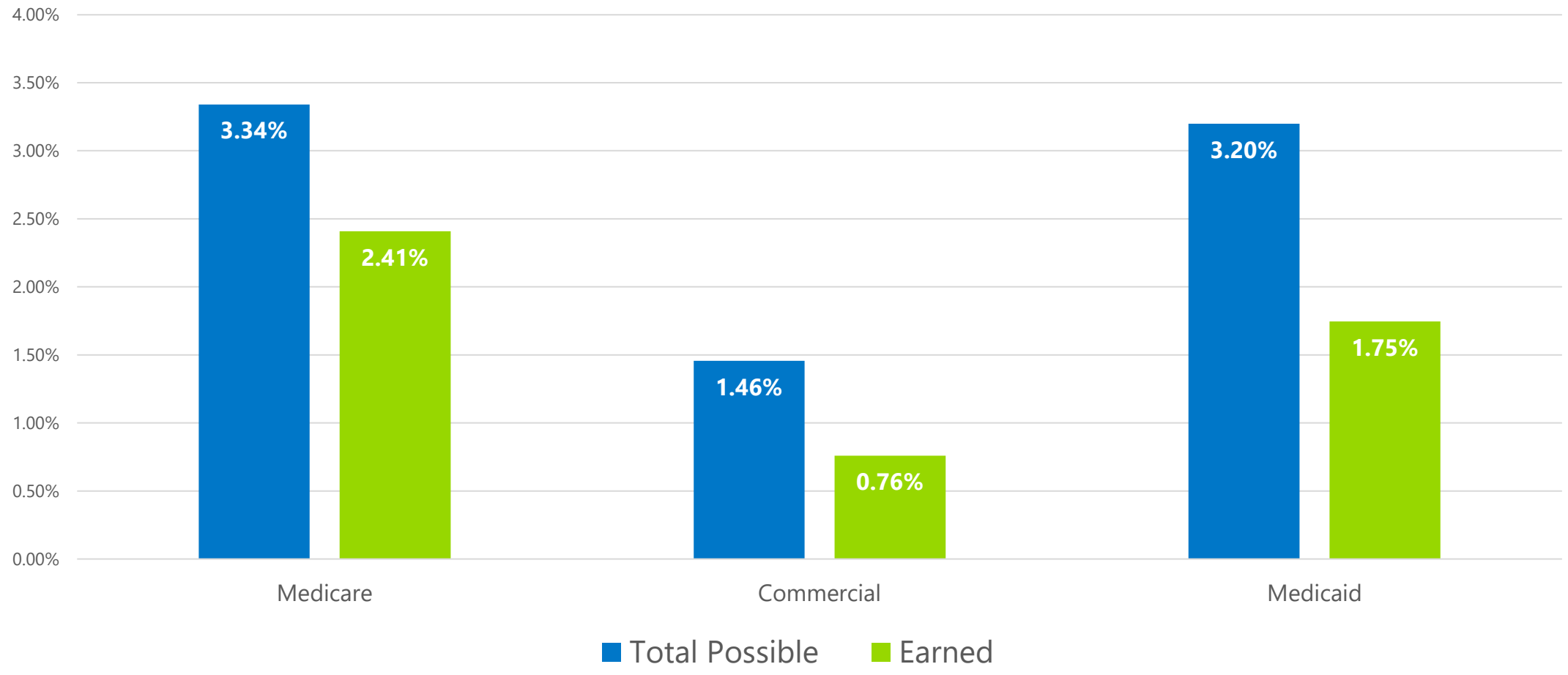
2020 state-financed VBP = 77%

Penetration of MCO VBP by ACH region (payer survey)



Percentages refer to the portion of MCO dollars in VBP arrangements in each region

Incentives (payer survey)



Provider types in VBP contracts, excluding hospitals (payer survey)

For each provider type, select the answer that best applies to how your organization engaged with providers in VBP "Many" = your organization engaged in VBP with a majority of this provider type "Select" = your organization engaged in VBP with a select group of this provider type "None" = your organization did not engage in VBP with this provider type	Many	Select	None
Behavioral health providers	1	4	5
Dentists	1	0	9
Home and community-based service providers	1	3	6
Long-term care facilities	1	1	8
Nurse-midwives	1	2	7
OBGYNs	2	1	7
Orthopedics	1	5	4
Primary care providers (i.e., physicians, advanced practice nurses, physician assistants)	9	1	0
Community Health Centers	3	4	2
Rural Health Centers and Critical Access Hospitals	1	4	4
Other specialists	1	4	2

n=9

*Green boxes highlight areas of consensus.

Experience with VBP

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Defining APM success (payer survey)

Payers define and evaluate success in APMs differently.

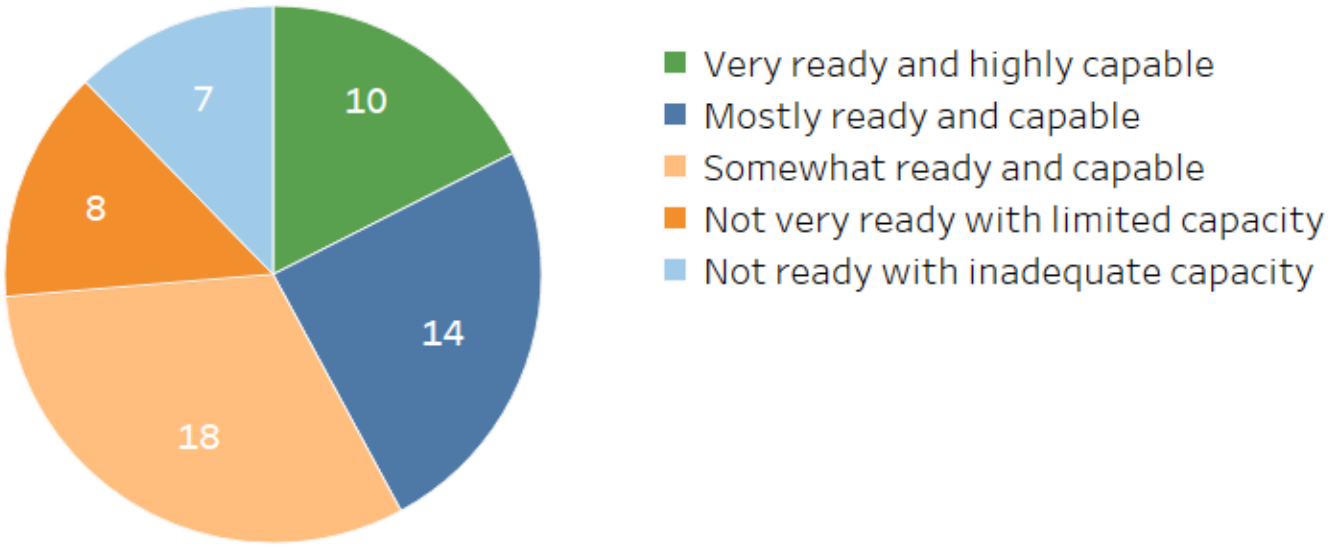
Financial outcomes
(Management of financial outliers, portion of possible provider rewards earned, reduced or maintained costs)

Patient satisfaction
(Willingness of members to recommend the plan to others, member experience, member health improvement)

Clinical quality ratings
(Medicare STARS, clinical process and outcome measures, HEDIS measures, patient safety)

Readiness for VBP (provider survey)

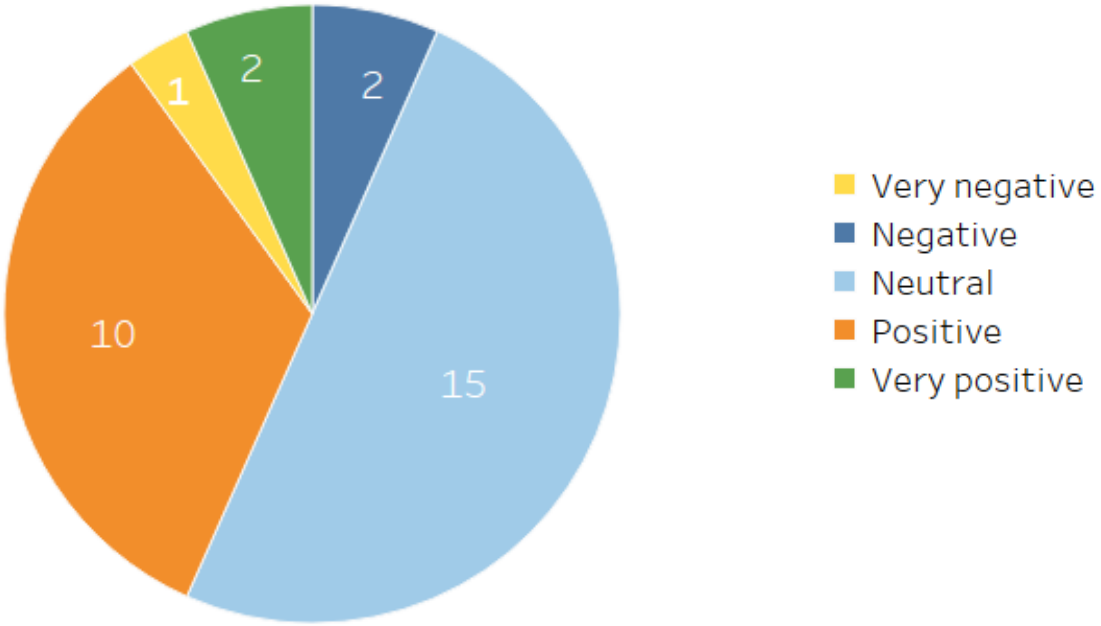
How would you describe your VBP readiness?



n=57

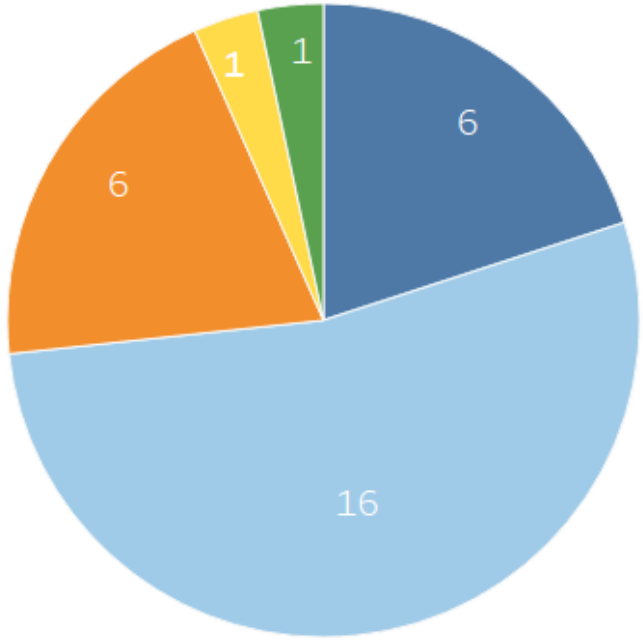
Experience with VBP (provider survey)

Organizational experience



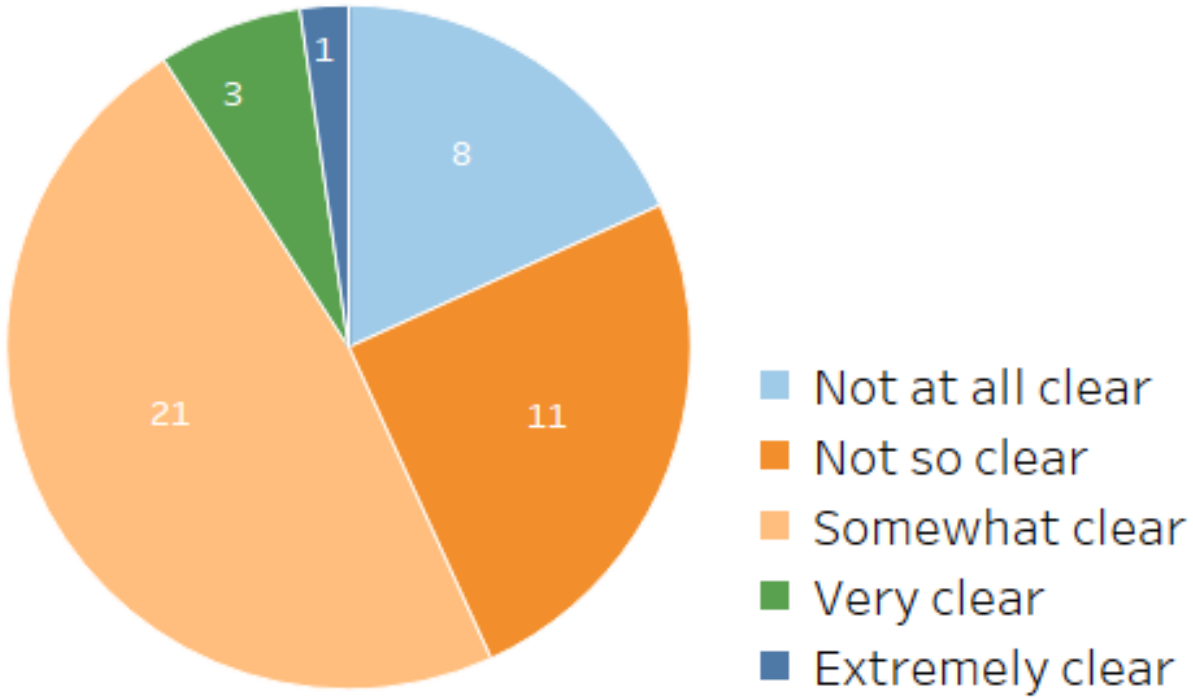
n=30

Clinician experience



n=30

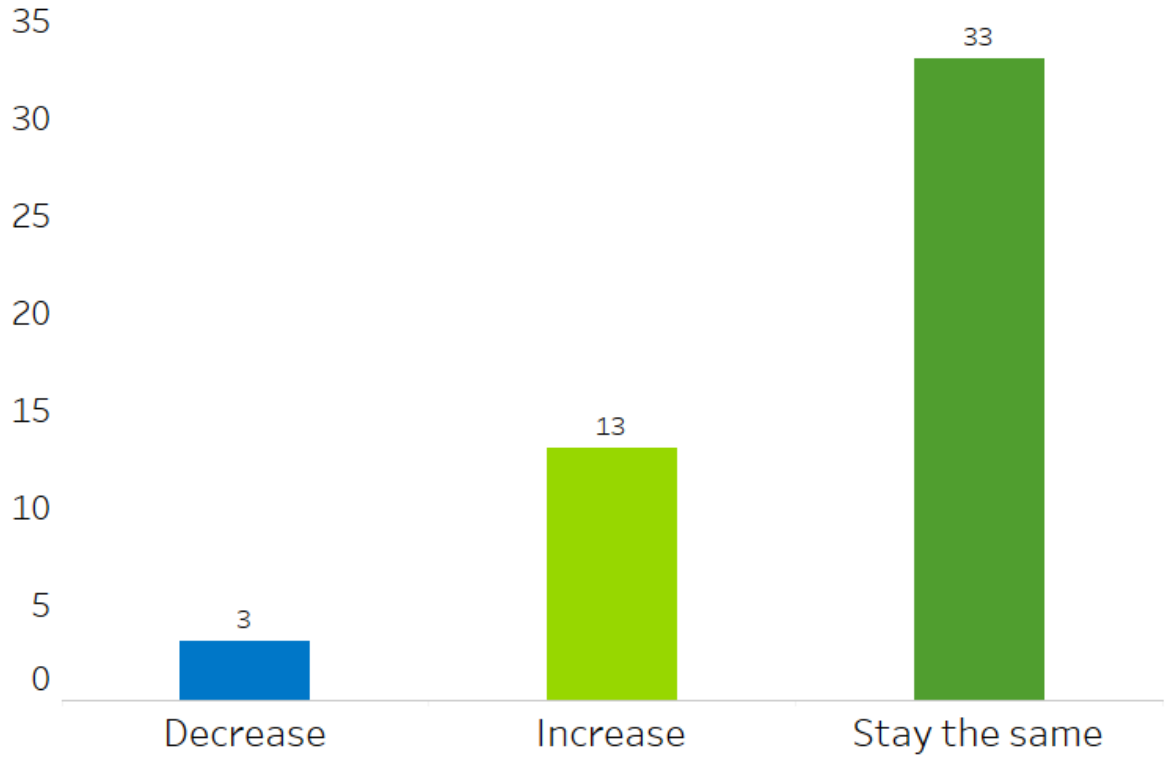
Perceived role clarity of HCA, payers, ACHs, and providers (provider survey)



n=44

Future participation in VBP (provider survey)

How do you expect your participation in VBP to change over the next 12 months (in terms of total revenue from VBP contracts)?



n=49

Barriers & enablers

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Barriers and enablers to VBP adoption for payers

From highest to lowest impact:

Top 5 enablers
Trusted partnerships and collaboration*
Aligned incentives/contract requirements*
Aligned quality measures/definitions*
Interoperable data systems*
Cost transparency

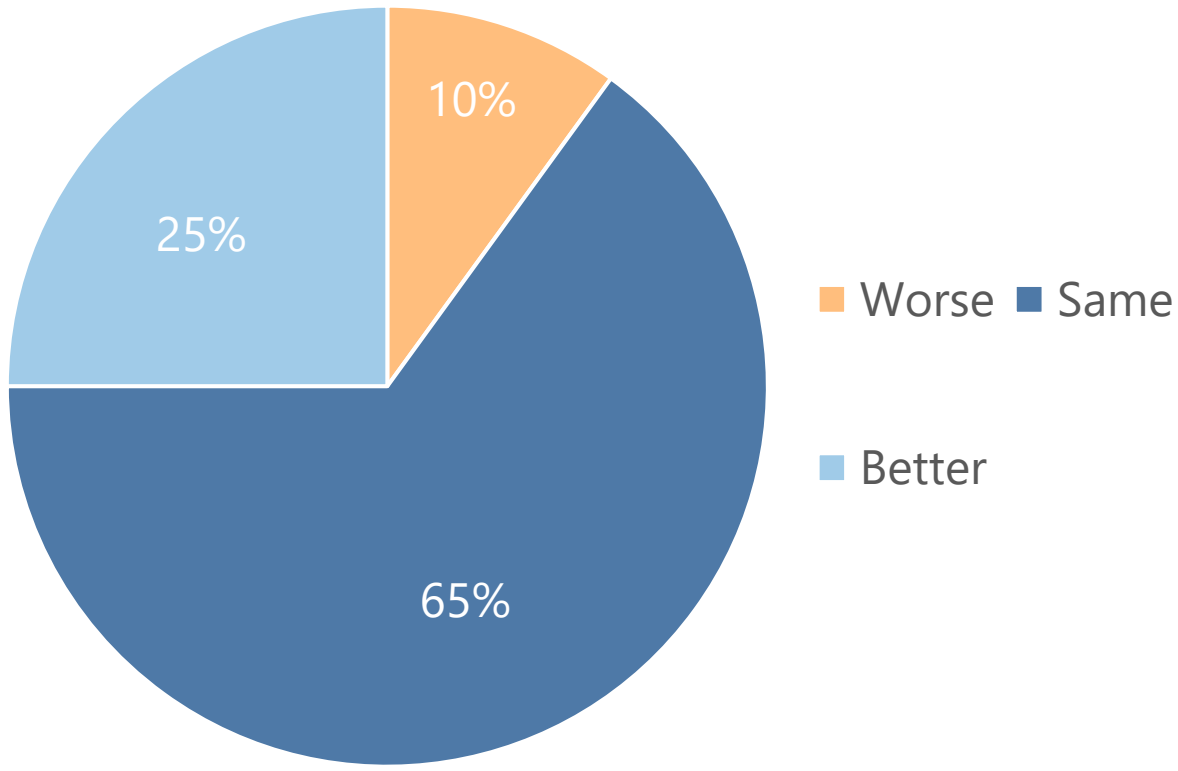
n=10

Top 5 barriers
Lack of interoperable data systems*
Payment model uncertainty*
Attribution*
Disparate incentives/contract requirements*
Disparate quality measures/definitions

*consistent with 2020 survey

Compared to 2019, how were these barriers in 2020? (payer survey)

- Barriers:
  - Lack of interoperable data systems
  - Payment model uncertainty
  - Disparate quality measures/definitions
  - Disparate incentives/contract requirements



Barriers and enablers to VBP adoption for providers

Top 5 enablers
Development of medical home culture with engaged providers (15)
Ability to understand and analyze payment models (15)
Access to comprehensive data on patient populations* (14)
Common clinical protocols and/or guidelines associated with training for providers (13)
Sufficient patient volume by payer to take on clinical risk (12)

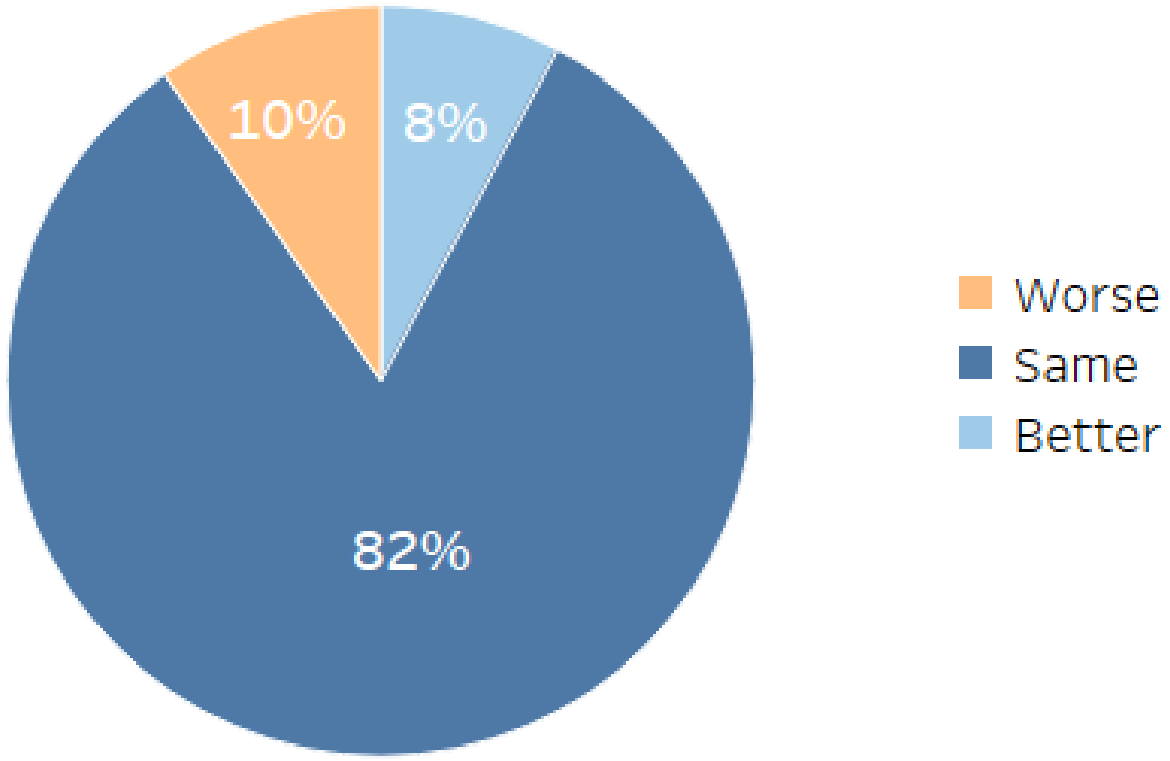
Top 5 barriers
Misaligned incentives and/or contract requirements* (24)
Lack of timely cost data to assist with financial management* (28)
Lack of access to comprehensive data on patient populations* (22)
Lack of interoperable data systems* (31)
Insufficient patient volume by payer to take on clinical risk* (20)

n=26

*consistent with 2020 survey

Compared to 2019, how were these barriers in 2020? (provider survey)

- Barriers:
  - Misaligned incentives and/or contract requirements
  - Lack of timely cost data to assist with financial management
  - Lack of interoperable data systems



Health equity

Data, social determinants of health, and health-related social needs

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Data collection and disaggregation (payer survey)

	# of health plans responding "Yes" to collecting the following data	# of health plans responding "Yes" to disaggregating performance by the following data
Race	9	7
Ethnicity	9	7
Language	9	3
Disability	5	2

Has your organization implemented any programs to address health disparities by race, ethnicity, or language?	# of health plans responding "Yes"
	7

n=9

Data collection and disaggregation (payer survey)

- Payers emphasize that RELD (race/ethnicity/language/disability) data are difficult to capture.
  - Individuals may not identify with any of the OMB categories
  - Reluctance to self-report data due to concerns or questions about why the information is being collected
  - Payers do not always have control over the information that is collected at enrollment (e.g., when someone enrolls through an employer, Medicare, the Health Benefit Exchange, etc.)
- Several plans are in the process of improving data collection methods.
- Most disaggregation is at the plan level and is not shared with providers.

Addressing Non-Medical Social Needs (payer survey)

- Most respondents articulated **broad commitments** to health equity
- Most plans provide **referrals or connections** to community-based organizations (CBOs) or government programs addressing non-medical social needs (NMSNs)
  - Several plans provide a limited list of direct services (such as meals or cell phone minutes for patients who qualify)
- **Payment structures** for providers who serve populations with high NMSNs are still not fully developed
  - 1 plan risk-adjusts some APMs by population social needs
  - 2 plans tie financial incentives to NMSN metrics or outcomes in some APM contracts

Barriers to addressing NMSNs (payer survey)

Data challenges

- Difficulty of reaching members for screening
- Lack of data-sharing about social determinants
- Lack of real-time data alignment across different parts of the system

Alignment challenges

- Duplication with community-based care coordination
- Difficulty of aligning interventions for long-term sustainability

Gaps in availability of needed services (example: affordable housing)

Challenges of measuring effectiveness of non-medical interventions

COVID-19 exacerbated problems and increased need

Data-driven action on disparities (provider survey)

- A larger share of providers reported collecting RELD data on this survey compared to previous years.
  - The share of providers assessing performance by RELD also increased.
- The share of providers implementing programs to address disparities by RELD has increased from **42 percent** on the 2019 survey to **51 percent** on the 2021 survey.

Practice transformation

Behavioral and physical health integration, workforce, and technical support

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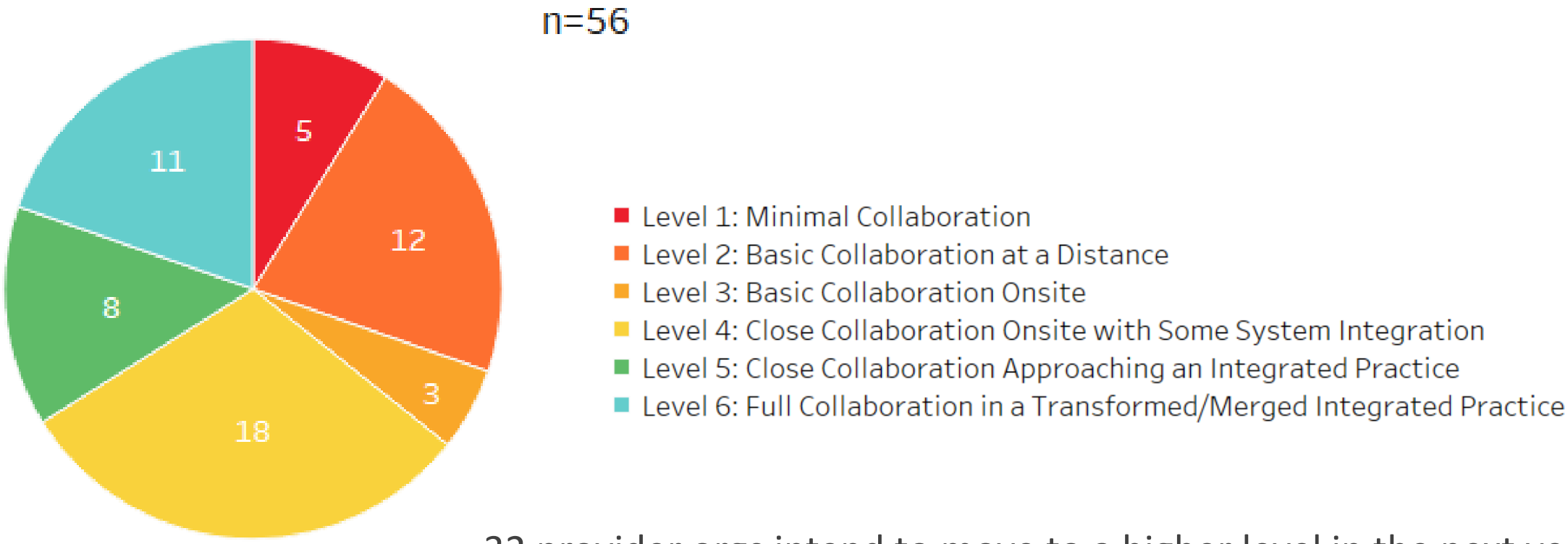
Integration (provider survey)

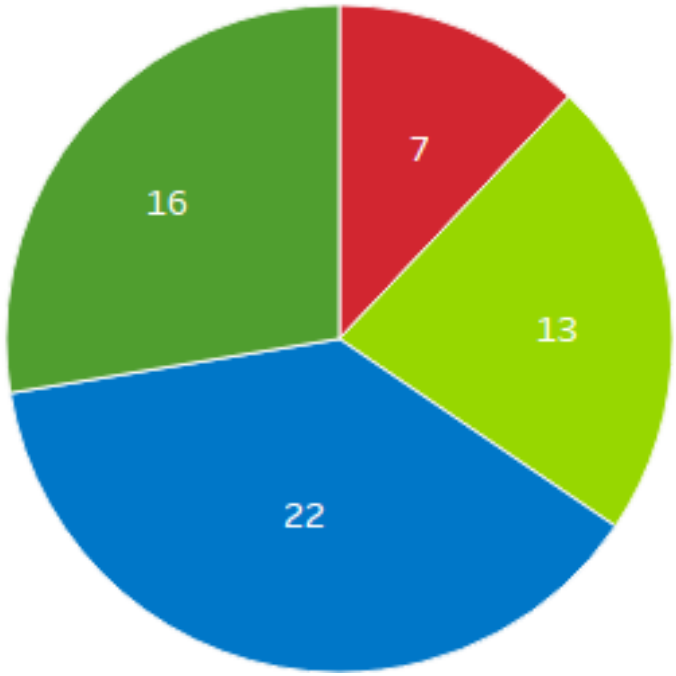
Reported level of SAMHSA's Six Levels of Collaboration/Integration



32 provider orgs intend to move to a higher level in the next year

Workforce (provider survey)

Is your organization participating in activities to prepare for integrated physical and behavioral health care, team-based care, and population management?



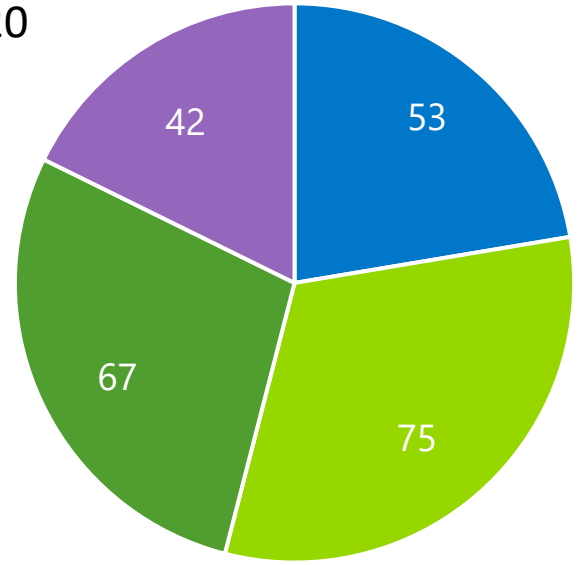
n= 59

- May be participating in conferences, webinars or other self-learning programs or interested in learning how to access training or support
- No - not participating in any formal program
- Yes - participate in Healthier Washington Collaboration Portal, AIMS Center programs or ACH activities
- Yes - participating in transformation and training opportunities through consulting or organizational resources

Technical assistance (provider survey)

What type of technical support has your organization **received**?

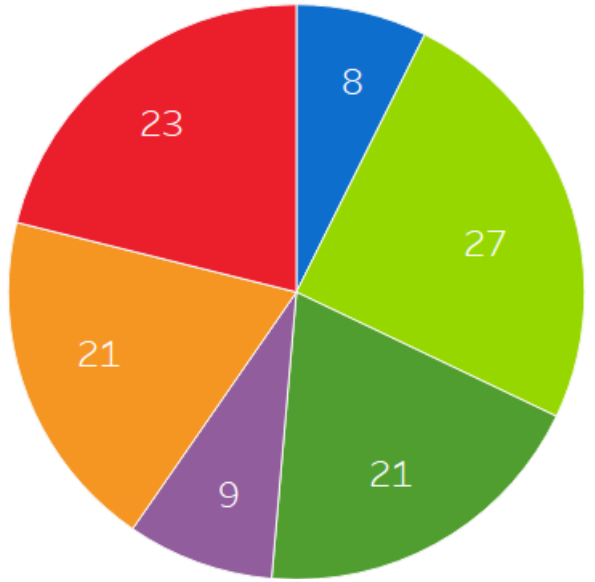
2020



n=113

- Value-based reimbursement
- Behavioral/physical health integration
- Practice transformation
- HIT/HIE planning, implementation, and/or reporting

2021



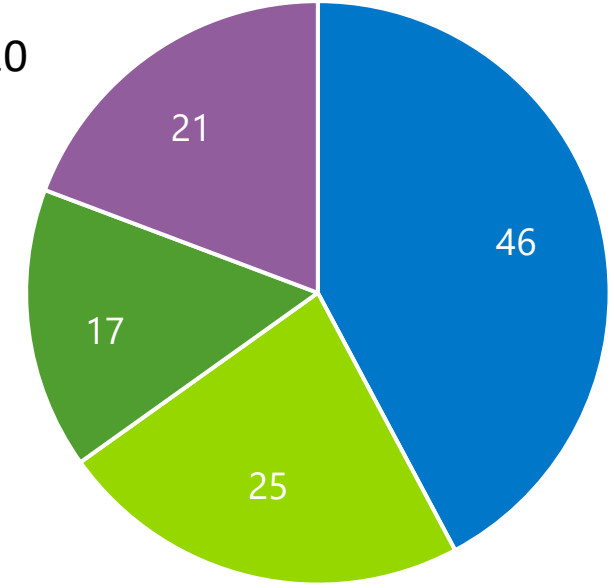
n=42

- Value-based reimbursement support
- Behavioral/physical health integration
- Practice transformation
- HIT/HIE planning, implementation, and/or reporting
- Addressing health inequities
- Addressing social determinants of health

Technical assistance (provider survey)

What type of technical support would be **most helpful** to your organization?

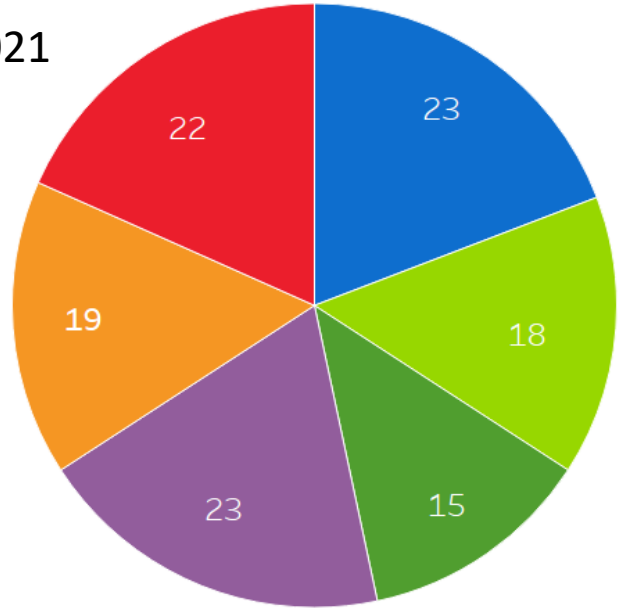
2020



n=123

- Value-based reimbursement
- Behavioral/physical health integration
- Practice transformation
- HIT/HIE planning, implementation, and/or reporting

2021



n=45

- Value-based reimbursement support
- Behavioral/physical health integration
- Practice transformation
- HIT/HIE planning, implementation, and/or reporting
- Addressing health inequities
- Addressing social determinants of health

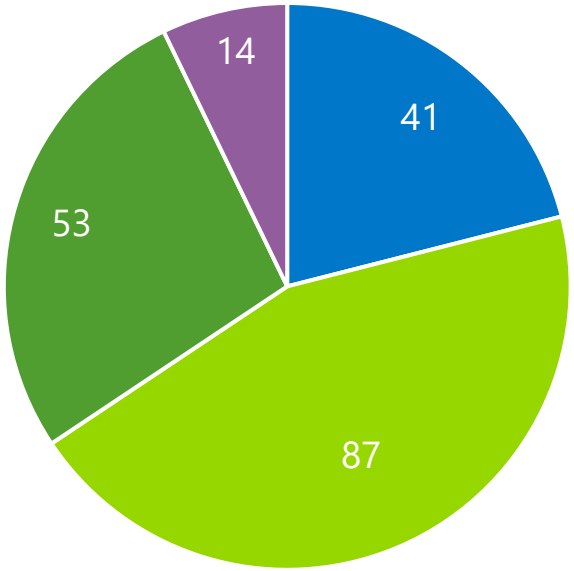
COVID-19

Washington State Health Care Authority

Impact of COVID-19 on VBP (provider survey)

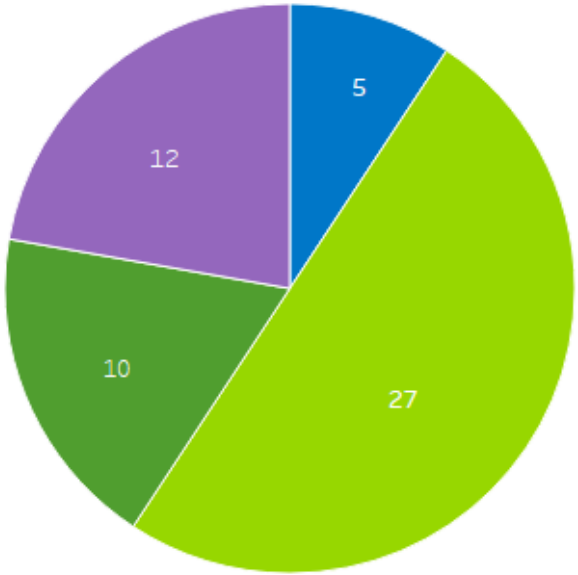
Has the COVID-19 pandemic affected your practice's ability or capacity in the following ways?

2020



n=98

2021



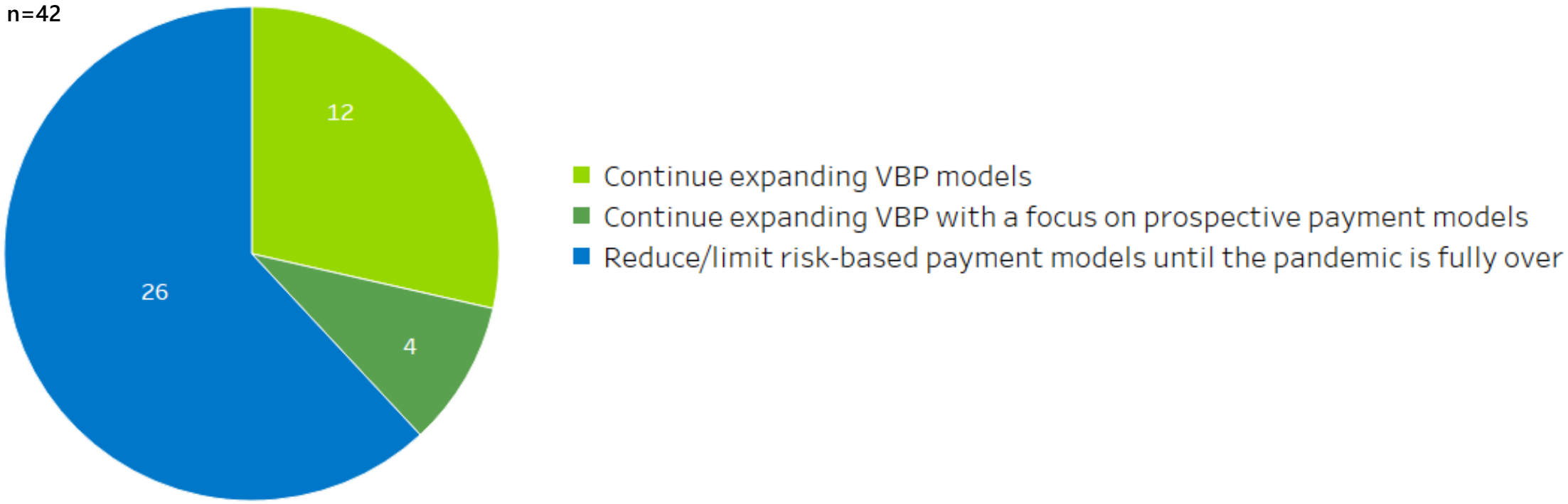
n=54

- Reduced willingness or ability to take on additional risk and/or VBP contracts
- Challenges to the sustainability of normal business operations
- Negative impacts on quality measure reporting and/or performance
- Other

- Reduced willingness or ability to take on additional risk and/or VBP contracts
- Challenges to the sustainability of normal business operations
- Negative impacts on quality measure reporting and/or performance
- Challenges to maintain ongoing and appropriate patient follow-up

Impact of COVID-19 on VBP (provider survey)

From your perspective, how should payers, purchasers, and providers adjust their VBP strategies in light of the COVID-19 pandemic?



Summary & takeaways

Washington State Health Care Authority

Revisiting HCA's purchasing goals…

- By the end of 2021:
  - 90 percent of state-financed health care and 50 percent of commercial health care will be in VBP arrangements

- As of 2020, 82 percent of Medicaid, 59 of commercial, and 80 of Medicare Advantage health care are in VBP arrangements
  - Total: 77 percent of state-financed health care
- This indicates we are making significant progress toward VBP goals

Summary of findings

- Health plans' VBP adoption increased from previous year.
- Providers' organizational and clinician experience with VBP has been generally neutral or positive.
- Providers generally plan to maintain or increase VBP participation and desire technical support across domains, especially health equity.
- Health plans and providers are facing the same top barriers, respectively, year to year.

Alignment is critical

For both providers and payers, these factors are **enablers when present** and **barriers when absent**:

Aligned incentives/contract requirements	Aligned quality measures/definitions	Interoperable data systems/access to comprehensive data on patient populations

Cross-system alignment and interoperability are key to VBP success

COVID-19 complicates VBP

The COVID-19 pandemic both **increased interest in VBP**, and **created barriers to expanding VBP**

- Providers in FFS arrangements suffered during the pandemic because of the decrease in overall health care utilization, making VBP more appealing
- Yet, providers and payers have reduced capacity to invest in the transformation to VBP while the pandemic continues.

Providers may be **less likely to choose VBP arrangements with downside risk** during the pandemic.

Minimizing the amount of effort and resources needed to engage in VBP arrangements will enable greater VBP expansion.

Addressing inequity through VBP is in its early stages

Stakeholders at every level are working to address inequity.

- More payers and providers are collecting and disaggregating race, ethnicity, language, and disability data than previously.
- Payers and providers generally report wanting to do more to reduce health disparities among patients/consumers.

There are still significant challenges to overcome before VBP can be fully leveraged to support health equity

- Data issues, silos, lack of role clarity

Coordination among payers, providers, and purchasers is necessary for VBP to reach its potential as a health equity tool.

To facilitate further progress…

- Improve timeliness and comprehensiveness of data shared with providers (multi-payer)
- Improve role clarity
- Align quality measures and incentives
- Foster collaborative and trusting relationships
- Invest in interoperability
- Support providers with health information technology (HIT)/health information exchange (HIE) and VBP technical support
- Support small to medium-sized providers and invest in improving provider experience
- Develop a more cohesive strategy to leverage VBP to improve health equity

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