Washington State Health Care Authority

2022 Paying for Value Survey results

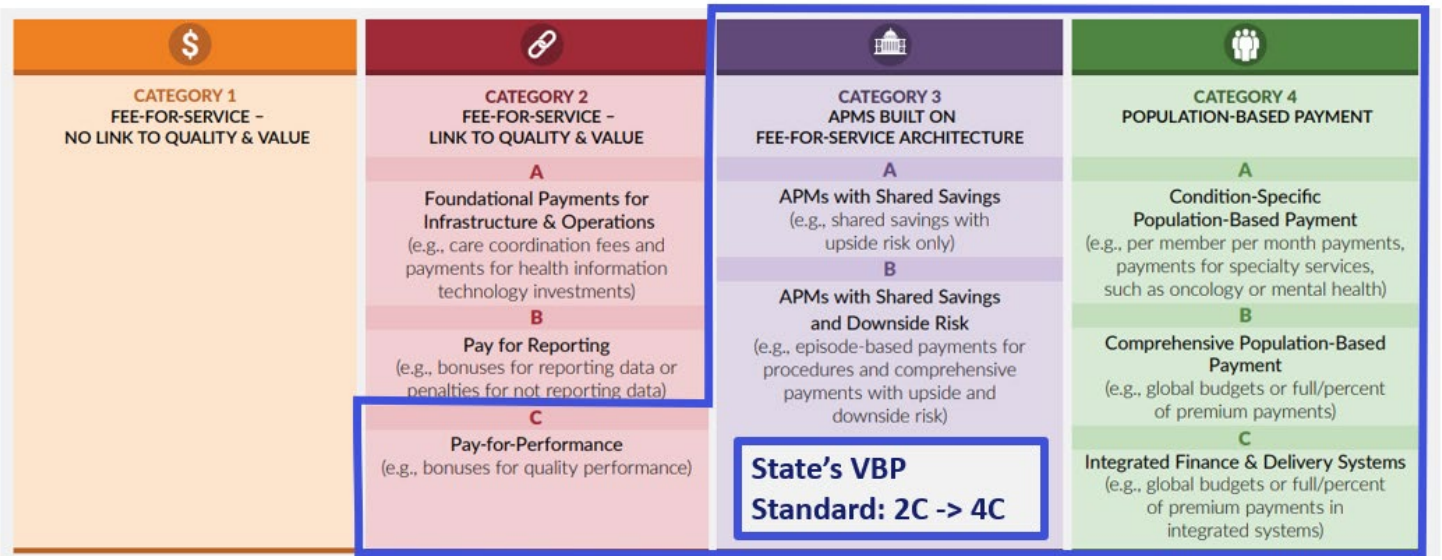
The Health Care Authority (HCA) purchases health coverage for almost 3 million people in Washington State through Apple Health (Medicaid) and the Public and School Employee Benefits Boards (PEBB and SEBB, respectively). Our mission is to provide equitable, high-quality health care through innovative health policies and purchasing strategies. Annually, HCA spends more than $19 billion across all three programs.

Value-based purchasing (VBP) describes a range of innovative payment strategies intended to contain costs while improving outcomes by tying payment to care quality. VBP arrangements are categorized according to the Health Care Payment Learning & Action Network (HCP-LAN) Alternative Payment Model (APM) Framework (see Figure 1). In 2016, HCA established a goal of driving 90 percent of state-financed health care payments into VBP arrangements in Categories 2C and above by the end of 2021.

Every year, HCA distributes the Paying for Value Survey to health care payers (plans) to gather information about participation in and experience with VBP. All payers in Washington are invited to participate in the survey, including PEBB/SEBB carriers, Apple Health (Medicaid) managed care organizations (MCOs), commercial plans, and Medicare Advantage plans. In 2022, HCA received responses from 12 payers, including five MCOs, five PEBB/SEBB carriers, and two commercial health plans. The 2022 survey asked respondents to report on calendar year 2021.

Due to overlap with other HCA-sponsored surveys during the same time period, HCA did not conduct a Paying for Value survey for providers in 2022.

Figure 1: HCP-LAN APM Framework and HCA's VBP Standard



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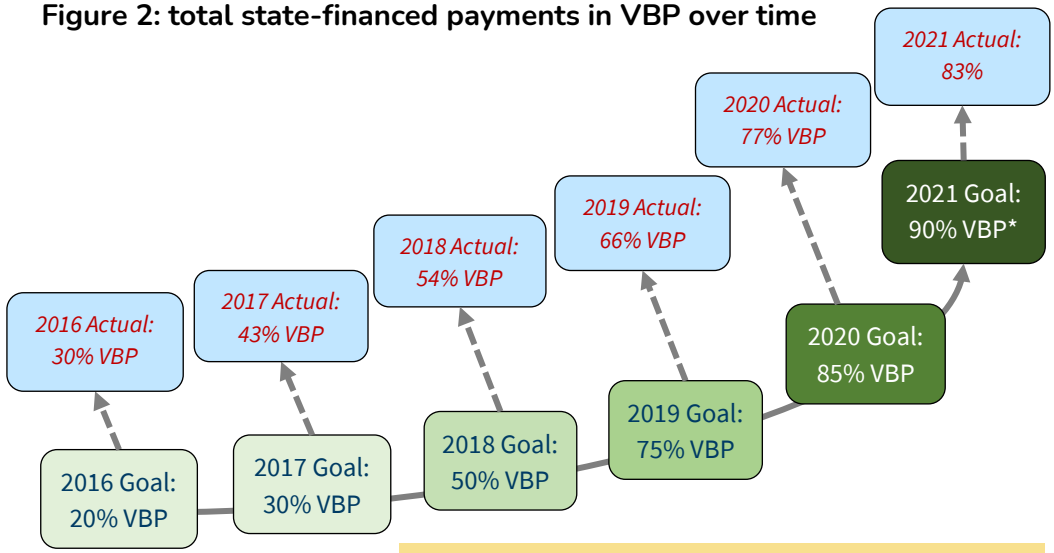
VBP adoption

In 2021, 83 percent of state-financed health care flowed through VBP arrangements in Category 2C or higher (see Figure 2). This represents steady year-over-year improvement despite the disruptions of the COVID-19 pandemic. Although VBP attainment overall fell short of the 90 percent goal, MCOs successfully achieved their COVID-19-adjusted target of 85 percent (see Figure 3).

Figure 2: total state-financed payments in VBP over time

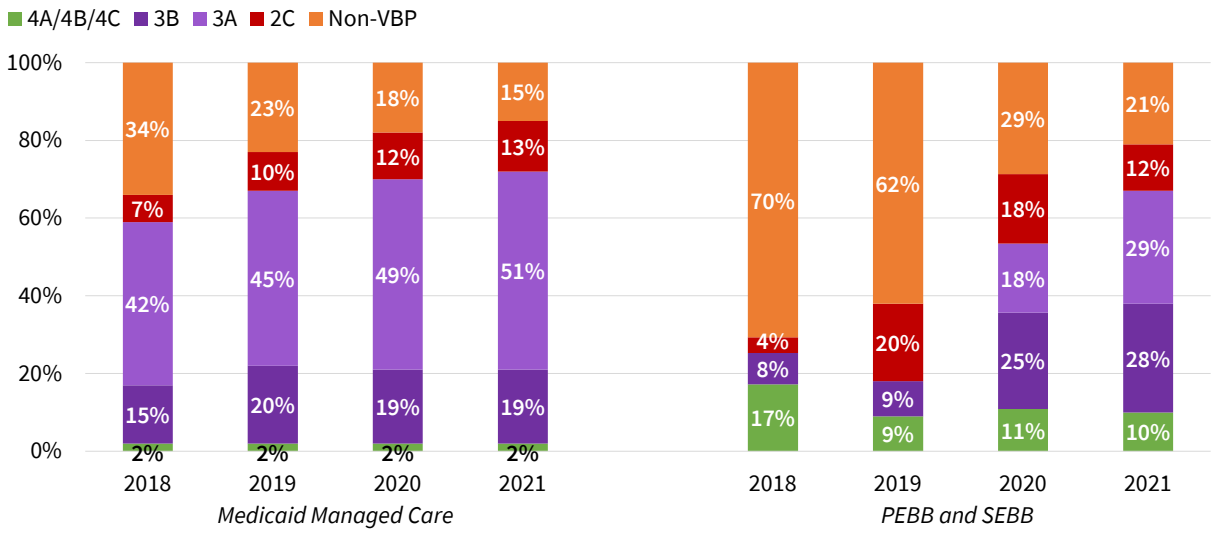


*The 2021 VBP MCO target was 85% rather than 90% due to COVID-19.

In 2021, the majority of payments across state-financed health care fell into Category 3 (see Figure 3). These APMs hold providers accountable for quality and offer shared savings if the total cost of care is under a designated benchmark. APMs in Category 3B also incorporate "downside risk," in which providers are partially financially responsible for care costs that exceed the benchmark. Research suggests that APMs with downside risk are more effective at containing costs while maintaining a high quality of care.[1] In Medicaid, the majority of Category 3 payments fall under Category 3A, while in PEBB/SEBB they are split between 3A and 3B.

Over time, the portion of APMs in Category 3A (shared savings only) has grown faster than APMs in Category 3B (upside and downside risk) across both PEBB/SEBB and Medicaid Managed Care. Although the adoption of APMs with downside risk has plateaued in recent years, this coincides with the COVID-19 pandemic. It remains to be seen whether this trend will continue beyond the end of the federal public health emergency.

Figure 3: state-financed health care by APM category over time



[1] https://www.healthaffairs.org/do/10.1377/forefront.20171120.211043/full/

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Barriers and enablers to VBP expansion

A major theme in 2022 payer survey responses was provider hesitancy. Payers report that many providers who remain in fee-for-service (FFS) arrangements choose not to transition to VBP, whether due to lack of interest or lack of ability. At the same time, providers who currently participate in APMs in Categories 2C or 3A are often reluctant to take on downside risk by progressing into Categories 3B and beyond. This hesitancy persists both in Medicaid and in the commercial market. When asked, "In your experience, what is the minimum enrollment required for a provider to accept downside risk?", payers gave thresholds as low as 1,000 or as high as 7,500 members per payer.

Table 1 displays the top five barriers and enablers impacting payers' ability to expand VBP. The survey allows payers to select the same factor as both a barrier and an enabler. For example, several plans reported that having interoperable data systems is an enabler, while lacking them is a barrier.

Table 1: barriers and enablers to VBP adoption and expansion in 2021

Barriers	Enablers
• Lack of interoperable data systems*	• Interoperable data systems*
• Payment model uncertainty*	• Trusted partnerships and collaborations*
• COVID-19	• Aligned quality measures/definitions*
• Provider readiness	• Cost transparency*
• Disparate incentives/contract requirements*	• Aligned incentives/contract requirements*

* Consistent with 2020

Health equity

Payers reported broad commitments to health equity. However, no payers reported tying equitable care or outcomes to payment or incorporating equity as a dimension of quality in an APM in 2021.

Coverage of health-related social needs (HRSNs) increased in 2021, with most payers offering coverage of one or more HRSNs, such as nutrition support and housing coordination. By contrast, in 2020 most payers reported referring their members to external resources and organizations rather than providing coverage themselves. Equity-focused data analysis also increased: eight respondents disaggregated data by race and ethnicity in 2021 (up from five in 2020) and six disaggregated by language or disability status (up from two). With a few exceptions, most payers use this disaggregated data for plan-level strategic decisions and do not include it in provider-level quality reports.

Payer-reported initiatives to improve health equity included:

- Provider education, such as cultural competency trainings and targeted online modules about specific care inequities
- Language initiatives, such as in-person interpretation during home visits, offering depression screenings in more languages, and sending multilingual birthday cards to encourage families to bring their children in for well-child care
- Targeted COVID-19 vaccine outreach to underserved communities
- A virtual doula program designed to support healthier birth outcomes among Black, Indigenous, and other communities of color

Many payers emphasized the challenges of addressing health equity. Demographic data are 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. The lack of integration between the social services system and the medical system creates barriers to appropriate follow-up after referring a patient for HRSN support and can lead to duplication with community-based care coordination.

Conclusions

VBP continues to expand in Washington

Between 2016 and 2021, HCA and its partners shifted the way Washington pays for health care, with the proportion of VBP payments growing from 30 to 83 percent. Although the 2021 achievement falls short of the 90 percent goal, it represents steady progress despite a global pandemic.

HCA and payers should explore VBP beyond primary care and hospital settings

VBP in Washington is not exclusive to primary care and hospital settings, but as HCA approaches the 90 percent goal, most primary care providers and hospitals that are willing and able to enter value-based contracts have already done so. Those that remain in FFS contracts may lack the administrative capacity, technical infrastructure, or interest necessary to transition to VBP. Payers should pursue APMs in less-saturated areas where providers may have been left out of conversations about payment reform, such as behavioral health, long-term care, and obstetric care.

COVID-19 had complex, wide-ranging impacts

Providers in FFS arrangements suffered during the pandemic because of the decrease in overall health care utilization. However, as of 2021 this had not yet translated into greater appetite for VBP. The volatility of the health care industry in recent years may be contributing to widespread provider hesitancy to engage in any APMs, particularly APMs with downside risk.

Health equity is not yet being addressed through VBP

Stakeholders at every level, including at HCA, are working to advance health equity. There are significant challenges to overcome before VBP can be leveraged most effectively. Payers continue to work toward complete, accurate, and timely data to enable meaningful and targeted equity incentives.