Washington State Health Care Authority

2023 Paying for Value Survey results

The annual Paying for Value Survey—conducted by the Washington State Health Care Authority (HCA)—collects information about health care plans' value-based payment (VBP) activity. VBP describes a range of payment strategies intended to contain costs while improving outcomes by tying payment to care quality. The survey collects quantitative data about VBP adoption, as well as qualitative information about designing and implementing VBP arrangements.

> **Note:** The acronym "VBP" can sometimes refer to value-based *payment* (arrangements between health plans and providers) and sometimes value-based *purchasing* (arrangements between health plans and HCA). For the purposes of this document, we use VBP to refer to value-based payment and spell out "value-based purchasing" to avoid confusion.

In 2023, HCA received responses from 11 payers, including five Apple Health (Medicaid) managed care organizations (MCOs), five Public and School Employee Benefits Boards (PEBB and SEBB, respectively) carriers, and one commercial health plan not contracted with HCA. The 2023 survey asked respondents to report on calendar year 2022.

The 2023 survey yielded several key insights:

- VBP adoption decreased by 4 percent in 2022.
- Measuring VBP adoption is important, but it is not the same as measuring the outcomes we care about most: improved quality, reduced costs, and health equity.
- HCA is investigating alternate ways to evaluate the success of Washington's value-based purchasing programs in the future, beyond a narrow focus on VBP adoption. This may mean changing the way we define VBP adoption or reworking incentives to impact priority outcomes more directly.

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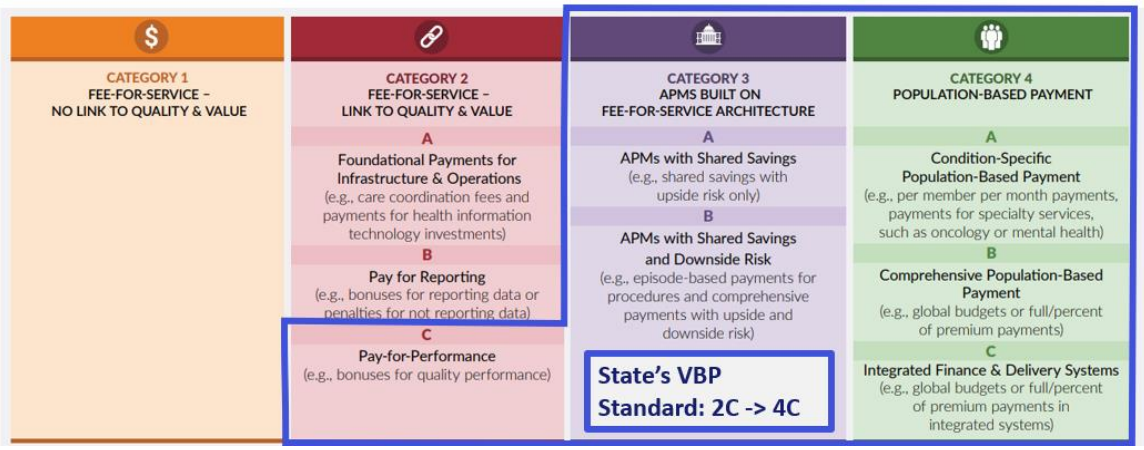
Background

HCA purchases health coverage for almost 3 million people in Washington State through Apple Health and PEBB/SEBB. 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.

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 value-based purchasing goal of driving 90 percent of state-financed health care payments into VBP arrangements that incentivize quality performance (HCP-LAN Categories 2C and above).

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



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 MCOs, commercial plans, and Medicare Advantage plans.

Why the survey is important

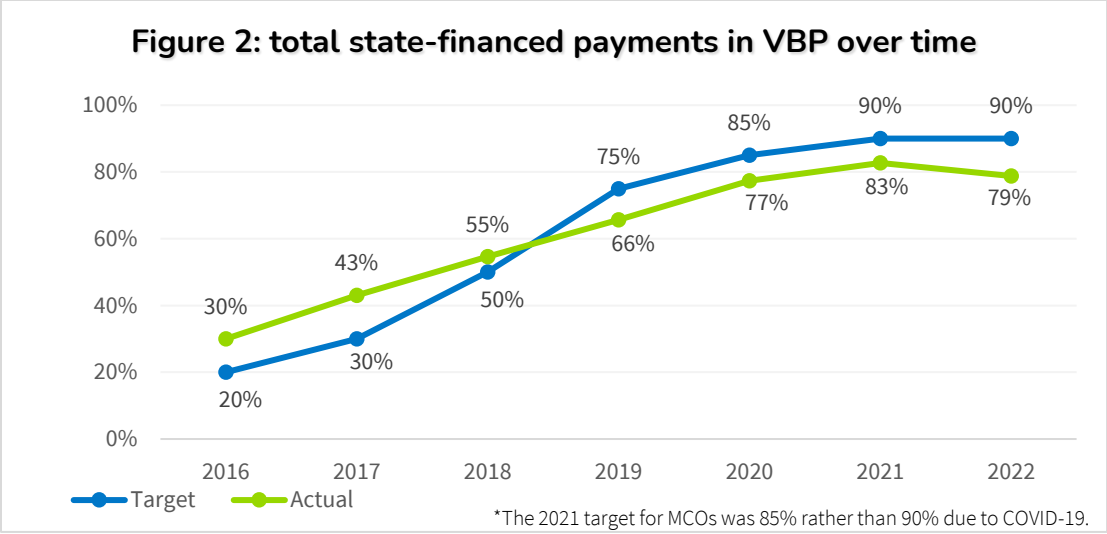
When conducting and analyzing this year's survey, HCA paid renewed attention to the **meaningfulness** of our value-based purchasing measures and the **effectiveness** of our overall value-based purchasing strategy in helping achieve health system goals. We hope to use this analysis to inform strategic direction by investigating the relationship between VBP adoption (the primary element being measured in the survey) and other priority outcomes like cost, quality, and equity of care.

Survey results

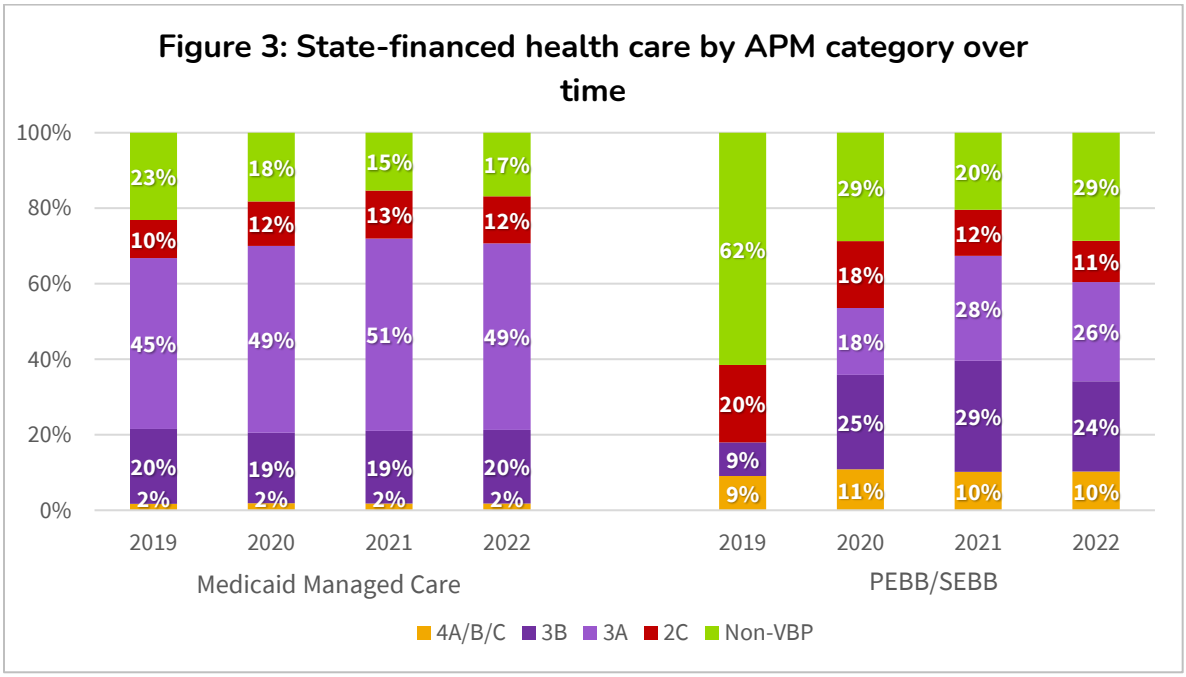
VBP adoption

In 2022, 79 percent of state-financed health care flowed through VBP arrangements in Category 2C or higher. "State-financed health care" in this context includes Medicaid managed care (83 percent VBP adoption) and PEBB/SEBB (71 percent VBP adoption). It does not include:

- Non-HCA health spending, such as Long-Term Care or Long-Term Services and Supports that go through the Department of Social and Health Services or public health programs that go through the Department of Health.
- Medicaid non-managed care (also called fee-for-service Medicaid) or wraparound payments for transportation and other services, which together make up around 27 percent of all Medicaid spending.



VBP adoption in 2022 decreased 4 percent from 2021. Most of the shift occurred in PEBB/SEBB, which saw a 9 percent increase in spending in non-VBP payment models (Figure 3). However, these numbers should be interpreted with caution; see **Calculating VBP adoption** in the **Analysis and implications** section.



Quality and equity initiatives

HCA advances value in its purchasing efforts by incentivizing plans to make progress on a **common set of quality measures** across a range of domains, including well-care visits for children and adults, cancer and disease screenings, care for chronic conditions, and behavioral health care. Adoption of this shared measure set by all state-contracted plans has been a key success of HCA's value-based purchasing strategy.

Because all claims flow through a patient's health insurer regardless of the source of care, payers often have a fuller picture of an individual's health care use than their primary care provider (PCP). This greater access to data might give payers a better vantage point to analyze quality and equity of care. Successful value-based care

arrangements depend on payers sharing data with providers that can drive meaningful analysis and timely clinical interventions.

Provider performance

Providers in VBP arrangements are held accountable for certain quality measures for their patients, such as the rate of blood sugar control among people with diabetes. Plans aggregate quality information for their enrollees and use various methods (e.g., written reports, online portals, and/or regular check-in calls) to communicate performance back to provider organizations.

Plans reported that data in provider-facing quality reports may reflect care provided anywhere from two weeks to three months earlier. Providers contracted with multiple plans are likely to receive multiple reports about each plan's enrollees at different times and showing different degrees of detail. Most plans do not systematically track the frequency that providers access the available data or how often providers use it to inform clinical practice.

Payer-reported actions in response to inequities

- Targeted member outreach
- Performing research and forming workgroups
- Using internal and external collaborations to address inequities
- Employing root cause analysis with equity lens
- Engaging communities most impacted by inequities
- Working towards universal screening for social factors that impact health outcomes
- Connecting members to community resources

Equity and disparities

When asked about data collection to identify and address inequities, payers gave a mix of responses. Almost all plans have a process to collect race and ethnicity data, more than half have a process for disability data, and about half have a process for sexual orientation/gender identity data. Most payers use this demographic data alongside utilization metrics and quality measures to identify inequities among their enrollees, and almost all of those routinely share their findings with providers. Although payers gave a range of examples of actions they might take after identifying an inequity, none reported using an APM to incentivize improved equity.

Barriers and enablers to VBP adoption

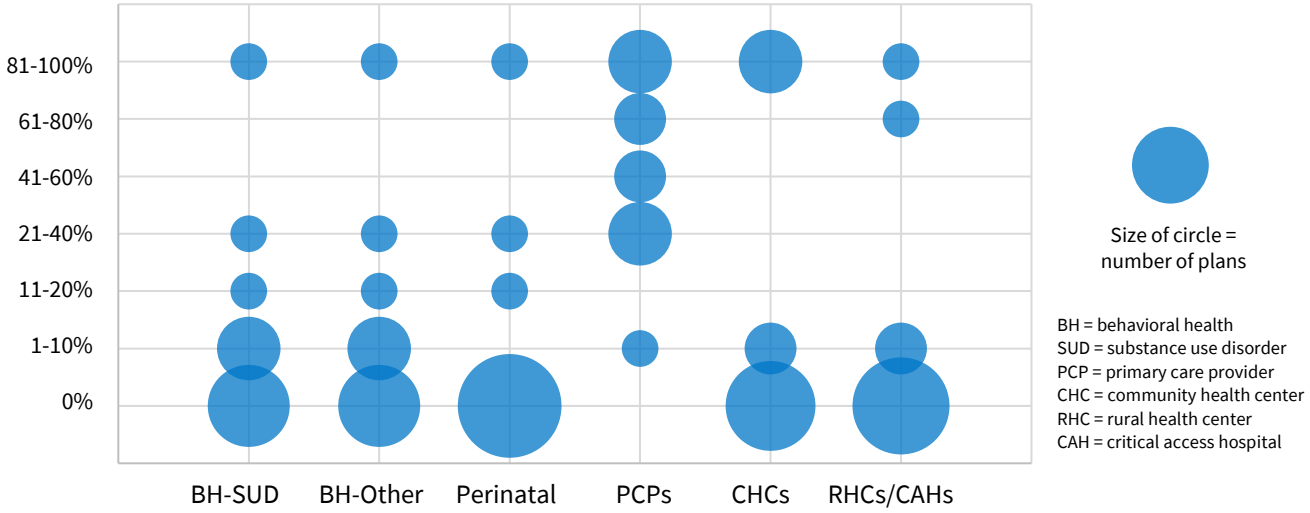
All survey respondents reported having VBP-specific strategic plans, which include goals related to quality (e.g., alignment with HCA quality measures), staffing (e.g., establishing a VBP leadership committee), and overall expansion of VBP (e.g., expanding shared risk and focusing on VBP for specialty care).

Survey respondents were asked about the top barriers and enablers impacting their abilities to adopt and expand VBP. Payers were able to select the same factor as both a barrier and an enabler. For example, several plans reported that having interoperable data systems and aligned contract incentives helps enable VBP adoption, while lacking them poses barriers. Respondents also had the option to write in barriers and enablers; one such barrier is the desire to maintain high reimbursement in commercial products, while an enabler is having dedicated staff to facilitate VBP work.

Provider participation in VBP

The survey asked payers about the provider types that engaged in a VBP arrangement in 2022 (Figure 4). Almost all payers reported that at least 20 percent of contracted primary care providers are engaged in VBP, with three payers indicating that number was over 80 percent. Half or more reported zero VBP participation from behavioral health (substance use disorder and other), perinatal providers, community health centers, and rural health centers. MCOs were more likely to engage community health centers in VBP than PEBB/SEBB plans.

Figure 4: Distribution of provider types engaged in VBP



From 2017 to 2021, HCA conducted Paying for Value Surveys for providers as well as plans. Hearing feedback from provider partners about workforce burnout and survey fatigue, HCA decided not to administer the survey in 2022 and 2023. As a result, HCA cannot assess how VBP adoption affects providers' experiences of payment and incentives, or recent trends in providers' perspectives about transitioning to new payment models. HCA may reopen the Paying for Value Provider Survey in future years.

Analysis and implications

VBP adoption does not directly measure provider accountability

Calculating VBP adoption

In order to interpret the achievement of 79 percent VBP adoption, it is important to understand how this number is calculated. In Apple Health managed care, MCOs must submit details of their spending and contracts within each APM category to an independent assessor (IA) for auditing and validation. In PEBB and SEBB, HCA collects information about PEBB/SEBB carriers' VBP practices in their non-state-financed Large Group line of business. HCA then estimates VBP achievement by assuming that payers maintain the same contracting behavior in PEBB/SEBB as in the Large Group line overall. This means that the decline in VBP adoption in PEBB/SEBB in 2022 may be a result of an actual change in PEBB/SEBB carrier contracting practices, or it may reflect changes in the Large Group market outside of PEBB and SEBB.

Interpreting VBP adoption

In either sector (Apple Health or PEBB/SEBB), readers might incorrectly assume that the percentage of VBP adoption is the same as the percentage of providers who are held accountable for the cost and quality of their patients' care. In reality, the portion of providers engaged in VBP may be much lower than the portion of dollars spent in VBP.

How is this possible if VBP contracts are heavily concentrated in primary care, one of the most efficient sectors of the health system?[1] Some APMs (categories 3A and above) hold primary care providers partially or fully responsible for their attributed patients' total cost of care. In those cases, HCA allows payers to include all money spent on those patients' care during the year toward the annual VBP adoption total.

In addition, HCA notes some variation in how payers report "VBP adoption" in category 2C. Some MCOs count the total cost of care for patients of PCPs enrolled in 2C arrangements toward their VBP adoption total. For example, some payers have included the cost of a patient's hospital stay in their VBP spending total because that patient's PCP was eligible for a quality performance bonus. However, if the performance bonus does not give the PCP a contractual reason to monitor or manage the patient's hospital costs or care experience, those costs should not be included in the VBP adoption total. This inconsistency will be corrected through more specific contract language in future years, but we note it here to highlight the importance of understanding the underlying mechanics of VBP adoption.

Most VBP adoption is built on FFS foundations and has limited financial implications for providers

The alternative to VBP is fee-for-service (FFS) payment. In FFS contracts, providers are paid for each patient they see and each service they provide. This means that providers receive the same pay whether or not the patient improves and regardless of the appropriateness of care. FFS payment also incentivizes seeing a high volume of patients and providing more expensive specialty services.

The vast majority of VBP adoption is in categories 2C (performance bonuses) and 3A (performance bonuses and shared savings). Although these meet the definition of "value-based payment" because they tie payment to quality, they are still built on FFS infrastructure and rely on traditional fee schedules. Only 22 percent of Medicaid managed care payments and 34 percent of PEBB/SEBB payments are in APMs that move away from FFS foundations by paying prospectively and giving providers partial financial responsibility for quality or total cost (categories 3B and 4A/B/C). The low rate of risk-bearing VBP adoption may stem from providers' reluctance to accept risk or manage different revenue streams. Another possibility is that payers do not have the infrastructure to appropriately price or administer population-based payment models that include risk, such as prospective payments and bundles.[2]

Even in VBP arrangements with quality bonuses or shared savings, HCA does not currently have visibility into how often these rewards make it down to the level of the individual practice or provider within larger healthcare systems. This is another topic that might be included in a revived provider survey.

VBP adoption alone does not change provider behavior

The idea behind VBP is that payment structures drive behavior; therefore, payers and purchasers can change provider behavior by changing how they pay for care. Traditional FFS payment incentivizes providers to increase the number of patients they see and the number of high-reimbursement services they prescribe in order to maximize revenue. In theory, an APM that rewards high-quality care and penalizes wasteful spending will incentivize providers to focus on value rather than volume.

Although HCA has made monumental progress toward its goal of 90 percent value-based payment in state-financed care, the rate of VBP adoption does not offer insight into whether payment reform has successfully shifted provider behavior. Several factors make it less likely that HCA's value-based purchasing efforts are having the desired effect.

First, **most providers contract with many different payers**, most of whom have not shifted away from FFS. HCA is the single largest purchaser in the state, covering about 25 percent of Washington residents, but the share of patients with state-financed coverage on any given provider's panel may be quite small. As a result,

[1] Excess Medical Care Spending. American Journal of Public Health, December 2020

[2] Value-Based Purchasing Design and Effect: A Systematic Review and Analysis. Health Affairs, June 2023

there may not be enough financial pressure on most providers to overcome the inertia of longstanding FFS structures and habits. In addition, incentives may simply not be powerful enough to motivate behavior, and many incentives are still reimbursed on a FFS basis. Together, these factors mean that provider revenue is still mostly tied to a volume-based business model.

Second, **access to performance data is key to provider behavior change in a VBP arrangement**.[3] All HCA-contracted plans prioritize an aligned measure set, but each plan shares quality data with providers about its own enrolled population and on its own schedule. Some provider groups may have the ability to analyze their entire patient populations, but others may be left trying to piece together data from five to ten separate plans for different segments of their patients. Performance data in this format is unlikely to be actionable for providers.

Finally, **this year's survey results indicate that the vast majority of providers engaged in VBP are primary care providers**. On one hand, this is strategic: many of HCA's incentivized quality measures rely on PCPs, and health systems built around primary care tend to be more efficient than those built around specialty care. Signaling a key definition of "value" in the health care system, in 2021 the Washington State Legislature set a goal of spending 12 percent of health care dollars on primary care, a significant increase from the 2022 primary care spending rates of 9.6 percent in Apple Health managed care and 6.7 percent in PEBB/SEBB.

On the other hand, primary care is already one of the most efficient segments of the health care system; its main contribution to wasteful spending is missed opportunities for preventive care. In theory, being contracted through an APM could encourage PCPs to build relationships with specialty providers and actively monitor patient care beyond the services they personally provide, especially when the APM includes an element of financial risk. However, outside of an integrated health system with infrastructure to support team-based, cross-specialty care, PCPs are unlikely to have meaningful influence over costs incurred by their patients in other parts of the health system, no matter what their contracts say

Primary care expenditure reports for 2022 also revealed that even though VBP contracts are concentrated in primary care, roughly half of primary care payments in Medicaid managed care and 98 percent of primary care payments in PEBB/SEBB are still made on a FFS basis. Being enrolled in an APM does not necessarily mean that providers have the ability to rein in costs and improve quality outside the walls of their own clinic.

It is too early to tell whether VBP in Washington will improve health care quality or reduce costs

There has not been a strong correlation between VBP adoption and quality improvement since the shift to VBP began in 2016. Plan-level quality incentives have yielded **mixed results** in both Apple Health managed care and PEBB/SEBB: a few measures have improved, while others have remained stagnant or worsened. In 2022, most plans' quality performance decreased compared to 2021. However, interpretation of quality trends is complicated by changes to measure specifications and calculation methods over time, as well as the severe disruptions of the COVID-19 pandemic.

By the same token, the shift to VBP has not shown significant impact on the rising cost of healthcare. PMPM costs increased by 25 percent between 2017 and 2021 in both Apple Health managed care and the Washington commercial insurance market.[4] During the same period, national medical costs grew by about 20 percent, while general inflation was about 15 percent.[5] Again, the seismic shifts in health care related to the COVID-19 pandemic disrupted progress and make it difficult to draw conclusions from cost trends over time.

[3] Measuring Success in Health Care Value-Based Purchasing Programs. RAND Corporation, 2014

[4] Annual Report to the Legislature. HCA Health Care Cost Transparency Board, August 2023

[5] How does medical inflation compare to inflation in the rest of the economy? Peterson-KFF Health System Tracker, July 2023

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Conclusion

HCA continues to advance paying for value in health care

HCA's value-based purchasing program since 2016 has successfully incentivized carriers to shift health care dollars into VBP arrangements and to adopt aligned quality measures. In just six years and despite a global pandemic, the share of state-financed health care in VBP arrangements more than doubled, increasing from 30 percent to 79 percent.

At the same time, VBP adoption decreased in 2022 for the first time since HCA began measuring it. Although some of the decrease may have resulted from how we measure and calculate adoption, it may also indicate changing attitudes and priorities of payers and providers in a post-pandemic health care landscape. For example, providers facing burnout might feel increased skepticism about investing in VBP models, heightened sensitivity to risk, and/or an increased priority on shoring up revenue. HCA is considering reinstating the provider-directed Paying for Value survey in future years to begin addressing these questions.

HCA remains committed to paying for value and leveraging our role as the state's largest purchaser to drive quality and reduce unnecessary spending in Washington's health system.

HCA is evaluating our VBP measurement strategy

Perhaps the most important conclusion from the 2023 Paying for Value Survey is that the primary indicator HCA has used to measure success, VBP adoption, does not directly reflect affordability, quality, and equity, or provider awareness and behavior change. HCA is investigating alternate ways to evaluate the success of Washington's VBP programs in the future. This may mean changing the way we define VBP adoption, using different measures to understand the effects of VBP adoption, or using new or different policy levers to impact priority outcomes more directly. HCA is also investigating ways to continue supporting and incentivizing meaningful VBP adoption in Washington, including considering attribution methods and quality measures appropriate for alternative payment models with specialty care providers, identifying best practices for promoting health equity through VBP, advancing strategies for payment models to support quality performance in low-volume services, and more.