Washington State Health Care Authority

2024 Paying for Value Survey results

The annual Paying for Value survey — conducted by the Washington State Health Care Authority (HCA) — collects information about value-based payment (VBP) activity from health care plans and provider organizations. 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 and qualitative information about designing and implementing VBP arrangements.

> **Note**: In this document, the acronym "VBP" refers to value-based payment (arrangements between health plans and providers). We'll spell out "value-based **purchasing**" when referring to arrangements between health plans and HCA.

In 2024, 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) carriers, and one commercial health plan not contracted with HCA. HCA also received responses from 23 provider organizations. The 2024 survey asked respondents to report on calendar year 2023.
The 2024 Survey yielded several key insights:

- **VBP adoption has leveled out in recent years**. Overall VBP adoption decreased by 1 percent in 2023 (1 percent decrease from MCOs, 2 percent increase from PEBB/SEBB carriers). Advanced VBP spending (arrangements in LAN Categories 3B and above) increased slightly in Medicaid managed care and remained the same for PEBB/SEBB. Category 4 payments in Medicaid managed care increased slightly for the first time since HCA began measuring VBP spending.
- **VBP adoption remains concentrated in primary care.** Arrangements holding specialty care providers directly accountable for care remain limited.
- **Most practice revenue is not tied to APMs.** Nearly half of provider organizations said that less than 5% of their practice revenue is tied to APMs from any payer.

To navigate to a specific section of the results, see below:

Washington State Health Care Authority

Background

We purchase health coverage for more than 2.75 million people in Washington, roughly a third of the state's total population. Our mission is to provide equitable, high quality health care through innovative health policies and purchasing strategies. Annually, we spend more than $19 billion across Apple Health, Public Employee Benefit Board (PEBB), and School Employee Benefit Board (SEBB).

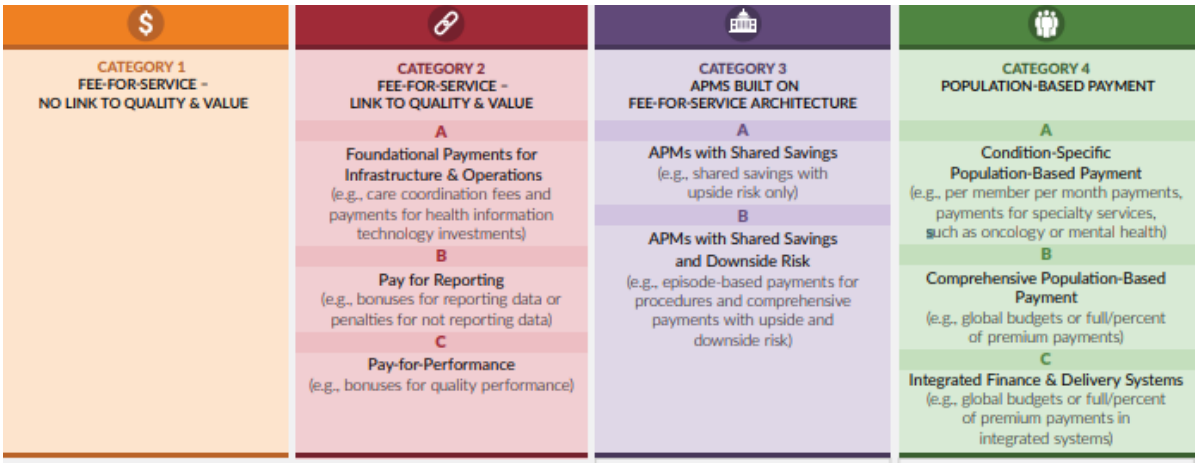
Value-based payment (VBP) describes a range of payment strategies intended to contain costs while improving outcomes by tying payment to care quality. Traditional health care payment, known as fee-for-service (FFS), encourages potential overuse of expensive, low-value services and does not reward higher value of care. VBP aims to change provider behavior by rewarding high quality care and minimizing wasteful spending. For example, VBP models may include:

- Incentivizing more time spent on care coordination between primary care and specialty providers
- Investing in technology to support streamlined reporting and workflows
- Focusing on quality outcomes and long-term health of patients rather than a high volume of services.

To measure VBP models, we use the **Health Care Payment Learning & Action Network** (HCP-LAN) Alternative Payment Model (APM) Framework (see Figure 1). We consider payment arrangements in Categories 2C and 3A as VBP because they tie payment to quality. However, they still use fee-for-service infrastructure and rely on volume-oriented payment. Health policy literature shows that advanced VBP models (Categories 3B and above) are more likely to meaningfully change the way that providers are paid to deliver services.[1]

In 2016, we 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). In 2022, we updated the state's Value-based Purchasing Roadmap to continue advancing along the HCP-LAN APM Framework via adoption of advanced models and leverage state purchasing power to improve overall health and health equity in Washington.

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



Every year, we distribute the Paying for Value Survey to Washington health care payers (also referred to as plans and carriers) to gather information about participation in and experience with VBP arrangements. For the first time since 2021, we also distributed the Paying for Value Survey to health care provider organizations to help HCA understand provider experiences with VBP and inform our approach to value-based incentives in the future.

[1] Value-Based Purchasing Design and Effect: A Systematic Review And Analysis (Health Affairs, 2023)

Washington State Health Care Authority

Payer survey results and analysis

HCA received responses from 11 payers in 2024:

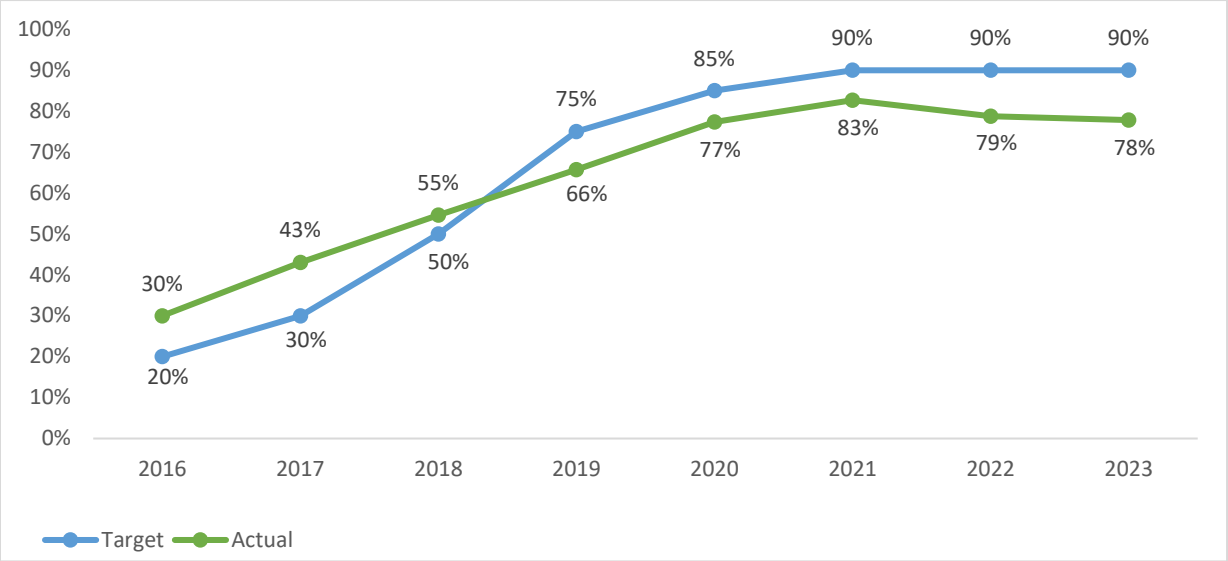
- Five Apple Health (Medicaid) managed care organizations (MCOs)
- Five PEBB/SEBB carriers
- One commercial health plan not contracted with HCA

The 2024 survey asked payers to report on calendar year 2023.

VBP adoption

In 2023, 78 percent of state-financed health care[2] flowed through VBP arrangements in Category 2C or higher (82 percent of Medicaid managed care payments and 73 percent of PEBB/SEBB payments). Excluding PEBB/SEBB payments tied to the Accountable Care Program (UMP Plus), 61 percent of PEBB/SEBB payments flowed through VBP arrangements.[3]

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



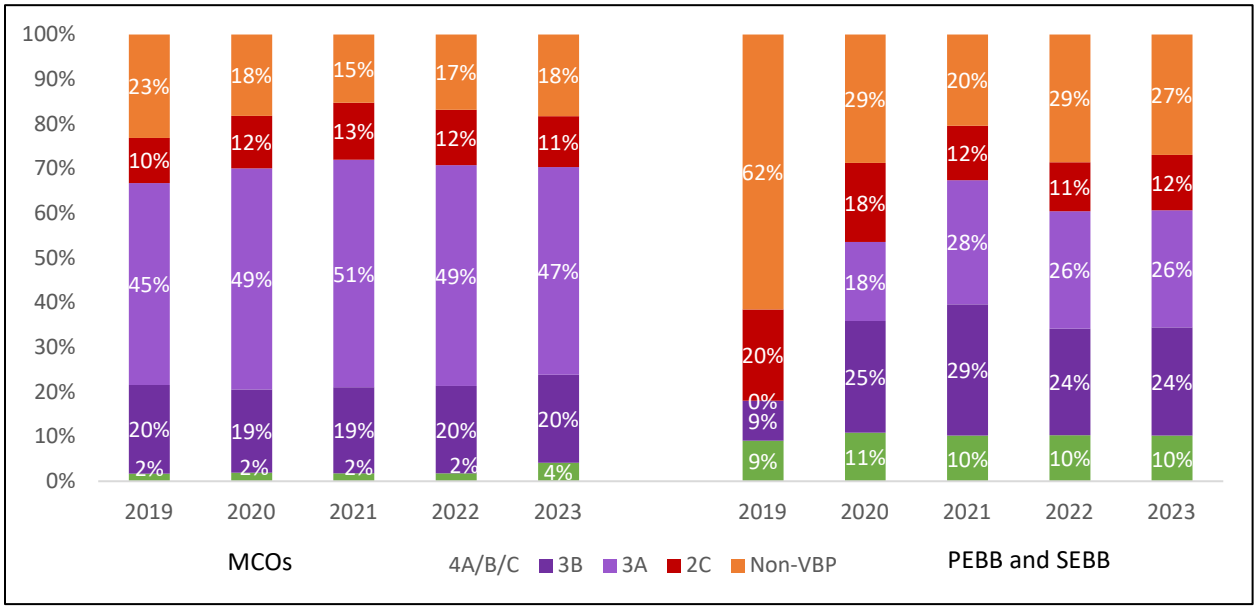
*The 2021 target for MCOs was 85% rather than 90% due to COVID-19

VBP adoption was similar from 2022 to 2023. Overall VBP adoption decreased by one percentage point from 2022 (Figure 2). Medicaid managed care saw a one percent decrease in spending in VBP payment models, while PEBB/SEBB plans saw a 2 percent increase in spending in VBP models (Figure 3). More state-financed health care spending is in Medicaid managed care than PEBB/SEBB, which led to an overall decrease in state-financed payments tied to VBP arrangements. This is the second year in a row that VBP adoption in Washington decreased.

Advanced VBP spending has remained relatively consistent year over year (Figure 3). Spending in advanced VBP models increased slightly in Medicaid managed care (from 22 percent to 24 percent) and remained the same for PEBB/SEBB (34 percent). Notably, spending in Category 4 payments increased slightly in Medicaid managed care for the first time since HCA began measuring VBP spending.

[2] "State-financed health care" excludes fee-for-service Medicaid and wraparound payments for other services (i.e., transportations) and non-HCA health spending (i.e., 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).
[3] As of December 2023, 6.3% of PEBB/SEBB enrollees were enrolled in ACP plans (UMP Plus).

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



Provider participation in VBP

Provider engagement data collection

In prior years, we solely used data about the percentage of dollars spent in VBP arrangements to define VBP adoption. This may have led to incorrect assumptions that the percentage of VBP adoption is the same as the percentage of providers who are held accountable for the cost and quality of patient care (detailed in the 2023 Paying for Value Survey).

In 2024, we asked payers to report annual approved payments through each type of payment arrangement and the percentage of providers enrolled in each type of payment arrangement. We collected provider engagement data for informational purposes, to help us compare various measurement approaches and support future goal setting.

Provider participation results & implications

There is a difference between payments tied to VBP arrangements and providers engaged in VBP arrangements. For PEBB/SEBB plans, 73 percent of payments were tied to VBP arrangements and a median of 48 percent (range: 35 to 49 percent) of providers were engaged in VBP arrangements. Based on survey constraints, we received provider engagement data only from PEBB/SEBB carriers and cannot report on Medicaid managed care provider engagement. Additionally, some payers struggled to respond to the question, indicating that both HCA and payers have work to do to understand how to characterize and target provider engagement in VBP.

Why this matters: Understanding the distinction between VBP-tied payments and VBP-engaged providers provides transparency about the breadth of incentives. If HCA wants to hold carriers accountable for promoting quality, equity, efficiency, and patient experience via value-based purchasing practices, then we need to understand the scale of providers that they contract with and that are meaningfully being held accountable.

VBP adoption is concentrated in primary care. In the qualitative section, the survey also asked payers about provider types that engaged in a VBP arrangement in 2023. More than half of payers reported zero VBP participation from:

- Behavioral health
- Perinatal providers
- Community health centers
- Rural health centers
- Specialty providers (overall and specific to orthopedic providers and medical oncologists).[4]

Of the 11 payers that responded, all reported that at least 40 percent of contracted primary care providers are engaged in VBP arrangements, with five payers indicating the number was over 80 percent. This discrepancy between primary and specialty provider participation is consistent with 2022 findings. The concentration in primary care may reflect that the underlying design of popular VBP models attribute accountability to primary care practitioners. Additionally, the quality measures we incentivize may favor primary care.

Why this matters: Understanding that most VBP arrangements are primary care-focused should inform our assessment of current VBP arrangements' effectiveness and meaningfulness. Based on survey results, most specialty care providers are only engaged in VBP arrangements via total cost of care arrangements, which indirectly influences their behavior (rather than direct engagement with specialty-focused VBP arrangements). We should consider how our incentives as a purchaser reach providers throughout the health care system.

Barriers and enablers to VBP adoption

We asked payers about the barriers and enablers to VBP adoption overall and specifically with specialty providers. The 2024 survey used open-response questions (rather than the multiple-choice questions used in prior year surveys).

Overall, payers reported consistent barriers and enablers to those described in previous years. One new response to the 2023 survey identified that testing short term/pilot payment arrangements enables VBP engagement and adoption, especially with specialists.

Demographic data and addressing inequities

Most payers collect demographic data through enrollment files, electronic health record data, and other forms of member self-report. Some payers do not impute any missing data; some infer disability based on claims diagnoses or services rendered. Multiple payers indicated that they do not impute member demographics at the individual level but may use last name and zip code analysis to impute demographic data at an aggregate level to run analytics for population-based initiatives. This is consistent with our 2023 survey, with the exception that more payers indicated that they collected sexual orientation and gender identity data in 2024.

Most payers use this demographic data in conjunction with utilization metrics and quality measures to identify inequities among their enrollees, and almost all of those routinely share their findings with providers. Payers gave a range of examples of actions they might take after identifying inequity, including:

- Contacting members
- Forming workgroups
- Performing gap analysis to identify areas for improvement

[4] HCA is currently prohibited by law from entering into VBP arrangements with Federally Qualified Health Centers (FQHCs). However, payers can enter VBP arrangements with FQHCs.

New actions mentioned in 2024 included:

- Leveraging the MCO Performance Improvement Project Program to address inequities
- Ongoing development of VBP arrangements specific to maternity care and equity-focused capacity building

Why this matters: This year, we introduced **new equity contract requirements** for managed care and PEBB/SEBB contracts, effective July 2024 and January 2026, respectively. Understanding how payers collect data and address disparities will help us hold payers accountable for reducing health disparities and promoting health equity.

Provider survey results & analysis

Survey and VBP participation

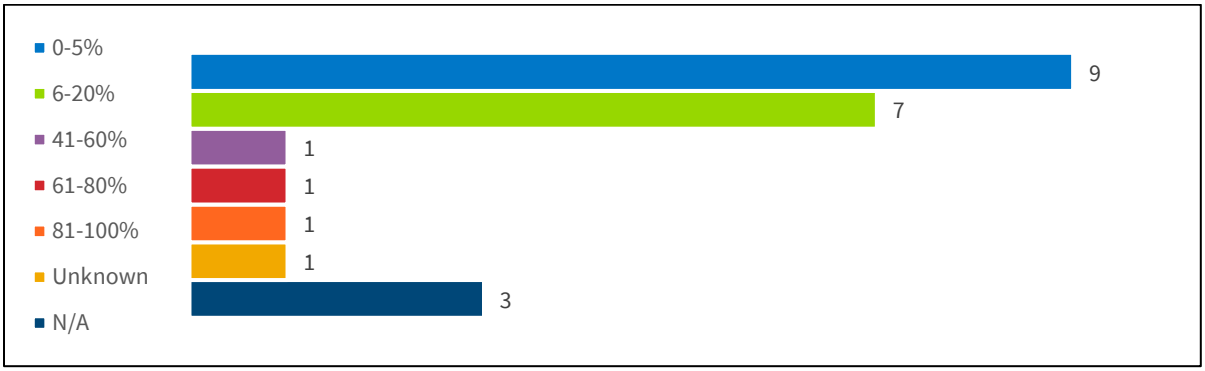
HCA received responses from 23 provider organizations. Of those respondents, 17 respondents offer primary care and 12 offer behavioral health care. Half of respondents employ fewer than 100 FTE employees, and eight employ fewer than 20 FTE employees. Additionally, 15 reported patient panels of over 1000.

Figure 4: VBP participation from 23 provider organizations (multiple responses permitted)

VBP category	Medicaid	Medicare	Commercial
Quality bonuses/pay for performance (2C)	8	7	9
Shared savings, upside only (3A)	4	4	8
Shared savings and shared financial risk, upside and downside (3B)	3	4	5
Population-based payments (4A–C)	3	2	3
None of the above (fee-for-service or other payment not tied to quality)	12	12	11

About half of provider organizations do not participate in VBP arrangements, and participation centers on quality bonuses or upside-only shared savings arrangements (Figure 4).

Figure 5: Percentage of each provider's revenue tied to VBP arrangements



Nearly half of provider organizations said that less than 5 percent of their practice revenue is tied to VBP arrangements from any payer, and just three provider organizations indicated that more than 40 percent of their

revenue is tied to VBP arrangements (Figure 5). Even so, about half of respondents said that VBP has improved quality in their organization and seven said that it increased team-based care.

Provider takeaways

In response to open-ended questions, respondents had mixed takeaways regarding the impact of VBP. Some provider organizations noted that participation in VBP models changes how providers are paid (i.e., distribution of quality incentives), and some indicated that it did not. Some respondents shared that VBP participation resulted in significant changes to the practice:

- Improved technology
- Improved outcomes tracking
- Standardized workflows
- Improved documentation.

One respondent noted that VBP participation did not lead to changes, as they don't have the staffing capacity to monitor closely and contact patients to close care gaps.

Respondents also expressed concern that VBP is used only as a cost savings tool, noting that it shifts the cost burden from insurance companies to providers and puts cost savings ahead of the duty for patient care. One provider stated that high quality health care sometimes costs, rather than saves, money. On the other hand, one provider stated that participation in VBP models has led to improved outcomes tracking and subsequent improvement in quality and cost effectiveness.

Why this matters: VBP adoption slightly decreased in 2022 and 2023. HCA and payers need to hear providers' perspectives about barriers to succeeding in VBP, and what kinds of payment models can best support high quality, coordinated patient care. As we consider our role as a purchaser and our strategic priorities, we will engage providers to incentivize meaningful VBP arrangements.

Conclusions

VBP adoption levels remain consistent in Washington and are primarily tied to fee-for-service architecture

VBP adoption rose steadily from 2016–2021. Since then, the percentage of overall health care payments tied to VBP arrangements has decreased slightly or leveled out. Advanced VBP adoption (Categories 3B and above) has remained consistent since 2020 (between 20 and 25 percent for MCOs and around 35 percent for PEBB/SEBB plans).

VBP payment arrangements in Categories 2C and 3A reward providers for quality care, but they remain tied to FFS infrastructure. This means that there may be little incentive or flexibility to dedicate time and resources to care coordination, reduction in unnecessary services (when appropriate), and patient-centered care.

Our goal for VBP arrangements in Washington is to incentivize provider behavior change and truly promote increased quality, equity, and patient experience. To achieve this, we will continue to work with payers and providers to thoughtfully consider the types of payment arrangements that change how providers are paid, enabling desired outcomes.

VBP adoption remains concentrated in primary care

Almost all VBP adoption is concentrated in primary care providers, with limited direct incentives moving specialty providers towards advanced payment arrangements. Some alternative payment models, such as

bundled or episode-based payments, are more appropriate for specialists than others. As we continue to incentivize meaningful VBP adoption, we may consider incentivizing payers to differentiate payment models for different provider types.

Most practice revenue is disconnected from VBP incentives

Almost half of provider survey respondents indicated that less than 5 percent of practice revenue is tied to VBP arrangements. Provider organizations also had mixed viewpoints on the effectiveness of VBP. They pointed out challenges and administrative burdens but also indicated that VBP arrangements have promoted better workflows, team-based care, and attention to quality. We will continue to gather input from provider organizations and consider how it should influence our value-based purchasing strategies.

HCA continues to evaluate our VBP measurement strategy

The 2024 Paying for Value Survey built on many of the questions raised in the 2023 survey. New data collection methods for PEBB/SEBB VBP adoption and providers engaged in VBP helped us better understand the breadth of VBP uptake in the state. As our VBP strategy continues to evolve, we will also modify our evaluation strategies for a deeper understanding of the quality and experience impacts for Washington individuals and families.