Value-Based Payment in Washington

Presentation to the Joint Select Committee on Health and Behavioral Health Oversight

December 11, 2024

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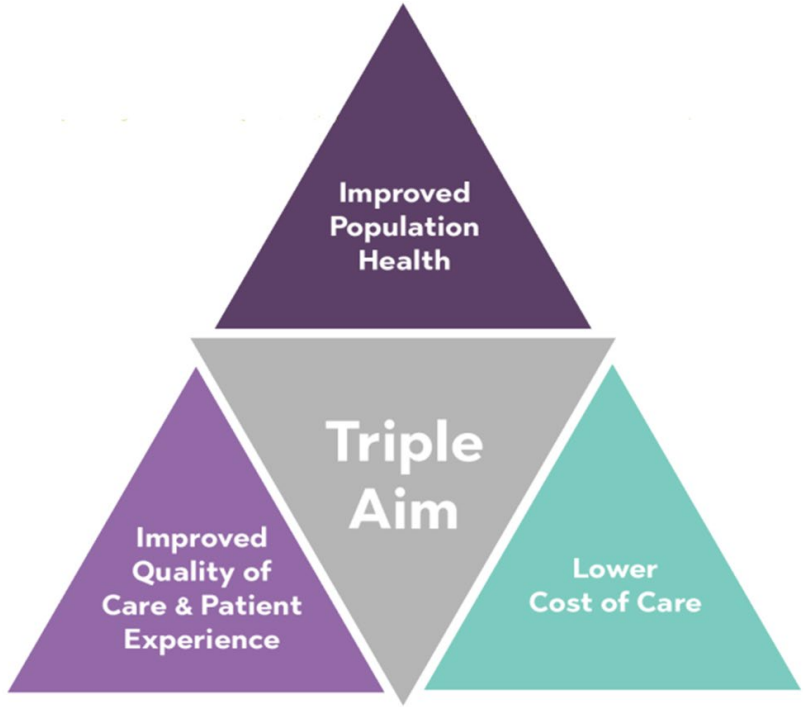
What is value-based payment (VBP)?

- In traditional fee-for-service (FFS) payment, providers are paid for each service or procedure performed.
- VBP is the concept of changing the way that we pay for health care services to **improve quality and health outcomes**.
- Shifting to VBP creates an opportunity for a system where **patients get the care they need when they need it**.



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Tradeoffs of fee-for-service vs. value-based payment

Fee-for-service payment

- Advantages
  - Clear and transparent reimbursement
  - Incentivizes providers to do more services
  - Can incentivize specific services
- Disadvantages
  - Fragmented care delivery
  - Potential for overutilization
  - Price failures lead to misutilization
  - Payment is disconnected from quality of care, patient outcomes

Value-based payment

- Advantages
  - Connects payment to desired outcomes (quality, equity, behavior change, patient experience, efficiency, reduced waste)
  - Opportunity to transform health care delivery system, care for whole patient
- Disadvantages
  - Burden on providers
  - Infrastructure requirements (data, training, staff)
  - Reconciling payments in an FFS world

HCA's value-based purchasing activities

Goals

VBP adoption

90% of HCA payments tied to VBP arrangements

Advanced VBP adoption

50% of HCA payments tied to advanced (risk-based) VBP arrangements

Health outcomes

Improve health and health equity

- HCA purchases health care services via insurance carriers, so it rarely has VBP arrangements directly with providers
  - UMP Plus options: Puget Sound High Value Network and UW Medicine Accountable Care Network
  - Pilot VBP model directly with Federally Qualified Health Centers (FQHCs) (alternative payment model 4)
- HCA's value-based purchasing programs
  - Performance guarantees
  - Multi-payer primary care transformation
  - Managed care organization (MCO) withhold

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HCA incentivizes MCOs to adopt VBP and improve quality

HCA withholds ~2% of MCO payments.

MCOs earn back the withhold based on **quality** and **VBP adoption**.

Component	Description	Portion of withhold earned
Quality of care	Rewards payers for improving quality of care and/or achieving target performance	75%
VBP Adoption	Rewards payers for increasing the portion of provider payments that are tied to VBP arrangements	10%
Advanced VBP adoption	Rewards payers for increasing the portion of provider payments that are tied to advanced (risk-based) VBP arrangements	5%
Potential provider bonuses/penalties	Rewards payers for VBP arrangements that have a minimum dollar impact for providers	10%

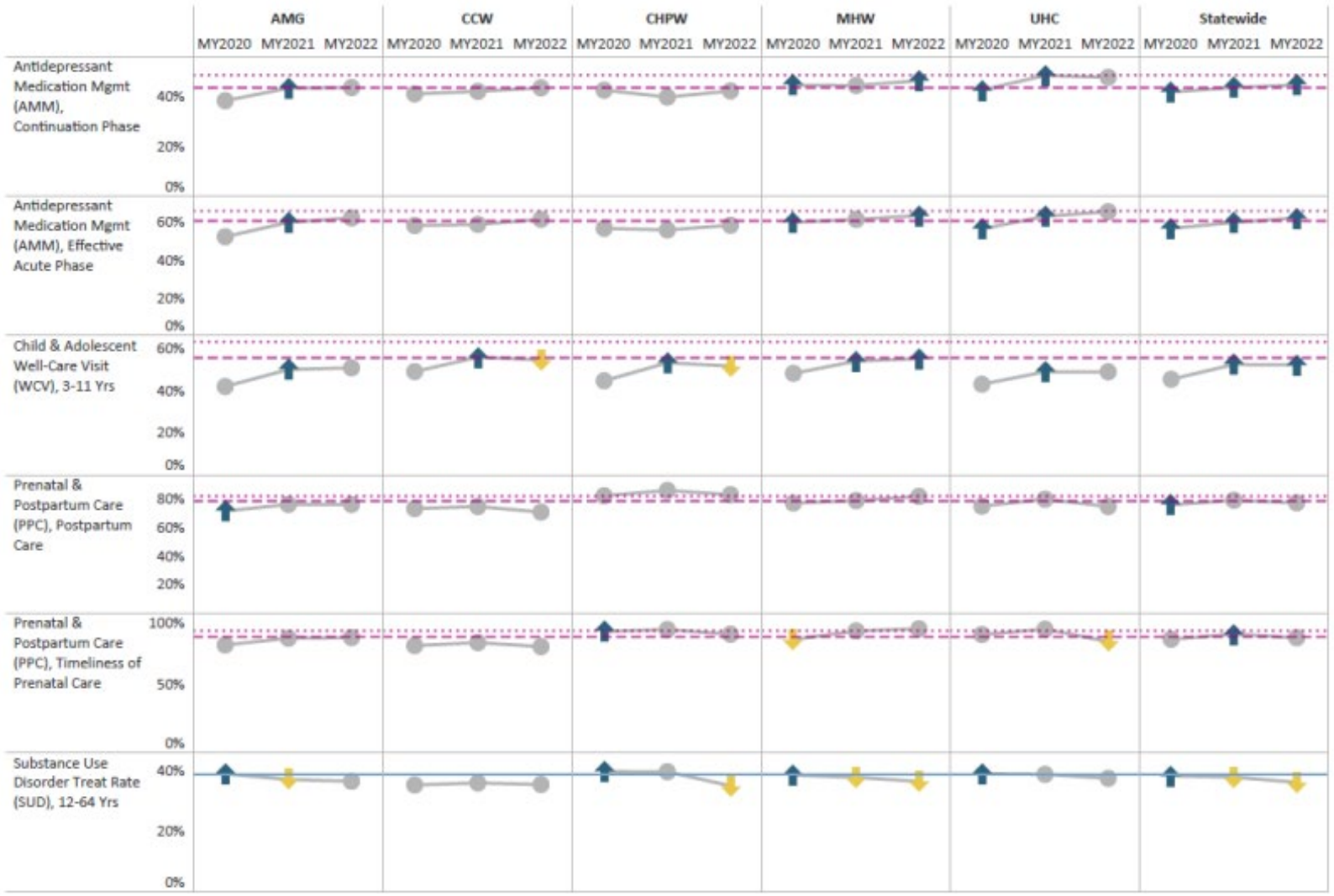
Apple Health plan quality performance

2023 Comparative and Regional Analysis report

MY2022 National 75th percentile
MY2022 National 50th percentile
MY2022 RDA behavioral health benchmark

No statistically significant change from previous measure year
Statistically significant increase from previous measure year
Statistically significant decrease from previous measure year

VBP performance for measurement year (MY) 2020 through MY2022; Integrated Managed Care (IMC) Shared Measures



Source: Comagine Health 2023 Comparative and Regional Analysis Report. (pages 49-51)
hca.wa.gov/assets/billers-and-providers/eqr-performance-measure-comparative-analysis-report-with-appendix-a-b-c-f-2023.pdf

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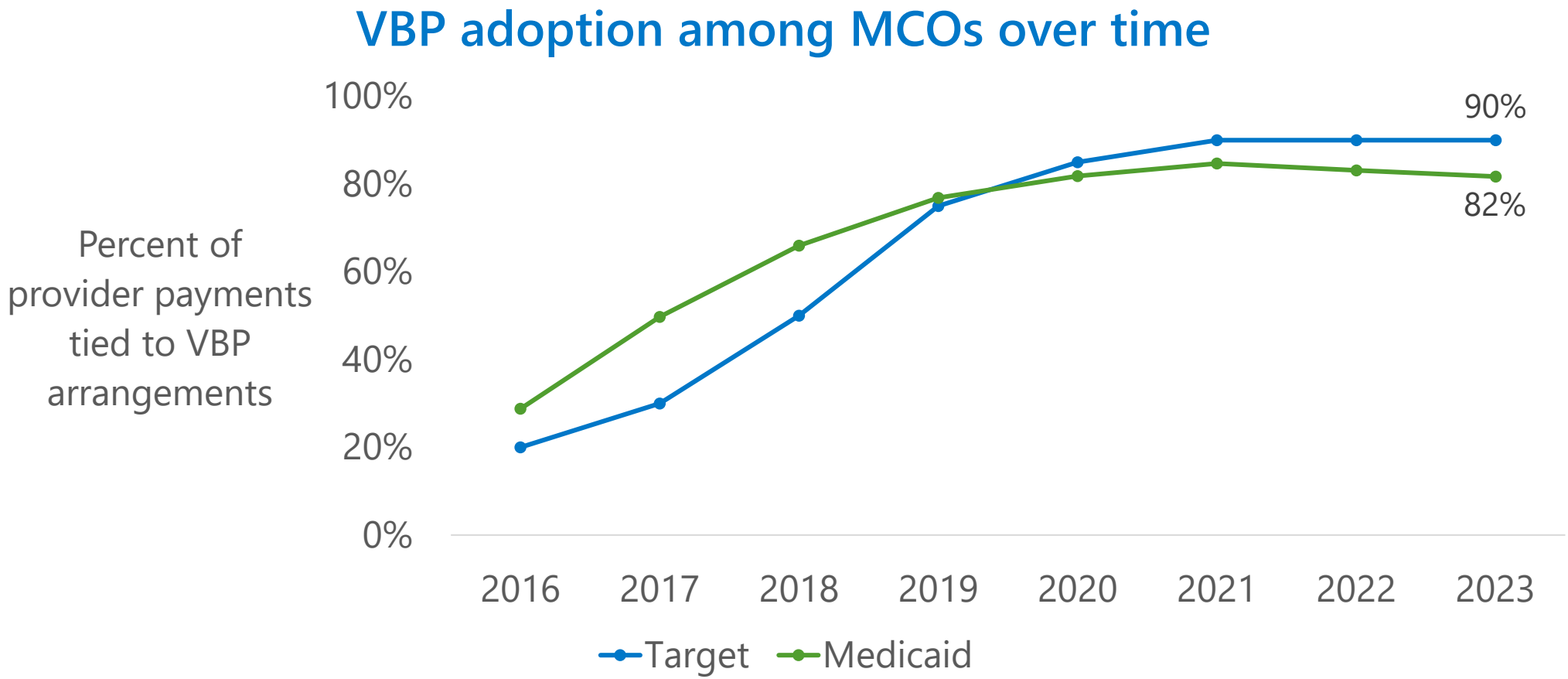
VBP adoption among MCOs (2016–2023)



Source: HCA annual Paying for Value Survey
hca.wa.gov/about-hca/programs-and-initiatives/value-based-purchasing/tracking-success

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Is VBP working? National evidence

National evidence about VBP is mixed.

- Some evidence that VBP arrangements produce better patient outcomes.
- Mixed evidence that VBP arrangements impact cost (particularly with administration, bonuses).
- VBP models with larger impact on revenue show greater impact on outcomes (quality, utilization, cost).

Nature and extent of participation must be considered.

- Most VBP is built on top of FFS payment and appears to have limited impact on practice revenue.
- Most VBP adoption has been voluntary. Volunteers tend to be better performers, and most drop out of models when there's risk involved.

Payment (including VBP) is a lever, not an end in itself.

- Effective VBP will require careful design, embracing nuance.
- To change care delivery, VBP models have to be widespread and aligned.

Is VBP working? Washington evidence

VBP adoption has leveled out over the years and is mostly added on to FFS payments.

- VBP adoption rose steadily from 2016–2021. In 2022 and 2023, adoption slightly decreased.
- Most VBP adoption is built on FFS payments, making it hard to incentivize meaningful provider behavior change.

HCA's VBP experience matches national trends, highlights importance of model design.

- Low performers often don't participate in voluntary VBP programs.
- COVID-19 pandemic made it hard to effectively evaluate VBP programs.
- Some evidence of improvements in quality of care.
- Limited/no evidence of cost savings—particularly over time.
- Programs should evaluate changes in how care is delivered, as well as in patient quality.

Elements of a successful VBP model

Tailor incentives to each provider's practice

Providers may need to be in multiple types of payment arrangements

Ensure providers have tools to succeed (staff, training, data, IT)

Plan for progress over time

Focus on core set of performance measures

Align payer efforts to minimize provider burden

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VBP direction & priorities

- **Meaningful VBP measurement and incentives**
  - MCOs have made big strides in adopting VBP models
  - HCA will focus on increasing the effectiveness of VBP in WA (directly and via MCOs)
- **Aligning payment models and quality measures across payers**
- **Making Care Primary**
  - CMS pilot VBP model for primary care. WA selected as one of eight states for pilot.
  - Multi-payer alignment, shift away from FFS payment over 10 years, increased accountability for cost/quality over time
- **VBP to promote health equity**
  - HCA will incentivize MCOs to decrease health disparities in quality performance (2026–)
- **Long term goal: expand VBP adoption in specialty and behavioral health care**
  - New quality measures, new payment mechanisms, and more coordination across providers

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Appendices

“Payment” vs “purchasing”

Value-based **purchasing**

- Arrangements between purchasers and payers

Value-based **payment**

- Arrangements between payers and providers
- Also called Alternative Payment Models (APMs)

Value-based **care**

- Care that providers offer to patients

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Categorizing Alternative Payment Models (APMs)

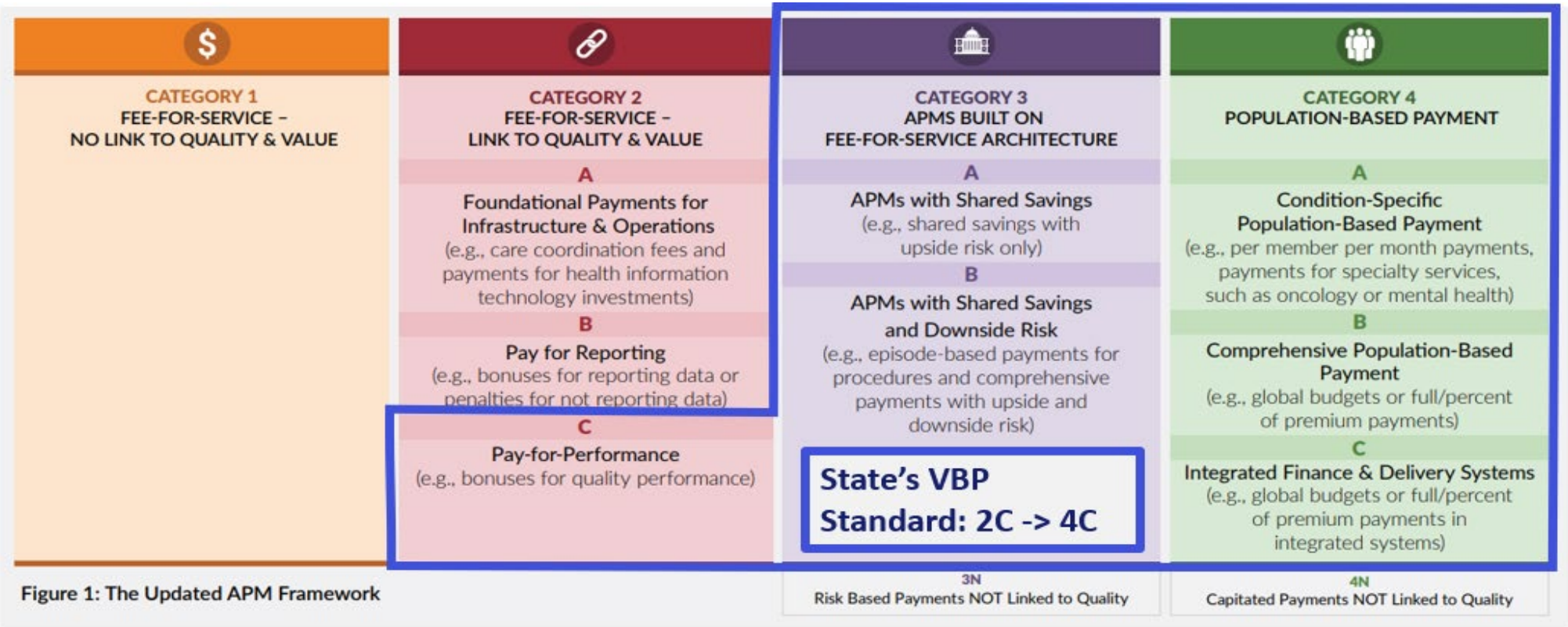

Figure 1: The Updated APM Framework

This framework was developed by the Health Care Payment Learning and Action Network.

HCA's VBP standard only includes those APMs that directly tie payments to quality.

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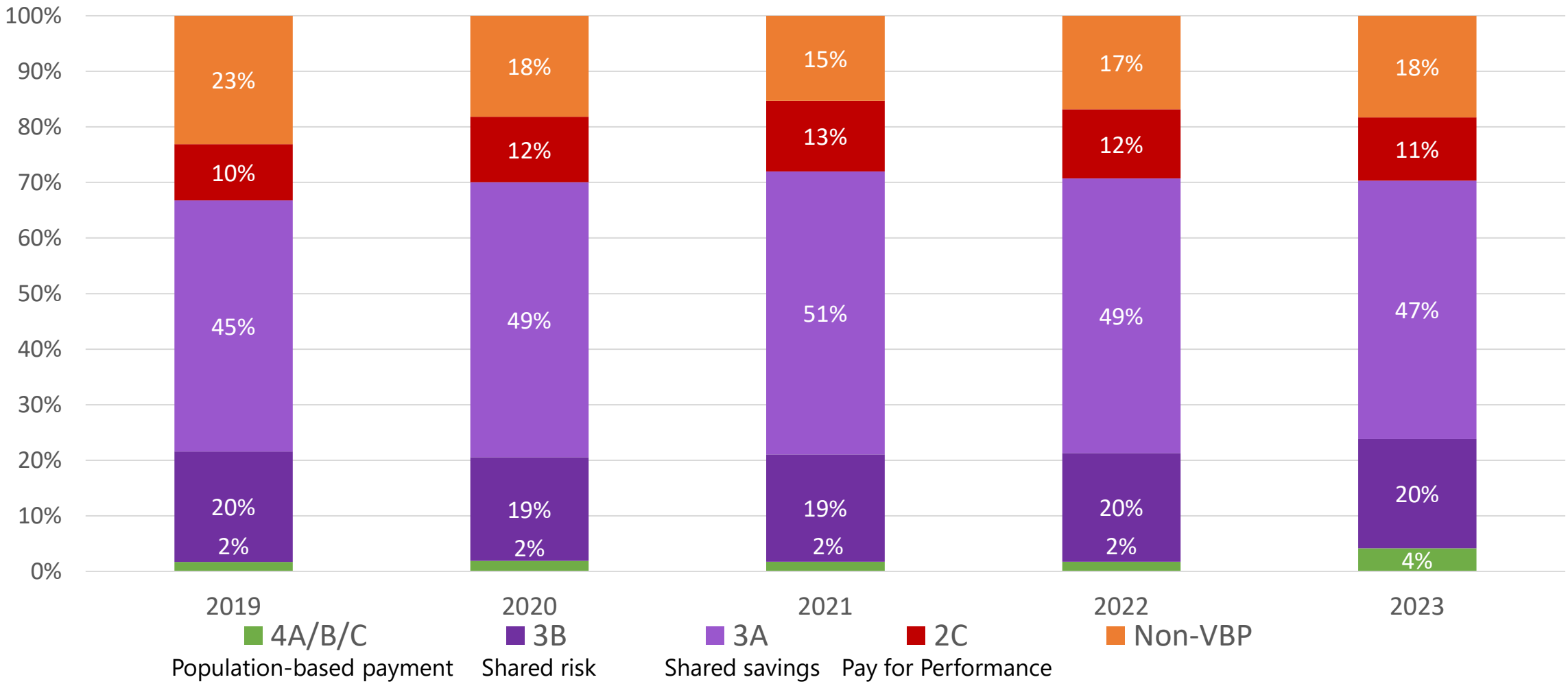
Trend in MCO payments by APM category, 2019–2023



HCA's VBP pilot with FQHCs ("APM4")

- Voluntary pilot VBP model direct with FQHCs (June 2017-Dec 2022)
- Prior to pilot, FQHCs were paid a cost-based encounter rate
- During pilot, FQHCs paid a prospective, per-member per-month rate
- Goal: shift away from encounter (volume)-driven reconciliation to incentivize team-based care and quality improvement
- Key VBP model design elements in APM4:
  - FQHCs could never be paid less than cost-based entitlement
  - FQHCs could retain payment above cost-based entitlement based on quality performance
- Evaluation (Nov 2022): https://www.hca.wa.gov/assets/program/leg-report-APM4-evaluation-20230112.pdf