



# 2019 Paying for Value survey results

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

# Background

HCA's roles and our Value-Based Purchasing (VBP) Roadmap

# HCA: purchaser, convener, innovator

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## ▶ Medicaid (Apple Health)

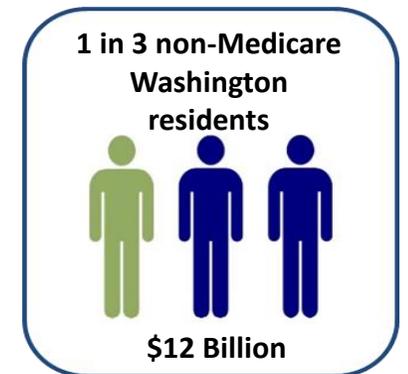
- ▶ 2.2 million covered lives
- ▶ Five managed care organizations (MCOs): Amerigroup, Community Health Plan of Washington, Coordinated Care, Molina, and United Healthcare

## ▶ 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
- ▶ State Innovation Models
- ▶ Centers of Excellence for Total Joint Replacement and Spinal Fusion



# HCA purchasing goals

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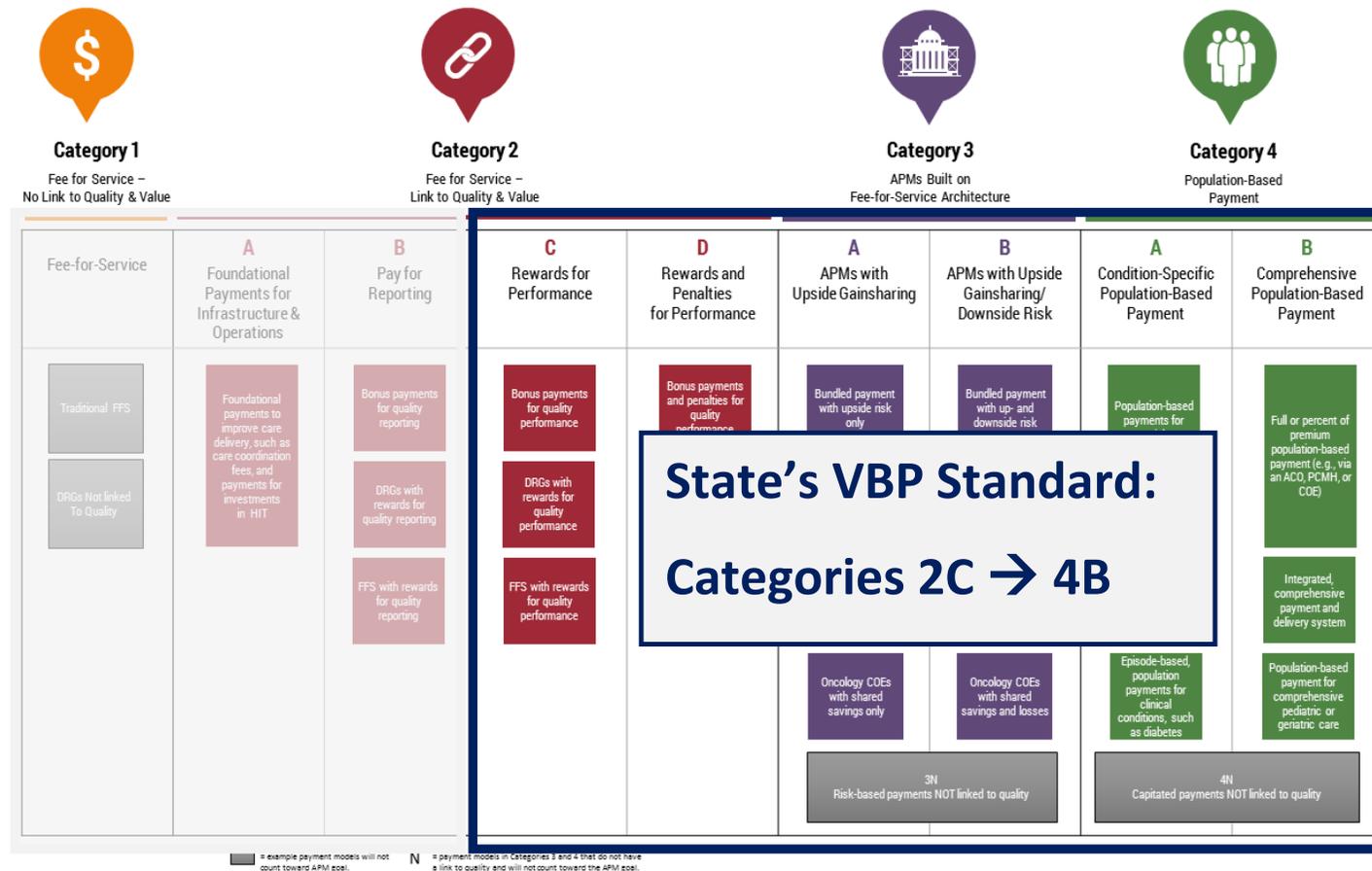
## ▶ By 2021:

- ▶ 90 percent of state-financed health care and 50 percent of commercial health care will be in VBP arrangements.
- ▶ Washington's annual health care cost growth will be below the national health expenditure trend.

### **Tools to accelerate VBP and health care transformation:**

- 2014 legislation directing HCA to implement VBP strategies
- SIM Round 2 grant, 2015-2019
- Medicaid Transformation 2017-2021

# Alignment with CMS Alternative Payment Models (APM) framework



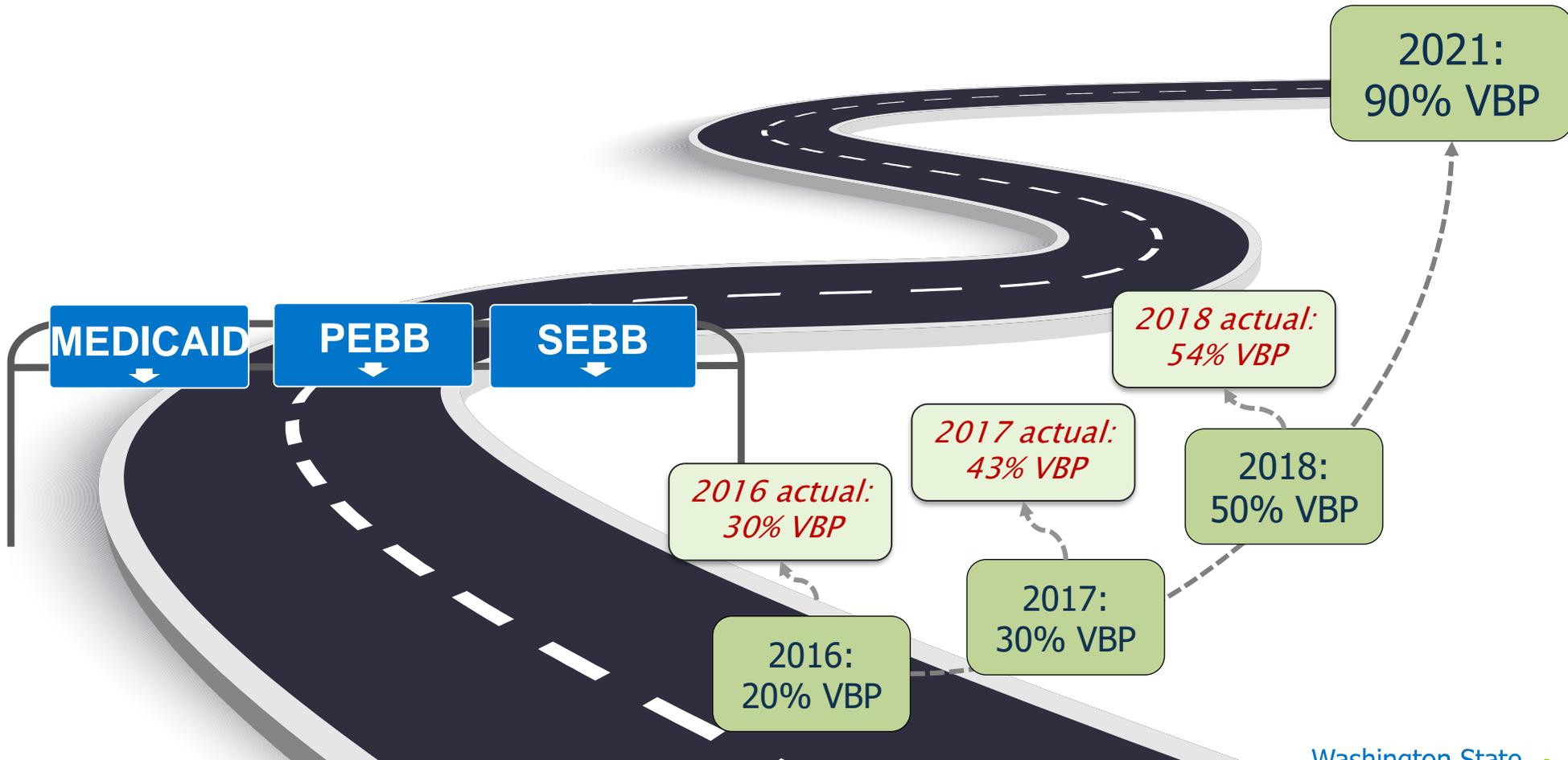
# VBP Roadmap

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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 action as necessary.

# VBP Roadmap (cont.)



# Guiding principles

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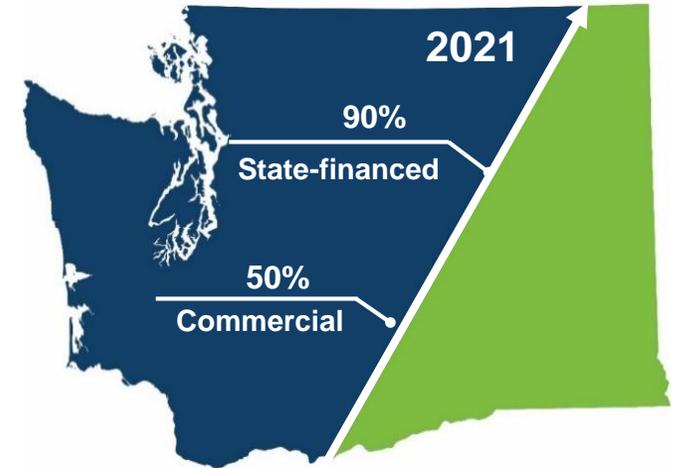
- ▶ A set of guiding principles lay the foundation for the VBP Roadmap and One HCA purchasing philosophy:
  - ▶ Continually strive for lower costs, better outcomes, and better consumer and provider experience.
  - ▶ Reward the delivery of person- and family-centered, high-value care.
  - ▶ Reward improved performance of HCA's Medicaid, PEBB, and SEBB health plans and their contracted health systems.
  - ▶ Align payment and delivery reform approaches with other purchasers and payers, where feasible, for greatest impact and to simplify implementation for providers.
  - ▶ Drive standardization and care transformation based on evidence.
  - ▶ Increase the long-term financial sustainability of state health programs.

# HCA's Paying for Value survey

Tracking progress in calendar year 2018  
and informing current and future strategy

# Overview

- ▶ Three surveys: MCO, commercial/Medicare health plan, and provider
- ▶ Purpose: track progress toward VBP goals
- ▶ 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
  - ▶ **New in 2019:** provider survey through SurveyMonkey

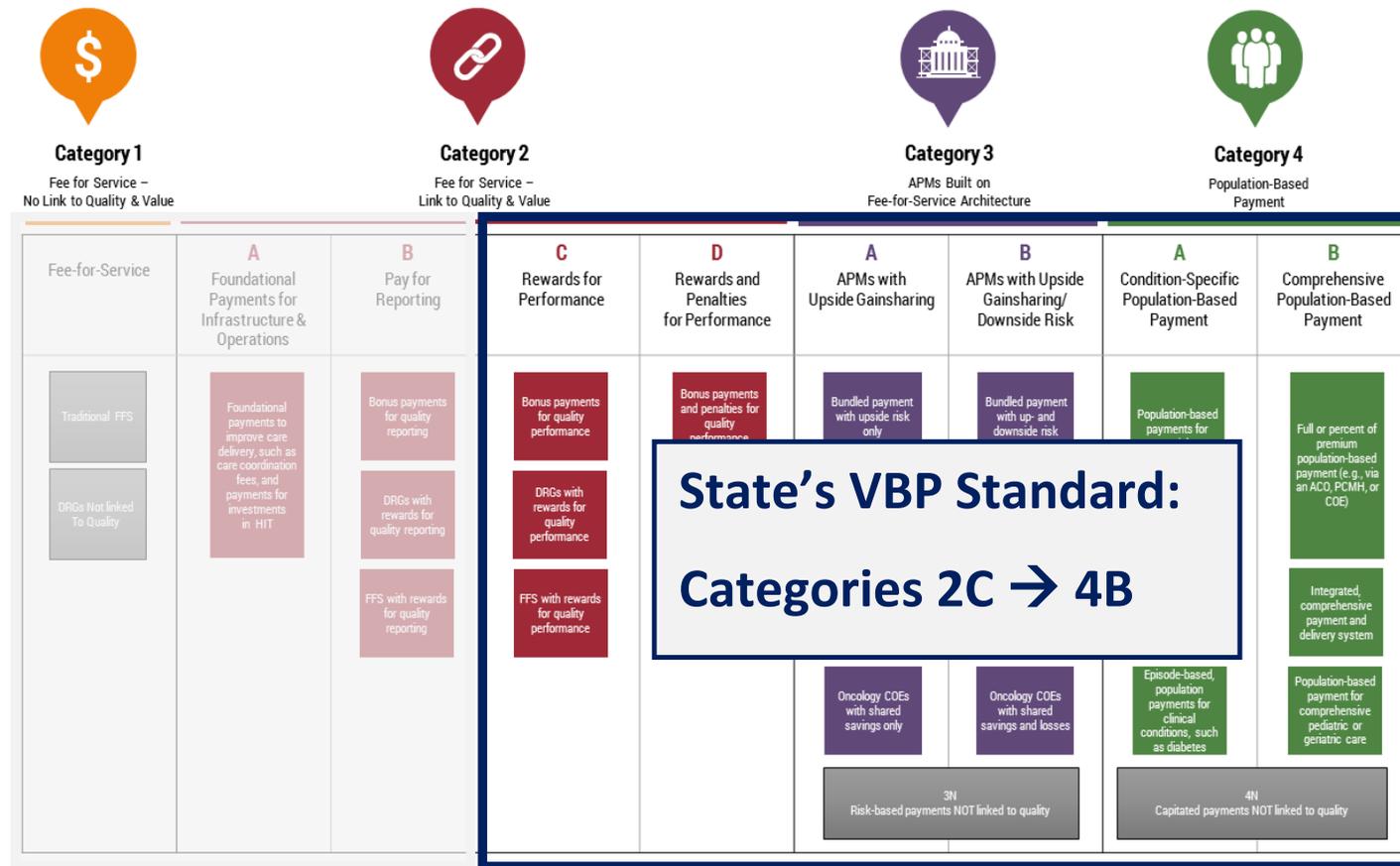


# Tying survey data to accountability

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- ▶ The MCO and provider surveys generate data for a number of accountability metrics relating to VBP attainment:
  - ▶ MCO survey:
    - Medicaid managed care capitation withhold
    - Determines the MCO's earn-back of the VBP portion of the withhold
  - ▶ Medicaid Transformation project
    - Determines the state's earned Delivery System Reform Incentive Payment (DSRIP) funding from the amount of at-risk funds (statewide accountability)
    - Determines earned DSRIP VBP incentives for MCOs and ACHs
  - ▶ Provider survey:
    - Some ACHs provide incentives to organizations that complete the survey

# Refresher: CMS APM framework



■ example payment models will not count toward APM goal. N = payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

**State's VBP Standard:  
Categories 2C → 4B**

# Survey templates – health plans

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## ▶ Quantitative section

- ▶ Statewide payments to providers by APM category
  - MCOs reported by ACH region
- ▶ Statewide covered lives by APM category
  - MCOs reported by ACH region
- ▶ Qualitative section (non-MCO survey only)
  - Rank top five barriers and enablers
  - Quality measurement
  - Shifting traditional organizational functions

# Survey templates – MCOs

Medicaid Total Assessed Payments by APM Category														
Category			Region: Accountable Communities of Health											
APM Category	APM Sub-category	Strategy	Better Health Together	Cascade	Greater Columbia	King	North Central	North Sound	Olympic	Pierce	SW Washington			
1 FFS - No Link to Quality	1	Fee-for-Service												
2 FFS - Link to Quality	2A	Foundational Payments for Infrastructure & Operations	Medicaid Total Statewide Covered Lives by APM Category											
	2B	Pay for Reporting	Region: Accountable Communities of Health											
	2C	Rewards for Performance	APM Category	APM Sub-category	Strategy	Better Health Together	Cascade	Greater Columbia	King	North Central	North Sound	Olympic	Pierce	SW Washington
	2D	Rewards and Penalties for Performance	1 FFS - No Link to Quality	1	Fee-for-Service									
3 APMs built on FFS Architecture	3A	APMs with Upside Gainsharing												
	3B	APMs with Upside Gainsharing and Downside Risk												
4 Population-Based Payment	4A	Condition-Specific Population-Based Payment												
	4B	Comprehensive Population-Based Payment												
Total Annual Pay			3 APMs built on FFS Architecture	3A	APMs with Upside Gainsharing									
			3B	APMs with Upside Gainsharing and Downside Risk										
			4 Population-Based Payment	4A	Condition-Specific Population-Based Payment									
			4B	Comprehensive Population-Based Payment										

# Survey templates – health plans

**Table 1: Total Annual Statewide Payments by APM Category (2017)**

APM Category	APM Subcategory	Strategy	Sector			
			Medicare	Individual Market	Small Group	Large Group
1 FFS - No Link to Quality	1	Fee-for-Service	\$ -	\$ -	\$ -	\$ -
2 FFS - Link to Quality	2A	Foundational Payments for Infrastructure & Operations	\$ -	\$ -	\$ -	\$ -
	2B	Pay for Reporting	\$ -	\$ -	\$ -	\$ -
	2C	Rewards for Performance	\$ -	\$ -	\$ -	\$ -
	2D	Rewards and Penalties for Performance	\$ -	\$ -	\$ -	\$ -
3 APMs built on FFS Architecture	3A	APMs with Upside Gainsharing	\$ -	\$ -	\$ -	\$ -
	3B	APMs with Upside Gainsharing and Downside Risk	\$ -	\$ -	\$ -	\$ -
4 Population-Based Payment	4A	Condition-Specific Population-Based Payment	\$ -	\$ -	\$ -	\$ -
	4B	Comprehensive Population-Based Payment	\$ -	\$ -	\$ -	\$ -
Total Annual Payments			\$ -	\$ -	\$ -	\$ -

For additional details on APM Categories, see HCP-LAN Alternative Payment Models (APM) Framework

**Table 2: Total Annual**

APM Subcategory	Strategy	Barriers and Enablers to VBP Adoption	
		I. Barriers	II. Enablers
1	Fee-for-Service	<p><b>I. Barriers:</b> In your organization's experience, what are the <b>TOP FIVE BARRIERS</b> to the adoption of VBP arrangements?</p> <p>Lack of interoperable data systems</p>	<p><b>II. Quality Measurement</b></p> <p><b>A) Alignment of Quality Measures Used to Assess Provider Performance in Current VBP Contracts</b> (Select most appropriate response in drop down and provide any additional information in area to right)</p> <p>1. Contracts. Does your organization use the same set(s) of quality measures (e.g., HEDIS measures, Statewide Common Measure Set, organization-specific measures) across provider contracts? If so, please provide information on the extent of alignment across contracts and what types of measures are used, if applicable.</p> <p>2. State. Has your organization made any effort to align quality measures used in VBP contracts with those used by the State (Health Care Authority)? If so, please provide information on the extent of alignment.</p> <p>3. Other Entities. Has your organization made any effort to align quality measures used in VBP contracts with those used by any other entities or payment initiatives (e.g., other payers, specific projects or initiatives)? If so, please provide information on the extent and nature of alignment.</p>
2A	Foundational Infrastructure	<p><b>B) Addressing health disparities is critical to improving health equity. Does your organization collect the following data on your members?</b></p> <p>Race</p>	<p><b>III. Traditional organization Functions</b></p> <p><b>A) Under certain VBP arrangements, organizations may shift traditionally organization-based functions onto contracted providers. Which of the following roles are your providers with VBP contracts performing, in all or in part? (Note: This refers to shared functionality rather than formal delegation.)</b> (Select "X" for each that applies and provide any additional information in area to right, if applicable)</p> <p>Care coordination</p> <p>Utilization management</p> <p>Provider network management</p> <p>Provider payments</p> <p>Quality management</p> <p>Other:</p>
2B	Pay for Reporting		
2C	Rewards for Performance		
2D	Rewards and Penalties for Performance		
3A	APM with Upside Gainsharing		
3B	APM with Upside Gainsharing and Downside Risk		
4A	Condition-Specific Population-Based Payment		
4B	Comprehensive Population-Based Payment		

For additional details on APM Categories, see HCP-LAN Alternative Payment Models (APM) Framework

# Survey templates – providers

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## ▶ Provider info:

- ▶ Name
- ▶ Type
- ▶ Size
- ▶ Service location

## ▶ Quantitative and qualitative:

- ▶ Revenue (total and percent VBP by APM Category)
- ▶ Rated experience with VBP
- ▶ Enablers/barriers
- ▶ Projected future participation in VBP

# Survey distribution

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## ▶ Health plan surveys:

- ▶ Direct outreach from HCA leadership
- ▶ MCO data submitted as a contract requirement (required of PEBB and SEBB plans, beginning in 2020)
- ▶ GovDelivery announcement (an email distribution list, with approximately 3,800 recipients)

## ▶ Provider survey:

- ▶ Direct outreach from HCA leadership
- ▶ Direct outreach from ACH executive directors
- ▶ GovDelivery announcement (an email distribution list, with approximately 3,800 recipients)

# Health plan survey

# Health plan survey respondents

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## ▶ MCOs (n=5):

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

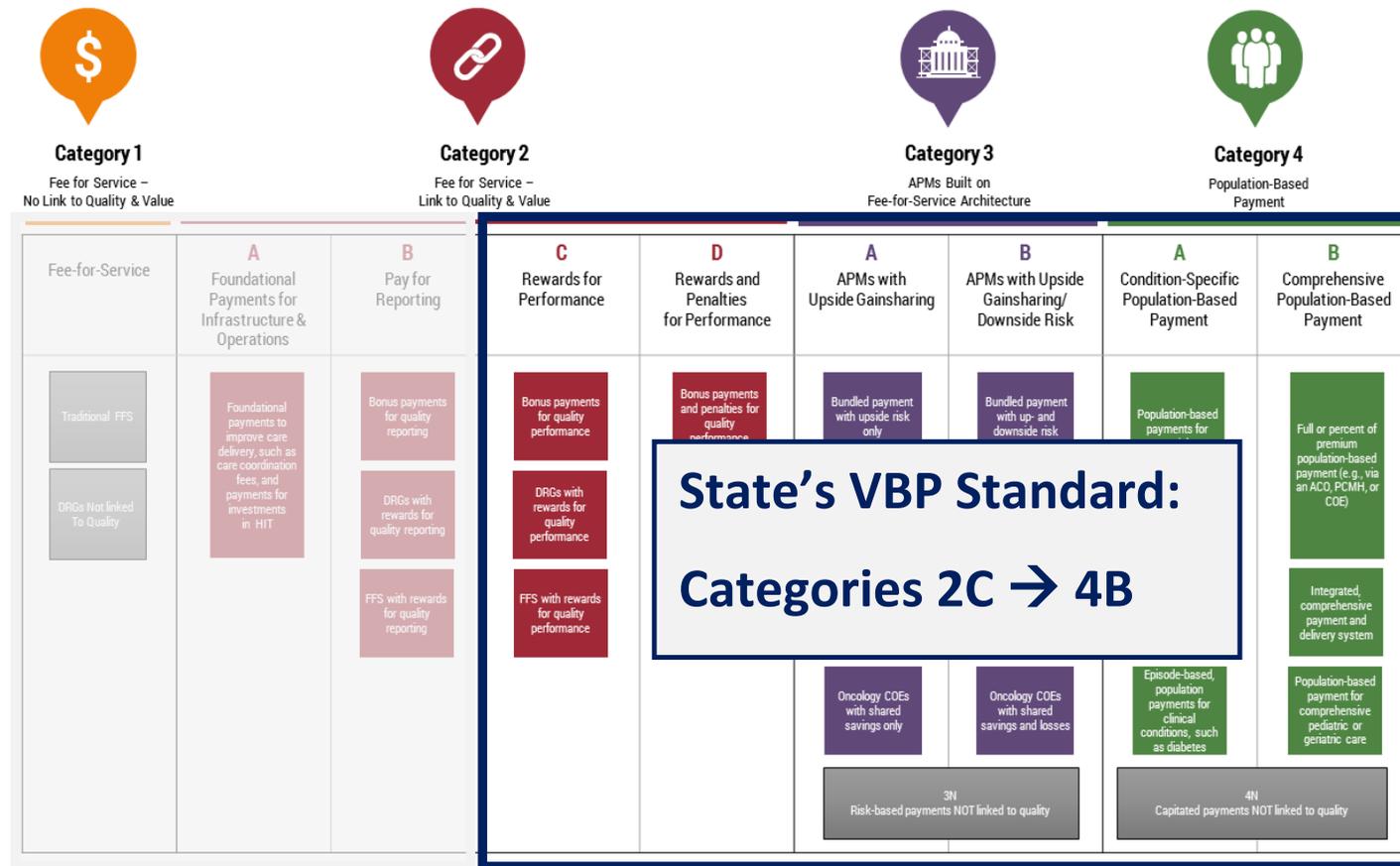
## ▶ Medicare and commercial health plans (n=11):

- ▶ Aetna
- ▶ Amerigroup\*
- ▶ Community Health Plan of Washington\*
- ▶ Coordinated Care\*
- ▶ Humana
- ▶ Kaiser Permanente Northwest\*
- ▶ Kaiser Permanente Washington\*
- ▶ Molina\*
- ▶ Premera\*
- ▶ Regence\*
- ▶ United Healthcare\*

\*Current HCA contractor

# Quantitative data results

# Refresher: CMS APM framework



N example payment models will not count toward APM goal. N payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

# Medicare results

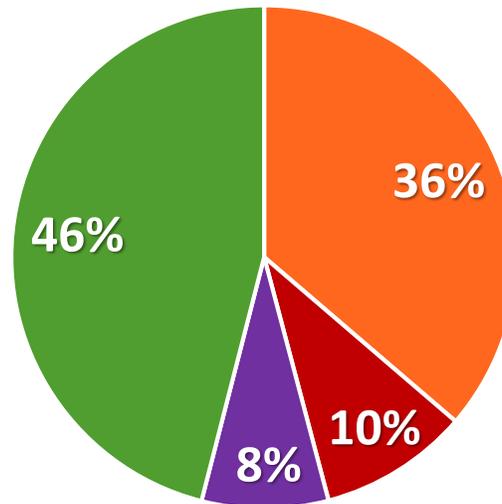
## CATEGORY 1 – 2B: FEE-FOR-SERVICE - NO LINK TO QUALITY

1 Fee-for-service	2A Foundational Payments for Infrastructure & Operation	2B Pay-for-Reporting
36%	0%	0%

## CATEGORY 2C – 2D: FEE-FOR-SERVICE - LINK TO QUALITY

2C Pay-for-Performance	2D Rewards and Penalties for Performance
10%	0%

## Medicare Advantage



■ 1-2B ■ 2C-2D ■ 3A-3B ■ 4A-4B

\$3,863,832,889  
n=10

## CATEGORY 3A – 3B: APMs BUILT ON FFS ARCHITECTURE

3A APMs with upside gainsharing	3B APMs with upside gainsharing and downside risk
8%	0%

## CATEGORY 4A – 4B: POPULATION-BASED PAYMENT

4A Condition-specific population-based payment	4B Comprehensive population-based payment
46%	0%

# Commercial results

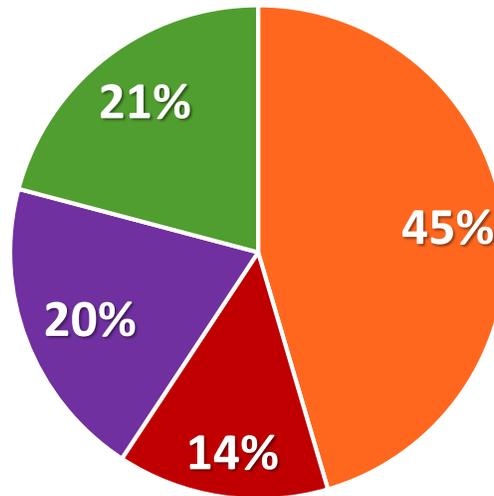
## CATEGORY 1 – 2B: FEE-FOR-SERVICE - NO LINK TO QUALITY

1 Fee-for-service	2A Foundational Payments for Infrastructure & Operation	2B Pay-for-Reporting
45%	0%	0%

## CATEGORY 2C – 2D: FEE-FOR-SERVICE - LINK TO QUALITY

2C Pay-for-Performance	2D Rewards and Penalties for Performance
14%	0%

## All Commercial



■ 1-2B ■ 2C-2D ■ 3A-3B ■ 4A-4B

\$12,657,194,486  
n=7

## CATEGORY 3A – 3B: APMs BUILT ON FFS ARCHITECTURE

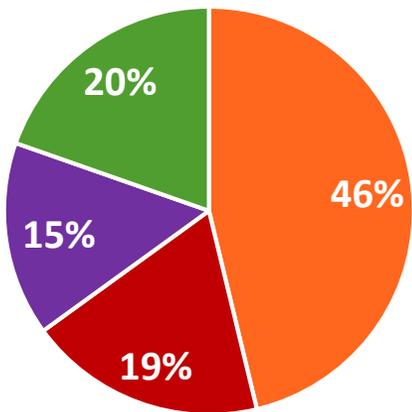
3A APMs with upside gainsharing	3B APMs with upside gainsharing and downside risk
15%	5%

## CATEGORY 4A – 4B: POPULATION-BASED PAYMENT

4A Condition-specific population-based payment	4B Comprehensive population-based payment
0%	21%

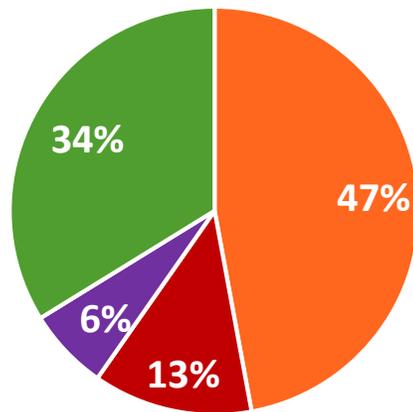
# Commercial results (cont.)

Individual Market  
- on Exchange



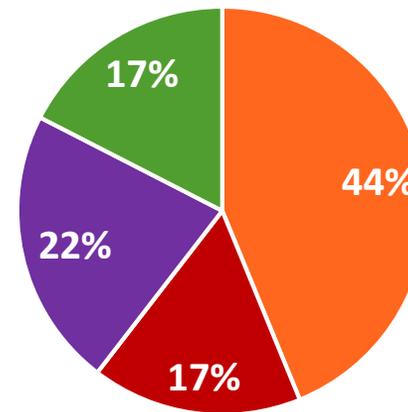
\$1,239,508,528  
n=6

Individual Market  
- off Exchange



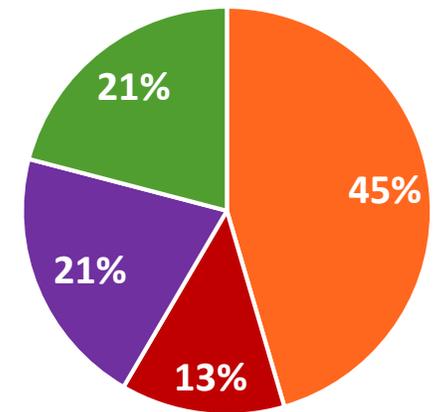
\$357,957,368  
n=2

Small Group



\$1,029,536,427  
n=4

Large Group



\$10,030,192,163  
n=5

1-2B 2C-2D 3A-3B 4A-4B

# Medicaid Managed Care results

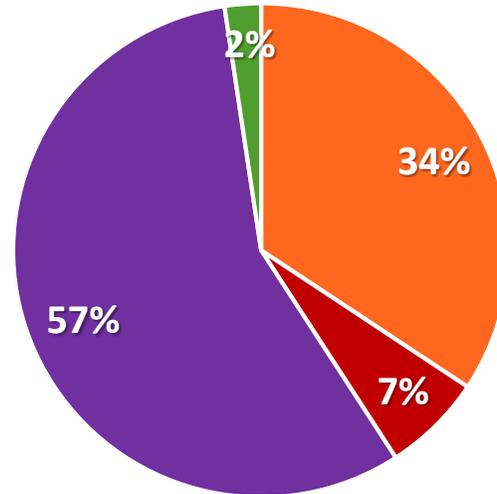
## CATEGORY 1 – 2B: FEE-FOR-SERVICE - NO LINK TO QUALITY

1 Fee-for-service	2A Foundational Payments for Infrastructure & Operation	2B Pay-for-Reporting
34%	0%	0%

## CATEGORY 2C – 2D: FEE-FOR-SERVICE - LINK TO QUALITY

2C Pay-for-Performance	2D Rewards and Penalties for Performance
6.4%	0.1%

## Medicaid Managed Care



■ 1-2B ■ 2C-2D ■ 3A-3B ■ 4A-4B

\$3,806,253,001  
n=5

## CATEGORY 3A – 3B: APMs BUILT ON FFS ARCHITECTURE

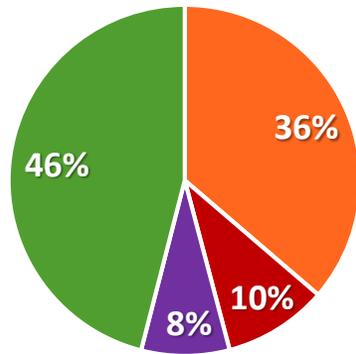
3A APMs with upside gainsharing	3B APMs with upside gainsharing and downside risk
42%	15%

## CATEGORY 4A – 4B: POPULATION-BASED PAYMENT

4A Condition-specific population-based payment	4B Comprehensive population-based payment
0%	2%

# Payments by APM Category

### Medicare Advantage



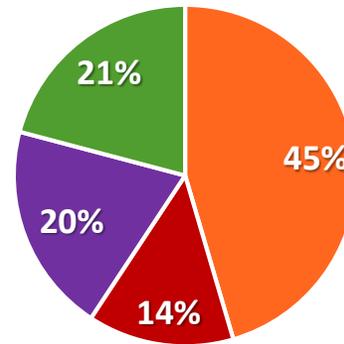
■ 1-2B ■ 2C-2D ■ 3A-3B ■ 4A-4B

n=10

Total payments = \$3.9B

VBP = \$2.50B (64%)

### All Commercial



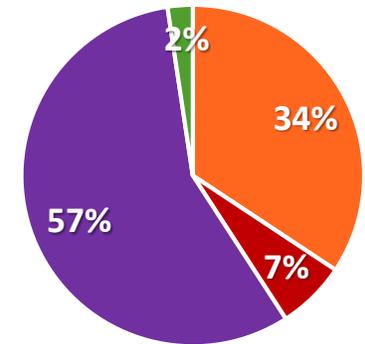
■ 1-2B ■ 2C-2D ■ 3A-3B ■ 4A-4B

n=7

Total payments = \$12.7B

VBP = \$6.9B (55%)

### Medicaid Managed Care



■ 1-2B ■ 2C-2D ■ 3A-3B ■ 4A-4B

n=5

Total payments = \$3.8B

VBP = \$2.5B (66%)

Statewide VBP = \$20.3B (58%)

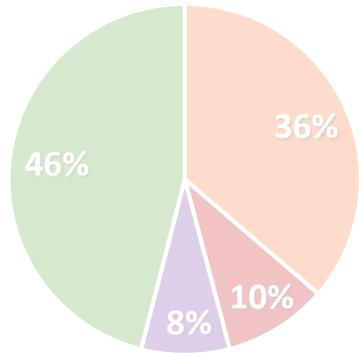
2018 survey results = 55%

2017 survey results = 37%

2016 survey results = 30%

# Payments by APM Category

## Medicare Advantage

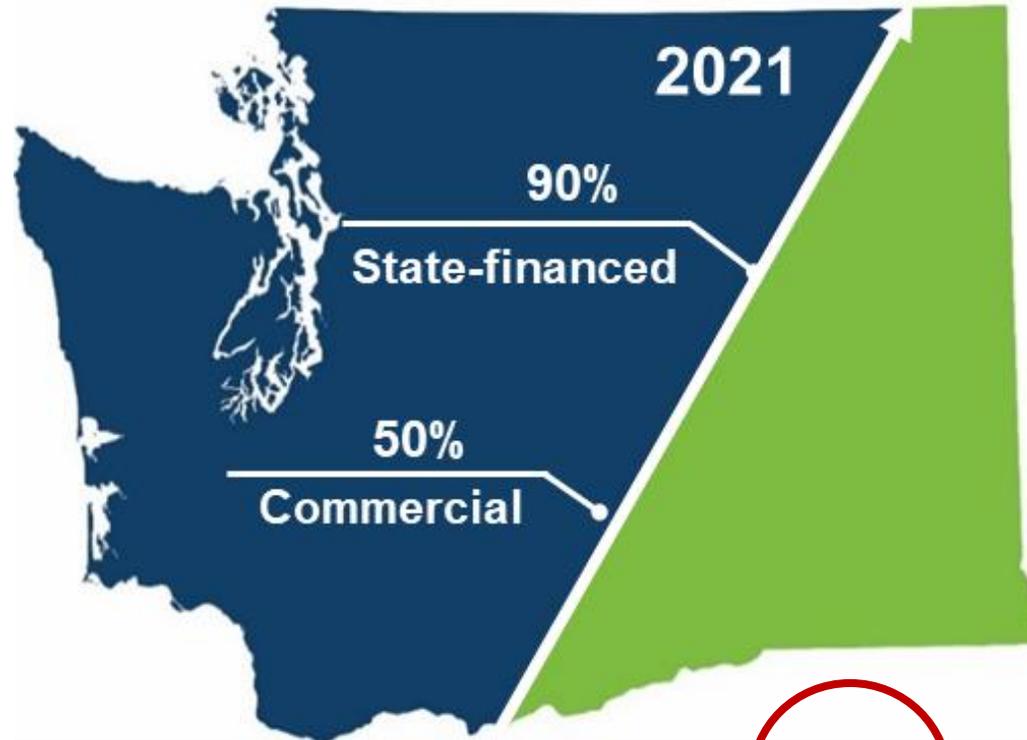


■ 1-2B ■ 2C-2D ■ 3A-3B ■ 4A-4B

n=10

Total payments = \$3.9B

VBP = \$2.50B (64%)



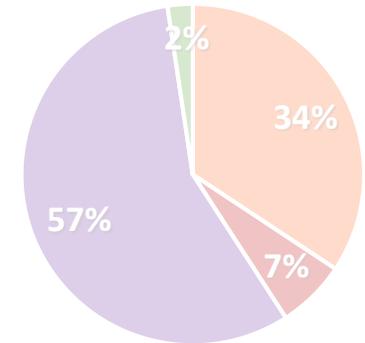
Statewide VBP = \$20.3B (58%)

2018 survey results = 55%

2017 survey results = 37%

2016 survey results = 30%

## Medicaid Managed Care



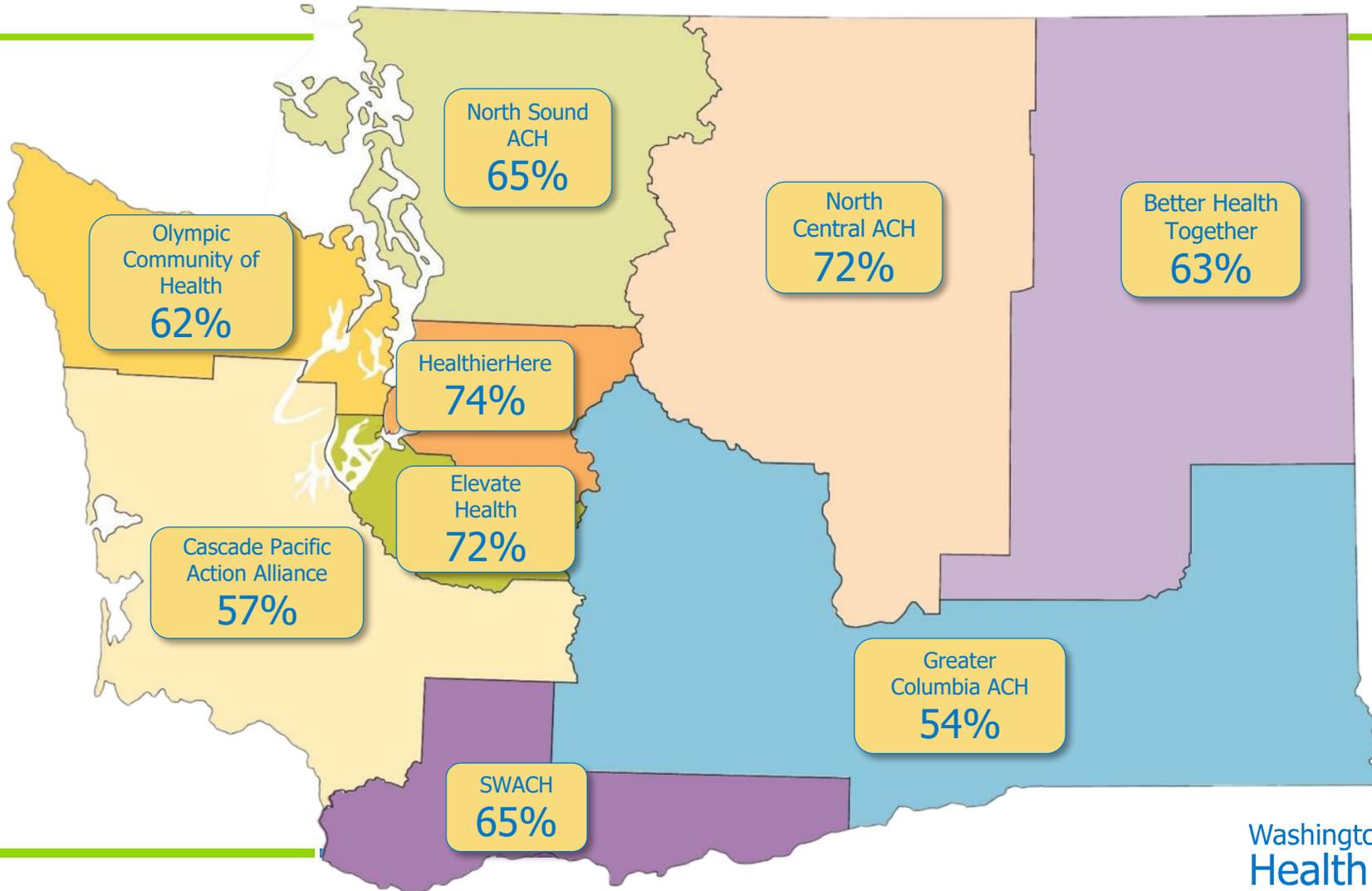
■ 1-2B ■ 2C-2D ■ 3A-3B ■ 4A-4B

n=5

Total payments = \$3.8B

VBP = \$2.5B (66%)

# MCO VBP by Accountable Community of Health



# Qualitative data results

Non-MCO health plan survey ONLY

# Health plan surveys (cont.)

## APMs and VBP

- |     |  |     |  |
|-----|--|-----|--|
| 5/6 | <ul style="list-style-type: none"><li>• Has your organization implemented any APMs with a primary care emphasis?</li></ul> | 1/6 | <ul style="list-style-type: none"><li>• Have you achieved certification for an APM as an Other Payer Advanced APM through the Quality Payment Program?</li></ul> |
| 5/6 | <ul style="list-style-type: none"><li>• Does your organization have a VBP strategic plan?</li></ul>                        | 6/6 | <ul style="list-style-type: none"><li>• Does your organization have a strategic plan to address social determinants of health (SDoH)?</li></ul>                  |
| 5/6 | <ul style="list-style-type: none"><li>• Does your organization evaluate APM success?</li></ul>                             | 6/6 | <ul style="list-style-type: none"><li>• Do you provide benefits that address SDoH?</li></ul>   |
| 2/6 | <ul style="list-style-type: none"><li>• Have you assessed the return on investment from APMs?</li></ul>                    |     |  |

**Note:** not all respondents completed this and the following sections of the health plan survey.

# Health plan surveys (cont.)

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Top enablers and barriers (from highest impact to lowest)

All payers: top four enablers
Trusted partnerships and collaboration
Aligned incentives/contract requirements
Interoperable data systems
Aligned quality measures/definitions

n=9

All payers: top four barriers
Payment model uncertainty
Disparate incentives/contract requirements
Attribution
Disparate quality measures/definitions

n=9

# Health plan surveys (cont.)

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## Quality measurement

- 7/9 { • Do you use the same set(s) of quality measures across provider contracts?
- 6/9 { • Do you adhere to the measure-specific definitions and specification for measures described in the Statewide Common Measure Set?
- 3/9 { • Do you change, tweak, or modify measure-specific definitions or specifications for measures described in the Statewide Common Measure Set?
- 4/9 { • Do you supplement measures from the Statewide Common Measure Set with additional measures in VBP contracts?
- 5/9 { • Have you made any effort to align quality measures used in VBP contracts with those used by any other entities or payment initiatives?

# Health plan surveys (cont.)

## Health equity

	# of health plans responding "Yes" to collecting the following data	# of health plans responding "Yes" to disaggregating performance by the following data
Race	6/6	3/6
Ethnicity	6/6	3/6
Language	5/6	3/6

Has your organization implemented any programs to address health disparities by race, ethnicity, or language?	# of health plans responding "Yes"
	5/7

# Health plan surveys (cont.)

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Survey question: Under certain VBP arrangements, health plans may shift traditionally payer-based functions onto contracted providers. Which of the following roles are your providers with VBP contracts currently performing—in all or in part?

**Note:** this refers to shared functionality rather than formal delegation.

Functionality	# of health plans responding "Yes"
Care coordination	6/7
Quality management	7/7
Utilization management	4/7
Provider network management	4/7
Provider payments	2/7

# Health plan surveys (cont.)

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## Regional transformation

The Medicaid Transformation project aims to leverage regional collaborative approaches to drive whole-person health and improved health system performance on cost and quality. ACHs are foundational to regional health system transformation.

	In what ways and capacities are you engaging with regional health systems transformation efforts in collaboration with ACHs?
ACH governance (e.g., Board of Directors)	3/4
ACH committee membership	4/4
ACH workgroup	4/4
Attend ACH meetings	4/4

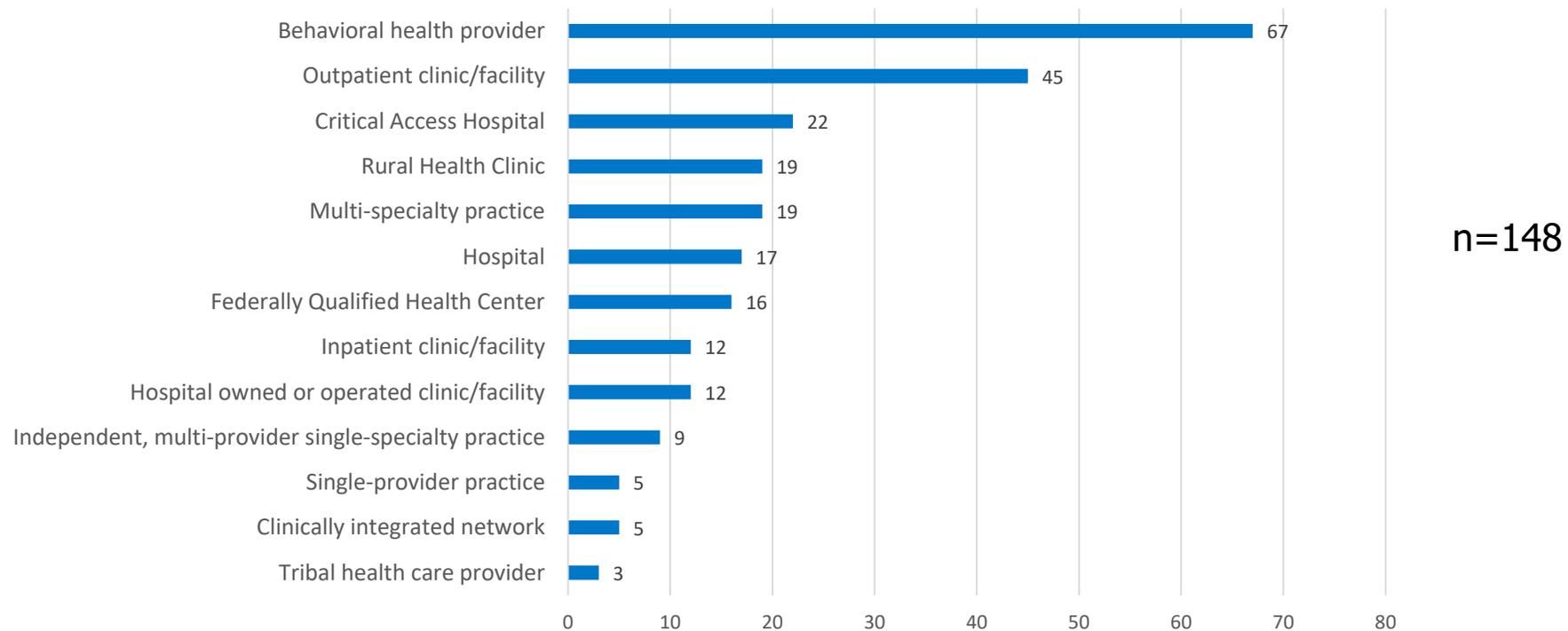
# Provider survey

2019 Paying for Value survey results

# Provider information

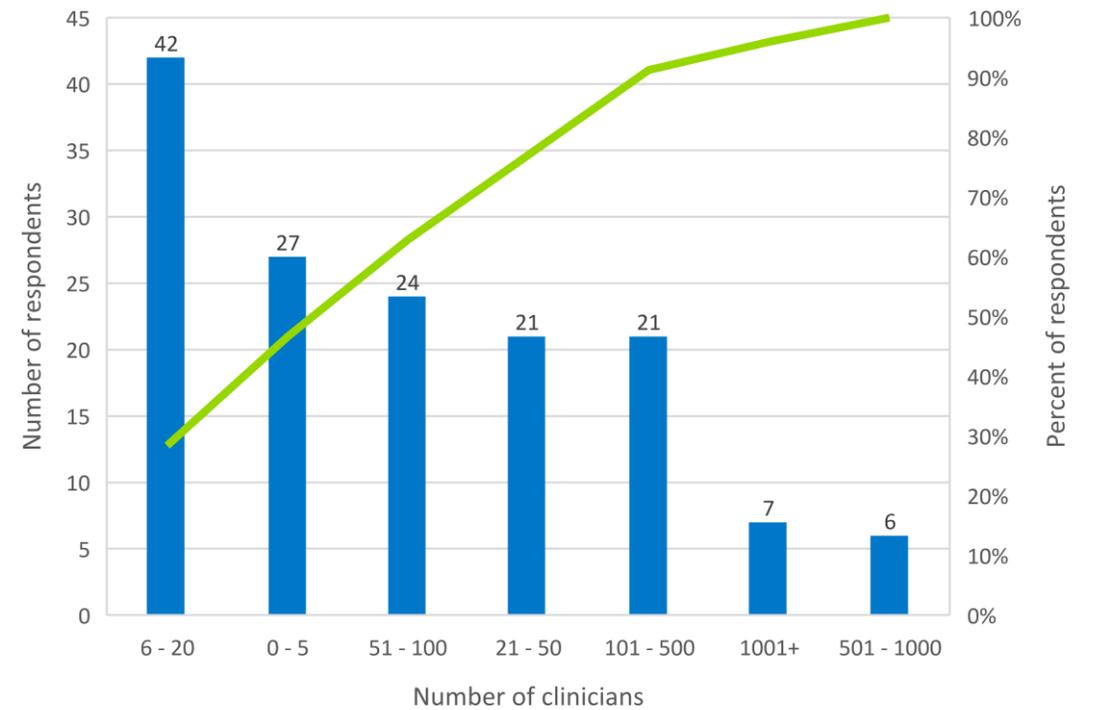
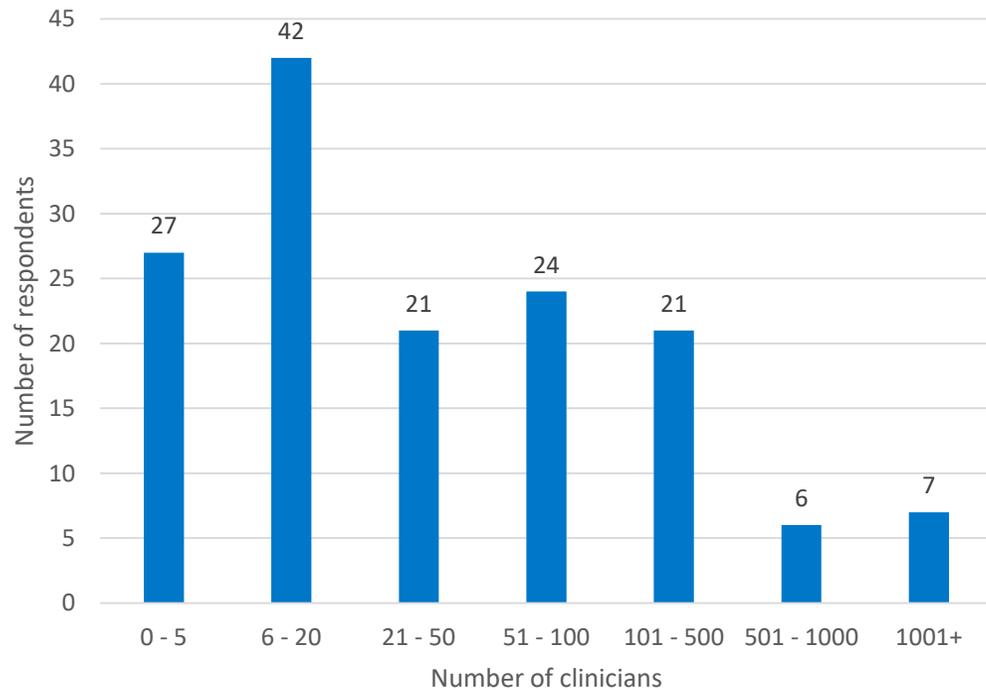
## Respondent organization type

(multiple selections per respondent possible)



# Provider information (cont.)

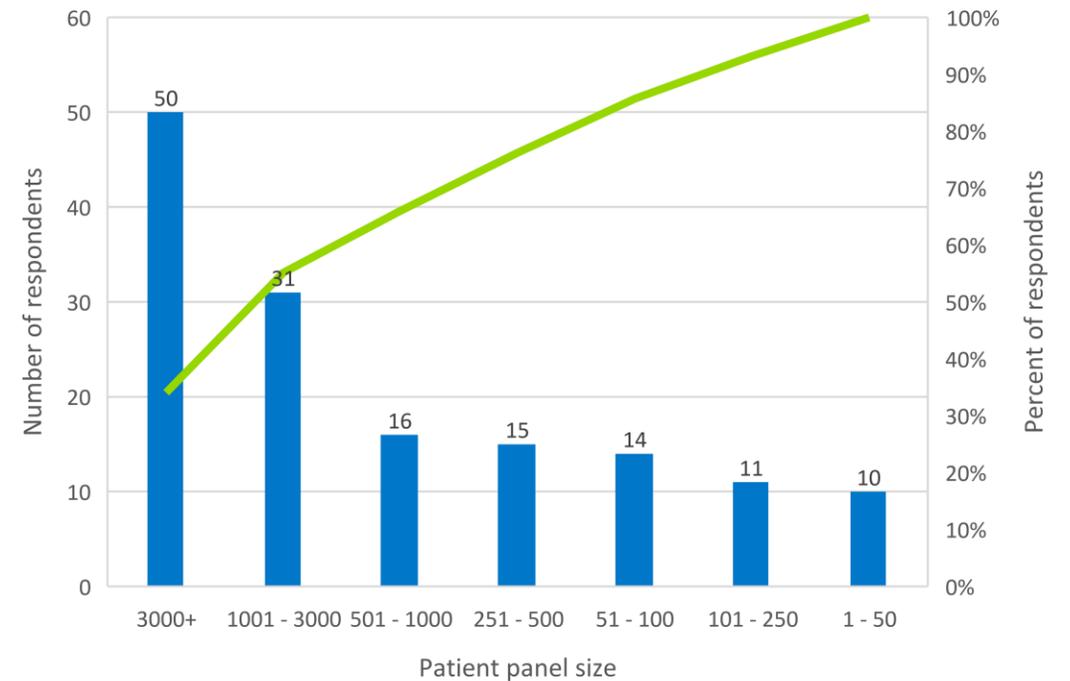
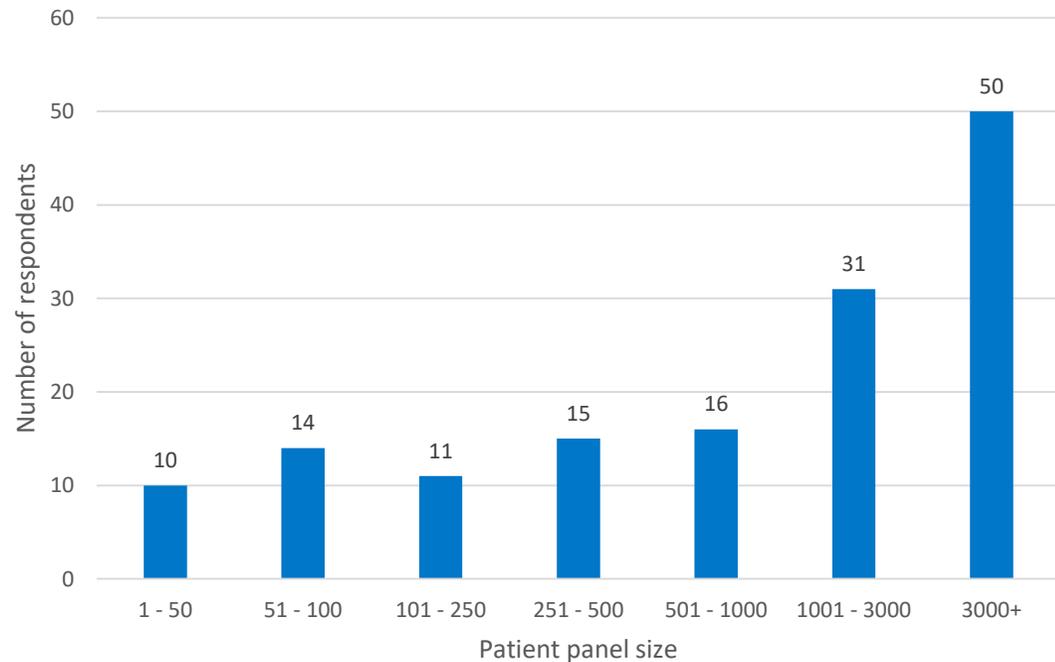
## Number of clinicians



n=148

# Provider information (cont.)

## Size of patient panel

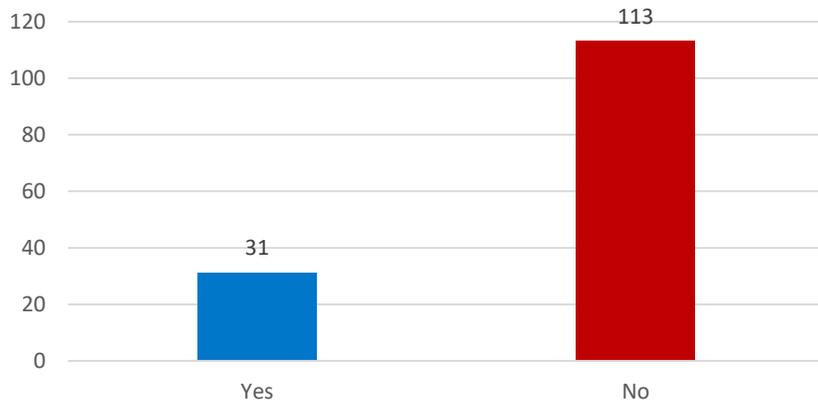


n=147

# Provider information (cont.)

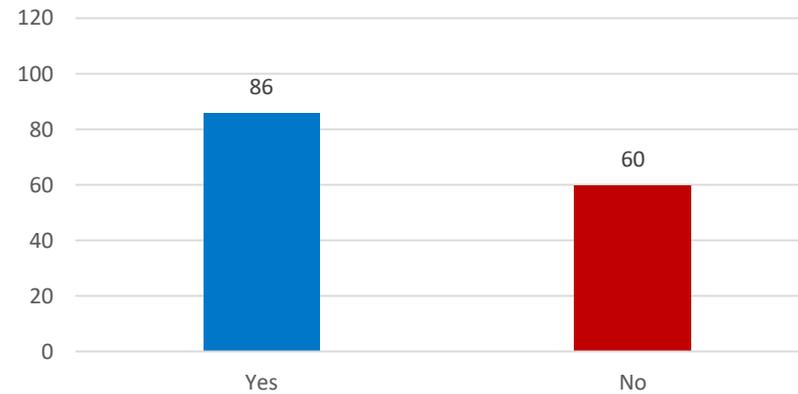
## Primary care medical home

Has your organization **achieved** Patient Centered Medical Home (PCMH) **certification?**



n=144

Does your organization **follow** a PCMH **culture?**



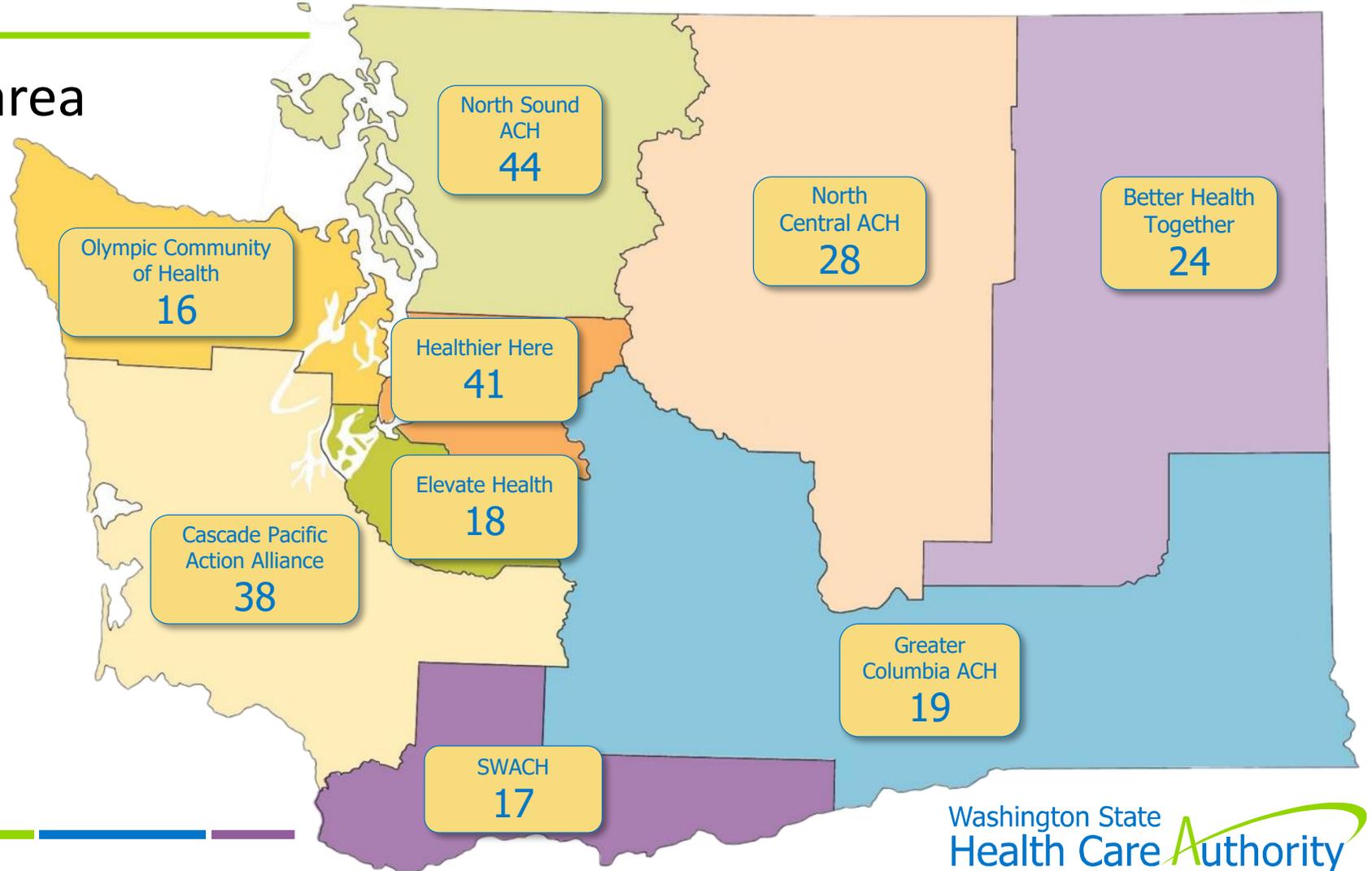
n=146

# Provider information (cont.)

## Respondent service area by ACH

(multiple regions per respondent possible)

n=148

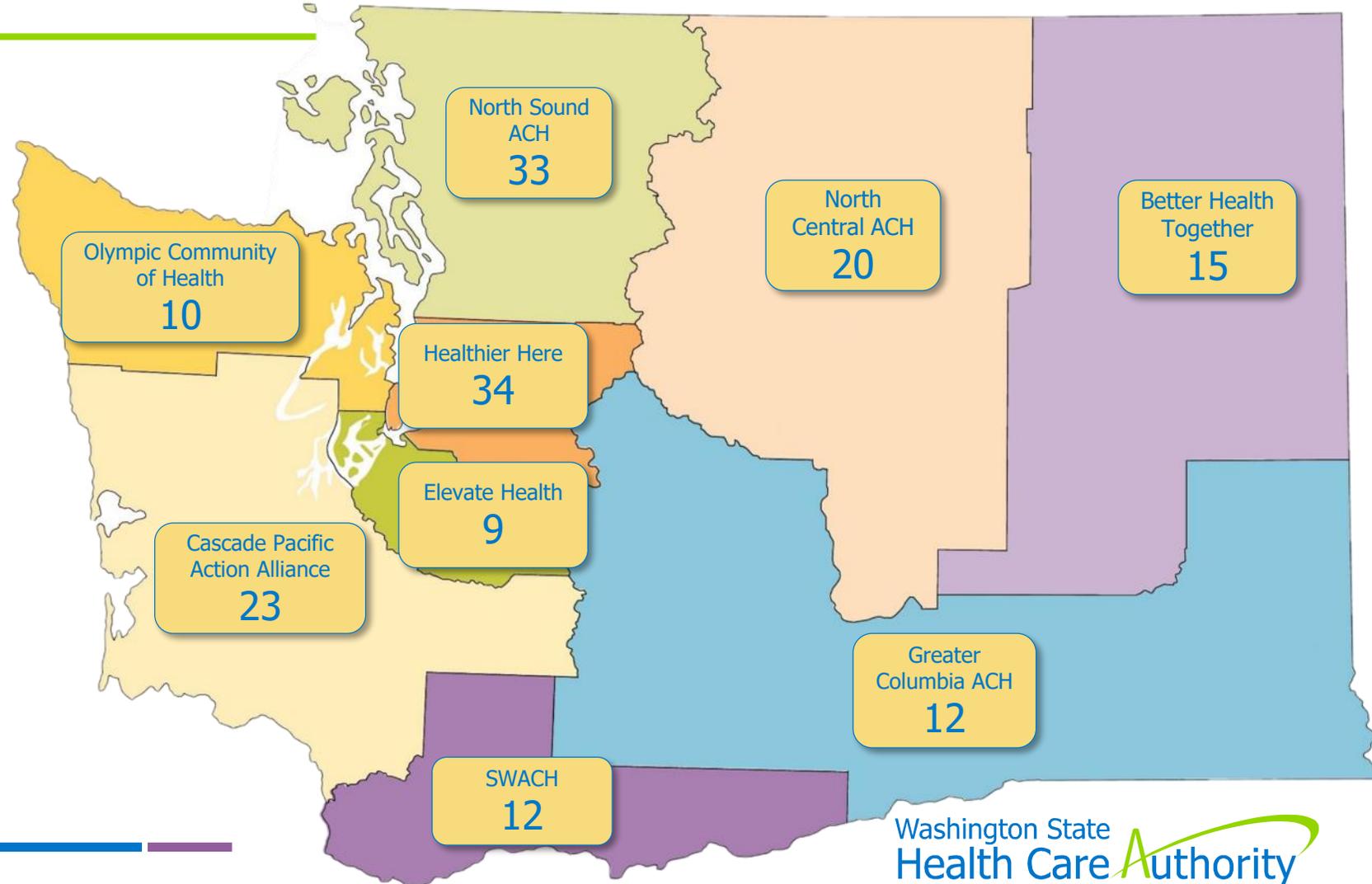


# Provider information (cont.)

## Respondents working directly with ACHs

(people involved in ACH project plans, governance structure, or regular meetings. Multiple regions per respondent possible.)

n=148

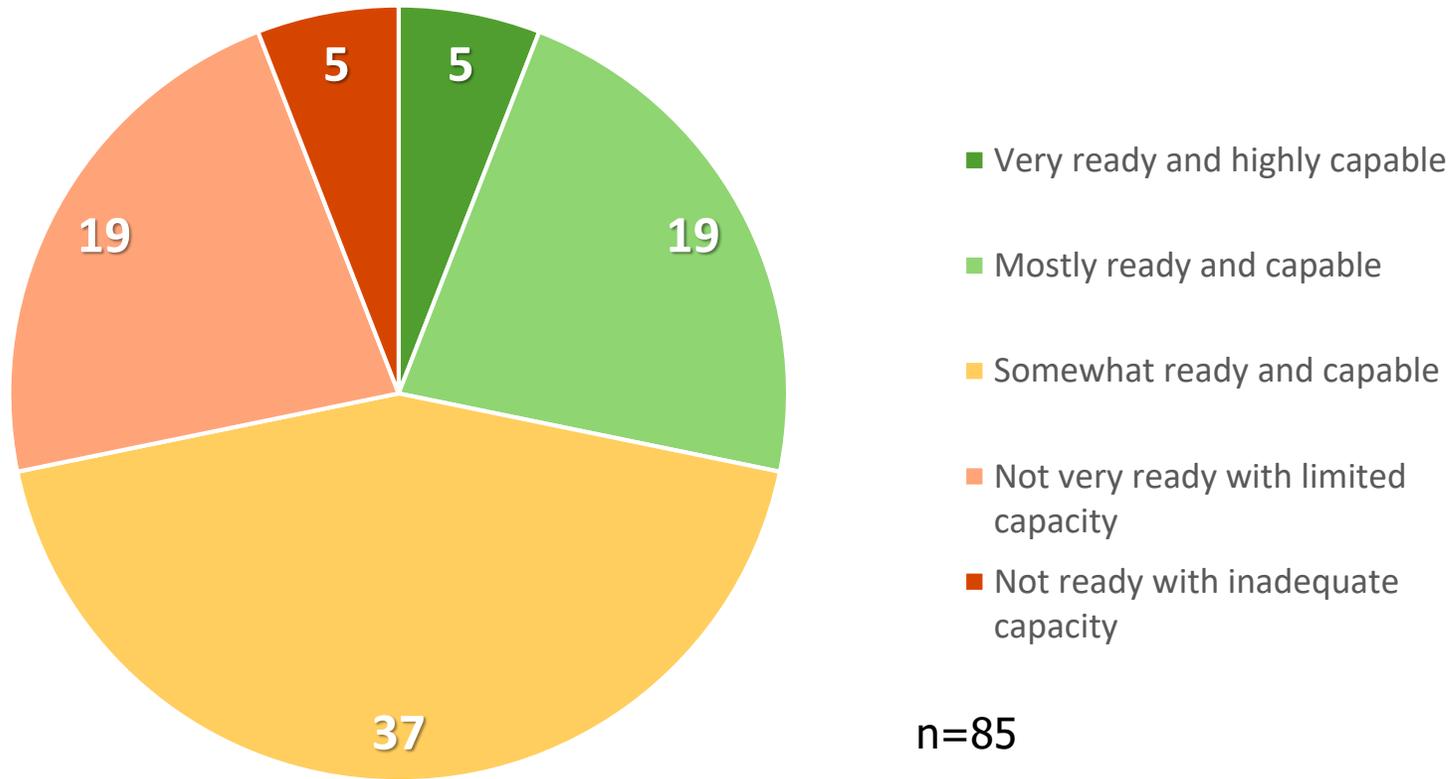


# Participation in VBP

Provider survey

# Participation in VBP

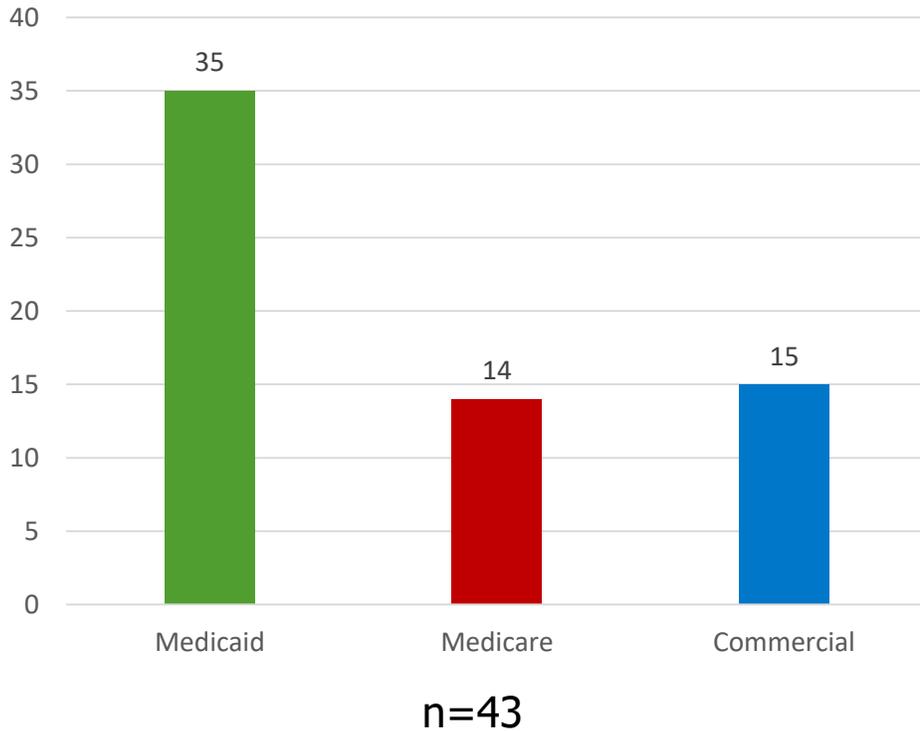
## VBP readiness and capability



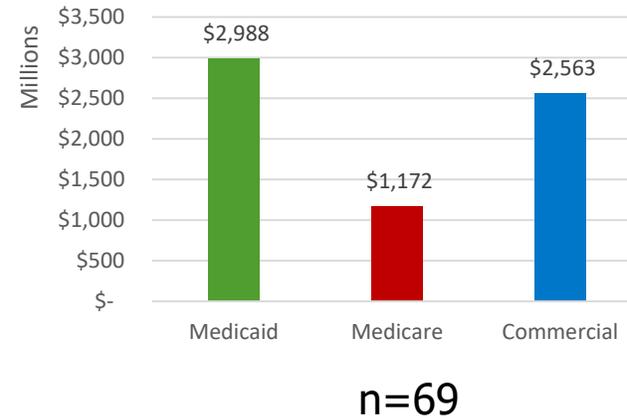
n=85

# Participation in VBP (cont.)

Respondents with any revenue in VBP categories 2C-4B by sector



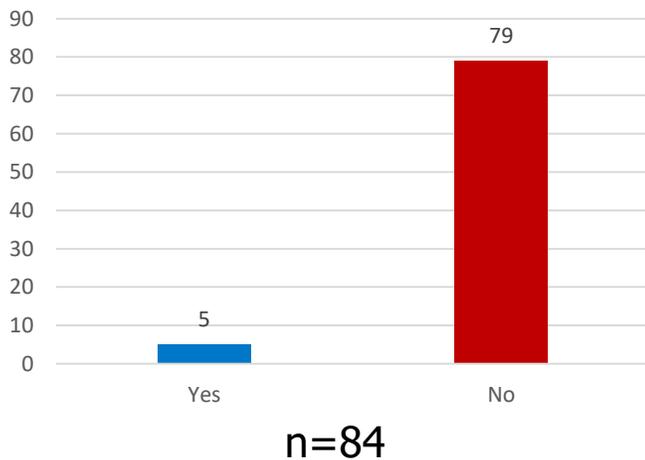
▶ Respondents' total revenue by sector



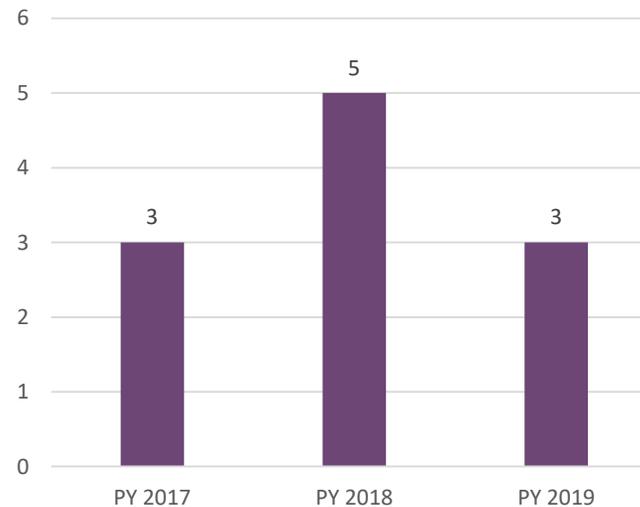
# Participation in VBP (cont.)

## CMS Quality Payment Program

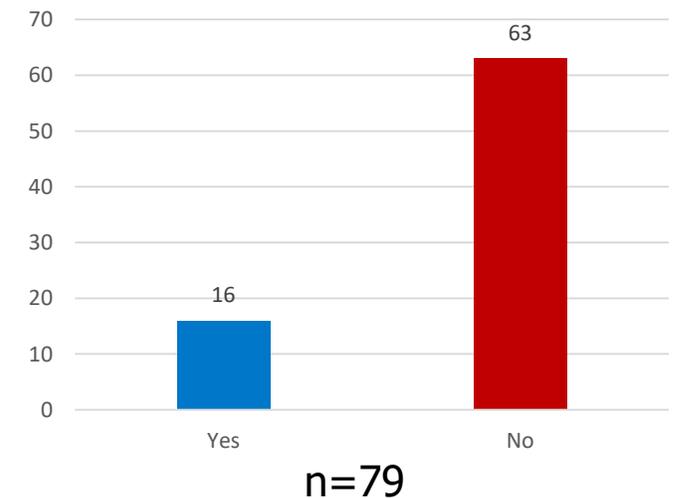
Have any of your clinicians achieved certification as a Qualifying Advanced Alternative Payment Model Participant (QP) through the CMS Quality Payment Program (QPP) for Medicare?



If you have clinicians who have achieved QP status through the QPP, for which Performance Years (PY) have they achieved it?



Do clinicians within your organization intend to apply for QP status for Advanced APMs through QPP in future QPP Performance Years?



n=7

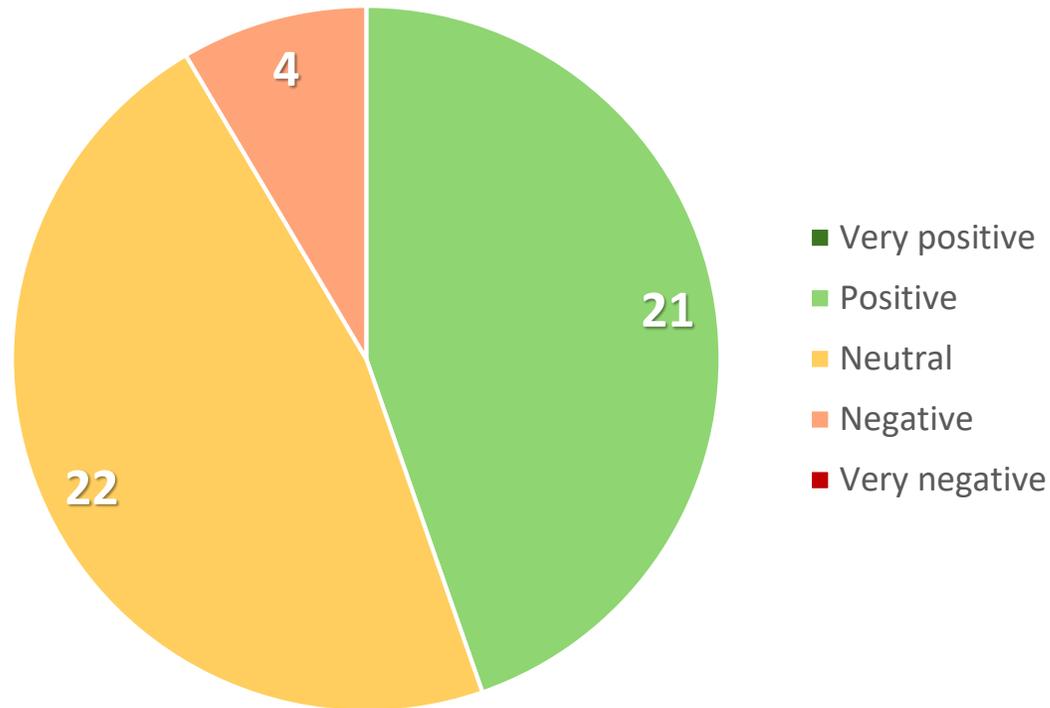
# Experience with VBP

Provider survey

# Experience with VBP

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## Organizational experience with VBP

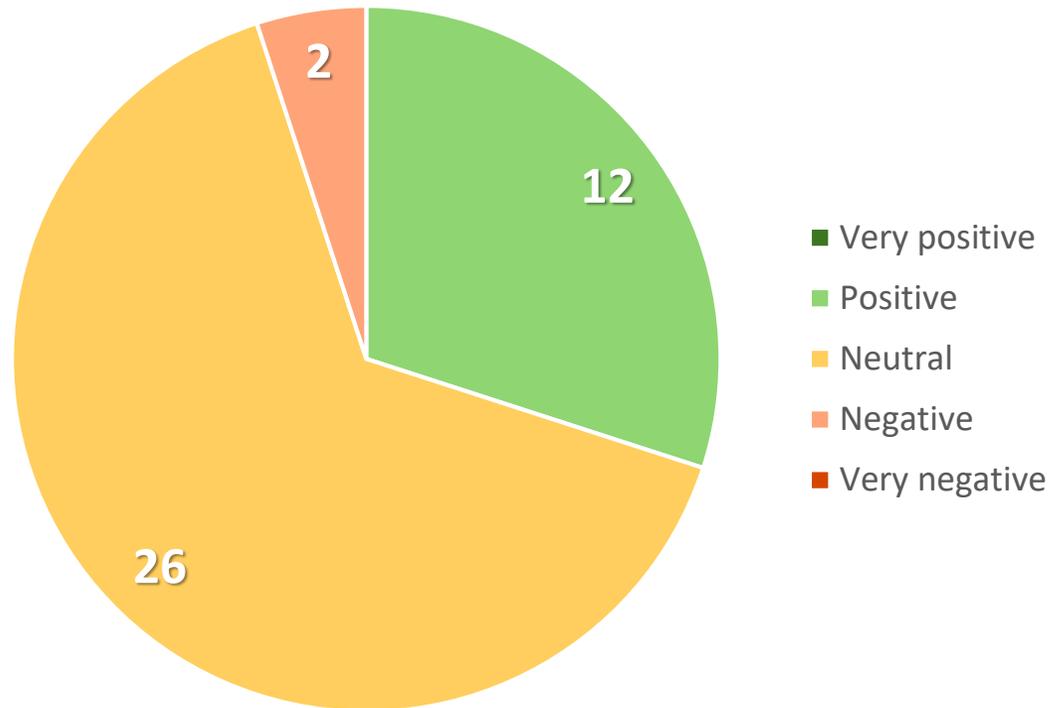


n=47

# Experience with VBP (cont.)

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## Clinicians' experience with VBP



n=50

# Experience with VBP (cont.)

## Top enablers and barriers

Top four enablers
Aligned quality measurements and definitions (23)
Trusted partnerships and collaboration with payers (21)
Development of medical home culture with engaged providers (20)
Aligned incentives and/or contract requirements (19)

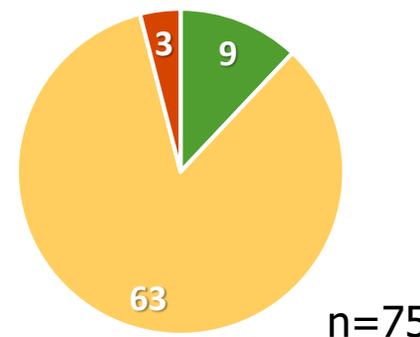
n=51

Top four barriers
Lack of timely cost data to assist with financial management (51)
Lack of access to comprehensive data on patient populations (33)
Misaligned incentives and/or contract requirements (33)
Lack of interoperable data systems (31)

n=78

*Experience relative to last year's barriers*

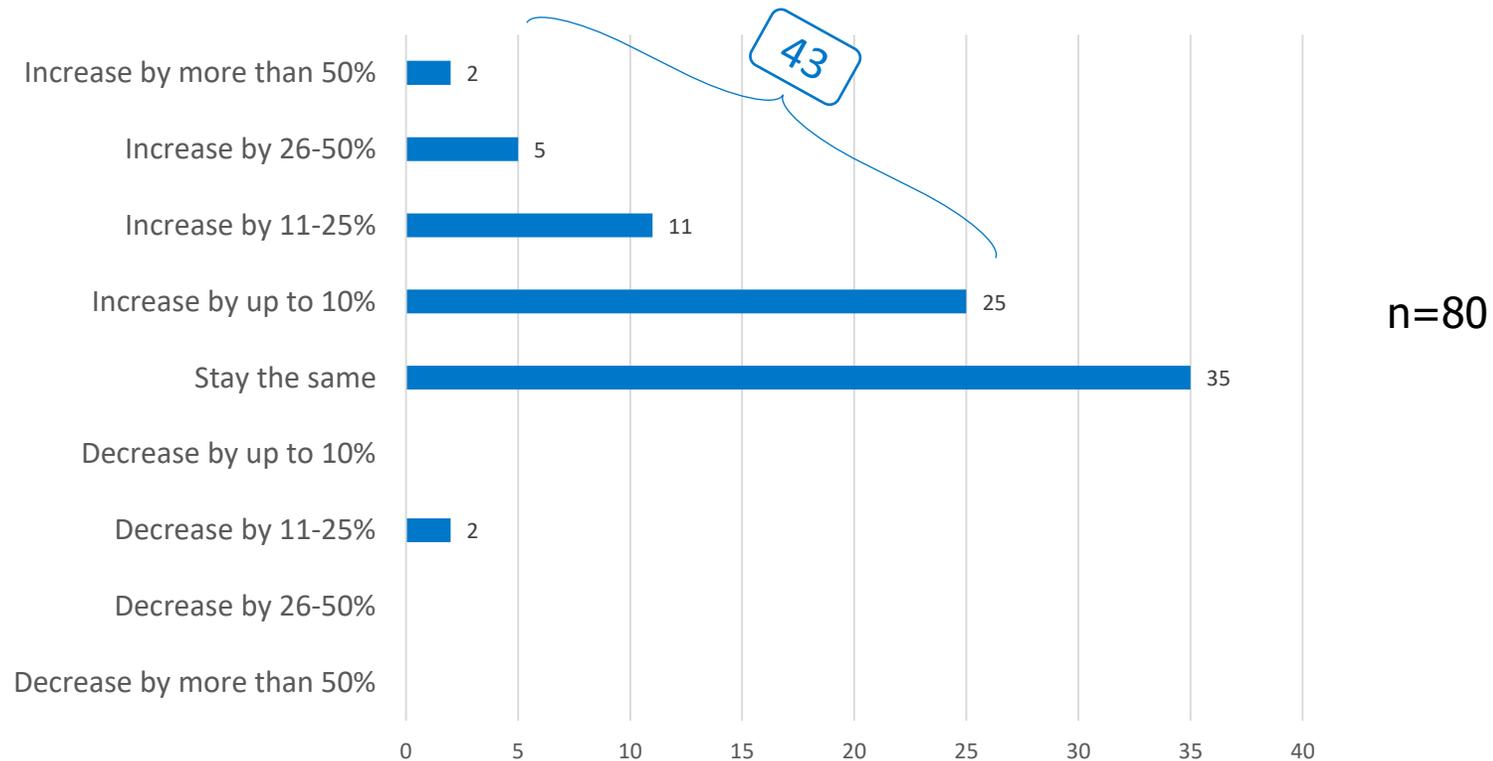
- Better
- About the same
- Worse



n=75

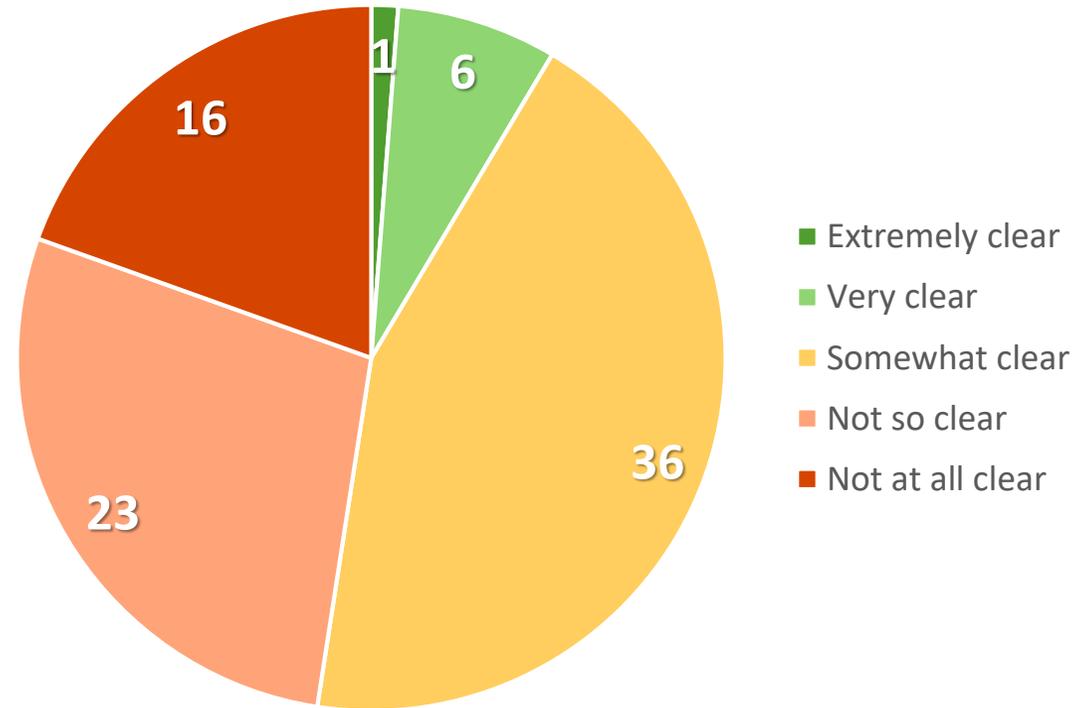
# Experience with VBP (cont.)

## Future plans for VBP over the next 12 months



# Experience with VBP (cont.)

Perceived role clarity of HCA, payers, ACHs, and providers



n=82

# Health disparities and equity

Provider survey

# Health disparities and equity

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	# of respondents selecting “Yes” to collecting the following data	# of respondents selecting “Yes” to assessing performance by the following data
Race	80	19
Ethnicity	78	20
Language	76	18

n=80

# Health disparities and equity (cont.)

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Survey question: Has your organization implemented any programs to address health disparities by race, ethnicity, or language?

"Yes"	"No, but we address other aspects of health disparities (e.g., income, housing status)"	"No"
34	32	17

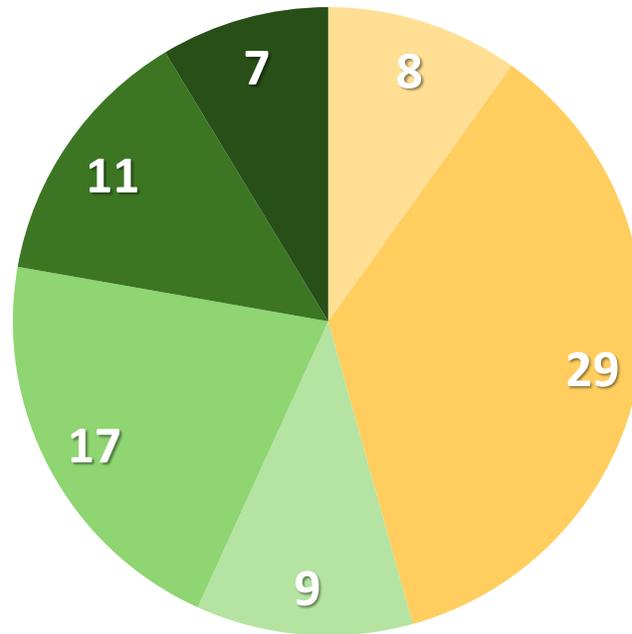
n=80

# Integration, workforce, and technical support

Provider survey

# Integration

Integration: reported level of SAMHSA's "Six Levels of Collaboration/Integration"



n=81

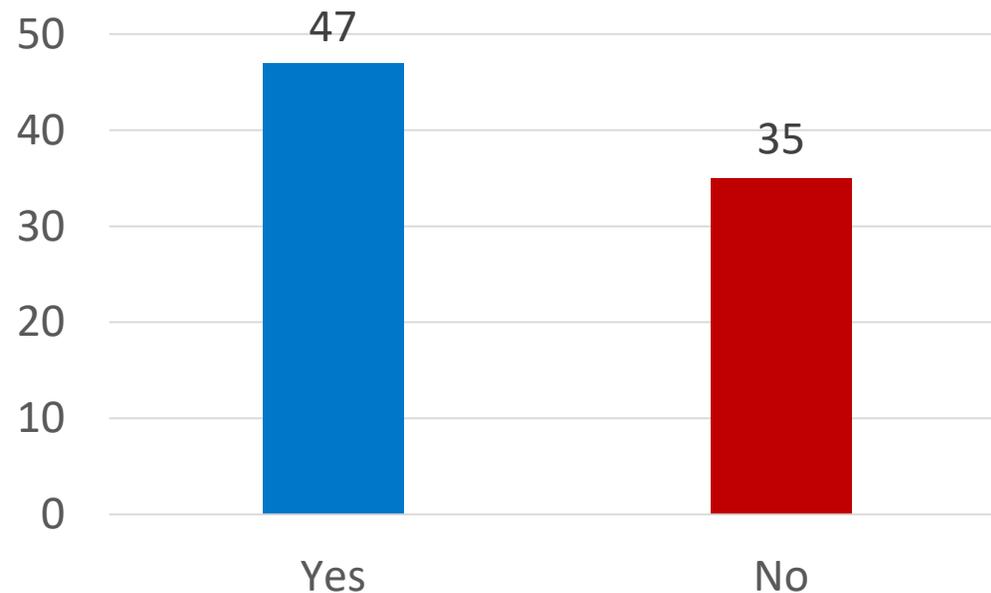
- Level 1: Minimal Collaboration
- Level 2: Basic Collaboration at a Distance
- Level 3: Basic Collaboration Onsite
- Level 4: Close Collaboration Onsite with Some System Integration
- Level 5: Close Collaboration Approaching an Integrated Practice
- Level 6: Full Collaboration in a Transformed/Merged Integrated Practice

55 providers intend to move to a higher level in the next year

# Integration (cont.)

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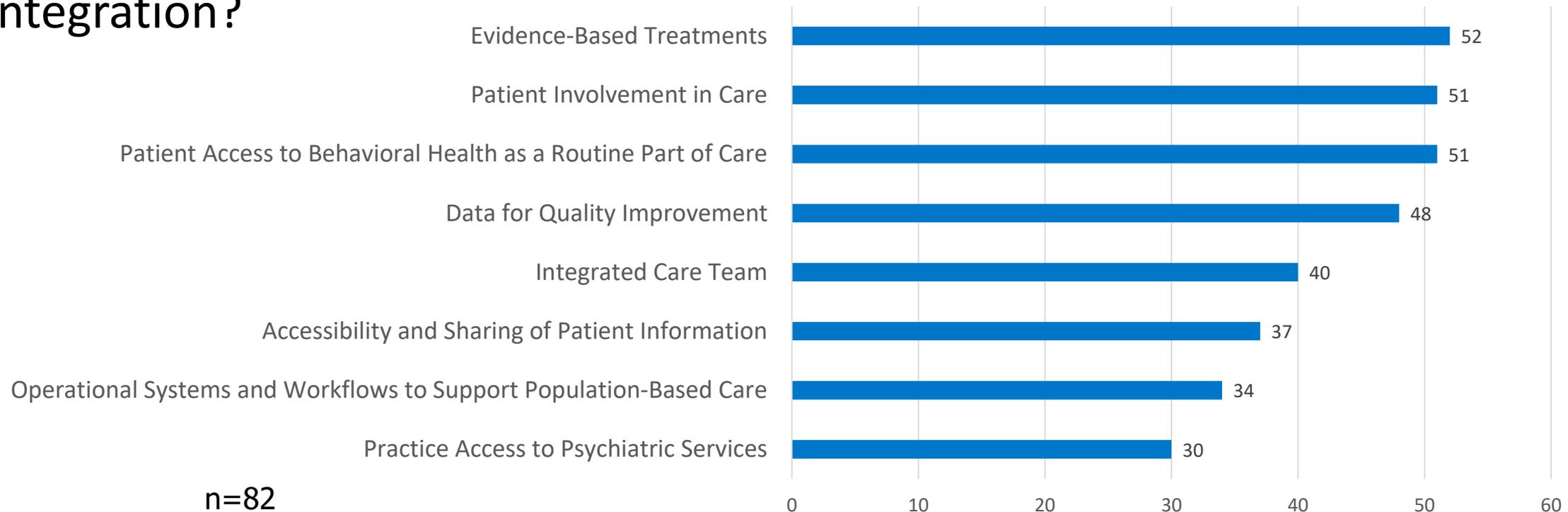
Survey question: Has your organization sought alignment with the Dr. Robert Bree Collaborative's recommendations for behavioral health integration?



n=82

# Integration (cont.)

Survey question: Has your organization sought alignment with the Dr. Robert Bree Collaborative's recommendations for behavioral health integration?

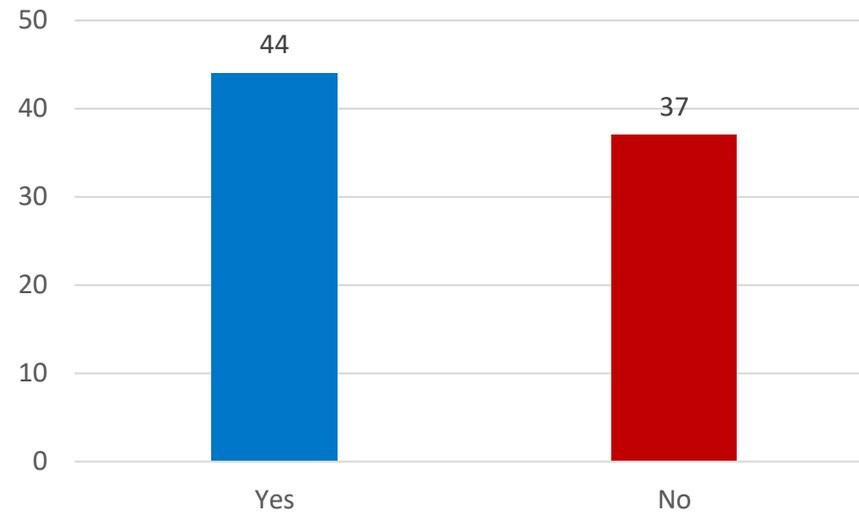


n=82

# Integration (cont.)

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Survey question: Has your organization completed the MeHAF self-assessment?

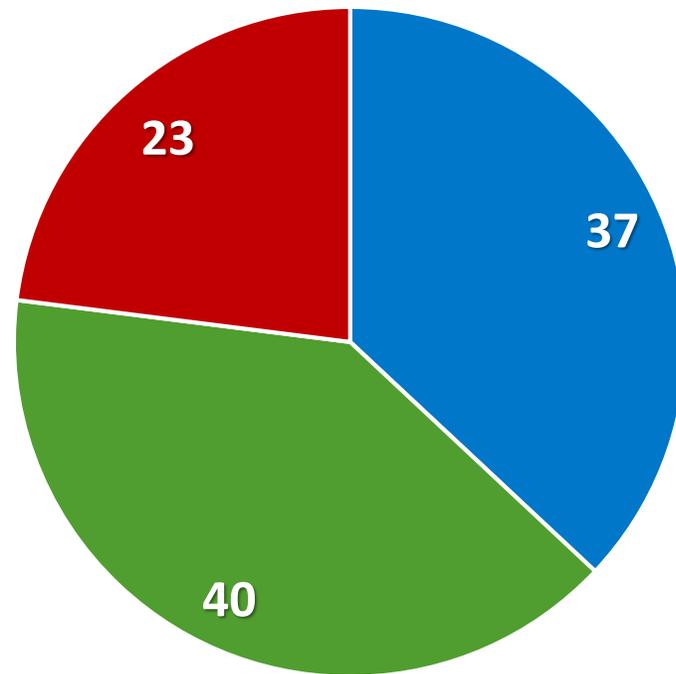


n=81

# Workforce

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Survey question: Is your organization participating in activities to prepare for team-based care and population management?

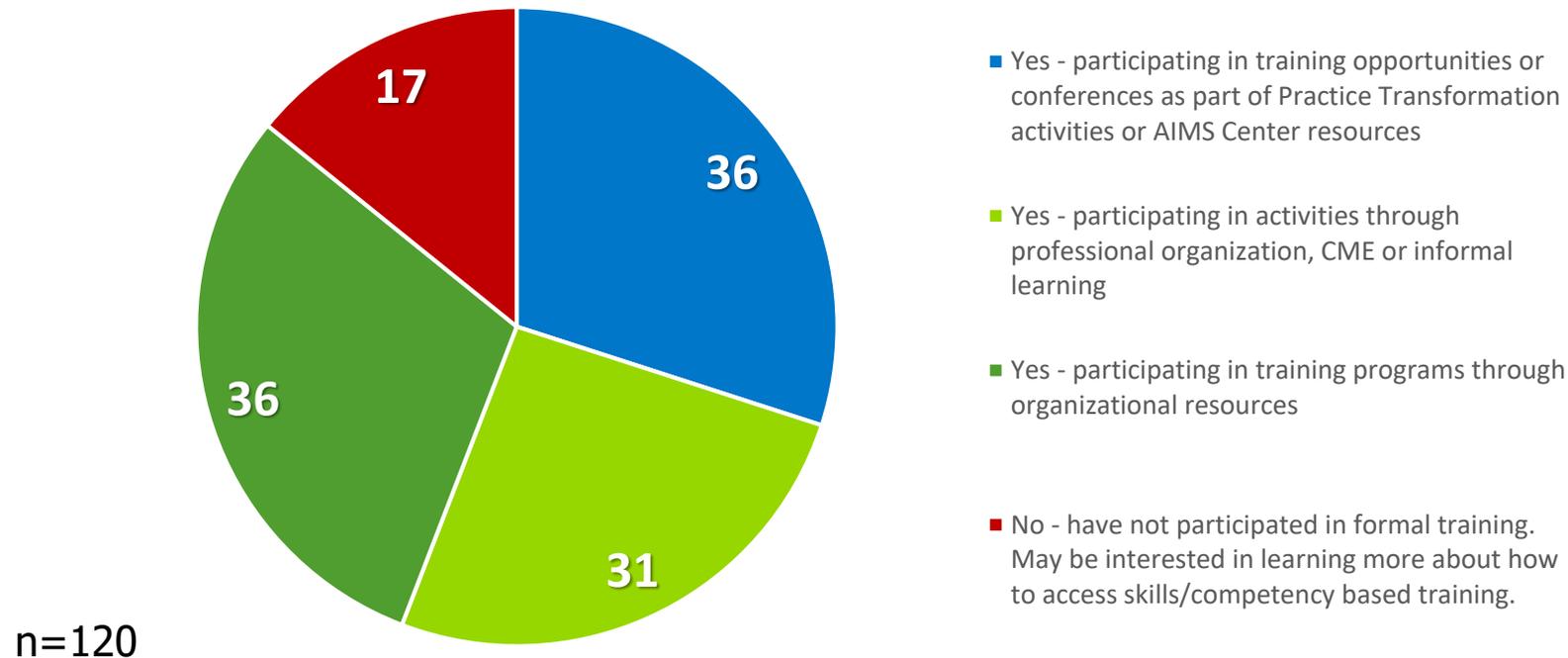


n=100

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

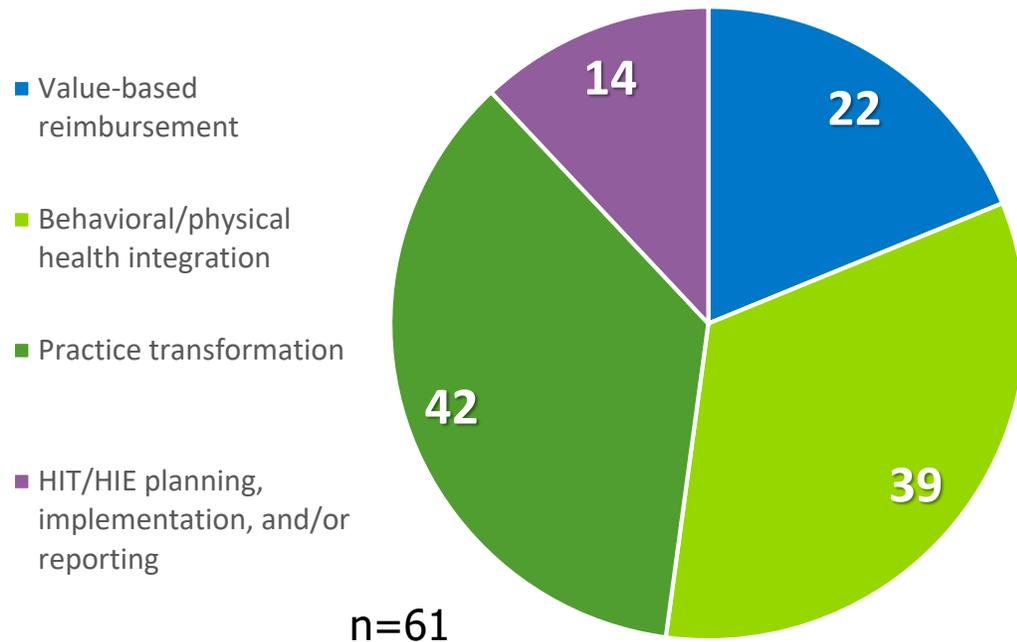
# Workforce (cont.)

Survey question: Is your organization participating in activities to support clinical training and skill/competency building for integrated physical and behavioral health care?

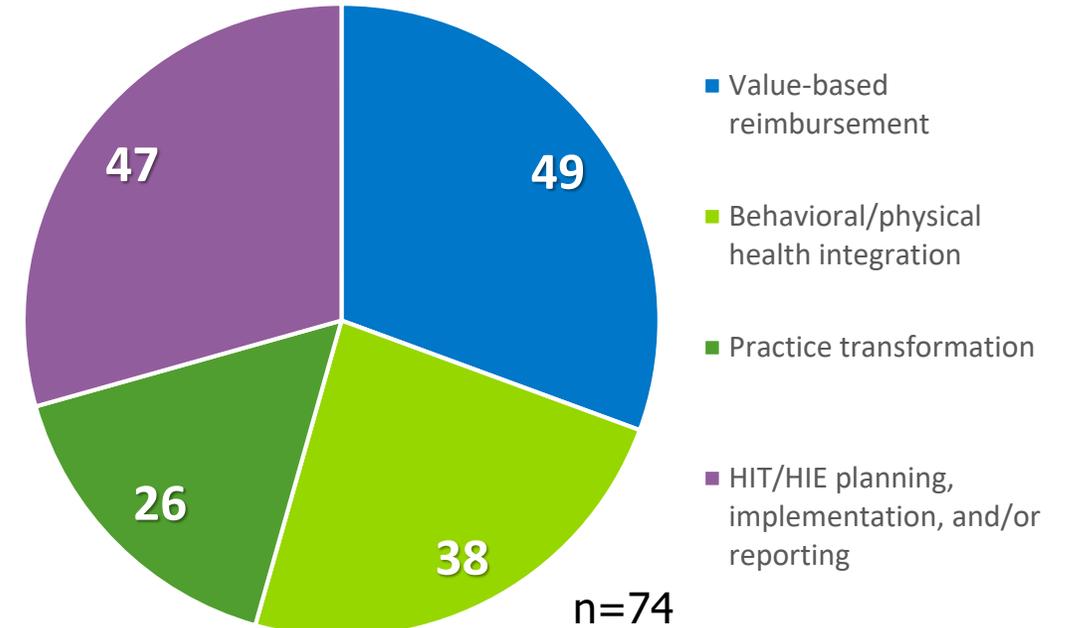


# Technical assistance

Survey question: What type of technical support has your organization **received**?



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



# Summary findings

Provider and health plan surveys

# Summary: top enablers

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## Providers

Top four enablers
Aligned quality measurements and definitions (23)
Trusted partnerships and collaboration with payers (21)
Development of medical home culture with engaged providers (20)
Aligned incentives and/or contract requirements (19)

## Health plans

All payers: top four enablers
Trusted partnerships and collaboration
Aligned incentives/contract requirements
Interoperable data systems
Aligned quality measures/definitions

# Summary: top barriers

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## Providers

Top four barriers
Lack of timely cost data to assist with financial management (51)
Lack of access to comprehensive data on patient populations (33)
Misaligned incentives and/or contract requirements (33)
Lack of interoperable data systems (31)

## Health plans

All payers: top four barriers
Payment model uncertainty
Disparate incentives/contract requirements
Attribution
Disparate quality measures/definitions

# Summary findings

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- ▶ Health plans' VBP adoption increased from previous year, outpacing targets.
- ▶ Providers' organizational and clinician experience with VBP has been generally positive.
- ▶ Providers generally plan to increase VBP participation and desire technical support. (Most technical support received to-date has been for practice transformation and behavioral health integration.)
- ▶ Health plans and providers are facing the same top barriers, respectively, year to year.

# Summary findings (cont.)

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## ▶ To facilitate further progress:

- ▶ Improve timeliness and comprehensiveness of data shared to providers (multi-payer)
- ▶ Improve role clarity
- ▶ Align quality measures and incentives
- ▶ Foster collaborative and trusting relationships
- ▶ Invest in interoperability
- ▶ Support providers with HIT/HIE and VBP technical support
- ▶ Support small to medium-sized providers and invest in improving provider experience



# Contact information

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