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

- 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

1 in 3 non-Medicare Washington residents

$12 Billion
HCA purchasing goals

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

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.)

2016:
- 20% VBP
- MEDICAID

2016 actual:
- 30% VBP
- PEBB

2017:
- 43% VBP
- SEBB

2017 actual:
- 43% VBP

2018:
- 50% VBP

2018 actual:
- 54% VBP

2018:
- 50% VBP

2019:
- 90% VBP
Guiding principles

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
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

State’s VBP Standard: Categories 2C → 4B
Survey templates – health plans

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
## Medicaid Assessed Payments by APM Category

<table>
<thead>
<tr>
<th>APM Category</th>
<th>APM Sub-category</th>
<th>Strategy</th>
<th>Better Health Together</th>
<th>Cascade</th>
<th>Greater Columbia</th>
<th>King</th>
<th>North Central</th>
<th>North Sound</th>
<th>Olympic</th>
<th>Pierce</th>
<th>SW Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Fee-for-Service</td>
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<tr>
<td>2</td>
<td>2A</td>
<td>Foundational Payments for Infrastructure &amp; Operations</td>
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<td></td>
<td>2B</td>
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<tr>
<td>3</td>
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<td>APMs with Upside Gainsharing</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>3B</td>
<td>APMs with Upside Gainsharing and Downside Risk</td>
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<td>4</td>
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</table>

### Medicaid Total Statewide Covered Lives by APM Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Region: Accountable Communities of Health</th>
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</thead>
<tbody>
<tr>
<td>FFS - No Link to Quality</td>
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</tr>
<tr>
<td>FFS - Link to Quality</td>
<td></td>
</tr>
<tr>
<td>APMs built on FFS Architecture</td>
<td></td>
</tr>
<tr>
<td>Population-Based Payment</td>
<td></td>
</tr>
</tbody>
</table>

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**Survey templates – MCOs**
Survey templates – health plans

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

<table>
<thead>
<tr>
<th>APM Category</th>
<th>APM Subcategory</th>
<th>Strategy</th>
<th>Medicare</th>
<th>Individual Market</th>
<th>Small Group</th>
<th>Large Group</th>
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<tbody>
<tr>
<td>1</td>
<td>FFS – No Link to Quality</td>
<td>1</td>
<td>Fee-for-Service</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>FFS - Link to Quality</td>
<td>2A</td>
<td>Foundation Payments for Infrastructure &amp; Operations</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2B</td>
<td>Pay for Reporting</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2C</td>
<td>Reimbursements for Performance</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>APMS built on FFS Architecture</td>
<td>3A</td>
<td>APMS with Upward Gainsharing</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>Population-Based Payment</td>
<td>4A</td>
<td>Condition-Specific Population-Based Payment</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4B</td>
<td>Comprehensive Population-Based Payment</td>
<td>$</td>
<td>-</td>
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<tr>
<td></td>
<td></td>
<td>Total Annual Payments</td>
<td>$</td>
<td>-</td>
<td>-</td>
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</tr>
</tbody>
</table>

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

Table 2: Total Annual Statewide Covered Lives by APM Category

<table>
<thead>
<tr>
<th>APM Category</th>
<th>APM Subcategory</th>
<th>Strategy</th>
<th>Medicare</th>
<th>Individual Market</th>
<th>Small Group</th>
<th>Large Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>FFS – No Link to Quality</td>
<td>1</td>
<td>Fee-for-Service</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>FFS - Link to Quality</td>
<td>2A</td>
<td>Foundation Payments for Infrastructure &amp; Operations</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2B</td>
<td>Pay for Reporting</td>
<td>$</td>
<td>-</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>2C</td>
<td>Reimbursements for Performance</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>APMS built on FFS Architecture</td>
<td>3A</td>
<td>APMS with Upward Gainsharing</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>Population-Based Payment</td>
<td>4A</td>
<td>Condition-Specific Population-Based Payment</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4B</td>
<td>Comprehensive Population-Based Payment</td>
<td>$</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Annual Covered Lives</td>
<td>$</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

For additional details on APM Categories, see HCP-LAN Alternative Payment Models (APM) Framework.
Survey templates – providers

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

► 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

**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

State’s VBP Standard:
Categories 2C → 4B
Medicare results

<table>
<thead>
<tr>
<th>CATEGORY 1 – 2B: FEE-FOR-SERVICE - NO LINK TO QUALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Fee-for-service</td>
</tr>
<tr>
<td>2A Foundational Payments for Infrastructure &amp;</td>
</tr>
<tr>
<td>Operation</td>
</tr>
<tr>
<td>2B Pay-for-Reporting</td>
</tr>
<tr>
<td>36% 0% 0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CATEGORY 2C – 2D: FEE-FOR-SERVICE - LINK TO QUALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>2C Pay-for-Performance</td>
</tr>
<tr>
<td>2D Rewards and Penalties for Performance</td>
</tr>
<tr>
<td>10% 0%</td>
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</table>

<table>
<thead>
<tr>
<th>CATEGORY 3A – 3B: APMs BUILT ON FFS ARCHITECTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3A APMs with upside gainsharing</td>
</tr>
<tr>
<td>3B APMs with upside gainsharing and downside risk</td>
</tr>
<tr>
<td>8% 0%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>CATEGORY 4A – 4B: POPULATION-BASED PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>4A Condition-specific population-based payment</td>
</tr>
<tr>
<td>4B Comprehensive population-based payment</td>
</tr>
<tr>
<td>46% 0%</td>
</tr>
</tbody>
</table>

$3,863,832,889
n=10
### Commercial results

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

<table>
<thead>
<tr>
<th>1 Fee-for-service</th>
<th>2A Foundational Payments for Infrastructure &amp; Operation</th>
<th>2B Pay-for-Reporting</th>
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</thead>
<tbody>
<tr>
<td>45%</td>
<td>0%</td>
<td>0%</td>
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#### CATEGORY 2C – 2D: FEE-FOR-SERVICE - LINK TO QUALITY

<table>
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<tr>
<th>2C Pay-for-Performance</th>
<th>2D Rewards and Penalties for Performance</th>
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<tr>
<td>14%</td>
<td>0%</td>
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#### CATEGORY 3A – 3B: APMs BUILT ON FFS ARCHITECTURE

<table>
<thead>
<tr>
<th>3A APMs with upside gainsharing</th>
<th>3B APMs with upside gainsharing and downside risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>15%</td>
<td>5%</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>4A Condition-specific population-based payment</th>
<th>4B Comprehensive population-based payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>21%</td>
</tr>
</tbody>
</table>

**All Commercial**

- 1-2B: 21%
- 2C-2D: 14%
- 3A-3B: 45%
- 4A-4B: 20%

**Total Commercial Revenue:** $12,657,194,486

**Total Commercial Count:** n=7
Commercial results (cont.)

Individual Market - on Exchange
- 20% 46%
- 15%
- 19%

$1,239,508,528
n=6

Individual Market - off Exchange
- 34% 47%
- 6%
- 13%

$357,957,368
n=2

Small Group
- 17% 44%
- 22%
- 17%

$1,029,536,427
n=4

Large Group
- 21% 45%
- 21%
- 13%

$10,030,192,163
n=5
Medicaid Managed Care results

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

<table>
<thead>
<tr>
<th>1</th>
<th>Fee-for-service</th>
<th>2A</th>
<th>Foundational Payments for Infrastructure &amp; Operation</th>
<th>2B</th>
<th>Pay-for-Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>34%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
<td></td>
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</tbody>
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**CATEGORY 2C – 2D: FEE-FOR-SERVICE - LINK TO QUALITY**

<table>
<thead>
<tr>
<th>2C</th>
<th>Pay-for-Performance</th>
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<tr>
<td>6.4%</td>
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<table>
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<tr>
<th>2D</th>
<th>Rewards and Penalties for Performance</th>
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<td>0.1%</td>
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**CATEGORY 3A – 3B: APMs BUILT ON FFS ARCHITECTURE**

<table>
<thead>
<tr>
<th>3A</th>
<th>APMs with upside gainsharing</th>
</tr>
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<tbody>
<tr>
<td>42%</td>
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<table>
<thead>
<tr>
<th>3B</th>
<th>APMs with upside gainsharing and downside risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>15%</td>
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**CATEGORY 4A – 4B: POPULATION-BASED PAYMENT**

<table>
<thead>
<tr>
<th>4A</th>
<th>Condition-specific population-based payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>4B</th>
<th>Comprehensive population-based payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>

$3,806,253,001
n=5
Payments by APM Category

Medicare Advantage
- n=10
  - Total payments = $3.9B
  - VBP = $2.50B (64%)

All Commercial
- n=7
  - Total payments = $12.7B
  - VBP = $6.9B (55%)

Medicaid Managed Care
- 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
- 46% n=10
- Total payments = $3.9B
- VBP = $2.50B (64%)

Medicaid Managed Care
- 36% n=7
- Total payments = $12.7B
- VBP = $6.9B (55%)

Statewide VBP = $20.3B (58%)
- 2018 survey results = 55%
- 2017 survey results = 37%
- 2016 survey results = 30%
MCO VBP by Accountable Community of Health

- Olympic Community of Health: 62%
- HealthierHere: 74%
- Cascade Pacific Action Alliance: 57%
- North Sound ACH: 65%
- SWACH: 65%
- Greater Columbia ACH: 54%
- North Central ACH: 72%
- Better Health Together: 63%
Qualitative data results

Non-MCO health plan survey ONLY
<table>
<thead>
<tr>
<th>Question</th>
<th>Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your organization implemented any APMs with a primary care emphasis?</td>
<td>5/6</td>
</tr>
<tr>
<td>Does your organization have a VBP strategic plan?</td>
<td>5/6</td>
</tr>
<tr>
<td>Does your organization evaluate APM success?</td>
<td>5/6</td>
</tr>
<tr>
<td>Have you assessed the return on investment from APMs?</td>
<td>2/6</td>
</tr>
<tr>
<td>Have you achieved certification for an APM as an Other Payer Advanced APM through the Quality Payment Program?</td>
<td>1/6</td>
</tr>
<tr>
<td>Does your organization have a strategic plan to address social determinants of health (SDoH)?</td>
<td>6/6</td>
</tr>
<tr>
<td>Do you provide benefits that address SDoH?</td>
<td>6/6</td>
</tr>
</tbody>
</table>

**Note:** not all respondents completed this and the following sections of the health plan survey.
### Top enablers and barriers (from highest impact to lowest)

<table>
<thead>
<tr>
<th>All payers: top four enablers</th>
<th>All payers: top four barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trusted partnerships and collaboration</td>
<td>Payment model uncertainty</td>
</tr>
<tr>
<td>Aligned incentives/contract requirements</td>
<td>Disparate incentives/contract requirements</td>
</tr>
<tr>
<td>Interoperable data systems</td>
<td>Attribution</td>
</tr>
<tr>
<td>Aligned quality measures/definitions</td>
<td>Disparate quality measures/definitions</td>
</tr>
</tbody>
</table>

n=9
### Health plan surveys (cont.)

#### Quality measurement

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

<table>
<thead>
<tr>
<th></th>
<th># of health plans responding “Yes” to collecting the following data</th>
<th># of health plans responding “Yes” to disaggregating performance by the following data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td>6/6</td>
<td>3/6</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>6/6</td>
<td>3/6</td>
</tr>
<tr>
<td>Language</td>
<td>5/6</td>
<td>3/6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has your organization implemented any programs to address health disparities by race, ethnicity, or language?</th>
<th># of health plans responding “Yes”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5/7</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Functionality</th>
<th># of health plans responding “Yes”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care coordination</td>
<td>6/7</td>
</tr>
<tr>
<td>Quality management</td>
<td>7/7</td>
</tr>
<tr>
<td>Utilization management</td>
<td>4/7</td>
</tr>
<tr>
<td>Provider network management</td>
<td>4/7</td>
</tr>
<tr>
<td>Provider payments</td>
<td>2/7</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>In what ways and capacities are you engaging with regional health systems transformation efforts in collaboration with ACHs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACH governance (e.g., Board of Directors)</td>
</tr>
<tr>
<td>ACH committee membership</td>
</tr>
<tr>
<td>ACH workgroup</td>
</tr>
<tr>
<td>Attend ACH meetings</td>
</tr>
</tbody>
</table>
Provider survey

2019 Paying for Value survey results
Provider information

Respondent organization type
(multiple selections per respondent possible)

- Behavioral health provider: 67
- Outpatient clinic/facility: 45
- Critical Access Hospital: 22
- Rural Health Clinic: 19
- Multi-specialty practice: 19
- Hospital: 17
- Federally Qualified Health Center: 16
- Inpatient clinic/facility: 12
- Hospital owned or operated clinic/facility: 12
- Independent, multi-provider single-specialty practice: 9
- Single-provider practice: 5
- Clinically integrated network: 5
- Tribal health care provider: 3

n=148
Provider information (cont.)

Number of clinicians

n=148
Provider information (cont.)

Size of patient panel

n=147
Primary care medical home

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>113</td>
</tr>
</tbody>
</table>

n=144

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>86</td>
<td>60</td>
</tr>
</tbody>
</table>

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

- Very ready and highly capable: 19
- Mostly ready and capable: 19
- Somewhat ready and capable: 5
- Not very ready with limited capacity: 5
- Not ready with inadequate capacity: 37

n=85
Participation in VBP (cont.)

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

Respondents’ total revenue by sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$2,988</td>
</tr>
<tr>
<td>Medicare</td>
<td>$1,172</td>
</tr>
<tr>
<td>Commercial</td>
<td>$2,563</td>
</tr>
</tbody>
</table>

n=43
n=69
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?

- Yes: 79
- No: 5

n=84

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

- PY 2017: 3
- PY 2018: 5
- PY 2019: 3

n=7

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

- Yes: 63
- No: 16

n=79
Experience with VBP

Provider survey
Experience with VBP

Organizational experience with VBP

- Very positive: 22
- Positive: 21
- Neutral: 4
- Negative: 0
- Very negative: 0

n=47
Clinicians’ experience with VBP

- Very positive: 26
- Positive: 12
- Neutral: 2
- Negative: 2
- Very negative: 0

n=50
Experience with VBP (cont.)

Top enablers and barriers

<table>
<thead>
<tr>
<th>Top four enablers</th>
<th>n=51</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aligned quality measurements and definitions (23)</td>
<td></td>
</tr>
<tr>
<td>Trusted partnerships and collaboration with payers (21)</td>
<td></td>
</tr>
<tr>
<td>Development of medical home culture with engaged providers (20)</td>
<td></td>
</tr>
<tr>
<td>Aligned incentives and/or contract requirements (19)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top four barriers</th>
<th>n=78</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of timely cost data to assist with financial management (51)</td>
<td></td>
</tr>
<tr>
<td>Lack of access to comprehensive data on patient populations (33)</td>
<td></td>
</tr>
<tr>
<td>Misaligned incentives and/or contract requirements (33)</td>
<td></td>
</tr>
<tr>
<td>Lack of interoperable data systems (31)</td>
<td></td>
</tr>
</tbody>
</table>

Experience relative to last year’s barriers

- Better: 3
- About the same: 63
- Worse: 9

n=75
Experience with VBP (cont.)

Future plans for VBP over the next 12 months

- Increase by more than 50%: 2
- Increase by 26-50%: 5
- Increase by 11-25%: 11
- Increase by up to 10%: 25
- Stay the same: 35
- Decrease by up to 10%: 2
- Decrease by 11-25%: 2
- Decrease by 26-50%: 2
- Decrease by more than 50%

n=80
Experience with VBP (cont.)

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

- Extremely clear: 36
- Very clear: 23
- Somewhat clear: 16
- Not so clear: 1
- Not at all clear: 6

n=82
Health disparities and equity

Provider survey
Health disparities and equity

<table>
<thead>
<tr>
<th></th>
<th># of respondents selecting “Yes” to collecting the following data</th>
<th># of respondents selecting “Yes” to assessing performance by the following data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td>80</td>
<td>19</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>78</td>
<td>20</td>
</tr>
<tr>
<td>Language</td>
<td>76</td>
<td>18</td>
</tr>
</tbody>
</table>

n=80
Survey question: Has your organization implemented any programs to address health disparities by race, ethnicity, or language?

<table>
<thead>
<tr>
<th>“Yes”</th>
<th>“No, but we address other aspects of health disparities (e.g., income, housing status)”</th>
<th>“No”</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>32</td>
<td>17</td>
</tr>
</tbody>
</table>

n=80
Integration, workforce, and technical support

Provider survey
Integration

Integration: reported level of SAMHSA’s “Six Levels of Collaboration/Integration”

- 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

n=81

55 providers intend to move to a higher level in the next year
Integration (cont.)

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

![Survey Results Graph]

Yes: 47
No: 35
n=82
Integration (cont.)

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

- Evidence-Based Treatments
- Patient Involvement in Care
- Patient Access to Behavioral Health as a Routine Part of Care
- Data for Quality Improvement
- Integrated Care Team
- Accessibility and Sharing of Patient Information
- Operational Systems and Workflows to Support Population-Based Care
- Practice Access to Psychiatric Services

n=82
Integration (cont.)

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

![Bar chart showing the number of respondents who have completed the MeHAF self-assessment.]

- Yes: 44 respondents
- No: 37 respondents

n=81
Survey question: Is your organization participating in activities to prepare for team-based care and population management?

- Yes - participating in Healthier Washington Collaboration Portal, AIMS Center programs or other TCPI activities: 37
- Yes - participating in transformation and training opportunities through consulting or organizational resources: 23
- 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: 40

n=100
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?

- Yes - participating in training opportunities or conferences as part of Practice Transformation activities or AIMS Center resources (36)
- Yes - participating in activities through professional organization, CME or informal learning (36)
- Yes - participating in training programs through organizational resources (31)
- No - have not participated in formal training. May be interested in learning more about how to access skills/competency based training (17)

n=120
Technical assistance

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

- Value-based reimbursement: 14
- Behavioral/physical health integration: 22
- Practice transformation: 42
- HIT/HIE planning, implementation, and/or reporting: 39

n=61

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

- Value-based reimbursement: 47
- Behavioral/physical health integration: 49
- Practice transformation: 26
- HIT/HIE planning, implementation, and/or reporting: 38

n=74
Summary findings

Provider and health plan surveys
## Summary: top enablers

### Providers

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<th>Top four enablers</th>
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### Health plans

<table>
<thead>
<tr>
<th>All payers: top four enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trusted partnerships and collaboration</td>
</tr>
<tr>
<td>Aligned incentives/contract requirements</td>
</tr>
<tr>
<td>Interoperable data systems</td>
</tr>
<tr>
<td>Aligned quality measures/definitions</td>
</tr>
</tbody>
</table>
## Summary: top barriers

### Providers

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</table>

### Health plans

<table>
<thead>
<tr>
<th>All payers: top four barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment model uncertainty</td>
</tr>
<tr>
<td>Disparate incentives/contract requirements</td>
</tr>
<tr>
<td>Attribution</td>
</tr>
<tr>
<td>Disparate quality measures/definitions</td>
</tr>
</tbody>
</table>
Summary findings

- 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.)

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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jd.fischer@hca.wa.gov