2020 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 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 (SIM)
  - 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 Project, 2017-2021
Alignment with CMS Alternative Payment Models (APMs) framework

State’s VBP Standard: Categories 2C → 4B
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
- 2016 actual: 30% VBP
- 2017: 30% VBP
- 2017 actual: 43% VBP
- 2018: 50% VBP
- 2018 actual: 54% VBP
- 2019: 75% VBP
- 2019 actual: 62% VBP
- 2021: 90% VBP
Foundational principles

1. Continually strive for smarter spending, better outcomes, and better consumer and provider experience, and hold HCA’s programs and contracted partners more accountable to meeting these shared goals.

2. Reward the delivery of person- and family-centered, high-value, affordable, and accessible care.

3. Support the delivery of whole-person care, centered on robust primary care and other prospective payment alternative payment models (APMs). This allows all members to receive a coordinated set of services that meets their physical health, behavioral health, and social needs.

4. Approach all purchasing with a health equity lens to continually improve health equity for all Washington residents across rural and urban regions, and proactively address social determinants of health.
5. Leverage purchasing power to drive improved performance of HCA's Medicaid, PEBB, and SEBB programs and their contracted health systems.

6. Align payment and delivery reform approaches with other purchasers and payers, where appropriate, for greatest impact and to simplify implementation for providers.

7. Engage in data-driven policymaking to advance standardization and care transformation.

8. Increase the long-term financial sustainability of state health programs.
HCA’s Paying for Value survey

Tracking progress in calendar year 2019 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
  - Provider survey through SurveyMonkey
Tying survey data to accountability

The MCO and provider surveys generate data for a number of accountability metrics relating to VBP attainment:

- **MCO Paying for Value 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) program funding from the amount of at-risk funds (statewide accountability)
  - Determines earned DSRIP VBP incentives for MCOs and Accountable Communities of Health (ACHs)

- **Provider Paying for Value 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 Total Assessed Payments by APM Category

<table>
<thead>
<tr>
<th>APM Category</th>
<th>APM Sub-category</th>
<th>Strategy</th>
<th>Region: Accountable Communities of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Fee-for-Service</td>
<td>Better Health Together, Cascade, Greater Columbia, King, North Central, North Sound, Olympic, Pierce, SW Washington</td>
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<tr>
<td>2</td>
<td>2A</td>
<td>Foundational Payments for Infrastructure &amp; Operations</td>
<td></td>
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<tr>
<td></td>
<td>2B</td>
<td>Pay for Reporting</td>
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<tr>
<td></td>
<td>2C</td>
<td>Rewards for Performance</td>
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<tr>
<td></td>
<td>2D</td>
<td>Rewards and Penalties for Performance</td>
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<tr>
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<td>3B</td>
<td>FFS - Link to Quality</td>
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<tr>
<td></td>
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<td>Condition-Specific Population-Based Payment</td>
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<td>Comprehensive Population-Based Payment</td>
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## Medicaid Total Statewide Covered Lives by APM Category

<table>
<thead>
<tr>
<th>Category</th>
<th>APM Category</th>
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<th>Strategy</th>
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<td>Pay for Reporting</td>
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<td>2C</td>
<td>Rewards for Performance</td>
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<td></td>
<td>2D</td>
<td>Rewards and Penalties for Performance</td>
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<tr>
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<td>3A</td>
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<td>3B</td>
<td>FFS - Link to Quality</td>
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<td>4A</td>
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<td>Comprehensive Population-Based Payment</td>
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### Medicaid Total Annual Payments

<table>
<thead>
<tr>
<th>Category</th>
<th>APM Category</th>
<th>APM Sub-category</th>
<th>Strategy</th>
<th>Region: Accountable Communities of Health</th>
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<td>1</td>
<td>1</td>
<td>Fee-for-Service</td>
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<td>2A</td>
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<tr>
<td></td>
<td>2B</td>
<td>Pay for Reporting</td>
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<td>2C</td>
<td>Rewards for Performance</td>
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<tr>
<td></td>
<td>2D</td>
<td>Rewards and Penalties for Performance</td>
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</tr>
<tr>
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<td>Fee-for-Service</td>
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<td></td>
<td>3B</td>
<td>FFS - Link to Quality</td>
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<td>4B</td>
<td>Comprehensive Population-Based Payment</td>
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### 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>Sector</th>
<th>Medicare</th>
<th>Individual Market</th>
<th>Small Group</th>
<th>Large Group</th>
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<td>S</td>
<td>S</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2 FFS - Link to Quality</td>
<td>2A Foundational Payments for Infrastructure &amp; Operations</td>
<td>$</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>$</td>
<td>$</td>
</tr>
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<td></td>
<td>2B Pay for Reporting</td>
<td>$</td>
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<td>2C Pay for Performance</td>
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<td></td>
<td>2D Pay for Reward</td>
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</tr>
<tr>
<td>3 APMs built on FFS Architecture</td>
<td>3A APMs with Upside Gainsharing</td>
<td>$</td>
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<td>$</td>
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</tr>
<tr>
<td>4 Population-based Payment</td>
<td>4A Condition-Specific Population-Based Payment</td>
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<td>Total Annual Payments</td>
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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>Sector</th>
<th>Medicare</th>
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<tbody>
<tr>
<td>1 FFS - No Link to Quality</td>
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<td>S</td>
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<td>2 FFS - Link to Quality</td>
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<td></td>
<td>2B Pay for Reporting</td>
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<td>S</td>
<td>S</td>
<td>S</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>2C Pay for Performance</td>
<td>$</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>$</td>
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<tr>
<td></td>
<td>2D Pay for Reward</td>
<td>$</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>$</td>
</tr>
<tr>
<td>3 APMs built on FFS Architecture</td>
<td>3A APMs with Upside Gainsharing</td>
<td>$</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>S</td>
<td>$</td>
</tr>
<tr>
<td>4 Population-based Payment</td>
<td>4A Condition-Specific Population-Based Payment</td>
<td>$</td>
<td>S</td>
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<td>Total Annual Covered Lives</td>
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<td>S</td>
<td>S</td>
<td>S</td>
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<td>$</td>
</tr>
</tbody>
</table>

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

### Barriers and Enablers to VBP Adoption

**I. Barriers:**
From the lists below, rank your perceived TOP FIVE barriers and TOP FIVE enablers to the adoption of VBPs by using the numbers 1 through 5 in column B (with "5" corresponding with the most significant barrier/enabler).

**A) Barriers:**
In your organization’s experience, what are the TOP FIVE BARRIERS to the adoption of VBP arrangements? (Select most appropriate response in drop down and provide any additional information in area to right)

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.
2. Pay. 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.
3. Other entities. Has your organization made any effort to align quality measures used in VBP contracts with those used by 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.

**B) Enablers:**
In your organization’s experience, what are the TOP FIVE ENABLERS to the adoption of VBP arrangements?

1. Alignment of Quality Measures Used to Assess Provider Performance in Current VBP Contracts
2. Alignment of Quality Measures Used to Assess Provider Performance in Current VBP Contracts
3. Alignment of Quality Measures Used to Assess Provider Performance in Current VBP Contracts
4. Alignment of Quality Measures Used to Assess Provider Performance in Current VBP Contracts
5. Alignment of Quality Measures Used to Assess Provider Performance in Current VBP Contracts

**II. Quality Measurement**

1. Aligning of Quality Measures Used to Assess Provider Performance in Current VBP Contracts
2. Aligning of Quality Measures Used to Assess Provider Performance in Current VBP Contracts
3. Aligning of Quality Measures Used to Assess Provider Performance in Current VBP Contracts
4. Aligning of Quality Measures Used to Assess Provider Performance in Current VBP Contracts
5. Aligning of Quality Measures Used to Assess Provider Performance in Current VBP Contracts

**III. Traditional Organization Functions**

1. APNs
2. APNs
3. APNs
4. APNs
5. APNs

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.)

**A) **

1. Care coordination
2. Utilization management
3. Provider network management
4. Provider payments
5. Quality management

**B) **

1. Care coordination
2. Utilization management
3. Provider network management
4. Provider payments
5. Quality management

**C) **

1. Care coordination
2. Utilization management
3. Provider network management
4. Provider payments
5. Quality management

**D) **

1. Care coordination
2. Utilization management
3. Provider network management
4. Provider payments
5. Quality management
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 3,950 recipients)

- **Provider survey:**
  - Direct outreach from HCA leadership
  - Direct outreach from ACH executive directors
  - GovDelivery announcement (an email distribution list, with approximately 3,950 recipients)
Health plan survey
Health plan survey respondents

**Medicaid MCOs (n=5):**
- Amerigroup
- Community Health Plan of Washington
- Coordinated Care
- Molina
- United Healthcare

**Medicare and commercial health plans (n=9):**
- Amerigroup*
- Community Health Plan of Washington*
- Coordinated Care*
- 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
### Commercial results

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Percentage</th>
<th>Payment</th>
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<td></td>
<td>Operation</td>
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<tr>
<td>2B</td>
<td>Pay-for-Reporting</td>
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#### CATEGORY 2C – 2D: FEE-FOR-SERVICE - LINK TO QUALITY

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<th>Category</th>
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<td>2C</td>
<td>Pay-for-Performance</td>
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<td>Rewards and Penalties for Performance</td>
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#### CATEGORY 3A – 3B: APMs BUILT ON FFS ARCHITECTURE

<table>
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<tr>
<th>Category</th>
<th>Description</th>
<th>Percentage</th>
<th>Payment</th>
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</thead>
<tbody>
<tr>
<td>3A</td>
<td>APMs with upside gainsharing</td>
<td>21%</td>
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<td>3B</td>
<td>APMs with upside gainsharing and downside risk</td>
<td>2%</td>
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<tr>
<td>3N</td>
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#### CATEGORY 4A – 4B: POPULATION-BASED PAYMENT

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<td>Condition-specific population-based payment</td>
<td>21%</td>
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<td>4B</td>
<td>Comprehensive population-based payment</td>
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<td>21%</td>
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<tr>
<td>4N</td>
<td>Comprehensive population-based payment</td>
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**Total Commercial Payments: $13,099,860,020**

59% of all health plan payments in WA

n=6
Commercial results (cont.)

Individual Market (on exchange)
- $1,040,703,279
  - 39% 1-2B
  - 25% 2C-2D
  - 16% 3A-3B
  - 19% 4A-4B
- n=6

Individual Market (off exchange)
- $326,202,385
  - 50% 1-2B
  - 33% 2C-2D
  - 11% 3A-3B
  - 6% 4A-4B
- n=4

Small Group
- $1,126,439,690
  - 40% 1-2B
  - 18% 2C-2D
  - 24% 3A-3B
  - 18% 4A-4B
- n=4

Large Group
- $10,606,514,666
  - 40% 1-2B
  - 21% 2C-2D
  - 15% 3A-3B
  - 25% 4A-4B
- n=5
Medicare Advantage results

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

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<tr>
<th></th>
<th>1 Fee-for-service (including 3N and 4N)</th>
<th>2A Foundational Payments for Infrastructure &amp; Operation</th>
<th>2B Pay-for-Reporting</th>
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<td>0%</td>
<td><strong>37%</strong></td>
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**CATEGORY 2C – 2D: FEE-FOR-SERVICE - LINK TO QUALITY**

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<th>2C Pay-for-Performance</th>
<th>2D Rewards and Penalties for Performance</th>
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<td>0%</td>
<td><strong>12%</strong></td>
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**CATEGORY 3A – 3B: APMs BUILT ON FFS ARCHITECTURE**

<table>
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<th>3A APMs with upside gainsharing</th>
<th>3B APMs with upside gainsharing and downside risk</th>
<th>3N APMs with upside gainsharing and downside risk</th>
<th>Total</th>
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<td><strong>%</strong></td>
<td>6%</td>
<td>5%</td>
<td>0%</td>
<td><strong>11%</strong></td>
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**CATEGORY 4A – 4B: POPULATION-BASED PAYMENT**

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<th>4A Condition-specific population-based payment</th>
<th>4B Comprehensive population-based payment</th>
<th>4N Comprehensive population-based payment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>%</strong></td>
<td>5%</td>
<td>36%</td>
<td>0%</td>
<td><strong>40%</strong></td>
</tr>
</tbody>
</table>

$4,713,964,462

21% of all health plan payments in WA

n=8
### Medicaid Managed Care Results

#### Category 1 – 2B: Fee-for-Service - No Link to Quality

<table>
<thead>
<tr>
<th>Fee-for-Service</th>
<th>Foundational Payments for Infrastructure &amp; Operation</th>
<th>Pay-for-Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>21%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

#### Category 2C – 2D: Fee-for-Service - Link to Quality

<table>
<thead>
<tr>
<th>Pay-for-Performance</th>
<th>Rewards and Penalties for Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>0%</td>
</tr>
</tbody>
</table>

#### Category 3A – 3B: APMs Built on FFS Architecture

<table>
<thead>
<tr>
<th>APMs with upside gainsharing</th>
<th>APMs with upside gainsharing and downside risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>45%</td>
<td>20%</td>
</tr>
</tbody>
</table>

#### Category 3N

<table>
<thead>
<tr>
<th>APMs with upside gainsharing and downside risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.05%</td>
</tr>
</tbody>
</table>

#### Category 4A – 4B: Population-Based Payment

<table>
<thead>
<tr>
<th>Condition-specific population-based payment</th>
<th>Comprehensive population-based payment</th>
<th>Comprehensive population-based payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

- Medicaid Managed Care Results: $4,299,291,582
- 19% of all health plan payments in WA
- n=5
Payments by APM Category

Medicare Advantage

- Total payments = $4.7B (21% of all health plan payments)
- VBP = $3.0B (63% of Medicare Advantage payments)

All Commercial

- Total payments = $13.1B (59% of all health plan payments)
- VBP = $7.9B (60% of all commercial payments)

Medicaid Managed Care

- Total payments = $4.3B (19% of all health plan payments)
- VBP = $3.3B (77% of all MCO payments)

Statewide VBP = 64%

- 2019 survey results = 58%
- 2018 survey results = 55%
- 2017 survey results = 37%
- 2016 survey results = 30%
Provider incentives

### Provider Incentives (% of total payments)

<table>
<thead>
<tr>
<th>Market sector</th>
<th>Percent of total payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare (n=8)</td>
<td>20.99%</td>
</tr>
<tr>
<td>All Commercial (n=6)</td>
<td>5.99%</td>
</tr>
<tr>
<td>Medicaid managed care (n=5)</td>
<td>2.92%</td>
</tr>
</tbody>
</table>

### Positive and Negative Incentives

<table>
<thead>
<tr>
<th>Market Sector</th>
<th>Percent of total incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare (n=8)</td>
<td>Negative Incentives: 1%</td>
</tr>
<tr>
<td>All Commercial (n=6)</td>
<td>Positive Incentives: 99%</td>
</tr>
<tr>
<td>Medicaid managed care (n=5)</td>
<td>Negative Incentives: 2%</td>
</tr>
<tr>
<td></td>
<td>Positive Incentives: 98%</td>
</tr>
<tr>
<td></td>
<td>Total Positive Incentives: 92%</td>
</tr>
</tbody>
</table>
HCA’s 2021 VBP goals

Medicare Advantage

- n=8
- Total payments = $4.7B
- (21% of all health plan payments)
- VBP = $3.0B
- (63% of Medicare Advantage payments)

Medicaid Managed Care

- n=5
- Total payments = $4.3B
- (19% of all health plan payments)
- VBP = $3.3B
- (77% of all MCO payments)

Statewide VBP = 64%
- 2019 survey results = 58%
- 2018 survey results = 55%
- 2017 survey results = 37%
- 2016 survey results = 30%
MCO VBP by Accountable Community of Health

- Olympic Community of Health: 82% (+20)
- North Sound ACH: 81% (+16)
- HealthierHere: 79% (+5)
- Elevate Health: 79% (+7)
- Cascade Pacific Action Alliance: 67% (+10)
- North Central ACH: 81% (+9)
- Greater Columbia ACH: 68% (+14)
- SWACH: 79% (+14)
- Better Health Together: 79% (+16)

Percentage increase from CY 2018 data

CY 2019 MCO VBP percentage
Qualitative data results
Non-MCO health plan survey ONLY
Health plan surveys (cont.)

APMs and VBP

- Has your organization implemented any APMs with a primary care emphasis? 6
- Does your organization have a VBP strategic plan? 5
- Does your organization evaluate APM success? 5
- Have you assessed the return on investment from APMs? 2
- Have you achieved certification for an APM as an Other Payer Advanced APM through the Quality Payment Program? 1
- Does your organization have a strategic plan to address health equity? 5
- Does your organization have a strategic plan to address social determinants of health (SDoH)? 5
- Do you provide benefits that address SDoH? 5

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

n=9
### 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>Interoperable data systems</td>
<td>Lack of interoperable data systems</td>
</tr>
<tr>
<td>Aligned incentives/contract requirements</td>
<td>Payment model uncertainty</td>
</tr>
<tr>
<td>Aligned quality measures/definitions</td>
<td>Disparate incentives/contract requirements</td>
</tr>
<tr>
<td>Trusted partnerships and collaboration</td>
<td>Disparate quality measures/definitions</td>
</tr>
</tbody>
</table>

n=9

n=9
Quality measurement

- Do you use the same set(s) of quality measures across provider contracts? 6
- Do you adhere to the measure-specific definitions and specification for measures described in the Statewide Common Measure Set? 6
- Do you change, tweak, or modify measure-specific definitions or specifications for measures described in the Statewide Common Measure Set? 1
- Do you supplement measures from the Statewide Common Measure Set with additional measures in VBP contracts? 5
- Have you made any effort to align quality measures used in VBP contracts with those used by any other entities or payment initiatives? 2

n=9
## 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</td>
<td>4</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Language</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<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></td>
<td>4</td>
</tr>
</tbody>
</table>

n=9
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</td>
</tr>
<tr>
<td>Quality management</td>
<td>6</td>
</tr>
<tr>
<td>Utilization management</td>
<td>6</td>
</tr>
<tr>
<td>Provider network management</td>
<td>5</td>
</tr>
<tr>
<td>Provider payments</td>
<td>5</td>
</tr>
</tbody>
</table>

n=9
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>
<th>n=9</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACH governance (e.g., Board of Directors)</td>
<td>5</td>
</tr>
<tr>
<td>ACH committee membership</td>
<td>6</td>
</tr>
<tr>
<td>ACH workgroup</td>
<td>6</td>
</tr>
<tr>
<td>Attend ACH meetings</td>
<td>6</td>
</tr>
</tbody>
</table>
For each provider type, select the answer that best applies to how your organization engaged with providers in VBP:

- "Many" = your organization engaged in VBP with a majority of this provider type
- "Select" = your organization engaged in VBP with a select group of this provider type
- "None" = your organization did not engage in VBP with this provider type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Many</th>
<th>Select</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health providers</td>
<td>1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Dentists</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Home and community-based service providers</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Long-term care facilities</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Nurse-midwives</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>OBGYNs</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Primary care providers (i.e., physicians, advanced practice nurses, physician assistants)</td>
<td>7</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other specialists</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

n=9
### Impact of COVID-19 on VBP adoption

| Has the COVID-19 pandemic affected your organization’s ability or capacity in the following ways? |  
|-------------------------------------------------------------------------------------------------|---|
| Reduced willingness or ability among providers to engage in new or expanded VBP contracts       | 5  |
| Challenges to the sustaining providers networks                                                | 2  |
| Negative impacts on quality measure reporting and/or performance                              | 7  |
| From your perspective, how should payers, purchasers, and providers adjust their VBP strategies in light of the COVID-19 pandemic? |  
| Reduce/limit risk-based payments until the pandemic is over                                   | 3  |
| Continue expanding VBP models                                                                 | 5  |
| Implement prospective APMs                                                                    | 4  |
| Pause the expansion of VBP and instead focus on sustaining access and improving the availability and provision of telehealth services | 4  |

n=9
Provider survey

2020 Paying for Value survey results
Provider information

Respondent organization type
(multiple selections per respondent possible)

- Behavioral health provider: 110
- Outpatient clinic/facility: 62
- Inpatient clinic/facility: 24
- Rural Health Clinic: 24
- Multi-specialty practice: 23
- Federally Qualified Health Center: 20
- Critical Access Hospital: 19
- Hospital: 16
- Independent, multi-provider single-specialty practice: 16
- Clinically integrated network: 10
- Hospital owned or operated clinic/facility: 9
- Tribal health care provider: 7
- Single-provider practice: 4

n=170
Provider information (cont.)

Number of clinicians

<table>
<thead>
<tr>
<th>Number of clinicians</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>34</td>
</tr>
<tr>
<td>6-20</td>
<td>46</td>
</tr>
<tr>
<td>21-50</td>
<td>28</td>
</tr>
<tr>
<td>51-100</td>
<td>20</td>
</tr>
<tr>
<td>101-500</td>
<td>26</td>
</tr>
<tr>
<td>501-1000</td>
<td>1</td>
</tr>
<tr>
<td>1001+</td>
<td>9</td>
</tr>
</tbody>
</table>

n=164
Size of patient panel

![Bar chart showing the number of respondents across different patient panel sizes.](chart)

- 1-50: 4
- 51-100: 9
- 101-250: 9
- 251-500: 16
- 501-1000: 22
- 1001-3000: 49
- 3000+: 55

Total respondents (n): 164
Primary care medical home

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

- **No**: 97
- **No, but pursuing certification**: 10
- **No, but we follow a PCMH culture**: 22
- **Yes**: 37

n=166
Provider information (cont.)

Respondent service area by ACH

(Multiple regions per respondent possible)

n=165

Number of respondents to 2020 survey

Increase in respondents from 2019

- Olympic Community of Health: 27 (+11)
- Cascade Pacific Action Alliance: 33 (-5)
- Elevate Health: 16 (-2)
- Healthier Here: 23 (-18)
- North Sound ACH: 27 (-17)
- SWACH: 19 (+2)
- North Central ACH: 21 (-7)
- Greater Columbia ACH: 32 (+13)
- Better Health Together: 40 (+16)
Provider information (cont.)

Respondents working directly with ACHs
(Person involved in ACH project plans, governance structure, or regular meetings. Multiple regions per respondent possible.)

n=157

Number of respondents in 2020 survey

Increase in respondents from 2019

- Olympic Community of Health: 18 (+8)
- North Sound ACH: 21 (-12)
- Cascade Pacific Action Alliance: 23 (+0)
- Elevate Health: 7 (-2)
- Healthier Here: 17 (-17)
- SWACH: 18 (+6)
- Greater Columbia ACH: 29 (+17)
- North Central ACH: 18 (-2)
- Better Health Together: 37 (+22)
Participation in VBP

Provider survey
Participation in VBP

VBP readiness and capability

- Very ready and highly capable: 9
- Mostly ready and capable: 13
- Somewhat ready and capable: 19
- Not very ready with limited capacity: 19
- Not ready with inadequate capacity: 37

n=97
Participation in VBP (cont.)

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

- Medicaid: 36
- Medicare: 13
- Commercial: 15
- Other government: 10
- Self-pay: 2

n=46
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: 97
- No: 7

n=104

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

- Yes: 84
- No: 23

n=107
Experience with VBP

Provider survey
Experience with VBP

Organizational experience with VBP

- Very positive: 1
- Positive: 7
- Neutral: 27
- Negative: 19
- Very negative: 5

n=59
Experience with VBP - comments

Positive:
- Focus on value instead of volume
- Helps put resources into quality improvement

Negative:
- Challenging with multiple payers and different VBP programs
- Access to timely data
- Minimal financial reward for administrative burden
Clinicians’ experience with VBP

- Very positive: 9
- Positive: 5
- Neutral: 8
- Negative: 29
- Very negative: 0

n=67
## Experience with VBP (cont.)

### Top enablers and barriers

<table>
<thead>
<tr>
<th>Top five enablers</th>
<th>n=59</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aligned quality measurements and definitions (27)</td>
<td></td>
</tr>
<tr>
<td>Trusted partnerships and collaboration with payers (24)</td>
<td></td>
</tr>
<tr>
<td>Access to comprehensive data on patient populations (23)</td>
<td></td>
</tr>
<tr>
<td>State-based initiatives (22)</td>
<td></td>
</tr>
<tr>
<td>Aligned incentives and/or contract requirements (22)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top five barriers</th>
<th>n=91</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misaligned incentives and/or contract requirements (39)</td>
<td></td>
</tr>
<tr>
<td>Lack of timely cost data to assist with financial management (37)</td>
<td></td>
</tr>
<tr>
<td>Lack of interoperable data systems (35)</td>
<td></td>
</tr>
<tr>
<td>Insufficient patient volume by payer to take on clinical risk (33)</td>
<td></td>
</tr>
<tr>
<td>Lack of access to comprehensive data on patient populations (29)</td>
<td></td>
</tr>
</tbody>
</table>
Experience with VBP (cont.)

Experience relative to last year's barriers

- Better: 3
- About the same: 75
- Worse: 8

n=86
Experience with VBP (cont.)

Realistically, how do you expect your participation in VBP to change over the next 12 months (in terms of total revenue from VBP contracts)?

2020 results:
- Decrease: 6
- Increase: 35
- Stay the same: 55

2019 results:
- Decrease: 2
- Increase: 43
- Stay the same: 35

n=96
n=80
Experience with VBP (cont.)

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

- Not at all clear: 15
- Not so clear: 31
- Somewhat clear: 39
- Very clear: 13

n=98
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><strong>2020 results</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>142</td>
<td>46</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>135</td>
<td>43</td>
</tr>
<tr>
<td>Language</td>
<td>134</td>
<td>35</td>
</tr>
<tr>
<td><strong>2019 results</strong></td>
<td></td>
<td></td>
</tr>
<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=148
n=80
Survey question: Has your organization implemented any programs to address health disparities by race, ethnicity, or language?

<table>
<thead>
<tr>
<th></th>
<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>2020 results</td>
<td>68</td>
<td>61</td>
<td>24</td>
</tr>
<tr>
<td>2019 results</td>
<td>34</td>
<td>32</td>
<td>17</td>
</tr>
</tbody>
</table>

n=153
n=80
Health disparities and equity (cont.): Themes in survey comments

- Translation services and language needs
- Homelessness outreach
- Screen for SDoH needs and refer to social services
- Committee or council to address health equity
- Analyze health disparities
- Community health workers
- LGBTQ focus
- Financial counseling
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

2020 results:
- Level 1: 6
- Level 2: 29
- Level 3: 31
- Level 4: 20
- Level 5: 17
- Level 6: 15

n=141

2019 results:
- Level 1: 7
- Level 2: 11
- Level 3: 17
- Level 4: 9
- Level 5: 29
- Level 6: 8

n=81

84 providers intend to move to a higher level in the next year
Survey question: Has your organization sought alignment with the Dr. Robert Bree Collaborative's recommendations for behavioral health integration?

2020 results:
- Yes: 82
- No: 57

2019 results:
- Yes: 47
- No: 35

n=139 for 2020, n=82 for 2019
Survey question: On which elements are you closely aligning with the Bree Recommendations for specifications and operational details?

<table>
<thead>
<tr>
<th>Element</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-Based Treatments</td>
<td>95%</td>
</tr>
<tr>
<td>Patient Involvement in Care</td>
<td>88%</td>
</tr>
<tr>
<td>Patient Access to Behavioral Health as a Routine Part of Care</td>
<td>87%</td>
</tr>
<tr>
<td>Integrated Care Team</td>
<td>81%</td>
</tr>
<tr>
<td>Data for Quality Improvement</td>
<td>79%</td>
</tr>
<tr>
<td>Accessibility and Sharing of Patient Information</td>
<td>74%</td>
</tr>
<tr>
<td>Practice Access to Psychiatric Services</td>
<td>58%</td>
</tr>
<tr>
<td>Operational Systems and Workflows to Support Population-Based Care</td>
<td>53%</td>
</tr>
</tbody>
</table>

n=120
Survey question: Has your organization completed the MeHAF self-assessment?

- Yes: 70
- No: 63

n=133
Survey question: Is your organization participating in activities to prepare for integrated physical and behavioral health care, team-based care, and population management?

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

n=138
Technical assistance

What type of technical support has your organization received?

- Value-based reimbursement: 53%
- Behavioral/physical health integration: 67%
- Practice transformation: 75%
- HIT/HIE planning, implementation, and/or reporting: 42%

n=113

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

- Value-based reimbursement: 46%
- Behavioral/physical health integration: 21%
- Practice transformation: 17%
- HIT/HIE planning, implementation, and/or reporting: 25%

n=123
Impact of COVID-19 on VBP

Has the COVID-19 pandemic affected your practice’s ability or capacity in the following ways?

- Reduced willingness or ability to take on additional risk and/or VBP contracts
- Challenges to the sustainability of normal business operations
- Negative impacts on quality measure reporting and/or performance
- Other

n=98
Impact of COVID-19 on VBP

From your perspective, how should payers, purchasers, and providers adjust their VBP strategies in light of the COVID-19 pandemic?

- Reduce/limit risk-based payment models until the pandemic is over
- Continue expanding VBP models
- Focus on global budget/capitated arrangements not necessarily tied to quality
- Pause the expansion of VBP and focus on sustaining access to and improving the availability and provision of telehealth services

n=97
Summary findings

Provider and health plan surveys
## Summary: top enablers

<table>
<thead>
<tr>
<th>Providers</th>
<th>Health plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Top five enablers</strong></td>
<td><strong>All payers: top four enablers</strong></td>
</tr>
<tr>
<td>Aligned quality measurements and definitions (27)</td>
<td>Trusted partnerships and collaboration</td>
</tr>
<tr>
<td>Trusted partnerships and collaboration with payers (24)</td>
<td>Aligned incentives/contract requirements</td>
</tr>
<tr>
<td>Access to comprehensive data on patient populations (23)</td>
<td>Interoperable data systems</td>
</tr>
<tr>
<td>State-based initiatives (22)</td>
<td>Aligned quality measures/definitions</td>
</tr>
<tr>
<td>Aligned incentives and/or contract requirements (22)</td>
<td></td>
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</tbody>
</table>
### Summary: top barriers

#### Providers

<table>
<thead>
<tr>
<th>Top four barriers</th>
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<tbody>
<tr>
<td>Misaligned incentives and/or contract requirements (39)</td>
<td></td>
</tr>
<tr>
<td>Lack of timely cost data to assist with financial management (37)</td>
<td></td>
</tr>
<tr>
<td>Lack of interoperable data systems (35)</td>
<td></td>
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<tr>
<td>Insufficient patient volume by payer to take on clinical risk (33)</td>
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</tbody>
</table>

#### Health plans

<table>
<thead>
<tr>
<th>All payers: top four barriers</th>
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<tbody>
<tr>
<td>Payment model uncertainty</td>
<td></td>
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<tr>
<td>Disparate incentives/contract requirements</td>
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<tr>
<td>Attribution</td>
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<tr>
<td>Disparate quality measures/definitions</td>
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</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.
To facilitate further progress:

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

Mich’l Needham
Chief policy officer
mich’l.needham@hca.wa.gov

Rachel Quinn
Special assistant for health policy & programs
rachel.quinn@hca.wa.gov

J.D. Fischer
Value-based purchasing manager
jd.fischer@hca.wa.gov

Mia Nafziger
Senior health policy analyst
mia.nafziger@hca.wa.gov