

2025 Paying for Value Survey results

The annual Paying for Value survey — conducted by the Washington State Health Care Authority (HCA) — collects information about value-based payment (VBP) activity from health care plans. VBP describes a range of payment strategies intended to contain costs while improving outcomes by linking payment to care quality. The survey collects quantitative data about VBP adoption and qualitative information about designing and implementing VBP arrangements. Tracking VBP activity helps us ensure our purchasing power matches our mission.

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

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

In 2025, we received responses from 10 payers, including five Apple Health managed care organizations (MCOs) and five carriers that provide coverage for PEBB/SEBB. The 2025 survey asked respondents to report on calendar year 2024.

The survey produced several key insights:

- **Overall VBP adoption increased for the first time since 2021.** Overall VBP adoption increased by 2 percent from 2023 (1 percent increase for MCOs, 2 percent increase from PEBB/SEBB payers).
- **VBP arrangements for specialty care remain low.** Some payers reported success adding new provider organizations to VBP arrangements. However, most of VBP is still centered in primary care, with specialty care arrangements not as engaged.
- **Payers used alternative payment models to support providers’ goals.** Incentivized quality measures improved health outcomes across payers’ organizations. Alternative payment models allowed payers to effectively engage providers in achieving their goals. These goals included patient outcomes, increased engagement, and better care coordination.

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Background





Value-based payment (VBP) describes a range of payment strategies intended to contain costs while improving outcomes by tying payment to care quality. Traditional health care payment, known as fee-for-service (FFS), encourages potential overuse of expensive, low-value services. FFS doesn't reward higher value of care.

In contrast to FFS, VBP aims to change provider behavior by rewarding high-quality care and minimizing wasteful spending. For example, VBP models may include:

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

To measure VBP models, we use the [Health Care Payment Learning & Action Network \(HCPLAN\) Alternative Payment Model \(APM\) Framework](#) (see Figure 1). We consider payment arrangements in Categories 2C and 3A as VBP because they tie payment to quality. Health policy literature shows that advanced VBP models (Categories 3B and above) are more likely to meaningfully change the way providers are paid to deliver services.¹

Figure 1: HCPLAN APM Framework and HCA's VBP standard

			
<p>Category 1 Fee for service — no link to quality and value</p>	<p>Category 2 Fee for service — no link to quality and value</p> <p>A: Foundational payments for infrastructure and operations (e.g., care coordination fees and payments for HIT investments)</p> <p>B: Pay for reporting (e.g., bonuses for reporting data or penalties for not reporting data)</p> <p>C: Pay for performance (e.g., bonuses for quality performance)</p>	<p>Category 3 APMs built on fee-for-service architecture</p> <p>A: APMs with shared savings (e.g., shared savings with upside risk only)</p> <p>B: APMs with shared savings and downside risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</p>	<p>Category 4 Population-based payment</p> <p>A: Condition-specific population-based payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</p> <p>B: Comprehensive population-based payment (e.g., global budgets or full/percent of premium payments)</p> <p>C: Integrated finance & delivery system (e.g., global budgets or full/percent of premium payments in integrated systems)</p>
		<p>3N: Risk based payments not linked to quality</p>	<p>4N: Capitated payments not linked to quality</p>

HCA's VBP standard includes Categories 2C–4C.

In 2016, we established a value-based purchasing goal to drive 90 percent of state-financed health care payments into VBP arrangements that incentivize quality performance (HCPLAN Categories 2C and above). In

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

2022, we updated the state’s [Value-based Purchasing Roadmap](#) to continue advancing along the HCPLAN APM Framework. This plan includes adopting advanced models and leveraging state purchasing power to improve overall health and health equity in Washington.

Every year, we distribute the Paying for Value Survey to Washington health care payers (also referred to as plans and carriers). The survey gathers information about participation in and experience with VBP arrangements. We’ll use the results of this analysis to inform our strategic direction and continue to encourage VBP adoption for more meaningful outcomes for cost, quality, and equity of care.

From 2017 to 2021, we also surveyed providers about their experience with VBP arrangements. However, to prevent administrative burnout and survey fatigue, we’ve stopped running this survey annually. The most recent provider survey results can be found in the [2024 Paying for Value Survey](#).

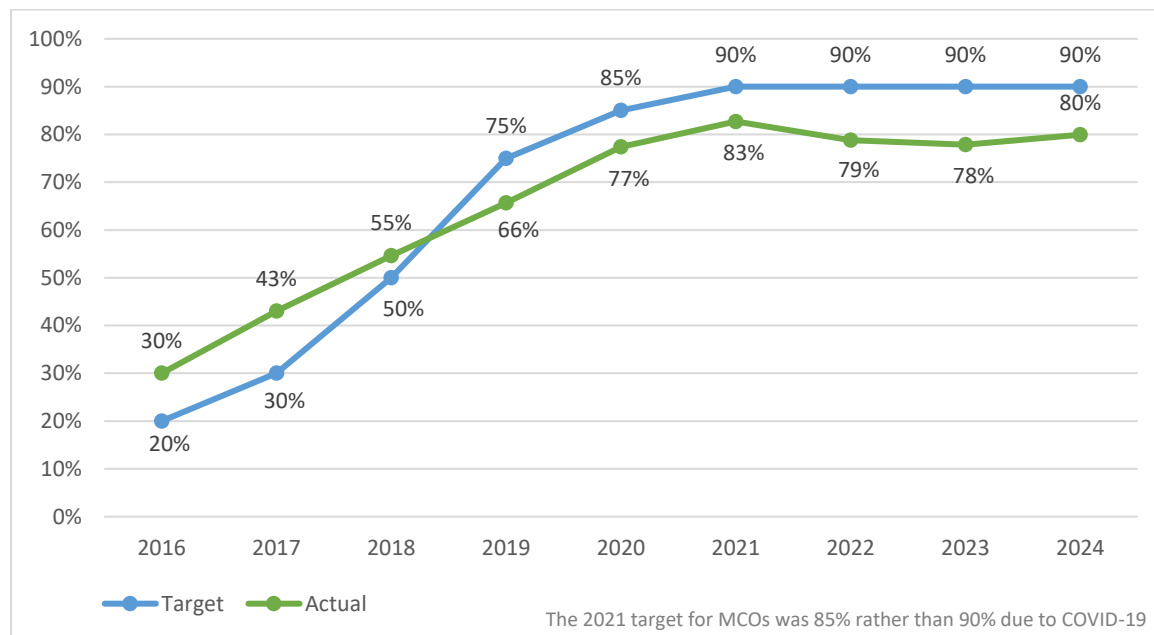
Survey results and analysis

In 2025, we received responses from 10 payers. The five Apple Health (Medicaid) managed care organizations (MCOs) and five PEBB/SEBB carriers. The 2025 survey asked payers to report on calendar year 2024.

VBP adoption

In 2024, 80 percent of state-financed health care² flowed through VBP arrangements in Category 2C or higher (83 percent of MCO payments and 75 percent of PEBB/SEBB payments). Not including PEBB/SEBB payments for the Accountable Care Program (UMP Plus), 62 percent of PEBB/SEBB payments flowed through VBP arrangements³. UMP plus plans were not renewed for next year due to financial impacts in the legislative budget and will end in December 2025.

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



² “State-financed health care” excludes fee-for-service Medicaid and wraparound payments for other services (i.e., transportations) and non-HCA health spending (i.e., long-term services and supports that go through the Department of Social and Human Services).

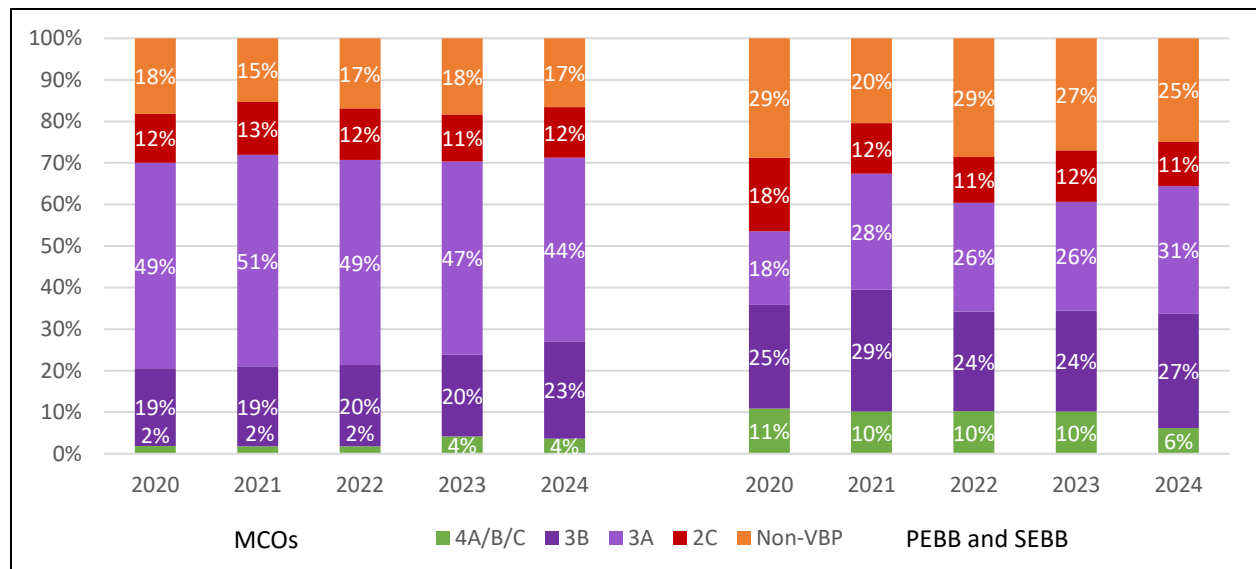
³ As of November 2025, 6.53 percent of PEBB/SEBB enrollees were enrolled in Accountable Care Program plans (UMP plus).

Overall VBP adoption increased for the first time since 2021. Overall VBP adoption increased by 2 percentage points from 2023 (Figure 2). This is the first increase after two years of declining participation; however, overall VBP participation still lags behind peak participation in calendar year 2021. Spending in VBP payment models among MCOs increased by 1 percent, while PEBB/SEBB plans increased 2 percent (Figure 3). Of the seven payers that increased in overall VBP adoption, two payers increased by at least 6 percent (one MCO and one PEBB/SEBB). This is the first VBP adoption increase in Washington since 2021.

Advanced VBP spending remains relatively consistent (Figure 3). Since last year, spending in advanced VBP models increased slightly for MCOs, from 25 percent to 27 percent. There was an overall increase in spending in shared risk (Category 3B) arrangements, but payments in population-based arrangements (Category 4) remained the same at 4 percent. Compared to last year, two MCOs showed notable increases in the shared risk arrangements, and all MCO population-based arrangements remained the same.

There was a minor decrease in advanced spending for PEBB/SEBB from 34 percent to 33 percent. For PEBB/SEBB, there was a three percent increase in Category 3B with a 4 percent decrease for Category 4 spending. One PEBB/SEBB plan showed an increase in population-based payments and a notable decrease in shared risk arrangements, while two other PEBB/SEBB plans that participated Category 4 arrangements last year decreased.

Figure 3: State-financed health care by APM category over time, 2020–2024



Why this matters: Understanding the trends for VBP adoption helps us determine the meaningfulness and effectiveness of our value-based strategy. This is the first peak in VBP adoption since 2021, with some plans, mostly MCOs, showing improvement. We can adapt our strategic efforts to not only help payers stay engaged but also meet agency goals to meet our shared desires of better helping patients.

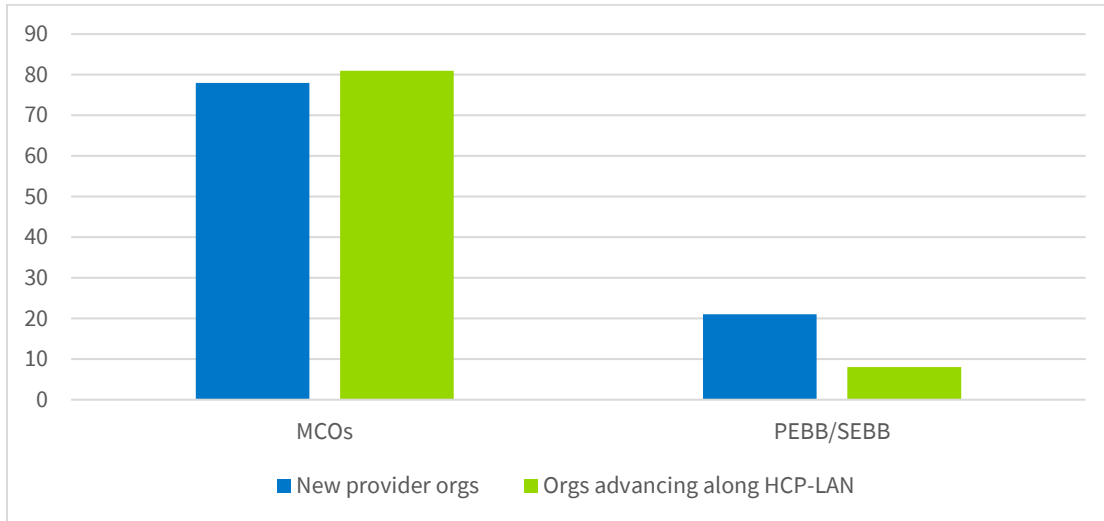
Provider participation in VBP

Provider organizations new to or advancing in VBP arrangements

We asked payers to report how many provider organizations were new to VBP arrangements in 2024 and how many provider organizations advanced along the HCPLAN framework. Seven payers (four MCOs and three

PEBB/SEBB plans) added new provider organizations in VBP arrangements. The number of new organizations ranged from one to 60 by payer, with an average of 14 (median of five organizations). Four payers (three MCOs and one PEBB/SEBB plan) advanced provider organizations along the HCPLAN framework. The number of advancing organizations ranged from one to 78 by payer, with an average of 22 (median of five organizations). Figure 4 displays the new provider organizations and how many organizations advanced along HCPLAN for MCOs and PEBB/SEBB plans.

Figure 4: Provider organizations new to or advancing in VBP arrangements

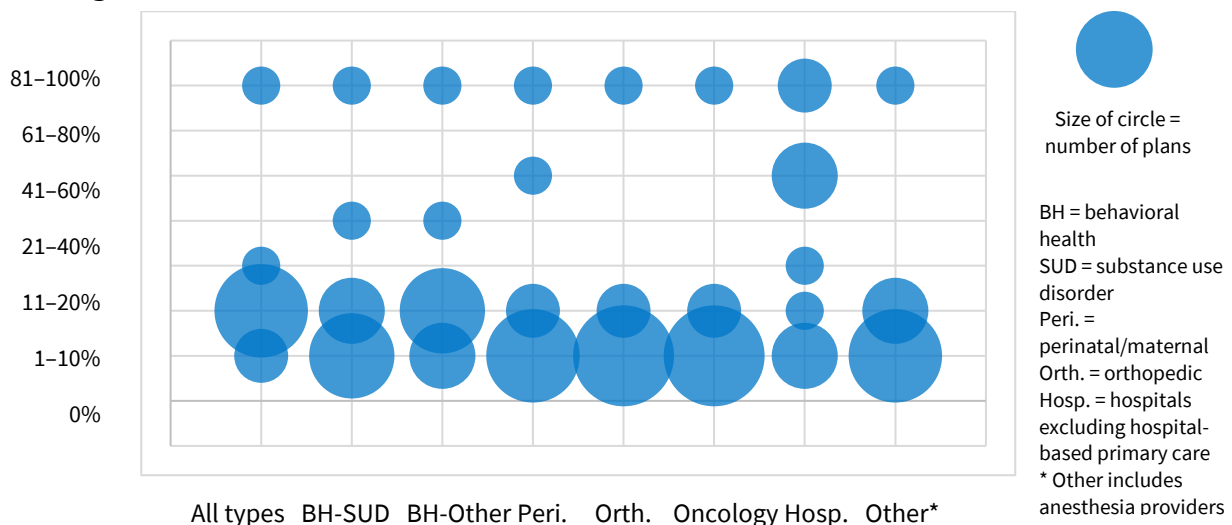


Specialty provider engagement

Prior Paying for Value Surveys and other carrier engagement demonstrated that most VBP adoption takes place in primary care. Given this, we wanted to better understand VBP engagement among specialty providers.

Figure 5 shows the percentage of specialty provider types participating in VBP arrangements. All payers offered some form of specialty VBP arrangements. However, the majority reported no VBP arrangements among most of the specialty care categories. Most payers targeted VBP arrangements were for behavioral health (substance use and other providers).

Figure 5: Distribution of specialty care provider types engaged in VBP arrangements



Enablers and barriers to VBP adoption

We asked payers about the barriers and enablers to VBP adoption. Responses were consistent with previous responses from payers. Overall barriers included provider readiness, limited data infrastructure, and administrative burden. When asked about barriers to specialty-specific VBP adoption, payers reported limited APM offerings and additional steps for reporting requirements due to a lack of nationally reported metrics.

Overall enablers of VBP adoption were increased provider engagement, aligned quality measures, and real-time data sharing. Enablers for specialty-specific VBP adoption include trusted partnerships, alignment of incentivized quality measurements with HCA goals, and achievable targets for providers.

Why this matters: This information will provide a better understanding of how specialty providers engage with VBP arrangements. Adding provider organizations may have increased overall VBP adoption, however, advanced VBP adoption remains stagnant. Addressing VBP arrangements with specialty providers could increase engagement with payers and provider organizations.

Payer goals and outcomes

Advancing organizational goals

We asked payers how VBP arrangements have helped advance their organizational goals. Payers reported that VBP has helped align performance goals with state priorities to improve patient outcomes. Examples included financial incentives for partners to improve performance and improve cost and quality utilization, reducing total cost of care. VBP supported efforts to increase more meaningful engagement with patients by evaluating and addressing health disparities and engaging providers in the coordination of care. One payer reported working with a primary care provider who embeds community health workers and social workers in their practice to increase accessibility to better focus on patient needs. Payers also reported using VBP arrangements to engage providers with nontraditional health care solutions, such as technology innovations.

Impact of VBP arrangements

We asked payers how they evaluate the impact of VBP arrangements on cost, quality, access, reduced health disparities, and other measures of impact. Understanding how payers reach their goals can highlight best practices, identify opportunities for improvement, and help us better support their efforts. A response summary is outlined in Table 1 below.

Table 1: Payer methods to evaluate the impact of VBP arrangements

Criteria	Evaluation methods
Cost	<ul style="list-style-type: none"> • Medical Loss Ratio (MLR) • Total cost of care • Trend analysis of VBP implementation (internal and using state/national benchmarks) • Risk-adjusted per-member per-month (PMPM) cost trends compared with attributed members in same geographic region • No formal cost analysis, but financial outcomes included on scorecards
Quality	<ul style="list-style-type: none"> • Healthcare Effectiveness Data and Information Set (HEDIS) measures (compared to national benchmarks and claims data) • Preventive care measures • Chronic condition management measures

- Patient-reported outcome measures
- Patient-experience measures

Access

- Claims-based proxies
- Member and provider surveys
- Contracted provider network monitoring
- Note: Not all plans provided methods for evaluating access and indicated that it is challenging to evaluate.

Reduced health disparities

- Stratification of HEDIS and other measures
- Member and provider surveys

Other measures of impact

- Patient and provider surveys
- Population health outcomes
- Review ER utilization, hospital readmissions, and inpatient utilization

Why this matters: Understanding how payers are evaluating their VBP arrangements provides insight into their decisions about present and future VBP participation, how they may measure success, and the effectiveness of outcomes. Payers providing examples of evaluation methods can provide insight into how HCA can focus strategic efforts on what helps payers achieve their organizations’ goals. This alignment can help support accountability and continue working towards cost-efficient quality improvements.

Demographic data and addressing inequities

Payers collect demographic data about race, ethnicity, and language. Resourcing data still relies on enrollment files, electronic health record data, and other forms of member self-report. Data collection for other factors such as disability, sexual orientation and gender identity, and rural status was more mixed. Those able to collect rely on equity-data frameworks and health equity assessments using self-reported information.

Some payers are developing ways to use VBP to address health inequities, such as providing upfront funds for community health centers and tying provider reimbursement to performance metrics for underserved populations.

Why this matters: We’re still in the process of implementing equity contract requirements. These requirements started from MCOs in July 2024 and will begin for PEBB/SEBB in January 2026. Understanding payers’ current activities related to demographic data collection and addressing inequities helps us understand the baseline and initial impacts of these contract requirements. This insight will also help us support more meaningful engagement in future health equity efforts.

Quality measurement

Incentivized quality measures

Payers are **incentivized by HCA** to achieve specific quality measures to encourage better patient outcomes. For example, the **2025 VBP Report Card** shows how MCOs met the criteria for eight shared quality measures. We

asked payers about quality measures they used in addition to quality measures we incentivize. All payers had at least one measure not incentivized by HCA. Some payers added measures to support provider priorities and improved population health. Other measures aim to educate patients and prevent avoidable admissions by helping patients manage chronic conditions or detect emerging illnesses. Examples of additional quality measures include:

- All-cause readmissions,
- Routine appointment wait satisfaction, and
- Follow-up post emergency department visit for people with high-risk multiple chronic conditions.

We also asked if payers retired any quality measures in 2024. Payers reported that they retired some measures to replace them with better-suited ones. In some cases, payers removed measures due to administrative burden.

Quality improvement

All payers reported seeing quality improvement from APMs. Particularly, payers described improved patient outcomes, more timeliness of care, and increased data sharing. One payer said their incentivized groups perform better in the same quality measures than contracted providers not in a VBP agreement. Payers reported that increased provider engagement also resulted in better care coordination, more timely interventions, and reduced hospital readmissions.

Why this matters: We are looking for more ways to help bolster efforts for accountability, efficiency, and performance. We want to make sure payers see improvements in quality based on APM arrangements. We also wanted to understand what matters to payers to help us hone the agency's quality measurement priorities in ways that are helpful to payers. Payers' input will help us continue aligning agency goals with quality measures that support organizational success and, ultimately, improved patient outcomes.

Conclusions

VBP went up slightly, but still below its peak

Overall VBP adoption increased for the first time since 2021, though is still below the peak from 2021. Advanced VBP continues to slightly increase for MCOs (increasing by three percent from last year) but is still stalled for PEBB/SEBB plans. HCA will continue to engage with payers, such as our current work to tailor the **common measure set** with provider and payer input to improve outcomes. A few payers showed notable increases, and we'll strategize with payers to enhance engagement with performance measures and improve VBP adoption rates.

Payers report some progress in adding new providers, but limited progress advancing providers to higher order models

Seven out of 10 payers added new provider organizations into VBP arrangements and four payers advanced organizations along the HCPLAN categories. Adding and advancing more provider organizations may have increased overall VBP adoption and advanced VBP adoption among MCO plans. PEBB/SEBB plans did not add or advance as many providers, which could contribute to stalled advanced VBP adoption outcomes.

One of the goals outlined in our **VBP roadmap** is to continue advancing along the HCPLAN framework. It is important for more providers participating in VBP arrangements, specifically advanced VBP, to help support

improved quality and better patient outcomes at lower cost of care. We'll continue working on this effort with payers and providers to engage more provider organizations in advanced VBP arrangements.

Payers are not expanding the types of modeling that they offer to target specialty care

Specialty providers are still not as engaged in VBP arrangements compared to primary care. Specialty VBP models can require more complex modeling and encounter more administrative barriers. HCA will continue to monitor trends and work with payers to consider ways to involve specialty care in VBP arrangements.

Payers report that VBP arrangements give them an opportunity to engage providers in advancing patient health and their goals

Payers reported engagement with providers and patients, improved care coordination, and aligned performance and incentives resulting from participating in VBP arrangements. These efforts align with payers' organizational goals and VBP objectives and often align with HCA's goals.

We understand that recent policies could pose risks to progress in VBP adoption. These policies include:

- **H.R. 1 implementation** that is likely to shift insurance coverage and put some provider revenue at risk,
- Medicare FFS and the Center for Medicare & Medicaid Innovation (CMMI) pushing mandatory models, and
- CMMI moving towards risk-based models.

HCA will work with payers and providers on opportunities for progress, such as the refinement of the common measure set, further implementation of health equity measures, and the proposed payment model work under the **Rural Health Transformation Program**.