Paying for health and value

Health Care Authority’s
Long-term Value-based Purchasing Roadmap
2022-2025
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Introduction

Health Care Authority's (HCA's) goal is to achieve a healthier Washington by containing costs while improving outcomes, patient and provider experience, and equity through innovative, value-based purchasing (VBP) strategies. This roadmap is an update to the 2019 Value-based Purchasing Roadmap, and sets forth HCA’s VBP priorities for the 2022-2025 period.1

The roadmap outlines HCA’s VBP progress to date, successes and challenges in implementing VBP, and priorities and levers in advancing VBP—ultimately shifting from paying for volume to paying for health and value. Specifically, it aims to focus on targeted health system transformation to ensure that payment ultimately drives higher quality services at a lower cost, enabling greater health equity and access and care for all people of Washington.

While HCA and the state's partners are working toward the 90 percent VBP goal for 2021, decisions and investments made today will lay a foundation for sustained health care transformation in 2022 and beyond. The recent State Innovation Models (SIM) grant that expired in 2019, and the Medicaid Transformation Project (MTP) waiver expiring at the end of 2021,2 have been critical to this effort. HCA will continue to focus on sustaining successful initiatives and testing new programs that advance Washington’s health and wellness systems.

HCA will also advance models that can best support providers and health plans recovering from the COVID-19 pandemic, and build upon current initiatives. This includes the rapid adoption of virtual care resulting from the health care industry’s response to the pandemic.

Background

Health care transformation initiatives

Federal legislation has been a catalyst for changing how health care is purchased. In 2010, the Affordable Care Act (ACA) established a goal that 90 percent of payments through Medicare would be linked to quality measures by 2018.3 4 In 2015, Congress passed the Medicare Access and Children’s Health Insurance Program Reauthorization Act (MACRA), which incentivizes Medicare providers to participate in alternative payment models (APMs).

Additionally, the CMS’ Physician-Focused Payment Model Technical Advisory Committee (PTAC) established under MACRA has proposed over 40 VBP payment models to date. The current administration has advanced VBP initiatives, including bundled payments (e.g., for radiation oncology), implementation of MACRA, and facility-based pricing.5

HCA has followed suit by transforming how health care is purchased throughout the state. HCA purchases health care through three state-financed programs: Washington Apple Health (Medicaid), Public Employees Benefits Board (PEBB), and School Employees Benefits Board (SEBB), each of which contribute to the 90 percent goal. In 2014, state legislation directed HCA to increase the use of value based contracting under state-financed health care programs.

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2 Washington State is exploring the option of a COVID-19 extension year. For more information, visit https://www.hca.wa.gov/assets/program/covid-19-extension-year.pdf
3 For more on the ACA’s Medicare VBP targets, visit https://www.nejm.org/doi/full/10.1056/NEJMp1500445
4 For more on Medicare meeting the ACA VBP targets, visit https://hcp-lan.org/2018-apm-measurement/
5 For the latest news from CMS on VBP programs, visit https://www.cms.gov/newsroom.
In 2015, CMS awarded Washington a four-year $65 million State Innovation Models (SIM) grant to achieve better population health by improving how care is paid for, focusing on “whole person” care. To further advance state program innovation and build on the SIM grant, CMS approved a Section 1115 Medicaid Waiver for MTP in 2017. The waiver allows the state to invest in Medicaid delivery and payment reform with Medicaid dollars. One way in which MTP advances VBP is through regional Accountable Communities of Health (ACHs); each region’s ACH supports providers in adopting VBP, and each ACH is required to develop plans to enable the success of APMs.

Figure 1: Timeline: health transformation initiatives

The COVID-19 pandemic

The COVID-19 pandemic has impacted every aspect of the state’s health care system and daily life for individuals. It has created tremendous uncertainty, especially for the many providers operating under fee-for-service arrangements who face dramatic revenue shortfalls. At the same time, the pandemic has disproportionately impacted historically marginalized populations and the providers who serve them, exacerbating inequities in Washington.

HCA’s approach to advancing VBP and achieving our goals must be responsive to and informed by the pandemic. In many ways, the pandemic has exposed the challenges Washington’s health care system faces, and makes HCA’s work toward a more equitable, affordable, and high-quality health care system even more urgent. The challenges associated with the COVID-19 pandemic present a rare opportunity to transform Washington’s health care system and further re-imagine health care delivery for the people of Washington.

The VBP program positioned the state to better respond to COVID-19 by allowing managed care organizations (MCOs) to make upfront monthly payments to financially distressed providers. VBP programs could further help providers by providing a more predictable funding stream through global payment and other pre-paid arrangements.

Ultimately, the pandemic exposed a critical flaw in fee-for-service (FFS) payment models when many providers found themselves financially vulnerable because of decreased utilization.6 The pandemic may encourage some providers to transition from FFS to VBP models, including, but not limited to, capitated arrangements. However the appetite for VBP will vary regionally, by model, and by provider type and

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capacity to implement new models (See page nine for a subset of provider responses on the Paying for Value survey relating to the pandemic).

In the short term, the pandemic has altered CMS’ VBP strategy, including but not limited to:
- Removing down-side risk from existing models for 2020.
- Relaxing quality reporting deadlines and requirements.
- Delaying scheduled termination and initial implementation of certain programs.

HCA similarly is implementing short-term changes to its VBP program, including adjusting the 2021 MCO VBP target rate to keep at 85 percent due to COVID-19, rather than increasing to 90 percent.

Considerations for HCA regarding COVID-19’s lasting impact on health care in Washington will shape how HCA approaches VBP, and inform how the state pursues the objectives outlined in this roadmap. These considerations include, among others:

- Telehealth and virtual care: the pandemic catalyzed a dramatic increase in the use of telehealth and virtual care throughout the state. While policies that fostered rapid adoption—including allowances for payment for a wide variety of services—will change as the pandemic subsides, telehealth and the provision of virtual care should continue to be a significant modality of care delivery beyond COVID-19. VBP arrangements in the future will consider the impact of virtual care on utilization, quality, outcomes, access, equity and patient experience.
- Primary care model: HCA’s work with providers and health plan stakeholders on primary care redesign predates the pandemic. Washington’s emerging primary care model may include new payment mechanisms that prioritizes value and equity. In the short term, as the model is implemented, HCA will confront the challenges providers, patients, and MCOs face as a result of the pandemic.
- Provider engagement: COVID-19 will impact provider interest and capacity to enter into new VBP arrangements. In the more immediate term, VBP arrangements may need to be modified to help support distressed providers.

Vision for paying for health and value

Annually, HCA spends more than $12 billion between Apple Health, PEBB, and SEBB programs. This gives HCA the market power to drive transformation as a convener and innovator.

HCA aims to achieve better quality, patient and provider experience, lower costs, and greater equity across Washington’s health care system through value-based purchasing (VBP).

HCA’s vision for VBP in 2025

- VBP arrangements will be aligned across all public purchasing programs and advance multi-payer primary care models where appropriate. We will leverage HCA’s purchasing power to continually drive the health care system toward improved outcomes, patient and provider experience, and equity while containing costs.
- VBP arrangements will be rooted in data-driven policy making, requiring HCA to collect and utilize actionable data to:
  - Reinforce accountability among delivery system networks as well as provider and MCO partners.
  - Exercise significant oversight to identify priorities, monitor progress, and improve performance.
Foundational principles for paying for health and value

HCA has established a set of foundational principles that will guide HCA’s efforts to achieve the above vision. HCA commits to:

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 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.

The rearview mirror

In 2016, HCA began setting annual VBP targets for state-financed health programs, with an ambitious target of 90 percent of state-financed health care payments occurring under VBP contracts by 2021. This section of the roadmap captures the methodology behind HCA’s VBP targets, recent VBP survey data, and successes achieved through HCA’s VBP program overall.
APM Framework: categories of VBP arrangements

There are different types of VBP arrangements that serve as viable alternatives to FFS payments. To help define our VBP targets, HCA adopted the APM Framework created by CMS through the Health Care Payment and Learning Action Network (HCP-LAN). The APM framework defines APMs along a spectrum, starting at fee-for-service payments with no link to quality or value (Category 1), and escalating to population-based payments, such as global budgets (Category 4).

HCP LAN updated the framework in 2017 to remove the former section 2D (a category where few APMs fell), and added 4C to more accurately account for integrated delivery systems.

HCA will adopt the revised framework beginning in 2022, and will implement the change throughout calendar year 2021. See figure 2: HCP-LAN APM Framework.

The target to achieve 90 percent of state-financed health care payments under VBP contracts refers to APM Framework categories 2C-4C, ranging from pay-for-performance to fully integrated models, and applies across all state-financed health programs, including Medicaid, PEBB, and SEBB. According to LAN, APM Category 4 payment models provide the greatest incentives and opportunities for providers to adopt a population health lens and achieve high quality, cost, and efficiency. While HCA defines VBP as ranging from Categories 2C-4C, HCA in the long term aims to move providers further “up” the framework.

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7 For more information about the 2017 refresh of the APM Framework, visit https://hcp-lan.org/apm-refresh-white-paper/.
8 To view the Health Care Payment Learning & Action Network, APM Framework white paper, visit https://hcp-lan.org/apm-refresh-white-paper/.
In 2018, HCA achieved 54 percent of state-financed health care payments to providers in APM categories 2C and above, exceeding its 2018 interim goal of 50 percent (See figure 4: Progress toward HCA’s 90 percent VBP adoption goal).
Paying for Value surveys

Each year, HCA surveys health plans and providers to measure VBP adoption and related barriers and enablers. HCA uses these Paying for Value surveys to track VBP adoption and progress towards HCA’s VBP goals, as well as inform ways to improve current and future initiatives. The most recent survey in 2020, outlined below, captures data from the 2019 calendar year.

In 2020, eight health plans and 173 unique provider organizations responded to the Paying for Value survey. The health plans reported that a significant portion of their provider payments were in APM Categories 2C and above in 2019. Medicare Advantage plans reported that 76 percent of their payments to providers fell under VBP models (up from 64 percent in 2018), and commercial plans reported 64 percent of provider payments though VBP models (up from 55 percent in 2018).

When asked about ways to make adoption of VBP possible and appealing, both health plans and providers cited similar enablers centered around trusted partnerships, aligned incentives, and aligned quality measures. Barriers to adoption of VBP varied more widely between health plans and payers.

For health plans, key barriers included payment model uncertainty and disparate quality measures and incentives. For providers, barriers included the lack of data and insufficient patient volume. Both providers and health plans cited the lack of interoperable data systems as key barriers to success (See figure 5: 2020 Paying for Value survey top enablers of VBP adoption, and figure 6: 2020 Paying for Value survey top barriers of VBP adoption).

Figure 5: 2020 Paying for Value survey top enablers of VBP adoption

<table>
<thead>
<tr>
<th>Health Plans</th>
<th>Providers</th>
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<tr>
<td>1. Trusted Partnerships and collaboration</td>
<td>1. Aligned quality measures/definitions</td>
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<tr>
<td>2. Aligned quality measures/definitions</td>
<td>2. Trusted Partnerships and collaboration</td>
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<tr>
<td>3. Interoperable data systems</td>
<td>(with payers)</td>
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<td>4. Aligned incentives/contract requirements</td>
<td>3. Access to comprehensive data on patient</td>
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<td></td>
<td>populations (e.g., demographics, morbidity data)</td>
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<td>4. Aligned incentives/contract requirements</td>
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The provider survey asked how the pandemic has affected provider practice's ability or capacity relative to VBP:

- Approximately 40 percent of responding providers noted a reduced willingness to take on additional risk and/or VBP contracts.
- Nearly 90 percent of responding providers cited negative impacts on quality measure reporting and/or quality performance, and over half noted challenges to the sustainability of normal business operations.

We also asked providers how the health system should adjust VBP strategies in light of the pandemic:

- Approximately 50 percent of responding providers suggested reducing or limiting risk-based payment models until the pandemic is over.
- Nearly 60 percent suggested pausing the expansion of VBP and instead focusing on sustaining access to telehealth services.

HCA is in the process of evaluating state-financed VBP adoption for 2019. In 2018, 54 percent of state-financed payments were APM Categories 2C and above. For Medicaid Managed Care, 66 percent of payments were APM Category 2C and above, with the majority—57 percent of all payments—in APM Categories 3A-3B. Of the payments made by PEBB, 29 percent of payments were APM Category 2C and above.
Figure 8: Health Care Authority’s value-based purchasing solar system, 2018

Washington Health Care Authority’s Value-Based Purchasing Universe, 2018

1: Fee for Service
$1,201,252,108
71% of PEBB payments

2C: Pay for Performance
$74,451,283
4.4% of PEBB payments

1: Fee for Service
$1,166,067,3543
40% of MCO payments

4B: Comprehensive Population-Based Payment
$81,270,390
2.4% of MCO payments

4N: Centers of Excellence
$1,865,889
0.1% of PEBB payments

3A: Infrastructure / Operational Payments
$12,311,930
0.4% of MCO payments

3B: Accountable Care Program
$128,500,371
7.5% of PEBB payments

2C: Pay for Performance
$221,010,588
60% of MCO payments

4B: Capitation
$288,905,489
17% of PEBB payments

3B: APM with Downside Risk
$515,714,112
15% of MCO payments

HCP LAN APM Framework

The HCP LAN alternative payment model (APM) framework defines APMs along a spectrum, starting at fee-for-service payments with no link to quality or value (Category 1) and escalating to population-based payments, such as global budgets (Category 4). The solar system above shows the Health Care Authority’s state-financed health care payments in each APM category, both through Medicaid managed care and the Public Employee Benefit Board (PEBB). HCA consider VIP payments as those which fall under categories 2C to 4C. Note: School Employee Benefits Board (SEBB) data is forthcoming.

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The 2018 data, however, does not capture several changes that advance VBP under PEBB since 2018 or the launch of the SEBB program in January 2020. The new statewide plan for public school employees is centrally managed and operated by the state, similar to the PEBB program, and extends VBP benefits to a new population.

Across both programs, HCA has initially focused on bundled payment models (including for hip and knee joint replacements) and accountable care arrangements. The accountable care plan approach includes shared risk, where providers take on financial and clinical responsibility for specific populations and provide integrated physical and behavioral health services to members.

**VBP successes**

HCA and its partners have made significant strides in recent years to advance VBP across the state, both in moving toward HCA’s VBP targets as well as through other avenues, such as multi-payer collaboration and partnership with ACHs. Several of HCA’s recent successes are highlighted below.

**Figure 9: Successes in VBP**

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples of Success</th>
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| New models or Requirements      | • **Hep C Free Washington’s Drug Modified Subscription Purchasing Model**: in 2019, CMS approved Washington’s request to negotiate with drug manufacturers for arrangements linking Medicaid payment to value. Under the agreement, Washington negotiated with drug manufacturer, AbbVie, to pay a set price for a course of hepatitis C treatment for Medicaid members. If a patient requires more medicine beyond the designated course of treatment, AbbVie has agreed to only charge a nominal amount.  

  

  **Cascade Care Public Option Plan VBP requirements**: participating public option plans are required to meet affordability standards linked to Medicare and evidence-based, value-driven protocols. Plans applying to offer a public option must demonstrate to the state that at least 30 percent of provider contracts for the public option plan would include VBP. Despite COVID-19, public option plans are still expected on the Washington marketplace starting January 1, 2021.  

  **SEBB contract ties medical loss ratio to value**: completed procurement for fully insured health insurance benefits options, including a new value-based payment strategy tying 10 health plans’ medical loss ratio to value.  

  **CMS grant to increase substance use disorder treatment capacity**: in September 2019, Washington was awarded a $3.8 million grant from CMS to increase treatment capacity of providers to deliver substance use disorder (SUD) treatment and recovery services for Medicaid clients. This will include assessing the feasibility of developing an APM for SUD. |

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9 To read more about the new SEBB program, visit [hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program](http://hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program).


11 To read more about the requirements for plans applying to offer the public option in Washington, visit [https://www.publicoptioninstitute.org/feed-wa-implementation-materials](https://www.publicoptioninstitute.org/feed-wa-implementation-materials).
treatment and recovery services that incentivize quality of care and long-term recovery.\(^{12}\)

- **Regence’s Total Care Program**: HCA is opting in to Regence’s Total Care Model, a value-based program inclusive of care management, beginning January 2021.

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<th>Enhanced or expanded ongoing programs</th>
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| - **VBP and quality components in PEBB and SEBB Accountable Care Programs**: Accountable Care Programs (ACPs) create networks of providers who are financially responsible for a population of PEBB and SEBB members. Networks typically include multiple hospitals and provider systems. From 2019 to 2020, ACP enrollment has increased from 30,000 to 38,852 members.  
- **Centers of Excellence Program in PEBB and SEBB for total joint replacement (TJR) and spine fusion**: PEBB and SEBB incentivize members to seek out surgeries and treatment at facilities that adopt and demonstrate use of Bree Collaborative-endorsed best practices. HCA released a Request for Information (RFI) for a new Centers of Excellence Program for bariatric care, for which HCA received three responses. HCA is now considering releasing a Request for Proposals.  

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<th>Milestones reached</th>
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| - **Community Health Plan of Washington (CHPW), Molina, and Coordinated Care of Washington (CCW) achieved CMS advanced APM certification**: HCA facilitated advanced APM certification under the MACRA Quality Payment Program for three health plans. CPHW is certified through 2020, Molina is certified through 2021, and CCW is certified through 2025.  
- **1115 Medicaid Transformation waiver**: In 2017, Washington State and CMS reached agreement on a five-year Medicaid delivery and payment reform project. Through this waiver, ACHs support providers in adopting VBP arrangements. ACHs facilitate VBP-enabling population health partnerships and investments, and allocate Delivery System Reform Incentive Payment (DSRIP) program funds to support and reward VBP adoption. DSRIP funds are also used to support Foundational Community Support (FCS) programs that advance equity by working to reduce housing and employment disparities among Medicaid recipients.  
- **Progress towards 90 percent VBP targets goal**: by 2021, HCA will tie 90 percent of payments made to providers for service delivery to quality. In 2018, 54 percent of payments were tied to quality, exceeding the 2018 interim goal of 50 percent.  

<table>
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<th>Administrative changes</th>
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| - **Two percent withhold in MCO contracts tied to quality and VBP**: HCA increased the percent withhold in MCO contracts tied to quality and VBP from 1.5 to 2 percent in 2020.  
- **Five common measures across all VBP contracts**: The Statewide

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\(^{12}\) To read more about Washington’s SUD grant, visit [hca.wa.gov/about-hca/behavioral-health-recovery/washington-receives-38-million-grant-increase-substance-use](hca.wa.gov/about-hca/behavioral-health-recovery/washington-receives-38-million-grant-increase-substance-use).
Common Measure Set provides a common foundation for measuring performance across the state. HCA established five common measures across all VBP contracts, promoting alignment for plans and providers in reaching quality goals.

- **Annual surveys and contract terms defined by APM Framework:** HCP-LAN APM Framework categories are included in managed care contract terms and the annual Paying for Value provider survey.

### Partnerships

- **Health Equity Collaboration with Community Health Plan of Washington:** In 2019, HCA partnered with CHPW and its parent organization, Community Health Network of Washington (CHNW), a network of 20 federally qualified health centers, to develop new integrated payment and health care delivery models that advance health equity. Over two years, HCA, CHPW, and CHNW are designing and incorporating new interventions that reduce health disparities, acting as a model for other Washington Medicaid providers and payers. In the partnership’s first year, the team is focused on new interventions that address maternal and child health inequities by developing a root cause analysis and associated interventions.

- **Technical support through Innovation Accelerator Program:** Washington receives technical support from CMS through its Innovation Accelerator Program (IAP) to invest in four key Medicaid service areas: SUDs, improving care for complex-needs patients, long-term services and support, and physical and mental health integration. Washington has been a participant in IAP since 2014. HCA’s current work with IAP is helping assess the state’s approach to homelessness risk adjustment; exploring how to develop a maternity care bundle that incentivizes postpartum care and integrates pediatric services; and projecting a financial simulation of a maternity bundle.

### Challenges

While the VBP program has achieved significant successes, HCA, plans, and providers face challenges in the transition to paying for health and value. One of the most consequential challenges facing HCA and its implementation of VBP is effectively collecting, sharing, and using actionable data. To better understand the sources of health disparities and gauge the impact of VBP on outcomes, cost, and patient and provider experience, leveraging accurate and timely data is essential. HCA will prioritize collection and utilization of actionable data to better understand the impact of VBP, track progress against HCA’s goals in a measurable way, and ultimately inform where to focus efforts going forward.

Another challenge to VBP advancement is alignment, both across HCA programs and across other Washington State agencies. Alignment can be particularly challenging as the Apple Health, PEBB, and SEBB population differ in terms of demographics, socioeconomic profiles, risk factors, and health status. These variances require careful attention and planning as to the type of VBP program that may be prioritized, and the potential impact to the providers and members that are affected by them.

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13 To read more about the Advancing Health Equity learning collaborative, visit [https://www.solvingdisparities.org/](https://www.solvingdisparities.org/).
14 To read more about CMS’ Innovation Accelerator Program, visit [https://innovation.cms.gov/innovation-models/map](https://innovation.cms.gov/innovation-models/map).
HCA recognizes that an aligned purchasing strategy is crucial for moving the needle on quality and cost. Different benefit structures and payment methodologies across Medicaid, PEBB, and SEBB mean that VBP levers may vary by necessity across programs. Accordingly, HCA will tailor new models to address the most pressing needs of public purchasing program members.

Finally, COVID-19 has had a detrimental impact on both state and provider finances and capacity to implement new payment methodologies. COVID-19 therefore poses challenges on multiple levels to advancing VBP in the near term.

**The road ahead**

HCA will strengthen and expand VBP by building upon existing processes and adding new initiatives. Throughout this journey, HCA will continue to engage providers, care coordinators, health plans, ACHs, and other key stakeholders to ensure a collaborative approach to VBP.

**Monitoring and evaluating VBP**

HCA’s long-term VBP vision includes more proactive engagement with partners and data to better inform and drive improvement in cost, quality, equity, and patient and provider experience.

To enable this shift through 2025, HCA plans to strengthen the way it monitors and evaluates its VBP programs. First, HCA will develop measurable objectives based on HCA’s foundational principles (see list of HCA’s foundational principles in an earlier section of this document). These objectives will be tracked and reported over time to quantitatively capture progress, successes, and roadblocks.

This will enable HCA, plans, and providers to gain deeper insights into the progression of the VBP program and its impact on care, and it will support ensuring that policy and program decisions are guided by shared principles and informed by timely data.

To improve monitoring, HCA will refine performance measurement to better reflect the state’s priorities and hold partners accountable to advance the APM Framework, and meaningfully drive improvements in quality, cost, equity, and experience objectives. This will include disaggregating data by race, ethnicity, and language to get a more complete picture of health equity in Washington.

**Key priorities for 2022-2025**

HCA has identified the following priorities to help guide VBP decisions and strategies for the 2022-2025 period. Each priority is linked to HCA’s foundational VBP principles, which were discussed in an earlier section of this document.

**Access**

**What:** the ability of members to access the behavioral, primary, and specialty care providers and services they need.

**Why:** for HCA to advance person- and family-centered, high-value health care, members must first be able to access a full continuum of providers and services. Differences in access geographically and by service inherently introduce and reinforce inequities in the health care system. COVID-19 threatens the financial stability of primary care practitioners reliant on FFS, further exacerbating access challenges. Access in particular remains a challenge for behavioral health and primary care services, especially for those in rural areas.

**How:** HCA will:
- Develop methods to measure access to a broad spectrum of services and provider types.
• Implement global budgets for rural providers (see below) with incentives to maintain and improve on access.
• Given COVID-19-related decline in utilization and associated savings for MCOs, HCA plans to require MCOs to attest to how they are using those savings. This will ensure providers remain financially viable and members are able to access care.

**Affordability**
**What:** the ability of HCA to use VBP arrangements to manage total cost of care.

**Why:** affordability is crucial to ensure both the long-term financial sustainability of all state health coverage programs and member access to care. HCA will continue to strive for smarter spending, using its purchasing power and through collaboration with other Washington purchasers and health plans, to develop approaches to manage total cost of care. HCA will also hold partners accountable to meeting affordability objectives as we move toward more advanced population-based payment models. This includes exploring how to address specialty care costs as well as other health care cost drivers.

**How:** for the 2022-2025 time period, with respect to affordability, HCA plans to:
• Establish and support the Health Care Cost Transparency Board, to calculate and analyze Washington’s health care cost trends (including total cost of care), as directed by 2020 legislation.15
• Align its VBP initiative with ongoing HCA work to measure and manage total cost of care.
• Support the development of total cost of care metrics and explore holding partners accountable to meeting total cost of care targets.
• Explore global budget payments as a mechanism to manage costs and support providers—particularly in rural communities—who would benefit from more reliable and sustainable funding streams that prioritize value over volume.
• Investigate reference-based pricing strategies for the PEBB and SEBB programs.

**Social determinants of health (SDOH)**
**What:** SDOH is defined by the Centers for Disease Control and Prevention as “the conditions in the places where people live, learn, work, and play” that impact health risks and outcomes. These conditions can be social, economic, and physical.16 Addressing SDOH includes incorporating approaches and measures to address SDOH and expanding access to nontraditional services, and requires coordinated efforts across Washington’s health and social service agencies.

**Why:** whole-person health care and health equity cannot be achieved without proactively addressing SDOH for all members of HCA purchasing programs. Health determinants reach far beyond traditional medical care, with an estimated 80 percent of a person’s health determined by their housing, access to food, and community, among other social factors.17

SDOH are currently included in the medical loss ratio numerator calculation for MCOs, which encourages MCOs to provide services and make investments outside of traditional medical care. HCA’s VBP strategy should further extend payment beyond traditional health care system and services to achieve its objectives.

**How:** HCA will address SDOH over the long-term through the following activities:
• Establish appropriate and impactful ways to capture partners’ impact on SDOH, and ultimately incentivize partners to address SDOH.
• Continue to examine the roles of MCOs, ACHs, PEBB, SEBB, and provider partners in advancing SDOH objectives. In addition, establish appropriate strategies to reward and hold partners accountable to

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16 To read more about the CDC’s definition of SDOH, visit [https://www.cdc.gov/socialdeterminants/index.htm](https://www.cdc.gov/socialdeterminants/index.htm)
supporting clients’ SDOH needs.

- Engage in standardization of SDOH data elements and processes for SDOH data-sharing across public and private partners.
- Explore including nontraditional and evidence-based services that address SDOH in bundled payments. This may include expanding benefits to include upstream, nonmedical interventions in state-financed health care programs, and more broadly throughout the health care system.
- Explore requiring MCOs to measure and report SDOH intervention impact.
- Actively engage with other Washington health and human services agencies to advance SDOH objectives.

**Health equity**

**What:** health equity is described by the Robert Wood Johnson Foundation as everyone having the “fair and just opportunity to be as healthy as possible.” Health inequities persist throughout the country. In Washington State, health inequities lead to health disparities among marginalized groups or groups otherwise excluded from opportunities to be as healthy as possible.

**Why:** HCA recognizes that our status as a purchaser allows us to influence health and the health care system to prioritize health equity and reduce health inequities. While this work poses many challenges and is incredibly nuanced, it is our moral imperative to engage in advancing equity. Health equity is not a stand-alone issue, but a vital thread throughout all activities, including the VBP program, it can be employed as a tool to combat inequities across racial, socio-economic, and other characteristics. The VBP program will seek to build on a HCA-wide strategic plan for health equity and exemplify a culture of health equity.

**How:** HCA will use its status as a purchaser to reduce health inequities and improve all members’ health status by acting through the following avenues:

- HCA will strive to view all programs and purchasing through a health equity lens and address health equity in future VBP program design.
- The Paying for Value surveys will continue to contribute to data collection around plan and provider health equity activities. The 2019 survey included questions for providers around data collection, performance assessment, and activities related to race, ethnicity, and language access;
- HCA will work to measure and hold partners accountable to advancing health equity, including segmenting quality data by race, ethnicity, and language categories. Successful measurement of health equity will require robust data system(s) that support data disaggregation to reveal meaningful health disparities.
- HCA will explore opportunities to move beyond risk-adjustment, which can hide inequalities, toward also requiring risk stratification. This additional step can shine a light on and allow for the measurement of disparities.

**Primary care**

**What:** reinforcing and supporting a robust primary care model, which the National Academy of Medicine defines as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of the family and the community.”

**Why:** successful delivery of accessible and affordable whole-person care relies on a robust primary care system that ensures quality and access for all Washington residents. Primary care providers are foundational to supporting more efficient, high-value care. Primary care providers also serve a critical role in supporting care continuity, and guiding patients through physical health, behavioral health, and social services systems.

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18 To read more about the definition of health equity, visit [https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html](https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html)
**How:** in strengthening Washington's primary care system, priority programs include:

- Expanding and optimizing the Health Homes program.
- Implementing of a Multi-payer Primary Care Transformation Model under which teams of multidisciplinary providers will be accountable for a patient's care.
- Consideration of primary care in all APMs and monitoring/addressing primary care spend.
- Potentially pursuing a primary care bundled payment or another APM model.
- Exploring how a pediatric alternative payment model intersects with a primary care model.

**Alignment**

**What:** cooperation and collaboration within HCA and across Washington State public agencies.

**Why:** opportunities exist for greater alignment across HCA program areas to more effectively drive VBP goals. An aligned purchasing strategy increases impact and is less burdensome for providers. HCA recognizes that different benefit structures and payment methodologies across Medicaid, PEBB, and SEBB mean that VBP levers may vary by necessity across programs.

**How:** HCA will better align programs by focusing on common VBP goals across programs. HCA will aim to ensure that across Medicaid, PEBB, and SEBB, providers and plans will be working to influence aligned outcomes. Externally, HCA will build on existing areas of alignment with other health and human services agencies, including:

- Partnering with Tribal governments to support Indian Health Care Providers (IHCPs) in their adoption of APMs, while ensuring the larger VBP strategy does not unintentionally harm the IHCP payment system.
- Continued partnership with the Health Benefit Exchange on Cascade Care's implementation and VBP requirements.

Other potential opportunities for alignment include new partnerships and activities, such as incentivizing more evidence-based SUD treatment; designing alternative purchasing arrangements for incarcerated youth or other specific at-risk populations; addressing churn between Medicaid and Washington Healthplanfinder; and bringing other SDOH benefits and services into the eligibility and enrollment process. **Note that these are not specific HCA plans at this time, but are examples for exploration.**

**Accountability and support**

**What:** holding partners accountable—including PEBB, SEBB, and managed care plans, providers, and FFS participants—for support in establishing and sustaining VBP programs.

**Why:** VBP needs to continue to be measured and monitored. HCA needs to also implement accountability and support mechanisms. Accountability is important to ensure that all partners under a VBP model are appropriately incentivized (and penalized) to maintain high levels of quality, access, and equity for all patients.

**How:** beyond increasing the scale of incentives, this could include transitioning from VBP withholds to penalties. By 2022, the 90 percent target will be out of date. HCA will need to consider how to enforce VBP adoption (potentially though new targets) beyond 2021. Additionally, HCA will work to ensure that accountability and support align across programs, streamlining processes for partners and more effectively influencing VBP implementation.

**Payment models**

To advance the above priorities, HCA will continue to promote value-based purchasing models, with a focus on driving the health care system toward providing whole-person, affordable, and accessible care for all.
Washingtonians. HCA specifically will focus on developing the following payment model initiatives.

**APM Targets:** HCA’s current targets for VBP adoption end in 2021. For the 2022-2025 time period, HCA will establish new targets, which may include:

- Introducing targets that move further along the VBP continuum, for higher-level payment models (e.g., HCP-LAN APM Framework category 3A and above).
- Introducing provider-type-specific targets.
- Moving toward per-member, per month payments, with gains-sharing based on quality metrics, improved outcomes, and improved SDOH.

**Rural Multi-Payer Model:** HCA is exploring a new payment model to drive delivery system transformation in rural communities, centered on a global budget, or capitation, concept for rural hospitals and providers. Global budgets are a fixed sum of funding for providers to deliver services to a specific population, allowing them more flexibility to allocate resources to best meet patient needs rather than maximize FFS revenue.

Global budgets also incentivize more active care management, and may include additional incentives around specific activities and outcomes. Based on the experiences from other states, HCA recognizes that successful global budget implementation will require a balanced approach. We must consider unintended consequences for vulnerable populations, actively ensure capabilities and readiness before implementation, secure multiple-payer participation and alignment, and allow for regional tailoring to meet local needs.

The COVID-19 pandemic further underscores the need for more predictable financing of services that prioritize value and population health. This model will advance appropriate care, meet community needs, and support rural providers through the health system transformation process. Focus areas include:

- Redesigning rural health system financing.
- Enhancing population health management.
- Addressing the rural health care workforce.
- Leveraging digital health, telehealth and secure information exchange.

**Multi-Payer Primary Care Transformation Model:** primary care is the foundation of any health care system and is a key priority for HCA. To support primary care providers and strengthen the primary care system for members, HCA is investigating the potential impact and implementation requirements of a Multi-payer Primary Care Transformation Model. Under this model, teams of multi-disciplinary providers will agree to be accountable for a patient’s care. COVID-19 has made it even more important that primary care providers have a steady funding stream rather than wholly relying on a FFS model. In July 2020, HCA announced a public comment period soliciting feedback for its Multi-payer Primary Care Transformation Model proposal.

**Episodes of care:** In addition to focusing on strengthening primary care, HCA plans to engage providers across the continuum of care. Specialty care, for example, poses cost and access challenges for the state and members. HCA will explore opportunities to pay for specialty care though episodic payments, to ultimately ensure that care provided across the care continuum is of high value. This builds on HCA’s Centers of Excellence Program in PEBB and SEBB for total joint replacement and spine fusion.

**Collaborative contracting**

Collaborative and innovative contracting approaches are important levers that HCA may use to advance VBP priorities. In addition to including existing VBP requirements in contracts with partners, HCA will consider

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20 CMS also recently announced the forthcoming Community Health Access and Rural Transformation (CHART) Model. HCA intends to apply for this funding.

21 [Ibid.](https://depts.washington.edu/uwchips/docs/brief-rural-hospitals.pdf)


23 Ibid.
modernizing its existing procurement process in partnership with CMS to support providers and plans. For example, this could include broad procurement of an electronic health record for providers across the state. Additionally, HCA may build on the Hepatitis C subscription model by identifying other areas where HCA could negotiate lower cost for drugs or other services (with CMS approval) when procured broadly.

**Medicaid Transformation Project (MTP)**

HCA’s VBP strategy is and has been closely linked to MTP, with ACHs acting as key partners in supporting the implementation of VBP. HCA plans to continue this focus and associated regional approach to transformation, ensuring that advancing VBP aligns with local needs and contexts. Additionally, a key priority of MTP and of many ACHs has been community-based care coordination (CBCC), which seeks to further HCA’s VBP goals to support care for individuals and families across the care continuum and address SDOH. Ultimately, CBCC alongside VBP, aims to achieve improved patient and provider experience, reduced costs, better outcomes, and health equity.

**Partner and community engagement**

Collaboration between HCA and its broad span of VBP partners is key for better population health outcomes. Through better alignment and closer partnerships, HCA will be able to support the scale and spread of VBP to other parts of the health care system. This would go beyond state-financed health programs, and more effectively impact SDOH and health equity. In particular, HCA will continue to engage community partners and Tribal governments in addressing SDOH and health equity challenges. HCA’s health equity strategy hinges on meaningful community engagement with external partners, such as ACHs, community-based organizations, and other groups.

HCA will also pursue public-private partnerships, where HCA may engage with employers and associations to advance successful commercial VBP models.

In terms of plan and provider collaboration, HCA is pursuing a Rural Multi-payer Model as described above. This model’s success is dependent on close collaboration with providers, plans, and other stakeholders, including ACHs serving rural regions.

**Roles in VBP across health system stakeholders**

Meanfully paying for health and value, rather than paying for volume of services will require multi-sector engagement and collaboration. As noted by the 2019 Paying for Value survey results, there is an opportunity to further clarify and engage stakeholders in refining the roles and responsibilities for defining, delivering, measuring, and reinforcing VBP.

The following table provides an initial outline of the key roles of plans, providers, ACHs, and the state. HCA looks to engage all stakeholders to ensure that VBP roles and responsibilities reflect partners’ strengths and needs.

**Figure 10: Ongoing roles of VBP stakeholders and partners**

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Defining VBP</th>
<th>Delivering VBP</th>
<th>Measuring VBP</th>
<th>Reinforcing VBP</th>
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</thead>
<tbody>
<tr>
<td>State</td>
<td>• Define VBP vision, targets, &amp; expectations of stakeholders</td>
<td>• Enable VBP through MCO contracting &amp; direct purchasing</td>
<td>• Issue and compile results from annual VBP surveys</td>
<td>• Incorporate MCO contract incentives</td>
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<tr>
<td></td>
<td></td>
<td>• Guide and support aligned investments</td>
<td>• Define key</td>
<td>• Allocate MCO &amp; ACH DSRIP VBP incentives</td>
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<tr>
<td>MCOs/PEBB and SEBB contractors</td>
<td>• Define provider contract options</td>
<td>• Contract with providers through APMs</td>
<td>• Provide timely and actionable data to providers</td>
<td>• Provide VBP adoption data through annual MCO survey</td>
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<td>• Provide qualitative report in quarterly meetings</td>
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<td></td>
<td>• Articulate business case for DSRIP projects in VBP terms</td>
<td>• Support VBP-enabling clinical practice transformation</td>
<td>• Facilitate VBP-enabling population health partnerships &amp; investments</td>
<td>• Encourage provider survey participation</td>
</tr>
<tr>
<td>Providers</td>
<td>• Define clinical practice value in VBP terms</td>
<td>• Deliver high-value care</td>
<td>• Assess/develop readiness</td>
<td>• Enter into APMs with MCOs</td>
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</tbody>
</table>