THE VALUE-BASED PURCHASING TOOLKIT

Washington State Health Care Authority

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Table of contents

| Introduction | 3 |
| 1. The Basics: What is value-based purchasing (VBP)? | 4 |
| 2. The Business Case: How will implementing VBP benefit my organization? | 5 |
| 3. The Options: What are examples of value-based approaches a purchaser should consider? | 6 |
| o Health Care Payment & Learning Action Network APM Framework | 6 |
| o Accountable Care Program | 7 |
| ▪ The HCA’s road to Value-based Purchasing | 7 |
| ▪ Boeing’s Story: Preferred Partnership | 8 |
| o Initial steps purchasers can take | 9 |
| o HCA’s contracting example | 10 |
| 5. The Pitch to Employees: How do I promote a new benefits plan to my workforce? | 12 |
| o Communications implementation timeline | 14 |
| 6. Media resources on health care trends | 15 |
Introduction

This toolkit provides information aimed at decision-makers of health care purchasing. It offers an overview of the principles behind value-based purchasing and a series of documents to help the decision-maker take next steps in the contracting process. True market transformation will not occur unless multiple purchasers send consistent quality and value signals to all participants involved in delivering care and invested in health.

Each section of this toolkit provides a basic framework of the terms and concepts behind value-based health care purchasing and points you to detailed information about these terms and concepts so you can expand your knowledge in ways that fit your needs. The toolkit also serves as a guide to the contract components used by the Washington State Health Care Authority (HCA) as it launched its Accountable Care Program.

To support the goal of implementing new models of care that drive toward population-based care, HCA has committed to a Value-Based Purchasing Roadmap that outlines how HCA will lead a movement to realize the major components of the Healthier Washington Initiative. Many of the resources shared in this toolkit are linked to the website www.hca.wa.gov/about-hca/healthier-washington.
1. The Basics: What is value-based purchasing (VBP)?

Value-based purchasing is a strategy employers can use to improve the quality and value of health care services provided to their employees. This strategy realigns the incentive structure of health care purchasing to ensure health plans and providers are accountable for delivering high quality, high value, a good patient experience and the most appropriate care to patients.

Value-based payment and value-based insurance design are two examples of value-based purchasing.

**Value-based payment** is a new payment method for health care services aimed at rewarding value (quality of health care), not volume (fee-for-service).

The HCA has implemented the VBP strategies into its book of business – Medicaid and public employee health coverage.

**HCA resources about VBP**
- Video: [Value-based Purchasing](#)
- Fact Sheet: [Paying for Value](#)
- Webinar: [Paying for Value: From Concept to Contract](#)
- Webinar: [Value-based benefit design](#)

**More resources**
- National Business Coalition on Health: [Value-based Purchasing: A Definition](#)
- Washington Health Alliance Blog: [Moving the health care market to value: Leveraging the power of purchasers](#)
- Video: [The Future of US Healthcare](#)
2. The Business Case: How will implementing VBP benefit my organization?

By adopting value-based purchasing and payment strategies for your organization, you will:

- Improve health outcomes for your workforce and their families.
- Increase productivity, attendance and daily engagement.
- Increase long-term financial sustainability of health programs for your organization and throughout the health care sector.

![Payment Drives System Transformation Table]

**HCA resources about the benefits of VBP**
- Fact sheet: The Savvy Health Care Purchaser
- Reports: Performance results for clinics, hospitals, and health plans

**Other resources about the benefits of VBP**
- Issue Brief: American College of Physicians recommends value-based insurance design to reduce consumer cost-sharing burden
- Infographic: Michigan Center for Value-based Insurance Design
- Seattle Business News: The Health Care Fix: How value-based medicine can help businesses and workers move away from a harmful, wasteful system
3. The Options: What are examples of value-based approaches a purchaser should consider?

There are many types of value-based payment approaches currently being used by providers, health plans and employers.

**The Health Care Payment-Learning Action Network (HCP-LAN) Alternative Payment Model Framework**

The Health Care Payment & Learning Action Network developed and released a framework of Alternative Payment Models below:

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
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<tbody>
<tr>
<td>Fee for Service – No Link to Quality &amp; Value</td>
<td>Fee for Service – Link to Quality &amp; Value</td>
<td>APMs Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
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<td>Condition-Specific Population-Based Payment</td>
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<td>Foundational Payments for Infrastructure &amp; Operations</td>
<td>APMs with Upside Gainsharing</td>
<td>APMs with Upside Gainsharing/Downside Risk</td>
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<td>Rewards and Penalties for Performance</td>
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Both the federal government (Medicare) and large purchasers like the HCA and Boeing have adopted purchasing strategies to drive clinical and financial accountability. Both HCA and Boeing have direct contracts with delivery systems.

**Toolkit resource: Quality Improvement Score Calculator**

Would you like to see how quality metrics lead to shared savings or deficit payments on a financial spreadsheet? The HCA has developed a Quality Improvement Score Calculator that allows you to key in cost of care per member per month plus the trend guarantee (the percentage decrease per member from the prior year in the contract).
Accountable Care Program

As part of the HCA’s goal to move from volume to value in purchasing health care, we introduced UMP Plus in 2016 to enrollees in HCA’s Public Employees Benefits Board (PEBB) Program.

Both accountable care networks have taken on accountability for:
- clinical performance (quality measures)
- financial trend
- patient experience

HCA’s road to value-based purchasing

The Public Employee Benefits Board (PEBB) is the division in HCA that purchases health care for Washington State employees and their families.

Through the Accountable Care Program (ACP), PEBB offers Uniform Medical Plan (UMP) Plus. The ACP was designed to improve the health of enrollees and hold providers and delivery systems accountable by rewarding them for the delivery of patient-centered, high-value care and increased quality improvement.

HCA has contracts with two provider networks: the Puget Sound High Value Network (PSHVN) and the University of Washington Accountable Care Network (UW). These networks will receive financial incentives to improve their performance on specific quality measures, or financial disincentives for no improvement. The ACP networks receive a bonus payment or make a deficit payment to HCA based on their quality of care and attainment of a lower cost of care.

The networks took on more than 10,000 enrollees in their first year and enrollment expanded in the 2017 plan year with an enrollment of 16,000. The networks initially covered five counties King, Kitsap, Pierce, Snohomish, and Thurston. Now the networks include Grays Harbor (PSHVN and UW), Skagit (UW only), Spokane (PSHVN only), and Yakima (PSHVN only). PEB’s intent is for UMP Plus to be offered statewide by 2020.

In order to calculate financial incentives, HCA developed the Quality Improvement (QI) Model. The QI Model measures the ACP network’s improvement on and attainment of quality measure targets from one year to the next. Quality measures in the QI Model are aligned with the Washington State Common Measure Set for Health Care Quality and Cost.

Regence Blue Shield serves as the third party administrator for UMP Plus, which involves processing all claims and managing the network. They also are the front line and some customer services resource for advising PEBB members which providers are in-network, explaining benefits, and handling complaints and appeals. Regence also makes it possible to offer an ancillary network. Enrollees receive network-level benefits when they see ancillary providers for covered services within the allowed service area.

By contracting directly with providers rather than using an existing ACO product from a payer, HCA had full leverage to negotiate the terms of the ACP contract. Some important pieces of the contract HCA negotiated include the selection of quality measures, care transformation projects, and the amount of upside and downside risk.
**Value-based insurance design** includes building incentives on the demand-side, or workforce side, to reward consumer behaviors that lead to better, more efficient care, and dis-incentivize care that does not. One example is providing positive financial incentives for primary care. Workforce/employees receive the best care - coordinated and efficient care - when they seek primary care.

VBP plan designs may include zero cost shares for diabetes monitors, tobacco cessation, telemedicine consultation. Offering $0 copays for primary care reduces financial barriers for accessing care before a problem becomes costly.

**HCA resources about accountable care plans**
- Video: How the quality improvement model works
- Webinar: Quality measurement and quality improvement model
- Fact sheet: Accountable Care Networks for Public Employees
- Fact sheet: Connecting the HCA’s Accountable Care Program to Value
4. The Groundwork: How do I begin contracting for a value-based accountable care plan?

There are many resources to assist purchasers in their value-based purchasing journey. You should follow a process that works for your agency.

A. Initial steps purchasers can take:

- **Look at the data**
  View data available on quality performance in Washington State’s health care system with the Community Checkup. The Community Checkup reports on health care across Washington State. It compares medical groups and clinics on certain aspects of effective care, including for people with chronic conditions such as diabetes, heart disease and depression. Scores are drawn from the Alliance’s large multi-payer database of claims data supplied by health plans and self-insured purchasers. And remember to consider ways to incentivize employees to seek care at high-performing medical groups.
  - [www.wacommunitycheckup.org](http://www.wacommunitycheckup.org)
  - [Purchaser Guidelines to Evaluate Contracts For Accountable Care Organizations](#)

- **Link to performance measures**
  Ask your broker and/or health plan partners to use the Washington State Common Measure Set for Health Care Quality and Cost in all contracts with providers. The Statewide Common Measure Set provides the foundation for health care accountability and measuring performance.
  - [Washington State Common Measure Set](#)

- **Expect best practices**
  Include recommendations for evidence-based best practices for providers in your contracts. The Washington State Legislature established the Dr. Robert Bree Collaborative so that public and private health care stakeholders would have the opportunity to identify specific ways to improve health care quality, outcomes, and affordability in Washington State.
  - [www.breecollaborative.org](http://www.breecollaborative.org)
B. HCA’s contracting example

Here are components the HCA used to contract its accountable care plan:

REQUEST FOR APPLICATION
The Request for Application established the HCA’s search for health care organizations or networks to provide an Accountable Care Program for PEBB enrollees in a five-county region (King, Kitsap, Pierce, Snohomish, and Thurston). It included a number of expectations, most importantly willingness to engage in a binding agreement built on financial and quality performance incentives and disincentives, implementing effective care delivery models and aligning health system reimbursement and financial incentives.

Section 3 of the RFA included key requirements (pages 12 to 19), including:
- Financial Approach and Guarantees
- Alternative Payment Models
- Measuring and rewarding quality
- Coordinating and standardizing care
- Member engagement and experience
- Timely access to care
- Required administrative and clinical services

ALTERNATIVE PAYMENT MODELS TEMPLATE
The RFA requires applicants have experience in moving away from fee-for-service payment models. An appendix to the RFA was an Alternative Payment Models Template. Completion of this form allows applicants to show which of nine payment models is in use by the prospective bidder. Additional space is allowed for alternative payment models not included in HCA’s list. By completing the form, HCA could assess such details as:
- Percentage of Current Business & Providers Covered Under this Model
- How Payment is Tied to Quality/ Performance
- Years payment strategy in place

PARTNER INFORMATION REQUEST FORM
To complete the RFA process, prospective bidders provided lists of clinical partners that would be engaged in the accountable care program. The Partner Information Request Form tells the following about the bidder:
- Partnering health systems
- Type of relationship
- Length of relationship
- Usage of electronic health records
GEOGRAPHICAL ANALYSIS
The Geographical Analysis produces a list of FTE internists and family practitioners within five, 10 and 15 miles of a given ZIP Code to help evaluate network adequacy.

QUALITY MEASURES FORM
Completion of the Quality Measures Form allows an examination of prospective accountable care networks along Community Checkup measures, such as blood sugar, cholesterol tests, eye exams, etc. the form includes space for scores that are lower than average. Space allows for inclusion of results that are more recent that may be favorable to the clinic.

These measures align with the National Committee for Quality Assurance (NCQA), a nonprofit that has developed quality standards and performance measures widely recognized for establishing national benchmarks

Transparency in health care means providing meaningful information to patients, health care purchasers and policymakers about the quality and cost of health care delivered by doctors, hospitals and other care providers.

PARTNER REQUEST ATTESTATIONS
The Partner Request Attestations lists minimum requirements, financial declarations, agreements on quality measurement benchmarks, prelaunch milestones and other terms. Outlines several requirements under the contracts and ensures commitment by the prospective awardee to the terms.
5. The Pitch to Employees: How do I promote a new benefits plan to my workforce?

The HCA used multiple tactics to inform eligible employees and retirees of the new networks available under the accountable care program. Communications approaches were based on enrollee surveys and focus groups to better understand how members choose a medical plan, what messaging would motivate members to change, effective terminology and their preferred methods of receiving information.

Key findings

<table>
<thead>
<tr>
<th>Overall Finding #1</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Choice, Cost, Quality, and Options are key factors in choosing a health care plan.</td>
<td>Emphasize cost savings and integration/coordination of care</td>
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<tr>
<td>• Members want to keep the doctor they have</td>
<td>1. Include specific information about cost savings</td>
</tr>
<tr>
<td>• They want to reduce their costs, particularly out-of-pocket costs such as monthly premiums, co-pays, and co-insurance.</td>
<td>• 30% savings in premiums is very motivating to members to change plans</td>
</tr>
<tr>
<td>• They want access to quality providers, and if they can't find one they want a vast network of choices to find a &quot;quality&quot; provider.</td>
<td>• No co-pays or co-insurance also is very motivating to members to change plans</td>
</tr>
<tr>
<td>• They want broad services, specialists, prescription coverage, and non-traditional options (massage, etc.)</td>
<td>2. Emphasize integration and coordination of providers</td>
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<tr>
<td></td>
<td>• Access to providers is more timely, easier, less paperwork</td>
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<tr>
<td></td>
<td>• Why is this better quality? -- Explain it to them.</td>
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<td>3. Don't forget to emphasize CHOICE</td>
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</table>
Overall Finding #2

Names are not as important as specific information on cost savings, but they have some preferences

Name for Plan
- Health Care 360 or Premier Health

Tagline for Plan
- Better health, better care, lower costs

Descriptors
- Choice
- No co-pays
- Personalized, convenient service
- Affordable
- Integrated
- Timely

Recommendation

Choose messages and names that emphasize cost, choice, and convenience.

1. Avoid using phrases such as "value" or "best"
   - Mixed acceptance on these descriptors. Either sounds cheap or like pet care.

2. Choose messages that describe the advantages of the plan.
   - Emphasize the lower cost
   - Emphasize better or improved care

Overall Finding #3

Members prefer, and need, various forms of communication and information

- Introduce the new plan via email and newsletter
- Highlight the advantages of the new plan
- Members want comparison charts
- Members want access to specific and detailed information about the new plan

Recommendation

Plan for email, web, and print communications with a "hook"

1. Send short introductory emails about the plan
   - Highlight lower cost
   - Consider a financial incentive for first year
   - Provide links to more information (comparison charts, detailed services, provider network)
   - Follow-up with newsletter or print

2. Provide a dedicated website
   - Comparison charts
   - All costs
   - Network information
   - Services covered
**Communications Implementation Timeline**
The timeline shows the phases the HCA used for communicating to employees, from engagement strategies to preparation of enrollment materials.

<table>
<thead>
<tr>
<th>Timing</th>
<th>Activities</th>
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<tbody>
<tr>
<td>**Phase 1</td>
<td>Pre-launch**</td>
</tr>
<tr>
<td><strong>June 2015</strong></td>
<td>Conducted focus groups and online survey of PEBB Program members for initial market research of the positioning and marketing of new health plan.</td>
</tr>
<tr>
<td><strong>July 2015 – January 2016</strong></td>
<td>Based on market research, communications team developed:</td>
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<tr>
<td></td>
<td>• Marketing strategy</td>
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<td></td>
<td>• Messaging framework</td>
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<td></td>
<td>• Communications plan</td>
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<td></td>
<td>• Implementation of communications plan</td>
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<td>• Animated video</td>
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<td></td>
<td>• Mailer</td>
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<td></td>
<td>• Customized member newsletter</td>
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<tr>
<td></td>
<td>• Website content</td>
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<td></td>
<td>• Post-open enrollment survey</td>
</tr>
<tr>
<td></td>
<td>• Analysis of marketing/communications effectiveness report</td>
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<tr>
<td><strong>November 1-30, 2015</strong></td>
<td>PEBB Program’s open enrollment</td>
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<tr>
<td><strong>December 2015</strong></td>
<td>Post open enrollment online survey</td>
</tr>
<tr>
<td><strong>January 1, 2016</strong></td>
<td>Coverage effective for accountable care networks</td>
</tr>
<tr>
<td><strong>January 2016</strong></td>
<td>Communications analyzes post-open enrollment online survey</td>
</tr>
<tr>
<td>**Phases 2 &amp; 3</td>
<td>Post-launch (Ongoing enrollment throughout 2016, and 2017 open enrollment)**</td>
</tr>
<tr>
<td><strong>April 2016 – January 2017</strong></td>
<td>Using feedback from December 2015 survey, communications team developed/will develop:</td>
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<tr>
<td></td>
<td>• UMP Plus member survey</td>
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<td></td>
<td>• Revised marketing strategy</td>
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<td></td>
<td>• Revised messaging framework</td>
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<td></td>
<td>• Communications plan</td>
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<td></td>
<td>• Implementation of communications plan</td>
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<td></td>
<td>• Bank of member testimonials</td>
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<td>• Handout for benefits fairs, website content, etc.</td>
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<td></td>
<td>• Video</td>
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<tr>
<td></td>
<td>• Post open enrollment survey</td>
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<td></td>
<td>• Analysis of marketing/communications effectiveness report</td>
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**HCA resources on pitching to employees**

Webinar: [Engaging and educating state employees about accountable care and value](#)

Brochure: [An introduction to UMP Plus](#)

Video: [Is UMP Plus right for you?](#)

**Additional resources**

National Business Coalition on Health: [Value-based Purchasing: A Definition](#)

Washington Health Alliance Blog: [Moving the health care market to value: Leveraging the power of purchasers](#)

Video: [The Future of US Healthcare](#)
6. Media resources on health care trends

Results from the 2016 Survey of America’s Physicians – which examines the perspectives and practice patterns of more than 17,000 physicians – indicate that almost 43 percent of surveyed physicians have some payment tied to quality, with 36 percent in ACOs. Still, 28 percent of those surveyed are unsure about the structure or purpose of ACOs. Additionally, more than half of surveyed physicians say they are unfamiliar with MACRA. (Report)

At the recent Becker’s Hospital Review CEO + CFO Roundtable, prominent physician leaders discussed ways for hospitals to develop clinically integrated networks. Recommendations included using a tiered approach to balance efficiency and scale, as well as three methods for strategic growth: network delivery, covered lives, and service line products. (Article)

A Modern Healthcare article discusses the fate of value-based payment under a new federal administration, including the agency responsible for creating and testing new models, CMMI. According to several industry experts quoted in the article, both parties generally support efforts to move away from fee-for-service to value, so accountable care is here to stay. (Article)

Report by The Atlantic looks at the epidemic of unnecessary and unhelpful health system treatments. Long after research contradicts common medical practices, patients continue to demand them and physicians continue to deliver. (Article)

Report by Seattle Business on ways value-based medicine can help businesses and workers move away from a harmful, wasteful system. (Article)