

Getting the best health care for your employees

The Value-based Purchasing Guide

Table of Contents

Introduction	1
1. The Basics: What is value-based purchasing (VBP)?	2
2. The Business Case: How will implementing VBP benefit my organization?	3
3. The Options: What are examples of value-based approaches employers should consider?	4
· VBP Case Study: HCA's Accountable Care Program	5
· HCA's Road to Value-based Purchasing	5
· Boeing's Preferred Partnership Plan	6
4. The Groundwork: How do I begin contracting for a value-based accountable care plan?	7
· A. Initial steps employers can take	7
· B. HCA's contracting example	8
5. The Pitch to Employees: How do I promote a new benefits plan to my workforce?	10
· Communications implementation timeline	10
6. More Proof: Media coverage of health care trends	12

Introduction

The nation’s health care system is hampered by poor coordination, waste and excessive costs. But health care purchasers are not helpless. Through their spending, employers can signal to health care providers and brokers that they expect greater quality and value from the care delivery system and an investment in improving the health of employees. This guide contains information and strategies to get there.



The Washington State Health Care Authority (HCA) purchases care for more than 2 million people in Washington State and has implemented value-based purchasing strategies for both Medicaid and public employee health coverage. State employees have the option of an Accountable Care Program, which is a case study in this guide.



This guide provides information for benefits managers and other health care purchasing decision-makers. It offers an overview of value-based purchasing and is part of an online [Purchaser Toolkit](#) that includes a series of documents to help the decision-maker take next steps in the contracting process.



1. The Basics:

What is value-based purchasing (VBP)?

Value-based purchasing (VBP) is a strategy employers can use to improve the quality and value of health care services provided to their employees.

This strategy ensures health plans and providers are financially accountable for delivering high-quality, high-value care and a satisfactory patient experience.

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



Develop value-based payment strategies.

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).

Value-based insurance design is an insurance benefit design strategy that encourages use of high-value clinical services by aligning consumer spending with high-quality and beneficial health services and medications.

Resources about VBP



- [Video: Value-based Purchasing](#)
- [Webinar: Paying for Value: From Concept to Contract](#)
- [Webinar: Value-based Benefit Design](#)
- [Washington Health Alliance Blog: Moving the Health Care Market to Value: Leveraging the Power of Purchasers](#)
- [Video: The Future of U.S. Health Care](#)

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 by rewarding high-quality, evidence-based health care.
- Increase productivity, attendance and employee satisfaction.
- Increase long-term financial sustainability of health benefits for your organization.

Typically, how much you pay for health care has nothing to do with the quality of health care services. With value-based purchasing we can measure quality of health care and providers are paid based on achieving it.

Resources about the benefits of VBP



- [Fact sheet: The Savvy Health Care Purchaser](#)
- [Report: Performance Results for Clinics, Hospitals, and Health Plans](#)
- [Issue Brief: American College of Physicians Recommends Value-based Insurance Design to Reduce Consumer Cost-Sharing Burden](#)
- [Report: The Health Care Fix: How Value-based Medicine Can Help Businesses and Workers Move Away From A Harmful, Wasteful System](#)

This is Volume-based Health Care:

I am just a medical condition.

My providers don't talk to each other.
I get tests repeated and confusing instructions.

My provider either tells me what to do or gives me no guidance at all.

This is Value-based Health Care:

I am treated as a whole person—mind and body.

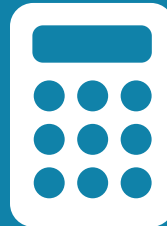
My providers work as a team to make sure I get the right amount and type of care.

My provider gives me the information I need to make a good decision.

3. The Options: What are examples of value-based approaches employers should consider?

There are many types of value-based payment approaches currently being used by providers, health plans and employers. The state aligns payment and delivery reform approaches with the Centers for Medicare and Medicaid Services (CMS) for greatest impact and to simplify implementation for providers. See the federal [alternative payment method framework](#).

Both the federal government (Medicare) and large employers, such as the HCA and Boeing, have adopted purchasing strategies to drive clinical and financial accountability. Both HCA and Boeing have direct contracts with providers and hospitals.



Learn How an ACO Works: Risk Calculator

Quality metrics can lead to shared savings or deficit payments on a financial spreadsheet. Use HCA's [Quality Improvement Score Calculator](#) 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). The calculator offers an interactive model of an ACO (Accountable Care Organization) where providers are responsible for both clinical quality and cost of care.

VBP Case Study: HCA's Accountable Care Program

As part of the HCA's goal to move to value-based purchasing, a new type of health plan was introduced in 2016 to enrollees in HCA's Public Employees Benefits Board (PEBB) Program. HCA established contracts with two provider networks: the Puget Sound High Value Network (PSHVN) and the University of Washington Accountable Care Network (UW). These networks receive financial incentives to improve their performance on specific quality measures, or financial disincentives for no improvement. The networks receive a bonus payment or make a deficit payment to HCA based on quality of care and attainment of a lower cost of care.



UMP Plus is the Accountable Care Program (ACP) benefit option for state and public employees.

Enrollment in these networks has grown each year, rising from 10,000 in 2016 to more than 25,000 in 2018. Both accountable care networks receive payment based on:

- Clinical performance (quality measures), such as the number of patients with diabetes that have their blood sugar at a healthy level
- Financial trend
- Patient experience

Employees in the ACP and their families enjoy:

- \$0 primary care visits
- 55 percent lower premiums than other options
- No prescription drug deductible
- 50 percent lower deductible than a classic state employee preferred provider organization (PPO) plan

HCA's Road to Value-based Purchasing

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

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 taken from 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 a customer services resource for advising PEBB members which providers are in-network, explaining benefits, and handling complaints and appeals.

By contracting directly with providers rather than using an existing ACO product from an insurance company, HCA had full ability 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 financial targets the networks had to reach.



Boeing's Preferred Partnership Plan

Boeing developed a value-based strategy to improve quality, enhance member experience and reduce costs. They wanted to maintain employee choice and improve quality of care. Boeing and its health insurance partners agreed on 15 standard national metrics, such as blood pressure, depression, diabetes and cholesterol control.

Of eligible employees, 15 percent to 35 percent enrolled. The ACO has delivered improvement in most metrics, increased screening rates and employees rate the plan 8.5 out of 10.

Like the HCA's plan, Boeing employees enjoy lower premiums and \$0 for primary care visits. Additionally, Boeing employees have no copay for generic drugs and benefit from a higher health savings account contribution.

HCA resources about accountable care plans



- [Video: How the Quality Improvement Model Works](#)
- [Fact sheet: Accountable Care Networks for Public Employees](#)
- [Fact sheet: Connecting the HCA's Accountable Care Program to Value](#)



Financial Incentives for Employees

- Lower employee premiums
- Higher company-funded health savings account
- \$0 primary care office copay
- \$0 generic drugs

High-quality primary care is at the heart of value-based care. Selecting a primary care provider encourages the patient to build a relationship with their provider as someone who is a trusted advisor in their health and has a 360-degree perspective on their needs.

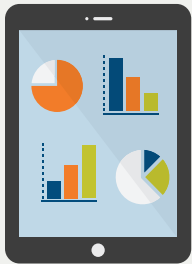
Value-based insurance design includes building incentives on the workforce side to reward consumer behaviors that lead to better, more efficient care, and reduce incidents of care that does not. One example is providing financial incentives for primary care, such as low copays or free primary care visits. Employees receive the best care – coordinated and efficient care at a lower cost—when they seek primary care instead of going to the emergency room.

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

4. The Groundwork: How do I begin contracting for a value-based accountable care plan?

A. Initial steps employers can take

Look at the data



View data available on quality performance in Washington State's health care system with the Community Checkup and the Washington Health Alliance. The annual Community Checkup report

compares medical groups and clinics on quality care, including for people with chronic conditions such as diabetes, heart disease, and depression. Scores are drawn from the Washington Health Alliance's database of claims data supplied by health plans and self-insured employers.

In your engagement with potential health system providers, ask if they pay providers for delivering high-quality care and whether they reduce payments for providers that give unnecessary or low-quality care.

Remember to consider ways to incentivize employees to seek care at high-performing medical groups. Share this information with your employees—post it in the breakroom!

There are many resources to assist employers in their value-based purchasing journey. Follow a process that works for your organization.

Resources about contracting for VBP

- [Washington Community Checkup](#)
- [Performance measures for employers](#)
- [Purchaser Guidelines to Evaluate Contracts for Accountable Care Organizations](#)
- [Savvy cost shopper](#)
- [Savvy quality shopper](#)
- [Savvy patient experience](#)
- [NRHI Report: Purchaser Roadmap: Pathway to Better Value](#)
- [Video: Why Purchasers have to drive value-based care](#)
- [Webinar: Engaging employers in affordability](#)

How to measure provider performance

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.

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.

• breecollaborative.org

Value-based products are more than narrow network health plans. A value-based plan rewards providers for providing quality care, treating chronic conditions using preventative care, and focusing on patient satisfaction and a high-quality patient experience—resulting in lower health care costs. If a plan isn't in part basing provider reimbursement on clinical quality and patient satisfaction, then it's not a VBP plan. The employer should ask their broker if there are financial incentives for these measures going to the providers.

B. HCA's contracting example

This guide is part of a health care purchaser's toolkit. The other part of the toolkit is a set of resources at www.hca.wa.gov/PurchasersToolkit.



The following pages of this guide show you what tools HCA used to seek a contract with health care providers for an accountable care plan (described on page 7). You may want to consider including similar steps and questions as you seek to create an accountable care or other value-based health plan. This section, which include hyperlinks directly to the website toolkit, includes the following:

- Request for Application
- Alternative Payment Models Template
- Partner Information Request Form
- Geographical Analysis
- Quality Measures Form
- Partner Request Attestations

Request for Application

The [Request for Application](#) (RFA) 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 a willingness to engage in a binding agreement built on financial and quality performance incentives and disincentives, implementation of effective care delivery models and aligning health system reimbursement and financial incentives. Section 3 of the RFA features 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 participate 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, and eye exams. 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. It outlines several requirements under the contracts and ensures commitment by the prospective network to the terms.

5. The Pitch to Employees:

How do I promote a new benefits plan to my workforce?

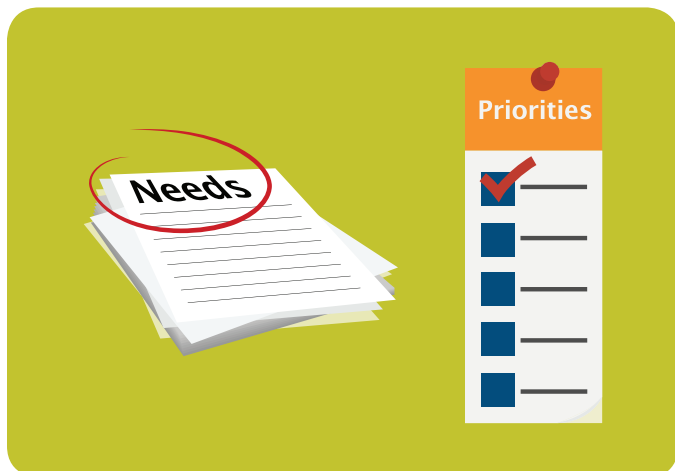
Key findings

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 group findings to better understand how members choose a medical plan, what messaging would motivate members to change, effective language, and their preferred methods of receiving information.

HCA resources on pitching to employees



- [Brochure: An Introduction to UMP Plus](#)
- [Video: Is UMP Plus Right for You?](#)



Finding #1

Choice, cost, quality, and options are key factors in choosing a health care plan.

- Members want to keep the doctor they have.
- Members want to reduce their costs, particularly out-of-pocket costs such as monthly premiums, co-pays, and co-insurance.
- Members want access to quality providers, and if they can't find one, they want a vast network of choices to find a "quality" provider.
- Members want broad services, specialists, prescription coverage, and non-traditional options (massage, etc.).

Recommendation

Emphasize cost savings and integration/coordination of care

- **Include specific information about cost savings**
30% savings in premiums is very motivating to members to change plans.
No co-pays or co-insurance is also very motivating to members to change plans.
- **Emphasize integration and coordination of providers**
Access to providers is more timely, easier, and involves less paperwork.
Why is this better quality? Explain it to them.
- **Don't forget to emphasize CHOICE!**

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.

- **Avoid using phrases such as “value” or “best”**

There is mixed acceptance of these descriptors.

May sound cheap or like pet care.

- **Choose messages that describe the advantages of the plan**

Emphasize the lower cost.

Emphasize better or improved care.

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.

- **Send short introductory emails about the plan**

Highlight lower cost.

Provide links to more information.
(comparison charts, detailed services, provider network)

Follow-up with an email or print newsletter.

- **Provide a dedicated website**

Comparison charts

All costs

Network information

Services covered

6. More Proof: Media coverage of health care trends

A report by Seattle Business on ways value-based medicine can help businesses and workers move away from a harmful, wasteful system.

(Article)

A 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)

A Huffington Post article explains the current fee-for-service landscape and how it reimburses physicians based on services rendered. Value-based purchasing, currently being implemented by a variety of organizations, is a solution that aims to incentivize better patient outcomes and lower spending.

(Article)

This article featured on the Washington Post describes the transition to a value-based payment system for various sizes of health care organizations – and speaks to the importance of “sharing lessons learned, investment in technology, staff and facilities, risk-based payment models and, most importantly, an increased focus on quality and cost savings.”

(Article)