

# Getting the best health care for employees

## The Value-based Purchasing Guide

Washington State  
Health Care Authority

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# Introduction

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The nation's health care system is hampered by poor coordination, waste, and excessive costs. But there is a path forward for health care purchasers. 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 2.5 million people in Washington State and has implemented value-based purchasing strategies for Medicaid and public employee and school employee health coverage. Public and school 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 a Purchaser Toolkit that includes links to additional documents to help the decision-maker take next steps in the contracting process.

# 1. The basics

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## What is value-based purchasing (VBP)?

VBP is a strategy used to improve the quality and value of health care services a person receives. VBP ensures health plans and health care providers are accountable for providing high-quality, high-value care and a satisfying patient experience.

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

**Value-based payment** is a payment method for providers that rewards providers for the quality of health care, rather than the volume or number of patients a provider sees. (This is called fee-for-service.)

**Value-based insurance design** encourages the use of high-value health care services by making those services and medications—like preventive and primary care—more affordable and accessible to enrollees.

### Resources about VBP

- [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

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### How will implementing VBP benefit my organization?

By adopting VBP and payment strategies for your organization, you will:

- Improve health outcomes for your employees 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 VBP, we can measure quality of health care, and providers are paid based on achieving it.

#### Resources about the benefits of VBP

- [Performance scores for clinics, hospitals, and health plans](#)
- [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. Tests are repeated and I receive confusing instructions.

My provider either tells me what to do or provides 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 ensure I'm receiving the right kind of care and right amount 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 VBP approaches currently being used by providers, health plans, and employers. The state aligns payment and delivery reform approaches with the Centers for Medicare & Medicaid Services (CMS) for greatest impact and to simplify implementation for providers. See the federal [alternative payment methodology framework](#).

Both the federal government (Medicare) and large employers, such as 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 Accountable Care Organization (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 calculate the cost of care per member per month, plus the trend guarantee. (This is the percentage decrease per member from the prior year in the contract.) The calculator offers an interactive model of an ACO where providers are responsible for both clinical quality and cost of care.



### VBP case study: HCA's Accountable Care Program (ACP)

A new type of health plan was introduced in 2016 to enrollees in HCA's Public Employees Benefits Board (PEBB) Program. The ACP became available in HCA's School Employees Benefits Board (SEBB) Program in 2020. HCA established contracts with two provider networks: the Puget Sound High Value Network and University of Washington Accountable Care Network.

The networks receive a bonus payment (i.e., share of savings generated) or make a deficit payment to HCA based on quality of care and attainment of a lower cost of care.



UMP Plus is the ACP benefit option for public and school employees.

Enrollment in these networks has grown each year, rising from 10,000 in 2016 to about 35,000 in 2021. Both networks may receive bonus payments 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 enrolled 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 public or school employee enrolled in a preferred provider organization (PPO) plan



### Examples of value-based insurance design benefits

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 do not. One example is providing payment 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.

## HCA's road to VBP

To calculate payment 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 Statewide 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 are also a customer services resource for advising PEBB and SEBB 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 has full ability to negotiate the terms of the ACP contract. Some important pieces of the contract negotiations include the selection of quality measures, care transformation projects, and the financial targets the networks had to reach.

### HCA resource about ACPs

- [Fact sheet: Accountable Care Networks for public and school employees](#)

# 4. The groundwork

## How do I begin contracting for a value-based ACP?

### A. Initial steps employers can take

#### Look at the data and ask questions

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. When engaging with potential health system providers, ask if they pay providers for delivering high-quality care and whether they reduce payments for providers who 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 VBP journey. Follow a process that works for your organization.



#### Resources about contracting for VBP

- [Washington Community Checkup](#)
- [NRHI report: Purchaser roadmap: pathway to better value](#)
- [Video: Why purchasers have to drive value-based care](#)

#### How to measure provider performance

Ask your broker and/or health plan partners to use [the Washington Statewide Common Measure Set for Health Care Quality and Cost](#) in all contracts with providers. The [Washington 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 have the opportunity to identify specific ways to improve health care quality, outcomes, and affordability in Washington State.

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. These result in lower health care costs. If a plan isn’t basing provider reimbursement on clinical quality and patient satisfaction, then it’s not a VBP plan. The employer should ask their broker if providers are receiving financial incentives for these measures.



## B. HCA's contracting example



This part of the guide shows what tools HCA uses when seeking a contract with health care providers for an ACP. Employers may want to consider including similar steps and questions when creating an accountable care or other value-based health plan. This section 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 HCA's search for health care organizations or networks to provide an ACP for PEBB enrollees in a five-county region (King, Kitsap, Pierce, Snohomish, and Thurston). **Note:** this RFA was the original procurement document that was for PEBB only.

The RFA included many 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, 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 that applicants<sup>1</sup> have experience in moving away from fee-for-service payment models.

An appendix in the RFA has an **Alternative Payment Models Template**.

Completion of this template allows applicants to show which of nine payment models is being used by the applicant. Additional space is allowed for alternative payment models not included in HCA's list. By completing the form, applicants can assess details, such as:

- Percentage of current business and 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, applicants should provide a list of clinical partners that will participate in the ACP. The **Partner Information Request Form** tells the following about the applicant:

- Partnering health systems
- Type of relationship
- Length of relationship
- Usage of electronic health records

### Geographical analysis

The **Geographical analysis** produces a list of 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 applicants among 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 more recent results that may be favorable to a clinic or health care facility.

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 health care providers and facilities.

### Partner request attestations

The **Partner request attestations** lists minimum requirements, financial declarations, agreements on quality measurement benchmarks, pre-launch milestones, and other terms. It outlines several requirements under the contracts and ensures commitment by the prospective network to the terms.

1. An applicant is also known as a bidder or health care system vying to be an accountable care network.

# 5. The pitch to employees

## How do I promote a new benefits plan to employees?

### Key findings

HCA used multiple tactics to inform eligible employees and retirees of the new networks available under the ACP. 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 members' preferred methods of receiving information.

 [HCA resources on pitching to employees](#)

- [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 provider they have.
- Members want to reduce their costs, particularly out-of-pocket costs, such as, monthly premiums, copays, 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 copays 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 copays

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