Washington State Health Care Authority

# Connecting provider payments to value

## How the Accountable Care Program works

### Quality Improvement Model

Currently, most providers receive fee-for-service (FFS) payments, which are based entirely on the volume of services they provide to patients. This system leads to fragmented care with variation in cost and quality. Value-based purchasing links provider payments to the quality and value of care.

Value-based purchasing is not "one size fits all." There are different ways to connect provider payments to value.

#### Accountable Care Program

The HCA's Public Employees Benefits (PEB) Division purchases health care for Washington State employees, retirees, and their families, and participating K-12 school districts and political subdivisions. The HCA is the largest commercial purchaser of health care in the state and is using its purchasing power to move away from payment based on volume of services to payment based on value.

Through the Accountable Care Program (ACP), PEB offers UMP Plus. The goals of the ACP are to improve the health of enrolled members in the Public Employees Benefits Board (PEBB) Program 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 UW Medicine Accountable Care Network and the Puget Sound High Value Network. These networks will be paid based on their ability to deliver high-quality care and keep PEBB members healthy, rather than payment based on performing a specific test or service.

These ACP 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 from HCA or make a deficit payment to HCA based on their quality of care and attainment of a lower cost of care.

#### Quality Improvement Model

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[1].

The QI Model generates an overall QI Score, based on the weighted average of 19 quality measures. The QI Score is then used to determine the share of savings and deficit payments.

Here are a few examples of quality measures in the QI Model:

- Percentage of members who reported they are "always" satisfied with how well their provider communicates with them
- Percentage of diabetes patients who had a blood sugar (HbA1c) test in the past year

[1] The Common Measure Set is a set of standard statewide measures of health performance that commercial and Medicaid plans report health care quality data on annually through the Washington Health Alliance. For more information, please visit: https://www.hca.wa.gov/assets/program/2016.12.20.Common-Measure-Set-Health-Care-Quality-Cost-Approved.pdf.

- Percentage of women 50-74 years old who had a mammogram to screen for breast cancer

Each of these measures refers to a percentage of applicable ACP members (for example, the percentage of ACP members 18-75 years old with diabetes whose most recent blood pressure is less than 140/90). Every measure is calculated using nationally vetted specifications. In addition, each measure is assigned:

- A weight – the degree of influence the measure has on the overall QI Score
- A mean score – the average percentage for each measure that is informed by various national data sources
- A target score – the percentage that the network should achieve on each measure, also informed by various national data sources

The QI Score for each measure is a blend of improvement and movement toward achieving a target score. When a network is further from the target score, the calculation weighs improvement more than quality. As the network approaches the target for an individual QI Score, the calculation weighs quality more than improvement to reward their strong performance.

This dynamic weighting ensures that the network has incentive to perform well, regardless of where their score is relative to the target.

## How the overall Quality Improvement Score affects payments

The overall QI Score drives the share of savings or deficit payments between the HCA and the network. If the ACP network generates more savings than the target would have created, the HCA pays the network a share of the savings. The percentage of the gross savings payment is dependent on the overall QI Score.

If the network generates less savings than the target would have created, the network pays HCA a share of the gross deficit. The percentage of the gross or deficit is dependent on the overall QI Score. This model incentivizes providers to improve on their quality by reducing potential deficit payments or by increasing shared savings.

## Aligning with national value-based payment movement

Congress signed the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015 to reward providers with higher Medicare reimbursement rates if they participate in value-based payments (VBPs) or Alternative Payment Models (APMs) starting in 2019. HCA's goal is to drive 90 percent of state's health care purchasing into value-based arrangements, and is closely tracking national movement and initiatives.

## Why are there 19 QIS Scores but only 15 measures are used in the ACP contracts?

The 15 measures used in the ACP contracts are a subset of measures in the Common Measure Set. Two of the 15 measures have more than one reporting element. For example, the measure called Antidepressant Medication Management has two QIS Scores for the following sub-components:

- Effective Acute Phase Treatment: the percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).
- Effective Continuation Phase Treatment: the percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

Likewise, the CG-CAHPs measure, which measures patient satisfaction, has four sub-components.

Providers receive QIS scores on each sub-component, meaning they receive a total of 19 QIS Scores for 15 measures.

## More information

To learn more about the Quality Improvement Score, visit https://www.hca.wa.gov/about-hca/healthier-washington/paying-value.