Practicing Medicine in the Era of Health Reform

Session 7
Health Plans and Quality

Tony Dodek, MD

August 11, 2015
Agenda

- Overview of nationally recognized organizations in quality measurement
- Performance Measurement: Framework, Principles and Pitfalls
- “Real World” example of quality measurement: BCBSMA's Alternative Care (AQC) contract
NATIONALLY RECOGNIZED ORGANIZATIONS IN QUALITY MEASUREMENT

**National Quality Forum**

- Multi-stakeholder, private, non-profit organization with over 375 members representing every aspect of healthcare delivery system.
- Sets national priorities and goals for performance improvement.
- Endorses national consensus standards for measurement and publicly reports on performance.
- Promotes the attainment of national goals through education and outreach programs.
NATIONALLY RECOGNIZED ORGANIZATIONS IN QUALITY MEASUREMENT

Agency for Healthcare Research and Quality

• Agency within the Department of Health and Human Services whose mission is to improve the quality, safety, efficiency, and effectiveness of health care.
• Safety and quality: Reduce the risk of harm by promoting delivery of the best possible health care.
• Effectiveness: Improve health care outcomes by encouraging the use of evidence to make informed health care decisions.
• Efficiency: Transform research into practice to facilitate wider access to effective health care services and reduce unnecessary costs.
NATIONALLY RECOGNIZED ORGANIZATIONS IN QUALITY MEASUREMENT

Choosing Wisely

- ABIM initiative in conjunction with Consumers’ Union
- Identification of five tests/procedures within each medical specialty whose necessity should be questioned or discussed
- 70 medical specialties participating
- Example: “Don’t do imaging for low back pain within the first six weeks unless red flags are present”
  (American Academy of Family Physicians)
NATIONALLY RECOGNIZED ORGANIZATIONS IN QUALITY MEASUREMENT

National Committee for Quality Assurance

- Private, non-profit organization that develops quality standards and performance measures for a variety of healthcare organizations.
- The annual reporting of performance against such measures has become a focal point for the media, consumers, and health plans, which use these results to set their improvement agendas for the following year.
- Seven accreditation programs, five certification programs and five physician recognition programs.
NCQA & National Rankings: 3 Components

CAHPS, HEDIS, and the NCQA Survey each impact health plan accreditation status and national ranking.
Measurement Pitfalls

**Your safer-surgery survival guide**

“For the first time ever, Consumer Reports has surgery ratings for 2,463 hospitals across the country, based on the percentage of a hospital’s surgery patients who died in the hospital or stayed longer in the hospital than expected for their procedure. See how the hospitals in your community fared.”
Measurement Pitfalls

Using that data, the authors of the Consumer Reports rating “do a disservice if they put information out there that misclassifies hospitals,” said Dr. Elizabeth Mort, chief quality officer at Massachusetts General Hospital, which was rated poorly.

Mort said she has concerns about whether the rating accurately accounts for patient volume or the severity of patients’ illnesses, something that is more accurately captured in medical records than in billing data. She also said the rankings may have grouped surgical procedures together that have varying degrees of expected complications, reflecting poorly on those hospitals that do the more complex treatments.
**Guiding Principles in Selecting Performance Measures for “High Stakes” Use**

- Wherever possible, measures should be drawn from nationally accepted standard measure sets.

- The measure must reflect something that is broadly accepted as clinically important.

- There must be empirical evidence that the measure provides stable and reliable information at the level at which it will be reported (i.e. individual, site, group, or institution) with available sample sizes and data sources.

- There must be sufficient variability on the measure across providers (or at the level at which data will be reported) to merit attention.

- There must be empirical evidence that the level of the system that will be held accountable (clinician, site, group, institution) accounts for substantial system-level variance in the measure.

- Providers should be exposed to information about the development and validation of the measures and given the opportunity to view their own performance, ideally for one measurement cycle, before the data are used for “high stakes” purposes.
Quality Measurement in the “Real World”: BCBSMA’s Alternative Quality Contract (AQC)
Alternative Quality Contract

- Context for AQC Development
- Overview of AQC Model
- AQC Results: The First Four Years
- AQC Support and Improvement Analytics
- Local and National Policy Context
Context for AQC Development
Economic Imperative in a Global Economy

Average spending on health per capita ($US PPP)

Total expenditures on health as percent of GDP

Source: OECD Health Data 2011 (Nov. 2011).
Massachusetts spends more on health care than any other state in the country

Per capita health care expenditure by state in 2009 dollars*

*Personal health care expenditures (PHC) are a subset of national health expenditures. PHC excludes administration and the net cost of private insurance, public health activity, and investment in research, structures and equipment.

Source: CMS Office of the Actuary
The increasing cost of health care in MA compared to other public spending priorities

**STATE BUDGET, FY2001 VS. FY2014 (BILLIONS OF DOLLARS)**

<table>
<thead>
<tr>
<th>Category</th>
<th>FY2001</th>
<th>FY2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Coverage</td>
<td>+$5.4 B</td>
<td>-$3.6 B</td>
<td>+37%</td>
</tr>
<tr>
<td>Health Care (State Employees/GIC; Medicaid/Health Reform)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health</td>
<td>-$22%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>-$31%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>-12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infrastructure/Housing</td>
<td>-14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Services</td>
<td>-11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Aid</td>
<td>-51%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Safety</td>
<td>-13%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Health Policy Commission, 2013 Cost Trends Report, data from the Massachusetts Budget and Policy Center
The Alternative Quality Contract:  
**Twin goals of improving quality and slowing spending growth**

In 2007, leaders at BCBSMA challenged the company to develop a new contract model that would improve quality and outcomes while significantly slowing the rate of growth in health care spending.


---

Sources: BCBSMA, Bureau of Labor Statistics.
The AQC Model
The Alternative Quality Contract

**Global Budget**
- Population-based budget covers full care continuum
- Health status adjusted
- Based on historical claims
- Shared risk (2-sided)
- Trend targets set at baseline for multi-year

**Quality Incentives**
- Ambulatory and hospital
- Significant earning potential
- Nationally accepted measures
- Continuum of performance targets for each measure (good to great)

**Long-Term Contract**
- 5-year agreement
- Sustained partnership
- Supports ongoing investment and commitment to improvement
# AQC Measure Set for Performance Incentives

<table>
<thead>
<tr>
<th></th>
<th>AMBULATORY</th>
<th>HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROCESS</strong></td>
<td>• Preventive screenings</td>
<td>• Evidence-based care elements for:</td>
</tr>
<tr>
<td></td>
<td>• Acute care management</td>
<td>• Heart attack (AMI)</td>
</tr>
<tr>
<td></td>
<td>• Chronic care management</td>
<td>• Heart failure (CHF)</td>
</tr>
<tr>
<td></td>
<td>• Depression</td>
<td>• Pneumonia</td>
</tr>
<tr>
<td></td>
<td>• Diabetes</td>
<td>• Surgical infection prevention</td>
</tr>
<tr>
<td></td>
<td>• Cardiovascular disease</td>
<td></td>
</tr>
<tr>
<td><strong>OUTCOME</strong></td>
<td>• Control of chronic conditions</td>
<td>• Post-operative complications</td>
</tr>
<tr>
<td></td>
<td>• Diabetes</td>
<td>• Hospital-acquired infections</td>
</tr>
<tr>
<td></td>
<td>• Cardiovascular disease</td>
<td>• Obstetrical injury</td>
</tr>
<tr>
<td></td>
<td>• Hypertension</td>
<td>• Mortality (condition -specific)</td>
</tr>
<tr>
<td></td>
<td><em><strong>Triple weighted</strong></em></td>
<td></td>
</tr>
<tr>
<td><strong>PATIENT</strong></td>
<td>• Access, Integration</td>
<td>• Discharge quality, Staff responsiveness</td>
</tr>
<tr>
<td></td>
<td>• Communication, Whole-person care</td>
<td>• Communication (MDs, RNs)</td>
</tr>
<tr>
<td><strong>EXPERIENCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EMERGING</strong></td>
<td>Up to 3 measures on priority topics for which measures lacking</td>
<td></td>
</tr>
</tbody>
</table>
As quality improves, provider share of surplus increases/deficit decreases

Linking Quality and Efficiency
The 2011 AQC ensures that providers have a strong incentive to focus on both objectives.

PMPM Quality Dollars
The 2011 AQC also allows groups to earn PMPM quality dollars regardless of their budget surplus or deficit. High quality groups earn more PMPM quality dollars.
AQC Results: The First Four Years
AQC Physician Participation
(Current as of February 2015)

**PCPs**

- 2009: 1,373
- 2010: 1,420
- 2011: 2,303
- 2012: 4,592
- 2013: 5,136
- 2014: 5,547
- 2015*: 5,664

**SCPs**

- 2009: 2,577
- 2010: 2,618
- 2011: 5,065
- 2012: 11,731
- 2013: 12,986
- 2014: 14,067
- 2015*: 14,777

*All 2015 figures as of February
Results Under The AQC:
Improvement of the 2009 Cohort of AQC Groups from 2007-2012

These graphs show that the AQC has accelerated progress toward optimal care since it began in 2009. The first two scores are based on the delivery of evidence-based care to adults with chronic illness and to children, including appropriate tests, services, and preventive care. The third score reflects the extent to which providers helped adults with serious chronic illness achieve optimal clinical outcomes. Linking provider payment to outcome measures has been one of the AQC’s pioneering achievements.
**AQC Results: Formal Evaluation Findings**

---

### Formal Academic Evaluation: Year 3 & 4 Results

*The New England Journal of Medicine*

**Changes in Health Care Spending and Quality 4 Years into Global Payment**

As compared with similar populations in other states, Massachusetts AQC enrollees had lower spending growth and generally greater quality improvements in the period 2009 through 2012. The AQC experience may be useful to policy-makers, insurers and providers embarking on payment reform. Although it is still early, these results suggest that a two-sided global budget model may serve as a foundation for slowing spending and improving quality.

---

### Savings Associated with the AQC Relative to Control Group, 2009-2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Weighted average savings on claims (% of current-year FFS claims)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>2.4%</td>
</tr>
<tr>
<td>2010</td>
<td>3.1%</td>
</tr>
<tr>
<td>2011</td>
<td>8.4%</td>
</tr>
<tr>
<td>2012</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

---

**AQC Physician Participation**

<table>
<thead>
<tr>
<th>Year</th>
<th>Participation (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>20%</td>
</tr>
<tr>
<td>2010</td>
<td>20%</td>
</tr>
<tr>
<td>2011</td>
<td>56%</td>
</tr>
<tr>
<td>2012</td>
<td>77%</td>
</tr>
</tbody>
</table>

---

Total Cost Results

The Harvard evaluation documented that AQC is reducing medical spending, but accounts also want to see reductions in total spending.

- By Year-3, BCBSMA met its goal of cutting trend in half (2 years ahead of plan).
- By Year-4, BCBSMA total cost trend was below state general economic growth benchmark (<3.6%).
AQC Support & Improvement Analytics
Components of the AQC Support Model

Our four-pronged support model is designed to help provider groups succeed in the AQC.

- **Data and Actionable Reports**
  - Chart showing data analysis and reporting.

- **Consultative Support**
  - Image of professionals discussing in a circular arrangement.

- **Best Practice Sharing and Collaboration**
  - Diagram of interconnected people symbolizing collaboration.

- **Training and Educational Programming**
  - Image of a classroom setting with training sessions.
Data and Actionable Reports

We distribute reports that can be used to help organizations recognize opportunities, develop goals and measure their success.

Daily
- Daily Census, Discharge, PCP Referrals and Inpatient & Outpatient Authorization Reports

Weekly
- New Member Report
- ED Utilization Report

Monthly
- AQC Member Call Tracking Grid
- Monthly Ambulatory Quality Report
- Monthly AQC Ambulatory Quality Measures Group Comparison Report
- Chronic Condition Opportunities Report
- Quality Diabetic Composite Score

Bi-Monthly
- Case Management Report

Quarterly
- Ambulatory Care Sensitive Conditions Report
- AQC Financial Dashboard
- Non-Emergent ED Report
- Top 100 Rx Report

Bi-Annually
- Practice Pattern Variation Report—Episode Treatment Groups (ETG)
- Practice Pattern Variation Report—Emergency Department Use for Specific Conditions

Annually
- Readmission Report
- AQC Ambulatory Quality Measures Score/Results
- AQC Hospital Quality Measures Score/Results

Recurring
- Cost and Use Report
- Site of Service Report
Practice Pattern Variation Analysis (PPVA)

Unpacking differences in the treatment components of specific episodes across clinicians in a single, defined medical specialty.

The results are **highly actionable** because they get to the root of variations in treatment costs for a defined and highly-specific clinical circumstance among physicians of the same specialty.

![Costs per Episode Graph]

Source: Greene RA, et al. *Health Affairs* 2008; w250-259
Benign Hypertension, With and Without Comorbidity
Individual Primary Care Physicians
Rate of ARB Use per 100 Episodes with ACE-I and/or ARB
2007

Rate = Episodes with ARB / Episodes with ACE-I and/or ARB

- The 12 primary care physicians in this group have rates of ARB use ranging from 13% to 55%.
- 9 physicians have rates above the network average.
Tendency to Use Upper GI Endoscopy:
Group Example

Inflammation of the Esophagus, Without Surgery
Individual Gastroenterologists
Rate of Upper GI Endoscopy Use per 100 Episodes
7/1/2009 - 6/30/2010
Group W

Rate = Episodes with Upper GI Endoscopy / Total ETG episodes

- The 52 individual gastroenterologists in this group have rates of Upper GI Endoscopy Use ranging from 18 to 100.
- No individual gastroenterologists have a rate of zero.
- 32 individual gastroenterologists have rates above the network average.
Suggested Guidelines for Endoscopies for Gastroesophageal Reflux Disease (GERD)

Provided by Massachusetts Medical Society and its Expert Panel of Gastrointestinal (GI) Specialists

David R. Cave, MD, PhD
Director, Chaired Gastroenterology Research
UMass Memorial Medical Center

Ram Chuttani, MD
Director, Interventional Gastroenterology and Endoscopy
Beth Israel Deaconess Medical Center

Myron Finkel, MD
Chief, Clinical Gastroenterology
Beth Israel Deaconess Medical Center

David R. Lichtenstein, MD
Dean of Endoscopy
Boston Medical Center

John H. Satterman, MD, FACP, FACG
Director of Endoscopy
Brenham and Women’s Hospital

Yvonne M. Troun, MD
Chief of Gastroenterology
Harvard Vanguard Medical Associates

Joel V. Weinstock, MD
Chief of the Division of Gastroenterology/Hepatology
Tufts Medical Center

Michael J. Mullen, MD
Chair of the Department of Medicine
MetroHealth Medical Center, Cleveland, Ohio

MMS’s Chairs, Committee on the Quality of Medical Practice

James Feldman, MD, MPH, FACP
Professor of Emergency Medicine
Boston Medical Center

Elizabeth Marz, MD
Associate Chief, Medical Office
Massachusetts General Hospital

Additionally, if at times of the day and once daily in the evening, with an increasing symptoms

When the patient takes 20 to 30 minutes to reduce

It is imperative that the patient be asked to return on a daily basis to have their symptoms relieved

It is not proper to have symptoms relieved

The physician should consult with the gastroenterologist for further evaluation.
Change in Performance Over Time:
Rate of Upper GI Endoscopy per 100 Episodes

Inflammation of the Esophagus, without surgery
Rate of Upper GI Endoscopy per 100 Episodes
PCPs and their HMO/POS Member Panel Experience
Provider Group XYZ vs Network Average across Measurement Periods 2009 to mid 2013

Change in Performance Over Time:
Rate of Upper GI Endoscopy per 100 Episodes

Provider Group XYZ vs Network Average across Measurement Periods 2009 to mid 2013
Low Back Pain as subset of Joint Degeneration of the Neck & Back, with & without surgery
Med Grp XYZ PCP Groups
Rate of Referral to Orthopedic Surgeon or Neurosurgeon per 100 Episodes
2006 - 2007

Rate = Episodes with at least 1 Referral to Ortho. Surg. or Neurosurg. / Total Episodes per PCP Group

- The 21 PCP groups associated with XYZ have referral rates to orthopedic surgeons and neurosurgeons ranging from 0 to 35 per 100 episodes.
- 3 groups have a rate of 0.
- 9 groups have rates at or above the network average.
Variation in Days-to-MRI for Low Back Pain

Low Back Pain as subset of Joint Degeneration of the Neck & Back, with & without surgery
Medical Group XYZ's PCP Groups
Average # of Days from Initial Visit to MRI
2006 - 2007

Rate = Sum of Days from Initial Visit to MRI / # of Episodes with MRI per PCP Group

- The 21 PCP groups associated with Medical Group XYZ have average days between initial visit and MRI ranging from 0 to 311 days.
- 12 PCP groups have average days less than the network average.
- The same 12 PCP groups also have average days less than 6
Change in Performance Over Time:
Rate of MRI per 100 Episodes for Low Back Pain

Low Back Pain
Rate of MRI per 100 Episodes
Groups of PCPs and their HMO/POS Panel
Provider Group ABC vs Network Average across Measurement Periods 2009 to mid 2013
Summary

- Payment reform gives rise to significant delivery system reform

- Rapid and substantial performance improvements are possible in the context of:
  - Meaningful financial incentives
  - Rigorously validated measures & methods
  - Ongoing and timely data sharing and engagement
  - Committed leadership

- For payment reform, deep provider relationships and significant market share are advantageous
  - For national payers, remote provider relationships pose engagement challenges; member-facing incentives (benefit design) an attractive lever

Priority Issues Ahead

- Expanding payment reform to include PPO presents unique challenges
  - Gaining strong employer buy-in & support will be important; and this means models must offer value from day-1

- Continued evolution of performance measures to fill priority gaps
  - Focus on outcomes, including patient reported outcomes (functional status, well being)

- Continued evolution of the delivery system:
  - Evolving the role of hospitals in the delivery system
  - Building deeper engagement of specialists
  - Bringing incentives (financial & non-financial) to front lines
  - Advancing innovations in virtual care

- Payment incentives to front line clinicians need continued attention