



# **Paying for Performance to Improve Quality, Outcomes and Affordability: Good Data and Measures Are Just the Beginning**

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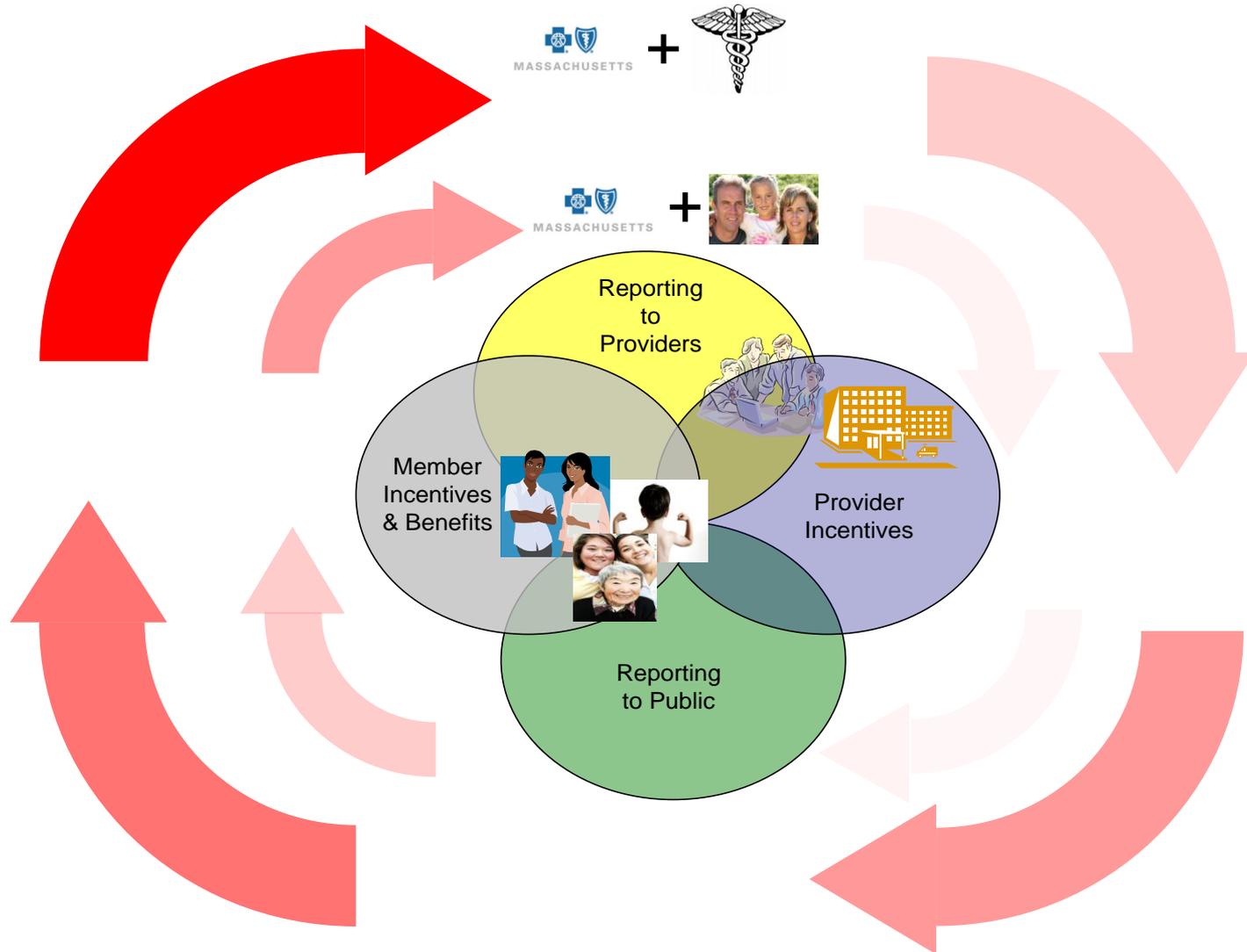
Performance Measurement and Improvement

*Presented at:*

Physician Value-Based Payment Modifier Special National  
Provider Call: *Experience from Private Sector Pay-for-  
Performance Programs*

*March 14, 2012*

# Advancing Quality and Safety Through Our Performance Measurement and Reporting Programs



# Guiding Principles in Selecting Performance Measures



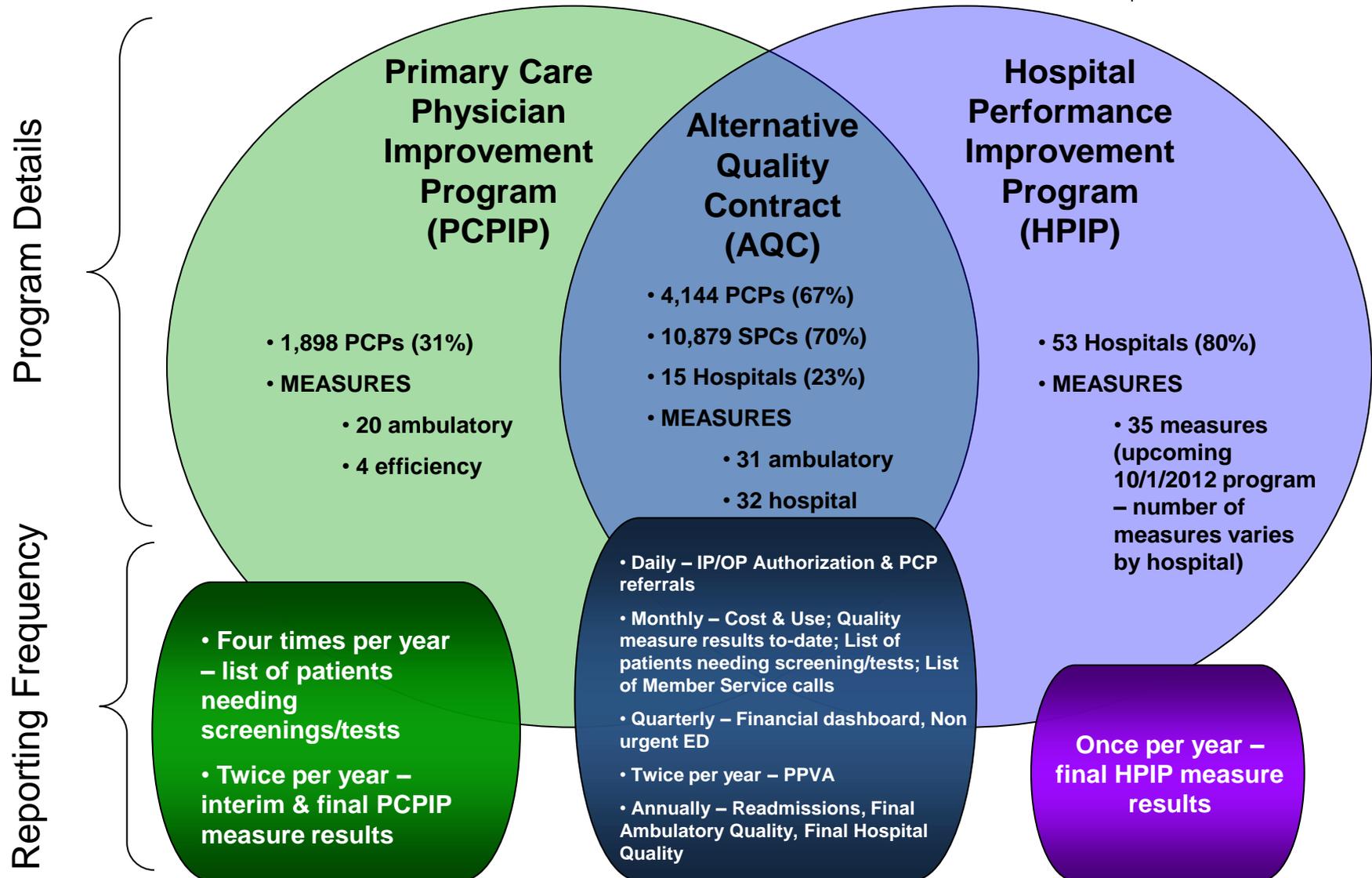
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- ◆ Wherever possible, our measures should be drawn from nationally accepted standard measure sets.
- ◆ The measure must reflect something that is broadly accepted as clinically important.
- ◆ There must be empirical evidence that the measure provides 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.

# Key Tools for Provider Engagement – Performance Measurement Programs & Reporting



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# Primary Care Physician Improvement Program (PCPIP)



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BCBSMA Primary Care Physician Improvement Program (PCPIP) was implemented in 2000.

Measures have evolved substantially over time with the initial focus on the Healthcare Effectiveness Data and Information Set® (HEDIS) process-based measures to measures of reported outcomes.

- Initial thresholds for receiving incentive payment based on panel size but have since evolved to meeting established performance targets.
- Measure set has also expanded to include various aspects of technology and efficiency in support of BCBSMA's vision of making quality health care affordable.

Beginning in 2010, PCPIP changed from individual physician to group-level measurement. The revised approach has the following benefits:

- Encourages collaboration on quality improvement efforts among physicians in the same group.
- Allows more physicians to be eligible for measures (i.e., meet minimum denominator thresholds).
- Ensures alignment with other BCBSMA incentive programs such as the AQC and gives physicians the opportunity to gain experience with group-level measurement should they enter into an AQC-like arrangement.

As the number of provider organizations entering into BCBSMA's Alternative Quality Contract (AQC) increase, the number of physicians participating in PCPIP will continue to decline.

- In 2008, 5,300 PCPs in the HMO Blue network participated in PCPIP.
- In 2011, the number of PCPs participating in PCPIP decreased to 1,898.

# Key Components of the Alternative Contract Model



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## Unique contract model:

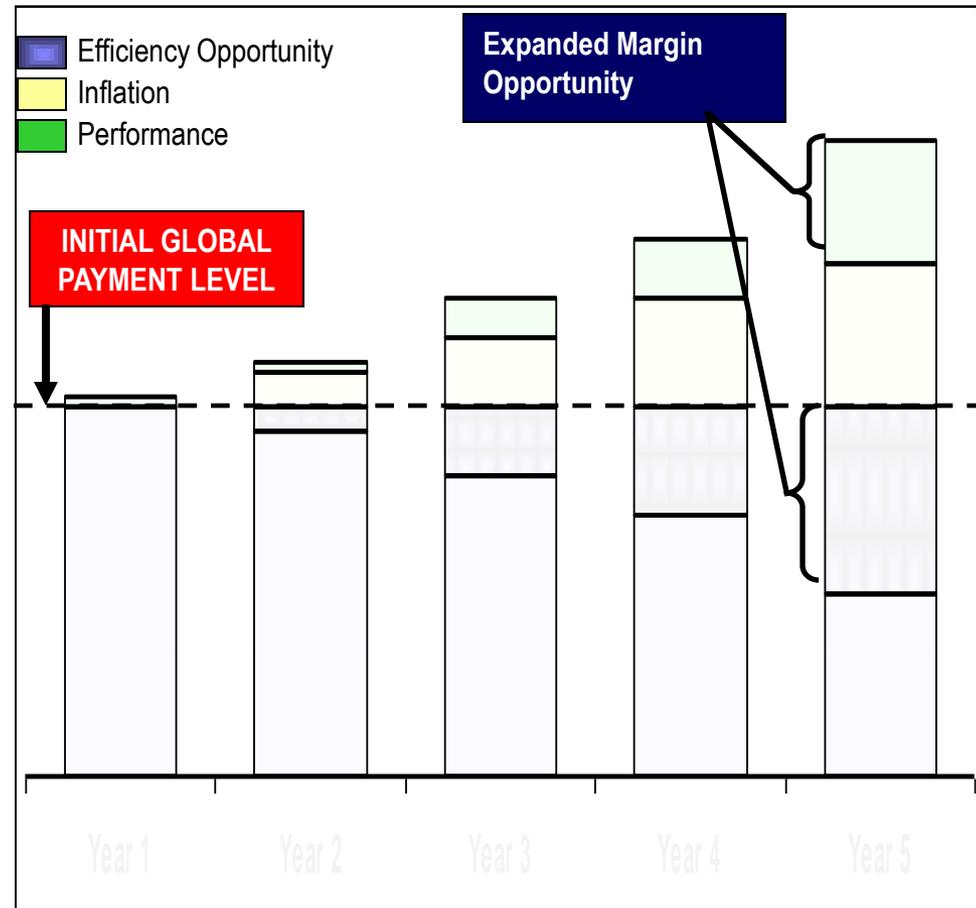
- Physicians & hospital contracted together as a “system” – accountable for cost & quality across full care continuum
- Long-term (5-years)

## Controls cost growth

- Global payment for care across the continuum
- Annual inflation tied to Consumer Price Index (CPI)
- Incentive to eliminate clinically wasteful care (“overuse”)

## Improved quality, safety and outcomes

- Robust performance measure set creates accountability for quality, safety and outcomes across continuum
- Substantial financial incentives for high performance (up to 10% upside)



## Ambulatory Measures

## Hospital Measures

Process

Measure	Score	Weight
<b>Depression</b>		
1 Acute Phase Rx	2.5	1.0
2 Continuation Phase Rx	1.5	1.0
<b>Diabetes</b>		
3 HbA1c Testing (2X)	3.0	1.0
4 Eye Exams	1.0	1.0
5 Nephropathy Screening	1.2	1.0
<b>Cholesterol Management</b>		
6 Diabetes LDL-C Screening	2.8	1.0
7 Cardiovascular LDL-C Screening	2.1	1.0
8 Breast Cancer Screening	1.2	1.0
9 Cervical Cancer Screening	1.3	1.0
10 Colorectal Cancer Screening	2.4	1.0
<b>Preventive Screening/Treatment</b>		
Chlamydia Screening		
11 Ages 16-20	3.1	0.5
12 Ages 21-25	1.8	0.5
<b>Pedi: Testing/Treatment</b>		
13 Upper Respiratory Infection (URI)	1.6	1.0
14 Pharyngitis	1.4	1.0
<b>Pedi: Well-visits</b>		
15 < 15 months	2.6	1.0
16 3-6 Years	2.0	1.0
17 Adolescent Well Care Visits	1.5	1.0

Measure	Score	Weight
<b>AMI</b>		
1 ACE/ARB for LVSD	2.0	1.0
2 Aspirin at arrival	2.5	1.0
3 Aspirin at discharge	1.5	1.0
4 Beta Blocker at arrival	1.5	1.0
5 Beta Blocker at discharge	1.3	1.0
6 Smoking Cessation	1.0	1.0
<b>Heart Failure</b>		
7 ACE LVSD	1.3	1.0
8 LVS function Evaluation	1.0	1.0
9 Discharge instructions	1.8	1.0
10 Smoking Cessation	3.0	1.0
<b>Pneumonia</b>		
11 Flu Vaccine	2.5	1.0
12 Pneumococcal Vaccination	2.9	1.0
13 Antibiotics w/in 4 hrs	1.4	1.0
14 Oxygen assessment	1.0	1.0
15 Smoking Cessation	3.1	1.0
16 Antibiotic selection	3.0	1.0
17 Blood culture	3.5	1.0
<b>Surgical Infection</b>		
18 Antibiotic received	1.3	1.0
19 Received Appropriate Preventive Antibiotic	1.4	1.0
20 Antibiotic discontinued	3.0	1.0
21 In-Hospital Mortality - Overall	3.0	1.0
22 Wound Infection	2.1	1.0
23 Select Infections due to Medical Care	2.8	1.0
24 AMI after Major Surgery	2.4	1.0
25 Pneumonia after Major Surgery	3.4	1.0
26 Post-Operative PE/DVT	2.0	1.0
27 Birth Trauma - injury to neonate	1.0	1.0
28 Obstetrics Trauma-vaginal w/o instrument	1.5	1.0

Outcomes

<b>Diabetes</b>		
18 HbA1c in Poor Control	3.2	3.0
19 LDL-C Control (<100mg)	2.4	3.0
<b>Hypertension</b>		
20 Controlling High Blood Pressure	1.3	3.0
<b>Cardiovascular Disease</b>		
21 LDL-C Control (<100mg)	2.4	3.0

Hospital Patient Experience (H-CAHPS) Measures		
Measure	Score	Weight
29 Communication with Nurses	4.0	1.0
30 Communication with Doctors	3.0	1.0
31 Responsiveness of staff	2.5	1.0
32 Discharge Information	2.8	1.0

Patient Exper.

<b>Patient Experiences (C/G CAHPS/ACES) - Adult 3</b>		
22 Communication Quality	1.9	1.0
23 Knowledge of Patients	1.9	1.0
24 Integration of Care	2.1	1.0
25 Access to Care	2.4	1.0
<b>Patient Experiences (C/G CAHPS/ACES) - Pediatric 3</b>		
26 Communication Quality	1.0	1.0
27 Knowledge of Patients	1.5	1.0
28 Integration of Care	2.5	1.0
29 Access to Care	2.8	1.0

Experimental

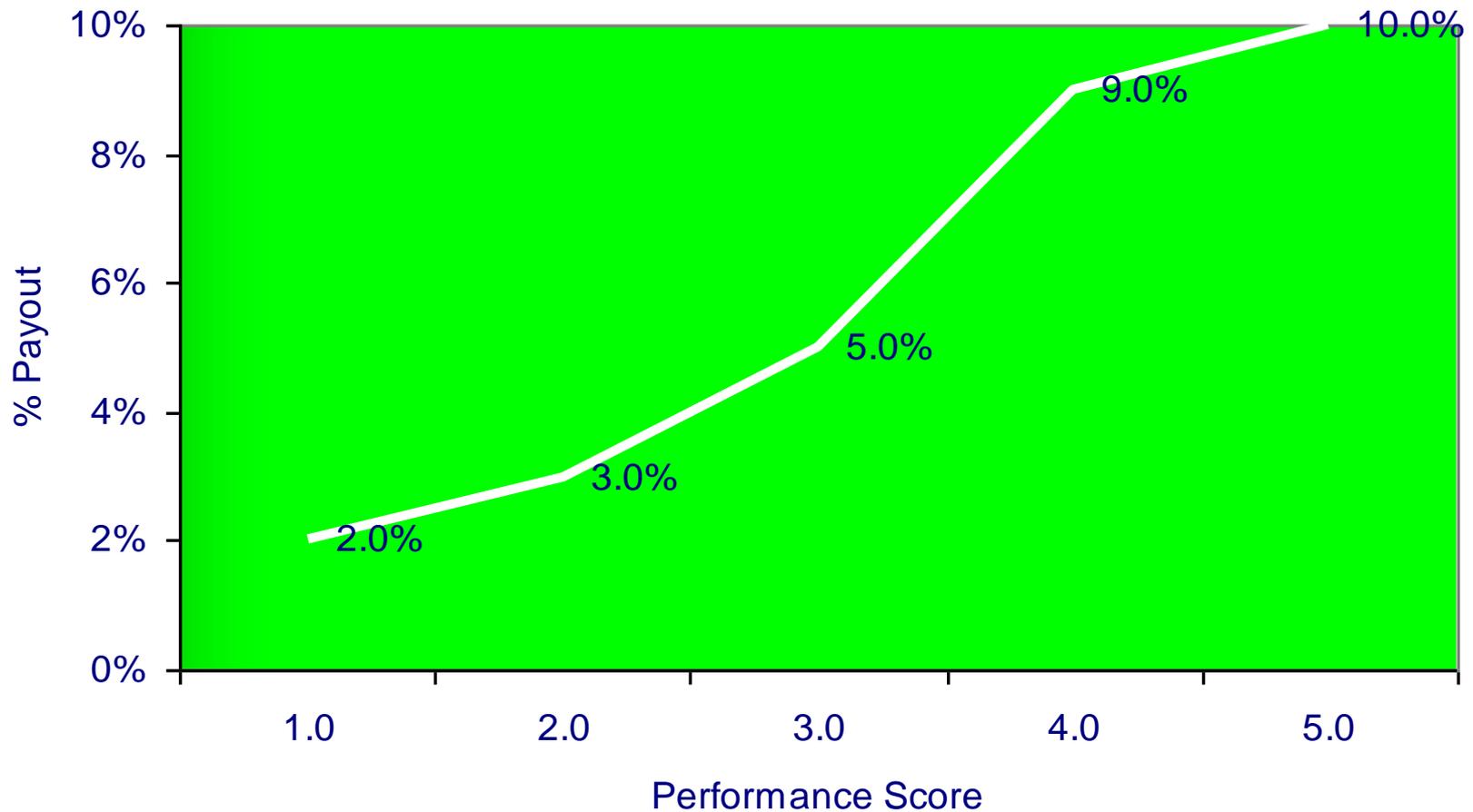
30 Experimental Measure A	5.0	1.0		33 Experimental Measure C	5.0	1.0
31 Experimental Measure B	5.0	1.0				

<b>Weighted Ambulatory Score</b> 2.2	<b>Weighted Hospital Score</b> 2.3
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# Performance Payment Model: Original

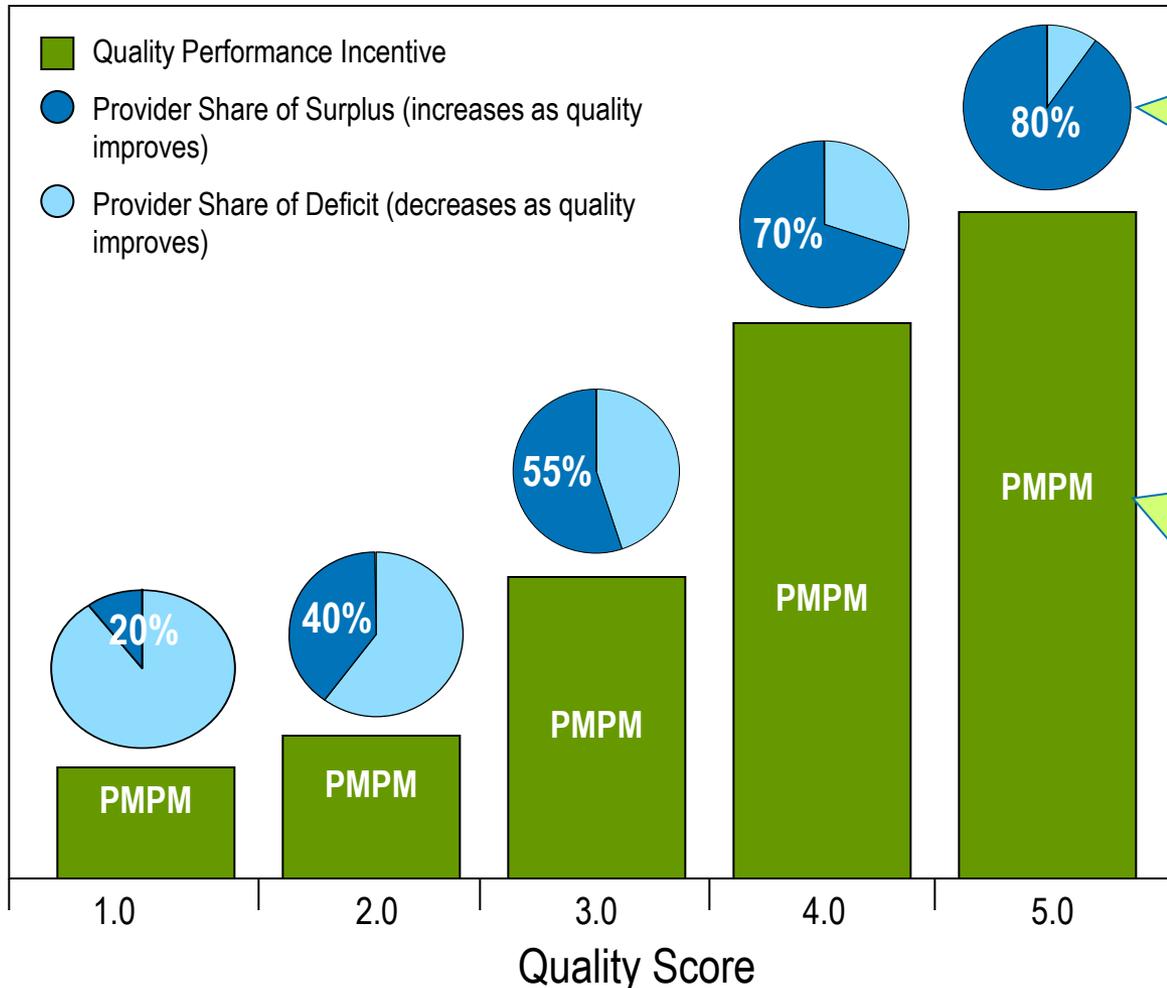


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# Performance Payment Model: Updated (2011)

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.

## Per Member Per Month (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 is Significantly Improving Quality



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- Year-1 improvements in the quality were greater than any one-year change seen previously in our provider network
  - Every AQC organization showed significant improvement on the clinical quality measures, including several dozen clinical process and outcomes measures
  - AQC groups exhibited exceptionally high performance for all clinical outcome measures with *more than half approaching or meeting the maximum performance target* on measures of diabetes and cardiovascular care
  - There were no significant changes in AQC groups' performance on patient care experience measures overall.
- Year-2 showed continued significant quality improvements among AQC groups relative to others
  - Some groups are nearing performance levels believed to be best achievable for a population

# AQC Improving Preventive and Chronic Care

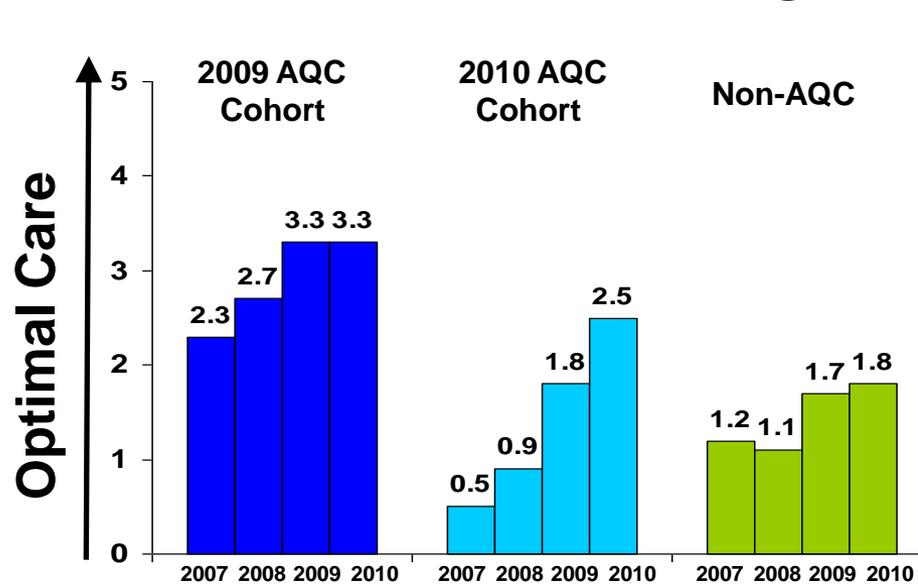


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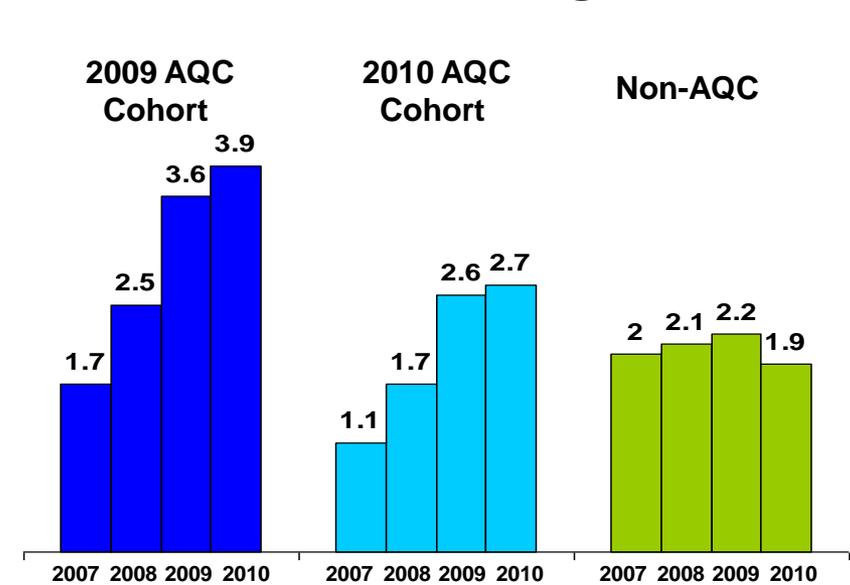
The 2009 AQC cohort continues to demonstrate success improving quality – achieving benchmarks significantly higher than non-AQC peers.

The 2010 AQC cohort made significant quality improvements in year-1 of their contract (2009 vs. 2010).

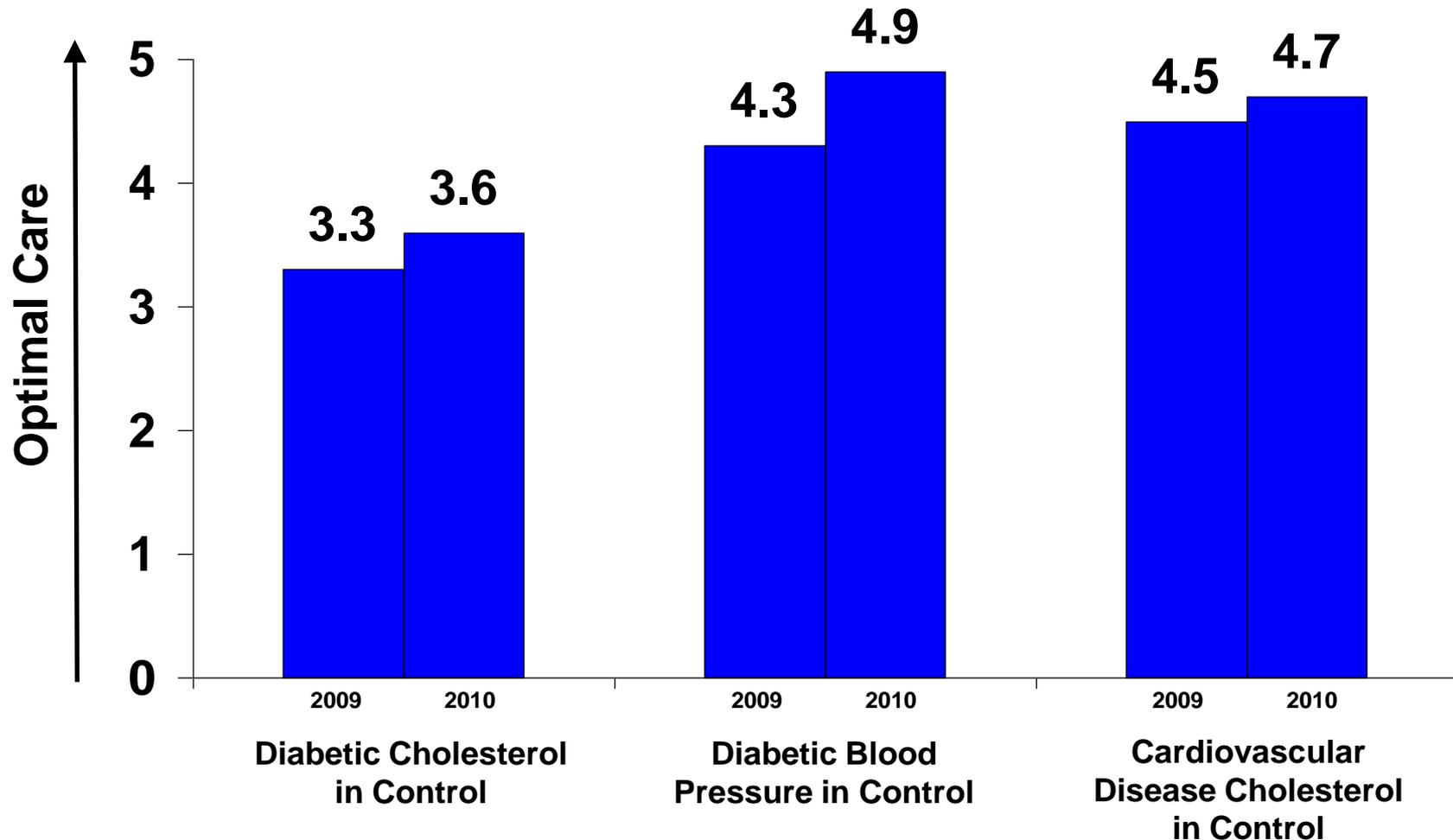
## Preventive Screenings



## Chronic Care Management



# AQC Groups Achieving Excellent Outcomes for Patients with Chronic Disease (2009 Cohort Only)

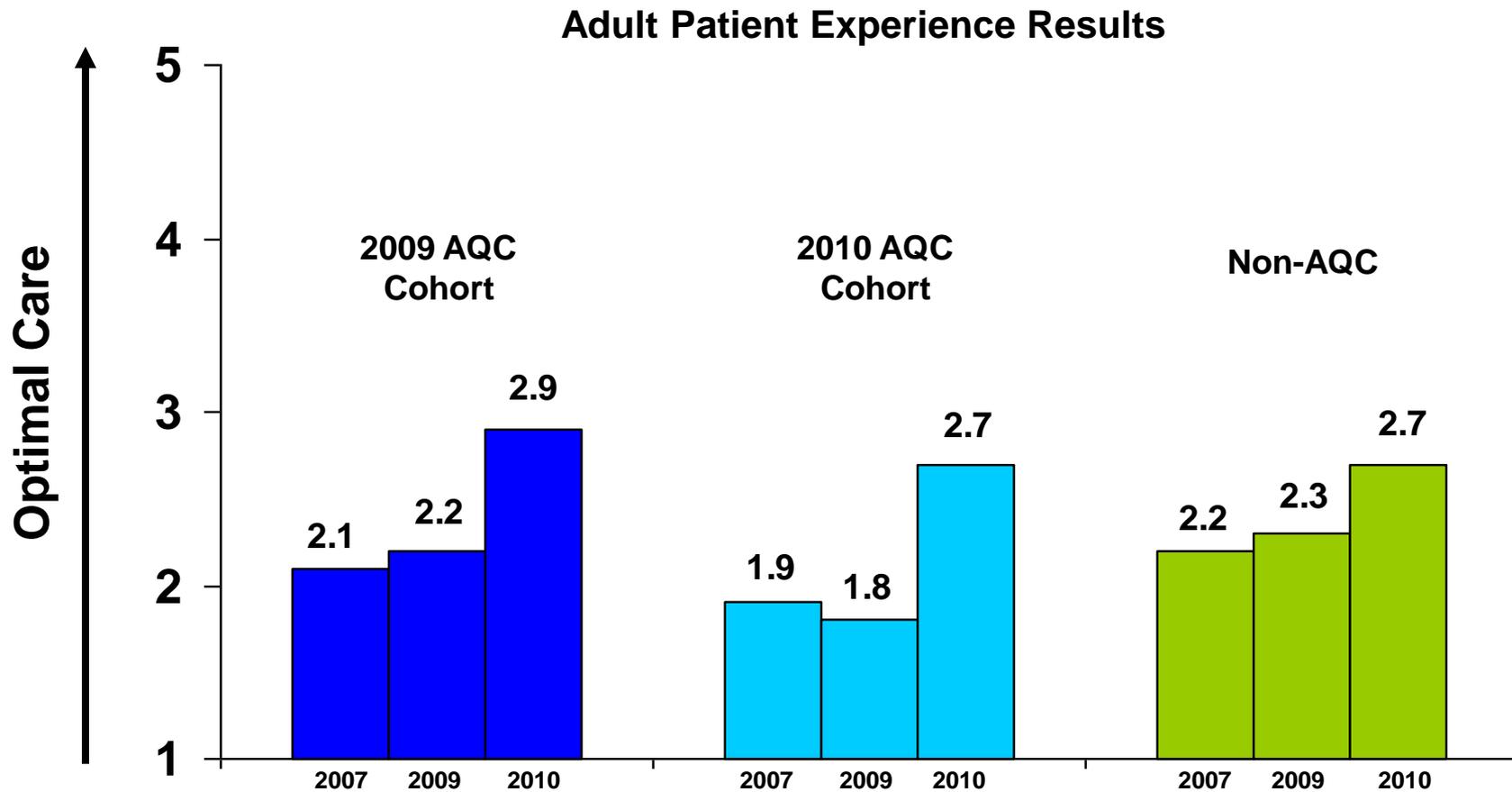


Results limited to AQC groups that received financial incentives for these measures in 2009.

# Adult Patient Experience Results, AQC vs. Non-AQC (2007-2010)



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# AQC is Significantly Reducing Costs



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BCBSMA is on track to reach our goal of reducing annual cost growth (trends) by 50% over 5 years

In Year-1, medical spending among AQC groups grew more slowly (2-pts) than the non-AQC network (Song Z et al. *NEJM* Sept 2011.) Savings deepened in Year-2.

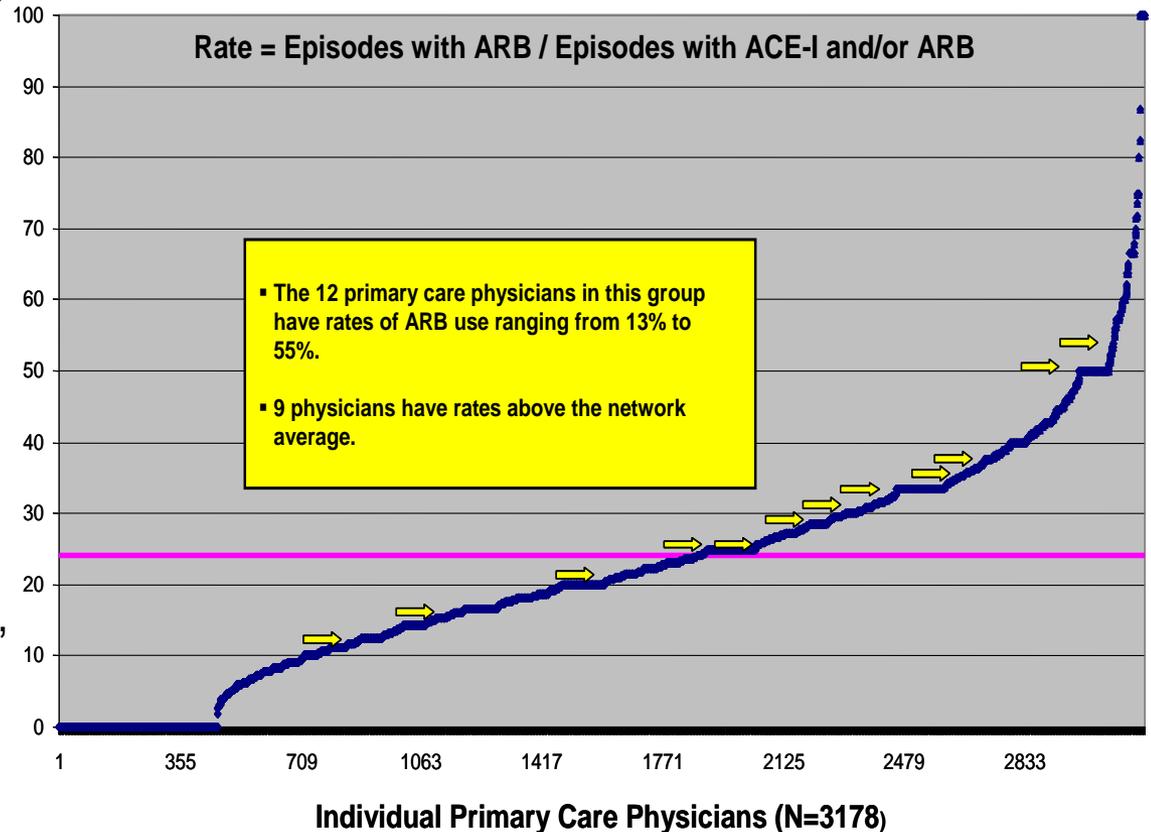
**Site-of-Service (Price).** In year-1, AQC groups focused largely on site-of-service issues as a key driver of cost and opportunity to improve integration of care. Over first 2 years, approximately \$2.5M savings due to use of lower cost settings.

**Use.** In year-2, AQC groups began to also show significant changes in use

- Medical/surgical admissions trend was 2% lower than non-AQC, which translates into approximately 300 admissions prevented (approximately \$6M)
- High tech imaging trend was lower than non-AQC, which translated into about 1500 fewer scans (approximately \$2M, reduced radiation exposure)

# Identifying & Addressing Clinically Wasteful Care

- Since 1970s, Wennberg et al. have called attention to unexplained practice pattern variations using maps
- Dr. Howard Beckman developed an analytic approach that makes the information clinically meaningful and actionable (Greene RA, et al. *Health Affairs* 2008; w250-259)
- Clinically-specific, specialty-specific approach to displaying practice pattern variations – engages physician leaders and front line physicians in addressing clinical waste
- Referral tendencies, use of procedures, use of diagnostics, use of therapeutics
- This is a slow but critical process
- Payment models that create accountability for resource use (e.g., global budget) gives a strong incentive to act on these data



- A payment model that establishes provider accountability for both medical spending and quality appears to be a powerful vehicle for realizing the goal of a high performance health care system with a sustainable rate of spending growth
- Rapid and substantial performance improvement appears to follow when:
  - Substantial financial incentives for improvement on well validated measures
  - Ongoing and timely data to inform improvement efforts
  - Organizational structure and leadership commitment to the goals
- Clinically-specific, specialty-specific approach to displaying practice pattern variations appears powerful to engaging physicians in addressing clinical waste
- We will continue to develop, expand and refine the AQC model, including
  - Implementation in PPO
  - Align member incentives through product design
- In 2012, we will continue working with providers who would like to be part of Medicare and/or Medicaid payment reform demonstrations under similar accountability models

# For More Information



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Doctor and the Doll by Norman Rockwell

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