National Quality Strategy Webinar

Using Payment to Improve Health and Health Care Quality

February 4, 2015

NATIONAL QUALITY STRATEGY

Better Care. Healthy People/Healthy Communities. Affordable Care.

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Agenda

- **Welcome**
  Ann Gordon, Facilitator
- **Presentation of the NQS Levers**
  Nancy Wilson, Executive Lead
  National Quality Strategy
- **Buying Value**
  Gerry Shea, Director
- **Blue Cross Blue Shield of Massachusetts Alternative Quality Contract**
  Dana Gelb Safran, Senior Vice President for Performance Measurement and Quality
- **Facilitated Discussion**
  Presenters
- **Question and Answer**

The National Quality Strategy: Using Payment to Improve Health and Health Care Quality

Nancy Wilson, B.S.N., M.D., M.P.H.

Background on the National Quality Strategy

- Established by the Affordable Care Act to **improve the delivery of health care services, patient health outcomes, and population health**
- The Strategy was first published in 2011 and serves as a **nationwide effort** to improve health and health care across America
- The Strategy was iteratively designed by public and private stakeholders, and provides an opportunity to **align quality measures and quality improvement activities**

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The IHI Triple Aim and NQS Three Aims

Improving the patient experience of care
(including quality and satisfaction)

Improving the health of populations

Reducing the per capita cost of health care

Better Care: Improve overall quality by making health care more patient-centered, reliable, accessible, and safe

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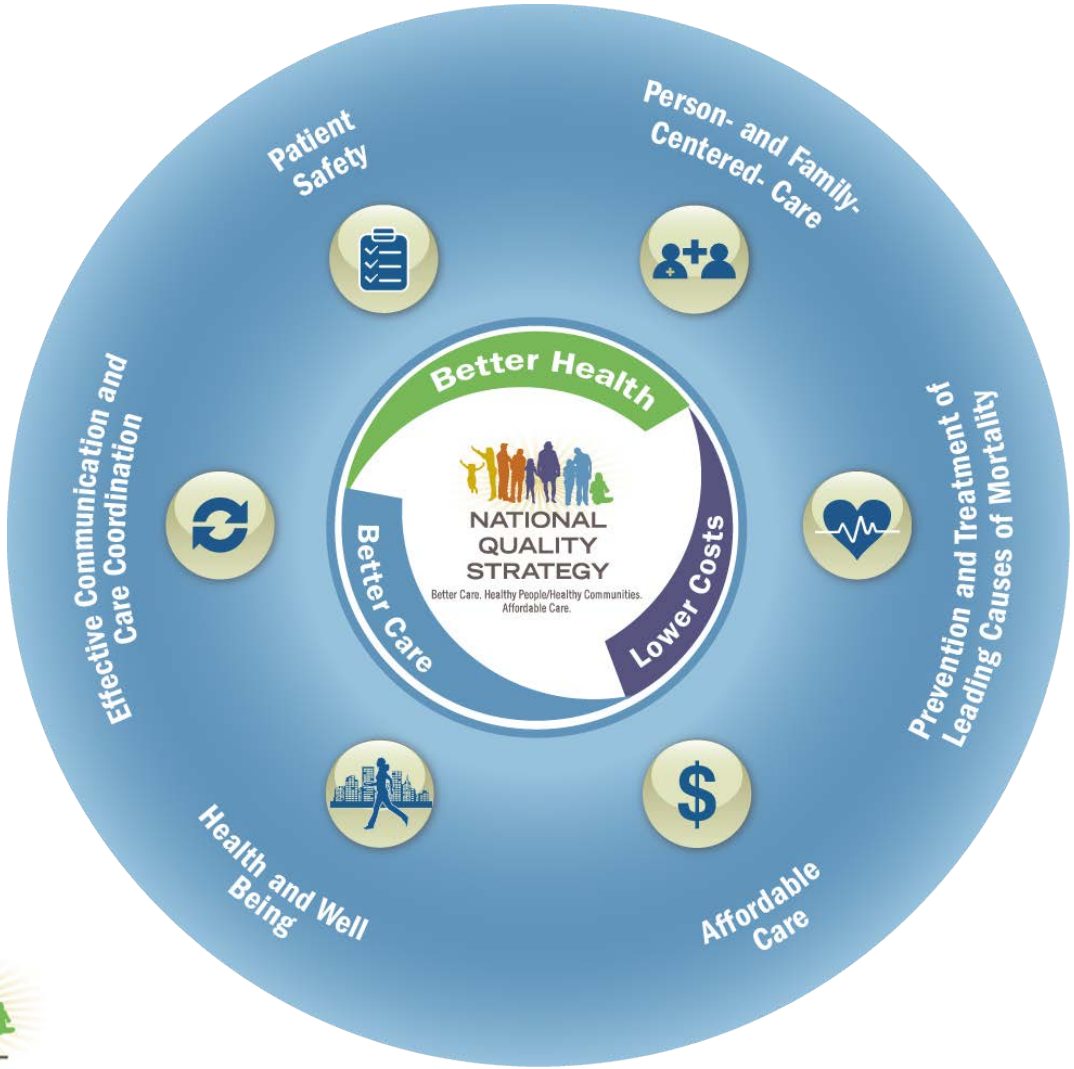
Healthy People/Healthy Communities.

Healthy People/Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health

Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government

Six National Quality Strategy Priorities



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Nine National Quality Strategy Levers

Measurement and Feedback

Public Reporting

Learning and Technical Assistance

Certification, Accreditation, and Regulation

Consumer Incentives and Benefit Designs

Payment

Health Information Technology

Innovation and Diffusion

Workforce Development

Payment

Reward and incentivize providers to deliver high-quality, person-centered care

Buying Value

Purchasing Healthcare That's Proven to Work

Switching from Volume Buying to Value Buying – THE Quality Challenge for Private Purchasers

Gerry Shea, Buying Value Director

NQS Webinar, February 4, 2015

Value-Based Purchasing is a Key Design Element in the ACA

- Starts with Framework for Major Improvement – The National Quality Strategy
- Requires Standardized Measures of Quality
- Adds major Investment Quality Improvement – The Partnership for Patients, CMMI, etc.
- Ties Medicare Payments to Quality Performance Overtime
- Calls for Alignment of Private and Public Purchasing

Value Purchasing Is The Primary Way Private Purchasers Support Quality Improvement

- Switching to value purchasing is the MOST important step purchasers can take to better care, better health, and lower costs
- But today, only 40 percent of private purchasing is tied to quality metrics – most of it modest, first generation programs
- Private purchasers typically pay healthcare bills without knowing whether the care was great, mediocre, or downright dangerous

To Be Successful, Value Purchasing Requires Good Measures & Alignment

- Measures of quality must be accurate and reliable
- Measures must be aligned across public and private purchasers and payers
- To change from volume-purchasing to value purchasing, private purchasers need core measure sets that are virtually “plug and play”
- Poor alignment of measures overwhelms everyone and impedes progress on quality

Medicare Hospital Value Payments 2011-2017

Policy	2011	2012	2013	2014	2015	2016	2017
Hospital Inpatient Quality Reporting Program /a	-2.0%	-2.0%	-2.0%	-2.0%	-1.0%	-1.0%	-1.0%
Meaningful Use Incentive Payments /b	.5%	1.7%	1.7%	1.3%	1.4% -1.0%	-2.0%	-3.0%
Hospital Acquired Conditions (Current) /c	-.02%	-.02%	-.02%	-.02%	-.02%	-.02%	-.02%
Hospital Acquired Conditions (ACA) /d					-1.0%	-1.0%	-1.0%
Readmissions /e			-1.0%	-2.0%	-3.0%	-3.0%	-3.0%
Hospital Value-Based Purchasing /f			1.0% - 1.0%	1.25% - 1.25%	1.5% - 1.5%	1.75% - 1.75%	2.0% - 2.0%

Notes:

- Percentages reflect approximate maximum potential impact to an individual hospital.
- The values in the column labeled "2017" remain constant thereafter.

a. Non-reporting hospitals lose 2% of their annual market basket update through 2014, then lose ¼ of that update from 2015 onwards. The actual percentage will vary depending on the market basket update each year (-1% is illustrative).

b. Incentive payments approximate CMS Office of the Actuary estimates in the "high adoption" scenario. Payment reductions represent reduction to annual market basket update by ¼, ½, and ¾ in 2015, 2016, and 2017, respectively for hospitals that have not qualified as meaningful users. The actual percentage will vary depending on the market basket update each year (-1%, -2%, and -3% are illustrative).

c. HACs reported through claims do not qualify DRG payment for severity adjustment.

d. Requires a 1% cut to those hospitals who rank in the top quartile of occurrences of HACs.

e. Hospitals that do not meet individualized hospital-specific readmissions benchmark face potential cut to up to a percentage ceiling .

f. Percentage of base-DRG payment subject to meeting quality measure requirements. Policy must be budget neutral, so potential for high-achieving hospitals to earn bonuses depending on the number of non-achieving hospitals.

The Buying Value Project

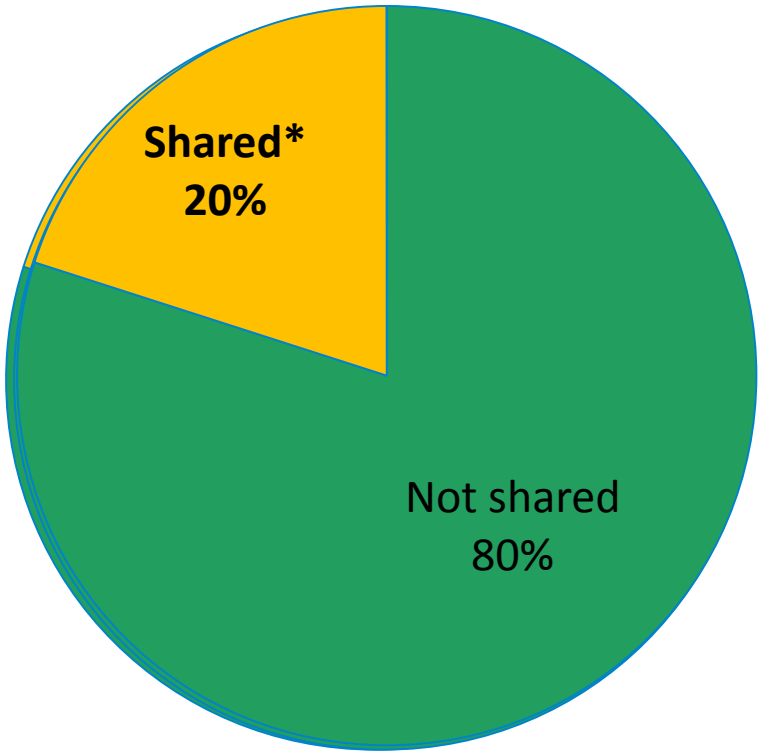
Buying Value is an Robert Wood Johnson Foundation-funded initiative of private health care purchasers—employers, leading business health organizations, and union health funds – that was launched in 2012.

- **Mission** – Private purchasers contribute to better health and lower health costs by buying on value rather than on volume.
- **Objective** – Enable widespread adoption of value purchasing in the private sector through alignment of measures among private purchasers and with federal and state public programs
- **Strategy**
  - **Measure Alignment Campaign** – Public and private purchasers, health plans, providers, and care delivery systems commit to core measure sets developed through multi-stakeholder consensus processes nationally, and at the regional or state level.
  - **Help for States/Other Stakeholders in Creating Aligned Measure Sets** – Online Measure Selection Tool and hands-on help.

Buying Value Work On Accelerating Value Purchasing in Private Sector

- Website www.buyingvalue.org (2012) – Basic info on value-purchasing – Primer, Legal Memo on Anti-Trust Issues
- "Starter" Core Measure Set (March 2013) – National purchasers, consumers, CMS & payers (health plans)
- Study of 48 Measure Sets in Use at State Level (2013) – Only 20% of measures used by more than one program; 25% of shared measures modified in some way; 39% of measures either non-standard or homegrown
- Model for Consensus Core Measure Sets – A multi-stakeholder, two-tier (national and regional or state) process for consensus core measure sets
- Online Measure Selection Tool (9/2014; Updated 1/2015) – web-based spreadsheet linked to measure databases that enables those creating measure sets to view in one place a multitude of important decision factors

2013 Buying Value Research Found Little Alignment Across Measure Sets



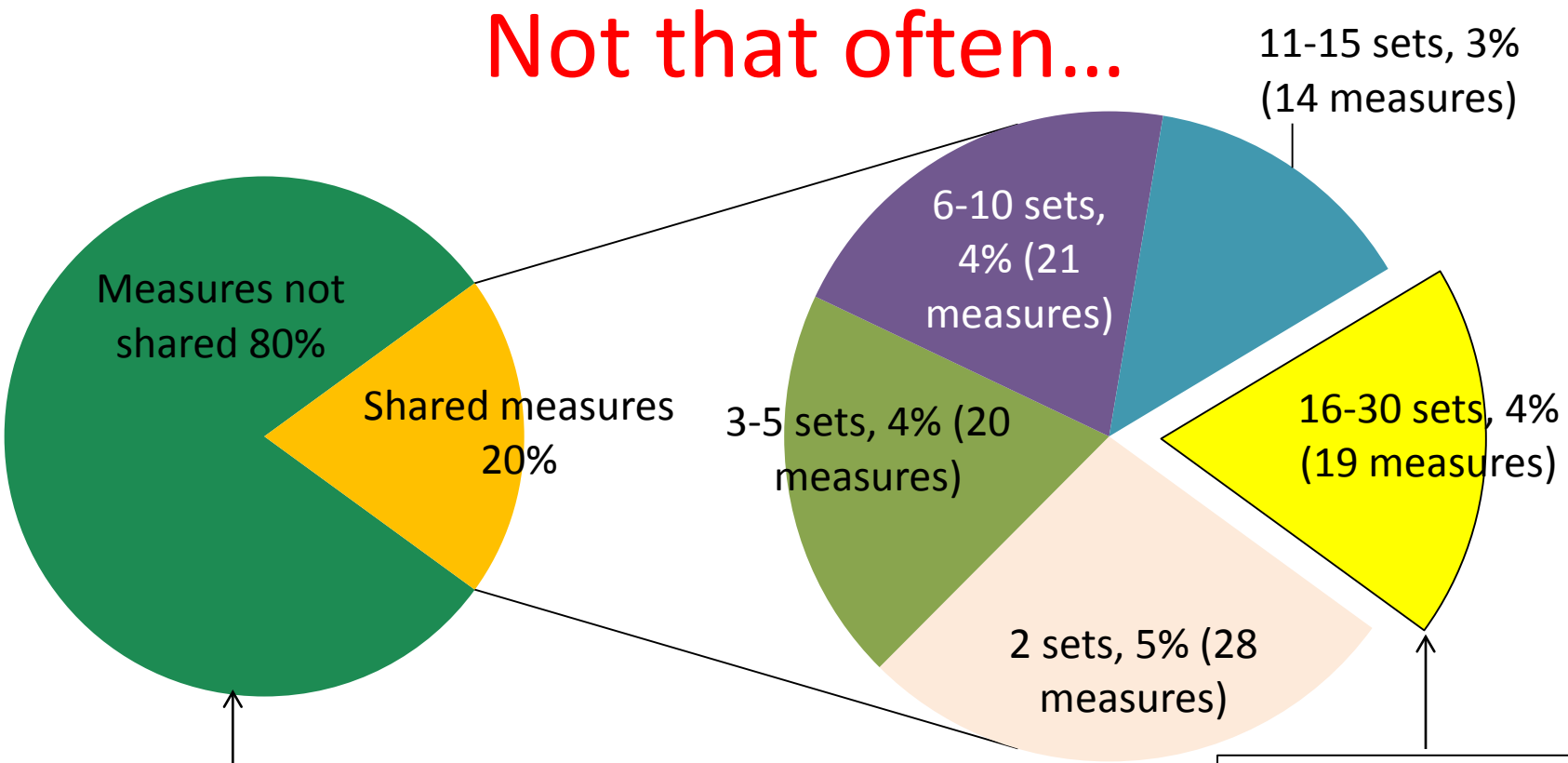
Number of distinct measures shared by multiple measure sets

n = 509

- Programs have very few measures in common or "sharing" across the measure sets
- Of the 1367 measures, 509 were "distinct" measures
- Only 20% of these distinct measures were used by more than one program
- * By "shared," we mean that the programs have measures in common with one another, and not that programs are working together

Buying Value
Purchasing Healthcare That's Proven to Work

How Often are "Shared Measures" Actually Shared?



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How Did We Get Into this Mess?

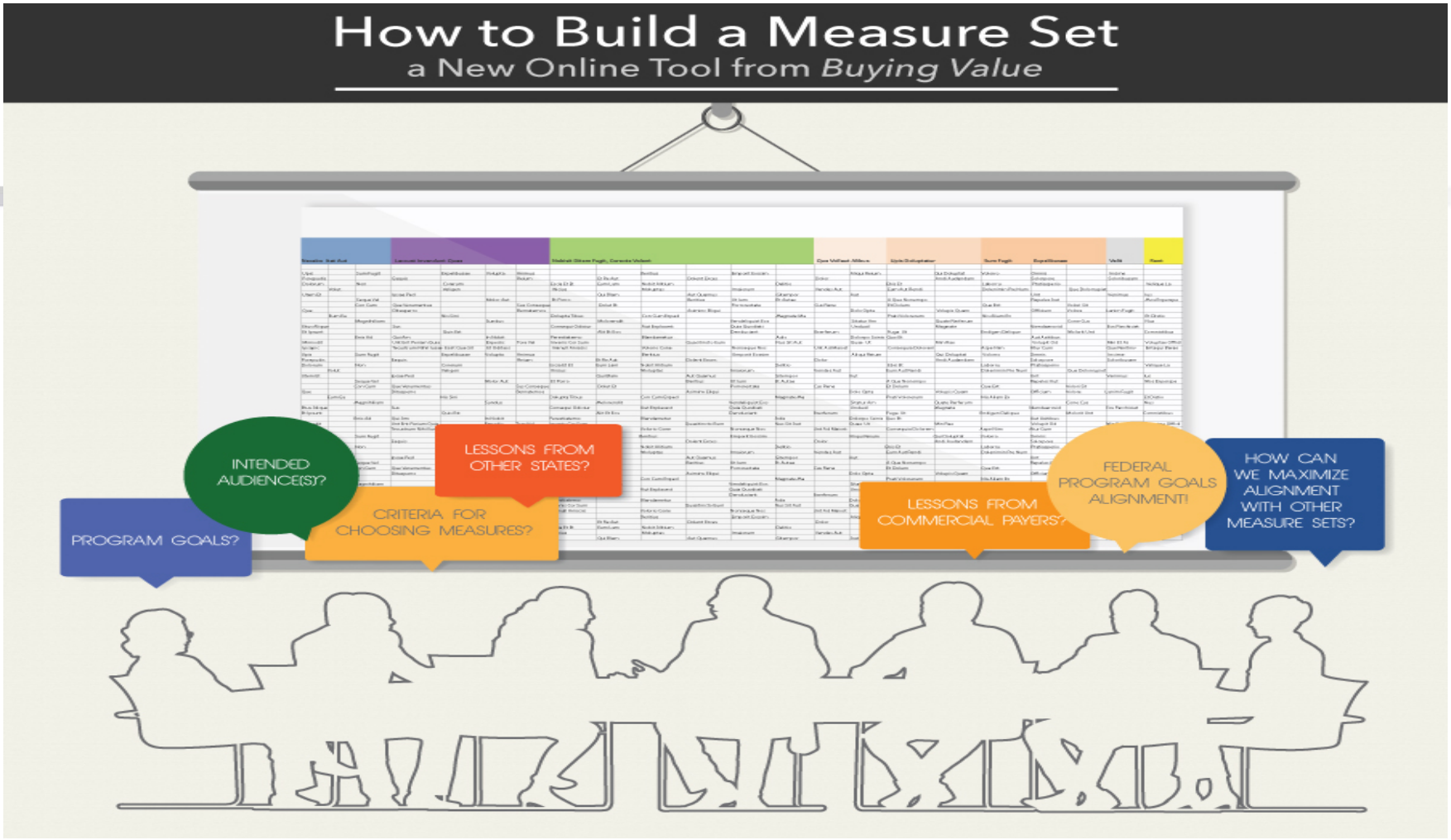
- Everyone supports the idea of alignment, but strong forces pull in the opposite direction
- Poor measure alignment reflects the failure of national organizations to make it a priority
  - Little or no help to Regional, State & Local Entities
  - "Build It (better measures) and They Will Come" remains the dominant paradigm
- Alignment needs to become a priority equal to development of better measures

Buying Value Model for Consensus Core Measure Sets – Spring, 2014

- Recommendations by large multi-stakeholder group (See "Resources" at www.buyingvalue.org)
- Features two tiers of consensus measure sets
  - National Core Set(s) of most commonly used, effective measures for major clinical conditions
  - Regional/State Core Set(s) of supplementary (not replacement) measures to meet local needs and test innovative measures
- Testing model awaits overdue reports from IOM Committee & AHIP project

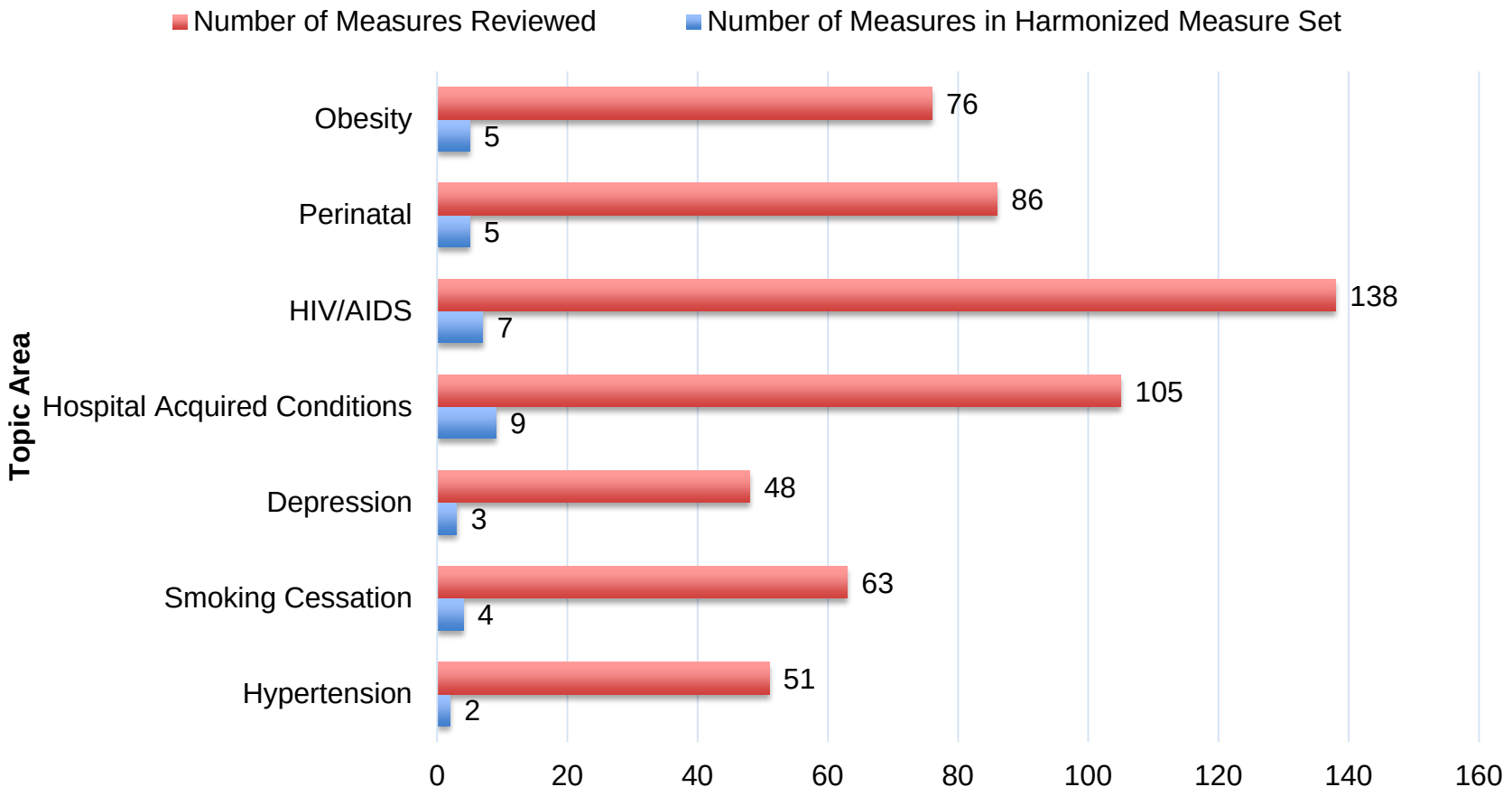
Buying Value Assistance for Those Creating/Revising Measure Sets

- Online Measure Selection Tool at www.buyingvalue.org
- Six Steps, from defining program goals and audiences, to picking measure selection criteria, to choosing existing measure sets for comparison purposes, to creating draft list of measures
- Single spreadsheet that is pre-populated with ten major federal measure sets, NQF data, and some state measure sets



A **webinar** on use of the tool and the 2015 updates to it is scheduled for **Tuesday, February 24, at 2 pm EST**., at https://mhca.webex.com/mhca/onstage/g.php?MTID=e3c3898c421f973fe0df6dbe5194770be
For audio only, call 650-479-3207 and use access code 665 533 484.

Success Story: Federal Agencies Agree to Cut Measures in 7 Areas from 567 to 35!



For More Information…

Gerry Shea

Director, Buying Value

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The Alternative Quality Contract (AQC):
Improving Quality While Slowing Spending Growth

Dana Gelb Safran, ScD
Senior Vice President,
Performance Measurement and Improvement
Blue Cross Blue Shield of Massachusetts

Presented to:
National Quality Strategy Priority in Action
4 February 2015

The Alternative Quality Contract:

Twin goals of improving quality and slowing spending growth

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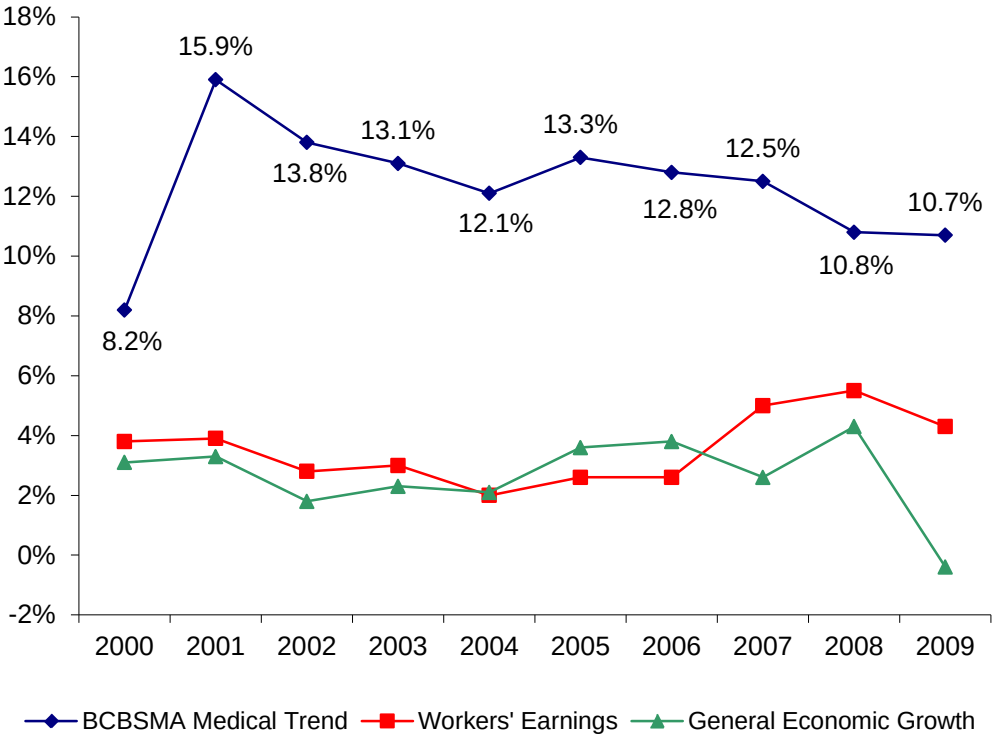
In 2007, leaders at BCBSMA challenged the company to develop a new contract model that would improve quality and outcomes while significantly slowing the rate of growth in health care spending.

The Massachusetts health reform law (2006) caused a bright light to shine on the issue of unrelenting double-digit increases in health care spending growth (Health Care Reform II).



Sources: BCBSMA, Bureau of Labor Statistics.

The Alternative Quality Contract

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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

Results Under The AQC:

Improvement of the 2009 Cohort of AQC Groups from 2007-2012

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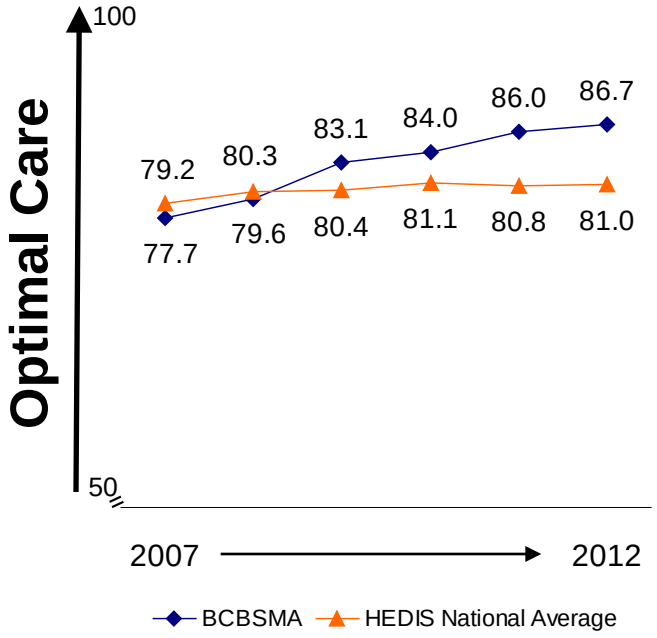
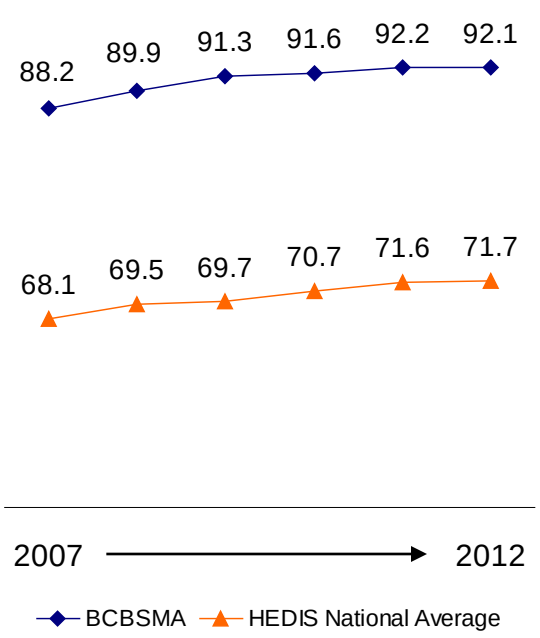
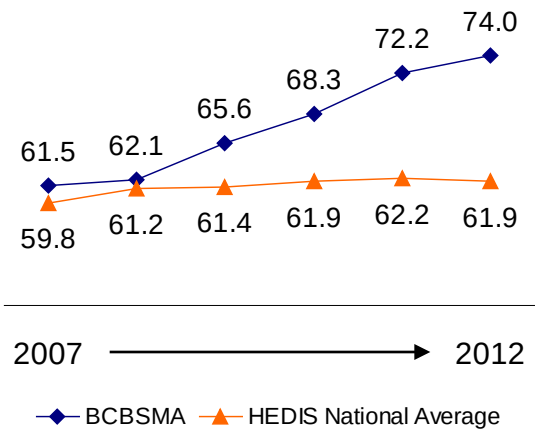
Adult Chronic Care



Pediatric Care



Adult Health Outcomes



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

SPECIAL ARTICLE

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

Zirui Song, M.D., Ph.D., Sherri Rose, Ph.D., [illegible]

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."

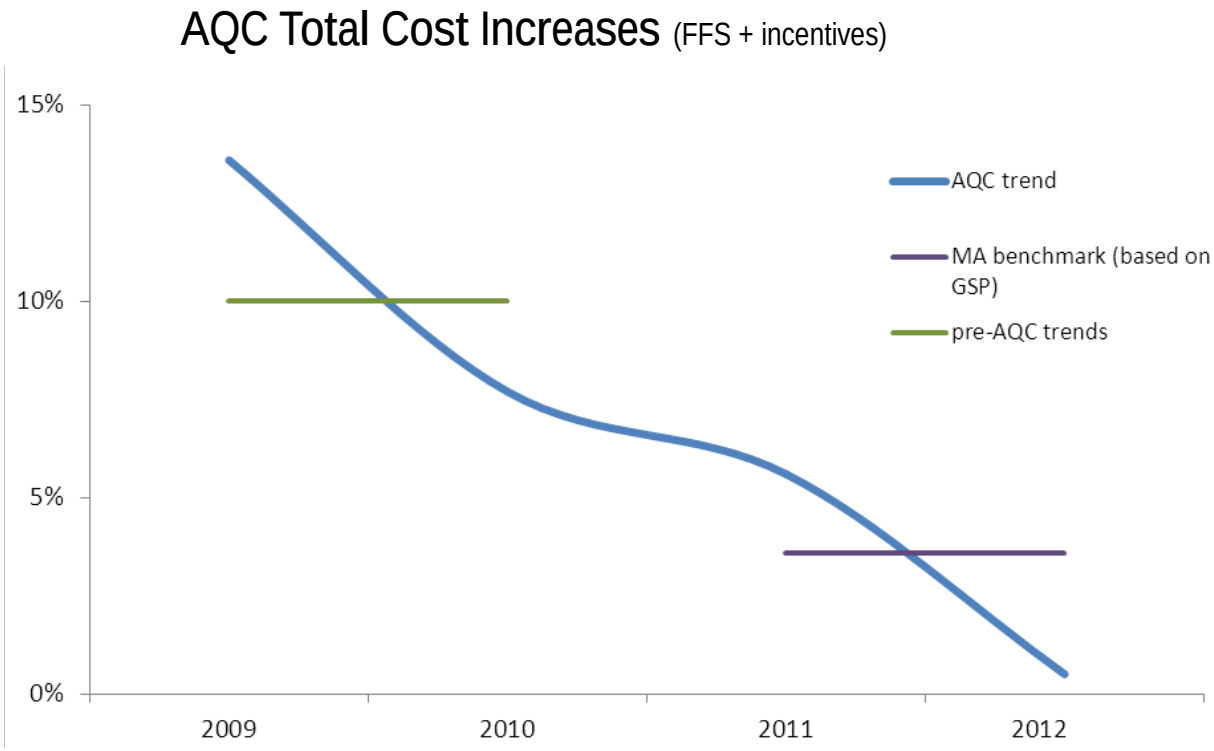
Savings Associated with the AQC Relative to Control Group, 2009-2012

	2009	2010	2011	2012
AQC Physician Participation[1]	20%	20%	35%	77%

Notes: (1) Calculated based on combined PCP and SCP participation as of December of each year.

Source: Song Z, et al. Changes in Health Care Spending and Quality 4 Years into Global Payment. *The New England Journal of Medicine*. 2014.

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%)

Components of the AQC Support Model

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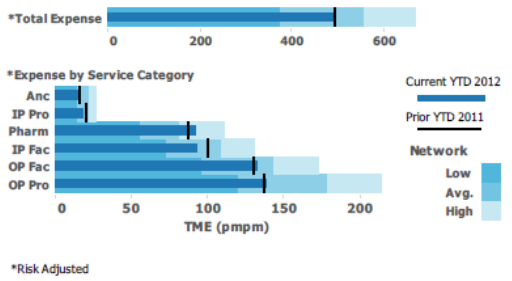
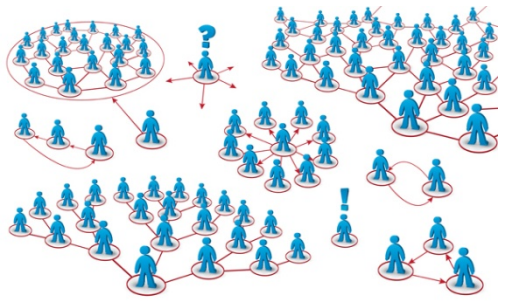
Our four-pronged support model is designed to help provider groups succeed in the AQC.

Data and Actionable Reports



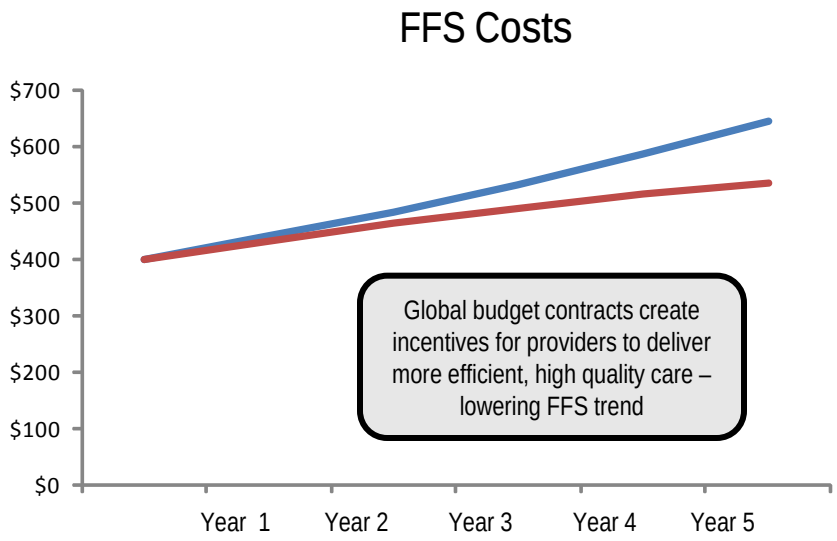
Consultative Support

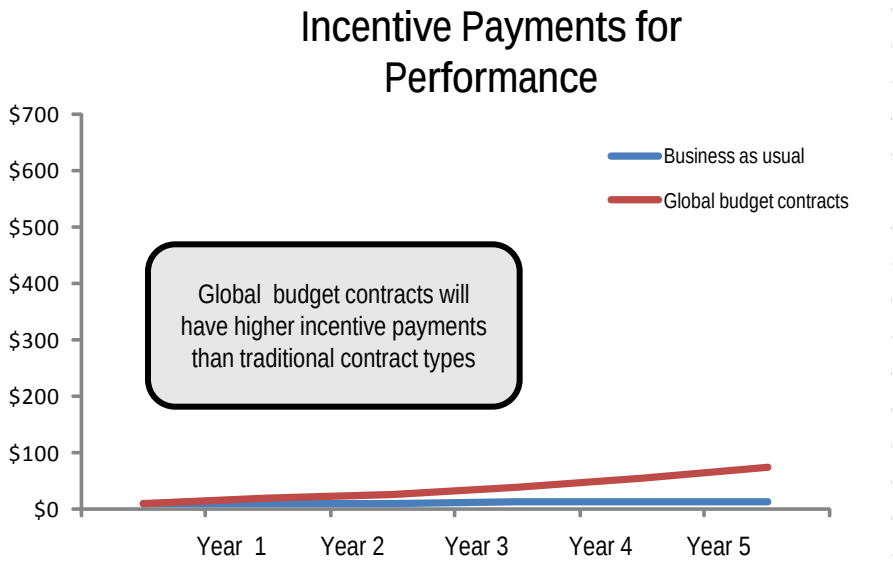


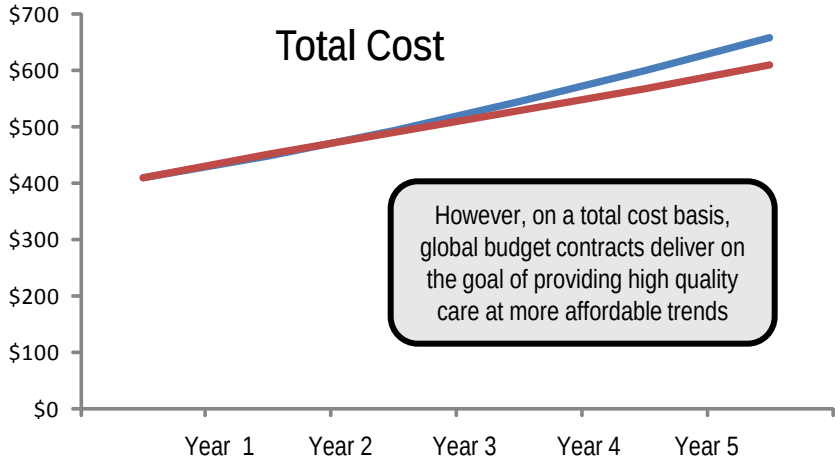
Best Practice Sharing and Collaboration

Training and Educational Programming

Account View: Illustration







While the charges associated with incentive payments rose relative to traditional contracts, the overall medical trend declined significantly

Summary and Priority Issues Ahead

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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

For More Information

Doctor and the Doll by Norman Rockwell

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Facilitated Discussion

Buying Value
Purchasing Healthcare That's Proven to Work

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How to Find More Tools and Resources

http://www.ahrq.gov/workingforquality

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Questions and Answers

Presenters

Questions and Answers

- For users of the audio broadcast, submit questions via chat

- For those who dialed into the meeting, dial 14 to enter the question queue

Thanks for attending today's event

The presentation archive will be available on www.ahrq.gov/workingforquality within two weeks

For questions or high resolution lever icons, please email NQStrategy@ahrq.hhs.gov.

For the new NQS Stakeholder Toolkit, visit: http://www.ahrq.gov/workingforquality/nqs/nqstoolkit.pdf

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