Discussion Paper from Art Jones, M.D.
For November 15, 2011 MAC Care Coordination Subcommittee Meeting

REPLACING QUALITY MEASURES WITH VALUE MEASURES

One of the lessons learned from the managed care programs of the 1980s is that we need to measure, report and reward quality care as well as improved utilization. There has been a gradual progression in the parameters we choose to measure this. HEDIS measures have been developed for this purpose. Initially, they rewarded providers for processes such as measuring HgbA1c. When feasible, these have been replaced with outcomes measures such as achieving a HgbA1c below a particular target. Often this is hampered by current coding issues that don't allow one to collect this information from encounter data. Some parameters have also been chosen to counter and detect any inappropriate underutilization of services. A good example is a pay-for-performance measure that requires at least one face-to-face encounter with each member of a certain age group. In an attempt to correct for population difference, Medicaid specific benchmarks have been determined.

As we migrate from mere quality to value, we should try to choose measures that impact cost as well as quality. Although it is true that provision of mammograms and Pap smears is a value measure in that it ultimately results in cost savings by reducing the chance for advanced malignancy years down the road, there are also measures that can be chosen that can achieve short term cost savings as well as improved quality of care. For example, reduction in 30 day re- hospitalization rates, hospitalization for ambulatory sensitive conditions or emergency room visits for conditions that can be dealt with in the PCP's office are quality measures that result in immediate savings.

Under capitation, MCOs already have a reason to add value measures to the typical HEDIS measures that HFS hold them accountable for. Now that DHFS is adding a shared savings model (CCEs), it also has a financial interest in adding measures that are more value based. Ideally, the incentive program should be structured to encourage providers to invest at least a portion of shared savings into activities that will generate additional value. Shared savings that result from improved utilization under CCEs will only be earned by meeting certain quality parameters. This is the opportunity to design quality parameters that will drive savings. It is also important to recognize that providers will have to invest resources to achieve shared savings. Many safety net providers do not have a cash flow position that allows them to spend dollars now in the hope of achieving shared savings a year later. Pay for performance programs (P4P) can provide more timely reimbursement. Although these will ultimately need to be funded from shared savings, DHFS will need to "prime the pump" by paying these incentives from day one. Since both DHFS and the provider will share in the savings that result from P4P programs, their cost should be paid off the top before shared savings are distributed.

Medical Home Network (MHN) has applied the principles above by designing both P4P and shared savings incentives. Although it may seem like a step back to rewarding process rather than outcome, their P4P program rewards processes that will generate short term savings and then ties payment of those shared savings to other quality measures. Like CCEs, MHN utilizes the current DHFS fee-for-service reimbursement mechanism. Providers will receive an add-on to their fee-for-service payment when they:

1. See their members within 7 days of discharge from the emergency room
2. See their members within 7 days of discharge from the inpatient setting.
3. See a newly assigned IHC member within 90 days of enrollment
4. See newborns within 7 days of delivery

Once IT capability allows tracking, inpatient providers will also be paid for providing PCPs a completed discharge summary within 72 hours of discharge. EDs will be paid for providing completed discharge plans within 24 hours of an ED visit.

There are several general principles that MHN takes into consideration when choosing quality measures that will serve as criteria for access to shared savings:

a. Design for maximum provider participation by making parameters achievable and recognizing improvement as well as achieving ultimate targets

b. Don't unfairly reward those with historical poor performance; use standard benchmarks for similar patient populations

c. Adjust for patient population differences when appropriate and feasible

d. When possible, use parameters that can be measured from claims data

e. Choose a manageable number of parameters based on provider resource availability

f. Avoid an all or none approach by separately paying for each achieved parameter and allow plans to reward high performers even if the overall plan does not reach the goal

g. Make payments significant enough to motivate providers

h. Don't restrict reward to dollars; reward high quality plans by facilitating membership growth

i. Align incentives among provider types whenever possible; recognize that achieving some goals may be counter-intuitive (for example, savings from reduced hospitalizations hit predominantly hospital budgets but are best achieved with cooperation from the hospital) and so financial reward should be distributed not only proportionate to those chiefly responsible for savings but also proportionate to which partner voluntarily gives up the most revenue to achieve overall savings.

j. Focus on population health that recognizes it often takes more effort to go from 85% to 90% compliance than it takes to go from 50 to 65% compliance and reward accordingly

k. Choose parameters that will generate both short and long term savings as well as improved quality; choose some parameters that detect under-utilization

l. Encourage reinvestment of savings into additional parameters by making it financially attractive to do so

m. Don't let incentive structure detract from achieving more general and important goals

n. Be sure payments get to the level of the decision maker, not just the organization he works for

o. Avoid rewarding those who merely hit the target by chance

p. Give regular provider feedback on performance

q. Provide timely and actionable data to providers so their targets are clearly defined and results achievable

r. Be transparent enough to promote healthy competitiveness without embarrassing anyone

s. Create a spirit of cooperation, reminding each that the ultimate goal is to improve the care of the entire population; share best practices

t. When possible, adjust for severity of illness so that providers are rewarded for good management of complex patients, not for cherry picking to avoid them

The following are the HEDIS measures and their mean values for the adult Medicaid population nationally followed by the measures that make up the CMS Star Rating Methodology. There is always the tension of only choosing measures that can be determined by encounter data vs. outcome measures that are more resource intensive to collect. The challenge will be to choose a limited number of quality/value metrics that are relevant to a sizeable part of the population, clinically important for this population, and reasonably easy to measure (i.e., do not involve complex data capture issues that will burn resources).

HEDIS EFFECTIVENESS OF CARE MEASURES

NATIONAL HMO Means—2009

MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Safety and Potential Waste			
Imaging Studies for Low Back Pain	73.9	N/A	76.1
Avoiding Antibiotics in Adults: Acute Bronchitis	24.0	N/A	25.6
All Cause Readmission rate	new 2011	new 2011	N/A
Wellness and Prevention			
Adult Body Mass Index Assessment	41.3	38.8	34.6
Smoking Cessation			
Advising Smokers to Quit	79.5	77.9	74.3
Discussion of Smoking Cessation Strategies	50.0	N/A	38.8
Discussion of Smoking Cessation Medications	53.3	N/A	43.4
Flu Shots for Adults	51.3	64.5	N/A
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	93.1	N/A	83.4
Postpartum Visit Between 21 and 56 Days After Delivery	83.6	N/A	64.1
Breast Cancer Screening	71.3	69.3	52.4
Cervical Cancer Screening	77.3	N/A	65.8
Colorectal Cancer Screening	60.7	54.9	N/A
Chlamydia Screening—16–20 Years	41.0	N/A	54.4
Chlamydia Screening—21–24 Years	45.4	N/A	61.6
Chlamydia Screening—Total Rate	43.1	N/A	56.7

Chronic Disease Management

Persistence of Beta-Blocker Treatment After a Heart Attack	74.4	82.6	76.6

MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Comprehensive Diabetes Care			
Blood Pressure Control (<130/80 mm Hg)	33.9	33.3	32.2
Blood Pressure Control (<140/90 mm Hg)	65.1	60.5	59.8
Eye Exams	56.5	63.5	52.7
HbA1c Screening	89.2	89.6	80.6
Good Glycemic Control			
(HbA1c <7% for a Selected Population)	42.1	N/A	33.9
(HbA1c <8%)	61.6	63.7	45.7
Poor Glycemic Control (HbA1c >9%)*	28.2	28.0	44.9
LDL Cholesterol Screening	85.0	87.3	74.2
LDL Cholesterol Control (<100 mg/dL)	47.0	50.0	33.5
Medical Attention for Nephropathy	82.9	88.6	76.9
Controlling High Blood Pressure	64.1	59.8	55.3
Cholesterol Management for Patients With Cardiovascular Conditions—			
LDL Cholesterol Screening	88.4	88.4	80.7
Cholesterol Management for Patients With Cardiovascular Conditions—			
LDL Control (<100 mg/dL)	59.2	55.7	41.2
Disease Modifying Anti-Rheumatic Drug	86.4	72.3	70.5
Drug Therapy in Rheumatoid Arthritis			

Use of Appropriate Medications for				
People with Asthma -	age 12-50 Years	91.4	N/A	86.0
	Overall rate	92.7	N/A	88.6
MEASURE		COMMERCIAL	MEDICARE	MEDICAID
Use of Spirometry Testing in the Assessment		38.8	28.5	28.6
and Diagnosis of COPD				
Pharmacotherapy Management of COPD				
Bronchodilaters		78.0	76.2	80.7
Systemic Corticosteroids		66.1	60.9	61.8
Annual Monitoring for Patients				
on Persistent Medications				
ACE inhibitors or ARBs		80.8	89.6	85.9
Anticonvulsants		62.0	69.7	68.7
Digoxin		83.6	92.0	88.9
Diuretics		80.4	89.8	85.4
Combined		80.3	89.2	83.2
Antidepressant Medication Management				
Acute Phase		62.9	63.7	49.6
Continuation Phase		46.2	50.6	33.0
Follow-Up After Hospitalization for Mental Illness				
Within 7 Days Post-Discharge		58.7	37.3	42.9
Within 30 Days Post-Discharge		76.8	54.8	60.2
Alcohol and Other Drug Dependence Treatment				
Engagement		16.1	4.6	12.3
Initiation		42.7	46.2	44.3

Consumer and patient engagement and experience

The CAHPS 4.0 survey measures members' experiences with their health care in areas such as claims processing and getting needed care quickly, and asks them to rate their health plan on a scale of 1–10.

Medicare Health Outcomes Survey (HOS) measures evaluate the physical and mental health of seniors enrolled in Medicare through a patient-based self-report of health status as a measure of quality of care.

Relative Resource Use

Resource use measures compare health plans' use of services—such as medications, outpatient visits, inpatient care, imaging and surgery—for patients with a given condition. Use of these services by all plans is averaged and risk-adjusted to create an "expected" resource use rate. NCQA then calculates an index showing the ratio of each plan's actual reported resource use to the risk-adjusted rate for the average plan. Plans that use more expensive services, such as inpatient hospital care, have higher actual-to-expected ratios than plans that use medications, outpatient care and other methods to manage conditions less expensively and more effectively. Evaluating resource use in tandem with quality measures for the same condition reveals that some plans deliver higher quality more efficiently than others, such as by avoiding hospital admissions and unneeded surgeries

Health plans report case mix-adjusted measures of resource use related to five chronic illnesses:

Asthma

Cardiovascular conditions

COPD

Diabetes

Hypertension

These measures incorporate cost and service frequency for each eligible member during the measurement year. All services administered to members identified with one of these conditions are attributed to the RRU measure for that condition. Each of the five RRU measures summarizes a health plan's utilization of several service categories:

• Inpatient Facility

• Evaluation and Management (E&M—Inpatient and Outpatient)

• Procedure and Surgery (Inpatient and Outpatient)

• Ambulatory Pharmacy Services

NCQA calculates two observed-to-expected (O/E) ratios for each health plan, one for quality and one for resource use. An O/E ratio is a plan's actual quality level or resource use (the observed"), divided by an

estimate of the quality level or resource use the plan would have if its population was the same as the average population of all other plans submitting data to NCQA (the "expected"). To enable comparison within plan types (HMO or PPO), NCQA indexes O/E ratios by dividing each plan's ratio by the national average O/E for all HMOs or PPOs. For the resource use index, shown as the horizontal axis on RRU scatter plots, a ratio of 1.00 represents the average resource utilization for all HMOs or PPOs nationally. A ratio greater than 1.00 represents higher-than-expected use; a ratio less than 1.00 represents lower-than-expected use. For the quality index, otherwise known as the Effectiveness of Care ratio and shown as the vertical axis on RRU scatter plots, a ratio greater than 1.00 represents better-than-expected performance; a ratio less than 1.00 represents lower-than-expected performance. For example, a PPO with a ratio of 1.12 for quality and 1.15 for resource use delivered quality that was 12 percent better than the average PPO serving similar patients and used 15 percent more resources than the PPO average.

Descriptive statistics are provided for composites with up to 10 indicators. With the exception of the COPD quality RRU composite, the summary statistics for composite measures are the simple, unweighted average of all measures and indicators in the composite. Since 2 of the 3 COPD indicators describe the same dimension of care (Pharmacotherapy Management), each indicator receives a weight of one-half.

Medicare-Medicaid Dual Eligibles

Medicare Advantage plans with higher quality scores (based on a star rating system) will receive higher payments. Plans will also share the savings from providing more efficient care, in the form of lower cost sharing or additional benefits.

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CMS Star Rating Methodology

Current Part C Measures

HEDIS

- Adult Access to Primary Care
- Anti-Rheumatic Drug for RA
- Breast Cancer Screening
- Cholesterol – CDC
- Cholesterol – CMC
- Colorectal Cancer Screening
- **Controlling Blood Pressure**
- Diabetes – Eye Exam
- **Diabetes – LDL-C < 100**
- Diabetes – Nephropathy
- **Diabetes – Blood Sugar Control**
- Glaucoma Screening
- Osteoporosis Management
- All Cause Readmissions*
- Adult BMI Assessment*
- COA[1] – Medication Review*
- COA[1] – Functional Status Assessment*
- COA[1] – Pain Screening*

CMS

- Complaints Tracking Module
- Corrective Action Plans
- Call Center – Foreign Language, TTY/TDD
- Voluntary Disenrollment *

CAHPS

- Annual Flu Vaccine
- Pneumonia Vaccine
- Getting Needed Care without Delays
- Getting Appointments and Care Quickly
- Customer Service
- Overall Rating of Healthcare Quality
- Overall Rating of Plan

HOS

- **Improving or Maintaining Physical Health**
- **Improving or Maintaining Mental Health**
- Monitoring Physical Activity
- Improving Bladder Control
- Reducing the Risk of Falling

IRE

- Timely Decisions about Appeals
- Reviewing Appeals Decisions

Part C Summary

- 36 Measures
- 5 at 3x weighting
- 12 at 1.5x weighting
- 19 at 1x weighting

Notes:
*New Measure for Bonus Year 2013
1) Care of Older Adults (COA)

Legend
- 1x Weighted Measures
- 1.5x Weighted Measures
- **3x Weighted Measures**

CMS Star Rating Methodology

Current Part D Measures

CMS
- Call Center – Pharmacy Hold Time
- Call Center – Foreign Language, TTY/TDD
- Drug Plan Provides Accurate Info for Plan Finder Website
- Enrollment Timeliness*

CAHPS
- Getting Information from Drug Plan
- Members' Overall Rating of Drug Plan
- Members' Ability to Get Prescriptions Filled Easily

IRE
- Appeals Auto-Forward
- Appeals Upheld

Patient Safety / Pharmacy Related
- **High Risk Meds**
- **Blood Pressure Medications for Diabetics**
- **Medication Adherence for Oral Diabetes Medication***
- **Medication Adherence for Hypertension (ACEI or ARB)***
- **Medication Adherence for Cholesterol (Statins)***

Part D Summary
- 14 Measures
- 5 at 3x weighting
- 7 at 1.5x weighting
- 2 at 1x weighting

Legend
- 1x Weighted Measures
- 1.5x Weighted Measures
- **3x Weighted Measures**

Notes:
*New Measure for Bonus Year 2013

* Change in technical specs from previous