Listening Session 3: *Linking Performance Measures with Payment and Financial Incentives*

Presenters:

Subject Matter Experts

- **Karen E. Joynt Maddox, MD, MPH** - Practicing Cardiologist, Barnes-Jewish Hospital; Associate Professor, Washington University School of Medicine and School of Social Work; and Co-Director, Center for Advancing Health Services, Policy & Economics Research
- **Mark Friedberg, MD, MPP** - Senior Vice President, Performance Measurement & Improvement, Blue Cross Blue Shield of Massachusetts
- **Nick Frenzer** - Population Health and Implementation Executive, Epic

Listening Session 3: *Linking Performance Measures with Payment and Financial Incentives*

Karen E. Joynt Maddox, MD, MPH

Associate Professor
Washington University School of Medicine

Evidence regarding the impact of different kinds of performance-based payment incentives on desired outcomes

Karen Joynt Maddox, MD MPH
Associate Professor
Washington University School of Medicine
March 2024

Type of risk: up, down, or both

Up-side only

- Some tracks of MSSP

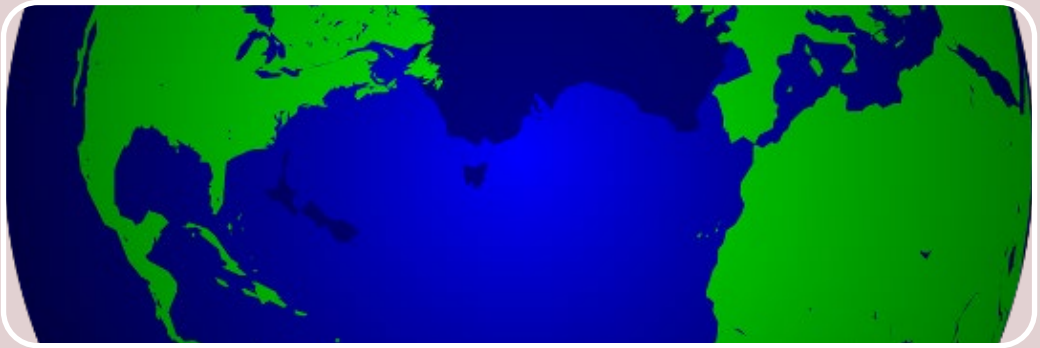
Two-sided

- Some tracks of MSSP, most site-specific ACO or TCOC programs, eventually
- BPCI, BPCI-A
- MIPS and other site-specific VBP programs

Down-side only

- HRRP
- HACRP

Included costs: global or limited



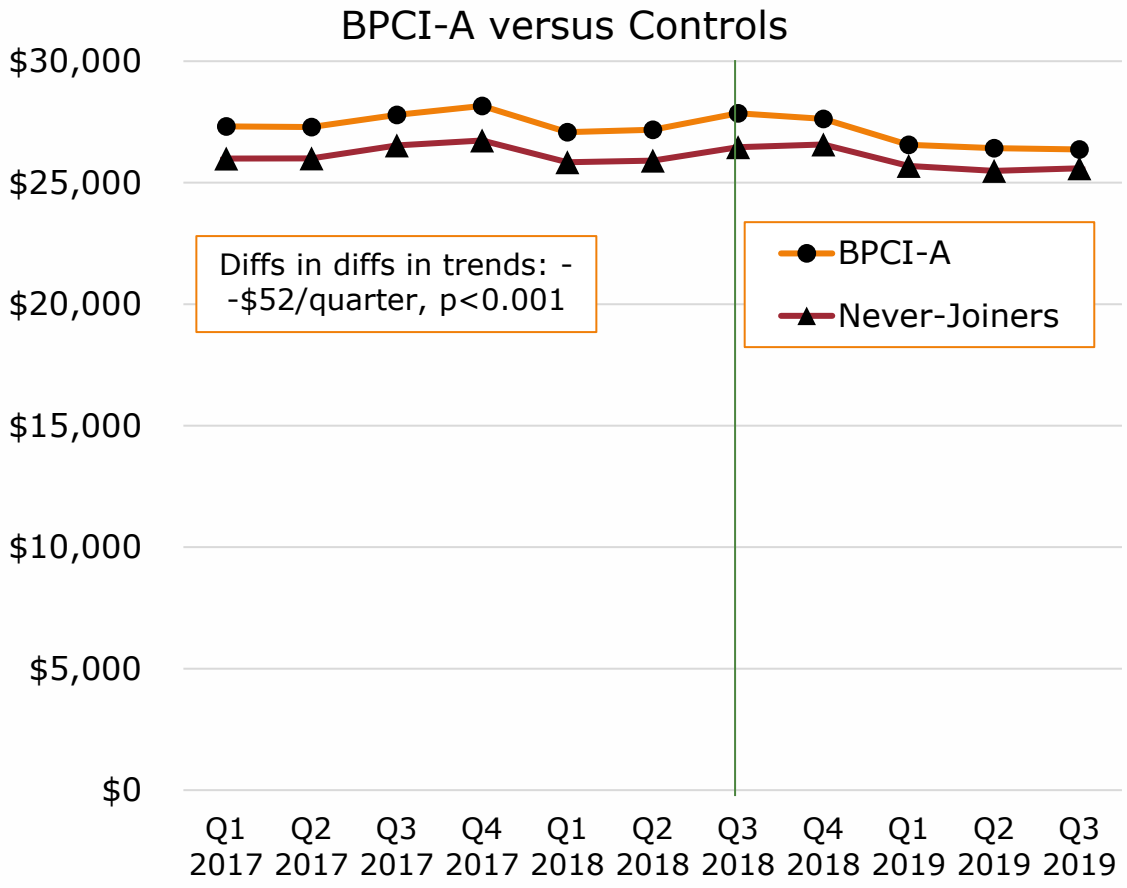
Global

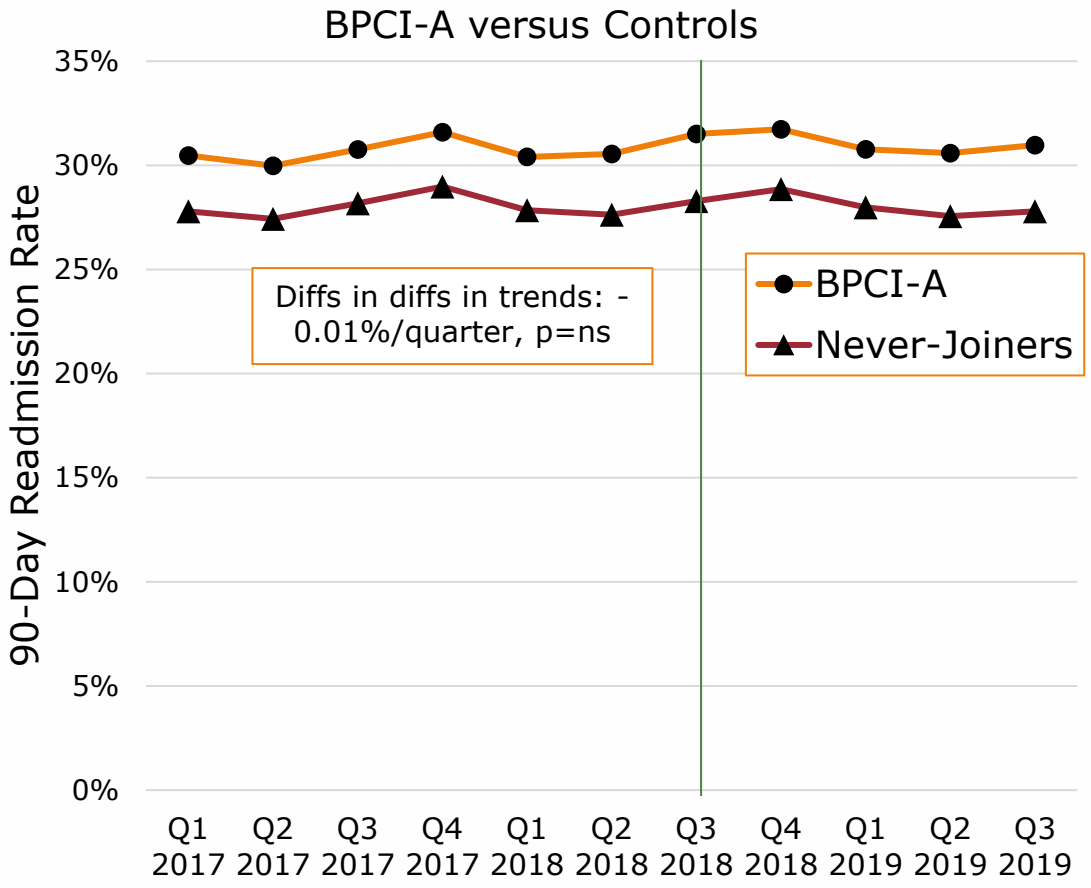
- MSSP
- Pioneer ACO
- ACO REACH and other newer ACO models

Limited

- HVBP and other site-specific programs (limited by patient population)
- BPCI/BPCI-A (limited by time)

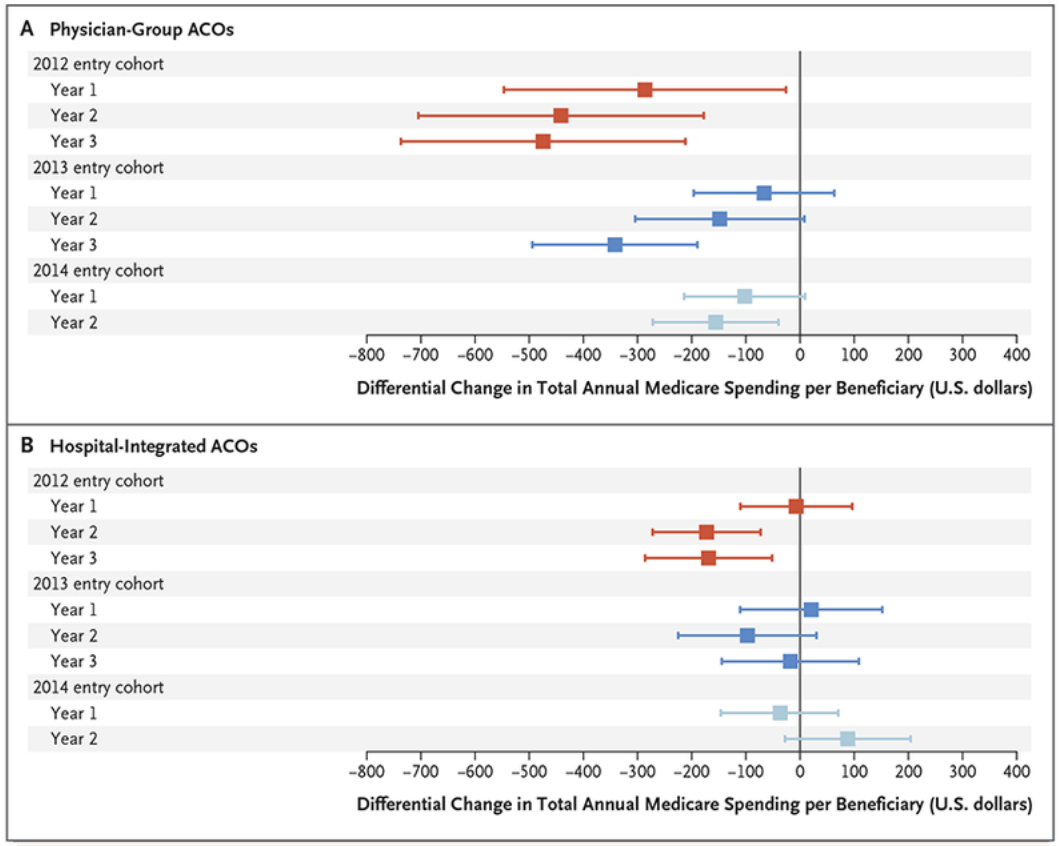
Evidence supporting model impact: BPCI-A



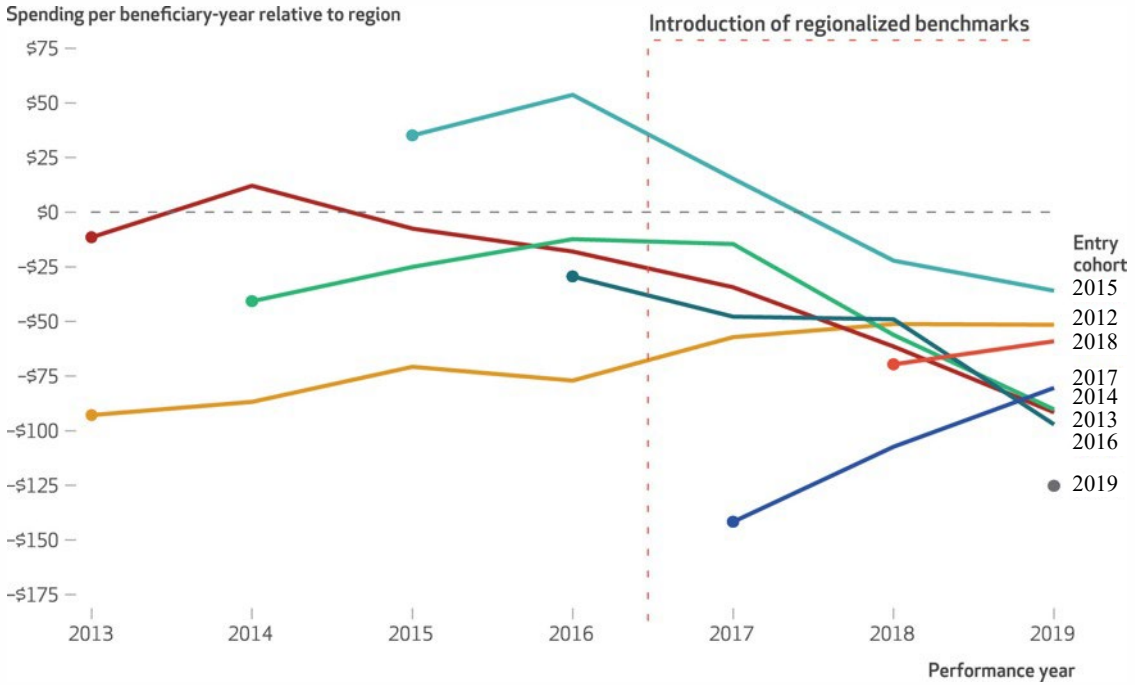


Joynt Maddox et al, NEJM 2021

Evidence supporting model impact: MSSP



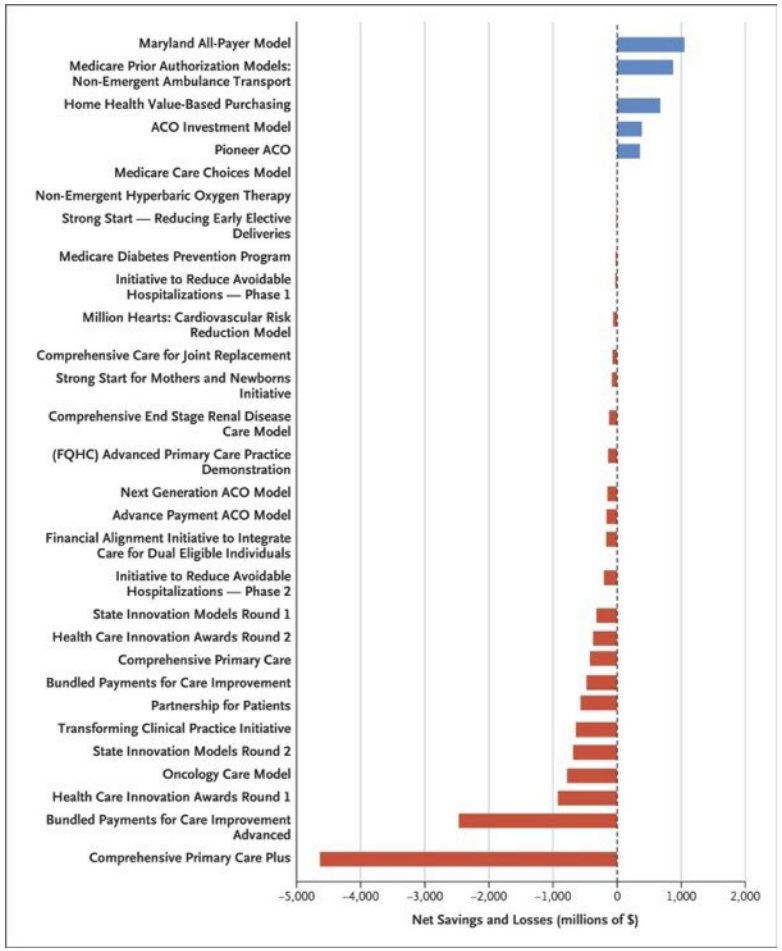
McWilliams et al, NEJM 2018



Lyu et al, HealthAffairs 2023

Evidence supporting models' impact

- Successes in reducing costs are not obviously driven only by program characteristics
- Type of risk and included costs vary; Maryland all-payer model and CPC Plus were both quite comprehensive but are at different extremes of savings
- Reconciliation payments matter too, and for voluntary programs they are part of the mechanism of the program

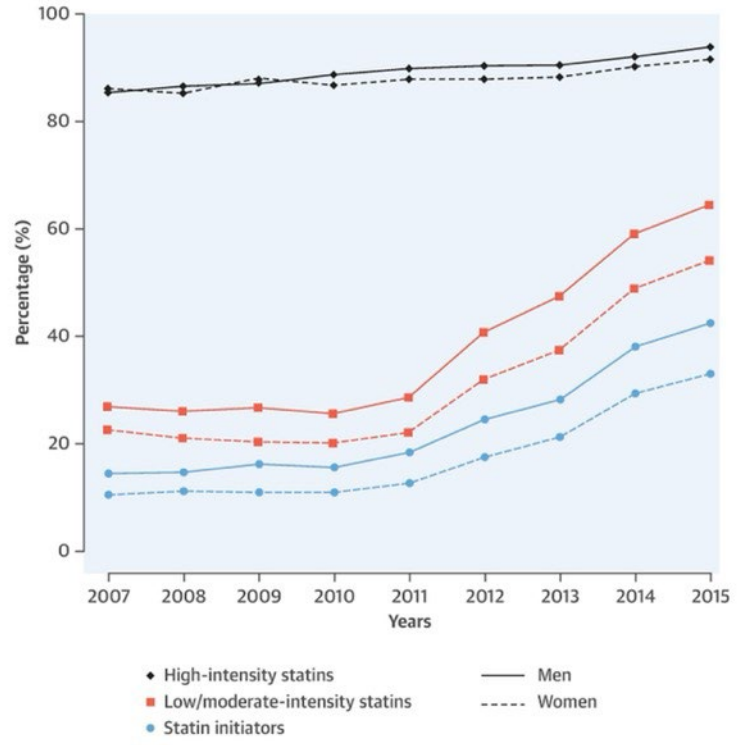


Source: Smith B. CMS innovation center at 10 years — progress and lessons learned. N Engl J Med. 2021; 384:759-764. doi:10.1056/NEJMsb2031138.

But what are our desired outcomes?

Statin use rates, 2007 to 2019

CENTRAL ILLUSTRATION: Trends in the Percentage of Women and Men Filling a High-Intensity Statin Prescription After Hospital Discharge for Myocardial Infarction Between 2007 and 2015



Peters, S.A.E. et al. J Am Coll Cardiol. 2018;71(16):1729-37.

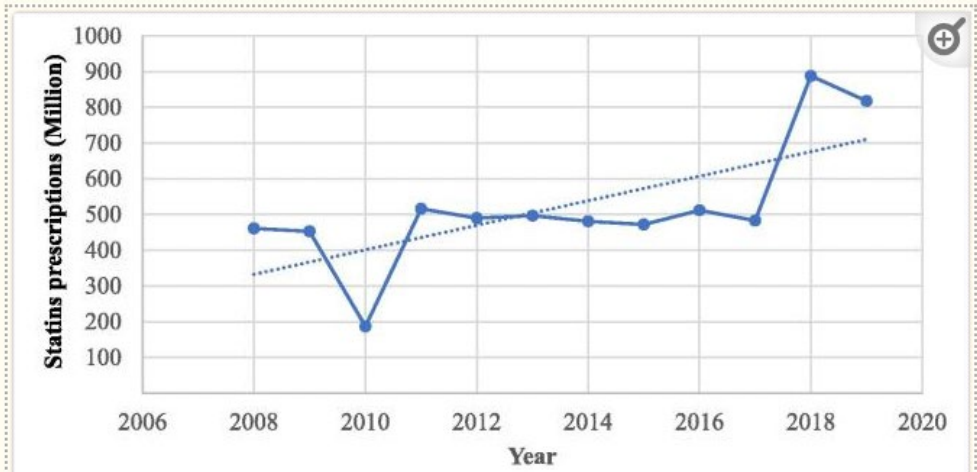
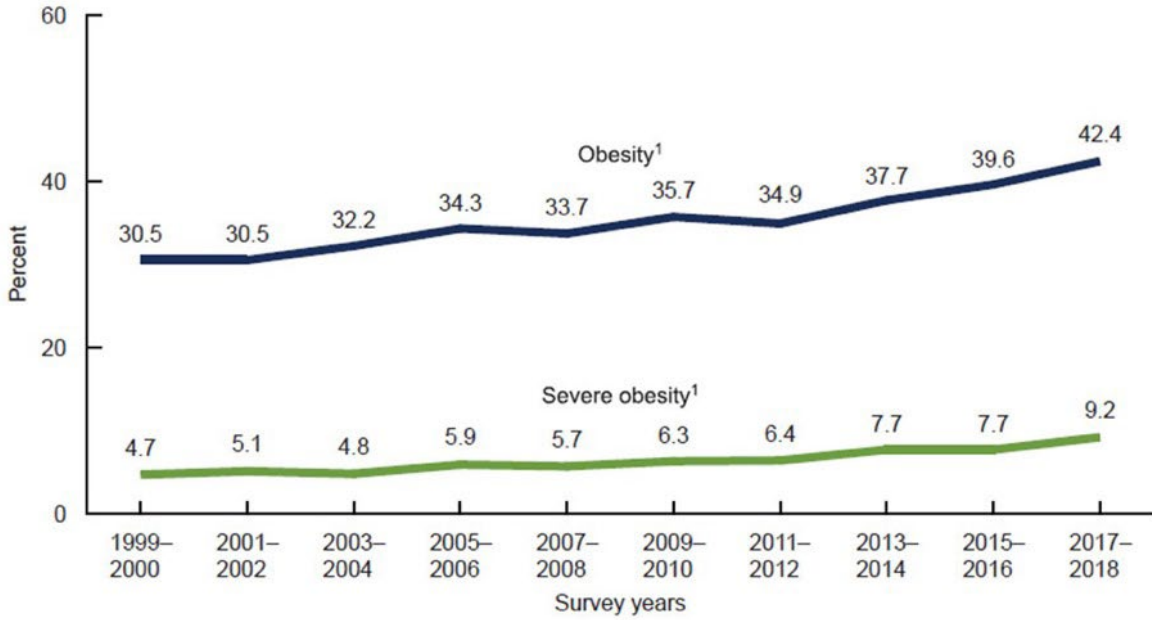


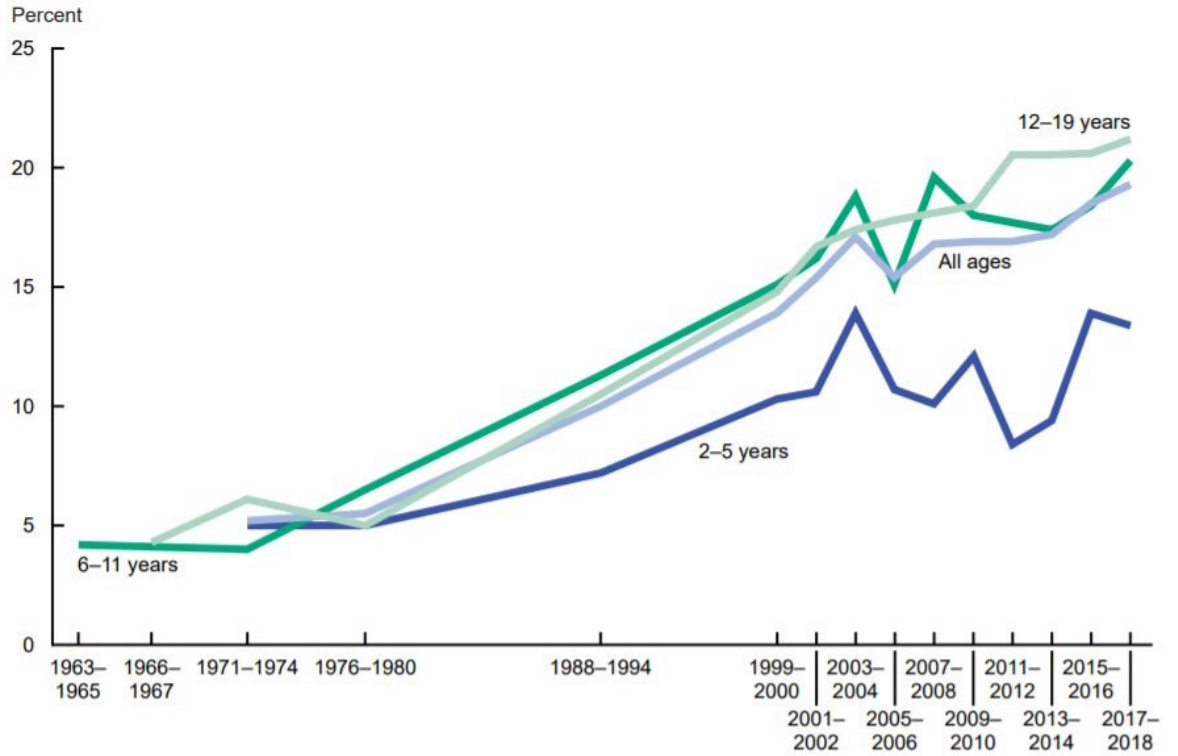
Fig. 2

Number of Statins Prescriptions, MEPS 2008–2019.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10203693/

Obesity rates, 2000 to 2018





https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity

Readmission rates, 2004 to 2020

Figure 1. Rate of 30-day all-cause readmissions by expected payer, 2010-2016

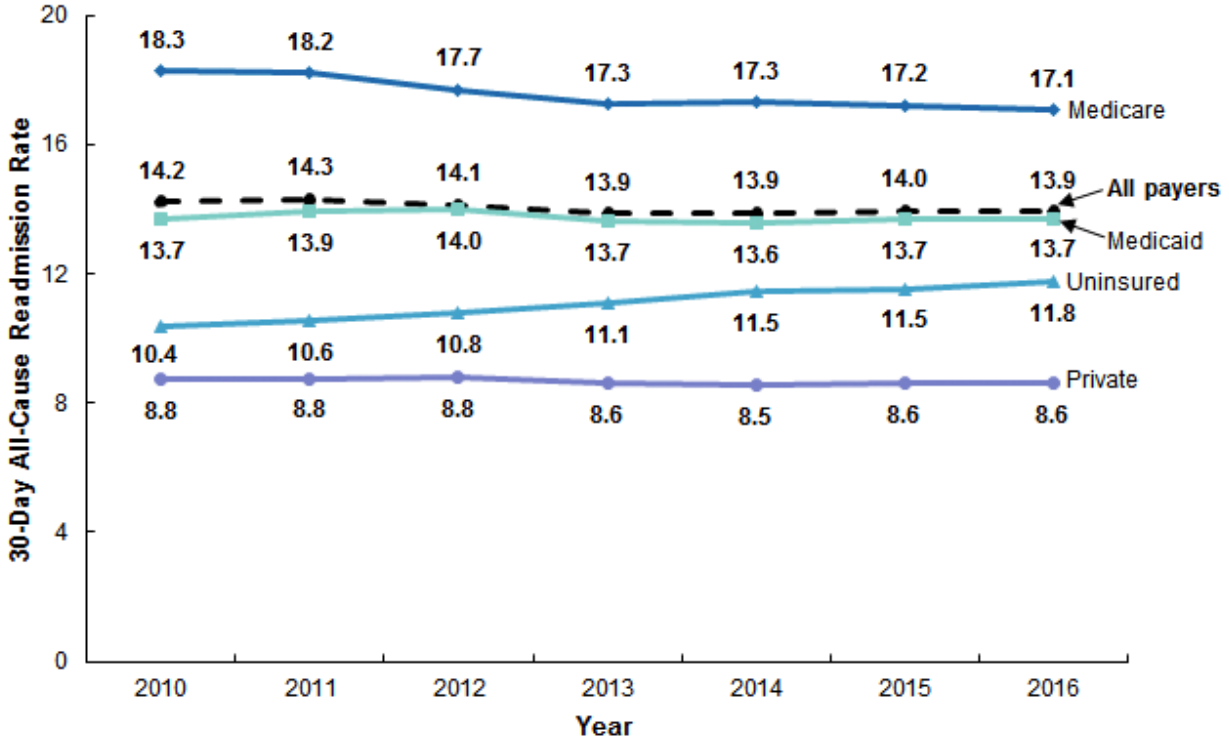
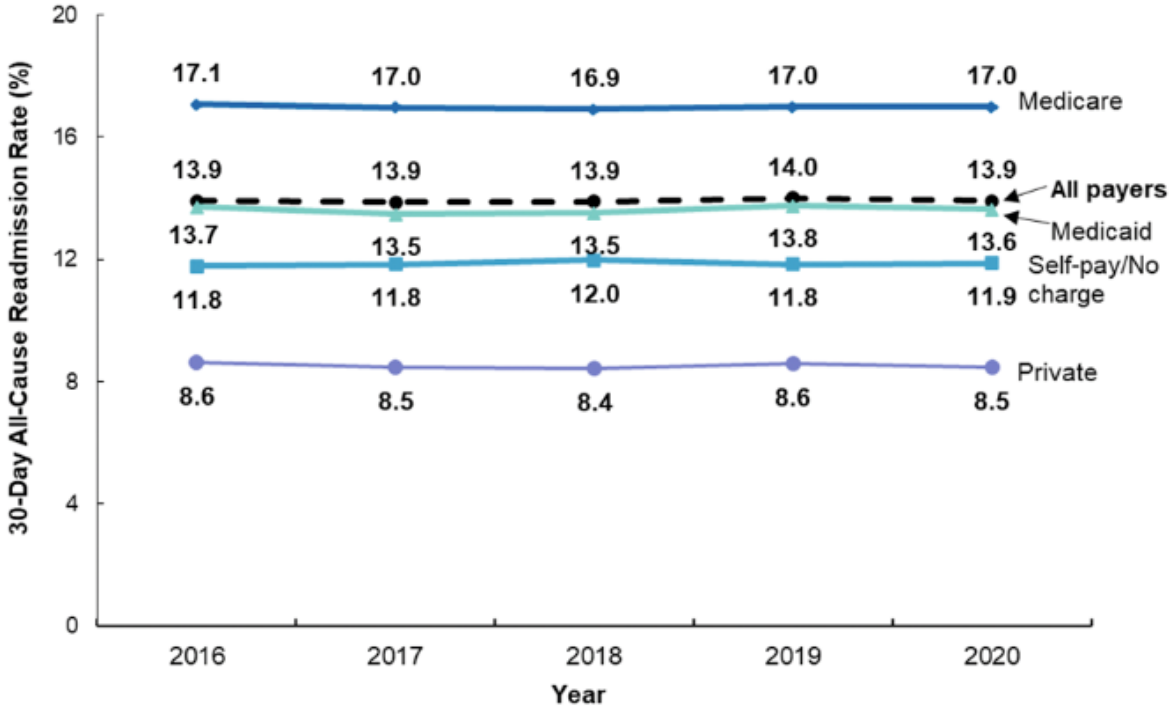


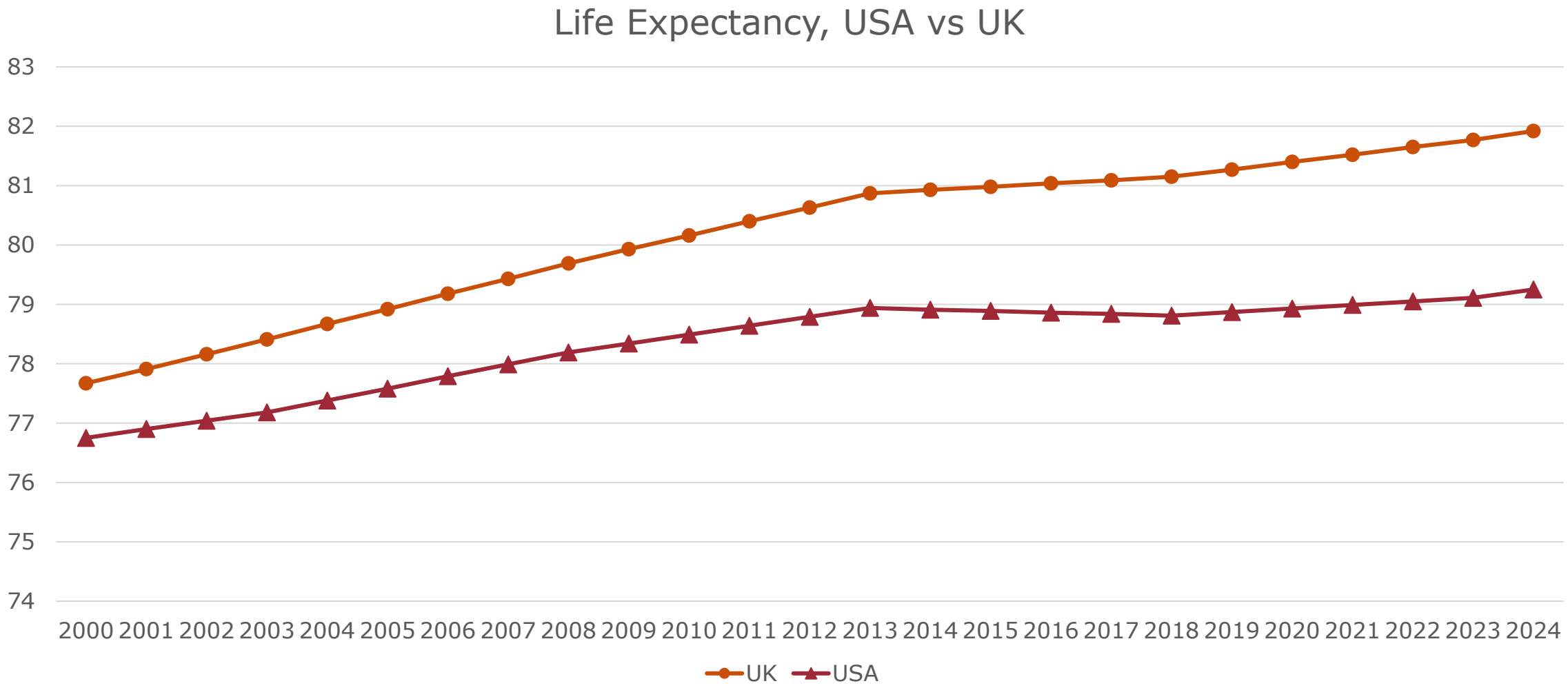
Figure 1. Rates of 30-day all-cause readmissions by expected primary payer, 2016-2020



Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Readmissions Database (NRD), 2016-2020.

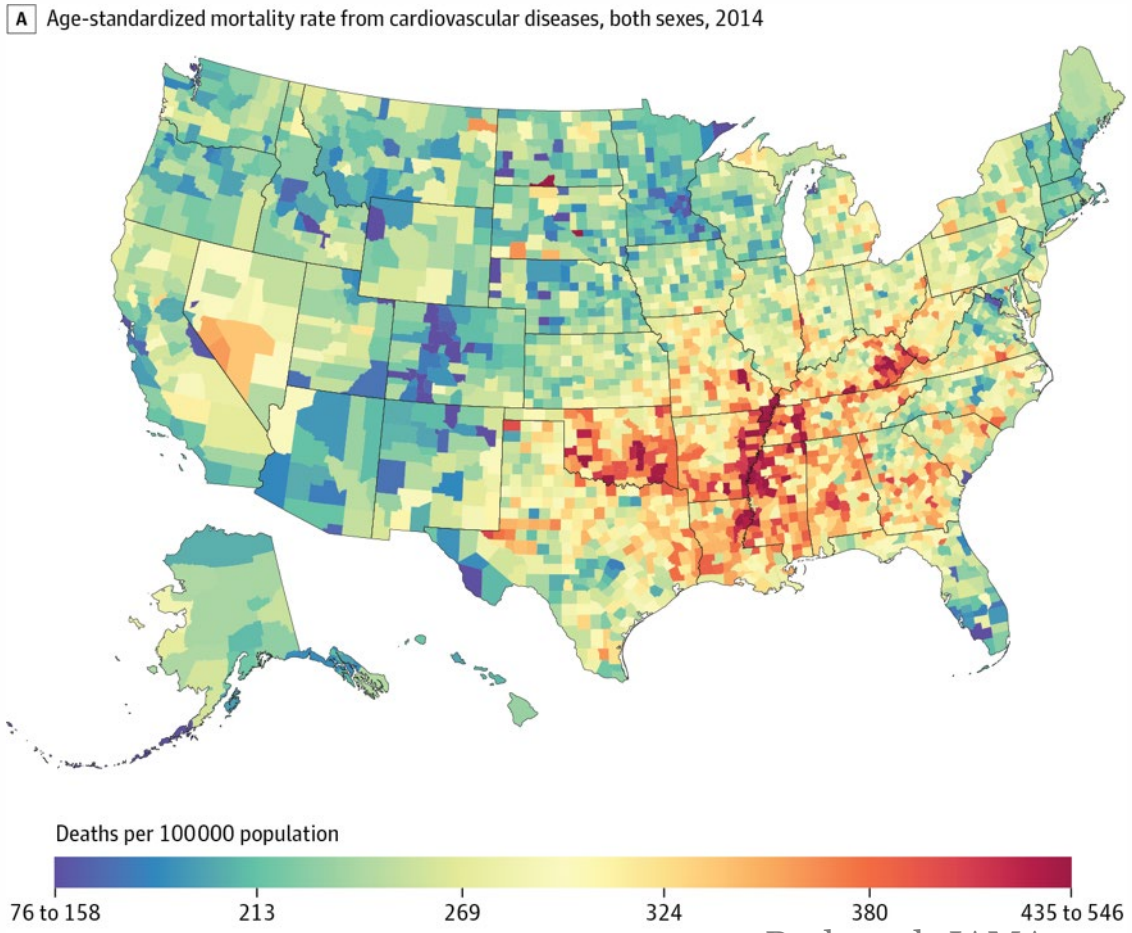
https://hcup-us.ahrq.gov/reports/statbriefs/sb248-Hospital-Readmissions-2010-2016.jsp
https://hcup-us.ahrq.gov/reports/statbriefs/sb304-readmissions-2016-2020.jsp

Population-level outcomes, 2004 to 2024

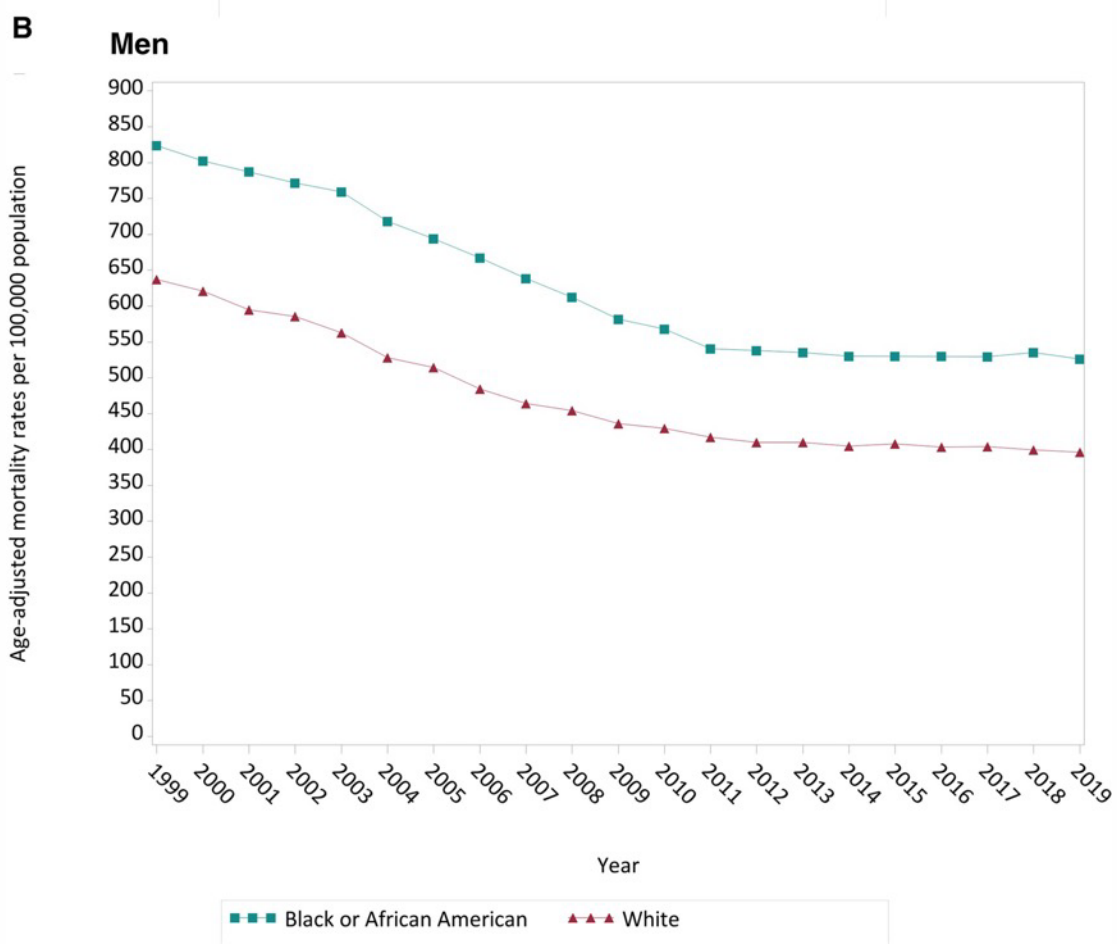


https://www.macrotrends.net/countries/USA/united-states/life-expectancy

Inequity is pervasive and persistent

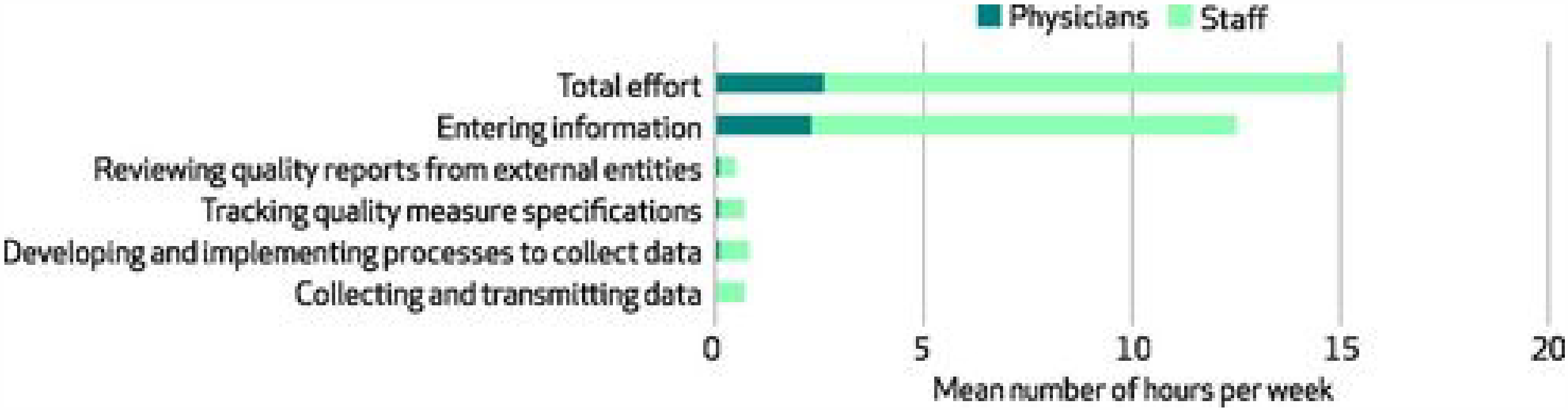


Roth et al, JAMA 2017



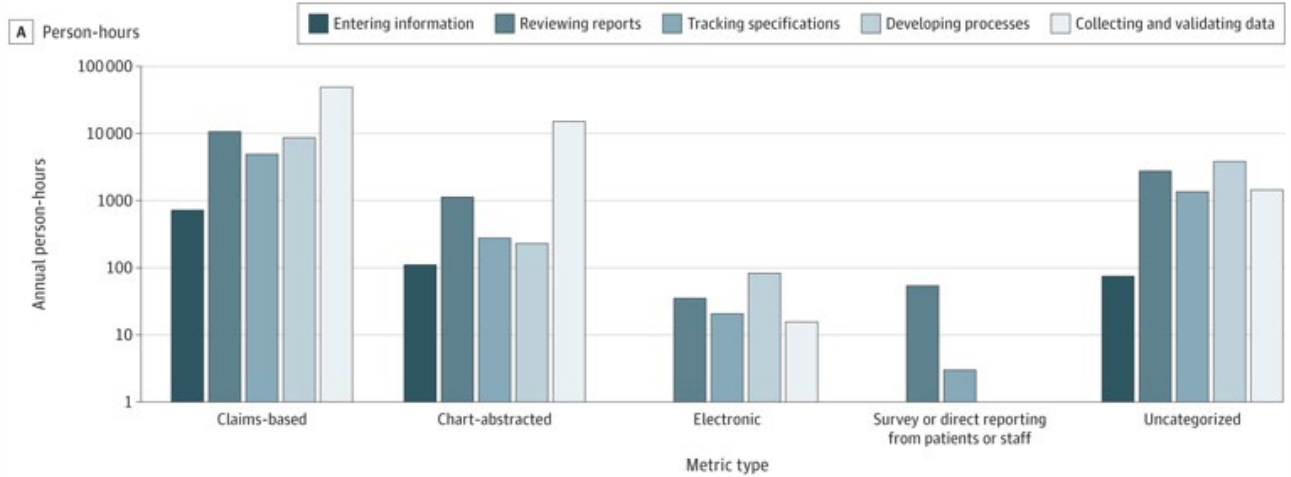
Kyalwazi… Joynt Maddox… Wadhera, Circulation 2022

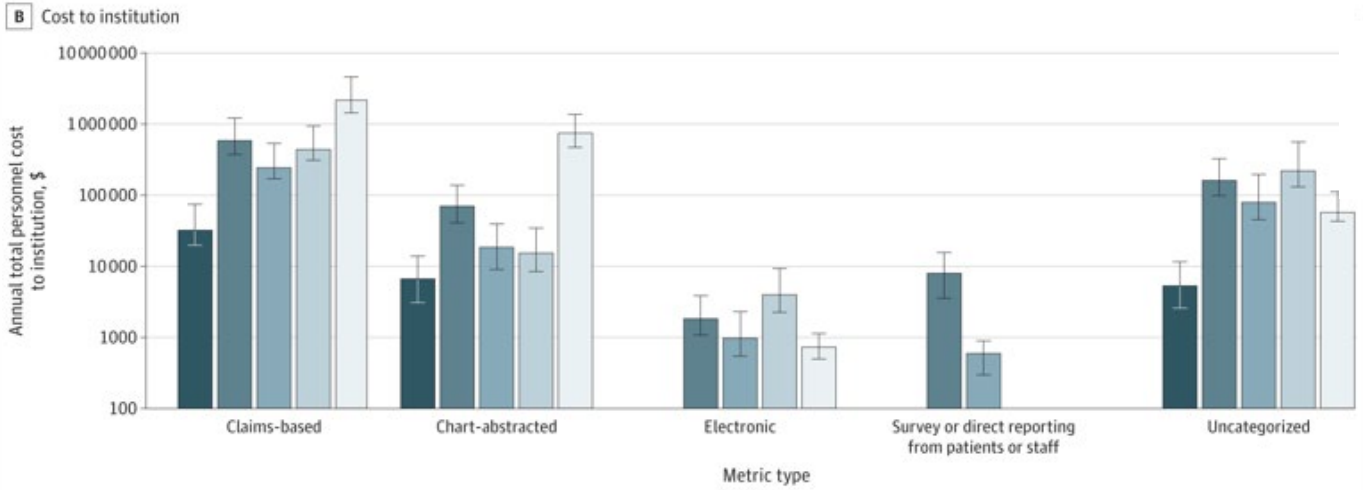
Administrative costs are untenable

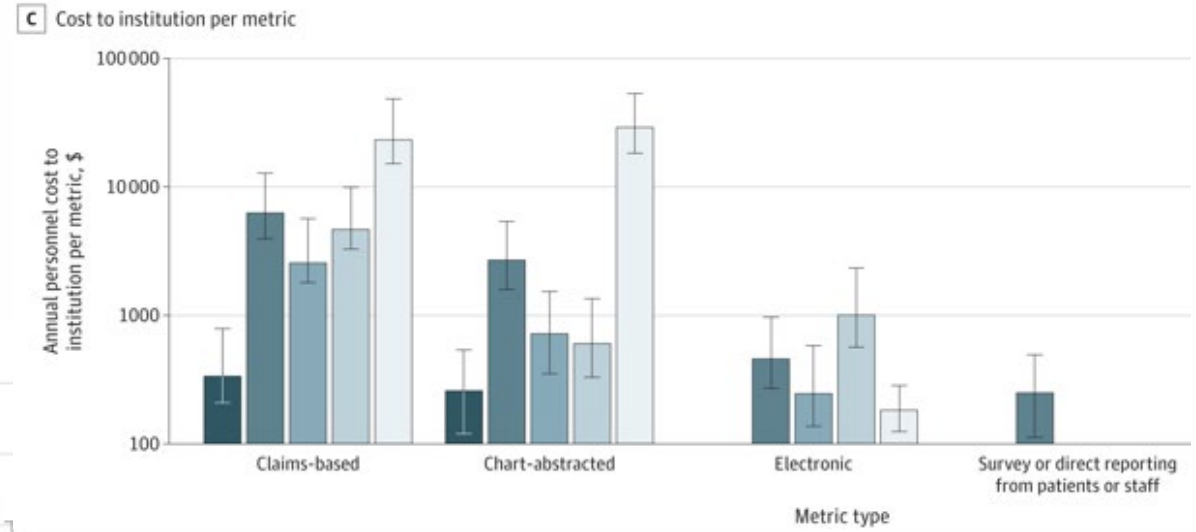


Casalino et al, HA 2016

Administrative costs are untenable

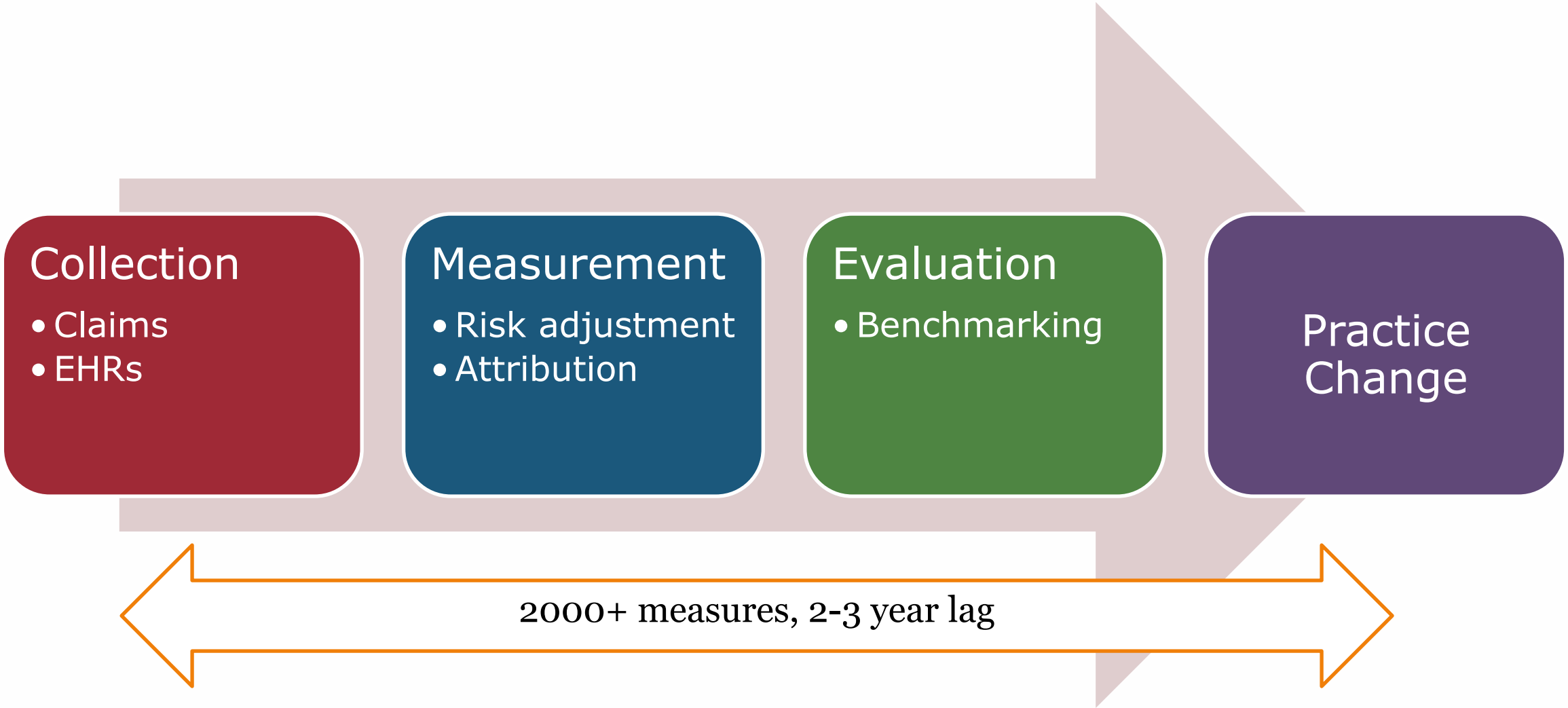






Saraswathula et al, JAMA 2023

Quality and cost measurement: why?



The “why” is health

Conclusions

- Payment reform has improved some measures of costs and quality but has not improved health
- Administrative burden has driven consolidation, corporatization, and less focus on wellness
- Down-side risk and global costing probably matter
  - IF they facilitate practice transformation
- Measurement should be simple, targeted, clear
  - Diabetes, hypertension, obesity, immunizations

Thank you!

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Listening Session 3: *Linking Performance Measures with Payment and Financial Incentives*

Mark Friedberg, MD, MPP

Senior Vice President, Performance Measurement & Improvement,
Blue Cross Blue Shield of Massachusetts

MASSACHUSETTS

BEST PRACTICES FOR DESIGNING PERFORMANCE-BASED PAYMENT INCENTIVES FOR PB-TCOC MODELS PAYER PERSPECTIVE

PTAC

March 26, 2024

Mark Friedberg, SVP, Performance Measurement & Improvement, Blue Cross Blue Shield of Massachusetts

BCBSMA ALTERNATIVE QUALITY CONTRACT (ACQ) STRUCTURE

AQC is for large groups. Our Small Group Incentive Program has a similar structure, with modifications.

Global Budget

Covering all medical services for a whole population, health status adjusted, shared risk

Quality Incentives

Significant earning potential for care quality, using valid & reliable measures, now including equity

Long-Term Contract

3 to 5-year agreements, sustained partnership, supports ongoing investment

RISK CONTRACT FEATURES

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Risk Component	AQC-HMO	AQC-PPO	Small Group
Members included	PCP selection (HMO)	Attribution (PPO)	PCP selection (HMO), attribution (PPO)
Risk Type	Global payment / TME. No service type exclusions.		
Risk Exposure	2-Sided Risk (Upside/Downside)		Upside Only
Efficiency Measurement	Beat Network Trend		Beat Network Average TME
Adjustments	Health Status, Pharmacy Benefits, High-Cost Member Truncation		
Incentives	• Quality-Based Risk Share PMPM • Quality PMPM	• Quality-Based Risk Share PMPM	• Efficiency PMPM • Quality PMPM
Quality Components	Ambulatory and Hospital Measures		Ambulatory Measures
Quality Measures	Process, Outcomes, Patient Experience, Equity		

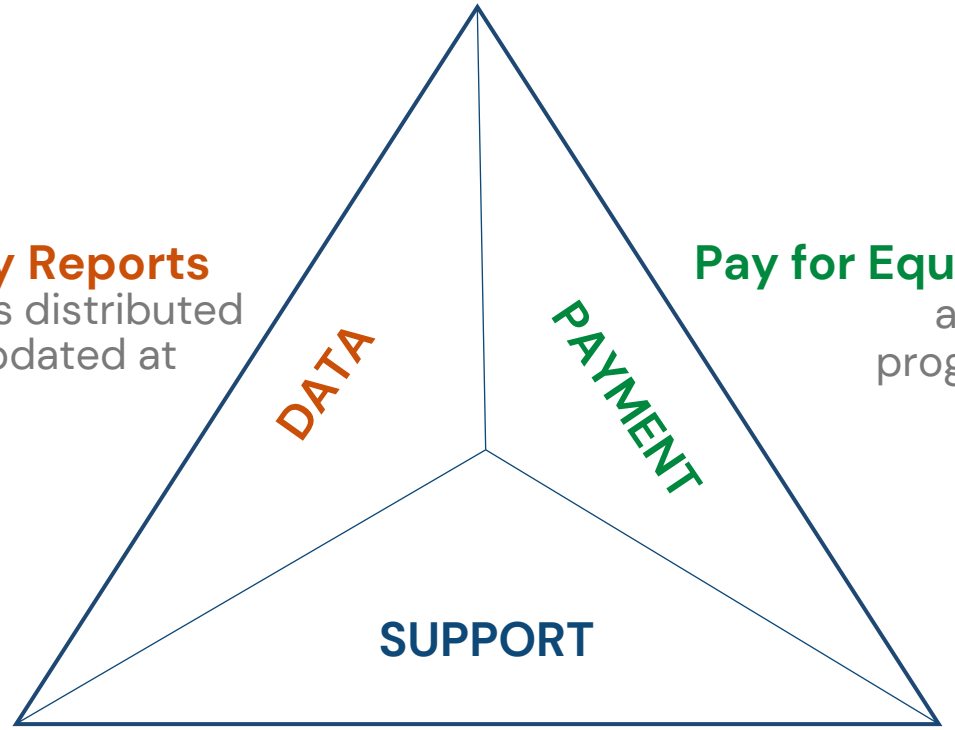
Abbreviations: AQC, Alternative Quality Contract; PCP, primary care practitioner; TME, Total Medical Expense; PMPM, per member per month

PAYMENT INCENTIVES ARE NOT ENOUGH, ESPECIALLY FOR NEW MEASURES

Adding equity to the Alternative Quality Contract (AQC) triad, for example

MASSACHUSETTS

Confidential **Equity Reports** to all AQC providers distributed September 2021, updated at least annually



Pay for Equity (P4E) Incentives added to AQC payment program beginning in 2023

Equity Action Community with Institute for Healthcare Improvement (IHI) launched November 2021

Health **Equity Grants** to contracted provider organizations in 2022-2023 that participate in the Equity Action Community via IHI

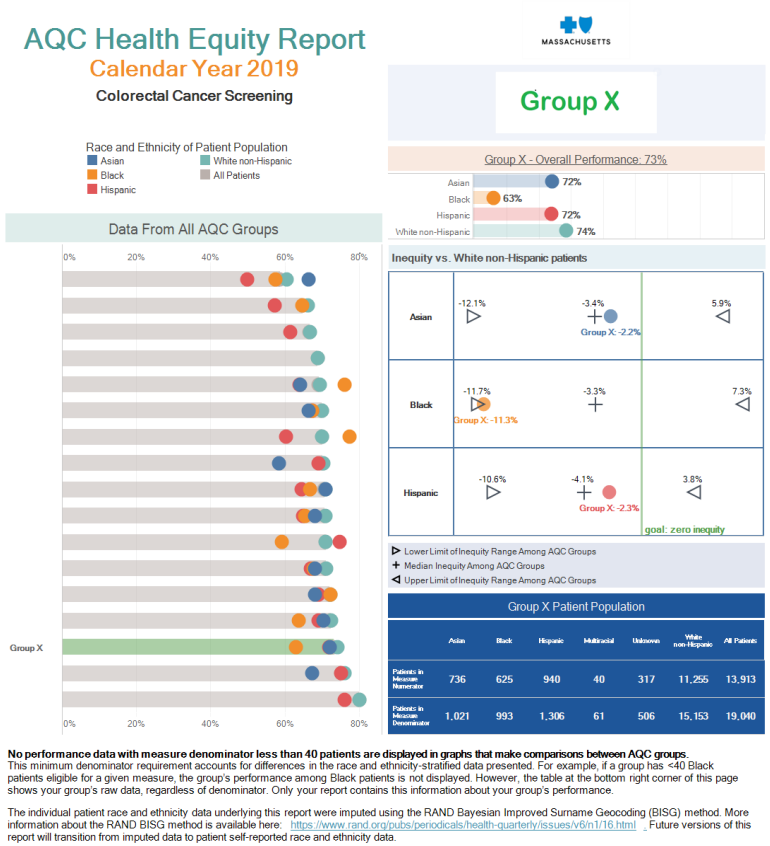
P4E explanation & podcast here

P4E technical detail here

Grant detail here

SHARING DATA WITH PROVIDERS

BCBSMA has produced equity audits for provider organizations and for publication on our website



No performance data with measure denominator less than 40 patients are displayed in graphs that make comparisons between AQC groups.
This minimum denominator requirement accounts for differences in the race and ethnicity-stratified data presented. For example, if a group has <40 Black patients eligible for a given measure, the group's performance among Black patients is not displayed. However, the table at the bottom right corner of this page shows your group's raw data, regardless of denominator. Only your report contains this information about your group's performance.

The individual patient race and ethnicity data underlying this report were imputed using the RAND Bayesian Improved Surname Geocoding (BISG) method. More information about the RAND BISG method is available here: https://www.rand.org/pubs/periodicals/health-quarterly/issues/v6/n1/16.html . Future versions of this report will transition from imputed data to patient self-reported race and ethnicity data.

HEALTH EQUITY REPORT

At Blue Cross, we have a deep commitment to quality, affordable health care, and that includes equity. As part of our commitment, each year we gather and publish data for more than 1.2 million of our commercial Massachusetts members, using measures widely leveraged by health plans and clinicians to monitor health care quality. See our 2020 data below.

This data has revealed racial and ethnic inequities in many areas of patient care. In partnership with the clinicians in our network, we're using our data to make meaningful change and to work toward our shared goal of eliminating racial disparities in the care our members receive. Read Coverage for examples of how we're partnering with Massachusetts provider organizations to address inequities in health care.

LEARN MORE

CHRONIC CONDITIONS

	Asian	Black	Hispanic	White
Asthma Medication Ratio	86.60%*	72.80%	74.60%	78.10%
Comprehensive Diabetes Care - BP control	85.10%	74.10%*	80.10%*	84.50%
Comprehensive Diabetes Care - HbA1c poor control (lower rates indicate higher quality care)	15.50%*	23.60%*	26.30%*	17.40%

Full report here

SUPPORT VIA EQUITY ACTION COMMUNITY

Technical assistance and up-front investment

$25 million in grant funding to AQC groups participating in the Equity Action Community.

AQC Providers	Data/Infrastructure	Equity improvement targets/efforts
Atrius Health	REL data collection, IT, staff trainings	Blood pressure
Boston Medical Center	Diabetes registry improvements	Diabetes, blood pressure, missed appointments
Baycare Health Partners, Inc.	REL data collection	Diabetes, blood pressure
Boston Children's Hospital Until every child is well	Developmental screening EHR modules	Well child visits, provider training in dev screening
Beth Israel Lahey Health	REL data collection, IT, equity dashboards	Diabetes
Mass General Brigham	REL data collection	Responding to racism/bias staff trainings
Reliant Medical Group	REL data collection	Blood pressure control, self-management tools
SONE Health	REL data collection, geographic data	Primary care access to close multiple gaps in care
South Shore Health	REL data collection, IT support	Implicit bias training for providers
Southcoast Health	REL data collection, staff trainings	Diabetes
Steward	Equipment to support access	Diabetes, cancer screenings, enhanced access
Tufts Medicine	REL data collection	Blood pressure

Abbreviations: AQC, Alternative Quality Contract; REL, race, ethnicity, and language; IT, information technology.

GUIDING PRINCIPALS GOING FORWARD

MASSACHUSETTS

- Always be clear on the purpose of performance-based payment programs
  - For BCBSMA, the purpose is to improve the quality, equity, and affordability of care received by our members
  - The “category” of a payment model is much less important than its demonstrated effectiveness
- Evaluate and refresh payment models regularly
- Increase financial incentive magnitude, relative to fee-for-service
- Make incentives winnable for providers
  - Part of this involves changing the incentive design
  - Continually improve quality of data and support to provider organizations

THANK YOU

Listening Session 3: *Linking Performance Measures with Payment and Financial Incentives*

Nick Frenzer

Population Health and Implementation Executive

Epic

Improving Data Collection and Timeliness of Data Sharing of Performance Information with Providers

Nick Frenzer

Population Health Executive

Epic

March 26, 2024

Agenda

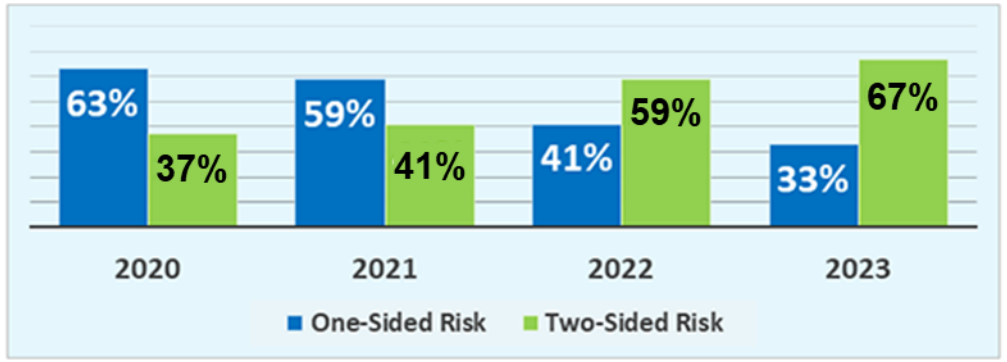
- **Current State**
  - Industry Examples
  - Key Issues
- **Strategy Recommendations**
  - Policy
  - Software
- **Key Takeaways**

Current State: Industry Examples

- Health Systems are willing to take on more risk
  - MSSP ACO participation is growing
  - Increased interest in tools that help groups track performance for risk-sharing agreements

2023 MSSP Participation

- More MSSP ACOs are taking on risk



- Levels A & B – 151 ACOs
- Levels C & D – 19 ACOs
- High Revenue – 45%
- Level E – 125 ACOs
- Enhanced – 161 ACOs
- Low Revenue -- 55%

National Association of ACOs. *Medicare ACO Participation by Year*. https://www.naacos.com/medicare-aco-participation.

Current State: Lack of Standardization

- Measure specifications & data ingestion requirements vary in different arrangements
  - ACOs & MIPS: eCQMs vs CQMs
  - Medicare Advantage contracts: Certified HEDIS measures

- Lack of standardization causes:
  - Inefficient data ingestion & sharing
  - Unintended exclusion of rural and specialty providers
  - Complex provider panels & reimbursement logic

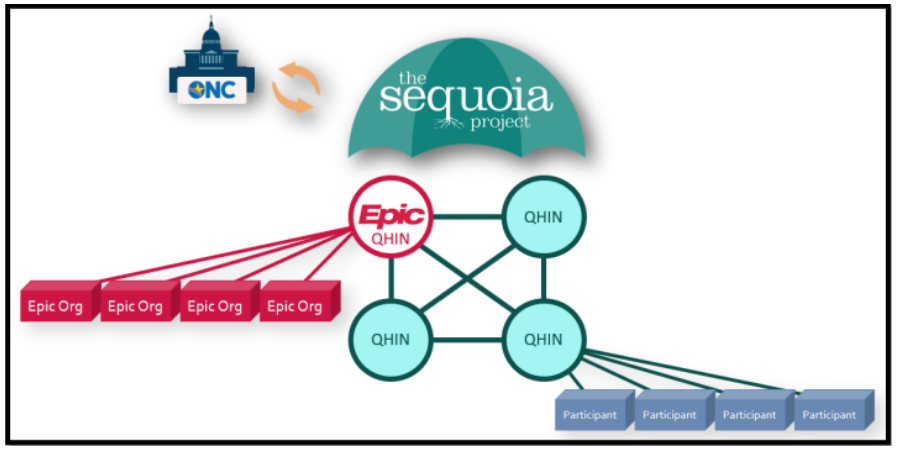
Policy Strategy

- TEFCA
  - Increase connectivity through TEFCA to provide opportunities for rural and safety net organizations
  - Encourage TEFCA adoption through policy initiatives
    - Connect TEFCA & information blocking policies (HTI-1)
    - Fund rural & safety net providers to join TEFCA
  - FHIR roadmap needed
- Identify a clear strategy for reporting electronic quality measures
  - Ex: QRDA vs FHIR?

Software Strategy: Epic's Approach

Epic's Approach

- Developed a QHIN to support customers joining TEFCA
- Strict adherence to standardized file formats and patient-matching algorithms
- Strategically provide clinics and providers with access to quality measure outcome dashboards
- Care Everywhere & Payer Platform



Software Strategy: Industry Gaps

Many measure types rely on claims data

EHR variability

Rural infrastructure

Support specialist involvement

Key Takeaways

- Standardizing quality measure reporting requirements across programs will facilitate more timely data collection and distribution
- Adherence to data and file formatting requirements facilitates efficient data exchange
- Rural participants need additional support to participate in APMs or other value-based programs