BCBSMA Pay for Performance Overview

Massachusetts Perinatal Quality Collaborative

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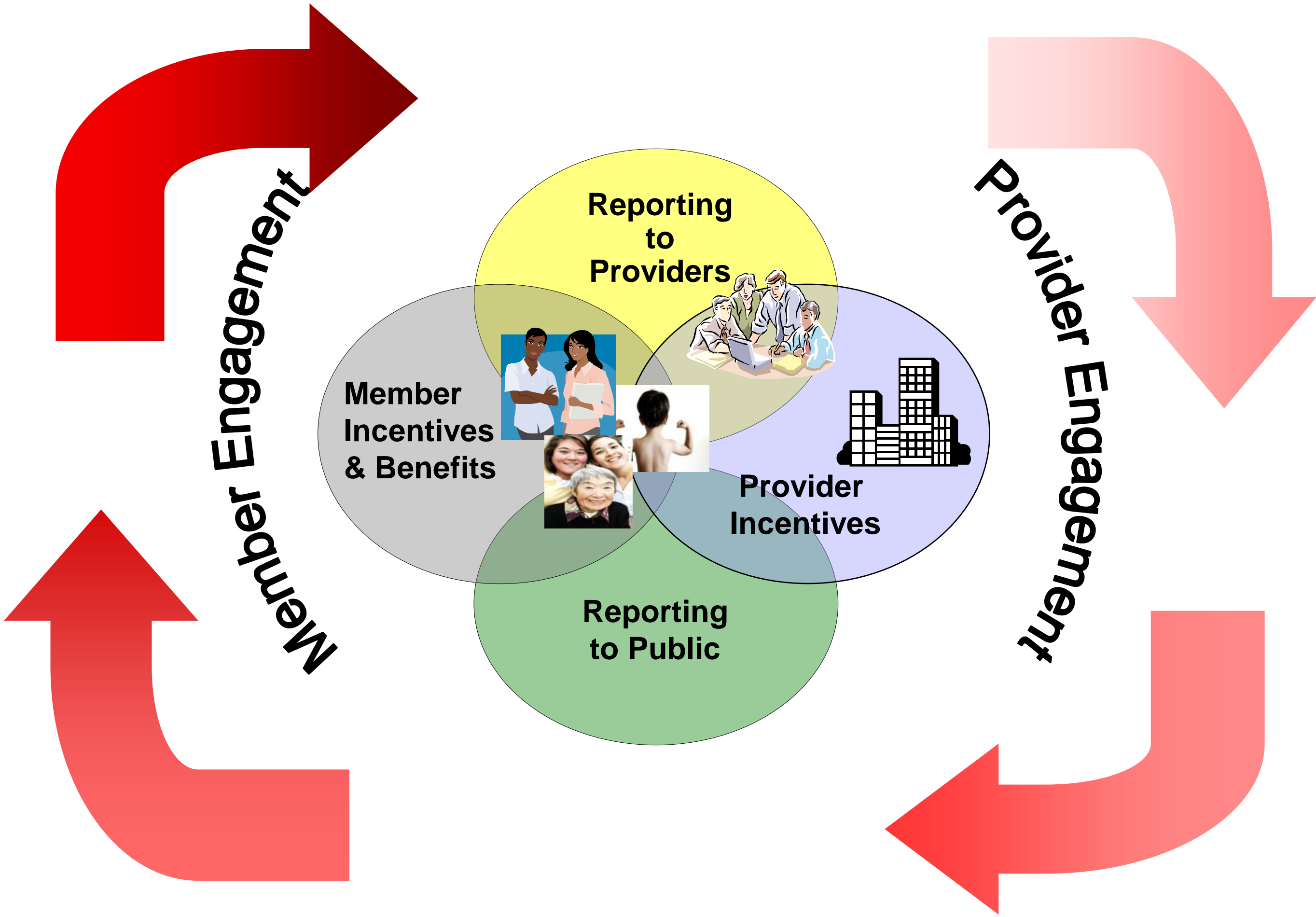
Advancing Quality, Outcomes and Affordability: Role of Performance Measurement, Reporting and Incentives



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 a majority of the 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.

Additional considerations

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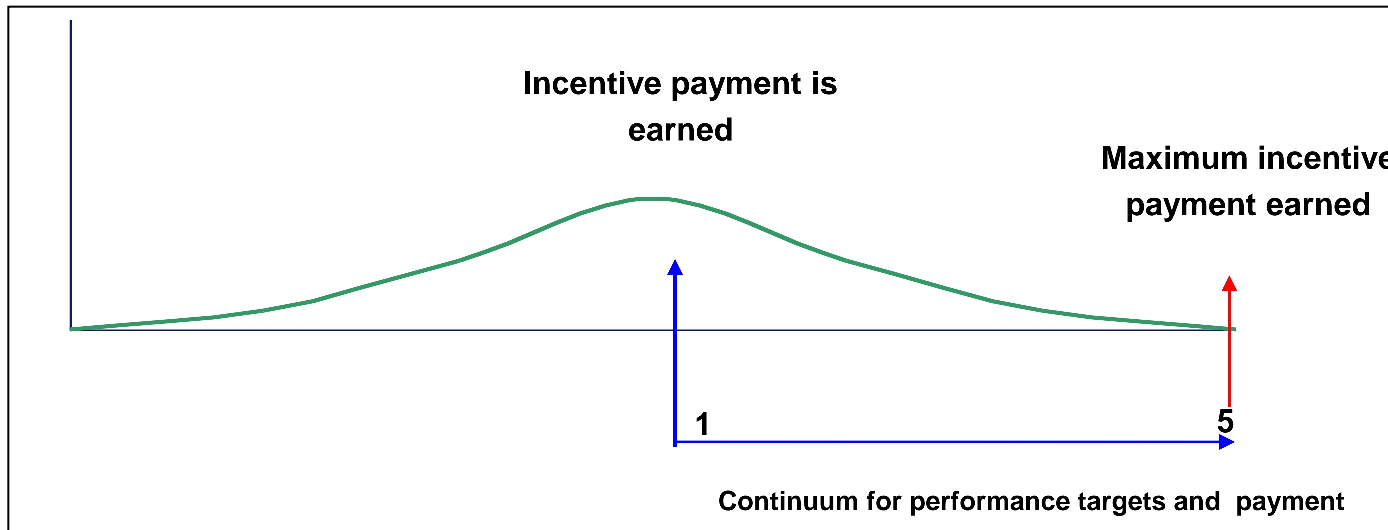
- Availability of the data
- Reporting burden
  - Align measures with those that our providers are required to report to other payers or for public reporting
- Accelerating uptake of clinically important evidenced based best practices
- Alignment with other BCBSMA uses of measures
  - Measures may be used for tiering, public reporting,etc

Measurement Methodology

- Targets set on *absolute* criteria for good performance
- Based on a de-noised statistical distribution of the data
  - Gate 1 is the level of performance at which incentive payments can be earned (50th percentile)
  - Gate 5 is the highest observed performance for a measure (99th percentile)
- Payment is earned for performance that falls anywhere along the continuum of performance
- Absolute targets set in first year of the contract and held constant for the length of the contract



Hospital Performance Incentive Program measures (FY2013)

Outcomes

- PSI 4 Death Among Surgical Patients
- PSI 06: Iatrogenic Pneumothorax, Adult
- PSI 07: Central Venous Catheter-Related Bloodstream Infection
- PSI 11: Post-Op Respiratory Failure
- PSI 12: Post-Op PE or DVT
- PSI 15: Accidental Puncture or Laceration
- PSI 17: Birth Trauma – Injury to Neonate
- PSI 18: OB trauma–vaginal w/ instrument
- PSI 19: OB trauma–vaginal w/o instrument
- PSI 90: Patient Safety for Selected Indicators
- 30 Day All Cause Readmission

Process

- CMS Measures - AMI, Pneumonia, HF, SCIP
- JCAHO- Elective Delivery prior to 39 weeks

Patient Experience

- Communication with Doctors
- Communication with Nurses
- Responsiveness of Hospital Staff
- Discharge Planning
- Pain Management
- Communication about Medicines

Reporting – only measures

- Included to accelerate uptake of clinically important, evidence-based processes that are linked to improved outcomes.

- Hospitals implement processes and provide reporting that demonstrates implementation and compliance tracking with the process – no targets.
  - Institute for Healthcare Improvement (IHI) 5 Million Lives campaign clinical bundles – now retired
  - IHI Perinatal clinical bundles for elective induction and for augmentation

- Governance component retired in 2010

AQC Measure Set for Performance Incentives

	Ambulatory	Hospital
Process	• Preventive screenings • Acute care management • Chronic care management – Depression – Diabetes – Cardiovascular disease	Evidence-based care elements for: • Heart attack (AMI) • Heart failure (CHF) • Pneumonia • Surgical infection prevention
Outcome	• Control of chronic conditions – Diabetes – Cardiovascular disease – Hypertension ****Triple weighted****	• Post-operative complications • Hospital-acquired infections • Obstetrical injury • Mortality (condition –specific)
Patient Experience	• Access, Integration • Communication, Whole-person care	• Discharge quality, Staff responsiveness • Communication (MDs, RNs)
Developmental	Optional -up to 3 measures on priority topics for which measures are lacking	

Ambulatory Quality: Results by domain

2009-2011

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Gate Score

4.5
4
3.5
3
2.5
2
1.5
1
0.5
0

AHRQ CMS HPEM

2011
2010
2009

AQC is Significantly Improving Quality

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Year-one improvements in quality were greater than any one-year change seen previously in our provider network

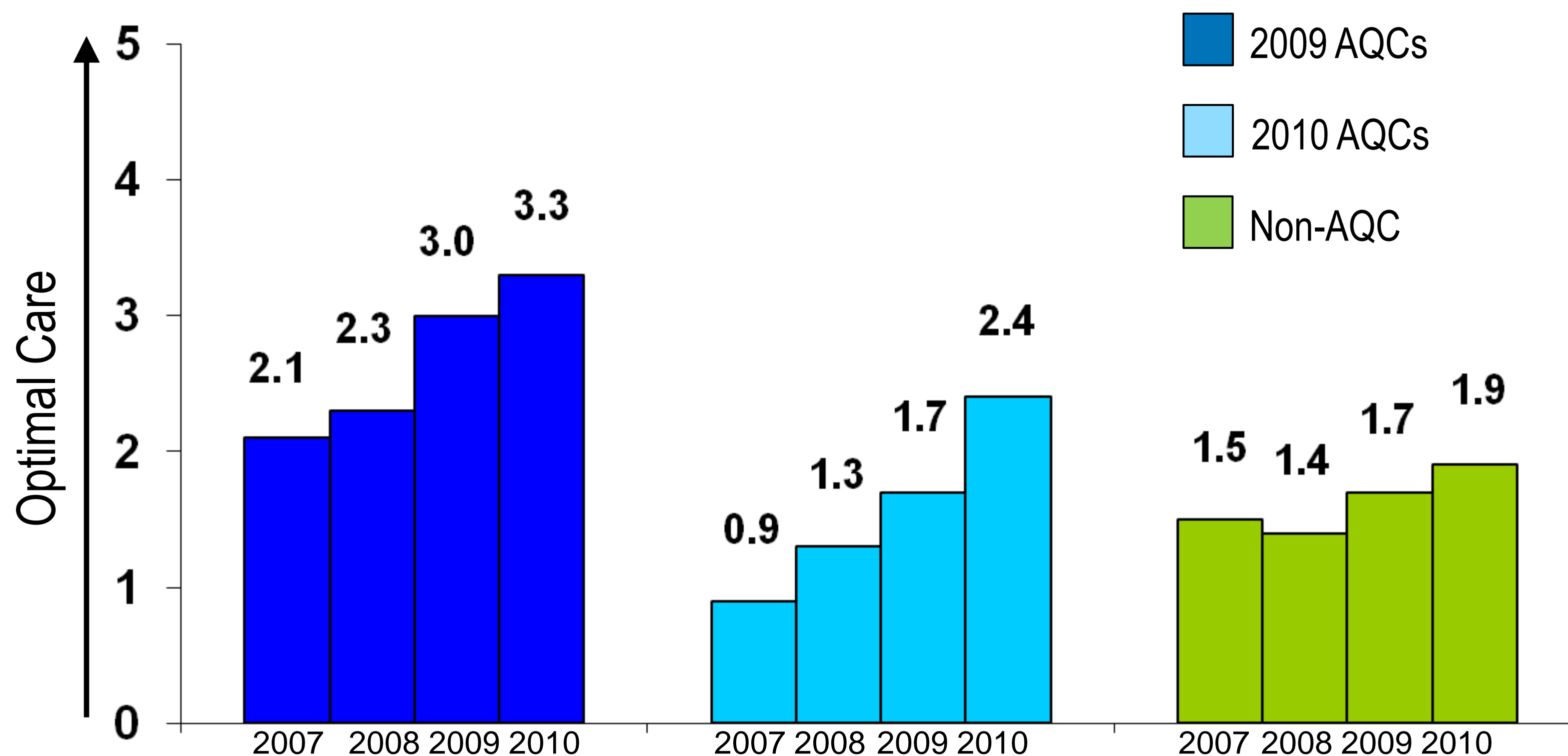
- Every AQC organization showed significant improvement on the clinical quality measures
- AQC groups exhibited exceptionally high performance for all clinical outcome measures with *more than half approaching or meeting the maximum performance target* on measures of diabetes and cardiovascular care.
- There were no significant changes in AQC groups' performance on patient care experience measures overall.

Year two 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.
- Significant improvements occurred in patient care experiences, including improved doctor-patient communication, access to care and integration of coordination.

Ambulatory Quality: Summary Results

- The 2009 AQC groups continue to improve quality and outcomes—sometimes approaching "best achievable" performance.
- The 2010 AQC groups made significant quality improvements in their first year.



AQC Improving Preventive and Chronic Care

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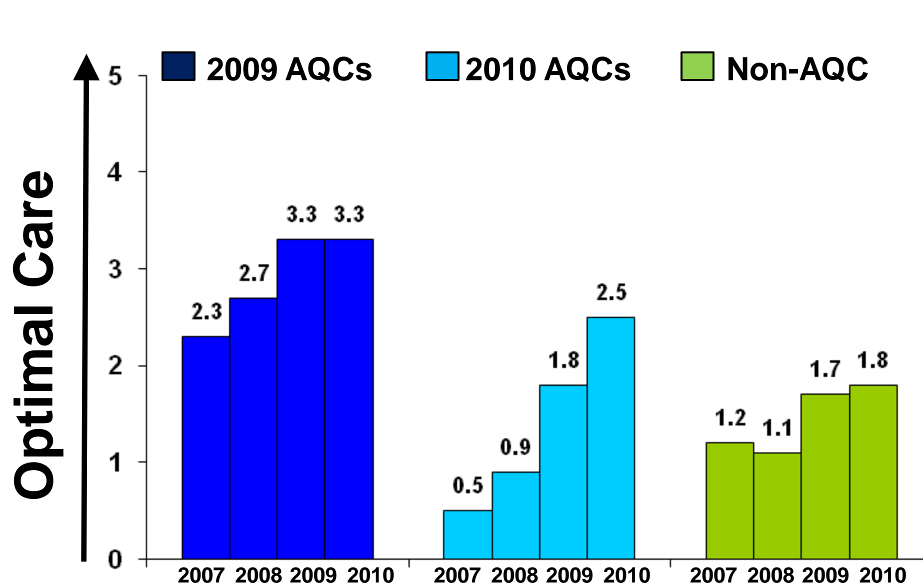
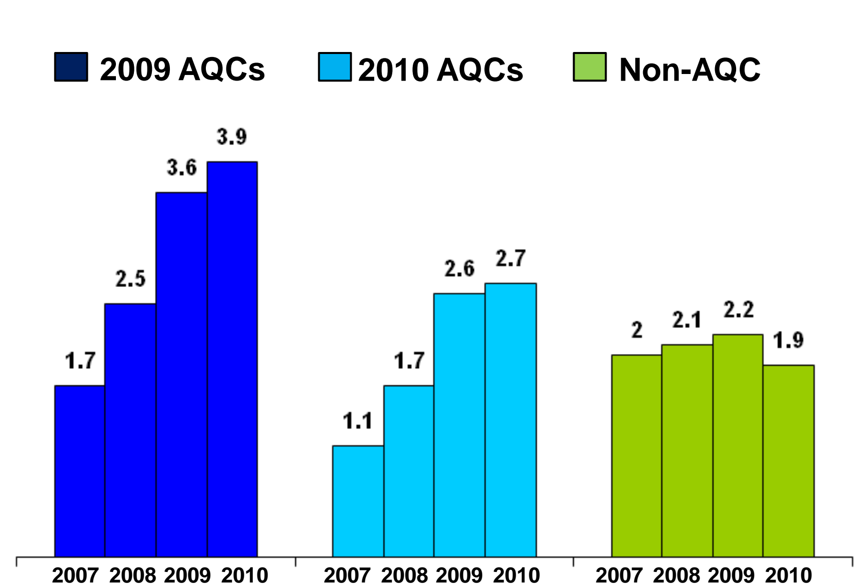
- The 2009 AQC cohort continues to demonstrate success improving quality—achieving benchmarks significantly higher than non-AQC peers.
- The 2010 AQC cohort made significant quality improvements in year one of their contract (2009 versus 2010).





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

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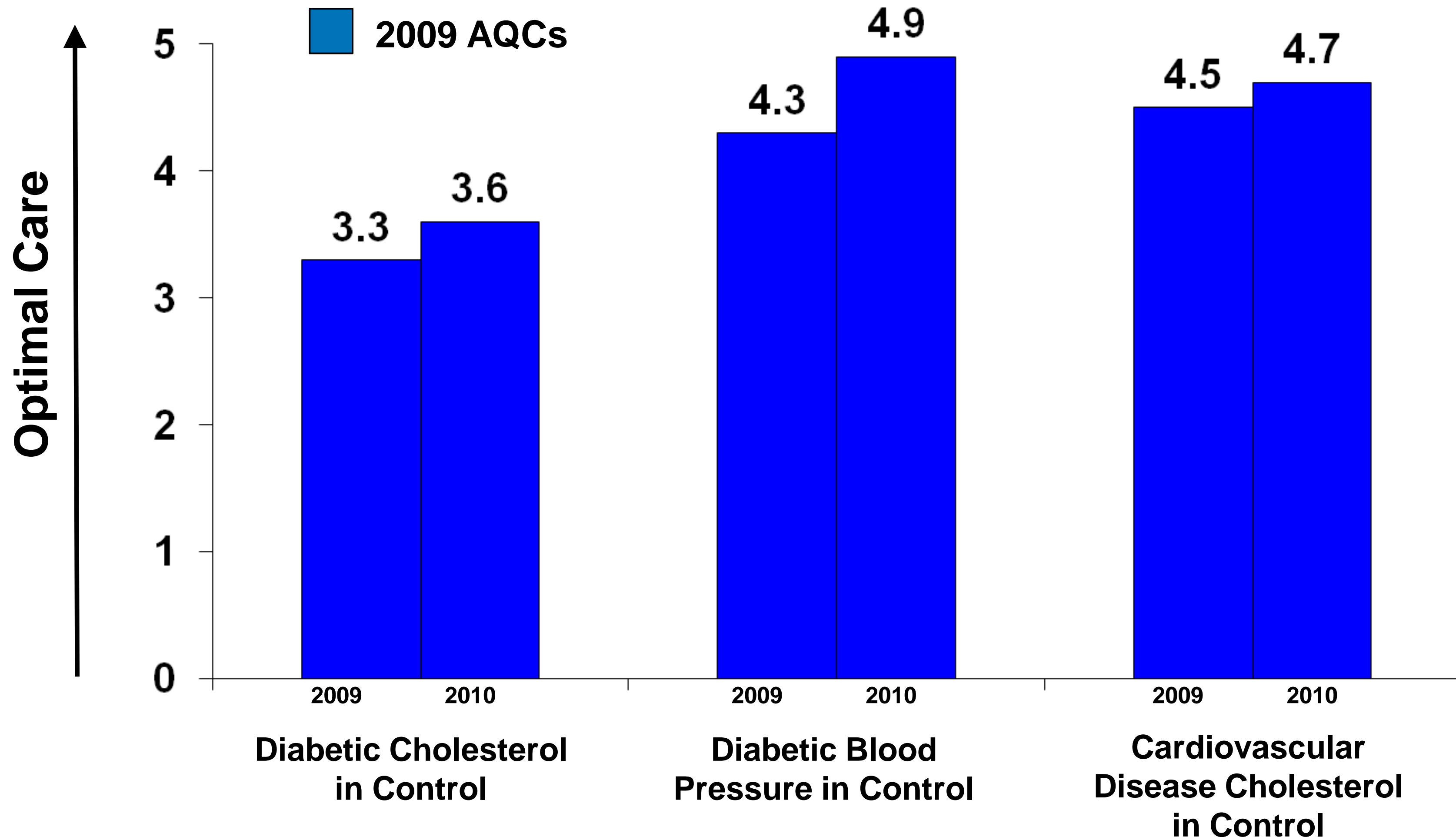

Results limited to AQC groups that received financial incentives for these measures in 2009.

Year-One Results: Formal Academic Evaluation

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Health Care Spending and Quality in Year 1 of the Alternative Quality Contract

Zirui Song, B.A., Dana Gelb Safran, Sc.D., Bruce E. Landon, M.D., [illegible], Yulei He, Ph.D., Randall P. Ellis, Ph.D., [illegible], Matthew P. Day, F.S.A., [illegible] E. Chernew, [illegible]

"The AQC system was associated with modestly lower medical spending in the first year after implementation…a 1.9% savings relative to the control group (non-AQC)."

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Thank you!