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

BPCI-A versus Controls

Diffs in diffs in trends: -$52/quarter, p<0.001

90-Day Readmission Rate

Diffs in diffs in trends: -0.01%/quarter, p=ns

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

But what are our desired outcomes?
Statin use rates, 2007 to 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

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Readmissions Database (NRD), 2010-2020.

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

Life Expectancy, USA vs UK

https://www.macrotrends.net/countries/USA/united-states/life-expectancy
Inequity is pervasive and persistent

A  Age-standardized mortality rate from cardiovascular diseases, both sexes, 2014

Roth et al, JAMA 2017

B  Men

Deaths per 100,000 population

76 to 158  213  269  324  380  435 to 546

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?

Collection
- Claims
- EHRs

Measurement
- Risk adjustment
- Attribution

Evaluation
- Benchmarking

Practice
Change

2000+ measures, 2-3 year lag
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
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

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

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

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

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SUPPORT

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

Grant detail here

P4E technical detail here

P4E explanation & podcast here

Grant detail here

P4E technical detail here
BCBSMA has produced equity audits for provider organizations and for publication on our website.

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

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.

<table>
<thead>
<tr>
<th>AQC Providers</th>
<th>Data/Infrastructure</th>
<th>Equity improvement targets/efforts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrius Health</td>
<td>REL data collection, IT, staff trainings</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>Boston Medical</td>
<td>Diabetes registry improvements</td>
<td>Diabetes, blood pressure, missed appointments</td>
</tr>
<tr>
<td>Baycare Health Partners, Inc.</td>
<td>REL data collection</td>
<td>Diabetes, blood pressure</td>
</tr>
<tr>
<td>Boston Children’s Hospital</td>
<td>Developmental screening EHR modules</td>
<td>Well child visits, provider training in dev screening</td>
</tr>
<tr>
<td>Beth Israel Lahey Health</td>
<td>REL data collection, IT, equity dashboards</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Mass General Brigham</td>
<td>REL data collection</td>
<td>Responding to racism/bias staff trainings</td>
</tr>
<tr>
<td>Reliant Medical Group</td>
<td>REL data collection</td>
<td>Blood pressure control, self-management tools</td>
</tr>
<tr>
<td>Sore Health</td>
<td>REL data collection, geographic data</td>
<td>Primary care access to close multiple gaps in care</td>
</tr>
<tr>
<td>South Shore Health</td>
<td>REL data collection, IT support</td>
<td>Implicit bias training for providers</td>
</tr>
<tr>
<td>Southcoast Health</td>
<td>REL data collection, staff trainings</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Steward</td>
<td>Equipment to support access</td>
<td>Diabetes, cancer screenings, enhanced access</td>
</tr>
<tr>
<td>Tufts Medicine</td>
<td>REL data collection</td>
<td>Blood pressure</td>
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Abbreviations: AQC, Alternative Quality Contract; REL, race, ethnicity, and language; IT, information technology.
GUIDING PRINCIPALS GOING FORWARD

• 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**
  o Industry Examples
  o Key Issues

• **Strategy Recommendations**
  o Policy
  o 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%

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