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THE ECONOMIC CASE FOR CLINICAL QUALITY MEASURES

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Despite the uncertainty in today's healthcare market, one thing remains clear: the move to value-based care and reimbursement is well under way.

While emphasis has consistently been focused on the Affordable Care Act (ACA) and its replacement, other important legislation is already in place that contains a great deal of policy relating to the transition to value-based reimbursement. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)—which provides financial incentives for providers to participate in risk-bearing, coordinated-care models and to move away from traditional fee-for-service reimbursement—was passed with overwhelming bipartisan support in both Houses. This suggests that the transition to value is likely to continue. According to a recent Deloitte report¹, however, half of surveyed physicians have never heard of MACRA, which is on track to fundamentally change how they are reimbursed under the Medicare Physician Fee Schedule (PFS). And although the first year for payment adjustments under MACRA is 2019, performance in 2017 will determine those payments for many providers.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

60%
COMPENSATION

In 2017, 60% of provider compensation will be tied to a performance-based payment adjustment driven by quality measures. Most participants will need to report 6 quality measures, including one outcome measure, for at least 90 days.

ADVANCED ALTERNATIVE PAYMENT MODELS (APMS)

5% INCENTIVE | **UP TO 4%**

Providers that participate in qualifying models, including Shared Savings Tracks 2 or 3, Next Generation ACO, and CPC+, and who meet specified quality performance targets, can earn a 5% incentive payment in 2019, in addition to payment adjustments of up to 4%.

The Centers for Medicare and Medicaid Services (CMS) has installed a Quality Measure Development Plan framework to build and improve quality measures that providers can use to meet MACRA requirements. These quality measures support the Merit-based Incentive Payment System (MIPS) and advanced Alternative Payment Models (APMs), which make up the two tracks of Medicare's Quality Payment Program. **Commercial insurers are also beginning to follow Medicare's lead².** Aetna expects 75% of its spend to be in the form of value-based contracts by 2020 and Blue Shield of California reported \$325 million in cost savings over a five-year period as a direct bi-product of its investment in accountable care.

The Deloitte survey revealed another key issue: physicians recognize that they will need new capabilities—especially as it relates to reporting—in order to address their increased financial risk. In the survey,



It is clear that the new payment reforms that are intended to deliver better care at lower cost share a common requirement: providers, payers, and other healthcare stakeholders must make fundamental changes in their day-to-day operations to improve quality and reduce the cost of care.

OBJECTIVE MEASUREMENTS SUPPORT CURRENT AND FUTURE REIMBURSEMENT MODELS

Critical to this transition from fee-for-service to value-based reimbursement is an objective measurement of value.

“Value can be defined as a proportion of quality with respect to cost. Provider organizations are increasingly held accountable for managing cost of care, but numeric measurement of quality, or effectiveness, is also required in order to complete the characterization of value. An approach that is increasingly being employed is the use of clinical quality measures (CQMs), which correlate health and healthcare outcomes that can be impacted by better management, as a representation of quality performance.”

We are still in the early stages of value-based reimbursement, and the model is sure to evolve in character as it represents an increasing proportion of total healthcare reimbursement. But while CQMs may comprise a relatively modest portion of reimbursement today, there is no evidence of substantial movement toward alternative objective measures of quality and value, so their use is likely to increase in the immediate future. In addition, an economic case can be built for how CQMs position providers for value-based reimbursement while supporting current fee-for-service models. It is thus important for provider organizations to develop or acquire measurement capability—and CQMs have emerged as an ideal approach—but more importantly, to develop processes, incentive structures, and technology that can drive performance. For providers who haven't yet begun to establish quality measures that support value calculations, this is the ideal time to begin putting those capabilities in place.

CLINICAL QUALITY MEASURES AND THEIR APPLICATION

CQMs represent metrics that shed light on the effectiveness or performance of providers and provider organizations and have been developed by several organizations that support healthcare quality, notably the **National Quality Forum**³. CQMs are typically expressed as a proportion, with explicitly defined denominator and numerator.

For example, consider a measure of diabetes management performance. HbA1c is a laboratory test that measures effectiveness of blood glucose control. The higher the figure, the higher the patient's average blood glucose in recent weeks. **The American Diabetes Association sets evidence-based targets for management**⁴, such as a stipulation that HbA1c should be kept to a value less than 7.0%. This becomes the basis for a common CQM used in risk- and quality-based reimbursement models for providers managing diabetic populations who are working to improve diabetes outcomes. A typical CQM for diabetes management is defined with a denominator representing all patients with a diagnosis of diabetes, and a numerator representing the subset with HbA1c under 7.0%. An outcome measure reported at 59% would indicate that 59% of the diabetic population under management had achieved the goal.

Other common CQMs include the proportion of individuals who meet recommendations for screening for breast cancer or colon cancer, both of which are easier to treat and have improved survival rates when detected early. Similarly, many risk factors associated with heart disease can be controlled through lifestyle modification and pharmacologic intervention, including statin therapy. That makes CQMs that measure the proportion of individuals who meet adherence recommendations for statin use another common choice.

CHOOSING CQMS FOR GREATEST IMPACT

For instance, employers often fund healthcare for their employees and dependents. In addition to carrying risk for cost, these employers have a stake in functional outcomes such as productivity and time loss. With the appropriate selection of measures, these outcomes can also correlate with CQM performance, such as CQMs that measure the effectiveness of screening and treatment of depression. In another scenario, where total cost of care is paramount, an important observation is that hospitalizations represent the largest single category of healthcare expense. The three conditions that represent the largest expense for preventable hospitalization in America are heart failure, bacterial pneumonia, and COPD, making those CQMs appropriate choices.

Strategic selection of CQMs also depends on the population at hand. Commercially insured employees, Medicare members, and vulnerable Medicaid populations bring significantly different demographics and challenges to the table, which will influence CQM choices. These choices also need to be considered in the context of long-term performance goals.

BALANCING STABILITY AND EVIDENCE WITH TEAM-BASED CARE

It takes time, consistency, and investment of resources to progressively improve performance, so stability is a valuable component of reimbursement methodology. But clinical evidence is not static. First and foremost, CQMs must be adapted to the latest evidence. The construction of CQMs on a solid foundation of science is fundamental to achieving and measuring health outcomes in the context of performance, and provider engagement will be jeopardized in the absence of this foundation. That means that it is vital that CQM definitions are sufficiently nimble to adapt to a constantly evolving evidence basis.

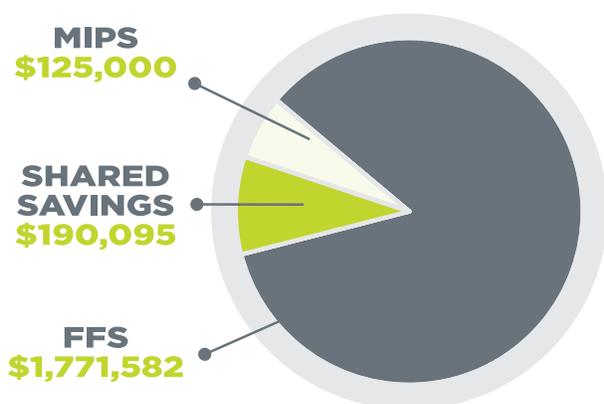
In an era of team-based care, the performance that is signified by a CQM outcome also represents the concerted work of every person in the provider organization, not just physicians. And patients are also members of the team, because, after all, the healthcare outcomes are theirs. The best performance in CQMs is achieved when workflows are explicitly defined and followed, technology is employed to optimize workflows and communication, and every team member is working at the top of his or her license. It is vital to avoid descending into a “blame game” in which physicians and other providers are held solely responsible for performance, and penalties are imposed on low performers. Optimal improvement is attained by moving the whole bell curve, not by applying correctional actions to the low end.

MODELING PAYBACK: THE ROLE OF CQMS IN THE TRANSITION FROM FEE-FOR-SERVICE TO VALUE-BASED REIMBURSEMENT

An economic model to evaluate the payback for the use of CQMs can be developed using data from a leading regional health system. The health system uses Enli CareManager to curate and codify evidence-based guidelines, create a shared care plan, and facilitate care team collaboration to drive clinical quality improvements in several key areas. In this case, the model includes CQMs for blood pressure screenings, diabetic A1c management, and cervical, breast, renal, and colon cancer screenings.

The model illustrates how CQM improvements support value-based reimbursement (VBR) contracts by helping providers avoid costly interventions, driving higher quality scores, and qualifying for payment adjustments and/or incentives. But the use of these CQMs also drives actions that close gaps in care, which translates to an increase in services, more office visits, and a lift in fee-for-service billings. In this example, the model shows an increase of \$2.2 M in revenue for a healthcare organization with 50 providers—an average increase of \$3.7K per provider per month.

CQMS BOOST REVENUE IN 50-PROVIDER ORGANIZATION BY \$2.2M



KEY ASSUMPTIONS

ORGANIZATION SIZE:
50 PROVIDERS

SERVICE RATES:

- OFFICE VISIT \$150
- PAP SMEAR \$150
- URINE ALBUMIN LAB TEST \$50
- A1C LAB TEST \$100
- MAMMOGRAPHY \$100
- COLONOSCOPY \$2,000

The model uses typical service rates for primary care office visits, lab tests, and screenings based on industry averages. Incremental MIPS revenue is based on median performance and results from a 2% increase in fee schedule payout for physicians as a result of higher quality scores. Shared savings incremental revenue assumes a median performer in the Medicare Shared Savings Program (MSSP) program.

THE ECONOMIC CASE FOR CQMS—NOW AND TOMORROW

While CQMs are an important and valuable element in the move to value-based care, we must keep in mind that healthcare is too comprehensive to be accurately evaluated by a handful of measures. We must avoid the specter of “teaching to the test” that can result from narrow pay-for-performance solutions. Healthcare ranks among the highest of responsibilities and there can be no substitute for professionalism, which starts by putting our patients’ interests above our own. As providers, if we jeopardize the trust of those we serve we can never be successful.

It is critical to put CQMs into the context of this principle and commitment. Providers who strive to meet appropriate clinical quality benchmarks can help close gaps in care and increase quality of outcomes, while improving current and future compensation. In the short term, providers see fee-for-service revenue that is tied to increased volume as care gaps are closed. At the same time, they are establishing competencies for upcoming reimbursement models with shared savings and incentive payments linked to established performance targets in value-based contracts.

To see how CQMs can contribute to your organization’s financial performance—today and tomorrow—contact us. We’ll help you model and build your own CQM economic case.



About the Author

Dr. Siemenczuk leads Enli’s effort to translate the latest evidence-based guidelines into codified clinical workflows, enabling providers to practice at the height of their licensure and reduce unwarranted variation in care. Previously, he served as CEO of Providence Medical Group where he oversaw the operational and financial accountability of the integrated healthcare delivery system, which spans over 700 physicians, 80 clinics and 8 hospitals. During his tenure at Providence, he received the President’s award for Excellence in recognition of best-of-nation outcomes in disease management using CareManager, an innovative disease and population health management software.

1. <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-are-physicians-ready-MACRA.pdf>
2. <https://healthpayerintelligence.com/news/private-payers-follow-cms-lead-adopt-value-based-care-payment>
3. http://www.qualityforum.org/Electronic_Quality_Measures.aspx
4. <http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose-control/a1c/>



ABOUT ENLI

Enli Health Intelligence® is the market leader in population health management technology. Enli enables care teams to perform to their full potential by integrating healthcare data with evidence-based guidelines embedded in provider workflows across the population and at the point of care.

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