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HPC DATAPOINTS

Quality Measurement Misalignment in Massachusetts

Increasing role of quality measurement

Health care quality measurement serves an increasingly important role in supporting the delivery of high-value health care, guiding improvement activities, and promoting accountability for health-related outcomes across providers. In recent years, payers have encouraged adoption of alternative payment models (APMs) into provider contracts, which generally incentivize the delivery of high-value care and link a portion of provider payment to the provider's performance on quality measures.[i,ii,iii] In the Massachusetts commercial market, 42% of members were covered by APM contracts, a 6.3 percentage point increase between 2015 and 2016.[iv]

Burden of non-aligned quality measurement

As commercial payers have implemented APM contracts, the quality measures selected for the contracts have not been well aligned across payers. This lack of alignment has contributed to a proliferation in the number of quality measures for which health care providers are asked to report performance and develop quality improvement strategies.[v] The result is an increase in administrative burden (for payers and providers, alike), limited ability to draw meaningful comparisons across populations, and mixed signals to provider organizations about quality priorities. A 2014 national survey found that physician practices spend an average of 785 physician and staff hours per physician annually on quality measure tracking and reporting across all payers, including Medicare and Medicaid.[vi] Based on a 2016 survey, the Massachusetts Health and Hospital Association estimates that over $67 million is spent annually on quality measurement and reporting for hospitals statewide, including hospital quality reporting to the federal government.[vii]

Further, despite a high number of measures being collected, a majority of them are process measures (e.g., whether a person received a blood test). Process measures are easier to collect through administrative data, such as claims, and they play an important role in informing high-value health care practices.[viii] However, there remains a shortage of outcome-based quality measures, which more directly assess health care outcomes (e.g., did the person's symptoms of depression improve, or is their diabetes under better control?).

In 2017, the HPC surveyed the three largest commercial payers in Massachusetts (Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan) to determine which

i United States, Congress. Patient Protection and Affordable Care Act. Public law 111-148, 23 March 2010.

ii Commonwealth of Massachusetts, Legislature. An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation. Chapter 224 of the Acts of 2012, 6 August 2012.

iii United States, Congress. Medicare Access and CHIP Reauthorization Act of 2015, Public law 114-10, 16 April 2015.

iv "2017 Annual Report on the Performance of the Massachusetts Health Care System". Center for Health Information and Analysis, Sept. 2017, http://www.chiamass.gov/assets/2017-annual-report/2017-Annual-Report.pdf.

v Blumenthal, David, and J. Michael McGinnis. "Measuring Vital Signs: an IOM report on core metrics for health and health care progress." JAMA, vol. 313, no. 19, 19 May 2015, pp. 1901–1902, doi:10.1001/jama.2015.4862.

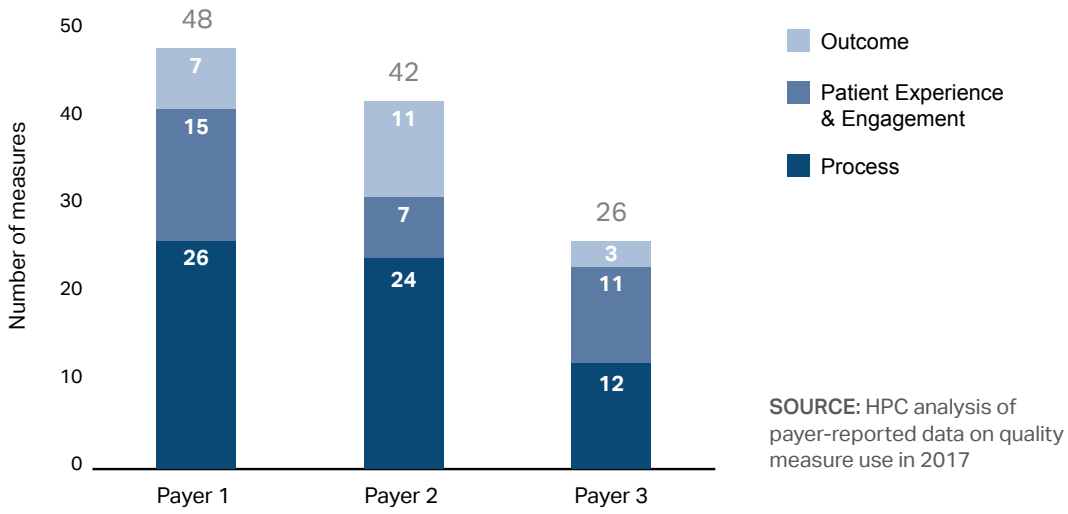
vi Casalino, Lawrence P. et al. "US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures". Health Affairs, vol. 35, no. 3, March 2016, pp. 401-406, https://doi.org/10.1377/hlthaff.2015.1258.

vii "MHA quality measurement and reporting resources survey results summary". Massachusetts Health & Hospital Association. 2017.

viii Saver, Barry G. et al. "Care that matters: quality measurement and health care". PLoS Med, vol. 12, no. 11, e1001902, 17 Nov. 2015, https://doi.org/10.1371/journal.pmed.1001902.

quality measures each payer uses in at least 10 APM contracts with providers organizations. Collectively, these three payers' APM contract arrangements covered 35.5% of members in the Massachusetts commercial market in 2016.[ix] A crosswalk of the measures used in these models shows a considerable degree of measure variability and a significant reliance on process-based measures.

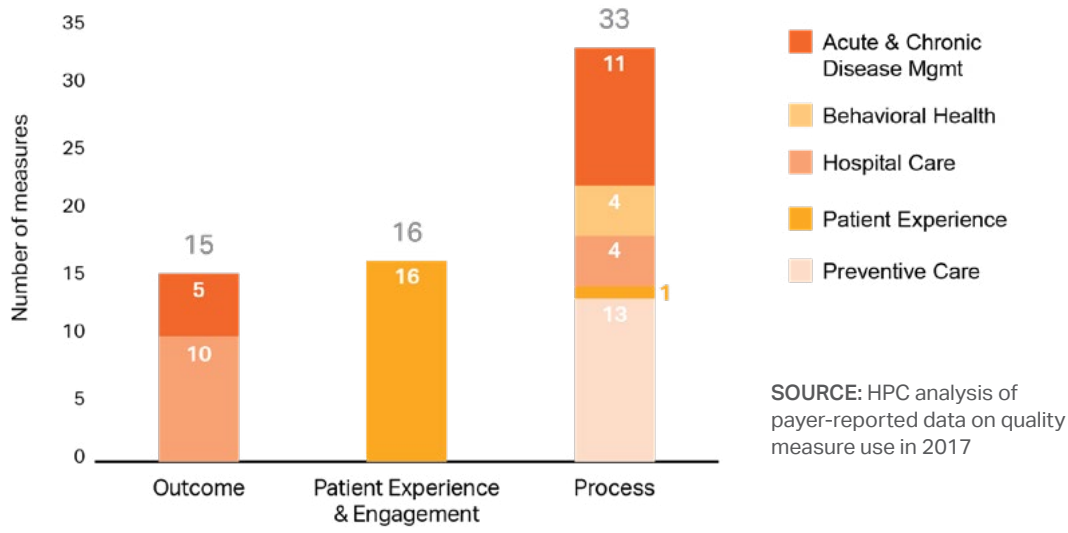
Number of measures used in 10+ APM contracts by three largest MA commercial payers, 2017



SOURCE: HPC analysis of payer-reported data on quality measure use in 2017

A total of 64 measures are used in 10 or more APM contracts by at least one of the three payers and about half of these measures are process measures. Additionally, commercial payers vary in the scope of quality measures used in their APM contracts – one payer reported consistent use of 26 measures in APM contracts while the others reported consistent use of over 40 measures.

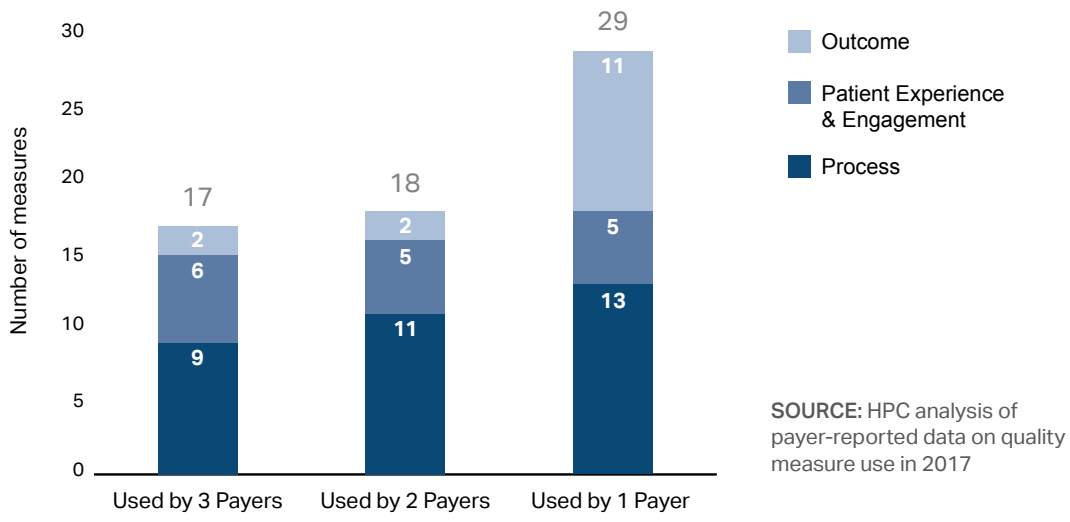
Number of measures used by one or more of the three largest MA commercial payers in 10+ APM contracts, by measure type, 2017



SOURCE: HPC analysis of payer-reported data on quality measure use in 2017

ix HPC analysis of Center for Health Information and Analysis data, membership measured in member months: "2017 Annual Report APM Databook". Center for Health Information and Analysis, Sept. 2017, http://www.chiamass.gov/annual-report/.

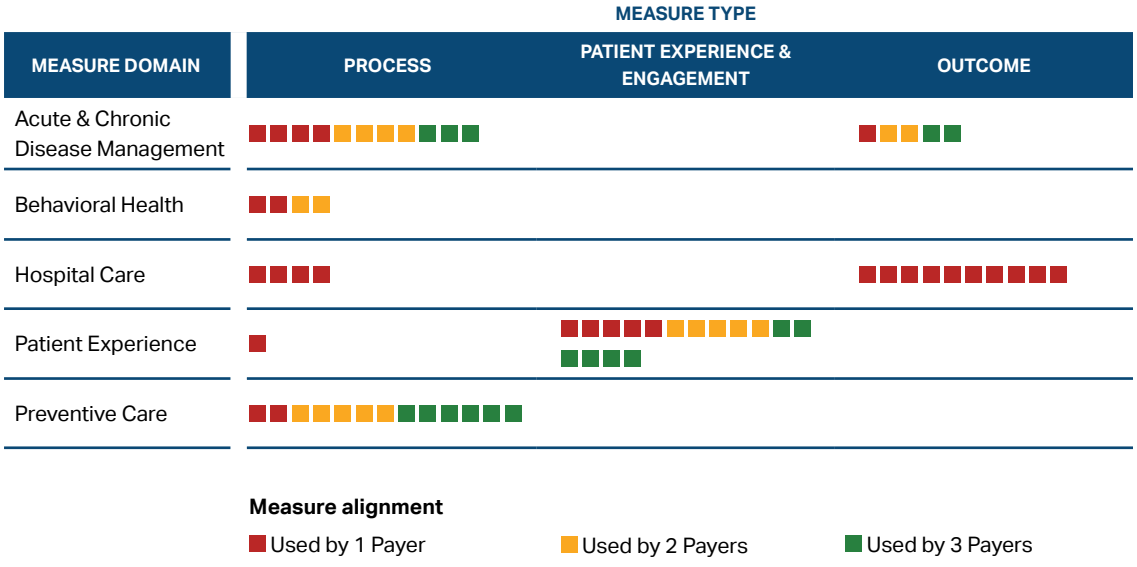
Number of measures three largest MA commercial payers use in 10+ APM contracts, by alignment across payers, 2017



SOURCE: HPC analysis of payer-reported data on quality measure use in 2017

Of the 64 measures consistently used in APM contracts by at least one of the three payers, 29 are unique to one payer across commercial plans. About half of the measures unique to one payer are hospital care measures; the majority of the remaining measures are acute and chronic disease management and patient experience measures. Only 17 measures used in at least 10 APM contracts are common to all three payers, including two outcome measures – Controlling High Blood Pressure and Comprehensive Diabetes Control: Blood Pressure Control. There are no common measures of outcomes for the rest of the population, such as behavioral health or population health measures (e.g., smoking cessation or BMI reduction), in APM contracts in Massachusetts today.

Number of measures used by one or more of the three largest MA commercial payers in 10+ APM contracts, by measure type, domain, and alignment across payers, 2017



SOURCE: HPC analysis of payer-reported data on quality measure use in 2017

The degree of alignment across payers also varies by domains of quality measure, such as preventive care, chronic disease management, behavioral health, hospital care, and patient experience. Overall, there tends to be more payer alignment in the domains of preventative care, chronic care, and patient experience and less overlap in the domains of behavioral health and hospital care. One payer reported consistently using hospital-based measures in its APM contracts, which is a way to incent coordination and accountability across different care settings.

Policy implications

There are considerable opportunities to increase health care quality measure alignment in Massachusetts. Further aligning quality measures across payers can focus improvement on critical areas of clinical quality, accelerate APM adoption, and allow for development of performance measurement in priority areas. Stakeholders should collaborate to define priority quality measures and domains and work to align measures used in APMs. Some states have already adopted aligned measure sets; for example, the Rhode Island Office of the Health Insurance Commissioner recently began requiring insurers to use aligned quality measure sets in contracts with quality-based payment terms.[x]

Beyond alignment on measures, there is an opportunity to shift the type of measures collected from process measures to more meaningful outcome measures. One potential reason why few outcome measures are currently used by commercial payers is that clinical outcome measures are resource intensive to develop and collect. This difficulty is reflected, in part, in the smaller number of outcome measures that have received endorsement from national quality measurement experts such as the National Quality Forum. In addition, outcome measures often need to be adjusted to account for patient risk factors that impact outcomes but are outside of provider control. Risk adjustment is particularly critical for measures related to behavioral health care – substance use disorder in particular – and population health, such as smoking cessation and BMI reduction.

Further, there is an opportunity to enhance quality measures across a range of clinical domains, including behavioral health, ambulatory medical care outcomes, and episodic care outcomes (e.g., orthopedic procedures). Enhancement of such measures is especially important for APM contracts which seek to incent accountability across the entire care continuum.

Investments in health information infrastructure could help reduce the time and money that organizations spend on developing and collecting quality measures. Advancement in outcome measures, in particular, would benefit from a centralized method for data collection and abstraction. Several other states have developed robust clinical data repositories that support quality measurement and reporting.[xi] Those states have been able to give providers access to timely clinical data and comprehensive information about how patients are using the health care system which can be used to improve care delivery and population health.

In order to further advance the population health goals set by the Commonwealth, continued collaboration among health care stakeholders is necessary to prioritize domains for quality measurement, align measures within priority domains, and to innovate on new measures of health care quality that will fill the measurement gaps noted above. Recognizing this policy imperative, the Executive Office of Health and Human Services, as supported by the HPC and other state agencies, is convening stakeholders and has begun working toward increased quality measure alignment across commercial and public plans and the implementation of a clinical data repository in Massachusetts.

x "Concise statement of the principal reasons for and against the adoption of the amendments to the OHIC Regulation 2, Powers and Duties of the Office of the Health Insurance Commissioner." State of Rhode Island and Providence Plantations Office of the Health Insurance Commissioner, 2016, http://www.ohic.ri.gov/documents/2016-Concise-statement-2016-amendments.pdf.

xi Health information exchanges in states such as Maryland and Rhode Island have clinical data repository capabilities: "CAliPHR: CQM Aligned Population Health Reporting Tool". Chesapeake Regional Information System for our Patients (CRISP), https://www.crisphealth.org/wp-content/uploads/2016/03/CAliPHR-Flyer-2_16.pdf; "2016-2018 Strategic Plan". Rhode Island Quality Institute, http://www.riqi.org/matriarch/documents/RIQI_PDF_brochure.pdf