

# **Bridges to Excellence: Recognizing High-Quality Care**

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# Acknowledgements

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# Pay for Performance is Widespread

- Inventories of programs across all types of payers document nearly 150 pay-for-performance programs<sup>1</sup>
- In a national survey, 52% of HMOs (covering 81% of enrollees) report using pay for performance<sup>2</sup>
- Medicare is slowly but surely moving to adopt pay for performance

1. The Leapfrog Group and MedVantage, 2007.

2. Rosenthal MB, et al. Pay for Performance in Commercial HMOs. *New England Journal of Medicine*, November 2, 2006.

# Methods of Ascertaining Performance Vary

- Information for pay for performance comes from a variety of sources
- For physicians, health plan claims data most commonly used to gauge performance
  - Readily available
  - Standard software can be used to create profiles
- Physicians, other clinicians often question the validity of both attribution and diagnosis based on claims, however

# Bridges to Excellence

- Launched in 2002 by multi-stakeholder coalition
- Design of program reflects reconciliation of payer-provider views on measurement
- All-payer construct
  - Practice self-assessment
  - Chart review on sample of patients
  - Risk adjustment available
- Payments flow to recognized physicians based on number of eligible patients in panel

# Physician Office Link

- Promotes office systems designed to improve quality, access, coordination
- NCQA Physician Practice Connections assessment tool; 3-year accreditation
- Measure domains include: Patient tracking and registry functions, electronic prescribing, support for patient self-management
- \$50 per patient per year (payments may vary by region)

# Diabetes Care Link

- Rewards high-quality diabetes care
- American Diabetes Association-NCQA Diabetes recognition program; 3-year accreditation
- Clinical data from 25 randomly selected charts: A1c, blood pressure, lipid, eye, foot, nephropathy testing
- \$80 per patient per year

# Research Design

- Would love to be able to test whether the launch of BTE caused practices to redesign, improve quality, but...we don't have the data
- Instead we can examine contemporaneous performance of recognized vs. non-recognized physicians to examine:
  - Whether BTE recognition is correlated with higher claims-based quality measures
  - Whether BTE recognized practices deliver care differently; more efficiently than others

# Data and Measures

- Pooled data from 2003-2006 from Massachusetts Group Insurance Commission all-payer data file: 6 major health plans in MA, all patients (50% of Mass residents including 7,000 physicians)
- Recognition status of physicians from NCQA
- ETG™ software used to capture resources per episode, by type of service (\$ standardized to eliminate fee differences among plan-provider pairs)
- Standard, HEDIS-like claims-based quality measures

# Sample Definition

- All Massachusetts physicians eligible for the POL or DCL, respectively
- POL specialties: internal medicine and family practice; DCL specialties: internal medicine, family practice, endocrinology
- Excluded physicians <200 episodes of care
- Excluded physicians <10 patients for a quality measure (only for that measure)

# Comparison of Claims-based Measures of Quality: POL

	Recognized Physicians	Non-recognized Physicians
Cervical cancer* screening	88.9	85.0
Mammography*	88.1	85.9
A1c Testing*	86.3	82.3
Lipid panel: CHD	89.6	86.4
Lipid panel: hypertension	45.1	43.8

\* Indicates statistically significant difference,  $p < .05$

# Comparison of Claims-based Measures of Quality: DCL

	Recognized Physicians	Non-recognized Physicians
A1c Testing*	84.1	85.0
Diabetic retinal exams*	99.2	98.2
Lipid panel: diabetic patients*	87.1	82.1
Microalbumin Testing*	76.2	58.5

\* Indicates statistically significant difference,  $p < .05$

# Share of Standardized Expenditures by Category of Service: POL

	Recognized Physicians	Non-recognized Physicians
Management*	35.8	32.3
Surgery	1.8	1.6
Facility	14.3	15.9
Inpatient ancillary*	0.1	0.2
Outpatient*	18.5	19.5
Prescription drugs*	29.0	30.5

\* Indicates statistically significant difference,  $p < .05$

## Comparison of Episode Costs: POL

	Recognized Physicians	Non-recognized Physicians
Number of episodes	191,527	1,114,334
Episodes/patient*	2.09	2.22
Standardized* resource use/episode	\$570	\$700

\* Indicates statistically significant difference,  $p < .05$

# Conclusions

- Retrospective review of medical charts and NCQA PPC site survey results identify better performers on claims-based measures of quality
- For POL physicians, BTE recognition associated with lower costs per episode, fewer episodes
- POL practice patterns suggest more use of “cognitive” inputs
- Less clear pattern of differences between DCL and comparison practices (depends on specialty)

# Limitations

- Cross-sectional study: no causal inference about impact of P4P possible
- Limited data for risk adjustment
- Generalizability of Massachusetts, first BTE rollout

# Implications

- BTE recognition appears to be associated with higher performance on claims-based quality metrics
- Patterns of care for POL-recognized physicians also appear to be consistent with better patient management, lower costs
- BTE recognition may complement claims-based approaches – advantages: all-payer, almost no sample size constraints, acceptance of clinicians
- More research is needed to establish whether BTE and similar programs encourage quality improvement