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QUALITY PAYMENT MODELS & METRICS

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18th CNHN Pediatric Practice Management Seminar

Thursday, December 10, 2015



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Faculty Disclosure

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I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

Learning Objectives

- Based on this presentation, changes you may wish to make in practice:
 - Understanding of the new role of quality in defining Value in health care
 - Understand sample NCQA- HEDIS Metrics
 - Learn how to begin to change clinical workflows to impact your quality metric performance

Audience Survey:

Physicians who are expert in fee-for-service billing will likely continue to be successful in relating to their payers without pursuing knowledge and understanding of alternative models of care and payment.

- A. True
- B. False

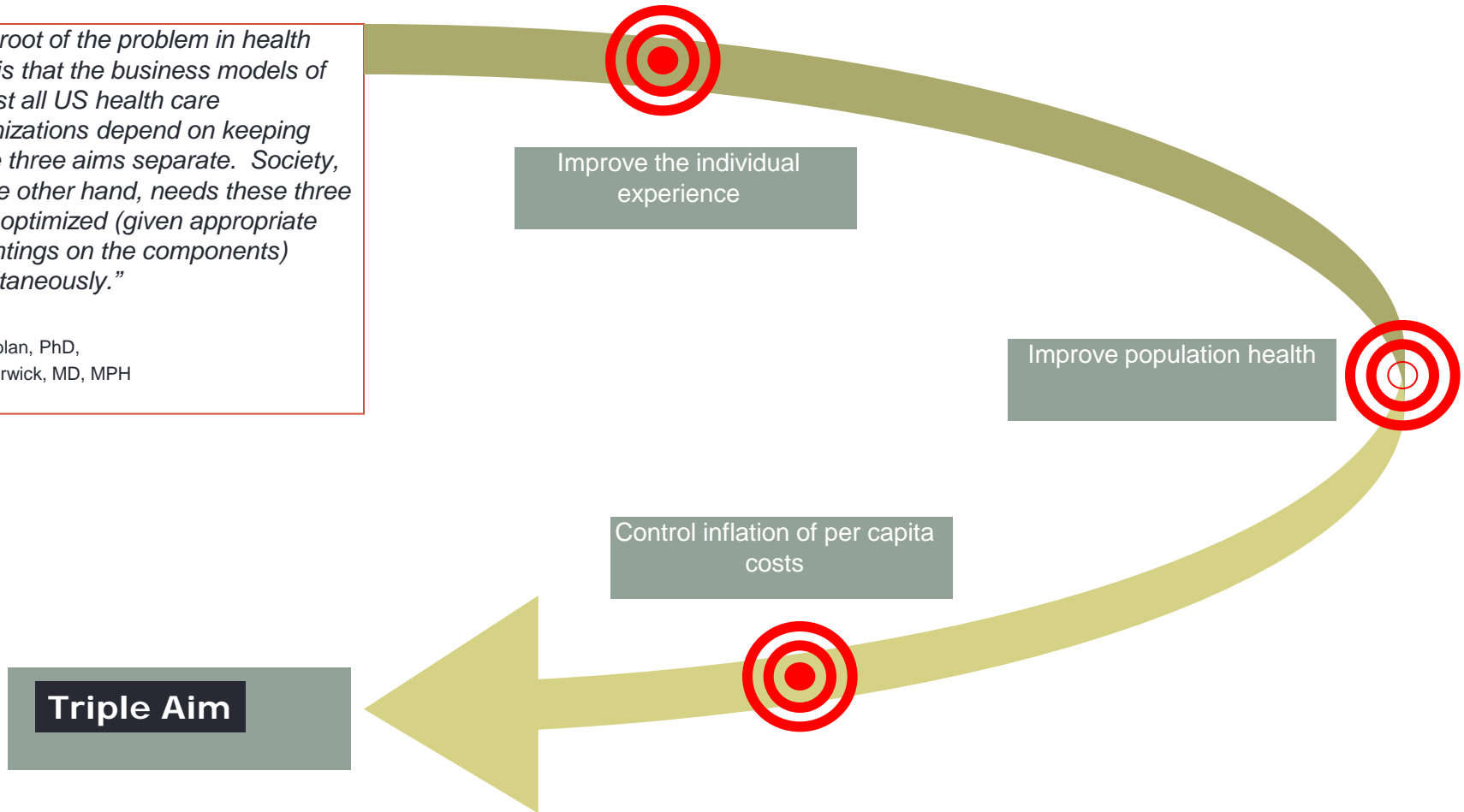
Basic Principles of pay for performance and value based payments



Why We Do What We Do? Achieving the “The Triple Aim”!

“The root of the problem in health care is that the business models of almost all US health care organizations depend on keeping these three aims separate. Society, on the other hand, needs these three aims optimized (given appropriate weightings on the components) simultaneously.”

Tom Nolan, PhD,
Don Berwick, MD, MPH



“The Triple Aim: Care, Health, And Cost,” *Health Affairs*, 27, no.3 (2008): 759-769. Donald M. Berwick, Thomas W. Nolan and John Whittington,



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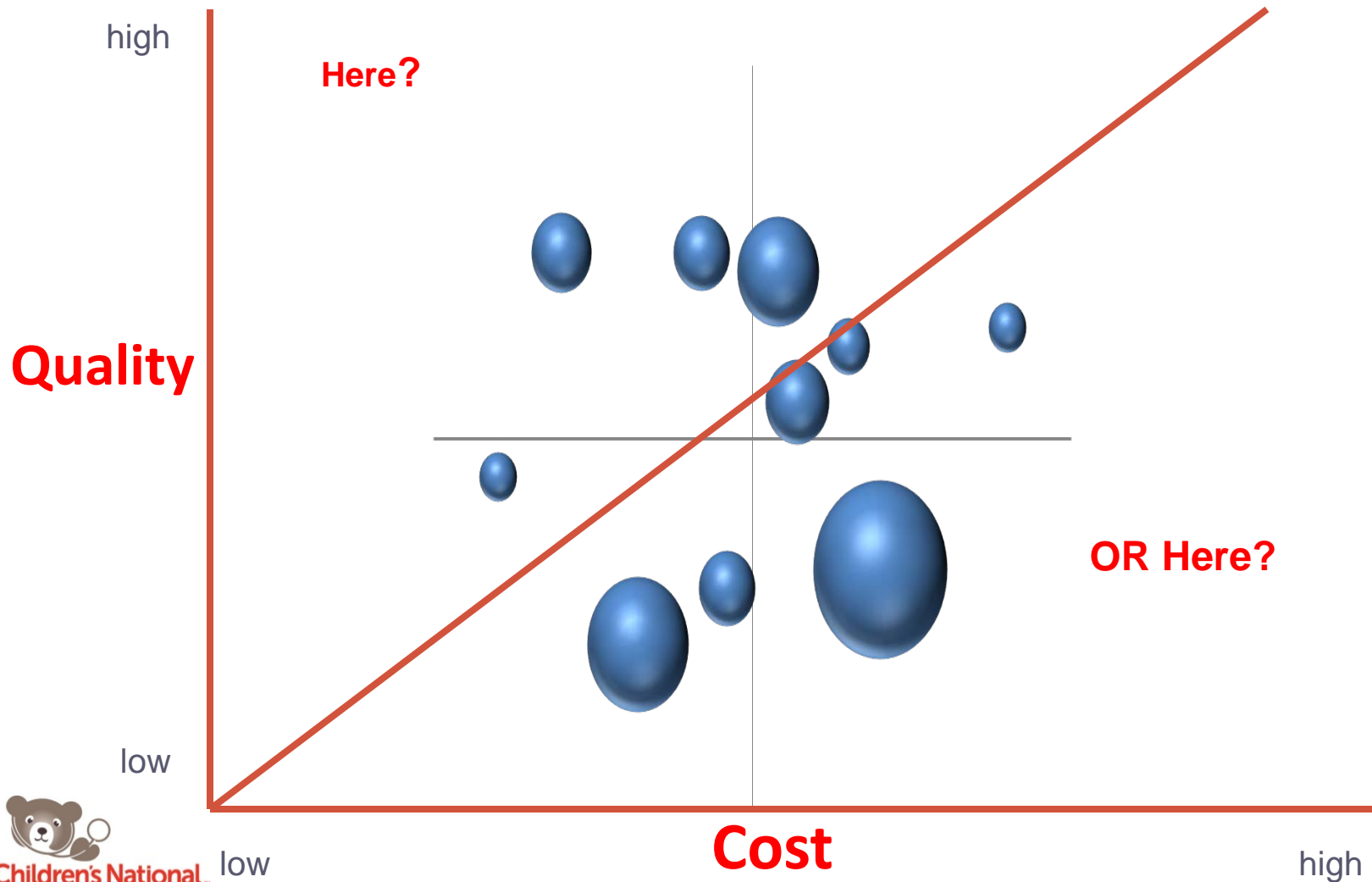
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Creating Value in Your Practice

- The Triple Aim: Improving –
 - health care (delivery- eg PCMH)
 - quality of care (outcomes- eg NCQA Measures)
 - the cost of care (right care at right time and right place)
- Creating Value Value = Quality / Cost
- **Payment will follow Value**

A Triple Aim “Valuegram”



A New Quality- Through the Lens of the Triple Aim

- Ability to reduce variation in outcomes including cost
- Ability to provide access allowing “right care, right time, and right place”- afterhours and walk-in (patient centric)
- Ability and performance in closing “Care Gaps”- claim analytics- look at evidenced based care that has not been delivered
- Member Experience- patient activation, shared decision making, and navigation



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The New Lexicon – of Health Care

- The Triple Aim
- Accountable Care
- The Value Equation for Health Care
- Value Based Contracting
- Value based insurance product design
- The New Quality
- Population Health
- Care Opportunities
- Variation
- Transparency
- Episodes of Care
- Patient Centered Medical Home
- Health Home for “Superutilizers”
- Narrow Networks



Definition: ACO

An Accountable Care Organization (ACO) is -

- a group of physicians, other healthcare professionals*, hospitals and other healthcare providers that
- accept a shared responsibility to deliver a broad set of medical services to a defined set (population) of patients across the age spectrum, and
- who are accountable for the quality and cost of care provided through alignment of incentives.

Principles of ACO Structure- Strong Tie to Medical Home

The **core purpose** of an Accountable Care Organization is –

- to provide accessible, effective, team-based integrated care based on the Joint Principles of the Patient Centered Medical Home for the defined population it serves
- which includes assurances that care is delivered in a culturally competent and patient and/or family-centered manner.

Newer Payment Models – Multimodal and Evolving to Risk Model

- **Enhanced Fee for Service**
 - Typically higher rates than “non” PCMH
 - Payment policy (afterhours care, care plan oversight)
 - Evolution to risk – capitation
- **Prospective Payments- funding infrastructure**
 - Care coordination
 - EHR
 - NCQA certification costs
 - Evolution to risk based on outcomes
- **Retrospective Payments- For Performance or Value (new)**
 - Quality Indicators
 - Patient experience
 - Evolution to risk based on a Gain Share

PCMH Reimbursement



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Retrospective Payments: Pay for Performance or Value

- Payment in addition to the Fee schedule
- Based on “performance” on certain agreed upon measures
- Program designed by payer(s)
- Comes as an amendment or attachment to the payer contract
- May involve a continuum of risk

Pay for Performance: Evolution

Newer Models of Accountable Care

- Gain Sharing – (shared savings) a method for physicians and other providers to share in a defined way in **savings** a program generates for the population

Gain share may be determined by –

- Improvements compared to a past year(s) in chosen utilization metrics- ER, Inpatient
- Improvements in Total Cost of Care (Medical Loss Ratios - MLR)
- **Meeting Quality Targets – the “Gate”**



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Concept of Financial Risk

- **Upside Risk** - you win- chance of getting a payment if performance targets are met or exceeded
- **Downside Risk** - you may not get a payment if targets are not met (even if you have resource costs in the effort), or in certain models you may lose payment by not hitting targets
- *Programs with downside risk typically have higher potential gains

Finding the Balance

- **Physician/Provider Centered – What you want and ? Need**
- **Patient/Family Centered Care- the PCMH- what your patients NEED**
- **Consumer Centered Care- What your patients WANT**

Making Quality Pay- 2015 Road Map

- Understand the Metrics and how to score
- Raise your practice Profile for Q (Value)
- Direct payments for Quality metric Thresholds
- Going through a “Quality Gait” to get to a Gain Share (savings on cost of care)

Pay for Performance or Value: Quality Measures



Types of Quality Measures

- Quality Indicators
 - HEDIS measures from the NCQA- See Supplemental Handouts
 - CHIP Measures- See Supplemental Handouts
 - Local- Medicaid EPSDT (lead screening)
- Patient experience
 - Patient satisfaction - CAHPS
- Utilization (Efficiency or cost) Measures
 - ER visits
 - Inpatient Admissions
 - Pharmacy- % Generic Rx's

Pay for Performance or Value-Quality Measures

- Quality Indicators

- Generally based on national guidelines and evidenced based measures
- NCQA, NQF, Joint Commission (JCAHO), CMS develop measures
- Can be reported on billing forms- CPT Category I and Category II codes , ICD codes, other (pharmacy)
- Measured from claims (administrative), or chart review , or both (hybrid)
- Can relate to a process or to an outcome
- Payer will define the measures, the reporting, the targets, and the payments in the contract

NCQA HEDIS Quality Measures

- Measure the per cent of patients who have had or not had a given health intervention
- Measures have a denominator of the eligible patient population
- Measures have a numerator of the patients who have had the intervention

Quality Measurement

- Administrative Measures
 - Claims data based
 - Claims are as good as the coding inputs
 - Viewing Care Gaps is not real time due to claim processing time/delay
- Hybrid Measures
 - Claims plus Clinical Data
 - Chart Review- manual (very expensive!!)
 - Use of Category 2 Codes for QI
 - EHR exports to Payer (CCDA to Application, HID)

HEDIS 101

- HEDIS = Healthcare Effectiveness Data and Information Set.
- Developed by the National Committee for Quality Assurance (NCQA) in 1993
- 90% of all health plans use HEDIS to measure performance, care, and service.
- HEDIS consists of 81 measures over 5 domains: Effectiveness of Care, Access/Availability, Experience of Care, Utilization & Relative Resource Use, & Health Plan Descriptive Information.

HEDIS 101

- Data for HEDIS is collected through surveys (CAHPS), medical chart reviews (hybrid metrics), and claims data (administrative metrics).
- HEDIS is one component of NCQA's accreditation process.
- HEDIS measures are updated on an annual basis by NCQA to reflect the most current clinical practice guidelines/evidence based healthcare practices.

CHIP – Core Set

2015 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set - Adobe Reader)

File Edit View Window Help

2015 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

NQF #	Measure Steward	Measure Name
Access to Care		
NA	NCQA	Child and Adolescents' Access to Primary Care Practitioners (CAP)
Preventive Care		
0033	NCQA	Chlamydia Screening in Women (CHL)
0038	NCQA	Childhood Immunization Status (CIS)
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15)
1407	NCQA	Immunizations for Adolescents (IMA)
1448	OHSU	Developmental Screening in the First Three Years of Life (DEV)
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
1959	NCQA	Human Papillomavirus Vaccine for Female Adolescents (HPV)
NA	NCQA	Adolescent Well-Care Visit (AWC)

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NCQA Quality Measures

1. Appropriate Testing for Children With Pharyngitis (CWP) Ages 2-18 years

- Diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode
- *Commercial, Medicaid (Admin.)*

2. Appropriate Treatment for Children With Upper Respiratory Infection (URI) Ages 3 months–18 years

- Given a diagnosis of URI and were NOT dispensed an antibiotic prescription.
- *Commercial, Medicaid*

Pediatric Well Care Visits

Preventive service E&M

- **Well Care Visits in the First 15 months of Life (W15)**
- **Well Care Visits in the 3rd, 4th, 5th and 6th years of Life (W34)**
- **Adolescent Well Care (AWC)***
- **Exploit EHR documentation prompts & coding for well care coordinated compliance**
 - BMI percentile, physical activity and nutritional counseling (WCC)
 - Completed, timely UTD immunization documentation (CIS/HPV/IMA)
 - Lead screening (LSC) - document date and result if in history⁺**(ACC contract)**
 - Chlamydia Screening (CHL) for sexually active 16-24 yo females

Important Points to Remember :

- Utilize age appropriate preventive service/health check CPT and ICD 10 codes
- Include age appropriate documentation supported ICD 10 codes for BMI and activity/nutrition counseling code



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Childhood Immunization- Combinations

- Compliance for measure is measured based on full immunization on or before the a given age

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combination 2	✓	✓	✓	✓	✓	✓				
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 4	✓	✓	✓	✓	✓	✓	✓	✓		
Combination 5	✓	✓	✓	✓	✓	✓	✓		✓	
Combination 6	✓	✓	✓	✓	✓	✓	✓			✓
Combination 7	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Combination 8	✓	✓	✓	✓	✓	✓	✓	✓		✓
Combination 9	✓	✓	✓	✓	✓	✓	✓		✓	✓
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Adolescent Immunizations- Combination 1 Compliance for measure is measured based on full immunization within age parameters

- Tdap/Td vaccination on or between 10th and 13th birthday
- Meningococcal conjugate/polysaccharide vaccination on or between 11th and 13th birthdates



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Child must be fully immunized for sub measure component within birthdate parameters

Behavioral Health Measures

- **Follow-up for Children Rx'd ADHD Medication**
 - 6-12 year olds dispensed ADHD medication
 - **Initiation Phase of Medication**
 - One practitioner visit within 30 days of dispensing event
 - **Continuation and Maintenance Phase**
 - Continuity of medication regimen for at least 210 days
 - Additional 2 practitioner visits within 270 days after the initiation phase ends
- **Antidepressant Medication Management**
 - 18 years and older diagnosed with major depression and newly treated with antidepressant medication, and remaining on antidepressant tx
 - **Effective Acute Phase Treatment**
 - Remain on antidepressant medication for at least 84 days (12 weeks)
 - **Effective Continuation Phase Treatment**
 - Remain on antidepressant medication for at least 180 days (6 months)

Codes Minimize record reviews for Hybrid Measures

From	To	POS	TOS	Procedure	Diagnosis	Charges	Units
11/07/2013	11/07/2013	11	NCSV	0502F	V221	\$0.01	

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Appropriate Medications for Asthma

- Patients aged 5-64 identified as having persistent asthma and who were appropriately prescribed medication during the measurement year
- Dispensed at least one prescription for an asthma controller medication during the measurement year

Description	Prescriptions		
Antiasthmatic combinations	· Dyphylline-guaifenesin	· Guaifenesin-theophylline	
Antibody inhibitor	· Omalizumab		
Inhaled steroid combinations	· Budesonide-formoterol	· Fluticasone-salmeterol	· Mometasone-formoterol
Inhaled corticosteroids	· Beclomethasone	· Flunisolide	· Triamcinolone
	· Budesonide	· Fluticasone CFC free	
	· Ciclesonide	· Mometasone	
Leukotriene modifiers	· Montelukast	· Zafirlukast	· Zileuton
Long-acting, inhaled beta-2 agonists	· Arformoterol	· Formoterol	
	· Salmeterol		
Mast cell stabilizers	· Cromolyn		
Methylxanthines	· Aminophylline	· Theophylline	
	· Dyphylline		



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HEDIS Lingo

- **HEDIS Care Opportunity = a “GAP” in Care**

A HEDIS Care Opportunity means that there is an outstanding service for a patient, that once completed will result in member compliance for a particular HEDIS measure.

- **How are HEDIS Care Opportunities identified?**

Health Plan identifies Care Opportunities through claims data following the HEDIS specifications for each measure. Certain EHR's can also identify Care Opportunities based on billings, age, etc

- **How are HEDIS Care Opportunities closed?**

Care Opportunities are closed by completing the required service(s) for the identified members in the specified timeframe and submitting the appropriate codes for the service(s) provided.

How to Close a Care Gap

- Understand Population Health- who is not in your waiting room- the other 25%
- Know the measure- connect with EBM/Good Care
- “See” the measure (gap in your patient)- develop a clinical workflow for tracking & closure:
 - a spreadsheet, your EHR, a payer portal
- Access- easy to get in /close all gaps at any opportunity (in for sick visit, do the well)- telehealth access
- Care Coordination- getting patients into the waiting room- “expand the waiting room” (telehealth, school clinic)
- Seek the incentive- most payers have a program now to align an incentive to the care



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Payment Reform: Medicare to Pediatrics



Case Study: Payment Reform in Tennessee

The Tennessee Health Care Innovation Initiative has 3 strategies

- **Primary care transformation** focuses on the role of the primary care provider in promoting the delivery of preventive services and managing chronic illnesses over a continuum of time. The initiative is developing an aligned model for-
 - patient centered medical homes (PCMH),
 - health homes for Serious and Persistent Mental Illness, and
 - hospital and ED admission/discharge/ transfer provider alerts to be implemented statewide.
- **Episodes of care** focus on the health care delivered in association with acute healthcare events such as a surgical procedure or an inpatient hospitalization. Episodes encompass care delivered by multiple providers in relation to a specific health care event.
- The **long-term services and supports** (LTSS) component focuses on improving quality and shifting payment to outcomes-based measures for the QulLTSS program and for enhanced respiratory care.



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<http://www.tn.gov/tenncare/HCFA/>

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Payment Reform in TN

Supported by a CMS SIM Grant – New Award of \$65M

- Administered by TennCare HCFA
- Timeline- Begins in 2014 –extends through 2018
- Goal- Move payment for health services to an outcomes based method= VALUE
- Goal – across all payers and all lines of business

<http://www.tn.gov/tenncare/HCFA/>

Payment Reform in TN

- Two components
 - Population health strategy- the PCMH
 - Specific services- Episodes of Care
- For both -Payment will reward both Cost savings (gain share) and Quality (quality thresholds)
- Has downside risk- high cost providers will pay back money
- 2014- First 3 Episodes launched- Total joints, Asthma, Maternity
- 2015- COPD, PCTI, Colonoscopy, Cholecystectomy
- Future - 2016 episodes include URI, Otitis, Pneumonia, ADHD

<http://www.tn.gov/tenncare/HCF/A/>

Episode of Care Payments

- The Episode is Defined- Otitis Media
- Quality metrics are selected for the episode- with targets thresholds
- The cost of an episode is measured (OV, Specialty care, lab, imaging, Drugs, OP surgery, Inpatient admissions) and all episodes for a given timeframe are averaged
- Your group's average is risk adjusted and compared to the cost of all other groups.
- Thresholds are set for the episode
- You are average, below average (good) , or above average (bad)
- Risk Sharing- If above the average cost threshold, you pay back
- If below the average cost threshold, you get a reward IF you have also passed the Quality "Gate"

<http://www.tn.gov/tenncare/HCF/A/>



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CMS Payment Reform Pilot in Maryland



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Perspective

Maryland's Global Hospital Budgets — Preliminary Results from an All-Payer Model

Ankit Patel, J.D., Rahul Rajkumar, M.D., J.D., John M. Colmers, M.P.H., Donna Kinzer, B.S., Patrick H. Conway, M.D., and Joshua M. Sharfstein, M.D.

N Engl J Med 2015; 373:1899-1901 | November 12, 2015 | DOI: 10.1056/NEJMp1508037

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NEJM: CMS Maryland pilot lowering costs

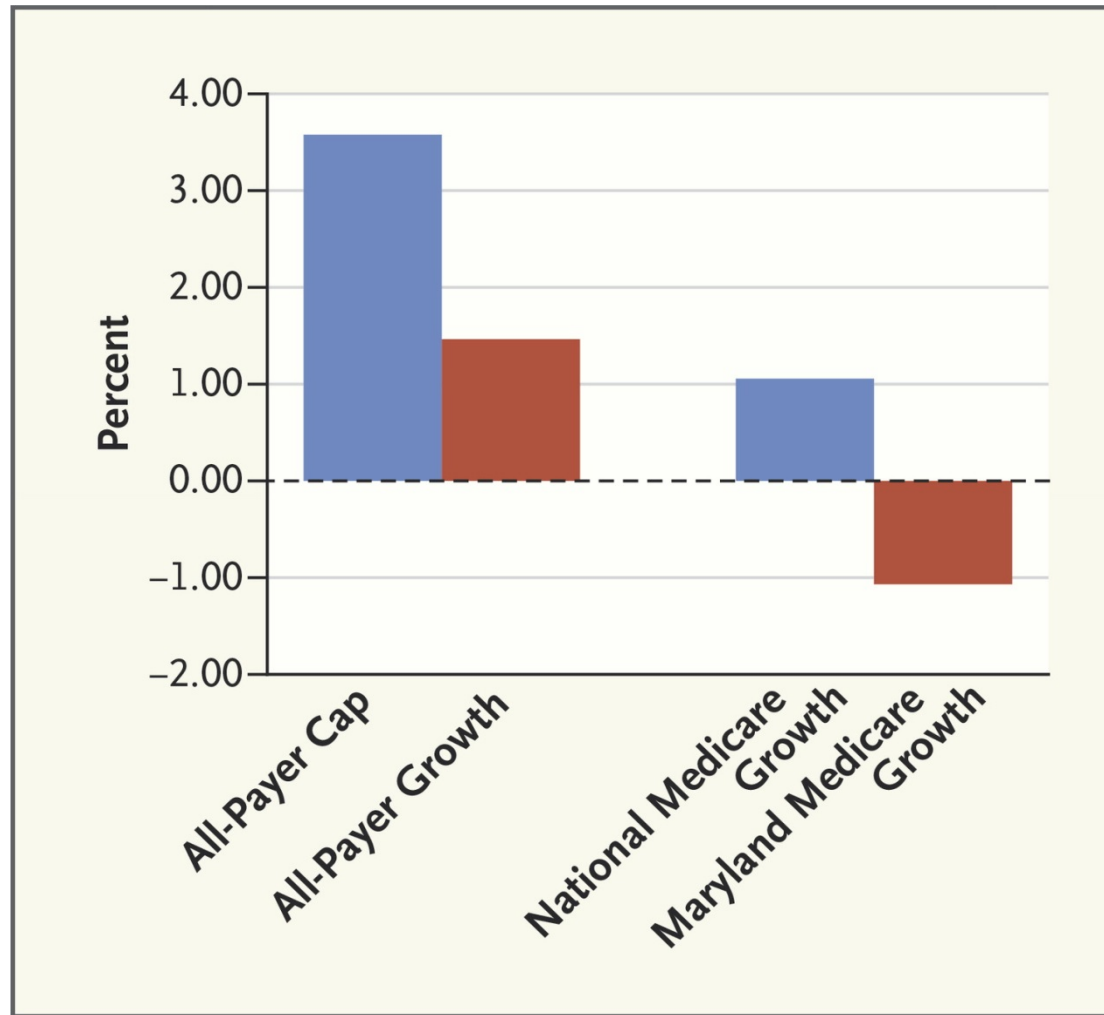
- **2014: CMS** and State of Maryland reached a five-year deal to create a system under which all payers set global budgets for hospitals to cover both inpatient and outpatient care for each year.
 - “Voluntary” program- within six months, every hospital in the state signed up to scrap fee-for-service reimbursement.
- **First year results (preliminary data)**
 - The program saved Medicare \$116 million in 2014, more than one-third of the \$330 million Maryland promised to save CMS over five years.
 - In addition, during the initiative's first year:
 - All-payer spending growth per capita in Maryland was about 1.45%, more than two percentage points below CMS' annual target;
 - Medicare per beneficiary hospital costs decreased in the state by slightly more than 1%, while such costs went up nationally by about 1%;
 - The readmissions rate among Medicare beneficiaries dropped faster than the national average, (although it still remains above the national average)



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Growth of Per Capita Hospital Costs, 2014.



Patel A et al. N Engl J Med 2015;373:1899-1901.

Maryland next steps: full continuum of care

NEJM: Patel, Conway & Sharfstein

- The terms of Maryland's agreement with CMS require the state to transition to a model that will reduce costs and improve quality over the full spectrum of care — not just hospital services — by 2019.
- CMS has empowered Maryland to develop its own payment models.
 - CMS promoting delivery-system transformation models, such as bundled-payment initiatives and patient-centered medical homes.
- CMS is committed to working with Maryland to design and launch new all-payer payment models that connect all health care providers, hospital and nonhospital, through value-based care models appropriate for the state's rate-setting system.
 - Maryland can also integrate local delivery-system reform efforts with public health activities and regional collaboration efforts to build the infrastructure to support these new approaches.
 - The global budget program promises to catalyze such integration. Through their fixed and guaranteed budgets, hospitals can offer providers incentives such as per-member per-month payments, shared savings, or capital funding for investments in care redesign.



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CMS: Bundled payment to hospitals/health systems for surgical episodes of care (2016)

- 2015: CMS finalizes bundled payment initiative for hip and knee replacements (begins 4/1/2016)
 - 2014: Over 400,000 Medicare beneficiaries underwent hip or knee replacement (\$ 7B just for hospitalization)
 - Wide variation in cost (\$16.5K - \$33K) and complications
- CJR: Comprehensive Care for Joint Replacement (CJR) begins 4/1/2016
 - Hospitals received payment and responsible for care from surgery through recovery- coordinating care (& payment) of hospital, physicians, home health agencies, skilled nursing facilities and other providers.
 - Hospitals with strong quality and spending performance will receive additional payment; if not, potential repayment to Medicare...



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Opportunities & Challenges for Pediatric Practices

- Maximizing fee-for-service revenues today
- Positioning for new value-based payment models- coming soon locally
- Developing practice and health system infrastructure, resources & experience to manage both within your practice AND across pediatric continuum of care for measurably better care and cost outcomes and patient engagement and satisfaction

