FEATURE

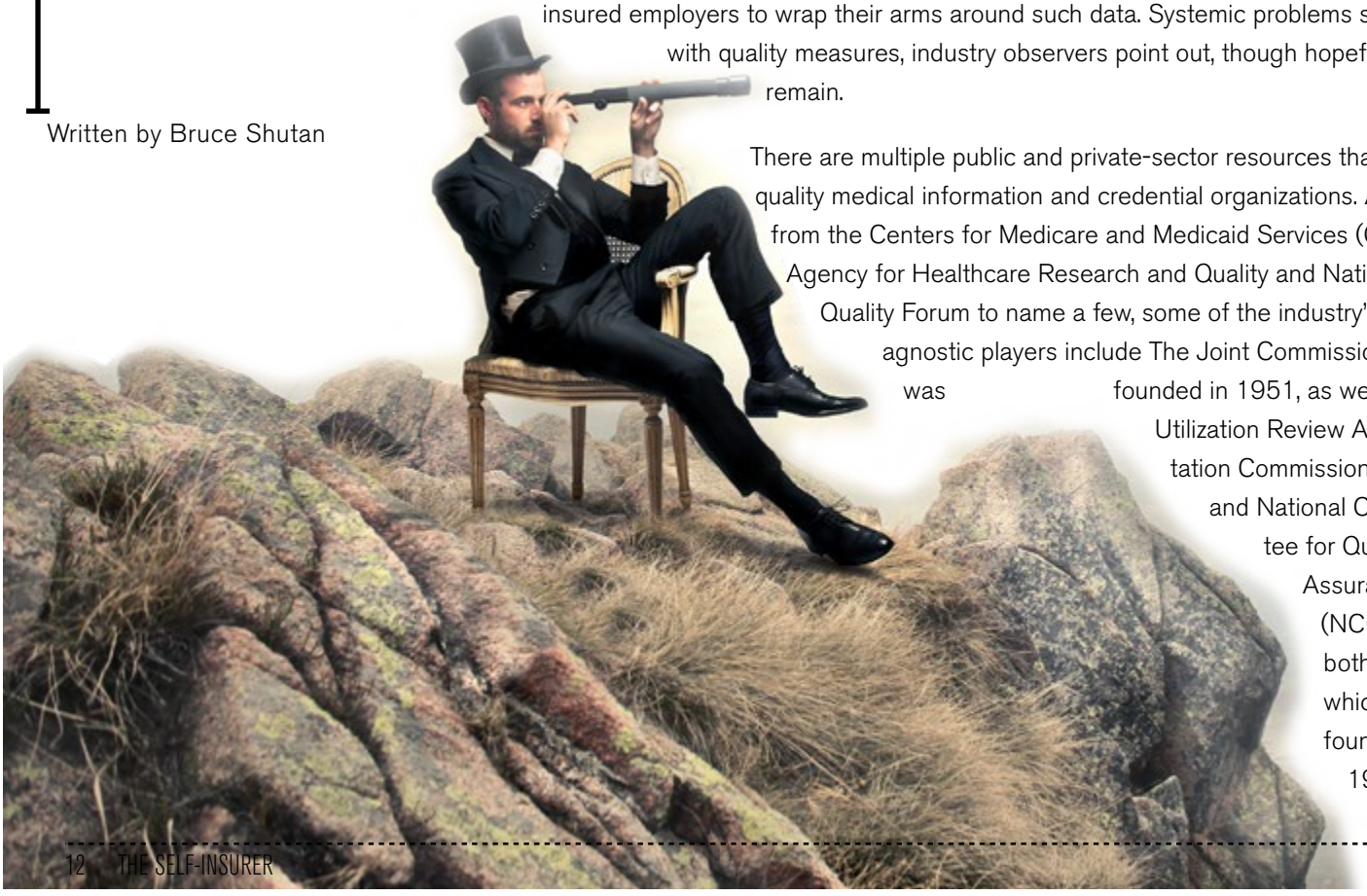
In Search of Health Care's Holy Grail

CONSENSUS IS BUILDING THAT DIRECT CONTRACTING WITH THE HIGHEST QUALITY PROVIDERS WILL NOT ONLY IMPROVE CLINICAL OUTCOMES BUT ALSO BEND THE COST CURVE. WHILE COMPREHENSIVE AND STANDARD MEASURES ARE ELUSIVE, PROGRESS IS BEING MADE.

Written by Bruce Shutan

The insatiable quest to slash employee health care costs can undermine health plan management if cost-sharing strategies drive plan design. That's why employers increasingly have realized that improving clinical outcomes is the more prudent path to that corporate objective.

The key to arriving at this coveted destination is through assessing quality of care. However, it has proven challenging for both fully insured and self-insured employers to wrap their arms around such data. Systemic problems still exist with quality measures, industry observers point out, though hopeful signs remain.



There are multiple public and private-sector resources that vet quality medical information and credential organizations. Apart from the Centers for Medicare and Medicaid Services (CMS), Agency for Healthcare Research and Quality and National Quality Forum to name a few, some of the industry's leading agnostic players include The Joint Commission, which was founded in 1951, as well as the Utilization Review Accreditation Commission (URAC) and National Committee for Quality Assurance (NCQA), both of which were founded in 1990.

These organizations largely focus on a multitude of disease-specific related outcomes, though apples-to-apples comparisons are highly elusive. "Some of them are actually measuring similar things, but not exactly the same, which makes it extremely complex to be able to appropriately report," explains Stephen Parodi, M.D., chairman of the Council of Accountable Physician Practices (CAPP), an affiliate of the AMGA Foundation, as well as a physician executive at Kaiser Permanente specializing in infectious disease.


Karen Marlo

In addition, there are several service providers focusing on quality data such as Quantros, which a panelist at SIIA's national conference in Austin last year described as the only one that aggregates quality info from both CMS and commercial payer populations. Others include Emperica, Embold Health, Grand Rounds and Accolade, which recently acquired MD Insider.

"Add on to it all of the money flowing from Silicon Valley into tools for employers, and it's pretty impressive," observes Karen Marlo, president of Resigility LLC and an employer relations consultant to NCQA. "There are a lot of people investing in these apps to change behavior."

NCQA's initial mission was to help large U.S. employers select a quality HMO. A year later the group created the Healthcare Effectiveness Data and Information Set known as HEDIS whose more than 90 evidence-based metrics determine health plan performance.

But some health care leaders say less is more when it comes to measuring quality. For example, CAPP would like the industry to adopt fewer but more meaningful measures. For example, Parodi notes that several CAPP groups are assessing physical and cognitive functions beyond an ability to perform activities of daily living instead of simply meeting, say, HEDIS measures for getting hemoglobin A1C for diabetes to a certain level. In short, they want to know whether patients are thriving rather than simply surviving.

This coalition of more than 30 of the nation's most integrated medical groups and health systems includes 80,000 physician leaders who hail from the Permanente medical groups, Mayo Clinic, Cleveland Clinic, Geisinger, Intermountain and others.

BUILDING CROSSWALKS

Quality data can help self-insured employers avoid a massive number of inappropriate medical procedures that continue to be performed across the U.S. One particularly helpful area encourages the use of imaging studies for low-back pain within the first 28 days of an incident, Marlo notes.

"Musculoskeletal is a major cost for a lot of employers," she observes. "It used to always be manufacturing. Now that so many of us sit at a desk, that lower-back pain is not discriminating and is hitting multiple segments."

There also are a series of NCQA metrics around common chronic illnesses as well as behavioral health, which she describes as "a huge issue that's bubbling up more and more in a scary way." As such, anti-depression medication management is critically important considering a lack of adherence to care among people who are hospitalized after a serious mental illness.

The focus is clearly on marrying quality and price data to steer people with chronic or serious conditions to high-quality providers with the best clinical outcomes at a reasonable cost. Indeed, the marketplace is teeming with service providers that help self-insured employers connect these moving parts.

Deerwalk, Inc., a population health, data management and health care analytics software company, mines quality data from nearly 1,000 different data sources. The information is integrated with Quantros provider quality ratings by practice area and matched against health plan claims. It's also paired with a reference-based pricing tool whose multiplier is pegged to a percentage over Medicare reimbursement, and enriched with risk scores as well as other utilization-based metrics.

Jeff Rick, chief operating officer of Deerwalk, says this approach offers "at least the raw materials" on which some meaningful reporting can be done, adding that "there's fairly significant lift to take that data out of a CMS environment and actually make it useful for an analytic purpose or for a self-insured employer,"

Jeff Rick

which he says isn't for the faint of heart.

"One of the things we very quickly realized is that the provider IDs provided by Quantros, and by extension CMS, are not NPIs [national provider identifiers) or anything of the sort," Rick explains. "So we had to spend a significant amount of time building that crosswalk between those and maintaining the crosswalk between those IDs."

STANDARDS AND EDUCATION

The challenge for employers is essentially twofold, according to Marlo. She says one involves making sense of quality data in the absence of standardized metrics. A seasoned health industry executive couldn't agree more.

Scott Ray, CEO of 6 Degrees Health who previously worked in a transplant centers-of-excellence network, doesn't have much confidence in today's quality metrics. Quality data largely comes from CMS, he says, leery of the federal government's ability to master this area. Beyond that, a smattering of proprietary information is collected from commercial entities. "Why would Blue Cross want to share the quality data they have with Cigna?" Ray asks rhetorically.

Another issue is getting employee populations to use price transparency and quality data tools, which Marlo says involves a significant communication and education campaign. But that's just the tip of a larger iceberg. She recalls, for example, how one large firm confided in her a wish to simply eliminate the bottom 10% of performing network physicians.

The fact is, measuring quality isn't cut and dried. If the same procedure performed on two patients results in different outcomes, it could be based on how their bodies reacted rather than a physician's performance, Ray says. Outcomes also could be skewed. Some facilities that perform only five to 10 kidney transplants a year may have a perfect track record because they cherry pick the easiest cases and refer tough ones to the Mayo Clinic and Johns Hopkins, he explains.

In addition, Ray believes it's difficult to compare hospitals when facilities have their strengths and weaknesses and may not ace every procedure. Indeed, there's tremendous complexity lurking in the health care system. In the case of organ transplants, pre- and post-op considerations must be assessed alongside the actual procedure. "It's not just having a great surgeon; it's about having all these other components," he explains.

Whereas deciphering the worst and mediocre health care facilities is fairly straight forward based on current quality data, identifying the best performers is tricky "because we don't have the full picture," explains Rob Archibald, the company's chief technology officer.

6 Degrees Health, whose software platform features transparent hospital financial and quality data, is in discussions with Quantros and other vendors to determine the best way to move forward with quality data.

SEALS OF APPROVAL

That path ultimately hinges on credentials and track records. Self-insured employers should consider the accreditation status of organizations when making direct contracting decisions, suggests Mark A. Crafton, executive director for The Joint Commission's Strategic Alliances Division of Business Development, Government and External Relations. He says The Joint Commission's Gold Seal of Approval will help them "identify organizations that have met national standards associated with improved clinical quality enhanced patient safety."


Mark Crafton

Performance measurement and review of clinical quality data is an inherent aspect of all accreditation and certification programs associated with The Joint Commission, which accredits more than 22,000 organizations nationwide.

"Organization performance on standardized measure sets is evaluated during the accreditation survey and for disease-specific certification, during both the on-site review and mid-cycle engagement," Crafton explains. "Standards within the Performance Improvement chapter of all manuals require organizations to make PI a priority, establish targets of acceptable performance and make demonstrable improvements."

Several Joint Commission certification programs require participation in national clinical registries that can be used to benchmark performance against national, state and regional peer groups, as well as organizations with similar characteristics. The Joint Commission requires registry participation in most cardiac certification products, and total hip and knee replacement, Crafton adds.

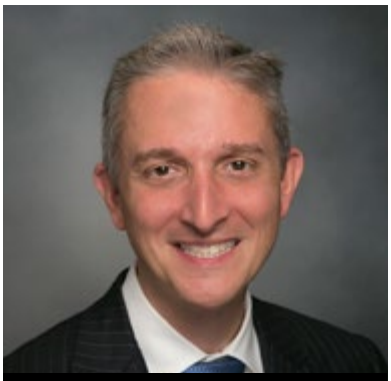
ESTABLISHING QUALITY INCENTIVES

But providing quality information isn't enough "to move market share and help consumers get to high-value providers," cautions Cheryl DeMars, CEO of an employer-owned nonprofit cooperative known as The Alliance. "That's why we established our Quality Path Program, which focuses on about 70 shop-able tests and procedures, and first assesses quality of care, not only at the hospital level, but individual physician level, using a high bar for quality."


Cheryl DeMars

Physicians and hospitals that pass muster move on to the contracting phase wherein lower bundled prices with warranties for care are negotiated based on the Alliance's purchasing power. The group, which is nearly 30 years old, features more than 240 self-funded employers. Members are scattered across Wisconsin, northern Illinois and eastern Iowa where almost 100,000 covered lives receive care from providers whose compensation is tied to performance and not volume. These self-insured groups are able to save an estimated 10% 14% of their total health care spend.

"We use quality information, coupled with price, to help our employers implement incentives, primarily through plan design, to create a pathway for their employees to go where care is good and costs are lower," DeMars reports.



Stephen Parodi

The Alliance uses quality measures produced by CMS, as well as medical specialty societies in orthopedics and other key areas, to find best available information that matters to both consumers and employers. Ideally, she says it's best that providers accept any quality methodology or assessment being used as "valid and a fair reflection of the care that they deliver."

While mounting demand for health care transparency serves as a tailwind for quality measurement engines, DeMars believes the recently introduced Lower Health Care Costs Act could strengthen that effort with the establishment of a national data warehouse.

In spite of obstacles to health data quality measurement, Parodi is sanguine about the future. He already has seen "demonstrable improvements," citing a recent paper published by the National Bureau of Economic Research. Groups that are integrated and multi-specialty in nature saw about a 36% reduction in Medicare expenditures relative to single-physician practices, the report noted, which squares with CAPP's mission. ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.