Value-Based Care in Managing Type 2 Diabetes (T2D):
From Healthcare System Dynamics to Quality Measures

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Johnson & Johnson Healthcare Systems
Introduction to Value-Based Care
Forces Driving Demand for Value-Based Care

**RISING COSTS**
- New treatments, technologies
- Employer challenges paying for healthcare
- Increased out of pocket, no improvement in outcomes

**MISALIGNED PAYMENT**
- Based on volume, not quality
- Payment system encourages misaligned incentives

**LACK OF INFORMATION**
- Minimal public information on quality, cost
- Incomplete data at point of care to support good decision-making
- Lack of data infrastructure to gather or share

**VARIABLE TREATMENT**
- Insufficient evidence on precision medicine
- Treatment varies; providers not adhering to best practices
- Quality by geography

HEALTHCARE INEFFICIENCIES
ACA Mandated that HHS Create a National Strategy for Healthcare Reform, Lead by CMS

HEALTHCARE REFORM
THE AFFORDABLE CARE ACT (ACA)

Department of Health and Human Services (HHS)

Public Stakeholders

Private Stakeholders

http://www.ahrq.gov/workingforquality/about.htm
IHI and NQS Triple Aim Strategies Simultaneously:

Improve

Lower

Population Health

Affordable Care

Quality Of Care

Improve

The IHI Triple Aim framework was developed by the Institute for Healthcare Improvement in Cambridge, Massachusetts (www.ihi.org). http://www.ahrq.gov/workingforquality/about.htm

Johnson & Johnson | DIABETES INSTITUTE, LLC
National Quality Strategy
The Triple Aim and Six Quality Priorities

Better Care
- Making care **safer** by reducing harm caused in the delivery of care.
- Ensuring that each person and family are **engaged** as partners in their care.
- Promoting effective communication and **coordination of care**.

Healthier People
- Promoting the most **effective** prevention and treatment practices for leading causes of mortality
- Working with **communities** to promote wide use of best practices to enable healthy living.

Smarter Spending
- Making quality care **more affordable** for individuals, families, employers, and governments

http://www.ahrq.gov/workingforquality/index.html
CMS Goal-Setting: Better Care, Smarter Spending, Healthier People

Incentives
• Promote value-based payment systems
  – Test new alternative payment models
  – Increase linkage of Medicaid, Medicare FFS, payments to value
  – Bring proven payment models to scale

Care Delivery
• Encourage the integration and coordination of services
• Improve population health
• Promote patient engagement through shared decision making

Information
• Create transparency on cost and quality information
• Bring electronic health information to the point of care for meaningful use

Evolution of Medicare-Based Programs

Category 1: FFS
Limited in Medicare FFS

Category 2: FFS – Link to Quality
PQRS VM

Category 3: Alternative Payment Models
ACOs PCMHs

Category 4: Population-Based Payment
Eligible Pioneer ACOs (year 3-5)

INCENTIVES: Target For ‘Fee-For-Service Linked to Quality’ and ‘Alternative Payment Models’ by 2016 and 2018

Polling Question 1:

Can fee-for-service payment model be associated with quality care?

A. Yes
B. No
MACRA: Medicare Access and CHIP Reauthorization Act of 2015 and Quality Care

Bipartisan Legislation Signed into Law in 2015

MIPS = Merit-based Incentive Payment Systems

- Repeals the Sustainable Growth Rate Formula
- Establishes new value-based framework
- Changes Medicare-based payments
- Pertains to Medicare Part B participants
- Allots bonus payment structure for APMs
- Streamlines the system (MIPS)


Two new payment systems will emerge by 2019

**Track 1:**

**FFS and Merit-Based Incentive Payment System**

- Advancing Care Info, 25%
- Clinical Practice Improve Activities, 15%
- Cost, 10%
- Quality, 50%

- ± 4% in 2019
- ± 9% in 2024

**Track 2:**

**Participation in Qualifying Alternative Payment Models**

MDs must receive a significant share of payments through an APM that:

- is risk-bearing, or
- is a medical home, and
- has a quality component and use EHR

- 50% in 2018
- 90% in 2024

**MIPS Exempt**

- 5% Bonus 2019-2024

Consolidates existing programs: EHR Meaningful Use, Physician Value-Based Modifier, Physician Quality Reporting System


The “Math” of Value and Behavior Change; The Quandary of Misaligned HCP Accountabilities

\[ M + I = B \]
\[ V = \frac{Q}{C} \]

Value Based

Traditional FFS

Value-Based Purchasing, Bundled Payments (M+I)

Shared Risk / ACO (M+I)

Measures + Incentives = Behavior Change

\[ M + I = B \]

Value = Quality of Care / Cost of Care

\[ V = \frac{Q}{C} \]

Polling Question 2:

True or False – a provider can only be accountable for one performance program at a time.

A. True
B. False
Medicare Star and HEDIS Measures
Medicare Star Ratings

• Medicare Advantage (MA) and Prescription Drug Plans (PDP) are measured across multiple quality and outcomes measures

• A star rating is assigned to each plan based on their measured performance

  ★★★★★  Excellent
  ★★★★    Above Average
  ★★★     Average
  ★★       Below Average
  ★        Poor

• Medicare Advantage plans can receive bonus payments, only if 4 or 5 star

Medicare Advantage Plan Star Ratings and Bonus Payments in 2012 – Data Brief, Page 1-2; Kaiser Family Foundation.
Medicare Star Domains

• Star ratings are based on plan performance across several domains
  • Part D/PDP plans have 4 domains
  • Part C/Health plans have 5 domains

<table>
<thead>
<tr>
<th>Medicare Health Plan Domains (Part C)</th>
<th>Medicare PDP Domain (Part D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staying Healthy: Screenings, tests and vaccines</td>
<td>1. Member experience with drug plan</td>
</tr>
<tr>
<td>2. Managing chronic conditions</td>
<td>2. Drug pricing and patient safety</td>
</tr>
<tr>
<td>3. Plan responsiveness and care</td>
<td>3. Customer service</td>
</tr>
<tr>
<td>4. Member complaints, problems getting services, and choosing to leave the plan</td>
<td>4. Member complaints, problems getting services, and choosing to leave the plan</td>
</tr>
<tr>
<td>5. Customer service</td>
<td></td>
</tr>
</tbody>
</table>

Medicare Advantage Plan Star Ratings and Bonus Payments in 2012 – Data Brief, Page 1-2; Kaiser Family Foundation.
Medicare Star Measures

- There are 47 quality measures that account for a plan’s overall Star rating (HEDIS®, CAHPS®, and HOS)
- Data is on a two-year lag
- Measures (weights) related to diabetes

Diabetes Care – Eye Exam (1.0)
Diabetes Care – Kidney Disease Monitoring (1.0)
Diabetes Care – Blood Sugar Controlled (3.0)
Adherence to Hypertension Meds (3.0)
Part D Medication Adherence for Oral Diabetes Medications (3.0)
Adult BMI Assessment (1.0)
Blood Pressure Controlled (3.0)

Medicare Stars: Health & Drug Plan Quality and Performance Ratings 2015; Part C & Part D Technical Notes;
Medicaid Core Set of Measures: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, Draft posted 8/5/2014
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2016_Star_Ratings_Measure_List.pdf
Star Ratings High Stakes Market Implications

Decreasing stars leads to competitive disadvantage

- Quality bonus payments (MA-PD)
- Complaints and disenrollment
- Poor overall performance (< 3 stars for 3 years in a row)
  - Low-performer icon (“scarlet letter”)
  - Enrollee notification
  - Removal

<table>
<thead>
<tr>
<th>Star Rating</th>
<th>Complaints/1,000</th>
<th>% Disenroll Annually</th>
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</thead>
<tbody>
<tr>
<td>★★</td>
<td>0.91</td>
<td>21.5%</td>
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<tr>
<td>★★ ½</td>
<td>0.55</td>
<td>17.48%</td>
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<tr>
<td>★★★</td>
<td>0.42</td>
<td>14.79%</td>
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<tr>
<td>★★★ ½</td>
<td>0.33</td>
<td>9.27%</td>
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<tr>
<td>★★★★</td>
<td>0.22</td>
<td>6.92%</td>
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<tr>
<td>★★★★ ½</td>
<td>0.15</td>
<td>4.89%</td>
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<tr>
<td>★★★★★</td>
<td>0.16</td>
<td>1.91%</td>
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</table>

The Value of Medicare Star Rating

Case Example

The value of 5 stars

Case example: In Worcester County, Massachusetts, 5-star plans receive approximately $8 per month per member more than 4.5-star plans. For one community health plan with its 28,000 members, increasing the plan rating by 0.5 star could mean additional revenue totaling $2.7 million a year. An added benefit of being rated a 5-star plan is the ability to enroll members all year, which could serve as a competitive advantage.

Medicare Plan Star Rating diabetes measures

Percentage of patients with diabetes:
• Who had a retinal or dilated eye exam
• Who were monitored for kidney disease or who had received medical attention for nephropathy
• With A1C >9% or who were not tested
• With LDL-C ≤100 mg/dL
• Who had an LDL-C screening test
• Who take oral diabetes medications as directed

*Medicare Advantage enrollees age 18-75
†Medicare Part D plan members

Polling Question 3:

Medicare Star Ratings:

A. Are comprised, in part, of HEDIS measures
B. Are a subset of HEDIS measures
C. Are based on measures with different weights
D. A and C
E. B and C
F. All of the above
National Committee for Quality Assurance and HEDIS

- NCQA recognition affects over 136 million people (43% of US population)
- Many employers – especially the Fortune 500 – do business only with NCQA-Accredited plans
- NCQA accreditation requires HEDIS reporting
- HEDIS reporting allows for standardized measurement and reporting for comparison purposes

HEDIS Measures
Seven Domains

- Electronic data clinical systems
- Access of care
- Experience of care
- Relative resource use
- Utilization
- Health Plan Descriptive
- Effectiveness of care

NCQA HEDIS 2016-17 Diabetes Measures and National Plan Performance

**T2D Measures**

- **HbA1c**
  - Testing
  - Poor control: HbA1c > 9%
  - Good Control: HbA1c < 8%
  - For selected populations: <7%
- Retinal eye exam
- Statin therapy
- Diabetes screening for individuals with neuro disorders
- Relative resource use (ED visits, for example)
- Nephropathy screening or evidence of nephropathy
- BP control <140/90 mmHg

**Ratings Results [ALL MEASURES]**

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<thead>
<tr>
<th>Performance</th>
<th>1.0</th>
<th>1.5</th>
<th>2.0</th>
<th>2.5</th>
<th>3.0</th>
<th>3.5</th>
<th>4.0</th>
<th>4.5</th>
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<tbody>
<tr>
<td>Private/Commercial Health Plans</td>
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</tbody>
</table>

Adapted from: [http://healthinsuranceratings.ncqa.org/2015/default.aspx](http://healthinsuranceratings.ncqa.org/2015/default.aspx)


CASE STUDY: Impact of HEDIS Diabetes Quality Measures

A Midwestern health plan case study: HEDIS® Measure for Comprehensive Diabetes Care

<table>
<thead>
<tr>
<th></th>
<th>PRE-PROGRAM</th>
<th>POST-PROGRAM</th>
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<tbody>
<tr>
<td></td>
<td>Rate</td>
<td>Benchmark</td>
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<tr>
<td>HbA1c Testing</td>
<td>87.6%</td>
<td>86.6%</td>
</tr>
<tr>
<td>Poor HbA1c Control</td>
<td>27.3%</td>
<td>26.1%</td>
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<tr>
<td>Eye Exams</td>
<td>54.5%</td>
<td>66.4%</td>
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<tr>
<td>Lipid Profile</td>
<td>79.1%</td>
<td>80.0%</td>
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<tr>
<td>Lipid Control (LDL &lt;130 mg/dL)</td>
<td>49.9%</td>
<td>48.4%</td>
</tr>
<tr>
<td>Monitoring Nephropathy</td>
<td>35.8%</td>
<td>56.0%</td>
</tr>
</tbody>
</table>

http://www.ncqa.org/publications-products/other-products/quality-profiles/focus-on-diabetes/addressing-the-quality-gaps#sthash.nf4eAySM.dpuf
Medicare Star Ratings vs. HEDIS Ratings

**BOTH**

- Leverage WEIGHTED quality measure sets
- Primary AND secondary accountabilities (plan trickle-down)
- Possess INDIRECT financial/competitive advantages

Developed by CMS, comprised of various measure sets, including some HEDIS (11)
• Accreditation AND directly linked to payment
• Applicable to Medicare Part C/D

Medicare Star Ratings vs. HEDIS Ratings

Developed by NCQA, and used for accreditation for plans and providers (ACO, PCMH, etc)
• Accreditation only, not directly linked to payment
• Reaches across >90% plans nationally, private and public

Leverage WEIGHTED quality measure sets
Primary AND secondary accountabilities (plan trickle-down)
Possess INDIRECT financial/competitive advantages
T2D Quality Measures
Definition of a Performance Measure

“A healthcare performance measure is a way to calculate whether and how often the health and healthcare system does what it should.”

Constructing a Measure

National Quality Foundation

Types of T2D Performance Measures

National Quality Foundation Definition

**Structural Measures**
Assess healthcare INFRASTRUCTURE

**Example:** The % of physicians in a practice who have systems to track and follow patients with diabetes

**Process Measures**
Assess STEPS that should be followed to provide good care

**Example:** The percentage of patients with diabetes who have had an annual eye exam in the last year

**Outcomes Measures**
Assess the RESULTS of healthcare that are experienced by patients

**Example:** The percentage of diabetes patients who are blind or have compromised vision

T2D Measures at the Intersection of Key Programs: Stars, ACO/PCMH and Commercial Plan Accreditation

**ACO/PCMH**
- HbA1c
- All-cause unplanned diabetes admissions

**MEDICARE STAR**
- Adherence to diabetes treatment
- Adherence to blood pressure treatment

**HEDIS**
- HbA1c Testing
- HbA1c <8%
- HbA1c <7% (select populations)
- Statin treatment for patients with diabetes

**Common To All:**
- Minimize HbA1c >9%
- BP < 140/90 mmHg
- BMI Assessment
- Eye Exam
- Kidney Disease Screening And Monitoring

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http://www.ncqa.org/portals/0/hedisqm/RRU/NCQA_Calculates_the_RRU_Quality_Index.pdf
# ACO Quality Measures for 2016

<table>
<thead>
<tr>
<th>Measure #</th>
<th>Description</th>
<th>Measure #</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACO - 8</td>
<td>Risk-Standardized, All Condition Readmission</td>
<td>ACO - 17</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
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<tr>
<td>ACO - 35</td>
<td>Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)</td>
<td>ACO - 18</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan</td>
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<tr>
<td>ACO - 36</td>
<td>All-Cause Unplanned Admissions Diabetes</td>
<td>ACO - 19</td>
<td>Colorectal Cancer Screening</td>
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<tr>
<td>ACO - 37</td>
<td>All-Cause Unplanned Admissions For Patients With Heart Failure</td>
<td>ACO - 20</td>
<td>Breast Cancer Screening</td>
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<tr>
<td>ACO - 38</td>
<td>All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions</td>
<td>ACO - 21</td>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented</td>
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<tr>
<td>ACO - 9</td>
<td>Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI))</td>
<td>ACO - 42</td>
<td>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease</td>
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<tr>
<td>ACO - 10</td>
<td>Ambulatory Sensitive Conditions Admissions: Heart Failure (AHRQ Prevention Quality Indicator (PQI))</td>
<td>ACO - 40</td>
<td>Depression Remission at Twelve Months</td>
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<tr>
<td>ACO - 11</td>
<td>Percent of PCPs who Successfully Meet Meaningful Use Requirements</td>
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<tr>
<td>ACO - 39</td>
<td>Documentation of Current Medications in the Medical Record</td>
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<td>ACO - 13</td>
<td>Falls: Screening for Future Fall Risk</td>
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<tr>
<td>ACO - 14</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
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<tr>
<td>ACO - 15</td>
<td>Pneumonia Vaccination Status for Older Adults</td>
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<td>ACO - 16</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up</td>
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<tr>
<td>ACO - 1</td>
<td>CAHPS: Getting Timely Care, Appointments, and Information</td>
<td>ACO - 5</td>
<td>CAHPS: Health Promotion and Education</td>
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<tr>
<td>ACO - 2</td>
<td>CAHPS: How Well Your Doctors Communicate</td>
<td>ACO - 6</td>
<td>CAHPS: Shared Decision Making</td>
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<tr>
<td>ACO - 3</td>
<td>CAHPS: Patients’ Rating of Doctor</td>
<td>ACO - 7</td>
<td>CAHPS: Health Status/Functional Status</td>
</tr>
<tr>
<td>ACO - 4</td>
<td>CAHPS: Access to Specialists</td>
<td>ACO - 34</td>
<td>CAHPS: Stewardship of Patient Resources</td>
</tr>
</tbody>
</table>

Note: Composite ACO measures follow **All or Nothing Scoring**: the minimum performance threshold for each component of the composite measure must be met to qualify.

[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-QM-Benchmarks-2016.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-QM-Benchmarks-2016.pdf)
Considerations: Future T2D Measure Designs

- Outcomes-driven
- Composite Structure
- Appropriate HCP accountability
- PRO-based
- Flexible > Static
Bringing it all Together
Ecosystem Quality Management of T2D
Pharmacy’s Role in Delivery of Quality Care

Pharmacy Quality Alliance
- Develops measures of safe and appropriate medication use
- Subset adopted for Medicare Star [pricing & safety domain]

Medicare Star Contract Strategies
- Pay for Performance – bonus payment based on star performance
- Preferred pharmacy network -- performance of chain or stores 
  “SECONDARY ACCOUNTABILITY”

NCQA
- Connected Care program – recognition for connectedness in the “medical community”
- Health Information Products – certification for appropriate understanding of pharmacy benefits

http://pqaalliance.org/about/default.asp
http://www.ncqa.org/programs/recognition/practices/patient-centered-connected-care
http://www.ncqa.org/programs/certification/health-information-products-hip
http://www.morx.com/star-ratings-overview
Ecosystem’s Role in Delivering Quality T2D Care

Pharmacy

- Develop as extension of care team
- Drive MTM and adherence
- Continue to support quality through primary and secondary accountabilities

Patient
Ecosystem’s Role in Delivering Quality T2D Care

Measure Developers

- Continue to evolve measures (process-outcomes)
- Use patient data capture for per-patient outcomes
- Ensure appropriate accountabilities
Ecosystem’s Role in Delivering Quality T2D Care

- Payer

  - Embrace population health management
  - Improve patient engagement and experience
  - Share patient data to the ecosystem to help drive better patient outcomes
Ecosystem’s Role in Delivering Quality T2D Care
Hospital System and HCPs

- Improve health information systems
- Drive care coordination, especially during expansion / consolidation
- Positively engage patients

Patient
Ecosystem’s Role in Delivering Quality T2D Care

- Develop treatments that help drive ecosystem quality
- Develop supporting solutions that improve T2D quality care
- Utilize patient-centric approach to development
Ecosystem’s Role in Delivering Quality T2D Care

Employer

- Sponsor diabetes prevention wellness programs
  - Implement value-based benefit design
  - Promote quality reports on HCPs and hospitals

Patient
Healthcare Ecosystem’s Role In The Triple Aim

Put the patient first
Integrate data
Shared population management
Patient self-management
Care Coordination
Embrace Quality-based care

T2D Patient