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POLICY BRIEF

The Clinical Performance Improvement Initiative

Massachusetts Group Insurance Commission

Introduction

> "The performance failures of our healthcare system are largely invisible and will continue to be invisible as long as we do not have a system that allows us to track cost-efficiency and quality performance of the providers and organizations that are central suppliers of our healthcare."
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> - Pacific Business Group on Health (PBGH), 2005

The Massachusetts Group Insurance Commission (GIC) has embarked on a groundbreaking plan to control costs, improve healthcare quality, and promote cost-efficiency. Labeled the Clinical Performance Improvement (CPI) Initiative, this multi-year effort has the potential to save the Commonwealth and its enrollees tens of millions of dollars, while improving the quality of care.

The Problem

The rising cost of healthcare may be the single greatest fiscal problem facing governments and the private sector in the United States today. Healthcare now consumes 16 percent of the nation's GDP, and it is projected to absorb 18 percent by 2012 and 20 percent within the next decade. The combination of double-digit increases in healthcare costs and slumping state revenues has forced state governments to drop hundreds of thousands of people from public health insurance programs. Meanwhile, private employers have cut back and, in some cases, eliminated health insurance for employees and retirees altogether.

The Roe Better Government Network researches and distributes public policy solutions for the benefit of the New England states. The Roe Papers are selected from among the most intriguing and original submissions to Pioneer Institute's annual Better Government Competition. Pioneer works with each submission's author to develop their ideas into detailed, actionable policy proposals.

We are appreciative of the Roe Foundation's generous support for this initiative. Their sustained funding has enabled Pioneer to vet these ideas with policy makers and experts as well as legislators and executive officials.

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From fiscal 1999 through fiscal 2003, the Commonwealth's Medicaid expenses climbed by almost $2 billion (or 47 percent), despite reductions in the types of services and the number of enrollees covered. For state employees and retirees, the average per enrollee cost of health insurance jumped by 35 percent (from $4,428 to $5,996) while the national average cost of employer-sponsored health insurance surged by 50 percent. The Group Insurance Commission (GIC), the public agency responsible for providing insurance to the state's 266,000 state employees, retirees and dependents, now spends more than $1 billion annually for enrollees' health insurance.

Compounding the challenge of achieving cost containment in the nation's most expensive state for healthcare, the GIC is faced with certain operational and political barriers. First, the Legislature, not the GIC, controls the premium contribution rate. Second, the GIC, which has steadily implemented higher deductibles, co-payments, and tiered pharmacy benefits, has reached a point at which further cost shifting to enrollees will do little to promote prudent utilization or significantly affect the cost of healthcare. And third, the GIC operates within an environment in which there is an expectation of comprehensive benefits.

While healthcare costs continue to climb, a body of evidence has emerged showing that Americans do not always receive the highest quality of care. Research has unearthed wide variations in the care received in American hospitals and doctors' offices.

At the physician level, where 80 percent of healthcare decisions are controlled, there is considerable variation in practice that can lead to poor quality, inefficient delivery of care, and wasteful spending. Unlike any other market, the information that consumers need to make rational decisions is either too complex to comprehend, too difficult to find or, in most instances, simply unavailable.

The Solution

As the largest employer-based purchaser of health insurance in New England, the GIC enjoys considerable presence in the local healthcare market. The agency and its consultant, Mercer Human Resource Consulting, have worked closely with six of the seven largest private insurance carriers in Massachusetts and sought input from numerous other stakeholders (including the Massachusetts Medical Society, Massachusetts Health Quality Partners, and Massachusetts Hospital Association) to develop physician performance profiles based on quality and cost-efficiency of care.

Using standards and benchmarks defined by the health profession itself and book-of-business claims information from the six health plans with whom the GIC contracts, the agency and Mercer have assembled a database that contains over nine million complete episodes of care and well over 120 million de-identified health claims. This may be the largest multi-payer data set in the United States used expressly for the purpose of analyzing cost-efficiency and quality.

While the American Diabetes Association suggests that 25 patients per doctor per condition is sufficient to identify significant differences between providers, the GIC uses at least 30 unique episodes per doctor to draw statistically robust answers to questions of provider quality and cost-efficiency. In fact, as a result of data aggregation, over half (56 percent) of the physicians in the Commonwealth have 100 or more complete episodes of care attributed to them.

The quality and cost-efficiency results for individual physicians were provided to the GIC's health plans, and it has used this information to develop various tiered physician and hospital networks, which reward enrollees with lower co-payments when care is sought from more effective and efficient providers.

Within these tiered networks, providers are divided into groups of higher and lower performing physicians and hospitals. The performance group to which a provider belongs (e.g., tier 1, tier 2, or tier 3) is then communicated to the enrollees through the plan literature, and a differential co-pay is attached to each tier to reward enrollees that seek care from higher performing providers.

By using market forces to steer care toward more efficient and effective providers, the GIC's approach provides an incentive for members to become better consumers of healthcare while at the same time engaging the provider community by assembling and distributing cost-efficiency and quality of care reports.

It is important to note that the GIC has not asked the plans to develop identically tiered products. In fact, it has encouraged the health plans to develop a variety of tiered plans, promoting a policy of "letting a thousand flowers bloom." Some health plans have tiered primary care physicians, while others have tiered specialists, and others have tiered hospitals. This range of plan designs allows market forces to work, and can enable the GIC to identify those products that best work to promote the use of higher-quality, cost-efficient providers.

The Clinical Performance Improvement Initiative represents a novel approach to tackling healthcare cost and quality problems. Few private sector plans, until now, have had enough claims experience to confidently measure efficiency and/or provider quality. As a result, tiered products, as described above, have remained a rarity in the marketplace. Only a few employers have experimented with plan designs that incorporate incentives for enrollees to switch to better-performing doctors.

An analysis by Mercer found that moving enrollees away from the least efficient and effective 15 percent of physicians to more efficient and effective doctors could generate savings of at least 7 percent in the first year, with cumulative reductions over three years that could exceed 20 percent. This may translate into savings of at least $75 million each year for the Commonwealth and our enrollees. As an early indicator of savings potential, the tiered hospital plans put in place over the past two years have already generated savings for the Commonwealth and GIC enrollees.

Going forward, the GIC will measure the success of the Clinical Performance Improvement (CPI) Initiative in a number of ways:

Cost Savings

As patients move to more efficient and effective providers, the agency will assess the effect on cost savings by measuring the reduction in per capita spending compared to the GIC's expected cost growth trend, the general rate of healthcare inflation, and the experience of similar purchasers.

Empowering the Consumer

The GIC will evaluate the impact of tiering on the shifting of enrollees to higher performing doctors by tracking movement within the plans. Also, survey data can capture information about enrollees' evolving attitudes and behavior patterns. Using relative risk scores, the GIC will also evaluate the impact that different incentive structures are having on the movement of the sickest members of the population to better performing and more cost-effective physicians and hospitals. Members of this group are those most in need of high quality care, and they also generate a disproportionate share of health care costs.

Improving Quality through Transparency

Research shows that the mere publication of provider performance data can have a significant and positive effect on physician practice patterns. Many physicians are unaware of the relative affordability of their pattern of practice and so the GIC expects that by making quality and efficiency information available, some physicians will improve their practice patterns. The GIC will monitor the movement of physicians between tiers and examine the changes within hospital and physician practices that lead to better overall performance.

With the first year of data analysis and the plan design stage completed, enrollees are currently in the process of signing up for one of the GIC's tiered health plans. As the CPI Initiative progresses, the GIC will conduct program evaluation on a continuing basis and work with other stakeholders in the state's health insurance market to refine the incentive structures and improve consumer information.

As more performance measures become available, a wider set of conditions and specialties will be incorporated into the GIC's analysis. Tiering for hospitals will become more sophisticated. Hospital performance metrics—which already include measures such as the average length of stay, illness severity, case mix, and contractual rates—may be expanded to include more condition-specific information.

Quality measures—which currently include compliance with industry standards, mortality rates, frequency of major complications, and the volume of particular procedures—will also be expanded. If the savings are, in fact, realized, the GIC will investigate the cost saving implications and potential clinical benefits of adding a pay-for-performance component to the CPI Initiative.

The GIC staff will also work with others in and out of state government to advance transparency, cost containment, and higher performance in the state's healthcare system. The GIC's experience will form the basis for collaboration with the new Health Care Quality Council, which will be created as a result of the state's landmark healthcare reform law. The GIC is also working with Mass Health to support its sister agency in its efforts to advance transparency, promote accountability, contain costs, and improve physician performance within the state's Medicaid program.

Conclusion

There is no easy solution to resolving the healthcare crisis. However, given the alternatives—reducing benefits, shifting more costs to employees, and ignoring quality variations among providers—the Clinical Performance Improvement Initiative represents an opportunity for significant cost savings and quality improvement and is being watched closely by those in the health research and insurance community as a potential model for national reform.

We recognize that in order to achieve real cost savings, not just cost shifting, every component of the healthcare system—purchasers, plans, providers, and patients—must be involved. Having the continued support of insurance carriers, the provider community, and the engagement of our enrollees as active consumers will be essential to achieving our common goals.

Although the CPI Initiative is different from traditional pay-for-performance models, it embraces the notion that transparency coupled with economic incentives can drive improvements in the quality of care while containing costs. It represents an important step towards reducing the variability in care and squeezing out the waste and inefficiency that exists in our healthcare system.

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