Metrics for the 2013 Obstetrician/Gynecologist Fee Uplift

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Outline of Presentation

1) Background on fee uplift
2) Metric development process
3) Description of metrics
4) Metric weights
5) Additional Resources

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Specialist Fee Uplifts - Goals and Principles

- Overall Physician Group Incentive Program (PGIP) goals
  - Transform physician payment from Fee-for-Service to Fee-for-Value
  - Invest in long-term changes in care processes
  - Emphasize population-based measures, rather than individual physician measures
- Patient Centered Medical Home (PCMH) -Neighborhood principles
  - Recognizes the important role of specialty practices within the PCMH model
  - Provide appropriate and timely consultations and referrals that complement and advance the aims of the PCMH practice(s)
  - Establish shared responsibility for relevant types of clinical interactions
- Specialist Uplift goals
  - Encourage conversations and collaboration between specialists and PCPs
  - Support and promote organized systems of care that recognize a shared responsibility for managing a patient population
  - Accelerate adoption of PCMH-Neighbor principles and agreements
  - Transform reimbursement from traditional fee-for-service to fee-for-value

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Eligibility for Fee Uplifts

A specialist must:

1. Be a member of a PGIP Physician Organization (PO)
2. Be nominated by their PO and, if applicable, one other PO with whom they have a significant shared patient population
   - Nominating PO(s) attest to the active engagement of the specialist in system transformation efforts and in enhancing the coordination and management of care in concert with primary care practices
3. Have a signed Primary Care-Specialist agreement with nominating PO(s)

These are necessary, but not sufficient, factors in determining who receives a fee uplift; BCBSM subsequently evaluates practices based on metrics described in presentation

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Metric Development Process

- Literature review for industry standard metrics and clinical guidelines
  - Searches through PubMed, National Guideline Clearinghouse
  - ACOG publications
  - HEDIS measures
  - Subject matter expert (SME) input
- Discussed metrics with OB/GYN SMEs and BCBSM clinical leaders
  - Dr. Cheryl Gibson Fountain (BPO)
  - Dr. Brent Davidson (HFHS)
- Evaluated plausibility of adopting metrics
  - Can metrics be calculated using claims or other available data sources?
  - Is the sample size adequate?
  - Is there sufficient variation to differentiate performance?
- Selected final metrics and sent to OB/GYN SMEs for final review

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DESCRIPTION OF METRICS

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Metric Calculations:

Practice Level vs Population-based

Practice Level	Population-based
Based on care directly provided by OB/GYNs in the practice	Based on care provided to the populations that the practice treats

Objectives of population-based metrics:

- Promote idea of shared responsibility
- Encourage communication and collaboration
- Encourage process creation vs focus on individual patients

Analytic advantages of population-based metrics:

- Increase sample sizes used to calculate metrics
- Patient case mix more similar at population level

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Primary C-sections

Description	Percentage of deliveries that were delivered via C-section where the mother had not had a previous Cesarean delivery
Metric calculation	Population-based
Metric type	Utilization
Rationale	Payments for C-sections are about 50% higher than vaginal births[1] and there are risks associated with the procedure for mothers/infants. Reducing primary C-sections can have a large impact on the overall rate since it will also prevent the necessity for a repeat C-section. It is also a Healthy People 2020 goal. [2]

[1] Truven Health Analytics. (2013, January). The Cost of Having a Baby in the United States. Retrieved from http://www.chqpr.org/downloads/CostofHavingaBaby.pdf.

[2] U.S. Department of Health and Human Services. (2011, October 31). Healthy People 2020 Summary of Objectives: Maternal, Infant, and Child Health. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/MaternalChildHealth.pdf.

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Hysterectomies

Description	Incidence rate of total/subtotal hysterectomies (per 1,000 females ages 15-64 per year), excluding those with cancer or ectopic pregnancy as an indication
Metric calculation	Population-based
Metric type	Utilization
Rationale	Hysterectomy rates have been decreasing but remain high in the US.[1] There are a number of alternative procedures for benign conditions that can reduce the costs and risks associated with hysterectomies.[2,3,4]

[1] Whiteman, M. K., Hillis, S. D., Jamieson, D. J., Morrow, B., Podgornik ,M. N., Brett, K. M., Marchbanks, P. A. (2008). Inpatient hysterectomy surveillance in the United States, 2000–2004. *Am J Obstet Gynecol.* 198(1), 34.e1–7.

[2] American College of Obstetricians and Gynecologists. (2008). ACOG practice bulletin: Alternatives to hysterectomy in the management of leiomyomas. *Obstet Gynecol*. 112(2 Pt 1), 387-400.

[3] American College of Obstetricians and Gynecologists. (2010). ACOG practice bulletin: Noncontraceptive uses of hormonal contraceptives. *Obstet Gynecol*. 115(1), 206-18.

[4] Papadopoulos, M. S., Tolikas, A. C., Miliaras, D. E. (2010). Hysterectomy—Current Methods and Alternatives for Benign Indications. *Obstet Gynecol Int*. 2010, pii: 356740.

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CAVE Efficiency Score

Description	Weighted average episode cost for medical conditions frequently treated by OB/GYNs, relative to peer group
Metric calculation	Population-based
Metric type	Utilization
Rationale	Analyzing diagnostic episode clusters can help in identifying efficient patterns of treatment.[1] By evaluating only the most commonly treated medical conditions and through other methodology modifications, CAVE produces more reliable estimates of efficiency than some other profiling systems.[2] CAVE is also used by Priority and BCN.

[1] Cave, D. G. (1995). Profiling Physician Practice Patterns Using Diagnostic Episode Clusters. *Med Care*. 33(5), 463-486.

[2] Business Wire. (2010, June 16). Cave Consulting Group ("CCGroup") Receives Patent on CCGroup Marketbasket System™. *Business Wire*. Retrieved from http://www.businesswire.com/news/home/20100616005299/en/Cave-Consulting-Group-%E2%80%9CCCGroup%E2%80%9D-Receives-Patent-CCGroup

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Women's Cost of Care PMPM

Description	Overall PMPM medical/surgical cost of care* + pharmacy actual cost for females ages 15 to 64
Metric calculation	Population-based
Metric type	Utilization
Rationale	There are wide variations in the cost of health care that do not have a direct relationship to improvements in quality of care.[1] Consistent with Organized Systems of Care, supports collaboration between PCPs and OB/GYNs in reducing costs for their shared populations.

*Cost of care reflects comparable patient care costs by removing charity care, bad debt and direct and indirect medical education

[1] Hussey, P. S., Wetheimer, S., Mehrotra, A. (2013). The Association Between Health Care Quality and Cost: A Systematic Review. *Ann Intern Med.* 158(1), 27-34.

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Generic Dispensing Rate

Description	Proportion of Rx scripts written for a generic drug
Metric calculation	Practice Level
Metric type	Utilization
Rationale	There are a number of drugs prescribed by OB/GYNs with generic alternatives bioequivalent and pharmaceutically equivalent to the branded product.[1] The average cost of a generic drug is 80-85% lower than brand.[2]

[1] Committee on Gynecologic Practice, American College of Obstetricians and Gynecologists. (2007). ACOG Committee Opinion No. 375: Brand versus generic oral contraceptives. *Obstet Gynecol*. 110(2 Pt 1), 447-8.
[2] U.S. Food and Drug Administration. (2012, September 19). Facts about Generic Drugs. Retrieved from http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/understandinggenericdrugs/ucm167991.htm

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Obstetrical Care

Description	Combination of three measures related to: 1) adequacy of prenatal care, 2) prenatal gestational diabetes screening, and 3) postpartum glucose screening for women diagnosed with gestational diabetes
Metric calculation	Population-based
Metric type	Quality
Rationale	The adequacy of prenatal care utilization index is captured using the birth certificate and is based on ACOG guidelines.[1] ACOG also recommends universal screening for gestational diabetes[2] and postpartum glucose screening for women diagnosed with gestational diabetes.[3]

[1] Kotelchuck, M. (1994). An evaluation of the Kessner Adequacy of Prenatal Care Index and a proposed Adequacy of Prenatal Care Utilization Index. *Am J Public Health*. 84(9), 1414-20.

[2] American College of Obstetricians and Gynecologists. (2011). ACOG Committee Opinion No. 504: Screening and Diagnosis of Gestational Diabetes Mellitus. *Obstet Gynecol*. 118(3), 751-3.

[3] American College of Obstetricians and Gynecologists. (2009). ACOG Committee Opinion No. 435: Postpartum screening for abnormal glucose tolerance in women who had gestational diabetes mellitus. *Obstet Gynecol*. 113(6), 1419-21.

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Breast Cancer Screening

Description	Proportion of females ages 50 to 64 who had a mammogram to screen for breast cancer
Metric calculation	Population-based
Metric type	Quality
Rationale	Modified from HEDIS to reflect the U.S. Preventive Services Task Force recommendations against universal screening for females ages 40 to 49.[1] Note that screening before age 50 will not negatively impact score.

[1] U.S. Preventive Services Task Force. (2009). Screening for breast cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 151(10), 716-36.

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HPV Vaccinations

Description	Two different metrics: 1) proportion of girls ages 13 to 17 who received at least one shot in the HPV vaccine series (*initiation*), 2) proportion of girls ages 13 to 17 who received all three shots in the HPV vaccine series out of those who received at least one dose (*completion*)
Metric calculation	Population-based
Metric type	Quality
Rationale	The Advisory Committee on Immunization Practices recommends vaccination between the ages of 11 and 12 and catch-up vaccination up to age 26.[1] OB/GYNs are critical to the catch-up period[2] and can encourage the vaccine to parents and pediatricians.

[1] Advisory Committee on Immunization Practices. (2012). HPV Vaccine Recommendations. *Pediatrics*. 129(3), 602-605.
[2] Committee on Adolescent Health Care, ACOG Working Group on Immunization. (2006). ACOG Committee Opinion No. 344: Human papillomavirus vaccination. *Obstet Gynecol*. 108(3 Pt 1), 699-705.

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Women's Evidence-based Care

Description	Combination of twenty HEDIS measures related to acute and chronic disease management for females ages 15 to 64
Metric calculation	Population-based
Metric type	Quality
Rationale	OB/GYNs have a tradition of providing primary care to women[1] and thus have a role in ensuring that they receive appropriate disease management, by treating patients for these diseases and/or coordinating with their PCPs. Managing chronic conditions is also an important component of preconception care.[2]

[1] American College of Obstetricians and Gynecologists. (2012). ACOG Committee Opinion No. 534: Well-woman visit. *Obstet Gynecol*. 120(2 Pt 1), 421-4.

[2] Johnson, K., Posner, S. F., Biermann, J., Cordero, J. F., Atrash, H. K., Parker, C. S., . . . Curtis, M. G. (2006). Recommendations to Improve Preconception Health and Health Care-United States . *MMWR*. 55(RR06), 1-23.

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Additional Resources

- More information about the Physician Group Incentive Program: http://www.bcbsm.com/providers/value-partnerships/physician-group-incentive-program.html

- OBGYN Specialist Uplift Rankings
  - Delivered to PGIP Physician Organizations
  - For each practices, includes details about each metric score

- 2013 Obstetrician/Gynecologist Fee Uplift Objectives and Selection Process
  - Delivered to PGIP Physician Organizations
  - Includes:
    - Eligibility/nomination criteria
    - Specifications for each metric
    - Details about the calculation process