Blue Cross Blue Shield of Michigan First Health Plan to Provide Reimbursement for Participation in QOPI

ASCO launched the Quality Oncology Practice Initiative (QOPI) Health Plan Program in 2006 as a way to help reduce redundancy of data collection and measurement in quality improvement programs. To date, 14 health benefit companies around the country have elected to participate in the QOPI Health Plan Program, and each health plan has established its own way of recognizing QOPI participation, such as a special designation in physician directories. Blue Cross Blue Shield of Michigan (BCBSM) is the only one of the health plans to provide a financial incentive to oncology practices that participate in QOPI.

“When developing this program with ASCO, we recognized that there were costs that practices would incur to collect data. We wanted to remove as many barriers as possible,” says Tom Leyden, manager of clinical program development at BCBSM, who oversees the QOPI initiative within BCBSM’s Physician Group Incentive Program (PGIP). Leyden’s associate Mark Casmer, manager of provider partnerships, adds, “We believed that providing financial incentive would encourage physician practices to participate. We especially wanted to encourage independent oncologists and smaller practices, and they are now becoming engaged in the program.” Indeed, of the approximately 221 oncologists currently involved in the BCBSM PGIP, approximately half are in solo practice and another 25% are in practices of two or three oncologists. The total number of QOPI participants in Michigan now exceeds that of any other state.

The BCBSM PGIP Oncology initiative was developed through extensive collaboration with oncologists from across the state of Michigan. In describing the development of the program, Leyden and Casmer said BCBSM was approached by local oncologists who wished to work with the health plan to improve the quality of oncology care and decrease costs. These oncologists eventually became the leaders of a larger group who worked collaboratively with BCBSM to structure the incentive program, using QOPI as the means to measure quality. “Pay-for-performance programs created in an ivory tower of a health plan are not practical,” says Casmer. “QOPI was a very reasonable way to start. It was an established program, developed by practicing clinicians, with a process in place for submitting data, so it would allow us to enhance quality as quickly as possible.”

The BCBSM PGIP Oncology initiative requires that oncologists participate in QOPI according to the QOPI methodology. QOPI participants must complete the set of core measures and select at least two other modules for data abstraction, one of which must be the end-of-life care module. The decision to require this module was made by the Michigan oncologists who collaborated on the program.

“We asked our oncologists what was most important to them. End-of-life care has been an important issue in Michigan for quite some time,” says Leyden. Douglas Blayney, MD, medical director of the University of Michigan Comprehensive Cancer Center, who was involved in the early development of the Oncology initiative, explains that the QOPI end-of-life module includes measures related to assessment of pain and dyspnea and actions to relieve these symptoms; hospice enrollment, referral to palliative care services, and timely use of these services; and the use of chemotherapy within two weeks of death. “All of these measures get to the core competencies and performance of oncologists who care for patients. These measures are applicable to oncologists who may subspecialize in a specific cancer, as well as oncologists who care for patients in the community, the hospital, or the academic setting,” says Dr Blayney, who currently serves as ASCO’s President-Elect. He also adds that “Additional QOPI modules measure adherence to guidelines for disease-specific care; the QOPI breast cancer, lymphoma, colorectal cancer, lung cancer, and supportive care modules also give participating oncologists methods to measure their performance and compare their own performance with those oncologists in their group and also against national benchmarks. For instance, at the University of Michigan, we have changed several of our processes in response to data comparing us to the rest of the QOPI participating practices.”

The BCBSM incentive program also requires that participating oncologists attend quarterly PGIP meetings. “Our goal is to provide a forum for the exchange of ideas, and the opportunities for learning are endless. We were inspired by the discussion at a recent meeting following the initial data collection process,” says Casmer. Dr Blayney, who attended that meeting, adds, “We compared strategies for engaging other physicians in the QOPI process and shared techniques for data extraction. Several practices banded together to hire clinical trial data managers to abstract charts.”

Leyden and Casmer emphasize that QOPI data are blinded: practice-specific information is not received by BCBSM or distributed to any other participating oncologists. Each PGIP Oncology group receives information specific to their practice as well as national benchmarks. The current BCBSM financial incentive (\$3,000 annually per physician) is based solely on participation in the PGIP initiative and active participation with QOPI, and is not currently tied to the outcomes of this data collection. “It’s not about who’s doing well and who isn’t. It’s about who’s doing well and how they did it,” says Casmer. Leyden notes that other BCBSM PGIP initiatives with various types of physicians have led to the

robust sharing of best practices based on the quality measurements. “We look forward to similar results with the oncologists participating in QOPI. Getting to that point of active collaboration and sharing of best practices requires building trust, both between oncology practices and BCBSM as well as among the practices themselves.”

Casmer adds, “This program is not about BCBSM telling oncologists what to do. It wouldn’t be successful that way. We have learned from our prior PGIP initiatives that for

these programs to be most successful, physicians need to be actively involved in the discussion regarding the set-up of the initiative.” Dr Blayney agrees. “Oncologists should be clear that QOPI is oncologist-driven, and a way to do the right thing. There has to be a measure of mutual trust before the process can go forward.”

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