The Third National Pay for Performance Summit

Mini Summit IV

Health Disparities and Pay for Performance

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Beverly Hilton Hotel
Los Angeles, California

Pay for Performance – Financial Health Disparities and the Impact on Healthcare Disparities

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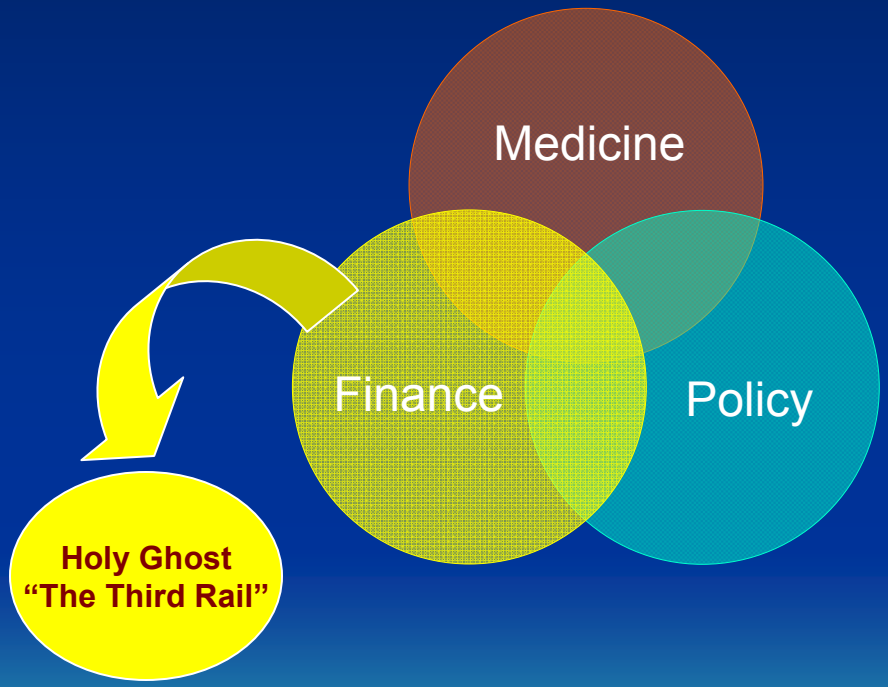
The Medical Holy Trinity



The Future of P4P

- “In the next 5 to 10 years pay-for performance-based compensation could account for 20% to 30% of what Medicare pays providers.”

Mark McClellan, MD
CMS Administrator (2004)

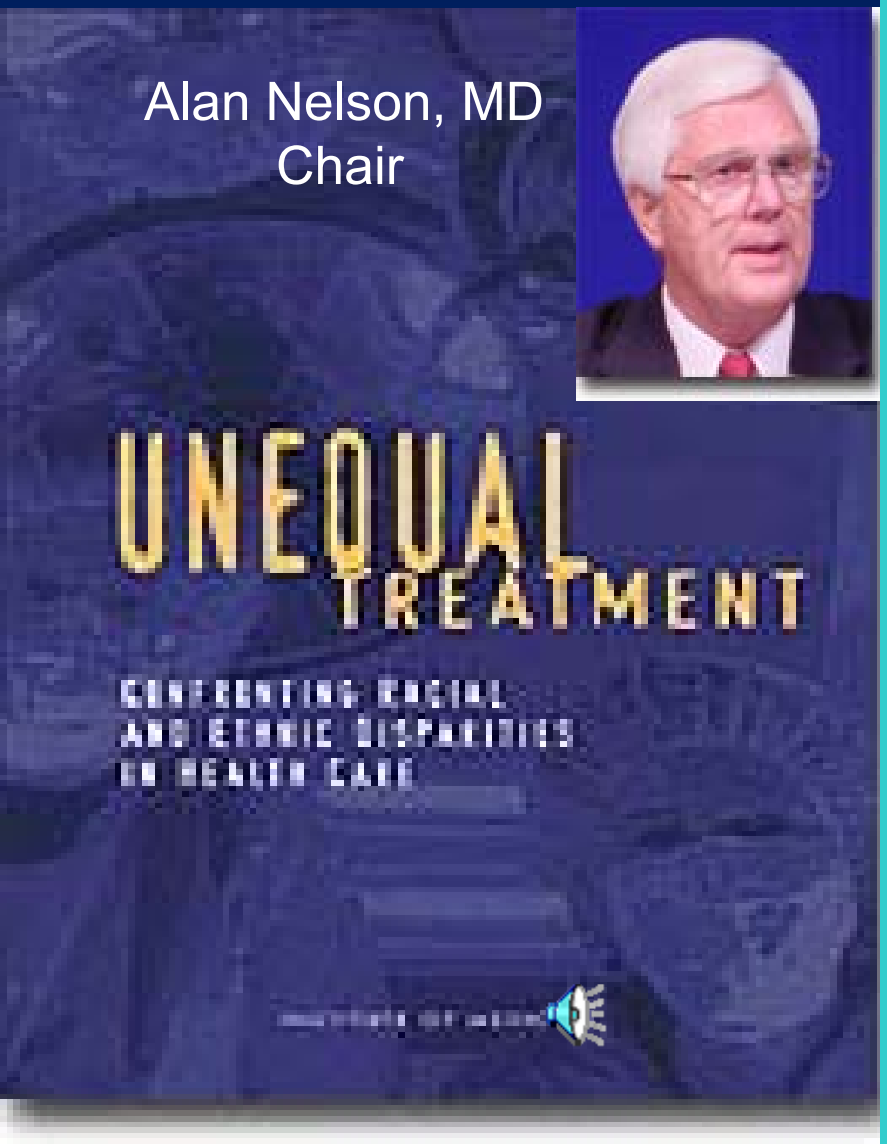
Quality Indicators and Health Disparities

Evidence-based Medicine

P4P applies EBM to improve medical quality in a cost efficient manner.

- Whose Evidence ?
- Based upon What Assumptions?
- Improved Quality for Who ?
- At What cost ?

Confirmation of Persistent Racial and Ethnic Health Disparities - 2002



Institute of Medicine study confirms the presence of racial and ethnic health disparities and the contribution of discrimination, bias, and stereotyping leading to inequities in health care.

Overview Utilization Trends in Racial and Ethnic Health Disparities

IOM Unequal Treatment Report

Utilization of Invasive Therapeutic and Diagnostic Procedures	CABAG, Angioplasty, Endarterectomy, Hip and Knee replacement, defibrillator implants, etc.	Blacks with highest rates CVD and arthritis	Blacks < Whites
Utilization and Access to Therapeutic Services	Transplants, waiting list, radiographic studies, physical therapy, medications and mammograms	Blacks with highest rates for kidney disease, CVD, DM, HBP and with greatest morbidity and mortality	Blacks < Whites
Utilization of Hospital Resources	Of all races Blacks use fewer hospital resources <$2805	Blacks with higher hospitalization rates and more co-morbidities	Blacks < All Other Races
Organ or Limb Removal	Orchiectomy, limb amputation and hysterectomy	Blacks less likely to chose these options	Blacks > Whites and most other races

Minorities Are Not All the Same

National Health Data by Race & Ethnicity

Healthy People 2010 Target Goals"

Deaths per 100,000 population

	Overall Cancer 1999	Breast Cancer 1999	Prostate Cancer 1999	Colorectal Cancer 1999	Infant Mortality 1999	Heart Disease 1999	Strokes 1999	DM 1999	Overall Death Rate All Causes 1999
Healthy People 2010	158.7	22.2	28.7	13.9	4.5	166	48	45	NA
Black	262↑	37.7↑	71.1↑	28.8↑	13.4↑	257↑	82↑	130↑	1184 (1)
White	202↑	28↑	31.1↑	21.1↑	6.4↑	214↑	60↑	70↑	881 (2)
Native American	132↓	13.1↓	19.3↓	14.5↑	7.9↑	134↓	39↓	107↑	725.5 (3)
Hispanic	126↓	17.8↓	20.8↓	12.8↓	6.5↑	151↓	40↓	86↑ 115*↑ Mexican*	613 (4)
Asian/PI	127↓	12.6↓	14.5↓	13.5↓	4.6↑	125↓	55↑	62↑	532.5 (5)

Healthy People 2010 Conference Edition, Volumes I & II, US DHHS, Jan 2000

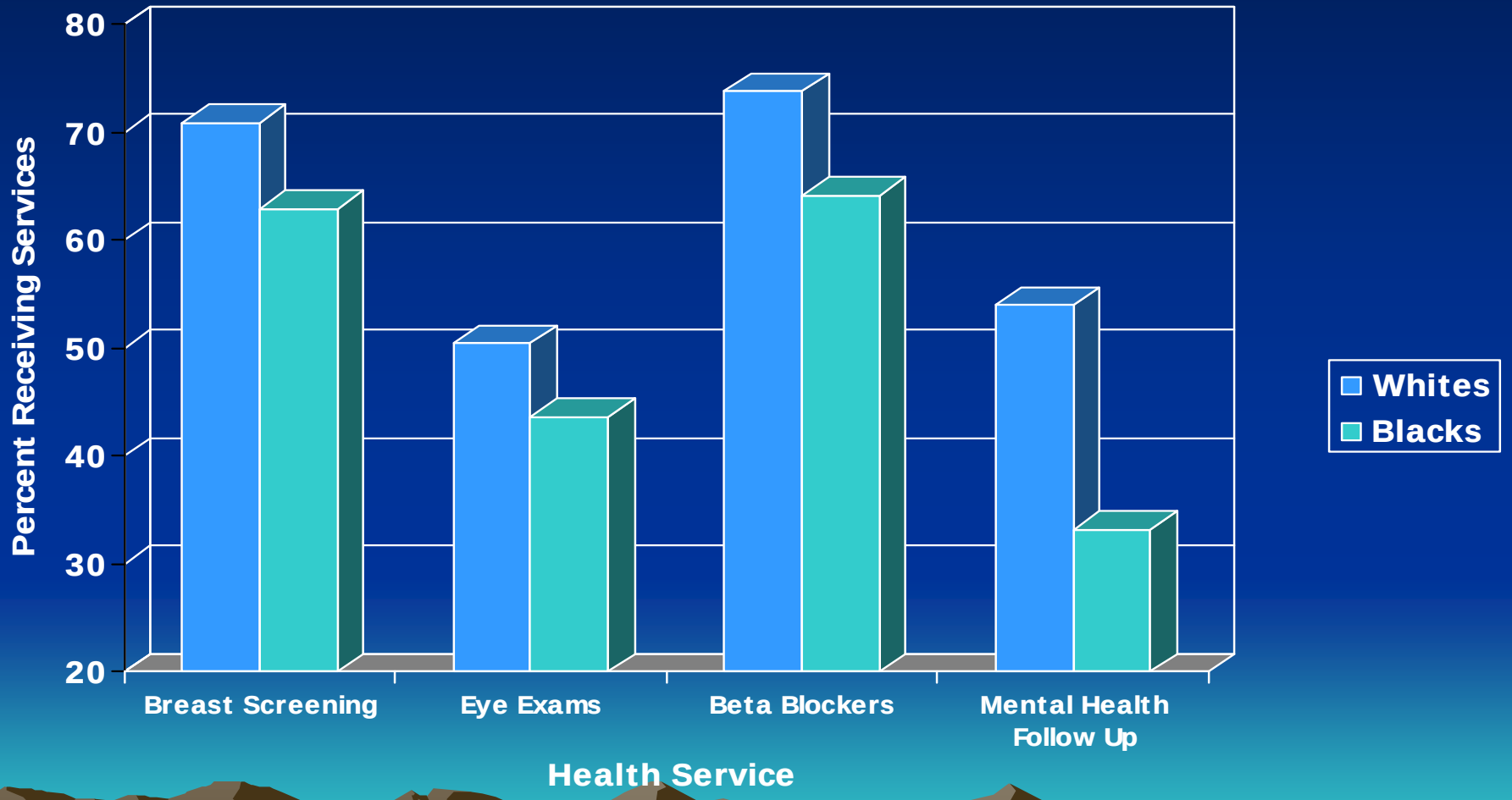
Quality of Care and Access to Care Comparisons by Selected Racial Groups 2000 – 2001

National Healthcare Disparities Report 2004 (AHRQ)

	Blacks	Hispanics	AI/AN	Asians	Poor
% lower quality of care compared to whites	Approx. 66%	Approx. 50%	Approx 33%	Approx. 10%	Approx. 60%
% lower access to care than whites	Approx. 40%	Approx. 90%	Approx 50%	Approx. 33%	Approx. 80%

Among Medicare Beneficiaries Enrolled in Managed Care Plans, African Americans Receive Poorer Quality of Care

Schneider et al., *JAMA*, March 13, 2002



Health Care Quality Indicator Disparities

August 2006 issue of the *American Journal of Preventive Medicine*

- In 2000 – 2001, the overall biennial breast screening rates for women 40yrs and older were:
  - 50.6 percent for non-Hispanic white women
  - 40.5 percent for black women
  - 34.7 percent for Asian-American women
  - 36.3 percent for Hispanic women, and
  - 12.5 percent for Native-American women.
- Therefore, 20% – 75% lower rates for minorities

- **In California, women with insurance have an overall breast screen rate at 64% but approximately 70% for whites but less for Asians (Filipino & Chinese), immigrants, non-English speaking and other minority women.**

- **Self-reported cancer screening for PAPS and mammography for African Americans and Latinos are near or equal to whites but when documented by medical records the actual screening rates are significantly less.**

California Integrated Health Association (IHA)

A Pay for Performance Initiative in California

History of California Integrated Health Association (IHA) P4P Initiative

- In July 2000 a high level working group of California health care leaders from health plans, physicians, medical directors, etc. met to discuss a new statewide initiative for P4P.
- January 2002 six California health plans (Aetna, Blue Cross, Blue Shield, CIGNA, HealthNet and PacifiCare) launched this new initiative.
- A score card of common performance measures were agreed upon with clinical measures weighted at 50%, patient satisfaction weighted at 40% and Information Technology (IT) at 10%.
- Updates of this initiative began in 2003

Integrated Health Association (IHA)
Evidence based Pay for Performance Quality Measures

Domain	Measure Description	Weights 2003	Weights 2004
Clinical	1. Childhood immunizations 2. Breast cancer screening 3. Cervical cancer screening 4. Use of asthma medication 5. Cholesterol – LDL screen & control 6. Diabetes- HbA1c screen & control 7. Chlamydia screening	50%	40%
Patient Satisfaction	1. Specialty care 2. Timely access to care 3. Doctor-patient communication 4. Overall ratings of care	40%	40%
IT Investment	1. Integrated clinical electronic data sets at group level 2. Support clinical decision making at point of care	10%	20%

Pay for Performance Initiative in San Diego County

Commercial HMO Products

- MCIPA is a for profit Independent Physician Association (IPA) that was established in San Diego County California and was managed by the UCSD Health Network in 1994. Since 2003 MCIPA has been managed by SynerMed located in Los Angeles.

- MCIPA generates $6 million yearly from commercial, senior and Medicaid direct health plan contracts and composed of 50 PCPs and over 50 specialty health care providers.

- The MCIPA has 12,000 enrollees (8,000 commercial) with providers and enrollees that are ethnically diverse. Enrollees are mostly Latino and African American but include Asian, African and other Immigrants and those of European descent.

- MCIPA providers and enrollees are predominantly located in Central & South regions of San Diego County.

MultiCultural IPA
MultiCultural Primary Care Medical Group, Inc.

Physician Medical Group Practice Mix by Race and Ethnicity

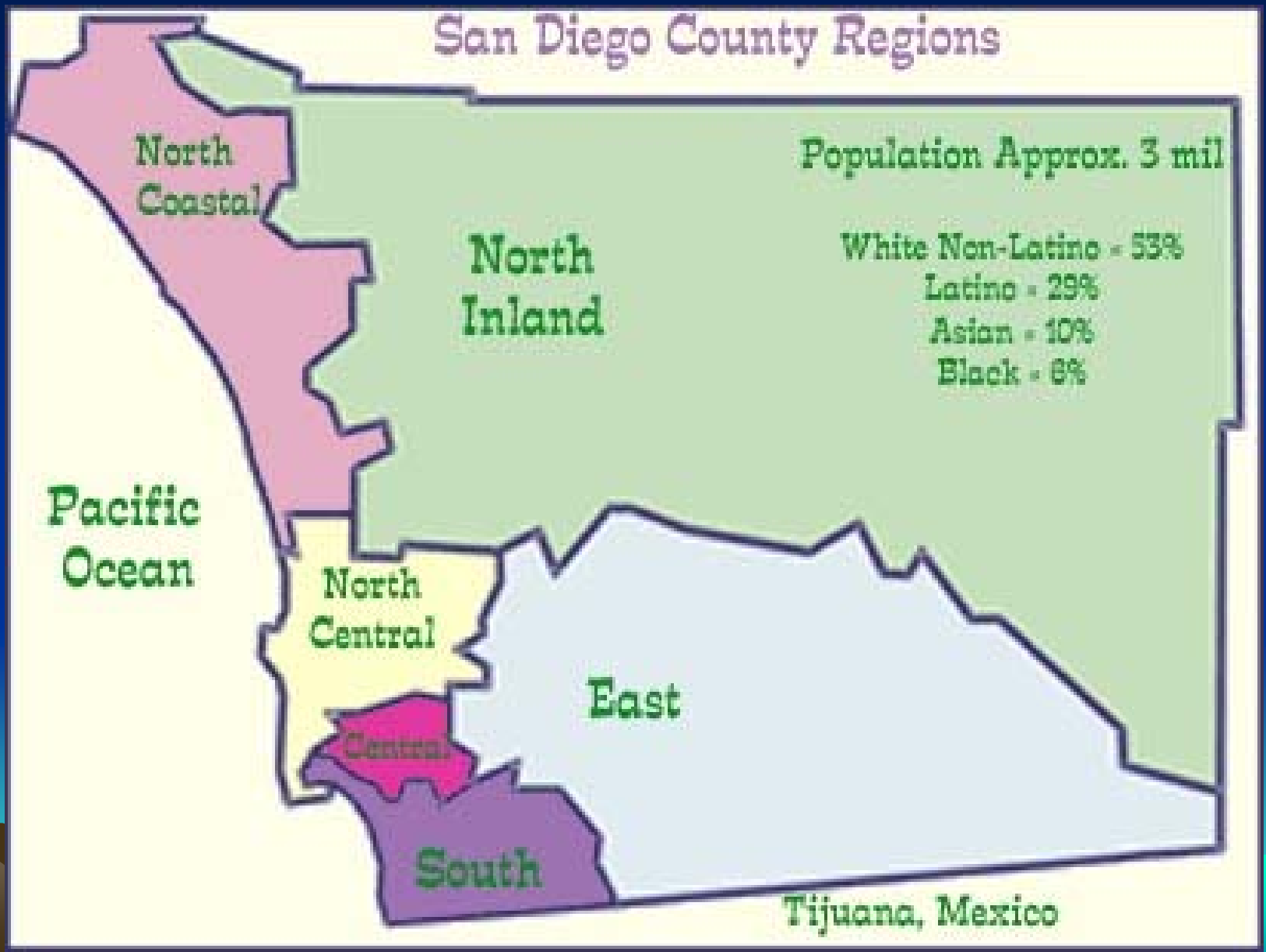
- Group I – 3 AA PCPs and 1 Asian PCP – Ethnic patient population mix is 68% Black, 17% Latino, 8% Asian and 7% European.
- Group II – 2 Latino PCPs – Ethnic patient population mix is predominately Latino.
- Group III – 1 Asian PCP – Ethnic patient population mix is predominately Asian (Filipino).
- Group IV – 1 European PCP – Ethnic patient population mix is predominantly European descent.

Physician Shortage Leads to High Patient Volumes

- San Diego County population is approximately 3 million with 8,700 physicians.
- Physician:population ratio in San Diego County is 1:350.
- Physician:population ratio for MCIPA service areas is approximately 1:1500.
- Therefore, MCIPA service areas have a physician shortage of 4 times fewer physicians than other parts of the county.

San Diego County

Regions include: North, North coastal, Central, Eastern, Inland and South regions.



San Diego County Demographics by Race, Ethnicity and Disease Burden

- Latinos, African Americans and Immigrant populations are concentrated in the Central and South regions of San Diego County.

- SD County Health Needs Assessment Report (2004):
  - *Populations with the highest disease burdens and greatest obstacles to access health care are found in the Central and South regions with African Americans suffering the highest disease burdens and Latinos the worst access.*

  - *Populations living in the Central and South regions of San Diego County have the highest hospitalization and death rates from diabetes, asthma, CHD and cancer.*

California HMO Report Card 2005
Medical Groups in San Diego County

Health Plan (HMO)	Cervical Cancer Screen	Breast Cancer Screen	Test Blood Sugar	Doctors Work as Team	Helpful Office Staff	Visits Start on Time	Overall Clinical Rating	Overall Patient Rating
Health Systems	Excellent ★★★★			Good ★★★		Fair ★★	Poor ★	
Scripps Mercy Med Grp	76%	67%	80%	86%	86%	66%	★★★	★★★
Scripps Mercy IPA	72%	67%	67%	85%	89%	64%	★★	★★★
Sharp Reese Steely	86%	84%	90%	85%	89%	61%	★★★★	★★★
Sharp Med Grp IPA	79%	74%	83%	85%	84%	53%	★★★	★★★
Sharp Med Group CV	79%	86%	83%	88%	82%	47%	★★★	★★★
Kaiser S. Calif Med Grp	NR	NR	NR	81%	86%	63%	NR	★★★
Independent Groups								
Center for Health Care	40%	66%	69%	82%	85%	56%	★★	★★★
Tri-Cities IPA	64%	57%	67%	81%	83%	56%	★ ★	★ ★
Multicultural IPA	50%	54%	74%	89%	86%	34%	★★	★ ★
Mid-County Physicians	59%	66%	64%	81%	84%	58%	★ ★	★★★
SD Physician Med Grp	70%	62%	70%	85%	83%	52%	★★★	★★ ★
UCSD Med Group	79%	79%	84%	80%	80%	42%	★★★	★ ★

The Inconvenient Truth

P4P Inequities for High-Risk Populations

Reasons for Low Quality Performance with High-Risk Populations

Inequities Encountered with Disproportionate Enrollment of High-Risk Populations

1. Inadequate baseline reimbursement
2. Administrative costs
3. Racial quality indicator disparities
4. Incomplete encounter data collection
5. Unfair quality measure comparisons
6. Tiered physician networks and physician economic profiling
7. De facto racial, ethnic and SES discrimination
8. Geographic physician shortages
9. The Ultimate Inequity – Worsening of health disparities

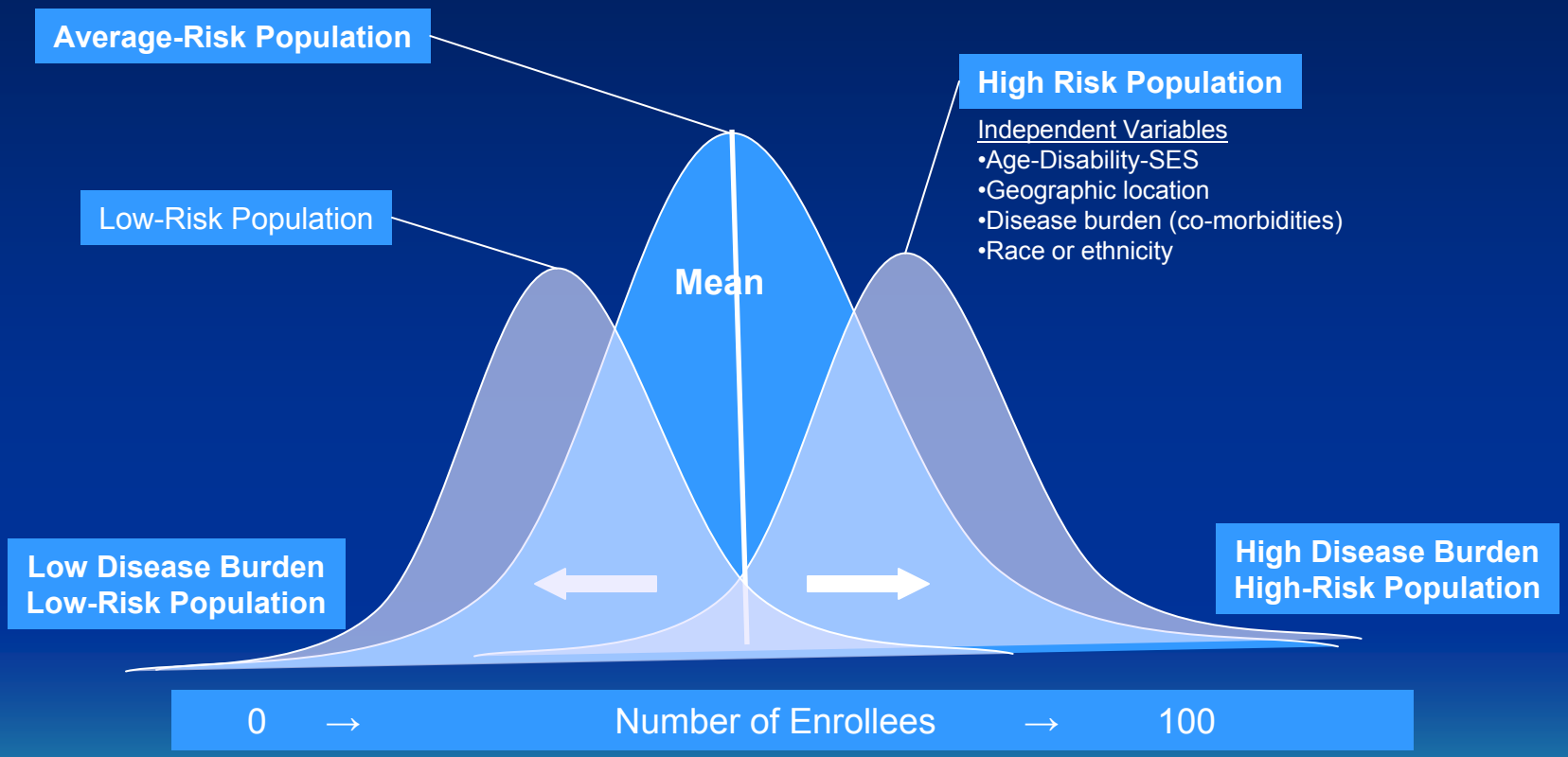
P4P Inequity #1 - Reimbursement

- Physicians' health services are reimbursed based upon the average costs which assumes the enrolled population has a bell-shaped curve "risk" distribution with low and high-risk populations.

- If the served population has an adverse risk selection based upon race, ethnicity, geographic location or SES the average service costs are expected to be higher.

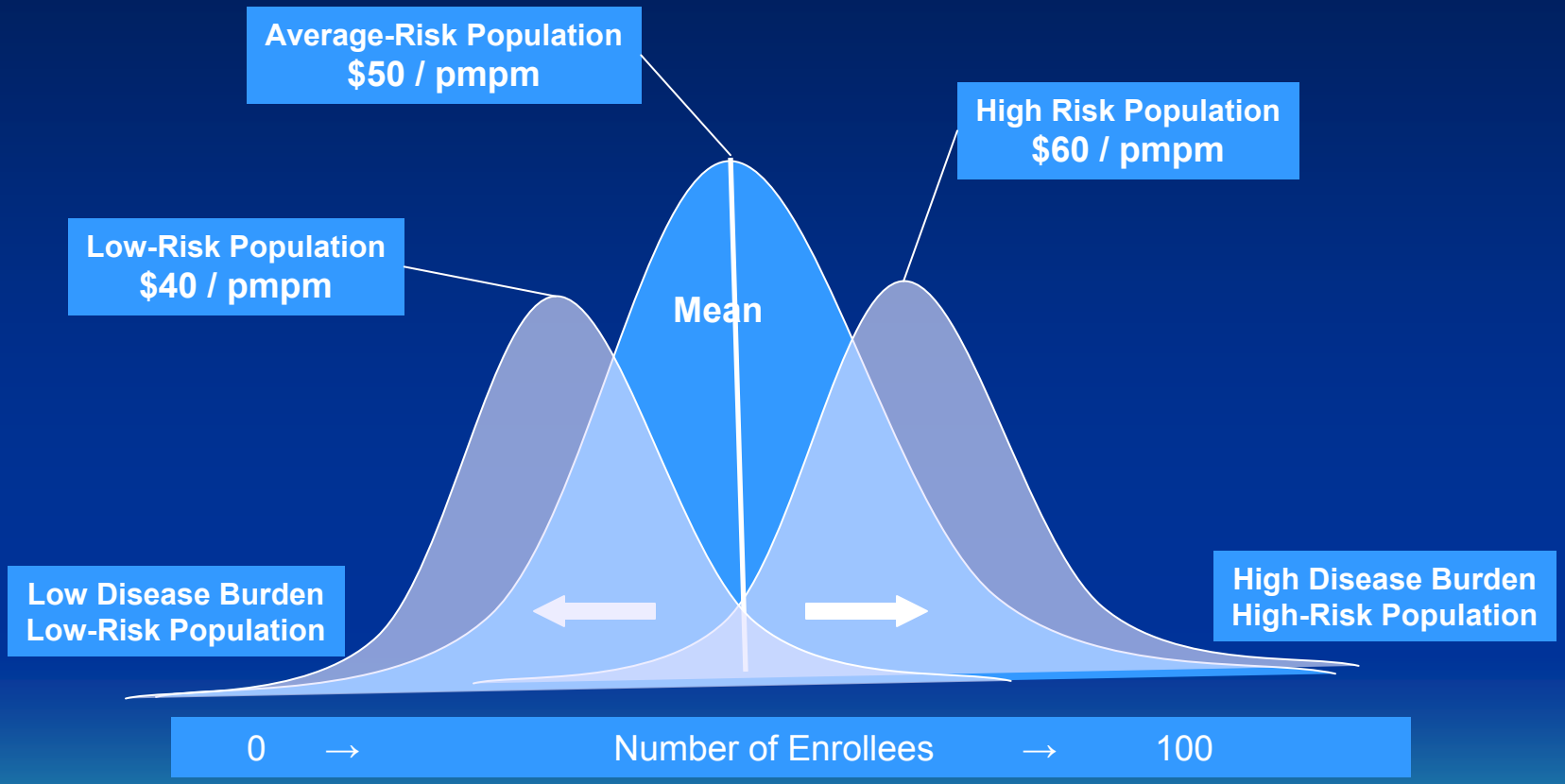
- If a group serving a high-risk population is reimbursed at the lower rates for the average-risk population they will receive less compensation for their populations actual risk.

Population Disease Burden and Risk Distribution Utilized in Managed Care Reimbursement Formulas



Population Disease Burden and Risk Distribution Utilized in Managed Care Reimbursement Formulas

Estimated Professional Capitated Cost ($) pmpm



Medical Group Managed Care Reimbursement Formula Assumptions for Commercial Product

- The contracting medical groups are reimbursed based upon ***average-risk*** costs minus HMO administrative withholds then reimbursement is more or less depending upon the number of services contracted and the groups negotiating strengths or weaknesses.

- Therefore, a medical group with a disproportionate ***high-risk*** population enrollment and a weak negotiation position due to small enrollment will likely receive a rate between the low vs. average-risk rates.

P4P Inequity #2 - Costs

- The HMO withholds up to $3 to $4 pmpm from participating physician groups to cover P4P incentive cost –NOT extra money.
- The physician group P4P quality improvement program cost $1 pmpm to implement.
- A fee is charge to the medical group ($2000 for small group) to cover costs of the patient survey portion.
- Therefore, the incentive withholds, the group program costs, plus other fees further diminishes physicians' reimbursements.

P4P Inequity #3
Racial Quality Indicator Disparities

- The groups serving populations having health disparities with the greatest disease burdens such as Blacks, Latinos and Asians have lower average baseline quality indicator levels than the general population.

- Therefore, P4P quality indicator criteria based upon low-risk groups will establish goals that are disproportionately higher when compared to the high-risk groups.

- Therefore, groups serving high disease burden (high-risk) populations will receive little or no financial benefit from the P4P incentive withholds and in fact may be penalized with even less reimbursement.

Cancer Screening in California
UCLA Center for Health Policy Research Health Interview Survey
Self-Reported Mammography - December 2003

Mammography by race/ethnicity – women age 40 and older, California 2001			
	Never Screened	Screened in Past Year	Screened in Past 3 Years
Race/Ethnicity	%	%	%
White	8.1	62.4	78.1
Latino *	17.7	55.4 *	69.9
Asian *	17.2	54.4 *	67.2
African American**	9.4	62.8 **	78.5
AI/AN	10.0	55.8	68.8
NH/OPI	Not enough data	47.5	63.4
Other Multiracial	16.8	56.7	69.6
Women age 18 & older	10.7	60.4	75.5

* Asian and Latino immigrants and non-English speaking women showed even lower screening rates.

** African American and other minorities self-reported cancer screening rates are 40% to 50% over-estimated when compared to medical records.

Relationship Among Race, Ethnicity, SES, Foreign Birth and Non-English Speaking on Cancer Screening Rates

- Am. J. Prev. Med. Feb. 1998: (Champion)
  - **Results showed AA women self-reported mammography with only 49% - 60% that could be verified with medical record documentation.**
- Cancer Epidemiology Biomarkers & Prevention, 1996.(Paskett)
  - **Results showed that low-income minority women self-reported mammography rates were only 77% correct and 67% correct for self-reported PAPS.**
- Cancer Epidemiology Biomarkers & Prevention, 1997: (Maxwell, AE)
  - **Results showed Filipino women 50 years and older residing in Los Angeles with 66% never having a mammogram, 42% had had one in the past 12 months, and 54% in the past 2 years.**
- J. General Internal Med., Dec. 2003 (Goel, MS)
  - **Results show foreign born women in US (Latino, Asian and Pacific Islanders) were significantly less likely to report cancer screening than US born counterparts.**

P4P Inequity #4
Incomplete Encounter Data Collection

- Physicians' services encounter data is utilized to measure physician groups' levels of compliance for quality improvement measures.
- Physicians with less information technology (IT) capacity tend to submit incomplete encounter data at higher rates.
- Therefore, incomplete collection of encounter data results in lower quality indicator scores.

P4P Inequity #5
Unfair Quality Measure Comparisons

- Each physician group's quality data are published as a quality report card.
- Physicians serving disproportionate high-risk populations will be perceived as giving poor quality and therefore negatively affect enrollment.

P4P Inequity #6

Tiered Physician Networks and Physician Economic Profiling

- Tiered Physician Networks:
  - Physicians or groups are partitioned into different tiers based upon cost efficiency.
- Physician Economic Profiling:
  - Those select physician groups that are deemed cost-efficient are placed into a select network tier that offer patients lower co-pays and a more enriched benefit plan.
- Traditional High-Risk Providers:
  - Physicians serving high-risk populations (SES, geographic location, high disease burdens or co-morbidities and race) are deemed less cost-efficient and further penalized by lower tiered plans that offer higher co-pays, fewer benefits and encourage patients not to enroll with traditional providers.

P4P Inequity #7

De facto Racial, Ethnic and SES Discrimination

- P4P creates disincentives for physicians and medical groups to not enroll high-risk patients that are disproportionately ethnic minorities.
- This creates a fertile environment for de facto racial, ethnic, social and economic discrimination.
- Thus, high-risk patients default to traditional health care providers further worsening quality indicator data due to lower baseline quality measures for high-risk populations.

P4P Inequity #8
Geographic Physician Shortages

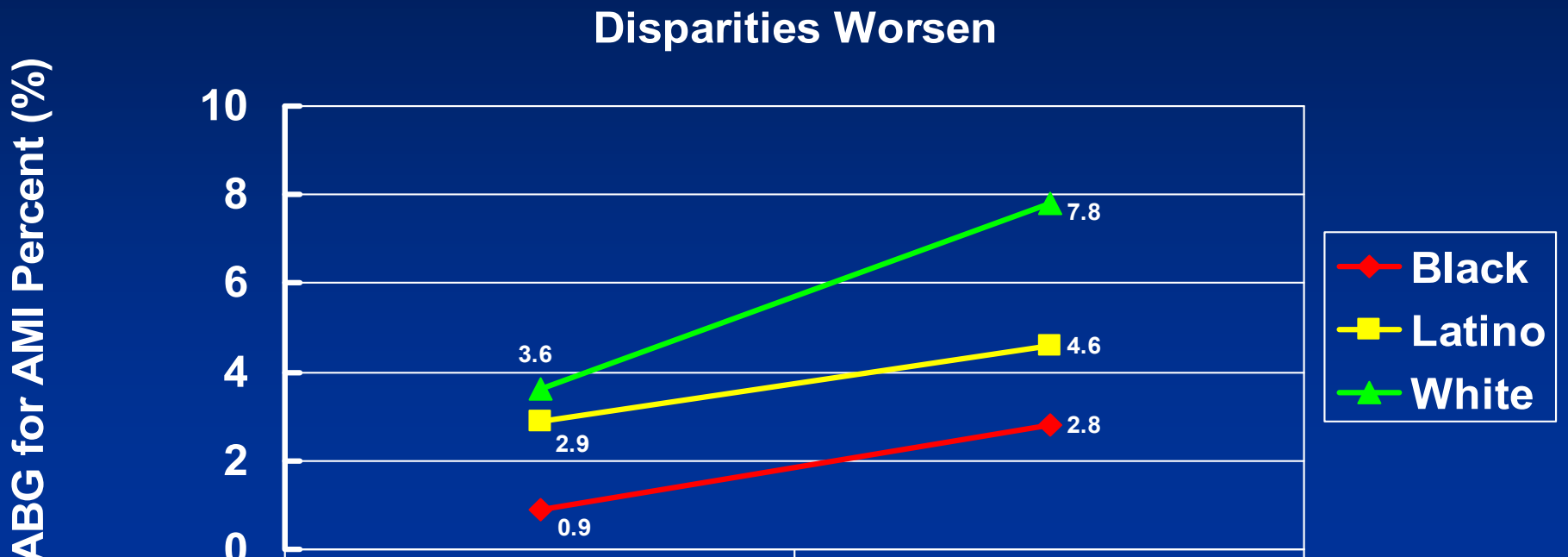
- Many minority and underserved populations live in physician shortage areas.
- Providers serving in underserved communities commonly have heavy patient loads.
- Poor access results in longer waits during office visits.
- Patient survey criteria many times penalize providers for practicing in communities where other providers avoid working.

P4P Ultimate Inequity #9
Worsening Health Disparities

- P4P programs that do not fairly and equitably compensate for high-risk populations and utilize inaccurate evidence-based quality indicator comparisons will not enhance the elimination of health disparities but may actually worsen health disparities.

New York CABG Report Card 1991

Werner, Circulation 2005



	Before Report Card 1991		After Report Card 1991	
Black	0.9	Disparity = 2.7	(32%) 2.8	Disparity = 5.0
Latino	2.9	Disparity = 0.7	(63%) 4.6	Disparity = 3.2
White	3.6		(46%) 7.8	

New York and Pennsylvania CABG Report Cards Caused "Cherry Picking"

- Report cards led to higher cost for both healthier patients (who got more CABG surgeries) and sicker patients (despite stable to declining surgery rates).

- Report cards roughly led to unchanged outcomes for healthy and much worst health outcomes for sick patients.
  - Dranove, Kessler, et al, J. of Political Economy, June 2003

Early Experience with Pay-for-Performance in California

Rosenthal, et al, JAMA, Oct. 2005 (Harvard School of Public Health)

- Finding:
  - For all 3 measures (cervical cancer screening, mammography and hemoglobin A1c), physician groups with baseline performance at or above the performance threshold for receipt of a bonus improved the least but garnered the largest share of the bonus payments ($3.4 million).

- Conclusion:
  - “Paying clinicians to reach a common, fixed performance target may produce little gain in quality for the money spent and will largely reward those with higher performance at baseline.”

Health Disparities Math

- Assume quality gradient of 1 → 10 (best):

Whites = 6 and minorities = 4

Disparity difference = 2

- Goal: Improve quality to 9:

We need to achieve a 50% (6 to 9) increase for whites and 125% (4 to 9) increase for minorities in order to achieve equity.

- If we achieved a 50% equal improvement for all:

Whites = 6 to 9 minorities = 4 to 6

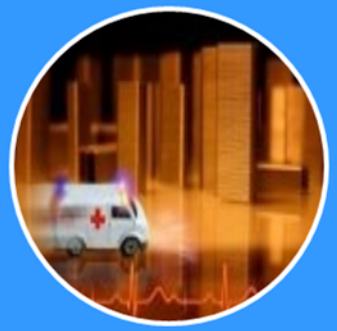
Disparity difference = 3

Therefore we have a worsening quality disparity of 50%.

The Health System Triad

How to improve quality and eliminate healthcare disparities.

Consumer



Healthcare System

Provider

Solutions to address inequities in all aspects of the triad

Lessons & Recommendations

Healthcare System Reform

- Health care disparities are quality issues that came about because of healthcare inequities.
  - ***Recommendation:***
  - ***Cautiously adopt the concept of P4P as a tool to address health disparities as a quality issue.***

- P4P is a potential tool to monitor and improve health disparities.
  - ***Recommendation:***
  - ***P4P has the potential to worsen health disparities. All performance measures must address population specific risk factors such as disease burdens, access disparities, geographic disparities and race as independent health-risk variables.***

- Baseline reimbursements should reflect the population's risk levels.
  - ***Recommendation:***
  - ***Mandate core payment reform that reflects the specific population's level of risk based upon disease burdens, geographic location, ses, race and ethnicity.***
  - ***P4P incentive payments should be based upon percent improvement of the actual groups' baseline quality measures rather than set levels that are based upon lower risk populations.***

Lessons & **Recommendations**

Provider Reform

- Physician groups associated with larger networks and fewer high-risk populations perform better probably because of access to better management tools and overall lower risk patients.
  - ***Recommendation:***
  - ***Medical practice integration and embracing information technology will be imperative for success. Independent physicians and small physician groups must find ways to integrate their practices with larger entities in order to take advantage of cost efficiencies and access to IT.***
  - ***Develop population specific P4P Quality Improvement programs with physicians and medical groups serving high-risk populations designed to eliminate healthcare disparities.***

Lessons and Recommendations
Consumer Reform

- Health Policy advocates should prioritize to bring about programs and legislation at both the state and national levels that promote reform by:
  - ***Recommendation:***
  - ***Allocate resources for outreach and education to address population and ethnic specific obstacles in achieving improved quality measures.***
  - ***Health policy changes that mandate HMOs to monitor health quality of minority and high-risk populations and then allocate resources to address any quality disparity.***

MultiCultural IPA
Quality Improvement Program (QIP)

- IPA will invest more than $500,000 over 3 years in supporting physicians to purchase and integrate EMR into their practices.
- IPA formed a partnership with group management company (SynerMed) and EMR company (MediTab) to utilizing an IPA integrated IT solution that will improve collection of encounter data and enhance access to specialist and ancillary services.
- Perform independent consumer surveys that will address the specific concerns for the population being served.
- Identify population specific QI measures and set goals that reflect the realities of the population being served.
- Long range phase of the QIP will be to improve quality process measures and quantify any quality improvement in health outcomes.

ISDN-H / BiDil Underutilization
Health Care Poor Quality

An opportunity to improve quality and adopt a population specific quality measure

- A-HeFT trial evidenced-based findings concluded that isosorbide-hydralazine (ISDN-H) combination was associated with a 43% drop in mortality risk, a 39% decrease hospitalization for African Americans with CHF and improvement in quality of life.

- After a year of being approved by the FDA registry data suggest that no more than 20% of the target population is taking BiDil or its separate generic components.

Hospitalization and Costs in A-HeFT

Circulation 2005; 112:3745-3753

End point	ISDN/hydralazine, n=518	Placebo, n=532	p
HF hospitalizations/ patient, mean	0.33	0.47	0.002
HF hospitalization LOS, mean (d)*	6.7	7.9	0.006
Cost of hospitalization, mean*	$12 896	$15 277	0.0045
Cost of care for HF, mean *	$5997	$9144	0.04
All healthcare-related costs, mean ($ US)*	$ 15 384	$19 728	0.03

LOS=length of stay

***cost of hospitalizations, ER and unscheduled physician visits, and nonstudy medications but excluding cost of study drug**

P4P Criteria for a Population Specific Quality Measure

P4P = EBM + Cost-efficiency + Patient Centered

BiDil =↓Mortality +↓Hospitalizations +↑Quality of Life

The Challenge

- Like it or not, P4P is a reality that is now being utilized and presumed to monitor and measure health quality – We must therefore become engaged and make P4P work for all populations.