National efforts in measuring and reporting on physician efficiency

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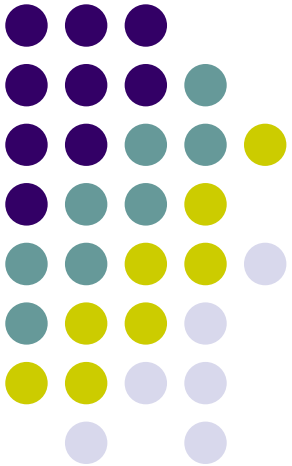
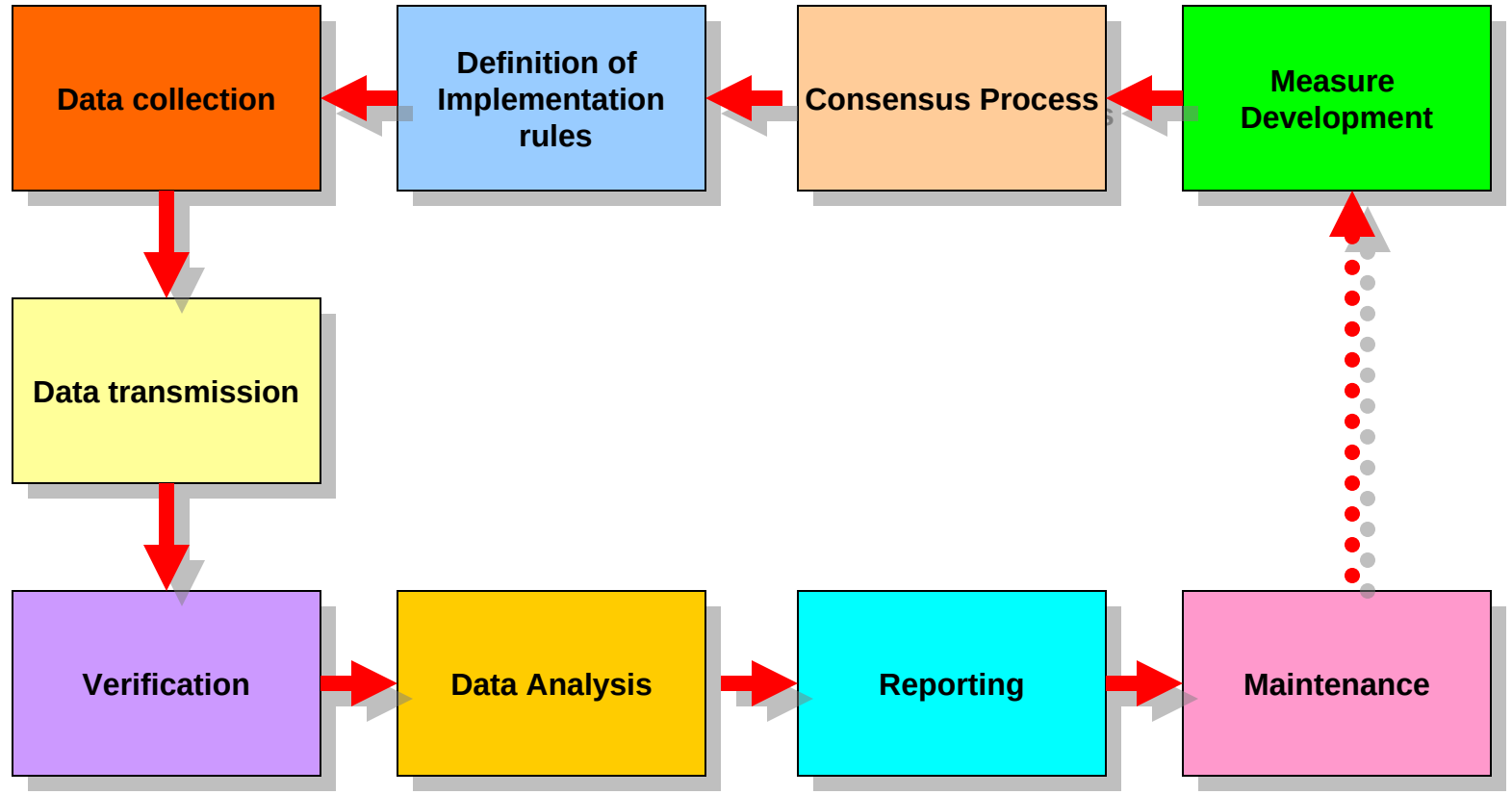


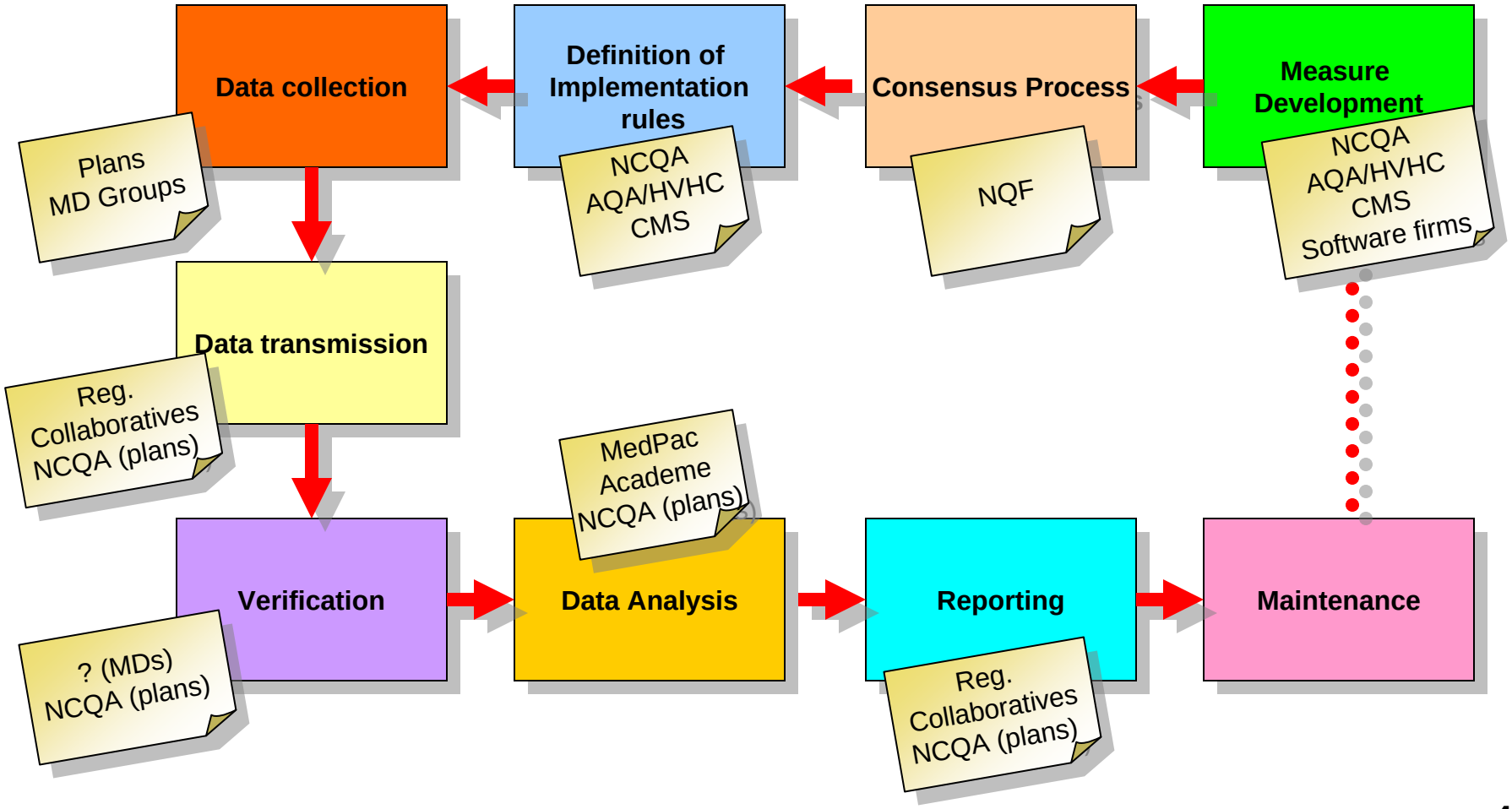
What is the problem?

- Inefficiencies and waste are suspected to be wide-spread throughout health care
- While we are able to measure and report on quality (even if rudimentary) – measurement of efficiency and/or waste has not been as widespread.
- As consumers' responsibilities for out-of-pocket costs increase (e.g, high deductible health plans) and plans' use differing approaches to classify physicians use of resources/cost, need for national approach has been heightened.

National quality measurement & reporting enterprise



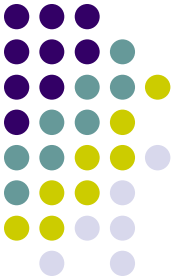
Players in the national enterprise



NCQA - Plans

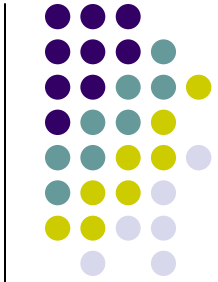
- Focus on age-sex, co-morbidity adjusted resource use (utilization) weighted by standardized dollars for six chronic conditions with existing HEDIS effectiveness-of-care measures
- Developed for applications with HMOs, PPOs, possibly viable for MD groups
- Collected through HEDIS as of 2007
- Public reporting as of 2009, details forthcoming
- Separate research effort underway to understand plan factors related to favorable quality + resource use results
- Refinement of risk adjustment approach is being explored

NCQA- MDs



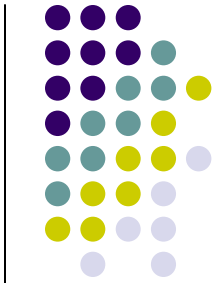
- Specification of HEDIS effectiveness-of-care measures at MD level
- No specific cost of care measures identified
- Detailed consensus-based implementation rules for use of person and population-level adjustment methodologies suggested
- No data collection based on these spec’s

High-Value Health Care/AQA



- AQA has endorsed efficiency definition
  - Costs of care: resources used to deliver the care
  - Quality of care: a measure of benefit (multidimensional and comprehensive)
  - Efficiency: costs of care associated with specific level of quality
  - Value: reflects the judgment of patient (or others) about the particular combination of costs (and their distribution) and quality (comprehensively assessed).
- RWJF grant to ABMS: Development of public domain episode-based cost of care measures by Dec 2009
- Experts, stakeholders, and researchers will develop and test detailed specs to seek endorsement of NQF

High-Value Health Care/AQA



- 20 Priority Conditions
  - CV: Angina, AMI, CHF
  - Resp: COPD, Asthma, Bronchitis, Pneumonia
  - Cancer: Breast, Prostate, Colon
  - Hypertension
  - Stroke
  - Hiatal Hernia/GERD
  - Osteo: Hip Fracture, Osteoarthritis,
  - Diabetes
  - Depression
  - Hysterectomy
  - Sinusitis
  - Spine: lumbar

CMS - 1

- Partially based on MedPac and GAO recommendations CMS took action …
- SOW of recent RFP (RTOP-08-007):
- (1) develop meaningful, actionable, and fair measures of resource use for both physician practices and hospitals with the ultimate goal of using the measures in CMS' value-based purchasing (VBP) initiatives and
- (2) provide feedback and education in order to encourage more efficient practice by physician practices and hospitals.
- SOW defines a phased pilot approach to expand CMS' understanding of the policy issues related to measuring physician-driven costs of care using episode grouper software and resource use report (RUR) design issues.
- Award expected soon

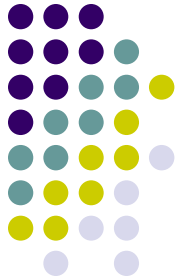
CMS - 2

- The SOW is to achieve the following:
- (1) expand CMS' capability to process Medicare FFS claims through commercial episode grouper products;
- (2) explore different risk adjustment options include:
  - (a) the processes built into each commercial episode grouper product,
  - (b) CMS' HCC model, and
  - (c) and a combination of a and b;
- (3) produce sample resource use reports (RURs) that include different models of attribution and benchmarking; and
- (4) generate "production" logic and documentation to "scale-up" production of RURs beyond the scope of initial contract.

Private organizations

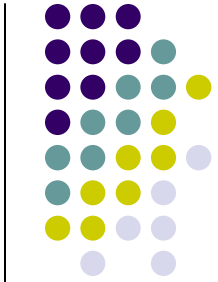
- Several firms (Medstat, Ingenix, 3M, others) offer proprietary tools to classify care reflected in administrative data into episodes to estimate risk and severity adjusted costs. Originally tools were not developed for public reporting or P4P purposes
- Tools differ in their specific definitions for particular conditions/episodes, data requirements, etc.
- Most tools allow for risk/severity adjustment as well as population (case-mix) adjustment at the MD level
- All tools leave significant room for customer preferences in calibrating particular methods and applications
- Focus is typically individual physician, by specialty
- In use for several years, continued refinements are being made
- A few side-by-side comparisons of tools for various applications are available (Medpac, Academe, Society Actuaries)
- Critical detail of tools are typically not available for public review; no tools have been endorsed by NQF

Consensus/Endorsement - NQF



- Intention to develope a comprehensive measurement framework to evaluate efficiency—defined as quality and costs—across episodes of care including:
  - Clear definitions
  - A discrete set of domains
  - Guiding principles for implementation
- Selected two priority conditions - AMI & LBP - to serve as operational examples to measure, report and improve efficiency across episodes of care

Consensus/Endorsement - NQF

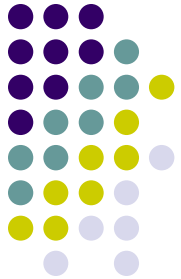


- Supports a patient-centered approach
- Addresses major gaps in existing performance measures: care transitions, patient-centered & cost of care measures
- Shifts focus from individual providers' performance to understanding their contribution to care: "shared accountability"
- Required to understand costs and their relationship to quality
- Could support reformed payment models

Consensus/Endorsement - Medpac

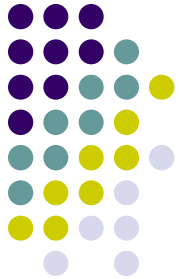
- March 2005 recommendation for CMS to measure physician resource use and report confidentially to physicians
- Evaluation of ETG and MEG groupers on Medicare claims
  - Both groupers effective in assigning high proportions of Medicare claims (and dollars) to episodes
  - Depending on attribution method chosen, up to 90% of episodes could be assigned to a given physician
  - For certain conditions (e.g. CAD) episode grouping technologies were not able to adjust for regional differences in diagnostic coding (Miami versus Minneapolis)

Performance Reporting



- Health plans
  - Plans in same markets may use different tools and methods to characterize MD cost
  - Application for network tiering and feedback to MDs; little public reporting
  - Significant pushback experienced by some plans
- Regional collaboratives usually relying on multi-payer data
  - BQI (6) and AFQ (14) communities aspire to measure and report on quality as well cost of care
  - IHA – exploring how to best measure cost and link to care results/quality
- Others
  - Bridges to Excellence/Prometheus
    - Development of case-based payment systems (relying on episode-grouping methods); not intended for public reporting purposes

Key issues for national resolution

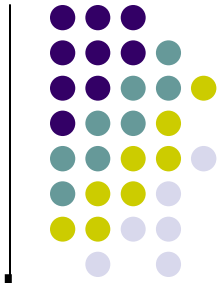


- Framework/Definition
  - Episodes of Care/Complex conditions
  - Appropriateness of care
  - Units of (shared) accountability
  - Unit price/utilization
  - Linkage of quality and cost results
- Reliability/Validity
- Useability – for and by whom?
- Infrastructure

Framework

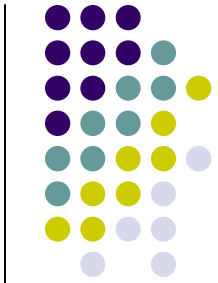
- Episodes of Care/Complex conditions
  - Detailed work to calibrate episode definitions; how to accelerate development and maintenance
  - Agreement on risk, severity, and population/episode adjustment approaches outstanding - performance of current public domain tools not clear in this context
  - How to account for regional coding/diagnostic differences
- Appropriateness of care
  - Conventional definitions of efficiency/value do not address appropriateness explicitly – arguably a major driver of unnecessary resource expenditures
  - What is feasible assessment framework for appropriateness?
- Units of (shared) accountability
  - When assigning co-accountability; who's responsible for aspects of episode (acute, non-acute)
- Unit price/utilization
  - Different MD receive different payments for same services from different plans based on negotiated rates. Based on rate differences MD may appear "efficient" in one but not another plan
  - Yet, employers and plans may want to assign to tiers based on the negotiated fees they are responsible
  - Need to resolve tension between inclusion of unit price-based efficiency and total resource use based efficiency
- Linkage of quality & cost results
  - Methods need to be identified about means to link performance results on effectiveness of care to cost of care

Reliability



- Minimum threshold for reliability needs to be established
  - Sample size requirements
- Thresholds for performance stability over time unclear

Usability



- Providers
  - Ensure actionability – is information provided that points to specific steps that can be taken to improve performance results
- Payers
  - Unit prices are critically important in determining relative efficiency of providers; use of standardized fee schedule not as compelling
- Consumers/Patients
  - Cost-of-care less relevant outside of high-deductible health plans
  - Out-of-pocket costs are relevant but may be unrelated to efficiency of providers

Infrastructure

- Detailed definitions on data elements & specific implementation rules needed
- Creation of multi-payer databases is resource intensive – linking same MDs between different databases
- National infrastructure possible – but untested; regional infrastructures may be inefficient – particularly when employing different approaches

Outlook

- Nascent efforts underway to create national consensus around cost-of-care measures
- National infrastructure is envisioned but not robustly tested
- Critical conceptual issues need to be addressed and resolved
- Ability to implement hinges on availability of highly detailed specifications and rules.