

The Quality Colloquium

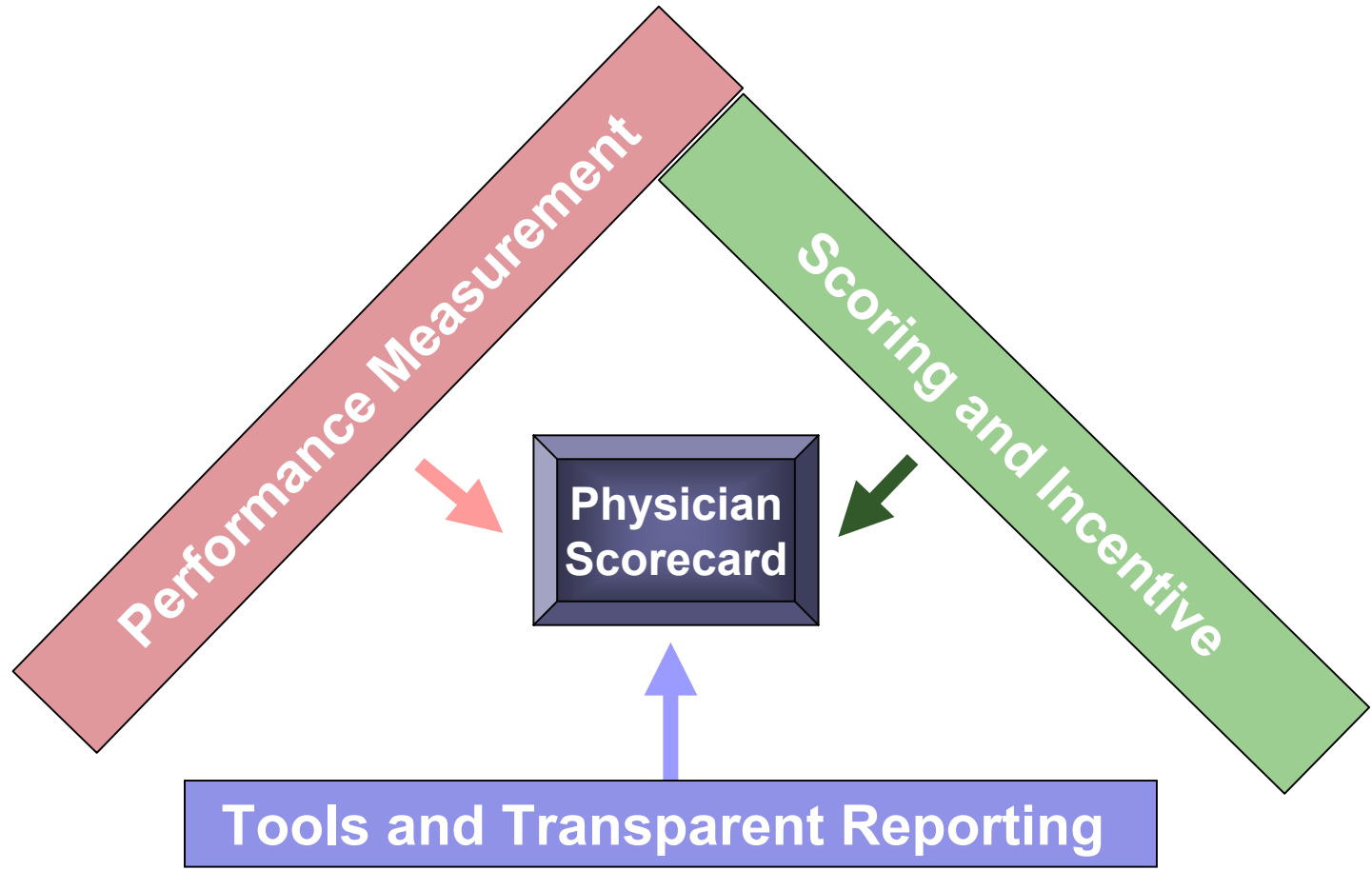
Is Pay for Performance an Experiment ?

August 21, 2006

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San Francisco, CA
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- **Introduction**
- **Progress in Measurement and Incentive for Physicians**
- **Challenges and Success**
- **Impact**
- **Predictions**

We build custom physician efficiency and quality measure scorecards and software applications used by health plans to report actionable results to plan members and physicians.



The issues:

- Gap in evidence-based care: 55% adherence (McGlynn, *NEJM* 2003)
- Double-digit medical cost trends: PWC predicts Medicare Trust Fund erosion by 2020

The response:

- IOM Report calls for Pay for Performance
- CMS P4P Projects: Premier Hospital, Physician Group Practice Demo, AQA Pilot in 5 States
- NCQA and AMA are developing specialty measures
- Employers requiring performance based purchasing
- Public reporting in California, Mass, Maine, Minn, etc

- 1. Measures that are Quantifiable, Feasible, Evidence-based**
- 2. Comparable and Within Scope for Providers in Specialty**
- 3. Statistically Reliable with Sufficient Sample Size and Reproducible**
- 4. Potential for Impact on Cost Trends and Outcomes**
- 5. Reported with Patient Detail for Process Improvement**
- 6. Develop in Partnership with Physician Community**



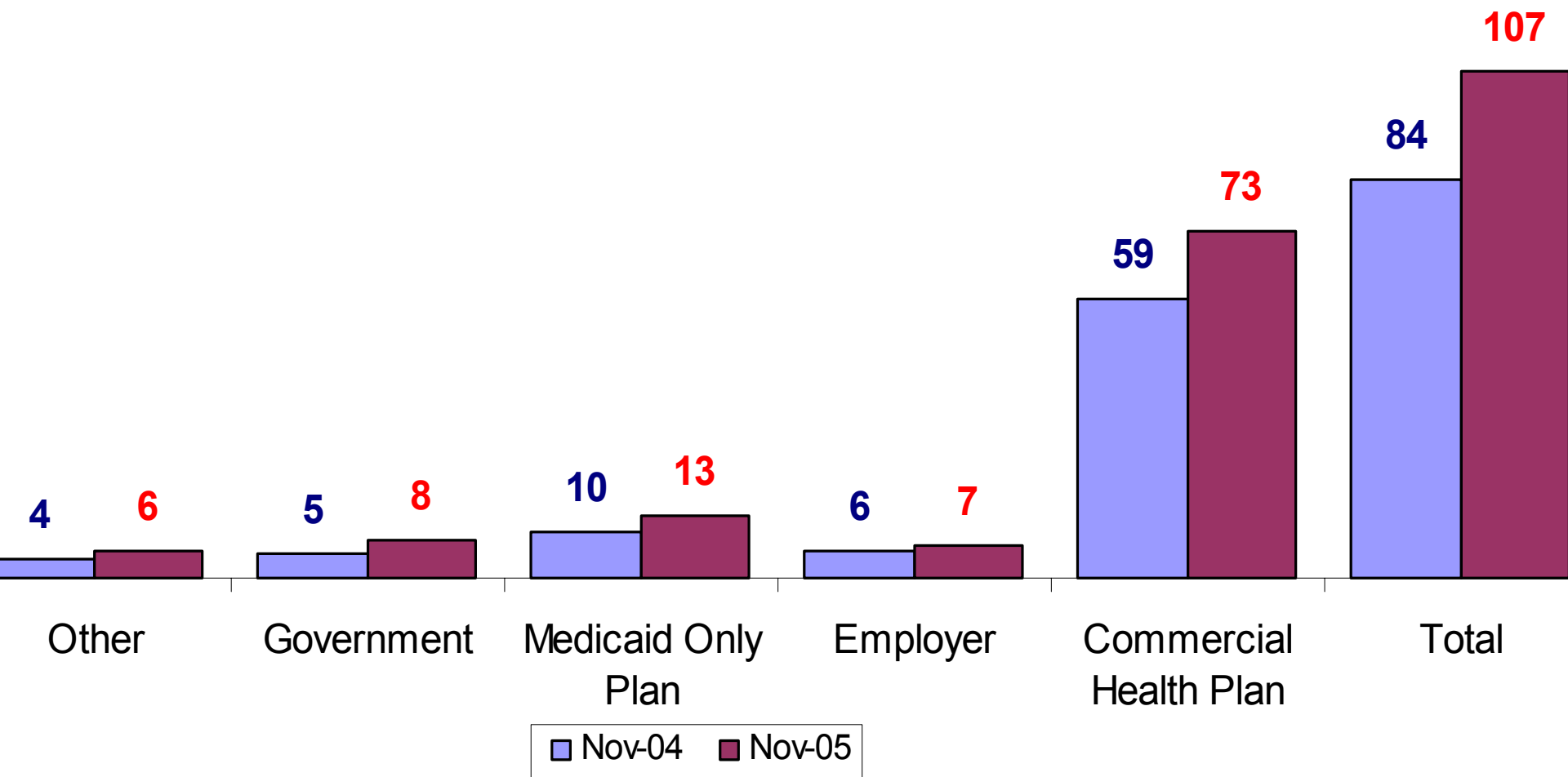
Features

- HEDIS measures
- HEDIS for MDs
- HMO product line
- Withhold or Bonus based payouts
- Hospital measures
- Balanced Scorecard
- Evidenced based quality
- Cost measures
- IT adoption measures
- HMO, PPO, CDH
- Tiered fee schedules
- PCP, Specialist + Facility
- Balanced Scorecard
- Shared savings for funding
- Integrate with DM
- Actionable MD info - alerts, registries, reminders
- All products, ASO

Benefits

- Informational
- Low impact on cost
- Preventive care
- Existing data sets
- Static consumer report cards
- Safety and medication errors
- Provider IT investment
- Collection of non-claims data (lab values, etc.)
- Personal, dynamic consumer report cards
- EMR Integration
- Sophisticated clinical info
- Point of care data integration
- Demonstrable ROI
- Responsible Public Reporting

Prediction: 145-160 programs in 2006



	<u>2003</u> n = 34	<u>2004</u> n = 78	<u>2005</u> n = 82
PCPs	32 94%	73 94%	78 95%
Specialists	13 38%	33 42%	43 52%
Hospitals	8 24%	17 27%	30 37%

Status in 2005 Reporting Categories

	2003 Survey n = 34	2004 Survey n = 50	2005 Survey n = 76
Clinical	89%	94%	91%
Patient Satisfaction	79%	56%	37%
Efficiency/Utilization	57%	46%	50%
IT/Infrastructure	39%	54%	42%
Administrative	54%	40%	25%
Other	32%	22%	26%

NOTE: in 2003 and 2004 both hospital and physician P4P programs were included in this question

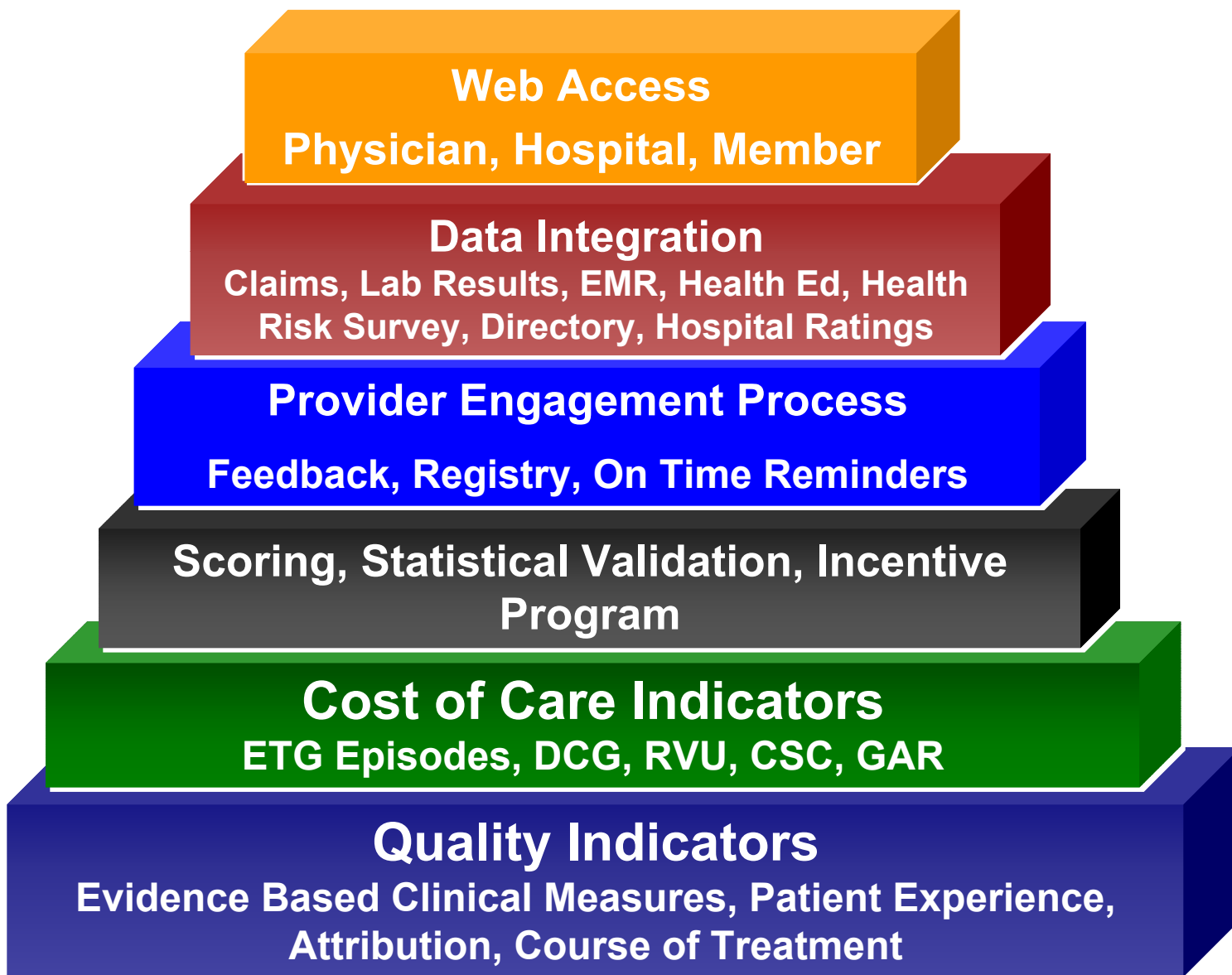
Status YE 2005: Weights for Categories

Clinical	52%
Efficiency/Utilization	35%
IT/Infrastructure	26%
Patient Satisfaction	22%
Administrative	15%
Other	28%

Source	Responses	%
HEDIS	68	87%
Internally developed efficiency measures	36	46%
Internally developed clinical measures	35	45%
Patient surveys	25	32%
National Quality Forum	19	24%
Bridges to Excellence	18	23%
AMA Consortium or Specialty Societies	13	17%
CMS	12	15%
AQA Starter Set	11	14%

n = 78

- **Evidenced-based or specialty supported measures**
- **Balance of care and cost measures**
- **New categories – IT adoption, patient experience**
- **Statistically reliable and valid**
 - Analysis of frequency and variation
 - Risk adjust clinical outcome and cost measure
 - Multiple statistical tests
- **Feasible**
 - Advanced administrative data (LOINC, EMR)
 - Within the physician span of control
- **Actionable**
 - Improvement requires on time patient detail





1. Identify Prevalent Conditions
2. Apply EBM to High Impact Conditions
3. Document Sources, Grade of Evidence)

4. Translate guideline into measure specification
5. Establish rules & test reliability
6. Review provider compliance rates and test accuracy at patient level

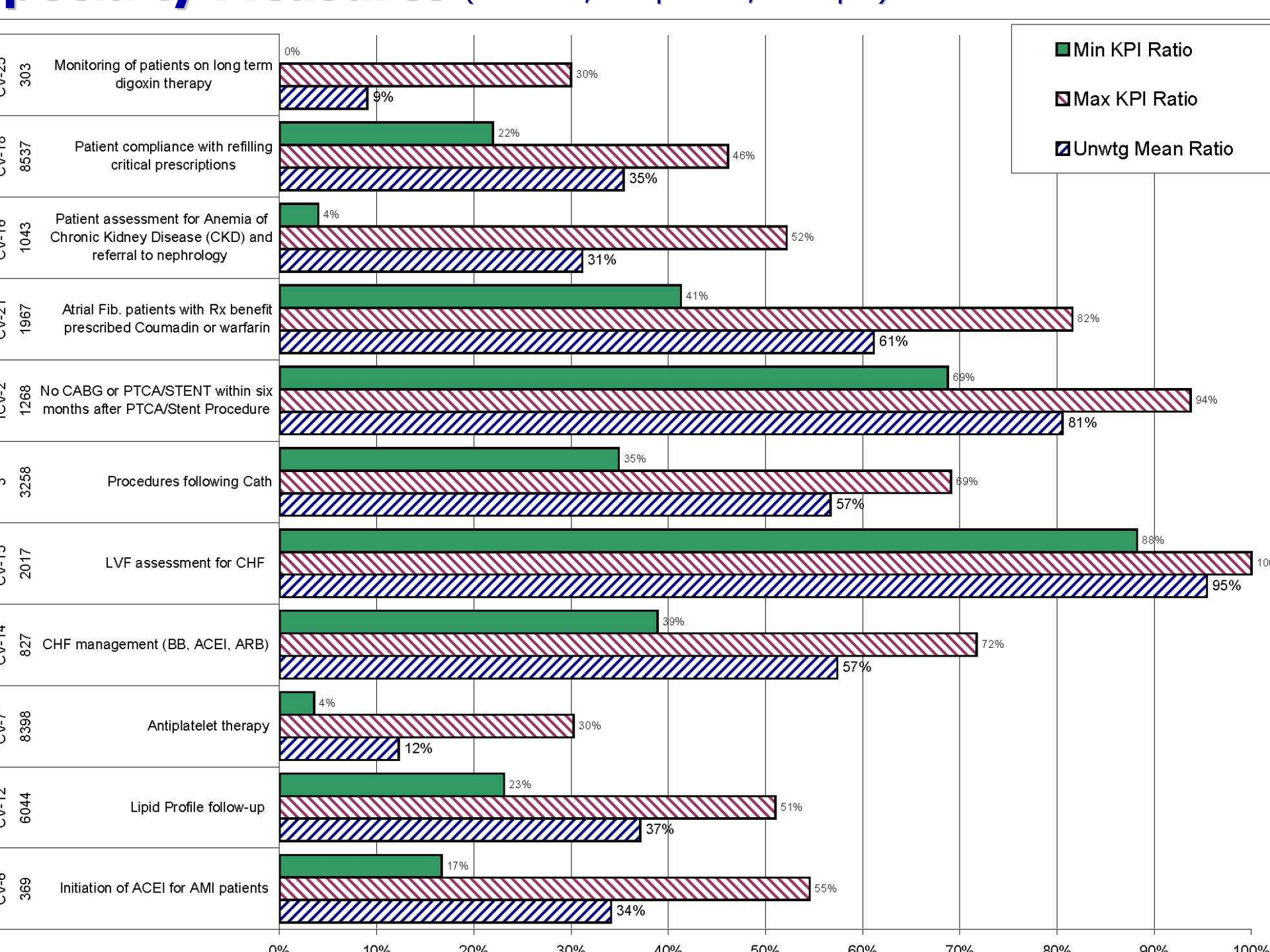
7. Perform statistical analysis
8. Validate results
9. Develop actionable reporting

Marketing -EBM Measures Dataset

MED-VANTAGE EBM CROSSWALK LISTING

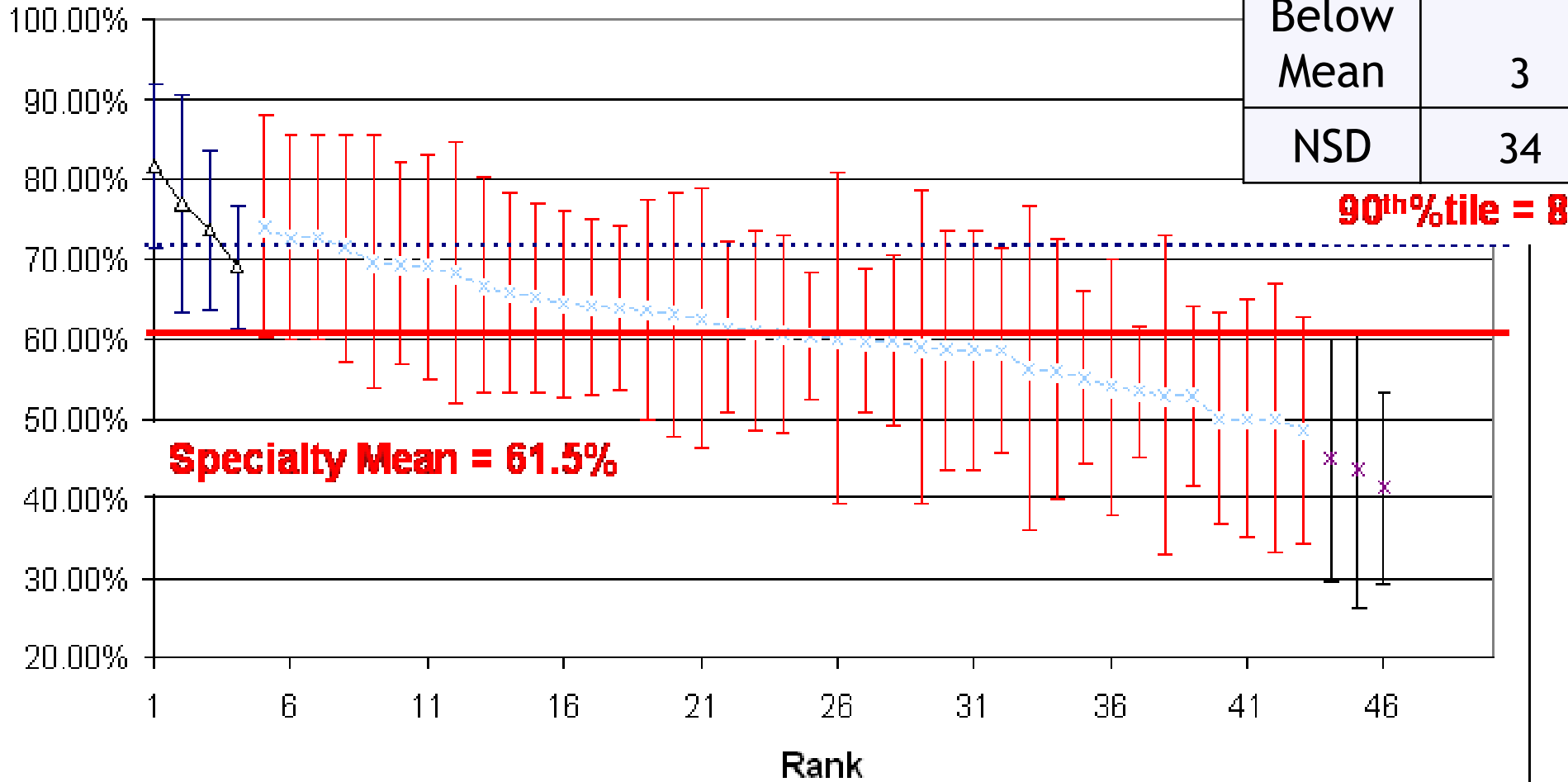
MED-VANTAGE EBM CROSSWALK LISTING

MV Ref #	Clinical Measures	Measure Description	Condition	Data Source	HEDIS	NQF	AMA	ACC/AHA	DOQI/CMS	AHRQ	RAND	ACS	CMS 2005 PAP	REFERENCES
	Cardiovascular/Renal													
1	Total Lipid Profile during preventive health visit, or problem oriented visit	CV preventive screening during problem or well adult visit	CV preventive screening-average risk	Admin			Δ	Δ						NCEP, 2002
2	Baseline lipid profile in those over 35 and/or with high risk CV factors (obesity, Hx of AMI, HTN, diabetes, etc.)	CV preventive screening	CV preventive screening - high risk; AMI HX; Diabetes, HTN, Diabetes, Metabolic Syn; Obesity	Admin	Δ	Δ	Δ	Δ				Δ	Δ	ACC/AHA, NCEP, 2002
3	Stress testing recommended either at preventive health visit or problem oriented visit for men over 45 and women 55 plus with 2 or more CAD high risk factors	AMI Risk Prevention in CAD	CAD	Admin			Δ							ACC, 2002, ACC, 2003, Am Heart J 2005;149:527-533.
4	Statin Therapy for patients with elevated lipid panel	AMI Risk Prevention in CAD; statin tx	AMI ;CAD;	Admin		Δ	Δ	Δ	Δ	Δ	Δ	Δ		ACC/AHA, 2002
5	Beta-Blocker Therapy for patients with history of AMI or post-AMI admission	recurrent AMI Risk Prevention in CAD/AMI; beta blocker tx	AMI	Admin	Δ		Δ	Δ	Δ	Δ	Δ		Δ	ACC/AHA, 2002
6	Initiation of ACEI in post AMI and CAD; . Consider chronic therapy for all other patients with coronary or other vascular disease unless contraindicated.	recurrent AMI/CHFRisk reduction; ACEI tx	AMI/CHF	Admin		Δ	Δ	Δ	Δ	Δ	Δ			HOPE Study, 2000, ACC/AHA, 2002, Scottish Intercollegiate Guidelines Network (SIGN); 2000
7	Use of aspirin and/or Plavix antiplatlet therapy in patients post PCTA	DVT/PE risk reduction in AMI-patient safety	AMI/PTCA	Admin			Δ						Δ	ACC/AHA, 2000, 2002, JAMA, 2004, BMJ 2005
8	Diuretic as first line drug in treating HTN	HTN drug tx.	HTN	Admin			Δ				Δ			NCEP, 2002, JNC 7, 2003, NHLBI/NIH



Result	# of MD
> Mean	4
At Mean	39
Below Mean	3
NSD	34

Cardiology - CV-21
Atrial Fibr patients with Rx benefit prescribed Coumadin or warfarin
90% CI (n>=15), alpha level = .10



<i>Domain</i>	Clinical KPI Measures	Eligible Patients	Total Received Services	Rate	Peer Avg.	Provider Percent
Coronary Artery Disease	Beta Blocker Compliance – % of Patients after MI on Beta Blocker	113	79	69.9%	83.6%	75th
	Continued ACEI Therapy after MI	117	79	67.5%	79.5%	65th
	LDL Test for CAD Population	115	85	73.9%	78.4%	50th
Total		597	431	72.2%	83.1%	77th

- **Challenges**

- Complex program requirements
- Complex technical requirements
- Complex methodological issues

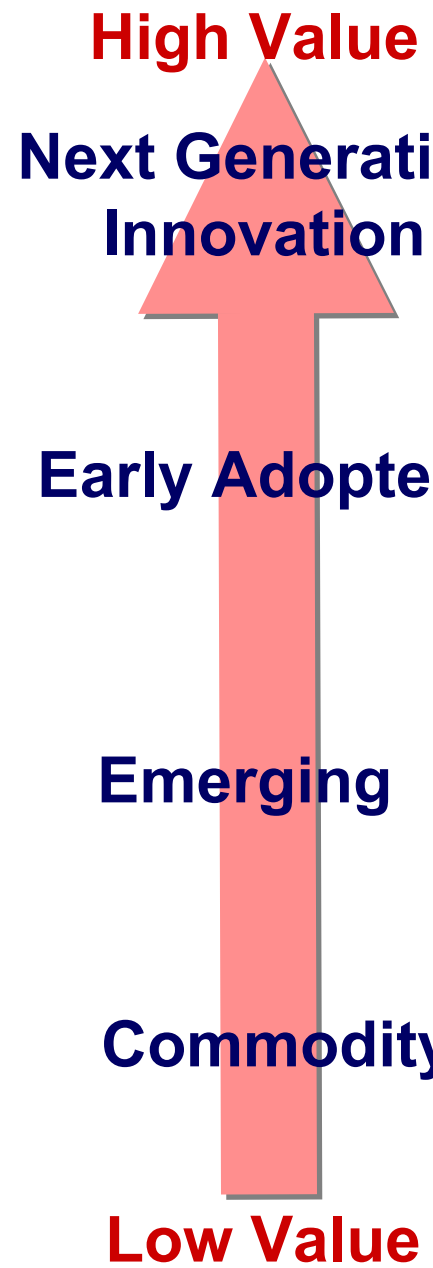
- **Successes**

- Provider engagement tools
- Business rules to address technical issues
- Advances in measurement methodologies
- Programmatic improvements

Plans Report Constraints	Responses	%
Small numbers problem	49	63%
Timeliness of the data	46	59%
Accuracy of the data	40	51%
Availability of lab data	39	50%
Assigning patients to doctors	25	32%
Need to use chart data	24	31%
Sharing/exchange of data with MDs	22	28%
Risk adjustment	21	27%
Availability of pharmacy data	18	23%
Defining a phys. practice/group	16	21%
Auditing the data	16	21%

Variation in Levels of Deployment - 2009

- 1. Under 5 – MD Condition Specific Performance (ABCBS)**
- 2. Under 10 - Hospital + MD Performance (CFP, BHI, Cigna, Aetna, UHC, Humana)**
- 3. Under 20 - MD Performance (MHPQ, Premera, BCBSMA, Priority)**
- 4. Over 100 - Hospital Performance (Subimo, Healthshare, CMS)**



THE WALL STREET JOURNAL

Tuesday, March 29, 2006

“Doctors Rap UnitedHealthcare For Its New Evaluation Program”

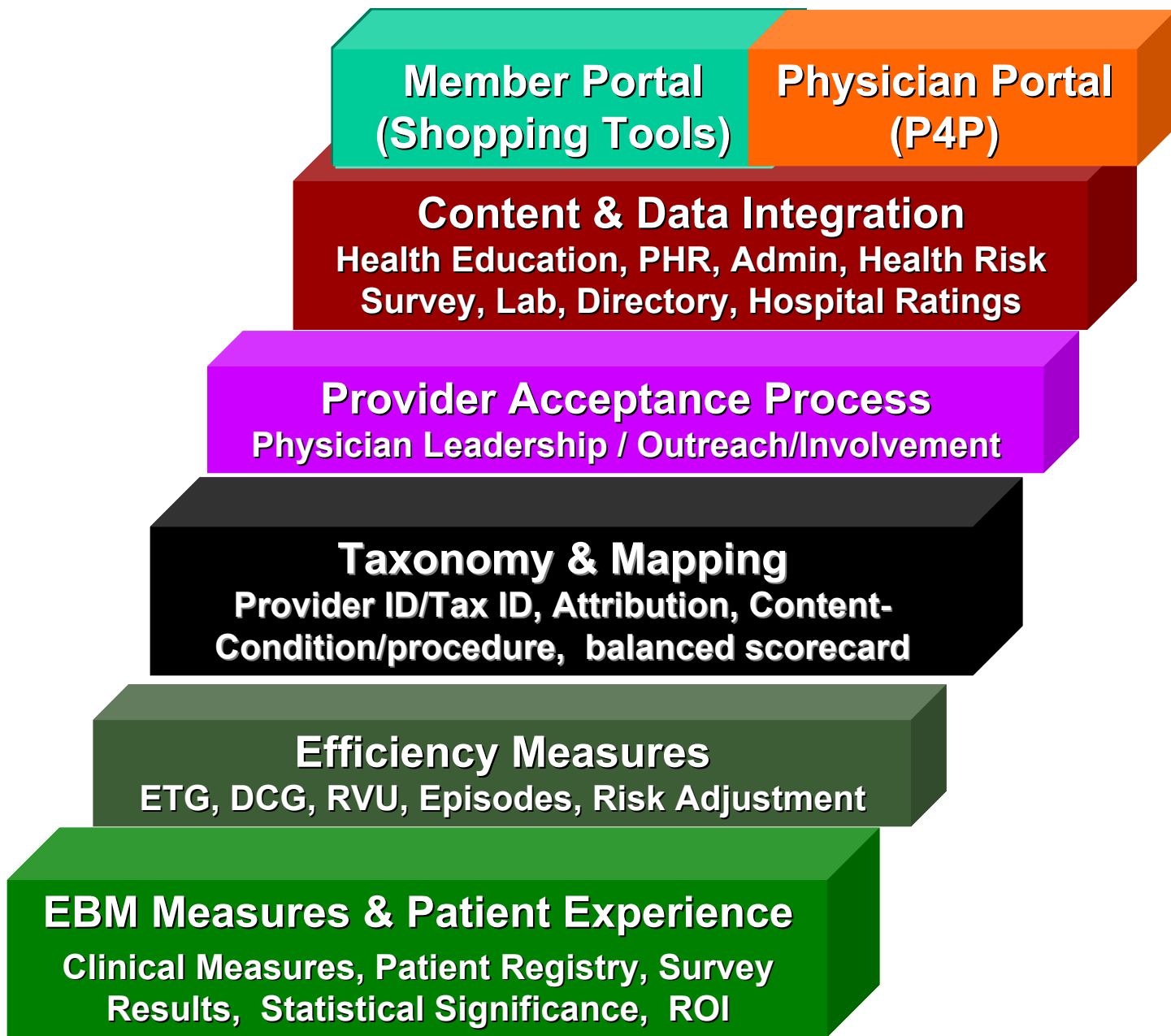
By Sarah Rubenstein

ST. LOUIS POST-DISPATCH

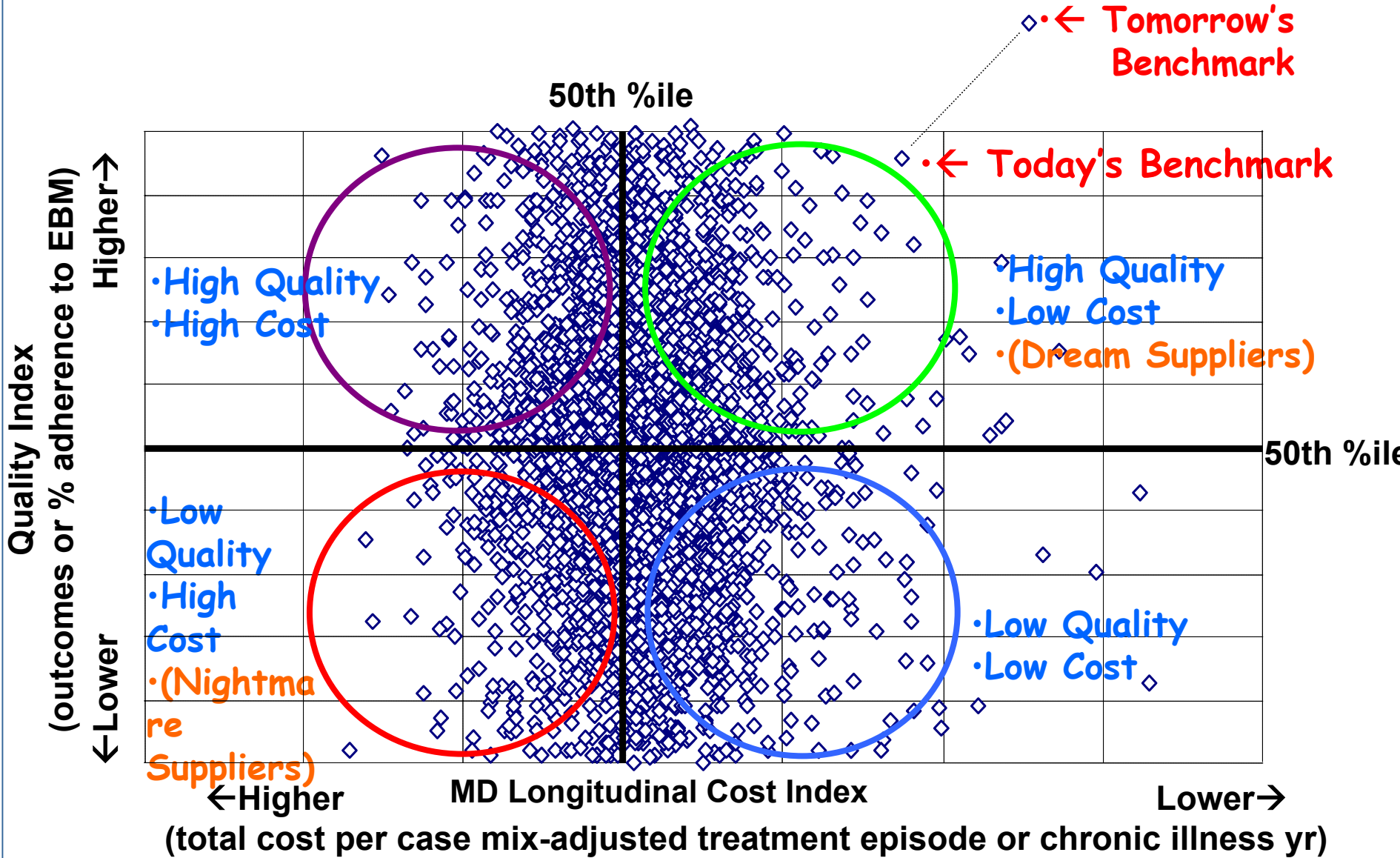
Sunday, February 13, 2005

“Health insurance program aimed at efficiency brings confusion, outrage“

By Judith Vandewater



1. P4P funding module
2. Balanced scorecard construction
3. Built EBM measures, configurable for multiple specialties
4. Target setting (mean, absolute, relative) using statistically sound methods
5. EBM references (grade of evidence, citations)
6. Patient registry, Electronic patient health record
7. Specialty Condition efficiency indexing
8. Non-admin data results reporting and chart results entry
9. Statistical validity checks (sample size, confidence intervals, percentile ranking, scoring)
10. RDBMS Platform
11. Scoring and payment calculation
12. Web design, electronic and non-electronic delivery
13. Exception reporting & data correction
14. Care alert generation (omissions/commissions, gaps, DDI checks)



Experienced Plans Recommend	Responses	%
Involve providers early in the design	61	74%
Use well-established/co-authored measures	52	63%
Be willing to make changes over time	40	49%
Pilot the P4P measures/reports first	26	32%
Use transparency/public reports as incentive	15	18%
Be clear where your own ROI will be	8	10%
Other	7	9%

n = 82

- **Patient Assignment** – methods to identify responsible MD
- **Course of Treatment** – timeframes for care, gaps in coverage
- **Clinical Measure Rules** - Composite Measures, Overall Clinical Index
- **Cost Measure Rules** - Specialty Condition Index, Goal Attainment Rates
- **Outlier Trim Methodology**
- **Risk Adjustment Methodology**
- **Statistical Tests for Validity** – Confidence intervals, correlation tests, minimum sample size, display rate, descriptive statistics



Methods of Scoring MD Performance	Responses	%
Performance above an absolute threshold	37	47%
Relative ranking to peer group – each measure	34	44%
Relative ranking to peer group – total score	21	27%
Relative ranking to peer group – efficiency index	9	12%
Relative improvement over previous reporting period	9	12%
Some combination of the above	27	35%
Other	12	15%

n = 78

- **Physician “co-authoring”**
- **Data and Measures**
 - **Physician control**
 - **Statistical reliability, sufficient sample size, risk adjustment**
 - **EBM based, broadly accepted, clinically relevant**
 - **Data collection must not impose higher administrative costs**
- **Information and Process that Fosters Improvement**
 - **Opportunity for correction, appeal**
 - **Detail for improvement**

Source: The Use of Performance Measurements to Improve Physician Quality of Care, A Position Paper, American College of Physicians, April 2004

Engagement Tools – Health Performance Institute

1. Non-profit, non-aligned organization serving physicians and health plans
2. **Mission: To enhance the collective understanding of how provider incentive programs and public display of provider performance can best promote health care quality, efficiency, and safety**
3. Offers non-proprietary (no license fee) clinical IT survey tool for health plans to use with providers
4. Launching EBMPedia, first national consensus and physician comment tool for > 200 quality measures with cross references to national standard sets (AQA, AHRQ, ACC, etc.) .

The screenshot shows the 'IT Survey' page on the HPI EBMPedia Measure Library. The page has a blue header with the HPI logo and 'EBMPedia Measure Library'. A search bar is in the top right. The left sidebar contains an 'Overview Menu' with links to 'HPI Home', 'HPI EBMPedia', and 'IT Survey Program'. Below that is a 'Surveys' section with a link to 'IT Survey'. At the bottom of the sidebar is a 'William Allen' user profile with links for 'my account' and 'log out'. The main content area is titled 'Home' and 'IT Survey'. It includes a submission timestamp, a definition of 'Electronic Disease Registry', a definition of 'Electronic Medical Record', and a definition of 'Electronic Prescribing'. Below these definitions are three form fields: 'Tax Identification Number: *', 'Name of Physician Group: *', and 'Does Your Office Utilize Electronic Disease Registry?'. The first two fields are empty text boxes. The third field has radio buttons for 'Yes' and 'No'. Below this are two more questions: 'Does Your Office Utilize Electronic Medical Records?:' and 'Does Your Office Utilize Electronic Prescribing?:', both with radio buttons for 'Yes' and 'No'.

SEARCH REQUESTED

Health Condition*

Select Provider by Name

or

Select Provider by Primary Clinic

* Required field

VIEW RESULTS BY

Order By

Display

Results 1 - 10 of 32 < 1 2 3 4 > < previous | next >

Care Opportunity

DOE, JOHN		HOME (616) 123-1234	WORK ---
PCP BELISTO, FRANK		BIRTH DATE 08/05/1956	AGE 77
Most Recent Visits:			
PCP <input checked="" type="checkbox"/> 04/06/2001	SPEC 09/02/1997	ER ---	IP ADMITS ---
Most Recent Tests:			
HBA 1C 05/22/2003	PROTEIN <input checked="" type="checkbox"/> ---	RET EXM <input checked="" type="checkbox"/> 07/17/1997	LIPID 05/22/2003
Most Recent Rx:			
INSULIN ---	ORAL ANTI-DIAB ---	RX COVERAGE Yes	
Related Health Conditions:			
Diabetes ---			

DOE, JOHN		HOME (616) 123-1234	WORK (616) 123-1234
PCP BELISTO, FRANK		BIRTH DATE 04/22/1943	AGE 60
Most Recent Visits:			
PCP 02/10/2004	SPEC ---	ER ---	IP ADMITS ---
Most Recent Tests:			
HBA 1C 06/03/2003	PROTEIN <input checked="" type="checkbox"/> ---	RET EXM <input checked="" type="checkbox"/> ---	LIPID 06/03/2003
Most Recent Rx:			
INSULIN ---	ORAL ANTI-DIAB ---	RX COVERAGE Yes	
Related Health Conditions:			
Diabetes ---			

DOE, JOHN		HOME (616) 123-1234	WORK ---
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My Profile

- [Home](#)
- [Funding](#)
- [Scoring](#)
- [Search Provider](#)
- [Search Registry](#)
- [Set-up & Maintenance](#)

Previous Screen | [My Profile](#) > [Overall Performance](#) > [Clinical Quality](#) > [Clinical Quality Detail](#)

Clinical Quality - Baseline Lipid Profile In Those Over 35 With High Risk CV Factors

Report Period: June 2003 - July 2005
 Patients Met Goal: 293
 Target Goals: < 130

[Compare Selected](#)
[Print Selected](#)

Select	Patient ID	Patient Name (Service / Rx History Details)	Sex	DOB	Street Address	City	State
<input type="checkbox"/>	49493826	Kim Jones	F	3/22/1978	1456 Maple Street	Bentonville	AR
<input type="checkbox"/>	49423426	Peter Hankins	M	5/18/1958	1254 Houston Street	Bentonville	AR
<input type="checkbox"/>	897693826	Jurad Malawi	M	4/1/1954	89 Reconcile, #322	Bentonville	AR
<input type="checkbox"/>	89694316	Anthony Baskins	M	2/12/1969	1250 0th Street, #435	Bentonville	AR
<input type="checkbox"/>	7865826	Ralph Sycamore	M	1/9/1963	21 Fillmore Street	Bentonville	AR

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© 2005 Med-Vantage, Inc. All Rights Reserved. QualScore™ Demonstration System. This system is patent pending.

Patient Profile

- [My Profile](#)
- [Search Registry](#)
- [Referral Support](#)
- [Patient Search](#)
- [Patient Risk Assessment](#)
- [Patient Tools](#)
- [Clinical Reference](#)

Start | [Previous Screen](#) | [Patient Profile](#)

Patient Profile - Kim Jones

Patient Demographic & Benefit Information

First Name: Kim	Date of Birth: 3/22/1978
Middle Name:	Age: 27
Last Name: Jones	SSN: 52-89-5632
Sex: F	Member ID: 49493826
Address Line 1: 1456 Maple Street	Primary Tel #: (585) 432-4532
Address Line 2:	Alt Tel #:
City: Rochester	Line of Business: Health Advantage
State: NY	Patient Deductible: \$ 2,000
Zip: 14647	Patient Co-insurance: 20% Liability
E-Mail: kjones@aol.com	Co-Pay: N/A
Eligibility: Active	Eligibility Date: 2/1/2003
Group ID: S080-9076	Group Name: Beacon

Clinical Measures for this Patient

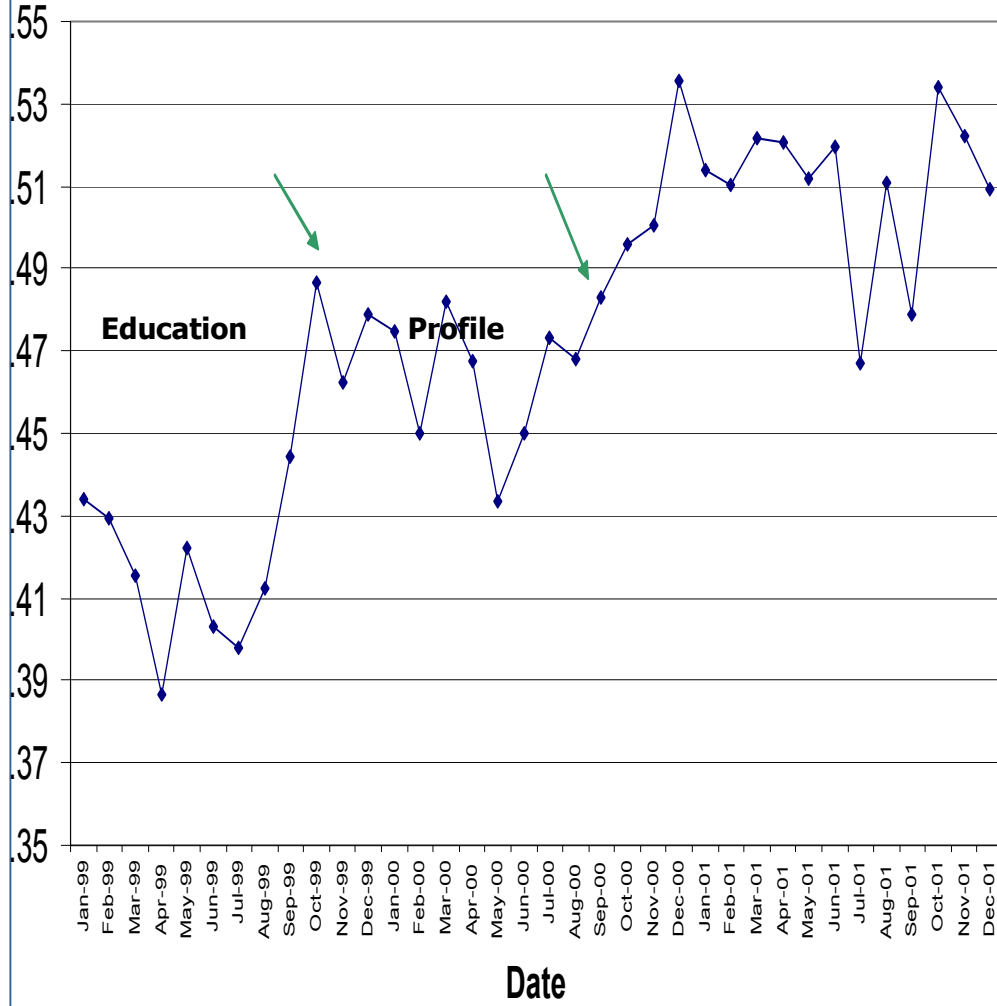
Measure Description	Patient Met Goal	Last Encounter	Claim Detail
Patient Compliance with refilling critical prescriptions	No	1/2/2004	Details
Baseline lipid profile in those over 35 with high risk CV factors	No	1/3/2004	Details
Diabetes screening in CAD patients	No	1/4/2004	Details

Diagnoses

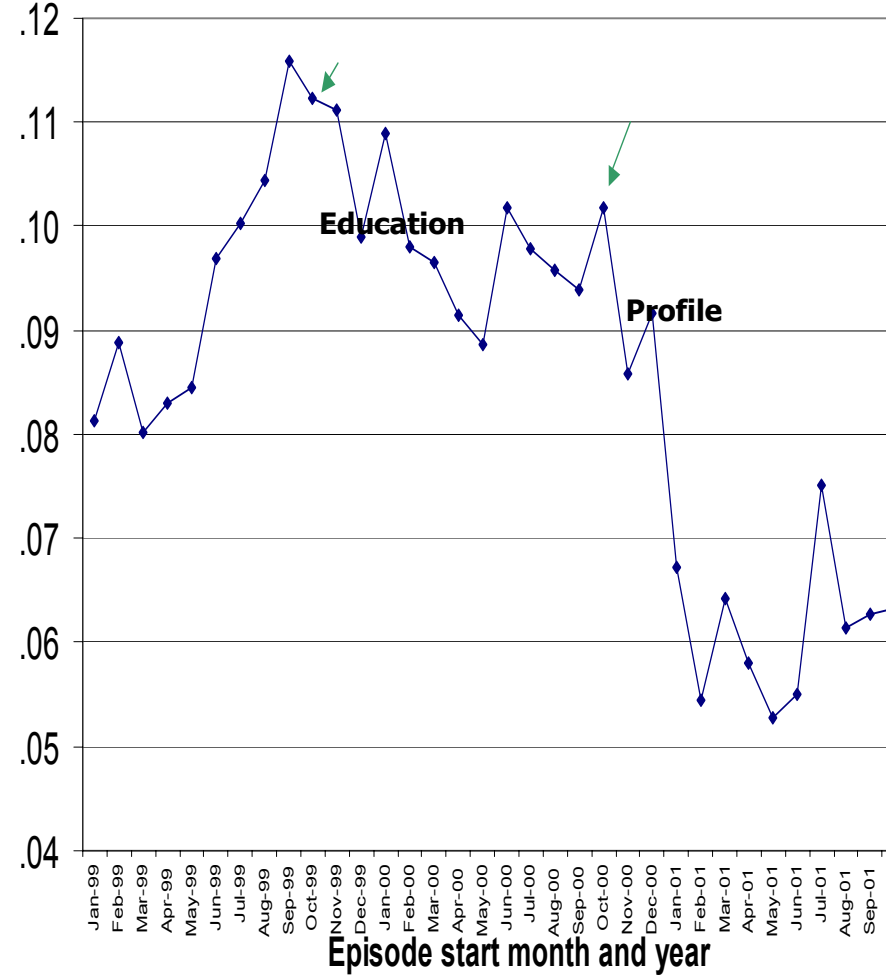
Claim No.	Dx 1	Description	Dx 2	Description	Condition	Date First	Date Last	Freq
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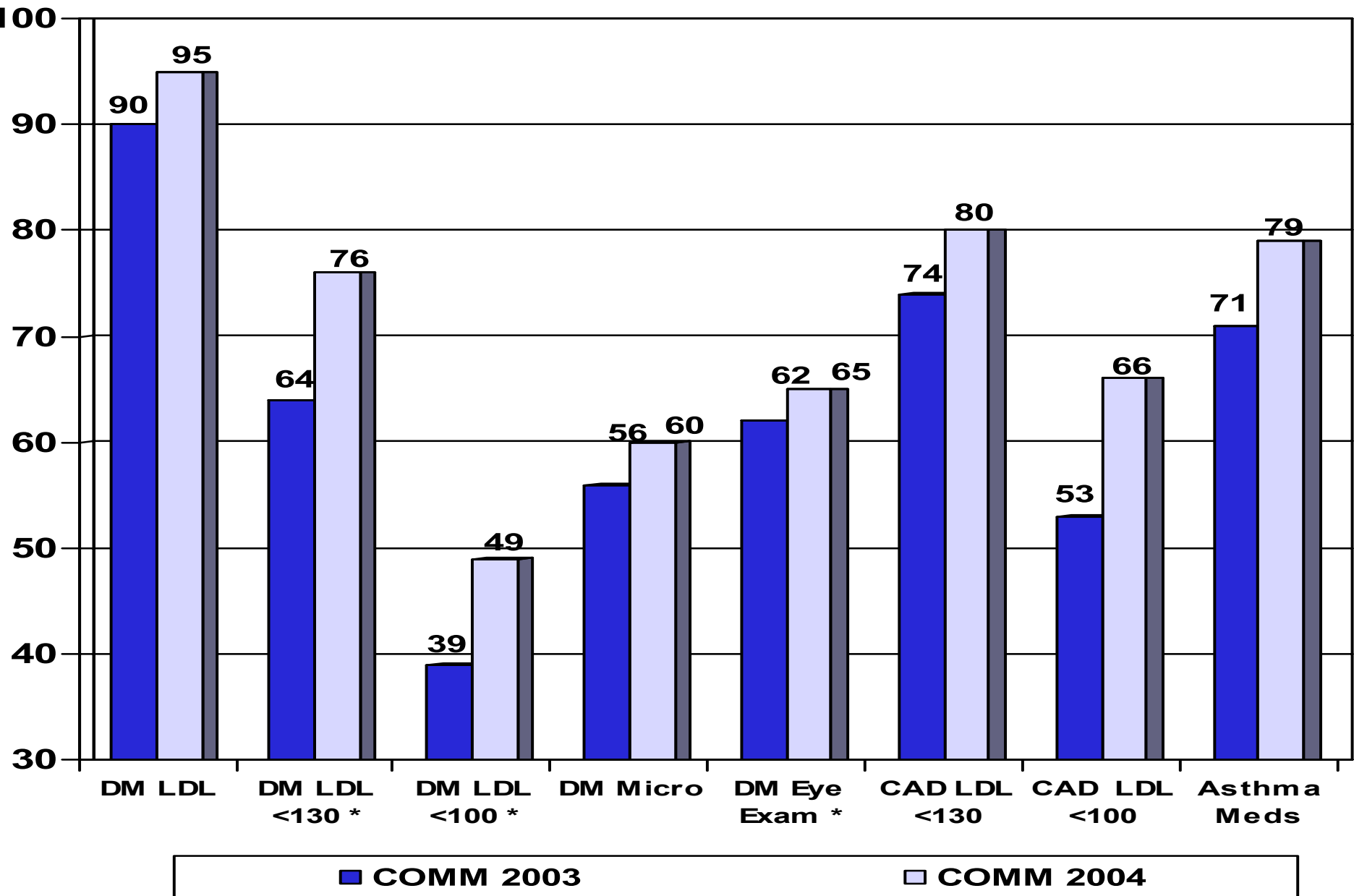
- **Robert Wood Johnson “Rewarding Results” Grant - 2002 to 2005**
 - **Implement and assess impact of 7 large P4P programs (MHQP, IHA, BTE, 3 BC plans, LIRR)**
- **Rand Assessment of Physician P4P Programs for Medicare**
 - **Thorough study of literature and existing programs**

First Line Antibiotics



Azithromycin





* Statistically Significant

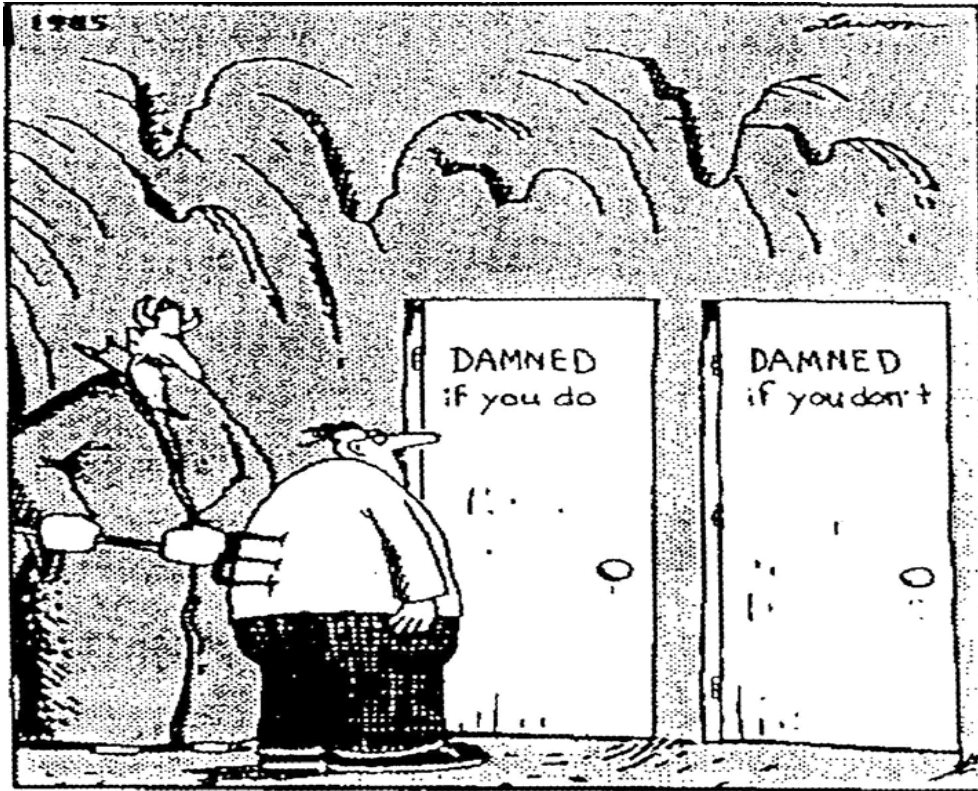
- **Actuarial Rolling Trend Analysis For Diabetes**
- **Baseline 2001/2002, Intervention 2003/2004**
- **CAD Provided Additional \$2 Million**

Journal of Healthcare Management Fall 2006

Profile ROI	2003	2004
Annual Savings on Trend	1,894,471	2,923,760
Annual Cost	1,148,597	1,148,597
ROI	1.5:1	2:1

Next Steps for Plans	Responses	%
Change the performance domains/weights	55	67%
Tie P4P to DM, tiering, benefit design changes	48	59%
Collaborate with others (e.g. employers, plans)	38	46%
Develop a public performance report	35	43%
Expand program to other products (PPO, ASO)	33	40%
Expand program from PCP to specialty	33	40%
Expand program to additional specialties	29	35%
Expand program to include hospitals	22	27%
Other	17	21%

- **Commitment to IT adoption**
- **Getting “actionable information” to physicians**
- **Public scorecards on quality, efficiency, and IT**
- **Integration of P4P and DM**
- **Growth in *consumer* incentives**
- **Continuing role of CMS**
- **‘Budget neutral’ P4P**
- **Continued push for standard ambulatory measures**
- **The emergence of “shared savings” models**



"C'mon, c'mon - It's either one or the other."

**Do the right thing.
It will gratify some...
and astonish the rest."**

Mark Twain

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