



Physician Tiering a.k.a. The Clinical Performance Improvement Initiative in Massachusetts

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Our New Reality



Massachusetts Group Insurance Commission

- The state's largest purchaser of health care after Medicaid
- Covers more than 267,000 state employees, retirees and their dependents
- In 2003, GIC launched the Clinical Performance Initiative focusing on improving provider performance and quality of care
- CPI requires health plans under contract with the GIC to incorporate provider "tiering"-differential payments based on value-into their product

Why did the Group Insurance Commission (GIC) Initiate Physician Tiering?

- Cost of employee health care in 2006 rose 7.7%
- Since 2000, the cost of family health coverage has risen 87% nationally
- Fewer than 55% of patients receive care that meets the standards of quality care
- Consumer information about providers is unavailable, difficult to find, or too complex to be usable
- “The GIC’s CPI Initiative seeks to improve health care quality and promote cost-effectiveness through increased transparency.”
- GIC Executive Director, Dolores Mitchell, looks for ways to “wring efficiencies from the system”
- Initiative rolled out July 1, 2006

*Commonwealth of MA GIC Fiscal Year 2007 Annual Report

Collaborating MA Plans

- Harvard Pilgrim
- Tufts Health Plan
- Unicare
- Fallon Community Health Plan
- Neighborhood Health Plan
- Health New England

GIC's CPI Initiative Attracts Interest and Recognition Nationally

- The Pioneer Institute's Better Government Competition Special Recognition Award 2006
- The Commonwealth Fund's "Value-Driven Health Care Purchasing : Four States That are Ahead of the Curve", *The Commonwealth Fund*, August 2007
- Government Accountability Office Report to Congress Case Study: Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency, April, 2007

Physician Tiering: How is it developed?

- Mercer Human Resource Consulting approached Mitchell to create an aggregated database that would allow GIC participating health plans to “rank the efficiency of their providers”
- “Resolution Health takes the database we created and uses quality measures based on nationally recognized clinical guidelines” (Delores Mitchell)
 - Sources are Ambulatory Records Certification, HEDIS measures, speciality society best-practice measures
 - 79 clinical measures

What is HEDIS?

- HEDIS=Health Effectiveness Data and Information Set
- Used by >90% of American health plans to measure performance
- 71 measures across 8 domains of care
- Used to make improvements in quality of care and service

What is Episode Treatment Group (ETG) Methodology?

- ETG is an industry standard grouping methodology by grouping raw claims data into case-mix adjusted ETG categories
- Evaluates diagnosis and procedure codes in each patient's data and groups those data into episodes of care
- The ETG grouper assigns a disease classification to each episode based on the underlying medical condition and any modifiers of that disease, such as relevant comorbid conditions

Basis of Quality Data

- Clinical quality data, calculated using 2006 claims data, using:
 - **Industry quality standards**
 - **Practice measures** (self reported)
 - EMR
 - E-prescribing
 - NCQA recognition (National Committee for Quality Assurance)
 - NCQA develops quality standards and performance measures for a broad range of health care entities.
 - Policies to reduce racial and ethnic disparities in the delivery of health care
 - Clinical and practice measures combined (using 50/50 weights) to create the quality z-score
 - A threshold is determined based upon 3 standard deviations from the norm.
 - Physicians who have a quality z-score below the threshold are designated as tier level 3
 - Physicians with the quality z-score above the threshold continue to the second threshold-an evaluation that combines both quality and cost-efficiency

John Carroll, Managed Care Magazine Magazine (October, 2007)

Determining Cost Efficiency Index

- Mercer uses commercial book of business data collected from GIC health plans to create a large database that includes all physicians in the plans
- Symmetry software groups an entire episode of care for each patient, including inpatient ambulatory, outpatient and pharmacy claims.
- Analytic team reviews entire set of treatments for a condition
- Analysis measures variations in the use of services between physicians not the actual costs
 - Similar case mixes assumed for all physicians
 - No disease-specific clinical outcomes used to measure quality
- Completed episodes of care assigned to the physician providing the majority of professional expense within the episode as long as they reached at least 25% of professional costs
- Efficiency Index created which compares actual to the average costs for a provider
 - >1 is below average in cost efficiency; <1 above average
 - Costs include management, surgery, facility, pharmacy depending on speciality

Development of a Cost-efficacy measure

- Episodes were weighted to emphasize care provided in most recent years
- Extreme conditions dropped , eg transplant

Which specialties were evaluated in Massachusetts?

- Cardiologists, dermatologists, gastroenterologists, orthopedists, allergists/immunologists, general surgeons, neurologists, ophthalmologists, otolaryngologists, endocrinologists, OB/GYN, rheumatologists
- Why?-most costly and with “significant variations in practice”

Tufts Health Plan Navigator Specialist Methodology

- Uses Mercer and Resolution to compare physician's quality and cost-efficiency
 - Case mix not taken into account
 - Disease-specific clinical outcomes not used
- Dermatology-Specific Practice Measures
 - Drug Safety: Pregnancy and Accutane
 - Tinea Pedis, Tinea Cruris or Tinea Corporis not on Lotrisone
 - Melanoma Annual Skin Exam

Tufts Navigator Continued

- Clinical and Practice Measures combined using a 50/50 ratio to create the Quality z-score.
- Physicians with a Quality z-score below the threshold are designated as copayment Level 3
- Physicians who have a Quality z-score above the threshold continue to the second threshold which evaluates both cost-efficiency and quality

Tufts Navigator Continued

- Cost-Efficiency Data
- Provided by Mercer Human Resource Consulting based on standardized costs during January 2004-December 2006
 - Measures variations in use of services between physicians
 - Case mix, clinical outcomes not used
 - Converted into Tufts costs (dependent on provider's contracting entity, place of service, code for service, physician's contracted rates)
- An overall cost-efficiency z-score is generated.
- Specialist's quality z-score and cost-efficiency z-score are given a 50/50 weighting to arrive at a total z-score
- Across each speciality, under GIC plan design, specialist distribution will be 20% tier one (excellent level), 65% tier two (good) and 15% tier three (standard)
- Physicians with insufficient quality and cost data are defaulted to copayment level 2

Tufts Health Plan's answer to their lack of accounting for dermatologists who specialize in complex conditions

- In a letter from Marc Spooner to the NPF (3/19/08):

“...I would also like to point out that there are physicians ...who specialize in complex conditions in which the treatment is more expensive. Determining which specialists are exclusively in this category is challenging based on the information traditionally stored by six health plans. Therefore it may be possible that a higher copayment for these “super-specialists” is not an indication of lower cost-efficiency or quality, but a means of cost sharing for these more expensive services”

Harvard Pilgrim Independence Plan: Practice Measures

Measure Name	Measure Description
Basal Cell and Squamous Ca annual skin exam	Identifies the percentage of patients with a history of BCC or SCC who have received a complete skin examination by a dermatologist over the past year
Drug Safety 1: Pregnancy_Accutane	Identifies the percentage of women on Accutane while pregnant during the measurement year
Lortisone_Unsafe	Identifies the percentage of pediatric patients with T. Pedis, T. Cruris or T. Corporis who are not receiving
Melanoma_annual skin exam	Identifies the percentage of patients with a history of melanoma who have received a complete skin exam by a dermatologist over the past year

424 MA dermatologists; 57.8% with 10+ Opportunities
Harvard Pilgrim Health Care Provider Relations Website

Response by the Medical Community

- March 18, 2008 letter from Dale Magee, President MA Medical Society stating:
- its concerns about physician tiering as it currently practiced
- Request for all the GIC's records regarding the CPI as well as communications between the GIC, its consultants and the participating health plans

New York State Challenged Established Physician Tiering Practices with Success

- Attorney General Andrew M Cuomo led initiative
- Forced adoption of his Model Code which was created in consultation with the AMA, Medical Society of the State of NY, consumer advocacy groups including Consumers Union and the National Partnership for Women and Families, North Shore Physician Organization
- Forces insurers to fully disclose to consumers and physicians all aspects of their ranking system
- Insurer must retain an oversight monitor (Ratings Examiner) who will oversee compliance with all aspects of the agreement and report to the AG q6months
- Under this national model, insurers will ensure that rankings for doctors are not based only on cost and clearly identify the degree to which any ranking is based upon cost

New York Times April 1, 2008

- Doctors and insurers will develop a national set of standards to measure physician performance
 - AMA, American College of Surgeons, Aetna, UnitedHealth, America's Health Insurance Plans agreed
- Various standards for grading physicians
- Independent parties to review ranks
- Uniformity of grading systems

Negative Implications of Current Physician Tiering in Massachusetts

- Penalizes physicians caring for the sickest patients
- Disease-specific clinical outcomes are not measured
- Patient severity mix not accounted for
- Young dermatologists will not sacrifice their cosmetic and surgical practices for ill medical dermatology patients
 - Sick patients will be undertreated
 - Sick patients will be cared for by a very limited number of physicians, i.e., decreased access to proper care for the patients who need it most

Problems continued

- Labeling physicians under the mantra of quality implies to patients incorrectly that could receive better care by going to a “select” physician, when in fact, they could be denied treatment that could be helpful to them a physician attempting to maintain a “select” rating

Suggestions for Profiling Criteria

- Include severity of patient population cared for
- Determine if a practice offers the full range of therapeutic options
- Determine the amount of free care to indigent patients
- Determine participation in clinical trials
- Determine participation in the education of other health care professionals