Getting Paid for Your Performance?  
You can’t outrun it, but you can keep pace with change.  

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Opening Comments - Vidya Kora, M.D.  
President, Indiana State Medical Association

P4P – History and Context - Jim McIntire  
Executive Vice President, ISMA

Pay for Performance (P4P) History and Context  
A lot of trends and initiatives have been pushing in the direction of measuring performance:
- Managed care = “Preferred providers”
- 1983 – Diagnosis-Related Groups (DRGs)
- 1990’s – Employer, Leapfrog Groups
- 1996 – HIPAA
- 1999 & 2001 – Institute of Medicine Reports quantify errors and promote evidence-based medicine
- 2003 – Medicare Prescription Drug, Improvement and Modernization Act
- 2004 – Executive Order – Health IT within 10 years
- 2005 – CMS proposed Physician Voluntary Reporting Program – measures troubling
- 2006 – AMA Agreement with Congress to prevent Medicare SGR cuts – develop 140 performance measures in 34 clinical areas by end of 2006
- Dec. 2006 – Medicare Tax Relief and Health Care Act authorizes Medicare Physician Quality Reporting Initiative (PQRI) effective July 1, 2007

History & Context (Indiana)  
- 2007 – Medicaid Hoosier Healthwise contracts add P4P provision
- March 7, 2007 – Indiana’s first medical errors report becomes available
- March 7, 2007 – Governor Daniels signs Executive Order to strengthen transparency and accountability through value-driven health care at prompting of HHS Secretary

What is P4P?  
- An effort by payers to improve quality while reducing/controlling costs.

P4P vs. Tiered & Narrow Networks  
- P4P – Sponsor establishes performance measures, collects related data, and pays for performance based on these measures. They are typically based on quality or a mixture of quality and efficiency (i.e., cost of care) measures.
- Tiered & Narrow Networks - Often called P4P programs, but are not really.
- Instead, they are primarily focused on efficiency (cost) measures.

Tiered & Narrow Networks  
- Tiered Networks – Physicians are assigned into two or more separate tiers.
- Narrow Networks – Small or select network of physicians within a larger physician network. Patients are only allowed to see physicians in the narrow network.
Payment Implication of Programs
- **P4P** – Physicians are paid bonuses based on quality.
- **Tiered & Narrow Networks** – Attempt to steer patients through co-pays and co-insurance to physicians who the plan has identified as providing the least expensive care.

**Behind the Scenes of P4P - Dan Kelsey**
Director of Practice Advisory Group, ISMA

**Wall Street Journal**
- “After Streak of Strong Profits, Health Insurers May See Decline”; July 31, 2006
- “Aetna, Others Face Dilemma: Hold Back Price Increases Or Watch Customers Walk?”
- Aetna CEO Ronald Williams:
  - “We have continued to exhibit strong pricing discipline,” “ Sometimes that’s more than what an employer can afford” but it’s necessary to maintain Aetna’s financial health, he adds.

**How is my Quality Determined**
- Insurers use Episode Treatment Grouper (ETG) software that processes claims data
- Determines episodes of care
- Determines expense of care for each line item and links it to a diagnosis code
- Expense of care (sum of allowed amounts)
- Calculates episode expected cost
- Average actual cost of all episodes of the same type
- Calculates a cost efficiency ratio
- Physician or group cost divided by expected cost
- Inclusion/Exclusion in the network is based on the cost efficiency ratio

**ETG Analysis - Sample**
- In this example, Dr. Ashton’s overall measure of case mix is 0.82, indicating an easy (with respect to resource requirements) mix of patients. His Performance Index, at 1.17 indicates that after adjusting for this easy case mix, he treats his patients 17% more ‘expensively’ than his peers. But Dr. Ashton seems to have trouble managing the care of only one type of ETG: Otitis media, with minor surgery. Subsequent ‘drill-down’ analysis will uncover the specific reason for this difficulty.

**Large Payers and P4P**
**Anthem Value Networks**
- Creates a Tiered/Narrow Physician Network
- Inclusion/Exclusion is at the group level
- Cost ratio is approximately 1.2
- Targets certain specialties in metropolitan service areas
- Currently measure only cost, hope to have quality in the future
- Value Networks are being included in proposals to national groups for contracts starting 1/1/08
- Where are Value Networks Offered?
  - Indiana
  - Evansville
  - Terre Haute
Value Network Specialties
- Urology
- Surgery
- Pulmonary Disease
- Otolaryngology
- Orthopedic Surgery
- Ophthalmology

Cigna Care Network
- Began January 1, 2007
- 21 Specialties
- 58 Nationwide service areas
- Must have managed episodes of care for 20 unique Cigna members over a 2 year period
- Uses Episode Treatment Grouper
- Lower copay or coinsurance levels for insureds

Cigna Care Network - Locations
- Available in 26 states and Washington DC (Includes Indiana)
- Excluding the Evansville metro area

Cigna Care Network - Specialties
- Allergy/Immunology
- Cardiology
- Cardio-Thoracic Surgery
- Colon and Rectal Surgery
- Dermatology
- ENT
- Endocrinology
- Gastroenterology
- General Surgery
- Hematology/Oncology
- Infectious Disease
- Nephrology
- Neurology
- Neurosurgery
- OB/GYN
- Ophthalmology
- Orthopedics and Surgery
- Pulmonology
- Rheumatology
- Urology
- Vascular Surgery

UnitedHealthcare - Premium Designation
• Letters mailed in Fall, 2006
• 21 Specialties, Offered Nationwide
• Two stage process - Quality/Efficiency
• One Star for Quality, a Second Star for Efficiency
• If Quality guidelines met, then eligible for efficiency star
• Use the ETG Grouper
• Tiered Network

**UnitedHealthcare - Specialties**

- Allergy/Immunology
- Cardiology (Interventional and Non-Interventional)
- Cardio-Thoracic Surgery
- Electrophysiology
- Endocrinology
- Family Medicine
- Infectious Disease
- Internal Medicine
- Nephrology
- Neurology
- OB/GYN
- Oncology
- Pediatrics
- Pulmonology
- Rheumatology
- Spine Surgery
- Sports Medicine
- Total Joint Replacement

**Aetna Aexcel Program**

- Began January, 2007
- Available to all PPO and POS products
- Benefits vary according to employer
- Concentric - Service from non-Aexcel physician considered out of network
- Multi-tier - Lower patient out of pocket cost to the patient when Aexcel physician is used
- Minimum of 20 cases in a two year period
- Use the ETG software

**Aetna Aexcel - Where is it offered?**

- Connecticut
- Washington DC
- Northern Virginia
- Maryland
- Cincinnati
- Cleveland
- Columbus
- Dayton
- Springfield, OH
- Northern Kentucky
- Southeast Indiana
- South Florida
Aetna Aexcel - Specialties

- Cardiology
- Cardio-Thoracic Surgery
- Gastroenterology
- General Surgery
- Neurology
- Neurosurgery
- OB/GYN
- Otolaryngology
- Plastic Surgery
- Urology
- Vascular Surgery

P4P Issues

- Patients
  - Copay/Coinsurance increases for the insured if practice or physician is not in P4P program
- Physicians/Practices
  - Total reimbursement to the practice will remain unchanged
  - If part of value network, no change
  - If not part of network, patient responsibility will increase and insurance reimbursement will decrease (Total reimbursement remains the same)
  - If not in network, practice may lose patients

P4P Issues

- Practice Accounts Receivable may increase if not part of network (longer time to collect copay)
- According to Anthem “there may be some inconvenience to the patient”
- Potential referrals to distant specialty groups
- Only based on claims data
- Is there a quality component (Hope to have it in the future)
- Inability of small groups to absorb outliers
- Patients may have to travel farther for service
- Fewer episodes of care could skew cost efficiency ratio
- Includes pharmacy data - what if patients do not fill their prescriptions? Lower costs - but not quality care?
- Subspecialists could be excluded from the network

CMS Physician Quality Reporting Initiative (PQRI)

- Effective July 1, 2007
- Eligibility
- Claims/Quality Hybrid Effort
- Reporting the Data
- 1.5% Bonus Payment
- How is it calculated?

PQRI - Reporting the Data

- Report data based on quality standards
- Work product of AMA Physician Consortium
- 2007 – 74 Different quality standards
- You pick the standards
- Pick at least 3
  - CMS - Report all that apply
  - Use CPT Level II or G Codes
  - Reported at the NPI Level

**PQRI - CMS Evaluates the Data**
- Evaluates presence of quality indicator based on claim data
- Drivers - Level 1 CPT code and diagnosis
- Claims from July 1 – December 31, 2007
  - Received by the CMS National Claims History file by February 29, 2008
  - Paid under the Medicare Physician Fee Schedule

**PQRI Reporting**
- Determination of Successful Reporting
- Reporting thresholds
  - If there are no more than 3 measures that apply, each measure must be reported for at least 80% of the cases in which a measure was reportable
  - If 4 or more measures apply, at least 3 measures must be reported for at least 80% of the cases in which the measure was reportable
- Analysis is expected to be performed at the individual level
  - Requires accurate and consistent use of individual National Provider Identifier (NPI) on claims

**PQRI – 80% Compliance**
- 80% of What?
- Reportable instances for the patient?
- Total possible claims?
  - Place of Service impact?
  - Reported every visit?
    - If Dx of Diabetes
    - E/M service on same claim
    - If the measure was previously reported, do you report it again?

**PQRI - Bonus Payment**
- Participating eligible professionals who successfully report may earn a 1.5% bonus, subject to cap
- 1.5% bonus calculation based on total allowed charges during the reporting period for professional services billed under the Physician Fee Schedule
- Claims must reach the National Claims History (NCH) file by February 29, 2008
- Bonus payments will be made in a lump sum in mid-2008
- Bonus payments will be made to the holder of record of the Taxpayer Identification Number (TIN)
- No beneficiary co-payment or notice to the beneficiary

**PQRI Bonus Calculation**
- Cap may apply when relatively few instances of quality measures are reported
- Cap calculation = (Individual’s instances of reporting quality data) X (300%) X (National average per measure payment amount)
National average per measure payment amount = (National charges associated with quality measures) / (National instances of reporting)

Indiana Medicaid
- RFS Required elements of P4P
- Three tiered model
  - 1st tier - OMPP provides financial/non-financial incentives to Managed Care Organizations (MCO’s)
  - 2nd tier - MCO’s provide incentives to physicians and providers
  - 3rd tier - MCO’s provide incentives to Medicaid recipients
- Based on priorities determined by the state
  - Emergency Room Utilization
  - Blood lead screening
  - Prenatal and post-partum care
  - Behavioral health and physical health coordination
  - Childhood and adolescent immunizations
- MCO must reinvest at least 50% of the incentives received from the state
- Medicaid will focus on primary care issues

A Practice Perspective- The Care Group LLC
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Opening Comments
The fundamental concepts of measuring quality healthcare and generating useful feedback to providers in order to help them improve practice patterns is a concept that fits nicely with our organization’s founding principals, mission statement, and corporate goals. We have been quality focused for years and fully support finding new ways to improve on any number of levels.

The Current P4P Reality
No one is “asking” if we want to participate in the program
No one is offering extra money – but instead talking about reductions, or pts having higher co-pays if the provider is not on the “list”.
For the past 2 years rumors have popped up in the final hours of conversion factor discussions that an off-set of a Medicare fee reduction may in some way be tied to P4P

Medicare’s Program
- We began reviewing the measures almost 2 years ago
- Identified the ones that seemed to pertain to us and began to think through what implementation might mean
- A part of this evaluation was also a comparison to measures being targeted by other payors as well as our specialty societies, and hospitals

First Steps
- Started gathering information and identified an administrative team
- Began to contact individual payors to discuss their intentions, timelines, methods, measures, etc. also expressed our willingness to participate in program design, review, and or feedback.
Identification Of Measures
- Certain conditions seem to be a focus for most payors
- Conditions such as DM, HTN, CHF, CAD, A Fib, Asthma, preventative health, etc.
- Began to compare and contrast the measures

Physician Input
- Formed a PCP and Cardiology Physician P4P committee
- Physician input was critical as some measures seemed to be more firmly anchored in a clinical standard of care than others
- Our intent was to identify the least common denominator between the various plans – but only the least common denominator that made clinical sense

Lipid Expectations On Post MI Pts
- Anthem – within 1 year
- HEDIS – 60 days post MI
- UHC – 90 days post MI
- CMS – 6 months post MI
- IHIE – 60-365 of MI, CABG, PTCA

United Healthcare
- Initial letters – Aug and Sept of 2005
  - “Performance assessment with feedback has emerged as an important vehicle to assist physicians in improving the quality of healthcare. There is an increasing demand by consumers and healthcare purchasers for meaningful data to support their healthcare decisions.”

Premium designation
- The designation program’s quality designation is separate from the efficiency designation
- Physicians must first meet the quality benchmarks in order to proceed to the efficiency analysis
- All physicians who meet the quality designation and those who also meet the efficiency criteria will receive a second designation indicating they meet the efficiency threshold.

United Web Listing – www.uhc.com

United Healthcare
- United has been very aggressive in the Indiana market.
- Have introduced their “Premium Designation Program”
  - 1 star = quality,
  - 2 stars = quality and efficiency
  - Triangle = not enough data or MD declined designation

“Practice Rewards”
- Quality is weighted at 51%
- Efficiency is weighted at 30%
- Administrative at 19%
- The Bar is set at a score of 5
- Need a score of 8 to receive a potential increase in reimbursement
- Without scoring a 5 you could lose a % of current reimbursement
Claims Data Approach
- Most payors are using claims data in some way or another - some only claims data
- The claims data approach is dangerous – and full of potential pitfalls
- An option of chart review is not easily accomplished - but has been on-going to a small
degree for years with many payors.

United - Significant Findings
- United readily admitted the roll out was a “bit premature” – but they were under pressure
by clients for the data
- Errors in the Provider files caused some incorrect designation
- Errors in the claims “logic” approach also caused problems in the MD designation

Sample Problems With Initial “Quality” Reports
- Examples :
  1. Dinged the MD for not doing a BUN - but a BMP or CMP was performed
  2. Dinged MD for not having an “annual visit” - MD saw the pt 3 times
  3. Dinged MD for not being Board certified - they are Board certified

Reports are Now on Version 3
- Changes have been made in the lab analysis - but still seeing occasional errors
- Medications - still an issue when the pt goes to an out of network, mail order or are
provided with samples
- Office visits - still an issue due to the way a visit is assigned to a disease process

“Annual Visits” Example
- If a patient is seen with HTN, DM, and CHF - annual visits are expected for those
  conditions
- Even if we address all 3 conditions - code and report all 3 diagnosis codes - the visit can
  only be “assigned” to one condition
- This leads to the MD getting “dinged” for not providing an annual visit for the other 2
  conditions

Report Formats
- Reports contain a pt ID number that is helpful to United... but means nothing to the
  provider
- The only Pt identifier is a first and last name - no middle initial, no DOB, no SS #

Patient Listing
- If a pt has multiple conditions - and if you do miss a lab it applies to each condition that
  requires that lab as the list and measures are by disease state so if required by 3 different
  disease states - that pt will show up 3 times on your report

Cost Efficiency - ETG
- Based on an Episode Treatment Grouper (ETG)
- All claims - physician, pharmacy, hospital etc. are classified into one of over 500 clinical
  ETG
- The physician with the highest dollar claim in the episode is assigned all costs
- You cannot go to the efficiency level until you first meet the quality level

United’s Administrative Component
- Measures the number of electronic claims versus paper claims
- Measures on line claim resolution versus phone calls

**United Administrative Measures**
- Confirmed with United they are only measuring web use in working claims
- Conducted ease of use survey with staff working real claims

**Sample Web Use Survey**
- 71 claims worked – only 27% could be resolved on line
- 23% - claim detail was not available
- 8% - no pt eligibility data on line
- 85% found the web user friendly on the claim types that could be worked – i.e. can’t add a modifier, change a dx, etc.

**Phone Calls and Paper Claims**
- Requested information as to the nature of the calls
- Were told they have no way to distinguish a claim call from any other phone call
- The number of paper claims per the Payor versus our records are significantly different

**United’s Response In November**
- The “quality” reports have been improved.... But not available for us to review yet
- The “web portal” for working claims has been completely redone
- Still not sending out “cost” reports for individual review or detail on calls, or paper claims

**United’s Letter In December**
- “We received helpful questions and advice from many of our network physician partners that will assist in refining the initial results”.
- “Based on that process and our own internal review, we will be revising and updating our next designation release.”
- “It is important to note that there has been no public reporting of the designation results from this release to any directories or websites.”

**Another P4P Reality....**
- Do you recognize these stages?
  - Denial
  - Anger
  - Bargaining
  - Depression
  - Acceptance

**Anthem’s “Value Network”**
- No connection to quality
- Encompasses all costs using an episode treatment grouper
- Calculates a “cost efficiency ratio”
- Members will have a lower out of pocket expense when picking a value network provider
- This is a sample “Tiered Network”

**Cardiologist**

**Value Network Findings**
• There appears to be errors in the calculation of the “benchmark” for some conditions – especially Electrophysiology
• The importance of using the most accurate and specific diagnosis code is very apparent

What Does This Mean?
• Your care is not cost effective?
• Your claims are not coded as specifically as they could be?
• The program being used is flawed?

Additional Actions
• Insist on the details
• Review and provide feedback – both the Provider and the Insurers would surely benefit from accurate information and a cooperative approach
• Offer to assist and discuss when possible, make your willingness known

Aetna and Cigna
• Despite asking repeatedly when the program would roll out in Indiana, we were told no time soon
• About 2 weeks later letters arrived - both letters were rec’d in October 2006
• We have requested detail on the measures as well as our practice detailed reports but have not yet received any detailed reports

Aetna Provider Search
Price Information

Employer Approach
• It is hoped that an increased focus on quality will also decrease costs
• Some organizations have been more aggressive than others in preparing patients for the P4P era
• This could be setting the stage for “tiered” networks, etc.

Who do you trust?
Medicare’s Program
• This one does have some reimbursement attached to it
• Must report from July 1, 2007 to December 31, 2007
• If 3 measures apply to you – then at least 3 must be reported to an 80% accuracy in order to be eligible to the bonus
• The 1.5% is subject to a limiting cap and reporting more than 3 will be in your best interest

What Measures Should You Consider?
• There are a variety of measures you might want to consider
• We all need the more detailed report in order to make final decisions
• Codes are matched to E/M codes – not all E/M codes were/are listed for each measure
• Codes are also matched to diagnosis codes – to report you need a listed E/M and a listed Dx

Thoughts
• The P4P Physician groups assisted in developing educational material, forms to capture information, forms to use in order to bill the G code
All of this was complete and ready to use... then CMS said they were going to use the category II codes when ava
• Have had discussion on the fact that it might be easier to focus on a few disease states instead of trying to do 7 or 8 all at once
• The 1.5 might not outweigh the implementation cost - but what if it's mandatory next year?

When Do We Report?
• Lots of unanswered questions:
• We need more detail as soon as possible
• Is reporting measured per patient or per encounter?

Some Prep Work You Can Do
• Request a report on diagnosis codes billed to Medicare from the office and from the hospital setting
• This will help give you a feel for the number of times you may need to report the codes
• Think about system issues - can your billing system file a zero dollar claim code?

Implementation Thoughts
• Do you have room on your encounter form to add at least 15 lines..... And still be able to read it?
• If you go to a second form - who will start the process and how will it be matched to the encounter form?
• How will you monitor internally for an 80% success rate?

Immediate Needs
• Define areas of focus and guidelines
• Continue to focus on pt satisfaction
• Design method to address reports that doesn't require a manual chart review
• Design MD prompt /tracking system
• Begin Physician communication - How, what, etc.
• Designate MD team for clinical input

Why Do You Need To Act Now?
• Major Payors will have your “quality” and “cost” information on their web sites very soon, if it's not there already
• Future scores will likely be based on today's services (claims)
• A determination of “quality” directly related to future reimbursement could be made on the care we are rendering today.

Additional Suggestions
• Check commercial payor web sites to see if your MDs are listed
• Be prepared to spend months to clarify any errors
• Check now to see who has the capabilities to work claims on line and if your staff has tried to use the web site
• Be prepared to understand the importance of diagnostic coding in an entirely new way

P4P Committee Activity
• Gather the measures the payors are using
• Compare and contrast measures
• Identify the conditions most payors have in common that pertain to your practice
• Begin to draft tools
• Don’t make the mistake of thinking you can pull this off in 30-45 days

Final Suggestion
• Don’t get stuck in the first 3 stages for any length of time
• The quicker you move on to acceptance the better off you’ll be

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Remedies
• Ask the payer to correct your errors – in writing!
• What are your options if a payer refuses to correct errors?
  o Check your contract - remedies provided?
  o File a complaint with the Indiana Department of Insurance?
  o Legal action?
    ▪ Breach of contract?
    ▪ Tort - defamation?
    ▪ Unfair business practices?

Legal Aspects of P4P - Julie Reed
Legal Counsel, ISMA

A Review of Two Legal Cases
• St. Louis
• Washington State Medical Association

St. Louis Response to UnitedHealth Pilot Program
• UnitedHealth started pilot Performance Program in St. Louis in 2005.
• Used 3-4 year old data.
• Supposedly based on quality and cost, but network only included 30% of physicians - 2-3% excluded on quality, rest on cost.
• State and county medical societies, large hospital groups, employers and the press got involved and threatened lawsuit for breach of contract.
• Program was stopped.
• Note: UnitedHealth Premium uses more current data.

Washington State Medical Association v. Regence BlueShield
• Regence BlueShield announced Select Network Plan in May 2006 for physicians providing “high quality, efficient care.”
• Created at request of Boeing to promote quality and efficiency – affected 8,000 patients.
• 500 physicians were excluded. Their patients received letters - physician failed to meet quality and efficiency standards; excluded from Network.
• WSMC and 6 physicians filed lawsuit on Sept. 20, 2006 (AMA joined in Nov.).
• Claims:
  o Claims data inaccurate.
  o Claims data outdated (4+ yrs).
  o Data samples too small.
Focus on cost only.
Does not consider patient population.

- Counts:
  1. Unfair and Deceptive Business Practices
  2. Defamation/Libel
  3. Intentional Interference with Commerce
  4. Breach of Contract

- Sought: Injunctive relief and damages
- Doctors and patients complained.

- Result:
  - Regence sent letters to members in June 2006 apologizing for the negative implications about the quality of care rendered by their physicians.
  - Network implementation deferred until July 1, 2007.

- Status
  - Principal issue is now moot.
  - Regence has not renounced reinstatement of network.
  - Parties currently attempting settlement talks.

What is the ISMA doing?

- Working with the AMA and other physician organizations
- Jim McIntire is attending a meeting with other state medical association directors on March 29 to discuss P4P initiatives and how physicians can respond
- Researching the issues
- Talking to payers
- Logging calls/complaints from members
- Educating our members

Conclusion

- Pay for performance is here to stay
- Insurers want to maintain profit margins
- Physicians can become engaged in the process
- Help determine the next phase – How will quality be measured instead of costs?
- Physician Consortium for Quality Improvement
- Keep in touch with the ISMA
- ISMA Website: [http://www.ismanet.org/p4p.htm](http://www.ismanet.org/p4p.htm)

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