Health Plan Tiered Networks Conference

# Physician Network Tiers: Integration of Quality & Efficiency Metrics Into Physician Payment


Presented by:

David V. Axene, FSA, MAAA, FCA

President & Consulting Actuary

Axene Health Partners, LLC


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# Overview

- Background
- Actuarial evaluation models
- Prevailing methodologies
- Impact of Supreme Court decision
- Emerging Challenges
- Q&A

# Background

- Provider performance measurement
  - Initially used to assess performance within managed care network (i.e., the good vs. the bad)
  - Some plans used results to drive payment arrangements, often bonuses and return of withhold methods
  - Spawned considerable processes and systems to normalize results for risk bias, demographic bias, etc.

# Background

*continued*

- Risk-mix and case-mix adjustors
  - "how do we assure we are comparing apples and apples?"
  - Carve-outs, stop loss limits, analysis by specialty peer groups, etc.
  - Many competing products have tried to dominant market without overwhelming success
  - ETG-based products provide greatest opportunity to blend clinical and financial analysis (e.g., ERGs, PRGs, etc.)

# Background

*continued*

- Benefit adjustors
  - Benefit levels (i.e., patient cost sharing, potential barriers to care) drive both cost and utilization. Even adding back the patient paid cost, the presence of patient cost sharing modifies use patterns
  - Analysis must be adjusted for benefit differences

# Background

*continued*

- Provider reimbursement/methodology differences
  - Analysis needs to reflect payments levels (i.e., lower payment levels can drive higher utilization rates)
  - Analysis needs to reflect payment methods (i.e., capitation can drive lower utilization, fee-for-service can drive higher utilization)
- Actuarial analysis provides a useful way of reflecting the above adjustments

# Actuarial Evaluation Models

- Actuarial Cost Models
  - F: Frequency
  - I: Intensity
  - $: Cost/service
  - PMPM: per member per month cost
- Convert health care utilization and cost budgets into easy to review and understand categories
- Appropriately adjusted for risk, case-mix, benefits, reimbursement, etc. useful information can be produced to compare programs, networks, individual providers, etc.

# Actuarial Evaluation Models

*continued*

| **PCP Services** | Util./M | Charge/Svc | PMPM |
|---|---|---|---|
| PCP Surgery | 41 | $37 | $.13 |
| IP Visits - PCP | 55 | 70 | .32 |
| Office Visits - PCP | 1,816 | 48 | 7.26 |
| Lab & Path – PCP Office | 843 | 8 | .52 |
| Consults - PCP | 12 | 114 | .12 |
| Immun. & Inject - Admin | 376 | 20 | .63 |
| Preventive Services - PCP | 239 | 49 | .97 |
| Cardiology - PCP | 64 | 24 | .13 |
| Pulmonology -PCP | 8 | 30 | .02 |
| Allergy - PCP | 92 | 34 | .26 |
| PCP Management | | | |
| **Total** | 3,547 | $35 | $10.36 |

# Actuarial Evaluation Models

*continued*

- These models can be modified to investigate common disease categories (i.e., ETG categories)
- ETGs provide clinically understandable and appropriate measurement categories
- Once normalized for factors, the results can be directly measured to determine prevailing differences

# Actuarial Evaluation Models

*continued*

- Studies show significant variation is evident
  - Hospital inpatient (50% - 200% of average)
  - Primary Care services (75% - 150% of average)
  - Specialty Care services (60% - 185% of average)
  - Pharmacy (60% - 200% of average)
  - All of above were normalized for demographics, case-mix, health status, and provider fees

# Prevailing Methodologies

- Identify meaningful provider performance differences for:
  - Network configuration
  - Provider tiering
  - Patient communication
  - Benefit configuration

# Prevailing Methodologies

*continued*

- Measurement factors
  - Individual provider fees
  - Referred provider/facility fees
  - Individual provider efficiency
  - Referred provider/facility efficiency
  - Use of high cost diagnostic procedures
  - Average Cost per patient (i.e., all services, selected services, by episode of care, etc.)
  - Provider/patient quality factors (e.g., office wait-time, appropriateness of referral, timeliness of referral)

# Prevailing Methodologies

*continued*

- Measurement factors – continued
  - Administrative cost (i.e., ease of working with provider)
  - Type of provider contract (i.e., physician, hospital, etc.)
  - Provider affiliations
  - Assigned providers
  - Specialty driven factors
  - "any willing provider" mandate inclusion

# Prevailing Methodologies

*continued*

- Quality/efficiency convergence
  - Provider quality measurements can readily be associated with efficiency measures
  - Highest quality providers tend to be those practicing the most efficiently
  - Most efficient providers tends to have the highest quality

# Impact of Supreme Court Decision

- Too soon to really tell, however, this will be a strong catalyst for increased provider measurement
- "Willing providers" have to be included, it doesn't preclude consequences of their behavior if part of the conditions of participation
- Will result in broader use of provider measurement processes
- Will eventually lead to challenging of provider assessment methodologies (better do it right!!!)

# Emerging Challenges

- What measurement cohorts will last?
- Gaining provider buy-in of methodologies (i.e., the "trust" factor)
- Linking with consumer driven healthcare products (will the patient really want to choose?)
- Will physicians be willing to self-manage themselves to the point required to succeed?
- What administrative burden can be absorbed in pricing structures?

# Q&A