BERKELEY CENTER
FOR HEALTH TECHNOLOGY

Physician Organization Relations with Insurers: Quality Improvement and Cost Management

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Overview

- Collaboration between physician organizations, insurers, and other stakeholders
- Selected outcomes from collaboration
- Challenges to physician organization

"Geez Louise—I left the price tag on."

Collaboration between Physician Organizations, Insurers, and Other Stakeholders

- California is unique in the USA in terms of the strong role played by large physician-led organizations. In other states, leadership has been assumed by hospital systems
- Physician organizations compete with one another for patients but also collaborate with one another on best practices for quality, efficiency, patient experience
- Collaboration is centered in the Integrated Healthcare Association (IHA), which includes leading physician organizations but also insurers, employers, government entities, and hospital systems (and a few professors ☺)

In California, Major Physician Organizations Collaborate with Insurers, Hospital Systems, and Purchasers (Employers and Government) through the Integrated Healthcare Association

Founded in 1994, the Integrated Healthcare Association (IHA) is guided by a 40 member board of industry leading health plans, physician organizations, hospitals/health systems, purchasers, regulators, consumer groups, universities, and pharmaceutical and technology companies.

www.iha.org

IHA Mission is to Use Multisector Collaboration to Measure, Reward, and Improve Performance: Quality, Patient Experience, Efficiency, Cost

IHA Develops and Publishes Reports on Best Practices, Trends, Geographic Variations, Areas Needing Additional Focus. It also provides detailed feedback to each physician organization on its performance relative to peers and to prior years

- **Measures:** 50 highly aligned measures of clinical quality, patient experience, utilization, total cost of care
- **Includes:** Commercial HMO, commercial ACO, Medicare Advantage, Managed Medi-Cal (Medicaid) members; 200 risk bearing physician organizations
- **What's Viewable:** Physician organization level performance data for commercial HMO and Medicare Advantage
- **Collaborators:** California Office of the Patient Advocate, National Committee for Quality Assurance, National Quality Forum, Pacific Business Group on Health
- **Data Partners:** 10+ health plans, 20 commercial ACOs, 200+ medical groups, independent physician associations & federally qualified health centers, Onpoint Health Data

Value-Based Pay-for-Performance (VBP4P) Program Is Collaborative Efforts with Insurers (Health Plans), Purchasers (Employers, Government)

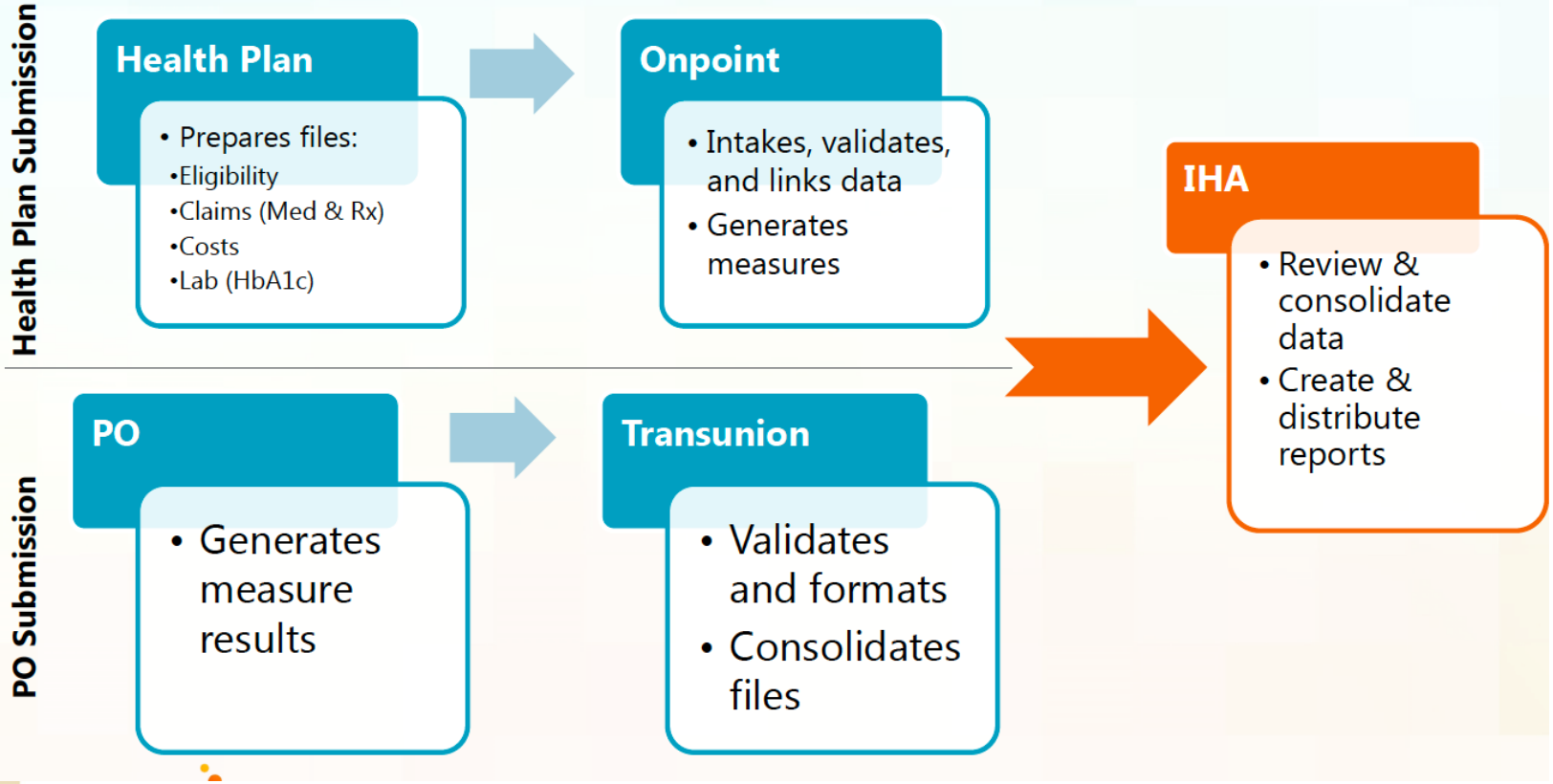
Clinical, Efficiency, and Cost Metrics

AMP Commercial ACO Measure Set

Measure Abbreviation	Measure Description	Measure Domain: Clinical Quality	Measure Domain: Resource Use	Measure Domain: Cost
AAB	Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	■		
AMR	Asthma Medication Ratio	■		
BCS	Breast Cancer Screening	■		
CBPD4	Comprehensive Diabetes Care: Blood Pressure Control <140/90 mm Hg	■		
CBPH	Controlling Blood Pressure for People with Hypertension	■		
CCO	Cervical Cancer Overscreening (Inverted Rate)	■		
CCS	Cervical Cancer Screening	■		
CDCE	Comprehensive Diabetes Care: Eye Exam	■		
CHL	Chlamydia Screening in Women	■		
CIS	Childhood Immunization Status: Combination 10	■		
COL	Colorectal Cancer Screening	■		
CWP	Appropriate Testing for Children with Pharyngitis	■		
HBACON	Comprehensive Diabetes Care: HbA1c Poor Control > 9.0% (Inverted Rate)	■		
HBASCR	Comprehensive Diabetes Care: HbA1c Testing	■		
IMA	Immunizations for Adolescents: Combination 2	■		
LBP	Use of Imaging Studies for Low Back Pain	■		
NEPHSCR	Comprehensive Diabetes Care: Medical Attention for Nephropathy	■		
SPC1	Statin Therapy for Patients With Cardiovascular Disease: Prescribing Rate	■		
SPC2	Statin Therapy for Patients With Cardiovascular Disease: Adherence Rate	■		
SPD1	Statin Therapy for Patients With Diabetes: Prescribing Rate	■		
SPD2	Statin Therapy for Patients With Diabetes: Adherence Rate	■		
EDU	Emergency Department Utilization		■	
PCR	All-Cause Readmissions		■	
TCOC	Total Cost of Care: Geography & Risk Adjusted ($250,000 Truncation)			■

Data are Collected Annually From Physician Organizations (PO) and Health Plans

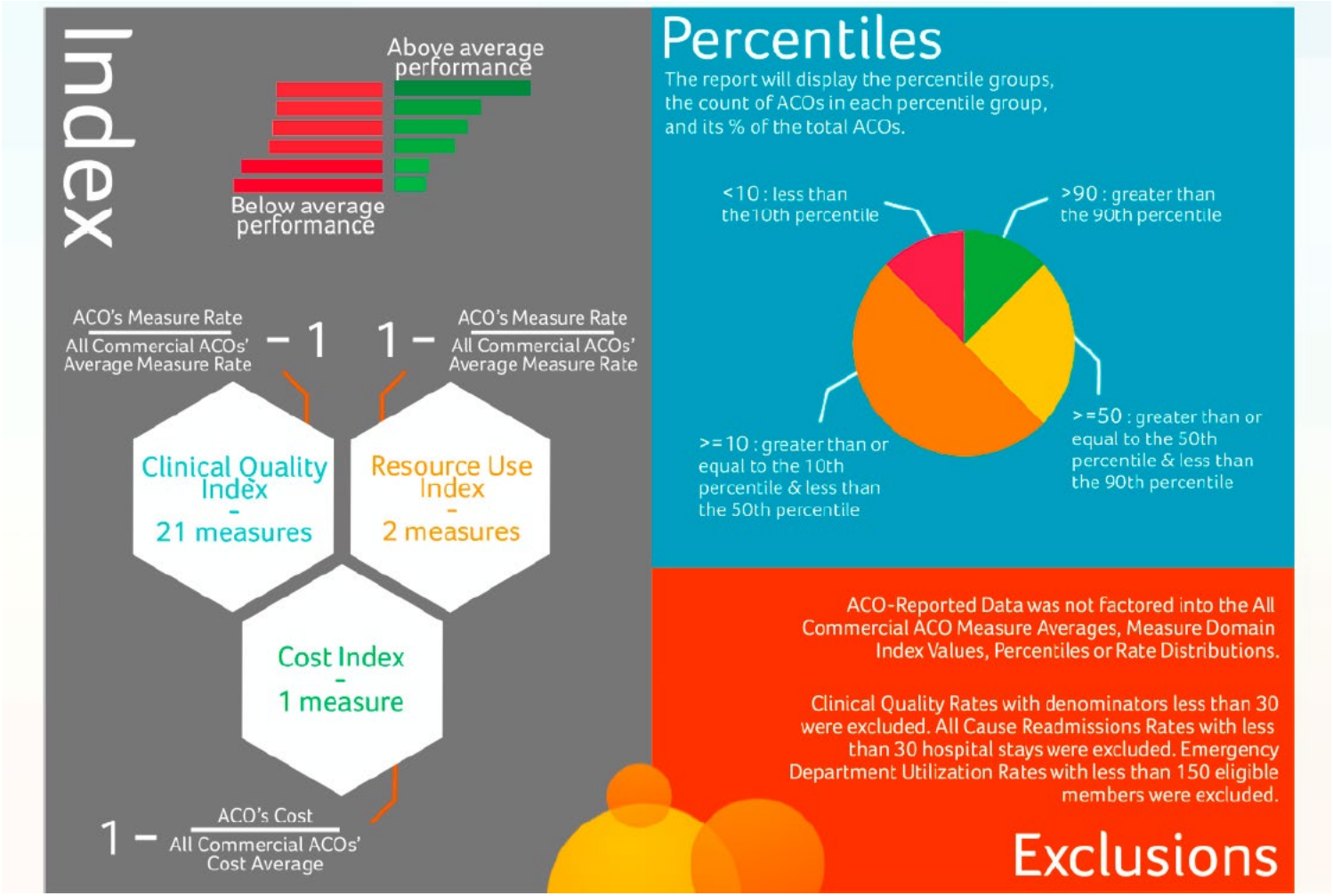
- Results were generated from the health plan data submission to Onpoint
- POs had the option to test self-reporting of commercial ACO results



Collection and Use of Performance Metrics

- Data are verified, compiled, compared, and disseminated
- Each PO gets its own results, with comparative rankings
- Summary reports are published on the web to be accessible to patients and other stakeholders
- Insurers pay annual bonuses to high-performing PO
- These are structured as shared-savings, with savings measured as the difference between total expected and actual costs per patient per year, contingent on high quality performance
  - No quality, no bonus (regardless of extent of savings)
- Trends are measured over time for each physician organization and for the groups collectively

Publication of Performance Metrics: Transparency is Key Value for Employers & Government



Reporting of Outcomes

- Performance metrics are reported for PO individually, by region, type of PO, over time, etc.
- Individual PO are given their results and benchmarks for comparison. They participate in working groups to improve performance on areas of concern
- Leading PO obtain financial bonuses but also prizes and recognition
- Metrics are published on the IHA website and by the state government and other stakeholders

Results Available to Each PO, with Benchmarks

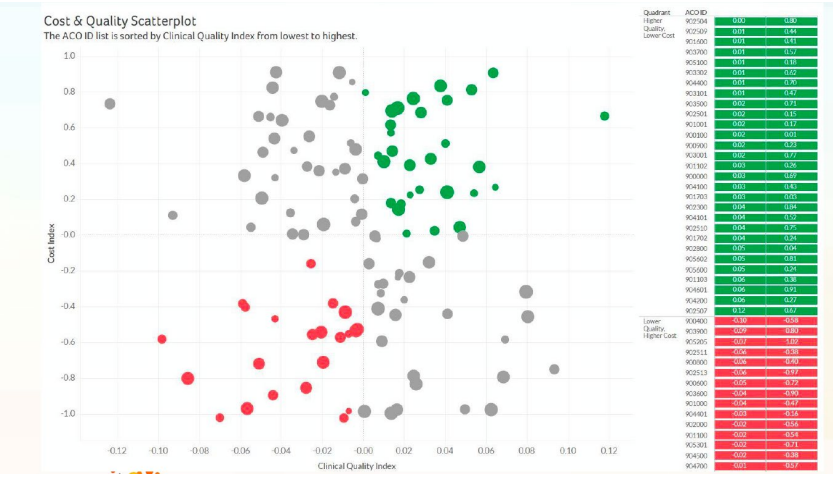
Annual 'Stakeholder Conference' Brings All PO Together to Share Best Practices

- Resource Use & Total Cost of Care Results .csv downloads
  - **Clinical Quality Results** (IHA_ACO_CQM_SRPO&PLAN)
    - Includes rates for all clinical quality measures generated from data submitted by participating health plans, as well as any PO reported results
    - 21 total clinical quality measures; with underlying indicators (e.g., age bands) 44 results per ACO contract
  - **Resource Use Results** (multiple)
    - Individual files for each resource use measure
    - Based on data submitted by participating health plans by commercial ACO contract
  - **Total Cost of Care Results** (IHA_TCOC250K_GEO_RISKADJ_958)
    - Includes $250,000 member cost truncation and geography & risk adjustment
    - Based on data submitted by participating health plans by commercial ACO contract

Results for Individual PO are Available Online

Percentile Performance by Measure Domain

ACO ID	ACO Name	Product	Enrollment	Clinical Quality Index Percentile	Resource Use Index Percentile	Cost Index Percentile
900200	Hilariously Fake Doctors	HMO	8,741	>=50	<10	>=10
900300	Seriously Fake Physicians	HMO	5,364	>=90	>=50	>=10
900401	Absurdly Fake Physicians	HMO	8,764	<10	>=50	>=50
900600	Wildly Fake Clinic	HMO	7,243	<10	>=10	>=10
900700	Wildly Fake Doctors	HMO	3,209	>=10	>=10	>=10
900800	Hilariously Fake Care	HMO	4,453	<10	>=50	>=10
900801	Absolutely Fake Physicians	HMO	8,186	>=10	>=10	>=90



Challenges to Physician Organization

- The large population density of California has fostered a strong ecosystem of physician organizations, but it is under pressure from hospitals and insurers
- Hospital-centered organizations are expanding into ambulatory and physician services
- Insurers are ambivalent about whether to collaborate with physician organizations or treat them as suppliers

Which Way the Hospital Systems?

- Hospitals have been merging into large systems, both within and across cities and regions, and diversifying into ambulatory services and employment of physicians
- They offer some of the advantages of physician-led organizations but often retain an institutional culture favoring specialty services over primary care
- They have obtained strong pricing power against insurers, due to consolidation of local markets, and hence have the revenues to purchase more physician practices and further consolidate
- Independent physician-led organizations have difficulty competing with hospital-systems for physician affiliations, due to the differences in financial strength
- Insurers favor physician-led over hospital-centered organizations, but are doing too little to reverse the trend towards consolidation

Which Way the Health Insurers?

- Collaboration on performance improvement is time-consuming and requires considerable staff time from insurers
- Insurers collaborate with each other through IHA but also compete with one another on premiums, customer relationships
- As competition becomes more intense, interest in collaboration wanes. Keeping insurers engaged in IHA and other forms of collaboration has been due to strong presence of physician organizations in California. Other states have weaker PO.
- National insurers now compete with one another primarily by shifting costs to enrollees (high cost sharing) rather than by striving to improve physician performance
- The public Medicare and Medicaid programs, and the insurance programs they work with, now are more collaborative than insurers focused on private sector employers

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