



MAG Issue Brief

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Physician Tiering Programs in Georgia

An Information Paper

Prepared by MAG's Third Party Payer Advocacy Office.

Introduction

Largely in response to business, government and consumer interests in having greater transparency of costs and charges by physicians and hospitals in the health care system and to further curtail health care costs, many insurance companies throughout the country are introducing new so called “transparency and/or value-based, tiering” programs. In Georgia, for example, Aetna has introduced the Aexcel® Designation program, United Healthcare has introduced the United Health Premium® physician designation and hospital comparison programs, and Cigna will be introducing the Cigna Care Network sometime this year. These products attempt to stratify physicians and other health care providers into tiered or selected networks that are based primarily on cost of care. This paper will briefly explain how these networks work, with a focus on Aexcel, identify problems that are associated with their use, and explain what MAG is doing to combat the problem. We have also attached a sample “patient” letter, which you may wish to distribute in your office.

Goals of Tiering Programs

In general, tiering programs purport, as stated in Aetna's Aexcel plan: “to allow patients to make well-informed health care decisions by informing them whether their physician's practice has demonstrated effectiveness in the delivery of care, based upon whether they have met certain clinical performance and efficiency measures and are therefore eligible to be given special designation.”² Another often-touted goal of efficiency profiling is that it allows health plans to control costs by enhancing health system cost efficiency. Tiered networks either use co-payments or co-insurance differentials or other incentives to try to steer patients to physicians in the least costly tier(s) or require patients to see only physicians who are in an exclusive network. In exchange for a smaller select choice of physicians, patients are offered a lower out-of-pocket cost.

Aetna's tiering program, like most others, is one aspect of an overall health care transparency program which includes: improving technology; measuring quality; measuring and publishing price and creating positive incentives such as those included as part of pay for performance programs. Beginning nationally in 2004, Aetna now has some 26 markets in which the Aexcel program is operating, which includes up to 25 office-based procedures measured for each medical specialty. The latest version of Aexcel began in Georgia in April 2007.⁷

Physician Legal Actions

These programs have not occurred without some dissension and even legal action within some states by members of the medical community. In August, New York Attorney General Andrew Cuomo demanded a “full justification” of the rankings that Aetna Inc. and Cigna Corp. implemented in New York. He stated that the ratings are confusing and potentially deceptive, in part because insurers don’t disclose how prone to error their rankings are. Mr. Cuomo also cautioned that rankings based on claims data can be badly flawed, and that insurers have conflicts of interest because of financial incentives to contain costs. In Connecticut, the Fairfield County Medical Association and a group of orthopedists sued Cigna and United Health in Superior Court in Danbury in July. In 2006, six Seattle-based physicians sued Regence Blue Shield, alleging deceptive business practices and defamation after it cut about 500 doctors from its network on quality and efficiency grounds.

What Physicians are Included?

Aetna’s Aexcel tiering program, similar to others, is primarily focused on specialty physicians, within the health plans larger physician network. Aexcel’s program includes some 12 areas of care including: cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetric/gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, urology and vascular surgery.² The plans appear to recognize that primary care physicians often have a much broader spectrum of diseases to diagnose and treat and efficiencies of cost and quality may be harder to measure.

How Does the Program Operate?

In brief, in a tiered physician network, the efficiency of a physician is measured through the health plan’s assignment of physicians into two or more separate tiers differentiated by their relative cost of care.⁵ Aexcel requires that a physician first meet a set of case volume and clinical performance measures prior to measuring the efficiency measures. Aetna looks at the specialist groups currently participating in their network and identifies those who have managed a minimum number of Aetna member cases. Physicians who meet the case volume threshold are then evaluated against several measures of clinical performance.⁶

Clinical Performance Measures

Clinical Performance is measured through the use of two standard “Clinical Effectiveness” measures, which include: adverse events during inpatient hospital stays and 30-day unplanned hospital readmission rates, as well as, those that apply specifically to certain specialties. For example, Obstetricians and Gynecologists are also measured for “Clinical Effectiveness” through assessment of their cervical cancer screening rates with patients, breast cancer screening rates, and HIV testing in pregnancy. All cardiologists are also measured for their use of Beta blockers use after a cardiac event, ACE inhibitor use in patients with congestive heart failure, and statin for members with cardiac disease.⁶

Efficiency Measures

If the physician has met the Clinical Performance measures, Aexcel next measures a physician’s “Cost Efficiency” through two methodologies: Symmetry Episode Treatment Groups™ and the Marketbasket system™ for Physician Efficiency Measurement™ from Cave Consulting Group. Nationwide, these represent two of the several programs now available, which also include Ingenix’s Episode Treatment Group (ETG) and MediStat’s Episode Groups (MEGs). Both methodologies reportedly measure the relative efficiency of physicians in their use of health care resources when treating a given medical condition. Both groups claim to evaluate costs by episodes of care.⁶

More simply, Aetna compares all of a physician’s claims for a series of patients with a certain diagnosis, such as asthma, and their provision of services, commonly called “episodes of care,” or, in this case, Episode

Treatment Groups (ETGs) with their peers-- other physicians' patient's ETG claims having the same diagnosis. Aexcel requires at least 20 episodes of care for each physician to qualify for the comparison, from both outpatient and inpatient settings. Physicians must score in the top half in both methodologies for Aexcel Designation.

Aetna then notifies the physician of their rating and reports the results on their Website. The rating is explained through three standard evaluations made of each physician: 1) Volume-the specialist saw enough Aetna members over the past two years to be evaluated for Aexcel designation; 2) Clinical Quality-The specialist was evaluated on the number of complications or problems for hospitalized patients and expected rate of readmission to the hospital once a patient is discharged and 3) Efficiency-a comparison of the resources used to treat health care events managed by this specialist as compared to resources used by other specialists in the same area and specialty.⁶ Again, physicians must score in the top half in both efficiency methodologies for Aexcel designation. If the physician is not designated, they must wait two years before they can again be considered. Physicians cannot access their competitor's information, unless the physician is an Aetna member.

Finally, Aetna states that they also consider Network Adequacy in their program. To ensure members have access to a sufficient number of specialists, they recognize that it may be necessary to add specialists. In this case, only specialists who have met the clinical performance standard are considered. Patients are also shown a Price Transparency page, which shows the physician's actual payment rates specific to the member's health plan for office visits; diagnostic tests; and major, minor and other procedures. Rates are provided for up to 30 of the most common services for each physician's specialty.⁶

Problems Associated With Tiering Programs

In a study commissioned by the AMA, *Economic Profiling of Physicians*, conducted by J. William Thomas, PhD, of the Institute for Health Policy, University of Southern Maine, the author explains the process by which health insurance claim records are used to produce cost-efficiency performance and why they are problematic.⁹ MAG staff used the standards and other study findings from this report to assess whether Aetna's Aexcel program, as presently defined, is producing valid results. Based on Dr. Thomas's assessment and based on the comparison MAG has made between the Aexcel program and Dr. Thomas's guidelines, MAG believes that evidence suggests that much of the profiling information used in Aexcel and other similarly designed programs is based on methodologies and measures, which are often inadequate, inaccurate, invalid and unproven.

Probably the most overarching question to begin with is whether claims data alone is adequate enough to even rank physicians. Since most physicians typically consider patient charts to be the only reliable source for such information, the answer is a resounding no. Claims data is not sufficient to rank physicians in this way.

The second most important question is in the adequacy of the 20 episodes of care per physician used by Aexcel, since this is one of the single most important measures lending to the accuracy of the ratings. Based on Dr. Thomas's study findings, we find that 20 episodes are considerably below the standard of 50 episodes, which was needed to achieve a 92% probability of accuracy. (Meaning that episode mean costs are within approximately \$200 of the specialist's true mean episode costs.) Even with the use of 30 episodes of care, the probable accuracy reached only 82%.⁹

The third flaw in Aexcel's program is its failure to directly tie measures of quality of care performance to the procedures performed, the tests ordered, and the medications prescribed. The physician efficiency of cost

comparisons are not directly based on whether the physician followed the most recently published treatment guidelines for that diagnosis, for example, but they are compared purely through a simple cost of services comparison. As Dr. Thomas notes in the AMA study, “if a physician performs every procedure, orders every test, and prescribes every medication that relevant clinical guidelines indicate, the episodes managed by that physician are very likely to appear more costly, and therefore inefficient in economic profiles.”⁹

A fourth flaw in Aexcel’s program is whether the episode expected costs are risk-adjusted. From the information Aetna provided, it is not clear whether they are adequately risk-adjusted. Dr. Thomas notes that although economic profiling calculations control for case-mix differences among physicians by partitioning claim databases into episodes and then attributing the episodes to individual physicians, it is questionable whether Aetna or any of the other plans control for differences in severity, complexity, and demographic characteristics among the patients managed. All of that information is not typically found on a physician claim form for a patient.⁹

Finally, Aexcel fails to meet a key task in economic profiling which is to properly attribute responsibility for episode costs to individual physicians. If only one physician is involved in a case, the costs are fairly straightforward. However, as is often the case, multiple physicians may be involved in a case, such as when a patient is initially seen by a primary care physician and subsequently referred to one or more specialists. How, then, is responsibility for episode costs assigned among the involved physicians? Health plans are all over the board in how they make these assignments, making it a very *ad hoc* decision. In Aexcel, the physician who represents at least 30% of the costs, are given full responsibility for all costs. Assigning all costs to one physician, even if he or she has provided up to 30% of the costs is hardly an accurate way to attribute all costs. Each physician evaluated under Aexcel or any other tiering program, should have only the charges they are responsible for directly incurring in their profile.⁹

In a Georgia physician’s recent Aexcel report brought to MAG’s attention, the physician was not Aexcel designated because of the higher costs, which were included in his profile. Surprisingly, in looking at the back-up data supporting his profile, he found that many of the cost procedures were not his at all, but were actually hospital costs that were added into his profile. Obviously, an accurate assessment of a physician’s efficiency cannot be achieved if the profile information includes additional costs beyond his own and with which he has no control.

MAG’s Actions to Date

MAG and its Third Party Payer Committee have been carefully monitoring the series of changes that has been happening in the area of Pay for Performance and Physician Tiering. In September, MAG sent a letter to Ronald A. Williams, CEO of Aetna Inc. informing him of our concerns and asking that he immediately end the Aexcel designation program as presently designed and that its results be removed from their Website. MAG’s General Counsel is carefully studying the legal implications of the program to Georgia’s physicians and is prepared to act following a series of preparatory steps.

Since then, Aetna’s Georgia office responded to MAG’s letter by providing a more indepth explanation of the Aexcel program and inviting MAG leadership to visit their office for a first hand view of the data processing effort. MAG plans to make the visit and glean a fuller picture of the program, in addition to gathering further information from MAG members about their designations.

An information paper was prepared on the topic of Pay for Performance in June of this year, with considerable attention given to the part rating systems play in performance measurement. MAG has worked

closely with the AMA Private Advocacy office in reporting physician tiering developments in Georgia and in finding out what is developing in other parts of the country. AMA published an informational paper on *Tiered and Narrow Physician Networks* in 2006, in addition to the Thomas paper referenced above. In fact, in 2006 AMA passed Resolution 285.972, which seeks to reveal the black box of tiering and limit its economic impact by stating:

Our AMA will: (1) seek to have third party payers disclose, in plain language, the criteria by which the carrier creates a tiered, narrow or restricted network; (2) monitor the development of tiered, narrow or restricted networks to ensure that they are not inappropriately driven by economic criteria by the plans and that patients are not caused health care access problems based on potential for a limited number of specialists in the resulting network (s); and (3) seek legislation regulation which prohibits formation of networks based solely on economic criteria and ensures that, before health plans can establish new panel networks, physicians are informed of the criteria for participating in those networks, with sufficient advance time to permit them to see the criteria. (Res. 806, I-06)

Just this year, MAG is submitting a resolution to the AMA on “Taking Back the Profession of Medicine,” which reaffirms AMA President Plested’s pledge that AMA’s positions be driven by a commitment to return the rightful prerogatives of the profession to the physicians of America and asks that the AMA strongly oppose the use of any system by any public or private third party payer that purports to rank members of the profession, place physicians into tiers or institute payment mechanisms that are based on measures that are not clinically sound or are based on data that are incomplete or not statistically significant.

In April, Aetna made a presentation to the MAG Third Party Payer Committee and other interested leadership members about Aexcel and a number of recommendations were made for adjustments in the program at that time. Prior to this, the Medical Association of Georgia convened their own Forum on Physician Profiling Issues and Pay for Performance in September, 2005 with presentations from the major health plans who had PFP programs in place and offered constructive comments at that time.

What Can Physicians Do?

All physicians are urged to check their profiling data with these plans. Regardless of whether you meet the criteria to be a designated physician, you must check the data used to determine if the data is accurate. Please report any inaccuracies to Cam Grayson or Donald J. Palmisano, Jr. at the MAG office.

Conclusion

MAG recognizes the increasing desire in today’s environment for the publication of accurate and meaningful data in the provision of medical services. However, it is our opinion that, as presently designed, tiered programs add further complexity to the health care system for patients and risk undermining the patient-physician relationship when patients are provided with inaccurate data and are restricted from seeing some physicians or are faced with choosing their physicians based on cost tiers. Inadequate measures of physicians’ cost efficiency performance can impugn physicians and damage reputations, and such measures will not produce efficiency improvements.

FOOTNOTES AND REFERENCES

1. AMA Policy Compendium, Policy on Tiering, 2007.
2. Aetna US Healthcare, Hartford, Connecticut, *Aetna Supports Health Care Transparency*, January, 2007.
3. American Medical Association, *AMA Policy Compendium*, Policy 285.972, Tiered, Narrow, or Restricted Physician Networks, 2006.
4. American Medical Association, *Pay for Performance: A Physician's Guide to Evaluating Incentive Plans*, Chicago, 2006.
5. American Medical Association, Private Sector Advocacy Unit, *Tiered and Narrow Physician Networks*, Chicago, pp. 1-10, June 2006.
6. ElGomayel, Ramzy, Aetna of Georgia, Alpharetta, Georgia, July 19, 2007 Letter to Physicians in Georgia on Aexcel™ Designation Process and Aexcel Evaluation Standards.
7. Kropp, Robert, M.D., M.B.A., *Consumer Directed Health Care Focus on Transparency*, Aetna US HealthCare, Alpharetta, Georgia, August, 2006.
8. Spicer, Jack, M.D., Aetna US Healthcare, Alpharetta, Georgia, Letter to John Harvey, M.D. with Aexcel Provider Performance Detail Report, MCC Provider Comparison, MCC Differential Analysis: Comparator Group and Aexcel Treatment Patient Comparison, August 21, 2007
9. Thomas, J. William, PhD, *Economic Profiling of Physicians: What Is It?* Institute for Health Policy, Muskie School of Public Service, University of Southern Maine, Developed for the American Medical Association, pp. 1-10, June 2006.

To Our Patients

Thank you for allowing us to provide medical care to you and your family. Providing quality Care to each of you based on your individual needs and desires is a responsibility we take very seriously.

You may have heard about recent efforts by insurance companies in Georgia to “rate” physicians, supposedly based on the quality of care the physician provides. Some of the programs now operating in Georgia include Aetna’s Aexcel™ Designation program, United Healthcare’s United Health Premium™ designation program and Cigna’s Care Network.

These systems often rate quality based on **cost** using computer programs that look at numbers and dollar amounts. They often also lump in your hospital costs with those of your physician. This is not the best way to judge whether or not you receive “quality” care — no cost-based computer program in the world can do that.

As a patient, you need confidence that your physician will provide you with the best medical care and not simply the cheapest. The easiest way to provide cheap health care is to provide less health care — and that is not fair to you.

We support scientific efforts designed to improve health care quality, and the Medical Association of Georgia in conjunction with the American Medical Association has established appropriate guidelines to measure physician quality. Unfortunately, most current insurance company rating systems do not meet these guidelines.

Please let us know if you have any questions about the medical care you receive in our office.

Our No. 1 goal is to provide you with quality medical care.