Considerations in Performance Measurement and Value-Based Purchasing for Providers Treating Vulnerable Patients

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Questions

- What are possible unintended consequences for vulnerable patients and their providers under performance reporting and VBP?
- How should provider status as treating high levels of vulnerable populations be defined and measured in ambulatory settings?
- How do quality scores vary for providers treating vulnerable populations versus other providers?
- What adjustments could be made to program design if these providers are differentially affected by performance reporting or VBP?

Methods

- Literature review
  - Structured discussions
  - 9 medical practices treating vulnerable populations
  - Technical experts (disparities, performance measurement, private P4P programs, case-mix adjustment methods)
- Data analysis - Community Tracking Study Physician Survey linked to Medicare claims
  - Exposure to performance-based incentives based on patient panel characteristics
  - Distribution of % of revenues derived from Medicaid
  - Preventive services by % patient panel that was black
- Technical Expert Panel meeting

Considerations in Performance Reporting and VBP for Providers Treating Vulnerable Patients

What are Possible Unintended Consequences?

- Providers may decide not to treat (or avoid) vulnerable patients
- Vulnerable patients may ultimately face reduced access to physician care
- Disparities in quality of care may increase
How Might Provider Status Be Defined and Measured?

- Measure on a continuum with cut points
  - Patient race/ethnicity and SES (e.g., Medicaid eligibility); HPSA; rural designation
- Define at practice level, where systematic quality improvement most likely to take place
- Ideally use self-reporting, but can use administrative data

How Do Quality Scores Vary for Providers Treating Vulnerable Patients versus Others?

- Limited evidence on performance scores by patient SES suggests lower performance scores for providers with more poor patients
- Specific patient characteristics related to adherence, but
  - Relationship is situational and hard to predict
  - Very limited and mixed data on associations between patient characteristics, adherence, and provider performance scores on specific quality measures
- Providers share responsibility for patient adherence

Possible Adjustments to Program Design:
Payments under VBP

- Differential bonus to high-performing providers treating disproportionate numbers of low-income patients
  - Accounts for lower reimbursement and fewer resources to invest in quality improvement
  - Target to providers who achieve a specified performance level
  - Can be done with or without adjustment of scores

Possible Adjustments to Program Design: Measures and Outreach

- Consider measures especially relevant to providers treating vulnerable patients: access to care, care coordination, literacy/language-appropriate materials
- Start with measures less dependent on adherence
- Tailor outreach to specific subgroups of providers
- Additional technical assistance or subsidies may be required to gain participation (depends on provider type and resources)
Some VBP Design Decisions May Require More Data

- How does quality of care differ?
- How might definition of provider status be refined to incorporate multiple characteristics?
- How might payment structure be refined to maximize provider incentives to improve quality while minimizing unintended consequences?

Conclusions

- Performance reporting and VBP should account for disadvantages faced by providers treating vulnerable patients
  - Risk of unintended consequences particularly high under VBP
- Lower cumulative reimbursement for providers treating low-income patients provides strong rationale for payment bump under VBP
- Limited data exist on the relationships between patient factors, adherence, and provider performance on specific quality measures