



BHCg/WHIO/GNS Healthcare Physician Value Study

Presentations by:

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Italian Community Center, Milwaukee, WI

Executive Summary

A top priority of the Business Health Care Group of Wisconsin (BHCg) and its member employers is to purchase high value health care. In continuing its mission, BHCg, with generous support from the Greater Milwaukee Business Foundation on Health (GMBFH), commissioned a second Physician Value study from GNS Healthcare – a leading provider of artificial intelligence (AI) applications in health care – to evaluate the value of care provided by physicians throughout Wisconsin. The Study uses claims data from the state’s all-payer claims database, WHIO – the Wisconsin Health Information Organization.

The Study is intended to support health system performance improvement and inform employer benefit program design to enable better health care decision-making, particularly with respect to the steering of patients to higher-value providers. Study data was used to develop the new BHCg-Centivo high-performance health plan, effective January 1, 2022.

Health care stakeholders (employers, brokers/consultants, health care providers) gathered to attend a presentation (both in-person and virtually) in Milwaukee on December 8 to learn about the results of the second BHCg/GNS Healthcare Physician Value Study, which continued to show the potential for significant cost savings through improved physician performance.

Jeff Kluever, Executive Director, BHCG

- **Purchasing high value health care – a top BHCG priority**
 - All stakeholders (employers, employees/dependents, community) benefit when health care value is increased – we all have a vested interest in helping to make Wisconsin a great place to do business
 - Wisconsin has high quality health care with strong access, but also high costs (with significant differences in cost effectiveness not linked to measurable differences in quality)
- **Commissioned study to evaluate health care**
 - Funded by BHCG and GMBFH – first study launched in 2019
 - Results of both the first and second Study revealed potential for substantial cost savings through improved physician performance
- **Wisconsin’s first high-performance, primary care-driven health plan option**
 - Study data was the foundation for development of the BHCG-Centivo high-performance health plan solution
 - Offered to BHCG member employers and administered by Centivo
 - Centivo selected after rigorous selection process
 - Track record of building successful high-performance solutions
 - Alignment with BHCG strategy
 - Continues BHCG’s mission to increase health care value by working directly with health systems/provider groups
 - Aligns objectives, includes accountability, rewards value – not volume
 - Primary care-driven model addresses medical homelessness
 - Strong relationships with primary care providers help members navigate the system and make better choices – “the right treatment at the right time”

Dana Richardson, Chief Executive Officer, WHIO

- **Wisconsin Health Information Organization (WHIO) All-Payer Claims Database (APCD)**
 - Provides health data and information to all stakeholders to advance action for better health and health care value
 - Have the people and tools needed to build a report from raw data, refurbished and reorganized over hundreds of hours
- **“Fit for purpose” = data appropriate for the intended use**
 - BHCG wanted to know – is there an opportunity to reduce costs and increase quality?
 - Who created the data? WHIO created from fully adjudicated claims (health plans, self-funded employers, Medicaid, Medicare)
 - Breadth of data? All geographic areas of WI; 75% of state’s population; all sites of cares; all diagnoses; and all services paid by insurance
 - How standardized is the data? Uses nationally recognized code sets and is more granular to support analytics

- How is data assessed for accuracy? Automated quality control, data evaluated at multiple steps
 - 99-100% fill rates for all required fields
 - WHIO maintains provider registry, updated regularly; data submitting organizations receive data quality reports
- **WHIO used data groupers to create useful information for the Study**
 - Episode Treatment Groups (ETG) – episode of care with a starting and ending point (every service provided in-between gets tagged as belonging to a specific ETG)
 - Episode Risk Grouper (ERG) – not every input/person is the same (different levels of risk); need to be able to predict what the risk is to stratify data according to risk
 - Normalized Pricing – apply a price to every single service in the database (the same regardless of who provided the care) to get rid of contractual differences
 - Allows for looking at differences in total cost (i.e., what resources were actually used for the same episode to get the same outcome?)
 - Evidence Based Measures (EBM) – the quality component
 - Over 700 quality measures sourced from organizations (e.g., NCQA, AHRQ, PQA, etc.) across the U.S.

Earl Steinberg, MD, MPP, Executive Vice President of Payer and Market Access/HEOR Lines of Business, GNS Healthcare

- **Second Physician Value Study objectives**
 - Using combined data from 2018-2019:
 - What is the quality and efficiency of each primary care provider?
 - What is the cost efficiency of individual specialists when performing certain procedures?
 - What is the cost savings potential when patients are incentivized to use more efficient PCPS/specialists; and/or the performance of lower performing PCPs/specialists is improved?
- **Data source (WHIO database)**
 - 2018/2019 claims from patients who had both medical and pharmacy benefits during both years
 - Patients attributed to assigned PCP or PCP with most of the costs if none was assigned
 - 151 episodes of care met Study criteria and were included
 - 294 EBMs related to preventive care and diseases commonly managed by PCPs were used
- **PCP quality and cost efficiency score calculation**
 - Quality scores calculated as a ratio of compliant EBM results divided by total compliant and non-compliant EBM results (“batting average” – denominator = total “at bats”; numerator = number of “at bats” when the care was consistent with the care the EBM said should be provided)
 - Cost efficiency score is the ratio of predicted costs to actual costs

- Costs were normalized, not actual, due to payers' insistence on keeping actual contract rates confidential
 - GNS Artificial intelligence (AI) platform used to develop predicted cost
 - Controlled for all variables
 - Each individual PCP received an overall cost efficiency score (weighted average of PCP's ETG cost efficiency scores)
- **Specialist cost efficiency scores**
 - MD-specific for specialists who performed any of 10 commonly performed procedures
 - Used same calculation methodology as for PCP cost efficiency scoring
- **AI Platform**
 - Uses causal learning – two advantages over “deep learning”
 - Causal learning can identify causal associations between variables; Deep learning can only identify statistical associations
 - Causal learning enables use of simulations to answer “what if” questions
 - The math used in GNS' AI platform developed by Judea Pearl (won Turing Award for it)
 - GNS put the math on a software platform that is scalable – can be used with large sets of data
- **Methods**
 - PCPs must have had at least 30 episodes of care to be included (end result – 4,587 included – 20%)
 - Did not include certain types of PCP specialists (e.g., geriatricians, gynecologists)
 - Tried to maximize the development of statistically valid results
 - 737,946 plan members included (mean age of 43); number of patients per PCP – mean of 205
 - Medicaid patients represented 45%; commercial patients, 32%; Medicare, 16%; other, 7%
- **PCP quality ranking distribution**
 - Required at least 80% confidence in the category ranking (performed sensitivity analyses)
 - Outstanding performers – 20%; good performers – 23%; typical performers – 14%; below average performers – 43%
- **PCP cost efficiency**
 - Approach – use causal learning platform to predict the cost for each patient/disease and risk adjusted (e.g., age, gender, severity, complication, etc.)
 - Patient cost efficiency scores aggregated and attributed to PCP
 - Overall efficiency score calculated (based on actual costs relative to predicted costs)
 - 4,829 PCPs included in cost efficiency analysis
 - Outstanding performers – 14%; good performers – 20%; typical performers – 30%; below average performers – 35%
 - 96% of total costs attributable to PCPs included in the Study
 - Found no statistical relationship between quality and cost
- **PCP cost savings opportunities**
 - \$810 million in total annual cost across all diseases evaluated

- One-year savings potential from moving patients to PCPs in top:
 - 80th percentile: \$455.5 million
 - 60th percentile: \$369.1 million
 - 50th percentile: \$324.7 million
- **Specialist cost efficiency analysis**
 - Analyzed nine different types of specialist procedures with \$681 million in normalized costs
 - \$57.65 million savings potential from bringing below average providers to 50th percentile or above
- **Combined annual potential cost savings for PCP and specialist procedures**
 - \$382.35 million (25.7%)
- **Conclusions**
 - Substantial variation in both quality and cost efficiency of care for PCPs and cost efficiency for specialists
 - Almost \$400 million could be saved if all physicians in study performed at the 50th percentile or above (or patients were moved to higher performing physicians)

Dave Osterdorf, BHCG Strategic Consultant & Chief Actuary, Centivo

- **BHCG/Centivo partnership**
 - Health care change comes slowly – using a sophisticated process based on data, we now have a way to make positive change with results
 - Shared goals: affordable, high quality health care for all that is cost sustainable for the business community with compensation tied to value
 - Closer connection between employers and providers
 - Strong member engagement with high performing PCP – results in better and more affordable health care for employers, employees, dependents and community
- **Health plan solution**
 - Model that fosters PCP relationships (PCP takes full responsibility and is held accountable)
 - Benefits that align to get people to choose high value health care (beyond transparency tools)
 - Underlying network concept (look at high value care and patient management) – incentivize PCP relationship (mandatory) with high value performers
 - Must have appropriate access
- **Proprietary networks**
 - Make high performing providers from each health system available
 - Remove low performing PCPs (about 25%) – data from Study was immediately used to develop networks; also use data to have PCPs to refer to high performing specialists – savings opportunity
- **Creates enduring patient/physician relationship**

- Data very robust, not a lot of noise/change (high performers remain high performers)
- Have the right level of access to PCP and primary care team (virtual and in-person)
- Alignment with plan design, operational efficiency and reimbursement
- **Must look at total cost of care**
 - Efficient care from providers with competitive prices
 - Patient health management (to avoid future care costs)
 - Risk and success sharing for a sustainable model
- **On-Site clinic solution**
 - Employer on-site/near-site clinics (good for episodic care, but not for holistic care management – lack data)
 - Take high performance data and bring into onsite clinics as entry point to referral process
- **Ultimate goal – make health care better**
 - Business community initiative – collaborative process and direct dialogue with providers to work on things that matter (continuous improvement)
 - Need commitment from both sides
 - Shooting for long-term process – want to work together (want every PCP to be high performing)
 - Pathway informed by data
 - More money spent in primary care, less specialty, through changing reimbursement
 - Accountability and alignment with data is very important

Dana Richardson

- **WHIO products and services**
 - Standard integrated database – longitudinal, used by researchers
 - Pre-built reports for providers/health plans (recognizes user to render relevant information)
 - Custom data extracts/analytics
 - Public reports – InfoBytes (topics of interest in Wisconsin)
 - Socioeconomic reference file (first in nation)
 - Characteristics (e.g., race/ethnicity, access to computer, income level, etc.) connected through unique unidentifiable key to a database to analyze disparities in health and care
 - Available 1/22 (maybe add to Study for next year)
- **Report format and delivery**
 - BHCg commissioned the Study – asked WHIO to distribute provider reports through secure portal so they can use for improvement
 - No public reporting
 - Provider organizations see who is performing well and who isn't – quality and cost scores – individual PCP ranking

- Provide directional information to begin improvement process (“who are my high performers and how can we emulate them?”; “where should I put my clinical improvement resources? etc.)

Q&A

Q. Did you look at what percentage of the low performing physicians’ patients were Medicaid?

A. Richardson: We did not, but we could have. However, about 40% of WHIO data comes from Medicaid, 40% from commercial and self-funded plans and 20% from Medicare plans. We recognize that risk factors aren’t shared evenly across plans.

Q. What intentions do you have to look at the necessity of procedures (like angioplasty)?

A. Steinberg: Looking at appropriateness of care is very difficult from claims data or even chart review. We are aware of other efforts to do that – it is possible we might include it next year.

Q. Results from the Study show savings opportunities that are significant. How can employers and providers work together – what are the major opportunities? How can we encourage providers to access the reports and act on them?

A. Richardson: The primary thing that has been missing in our environment is really an incentive to want to change. The information is available and has been, but this time the difference is Centivo. Now there is a reason for them to pay attention to the data and want to improve. Providers are willing and wanting to provide the best care possible, but there are a lot of obstacles. Provider organizations need a reason to use resources to change. What BHCG and Centivo are doing gives them that – need an outside entity to enable that.

Steinberg: My previous health system employer used quality as a basis for payment in part – they measured and provided it and invested in quality improvement. The opportunity to improve is there, but it requires investment (health systems invest a lot in payment systems, but not so much in quality improvement).

Osterndorf: When the Study was done the first time, provider community had a relatively antagonistic attitude toward it – but that has changed over the last 18 months. They seem to have gotten their heads around it, but engagement levels vary. Employer community voice is important (commercial payers keep them in business), they have an expectation providers will improve. Providers know they needed a push.

Q. What is Centivo’s approach to the provider community and how does it differ from other health plans?

A. Osterndorf: This is hard work, but you have to be committed to it. Centivo has the benefit of not having other pieces of business (e.g., don't run Medicare Advantage plans, don't have to make compromises to protect other business). We work for self-funded employers which requires us to share data that providers don't have and set up systems to reinforce the structure. We need to have a simple way to create PCP relationships for members (spend time and energy on the technology) and a monitoring system that is continuous and that everyone understands.