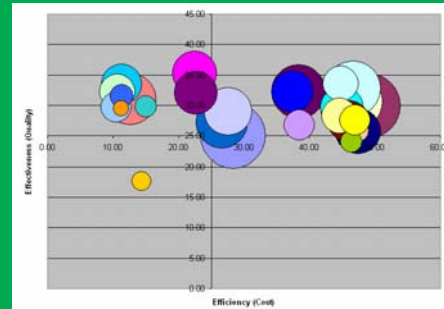


The Current State of Ambulatory Care Measures Acting today while looking to tomorrow

François de Brantes
November 11, 2005



Can we really afford to ignore efficiency?



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Measuring physician efficiency reliably is difficult but doable today

There are several methods in the market today, used widely by plans, to compare the cost of care:

- United HealthCare has launched its Premium Network program in 40 markets
- Cigna has launched its high performance network in many markets
- Aetna has launched Aexcel in most of its markets
- Many Blues plans are following suit



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The rules applied by each end user in measuring efficiency vary greatly

While all the applications use severity adjustments and group claims data into natural disease/procedure/event clusters to identify a longitudinal episode of care, many other basic rules vary:

- Attribution – there are at least 6 different ways to attribute patient episodes to providers (most claims, % cost, multiple or single attribution, etc...)
- Sample sizes – some users have set their minimum at 5 episodes, others use 10 or more
- Inpatient care – users can decide whether or not to include inpatient costs as part of an episode or not

In all there are more than 1,000 permutations which can lead to significantly different results, even when using the same application



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Bridges To Excellence, Leapfrog, PBGH, NCQA, AHIP worked together to inform payers and purchasers

We focused on the payer's view of efficiency: cost of care for the patient, not the providers cost of delivering the care

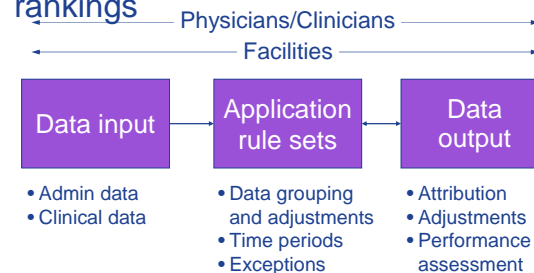
We accepted the validity of claims as the unit to count the cost of care for a patient

We accepted the validity of current commercial applications (ETGs, DCGs, MEGs, etc...) as a means to group claims into homogenous episodes

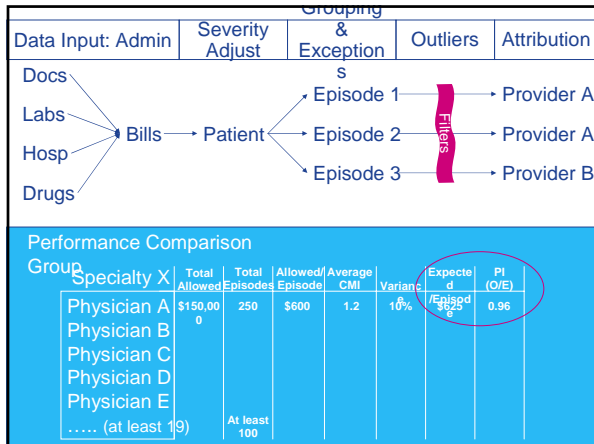


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There are three basic process steps to create relative performance rankings



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There are some important issues and shortcomings to understand

Clusters and “n”s – Patients cluster around certain physicians, and a plan’s plan member distribution is very Pareto-like, with 80% of the plan members seeing about 30% of the physicians in the network. As such, most plans can only reliably measure 30% of their network physicians – *making data aggregation a necessity to produce reliable metrics on all physicians in a community*

Compounding variability – Performance group comparisons compound two types of variability, the individual provider’s and the group’s. It’s important to understand both to appropriately rank the providers



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There are some important issues and shortcomings to understand

Dollar denomination – At some point, any efficiency metric or system must be converted to dollars to make it actionable by payers. It’s therefore critical to understand the impact of the provider’s societal mission on \$\$ charged

“Performance indices” – While these establish relative rankings, they can also build in some significant biases against better quality physicians. There are ways to mitigate against the bias, but none are foolproof and PIs should not be used until application vendors have better addressed this issue.



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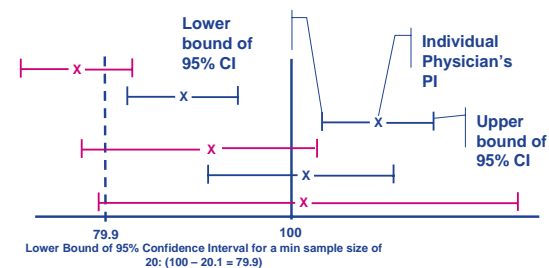
Performance indices are highly sensitive to episode volumes of the physicians included in the group

| Event Count | 95% Confidence Interval | |
|-------------|-------------------------|---------------|
| | Low Interval | High Interval |
| 10 | E – 0.310 | E + 0.428 |
| 20 | E – 0.201 | E + 0.309 |
| 50 | E – 0.152 | E + 0.193 |
| 100 | E – 0.107 | E + 0.129 |



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Misclassification can be minimized by using the right approach



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Synopsis of recommendations

- Avoid methodological errors around
 - Data volume (sufficient experience to allow statistically sound measurement)
 - Data sources (include all professional, facility and pharmacy claims)
 - Attribution of costs to care providers (“allowed dollars” threshold of professional care for assignment of responsibility)
- Incorporate outlier, case-mix and severity adjustment
- Measure and compare against comparable peer groups only (e.g., within provider specialty, using mission adjustments)
- Report performance in valid statistical groupings, avoiding the implied precision of numerical rankings



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We can measure most physicians today

Cost of care can be measured on 100% of ambulatory costs

Quality of care can be measured on 60% of ambulatory costs, but you need a few ingredients to make it work:

- Third-party reviewed self-reported data (that's BTE's model)
- A large database of medical and drug claims, plus lab data
- The will to move ahead even if it's not perfect



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