

Provider Profiling: Implementation Issues within Florida MediPass

Virginia A. Schaffer, MA
Allyson Hall, PhD

Florida Center for Medicaid & the Uninsured
College of Public Health and Health Professions
University of Florida
352/273-5059

Sponsored by
The Agency for Health Care Administration



June, 2004

Table of Contents

| | |
|---|----|
| Executive Summary | 1 |
| I. Introduction and Background | 2 |
| II. Study Methodology..... | 3 |
| III. Key Informant Views on Provider Profiling..... | 5 |
| IV. Findings from the State Interviews..... | 5 |
| A. Arkansas..... | 5 |
| B. Indiana..... | 8 |
| C. Louisiana..... | 9 |
| D. North Carolina | 10 |
| E. Massachusetts | 12 |
| F. Additional State Information | 13 |
| V. Findings from Physician Interviews | 14 |
| VI. Conclusion | 15 |
| VII. Implications for AHCA | 17 |
| VIII. References..... | 20 |

Executive Summary

Provider profiling use epidemiological methods to compare physician practice patterns across various dimensions of care. These dimensions of care may include length of stay, procedures ordered or cost per diagnosis – related group (DRG). The premise behind provider profiling is that physicians with appropriate information will change the way they practice in order to conform to acceptable guidelines thereby improving the quality of care. Increasingly, managed care organizations and other delivery entities are using provider profiling as a means to understand and control costs.

This report provides the Agency for Health Care Administration (AHCA) with important conclusions made from reviewing literature regarding provider profiling programs. Findings from interviews with key informants, state Medicaid agency officials, and physicians are also provided to highlight the important conclusions and implications of implementing provider profiles.

Specifically, areas of concern for the current AdvancedMed profiling system used by AHCA would be the time lags associated with data used to compile provider profiles, the current configuration of reports and its usefulness for providers, and the level of input Medicaid physicians have on the design and implementation of the provider profiling program. As AHCA considers the implementation of provider profiles within its Medicaid program, the following guidelines are critical to assuring some level of success:

- The initial emphasis should be on quality improvement
- Performance measures should be clinically important
- Accountability for performance should be limited to patients and services for which physician is directly responsible
- Adequate risk and case mix adjustment must be incorporated in the program design with accompanying explanation of how data was adjusted
- Physicians should be involved early in the design and implementation of provider profiling strategies in order to generate ‘buy-in’
- Performance reports should be clear and easy to understand and coupled with provider feedback and educational opportunities
- Provider profiling programs should make every attempt to use accurate data

I. Introduction and Background

Provider profiling is a term used to describe the process of compiling and disseminating performance feedback information to physicians and other clinicians. Essentially, provider profiling use epidemiological methods to compare physician practice patterns across various dimensions of care including length of stay, drug utilization, procedures ordered, or cost per diagnosis related group (DRG). Provider profiling reports are used in a variety of organizations including managed care companies, hospitals, and in large group practices. Increasingly, managed care organizations and other delivery entities are using provider profiling as a means to understand and control costs and improve the quality of care and as a tool to ensure that they are ‘getting value for money’ (Goldfield et al, 2003).

Several years ago, the Agency for Health Care Administration (AHCA) via its fiscal intermediary Affiliated Computer Services, Inc. (ACS) contracted with Advanced Med to provide data management activities for Medicaid claims data. At that time, AHCA’s plan was to use AdvancedMed to generate and distribute risk-adjusted performance reports to their primary care physicians who participate in the MediPass program. Without understanding the complexity of patients in different groups, comparisons made between providers (or any other variable for that matter) are futile (Goldfield, 1996). AdvancedMed would produce formatted reports showing aggregated actual measures of use activity, expected measures of use activity, a morbidity index, and actual and expected costs. For any one time, claims data for a one-year period (four quarters) would be available for analysis. New data uploads were to be performed each quarter, at which time the oldest quarter’s data would drop out of the data set and a new quarter’s data would be added. Accordingly, data should be accurate (i.e. low rate of random errors such as the reversing of digits), unbiased (e.g., providers have not systematically adjusted their CPT coding for payment purposes), and have a low rate of missing values (Brand et al, 1995).

The Agency for Health Care Administration (AHCA) contracted with the Florida Center for Medicaid and the Uninsured (FCMU) to examine the issues around the introduction of a provider profiling program within the Florida Medicaid program. During the first phase of this study, a literature review revealed that as currently configured, the AdvancedMed program may not be very effective in changing provider behavior, improving quality of care and reducing health care disparities.¹ One reason has to do with the 8 to 9 month time lag between dates of service and the date when the data become available from AdvancedMed. Physicians who modify their behavior will not begin to see these changes reflected in data until several months later. In addition, because the data is aggregated over 1 year, it will take even longer before doctors can start to see the full effect of changes they may have made. One quarter's data can be isolated in the database. This example highlights why physician profiling has been heavily criticized because of 1) perceived adverse effects of pressures to restrict services on quality of care, 2) reporting is thought to be based on poor quality data and 3) inadequate risk adjustment (American College of Physicians, 2001).

It is our understanding that ACS and AHCA no longer contracts with AdvancedMed. However, AHCA remains interested in learning whether programs such as AdvancedMed's could be of value to the state. The study conducted by FCMU reviewed the existing literature base, researched current provider profiling programs by interviewing state Medicaid agency officials, and gathered pertinent information from other sources such as key informants, organizational websites, and journal articles. To the extent possible, clinical outcomes measures should be related to the processes of care that can be easily modified by the physician or practice (Massachusetts Medical Society, 1999). However, it is important to recognize that provider performance measures may never be able to accurately portray the quality of medical care delivered to patients (Brand et al, 1995).

II. Study Methodology

¹ See Dimoulas E and Hall A *Literature Review on Provider Profiling* submitted to the Agency in June, 2003

The overall purpose of the provider profiling study was to collect and document pertinent data from other Medicaid agencies and health plans regarding systems of compiling and reporting provider performance. In addition, this project aimed to collect MediPass physician views on profiling.

Initial activities focused on identifying and contacting key informants particularly within state agencies. Preliminary inquiries revealed that only a handful of states had implemented provider profiling programs within their primary care case management programs. Further research revealed that states may encourage provider profiling programs as part of Medicaid Managed Care or Primary Care Case Management contracts, however interviews were not conducted with individual Managed Care Organizations or other private sector groups. In addition, information searches had shown that organizations such as the Center for Health Care Strategies/Mathematica, Center for Studying Health System Change, Positive Health care, the Special Committee on Physician Profiling, and American Public Human Service Association had conducted research and were disseminating information such as issue briefs and presentations on the area of provider profiling.

Interviews were completed with Medicaid agency officials in Arkansas, Indiana, Louisiana, North Carolina, and Massachusetts. Information or brief interviews were conducted with Georgia, Maryland and Texas. Please refer to Appendix 1 to review the Provider Profiling Matrix that highlights details about each state's program. Medicaid state contacts were asked to comment on their state's involvement with provider profiling and to discuss problems, limitations, and successes associated with their programs. In addition questions related to implementation and evaluation of their provider profiling programs were asked.

Providers and their office staff were also interviewed about provider profiling. In some instances, questions were included as part of a series of questions on their overall experiences with MediPass. In other instances, providers were explicitly asked to comment on the usefulness of the reports generated by AdvancedMed. Questions for

both sets of physicians were designed to get their opinions about potential effects of profiling and what measures they would find useful in improving the quality of their practice. We completed 4 in depth interviews with providers about profiling. Fourteen other physicians have been interviewed about MediPass in general.

III. Key Informant Views on Provider Profiling

Many of the key informants stressed that any kind of provider profiling activity must be grounded in quality improvement activities, rather than as a way to play ‘punitive games’ with physicians that can threaten their practices and reputations. For example, one agency said that their profiling activity stems from a goal to improve quality of care, which can lead to better satisfaction and improved compliance among their HIV positive patients. One informant noted that ‘provider profiling is not intended to be used to address issues of physician competency, including medical knowledge and skills. The ultimate goal is to improve clinical outcomes’. Therefore, as one key informant points out, provider profiling activities are challenged by ensuring data are available and meet appropriate quality and risk adjustment standards.

Gaining provider acceptance and believability is an important aspect of any profiling activity. Understandably many physicians are resistant to any kind of monitoring. Physicians want to have their autonomy and there is a general sense that profiling can interfere with this. Key informants suggested that one way to overcome this kind of resistance is to ground performance measures in accepted practice guidelines.

IV. Findings from the State Interviews

The following section provides pertinent details from interviews conducted with officials at five state Medicaid agencies. Interviews were conducted with officials in Arkansas, Indiana, Louisiana, North Carolina, and Massachusetts while information was collected on Maryland and Texas. Please refer to Appendix 1 to review the Provider Profiling Matrix that highlights details about each state’s program.

A. Arkansas

A number of stakeholders identified Arkansas as a leader in using provider profiling within Medicaid primary care case management programs. Arkansas Medicaid is involved in two sets of profiling activities – *PCP Profiles* and *The Angels Program: High Risk OB/GYN*.

PCP Profiles: The Arkansas Foundation for Medical Care (AFMC) conducts provider profiling activities for the Arkansas Medicaid program. The profiling initiative began in 1995 and for the last six years has provided profile reports to PCPs in the Medicaid program. Arkansas Medicaid Primary care physicians receive quarterly reports that include graphs and tables designed to help providers compare their costs and utilization to the statewide average. Appendix 2 contains a copy of the PCP profile that is sent to providers. The first page of the report contains a letter from the medical director. Center pages include the performance report and provides cost and utilization information for the quarter and year to date. Physicians can compare their performance to state totals using the ‘index’ (3rd and 5th columns). The index is the ratio for the individual physician compared to the corresponding state value. For example, for the quarter reported in the profile, this physician’s total cost PMPM is about 12 percent higher than the state average (see last line of the table). The report also includes quarterly pharmacy cost and utilization patters for the physician’s panel and the state average. The last page provides some general information on pharmacy claims for the state.

Until recently the PCP profile was not risk-adjusted. Over time however, physicians began to advocate for some kind of risk adjustment methodology. Beginning in the fall of 2003, the Johns Hopkins Adjusted Clinical Group Case-Mix System (ACG) is used to calculate a risk-adjusted efficiency ratio. This ratio is the mean cost per patient per quarter for that PCP divided by the PCPs expected cost per quarter. The expected cost per quarter is calculated based on the severity of the patient’s caseload using the Hopkins methodology. When asked why AFMC decided to use the Hopkins system, the Arkansas key informant mentioned that ‘it was the methodology that most people in the

office were familiar with'.² They had hoped to introduce the risk-adjustment sooner, but that there was a significant learning curve associated with its introduction.

AFMC also send a yearly profile to PCPs that tracks EPSDT/preventive screening (see Appendix 3). This profile shows the number eligible beneficiaries who are screened and not screened during the previous year. The tables also show the potential income lost to the provider for not performing all of the required screens. AFMC plans to do profile for diabetes in the near future.

The format of the two reports was vetted with the board of directors of the Arkansas Medical Care Foundation, all of whom are physicians. The board members provided comments on the structure and design of several iterations the reports. In addition, Medicaid provider representatives solicited feedback on report format from the physicians. To date, the state has not conducted a formal evaluation of the program.

The Angels Program: High Risk OB/GYN: Arkansas has a targeted quality initiative aimed at improving outcomes for mothers at high risk for having an adverse pregnancy. The program began 2 years ago with the development of clinical guidelines for high-risk pregnancies. The original intent was to use existing guidelines developed by the American College of Obstetrics and Gynecology. However, early in the process they realized that the guidelines would need to be customized to meet the needs of Arkansas Medicaid population. For example, the rural nature of the state may limit access to emergency rooms and that special focus needed on high-risk mothers with asthma. As a result, Arkansas Medicaid worked to adapt the clinical guidelines to meet the State's particular needs.

An integral component of the process was getting clinicians to agree to the guidelines. This was an iterative process. Guideline development was the topic of weekly conference calls (on average about 35 providers attended the calls). Guidelines

² Another possible reason for the use of the ACG system is that it offered free of charge (for capitation and rate-setting purposes only) to state Medicaid programs. In addition to Arkansas, the ACG system is used in Kansas, and Oklahoma.

were also posted on the Medicaid website. In addition nurses and other medical workers did outreach to providers throughout the state. Throughout the process providers were encouraged to comment and suggest revisions.

The agreed upon clinical practice guidelines were used to create claims groupings (using ICD and CPT codes) which were incorporated into the physician profiler (done by EDS). The profiles compare physicians to their peer groups with respect to cost and utilization across a number of dimensions including drug utilization, inpatient hospitalizations, outpatient referrals, and emergency room utilization.

Establishing the peer groups for the clinicians engaged in high-risk pregnancies was somewhat challenging. In Arkansas potentially family practice, general practice, OB/GYN, internal medicine (including sub-specialties) and pediatric specialties are all considered PCPs. Arkansas Medicaid sent letters to all of the providers asking them define what specialty they actually practice in and the extent to which they are involved in pregnancy care. Based on their responses, physicians were grouped into various categories or peer groups.

To date, providers have received the OB/GYN profile favorably. Contacts at Arkansas Medicaid attribute this to the fact that the physicians were involved in the guideline development and that the profiles are based on these guidelines. Furthermore, Arkansas Medicaid worked towards securing 'buy-in' from the state medical society. Next steps involve visits to outlier physicians needing corrective training and action. These visits have been shown to be very time consuming and labor intensive and can take up to 4 hours per visit.

B. Indiana

Although the Indiana Medicaid program, known as the Indiana Health Coverage Programs (IHCP), does not create or distribute reports through an established provider profiling program, IHCP does monitor providers. In conjunction with their contractor, Health Care Excel, IHCP examines provider health care delivery and utilization patterns

for purposes of detecting issues such as the over-utilization of services. The three business functions within Health Care Excel are Medical Policy (MP), Prior Authorization (PA), and Surveillance and Utilization Review (SUR). The objectives listed below are examples of SUR responsibilities in regards to the IHCP contract.

- Monitor utilization to identify potential misutilization of IHCP.
- Identify utilization trends and patterns and develop audits.
- Develop statistical profiles of health care delivery and utilization patterns by providers and members in various categories of services.
- Identify concerns in the level of care or quality of covered services that are funded by the IHCP and make appropriate referrals.

Since approximately 1998, Health Care Excel has worked with IHCP to develop statistical profiles of health delivery and utilization patterns by providers to detect over-utilization. Through current approaches, SUR attempts to take a proactive approach in monitoring and detecting areas of concern. Health Care Excel initiates appropriate action with IHCP when findings such as over-utilization are identified. For providers who are identified with issues such as over-utilization, it was not reported whether an incentive component was part of the action plan in addressing these issues with providers. Health Care Excel and IHCP work together to review the statistical profiles to determine appropriate evaluation parameters and guidelines for the SUR function.

C. Louisiana

Since 2002, as a response to a legislative mandate, the Louisiana Department of Health and Hospitals' Medicaid Pharmacy Program has conducted peer-based profiling for providers. There were many components to the legislative mandate, but overall, legislators were establishing programs such as prior authorization and provider profiling with the hopes of monitoring costs and quality. Within the Louisiana pharmacy program, providers or "prescribers" are sent information that compares them to a peer-based comparison group. Selecting providers who have similar specialties and number of patients is generally how these peer-based comparison groups are created. In addition, attempts have been made to create comparison groups geographically. In 1996, a separate disease management initiative including provider profiling was established and perhaps in the future, these profiles will be linked. However, this interview concentrated

only on the pharmacy provider profiles. An interview was not conducted with any official working with the disease management provider profiles.

Louisiana Medicaid, an office of the Bureau of Health Services Financing in the Department of Health and Hospitals (DHH), contracts with Unisys to compile provider data and create profiles. Unisys works with data specialists at Louisiana Medicaid to risk-adjust the data used for profiling. At the time of enrolling as a provider in the Louisiana Medicaid network, providers are sent a baseline profile to see where their prescribing patterns currently compare to others. Within a year, providers are sent an annual review with updated information so these providers can see how they fit with peers in their provider comparison group. The profiles are in color and contain graphs and charts that present providers with information about their prescription/drug utilization and how they compared to their peers with accompanying explanations. Since the Louisiana Medicaid Pharmacy Program has only been administering the provider profiling program for two years, it is not known at this time whether using a contractor will become too costly. In addition, it is too early to estimate whether the implementation of provider profiles will indeed reduce costs or prescription rates and whether implementing a structured incentive program would also be beneficial.

A great deal of time was taken with physicians and the local health community to implement this program. Any program like this cannot be perceived as “big brother” or as an attacker showing which providers are doing something wrong. Bureau of Health Services Financing and DHH develop processes to evaluate the program. This is a young program that is still evaluating and making changes as necessary. A team of individuals that includes Medicaid’s medical director, pharmacists, and DHH staff members meet to evaluate and discuss needed improvements to the peer-based profiling program. Officials believe that given the youth of the pharmacy provider profiling program, it is difficult to report whether the program is effective. However, the state is consistently analyzing feedback to determine the success of the program as well as future directions.

D. North Carolina

Within the Carolina Access II and III program (North Carolina's primary care case management program) enhanced case management services are provided to physicians in the area of diabetes and asthma. Provider profiles are currently being developed as part of this enhanced case management activity (see Appendix 4 for example of a mock profile). The profile will contain two graphs. The first graph will show a physician's total per member per month cost for the last 4 quarters as well as emergency room utilization for non-emergent conditions. The graph compares the PCP to their peers and to the network as a whole. Peers are defined as physicians of the same specialty within the same geographic region. The profile also contains utilization rates per 1000 member months for the last and current quarters. The PCP is also compared to the network and their peer. Specific utilization rates for asthma and diabetes are also included. The profile is to be mailed quarterly.

Access II and III consist of 13 networks are in western North Carolina who provide services to approximately 550,000 Medicaid enrollees. The board of each network is comprised of local community providers (hospitals, physicians, FQHCs, and substance abuse and mental health centers). Quality improvement activities originated from the physician leaders on these boards. These physician leaders were able to generate considerable 'buy-in' for profiling activities between the Access II and III physicians. Much of this was achieved through frequent meetings with the physicians to discuss quality improvement activities. Currently, numbers used to compute the profiles were risk-adjusted. In previous years North Carolina used a proprietary company to for risk-adjustment. However, the cost proved to be prohibitive and the current reports will not be risk-adjusted. It is anticipated that in the future North Carolina will acquire the technology to perform the risk adjustment themselves.

North Carolina has two additional ongoing profiling activities. To control pharmaceutical expenditures, Access II and III created the Prescription Advantage List (PAL). The PAL list ranks medications in each class in order from the least to most expensive. Physicians are encouraged, but not required to prescribe the least expensive drugs (drugs included in tier 1 of the list. Tiers 2 and 3 are more expensive drugs).

Periodically each network receives a scorecard comparing the networks' use of drugs in tiers 1, 2, and 3 to the rest of the networks. North Carolina also distributes to all physicians a report card that compares a physician's utilization and cost to their peers (Appendix 5).

E. Massachusetts

The provider profiling program for MassHealth (MassMedicaid) provides profiles for approximately 400 Primary Care Clinician (PCC) plan providers who have 200 or more plan members. MassMedicaid utilizes a contract with the Massachusetts Behavioral Health Partnership, often referred to as the "The Partnership," to compile these provider reports. HEDIS measures are used and current indicators in the profiles are asthma, cancer, diabetes, and well-care visits. Recently, a pediatric behavioral health-screening indicator was added. In addition, top brand prescription and emergency room rates are measured. Risk adjustments are not used for provider profiles and there are no financial incentives or sanctions related to profiles. MassMedicaid is constantly trying to improve the provider profile by determining best practices to streamline the process.

Profiles have been distributed since 1995 and since then, consistent efforts have been made to ensure that the profile is a useful tool. Profiles are viewed as educational, interventional tools that provide useful information to providers. The reports are approximately 25 pages long with 1 graph/chart per page detailing the pertinent indicator and provide the necessary information and explanation of that indicator. Providers are sent the profiles twice a year – in the spring and fall. The providers are surveyed to get their feedback about the provider profiling program. In addition, practice site visits are conducted to both educate about the profile, but also obtain evaluation information. In addition, RNs play a role in providing important feedback regarding the provider profiles. Currently, longitudinal data is being reviewed to determine effects of program. It seems that there has been positive effects, however, the provider profiling program is most likely not the only reason.

In the Center for Health Services Research and Policy’s *Negotiating the New Health System*, readers are provided excerpts of state contracts regarding Medicaid Managed Care, Primary Care Case Management, and the State Children’s Health Insurance Program. Specifically, within the quality assurance section, there are details about the contracts’ requirements on areas such as provider profiling. Table 1 provides the Massachusetts Medicaid Managed Care contract specifications for provider profiling (Rosenbaum et al, 2000).

Table 1. Massachusetts Medicaid Managed Care Contract – Provider Profiling

| |
|---|
| <p>"Section 2.10 Quality Management... E. Provider Profiling</p> <p>The Contractor shall conduct PCP and other Provider profiling activities at least annually. Such profiling activities shall include, but not be limited to:</p> <ol style="list-style-type: none"> 1. Developing PCP and Provider-specific reports that include a multi-dimensional assessment of a PCP or Provider's performance using clinical, administrative, and member and Enrollee satisfaction indicators of care that are accurate, measurable, and relevant to the MassHealth population. 2. Establishing PCP, Provider, group, plan or regional benchmarks for areas profiled, where applicable, including MassHealth-specific benchmarks were appropriate. 3. Providing feedback to individual PCPs and Providers regarding the results of their performance and the overall performance of the Provider Network, including performance related to Enrollees. 4. Identifying areas of improvement for individual PCPs and Providers, and/or groups of Providers and establishing quality improvement goals for priority areas in which a Provider or Providers do not meet established Contractor benchmarks relevant to Enrollees..." Massachusetts Contract, pages 57-61. |
|---|

F. Additional State Information

Information was collected about Georgia, Maryland, and Texas through state Medicaid agency websites, journals, and brief interviews with Medicaid staff. Utilizing the website for the Georgia Health Partnership, it appears that the state has implemented a provider profiling program with their contractor ACS. It appears that Georgia’s main goal in developing the profiles is somewhat like Indiana’s in that the main area of analysis is utilization. However, Georgia disseminates Primary Care Case Management providers with quarterly reports that contain utilization rates specified for nine target areas and the rates are developed for each participating provider, for each participating specialty group, and for all PCPs combined (Rosenbaum et al, 2000).

Neither the state of Maryland nor its data contractor engages in creating or compiling provider profiles. Currently, approximately 470,000 enrollees are served 7 Managed Care Organizations (MCO) that are contracted to provide Medicaid Managed Care. Within the contract specifications between the state of Maryland and any MCO applicant, the following is stated, “L. The applicant’s proposed written utilization management program that specifies, at a minimum, policies and procedures for: (7) Integration of activities with quality improvement for provider-profiling” (Rosenbaum et al, 2000). It does not appear that provider-profiling activities are required, but strongly encouraged. Therefore, MCOs can determine the level at which they want to create and implement a provider profiling program.

Although there have been programmatic and contractor changes since 1998-1999, the mock provider profile (see Appendix 6) displays what Texas has developed and disseminated to providers. Currently, it is not known whether this report format is still being disseminated or if provider profiling is being conducted. In reviewing the Texas provider profile, the main focus of analysis is cost and utilization. In addition, provider and comparison panel data is used, however, explanatory data is not supplied on the report. Table 2 presents the language provided for applicants responding to the Texas Request for Proposals (RFP) regarding the Medicaid Managed Care program (STAR) and Medicaid Expansion Project (Primary Care Case Management).

Table 2. Texas RFP – Provider Profiling

| |
|--|
| "Quality Improvement and Utilization Management Activities The STAR Network Administrator will perform several activities designed to monitor the quality of medical care being performed by network providers, and other activities designed to monitor the utilization of services. There will be a separate Quality Monitoring contractor who will provide an external review of quality of care. This effort must be supported by the STAR Network Administrator. The separate and distinct effort undertaken by the STAR Network Administrator will include ... provider profiling with analysis and corrective action plans associated with aberrant patterns of care..." Texas RFP, pages 3-4. |
|--|

V. Findings from Physician Interviews

Medicaid’s fiscal agent, ACS sends provider utilization summary reports to MediPass PCPs. These reports compare physicians and/or groups within a specific geographic location to other physicians/groups in the same PCP specialty within that

geographic region. The summary includes several areas of comparison including office visits, ER visits, outpatient visits, physician referrals, lab and x-ray procedures etc. Measures that are below average relative to the peer group are identified with a 'u', while those above average are identified with an 'o.'

Although some offices are familiar with profiles they receive from other health plans, very few office managers or physicians recalled receiving reports from ACS or MediPass. Among those who did, none of them found the reports particularly useful or meaningful. In particular they were concerned about whether the comparisons with the peer group were appropriate. The 'o' and 'u' indications provided no sense of how much they differ from their peers and why. When asked about the kinds of information would they want to have on a profile, most mentioned that pharmaceutical/drug utilization information would be very important.

When asked to comment on the overall usefulness of a profile, most commented that a well-designed and meaningful profile could be very important to their practice. Several offices already get profiles from other programs and they use the results to discuss problems and implement changes to make improvements. In response to whether the AdvancedMed format would be useful, many replied that it would, although they would like extensive training on the report. In particular, physicians want to be sure that there are 'apples to apples' comparisons. This relates to what is found in the literature base - physicians appear more willing to accept evaluations based on peer comparisons rather than those of expert panels (Brand et al, 1995).

VI. Conclusion

Utilizing the information collected from the interviews in addition to literature review, particular areas of concern for the current AdvancedMed profiling system used by AHCA would be the time lags associated with data used to compile provider profiles, the current configuration of reports and its usefulness for providers, and the level of input Medicaid physicians have on the design and implementation of the provider profiling

program. Most state Medicaid agency officials that were interviewed did not specifically discuss time lag issues with the data. However, perhaps programs that have had more time to implement provider profiling (e.g. Arkansas and Massachusetts) have utilized evaluative processes to address their specific data concerns. Most officials interviewed did discuss the importance of physicians being involved in the implementation of their program and that the providers helped to improve their state's program by making suggestions on how the reports could be most useful to them.

All of the state officials interviewed reported that no incentive structure was tied into the profile program. According to 1999 data from the Center for Studying Health System Change (HSC), physicians in practices of two or more said they are less often subject to financial incentives based on profiling (14 percent), which are more likely to restrain use of services, than incentives based on patient satisfaction (24 percent) and quality (19 percent), which are more likely to encourage use. Stoddard, Grossman, & Rudell (2002), also point out that profiling or other cost-control incentives could conflict with quality incentives, and productivity incentives with patient satisfaction incentives. Therefore, given that the ultimate objective of any performance assessment is to translate information into action, there must be careful consideration to how performance reports or profiles will be created, implemented, and presented to providers.

Noren, Thibodeau, Insigna, & Landon (1999), in a summary of studies on the effectiveness of provider profiling, argue that there are several factors that might boost the success of provider profiling. First, feedback must be timely. Physicians will have difficulty in applying results if there is a considerable lapse between when services were rendered and when they receive the profile. Second, physicians must be able to control the variables being measured. Third, physicians must be convinced of the need for improvement within their practice. Accordingly, how and whom administers feedback is critical to its success. Physicians may be more likely to respond favorably to feedback if a trusted colleague presents it and if provided in an easily interpreted format. Lastly, physicians should be provided a forum in which to discuss and ask questions about the profiles (Koska, 1990).

As mentioned earlier, some states may have provider profiling occurring within Medicaid provider networks, however, these programs are solely administered by the MCOs and are not necessarily required by the state. Currently, Florida NetPASS and PhyTrust, the contracted organizations who work with Florida's Minority Physician Network (MPN) Program, send periodic performance reports to their primary care physicians (PCP). Specifically, Florida NetPASS disseminate reports to providers showing the utilization of their MediPass beneficiaries and also compare the PCPs to their peers on a variety of measures (Lemak et al, 2004). PhyTrust also sends PCPs similar reports as well as quarterly newsletters and provides monthly in-services and trainings for their PCPs and quarterly meetings (Lemak et al, 2004). Generally, this is helping to make MediPass function better by offering providers timely beneficiary utilization information (Lemak et al, 2004).

Many believe that the provider profiling efforts to measure and improve quality of care are secondary to the goal of cost control. However, the effect of provider profiling on health care costs is unclear. A meta-analysis of 12 studies concluded provider profiling has a modest effect on physician behavior (Balas et al, 1996). The authors indicated the potential cost savings are unlikely to exceed the costs profiling (Balas et al, 1996). Others have noted that rigorously designed studies are needed to assess the effectiveness of provider profiles on physician behavior and cost of care.

VII. Implications for AHCA

The Agency for Health Care Administration contracted with AdvancedMed, Inc. to provide risk-adjusted provider information for all Medicaid primary care providers. The risk-adjusted data are provided via a secure Web interface. Formatted reports can be run at anytime showing aggregated actual measures of use activity, expected measures of activity, a morbidity index, and actual and expected costs. For any one time, claims data for a one-year period (four quarters) is available for analysis. New data uploads were to be performed each quarter, at which time the oldest quarter's data would drop out of the data set and a new quarter's data would be added.

One important result of this database's architecture is that, on average, there is an 8 to 9 month lag period between the date of service and the date when the data become available from AdvancedMed. An important consequence of this lag time is that physicians who modify their behavior will not begin to see those changes reflected in the data until many months later. Furthermore, because the data is aggregated across 1 year, it will take even longer before physicians begin to see the full effect of their behavior change. A single quarter's data cannot be isolated in the database. For example, a physician who changes his or her behavior on September 1, 2003 will begin to see the effect of this change in April 2004, when the first data concerning that date is made available. The full effect of this behavior change will not be seen until April 2005, when a full year of changed practice is aggregated in the data.

This study conducted a literature review and interviews with key informants, state Medicaid agency officials, and providers in order to assess the contracted provider profiling system. These research activities provided some indication that as currently configured, this provider profiling program will not be very effective in improving the quality of care and/or reducing health care expenditures. First, the lag time associated with the AdvancedMed reporting system does not encourage physician response to the data presented to them. Second, the feedback reports as they are currently configured are not particularly useful to providers. For example, reports provide a total count of all services provided and compares them to an expected total count. Similarly actual and expected per member per month figures are provided. However, the counts and the per member per month figures are only disaggregated into broad service or diagnostic categories. Finally, it is unclear what level of input Medicaid physicians may have had in the design and implementation of the profiling program or in the feedback process. Of special concern is the fact that Medicaid physicians may not understand how the data were risk-adjusted.

As AHCA considers the implementation of provider profiles within its Medicaid program, the following guidelines are critical to assuring some level of success:

- The initial emphasis should be on quality improvement
- Performance measures should be clinically important
- Accountability for performance should be limited to patients and services for which physician is directly responsible
- Adequate risk and case mix adjustment must be incorporated in the program design with accompanying explanation of how data was adjusted
- Physicians should be involved early in the design and implementation of provider profiling strategies in order to generate 'buy-in'
- Performance reports should be clear and easy to understand and coupled with provider feedback and educational opportunities
- Provider profiling programs should make every attempt to use accurate data

VIII. References

- American College of Physicians (2001). Assessing individual physician performance by managed care organizations. A white paper prepared by the American College of Physicians, American Society of Internal Medicine.
- Balas, E.A., Boren, S.A., Brown, G.D., Ewigman, B.G., Mitchell, J.A., & Perkoff, G.T. (1996). Effect of physician profiling on utilization: Meta-analysis of randomized clinical profiles. *Journal of General Internal Medicine*, *11*, 584-590.
- Brand, D.A., Quam, L., & Leatherman, S. (1995). Medical practice profiling: Concepts and caveats. *Medical Care Research and Review*, *52*, 223-251.
- Georgia Health Partnership. <http://www.ghp.georgia.gov/wps/portal>
- Goldfield, N. (1996). Understanding your managed care practice: The critical role of case mix systems. In N. Goldfield, & P. Borland (Eds.), *Physician profiling and risk adjustment*. Aspen Publishers, Inc.: Maryland.
- Goldfield, N., Gnani, S., & Majeed, A. (2003). Primary care in the United States: profiling performance in primary care in the United States. *British Medical Journal*, *326*, 744-747.
- Koska, M.T. (1990). Physician practices go under the microscope. *Hospitals*, *64*, 32-37.
- Lemak, C.H., Hall, A.G., Johnson, C.E., Saxena, P., Aftuck, C., & Johnson, C. (2004). *Evaluation of Florida's minority physician network (mpn) program*. Report prepared for the Florida Agency for Health Care Administration.
- Marder R and Sheff RA (2003) *10 steps to successful physician profiling*, HCPro Inc, Marblehead, MA
- Massachusetts Medical Society (1999). Stason, W.B. (Ed). Principles for profiling physician performance. *Massachusetts Medical Society: The Health Report*, 1-40.
- Noren, J., Thibodeau, R.M., Insinga, R., & Landon, B.M. (1999). Turning analysis into action: Profiling as a change agent. In N.F. Piland and K.B. Lynam (Eds.), *Physician Profiling: A Source Book for Health Care Administrators*. Jossey-Bass Publishers: San Francisco.
- Rosenbaum, S., Stewart, A., & Sonosky, C. (2002). *Negotiating the new health system* (4th ed.). Washington, DC: Center for Health Care Strategies.
http://www.gwu.edu/~chsrp/Fourth_Edition

Appendix 1. Provider Profiling Matrix

| State or Organization | Profiling Mechanism | Measures or Indicators Used | Contractor Used | Length of time using profiles | Distribution of profiles | Incentive Structure | Profile Categories | Risk Adjustment (examples: ACG, CDS, GRAM) | Data used for Profile* | Evaluation of Profile Effectiveness |
|-----------------------|---|---|--------------------------------------|--------------------------------------|--|---|---|--|--|--|
| Arkansas | Letter from Medical Director, Booklet with Profile and Graphs | Inpatient, Outpatient, ER, Cost PMPM, Psych, Rx | Arkansas Foundation for Medical Care | 9 years (1995) OB - 2 years | Quarterly to Primary Care Provider | Not Reported | EPSDT OB/GYN (Separate Profiles) | ACG | Provider, State Comparison, Explanatory | No formal evaluation |
| Florida | Planned to send reports to providers | Actual and Expected Utilization and Costs, and Morbidity | ACS contracted with Advanced Med | Profiles never sent out | Annual distribution planned, time lag of data concern | Not planned | TBA | Risk adjustments planned (ACG and/or CRG) | Provider | TBA |
| Georgia | Utilization Reports | Utilization | ACS | At least since 2000 | Quarterly | ** | ** | ** | ** | Provider Advisory Committee |
| Indiana | Statistical Profiles to detect provider over-utilization | Delivery and Utilization Patterns, Categories of Services | Health Care Excel | Not Profiles Monitor 6 years 1998 | Reports are not sent directly to providers | None | None specified | Not reported | Provider | Health Care Excel and State work on determining effectiveness |
| Louisiana | Packet with provider information and graphs | Rx Patterns Disease Mgmt – not linked | Unisys | 2 years (2002) | Initial Receipt of Packet then Annual Review within Peer Group | Young program, too soon to develop incentives | Rx Disease Mgmt Initiatives – maybe linked someday | Data is risk-adjusted | Provider, Comparison to Peers, Explanatory | DHH review process by Medical Director, Pharmacists, and staff |

***Provider, Comparative, and/or Explanatory**

Provider – unique information about each physician

Comparative – compares physicians to other physicians

Explanatory – provides an explanation on how data were derived (Marder and Sheff, 2004)

** Information not collected

Appendix 1. Provider Profiling Matrix Continued

| State or Organization | Profiling Mechanism | Measures or Indicators Used | Contractor Used | Length of time using profiles | Distribution of profiles | Incentive Structure | Profile Categories | Risk Adjustment (examples: ACG, CDS, GRAM) | Data used for Profile* | Evaluation of Profile Effectiveness |
|-----------------------|--|---|---|-------------------------------|---|---------------------|--|---|--|---|
| Maryland | ** | ** | Each of the 7 MCOs are responsible for profiling | ** | ** | ** | ** | ** | ** | ** |
| Massachusetts | Provider Profiles | HEDIS Rx – Top Brands and ER | Mass Behavioral Health Partnership – sometimes called “The Partnership” | 9 years (1995) | Bi-Annually | Nothing financial | Asthma Cancer Diabetes Well-Care (Recently - Pediatric Behavioral Health Screening) | No risk adjustments used for provider profiles | Provider and Explanatory | Visits to Provider, Provider Surveys and Hotline, and Feedback from RNs |
| North Carolina | Utilization and Disease Mgmt. Report | ACS rates, Rx costs, Asthma, HA1c | NC DHHS - Division of Medical Assistance (Managed Care) | At least 2 years | Quarterly to Providers within Access II and III Network | Not Reported | Asthma Diabetes | DxCG was previous profiling contractor. Too costly, but plan to use DXCG methods. | Provider, Peer Group and Network Comparisons | Meet with clinical directors 6 times a year |
| Texas | Refer to Appendix 6 (Medicaid Managed Care is STAR and STAR+PLUS) | Refer to Appendix 6 (Utilization and Cost) | Contractor may have changed since 1998-1999 | ** | Using Appendix 6, Quarterly | ** | Refer to Appendix 6 | ** | Refer to Appendix 6 (Provider and Comparison) | ** |

***Provider, Comparative, and/or Explanatory**

Provider – unique information about each physician

Comparative – compares physicians to other physicians

Explanatory – provides an explanation on how data were derived (Marder and Sheff, 2004)

** Information not collected

Appendix 2. Arkansas Provider Profile

Arkansas Medicaid Pharmacy Claims

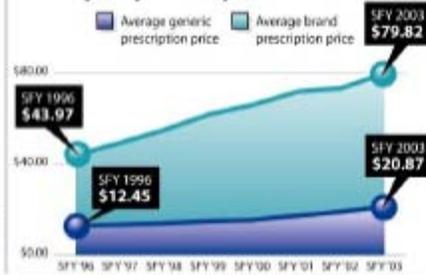
SFY: State Fiscal Year

■ On average, the total amount paid for pharmacy claims increases by 13-22% each year.

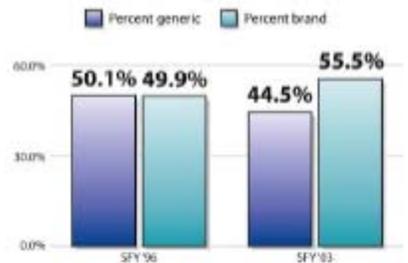
■ It is important to reiterate that brand name medications are significantly more expensive than generic medications. Generic medications have a large share in terms of volume but not in drug costs. During SFY 2003, approximately 44% of prescriptions dispensed to Medicaid recipients in Arkansas were generic, costing over \$54 million. The other 56% of prescriptions dispensed were brand name, costing over \$258 million.



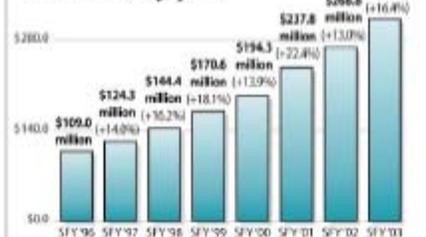
Cost per prescription



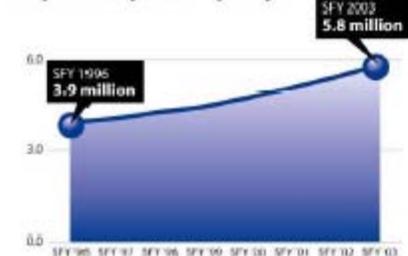
Brand name vs. generic utilization



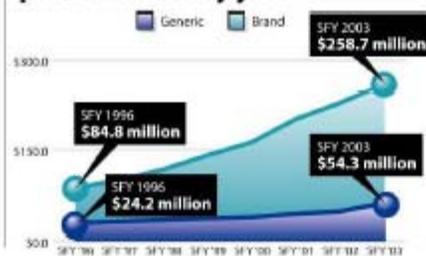
Total paid amount, by year



Total number of prescriptions per year



Brand and generic paid amounts by year



SOURCE: Division of Medical Services (DMS) and Electronic Data Systems (EDS)

PCP Profile

October-December 2003

Quarter ending December 31, 2003
Year-to-date: January 1, 2003-December 31, 2003

Please be sure the physician listed below is aware of the contents of this report as it reflects their individual Medicaid patient panel utilization data.

This is the last PCP Profile report for 2003. The Arkansas Foundation for Medical Care has provided these reports for more than six years to active Arkansas Medicaid PCP partners throughout the state. These reports are designed to assist you in quickly reviewing the costs and utilization associated with your caseload. By analyzing the table on the inside panel of this report, you can also compare your costs and utilization to the statewide average in each category.

As part of our effort to continuously improve our service to you and Medicaid, we began the implementation of risk adjustment last quarter. The annual risk adjusted efficiency ratio on the inside panel of this report makes the comparison of your performance to other providers more precise and meaningful. This adjusted efficiency ratio is computed by using the Johns Hopkins Adjusted Clinical Groups software and takes into account the gender, age and diagnoses of your patients and adjusts the ratio accordingly. Thus, variations in the level of efficiency are not normally due to these factors that frequently effect resource consumption. If an asterisk appears next to your adjusted efficiency ratio, you should review your detail report to determine if or where increases in efficiency can be achieved without compromising the level of care provided to your recipients.

This quarter includes a major addition to the data that has been excluded from PCP Profile reports of the past. **Since**

Medicaid now requires PCP referrals for mental health services provided to recipients under age 21, these claims are now included in the data within your PCP Profile report. You can see a summary of the cost of these services delivered to your patients on the inside panel of this report. If you would like to review these claims in more detail, please contact us to obtain a detail report.

After reviewing this utilization profile and other data, physicians are encouraged to contact us with any questions regarding the report:

- If you have questions after reviewing this PCP Profile, please contact Jason Scheel, Manager of PCP Profiling, at 501-375-1200, ext. 606.
- For a more detailed report, or to schedule an MMCS provider relations representative visit, contact Peggy Starling, MMCS Provider Relations Manager, at 501-375-1200, ext. 620.
- If you have remaining questions you may contact me directly at 501-244-2200.

Michael Moody
Michael Moody MD,
Corporate Medical Director, AFMC



DIVISION OF MEDICAL SERVICES

JAMES K. ANYDOCTOR, M.D.
555 ANYSTREET
ANYWHERE, AR 55555

Appendix 2. Arkansas Provider Profile Continued

Annual Risk Adjusted Efficiency Ratio

YOUR Adjusted Efficiency Ratio: 0.875

Explanation of Risk Adjustment Process

Data: Claims data for the most recent four quarters were used for the analyses. Individual claims (paid amounts) exceeding \$25,000 were eliminated from the data set.

Population: Only PCP's (1180) with at least 10 enrollees in each of the most recent four quarters were included in the analysis.

Unit of Analysis: The mean cost per patient per quarter per PCP was the fundamental unit used for the risk adjustment process.

Adjusted Efficiency Ratio (AER).

The AER is the mean cost per patient per quarter for the given PCP divided by that PCP's expected cost per patient per quarter. The expected cost per patient per quarter is adjusted for the cost severity of the PCP's case load using the Johns Hopkins Adjusted Clinical Groups software. For this data set the mean AER was 1.000 and the upper 95% confidence limit for the mean was 1.438.

***** An AER greater than 1.438 (noted by an asterisk) indicates that PCP's resource utilization with respect to costs was significantly greater than the average for the population.

NA A value of NA in the Adjusted Efficiency Ratio area above indicates that your patient panel was too small to establish statistical confidence with risk adjustment.

Arkansas Medicaid Primary Care Physician Performance Report

| Prov # 103077001 | JAMES K. ANYDOCTOR, M.D. | | | | STATE TOTALS | |
|---|------------------------------------|-------|--------------------------------|-------|------------------------------------|--------------------------------|
| | Quarter 10/01/2002 - 12/31/2002 | Index | YTD 10/01/2002 - 12/31/2002 | Index | Quarter 10/01/2002 - 12/31/2002 | YTD 10/01/2002 - 12/31/2002 |
| Average number of enrollees | 155 | | 132 | | 324930 | 318065 |
| Total Facility ER Visits | 22 | | 53 | | 48736 | 205252 |
| Fac ER Visits / 100 Enrollees Per Month | 4.7 | 0.94 | 3.3 | 0.61 | 5 | 5.4 |
| Facility ER Costs | \$1,851 | | \$4,779 | | \$3,901,306 | \$16,080,927 |
| Facility ER Cost Per Visit | \$84 | 1.05 | \$90 | 1.15 | \$80 | \$78 |
| Facility Emergency ER Visits | 16 | | 37 | | 34374 | 138279 |
| Facility Non-Emer ER Visits | 6 | | 16 | | 14362 | 66973 |
| Total Physician ER Visits | 13 | | 47 | | 46447 | 196268 |
| PHYS ER Visits / 100 Enrollees per Month | 2.8 | 0.58 | 2.9 | 0.57 | 4.5 | 5.1 |
| PHYS ER Costs | \$754 | | \$2,303 | | \$2,121,103 | \$8,590,574 |
| PHYS ER Cost Per Visit | \$58 | 1.26 | \$49 | 1.11 | \$46 | \$44 |
| Total Physician Emergency ER Visits | 11 | | 35 | | 38031 | 151453 |
| Total Physician Non-Emer ER Visits | 2 | | 12 | | 8416 | 44915 |
| Direct PCP Cost | \$6,920 | | \$24,238 | | \$9,929,813 | \$44,397,344 |
| Direct PCP Cost PEPM | \$15 | 1.5 | \$15 | 1.25 | \$10 | \$12 |
| Other Physician Costs | \$10,823 | | \$30,256 | | \$20,328,080 | \$89,711,520 |
| Other Physician Cost PEPM | \$23 | 1.1 | \$19 | 0.79 | \$21 | \$24 |
| Mental Health Services & Other Costs | \$36,862 | | \$121,292 | | \$67,147,975 | \$298,602,347 |
| Mental Health Services & Other Costs PEPM | \$79 | 1.14 | \$76 | 0.97 | \$69 | \$78 |
| Hospital Admission | 2 | | 13 | | 9508 | 40802 |
| Hospital Adm. per 100 Enrollees per Month | 0.4 | 0.4 | 0.8 | 0.75 | 1 | 1.1 |
| Hospital Cost | \$5,688 | | \$34,101 | | \$24,380,278 | \$97,341,637 |
| Hospital Cost Per Adm | \$2,834 | 1.12 | \$2,625 | 1.1 | \$2,537 | \$2,988 |
| Total Pharmacy Cost | \$33,269 | | \$106,544 | | \$51,230,872 | \$182,958,119 |
| Pharmacy Cost PEPM | \$71 | 1.34 | \$67 | 1.4 | \$53 | \$48 |
| Total Cost | \$96,147 | | \$323,613 | | \$178,038,427 | \$737,682,268 |
| TOTAL COST PEPM | \$208 | 1.12 | \$203 | 1.05 | \$184 | \$193 |

QUARTERLY PHARMACY COST AND UTILIZATION PATTERNS

| | YOUR PATIENT PANEL | STATE AVERAGE |
|---------------------------------------|--------------------|---------------|
| Pharmacy Cost PEPM | \$71 | \$53 |
| Percentage of Enrollees with a script | 70.3% | 61.6% |
| Scripts Per Enrollee* | 5.7 | 4.49 |
| Average Cost Per Script | \$53.31 | \$57.00 |
| ** Generic Prescription Index | 0.4391 | .4432 |

* Number of scripts per enrollee who had at least one prescription during the quarter
 ** Generic Prescription Index is the ratio for generic prescriptions compared to all prescriptions. For example, a GPI of .55 indicates that 55 percent of all prescriptions were generic during the specified time period.

According to recent Medicaid data, prescription expenditures continue to rise. It is important for prescribers to keep in mind that brand name medications are significantly more expensive than generic medications. By making the effort to prescribe generic medications when it would be therapeutically neutral for the patient, physicians can help keep unnecessary expenses down without sacrificing quality of care.

Arkansas ConnectCare Program Average cost per prescription

| Quarter | Average Cost per Prescription |
|-----------|-------------------------------|
| Q1 - 2002 | \$52.30 |
| Q2 - 2002 | \$53.28 |
| Q3 - 2002 | \$52.46 |
| Q4 - 2002 | \$52.73 |
| Q1 - 2003 | \$55.92 |
| Q2 - 2003 | \$57.89 |
| Q3 - 2003 | \$58.48 |
| Q4 - 2003 | \$57.00 |

* Mental Health Services and Other Costs are all referable costs for Mental Health Services and all other costs not shown in any other cost category.
 * The physician's index is the ratio for the individual physician compared to the corresponding state value. For example, a figure 50% higher than the state value would have an index of 1.50.
 * 'Other physician costs' are those billed by any physician other than yourself. 'Other costs' include personal care, home health, and various other costs.
 * This report categorically excludes transportation, vision, and various other costs not referable to the PCP program. It also excludes Arkansas Medicaid PCP Management Fees.

Appendix 3. Arkansas Provider Profile (EPSDT/Preventative Health Screening)

Tools Available for You!

Well Child Tools to Encourage Care of a New Baby

AFMC is eager to provide you with any of these tools that would help you reach your patient population. You may order these tools, free of charge, by calling 1-877-375-5700 or visit www.afmc.org.

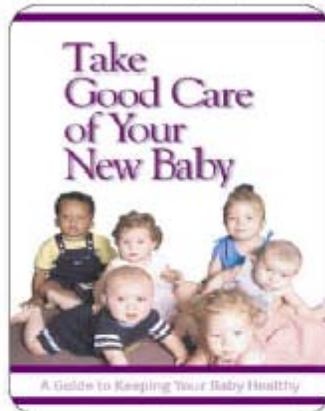
Chart Folder With Preprinted Immunization Record



Well Child Poster (Available in Spanish)



Well Child Manual (Available in Spanish)



Well Child EPSDT Sticker



Well Child Immunization Sticker



Developmental Milestones for Children Flyer



SFY 2004 Preventive Health Screening Procedure Codes

| 2003 PROCEDURE CODE | 2004 PROCEDURE CODE BY AGE | | | | MODIFIERS | |
|-----------------------------|----------------------------|-----------|------------|-------------|------------|------------|
| | <1 YEAR | 1-4 YEARS | 5-11 YEARS | 12-17 YEARS | MODIFIER 1 | MODIFIER 2 |
| ARKIDS A | | | | | | |
| Z0612 - New Patient | 99381 | 99382 | 99383 | 99384 | EP | U1 |
| Z0612 - Established Patient | 99391 | 99392 | 99393 | 99394 | EP | U2 |
| ARKIDS B | | | | | | |
| Z2339 - New Patient | 99381 | 99382 | 99383 | 99384 | None | |
| Z2339 - Established Patient | 99391 | 99392 | 99393 | 99394 | None | |

SOURCE: Medicaid Crosswalk, 10/20/2003

PCP Profile

SFY 2003

July 1, 2002 - June 30, 2003

EPSDT/Preventative Health Screening

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program helps children on Medicaid from birth to 20 years of age receive all the health services they need, including screening to identify health needs. EPSDT and Preventive Health Screening is an integral part of comprehensive medical care from the cradle to the grave. Medicaid pays for treatment for medical, dental, hearing, vision, and other needs that are identified.

Arkansas Medicaid data from SFY 2003, shows a definite need for improvement in EPSDT screening rates. Extensive analysis of the data shows that several problems are causing our deficiency in a program in EPSDT screening.

The most likely cause for our low screening rates is the lack of information. Many PCPs who had eligible recipients within their patient population did not bill one full EPSDT or Preventive Health Screen during SFY 2003 by using procedure code Z0612, Z1652, Z2339 or 99432. Furthermore, approximately 66% of the eligible recipients not screened did receive outpatient services. These outpatient services were billed most often with diagnosis codes such as: Acute Upper Respiratory Infections, Otitis Media and Acute Pharyngitis. Some providers have billed interperiodic or partial screening codes without first completing the full EPSDT or Preventive Health Screen.

Frequently the only opportunity to screen patients is while they are in the office for an acute care episode. It is entirely appropriate for a provider to conduct and bill the full EPSDT or Preventive Health Screen and treat the patient during these visits if a screen is due.

The inside panel of this report will illustrate in red the number of recipients who were signed up under your care that were

not screened during SFY 2003. If you would like to contact these recipients to recommend that they be screened, a detail report including their name and address is available by contacting your provider representative.

The back page of this report provides tools for improving your EPSDT screening rates and offers updated billing information since the codes for billing these services have changed due to HIPAA regulations.

The purpose of this report is to provide informative data and tools for improvement. By following the guidelines in this report, EPSDT screening rates should increase. This will also significantly increase revenue to ConnectCare PCPs.

After reviewing this utilization profile and other data, physicians are encouraged to contact us with any questions regarding the report.

- If you have questions after reviewing this PCP Profile, please contact Jason Scheel, Manager of PCP Profiling, at 501-375-1200, ext. 606.
- For a more detailed report, or to schedule an MMCS provider relations representative visit, contact Paddy Starling, MMCS Provider Relations Manager, at 501-375-1200, ext. 629.
- If you have remaining questions you may contact me directly at 501-244-2200.

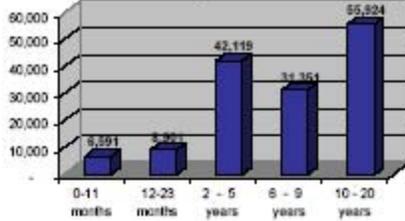
Michael Moody
Michael Moody MD
Corporate Medical Director AFMC



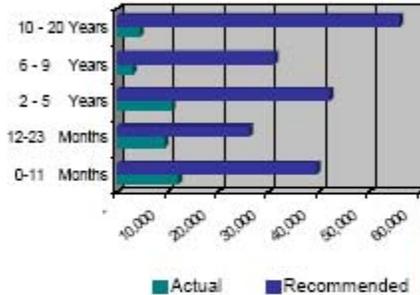
DIVISION OF MEDICAL SERVICES

Appendix 3. Arkansas Provider Profile (EPSDT/Preventative Health Screening) Continued

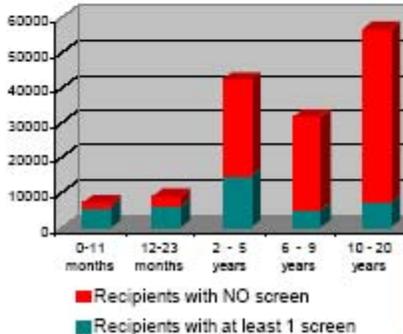
ARKIDS A Enrollees Eligible for EPSDT Screening



ARKIDS A
EPSDT SCREENING DURING SFY2003
Actual screens compared to Recommended Schedule



ARKIDS A
Recipient Screening During SFY2003



SFY 2003 EPSDT / PREVENTIVE HEALTH SCREENING PROFILE

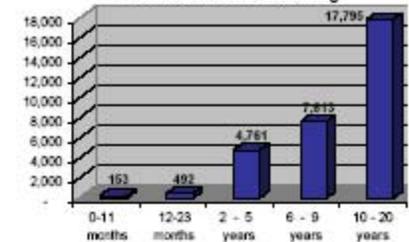
Recipients under the care of **123456789 JAMES K. ANYDOCTOR. MD**
for most of SFY 2003.

| Age Group | ARKIDS A EPSDT SCREENING | | | | ARKIDS B PREVENTIVE HEALTH SCREENING | | | |
|---------------|-----------------------------|---------------------|-----------------|-----------------------|---|---------------------|-----------------|-----------------------|
| | Eligible # of Recipients | Screens Performed** | Screens Allowed | Potential Income Lost | Eligible # of Recipients | Screens Performed** | Screens Allowed | Potential Income Lost |
| 0-11 Months | 18 | 41 | 108 | \$3,685.00 | 0 | 0 | 0 | \$0.00 |
| 12-23 Months | 27 | 23 | 81 | \$3,190.00 | 1 | 0 | 3 | \$165.00 |
| 2-5 Years | 83 | 28 | 83 | \$3,025.00 | 6 | 1 | 6 | \$385.00 |
| 6-9 Years | 58 | 4 | 58 | \$2,970.00 | 12 | 1 | 12 | \$605.00 |
| 10-20 Years | 95 | 10 | 96 | \$4,730.00 | 27 | 3 | 27 | \$1,320.00 |
| Totals | 282 | 106 | 426 | \$17,600.00 | 48 | 5 | 50 | \$2,475.00 |

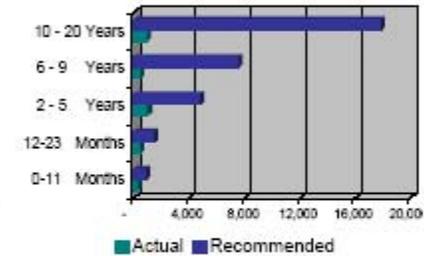
A PCP was paid the managed care fee for seven, or more, months for recipients aged 0-11 months and 11-12 months for all other eligible recipients during SFY2003.

** Total number of full EPSDT screens performed on eligible recipients during SFY2003. Screens performed on ineligible recipients, or recipients not assigned to this PCP, are not shown.

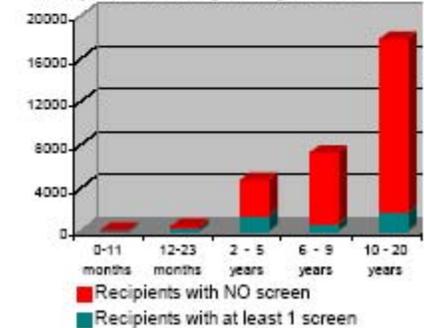
ARKIDS B Enrollees Eligible for Preventive Health Screening



ARKIDS B
PREVENTIVE HEALTH SCREENING SFY200:
Actual screens compared to Recommended Schedule



ARKIDS B
Recipient Screening During SFY2003



Recipients under your care for ANY part of SFY2003.

| Age Group | ARKIDS A EPSDT SCREENING | | | ARKIDS B PREVENTIVE HEALTH SCREENING | | |
|---------------|-----------------------------|---------------------------------|------------------------------------|---|---------------------------------|------------------------------------|
| | Eligible # of Recipients | Recipients Screened by this PCP | Recipients NOT Screened by any PCP | Eligible # of Recipients | Recipients Screened by this PCP | Recipients NOT Screened by any PCP |
| 0-11 Months | 43 | 34 | 4 | 0 | 0 | 0 |
| 12-23 Months | 67 | 27 | 28 | 4 | 0 | 4 |
| 2-5 Years | 195 | 42 | 139 | 26 | 1 | 25 |
| 6-9 Years | 128 | 7 | 115 | 34 | 2 | 32 |
| 10-20 Years | 228 | 19 | 206 | 60 | 4 | 56 |
| Totals | 661 | 129 | 492 | 124 | 7 | 117 |

Your office was paid at least 1 managed care fee for these recipients during SFY 2003.

Recipients may have had more than one PCP during SFY 2003.

The recipients, whose counts are indicated in red, were not screened by ANY PCP during SFY 2003.

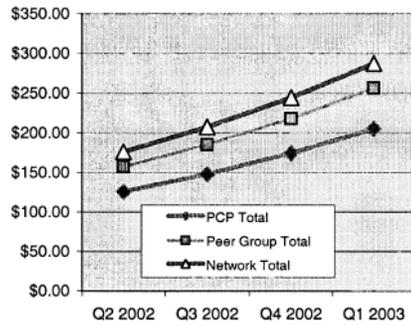
COMPLETE EPSDT screens, during SFY 2003, were billed with one of the following procedure codes: Z0612,Z1652,Z2339 or 99432.

Appendix 4. North Carolina Mock Provider Profile

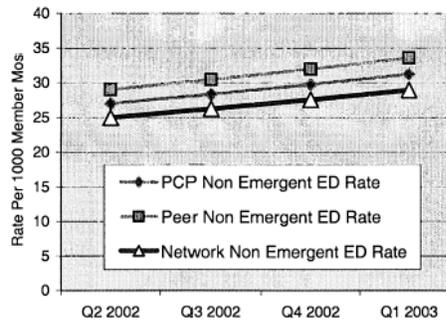
Name: My Multispecialty Practice
Managed care provider type: Access II
Administrative Entity: Access II Care of Western NC
ID: 2231111
Address 1: 12 Drs Park Drive
Address 2: Ashville, NC 27110

Time Period: 1/1/2003 through 3/31/2003
Peer Group: Internal Medicine
Average monthly enrolment: 2400
Eligibility 0-21: 1200
Eligibility >21: 1200

Total PMPM



Non-Emergent ED Rate



| Utilization (rate per 1000 MM) | PCP Last Quarter | PCP Current Quarter | Peer | Network |
|--------------------------------|------------------|---------------------|------|---------|
| PCP | 40 | 42 | 53 | 59 |
| Specialist | 30 | 34 | 42 | 47 |
| Hospital Inpatient | 12 | 8 | 10 | 11 |
| Out-patient | 88 | 113 | 141 | 158 |
| Pharmacy | 1952 | 1807 | 1620 | 1552 |
| ED Total | 60 | 58 | 73 | 81 |
| ED Non emergent | 30 | 31 | 34 | 29 |
| Labs | 100 | 103 | 129 | 144 |
| X-rays | 12 | 11 | 14 | 15 |
| Inpatient Mental Health | 0 | 0 | 0 | 0 |
| Out-patient Mental Health | 140 | 102 | 128 | 143 |

| Disease Management Utilization (rate per 1000 MM) | PCP Last Quarter | PCP Current Quarter | Comparison | Network |
|---|------------------|---------------------|------------|---------|
| Asthma | | | | |
| Case Rate | | | | |
| Case Count | 82 | 82 | 62 | 750 |
| ED asthma visits | 2.20 | 2.75 | 3.44 | 4.30 |
| IP asthma discharges | 0.00 | 4.00 | 5.00 | 6.25 |
| Diabetes | | | | |
| Case Rate | | | | |
| Case Count | 185 | 231 | 289 | 361 |
| ED diabetes visits | 1.20 | 1.50 | 1.88 | 2.34 |
| IP diabetes discharges | 0.03 | 0.04 | 0.05 | 0.06 |
| Eye Exam % | | | | |
| Lipid Test % | | | | |
| HbA1c Test % | | | | |

Appendix 5. North Carolina Provider Report Card

REPORT: HMSR4051

NORTH CAROLINA MMIS
 CAROLINA ACCESS QUARTERLY UTILIZATION REPORT
 04/01/2003 - 06/30/2003

DATE: 09/26/2003

PRACTICE NAME: [REDACTED]
 PROVIDER NUMBER: [REDACTED]
 CA PCP TYPE: 037 - PEDIATRICS
 COUNTY: [REDACTED]

OFFICE MANAGER: PLEASE DISTRIBUTE THIS REPORT TO ALL PHYSICIANS IN THE PRACTICE.

| SERVICE CATEGORY | CURRENT QTR | | CURRENT QTR | | QUARTERLY AVE. LAST 4 QUARTERS - PCP | |
|-----------------------------------|-------------|----------|---------------------|---------------------|--------------------------------------|---------|
| | PCP RATE | PCP PMPM | PCP PEER GROUP RATE | PCP PEER GROUP PMPM | RATE | PMPM |
| (1) PCP OFFICE SERVICES | 576 | \$29.52 | 339 | \$18.17 | 616 | \$32.69 |
| (2) TOTAL ER/URGENT CARE SERVICES | 47 | \$10.74 | 42 | \$10.20 | 49 | \$11.57 |
| A. IDENTIFIED EMERGENCY | 27 | \$7.16 | 25 | \$7.03 | 31 | \$8.13 |
| B. NON-EMERGENT | 20 | \$3.58 | 17 | \$3.17 | 18 | \$2.44 |
| (3) PHARMACY | 706 | \$49.60 | 512 | \$29.41 | 729 | \$52.45 |
| (4) HOSPITAL INPATIENT | 3 | \$8.07 | 3 | \$14.04 | 5 | \$15.37 |
| (5) INPATIENT MENTAL HEALTH | 1 | \$2.62 | 1 | \$2.16 | 1 | \$2.81 |
| (6) SPECIALISTS/REFERRALS | 63 | \$9.89 | 96 | \$10.14 | 74 | \$10.34 |
| (7) LABS | 53 | \$1.95 | 18 | \$0.51 | 52 | \$1.78 |
| (8) X-RAYS | 10 | \$1.28 | 2 | \$0.71 | 9 | \$1.29 |
| (9) MENTAL HEALTH OUTPATIENT | 92 | \$9.70 | 189 | \$28.65 | 79 | \$8.11 |
| (10) OUTPATIENT/AMBULATORY | 50 | \$24.64 | 61 | \$22.15 | 55 | \$23.74 |

| PMPM CALCULATIONS | CURRENT QUARTER | | PCP LAST 4 QTRS | | LAST 4 QUARTERS | |
|----------------------------|-----------------|----------------|-----------------|----------------|-----------------|----------------|
| | PCP | PCP PEER GROUP | PCP | PCP PEER GROUP | PCP | PCP PEER GROUP |
| (11) PRIMARY CARE PROVIDER | \$30.92 | \$21.80 | \$34.43 | \$23.61 | \$34.43 | \$23.61 |
| (12) ALL OTHER SERVICES | \$147.34 | \$157.22 | \$157.40 | \$161.48 | \$157.40 | \$161.48 |
| (13) TOTAL SERVICES | \$178.26 | \$179.03 | \$191.83 | \$185.09 | \$191.83 | \$185.09 |

(14) AVERAGE MONTHLY ENROLLMENT BY AGE: AGES 0 - 21: 3,659 AGES > 21: 5 AVERAGE TOTAL MONTHLY ENROLLMENT: 3,664

FROM : MANAGED CARE UNIT
919 716 0844
2004-03-10
14:45
#450 P. 02/03

Appendix 6. Texas Mock Provider Profile

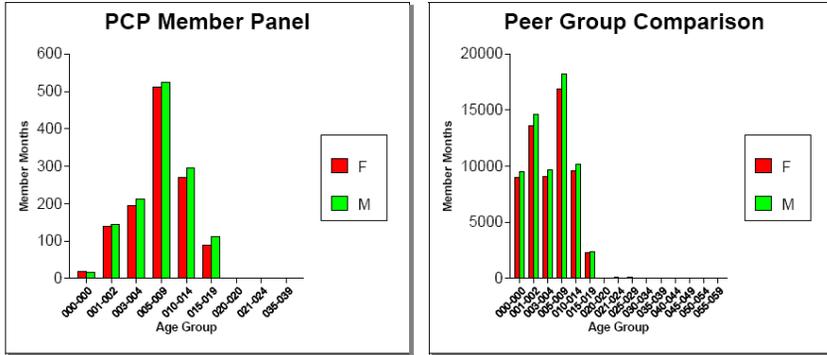
TEXAS HEALTH NETWORK

PROVIDER PROFILE REPORT

Name: DOCTOR KID
 ID: P00000001
 Address: 301 SCHOOL BLVD, SOMEWHERE, TX 00000
 SA: ANYWHERE SERVICE AREA

Time Period: 3/1/98 to 2/28/99
 Specialty/Peer Group: Pediatrics
 Member Months: 7448
 Illness Burden: 0.74
 Actual/Expected Ratio: 0.87

Membership Age and Sex Distribution

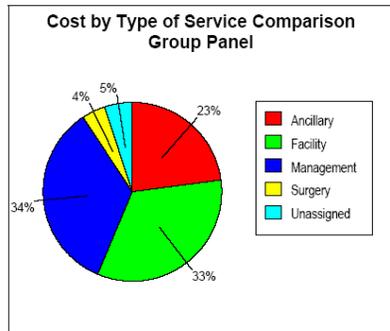
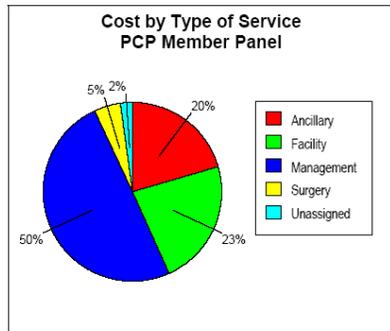


Cost by Type of Service

PCP Member Panel

Comparison Group Panel

| | PCP Member Panel | Comparison Group Panel |
|------------|------------------|------------------------|
| Ancillary | \$13.95 | \$24.20 |
| Facility | \$15.54 | \$35.42 |
| Management | \$33.90 | \$36.33 |
| Surgery | \$3.28 | \$4.53 |
| Unassigned | \$1.49 | \$5.33 |
| Total | \$68.15 | \$105.81 |



Birch & Davis Health Management Corporation

DOCTOR KID

TEXAS HEALTH NETWORK

PROVIDER PROFILE REPORT

| Utilization Summary | PCP \$MPM | PCP Svcs. Per 1000 Members Annualized | Weighted Measure | Comparison Panel \$MPM | Comp. Svcs. Per 1000 Members Annualized |
|---------------------------|-----------|---------------------------------------|------------------|------------------------|---|
| Inpatient Maternity | \$0.61 | 153.1 | \$0.82 | \$0.64 | 242.8 |
| Inpatient All | \$8.98 | 2241.1 | \$12.10 | \$23.25 | 7685.7 |
| All Professional Services | \$37.54 | 13907.6 | \$50.57 | \$74.16 | 39158.3 |
| EPSDT Dental | \$0.60 | 568.7 | \$0.80 | \$0.71 | 643.7 |
| EPSDT Visits | \$1.94 | 581.6 | \$2.61 | \$3.45 | 1034.4 |
| ER Visits | \$4.28 | 331.9 | \$5.76 | \$3.97 | 647.0 |
| Family Planning | \$0.11 | 128.9 | \$0.15 | \$0.06 | 42.2 |
| Immunizations | \$0.23 | 546.2 | \$0.31 | \$0.55 | 1333.8 |

Specialist Utilization # of Services

| Specialty Services | # of Services |
|--------------------|---------------|
| Specialty Services | 8817 |

| Inpatient Utilization | PCP | Comparison Panel |
|---------------------------------|-----|------------------|
| Inpatient Bed Days/1000 members | 106 | 374 |
| Discharges/1000 members | 39 | 94 |
| Average Length of Stay | 2.8 | 4.0 |

Location of Primary Visits

% of visits by following locations

| | PCP | Comparison Panel |
|---------------------|-----|------------------|
| Office | 22% | 92% |
| Outpatient Hospital | 78% | 8% |

Birch & Davis Health Management Corporation

DOCTOR KID