

# California Pay for Performance Program Updates



**Integrated Healthcare Association**  
**January 19 and 24, 2011**

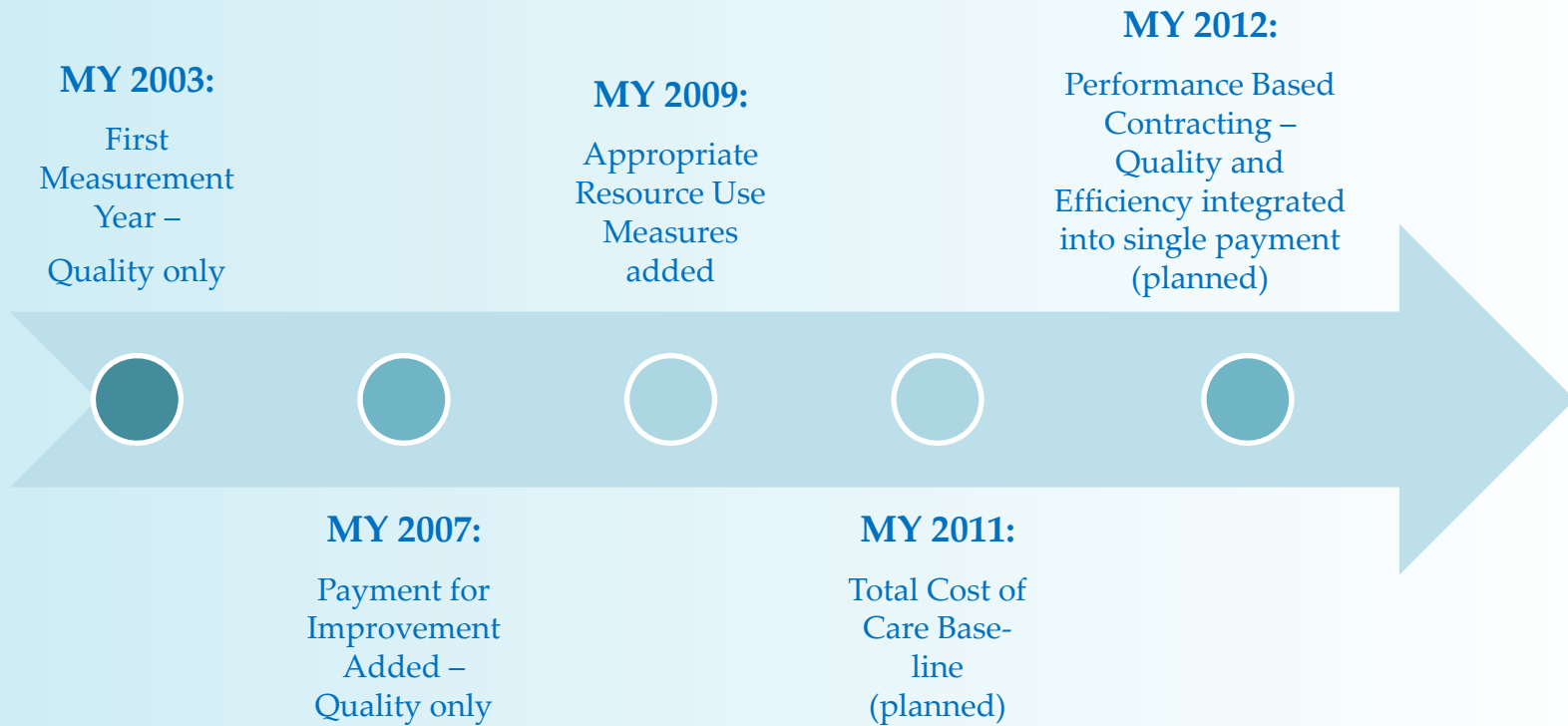
# Agenda

- Overview
- New Measures for Measurement Year (MY) 2010
- New Measures for MY 2011
- Q & A
- Performance Based Contracting
- Standard Payment Method (SPM)
- Q & A

## Presenters

- Keely Macaulay, Program Manager, NCQA
- Jerry Penso, MD, Chair, P4P Technical Quality Committee and Medical Director, Continuum of Care, Sharp Rees-Stealy Medical Group
- Dolores Yanagihara, P4P Program Director, IHA

# California P4P Program Evolution



## Program Participants

### Eight CA Health Plans:

- Aetna
- Anthem Blue Cross
- Blue Shield of CA
- CIGNA
- Health Net
- Kaiser\*
- PacifiCare/United
- Western Health Advantage

### Medical Groups and IPAs:

- 221 Physician Organization
- 35,000 Physicians
- 10 million commercial HMO/POS members

\* Kaiser Permanente medical groups participate in public reporting only, starting MY 2005

# CA P4P Measurement Evolution

Original 25 measures have expanded to 87 measures

Measurements	MY 2003	MY 2009	MY 2010
Clinical - Preventive	8	14	18
Clinical - Chronic	3	5	7
Clinical - Acute	0	4	4
Patient Experience	6	9	9
Information Technology (IT)	8	11	11
Systemness	0	7	8
Coordinated Diabetes Care	0	11	14
Efficiency/Resource Use	0	16	16
<b>Total</b>	<b>25</b>	<b>77</b>	<b>87</b>

# Timeline for P4P Manuals

Date	Action
September 1	Draft P4P manuals for current and next measurement year (including testing measures) posted
September - October	Public comment and review of comments by P4P committees
End of November	Final P4P manual for <u>current</u> measurement year posted
End of December	Updated draft P4P manual for <u>next</u> measurement year posted

Manuals located on the IHA Web site at:  
[http://www.iha.org/manuals\\_operations.html](http://www.iha.org/manuals_operations.html)

# **New Measures for MY 2010**



# MY 2010 Clinical Measures

- **Preventive Care**
  - Childhood Immunizations
    - **Combination**
  - **Adolescent Immunizations**
  - Chlamydia Screening
  - Evidence-Based Cervical Cancer Screening
  - Breast Cancer Screening\*
  - Colorectal Cancer Screening
- **Chronic Disease Care**
  - Cholesterol Mgmt: LDL-C Screening & Control <100
  - Monitoring of Patients on Persistent Medications
  - **Asthma Medication Ratio**
- **Acute Care**
  - Appropriate Testing for Children with Pharyngitis
  - Treatment for Children with Upper Respiratory Infection
  - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
  - Use of Imaging Studies for Low Back Pain
- **PO Encounter Threshold for Reporting**
  - 4.00 encounters per member per year

\* Breast Cancer Screening: Ages 42-69 will continue to be collected for reporting and payment. A 52-69 age band will be collected to establish a baseline for MY 2011. See explanation of change in MY 2011 section.

## Childhood Immunizations: **Combination**

- Description: Percentage of children who turned two years of age during measurement year who were identified as having had the following combination series by their second birthday:

Combination	DTaP	IPV	MMR	Hib	HepB	VZV	PCV
Combination – All Antigens	✓	✓	✓	✓	✓	✓	✓

- “All or none” measure
- Eligible Population: Same as other childhood immunization status measures
  - Exclude children who had contraindication for specific vaccine

# Adolescent Immunizations

- Description: Percentage of adolescents 13 years of age who were appropriately vaccinated against meningococcal and tetanus/diphtheria
- Eligible Population:
  - Turn 13 years of age during the measurement year
  - Continuously enrolled 12 months prior to 13<sup>th</sup> birthday
- Numerator compliance:
  - One meningococcal conjugate (MCV4) or meningococcal polysaccharide vaccine (MPSV4) on or between member's 11<sup>th</sup> and 13<sup>th</sup> birthdays
  - One tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) on or between the member's 10<sup>th</sup> and 13<sup>th</sup> birthdays

## Asthma Medication Ratio

- Description: Percentage of members 5-50 years of age who were identified as having persistent asthma and have a ratio of controller medications to total asthma medication of 0.50 or greater during measurement year

### Units of Controller

Units of Controller + Units of Reliever

- Medications not weighted
- Multiple inhalers of the same medication filled on same date counted as one dispensing event
- Eligible Population:
  - Members identified as having one-year persistent asthma
  - Continuously enrolled during measurement year
  - Remove members who had no reliever or controller meds
- Report two age stratifications (5-11 years; 12-50 years) and total rate

# MY 2010 Coordinated Diabetes Care Measures

- Diabetes Clinical Measures
  - HbA1c screening, poor control >9, control <8, control <7
  - LDL-C screening, control <100
  - Nephropathy Monitoring
  - Blood Pressure Control for People with Diabetes <140/90
  - Optimal Diabetes Care Combo 1 (LDL-C control<100, HbA1c control <8, Nephropathy Monitoring)
  - Optimal Diabetes Care Combo 2 (Combo 1 + BP <140/90)
- Diabetes Registry and Related Activities
  - Diabetes Registry (including blood pressure)
  - Actionable Reports on Diabetes care
  - Individual Physician Reporting on Diabetes measures
- Diabetes Care Management

## Blood Pressure Control for People with Diabetes <140/90

- Description: Percentage of members 18-75 years of age with diabetes (type 1 and 2) who had their blood pressure in control < 140/90 mm Hg
- Eligible Population: Same as other diabetes measures
- Use CPT-II codes or data from registry or EMR
- Use the most recent BP reading during measurement year
- Do *not* include :
  - BPs taken during acute inpatient stay or ED visit
  - BPs taken during outpatient visit where diagnostic test or surgical procedure performed
  - BPs obtained same day as major diagnostic or surgical procedure
  - BP readings taken by member

## Optimal Diabetes Care

- Description: Percentage of members 18-75 years of age with diabetes (type 1 and 2) who met the numerator criterion for *each* of below numerator rates.

Combo 1: LDL-C control <100, HbA1c control <8, Nephropathy Monitoring

Combo 2: All criteria in Combo 1 and BP <140/90

- “All or none” measures
- Combo 1 is only measure recommended for public reporting and payment
- Eligible Population: Same as other diabetes measures

# MY 2010 Data Collection and Reporting Timeline Highlights

Data Submission File Layouts are posted on IHA Web site

- *March 25 ~ May 2, 2011* – Submit Data Layout Test Files to DDD
- *May 6, 2011* – Send Submission Files to Auditors
- *May 13, 2011* – Submit Auditor-Locked P4P Results to DDD
- *May 24 ~ May 31, 2011* - PO Validation Period

For full data collection and reporting timeline, refer to the MY 2010 P4P manual.

Frequently Asked Questions (FAQ) are posted on IHA Web site periodically, and contain specification clarifications and changes. We strongly recommend that you adhere to information in the FAQs.

# MY 2010 Patient Experience Measures

- Timely Care and Service composite
- Quality of Doctor-Patient Interaction composite
- Coordination of Care composite
- Office Staff composite
- Health Promotion composite
- Overall Rating of Care
  - Rating PCP
  - Rating Healthcare
- Specialty Care
  - Getting Appointment with Specialist
  - Rating of Specialist

# MY 2010 IT-Enabled Systemness Measures

- Data Integration for Population Management
- Electronic Clinical Decision Support at the Point of Care
- Care Management
  - Coordination with practitioners
  - Chronic care management
  - Continuity of care after ER or hospitalization
- **Electronic Reporting of Blood Pressure for People with Hypertension**
- Physician Measurement and Reporting

# Electronic Reporting of Blood Pressure for People with Hypertension

- Description: PO has process in place to collect and electronically store blood pressure for patients with hypertension, and uses the information for population management, patient care, and data exchange with business partners
- Requirement: By December 31, 2010, blood pressure collected for at least 10% of Commercial HMO/POS patients with hypertension and electronically stored in format that can be searched/queried and extracted.
  - Registry, CPT-II codes, or EMR may all qualify
- Scoring: 3 points for an organization if they perform the element, 0 points if they do not perform the element

# MY 2010 IT-Enabled Systemness Measures: Survey Tool

- Online survey open February 2<sup>nd</sup> – March 3<sup>rd</sup>
- New measure, **Electronic Reporting of Blood Pressure for People with Hypertension**, requires POs to supplement current survey to earn full points
- POs do not need to complete whole survey; only new measure or measures seeking to increase score
- Each PO received email from NCQA indicating points for MY 2010 if not supplemented
- Technical training sessions are scheduled for:
  - Tuesday, February 1, 2011, 1:00-2:00 PM, PST
  - Monday, February 7, 2011, 10:00-11:00 AM, PST

# MY 2010 Appropriate Resource Use Measures

- Inpatient Hospital Rates
  - Discharges
  - Bed Days
  - Average Length of Stay (*information only*)
- Maternity Discharges and ALOS (*information only*)
- Hospital Readmissions within 30 Days
- Emergency Room Visits
- Outpatient Procedures Utilization
- Generic Prescribing
  - 7 therapeutic areas
  - Overall generic rate (*information only*)

# MY 2010 P4P Domain Weightings

P4P Domain	MY 2010 Weighting
Clinical	40%
Coordinated Diabetes Care	20%
IT-Enabled Systemness	20%
Patient Experience	20%
Appropriate Resource Use	Standard gain-sharing arrangement recommended

# New Measures for MY 2011



## Transformation of MY 2011 P4P Measure Set: Priority Areas

- Increase impact on outcomes
- 6 priority areas selected based on clinical importance, potential of addressing resource use variation, and interest to consumers
  - Prevention
  - Cardiovascular
  - Diabetes
  - Maternity
  - Musculoskeletal
  - Respiratory
- Build measurement “suites” in priority areas
- Potential for composite measurement

# MY 2011 Clinical Priority Areas

- **Prevention**

- Childhood Immunizations
  - Combination
- Adolescent Immunizations
- Chlamydia Screening
- Evidence-Based Cervical Cancer Screening
- Breast Cancer Screening-  
**Ages 52-69**
- Colorectal Cancer Screening

- **Cardiovascular**

- Monitoring of Patients on Persistent Medications
- Cholesterol Mgmt: LDL-C Screening & Control <100

- **Respiratory**

- Asthma Medication Ratio
- Appropriate Testing for Children with Pharyngitis
- Treatment for Children with Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

- **Musculoskeletal**

- Use of Imaging Studies for Low Back Pain

- **Maternity**

# MY 2011 Clinical **Priority Areas** (cont.)

- **Diabetes**

- HbA1c screening, poor control >9, control <8, control <7
- LDL-C screening, control <100
- Nephropathy Monitoring
- Blood Pressure Control for People with Diabetes <140/90
- Optimal Diabetes Care Combo 1 (LDL-C control<100, HbA1c control <8, Nephropathy Monitoring)
- Optimal Diabetes Care Combo 2 (Combo 1 + BP <140/90)

- **PO Encounter Threshold for Reporting**

- **4.25** encounters per member per year

## Breast Cancer Screening - **Ages 52-69**

- Breast Cancer Screening: **Ages 52-69** will be collected for reporting and payment in MY 2011
  - USPSTF released new Breast Cancer Screening guidelines in November 2009
  - P4P urged NCQA to expedite its decision on whether to change HEDIS to align with USPSTF; however, NCQA's decision will not be final until mid-2011
  - P4P received multiple comments from POs regarding concern about evidence for routine screening for women ages 40-49
  - P4P committees agreed that evidence for breast cancer screening is strongest for women 50-69

# MY 2011 Patient Experience Measures

- Timely Care and Service composite
  - PCP
  - Specialist
- Quality of Doctor-Patient Interaction composite
  - PCP
  - Specialist
- Coordination of Care composite
- Office Staff composite
- Health Promotion composite
- Overall Rating of Care
  - Rating PCP
  - Rating Healthcare

# Transformation of MY 2011 P4P Measure Set: **Meaningful Use of Health IT**

- Original IT-Enabled Systemness Domain in place for 4 years
  - Evolve to remain current
  - Raise the bar
  - Take advantage of national work
- For MY 2011:
  - Align with CMS/ONC “meaningful use” measures to improve clinical outcomes by leveraging technology
  - Adopt 15 CMS/ONC “core” measures
  - Adopt 2 CMS/ONC “menu” measures related to population management
  - Maintain current P4P chronic care management measures for diabetes, depression, and one other significant condition
- For MY 2012:
  - Recommendation to adopt additional 6 CMS/ONC “menu” measures

## **Meaningful Use of Health IT: “Core” Measures for MY 2011**

1. Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines
2. Implement drug-drug and drug-allergy interaction checks
3. Generate and transmit permissible prescriptions electronically
4. Record demographics: preferred language, gender, race, ethnicity, and date of birth
5. Maintain an up-to date problem list of current and active diagnoses
6. Maintain active medication list
7. Maintain active medication allergy list
8. Record and chart changes in vital signs: height, weight, blood pressure, calculate and display BMI, and plot and display growth charts for children 2-20 years, including BMI
9. Record smoking status for patients 13 years old or older

## **Meaningful Use of Health IT: “Core” Measures for MY 2011 (cont.)**

10. Implement one clinical decision support rule relevant to specialty or high clinical priority, along with the ability to track compliance with that rule
11. Report ambulatory quality measures to CMS or the State
12. Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request
13. Provide clinical summaries for patients for each office visit
14. Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically
15. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities

## **Meaningful Use of Health IT:** **“Menu” & Current P4P Chronic Care Management Measures for MY 2011**

### CMS/ONC “Menu” Measures:

1. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach
2. Send reminders to patients per patient preference for preventive/follow up care

### Current P4P Chronic Care Management Measures:

1. Diabetes
2. Depression
3. Other clinically important conditions

## **Meaningful Use of Health IT:** **“Menu” Measures Recommended for MY 2012**

1. Implement drug formulary checks
2. Incorporate clinical lab-test results into certified EHR technology as structured data
3. Provide patients with timely electronic access to their health information
4. Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient
5. Perform medication reconciliation for patients received from another setting of care or provider of care or at relevant encounters
6. Provide summary of care record for each transition to another setting of care or referral to another provider of care

## Meaningful Use of Health IT: Scoring

- Use CMS/ONC criteria to determine qualification by measure at the individual physician level
- P4P score for each measure determined by % of PCPs or % of patient population covered by PCPs that meet CMS/ONC criteria

Percent of PCPs who Meet Intent of Measure	P4P Points
1-24	1
25-49	3
50-74	4
75+	5

# MY 2011 Appropriate Resource Use Measures

- Inpatient Hospital Rates
  - Discharges
  - Bed Days
  - Average Length of Stay (*information only*)
- Maternity Discharges and ALOS (*information only*)
- Hospital Readmissions within 30 Days
- Emergency Room Visits
- Outpatient Procedures Utilization
- Generic Prescribing
  - 7 therapeutic areas
  - Overall generic rate (*information only*)
- **Total Cost of Care (baseline)**

## Total Cost of Care

- Description: Total amount paid to any provider (including facilities) to care for all members of a PO for a year
- Eligible Population: Medical and pharmacy benefit; enrolled in PO for at least one day
- Risk adjustment: Concurrent DxCG Relative Risk Score for health status; will be reported by “market” to account for cost differences due to geography, etc.
- Outliers: Costs above \$100,000 per member per year
- Exclusions:
  - Mental health or chemical dependency services
  - Acupuncture or chiropractic services
  - Dental or vision services
  - P4P incentive payments

# MY 2011 P4P Domain Weightings

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## P4P Domain

## MY 2011 Weighting

Clinical (restructured into  
priority areas)

50%

Meaningful Use of Health IT

30%

Patient Experience

20%

Appropriate Resource Use

Standard gain-sharing  
arrangement recommended

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# Q & A

# Performance Based Contracting



# Purpose/Objectives of Performance Based Contracting

Purpose: to revitalize/retool the P4P program against the backdrop of affordability

## Objectives:

- Expand priorities to include cost control (affordability)
- Continue to promote quality
- Standardize health plan resource use measures and payment methodology
- Increase the amount of incentive potential and include in contract/agreement

# 1. Harmonize/Standardize Utilization Measures

- Total Cost of Care Measure
  - Total amount paid to any provider (including facilities) to care for all members of a PO for a year
  - Adjusted for health status, geography, and possibly other factors such as affiliation with teaching hospital or other market impacts
  - Specifications developed by P4P Technical Efficiency Committee
  - Growing national consensus supporting measurement of total costs
  - Timeline: test in 2010, baseline for MY 2011, use for incentive payments for MY 2012
- Underlying key indicators to inform POs about their performance relative to peers in specific aspects of care
  - Inpatient acute care discharges PTMY
  - % Outpatient procedures done in preferred facility
  - ED Visits PTMY
  - Other metrics used by plans and/or nationally endorsed
  - Readmissions within 30 days
  - Bed days PTMY
  - Generic Rx (7 therapeutic areas)

## 2. Integrate Quality and Utilization Incentives

- Incentive amount determined by performance on both cost and quality
- Different views of cost will be examined
  - Total cost attainment: *How does PO's Total Cost of Care (TCC) compare to TCC of other POs in same market?*
  - Target trend attainment: *Does PO's TCC trend over previous year meet the P4P target of CPI+1%?*
  - PO trend improvement: *Did PO's TCC trend over previous year decrease compared to the PO's historical trend?*
- Quality measured by composite of Clinical, Patient Experience, Meaningful Use of Health IT
  - Consider attainment and improvement

## 2. Integrate Quality and Utilization Incentives (cont.)

- Robert Wood Johnson Foundation grant to model impact of different design options
- Timeline:

Date	Milestone
November 2010- July 2011	Test Total Cost of Care measure
January-July 2011	Model Performance Based Contracting design options
August 2011	Finalize recommendation for design of Performance Based Contracting
September 2011	Public comment
November 2011	Final Steering Committee approval of Performance Based Contracting design

# Standard Payment Method (SPM)



# Paying for Attainment and Improvement

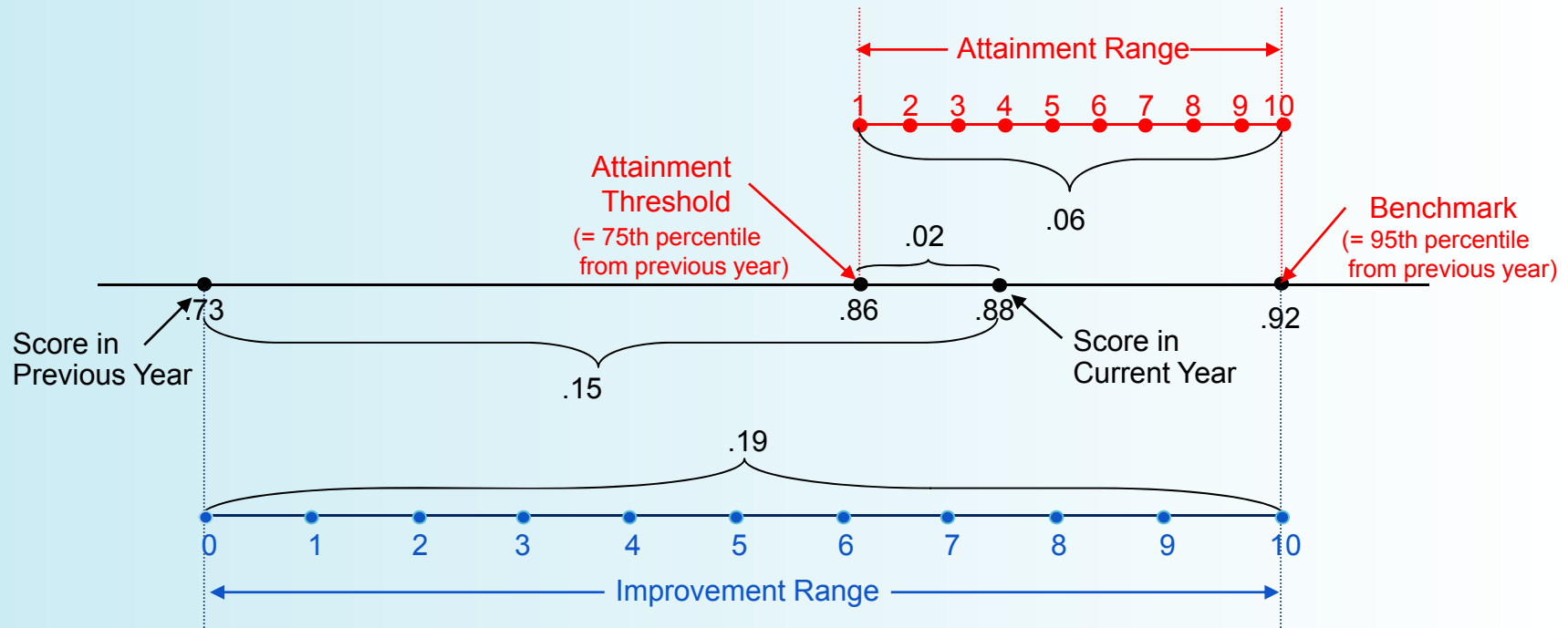
- Official P4P recommendation starting in MY 2009
- Based on CMS' Hospital Value-Based Purchasing Model
- Incorporates both attainment and improvement, with 0-10 points possible for each per measure
- Goal: Award P4P dollars to lower performing POs that are improving
  - Assuming fixed bonus pool, some dollars will shift from higher performers to lower performers

# Paying for Attainment and Improvement

- Attainment
  - To earn attainment points, PO must meet or exceed score associated with P4P 75th percentile (including Permanente groups) for *previous measurement year*
  - To earn full 10 attainment points, PO must meet or exceed score associated with P4P 95th percentile (including Permanente groups) for *previous measurement year*
- Improvement is percent the PO closed gap from its last year's score and last year's 95<sup>th</sup> percentile score
- Select higher of two scores as measure score

# Paying for Attainment and Improvement (cont.)

## Measure: Nephropathy Monitoring



Attainment Range:  $.92 - .86 = .06$   
 Attainment Scale:  $.06 / 9 = .0067$   
 Attainment Value:  $.88 - .86 = .02$   
 Attainment Points:  $1 + .02 / (.0067) \approx 4$

Improvement Range:  $.92 - .73 = .19$   
 Improvement Scale:  $.19 / 10 = .019$   
 Improvement Value:  $.88 - .73 = .15$   
 Improvement Points:  $.15 / (.019) \approx 8$

PO earned: 4 points on Attainment and 8 points on Improvement  
 PO score: Maximum of Attainment and Improvement points = 8 points

## Paying for Attainment and Improvement (cont.)

- Systemness and Diabetes Registry only scored on attainment
- POs only scored on measures with valid result
  - Not “punished” for not meeting denominator criteria for certain measures due to PO size or population
- Sum scores for all measures in a domain
- Calculate domain score as percent of possible points
- Translate domain score to payment based on score and enrollment for each PO
- Each health plan continues to set its own P4P payout budget
- Full budgeted amount is paid out

## Paying for Attainment and Improvement (cont.) SPM Threshold Concerns

Concern 1: Inclusion of Kaiser Permanente groups in thresholds

- IHA analyzed SPM scores and corresponding modeled payments under scenarios with and without Permanente
- Removing Permanente groups from thresholds would:
  - Increase average SPM scores of higher performing POs
  - Increase average payout to higher performing POs and decrease payout to other POs

## Paying for Attainment and Improvement (cont.) SPM Threshold Concerns

Concern 2: Use of 75<sup>th</sup> percentile as attainment threshold. It was suggested to use 50<sup>th</sup> percentile instead.

- IHA analyzed SPM scores and corresponding modeled payments under 50<sup>th</sup> and 75<sup>th</sup> percentile scenarios
- Decreasing attainment threshold to 50<sup>th</sup> percentile would:
  - Increase average SPM scores of higher performing POs more than for other POs
  - Increase average payout of higher performing POs and decrease payout to other POs

## Paying for Attainment and Improvement (cont.)

Plan	Adopt?
Aetna	Yes, MY 2009
Anthem Blue Cross	No
Blue Shield	Yes, MY 2011
CIGNA	Yes, MY 2010 (modified)
Health Net	No
United/PacifiCare	Yes, MY 2009
Western Health Advantage	Higher of their method and SPM for MY 2010

# Q & A

# California Pay for Performance

For more information:

[www.iha.org](http://www.iha.org)

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