

Highlights of P4P Program Changes

*Integrated Healthcare Association
February 6th and 10th, 2009*



Agenda

- Overview
- MY 2008 Updates
- MY 2008 Testing Measures
- Measure Adoption Timeline
- Potential MY 2009 Testing Measures
- Live Q&A
- Changes to the MY 2009 Measure Set
- Payment Methodology Recommendations
- Live Q&A

Overview: Goal of P4P

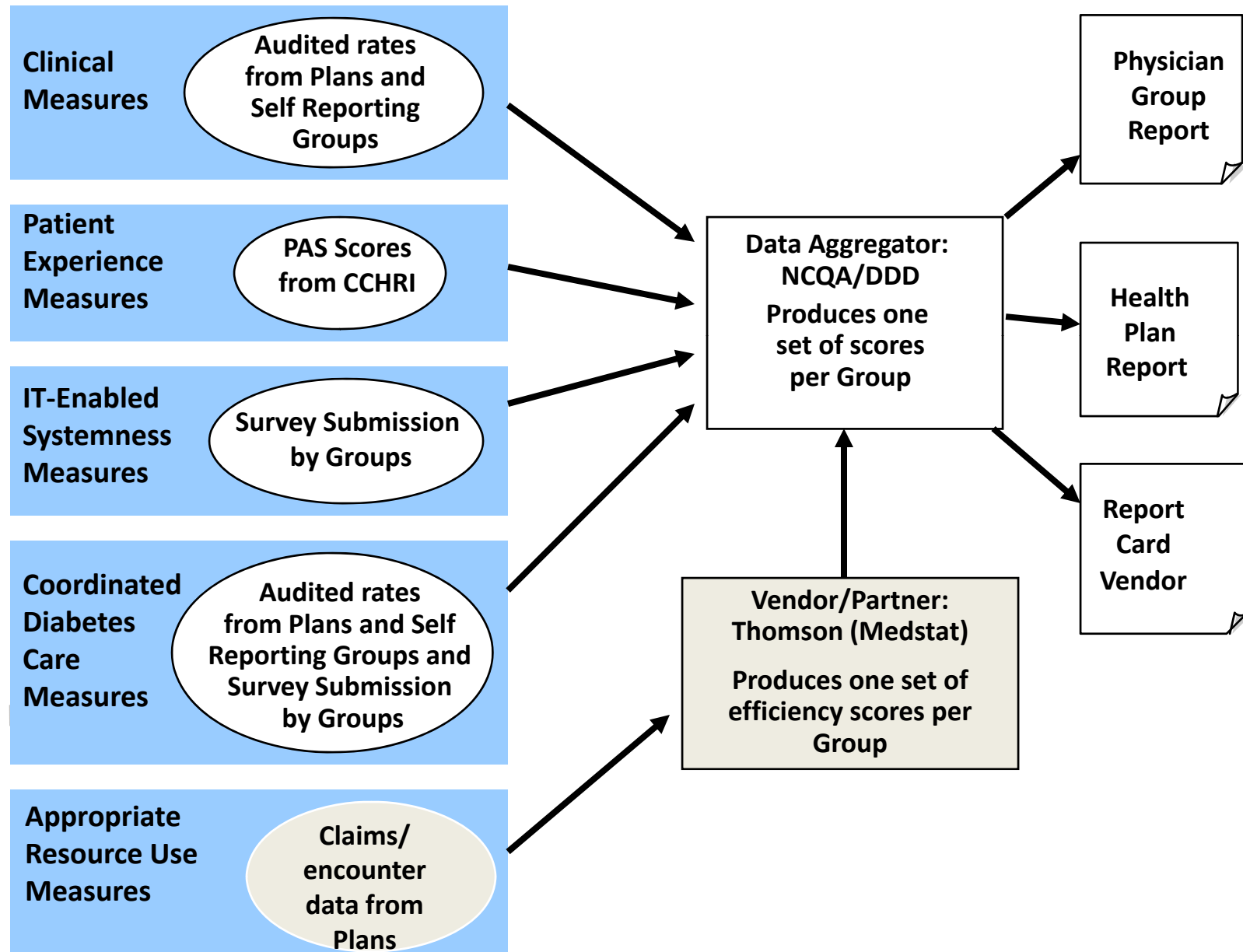
To create a compelling set of incentives that will drive breakthrough improvements in clinical quality and the patient experience through:

- √ Common set of measures
- √ A public report card
- √ Health plan payments to physician groups

Overview: Guiding Principles

- Measures:
 - ✓ Use nationally vetted, standardized measures whenever possible
 - ✓ Test new measures and seek public comment prior to adoption
 - ✓ Move toward outcome measures
- Data Collection:
 - ✓ Only allow electronic data for full eligible population
 - ✓ Health plan data is supplemented by physician group data
- Data Aggregation:
 - ✓ Combine results across plans to create a total patient population for each physician group
 - ✓ Allows more complete and robust measurement and reporting

Overview: Data Collection & Aggregation



MY 2008 Updates

Coordinated Diabetes Care Domain

- NCQA worked with a Diabetes Expert Panel to review recent studies and re-examine its target of <7.0%. The analysis resulted in NCQA deciding to make the following changes, which have been adopted by P4P:
 - Add an indicator for HbA1c < 8.0%
 - Adjust the indicator for HbA1c < 7.0 % by adding exclusions

Coordinated Diabetes Care Domain

- For the HbA1c control <7.0% indicator, exclude members who meet any of the following criteria:
 - 65-75 years of age as of December 31 of the measurement year
 - Coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)
 - Ischemic vascular disease (IVD)
 - Chronic heart failure (CHF)
 - Prior myocardial infarction (MI)
 - Chronic renal failure (CRF)/end-stage renal disease (ERSD)
 - Dementia

Coordinated Diabetes Care Domain

- Changed HbA1c Good control (<7.0%) to HbA1c (<8.0%)
 - Rationale for change: <8.0% is a more appropriate goal for the overall population
- Moved HbA1c Good control (<7.0%) to the Transition measure set
 - Rationale: Exclusions have been added to <7.0%, therefore further assessment is needed before adopting

Coordinated Diabetes Care Domain

- Diabetes Care Clinical Measures
 - *HbA1c Testing and Control >9.0% and <8.0%*
 - *LDL Screening and Control <100*
 - *Nephropathy Monitoring*
- Diabetes Registry and Related Activities
 - Electronic diabetes registry integrating at least two clinical data sources and updated at least quarterly
 - Blood pressure contained in registry
 - Actionable reports to MDs from diabetes registry at least twice annually
 - Individual MD measurement on all above diabetes measures at least annually
- Diabetes Care Management Process

IT-Enabled Systemness Domain

- While Systemness scores are valid for 3 years, there are two changes to the MY 2008 survey that may require POs to re-submit / supplement portions of their MY 2007 Systemness survey:
 - Measure 1A – must provide evidence of non-diabetes related activities
 - Measure 3B – must provide evidence that diabetes is part of your care management process
- Scoring change – Apply a conversion factor of .75 to account for P4P domain weighting change from 20% to 15%

*MY 2008 Testing Measures
(collected in 2009)*

MY 2008 Testing Measures

- Test in 2009 for potential inclusion in MY 2010
- Clinical
 - Blood Pressure Control for Patients with Diabetes
 - Optimal Diabetes Care
 - Adolescent Immunization
 - Asthma Medication Ratio

Blood Pressure Control for Patients with Diabetes

- Description: Percentage of members 18-75 years of age with diabetes (type 1 or 2) who had their blood pressure in control
- Eligible Population: Same as other diabetes clinical measures
- Two levels of control measured:
 - < 130 / 80
 - < 140 / 90
- Use CPT II codes or data from registry or EMR

Blood Pressure Control for Patients with Diabetes

- Use the most recent BP reading during the measurement year
- Do not include :
 - BPs taken during acute inpatient stay or ED visit
 - BPs taken during outpatient visit for the sole purpose of having diagnostic test or surgical procedure performed
 - BPs obtained same day as major diagnostic or surgical procedure
 - BP readings taken by the member

Optimal Diabetes Care

- Description: Percentage of members 18-75 years of age with diabetes (type 1 or 2) who had each of the following:
 - HbA1c control <8.0%
 - LDL-C control <100 mg/dL
 - BP control <140/90 mm Hg
- “All or nothing” measure
- Eligible Population: Same as other diabetes clinical measures

Adolescent Immunization

- Description: Percentage of adolescents who were appropriately vaccinated against meningococcal and tetanus/diphtheria
- Calculate rate for each vaccine and a combination rate
- Eligible population:
 - Age: Adolescents who turn 13 years of age during the measurement year
 - Continuous enrollment: 12 months prior to the member's 13th birthday

Adolescent Immunization

- Numerator compliance:
 - One meningococcal conjugate (MCV4) or meningococcal polysaccharide vaccine (MPSV4) on or between member's 11th and 13th birthdays
 - One tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) on or between the member's 10th and 13th birthdays

Asthma Medication Ratio

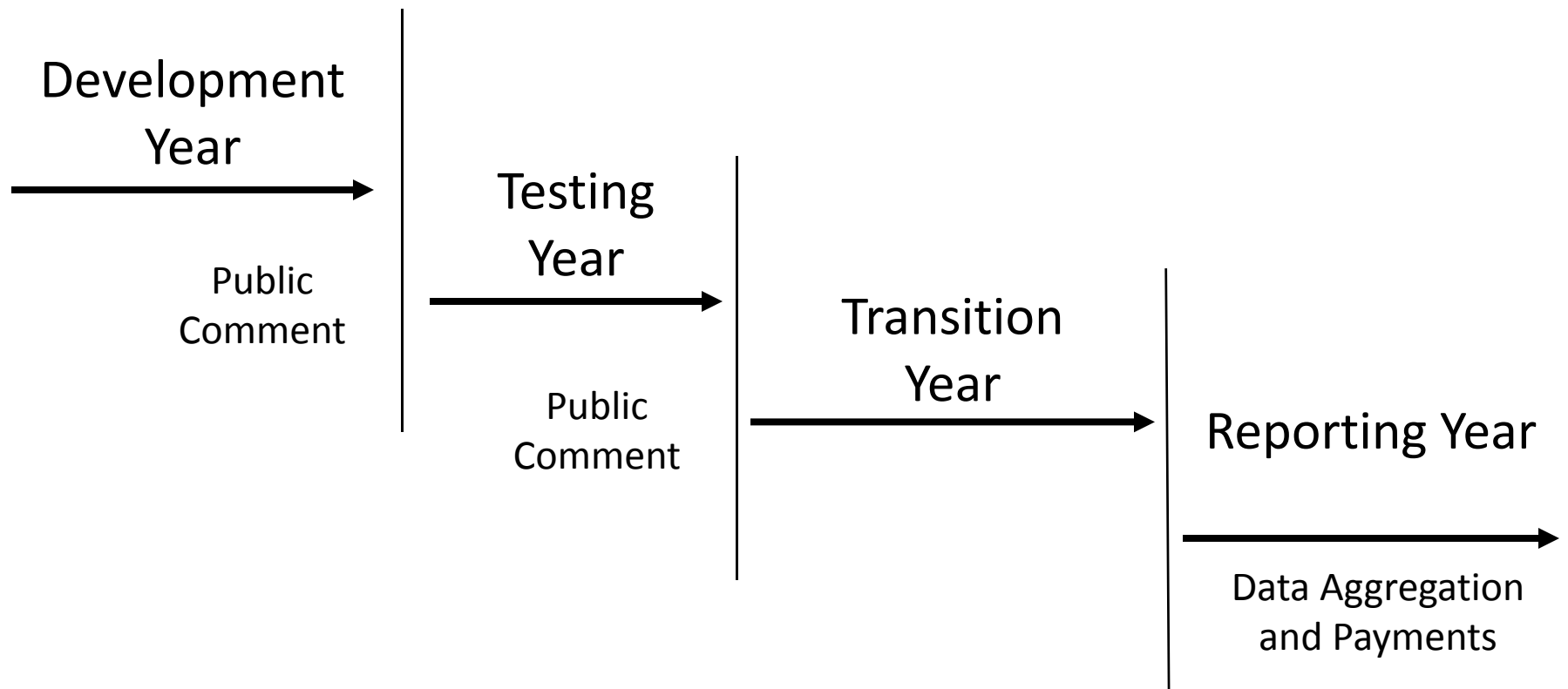
- Description: The ratio of controller medications over controller medications plus short acting/reliever medications for persistent asthmatics
- P4P tested an Asthma Medication Ratio (AMR) measure in Spring 2008, which was developed by Kaiser. The Kaiser measure is under revision
- NCQA is in the process of selecting a nationally vetted, standardized asthma measure – which may be the revised Kaiser measure

Asthma Medication Ratio

- There are 2 possibilities for the AMR measure:
 - If NCQA completes testing, and final specifications (which are sufficiently similar to the specifications P4P tested in Spring 2008) are ready for the September 1, 2009 release of the MY 2009 manual, the current Use of Appropriate Medications for People with Asthma will be replaced by the AMR measure
 - If specifications are not finalized, or if they have changed significantly, then continue to use the current asthma measure for MY 2009 and adopt the AMR measure for MY 2010

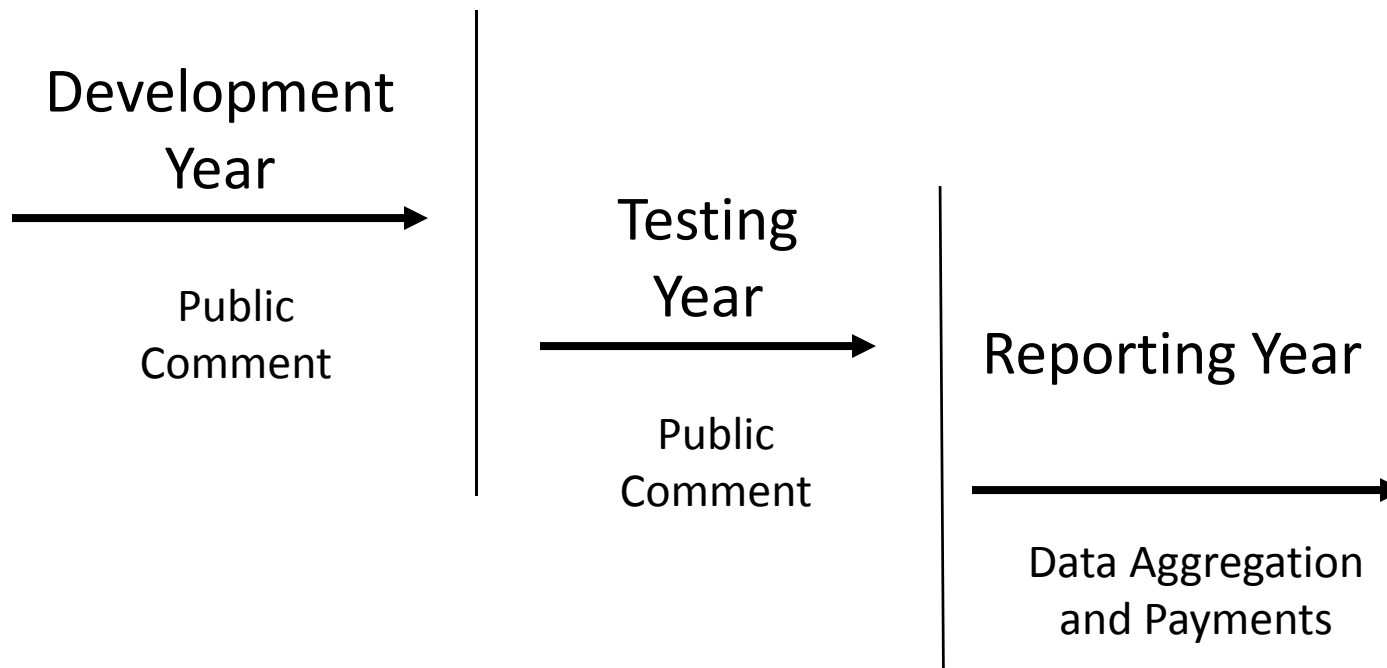
Measure Adoption Timeline

Previous Measure Adoption Timeline



New Measure Adoption Timeline

(effective for MY 2009)



Measure Adoption Process

1. Staff research
2. Technical Quality Committee recommends measures for testing
3. Steering Committee confirms measures for testing
4. Draft specifications developed
5. Public Comment on proposed testing measures
6. Technical Quality Committee reviews comments and recommends modifications if needed
7. Steering Committee reviews and approves for testing
8. Testing and analysis of results
9. Repeat steps 2, 3, 5, 6, 7 related to measure adoption

*Potential MY 2009 Testing Measures
(collected in 2010)*

Potential MY 2009 Testing Measures

- The testing measures to be tested in 2010 for MY 2009 have not yet been determined. The following measures are under consideration:
 - Childhood Immunization combination rate
 - Blood Pressure Control for all people with Hypertension
 - Frequency of Selected Procedures
 - Medication Management, including Persistence (contingent on NQF)
 - Comprehensive Clinical Measurement Tool (contingent on NQF)
- There will be opportunity for public comment before testing measures are selected

Live Q&A

*Changes to the MY 2009
Measure Set*

Domain Weighting

Domain	MY 2008	MY 2009
Clinical	40	40
Coordinated Diabetes Care	20	20
IT-Enabled Systemness	15	20
Patient Experience	25	20
Appropriate Resource Use		Standard gain-sharing arrangement recommended

Changes to MY 2009 Measure Set

- Clinical
 - Replaced original Cervical Cancer Screening measure with Evidence-Based Cervical Cancer Screening
- Coordinated Diabetes Care
 - Added HbA1c <7.0% (with exclusions)
- IT-Enabled Systemness
 - Removed Access and Communication
 - Added Interoperability
 - Changed Scoring
- Appropriate Resource Use Domain added

Clinical Domain

- Replaced original Cervical Cancer Screening measure with Evidence-Based Cervical Cancer Screening of Average-Risk, Asymptomatic Women (ECS)
 - Description: Women 21 years of age and older who received cervical cancer screening in accordance with evidence-based standards. Three separate overall rates are calculated for this measure based on the same eligible population.
 - Rate 1: Appropriately Screened
 - Rate 2: Not Screened
 - Rate 3: Screened Too Frequently

ECS – Eligible Population

- Ages: Women 24 years and older as of December 31 of measurement year
- Continuous Enrollment:
 - Self-Reporting POs: The measurement year and the two years prior to the measurement year in the PO
 - Health Plans: : The measurement year and the two years prior to the measurement year in the health plan and in the PO
- Allowable Gap: No more than one gap in enrollment of up to 45 days during each year of continuous enrollment

ECS - Eligible Population

- Anchor date: December 31 of measurement year
- Exclusions: Must have occurred by December 31 of the measurement year
 - A diagnosis of dysplasia in the past five years
 - An abnormal Pap test in the past five years
 - Any history of cervical cancer (the organization should look through the administrative data for a history of cervical cancer as far back as possible in the member's history)

ESC – Appropriately Screened

- Description: Women who were screened for cervical cancer according to evidence-based guidelines
- A higher rate indicates better performance
- Denominator: The eligible population
- Numerator: The number of women 24 years of age and older who had the appropriate number of Pap tests according to evidence-based guidelines
 - Note: If two or more claims/encounters with qualifying numerator codes for pap test occur within 120 days of each other, county only the first one

ESC – Appropriately Screened

- Three categories of Appropriately Screened
 - women ages 24–64 years with hysterectomies who had no Pap tests subsequent to their hysterectomy in the MY or the two years prior to the MY
 - women 24–64 years who have not had a hysterectomy and had a single Pap test in the MY or the two years prior to the MY
 - women 65 years and older who had no Pap tests in the MY

ESC – Not Screened

- Description: Women who should have been screened for cervical cancer, but were not, based on the available data
- Additional outreach could be done to encourage these women to come in for a Pap test
- A lower rate indicates better performance
- Denominator: The eligible population
- Numerator: The number of women 24-64 years of age who did not receive a Pap test in measurement year or the two years prior to the measurement year

ECS – Screened too Frequently

- Description: Women who received more cervical cancer screenings than necessary according to evidence-based guidelines
- A lower rate indicates better performance
- Denominator: The eligible population
- Numerator: The number of women 24 years of age and older who received more Pap tests than necessary according to evidence-based guidelines
 - Note: If more than two claims/encounters with qualifying numerator codes for Pap test occur within 120 days of each other, count only the first one

ECS – Screened too Frequently

- Three categories of Screened too Frequently
 - women 24–64 years with hysterectomies who had one or more Pap tests subsequent to their hysterectomy in the MY or the two years prior to the MY
 - women ages 24–64 years who have not had a hysterectomy, who had two or more Pap tests in the MY or the two years prior to the MY
 - women ages 65 and older who had one or more Pap tests in the MY

IT-Enabled Systemness Domain

- Removed Access and Communication
- Added Interoperability
- Changed Scoring

Removed Access and Communication Measure

Rationale:

- This measure required POs to electronically distribute/post standards
- Compliance with the standards was not tracked as part of this measure
- This measure is not meaningful without tracking compliance
- Patients' perceptions of access is already captured in PAS

Added Interoperability – Measure 4

- Description: The organization uses a standard format for receiving and transmitting pharmacy data and lab results data, and encourages its business partners to do the same
- Intention is to increase interoperability and to decrease the burden of data exchange

Interoperability – Measure 4

- The organization does the following for its commercial HMO/POS population:
 1. Receives pharmacy data from all contracted health plans in CALINX Rx format
 2. Transmits lab results data to all contacted health plans in CALINX Lab (or other standard HL-7 format preferred by plan) for at least 50% of HEDIS and P4P-related lab tests performed
 3. Requests CALINX Lab from all laboratories servicing the organization's members at least twice annually until the laboratory develops the ability to produce CALINX lab

Interoperability – Measure 4

- Scoring
 - 3 points: The organization meets all 3 items
 - 2 points: The organization meets 2 items
 - 1 point: The organization meets 1 item
 - 0 points: The organization does not meet any of the items

Changed Systemness Domain Scoring

- Domain weighting increased from 15% for MY 2008 to 20% for MY 2009
- Overall P4P scores are calculated by applying a weighting of .67 to PO's total points earned
- For example, if PO earned a total of 30 points, PO's overall calculated P4P score would be 20
- Scores are rounded to the nearest whole number

Appropriate Resource Use Domain

- Measures
 - Inpatient Readmission within 30 Days
 - Inpatient Utilization – Acute Care Discharges
 - Inpatient Utilization – Bed Days
 - Outpatient Surgeries Utilization – % Done in ASC
 - Emergency Department Visits
 - Generic Prescribing

Appropriate Resource Use Domain

- Thomson Reuters Healthcare will run these measures using the claims and encounter data submitted by participating health plans
- For each PO, each of the measures will be calculated in two ways:
 - Unadjusted results for each contracted health plan, to be used for shared savings
 - Risk-adjusted results aggregated across all contracted health plans, for comparative information

Appropriate Resource Use Domain

- Baseline measurement for MY 2008
- “Live” measure for MY 2009
- Intended for use in shared savings arrangement
- No public reporting planned

Inpatient Readmissions Within 30 Days

- Description: The number of inpatient readmissions (any cause) within 30 days of discharge during the measurement year
- Risk Adjustment: CMS DRG mix
- Include all discharges that occur from January 1 to December 1 of the measurement year
- A readmission is also an index discharge for another potential readmission within 30 days

Inpatient Readmissions Within 30 Days

- Exclusions:
 - Discharges to a skilled nursing facility
 - Maternity and pediatric discharges
 - Readmission to another acute care facility within a day of discharge
 - Discharges of members who were discharged deceased

Inpatient Utilization – Acute Care Discharges

- Description: Utilization of non-maternity acute inpatient services
- Risk Adjustment: Concurrent DxCG Relative Risk Score
- Outliers: <30 or >70 discharges PTMY
- Long lengths of stay “Winsorized” at 3 standard deviations from the mean across all plans and POs for each DRG

Inpatient Utilization – Acute Care Discharges

- Exclusions:
 - Mental health or chemical dependency services
 - Members who require Coordination of Benefits because the health plan is not the primary payer
- Reliability statistics will be provided

Inpatient Utilization – Bed Days

- Description: Total bed days associated with non-maternity related discharges
- Risk Adjustment: Concurrent DxCG Relative Risk Score
- Outliers: <30 or >70 discharges PTMY
- Long lengths of stay “Winsorized” at 3 standard deviations from the mean across all plans and POs for each DRG

Inpatient Utilization – Bed Days

- Exclusions:
 - Mental health or chemical dependency services
 - Members who require Coordination of Benefits because the health plan is not the primary payer

Average Length of Stay

- Not intended as payable measures; provided as additional information
- Description: Average Length of Stay (ALOS) associated with both non-maternity related and maternity related discharges
- Risk Adjustment: CMS-DRG mix
- Long lengths of stay “Winsorized” at 3 standard deviations from the mean across all plans and POs for each DRG

Outpatient Surgeries Utilization – % Done in ASC

- Description: The percent of selected outpatient/ambulatory surgeries and procedures that are done at a non-hospital affiliated Ambulatory Surgery Center
- Risk adjustment: Concurrent DxCG Relative Risk Score
- Exclusions:
 - Mental health or chemical dependency services
 - Members who require Coordination of Benefits because the health plan is not the primary payer

Emergency Department Visits

- Description: Utilization of emergency department visits per 1000 member years (PTMY)
- Risk adjustment: Concurrent DxCG Relative Risk Score
- Outliers: ED utilization rate of <60 or >250 PTMY

Emergency Department Visits

- Exclusions:
 - ED visits that result in an inpatient admission
 - Mental health or chemical dependency services
 - Members who require Coordination of Benefits because the health plan is not the primary payer

Generic Prescribing

- Description: The level of generic prescribing will be measured as a simple prescription rate for seven specific therapeutic classes
 - Cholesterol (Statins)
 - Depression (SSRIs/SNRIs)
 - Allergy and Respiratory
 - Nasal Steroids
 - Allergy - Oral
 - Asthma
 - Anti-Ulcer Agents
 - Cardiovascular, Cardiac-Hypertension
 - Diabetes - Oral
 - Anxiety/Sedation (sleep aids)

Generic Prescribing

- Risk Adjustment: None
- Generic status will be identified through *RED Book™*
- Exploring the impact and feasibility of using plan-defined definitions of brand and generic

Payment Methodology Recommendations

Payment Methodology Recommendations

- Linking Payment Potential to Data Sharing
- Gain Sharing for Appropriate Resource Use measures
- Comprehensive Payment Methodology that incorporates both Attainment and Improvement

Linking Payment Potential to Data Sharing

- Encourages bi-directional flow of data
- Official recommendation starting in MY 2009
- Two data sharing levels
- Two-fold difference in payment for MY 2009, increasing to three-fold starting in MY 2010
- Health plans should redistribute any money they “save” due to lower payments to non-sharing POs
- Plans must be sharing pharmacy, facility, and other paid claims (POS, OOA, OON) that are electronically available in order to apply the payment differential

Data Sharing Requirements

“Meets Target” – qualifies for maximum payment potential

- Share all P4P and HEDIS-related lab results and other supplemental clinical data electronically available
- Share complete data for all members and lab providers (not just for Quest and LabCorp)
- Provide data in agreed upon standard format
 - CALINX for lab results
 - Standard IHA/CCHRI format for other data
- Transmit data quarterly (due dates to be determined by health plan work group)
- Provide required documentation with the last file annually

Data Sharing Requirements

- POs may use any transmission route as long as they meet all criteria
- POs and plans only held accountable for sharing clinical information they have available electronically
- POs that don't collect or store clinical information electronically can meet criteria by requesting their lab provider to send results on their behalf
- For MY 2009, quarterly submissions not required to meet target. Signed authorization form by April 1 and one file by Q4 2009 with refresh file during Q1 2010 will qualify

Gain Sharing for Appropriate Resource Use measures

- Official recommendation for MY 2009
- Thomson Reuters Healthcare (Thomson) will run the utilization rates for each measure for each plan and provide unadjusted results to plans
- Each health plan will determine total actual payments associated with services being measured for baseline year, and calculate unit cost for each service for each PO
- Unit cost will be multiplied by number of units saved in subsequent year to determine amount of savings for each PO for each metric

Gain Sharing for Appropriate Resource Use measures

- Thomson will also calculate aggregated, risk adjusted rate for each PO to determine its statewide (or regional, if possible) performance
- Savings will be shared between the health plan, PO, and premium trend reduction, based on the PO's relative statewide/regional performance
- In order to ensure savings for one metric is not offset by “backsliding” in another metric, to qualify for any savings payment, a PO's performance cannot statistically significantly decrease for any metric

Gain Sharing for Appropriate Resource Use measures

PO's aggregated risk-adjusted score (statewide or regionally)	PO portion of savings	Health Plan portion of savings	Premium reduction portion of savings
Top quartile	50	25	25
50 th to 74 th percentile	40	30	30
25 th to 49 th percentile	30	35	35
Bottom quartile	20	40	40

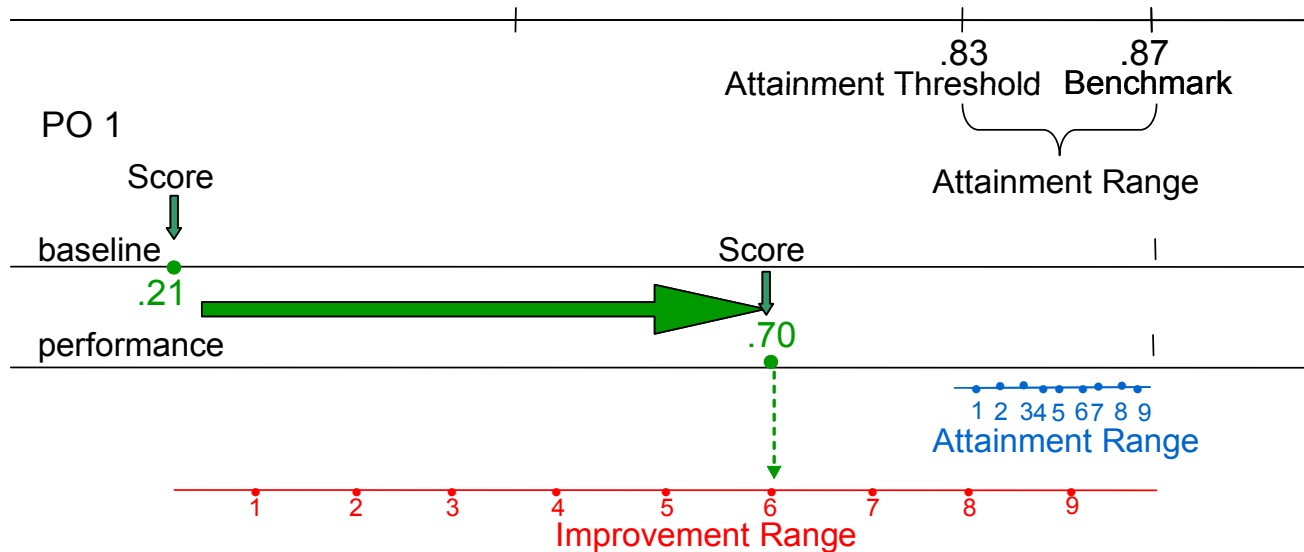
Recommended Comprehensive Payment Methodology

- Official recommendation for MY 2009
- Score each measure 0-10 points for attainment and 0-10 points for improvement
 - Must be in top quartile to earn attainment points
 - 95th percentile and above earn full points
- Select higher of two scores for payment
- Sum scores for all measures in a domain
- Translate domain score to payment

Recommended Comprehensive Payment Methodology

Earning Quality Points Example

Measure: Cervical Cancer Screening



PO 1 Earns: 0 points for attainment
6 points for improvement

PO 1 Score: maximum of attainment or improvement
= 6 points on this measure

Recommended Comprehensive Payment Methodology

- POs are only scored on measures for which they have a valid result, so they are not “punished” for not meeting the denominator criteria for certain measures due to PO size or population
- Systemness is only scored on attainment
- Each health plan continues to set its own P4P payout budget
- The full budgeted amount is paid out

Live Q&A