2009-2010 Pay for Performance Program Updates

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Los Angeles, California
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Agenda

- What's New for MY 2009
  - Performance Measures
  - P4P Policy
  - Payment Recommendations
- Proposed Changes for MY 2010
- Looking Ahead to MY 2011
  - Episode Measures to support QI
  - Performance Based Contracting

What's New for Measurement Year 2009

Approved Changes for MY 2009

1. Increase in Encounter Rate Threshold
2. Replace Cervical Cancer Screening measure with Evidence-based Cervical Cancer Screening
3. Add HbA1c <7.0%
4. Delete Systemness Measure 4: Access and Communication Standards
5. Systemness Scoring
6. Add Appropriate Resource Use measures
7. Payment Recommendations
8. New Measure Adoption Timeline

1. Encounter Rate

- Threshold
  - Standardized Encounter Rate by Service Type specifications *(effective MY 2008)*
  - Assures at least minimal level of data completeness
  - Increase threshold from 3.75 to 4.0
- Self-Reporting *(effective MY 2008)*
  - PO must meet encounter rate threshold for every health plan with which it contracts
  - To accommodate potential data capture issues, a one plan exception may be made

2. Evidence-based Cervical Cancer Screening

- Eligible Population: Women 24 years and older as of December 31 of measurement year
- All women in the eligible population will be included in one of the following three rates:
  - Rate 1: Appropriately Screened
  - Rate 2: Not Screened
  - Rate 3: Screened Too Frequently
- P4P is only reporting and paying on the Appropriately Screened rate

2. *Evidence-based Cervical Cancer Screening*

Number of Pap Tests	24-65 Years With No Hysterectomy	24-65 Years With Hysterectomy	67 Years and Older
Zero	Not Screened	Evidence-Based Screening	Evidence-Based Screening
Exactly 1	Evidence-Based Screening		
1 or more		Screened Too Frequently	Screened Too Frequently
2 or more	Screened Too Frequently		

2. Evidence-based Cervical Cancer Screening Exclusions

- Any of the following that have occurred by December 31 of the MY
  - A diagnosis of dysplasia in the past five years
  - An abnormal Pap test in the past five years
  - Any history of cervical cancer*
  - Any previous exposure to DES*
  - Any diagnosis of HIV*

* *look through the administrative data as far back as possible in the member's history*

3. New Coordinated Diabetes Care Clinical Measure: HbA1c < 7.0%

- Exclude members who meet any of the following criteria:
  - 65-75 years of age as of December 31 of the MY
  - 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

4. Remove Systemness Measure on Access & Communication Standards

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

5. Systemness Scoring

- Previous: Earning any 20 of 30 possible points earned a PO full credit
- Starting with MY 2009: A PO must earn all possible points to get full credit
  - All measures will be scored
  - Total points based on all measures will be converted to the weighting for the domain

6. Appropriate Resource Use Measures

- Inpatient Readmissions within 30 Days
- Inpatient Utilization—Acute Care Discharges
- Inpatient Utilization—Bed Days
- Outpatient Surgeries Utilization
- Emergency Department Visits
- Generic Prescribing

6. Appropriate Resource Use Measures

- Thomson Reuters will run these measures using the claims and encounter data from 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

6. Appropriate Resource Use Measures

- Baseline measurement for MY 2008
- Reports to be distributed early December
- Intended for use in shared savings arrangement
- No public reporting planned

6a. Inpatient Readmissions within 30 Days

- Description: The number of inpatient readmissions (any cause) within 30 days of discharge during the MY
- 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
- Exclusions:
  - Discharges to a skilled nursing facility
  - Maternity and newborn discharges
  - Readmission to another acute care facility within a day of discharge
  - Discharges of members who were discharged deceased

6b. Inpatient Utilization – Acute Care Discharges or Bed Days

- 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
- 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

6c. 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

6d. Outpatient Surgeries Utilization – % Done in ASC

- Description: The percent of selected outpatient/ ambulatory surgeries and procedures that are done at a free-standing/"preferred" 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

6e. Emergency Department Visits

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

6f. Generic Prescribing

- Description: Percent generic 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)
- Risk Adjustment: None
- Generic status will be identified through *RED Book*™

7. Approved MY 2009 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

7a. Linking Payment Potential to Data Sharing

Overview:

- Encourages bi-directional flow of data
- Two data sharing levels, with two-fold payment potential differential between levels
- Health plans continue to pay out their full budgeted amount; money "saved" due to lower payments to non-sharing POs redistributed to sharing POs
- Payment differential only applies if plan shares with POs electronically available pharmacy, facility, and other paid claims (POS, OOA/OON)

7a. Data Sharing Requirements

- 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
  - First transmission due December 2009
- Provide required documentation with the last file annually

7a. 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

7a. Adoption of Data Sharing Recommendation

Plan	Adopt?	Requirement for Full Payment
Aetna	Yes	Express intent to share data and be working in good faith to get data flowing
Anthem	No	
Blue Shield	Yes	Return signed authorization form
CIGNA	No	
Health Net	Yes	Send authorization form
PacifiCare	Yes	Contract with Labcorp; Send lab results from other lab providers by Dec 1, 2009 for dates of service Jan-Sept 09, and by Feb 28, 2010 for dates of service Oct-Dec 2009
Western Health Advantage	No	

7b. Standard Gain Sharing Method

- Applies to Appropriate Resource Use (ARU) measures
- Thomson Reuters runs the ARU measures with health plan data
- Health Plan calculates savings associated with reduced utilization of specific services
- Health Plan shares portion of savings with PO
- Portion PO earns based on relative risk-adjusted regional performance

7b. Standard Gain Sharing Method

- To qualify for payment:
  - Improvement must be statistically significant
  - No statistically significant decrease for any metric

7b. Standard Gain Sharing Method

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
50th to 74th percentile	40	30	30
25th to 49th percentile	30	35	35
Bottom quartile	20	40	40

7b. Adoption of ARU Measures and Recommended Gain Sharing Method

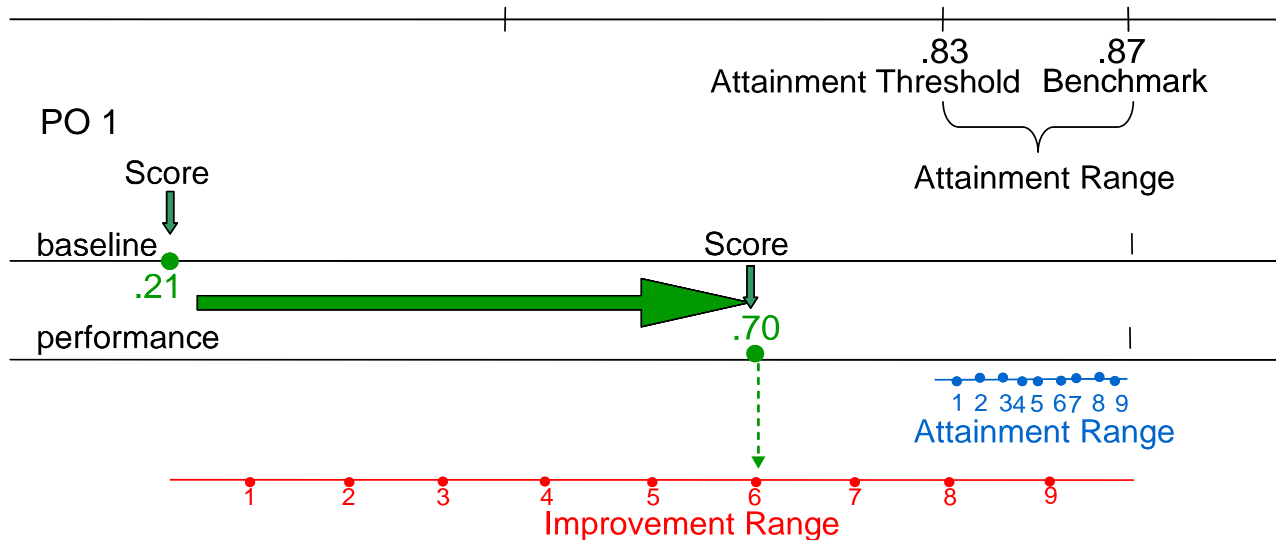
Plan	Adopt ARU?	Adopt Gain-sharing?
Aetna	No	No
Anthem Blue Cross	Use similar measures	Have own shared savings program
Blue Shield	Use similar measures	Have own shared savings program
CIGNA	No	No
Health Net	Use similar measures	Have own shared savings program
PacifiCare	Yes – All 6	No
Western Health Advantage	Yes – Generic Rx	No

7c. Recommended Attainment/ Improvement Methodology

- Score each measure 0-10 points for attainment and 0-10 points for improvement
  - Must be in top quartile to earn attainment points based on previous year's percentiles including Kaiser
  - 95th percentile and above earn full points based on previous year's percentiles including Kaiser
- Select higher of two scores
- Sum scores for all measures in a domain
- Translate domain score to payment

7c. Recommended Attainment/ Improvement Methodology

Earning Quality Points Example



PO 1Earns: 0 points for attainment

6 points for improvement

PO 1 Score: maximum of attainment or improvement

= 6 points on this measure

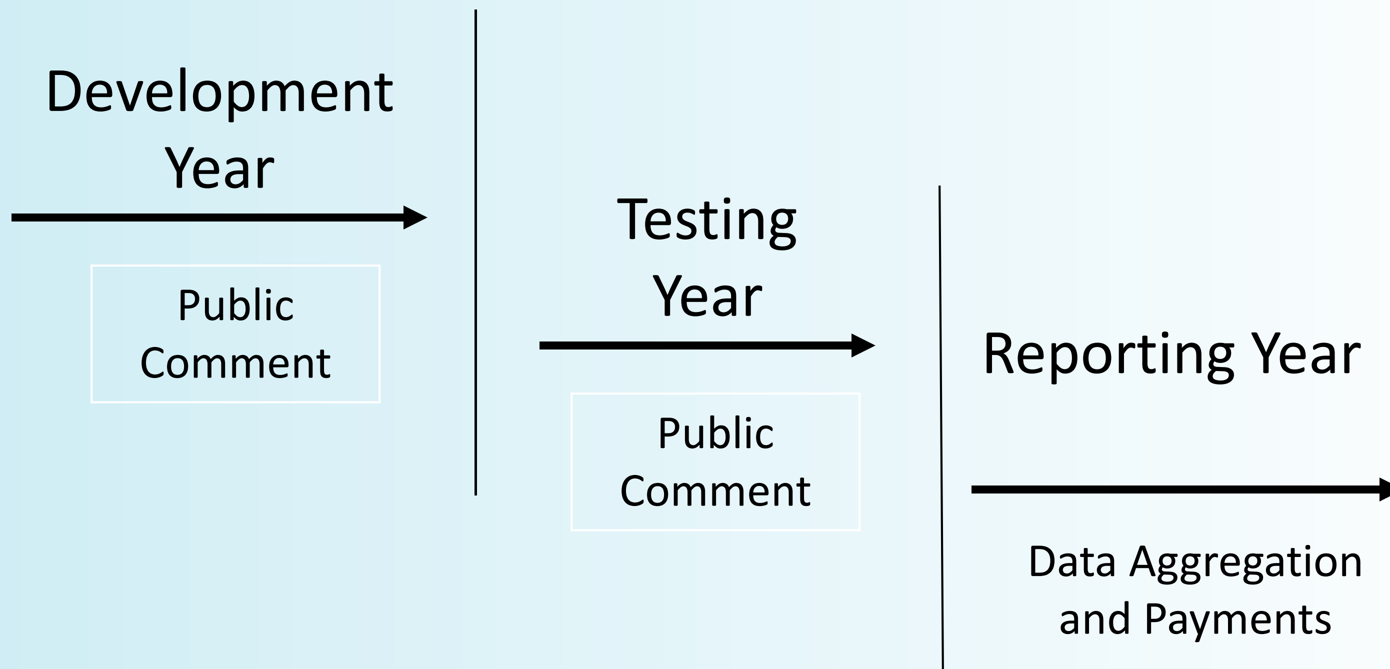
7c. Recommended Attainment/ Improvement Methodology

- Systemness and Diabetes Registry are only scored on attainment
- 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
- Each health plan continues to set its own P4P payout budget
- The full budgeted amount is paid out

7c. Adoption of Attainment/ Improvement Methodology

Plan	MY07 Pay for Improvement?	MY09 Adopt Recommended Method?
Aetna	Yes – 20%	Yes
Anthem Blue Cross	No	No
Blue Shield	Yes – 16%	Modified version
CIGNA	Yes – 16%	No
Health Net	Yes – 40%	No
PacifiCare	No	Yes
Western Health Advantage	Yes – 1%	No

8. New Measure Adoption Timeline



Proposed Changes for MY 2009

The following changes are currently posted for public comment:

- Delete Use of Appropriate Medications for People with Asthma
- Testing Measures – proposed to be tested in 2010 for MY 2009:
  1. Asthma Medication Ratio
  2. Blood Pressure Control for People with Diabetes
  3. Optimal Diabetes Care
  4. Childhood Immunizations
     - Additional antigens
     - Combination rate

Delete Use of Appropriate Medications for People with Asthma

- Rationale:
  - specification changes in the measure
  - current high performance on the measure
  - intent to replace it with Asthma Medication Ratio measure for MY 2010

Test Modified Asthma Medication Ratio

- Based on work of American Academy of Allergy, Asthma and Immunology
- Modified specifications from P4P measure successfully tested in 2008
- Description: Percentage of members 5-50 years of age with persistent asthma who had ratio of controller medications to total asthma medication of .50 or greater during the MY
- Patients with ratio of 0.5 or greater experience significantly fewer asthma exacerbations

Re-test Blood Pressure Control for People 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 (continued)

- 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

Re-test 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

Test Additional Childhood Immunization Measures

- Additional Antigens: Hepatitis A and Rotavirus
- Three combination rates – "all or none"

Combination	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	RV	Influenza
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 7	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Changes for Measurement Year 2010

Proposed New Measures for MY 2010

- Clinical
  - Asthma Medication Ratio
  - Childhood Immunizations – additional antigen/combo
  - Adolescent Immunizations
- Coordinated Diabetes Care
  - Blood Pressure Control for People with Diabetes
  - Optimal Diabetes Care
- Systemness
  - Electronic Reporting of Blood Pressure for People with Hypertension

Electronic Reporting of Blood Pressure for People with Hypertension

- Collect and electronically store BP readings for at least 10% of commercial HMO/POS patients with HTN
- Data must be in format to be able to support population management, patient care and data exchange
  - Search
  - Extract
  - Manipulate
  - Analyze
- Must be in place by December 31, 2010

Looking Ahead to Measurement Year 2011

Looking Ahead to MY 2011

- Episode Measures to support QI
- Performance Based Contracting

IHA P4P Project
Episode-Based Efficiency Measurement

September 24, 2009 Update

HEALTHCARE

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Episode-Based Efficiency Measurement

- Previously analyzed but not released
- New analytic method (published in MedPAC report) now available to quantify efficiency by episode of care:

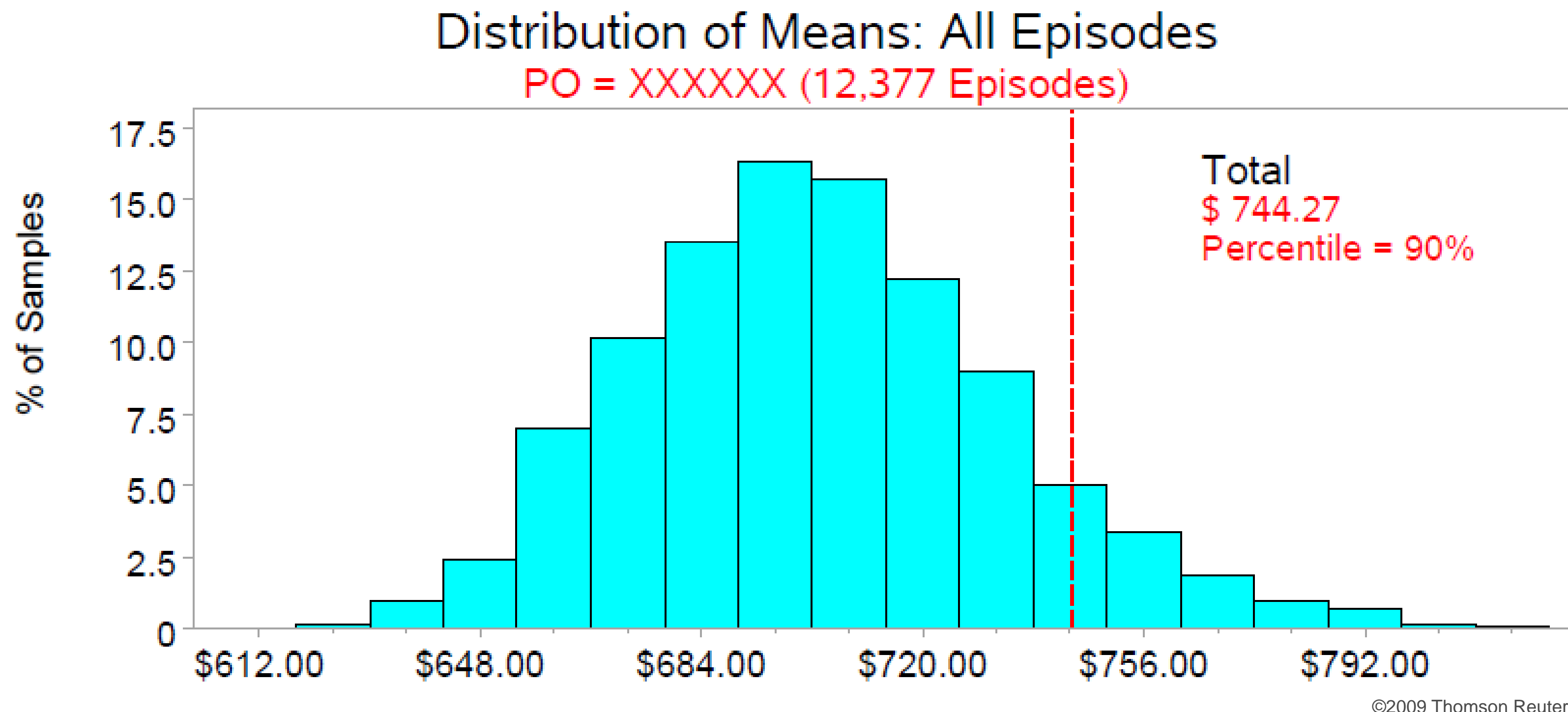
  "Are resources used by a PO to treat its mix of patients more or less efficient than average resources used in California to treat patients with the same characteristics?"

- New approach for including service categories in efficiency measure
  - Minimizes data quality issues
  - Consistent with NCQA methodology

Episode-Based Efficiency measures

- Overall Efficiency (across patients and episodes)
- Efficiency by Episode Category (e.g., diabetes, hypertension, asthma)
- Drill-down to service categories
  - Inpatient
  - Office visit
  - Drug
  - Lab
  - Radiology
  - ER

Comparing Actual to Expected Costs



- PO has a total of 12,377 episodes
- Average standard cost per episode is $ 744
- Compare to distribution of mean costs based on samples of comparable episodes from CA-based POs (range: $600 - $800)
- Observed mean costs falls at the 90th percentile of mean costs for comparable samples of episodes

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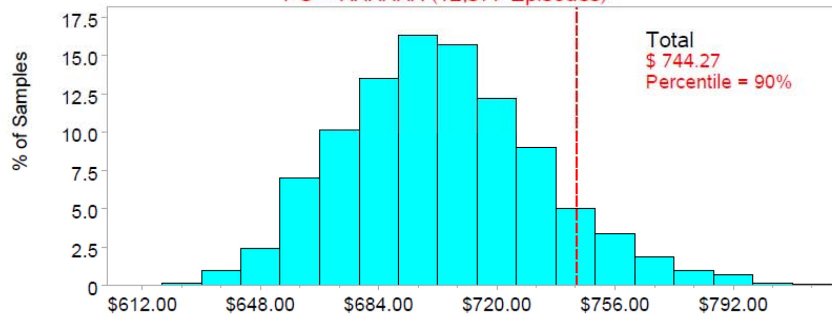
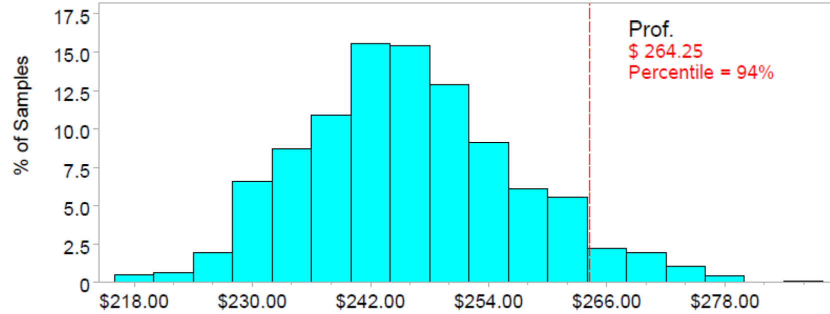
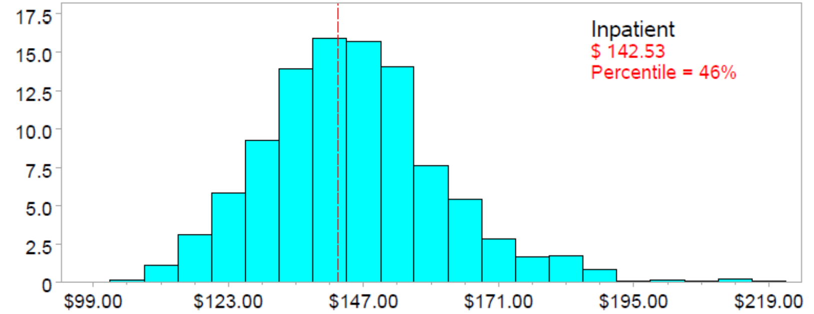
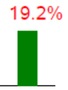
Distribution of Means: All Episodes

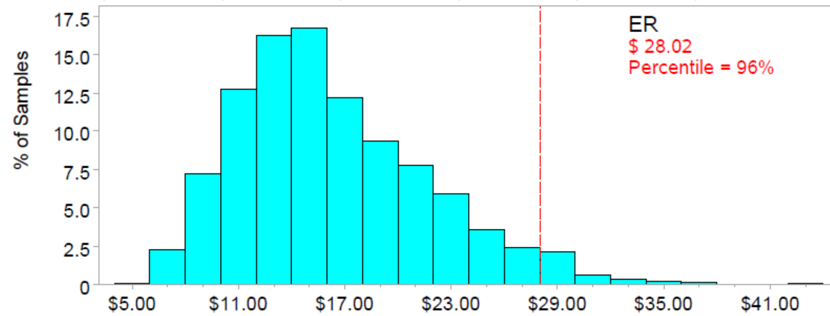
PO = XXXXXX (12,377 Episodes)

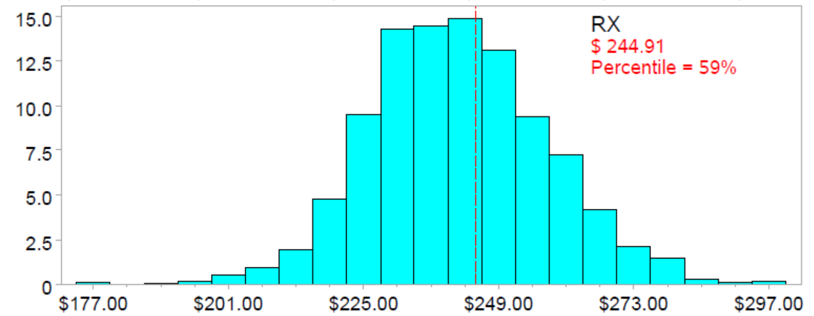


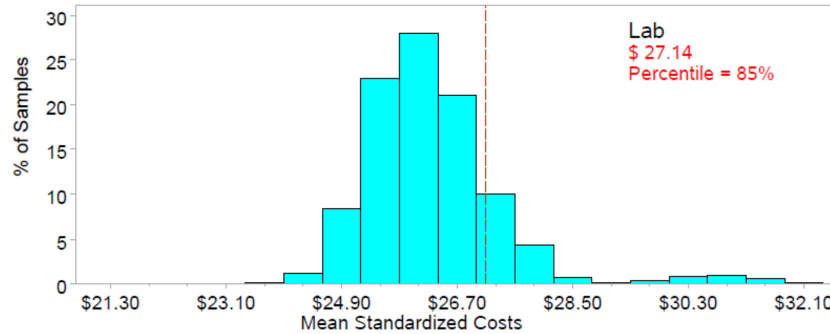


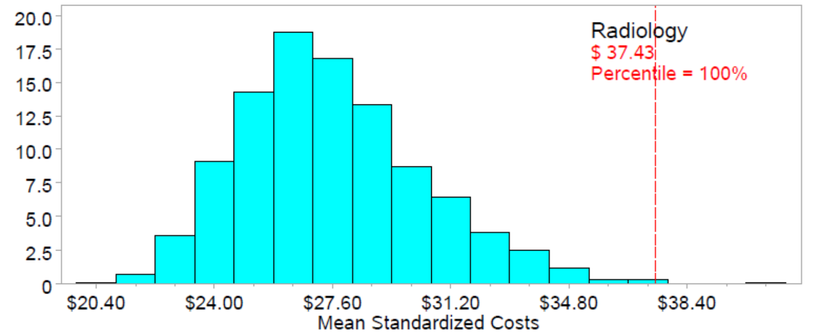












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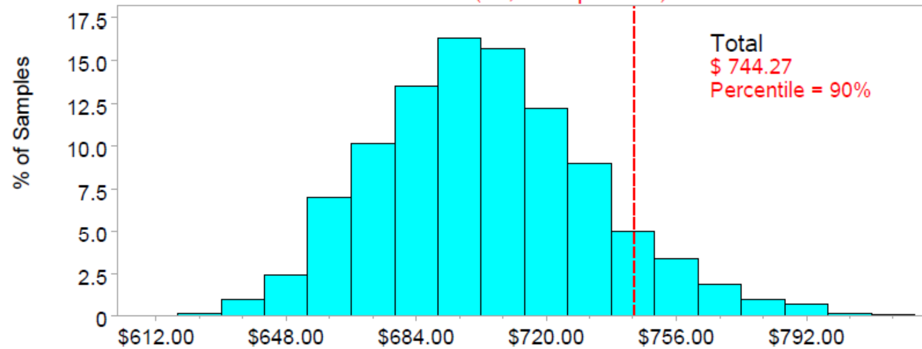
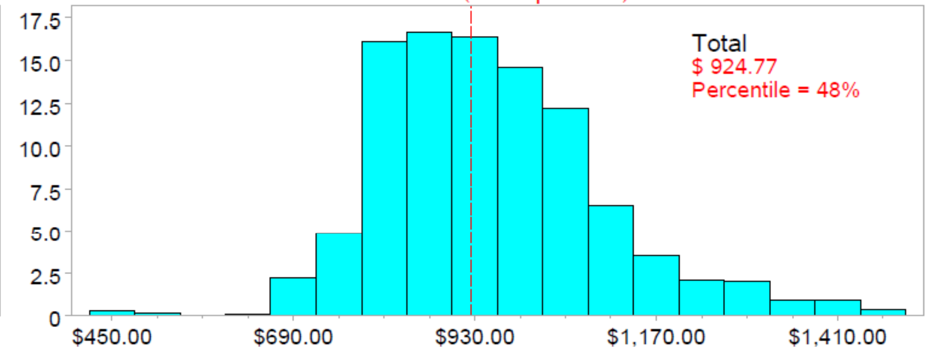
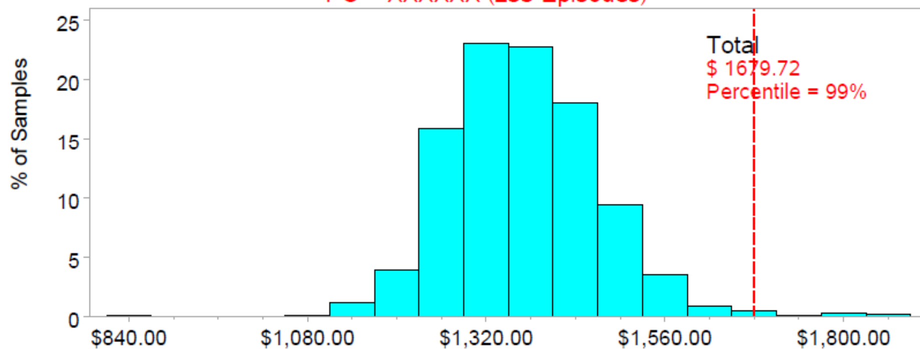
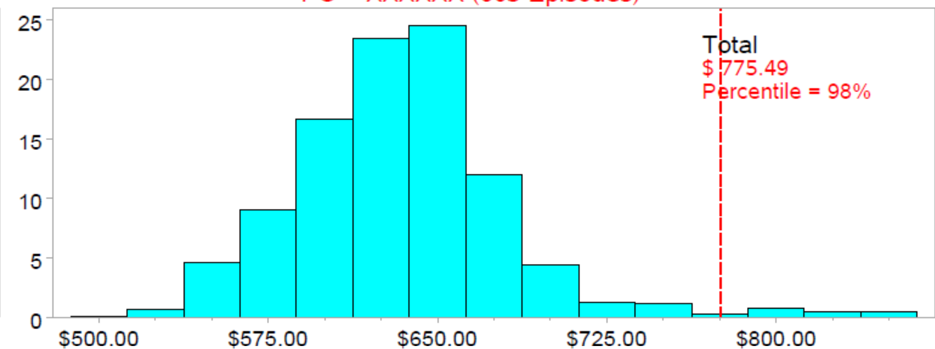
Note: The green bar next to each histogram indicates the percentage of total dollars represented by that service category.

Comparing Actual to Expected Costs Across Conditions









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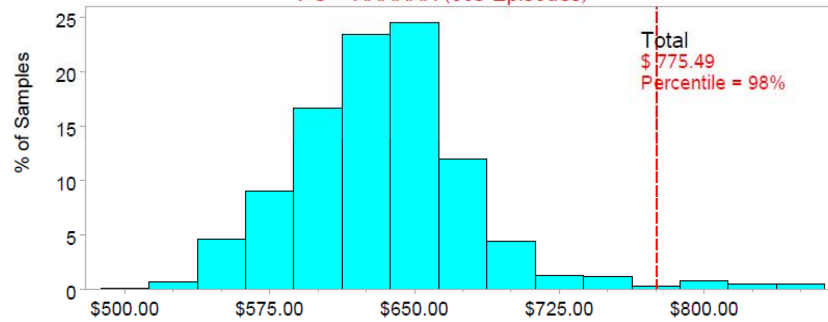
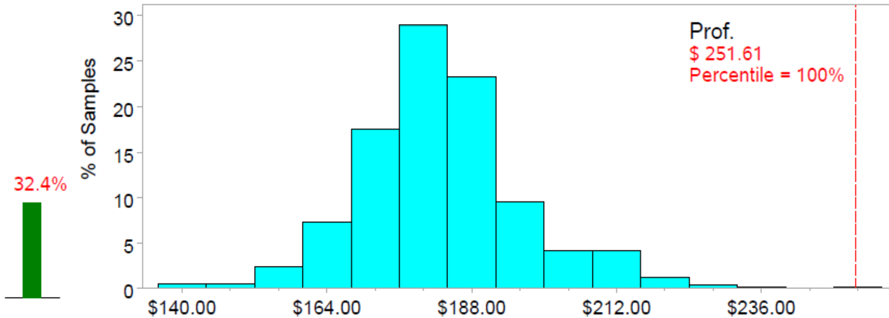
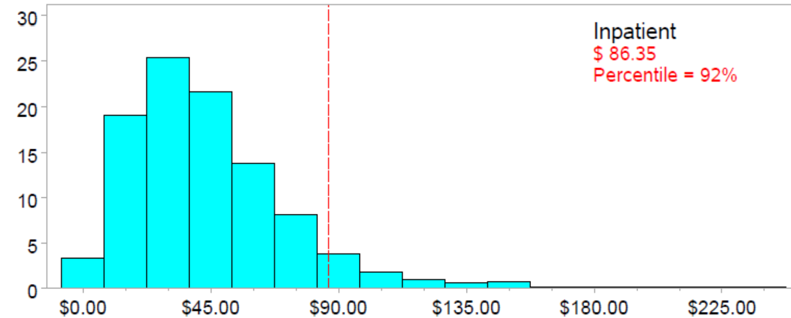
Distribution of Means: Hypertension Episodes

PO = XXXXXX (603 Episodes)



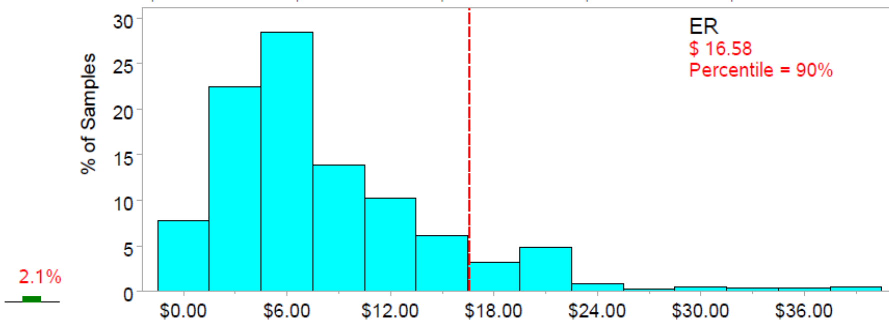
32.4%

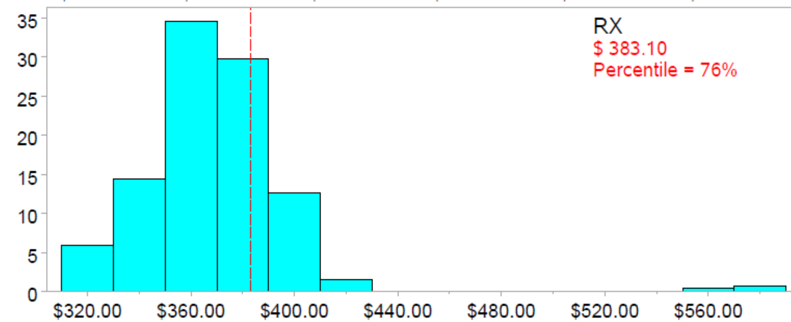




11.1%

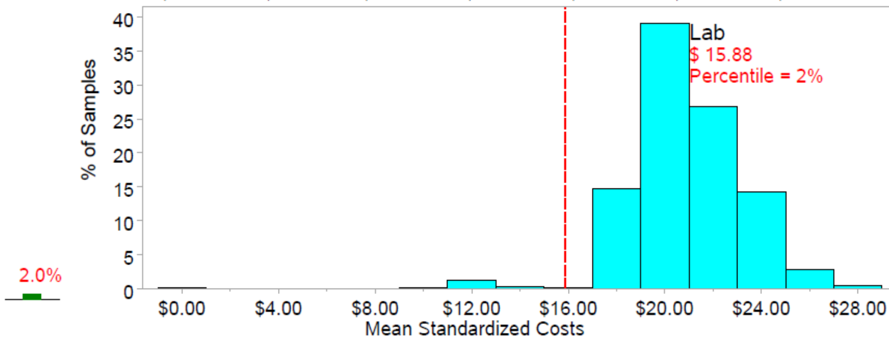
2.1%

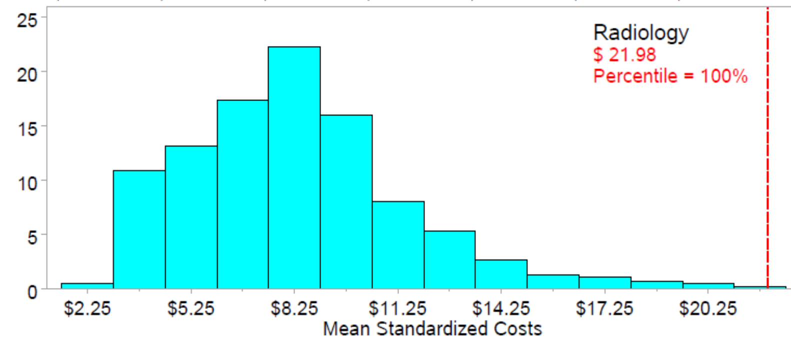




49.4%

2.0%





2.8%

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Note: The green bar next to each histogram indicates the percentage of total dollars represented by that service category.

Episode-based Efficiency – Next Steps

- Analyses of Efficiency by Physician Organization
  - Overall Efficiency (with service category drill down)
  - 5-10 Selected Conditions (with service category drill down)
- Dissemination of reports to POs by mid October
- Webcasts to explain methodology and results
- Stakeholder feedback and comment
- Review by Technical Efficiency Committee
- P4P Steering Committee decision on whether to pursue additional work on episode measures

Marketplace Context

- Affordability problems have significantly worsened since P4P started – with impacts on HMO enrollment
- Variation in resource use by geographic location and physician is now a major part of the national policy discussion
- Given these market conditions, we need powerful metrics, incentives, and results
- Opportunity to build on common metrics and improve on weaknesses of historic risk sharing

Performance-Based Contract: Principles

- Continue to measure, report, and reward quality achievement and improvement
- Increase emphasis on efficiency and affordability
- Increase potential opportunity for earnings from the current 1% of total revenue toward 10% over 5 years
- Incorporate P4P into standard contract amendment

Quality Measures

- Continue to expand the quality measure set
- Maintain current measures
  - Clinical
  - Patient Experience
  - IT-Enabled Systemness
  - Coordinated Diabetes Care
- Expand measurement areas
  - Add inpatient quality measures
  - More outcomes/specialty measures
    (currently constrained by electronic data sources and sample size)

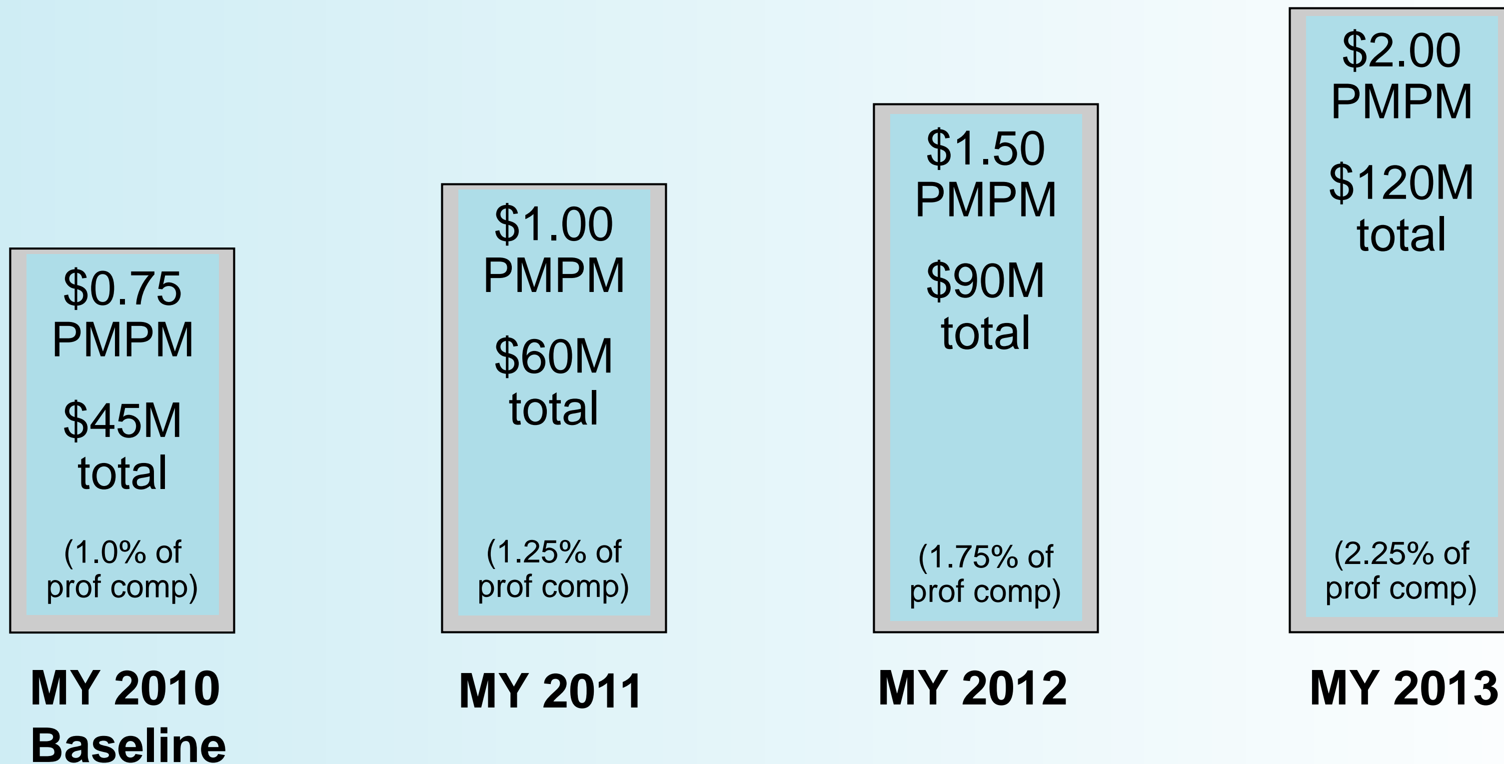
Efficiency Measures

- Expand measure set to include Total Cost of Care by MY 2011
- Current Measures:
  - Appropriate Resource Use
- Future Measure:
  - Total Cost of Care
  - Leading indicators to support quality improvement (not for payment)
    - Appropriate Resource Use
    - Episode of Care
    - Overuse of procedures

Incentive Framework

- Increase overall payment potential to 7% of compensation by MY 2013 (paid in 2014) and eventually to 10%
- Quality incentive
  - fixed budget, incrementally increasing each year
  - funded from budgeted capitation increases
  - comprises 2+% of incentive potential by MY 2013
- Efficiency incentive
  - variable budget
  - funded from on gain sharing
  - comprises 4-5% of incentive potential by MY 2013

Quality Incentive Framework



Assumptions: (1) total enrollment of 5 million members
(2) MY 2010 P4P payout of $45M (same as expected for MY 2009)
(3) professional capitation of $75 PMPM for 2010; increasing $5 per year

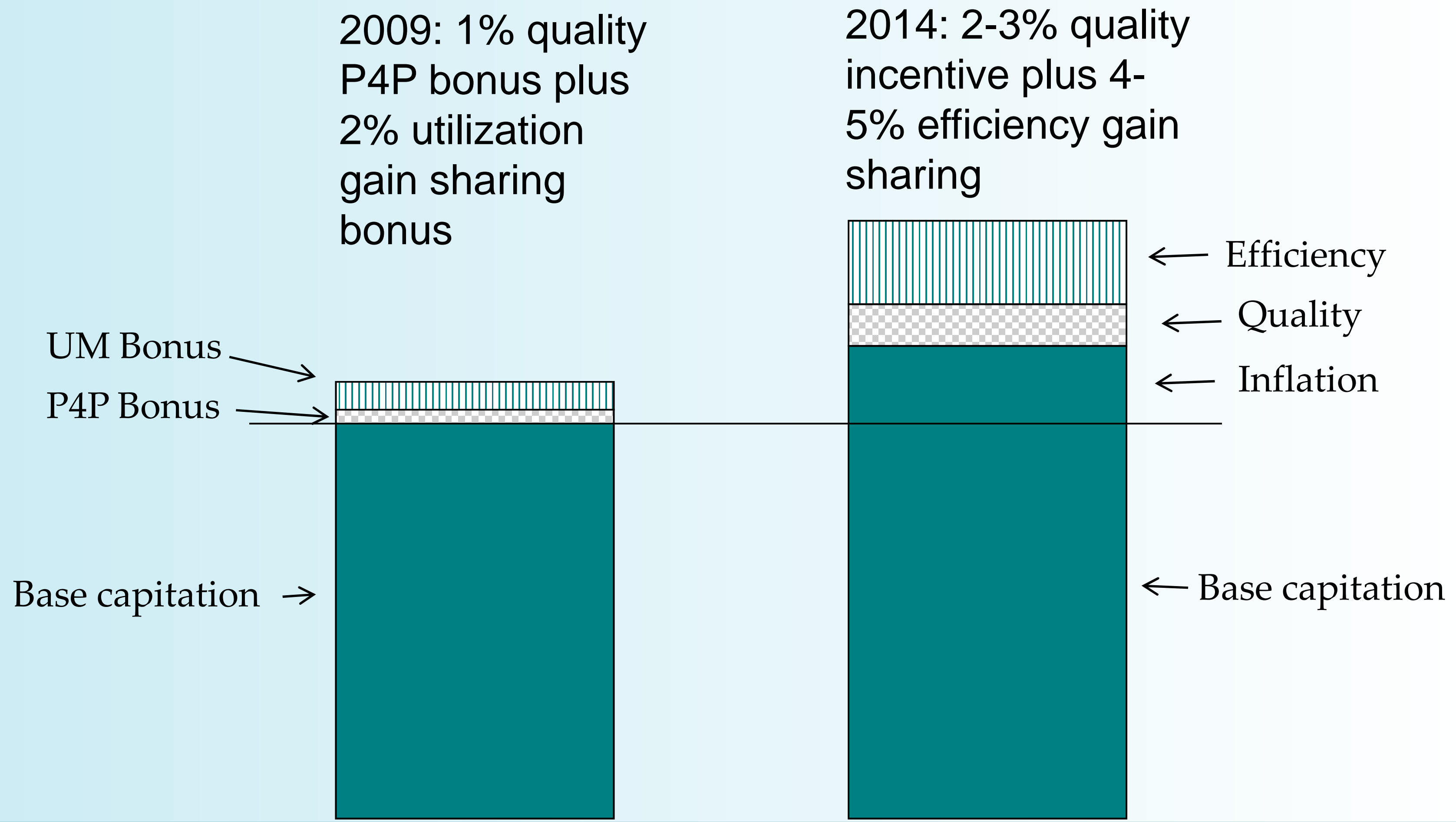
Professional vs. Global Capitation

Quality* and Efficiency Bonus
Facility, Pharmacy, Other
Professional Capitation

Quality* Bonus
Global Payment

* Use both ambulatory and inpatient quality measures

Performance Based Incentive Framework



Thank you for participating in the Eighth Annual P4P Stakeholders Meeting

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