The State of P4P Address

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Integrated Healthcare Association (IHA)

8th Annual P4P Stakeholders Meeting
Los Angeles, California
September 24, 2009

Agenda

- California P4P Program Results
- Developing/Harmonizing Efficiency Measures
- Next Generation: Performance Based Contracting

California P4P Program Evolution

2000: Stakeholder discussions started

2002: Testing Year

2003: First Measurement Year

2004: First Payment and Reporting Year

2009: Seventh Measurement Year, Sixth Reporting and Payment Year

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:

- Over 225 Groups
- 35,000 Physicians

10.5 million commercial HMO members

California P4P Measurement Evolution

Original **25** measures have expanded to **67** measures

Measurements	2003	2009
Clinical - Preventive	8	14
Clinical - Chronic	3	5
Clinical - Acute	0	4
Patient Experience	6	9
Information Technology (IT)	8	11
Systemness	0	7
Coordinated Diabetes Care	0	11
Efficiency/Resource Use	0	6
Total	25	67

CA P4P Measurement & Incentive Weighting

Domain	2009 % Payment
• Clinical	40%
– Mostly HEDIS-based	
• Coordinated Diabetes Care	20%
• Patient Experience	20%
– Use CG-CAHPS	
• IT-Enabled Systemness	20%
	100%

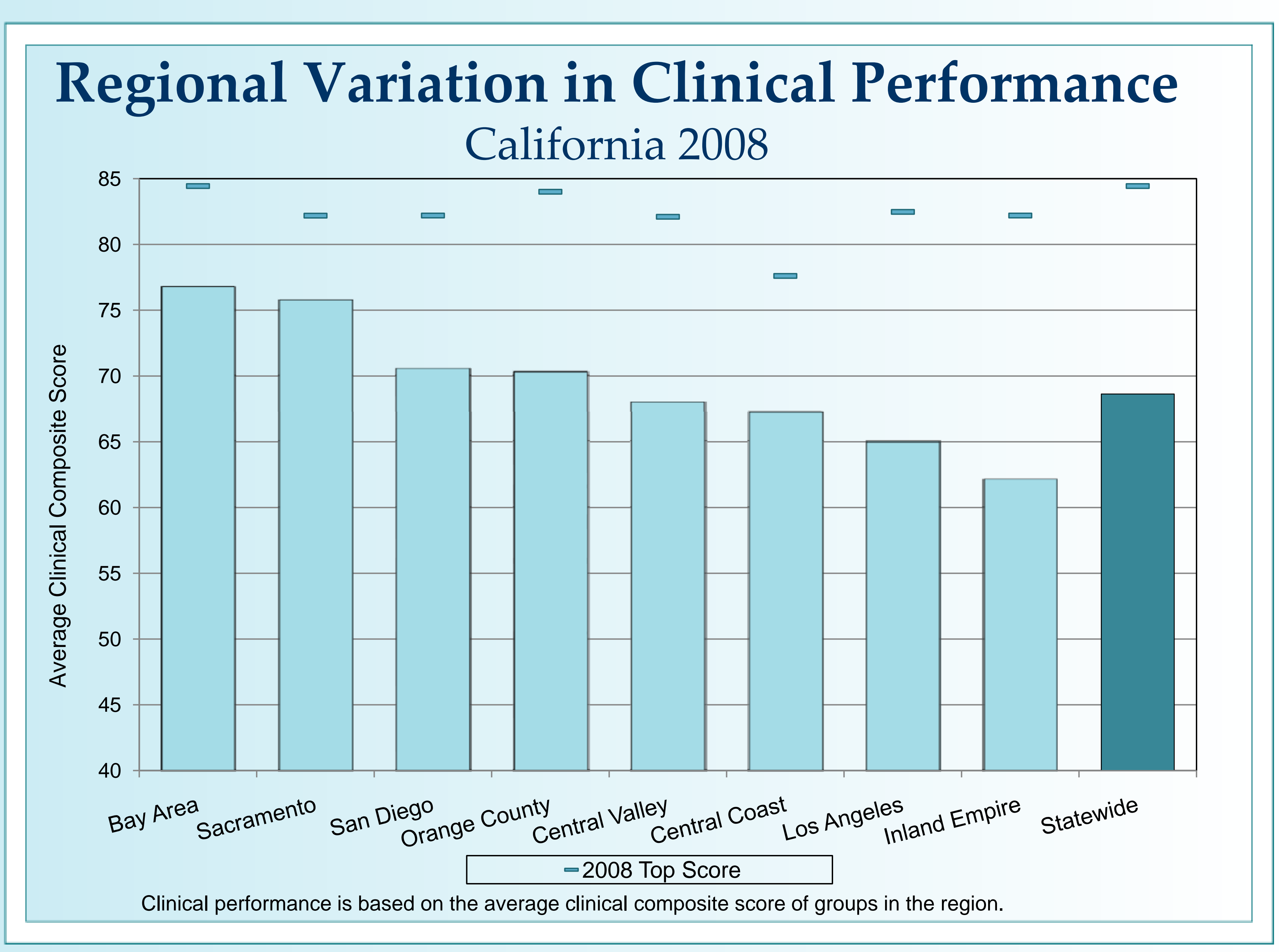
Separate Funding Pool	
• Appropriate Resource Use/Efficiency	Gain-sharing

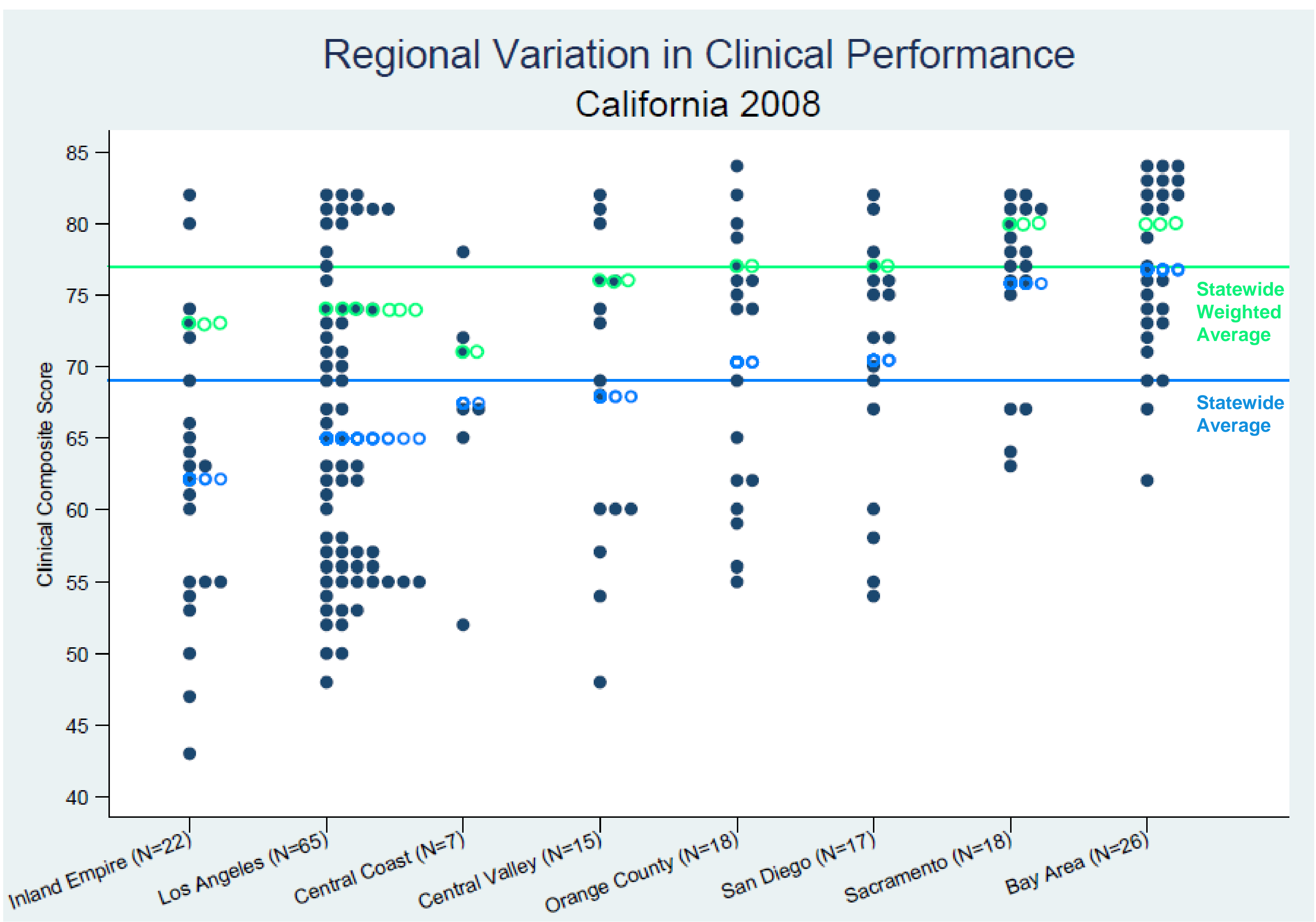
Finding/Lesson #1:
Results Consistent with National P4P Trends

- Steady incremental Clinical performance improvement
  - Average annual increase of 3 percentage points
  - 1.3 to 25.6 percentage point increases since measure inception through 2008
- Patient Experience performance remained stable, with only marginal improvement
  - Initial promising increase between 2003 and 2004 of 2.23 percentage points in average improvement
  - Little to no increase since then
- Significant information technology (IT) adoption

Finding/Lesson #2: Dramatic Regional Variation

- Clinical composite scores range from 62% to 77%
- May help explain overall mediocre performance of California in comparison to other states
- Prompted recognition and pay for improvement
  - Ronald P. Bangasser Memorial Award for Quality Improvement introduced in 2007
  - 20% of bonus pool to be allocated to improvement
- Research on socio-economic and payment disparities


Regional Variation in Clinical Performance
California 2008
Average Clinical Composite Score
85
80
75
70
65
60
55
50
45
40
Bay Area
Sacramento
San Diego
Orange County
Central Valley
Central Coast
Los Angeles
Inland Empire
Statewide
2008 Top Score
Clinical performance is based on the average clinical composite score of groups in the region.



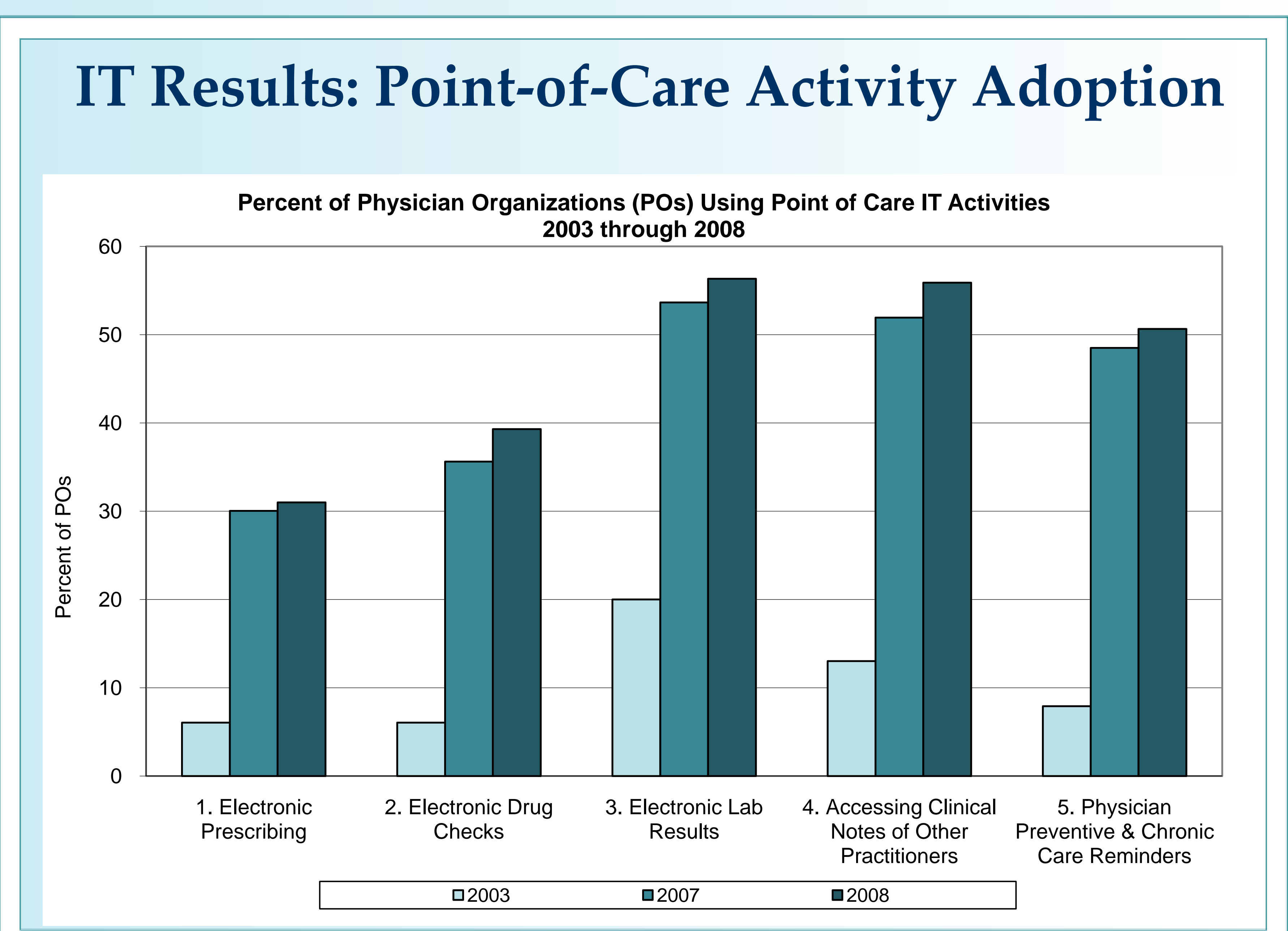
Average clinical composite score of groups in the region – includes Kaiser

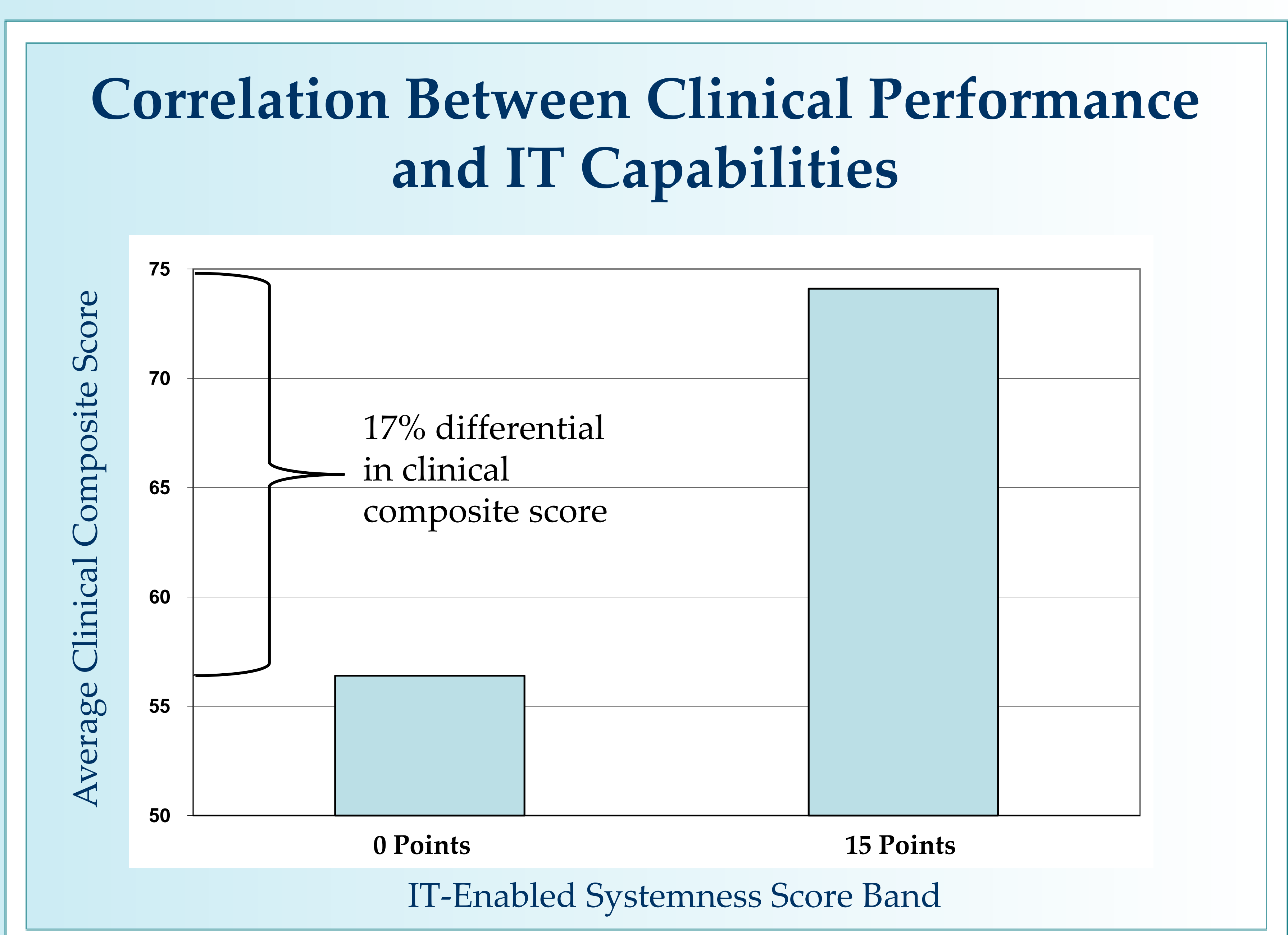
Weighted Average clinical composite score of groups in the region – includes Kaiser

Finding/Lesson #3: Accelerated IT Adoption

- Over two-thirds of physician groups demonstrated improved IT capability
- Almost one-third of physician groups demonstrated robust care management processes
- Observed correlation between IT capability and clinical performance
  - 17 percentage point difference in overall clinical score between groups earning full IT performance score and groups with no score

IT Results: Point-of-Care Activity Adoption




Correlation Between Clinical Performance and IT Capabilities
Average Clinical Composite Score
75
70
65
60
55
50
17% differential
in clinical
composite score
0 Points
15 Points
IT-Enabled Systemness Score Band

Self-Reporting Status 2008

	Enrollment	No. of Groups
SRPO [1]	4,205,046	107
Non-SRPO	813,332	94
Sub-total	5,018,378	201
Kaiser Permanente	5,457,147	28
Total	10,475,525	229

[1] SRPO: Self-Reporting Physician Organization

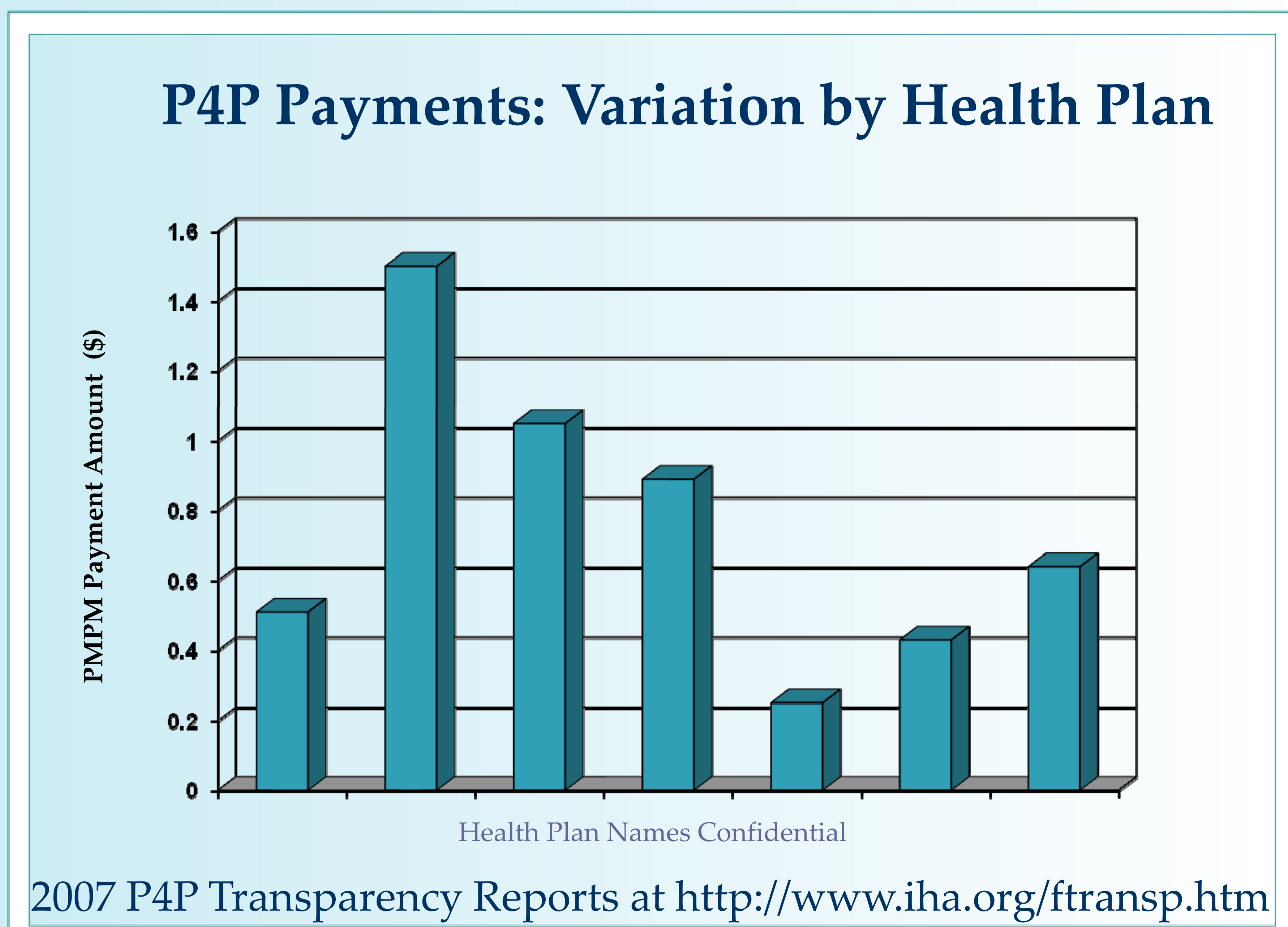
(SRPO as Percent of Total Enrollment = 83.8%)

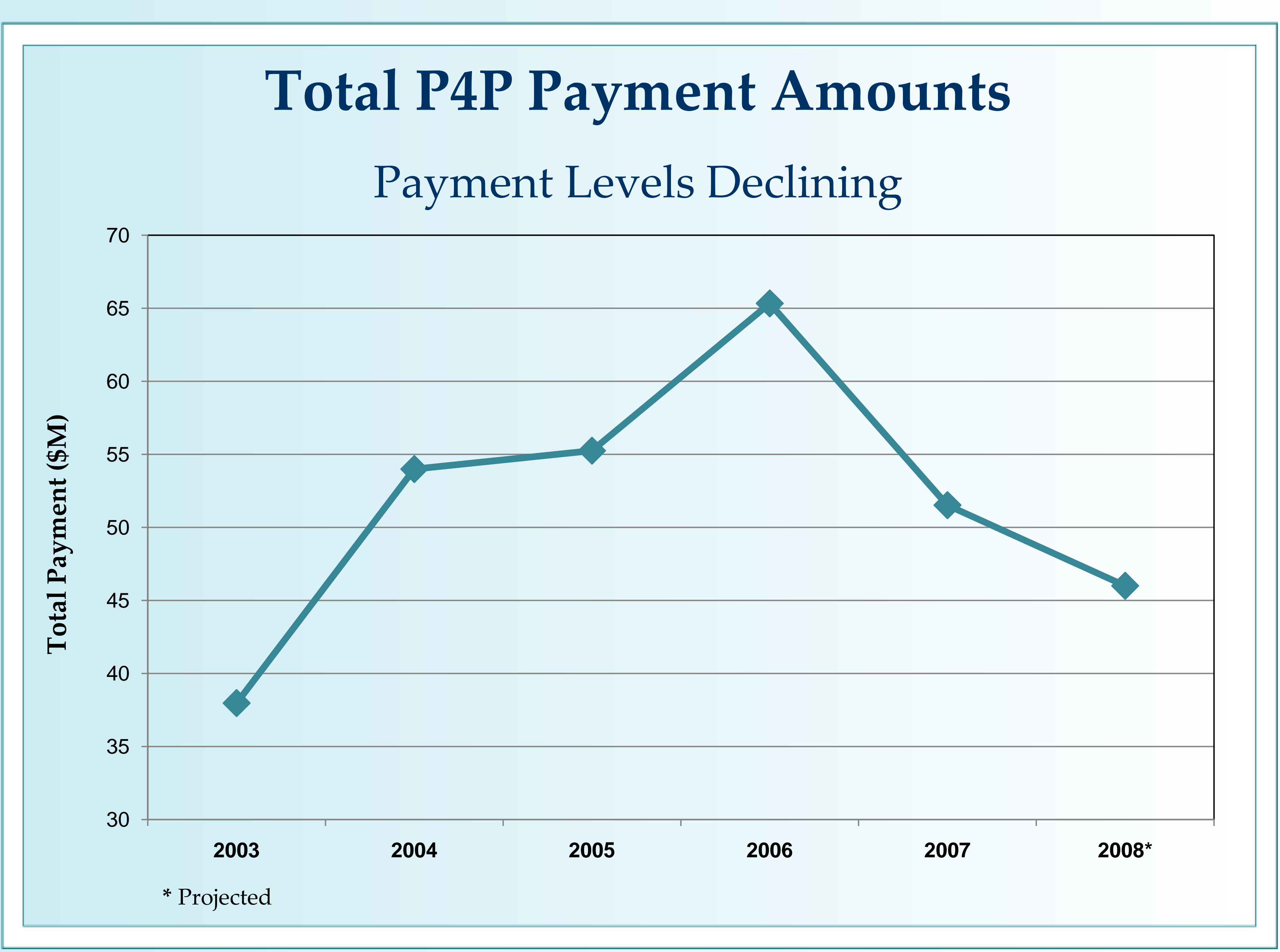
Finding/Lesson #4: Data Limitations Restrict Measurement

- Physician groups have improved data collection and created electronic repositories for clinical information
- Sharing clinical data with health plans has been challenging
  - Trust/political issues
    - Code of Conduct for Bi-Directional Data Exchange (CAPG)
  - Technical issues
  - Audit requirements
- P4P incentives included to encourage data sharing (effective MY 2009)

Finding/Lesson #5: Incentive Amounts Insufficient

- Incentive payments average ~1% of physician group compensation
- Nationally, average is about 7% (includes efficiency) for physician P4P
- Nearly eightfold difference between lowest and highest paying health plan
  - Payment variability has led to "free-rider" concerns and reduction in payments from higher paying plans
- Incentive payments are decreasing while number of measures continue to increase


P4P Payments: Variation by Health Plan
PMPM Payment Amount ($)
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
Health Plan Names Confidential
2007 P4P Transparency Reports at http://www.iha.org/ftransp.htm


Total P4P Payment Amounts
Payment Levels Declining
Total Payment ($M)
70
65
60
55
50
45
40
35
30
2003
2004
2005
2006
2007
2008*
* Projected

Number of P4P Measures and Bonus Payments

	MY 2003	MY 2008
Clinical	11	24
Patient experience	6	9
IT	8	11
Systemness	0	8
Coord Diab Care	0	10
Efficiency	0	0
Total	25	62
Total Bonus $	$38M	$45M (est.)
Total Bonus $ Per Measure	$1.52M	$726K

Finding/Lesson #6: Stakeholder Engagement

- **California Physician Groups:**
  - Highly engaged and rate program as important; mean score 4.0*
- **California Health Plans:**
  - Rate success as only modest; mean score 2.5*
- **Nationally:**
  - Strong belief by program sponsors that P4P works to change behavior

** Source: Health Affairs Volume 28 , Number 2, "Taking Stock Of Pay-For-Performance: A Candid Assessment From The Front Lines," C. Damberg, K. Raube, S. Teleki, and E. dela Cruz*

Pay for Performance (P4P): A Foundation for Payment Reform

- Standardization of quality measures ✓
- Aggregation of payer data for measurement ✓
- Improved electronic data collection – merging administrative and clinical data streams ✓
- Public reporting of performance ✓
- Cultural acceptance of measurement and public reporting by physicians and hospitals ✓
- Development of utilization/efficiency metrics ✓

Evolution of payment reform

Past and Emerging Models of Accountability in Provider Payments

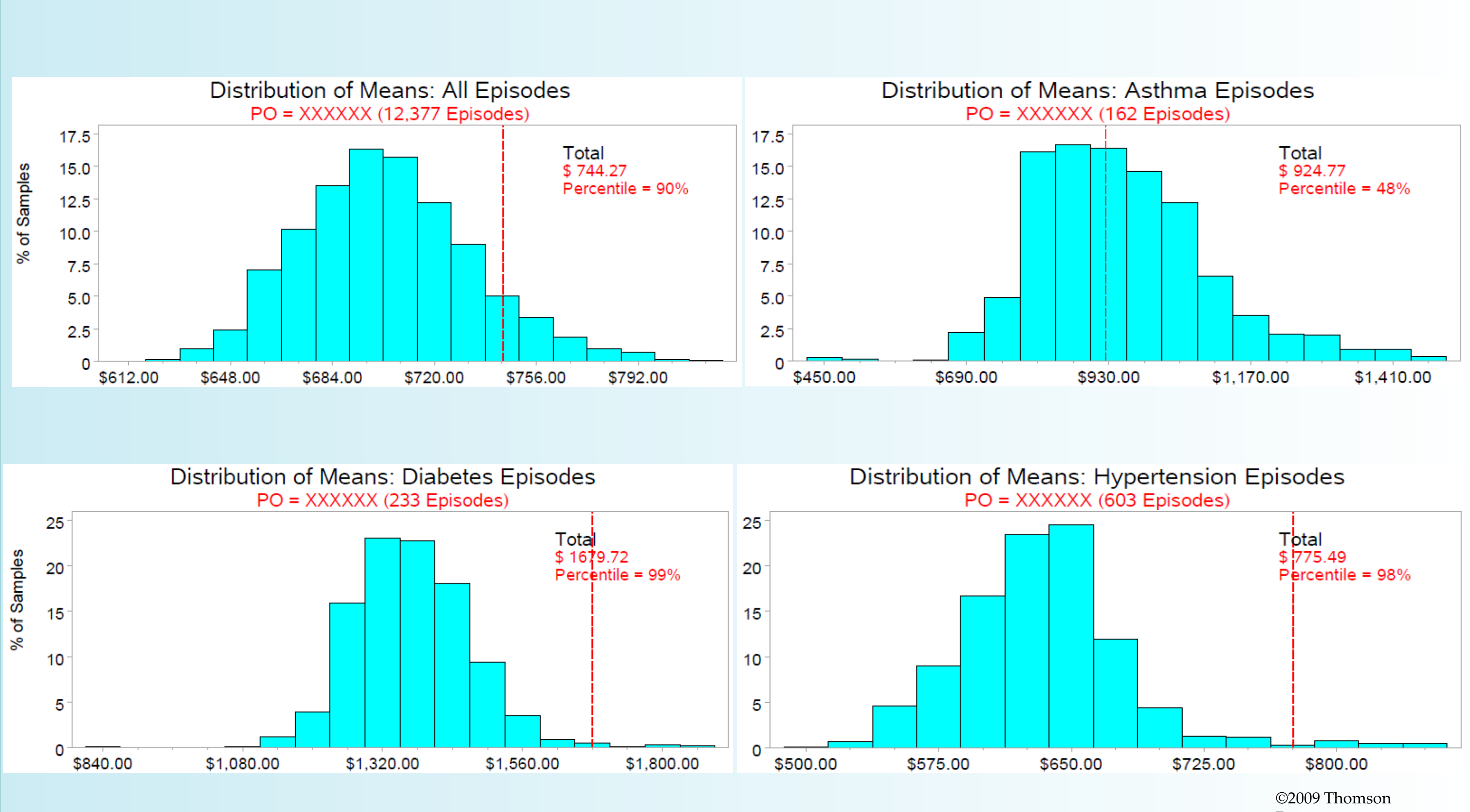
Supporting Better Performance		Paying for Better Performance		Paying for Higher Value	
Pay for reporting. Payment for reporting on specific measures of care. Data primarily claims-based.	**Payment for coordination.** Case manage-ment fee based on practice capabilities to support preventive and chronic disease care (e.g., medical home, interoperable HIT capacity).	**Pay for performance.** Provider fees tied to one or more objective measures of performance (e.g., guideline-based payment, nonpayment for preventable complications).	**Episode-based payments.** Case payment for a particular procedure or condition(s) based on quality and cost.	**Shared savings with quality improvement.** Providers share in savings due to better care coordination and disease management.	**Partial or full capitation with quality improvement.** Systems of care assume responsibility for patients across providers and settings over time.

Developing/Harmonizing
Efficiency Measures

P4P Efficiency Measurement

- Original Intent:
  - Episode and population-based measures
  - Standardized and actual costs
- Findings/Conclusions:
  - Data limitations
  - Small numbers issue
  - Data does not yet support episode measures for payment but may support QI
- Current Measure Strategy:
  - Start with Appropriate Resource Use measures
  - Move to Total Cost of Care

Comparing Actual to Expected Costs Across Conditions



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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 to POs by end of October
- Encourage feedback and comment
- Review by Technical Efficiency Committee
- Decision to continue episode measurement or not

Appropriate Resource Use Measures

1. Inpatient Utilization—Acute Care Discharges
2. Inpatient Utilization—Bed Days
3. Outpatient Surgeries Utilization
4. Emergency Department Visits
5. Inpatient Readmissions within 30 Days
6. Generic Prescribing

2008 – Baseline Measurement Year

2009 – First Measurement Year

2010 – Full Implementation

Total Cost of Care

- Measure by PO using standardized and **actual cost** (risk adjusted)
- Aggregate claims/encounter data across plans

2010 – Baseline Measurement Year

2011 – First Measurement Year

2012 – Full Implementation

Next Generation: Performance Based Contracting

Migrate P4P to Performance-based Contract

- Incorporate P4P into standard contract amendment
- Increase potential bonus opportunity from the current 3% (1% P4P/2% UM) of total revenue to 7% over 5 years
- Increase emphasis on efficiency and harmonize efficiency measures
- Develop information to support benefit design changes to engage consumers

Performance-Based Contract: CAPG Feedback

- Favorably influence rate trend for HMO
- Stimulate responsible and manageable acceptance of risk by groups
- Recognize regional variation in cost and population demographics
- Uphold robust stimuli for high efficiency groups; stimulate improvements in less efficient groups
- Avoid drawn-out contractual complexity
- Protect gains in quality improvement, HIT, provider engagement

Performance-Based Contract Overview

- Quality
  - Add inpatient measures
  - Increase bonus contribution annually, funded from budgeted capitation increases
- Efficiency
  - Use Total Cost of Care to determine gain-sharing (2011)
  - Provide leading indicators such as Appropriate Resource Use, Episodes, etc. to support improvement
  - Funded from gain sharing
- Consumer Engagement
  - Quality and Total Cost of Care = Value
  - Tiering/Variable Co-pays

Quality Incentive Framework

MY 2010 Baseline	MY 2011	MY 2012	MY 2013
$0.75 PMPM	$1.00 PMPM	$1.50 PMPM	$2.00 PMPM
$45M total	$60M total	$90M total	$120M total
(1.0% of prof comp)	(1.25% of prof comp)	(1.75% of prof comp)	(2.25% of prof comp)

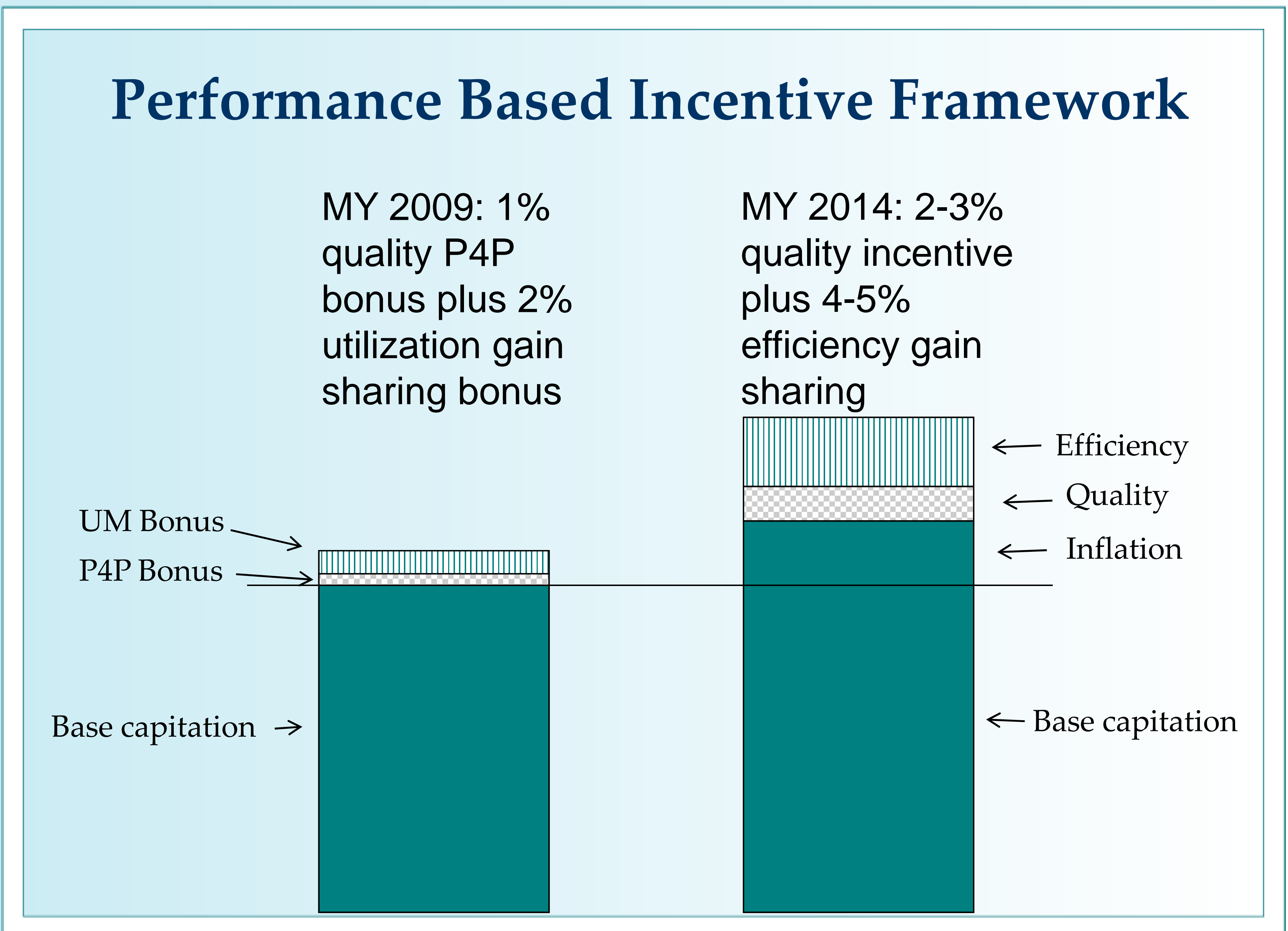
Assumptions: (1) total enrollment of 5 million members
(2) MY 2010 P4P payout of $45M (same as expected for MY 2009)
(3) professional capitation of $75 PMPM for 2010; increasing $5 per year

Efficiency Framework

	MY 2009	MY 2011
Efficiency Measures for Payment	Appropriate Resource Use Measures 1. Readmission in 30 Days 2. Discharges PTMY 3. Bed Days PTMY 4. % Outpatient Surg in ASC 5. ER Visits PTMY 6. Generic Prescribing	Total Cost of Care
Incentive payment	~2%	4-5%
Leading Indicators for Process Improvement	NA	Appropriate Resource Use Measures Episodes of Care Overuse of Procedures

Consumer Engagement

- Develop value tiers for POs
  - Stakeholders agree on common criteria based on quality and efficiency performance metrics
- Implement tiered co-pay benefit design starting in 2012



Performance Based Incentive Framework
MY 2009: 1% quality P4P bonus plus 2% utilization gain sharing bonus
MY 2014: 2-3% quality incentive plus 4-5% efficiency gain sharing
UM Bonus
P4P Bonus
Base capitation
Efficiency
Quality
Inflation
Base capitation

California Pay for Performance

For more information:

www.iha.org

(510) 208-1740

Pay for Performance has been supported by major grants from the California Health Care Foundation