Value Based Pay for Performance Results for Measurement Year 2013

September 2014
Program Overview
Value Based Pay for Performance

$500m paid out

200 Medical Groups and IPAs
35,000 physicians

10 Plans

9 Million Californians
Stakeholder Governance

Committee Structure for Health Plan & Physician Organization Involvement

Governance Committee

- Technical Payment Committee
  Contracting, Actuarial, and Medical Economics Experts
- Technical Measurement Committee
  Clinical and Data Reporting Experts

IHA Staff + Partners

TRUVER HEALTH ANALYTICS
NCQA
IHEA ADVOCATE
Core Program Elements

The California P4P program aims to create a compelling set of incentives that will drive improvements in clinical quality, resource use, and patient experience through:

- A Common Set of Measures
- Health Plan Incentive Payments
- A Public Report Card
- Public Recognition Awards
Program Evolution

- **2003**: Payment for Improvement added – Quality only
- **2007**: Appropriate Resource Use measures added
- **2009**: Value Based P4P – Quality and Resource Use integrated into single incentive program
- **2011**: Total Cost of Care measure added
- **2013**: First payments for Value Based P4P
Transition to Value Based P4P

**P4P Classic**
- Emphasis on quality improvement
- Separate incentives for quality and resource use
- Standardizes health plan quality measures and payment methodology

**Value Based P4P**
- Emphasis on affordability and value
- Combined incentive for quality and resource use
- Standardizes health plan resource use measures, as well as quality measures and payment methodology
## Physician Organization Participation in P4P

<table>
<thead>
<tr>
<th>Total Participating Physician Organizations (POs)</th>
<th>206</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participation in:</strong></td>
<td></td>
</tr>
<tr>
<td>• Self-Reporting</td>
<td>152 (73.8%)</td>
</tr>
<tr>
<td>• Meaningful Use of Health IT Survey</td>
<td>160 (77.7%)</td>
</tr>
<tr>
<td>• Patient Experience Survey</td>
<td>162 (78.6%)</td>
</tr>
<tr>
<td><strong>Type of Organization</strong></td>
<td></td>
</tr>
<tr>
<td>• Medical Group Practice</td>
<td>33.0%</td>
</tr>
<tr>
<td>• Independent Practice Association (IPA)</td>
<td>49.0%</td>
</tr>
<tr>
<td>• Foundation Model</td>
<td>6.0%</td>
</tr>
<tr>
<td>• Mixed Model (MG, IPA, or Foundation)</td>
<td>12.0%</td>
</tr>
<tr>
<td><strong>Total PO HMO/POS Enrollment (as of 12/31/13)</strong></td>
<td>9.6 million</td>
</tr>
<tr>
<td>• Bay Area, Sacramento</td>
<td>3.2 Million</td>
</tr>
<tr>
<td>• Central Coast, Central Valley, North</td>
<td>728,883</td>
</tr>
<tr>
<td>• Inland Empire</td>
<td>1.1 Million</td>
</tr>
<tr>
<td>• Los Angeles</td>
<td>2.7 Million</td>
</tr>
<tr>
<td>• Orange County, San Diego</td>
<td>1.7 Million</td>
</tr>
</tbody>
</table>
Measurement Approach

• **Measures:**
  - Use nationally vetted, standardized measures where possible
  - Test new measures and seek public comment prior to adoption
  - Move toward outcome measures

• **Data Collection:**
  - Focus on electronically available data

• **Data Aggregation:**
  - Combine results across plans to create a total patient population for each physician organization
  - Allows more complete and robust measurement and reporting
# Data Sources and Collection

## Quality Measures

### Clinical Quality
- Organization-level results reported by health plan and physician organization
- Not a sample – all members included
- Audited

### Patient Experience
- Clinician and Group CAHPS survey of physician organization members
- Administered by CHPI

### Meaningful Use of Health IT
- Survey of physician organizations
- Compiled by NCQA

## Resource Use Measures

### Appropriate Resource Use
- Health plan submits complete claims and encounters for all members
- Calculated by Truven Health Analytics

### Total Cost of Care
- Health plan supplements claims and encounter data with member-level total payments
- Calculated by Truven Health Analytics
Quality Results
Measurement Year 2013
Quality Composite Components

Clinical
Process and outcomes measures focused on six priority clinical areas
- Prevention
- Cardiovascular
- Diabetes
- Maternity
- Musculoskeletal
- Respiratory

Patient Experience
Patient ratings of care overall and for five components:
- Communicating with Patients
- Coordinating Care
- Health Promotion
- Helpful Office Staff
- Timely Care and Service

Meaningful Use of Health IT
Percent of providers meeting intent of CMS Meaningful Use core requirements
Steady, Gradual Gains on Clinical Quality

Performance for the average physician organization increased for all—but one—clinical measures in 2013. Below are example measure results from each clinical priority area for 2008-2013.
Performance Mixed Against National Average

P4P physician organization performance is mixed when compared against the average HMO/POS HEDIS benchmarks. Below are five example measures.

- LDL Control
- HbA1C Control <8.0%
- Use of Imaging Studies for Low Back Pain
- Colorectal Cancer Screening
- Appropriate Treatment for Children with Upper Respiratory Infection

Clinical Priority Area:
- Cardiovascular
- Diabetes Care
- Musculoskeletal
- Prevention
- Respiratory

Measure Rate (%)

Avg 2013  HMO/POS National Avg 2013
Of the clinical measures, Evidence-Based Cervical Cancer Screening improved the most in 2013. The underlying indicators show that the improvements came from POs decreasing the rate of over screened women. Cervical cancer is slow growing; over testing can result in false positives that lead to increasingly invasive procedures which cause unnecessary anxiety for the patient and add costs to the health care system.
Comparing rates reported by health plans and physician organizations highlights persisting data gaps. Physician organizations often have better lab and registry data, while plans have better pharmacy data. The resulting pattern in the data indicates the need for better data sharing between plans and physician organizations.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Health Plan Reported Rate</th>
<th>Physician Organization Reported Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Immunization Status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combination 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Care: Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control &lt;140/90 mm Hg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Care: HbA1c Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 8.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optimal Diabetes Care: Combo 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optimal Diabetes Care: Combo 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of Days Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Diabetes Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of Days Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RAS Antagonists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of Days Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statins</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lab and Registry Based Measures

Pharmacy Based Measures
The correlation between HbA1c screening and control is 0.78 (p<0.0001). Physician organizations that do a better job making sure diabetic patients receive blood sugar tests tend to have a higher proportion of diabetic patients whose blood sugar is controlled.
Patient experience scores reflect the percent of patients selecting the “top box” score for questions related to specific components of care. The physician organization average was relatively stable from 2012 to 2013 with Overall Ratings of Care showing a slight uptick from 65.4% to 66.2%.
Overall Ratings of Care scores in 2013 ranged from 49 to 80, with half of physician organization scores falling between 62.0 and 70.8. This is a much tighter distribution than for most clinical measures.
Strong but Varied Adoption of Health IT

The average P4P physician organization in 2013 had 64% of their providers meeting the intent of the Meaningful Use Stage 1 core requirements. Physician organizations varied widely – from 9 organizations with fewer than 10% of providers meeting intent to 21 organizations with all providers meeting intent.
Cost and Resource Use Results
Measurement Year 2013
Total Cost of Care Measure

- **Description:** Total amount paid to any provider to care for all members of a physician organization (PO) for a year
  - Professional, facility (inpatient and outpatient), pharmacy, and ancillary costs
  - Capitation, fee-for-service, member cost share, admin. adjustments
- **Outliers:** Costs above $100,000 per member per year truncated
- **Risk adjustment:** Concurrent DCG Relative Risk Score with $100K truncation adjusts for age, gender, and health status
- **Other adjustment:** CMS Hospital Wage Index derived Geographic Adjustment Factor for geographic pricing differences
- **Exclusions:**
  - Mental health and chemical dependency services
  - Acupuncture and chiropractic services; dental and vision services
  - P4P quality incentive payments
Total Cost of Care Averages $3,817, up 2.5%

The Bay Area and Sacramento region had the highest average per-member cost in 2013 at $4,390, while the Inland Empire region had the lowest at $3,308. All regions had a relatively modest year-over-year cost trend, with the lowest increase of 1.8% in Los Angeles, and the highest increase of 4.0% in Orange County and San Diego.

<table>
<thead>
<tr>
<th>Region</th>
<th>POs</th>
<th>2013 Member Years</th>
<th>2013 Average TCC</th>
<th>2012 Average TCC</th>
<th>2012-2013 Average TCC Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bay Area, Sacramento</td>
<td>27</td>
<td>556,034</td>
<td>$4,390</td>
<td>$4,276</td>
<td>2.7%</td>
</tr>
<tr>
<td>Central Coast, Central Valley, North</td>
<td>24</td>
<td>244,519</td>
<td>$3,983</td>
<td>$3,901</td>
<td>2.1%</td>
</tr>
<tr>
<td>Inland Empire</td>
<td>26</td>
<td>292,857</td>
<td>$3,308</td>
<td>$3,216</td>
<td>2.9%</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>63</td>
<td>814,090</td>
<td>$3,592</td>
<td>$3,529</td>
<td>1.8%</td>
</tr>
<tr>
<td>Orange County, San Diego</td>
<td>36</td>
<td>611,120</td>
<td>$3,775</td>
<td>$3,628</td>
<td>4.0%</td>
</tr>
<tr>
<td>P4P Population</td>
<td>176</td>
<td>2,518,620</td>
<td>$3,817</td>
<td>$3,722</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

Information is based on data from six health plans and only reflects members with pharmacy coverage.
There is wide variation in Total Cost of Care across physician organizations within a region. Los Angeles showed the most variation, ranging from $1,900 to $6,000 PMPY. Bay Area/Sacramento and Orange County/San Diego showed the least – but still substantial – variation, with a roughly $2,000 range across organizations.

(1) Excludes Kaiser Permanente’s 28 POs across California.
(2) Risk Adjusted TCC is geography adjusted using CMS’ Hospital Wage Index Geographic Adjustment Factor.
The median Total Cost of Care for the smallest physician organizations is $3,517 per member per year (PMPY), compared to $3,886 PMPY for the largest physician organizations. However, the largest organizations have the least variation in cost, reflecting the higher reliability of measurement for larger organizations.
Weak Correlation between Cost and Quality

Cost and quality performance is not correlated, regardless of a physician organization’s region. The correlation between Quality Achievement Score and Geography & Risk-Adjusted Total Cost of Care for 2013 is very low and not significant (correlation = +0.054, p<0.4905).
In 2013, the top one percent of costliest patients cared for by physician organizations participating in P4P accounted for 28% of total costs. The costliest five percent of patients accounted for 47% of total costs, while the costliest ten percent accounted for 57.4% of costs. The lowest cost half of patients accounted for only 10% of costs.
Steady Decline in Average Cost Increase

The percent change in the average Total Cost of Care has consistently increased at a decreasing rate: from an initial double digit increase of 10.9% from 2008-2009 to an increase of 2.7% for 2012-2013. While this increase is closer to it still exceeds the increase in CPI from 2012-2013 of 1.5%.

Note: Changes to plan data and measures methodologies may affect comparisons across years.
A large degree of variability exists across physician organizations in their 2012-2013 cost trends, including over 33% of physician organizations with decreased costs.
Overall, lower cost trends were observed for physician organizations with higher baseline costs. There is a correlation of -0.119 between the 2012 Geography & Risk-Adjusted TCC and the 2012-2013 TCC Trend (p<0.0002). However, some high cost organizations had a double-digit TCC trend.
Relative risk scores are the basis for risk adjustment in the Total Cost of Care and several ARU measures. PO risk scores are strongly correlated with encounter rates (correlation of +0.3963, p<0.0001). Higher risk scores reflect a sicker population and more complete diagnosis capture, resulting in higher expected utilization and —in turn— better performance.
Appropriate Resource Use Measures

- **Inpatient Utilization:** Acute Care Discharges, Bed Days, LOS
- **All-Cause Readmissions**
- **Emergency Department Visits**
- **Maternity:** Cesarean Section Rate, VBAC Rate*
- **Outpatient Procedures Utilization — % Done in Preferred Facility**
- **Generic Prescribing**
  - Antidepressants
  - Antihyperlipidemias
  - Antimigraine
  - Anti-Ulcer
  - Anxiety/Sedation—Sleep Aids*
  - Cardiac—Hypertension and Cardiovascular
  - Diabetes
  - Nasal Steroids
  - Overall

- **Frequency of Selected Procedures**
  - Back Surgery*
  - Total Hip Replacement*
  - Total Knee Replacement*
  - Bariatric Weight Loss Surgery*
  - PCI*
  - Carotid Catheterization*
  - CABG*
  - Cardiac Endarterectomy*
Discharges are Down, Readmissions are Up

Inpatient discharges and bed days have both decreased for each of the last three years, though reductions are smaller in 2013 than they were for the past two years. Inpatient readmissions rose 4.5%, while emergency department visits were up 1.7%.
Increases Continue in Generic Prescribing

Generic prescribing rates have consistently increased overall and across five of the seven therapeutic areas measured in P4P. The two exceptions are anxiety/sedation and cardiovascular, where the generic prescribing rate decreased from 2012 to 2013 due to a change in the measure specifications.
Most of the “Frequency of Selected Procedures” measures registered a slight uptick or held steady in 2013 after across-the-board declines in 2012. The two exceptions were Angioplasty and Bariatric Weight Loss Surgery, which both continued to decline.
Value Based P4P Design & Results
## Value Based P4P Overview

<table>
<thead>
<tr>
<th>Does the PO qualify?</th>
<th>Did the PO improve?</th>
<th>How much is the PO’s incentive payment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Gate</td>
<td>Resource use compared to prior year</td>
<td></td>
</tr>
<tr>
<td>TCC Trend Gate</td>
<td>Selected inpatient, outpatient, ED, and prescribing measures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Net savings for all ARU measures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality determines share of savings</td>
<td></td>
</tr>
</tbody>
</table>
Value Based P4P Design

- **Performance gates**
  - Quality
  - Total Cost of Care Trend
- **Calculate share of savings based on resource use**
- **Adjust share of savings for Quality**
- **Sum adjusted shared savings**
Value Based P4P Design – Does the PO Qualify?

**Step 1 – Performance Gates**

- **Quality Composite Score above gate**
  - Threshold = 10% of possible points
    - 50% - Clinical
    - 20% - Patient Experience
    - 30% - Meaningful Use of Health IT
  - Use better of attainment or improvement points

- **Total Cost of Care Trend below gate**
  - Threshold = Consumer Price Index + 3%
  - Year-over-year trend
  - Using Total Cost of Care (risk-adjusted) including 85% confidence interval

**Step 1a – Quality Gate**
- yes → PO does not qualify for value Based P4P incentive
- no → Step 1b – Total Cost of Care Trend Gate

**Step 1b – Total Cost of Care Trend Gate**
- yes → PO does not qualify for value Based P4P incentive
- no → Step 2 – (repeat for each ARU measure) – Calculate Base Incentive Amount using Appropriate Resource Use (ARU) Measures

**Step 2**
- Step 3a
  - Apply Quality Adjustment to base Incentive Amount

**Step 3a**
- Sum Incentive Amounts across ARU Measures; negative amounts offset positive amounts

**Step 4**
- Value Based P4P SHARED SAVINGS INCENTIVE
Value Based P4P Design – Did the PO improve?

Step 2 – Calculate shared Savings amount

Measures Not Risk-Adjusted
- “MORE is better”
  - % Outpatient Procedures in Preferred Facility
  - Generic Prescribing

Risk-Adjusted Measures
- “LESS is better”
  - Acute Care Discharges
  - Inpatient Bed Days
  - All-Cause Readmissions
  - ED Visits
Value Based P4P Design - How much is the PO's incentive payment?

Step 3 – Adjust Share of Savings for Quality

- Same Quality score as used for Quality Gate
- **High** quality *increases* share of savings
- **Low** quality *decreases* share of savings
Step 4 – Sum Shared Savings Across Measures

- Each measure’s shared savings can be positive or negative
- Negative amounts offset positive amounts
  - If sum of all measures >$0, physician organization earns incentive
  - If sum of all measures <$0, physician organization earns no incentive
Value Based P4P Design

To earn ANY award:
- Meet minimum level of quality
- Below TCC trend gate
- Net improvement on resource use measures

To MAXIMIZE award:
- Greater resource use improvement
  - Complete diagnosis coding and risk capture
- Higher quality

\[
\begin{align*}
\text{Step 1a – Quality Gate} & \\
\text{Step 1b – Total Cost of Care Trend Gate} & \\
\text{Step 2 – (repeat for each ARU measure)} & \text{Calculate Base Incentive Amount using Appropriate Resource Use (ARU) Measures} \\
\text{Step 3a} & \text{Apply Quality Adjustment to base Incentive Amount} \\
\text{Step 4} & \text{Sum Incentive Amounts across ARU Measures; negative amounts offset positive amounts} \\
\text{Value Based P4P} & \text{SHARED SAVINGS INCENTIVE}
\end{align*}
\]
## Value Based P4P – Full-Risk POs

- **Plan Option #1:**
  - Pass both performance gates
  - Incentive based on quality

- **Plan Option #2:**
  - Pass both performance gates
  - Value Based P4P incentive for generic prescribing only

- **Plan Option #3:**
  - Pass both performance gates
  - Incentive based on value, defined as quality adjusted by cost

### Option #3 Design

<table>
<thead>
<tr>
<th>Step 1a – Quality Gate</th>
<th>PO does not qualify for Value Based P4P incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>PO does not qualify for Value Based P4P incentive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 1b – Total Cost of Care Trend Gate</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use Quality Composite Score</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 3a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apply adjustment for Total Cost of Care (amount)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distribute incentives based on the cost-adjusted quality score</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Value Based P4P FULL-RISK PO INCENTIVE</th>
</tr>
</thead>
</table>
Physician organizations must achieve a Quality Composite Score of 10 or higher in order to be eligible for incentives in the Value Based P4P program. This is the equivalent of earning one point for attainment or improvement on each measure. Out of 198 organizations, 168 met the threshold for 2013.
Step 1B: Most Pass the Cost Trend Gate

The recommended Total Cost of Care (TCC) Trend Gate threshold for 2013 of 5.2% is based on a rolling three-year average of CPI plus 3 percentage points. Using this threshold and including an 85% confidence interval, 73% of physician organizations would meet the Value Based P4P TCC Trend Gate in 2013.

Note: trends shown in the chart are the 2012-2013 cost trend; performance at the TCC Trend Gate is assessed using the lower limit of the 85% confidence interval of the TCC trend. The 26.9 percent of plan-PO dyads (158 of 588 total across five health plans) that missed the 5.3% cost trend gate are based on the confidence interval around trend; 46.1 percent (271 of 588 total) of plan-PO dyads had trends above the 5.3% threshold.
Step 2: Most Improve on Multiple Resource Use Measures

Value Based P4P incentives are driven by net savings (i.e. improvement) across Appropriate Resource Use measures. Over 55% of plan-physician organization dyads showed improvement on 3 or more ARU measures; 4.0% with improvement on all 5 measures.

Five measures compared include Inpatient Bed Days, All-Cause Readmission, ED Visits, Outpatient Surgery Utilization, and Generic Prescribing – Overall.
Step 3: Most That Pass Gates Earn 40-50% of Savings

Below is the quality-adjusted share of savings for the 64% of plan-physician organization (PO) dyads that pass both the Quality and TCC Trend Gates (teal). Most of these plan-PO dyads would receive a 40-50% share of total savings earned from Appropriate Resource Use improvement. Also shown are the plan-POs that did not pass the quality (red), TCC trend (blue), or both (orange) gates.

<table>
<thead>
<tr>
<th>Quality Composite Score</th>
<th>N/A</th>
<th>10-14</th>
<th>15-23</th>
<th>24-32</th>
<th>33-42</th>
<th>43-51</th>
<th>52-60</th>
<th>61-69</th>
<th>70-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Plan-POs</td>
<td>Did Not Pass Gates</td>
<td>32.5%</td>
<td>35%</td>
<td>40%</td>
<td>45%</td>
<td>50%</td>
<td>55%</td>
<td>60%</td>
<td>65%</td>
<td>67.5%</td>
</tr>
<tr>
<td></td>
<td>Passed Both Gates</td>
<td>32.5%</td>
<td>35%</td>
<td>40%</td>
<td>45%</td>
<td>50%</td>
<td>55%</td>
<td>60%</td>
<td>65%</td>
<td>67.5%</td>
</tr>
<tr>
<td></td>
<td>Missed Both Gates</td>
<td>32.5%</td>
<td>35%</td>
<td>40%</td>
<td>45%</td>
<td>50%</td>
<td>55%</td>
<td>60%</td>
<td>65%</td>
<td>67.5%</td>
</tr>
<tr>
<td></td>
<td>Missed Quality Only</td>
<td>32.5%</td>
<td>35%</td>
<td>40%</td>
<td>45%</td>
<td>50%</td>
<td>55%</td>
<td>60%</td>
<td>65%</td>
<td>67.5%</td>
</tr>
<tr>
<td></td>
<td>Missed TCC Trend Gate</td>
<td>32.5%</td>
<td>35%</td>
<td>40%</td>
<td>45%</td>
<td>50%</td>
<td>55%</td>
<td>60%</td>
<td>65%</td>
<td>67.5%</td>
</tr>
</tbody>
</table>
Learning from a Decade of P4P Experience

- Quality has improved
- Importance of stakeholder involvement and engagement
- Value of standardization and alignment
- Balancing act between simplicity and methodological rigor
- Understanding/definition of quality is constantly evolving