Value Based Pay for Performance Incentive Design

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Executive Summary

About the Value Based P4P Program

Historically, physicians and physician organizations (POs) have received the same payment regardless of the quality of care they provide. To change this equation, in 2001, the Integrated Healthcare Association (IHA), working with California health plans and physician organizations, launched a statewide pay-for-performance initiative with a goal of creating compelling incentives to drive improvements in clinical quality and patient experience. The program’s core components include: (1) a common set of measures, (2) health plan incentive payments, (3) a public report card, and (3) PO recognition awards.

While steady quality improvements were achieved, the dramatic increase in health care costs over the past decade overshadowed gains in quality. In 2010, IHA stakeholders called for modification of the existing program to reward performance on quality, cost, and utilization measures in an integrated fashion. The Value Based Pay for Performance (VBP4P) program was developed, and today includes 10 health plans and 200 California physician organizations caring for 9 million Californians enrolled in commercial HMO and POS plans.

The transition to value involved all four program components: common measures, incentive payments, public reporting, and awards. This document outlines in detail the VBP4P incentive design for health plan payments. All participating health plans, with the exception of Kaiser Permanente, use the program’s performance results to pay incentives to POs. To date, five health plans—Aetna, Anthem Blue Cross, Blue Shield of California, Cigna, and UnitedHealthcare—have committed to transitioning to the VBP4P incentive design; three health plans made payments using the design in 2016.

VBP4P Incentive Design

IHA’s VBP4P incentive design, which combines clinical quality, patient experience, cost, and resource use measures, is one of the largest alternative payment models in the country. At its core, the program is based on shared savings, adjusted for performance on quality measures. The overall VBP4P design is intended to improve quality, decrease costs, and reward providers for delivering higher-value care.

The design is upside risk only; participants can earn an incentive through shared savings but bear no downside financial risk. To be eligible to earn any share of savings, POs must first meet minimum quality and total cost of care (TCC) standards, known as the Quality Gate and TCC Gate. POs that do not meet both thresholds are ineligible for incentives.

Savings are earned through improved resource use, based on five common measures: inpatient bed days, readmissions, emergency department (ED) visits, outpatient procedures, and generic prescribing. Incentive amounts are summed across all measures. Any shared savings earned are divided between the health plan and the PO. To maximize the amount of incentive earned, POs must make greater improvements in resource use while simultaneously offering higher quality.

Improving resource use year to year is challenging, particularly for POs that are already relatively efficient. To ensure that POs with efficient resource use are appropriately rewarded, a complementary attainment incentive was added to the design in 2015. This methodology builds in a supplement to the shared-savings calculation for POs that are consistently exceeding population benchmarks for resource use. More information can be found at http://www.iha.org/ and questions can be sent to p4p@iha.org.
Overview

Since 2001, the IHA through the California P4P program has created a successful statewide performance measurement collaboration that includes uniform measures, aggregated data collection and validation, a single public report card, and a trusted governance process. The Value Based Pay for Performance (VBP4P) strategic initiative emerged from the California P4P program to help moderate the commercial HMO cost trend in California while continuing to improve the quality of care. A key component of the initiative involved transitioning health plan financial incentives to physician organizations (POs) from focusing solely on rewarding quality to rewarding value by adding costs and resource use as performance components.

The VBP4P incentive is a shared-savings model that incorporates the quality, cost, and utilization of health care services. The value-based incentive design was developed in collaboration with P4P-participating health plans and POs and approved in 2012. Starting in Measurement Year 2013, health plans began to phase out the former quality-only P4P incentive program and implement the VBP4P incentive design. As plans implemented the new design, refinements were made and adopted by the three IHA VBP4P committees—Governance, Technical Measurement, and Technical Payment. These design changes are logged for reference in Appendix E.

Incentive Design Objectives

The purpose of VBP4P is to revitalize the P4P program against a backdrop of affordability. The objectives of this strategic initiative are as follows:

- Prioritize cost control.
- Promote quality.
- Standardize health plan utilization measures and payment methodology.
- Increase funding to the incentive program using a shared-savings and attainment model.

Incentive Design Guiding Principles

1. Savings generated by VBP4P are intended to contribute to lower cost trends and a more competitive, value-based HMO product.

2. VBP4P is intended to be available to all POs—including full-risk POs—that contract for commercial HMO or POS business with one or more participating health plans.

3. POs that contribute to HMO price competitiveness through efficiencies and quality should be rewarded for their efforts to provide value.

4. VBP4P should not increase a health plan’s total cost trend. The shared-savings design must balance appropriate PO rewards for successfully achieving quality and cost targets with budgeting for potential overruns by other POs.
Incentive Design Elements

There are five core elements of the VBP4P incentive design: common measure set, performance gates, incentives based on appropriate resource use (ARU), quality adjustments, and summation of incentive amounts across measures. VBP4P payments can be earned in two ways: through shared-savings incentives that reward year-over-year improvement and attainment incentives that reward continued excellence in resource stewardship. POs that both improve and achieve the attainment benchmark can earn incentives through both pathways.

The VBP4P incentive design relies on a common measure set. To be eligible to earn any share of savings, POs must first meet quality standards, as well as demonstrate a total cost of care trend and amount below established thresholds. These standards are referred to as performance gates, specifically the Quality Gate and the TCC Gates.

Shared savings are generated by PO improvements in resource use, based on five common measures: inpatient bed days, readmissions, emergency department (ED) visits, outpatient procedures, and generic prescribing. Any savings generated are shared between the health plan and the PO. Additionally, to reward POs that consistently demonstrate excellent performance on resource use, an attainment incentive supplements the estimated shared savings. A PO’s performance on each ARU measure is compared to population benchmarks—POs achieving and maintaining these high-performance levels are eligible for the supplemental incentive.

A quality adjustment is made to both the shared-savings and attainment incentives that increases or decreases the amounts to reflect a PO’s quality performance. Finally, shared-savings and attainment incentives are summed across all five resource use measures. Each measure’s shared savings can be positive or negative, and positives—either through savings or attainment—can offset negatives. To maximize an incentive award, POs must demonstrate greater resource use improvement while simultaneously offering higher-quality care.

To balance the need for standardization and adaptability, the VBP4P committees characterize design elements as core and optional. The core elements are considered essential to the VBP4P design, while optional design elements offer health plans flexibility to fine tune the methodology to accommodate their business practices and strategies.

<table>
<thead>
<tr>
<th>Core Design Elements</th>
<th>Optional Design Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Common Measure Set</td>
<td>▪ Threshold/Gate Values</td>
</tr>
<tr>
<td>▪ Performance gates</td>
<td>▪ Multiplier Ranges/Values</td>
</tr>
<tr>
<td>o Quality Gate</td>
<td>★ Throughout the document, committee recommendations on optional design elements are signified with a star; a summary of all recommendations on optional values is included in Appendix A.</td>
</tr>
<tr>
<td>o Total Cost of Care Trend Gate</td>
<td></td>
</tr>
<tr>
<td>▪ Quality Adjustment</td>
<td></td>
</tr>
<tr>
<td>▪ ARU Shared Savings Calculation</td>
<td></td>
</tr>
<tr>
<td>▪ ARU Attainment incentive</td>
<td></td>
</tr>
</tbody>
</table>

Throughout the document, committee recommendations on optional design elements are signified with a star; a summary of all recommendations on optional values is included in Appendix A.
Value Based P4P Design Diagram

**Does the PO qualify?**
- **Step 1a – Quality Gate**
  - yes → **Step 1b – Total Cost of Care Trend Gate**
  - no → PO does not qualify for VBP4P incentive
- **Step 1b – Total Cost of Care Trend Gate**
  - yes → PO does not qualify for VBP4P shared savings
  - no → PO does not qualify for VBP4P incentive

**Did the PO improve or maintain efficient resource use?**
- **Step 2**
  - Calculate Base Shared Savings Amount based on PO ARU improvement from prior year
- **Step 3**
  - Apply Quality Adjustment to base shared savings amounts
- **Step 4**
  - Sum Shared Savings Amounts across ARU Measures

**How much is the PO’s incentive payment?**
- **Step 5 – Combine net shared savings and attainment incentives into Value Based P4P Incentive Payment**

**ATTAINMENT**
- **Step 1a – Quality Gate**
  - yes → **Step 2**
  - no → PO does not qualify for VBP4P incentive
- **Step 2**
  - Calculate Base Attainment Incentive based on PO ARU performance relative to benchmark
- **Step 3**
  - Apply Quality Adjustment to base attainment incentive amounts
- **Step 4**
  - Sum Attainment Incentive Amounts across ARU Measures
Calculating Value-Based Incentive Payments

The core design elements—a common measure set, performance gates, shared savings and attainment based on resource use, and summation of incentive amounts—can be tracked across the parallel and complementary shared-savings and attainment incentives, which ultimately converge.

The shared-savings incentive assesses a PO’s performance relative to its prior year performance. The attainment incentive assesses a PO’s performance relative to population benchmarks and is designed to reward high-performing POs that meet and maintain excellent resource use standards. The incentives are then combined; POs that both improve and meet attainment benchmarks are eligible to earn both incentives. The design, including shared savings and attainment, is outlined in detail below.

Common Measure Set

The VBP4P incentives are founded on a common measure set established for the program. The measure set is updated annually and evolves as advancements in health care performance measurement occur. For the VBP4P design, the measures can be categorized as follows:

- **Quality** measures that cover clinical care, patient experience, and meaningful use of health IT. These measures are used as a performance gate and as an adjustment that increases or decreases a PO’s VBP4P incentives.

- **Appropriate Resource Use** measures capture key aspects of utilization—inpatient bed days, ED visits, readmissions, outpatient services, and generic prescribing—that contribute to the overall costs of care and are influenced by physician organization coordination and management of patient care. Improvement and attainment on these measures drive the incentive amounts.

- **A Total Cost of Care** measure comprised of actual payments associated with care for all commercial HMO/POS enrollees in a PO. The TCC trend (i.e., percent change between years) and TCC amount are used in the performance gates for VBP4P. More on the TCC measure can be found here.

Step 1: Apply Performance Gates

Both shared-savings and attainment incentives require POs to meet performance gate thresholds to be eligible for any incentive. These performance gates ensure that POs meet specified quality and cost performance criteria to be eligible for a VBP4P incentive. The first eligibility gate, the Quality Gate, is applied for both shared savings and attainment. The second eligibility gate, the TCC Gate, is specifically tailored to the shared-savings and attainment incentives. For shared savings, the cost gate assesses TCC Trend. For attainment, the cost gate assesses relative TCC Amount.

POs that do not meet the Quality Gate are ineligible for any VBP4P incentives. Both the Quality Gate and the appropriate TCC Gate must be met in order to be eligible for an incentive, whether it is based on shared savings or attainment.

a. **Quality Gate**

This performance gate establishes a minimum level of quality performance that a PO must demonstrate to be eligible for any VBP4P incentives.

- A quality composite score (QCS) for each PO is calculated by IHA based on performance across the clinical quality, patient experience, and meaningful use of health IT domains. A detailed description of the QCS methodology is available here. Of note, the methodology:
Includes all measures in these domains that are recommended for payment.

- Uses aggregated results that reflect performance across all contracted health plans.
- Scores measure performance for both attainment and improvement.

- A PO’s QCS must meet or exceed the Quality Gate threshold to earn VBP4P incentives from health plans.

**Quality Composite Score Example**

<table>
<thead>
<tr>
<th>P4P Quality Domain</th>
<th>VBP4P Domain Score</th>
<th>VBP4P Domain Weighting (MY 2015)</th>
<th>Weighted Domain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>40</td>
<td>60%</td>
<td>24</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>29</td>
<td>30%</td>
<td>8.7</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>67</td>
<td>10%</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Quality Composite Score</strong></td>
<td></td>
<td></td>
<td><strong>39</strong></td>
</tr>
</tbody>
</table>

★ VBP4P committee recommendation: The recommended Quality Gate threshold is set at the current year 10th percentile, which sets a bar for quality that is attainable for POs while still ensuring high performance.

**b. Total Cost of Care Gates**

The cost performance gates establish ceilings that POs cannot exceed to be eligible for an incentive. The gates serve to reinforce and ensure that the calculated incentives based on ARU are not directly at odds with corresponding performance on cost.

- Shared savings reward improvement in resource use, so the complementary cost performance gate assesses Total Cost of Care Trend.
- The attainment incentive rewards relative performance in resource use, so the complementary cost performance gate assesses Total Cost of Care Amount.

**TCC Trend Gate (for Shared Savings only)**

This performance gate establishes a maximum TCC Trend that POs cannot exceed to be eligible for shared savings.

- To be eligible for shared-savings incentives, a PO’s TCC trend, including a confidence interval, must be below the TCC Trend Gate threshold. The recommended threshold is tied to the consumer price index (CPI) and described in more detail later.
- The TCC Trend is the percent change between a PO’s current TCC measurement and prior measurement year TCC and is specific to each health plan.
- A one-sided 85% lower confidence interval around the estimated TCC trend is calculated to help ensure that POs with small plan membership are not excluded from participation due to less stable TCC results.
• Consistently high-cost POs represent the greatest savings opportunity, and to abide by the guiding principle that all POs should be able to participate, these POs are eligible for VBP4P incentives but may be subject to a more challenging TCC trend gate.

☆ VBP4P committee recommendation: The recommended TCC Trend Gate threshold is based off of and set slightly above the CPI. In alignment with the original program goal of reducing costs, the recommended TCC Trend Gate threshold will start at CPI+3 percentage points and gradually decrease over time, as outlined below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Standard</th>
<th>High Cost PO</th>
</tr>
</thead>
<tbody>
<tr>
<td>MY 2016, MY 2017</td>
<td>CPI+2%</td>
<td>CPI + 0%</td>
</tr>
<tr>
<td>MY 2018, MY 2019</td>
<td>CPI+1%</td>
<td>CPI-1%</td>
</tr>
</tbody>
</table>

☆ VBP4P committee recommendation: Consistently high-cost POs are defined as those POs that are above the 90th percentile in geography- and risk-adjusted TCC for a contracted health plan for both the baseline and measurement year.

**TCC Amount Gate (for Attainment Incentive only)**
This performance gate establishes a maximum TCC amount.

• To be eligible for attainment incentives, a PO’s TCC amount cannot exceed the gate value. POs with TCC amounts above the gate are ineligible for attainment incentives.
• The TCC Amount is the PO’s TCC result, including geography and risk adjustment, for a respective health plan.

☆ VBP4P committee recommendation: The recommended TCC Amount Gate threshold is the same as consistently high-cost PO definition—the 90th percentile geography- and risk-adjusted TCC for a contracted health plan for both the baseline and measurement year.

Step 2: Calculate Base Incentive Amounts
Step 2 begins the calculation of incentive amounts for eligible POs. The base shared-savings amount estimates the value of improvement on the appropriate resource use measures; the base attainment incentive estimates a bonus representing the ongoing value to the health plan of maintaining excellent performance on the ARU measures. In other words, POs generate incentives through resource stewardship that results in savings for the health plan. Those savings then serve as the basis for the combined net shared-savings and attainment incentive.

The following general principles apply to both the shared-savings and attainment base incentive calculations:
• ARU measure performance is based on the PO’s results specific to each contracted plan—this ensures health plan payments track to their own utilization experience with a PO.
• Incentives are calculated for each ARU measure:
Inpatient bed days.
- All-cause readmissions.
- ED visits.
- Outpatient procedures—preferred facility use.
- Generic prescribing.

Shared Savings

The shared-savings calculation compares a PO’s current and prior year utilization performance and quantifies any improvement (or declines). The calculation then translates the measured improvement (or decline) into an estimate of savings (or added costs). To get to dollars, the improvement in the rate must be: (1) scaled to reflect the size of the PO’s membership, (2) priced to incorporate the estimated costs for each ARU measure, and (3) split to reflect the initial share of savings between the health plan and physician organization.

- A PO’s utilization target for each ARU measure is generally its own prior year performance. (See Methodological Considerations for handling of small POs and a recommended adjustment to the targets for generic prescribing.)
- The total estimated savings amount is calculated using the units of improvement or decline achieved by the PO for a particular resource use measure.
- Units of improvement are translated to an estimate of savings by pricing the units according to their respective costs. For example, if a PO avoided or reduced 100 bed days and the cost per bed day is $3,500, the total estimated savings are $350,000.
- Estimated savings can be positive or negative. All amounts are carried through to the final calculation.
  - Savings are positive if the PO’s measure performance improved compared to the previous year.
  - Savings are negative, reflecting added costs, if the PO’s measure performance declined compared to the previous year.

★ VBP4P committee recommendation: The base incentive amount for the PO starts at 50% of the shared-savings amount.

★ VBP4P committee recommendation: Target is a PO’s own prior year performance for the same measure; a special adjustment is offered to account for drug patent status changes.

Attainment Incentive

POs that deliver care efficiently and show excellent resource stewardship are leading the way to value. The attainment incentive increases the payment opportunity for these POs. POs that exceed the attainment benchmarks for an ARU measure for the current and previous year—demonstrating they have achieved and maintained efficient resource use—earn a supplement that is incorporated into their incentive.

- For each ARU measure, a PO’s performance for the measurement year and prior year are compared to the respective attainment benchmarks (see recommendation below).
- For any ARU measure where the PO meets or exceeds the respective benchmarks for both years, the PO earns the corresponding attainment incentive amount.
• If the PO does not meet the identified benchmark criteria for an ARU measure for either the measurement or baseline year, the PO does not earn the attainment incentive for that measure.

★★ VBP4P committee recommendation: Recommended attainment benchmarks reflect a two-tier set of targets set at the 75th and 90th percentiles of performance for all POs in the population. The higher benchmark earns a larger incentive.

Step 3: Apply Quality Adjustment to Base Incentive Amount
In addition to determining PO eligibility for incentives (see Step 1), quality also affects the incentive amount a PO earns. The quality adjustment adjusts a PO’s base incentives up or down. POs with higher quality will see their incentive increase, while POs with lower quality will see their incentive decrease.

a. Quality Adjustment
The quality adjustment translates a PO’s quality performance into an upward or downward adjustment (i.e., multiplier) that is applied to both the shared-savings and attainment incentives.
- A PO’s quality composite score (same as described in Step 1) is used to determine its quality multiplier.
- The quality multiplier is calculated based on a continuous linear scale that is capped with a floor (minimum) and a ceiling (maximum). Below the floor (i.e. the Quality Gate) POs earn nothing; above the ceiling they continue to earn the maximum quality multiplier. Between the floor and ceiling, increases in the quality composite score result in a higher multiplier and greater incentive amount.
- The quality multiplier is applied to the base shared savings and attainment amounts for each ARU measure.

★★ VBP4P committee recommendation: Quality multipliers of 0.65 to 1.35, which provide for a 35% increase or decrease in a PO’s incentive. A PO’s QCS at the 10th percentile would earn the minimum quality multiplier and a PO’s QCS at the 90th percentile would earn the maximum quality multiplier.

Step 4: Sum the Incentive Amounts Across ARU Measures
The final step is to sum the quality-adjusted incentive amounts across ARU measures. Summing the incentives across measures establishes a broad level of accountability by requiring that POs offset any losses from ARU declines to earn an incentive.

Shared Savings
The quality-adjusted shared savings (Step 3) will be positive if performance on the measure improved or negative if performance on the measure declined. Summing the estimated savings or losses for each ARU measure generates an estimate of net shared savings that can be positive (reflecting net savings) or negative (reflecting net added costs). To earn net positive shared savings, a PO’s savings from improvements for some ARU measures must offset any declines in a PO’s performance on ARU measures that declined.

Attainment Incentive
The quality-adjusted attainment incentives (Step 3) will be positive for any ARU measure where the PO has achieved and maintained strong performance. For any measures where a PO has not met and
maintained the benchmark performance, the incentive is simply $0. Summing the attainment incentives across measures yields a total attainment incentive amount.

**Step 5: Combine the Shared-Savings and Attainment Incentives**

Health plans combine a PO’s net shared savings (positive or negative) and net attainment incentives ($0 or positive) to determine the final VBP4P incentive payment amount.

- If the combined incentive is positive, the PO earns that amount as a VBP4P incentive.
- If the combined incentive is negative, the PO earns $0 and does not bear the estimated loss.

**Methodological Considerations**

**Small POs**

Reliability and year-over-year stability of measure results is problematic for some POs, especially small POs. Therefore, the VP4P committees recommended calculating a weighted small PO result for the ARU measures on a plan-specific basis and using this as the basis for shared savings calculations. This Weighted Small PO Result will be provided to small POs in addition to the PO’s own measure result.

- Small POs are defined as those with fewer than 1,500 member years of commercial HMO/POS enrollment with a plan.
- To calculate the weighted small PO result, the results for all small POs within each plan are pooled.
- A weighted average, based on enrollment, is used to blend the pooled result with each small PO’s own measure result.
- The weighting placed on the PO’s own result increases proportionally with membership from 0 member years up to 1,500 member years.

**Generic Prescribing**

The VBP4P design generally measures improvement against the PO’s respective prior year performance for each resource use measure. For the generic prescribing therapeutic measures, the VBP4P committees offered a recommended adjustment in certain instances. Specifically, the issue that was identified was the possibility that the expiration of patents for major brand drugs and the emergence of new blockbuster drugs may result in a strong secular trend. For example, when a brand-name drug goes off patent, a PO would receive credit—and earn shared savings—for prescribing a generic drug without making any intentional change in prescribing behavior.

As a result, the committees developed a recommended approach for adjusting the measure target in instances where changes in drug classifications and availability are likely to have an across-the-board and noticeable impact. Specifically, the approach involves identifying the impacted therapeutic areas in advance and then measuring each plan’s observed change for their population.

⭐ **VBP4P committee recommendation:** Set the benchmark for generic improvement at the 25th percentile of the actual P4P performance for the year, determined on a plan-specific basis. Adjustment should be applied only to therapeutic areas where significant market change is identified, for both patent expirations and release of new drugs, only when the estimated adjustment aligns with the anticipated market change, and applied consistently to the benchmarks for all POs.
Full-Risk POs

Overview
One of the guiding principles for VBP4P is that the program is intended to be available to all POs, including full-risk POs. The amount of savings to be shared in VBP4P is calculated based on reductions in unnecessary resource use (such as inpatient bed days and ED visits) and adjusted by quality performance. Full-risk POs receive a member-level capitated payment that covers hospital service utilization. As a result, reductions in resource use in full-risk POs do not yield any health plan savings that can be shared. As such, a special incentive design is needed for full-risk POs.

Design Summary
The recommended design for these physician organizations applies the Quality gate and TCC Trend gate, and as long as the PO passes the gates, the PO would be eligible for an incentive. The recommended design then creates a value score by adjusting the quality composite score to a PO’s performance on the TCC amount. The value score is then used to distribute incentives.

1. **Apply Performance Gates**: Determine if the PO passes the VBP4P performance gates for quality and cost trend. If so, the PO is eligible for an incentive.
2. **Calculate Quality Composite Score**: see [QCS methodology](#).
3. **Generate Value Score**: Apply TCC adjustment to QCS to adjust the QSC up or down based on a PO’s relative performance on the TCC amount. The PO’s TCC performance compares a physician organization’s geography- and risk-adjusted TCC amount against PO performance for the P4P population as a whole.
4. **Determine Incentive Payment**: Value scores for POs and memberships would be used by health plans to distribute incentives across their full-risk POs.

For an example of the calculation, see Appendix C.

★ VBP4P committee recommendation: The cost performance adjustment varies based on a continuous linear scale from a decrease of 20% to an increase of 20% based on the PO’s geography- and risk-adjusted TCC for the measurement year and specific plan. The maximum and minimum adjustments correspond with the 10th and 90th percentiles of P4P PO performance on TCC (including geography and risk adjustment).
APPENDIX A: Value Based P4P Recommended Values

To help channel variability and to serve as a basis for comparing programs across health plans, the VB4P committees have identified recommended values for the incentive methodology.

<table>
<thead>
<tr>
<th>Design Element</th>
<th>Recommended Value</th>
<th>Notes/Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Gate</td>
<td>At or above current year 10th percentile.</td>
<td>Based on changes to the measure set, QCS are expected to drop substantially and does not correspond to any change in performance. The recommendation is to change the target gate to the current year 10th percentile to mitigate the anticipated impact.</td>
</tr>
<tr>
<td>TCC Trend Confidence Level</td>
<td>85%</td>
<td>Using a one-sided 85% confidence level increases the certainty that a PO is correctly excluded at the TCC Trend Gate.</td>
</tr>
<tr>
<td>TCC Trend Gate</td>
<td>Standard Threshold&lt;br&gt;MY 2016-2017: CPI+2%&lt;br&gt;MY 2018-2019: CPI+1%&lt;br&gt;High-Cost POs&lt;br&gt;MY 2016-2017: CPI+0%&lt;br&gt;MY 2018-2019: CPI-1%</td>
<td>The recommendation is to use a three-year average of the U.S. CPI, which would be based on the measurement year and the two years immediately preceding the measurement year. The TCC Trend Gate for high-cost POs is set at 2 percentage points below the standard threshold.</td>
</tr>
<tr>
<td>TCC Amount Gate</td>
<td>POs with geography- and risk-adjusted TCC above the plan-specific 90th percentile for both baseline and measurement year</td>
<td>To reward POs that consistently demonstrate excellent performance on resource use, an attainment incentive supplements the estimated shared savings. The recommended TCC Amount Gate threshold is the same as consistently high-cost PO definition—the 90th percentile geography- and risk-adjusted TCC for a contracted health plan for both the baseline and measurement year.</td>
</tr>
<tr>
<td>High-Cost PO Definition</td>
<td>POs with geography- and risk-adjusted TCC above the plan-specific 90th percentile for both baseline and measurement year</td>
<td>The committees believed it was important to hold POs that have consistently high costs to a stricter TCC Trend Gate to further incent improved affordability.</td>
</tr>
<tr>
<td>Quality Adjustment</td>
<td>Continuous linear scale based on quality composite scores at the current year 10th percentile to the gold standard at the 90th percentile, corresponding to quality multipliers of 0.65 to 1.35.</td>
<td>This provides about a two-fold difference between the lowest qualifying performers and the highest performers and reinforces the importance of quality in the VB4P design. Considering the quality adjustment in isolation, multipliers of 0.65 and 1.35 correspond with a PO earning a 32.5% and 67.5% share of the savings, respectively.</td>
</tr>
</tbody>
</table>
APPENDIX B: Optional ARU Adjustments to Base Incentive

<table>
<thead>
<tr>
<th>Option 1: ARU Attainment Adjustment to Base Incentive Amount (alternative to attainment pathway)</th>
<th>Option 2: ARU Improvement Adjustment to Base Incentive Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>For POs that start at a better level of performance, it is presumably more difficult to improve. In recognition of this, health plans may choose to vary the percentage of savings that a PO earns for improvement on a particular ARU measure based on the PO’s baseline performance on that ARU measure.</td>
<td>To incentivize POs to maximize their improvement on a particular ARU measure, health plans may choose to vary the percentage of savings that a PO earns based on the magnitude of improvement the PO achieves.</td>
</tr>
<tr>
<td>(1) POs that start at a better level of performance on the measure earn a higher percentage of savings for that measure.</td>
<td>(1) POs that perform a larger amount better than their target for a measure earn a higher percentage of savings for that measure.</td>
</tr>
<tr>
<td>(2) POs that start at a worse level of performance on the measure earn a lower percentage of savings for that measure.</td>
<td>(2) POs that perform minimally better than their target for a measure earn a comparatively lower percentage of savings for that measure.</td>
</tr>
<tr>
<td>(3) P4P recommended values are summarized below and can be found in Appendix C.</td>
<td>(3) P4P-recommended values for the ARU improvement adjustment are summarized below and can be found in Appendix C.</td>
</tr>
</tbody>
</table>

**Recommended ARU Attainment Adjustment Values**

<table>
<thead>
<tr>
<th>Relative Baseline Year ARU Performance</th>
<th>Multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top Quartile</td>
<td>1.3</td>
</tr>
<tr>
<td>2nd Quartile</td>
<td>1.1</td>
</tr>
<tr>
<td>3rd Quartile</td>
<td>0.9</td>
</tr>
<tr>
<td>Bottom Quartile</td>
<td>0.7</td>
</tr>
</tbody>
</table>

The recommended values provide for a 30% increase or decrease to a PO’s estimated shared savings.

**Recommended ARU Improvement Adjustment Values**

<table>
<thead>
<tr>
<th>ARU Improvement</th>
<th>Multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top Quartile</td>
<td>1.15</td>
</tr>
<tr>
<td>2nd Quartile</td>
<td>1.10</td>
</tr>
<tr>
<td>3rd Quartile</td>
<td>1.05</td>
</tr>
<tr>
<td>Bottom Quartile</td>
<td>1.00</td>
</tr>
<tr>
<td>No Improvement</td>
<td>1.00</td>
</tr>
</tbody>
</table>

The recommended values provide for up to a 15% increase to a PO’s estimated shared savings.
APPENDIX C: Full-Risk Example Calculation

To highlight the application of the VBP4P incentive design for full-risk physician organizations, the example below presents a scenario for a health plan with six full-risk POs that all pass the Quality and TCC Trend Gates. Each PO has 10,000 member months; one of two quality composite scores (25 or 45); and one of three Total Costs of Care (geography- and risk-adjusted).

- Budget = $105,000
- Total membership = 60,000 member months
- Incentive per value-weighted member month *(referred to as x in the table below)*
  = budget / total value-weighted membership
  = $105,000 / 2,100,000 = $0.05 PMPM

<table>
<thead>
<tr>
<th>Example</th>
<th>Quality Composite Score</th>
<th>Total Cost of Care*</th>
<th>Cost Adjustment</th>
<th>Value Score (cost-adjusted quality)</th>
<th>Membership (member months)</th>
<th>Value-Weighted Membership</th>
<th>Incentive ($PMPM)</th>
<th>Total Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-Risk PO A</td>
<td>45</td>
<td>$2,895</td>
<td>1.2</td>
<td>54</td>
<td>10,000</td>
<td>540,000</td>
<td>$2.70</td>
<td>$27,000</td>
</tr>
<tr>
<td>Full-Risk PO B</td>
<td>25</td>
<td>$2,895</td>
<td>1.2</td>
<td>30</td>
<td>10,000</td>
<td>300,000</td>
<td>$1.50</td>
<td>$15,000</td>
</tr>
<tr>
<td>Full-Risk PO C</td>
<td>45</td>
<td>$3,666</td>
<td>1</td>
<td>45</td>
<td>10,000</td>
<td>450,000</td>
<td>$2.25</td>
<td>$22,500</td>
</tr>
<tr>
<td>Full-Risk PO D</td>
<td>25</td>
<td>$3,666</td>
<td>1</td>
<td>45</td>
<td>10,000</td>
<td>250,000</td>
<td>$1.25</td>
<td>$12,500</td>
</tr>
<tr>
<td>Full-Risk PO E</td>
<td>45</td>
<td>$4,437</td>
<td>0.8</td>
<td>36</td>
<td>10,000</td>
<td>360,000</td>
<td>$1.80</td>
<td>$18,000</td>
</tr>
<tr>
<td>Full-Risk PO F</td>
<td>25</td>
<td>$4,437</td>
<td>0.8</td>
<td>20</td>
<td>10,000</td>
<td>200,000</td>
<td>$1.00</td>
<td>$10,000</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60,000</td>
<td>2,100,000</td>
<td>$1.75</td>
<td>$105,000</td>
</tr>
</tbody>
</table>

*Geography and risk adjusted

**Calculation Steps for Full-Risk PO A:**

**Step 1 – Apply Performance Gates**
Based on the identified assumptions, we know that the PO has passed both performance gates and is eligible for an incentive.

**Step 2 – Calculate Quality Composite Score**
The starting point for the value score calculation is the quality composite score, which, for ease of illustration, has already been calculated and is displayed in the table above. PO A’s performance on the clinical quality, patient experience, and meaningful use of health IT measures translates into a composite score of 45.

**Step 3 – Generate Value Score**
The next step is to determine the PO’s value score that will be used to determine the incentive amount, by applying the adjustment for the PO’s relative performance on geography- and risk-adjusted TCC to the quality composite score. PO A’s geography- and risk-adjusted TCC is the same as the aggregated 10th...
percentile, so the PO will earn the maximum adjustment of 20% as recommended by the VBP4P committees. For POs with costs for a plan between the 10th and 90th percentiles, the cost adjustment would be determined in a linear fashion (similar to the quality multiplier in the VBP4P design for shared-risk POs).

\[
\text{Cost adjustment} = fn(\text{Total Cost of Care}) = fn(\$2,895) = 1.2
\]

Applying this cost adjustment to the PO’s quality composite score yields a value score of 54.

\[
\text{Value Score} = \text{Quality Composite Score} \times \text{Cost Adjustment} = 45 \times 1.2 = 54
\]

**Step 4 – Determine Incentive Payment**

To distribute the budget, the health plan determines the value-weighted membership for each PO. For PO A, this would be 540,000.

\[
\text{Membership-Weighted Value} = \text{Value Score} \times \text{Membership} = 54 \times 10,000 = 540,000
\]

The health plan can calculate the incentive per value score unit by dividing the total budget by the sum of value weighted membership (shown above the table). In this case, incentive per value score unit is $0.05. Applying the $0.05 per value point incentive to PO A’s value score of 54, we see that PO A will earn $2.70 per member month, or a $27,000 incentive total.

\[
\text{Incentive} = \text{Value Score} \times \text{Incentive} = 54 \times 0.05 = 2.70
\]

\[
\text{Total Incentive} = \text{Incentive} \times \text{Member Months} = 2.70 \times 10,000 \text{ member months} = 27,000
\]
APPENDIX D: Resources

Measure Set and Specifications
- **VBP4P Common Measure Set** outlines all measures collected in VBP4P, including designations for those recommended for payment and public reporting. The measure set also includes measures collected for Medicare Advantage Stars.
- **VBP4P Manual** includes technical measure specifications, along with data collection and reporting guidelines.

Incentive Design Development
- **Quality Composite Score Methodology**

Value Based P4P Program
- **Fact Sheet**: Value Based Pay for Performance for Physician Groups – Key Pay-for-Performance Design Decisions
- **Issue Brief**: Charting a Course to Value in Physician Group Payment – Key Pay-for-Performance Design Decisions

Special Thanks VBP4P Technical Payment Committee:
Michael van Duren, MD: Sutter Health *(CHAIR)*
Mollie Allan: Sharp Health Plan
Carla Allison: Cigna
Eric French, HealthNet
Caroline Goldzweig, Cedars Sinai
Ritu Grover: Aetna
Travis Herzog: Anthem Blue Cross
Leigh Hutchins: NAMM California
Anil Keswani: Scripps Health Plan Services
Matthew Low: UnitedHealthcare
Khanh Nguyen: Hill Physicians Medical Group
Judy Shubin: MemorialCare Medical Foundation
Alexander Vojta: Blue Shield of California
APPENDIX E: Guidance for MY 2016 Incentive Design Implementation

Background:
To account for catastrophic cases and increase the predictive accuracy of risk adjustment for the Total Cost of Care (TCC) measure, the methodology includes truncating (or capping) member costs at $100,000 per member per year. The risk-adjustment model is calibrated to predict costs up to $100,000. This year to build out and validate TCC service categories, IHA staff collected additional detail from health plans on each plan-physician organization (PO) risk arrangements. Initial data quality checks for MY 2016 identified an uneven distribution of truncated costs at the health plan level, and additional analysis indicates the issue carries through to PO-level TCC results. Specifically, the data shows that truncated costs vary based on the level of exposure to capitated payments. The data suggests a systematic bias when comparing TCC across POS, it does not in most cases impact a PO’s relative performance to itself year over year.

Since the data issue affects only comparisons between POS but not an individual PO’s year over year trend, the TCC can support trend gate determinations. With this in mind, the Governance Committee recommended and IHA concurred with releasing the TCC trend results to participants for incentive purposes only. Further, they recommended not releasing the TCC results for recognition awards or public reporting until the issue is resolved.

The TCC results from a technical perspective play a role in 4 distinct elements in recommended incentive design:

1. TCC Trend Gate — eligibility determination for shared savings
2. Identifying High-Cost POS — set threshold for TCC Trend Gate
3. TCC Amount Gate — eligibility determination for attainment incentives
4. Full-risk Design — TCC multiplier

To support health plans in implementing the VBP4P incentive design using the MY 2016 TCC results, IHA staff want to review each of these elements and offer options for consistent design implementation.

1. **TCC Trend Gate (both Shared Risk and Full Risk designs)**
The data issue identified affects only comparisons between POS and not a PO’s year over year TCC trend. The TCC Trend Gate is applied to establish maximum TCC Trend that POS cannot exceed to be eligible for shared savings. The standard threshold for MY 2016 is CPI+2%. CPI for MY 2016 payments is 1.0%, so the recommended TCC trend gate is 3.0%. Since the data issue does not affect PO’s year over year TCC trend results, the Governance Committee recommended applying the recommended TCC Trend Gate to identify POS eligible for shared savings.

Staff Recommendation:
IHA staff recommends using the reported TCC trend results to apply the TCC Trend Gate.

2. **Identifying High-Cost POS (for Shared Risk designs)**
Consistently high-cost POS are defined as those POS that are above the 90th percentile in geography- and risk-adjusted TCC for a contracted health plan for both baseline and measurement year. The TCC Trend Gate for high-cost POS is set at 2 percentage points below the standard threshold. For MY 2016, the recommended threshold is CPI+0%. CPI for MY 2016 payments is 1.0%, so the recommended TCC trend
gate for high-cost POs is 1%. In prior years, consistently high-cost POs make up about 4% of all PO-plan contracts. Due to the identified issue, comparisons between POs will not be reported, thus no clear way to identify high-cost POs for MY 2016.

Staff Recommendation
IHA staff recommends applying the same TCC Trend Gate across all POs for MY 2016. To be eligible for shared-savings incentives, a PO’s TCC trend must be below the TCC Trend Gate of CPI+2%. CPI for MY 2016 payments is 1.0%, so the recommended TCC trend gate is 3.0%.

3. TCC Amount Gate (for Attainment Incentive only)
The attainment incentive rewards relative performance in resource use. A PO’s performance for the baseline year and measurement year must meet or exceed the recommended benchmarks for both year in order to earn an attainment incentive amount. POs must meet or exceed the TCC Amount Gate to be eligible for an Attainment Incentive. The recommended TCC Amount Gate threshold is the same as consistently high-cost PO definition – the 90th percentile in geography- and risk-adjusted TCC for the baseline and measurement year for a contracted health plan. For MY 2016, the percentile range to identify consistently high-cost POs will not be reported to participants.

Staff Recommendation
IHA staff recommends waiving the TCC Amount Gate for MY 2016.

4. Full Risk Incentive Design – Cost Multiplier
The recommended design for these physician organizations applies the Quality gate and TCC Trend gate, and as long as the PO passes the gates, the PO would be eligible for an incentive. The design then creates a value score by adjusting the quality composite score to a PO’s performance on the TCC amount – using a TCC multiplier. The value score is then used to distribute incentives. The value score is generated by applying the TCC multiplier to QCS to adjust the QCS up or down based on a PO’s relative performance on the TCC amount. The PO’s TCC performance compares a PO’s geography- and risk-adjusted TCC amount against PO performance for the P4P population as a whole. This comparison is not advisable given the surfaced TCC issue.

Staff Recommendation
IHA staff recommends stratifying POs by risk types in order to establish the 10th and 90th percentiles for geography- and risk-adjusted TCC. The cost multiplier can then be generated based on PO performance in the full risk group.
APPENDIX F: Log of Approved Design Changes

November 2017 Updates
- Guidance for MY 2016 incentive design implementation (Appendix F).

May 2017 Updates
- Updated Quality Gate.
- Updated weights for Clinical Quality, Patient Experience, and Advancing Care Information domains

March 2016 Updates
- Updated recommended design for full-risk POs to use standard value-based design.

November 2015 Updates
- Addition of Attainment Incentive.
- Removal of ARU Attainment Adjustment.

December 2014 Updates
- Added information on full-risk physician organization incentive design options.

May 2014 Updates
- New full-risk physician organization incentive design option.
- Recommended target adjustment for generic prescribing measures.
- Removed optional aggregated performance improvement gate.
- Clarified 90th percentile used in defining high cost POs.

September 2013 Updates
- Note about the development of a standard target adjustment for Generic Prescribing measures.
- Recommended values for the optional ARU Attainment Adjustment.
- Recommended values for the optional ARU Improvement Adjustment.
- Special handling of small physician organization results to address instability.

March 2013 Updates
- Recommended values for the Total Cost of Care Trend Gate threshold, including confidence level.
- Definition of consistently high-cost physician organizations.
- Set the maximum quality multiplier at a gold standard instead of the maximum physician organization score for the year.