The following document incorporates changes to the initial design prompted by the special public comment period in July 2012, as well as additional program details formalized and approved by the P4P committees, including:

March 2013 Updates

- Recommended values for the Total Cost of Care Trend Gate threshold, including confidence level (pages 6, 7, and 17)
- Definition of consistently high cost physician organizations (pages 7 and 17)
- Set the maximum quality multiplier at a gold standard instead of the maximum physician organization score for the year (pages 9, 20, and 17)

September 2013 Updates

- Note about the development of a standard target adjustment for Generic Prescribing measures (page 8)
- Recommended values for the optional ARU Attainment Adjustment (pages 10 and 18)
- Recommended values for the optional ARU Improvement Adjustment (pages 11 and 18)
- Special handling of small physician organization results to address instability (page 12)

May 2014 Updates

- New full-risk physician organization incentive design option (page 13)
- Recommended target adjustment for generic prescribing measures (page 9)
- Removed optional aggregated performance improvement gate (pages 8, 5, and 16)
- Clarified 90th percentile used in defining high cost POs (page 18)

December 2014 Updates

- Additional information on full-risk physician organization incentive design options (pages 12 and 19)

If you have any questions about the updated design or Value Based P4P generally, please email p4p@iha.org.
Overview

Value Based Pay for Performance (P4P) is a strategic initiative that the California P4P program is undertaking to moderate the commercial HMO cost trend in California, while continuing to improve quality of care. Value Based P4P is a shared savings incentive model which incorporates the quality, cost, and utilization of health care services. The new program design was developed in collaboration with health plans and physician organizations (PO) participating in P4P, and is intended to go into effect starting in 2013.

Objectives

The purpose of Value Based P4P is to revitalize/retool the P4P program against the backdrop of affordability. The objectives of this strategic initiative are as follows:

- Reorder priorities to emphasize cost control (affordability)
- Continue to promote quality
- Standardize health plan efficiency measures and payment methodology
- Increase funding to the incentive program using a shared savings model.

Guiding Principles

- Savings generated by Value Based P4P are intended to contribute to lower cost trends and a more competitive, value based HMO product.
- Value Based P4P is intended to be available to all POs, including full risk POs, that contract for commercial HMO or POS business with one or more health plans participating in P4P. Recognizing the value of alignment across health plans, all health plans and POs are encouraged to participate in Value Based P4P.
- POs that contribute to HMO price competitiveness via low total cost trend and improved utilization, and demonstrate quality, should be rewarded for their efforts to provide value.
- Value Based P4P should not increase a health plan’s total cost trend. The shared savings program design must balance the need to assure appropriate rewards for POs that successfully achieve quality and cost targets, and budget for potential overruns by other POs.

Background

The Integrated Healthcare Association (IHA) P4P program has created a successful statewide collaboration including uniform measures, aggregated data collection and validation, a single public report card and a trusted governance process. While steady improvements have been achieved in the quality metrics, the dramatic increase in healthcare costs over the past decade
has overshadowed the gains in quality. The IHA P4P stakeholders have called for modification of the existing P4P program to reward quality, cost, and utilization in an integrated fashion. Starting in Measurement Year 2013, the IHA P4P program intends to phase out the current P4P incentive program and transition to Value Based P4P.

**Value Based P4P to Replace Current Incentive Programs**

Value Based P4P is intended to replace the incentive programs currently in place that focus on quality alone or resource use/cost alone. These include the P4P quality incentives, Appropriate Resource Use shared savings incentives, and other health plan proprietary shared risk incentive programs. However, health plan-PO arrangements that focus on both quality and resource use/cost, such as Accountable Care Organization (ACO) arrangements, are more aligned with the goals of Value Based P4P. If these ACO types of arrangements are already in place, they might supersede the opportunity to participate in Value Based P4P so as not to be duplicative.

**Initial Value Based P4P Design Rejected**

An initial Value Based P4P design was developed in 2010 and 2011, which determined a base incentive amount on a PO’s performance on total cost of care (TCC) amount and TCC trend compared to targets, and used quality performance to modify the base incentive amount up or down. While conceptually appealing, when health plans modeled the design, they found that it would likely be cost additive. They were also concerned that some POs would be rewarded or penalized based on factors they did not control. The initial design was therefore rejected, and a Value Based P4P Technical Design Team was formed to develop an alternative design that would meet the objectives of Value Based P4P.

**Value Based P4P Technical Design Team Revamps Design**

The Value Based P4P Technical Design Team, comprised of health plan representatives with contracting, network, actuarial, analytical, and/or technical expertise, met monthly between November 2011 and May 2012. They considered different design options, modeled the impact of various designs, and convened discussions internally to understand what design features and corresponding output would or would not be acceptable.

What emerged from this process was a significant change to the Value Based P4P incentive basic design construct, where the base shared savings amount is determined by improvements on individual Appropriate Resource Use measures, with performance on Total Cost of Care trend serving as a gate, and performance on Quality serving both as a gate and as an adjustment to the incentive payment amount. The Appropriate Resource Use measures are in the control of POs, and using these measures as the basis for shared savings incentives addresses one of the concerns with the original design. Details of the design follow.
Standardization of performance measures and the basic design construct for the incentive is a key component of the Value Based P4P program, and is believed to maximize the potential success of the program. However, as with all P4P recommendations, health plan adoption of all or some aspects of the recommendations is completely voluntary.

Notwithstanding, it is critical for detailed program methodology to be available to POs at the beginning of the measurement year. Each health plan is responsible for sharing this information with their contracted POs. Additionally, IHA will continue to collect and post each health plan’s intended Value Based P4P methodology annually in the Advanced Notice of Payment Methodology and Amount document.
Core and Optional Design Elements

Each Value Based P4P design element has been designated as either “core” or “optional.” Core elements are considered essential to the Value Based P4P design. Deviation from these elements would be perceived as not adhering to recommended Value Based P4P program.

The following are core design elements:

- Standardized measures
- Quality Gate
- Total Cost of Care Trend Gate
- Shared Savings Calculation
- Quality Adjustment

Optional design elements can be modified or waived while still complying with the spirit of the program. The optional elements allow health plans to fine tune the Value Based P4P methodology to meet their business needs, while at the same time helping to channel variability.

The following are optional design elements:

- Threshold/gate values
- Multiplier ranges/values
- ARU Attainment Adjustment
- ARU Improvement Adjustment
Steps for Determining Value Based Performance Awards

There are four components to the Value Based P4P incentive design: performance gates, shared savings base incentive calculations, adjustments to the base incentive amount, and summation of incentive amounts across measures. Each of these is discussed in more detail below, and a flow chart of the design is provided in Appendix A, and the recommended thresholds and multiplier values are provided in Appendix C.

Step 1: Apply Performance Gates

a. Quality Gate

Reducing costs and utilization at the expense of quality would not provide value and is contradictory to what Value Based P4P is trying to achieve. Therefore, a Quality Gate is the first step in Value Based P4P to assure a minimum level of quality is maintained. The level should be attainable and not automatically eliminate a quarter of the POs, but it should demonstrate that the PO is engaged in improving quality.

(1) POs must meet or exceed the Quality Gate threshold to be eligible for any Value Based P4P incentive payment.

(2) IHA calculates a Quality Composite Score for each PO, based on data aggregated across all contracted health plans.

(a) Quality Composite Scores include the P4P clinical quality, patient experience, and meaningful use of health IT domains.

(b) Each measure in the clinical and patient experience domains is scored on attainment and improvement, and the higher score is used; meaningful use of health IT is scored on attainment only.

(c) Domain scores are calculated as the percent of possible points earned.

   o Possible points are based only on measures for which the PO had a valid result.

(d) Domain scores are then weighted by the P4P recommended payment weighting for the domain.

<table>
<thead>
<tr>
<th>Quality Composite Score Example Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P4P Quality Domain</strong></td>
</tr>
<tr>
<td>Clinical</td>
</tr>
<tr>
<td>Patient Experience</td>
</tr>
<tr>
<td>Meaningful Use of Health IT</td>
</tr>
<tr>
<td>Quality Composite Score</td>
</tr>
</tbody>
</table>
The recommended Quality Gate threshold is outlined in Appendix C.

b. Total Cost of Care (TCC) Trend Gate

To keep the focus on containing total costs and cost trends in support of the Value Based P4P goal to bend the cost trend, a PO’s year-over-year total cost trend must meet certain parameters for the PO to qualify for an incentive based on improved utilization. The TCC Trend Gate threshold should be set so that it is seen as potentially achievable by POs, and yet contributes to a lower overall trend.

(1) POs must meet the TCC Trend Gate threshold to be eligible for any Value Based P4P incentive payment.

(2) IHA (through its contract with Truven Health Analytics) calculates a PO’s plan-specific risk-adjusted TCC Trend from the previous year to the current measurement year for each contracted health plan.

(3) A confidence interval will be added to the TCC Trend, so that if the lower bound of a PO’s confidence interval is below the TCC Trend Gate threshold, the PO will pass the Gate, even if their calculated TCC Trend is above threshold.

(4) All POs within a plan – either within a market, or statewide – start with the same TCC Trend Gate threshold.
(a) An exception is POs that have consistently high TCC. These high cost POs will have a lower TCC Trend Gate threshold than other POs.

(5) Actuarial adjustments may be made to account for differences in and changes to hospital contracting arrangements, plan benefit design, etc.

(6) The TCC Trend Gate is keyed off of the Consumer Price Index (CPI), using the average change in the national CPI over three years, such that the last year of the three years is the measurement year.

(7) To keep POs engaged and allow them time to reduce their cost structures, the TCC Trend Gate threshold will start out higher and then gradually be reduced down toward CPI.

(8) The recommendations for the level of confidence for the TCC Trend, the definition of high cost POs, the TCC Trend Gate thresholds for high cost POs and other POs, and the schedule for reducing the TCC Trend Gate are outlined in Appendix C.

**Distribution of TCC Trend for 2012**

![Distribution of TCC Trend for 2012](image)

**Step 2: Calculate Shared Savings Base Incentive Amount**

The shared savings base incentive amount is determined by each individual health plan using their plan-specific P4P results. The shared savings calculation is based on year-over-year improvement on specific resource use measures.

a. A PO’s shared savings base incentive amount is calculated by each of its contracted health plans based on the PO’s plan-specific performance.
b. Calculations are done separately for each ARU measure.

(1) Current measures:  
- Inpatient discharges or bed days PTMY  
- All-cause readmissions  
- Emergency Department visits PTMY  
- % Outpatient procedures in preferred facility  
- % Generic Prescribing – 6 therapeutic areas

(2) Other resource use measures will be added in future years, as appropriate, e.g., preference- and supply-sensitive procedure rates.

c. Health plans determine a PO’s plan-specific utilization target for each ARU measure based on the PO’s previous year’s performance and changes in performance across the whole network.

(1) Since Value Based P4P is an improvement model, the target will generally be the PO’s previous year performance.

(2) To account for the impact of patent expirations on generic prescribing, the P4P committees have recommended that the target for generic prescribing measures should be a PO’s baseline performance adjusted by the 25th percentile of baseline-to-measurement year change across all POs for a plan. This adjustment to the utilization target would be appropriate for therapeutic areas that have recently undergone a patent expiration or the recent release of a major branded drug. Performance is risk adjusted (where applicable) to account for differences in patient populations.

(3) The risk-adjusted metric used to assess performance and change over time is the Observed-to-Expected (O/E) ratio (see Appendix B for more information on O/E ratio).

c. Health plans calculate a PO’s prospective unit cost for a unit of utilization for each ARU measure using their own methodology.

d. The savings amount is the number of units of utilization better than the PO’s target multiplied by the cost per unit of utilization. The savings amount can be positive or negative, and all amounts will be carried through to the final calculation.

(1) Savings are positive if the PO’s performance on the measure improved compared to the previous year.

(2) Savings are negative if the PO’s performance declined compared to the previous year.

e. The base incentive amount for the PO starts at a 50% share of the savings amount.
Step 3: Make Adjustments to Base Incentive Amount

One or more adjustments are made to the base incentive amount. The overall percentage of shared savings earned by a PO, after all adjustments are made, is intended to be in the range of 25% to 75% of savings.

a. Quality Adjustment to Base Incentive Amount
   There will no longer be incentives paid on quality alone. Instead of quality performance being the basis of bonus incentive payments, quality is the expectation. As such, quality serves both as a gate (see 1.a.) and as a multiplier, which adjusts up or down the amount of shared savings incentive a PO earns.

   (1) Quality performance is based on the Quality Composite Score (see 1.b.(2) above).
   (2) The Quality Multiplier is calculated based on a continuous linear scale.
       (a) Below the Quality Gate, the Quality Multiplier is zero.
       (b) The minimum Quality Multiplier is assigned to the Quality Gate threshold.
       (c) For each increase in Quality Composite Score, there is an incremental increase in the Quality Multiplier.
       (d) The maximum Quality Multiplier is set at a “gold standard” of performance.
   (3) The recommended Quality Multiplier scale is outlined in Appendix C.
b. **ARU Attainment Adjustment to Base Incentive Amount (optional)**

For POs that start at a better level of performance (e.g., lower inpatient bed days), 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.

(1) POs that start at a better level of performance on the measure earn a higher percentage of savings for that measure.

(2) POs that start at a worse level of performance on the measure earn a lower percentage of savings for that measure.

(3) P4P recommended values are summarized below and can be found in Appendix C.

**Recommended ARU Attainment Adjustment Values**

<table>
<thead>
<tr>
<th>Baseline Performance</th>
<th>% Earned</th>
<th>Multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top Quartile</td>
<td>65%</td>
<td>1.3</td>
</tr>
<tr>
<td>2\textsuperscript{nd} Quartile</td>
<td>55%</td>
<td>1.1</td>
</tr>
<tr>
<td>3\textsuperscript{rd} Quartile</td>
<td>45%</td>
<td>0.9</td>
</tr>
<tr>
<td>Bottom Quartile</td>
<td>35%</td>
<td>0.7</td>
</tr>
</tbody>
</table>
c. **ARU Improvement Adjustment to Base Incentive Amount (optional)**

In order 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 at PO achieves.

(1) POs that perform a larger amount better than their target for a measure earn a higher percentage of savings for that measure.

(2) POs that perform minimally better than their target for a measure earn a comparatively lower percentage of savings for that measure.

(3) P4P recommended values for the ARU Improvement Adjustment are summarized in the table below and can be found in Appendix C.

<table>
<thead>
<tr>
<th>ARU Improvement</th>
<th>Multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top Quartile of Improvement</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 of Improvement</td>
<td>1.00</td>
</tr>
<tr>
<td>No Improvement</td>
<td>1.00</td>
</tr>
</tbody>
</table>

**Step 4: Sum the Incentive Amounts Across Measures**

The final step is to sum the shared savings amounts for each ARU measure. Individual ARU measure shared savings incentive amounts can be positive or negative. Negative amounts offset positive amounts when shared savings incentive amounts are summed across all ARU measures.

a. Health plans calculate savings for each contracted PO for each ARU measure (see steps 2 and 3 above).

   (1) Savings are positive if performance on the measure improved.

   (2) Savings are negative if performance on the measure got worse.

b. Health plans sum a PO’s savings across all ARU measures.

   (1) A PO’s savings from improvements in some ARU measures are offset if the PO’s performance has decreased on other ARU measures.

   (2) If the sum across all ARU measures is positive, the PO earns that amount as a shared savings incentive.

   (3) If the sum across all ARU measures is negative, it is zeroed out; the PO bears no risk.
**Special Consideration – Full Risk POs**

One of the guiding principles for Value Based P4P (see page 2) is that the program is intended to be available to all POs, including full risk POs. The amount of savings to be shared in Value Based P4P is calculated based on reductions in resource use (such as inpatient bed days and ED visits), and adjusted by quality performance. Reductions in resource use in full-risk POs, however, do not yield any health plan savings to share. As a result, a special incentive design is needed for full-risk POs. Three recommended design options for full-risk POs are outlined below.

a. **Apply the Value Based P4P performance gates (i.e. Quality and TCC Trend gate), and as long as the PO passes the gates, the PO would be eligible for an incentive based on Quality performance, using the health plan’s current methodology (e.g. classic P4P payment methodology) for Quality incentives.**

b. **Apply the full Value Based P4P design outlined in this document to the generic prescribing measures only.**

Apply the Value Based P4P performance gates (i.e. Quality gate and TCC Trend gate), and as long as the PO passes the gates, the PO would be eligible for an incentive. Create a value score, adjusting the Quality Composite Score 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. This value score would then be used by health plans to distribute incentives across their full-risk POs.

P4P recommended values for the cost adjustment to the Quality Composite Score are available in Appendix C.

Health plans may use any one or a combination of the different methodologies in their Value Based P4P incentives.
Special Consideration – Small POs

Reliability and year-over-year stability of measure results is problematic for some POs, especially small POs. In the spirit of supporting universal PO participation, the P4P committees considered options that would allow small POs to participate in Value Based P4P despite the measurement stability difficulties. For small POs, the recommended solution is to calculate a Weighted Small PO Result for the ARU measures on a plan-specific basis and use 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.

a. Small POs are defined as those with fewer than 1,500 member years of Commercial HMO/POS enrollment with a plan.

b. To calculate the Weighted Small PO Result, the results for all small POs within each plan are pooled.

c. A weighted average, based on enrollment, is used to blend the pooled result with each small PO’s own measure result.

d. The weighting placed on the PO’s own result increases proportionally with membership from 0 member years up to 1,500 member years.

(1) For example, at an enrollment of 750 member years, the Weighted Small PO Result will be based 50% on the PO’s own measure result and 50% on the plan’s small PO pool.
**Health Plan Funding Options**

Another guiding principle for Value Based P4P is that the program should not increase a health plan’s total cost trend. The recommendation to allow negative “savings,” which offset positive savings (see step 4), helps address this. Other ideas are provided below for health plan consideration. Each health plan will determine on their own how they will fund their Value Based P4P program so that it is cost neutral.

a. Incentive pool based on a health plan’s total cost performance
   
   (1) The incentive pool could be comprised of any amount below the total of the health plan’s commercial HMO/POS costs for the previous year and the plan’s budgeted overall commercial HMO/POS trend.

   (2) Each PO’s incentive amount could then be proportionally adjusted (up or down) to fit the pool.

b. Plans would initially pledge funds that are redirected from other incentive programs; these pledged amounts could taper off over time and the program would become more self-funding

   (1) Current P4P quality incentives

   (2) Current P4P ARU incentives

   (3) Other plan-specific (shared risk) incentive programs

c. “Performance Based Capitation Contracting”

   (1) POs would agree to a lower base capitation increase in line with CPI.
      
      (a) Baseline capitation levels would be lower than the recent trend increase in California capitation agreements, which have tended to be higher than CPI and FFS cost trends.

   (2) POs could earn an additional cap increase for the subsequent year by achieving specific quality and affordability targets directly within their control.
      
      (a) Reward POs for taking actions that improve quality of care while decreasing cost of care.

      (b) There should be upside potential, beyond the normal cap increase.

   (3) Earned cap increases would be for the subsequent year only, i.e., they would be non-cumulative.

   (4) Health plans would agree to take the risk that unit costs would offset the efficiency actions of the POs, in return for POs accepting capitation increases that bend the cost curve.
**Evaluation of Impact**

P4P will use an iterative process to evaluate and fine tune the Value Based P4P program design. There will be an annual evaluation of whether the Value Based P4P program is meeting its objectives. Program performance metrics will be developed to monitor progress and will be used as the basis for the evaluation. If the evaluation indicates that the program is not meeting its objectives, appropriate modifications will be considered to address the shortcomings.

**Next Steps**

With standardized measurement of quality and cost available, it is possible to use these measures to assess the value produced by each PO in a consistent way statewide. Work will be done by the P4P Technical Payment Committee to recommend a preferred way to bring these two domains together in a calculation of value. The value calculation could support value based benefit design efforts by health plans and employers and engage consumers in making value based healthcare decisions. It will take the active engagement of all stakeholders to make a value based healthcare system a reality.
APPENDIX A: Value Based P4P Basic Design Construct

**Step 1a – Quality Gate:**
Is Quality Composite Score ABOVE Threshold?

**Step 1b – Total Cost of Care Trend Gate:**
Is TCC Trend BELOW Threshold?

**Step 2** (repeat for each ARU measure) –
Calculate **Base Incentive Amount** Using Appropriate Resource Use (ARU) Measures =
# of units of utilization below target
* unit cost per unit of utilization
* 50%

**Step 3a** – Apply **Quality Adjustment** to Base Incentive Amount

**Step 3b** (optional) – Apply **ARU Attainment Adjustment** to Base Incentive Amount

**Step 3c** (optional) – Apply **ARU Improvement Adjustment** to Base Incentive Amount

**Step 4** –
Sum Incentive Amounts across ARU Measures; negative amounts offset positive amounts

Value Based P4P SHARED SAVINGS INCENTIVE
APPENDIX B: Observed-to-Expected Ratio

A common characteristic of the measures that include risk adjustment is the use of an observed-to-expected ratio (also referred to as an observed/expected [O/E] ratio). The ARU measures that use an O/E ratio to assess performance are:

- Inpatient discharges PTMY
- Inpatient bed days PTMY
- All-cause readmissions within 30 Days
- Emergency Department visits PTMY

Assessing Performance

The O/E ratio compares the PO’s observed rate for the ARU measure with the PO’s expected rate for that measure.

\[
\frac{O/E \text{ Ratio}}{\text{ Expected Rate}} = \frac{\text{Observed Rate}}{\text{Expected Rate}}
\]

The observed rate is the PO’s utilization rate for that ARU measure calculated per the specifications (e.g. number of bed days per 1,000 member years or percent of admissions that result in a readmission).

The expected rate, which considers the risk or illness burden of the PO’s population, is calculated by IHA (through its contract with Truven Health Analytics) and represents the utilization rate that is expected for the PO based on the age, gender, and health status of the PO’s members. POs with higher-risk (i.e., sicker) members are expected to have higher utilization and, therefore, have higher expected rates. Similarly, POs with lower risk members are expected to have lower utilization and have lower expected rates. Please note that the calculation of the expected rate is based on utilization and risk patterns in the P4P population, not on national or other external benchmarks.

<table>
<thead>
<tr>
<th>O/E Ratio</th>
<th>Interpretation – Given the risk of the PO’s members:</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 1.0</td>
<td>PO’s utilization is higher than expected</td>
<td>1.3 means the PO’s utilization is 30% higher than expected</td>
</tr>
<tr>
<td>= 1.0</td>
<td>PO’s utilization is the same as expected</td>
<td></td>
</tr>
<tr>
<td>&lt; 1.0</td>
<td>PO’s utilization is lower than expected</td>
<td>0.9 means the PO’s utilization is 10% lower than expected</td>
</tr>
</tbody>
</table>

Assessing Year-over-year Change

Since a lower rate on these ARU measures indicates better performance:

- A year-over-year decrease in O/E ratio indicates improvement in performance, and
- A year-over-year increase in O/E ratio indicates a decrease in performance.
APPENDIX C: Value Based P4P Recommended Values

As indicated on page 4, the gate thresholds and multiplier ranges are considered “optional” elements in the Value Based P4P design, and can be modified or waived while still complying with the spirit of the program. To help channel variability and to serve as a basis for comparing programs across health plans, the P4P 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>Quality Composite Score of 10%</td>
<td>A score of 10% indicates that a PO earned, on average, 1 point for every measure. This means they met the 75th percentile threshold or closed the gap 10% between their prior year performance and the benchmark. This shows a PO is engaged in quality improvement.</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</td>
<td>The recommendation is to use a three-year average of the US Consumer Price Index, which would be based on the two years immediately preceding the measurement year and the measurement year.</td>
</tr>
<tr>
<td></td>
<td>• Standard Threshold</td>
<td>The recommendations for 2015 and 2016 are aspirational goals that will be reviewed as the program proceeds.</td>
</tr>
<tr>
<td></td>
<td>• High Cost POs</td>
<td>The TCC Trend Gate for High Cost POs is set two percentage points below the standard threshold.</td>
</tr>
<tr>
<td>High Cost PO Definition</td>
<td>POs with Geography Adjusted TCC above the plan-specific 90th percentile for both baseline and measurement year</td>
<td>The Committees felt it was important to hold POs that have consistently high costs to a stricter TCC Trend Gate to further incent improved affordability for these POs.</td>
</tr>
<tr>
<td>Quality Adjustment</td>
<td>Continuous linear scale based on Quality Composite Scores from the quality gate threshold of 10% to the gold standard of 75%, 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 Value Based P4P 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 C: Value Based P4P Recommended Values
(continued)

<table>
<thead>
<tr>
<th>Design Element</th>
<th>Recommended Value</th>
<th>Notes/Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ARU Attainment Adjustment (Optional)</strong></td>
<td>Adjust incentive by quartile of performance in baseline year:</td>
<td>Considering the ARU Attainment Adjustment in isolation, multipliers of 0.7 and 1.3 correspond with a PO earning a 35% and 65% share of the savings, respectively.</td>
</tr>
<tr>
<td></td>
<td>• Top Quartile: 1.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 2nd Quartile: 1.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 3rd Quartile: 0.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bottom Quartile: 0.7</td>
<td></td>
</tr>
<tr>
<td><strong>ARU Improvement Adjustment (Optional)</strong></td>
<td>Additional incentive awarded to POs with greatest improvement between years:</td>
<td>These adjustments provide for an increase of 5% to 15% to a PO’s incentive for making greater improvements relative to other POs. Specifically, the top quartile of POs that had positive improvement on an ARU measure will earn a 15% increase to their incentive. The next two quartiles would earn a 10% and 5% increase, respectively. There would be no adjustment for the 25% of POs with the lowest improvement and for those POs whose performance declined (i.e., negative savings). Considering the ARU Improvement Adjustment in isolation, multipliers of 1.0 and 1.15 correspond with a PO earning a 50% and 57.5% share of the savings, respectively.</td>
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<tr>
<td></td>
<td>• Top Quartile: 1.15</td>
<td></td>
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<td></td>
<td>• 2nd Quartile: 1.1</td>
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<td>• 3rd Quartile: 1.05</td>
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<td>• 4th Quartile: 1.0</td>
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<td>• No Improvement: 1.0</td>
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<tr>
<td><strong>Full-Risk Physician Organization Cost Adjustment (design option #3)</strong></td>
<td>The cost performance adjustment varies based on a continuous linear scale from a decrease of <strong>20%</strong> to an increase of <strong>20%</strong> based on the PO’s geography- and risk-adjusted Total Cost of Care for the measurement year and specific plan. The adjustment is applied relative to the 10th and 90th percentile of P4P TCC performance for all POs.</td>
<td>Using the recommended values, a physician organization would receive up to a 20% increase or decrease in their score based on whether they were at the 10th percentile or 90th percentile, respectively, of P4P cost performance. PO’s with cost results at or below the 10th percentile would receive the maximum increase of 20%; PO’s with cost results at or above the 90th percentile would receive the maximum decrease of 20%.</td>
</tr>
</tbody>
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