Value Based Pay for Performance in California

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Value Based P4P is a shared savings model which holds physician organizations accountable for the cost, cost trend, and resources used for all care provided to their commercial HMO/POS members, as well as the quality of this care.

INTRODUCTION: FROM QUALITY TO VALUE IN P4P

IHA's California Pay for Performance (P4P) program is designed 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, a public report card, health plan incentive payments, and public recognition. Founded in 2001, this program represents the longest running U.S. example of data aggregation and standardized results reporting across diverse regions and multiple health plans. The Integrated Healthcare Association (IHA) runs the program on behalf of eight health plans representing 9 million commercial HMO/POS enrollees, and is responsible for collecting data, deploying a common measure set, and reporting results for approximately 35,000 physicians in over 200 physician organizations (PO).

Since the program's inception, stakeholders have focused primarily on measuring and improving quality; however, during this time, the costs of care have continued to rise unabated. This has fueled concerns over the long-term sustainability of the HMO product in California, and focused the attention of P4P stakeholders on cost alongside quality.

In response, the P4P program adopted value, which encompasses both cost and quality, as the ultimate goal between 2011 and 2015. The primary initiative for reaching this goal is Value Based Pay for Performance (Value Based P4P), a shared savings model which holds POs accountable for the cost, cost trend, and resources used for all care provided to their commercial HMO/POS members, as well as the quality of this care. The new program design was developed in collaboration with health plans and POs participating in P4P, with the intent of aligning POs and health plans toward a more price-competitive HMO product. Specific objectives are:

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

Significant time and effort has been invested over the last two years in reaching a broad consensus among health plans and POs on key parameters of the Value Based P4P design. A major initial hurdle involved the collection of baseline data on total cost of care, which required working through challenging technical issues of data element definition and data aggregation from multiple plans, reaching agreement on how the resulting data could be used, and creating non-disclosure agreements to protect this sensitive data. Extensive subsequent discussions took place related to how total cost of care data would be incorporated into the Value Based P4P design to ensure that all stakeholders had the opportunity to participate in the design of the program.

This issue brief reviews the core elements of the current P4P program, introduces the design of value based P4P, and highlights results to date.

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PAY FOR PERFORMANCE IN CALIFORNIA: OVERVIEW AND CURRENT STATUS

Quality incentive payouts from health plans to California POs started at $38M in 2004, peaked at $65M in 2007, and leveled off at about $50M for each of the last several years, in part the result of diminishing HMO enrollment. In all, about $450M has been paid, not including measurement year 2012 (for which payout takes place in 2013). Seven California health plans contribute data and provide incentive payments based on the aggregated P4P results: Aetna, Anthem Blue Cross, Blue Shield of California, Cigna Healthcare of California, Health Net, UnitedHealthcare, and Western Health Advantage. Each plan determines its own budget and methodology for calculating incentive payments to the POs. Kaiser Permanente POs serving both Northern and Southern California participate in public reporting only.

California POs benefit from a common rating system, avoiding the duplication and confusion that would result from each health plan creating a separate incentive program. Having a standardized measure set also benefits consumers, since California consumers are able to get comparable information on the clinical performance of nearly 200 POs on the website of the state's Office of the Patient Advocate (**www.opa.ca.gov**).

The original measure set implemented in 2003 included 25 measures; by 2013, the P4P common measure set had grown to a total of 73 measures recommended for payment and 21 additional measures for collection and internal reporting. Each year, measures are reviewed through P4P's governance process; measures may be modified, added, or retired. The core domains and measures used for payment are briefly outlined below; the complete set of measures included in the *Approved MY 2013 P4P Measure Set* available at **www.iha.org**.

Clinical Quality Domain The 31 clinical quality measures include process and outcome measures, using standardized national measures wherever possible. Measurement focuses on six priority areas: prevention, cardiovascular, diabetes, maternity, musculoskeletal, and respiratory. The clinical domain relies solely on electronic data sources, including automated claims and encounter data and supplemental administrative databases.

Meaningful Use of Health Information Technology Physician organizations complete an online tool to collect information for the 15 measures in this domain, which align with the CMS and Office of the National Coordinator for HIT measures of meaningful use requirements. The survey covers various aspects of HIT in clinical practice, including use of computerized physician order entry, electronic transmission of prescriptions, maintenance of active medication and medication allergy lists, and recording of demographics, vital signs, smoking status, and ambulatory clinical quality measures.

Patient Experience Patient ratings of care received from doctors and other providers in the PO are collected via the Patient Assessment Survey (PAS), which is aligned with the national CAHPS Clinician and Group survey tool. The 6 measures included in the 2013 P4P measure set relate to doctor-patient communication, timely access to care, coordination of care, and overall ratings of care.

Appropriate Resource Use Health plans submit enrollment, claims and encounter data for calculation of the 12 measures in this domain. Core measures focus on:

- inpatient utilization (acute care discharges, bed days)
- inpatient readmissions (HEDIS-based all-cause)
- emergency department visits
- outpatient procedures utilization (percentage done in a preferred facility)
- generic prescribing for several conditions (anti-ulcer, cardiac—hypertension and cardiovascular, diabetes, nasal steroids, antidepressants, anti-hyperlipidemics)
- Cesarean section rate for low-risk birth

Total Cost of Care TCC measures actual payments associated with care for all commercial HMO/POS enrollees in a PO, including all covered professional, pharmacy, hospital, and ancillary care, as well as administrative payments and adjustments. Participating health plans report a single lump sum payment for each member of all contracted POs to a data aggregator; the lump sum includes both capitation and fee-for-service payments, as well as member co-payments, paid to the PO or any providers caring for its members (e.g., hospitals, pharmacies, etc.). Per member costs above $100,000 per year are truncated; payments for mental health and chemical dependency services, acupuncture or chiropractic services, dental and vision services, and P4P quality incentive payments are excluded from the calculation. Member-level relative risk scores are calculated using Verisk's DxCG Relative Risk methodology to adjust for a member's age, gender, and health status (identified through diagnosis codes). Of note,

this approach does not release unit cost information, in part due to confidentiality clauses in plan-provider contracts and concerns about competitor access to price information. As a result, the health plans do not share information on the cost of each inpatient admission or MRI; those costs are rolled up into a single cost figure associated with each member. More granular price information may become available over time, as the program matures.

Extensive information is available on the history, evolution, and current status of P4P in California on IHA's website, **www.iha.org**.

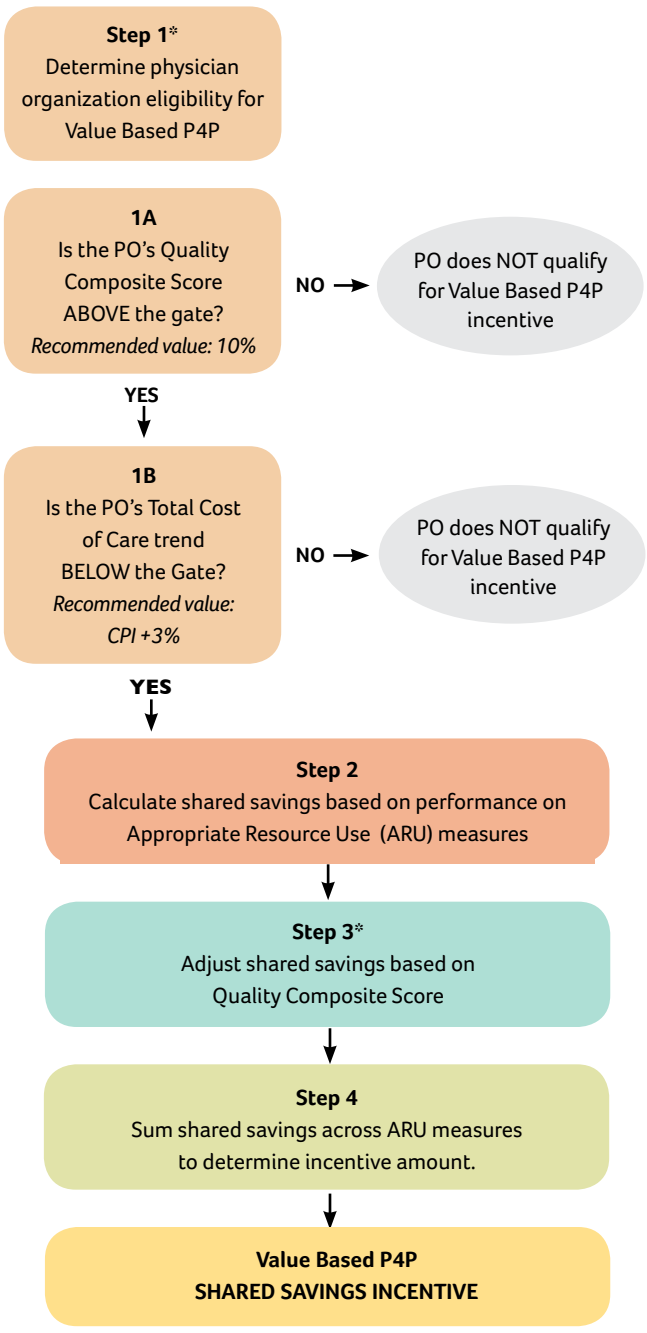
VALUE BASED PAY FOR PERFORMANCE: DESIGNING THE FUTURE OF P4P

Standardization of performance measures is a central element of pay for performance, and a key advantage of the Value Based P4P design is the potential for health plans to consolidate their incentive programs into a single shared savings initiative. At present, health plans utilize IHA's P4P program to reward POs for quality, and maintain distinct shared savings programs to create incentives for utilization management. Value Based P4P provides an opportunity to consolidate these two approaches, integrating cost and quality incentives with the potential to increase the overall pool available to reward performance. However, as with all P4P recommendations, health plan adoption of all or some aspects of the recommendations is completely voluntary. There are four components to the Value Based P4P incentive design, as outlined below and summarized in the flow chart in Figure A.

Step 1: Determine physician organization eligibility for Value Based P4P. POs must meet minimum standards for both quality and cost of care in order to gain entry into the incentive program. The Quality Composite Score incorporates results from clinical quality, meaningful use of HIT, and patient experience of care metrics described above. The cost "gate" is trend in the Total Cost of Care measure described above. For 2013, the IHA-recommended values are a Quality Composite Score of 10% and an increase in Total Cost of Care that does not exceed CPI+3%. Recognizing that measurement is imperfect, a one-sided 85% confidence interval increases the certainty that a PO is correctly excluded at the TCC trend gate. If either quality or cost threshold is not met, the PO is ineligible for incentive payments.

Figure A

VALUE BASED PAY FOR PERFORMANCE: FOUR KEY STEPS



**Steps 1 and 3 feature additional optional steps that health plans may choose to include, as described in text*

For high-cost POs, defined as those at the 90th percentile of the cost distribution for two consecutive years (adjusted for geography), the Total Cost of Care trend gate is CPI +1%. The more stringent threshold for high-cost physician organizations resulted from extensive discussion regarding how to engage the high-cost POs in Value Based

P4P without rewarding them for historically high costs. Setting an absolute cost threshold would have excluded them altogether, while applying the same trend threshold across all POs would have allowed high-cost POs to qualify for the program with a larger year-over-year cost increase. The design decision to set the threshold for the high-cost POs at CPI +1% creates an ambitious but attainable target.

An additional optional third "gate" is available to health plans interested in minimizing the likelihood that POs qualify for Value Based P4P based on random variation rather than performance. This Aggregated Performance Improvement gate requires that POs show improvement on an appropriate resource use measure aggregated across the PO's contracted health plans in order to be eligible for an incentive payment for that measure.

Step 2: Calculate shared savings based on performance on the Appropriate Resource Use (ARU) measures. As described above, the 12 ARU measures include inpatient utilization and readmissions, emergency department visits, outpatient procedures utilization (percentage done in a preferred facility), generic prescribing for several therapeutic areas, and cesarean section rate for low-risk birth (new in 2013). IHA's recommended approach, which can be adjusted by health plans to meet specific objectives, is as follows for each appropriate resource use measure: the number of units of utilization below the target is multiplied by the unit cost; 50 percent of the resulting amount (which may be positive or negative) is the PO's base incentive amount for that ARU measure. The recommended shared savings calculation is based on year-over-year improvement on the resource use measures rather than attaining specific targets. As a result, POs must show continued improvement each year in order to qualify for shared savings on an annual basis.

Step 3: Adjust shared savings based on Quality Composite Score. IHA's recommended quality adjustment translates to a two-fold difference between the lowest- and highest-performing physician organizations. The sizeable adjustment to the incentive amount based on quality reflects a key design decision to maintain quality as a key component of the shared savings model alongside cost.

In addition to the quality adjustment, there are two optional adjustments that health plans may choose to apply in Value Based P4P: 1) ARU attainment and 2) ARU improvement. Through the ARU attainment adjustment, health plans can increase the reward for POs that are high-performers on specific ARU measures, recognizing that continued improvement becomes more difficult over time. The ARU improvement adjustment provides a way for health plans to incentivize POs to maximize their improvement on particular ARU measures.

Step 4: Sum shared savings across ARU measures to determine incentive amount. POs that performed well on some measures and poorly on others can still receive an incentive payment—as long as the net result is favorable. Shared savings, in the Value Based P4P design, applies to the PO's performance across all ARU measures. While POs cannot earn incentives unless the net result is positive, there is no "downside risk"—a net negative shared savings does not require repayment to a health plan.

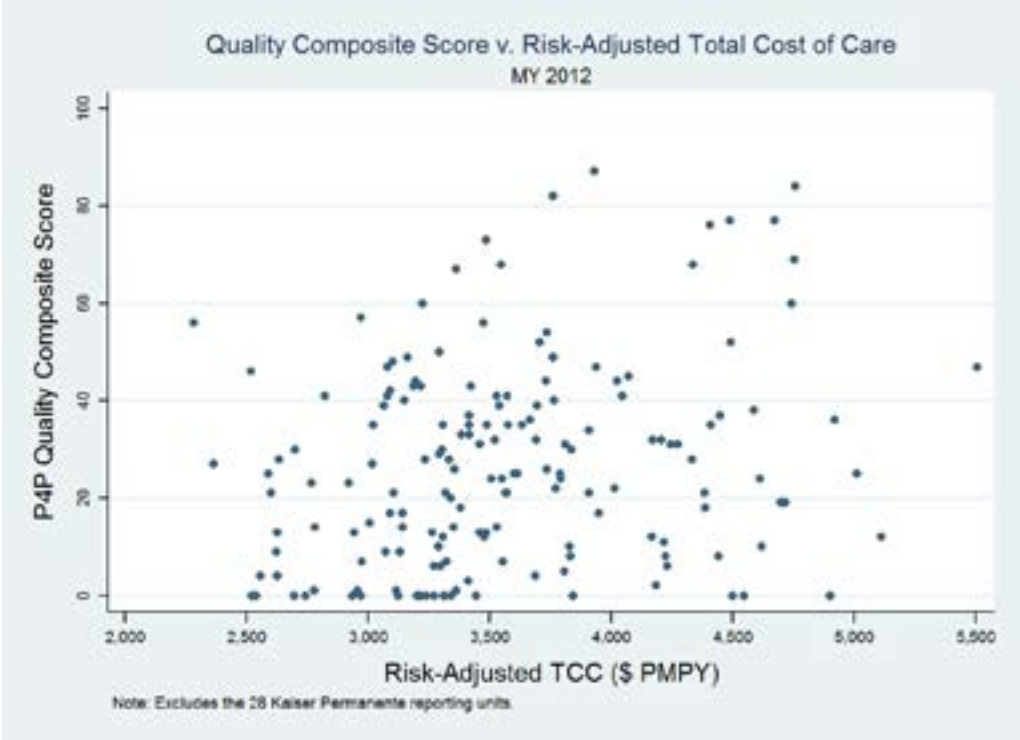
Additional details on the process, metrics, and calculations for each step are available in the March 2013 document Value Based Pay for Performance Design, available at **www.iha.org**.

IMPLEMENTATION AND RESULTS

Implementation of Value Based P4P is well underway. To assist both health plans and POs with the process of understanding and using the results of the Value Based P4P process, IHA created tailored worksheets allowing each organization to modify key variables (e.g., the value of the quality and cost trend thresholds that determine eligibility for incentives) and observe the effect of the change on the shared savings payment. For example, if the Quality Composite Score threshold was 5% or 50% instead of the recommended value 10%, what would be the effect on the shared savings paid out (by the health plan) or earned (by the PO)?

One health plan, Blue Shield of California, has adopted the new program design in full for measurement year 2013 and will pay POs based on the results when they become available in 2014. Two other health plans, UnitedHealthcare and Aetna, have begun the transition process and will fully implement Value Based P4P for measurement year 2014. The remaining health plans are moving in that direction over the next 1-2 years. A major reason for the staggered implementation process is that the health plans have different contracting cycles; since the shared savings component of Value Based P4P requires modification to the plan-provider contract, the implementation timeline varies for each plan. Regardless of their stage in the transition

Figure B



process, all of the health plans are continuing to collect and submit data on the P4P metrics.

Even before the first full cycle of measurement, reporting, and incentive payments based on Value Based P4P is completed in 2014, the initiative has yielded tangible results. Physician organizations are highly engaged in understanding their results, particularly on Total Cost of Care. High-cost POs are particularly interested—for the first time they have clear and complete information on their cost performance relative to peers. Moreover, the engagement from participants indicates that the measurement approach and early results are viewed as credible by both POs and health plans.

Indeed, the initial data on Total Cost of Care demonstrates interesting results as shown in the scatterplot (Figure B). Risk-adjusted total cost of care, on a per member per year basis, ranges from under $2,300 to approximately $5,500 for measurement year 2012. The POs at the high end are more than twice as costly as those on the low end of the distribution—and there is no clear correlation with Quality Composite Scores. It will be interesting to track the scatterplot results over time; while it may not be possible to attribute changes to the Value Based P4P program, the program may well contribute to lower costs, higher quality, and less variation in both cost and quality scores as a result of systematic feedback to POs.

Next Steps

Value Based P4P will evolve and improve as implementation continues; IHA's process includes regular opportunities for participant review and feedback, with annual modifications to the design and metrics as approved by the P4P committees. Even as implementation is in full swing, the program provides a template for the next phase of IHA's performance measurement efforts: accountable care organizations (ACO). Based on stakeholder requests, work is underway to use Value Based P4P as a starting point to develop a standard approach to shared savings for ACOs. This initiative provides an opportunity to expand the scope of standardized performance measurement on both cost and quality so that it includes PPO enrollees—a first for P4P in California.

IHA's Pay for Performance team—Lindsay Erickson, Brian Goodness, Kelly Miller, and Gail Rusin —contributed significantly to the development of both the program and this issue brief.