California P4P and Performance Based Contracting

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Agenda

- California P4P Program Basics
- California P4P Results
- Developing/Harmonizing Efficiency Measures
- The Road Ahead: Performance-Based Contracting

CA P4P Program Evolution

2003
Measure/report/incentivize
Quality only

2009
Measure Efficiency alongside Quality and incentivize both

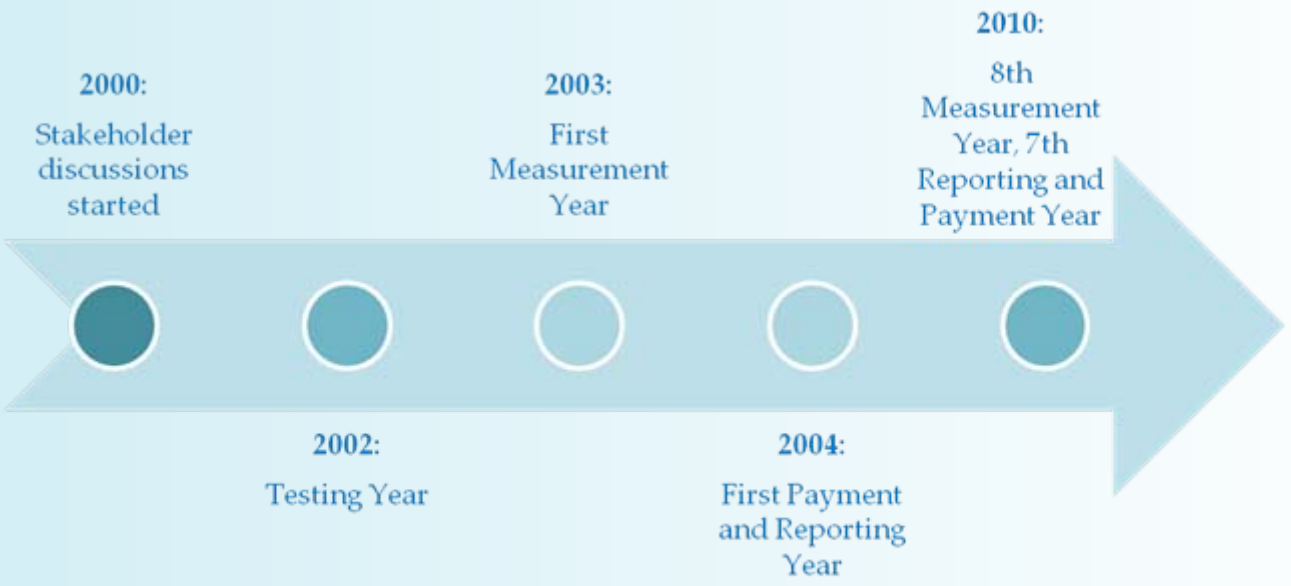
2011
Incentivize Efficiency and use Quality as threshold and multiplier
– OR – Fund Quality incentive out of Efficiency Savings

Original Goal of P4P

To create a compelling set of incentives that will drive breakthrough improvements in clinical quality and the patient experience through:

- √ Common set of measures
- √ A public report card
- √ Health plan payments to physician groups

California P4P Program Overview



Program Participants

Eight CA Health Plans:

- Aetna
- Anthem Blue Cross
- Blue Shield of CA
- CIGNA
- Health Net
- Kaiser*
- PacifiCare/United
- Western Health Advantage

Medical Groups and IPAs:

- Over 225 Groups
- 35,000 Physicians

10.5 million commercial HMO members

CA P4P Measurement Set

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

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

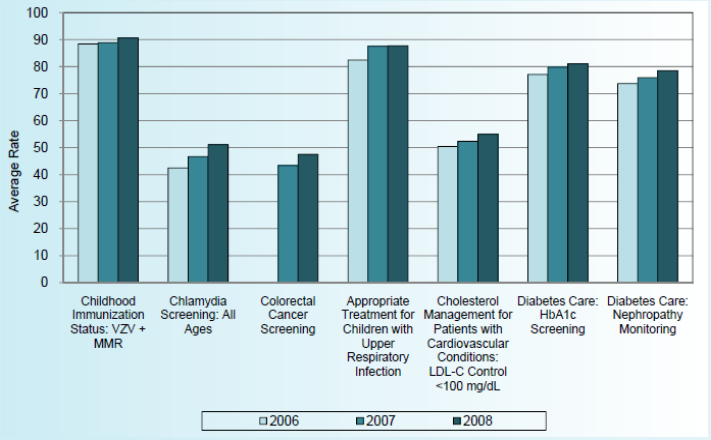
CA P4P Results

Finding #1: Results Consistent with National P4P Trends

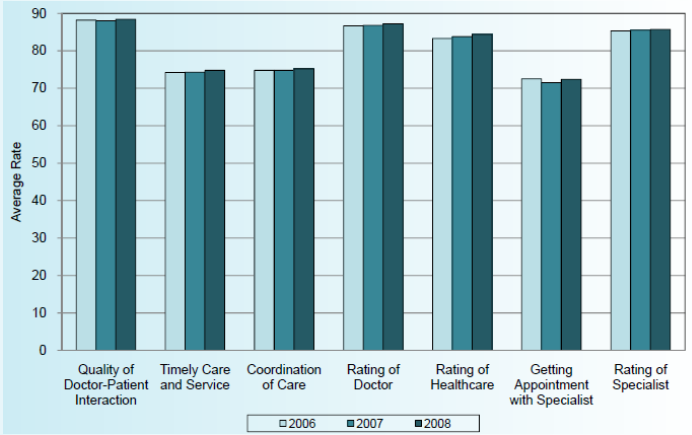
- Steady incremental Clinical performance improvement
  - Average annual increase of ~3 percentage points
  - 1.3 to 25.6 percentage point increases since measure inception through 2008
- Patient Experience performance remained stable, with only marginal improvement
  - Initial promising increase between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

CA P4P Results

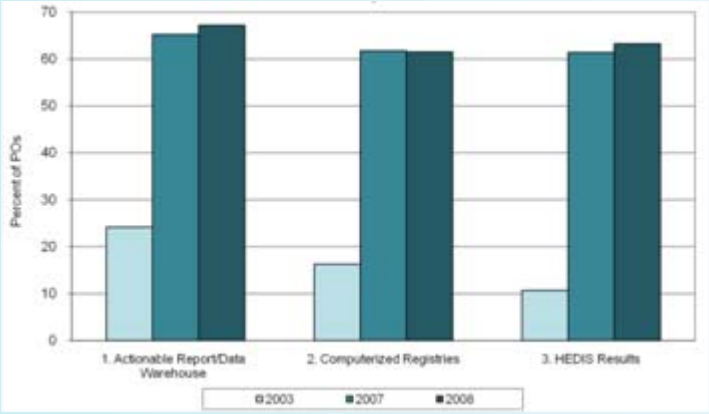
Clinical Averages 2006-2008



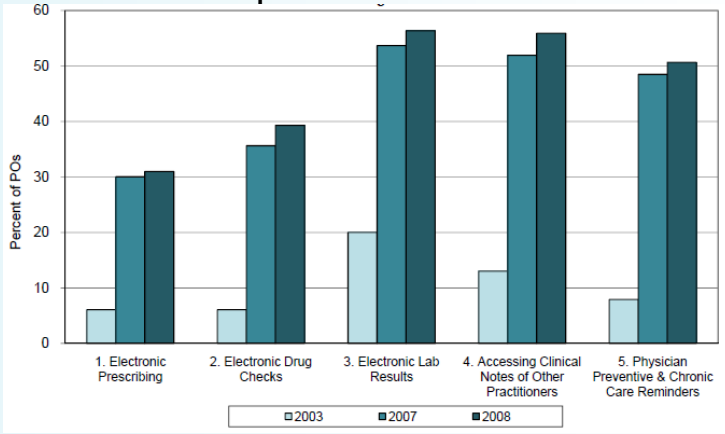
Patient Experience Averages 2006-2008



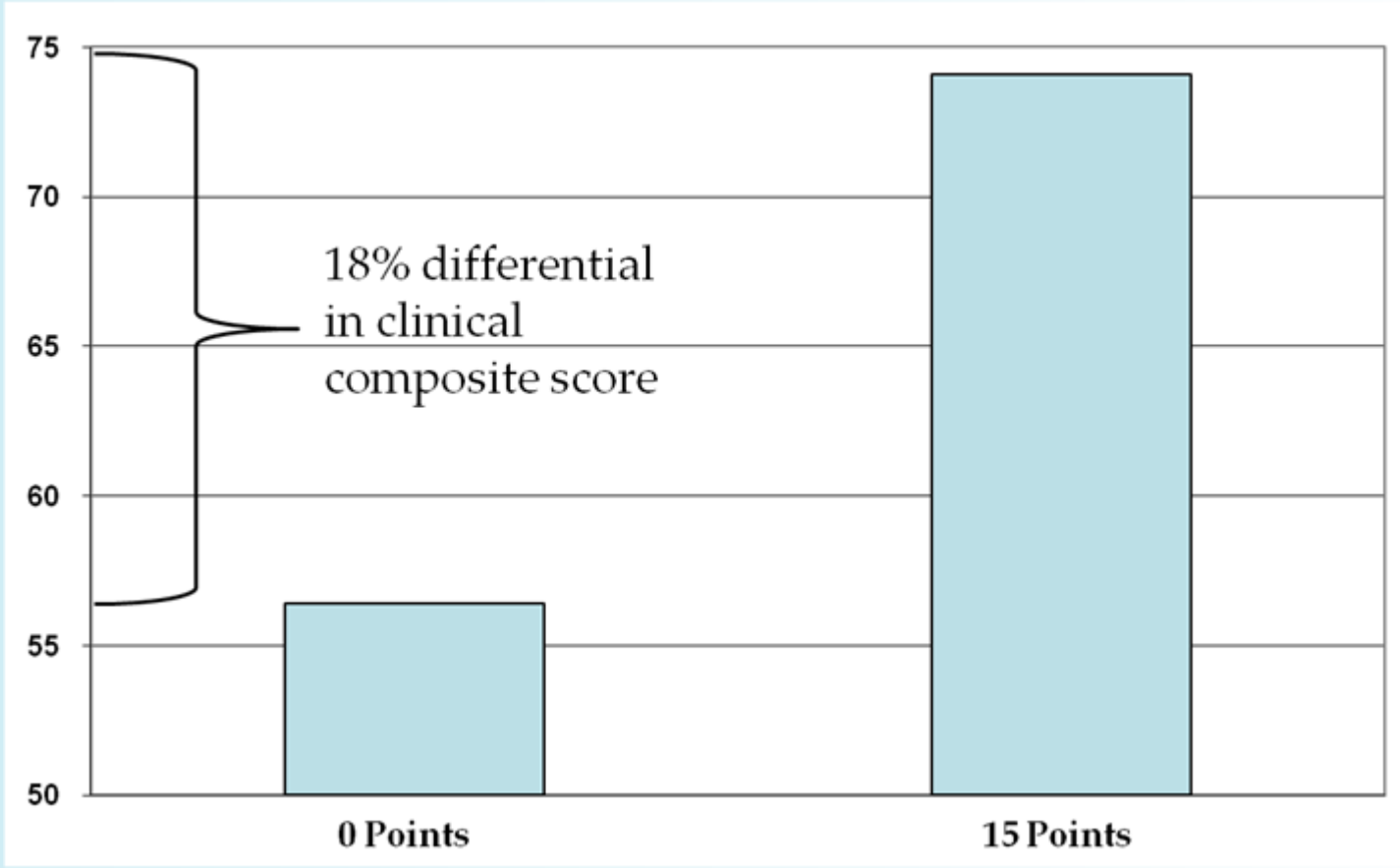
Population Management IT Activity Adoption 2003-2008



Point of Care IT Activity Adoption 2003-2008



2008 Correlation Between Clinical Performance and IT Capabilities

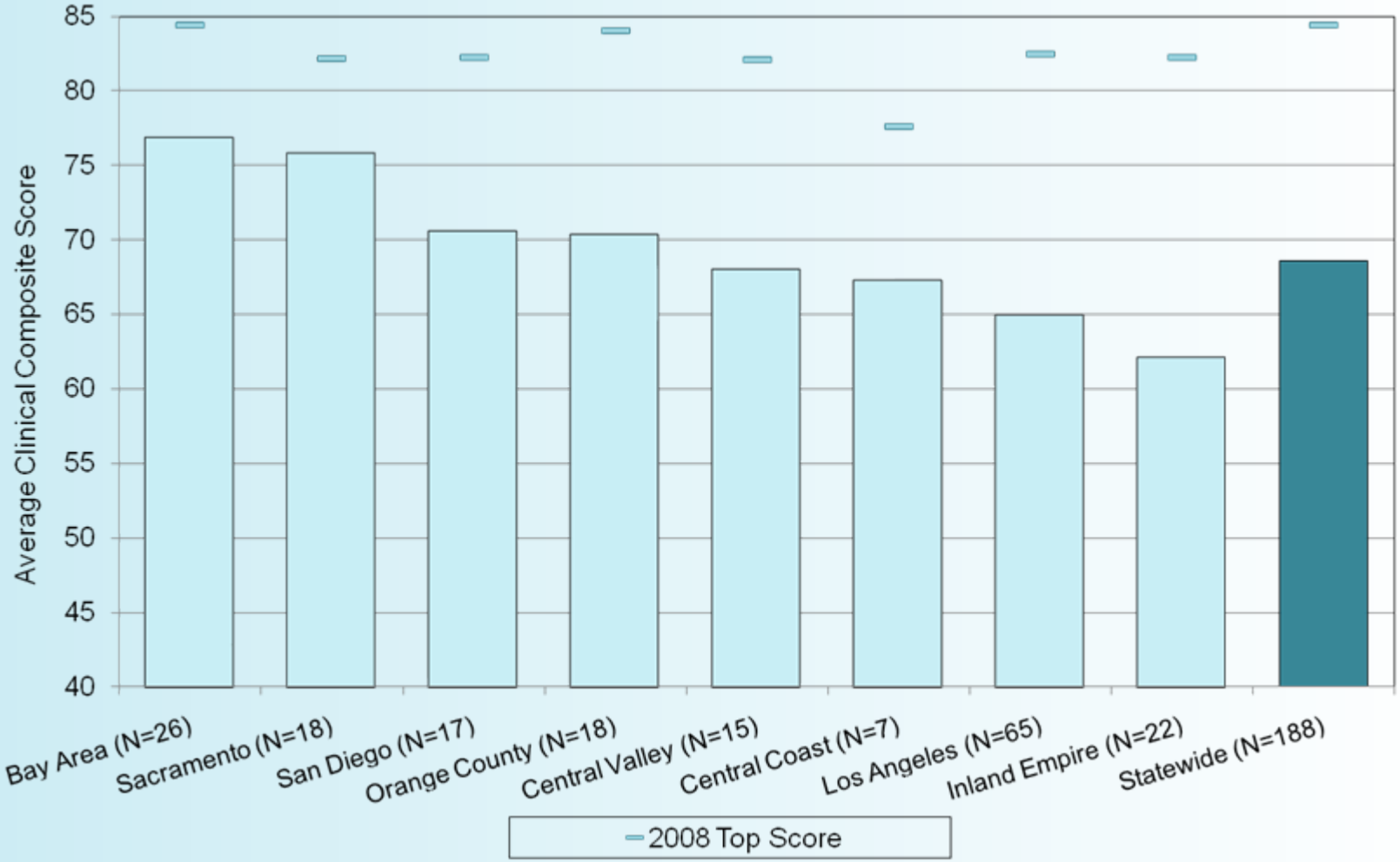


Finding #2: Dramatic Regional Variation in CA

- Clinical composite scores range from 62% to 77%
- May help explain overall mediocre performance of California in comparison to other states
- Prompted recognition and pay for improvement
  - Ronald P. Bangasser Memorial Award for Quality Improvement introduced in 2007
  - Recommended payment methodology uses the higher of attainment and improvement
- Inspired research on potential causes e.g., socio-economic and payment disparities

Regional Variation in Clinical Performance

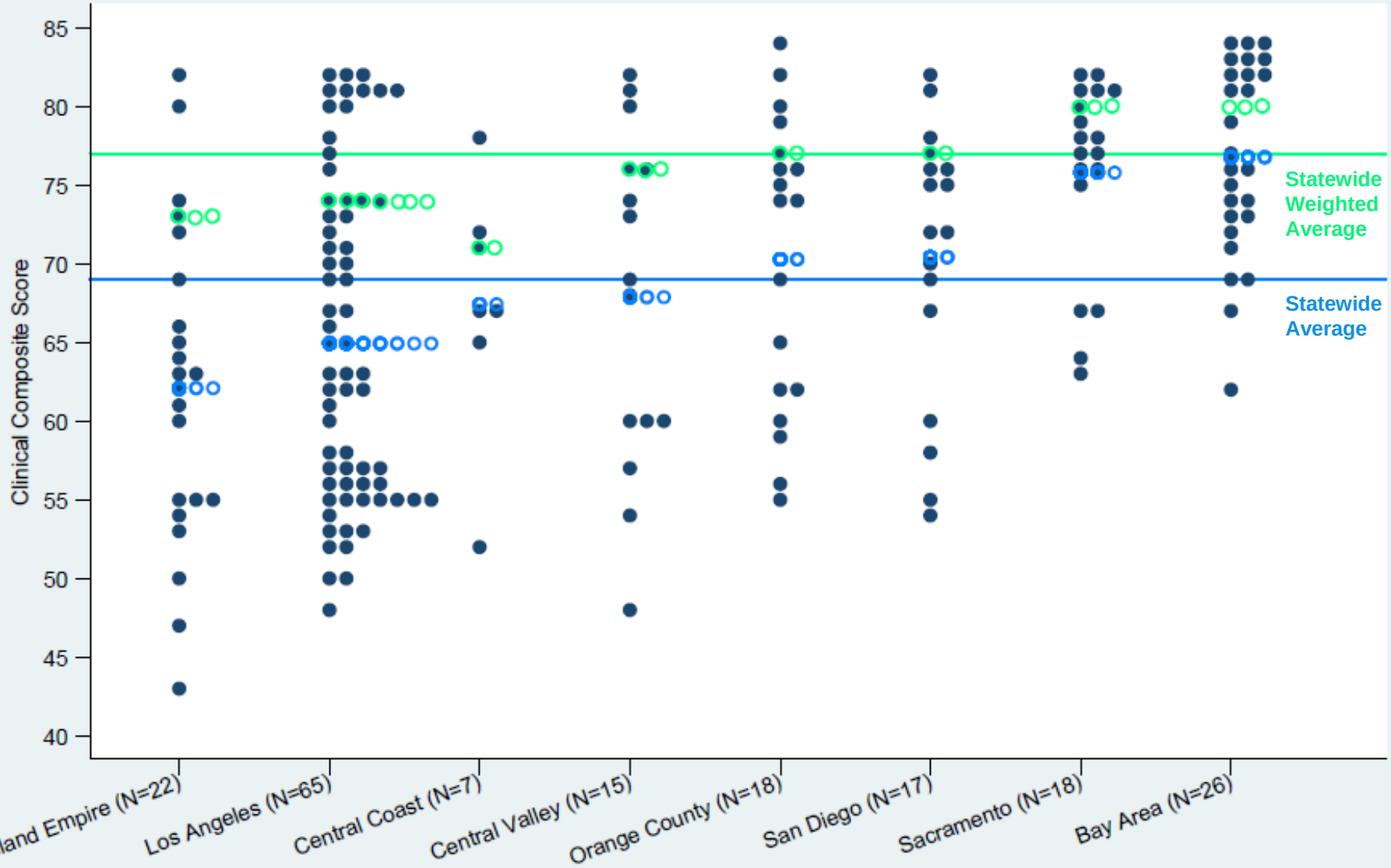
California 2008



Clinical performance is based on the average clinical composite score of groups in the region.

Regional Variation in Clinical Performance

California 2008



Regional Average

Regional Weighted Average

Finding #3: Differing Points of View on Incentives

- Physician Groups – Quality incentive payments averaging ~1% of physician group compensation are insufficient
- Health Plans – level of improvement is insufficient for incentives paid ($315 M in 6 years)
- Nationally, average P4P incentive ~7% of total compensation (includes efficiency)
- Wide payment variability across participating health plans (over 6-fold difference) has led to "free-rider" concerns and reduction in payments from higher paying plans

Developing/Harmonizing Efficiency Measures

The Push for Efficiency Measurement

- Demand by purchasers and health plans that cost be included in the P4P equation

  Quality + Cost = Value

- Opportunity for common approach to health plan and physician group cost/risk sharing
- Demonstrate the value of the delegated, coordinated model of care

Measuring Efficiency

- Original Intent:
  - Episode and population-based measures
  - Standardized and actual costs
- Findings/Conclusions:
  - Data limitations
  - Small numbers issue
  - Episode results interesting, but not actionable without further drill down
- Current Measure Strategy:
  - Start with Appropriate Resource Use measures
  - Move to Total Cost of Care

Appropriate Resource Use Measures

- Used HEDIS Use of Services metrics as basis for standardizing existing health plan measures

1. Inpatient Utilization—Acute Care Discharges
2. Inpatient Utilization—Bed Days
3. Inpatient Readmissions within 30 Days
4. Emergency Department Visits
5. Outpatient Surgeries Utilization—% Done in ASC
6. Generic Prescribing (7 therapeutic areas)

2008 – Baseline Measurement Year

2009 – First Measurement Year

2010 – Full Implementation

Total Cost of Care

- Total amount paid to care for members of a physician group for a year
- Adjust for health risk, geography, and possibly other factors such as affiliation with teaching hospital or other market impacts
- No standardized measure currently available

2010 – Baseline Measurement Year

2011 – First Measurement Year

2012 – Full Implementation

The Road Ahead: Performance Based Contracting

Marketplace Context

- Affordability problems have significantly worsened since P4P started – with impact on HMO enrollment
- Variation in resource use by geographic location and physician is now a major part of the national policy discussion
- Incentive payments already weighted toward efficiency
- Need bold change to stimulate rapid re-engineering
- Opportunity to build on common metrics and learn from current best practices to improve on weaknesses of historic risk sharing

Migrate P4P to Performance Based Contract

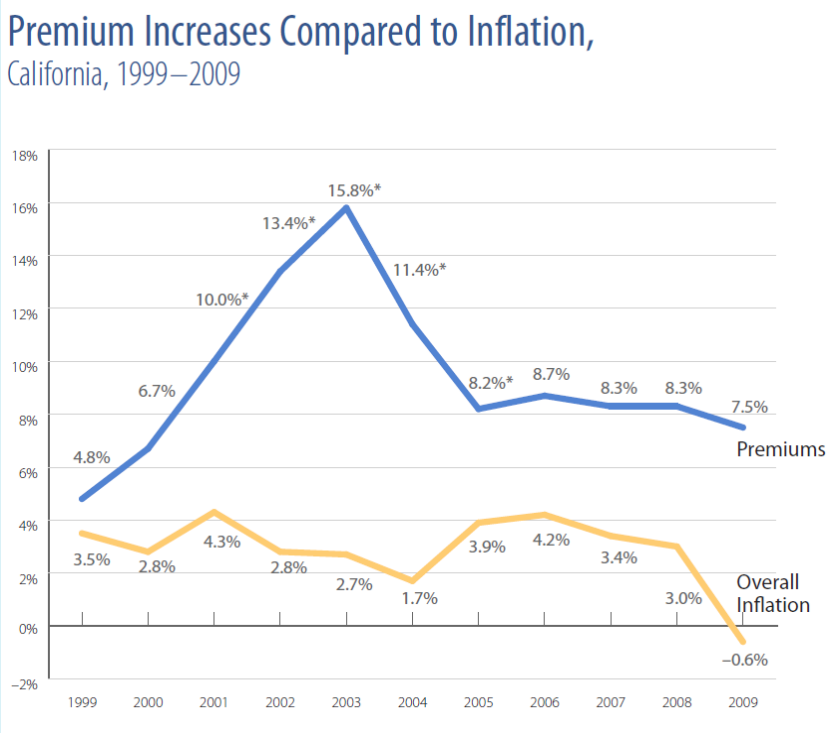
- Incorporate P4P into standard agreement
- Transition from a small add-on bonus to a significant part of professional compensation
- Increase emphasis on efficiency and harmonize efficiency measures
- Down the road, develop information to support benefit design changes to engage consumers

Elements of Performance Based Contract

1. Continue to measure and publicly report Quality performance
2. Revamp the Quality measure set to maximize impact
   - Focus on outcomes, condition-focused composites
   - Add inpatient measures and Care Transitions
   - Align with measures of Meaningful Use

Elements of Performance Based Contract

3. A P4P goal to reduce the HMO premium trend line and achieve HMO premium inflation equal to (CPI) by 2016.



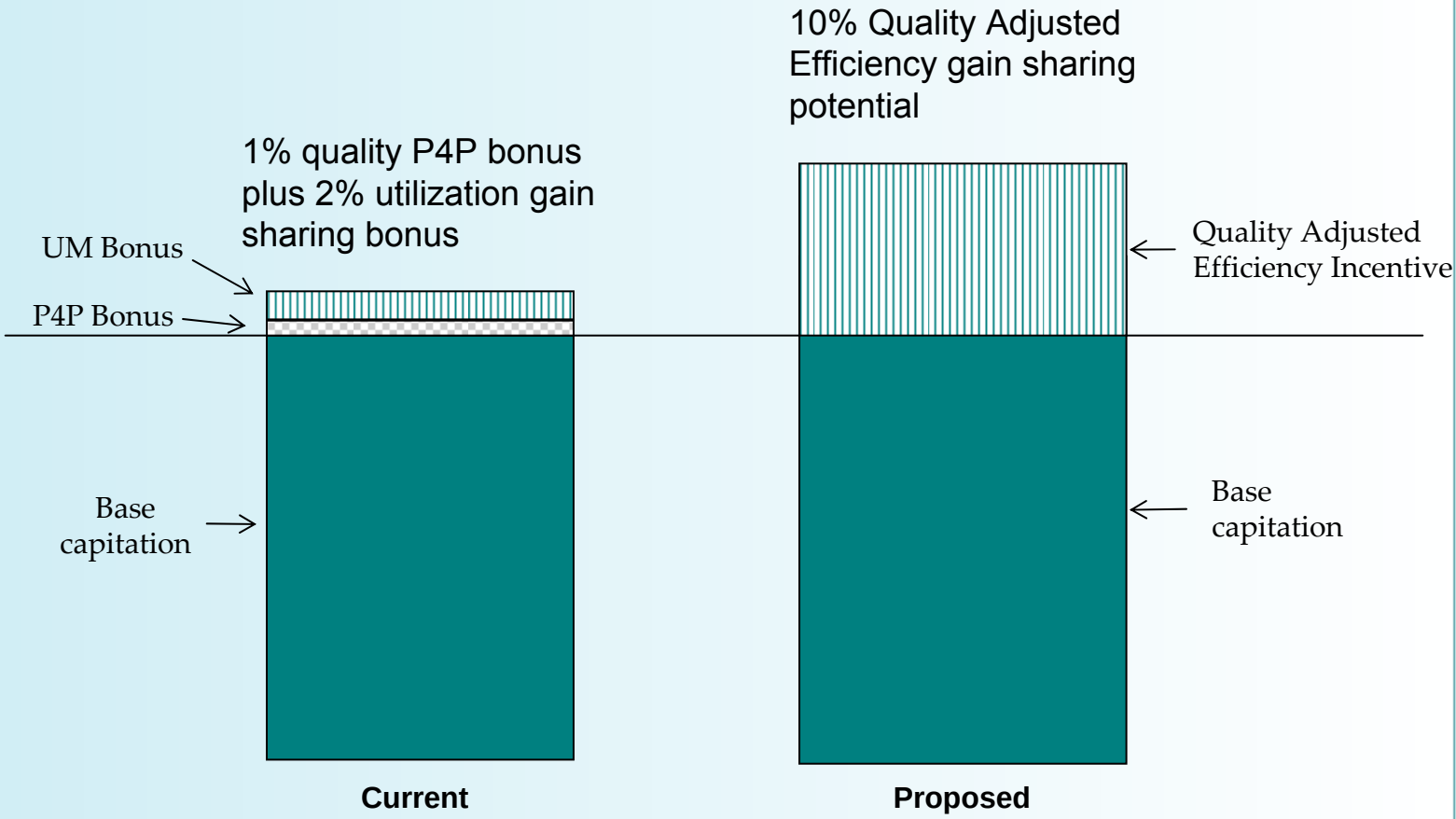
Elements of Performance Based Contract

4. The existing P4P Efficiency measures will be expanded and harmonized across health plans and represent, in total, significant health care cost drivers. In addition, Total Cost of Care will be incorporated into Efficiency measurement.
5. Efficiency will be measured using aggregated data to smooth out anomalies and create a better reflection of performance.

Elements of Performance Based Contract

6. Incentives for Quality and Efficiency will increase annually from about 3% of compensation today to 10% by 2016.
7. Effective Measurement Year 2011, but no later than Measurement Year 2012, Efficiency performance will be the basis of incentive payments, with adjustment for Quality performance.

Performance-Based Incentive Framework



California Pay for Performance

For more information:

www.iha.org

(510) 208-1740

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