Value Based Pay for Performance

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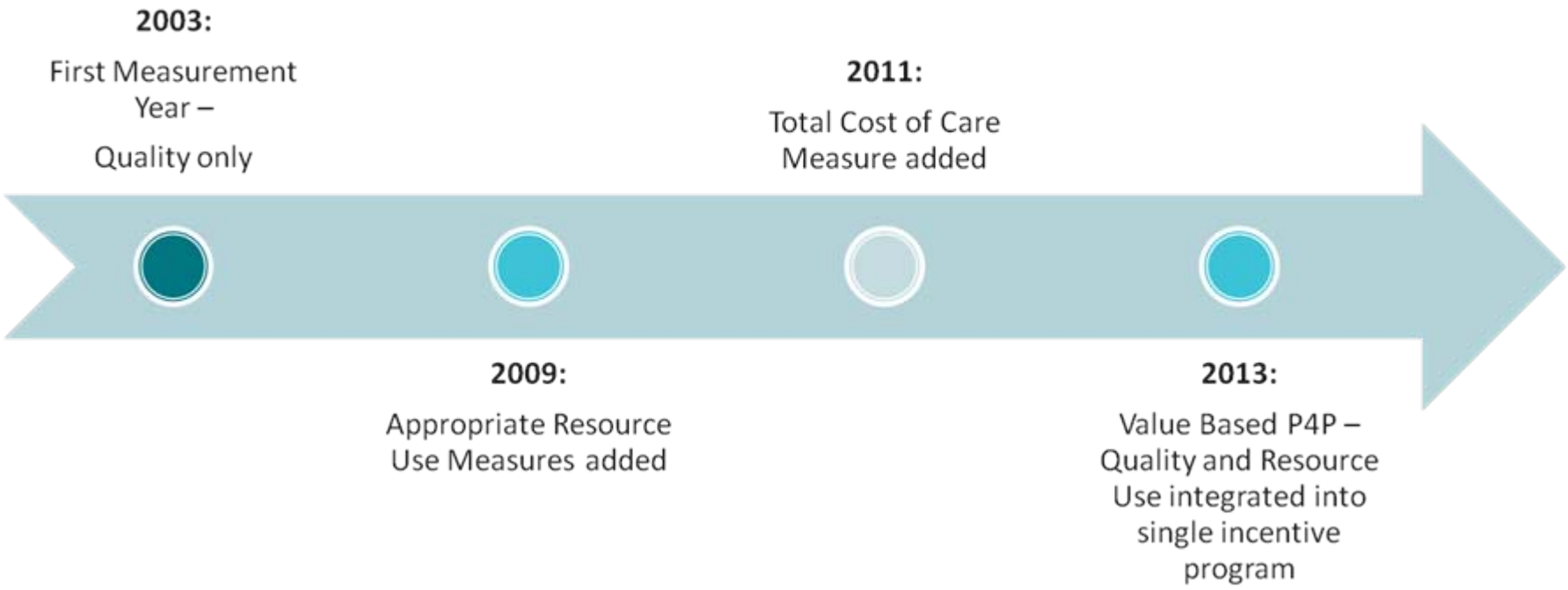
Overview

- Background
- P4P Classic
- Value Based P4P
- Challenging design decisions
- Questions

IHA P4P Program Evolution



Program Participants

Ten CA Health Plans:

- Aetna
- Anthem Blue Cross
- Blue Shield of CA
- Chinese Community* (2012)
- CIGNA
- Health Net
- Kaiser Permanente* (2005)
- UnitedHealthcare
- Sharp Health Plan* (2013)
- Western Health Advantage

Physician Organizations:

- 200 medical groups and IPAs
- 35,000 physicians
- 9 million commercial HMO/POS members

** Currently participate in public reporting only*

California P4P Program Goals

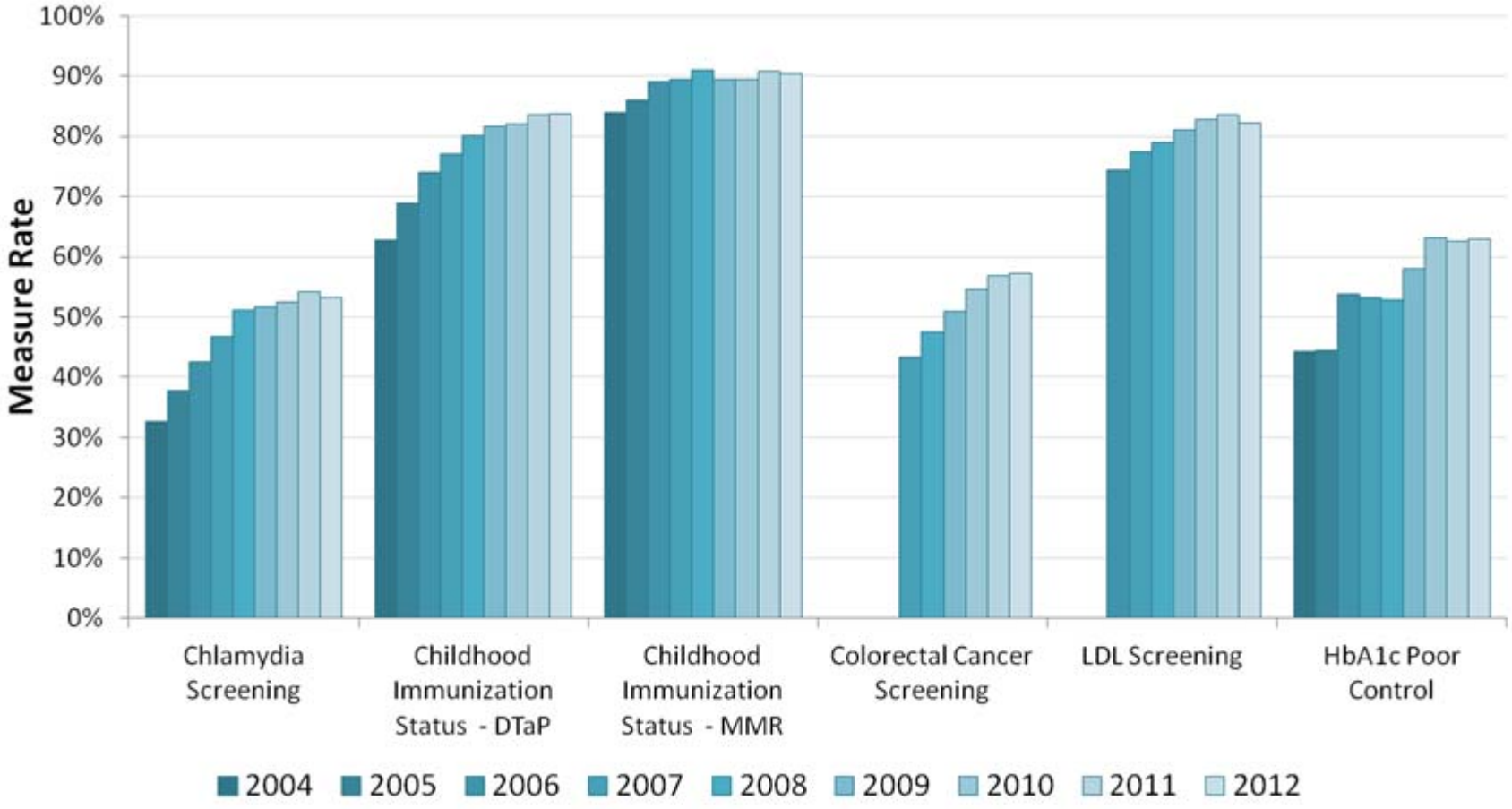
- **Goal:** To create a compelling set of incentives that will drive breakthrough improvements in clinical quality and the patient experience through:
  - ✓ Common set of measures
  - ✓ Health plan payments to physician groups
  - ✓ A public report card

P4P Classic - Design

Quality Domain		Payment
▪ Clinical	Process and outcome measures focused on: ▪ Prevention ▪ Cardiovascular ▪ Diabetes ▪ Maternity ▪ Musculoskeletal ▪ Respiratory	50%
▪ Patient Experience	Patient ratings of care aligned with the CAHPS Clinician and Group survey	20%
▪ Meaningful Use of Health IT	Aligned with CMS and ONC for HIT meaningful use requirements	30%

Quality Improvement

- Quality performance has steadily increased

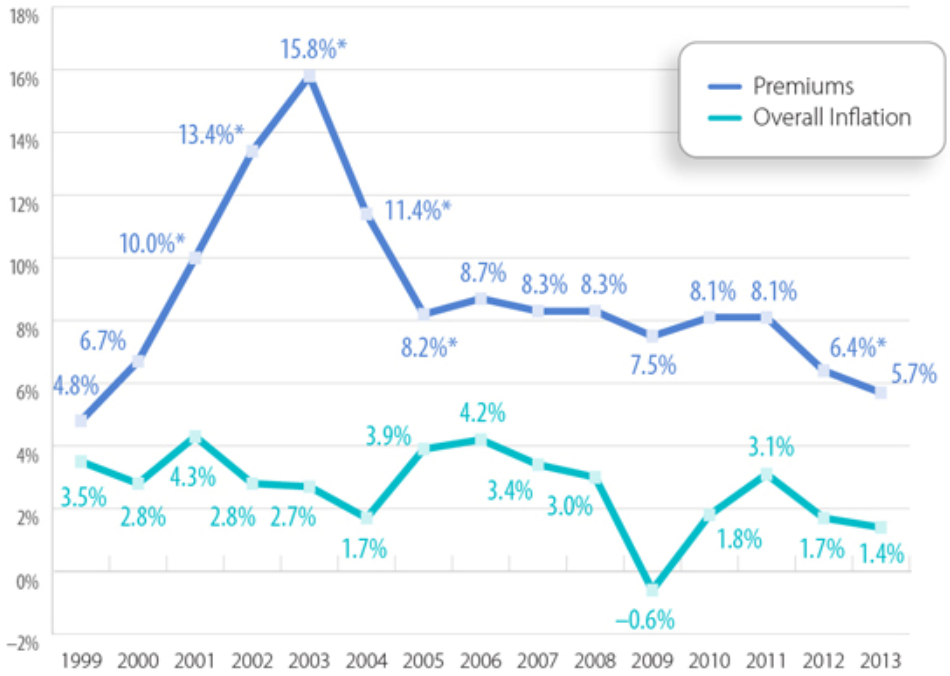


Cost Growth Has Persisted

- Premiums in California have increased more than 185% over the life of the P4P program

Premium Increases Compared to Inflation

Family Coverage, California, 1999 to 2013



*Estimates are statistically different from the previous year shown.

Sources: CHCF/NORC California Employer Health Benefits Survey: 2007–2013; CHCF/HSC California Employer Health Benefits Survey: 2005–2006; CHCF/HRET California Employer Health Benefits Survey: 2004; Kaiser/HRET California Employer Health Benefits Survey: 1999–2003; California Division of Labor Statistics and Research, Consumer Price Index, California Average of Annual Inflation (April to April) 1999–2013.

Health Plan Perspective

- Over $500 Million in IHA P4P incentives paid out to provider organizations over 10 years with incremental, but not breakthrough performance in quality ($1.3 Billion in total incentive payouts)
- Focus of original P4P program was exclusively quality; excludes focus on other components of Triple Aim
- HMO membership declining in California, in part because of deterioration in cost advantage to PPO model
- Capitation provides powerful incentive for providers to manage costs, but savings are not shared with employers and members and cost trends were not controlled
- Need a shift in emphasis to Value-Based contracting with medical groups to address quality, costs and trend

Physician Organization Perspective

- Clinical and utilization incentives from plans have been around for many years, but they varied greatly in metrics and funding
- Clinical was a good first step as it is a daily task for physicians, a key point of professional pride and data was mostly available to POs
- The facility utilization expense data was mostly unavailable for most POs
- POs struggled with finding applicable, defendable benchmarks for clinical and financial utilization

Value Based P4P Objectives

- 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.

Value Based P4P Guiding Principles

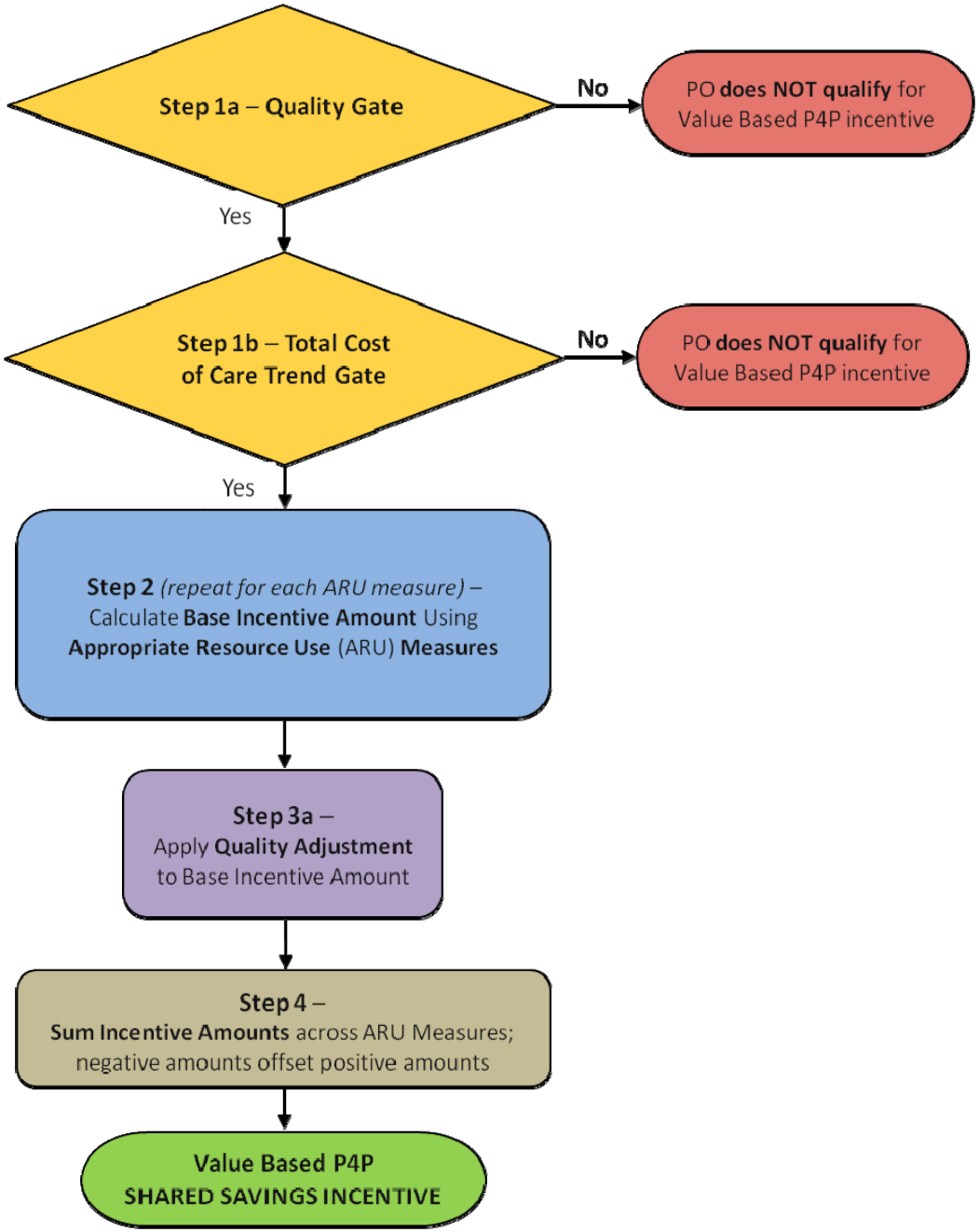
- Savings generated by Value Based P4P are **intended to contribute to lower cost trends** and a more competitive, value based HMO product.
- Value Based P4P is intended to be **available to all POs**, including full risk POs, that contract for commercial HMO or POS business with one or more health plans 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.

What is Value Based P4P?

- Combines shared savings and quality to drive value
  - Incentivize physician organizations (PO) to eliminate waste and unnecessary utilization and deliver high quality care
- Worst PO can do is earn no incentive
- Intended to replace current incentive programs that focus separately on quality and resource use
- May not be needed for POs already in accountable care contracting arrangements

Value Based P4P Design

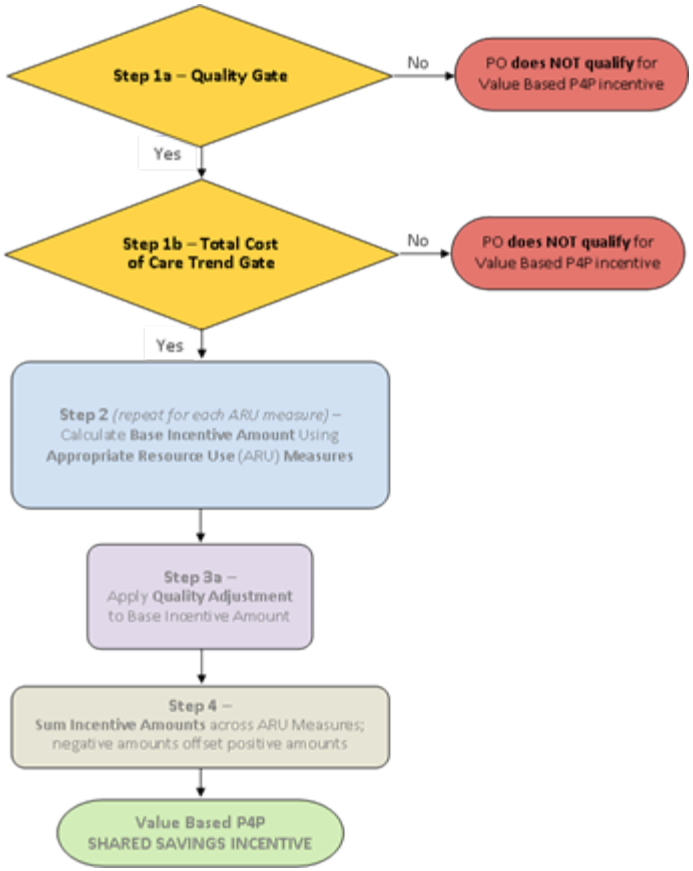
1. Performance gates
   - Quality
   - Total Cost of Care Trend
2. Calculate share of savings based on resource use
3. Adjust share of savings for Quality
4. Sum adjusted shared savings



Value Based P4P Core Design

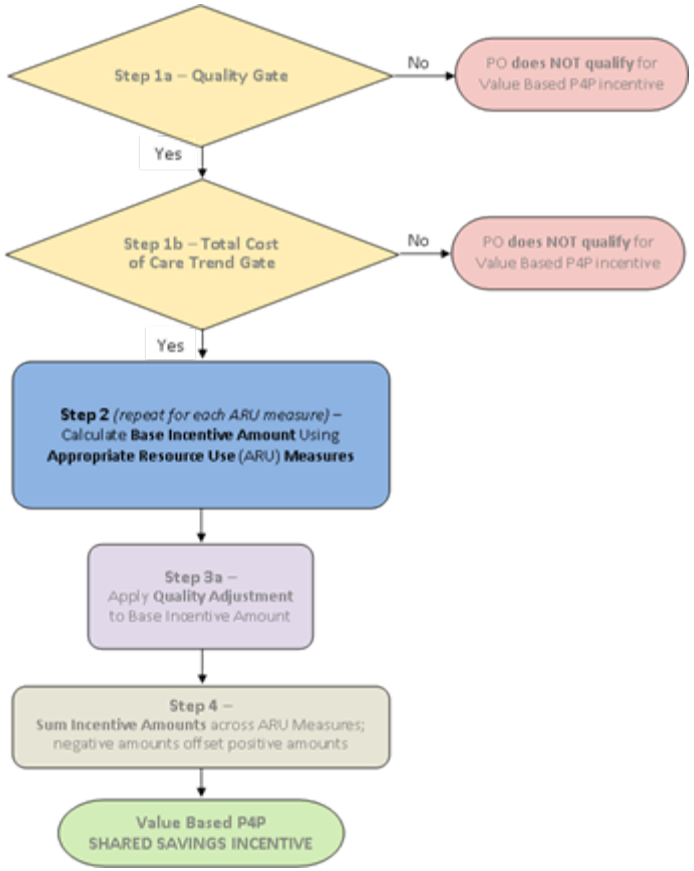
STEP 1 – DETERMINE INCENTIVE ELIGIBILITY

- Quality Composite Score of at least 10%
- Total Cost of Care Trend below gate



Value Based P4P Core Design

STEP 2 – CALCULATE SHARED SAVINGS AMOUNT



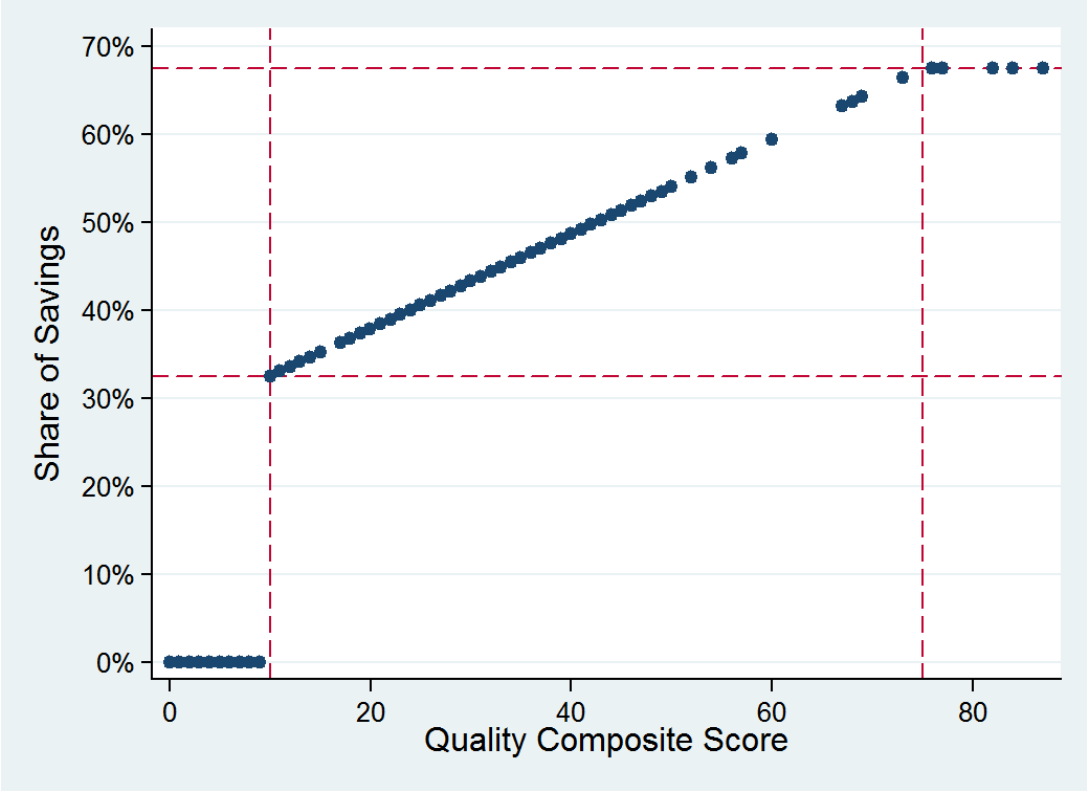
ARU Measures

- Inpatient Bed Days
- All-Cause Readmissions
- ED Visits
- Outpatient Procedures Done in Preferred Facility
- Generic Prescribing
  - Antidepressants
  - Antihyperlipidemics
  - Anti-ulcer
  - Cardiovascular/Hypertension
  - Diabetes
  - Nasal Steroids

Value Based P4P Core Design

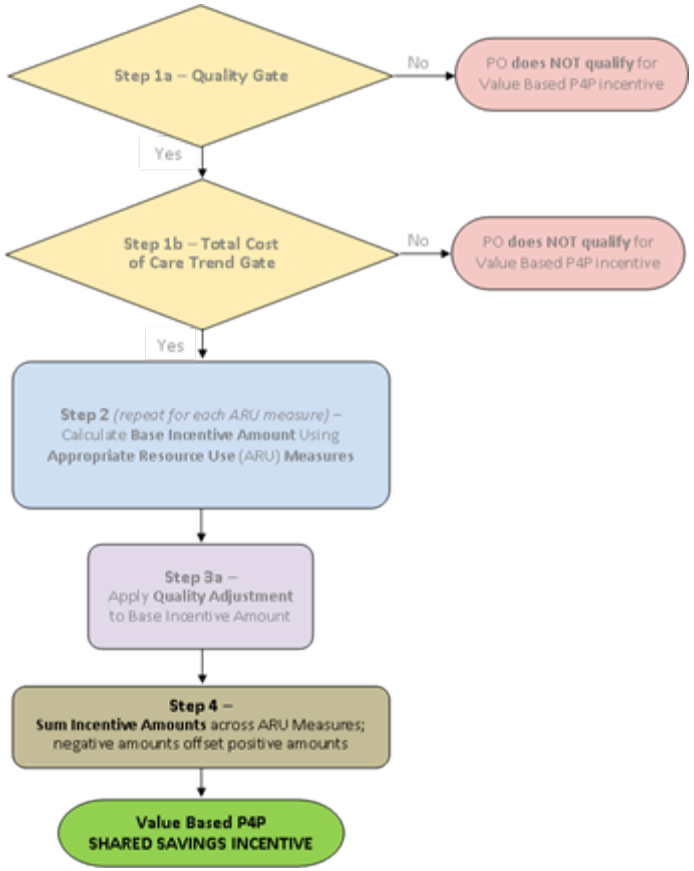
STEP 3 – ADJUST SHARE OF SAVINGS FOR QUALITY

- HIGH quality INCREASES share of savings
- LOW quality DECREASES share of savings



Value Based P4P Core Design

STEP 4 – SUM SHARED SAVINGS ACROSS MEASURES



- Each measure's shared savings can be positive or negative
- Negative amounts offset positive amounts
- If sum of all measures >$0, PO earns incentive
- If sum of all measures <$0, PO earns no incentive

Key Decision Points

1. How should geographic differences in cost be addressed?
2. What cost trend is needed to be eligible for an incentive?
3. Should high cost providers be eligible for incentives?
4. How can providers with limited membership participate?
5. Should improvement targets be adjusted for industry trends?
6. How to balance flexibility and standardization?

1. How should geographic differences in cost be addressed?

- Unique concern when making cost performance comparisons
- CONCLUSION: When using point-in-time cost apply CMS geographic adjustment factors.

2. What cost trend is needed to be eligible for an incentive?

- CONCLUSION: Less than or equal to 3% above CPI
  - Use a 3 year average of the US Consumer Price Index
  - Include an 85% Confidence Interval

Measurement Year	TCC Trend Gate Threshold
2013	CPI + 3
2014	CPI + 3
2015	CPI + 2
2016	CPI + 1

3. Should high cost providers be eligible for incentives?

- CONCLUSION: Yes, but set the TCC trend gate lower
  - High cost organizations defined…
    - *BY* Geography- and risk-adjusted Total Cost of Care
    - *AS* exceeding the 90th percentile for 2 consecutive years

4. How can providers with limited membership participate?

- Greater variability in results for physician organizations with low membership

- CONCLUSION: Use a weighted result for payment purposes for POs with less than 1,500 member years

5. Should improvement targets be adjusted for industry trends?

- Potential for windfall payments simply because a drug loses patent protection

- CONCLUSION: Use 25th percentile of actual improvement generic prescribing to adjust benchmark

6. How to balance flexibility and standardization?

CORE DESIGN ELEMENTS	OPTIONAL DESIGN ELEMENTS
Standardized measures	Gate threshold values
Quality Gate	Adjustment ranges and values
Total Cost of Care Trend Gate	ARU Attainment Adjustment
Shared Savings Calculation	ARU Improvement Adjustment
Quality Adjustment	

Lessons Learned

- It is a balancing act between simplicity and methodological rigor
- Stakeholder input and feedback is critical
- Even the best sounding concept doesn't always work out—mathematically or practically
- Despite sharing the common mission of improving health and healthcare finding a middle ground is still hard work
- It's never finished…but a good start

Questions