Case Study: The IHA California P4P Program – Developing Efficiency Measurement

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"Efficiency Measurement: The Pot of Gold At the End of the Rainbow?"

Overview

- The Push for Efficiency Measurement
- Defining Our Needs
- Selecting a Vendor
- Developing Measures
- Getting Data
- Socialization
- Going Full Cycle

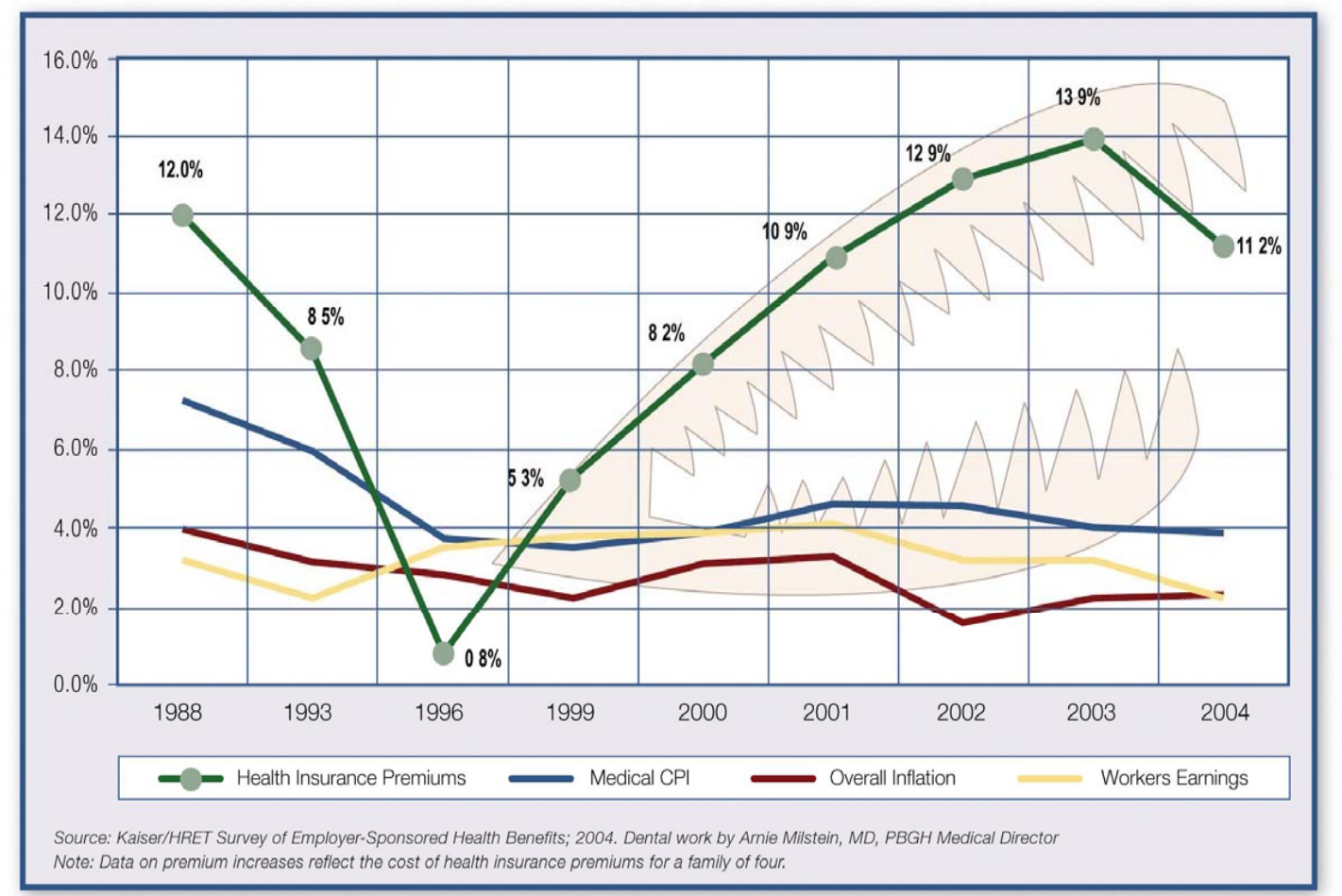
The Push for Efficiency Measurement

- 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

Why Efficiency Measurement?



Defining Our Needs

- Use vendor to scrub and aggregate data health plan data, run efficiency measures, and distribute results
- Use both episode-based and population-based approaches
- Include both cost per unit and utilization starting in Year 1
- Adjust for both case mix and severity of illness
- Balance year to year stability with inclusion of as many encounters/services/costs as possible

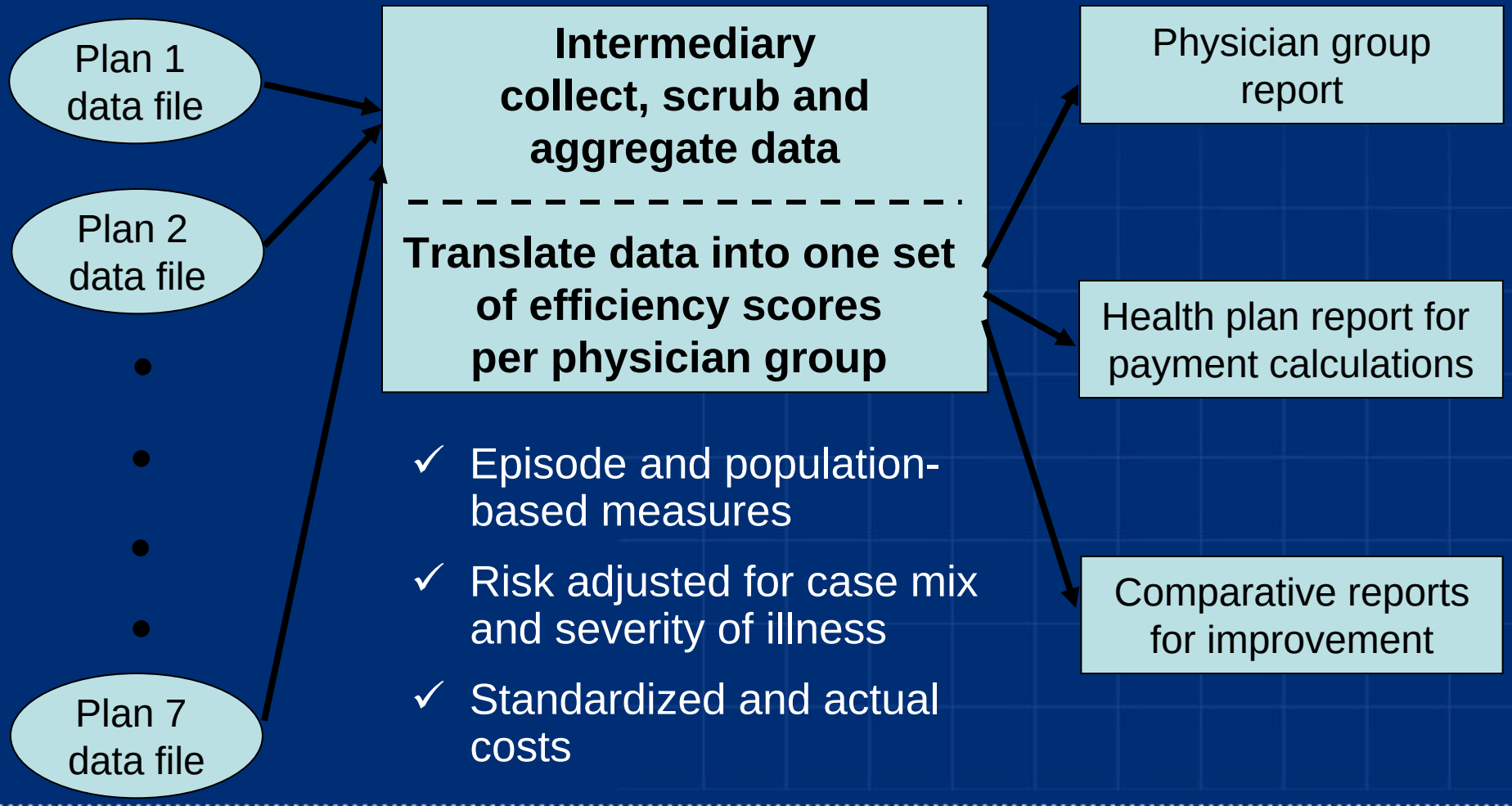
Defining Our Needs

- Produce a single overall efficiency score as well as scores for specific clinical areas or specialties
- Focus on group level measurement initially; explore feasibility of pursuing physician level reporting in future
- Ensure potential for a single data submission process for efficiency and quality measurement

Defining Our Needs

- Considered standardizing currently used resource use measures (admits/1000, etc.) as interim measures
- Rejected – stakeholders anxious to get to sophisticated efficiency measures ASAP and didn't want to spend resources on standardizing what was already being done

Framework: Efficiency Measurement in P4P



- ✓ Episode and population-based measures
- ✓ Risk adjusted for case mix and severity of illness
- ✓ Standardized and actual costs

Principles: Efficiency Measurement in P4P

- Collaborative development/adoption
- Coordination across plans
- Alignment with national measures when feasible
- Thorough testing and analysis prior to implementation
- Transparent methodology
- Risk adjustment to support fairness
- Rigorous approach for validity and reliability
- Actionable results to support efficiency improvement

Selecting a Vendor

November 2005	RFI sent to 13 vendors; 10 submitted responses
May 2006	RFP sent to top 3 vendors
May-July 2006	Sample data provided to finalists for “bake-off” (feasibility study and demonstration of capabilities)
July 2006	Final vendor presentations to multi-stakeholder P4P group
August 2006	Vendor selection

Developing Measures

- Established Technical Efficiency Committee
  - Guides overall development and testing of efficiency measures
  - Composed of physician group, health plan, purchaser representatives and subject experts

CA Advantages for Efficiency Measurement

- Unit of measure – Physician group vs. individual physician measurement makes attribution more reliable
- Large sample size – Aggregation of plan data allows for adequate sample size
- Consistent benefit package – HMO/POS member population provides relatively consistent benefits
- Stakeholder trust – Relatively good

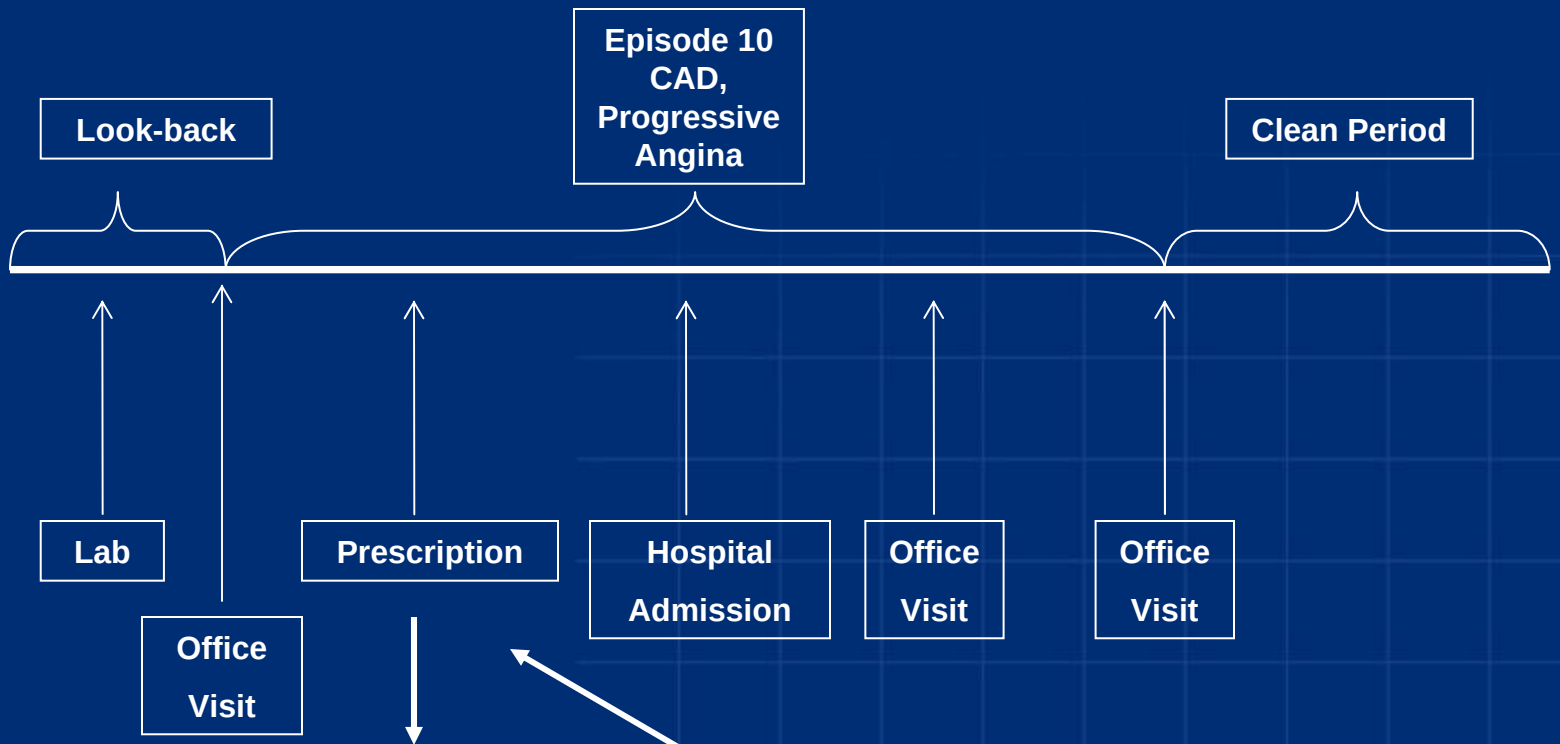
Basic Methodology

- Population-based:
  Diagnostic Cost Groups (DCG)

- Episode-based:
  Thomson's Medical Episode Grouper (MEG),
  risk adjusted by MEG/Disease Staging and DCGs

- Ratio of observed vs. expected cost for same episode, severity level, complexity level

Episode Construction



DRUG TRANSACTION FILE

PATID	*NDC*	SERVDATE
01	ISDN	95-01-15
01	INSUL	95-02-15
01	INSUL	95-04-15
01	AMOX	95-04-15
01	AMOX	95-11-15

LOOKUP TABLE

NDC	EPGRP
ISDN	10
INSUL	359
INSUL	360
INSUL	361
AMOX	484
AMOX	86

Efficiency Measures

1. Generic prescribing
   - Calculated by cost and by number of scripts
2. Overall Group Efficiency
   - Episode and population based methodologies
   - Calculated using both standardized and actual costs
3. Efficiency by Clinical Area
   - Calculated using standardized costs
4. Actual to Standardized Pricing Indices

Generic Prescribing

- Focus on four therapeutic areas:
  - Statins
  - PPIs
  - SSRIs / SNRIs
  - Nasal steroids
- Cost (or # of scripts) for All Generic Rx in 4 Tx areas
  Cost (or # of scripts) for All Rx in 4 Tx areas
- No risk adjustment

Overall Group Efficiency

- Population-based:

$$\frac{\text{Average Observed costs PMPY}}{\text{Average Expected costs PMPY}}$$

- Episode-based:

$$\frac{\text{Sum of Observed costs for all episodes}}{\text{Sum of Expected costs for all episodes}}$$

- Risk adjusted
  - patient complexity
  - disease severity
  - geographic wage differences

Efficiency by Clinical Area

- Areas of high variation, high cost
- Examples of possible clinical areas include:
  Diabetes, Asthma, Acute Low Back Pain, Hypertension, Cardiovascular (CHF, AMI, CAD, Angina), COPD
- $\frac{\text{Sum of Observed costs for all episodes in clinical area}}{\text{Sum of Expected costs for the same set of episodes}}$
- Risk adjusted
  - patient complexity
  - disease severity
  - geographic wage differences

Actual to Standardized Pricing Indices

- Ratio of actual costs to standardized costs, overall and for different service categories
- Directly identifies relative pricing differences for any available service category breakdowns
- Examples of service category breakdowns: professional, facility inpatient, facility outpatient, radiology, lab, Rx
- FFS:

$$\frac{\text{sum of allowed amounts for services in denominator}}{\text{sum of standardized costs for all FFS services in claims}}$$

- Capitated:

$$\frac{\text{total capitation amount paid to group}}{\text{standardized costs for all services on capitated encounters}}$$

Methodological Considerations

- Use internal benchmarks to calculate “expected”
  - Based on the average risk adjusted cost across all 7 health plans
- 12 month measurement period, unless otherwise indicated through testing
- Outlier methodologies to eliminate 1% of highest and lowest cost episodes
- Clinical exclusions to be determined (e.g. transplants)

Getting Data

- Sign Business Associate Agreements
  - 15 months and counting for one health plan
- Address antitrust concerns
  - Opinion from legal counsel
  - Guidelines for acceptable reporting
- Confidentiality clauses in contracts
  - Obtain Consent to Disclosure Agreements
    - Physician Groups
    - Hospitals

Getting Data

- Explore using public sources of data for hospital costs
- Obtain useable data from health plans
  - Multiple data submissions needed

Impact on Timing of Measurement

	Standardized Costs	Actual Costs
Generic Prescribing	MY 2007	
Population-based • overall efficiency	MY 2008	MY 2009
Episode-based • overall efficiency • efficiency by clinical area	MY 2008 MY 2008	MY 2008 MY 2008
Actual to Standardized Pricing Indices		MY 2009

Socialization of Efficiency Measurement

Communication

- Breakout sessions at annual P4P Stakeholders meetings and annual CAPG conferences
- Audio conference updates
- Newsletter articles
- Regional meetings to explain how to understand and use results for performance improvement (planned)

Policy

- Delay sharing of group-specific results

Efficiency Measurement: Reporting

	PO '08 / '10	Plan '08 / '10	Public '08 / '10
all episode groups combined	Yes / Yes	**No** / Yes	No / TBD
episode groups in selected clinical areas	Yes / Yes	**No** / Yes	No / TBD
by service type within each selected clinical area	Yes / Yes	**No** / Yes	No / No
each episode, by service type and by disease severity / patient complexity stratification	Yes / Yes	**No** / TBD	No / No
care for all members in PO	Yes / Yes	**No** / Yes	No / TBD
summary information (min, max, mean, SD, percentiles)	Yes / Yes	Yes / Yes	No / No

Going Full Circle

- Development of episode and population-based measures taking too long
- Need to address affordability of HMO product now
- Attempting to standardize currently used resource use measures (admits/1000, etc.) for immediate implementation

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