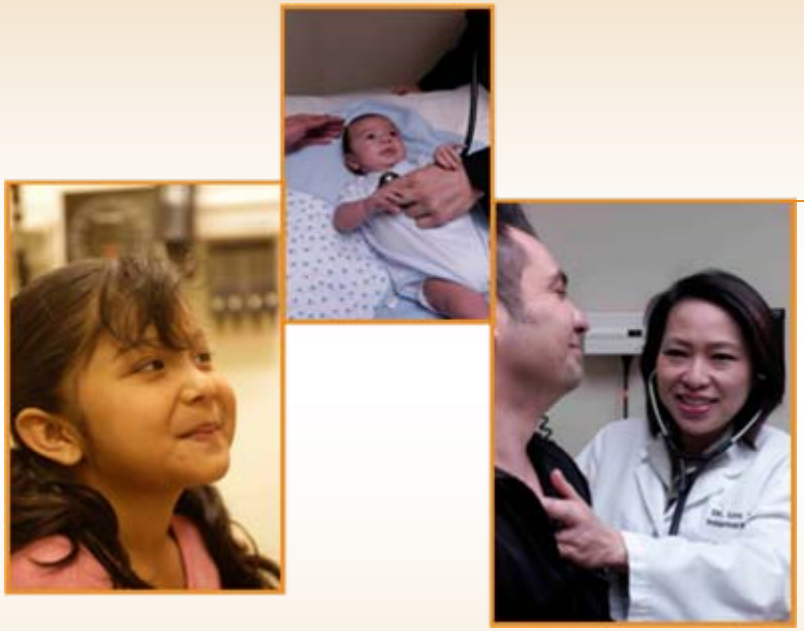


Partners for Quality

Darnell Dent
Chief Executive Officer

August 27, 2007

COMMUNITY HEALTH PLAN

Created in 1992 by a group of community health centers throughout the state. Our non-profit health plan is driven by a strong business and social mission to develop and administer products to serve individuals and families not served by the broader market.

State-Sponsored Programs

- **Medicaid (Healthy Options)**
- **Basic Health (BH)**
- **State Children's Health Insurance Plan (SCHIP)**
- **Public Employees Benefits Board (PEBB)**
- **General Assistance Unemployable (GA-U) pilot**

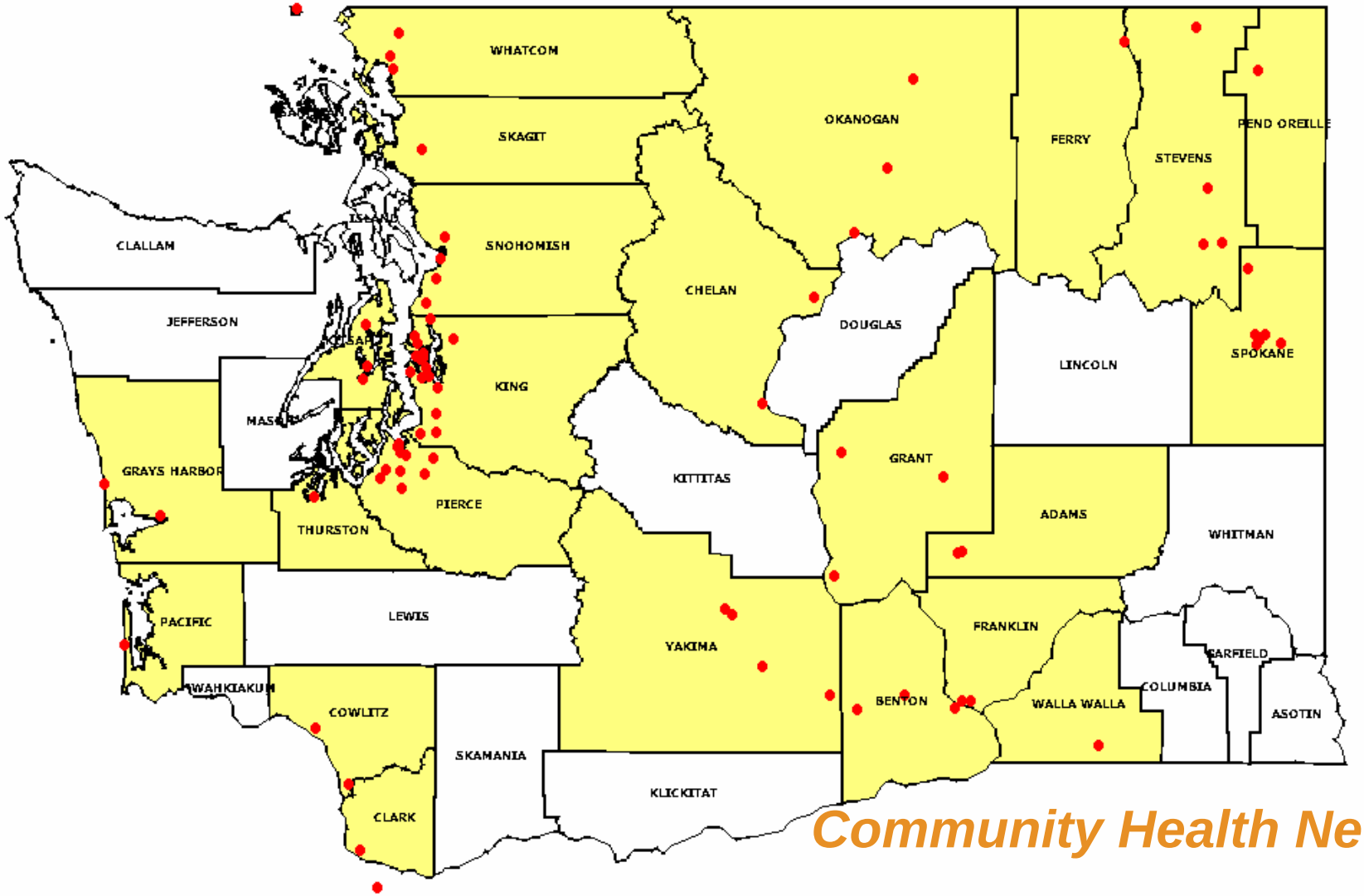
Medicare Programs

- **Medicare Advantage**
- **MA - Prescription Drug (MA-PD)**
- **MA – Special Needs Plan (SNP) Urban**
- **MA – Special Needs Plan (SNP) Rural**

Provider Network

- 34 of 39 counties in Washington State
- Over 330 primary care clinic sites
- 1,600 primary care providers
- More than 8,000 specialists
- Over 90 hospitals

Community Health Plan CHC Clinic Sites



Community Health Network

What is P4P?

“Pay for performance is not simply a mechanism to reward those who perform well or to reduce costs; rather, its purpose is to align payment incentives to encourage ongoing improvement in a way that will ensure high quality care for all.”

Committee on Redesigning Health Insurance Performance Measures 2006 (IOM)

P4P Industry Trends

- Many programs have emerged over past 5 years
- Feds, State, plans, provider groups, and employer coalitions have implemented and continue to refine their programs
- Early problems included too many measures, lack of efficient reporting, difficulty in selecting measures all parties value/trust
- Difficult to draw conclusions – still not a proven model based on existing data

Future Directions

- **P4P is here for the foreseeable future - will continue to evolve and improve over time**
- **Feds and State are moving forward and adopting programs (CMS for Medicare)**
- **Rewards from existing $; also considering penalties such as enrollment impacts (freezing or reducing assignment)**
- **Data collection is evolving from claims based data to more clinical data and self reported performance data**

P4P at Community Health Plan

Performance Evaluation Tool (PET)

- **PET Program 2000 – 2006**
  - **Withhold ($1pmpm) over past 6 years with some changes in measures**
  - **Tied to clinical outcomes and service quality**
  - **Some years incentive tied to capability building (HEDIS training; chart reviews)**
  - **Targets related to absolute performance thresholds as well as improvement %**
  - **Varying methods of data collection and reporting**

Evolution of the Program

Year	Measures/Targets	Data Sources	Results
2000 (.50pmpm)	• 22 measures across 3 areas: Quality of Care and Service; Access to Services; Care Management • Points earned for performance thresholds – excellent and standard, as well as improvement • Total pts vs. Possible pts • Long term (3 yr) targets set	Encounter data/claims data Self reported data NWRG data HEDIS like data	No $s tied to this year…was a one year "heads up" to program (.50pmpm tied to participation in Access Collaborative 19/19 CHCs earned $.50pmpm
2001 ($1pmpm)	• Same 22 measures and scoring methodology - some refined methodology based on lessons learned prior year	Encounter data/claims data Self reported data NWRG data HEDIS like data	First year it really counted! 19/19 CHCs earned 85% of ($1pmpm) or above.

Evolution of the Program

Year	Measures/Targets	Data Sources	Results
2002 ($1pmpm)	• 22 measures (7 service quality; 15 clinical quality) • Performance thresholds and improvement Total pts vs. Possible pts	NWRG survey HEDIS specifications	.50pmpm tied to pts earned for service quality measures 19/19 of CHCs earned 50% or higher of .50pmpm ($.25) .50pmpm tied to clinical measures but scoring problems thus 100% of CHCs earned the other .50pmpm for attending a CHP sponsored HEDIS training
2003 ($1pmpm)	• 21 measures (7 service quality, 14 clinical quality) • Performance thresholds and improvement • Total pts vs. Possible pts	NWRG survey HEDIS specifications	.50pmpm tied to pts earned for service quality measures 16/19 CHCs earned 50% or higher of .50 pmpm ($.25) Other .50pmpm tied to "participation in chart abstraction exercise" – all earned

Evolution of the Program

Year	Measures/Targets	Data Sources	Results
2004 ($1pmpm)	• 12 measures total (encounter data, service quality and clinical quality) • Reduced to one performance threshold "target", and improvement *service quality targets moved to focus on only "very" satisfied instead of "somewhat and very" Changed scoring methodology to where each measure worth .05 or .10 Added "best practice" bonus payment for each – now possible to earn more than $1.00pmpm	NWRG survey HEDIS hybrid methodology Claims data	10/19 CHCs earned $.50pmpm or above 9/19 CHCs earned less than $.50pmpm I CHC earned $1.00pmpm

Evolution of the Program

Year	Measures/Targets	Data Sources	Results
2005 ($1pmpm)	• Reduced to 6 measures (quality of service, clinical quality and encounter data timeliness) • one performance threshold "target", or improvement, or "best practice" • Each measure worth $.20pmpm + • Possible to earn more than $1.20pmpm • lowered some service targets	NWRG survey HEDIS hybrid methodology with over sampling to lower margin of error Claims data	Two clinical measures were thrown out due to methodology error so each CHC got a minimum of $.40pmpm 7/18 CHCs earned $1pmpm or more 7/18 CHCs earned $.50 - $.95 4/18 CHCs earned .40 (due to methodology error)
2006 ($1pmpm)	• Same as 2005	Same as 2005 – fixed methodology error	TBA August, 2007

Evolution of the Program

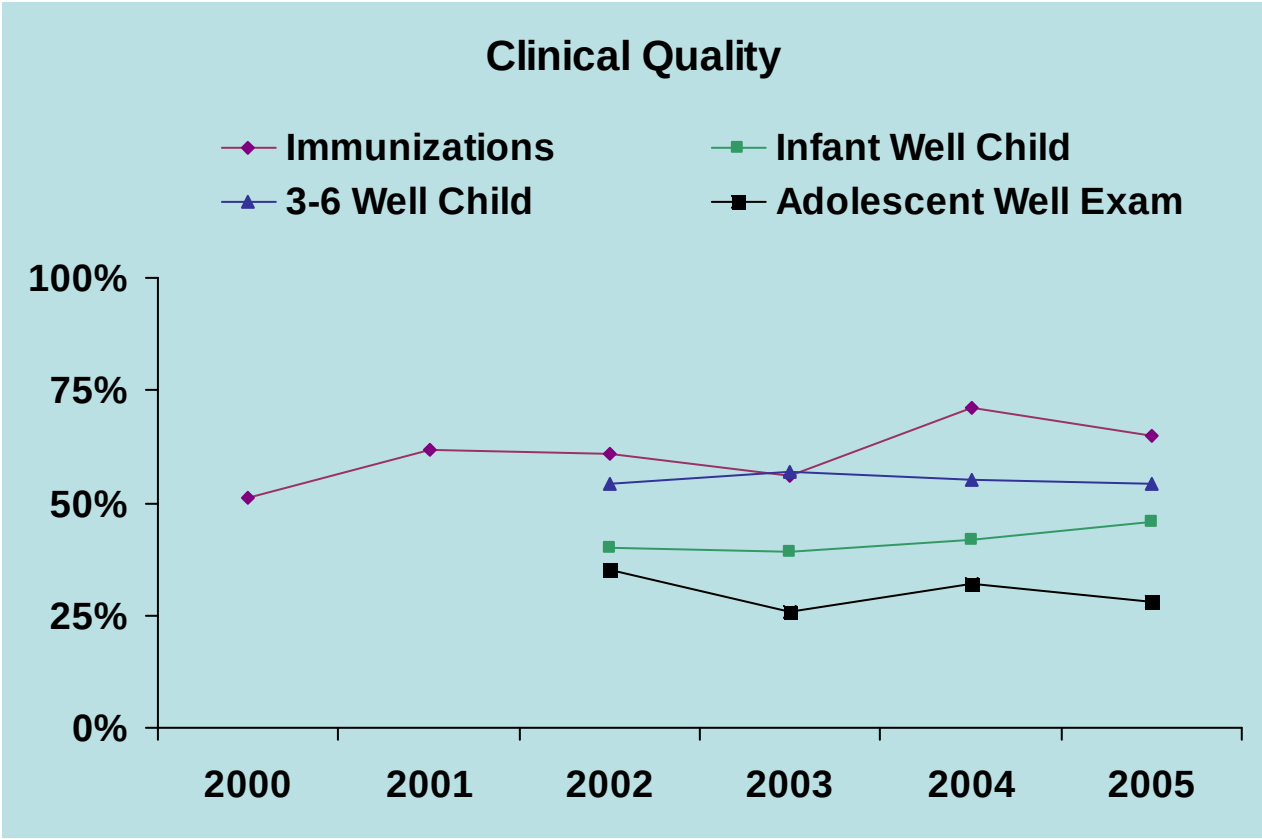
Six Measures used in 2005 - 2006

- **Routine care access**
- **Urgent care access**
- **Well-child visits**
- **Childhood immunizations**
- **Courtesy and respect from office staff**
- **Encounter data timeliness**

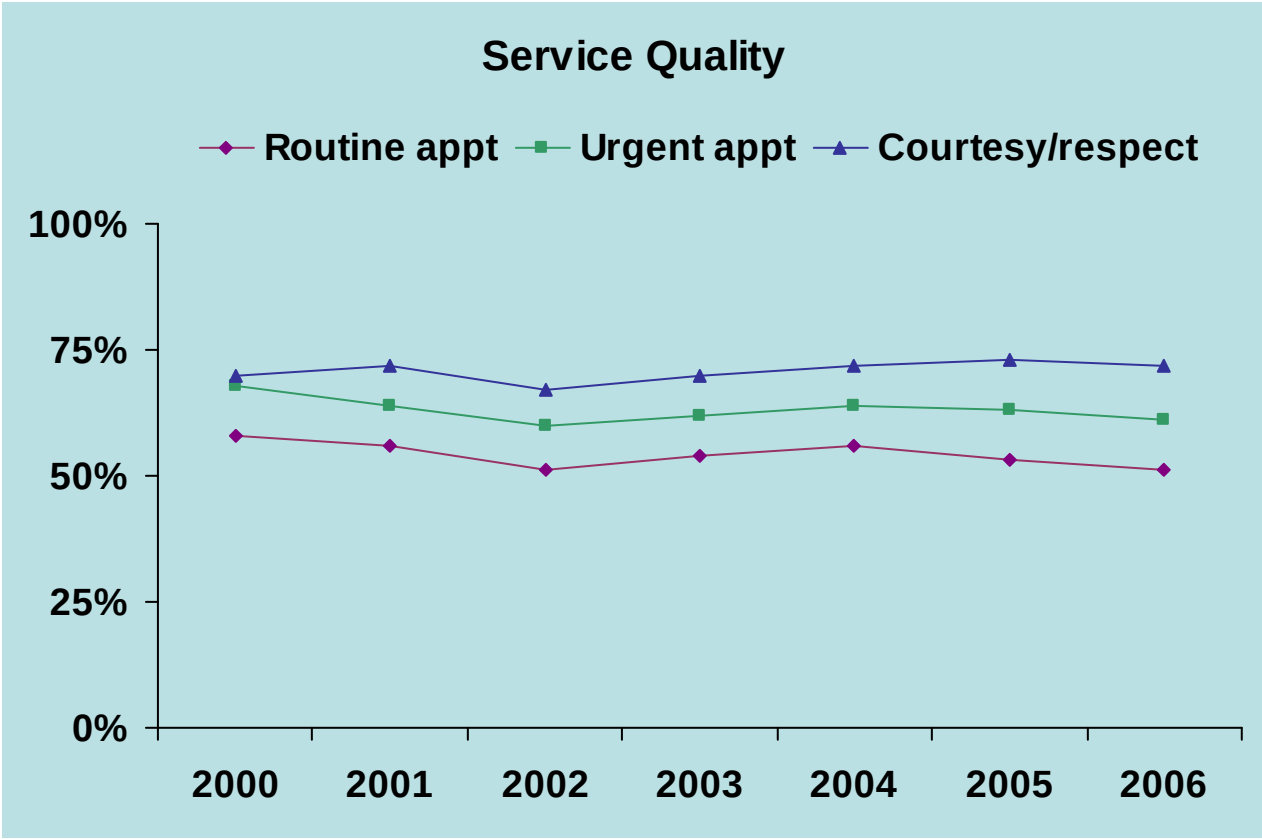
Evolution of the Program

- Adjusted along the way based on lessons learned and best practices
- Went from 22 to 6 measures
- Data sources remained constant , methodology changed
- Steady rate of $1.00pmpm funding but added ability to earn more that $1.00pmpm (bonus structure)
- Variable results
- Less $ earned by CHCs over time
- No measurable improvement in performance

PET Program Results



PET Program Results



Lessons Learned

- **Concerns with funding mechanism and amount**
- **# and types of measures – fewer is better**
- **Data integrity issues**
- **Trust issues due to data collection and reporting errors**
- **Inconsistent and insufficient investment in other key strategies – support for QI (technical assistance, training, collaboratives…)**

From Evolution to Revolution

- Include providers in design and selection of measures
- Use nationally recognized easy to understand measures
- Data sources – valid, tested, easily accessible
- Reward high performance and improvement
- Incentives should be at the provider group level (reward team/system)
- Administratively flexible
- Ensure other system support mechanisms in place

Next Chapter

- Continue to fund and support grant program
- Study and learn from others (other ACAP plans, use of patient incentives…)
- Focus on system-level supports
- Begin integration with 5 year initiatives…
  - Become a 3-star Plan (optimize access and service quality)
  - Care Model Re-design
  - Create useful, actionable data

Thank you!

Darnell Dent

Chief Executive Officer

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