Mini Summit I

The Effectiveness of Pay for Performance: Lessons Learned and Program Adaptations for California P4P

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National P4P Summit

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Agenda

- California P4P Program Formation
- Results
- Lessons Learned and Program Responses

California P4P Program Formation

- Driving forces
  - Anti-managed care backlash
  - Multiple performance programs
    - Burdensome data collection
    - Conflicting results
    - Dispersion of effort
  - Demonstrate value of premium increases

California P4P Program Goals

<u>Original Goal</u>

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

<u>Expanded Goal</u>

Incorporate improvements in cost and resource use

California P4P Participants

Health Plans:

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

Medical Group and IPAs:

- 230 groups
- 35,000 physicians

11 million commercial HMO members

** Kaiser participates in the public reporting only*

California P4P Guiding Principles

- Measures:
  - Use nationally vetted, standardized measures whenever possible
  - Test new measures and seek public comment prior to adoption
  - Move toward outcome measures
- Data Collection:
  - Only allow electronic data for full eligible population
  - Health plan data is supplemented by physician group data
- Data Aggregation:
  - Combine results across plans to create a total patient population for each physician group
  - Allows more complete and robust measurement and reporting

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California P4P Measurement Domains and Payment Weighting

Domain	% Payment
• Clinical – Mostly HEDIS-based	40%
• Patient Experience – Use CG-CAHPS	20%
• IT-Enabled Systemness – Adapted from Physician Practice Connection	20%
• Coordinated Diabetes Care	20%
• Appropriate Resource Use – Based on HEDIS Use of Services	Gain-sharing

Summary of Performance Results

- Clinical: continued modest improvement on most measures
  - 5.1 to 12.4 percentage point increases since inception of measure
- Patient experience: scores remain stable but show no improvement
- IT-Enabled Systemness: most IT measures are improving
  - Almost two-thirds of physician groups demonstrated some IT capability
  - Almost one-third of physician groups demonstrated robust care management processes

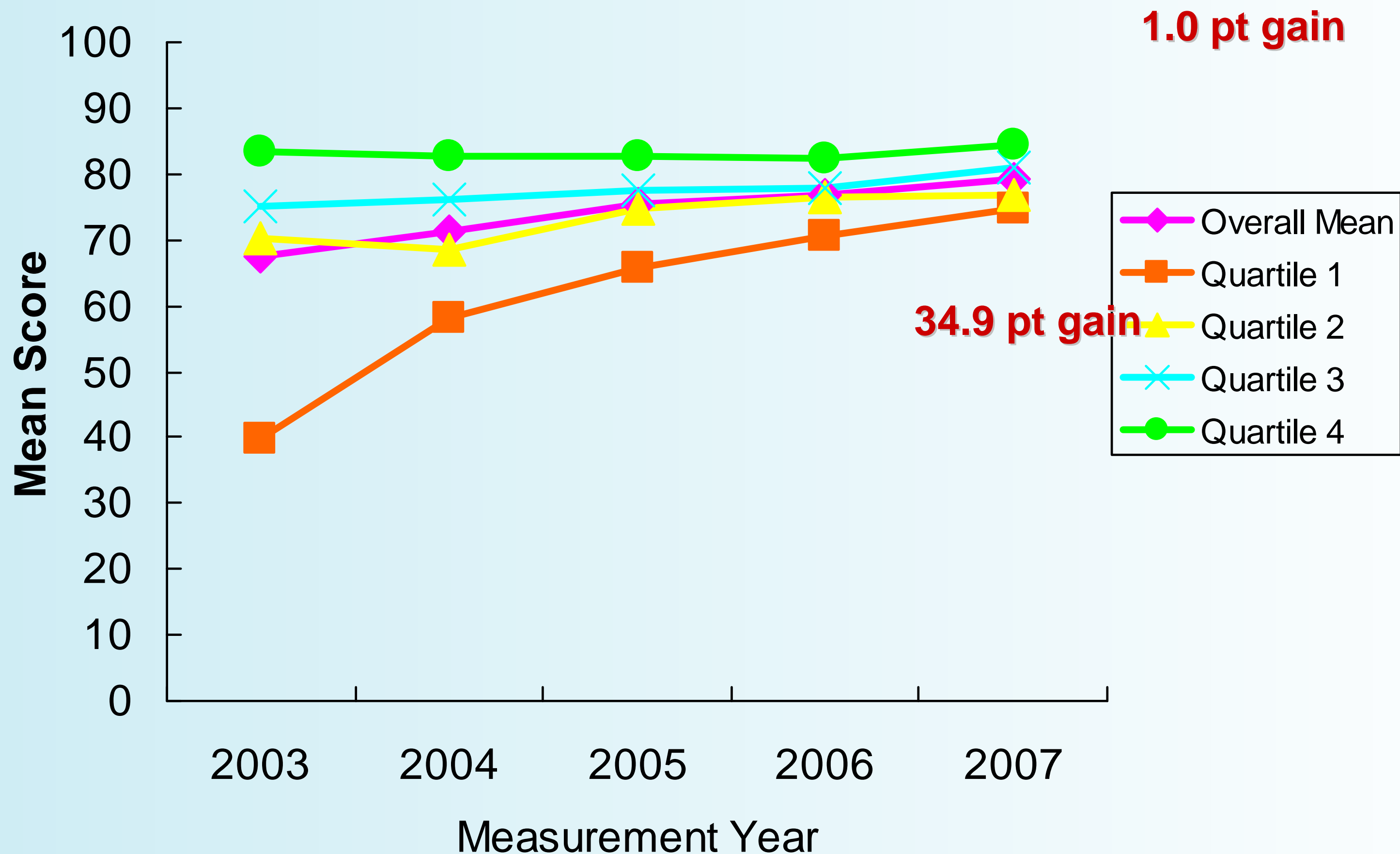
Steady, incremental performance improvements but "breakthrough" point not achieved yet.

Percentage Point Gains by Quartile

Clinical Measure	Lowest 1st quartile	2nd	3rd	Highest 4th quartile
Asthma	1.7	2.3	2.1	1.8
Breast Cancer	6.3	3.1	5.0	6.0
Cervical Cancer	16.8	8.5	6.3	4.6
Chlamydia	5.3	11.6	13.9	12.6
MMR	5.1	6.9	4.2	2.0
VZV	7.3	8.0	6.2	3.0
HbA1c Screen	24.5	8.5	8.8	5.9
HbA1c Control	12.3	5.3	11.2	3.5
URI treatment	4.7	4.6	3.9	1.2

Diabetes Care: HbA1c Screening

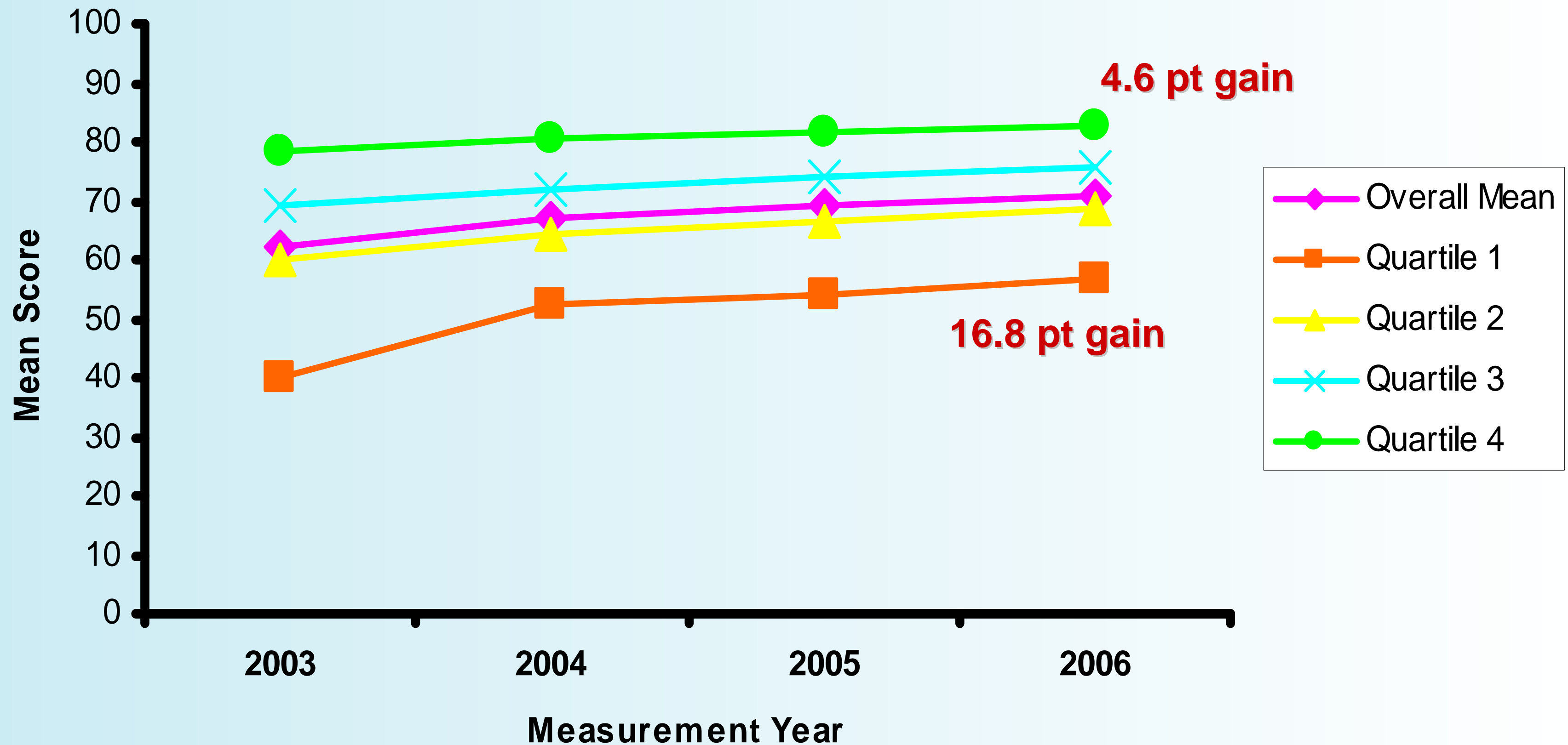
11.8 percentage pt overall gain in performance



23.4 pt spread: 25.0 pt reduction in variation (10-90th percentile spread)

Cervical Cancer Screening

9.08 percentage pt overall gain in performance



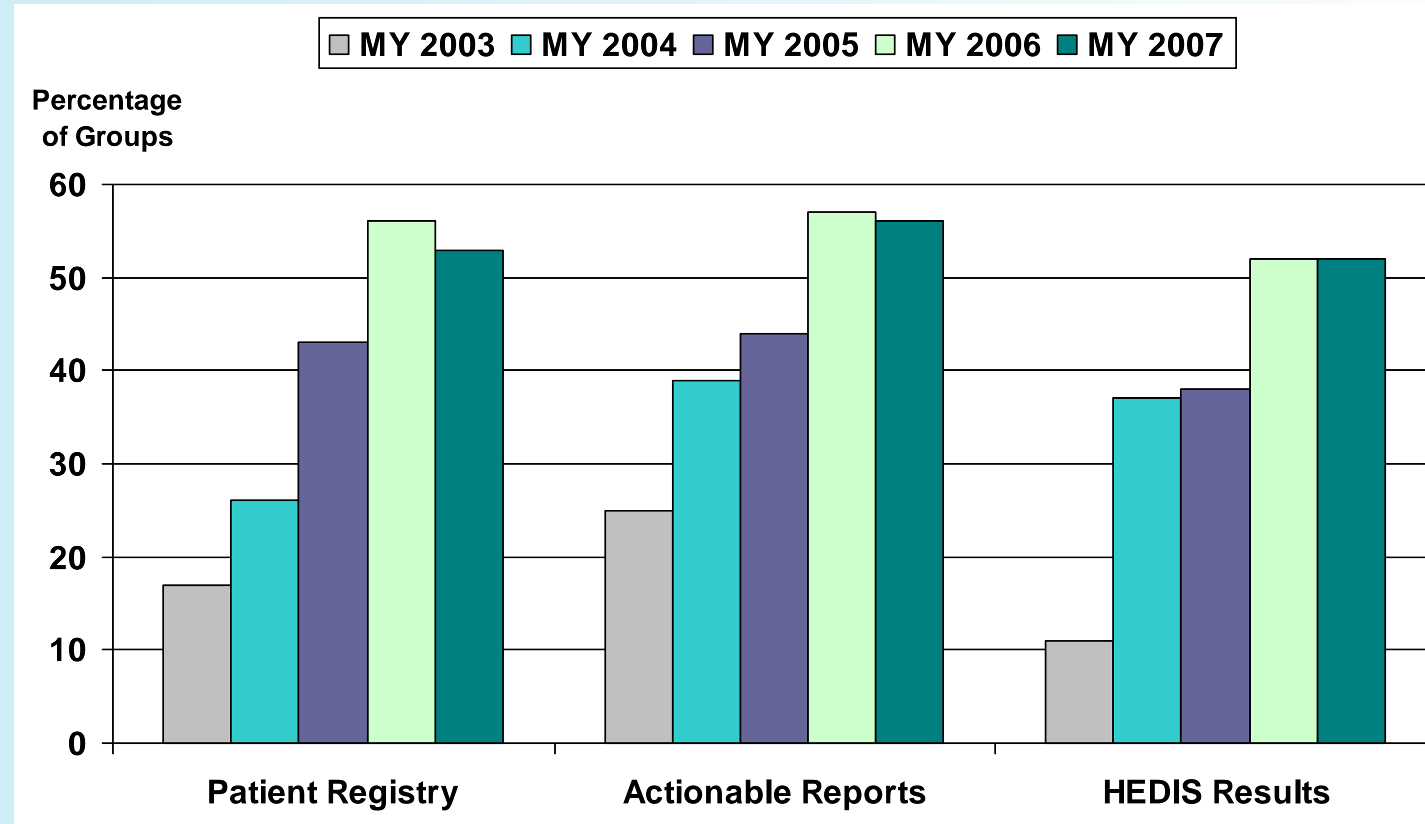
25.6 pt spread: 11.5 pt reduction in variation (10-90th percentile spread)

Patient Experience Results

Measure	MY 2005	MY 2007	Mean Difference
Rating of Health Care	83.2	83.9	+0.7
Rating of Doctor	86.2	86.9	+0.7
Coordination of care	73.9	74.5	+1.2
Doctor Communication	87.2	88.2	+1.0
Timely Care and Access	73.8	74.5	+0.7
No Problem Seeing Specialist	71.7	71.0	-0.7
Rating of Specialist	84.2	85.3	+1.2

Note: Mean scoring, all items converted to a 100 point scale

IT Results: Population Management
MY 2003 – MY 2007



California P4P Program

Physician Group Engagement

- Program Strengths
  - Physician groups are highly engaged
  - 74% believe the measures are reasonable
  - Widespread support for increased incentives
  - Increased focus on quality improvement and IT capabilities
- Program Weaknesses
  - Lack of consumer interest in public reporting
  - Concern about the potential for too many measures
- Overall Rating - 65% rated the program as a “4” or “5” (on a 1 to 5 scale) for importance with a mean score of 3.86.

Health Plan Engagement

- Program Strengths
  - Increased collaboration
  - Push toward QI
  - Investments in IT
  - Greater accountability and transparency
- Program Weaknesses
  - Improvements viewed as marginal
  - Concerns about "teaching to the test"
  - Lack of a positive ROI
  - Failure of clinical data fed to raise plan HEDIS scores
- Overall Rating - 2.5 mean score (1 to 5 pt. scale)

Lessons Learned #1: Measures

Lesson

- Clinical improvement has been incremental
- Evidence points to "teaching to the test" vs. systemic improvements

P4P Response

- Created Coordinated Diabetes Care Domain to focus attention on redesign needed to drive breakthrough improvement
- Considering use of multiple chronic care measure domains or comprehensive clinical measurement systems (e.g., Rand QA Tools)

IT-Enabled "Systemness" Domain

- Data Integration for Population Management
- Electronic Clinical Decision Support at the Point of Care
- Care Management
  - Coordination with practitioners
  - Chronic care management
  - Continuity of care after hospitalization
- Interoperability
- Physician Measurement and Reporting

Coordinated Diabetes Care Domain

- Diabetes Clinical Measures
  - HbA1c screening, poor control >9, good control <8
  - LDL screening, control <100
  - Nephropathy Monitoring
- Diabetes Population Management Activities
  - Diabetes Registry (including blood pressure)
  - Actionable Reports on Diabetes care
  - Individual Physician Reporting on Diabetes measures
- Diabetes Care Management

Lessons Learned #2: Regional Variation

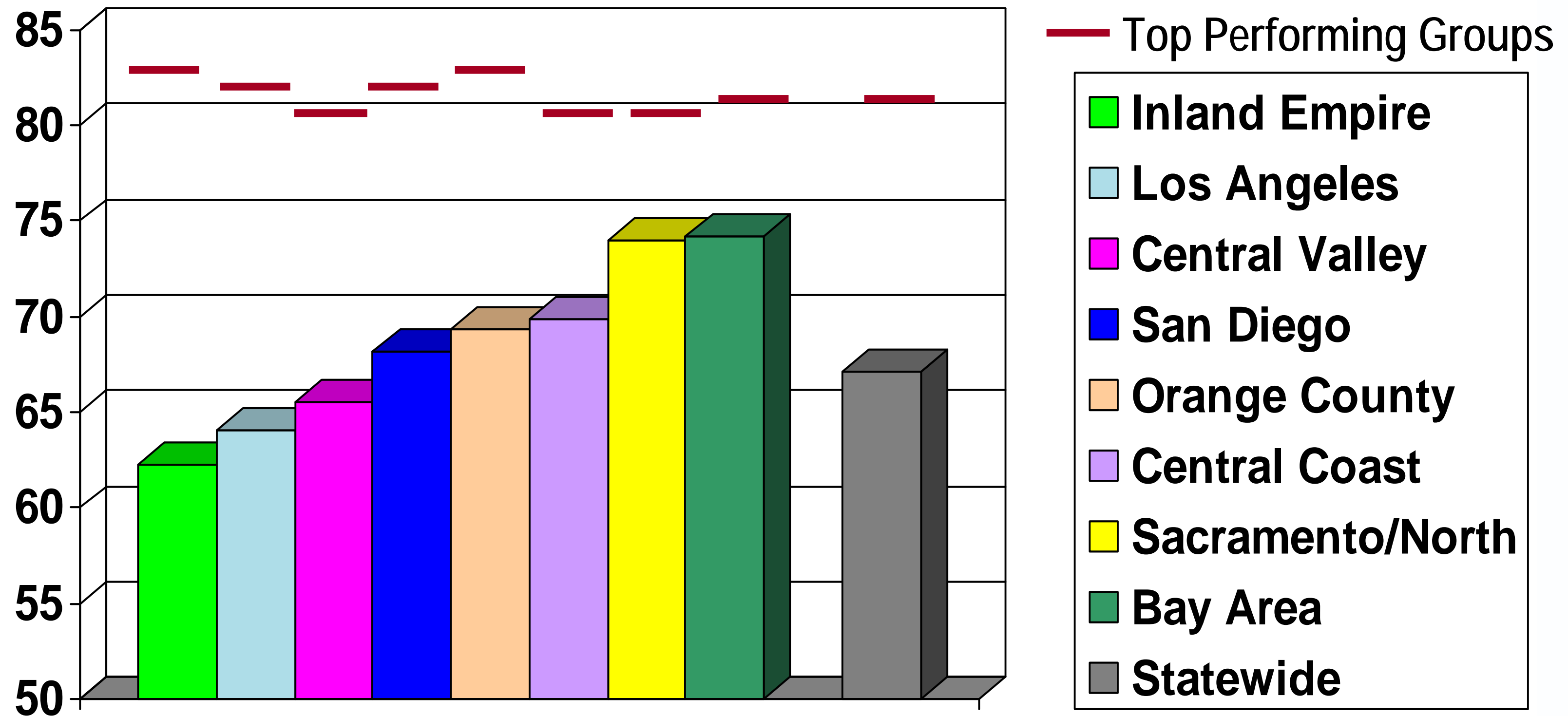
Lesson

- Wide variation across regions exists; contributes to overall "mediocre" statewide performance
- Big gains may be possible with focused attention on certain regions

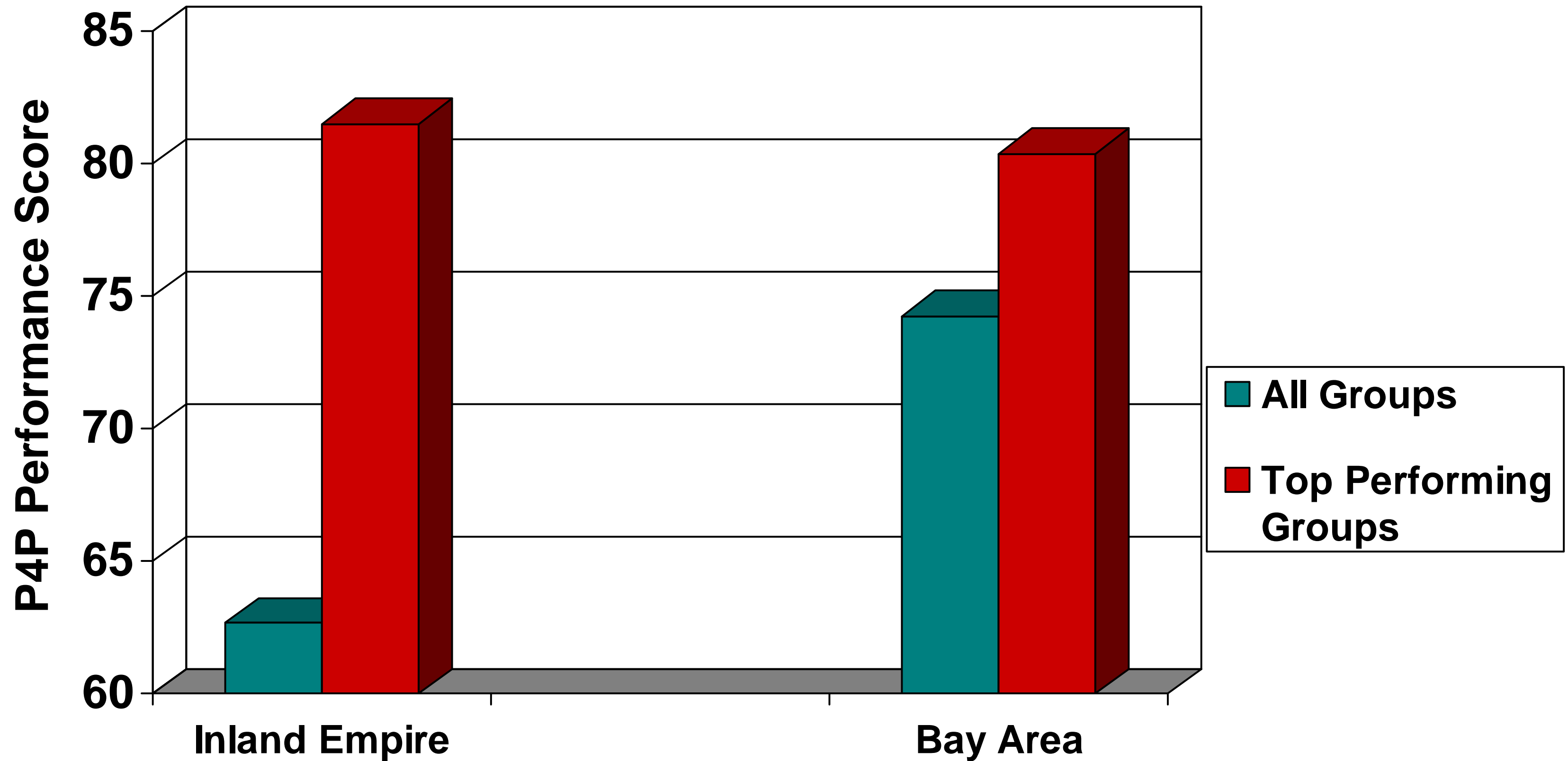
P4P Response

- Pay for and recognize improvement

CA P4P Regional Variation: Clinical Composite Score



CA P4P Regional Variation: A Tale of Two Regions



CA P4P Regional Variation: A Tale of Two Regions

	Inland Empire	Bay Area
PCPs/100K Pop.	53	116
% Pop. Medi-Cal	17%	12%
% Hispanic	43%	21%
Per Capita Income	$ 21,733	$ 39,048

Are Quality Disparities Correlated with Reimbursement Disparities?

The data and subjective experience suggest that even in a uniformly, well-insured population:

Physicians in geographies with low socioeconomics

Disproportionately lower reimbursement

Diminished physician and organizational capacity

Reduced access and quality of healthcare

Lesson Learned #3: Incentives

<u>Lesson</u>

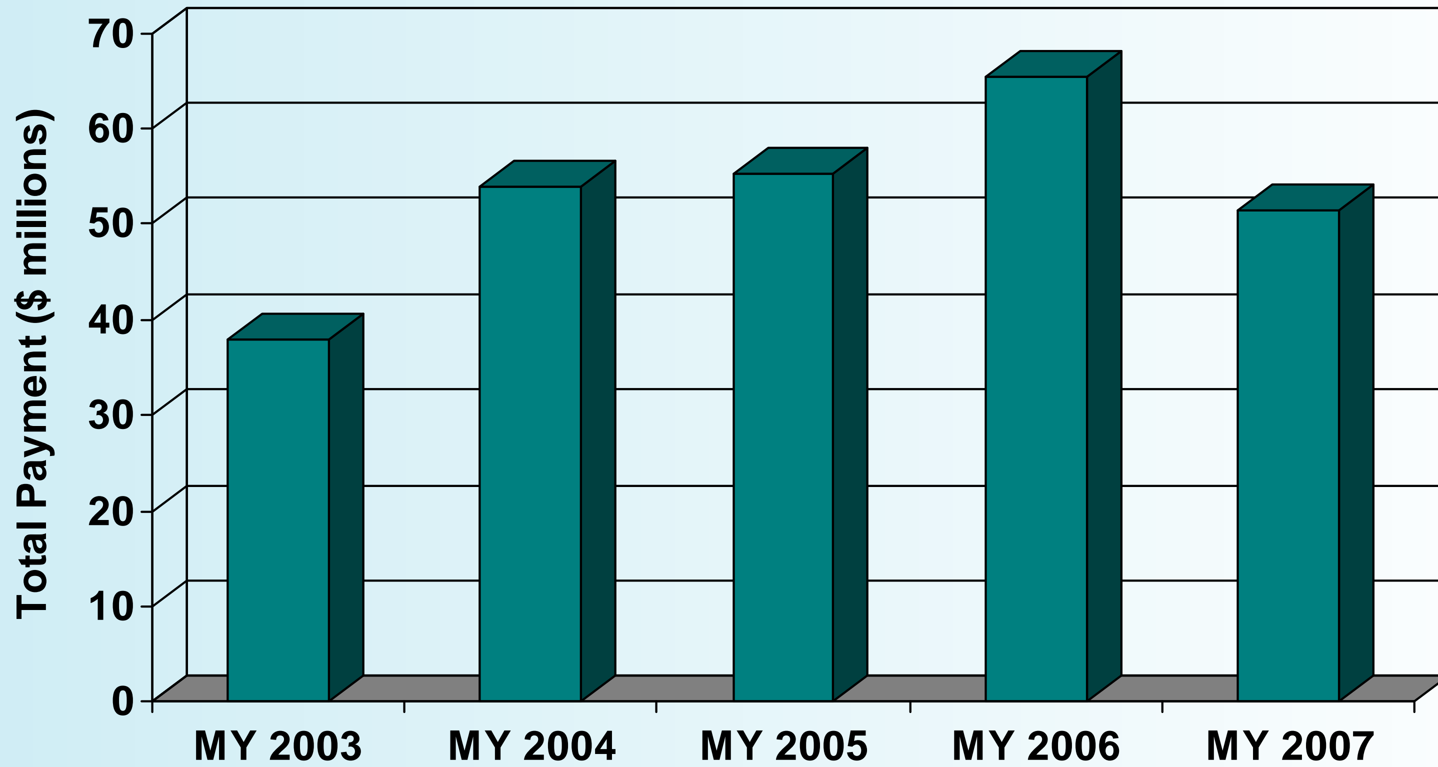
- Incentives may not be properly targeted or structured to achieve desired outcomes

- Pay must keep pace with measure set expansion

<u>P4P Response</u>

- Increased attention to "pay"
  - Resolved antitrust concerns; formed Payment Committee
  - Reduce payment variability through methodology recommendations, including minimum payment
  - Eliminate "black box" by advanced notice of payment methodology

CA P4P Health Plan Payments



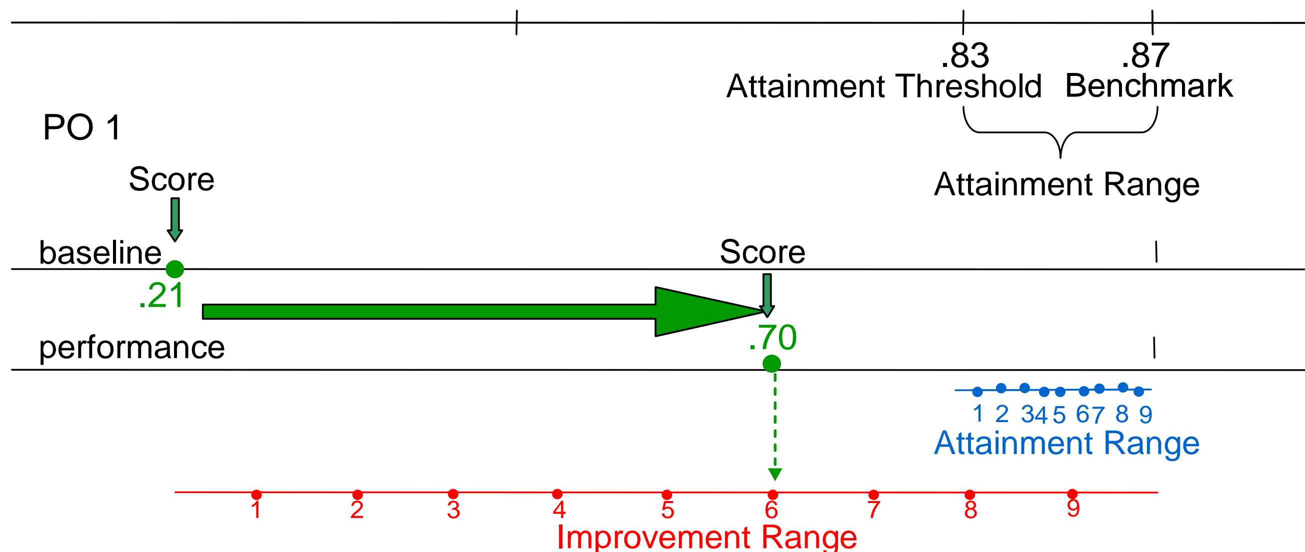
CA P4P Payment Methodology Recommendations for MY 2009

- Comprehensive Payment Methodology that incorporates both Attainment and Improvement
- Linking Payment Potential to Data Sharing
- Gain Sharing for Appropriate Resource Use measures

Paying for Attainment & Improvement

Earning Quality Points Example

Measure: Cervical Cancer Screening



PO 1Earns: 0 points for attainment
6 points for improvement

PO 1 Score: maximum of attainment or improvement
= 6 points on this measure

Next Generation P4P: Performance-Based Contracting

Gainsharing
Quality Bonus
Base Payment

Performance-based Contracting:

- Quality Benchmarks
- Efficiency Targets
- 10+% Potential Payment

Lesson Learned #4: Affordability

Lesson

- Diminishing price competitiveness of HMO product demands greater attention to cost
- Health plan commitment is wavering in the absence of a clear ROI

P4P Response

- Implement efficiency and resource use measures
- Develop business case and ROI
  - implement overuse and misuse measures
  - develop method to measure ROI
  - improve HEDIS data

Cost Efficiency Measurement

- Appropriate Resource Use measures
  - Inpatient acute care discharges PTMY
  - Bed days PTMY
  - Readmissions within 30 days
  - ED Visits PTMY
  - Outpatient surgeries — % done in ASC
  - Generic prescribing

- Episodes of care testing

California Pay for Performance

For more information:

www.iha.org

(510) 208-1740

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