The California P4P Program Development of Efficiency Measures: Episodes, Appropriate Use, and Total Cost of Care

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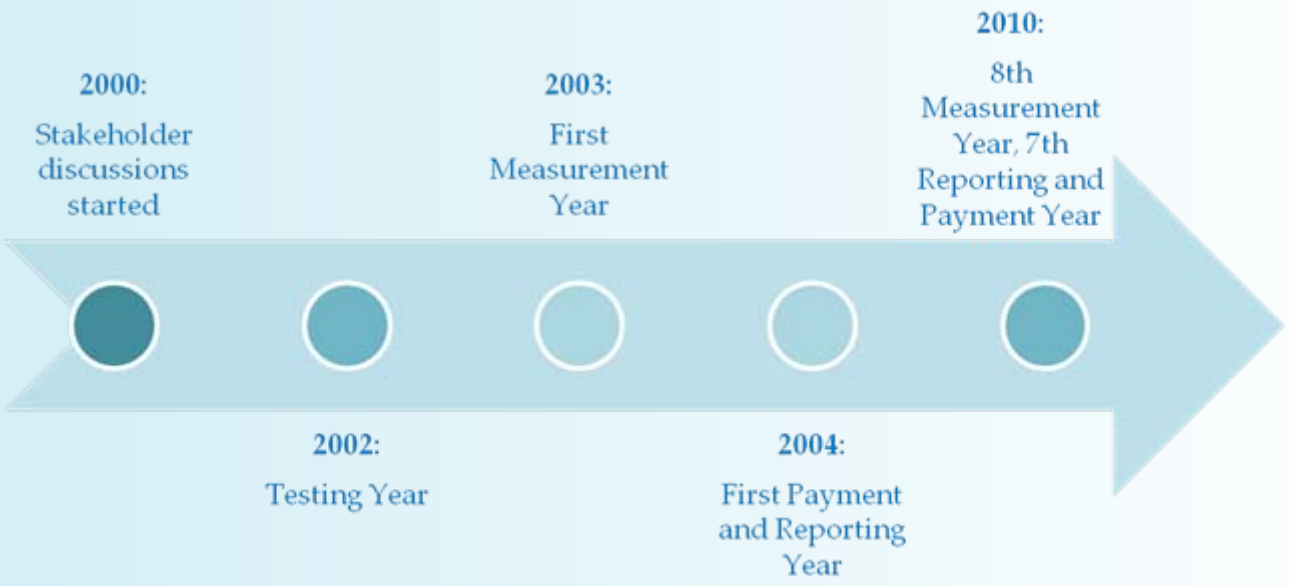
"Efficiency Measurement: The Pot of Gold At the End of the Rainbow?"

Part III

Agenda

- Overview
- Findings
- Current Status
- What's Next

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 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, IT-Enabled Systemness, and the patient experience through:

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

CA P4P Measurement Evolution

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

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

Principles: Efficiency Measurement in P4P

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

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

Measuring Efficiency

- Original Intent:
  - Episode and population-based measures
  - Standardized and actual costs
- Findings/Conclusions:
  - Data limitations
  - Small numbers issue
  - Data does not support episode measures for payment or for quality improvement
- Current Measure Strategy:
  - Start with Appropriate Resource Use measures
  - Move to Total Cost of Care

Getting Data

- Sign Business Associate Agreements
- Address antitrust concerns
  - Opinion from legal counsel
  - Guidelines for acceptable reporting
- Overcome confidentiality clauses in contracts
  - Obtain Consent to Disclosure Agreements
    - Physician Groups
    - Hospitals
- Obtain useable data from health plans
  - Multiple data submissions needed

Development Timeline

November 2005 – July 2006	RFP process for vendor selection; Thomson Reuters selected
October 2006	Multi-stakeholder Technical Efficiency Committee formed
May 2007	Antitrust guidelines adopted
May 2007 – current	Consent to Disclosure Agreements
March 2008	BAAs signed and data received
July 2008 – January 2009	Testing and health plan data quality meetings
October 2009	Episode reports distributed

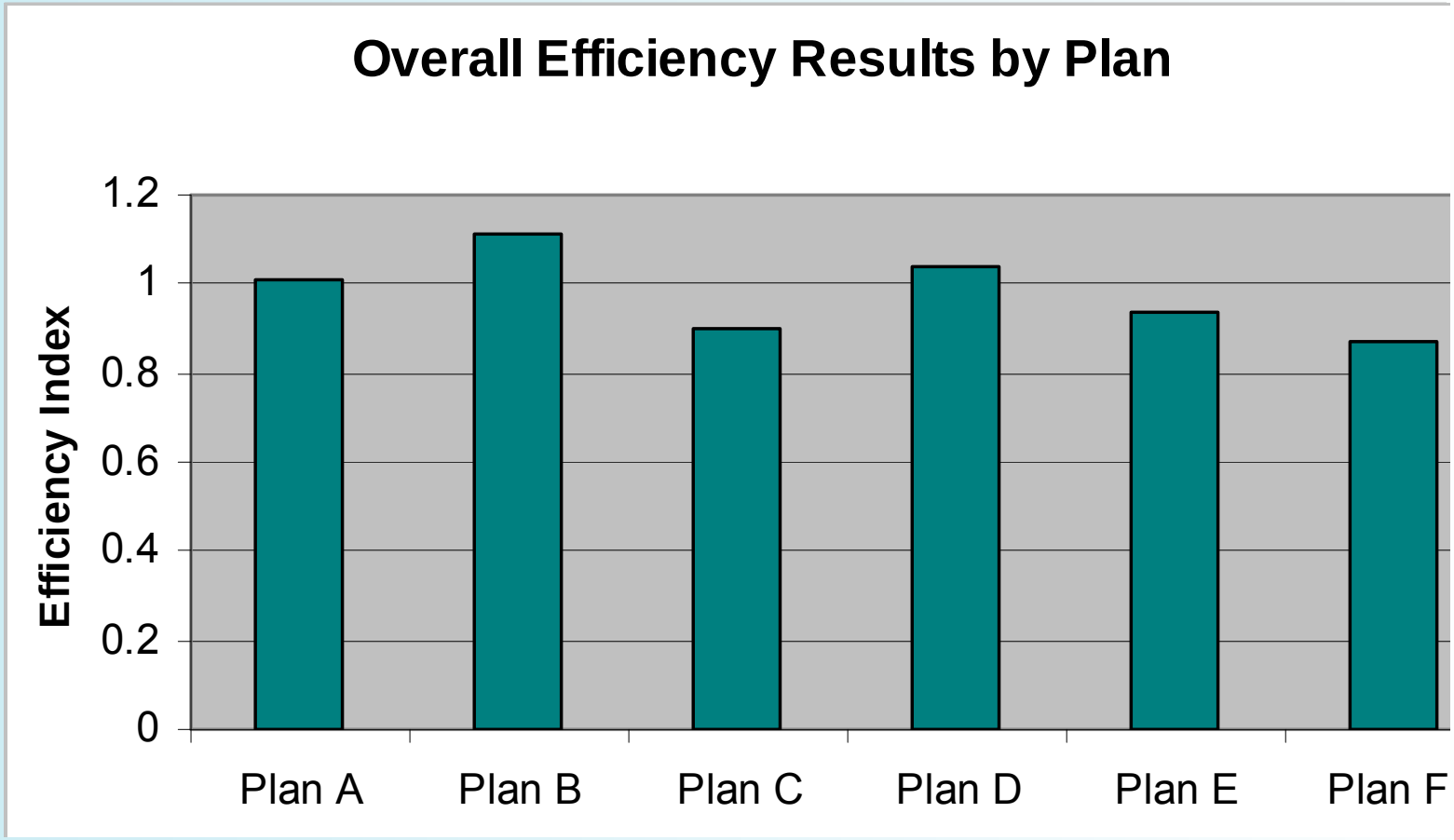
Findings: High Level

- Collected and aggregated data from 6 health plans
  - Numerous data fixes needed to standardize data across plans
- Produced overall population and episode-based efficiency results
  - Reasonable and normally distributed
- Drilled down to single episode groups and service categories
  - Greater granularity of drill down = more data gaps/inconsistencies identified

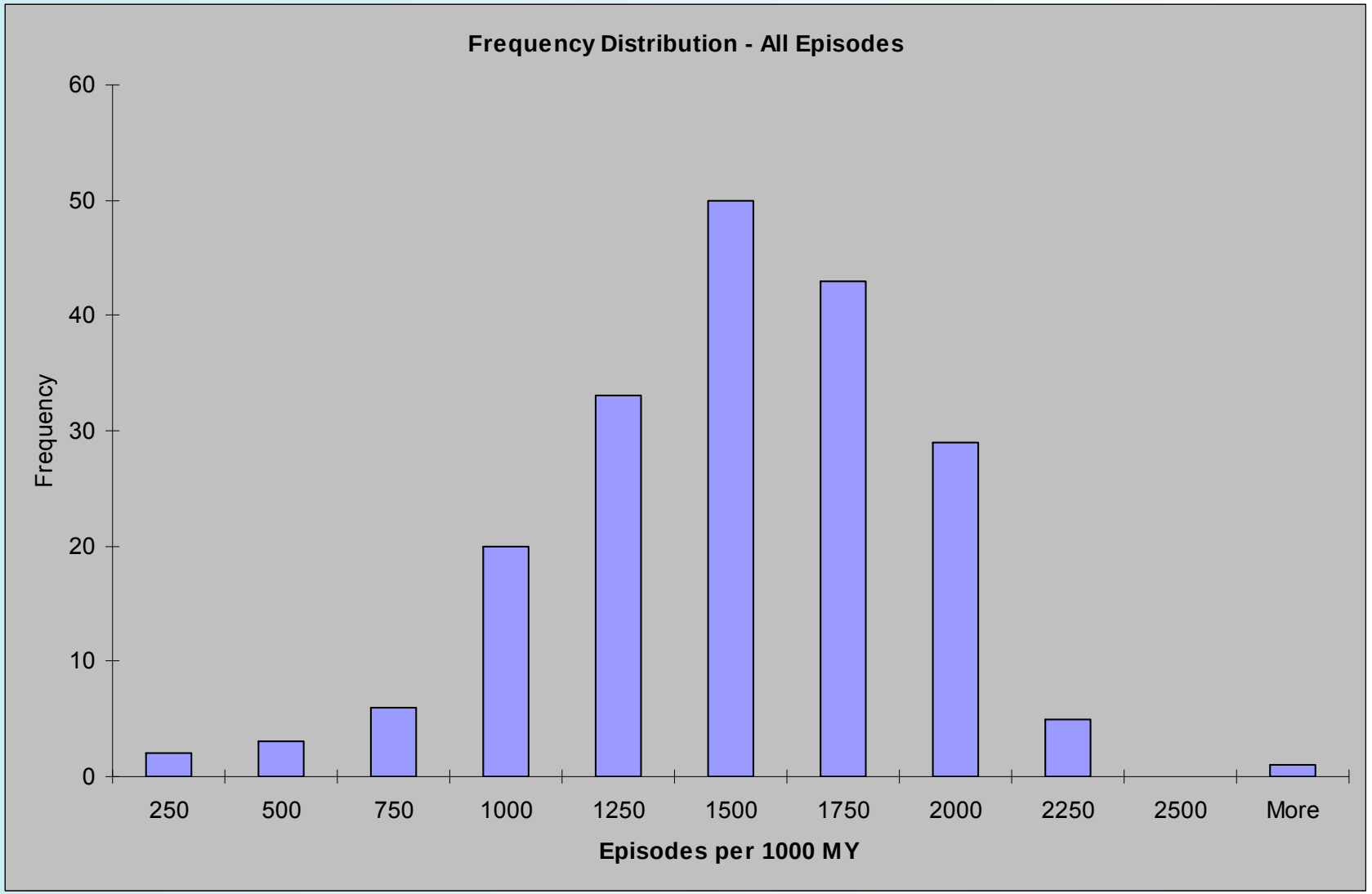
Findings: Episodes of Care

- Variation in overall efficiency across plans
  - True differences or driven by data?
  - Similar finding in MA
- Limited number of high cost episode groups occur frequently enough to produce results for at least 50% of POs
- Episodes that are driven by pharmacy, professional, and lab are the most reliable
- Number of episodes per 1000 member years varies greatly across POs
  - Proxy for data completeness

Plan Level Episode Efficiency



	Episode Type	Percent of Cost	Percent of POs with 30+ Episodes
1	Diabetes Mellitus Type 2 and Hyperglycemic States Maintenance	5.6%	84.9%
2	Renal Failure	5.5%	37.0%
3	Essential Hypertension, Chronic Maintenance	4.5%	88.5%
4	Angina Pectoris, Chronic Maintenance	4.3%	66.7%
5	Neoplasm, Malignant: Breast, Female	3.2%	39.1%
6	Delivery, Vaginal	2.5%	63.5%
7	Osteoarthritis, Except Spine	2.3%	77.6%
8	Asthma, chronic maintenance	2.2%	77.6%
9	Other Arthropathies, Bone and Joint Disorders	2.0%	88.0%
10	Human Immunodeficiency Virus Type I (HIV) Infection	1.7%	15.1%
11	Rheumatoid Arthritis	1.5%	39.6%
12	Neoplasm, Malignant: Colon and Rectum	1.4%	18.8%
13	Delivery, Cesarean Section	1.4%	34.4%
14	Other Inflammations and Infections of Skin and Subcutaneous Tissue	1.2%	90.1%
15	Other Gastrointestinal or Abdominal Symptoms	1.1%	85.9%
16	Complications of Surgical and Medical Care	1.1%	47.9%
17	Multiple Sclerosis	1.0%	15.6%
18	Infections of Skin and Subcutaneous Tissue	1.0%	81.3%
19	Other Ear, Nose and Throat Disorders	1.0%	89.1%


Frequency Distribution - All Episodes
60
50
40
30
20
10
0
Frequency
250
500
750
1000
1250
1500
1750
2000
2250
2500
More
Episodes per 1000 MY

Conclusion after Testing

- Data does not yet support episode of care based measurement for payment but is now good enough for sharing with POs
- Many episode groups should be discarded because numbers too small for reliability

Episode-Based Efficiency Measures

- New analytic method published in MedPAC report

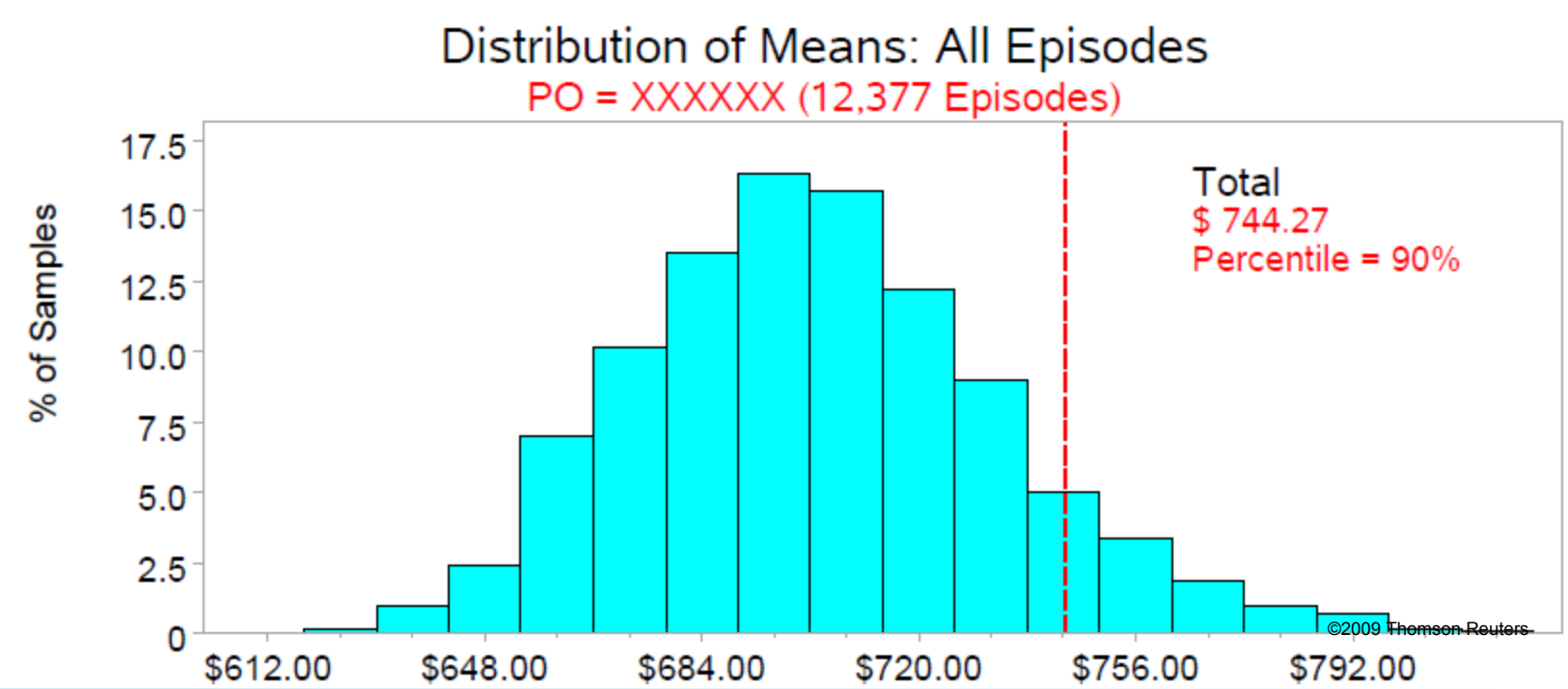
  "Are resources used by a PO to treat its mix of patients more or less efficient than average resources used in California to treat patients with the same characteristics?"

- Overall Efficiency (across patients & episodes)
- Efficiency by Selected Episode Group
- Drill-down to service categories

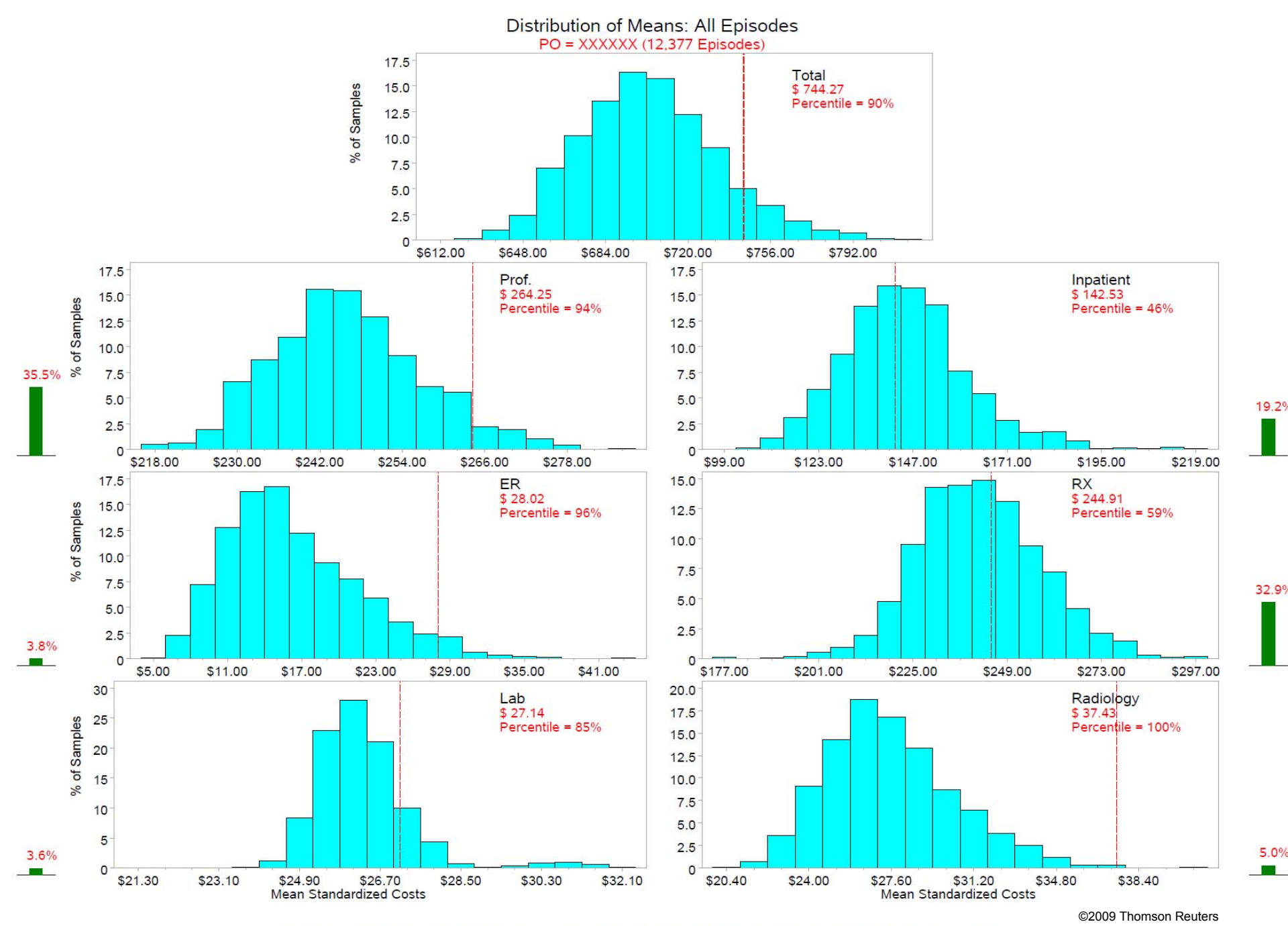
  -Inpatient
  -Office visit
  -Drug

  – Lab
  – Radiology
  – ER

Comparing Actual to Expected Costs

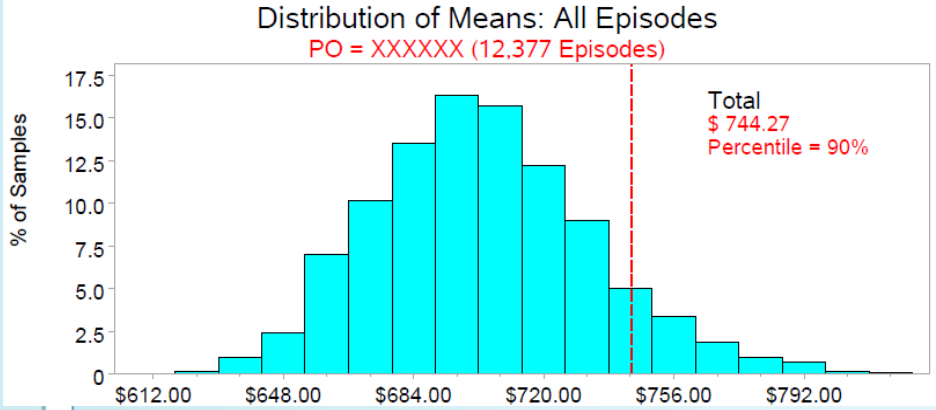


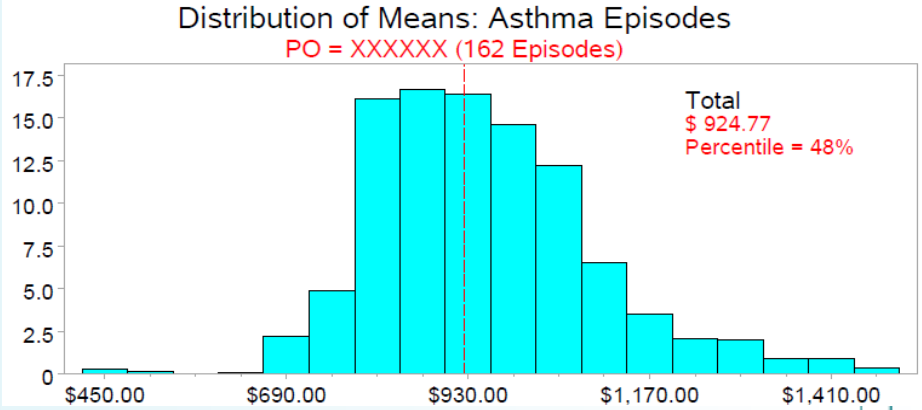
- PO has a total of 12,377 episodes
- Average standard cost per episode is $ 744
- Compare to distribution of mean costs based on samples of comparable episodes from CA-based POs (range: $600 - $800)
- Observed mean costs falls at the 90th percentile of mean costs for comparable samples of episodes

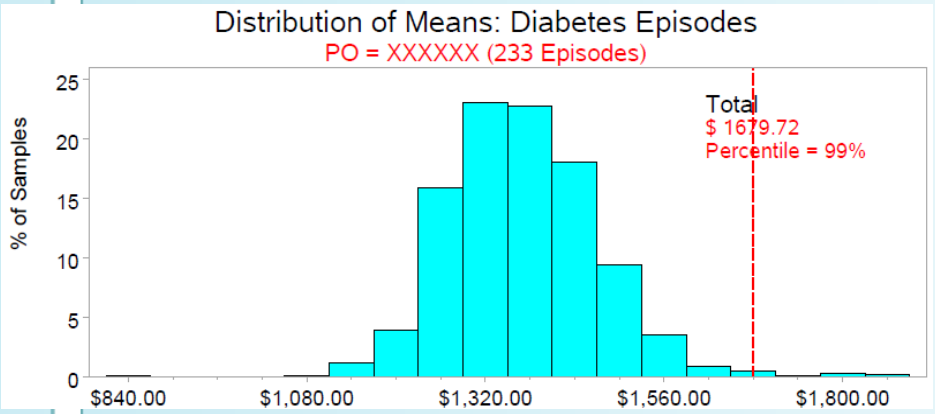


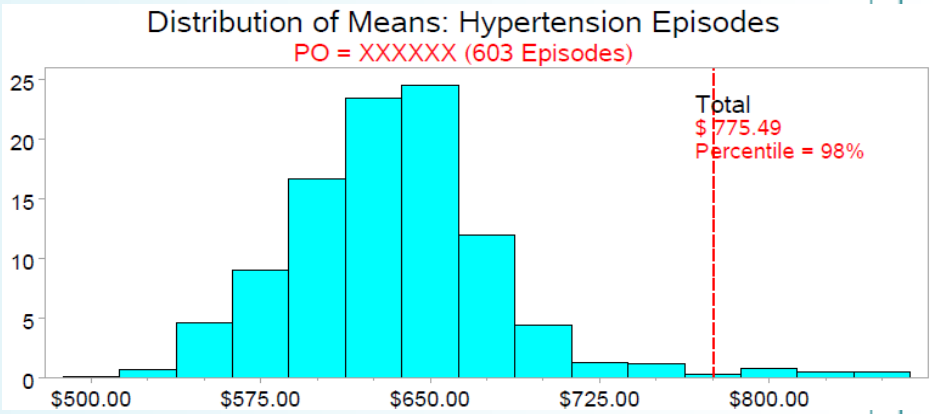
Note: The green bar next to each histogram indicates the percentage of total dollars represented by that service category.

Comparing Actual to Expected Costs Across Conditions









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Back to the Basics

- Episode results interesting, but not actionable without further drill down
- Growing need to address affordability
- Standardized currently used appropriate resource use measures for implementation in MY 2009
  - Inpatient acute care discharges PTMY
  - Bed days PTMY
  - Readmissions within 30 days
  - ED Visits PTMY
  - Outpatient surgeries — % done in ASC
  - Generic prescribing

Appropriate Resource Use Domain

- MY 2008 results distributed December 2009
- MY 2009 results to be distributed July 2010
- Intended for use in shared savings approach
- No public reporting planned

Appropriate Resource Use Domain

- For each PO, each of the measures will be calculated from health plan data in two ways:
  - Results for each contracted health plan
    - Health plan to apply its actual costs and share savings generated by a PO's improvement
    - Health plans may also reward POs for attainment
  - Results aggregated across all contracted health plans
    - Allows PO to understand how its utilization compares to other POs

ARU Methodology Basics

- Observed rate and risk adjusted rate provided

Risk adjusted rate =
[Observed Rate/Expected Rate] * Population Rate

- Confidence intervals provided
- Outliers shown in report, but removed when calculating benchmarks
- Benchmarks derived from results of all POs statewide

ARU Methodology Basics

	Readmissions	Inpatient Discharges/Bed Days	ED Visits	Generic Prescribing
Risk Adjustment	CMS DRG case mix	Concurrent DxCG Relative Risk Score	Concurrent DxCG Relative Risk Score	None
Exclusions	• Maternity/newborn • Discharge to SNF • Admission to other acute care facility < 1 day • Discharge deceased	• Maternity/newborn • Readmissions • Mental health & chemical dependency • Discharge to other acute care facility	• Admissions • Mental health & chemical dependency	• Self-injectibles
Outliers	None	• <30 or >70 PTMY total discharges • Days Winsorized at 3 SD from mean/DRG	• < 60 or > 250 PTMY ED rate	None

Move to Total Cost of Care

- Total amount paid to care for members of a physician group for a year
- Adjusted for health risk, geography, and possibly other factors such as affiliation with teaching hospital or other market impacts

2010 – Baseline Measurement Year

2011 – First Measurement Year

2012 – Full Implementation

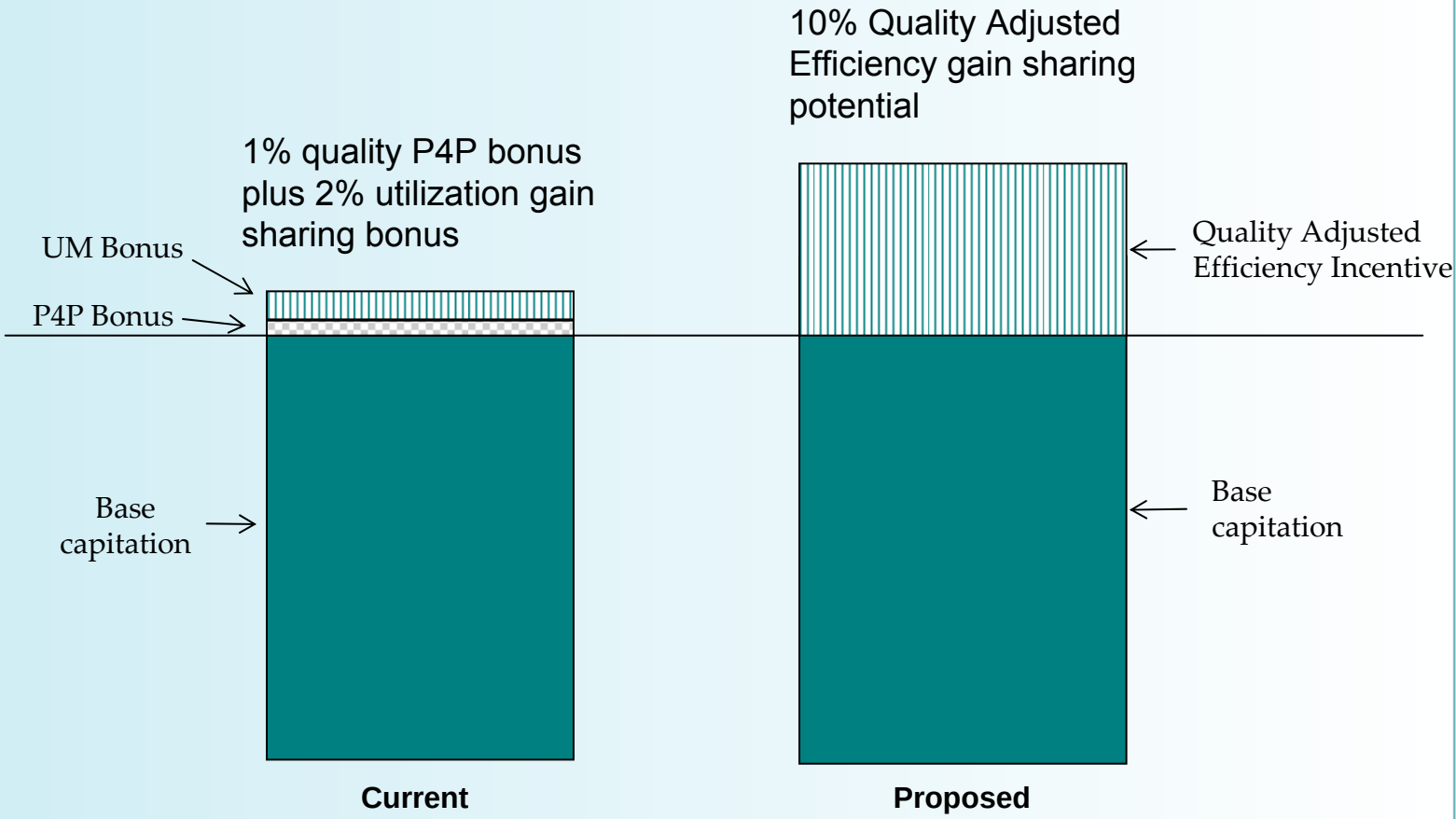
Migrate P4P to Performance Based Contract

- Incorporate P4P into standard agreement
- Increase potential bonus opportunity from the current 3% (1% P4P/2% UM) of professional compensation toward 10%
- Increase emphasis on efficiency and harmonize efficiency measures
- Down the road, develop information to support benefit design changes to engage consumers

Performance Based Contract Overview

- Quality
  - Add inpatient measures and Care Transitions
  - Expand outcomes measures
  - Use quality performance as a threshold and multiplier to determine amount of efficiency incentive payment
- Efficiency
  - Use Total Cost of Care to determine gain sharing (2012)
  - Continue to provide Appropriate Resource Use measures as leading indicators to support improvement
  - Funded from gain sharing and budgeted capitation increases

Performance Based Incentive Proposed Framework



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  - Move to Total Cost of Care in the Context of Performance Based Contract

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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