Getting to Total Cost of Care in California's P4P Program

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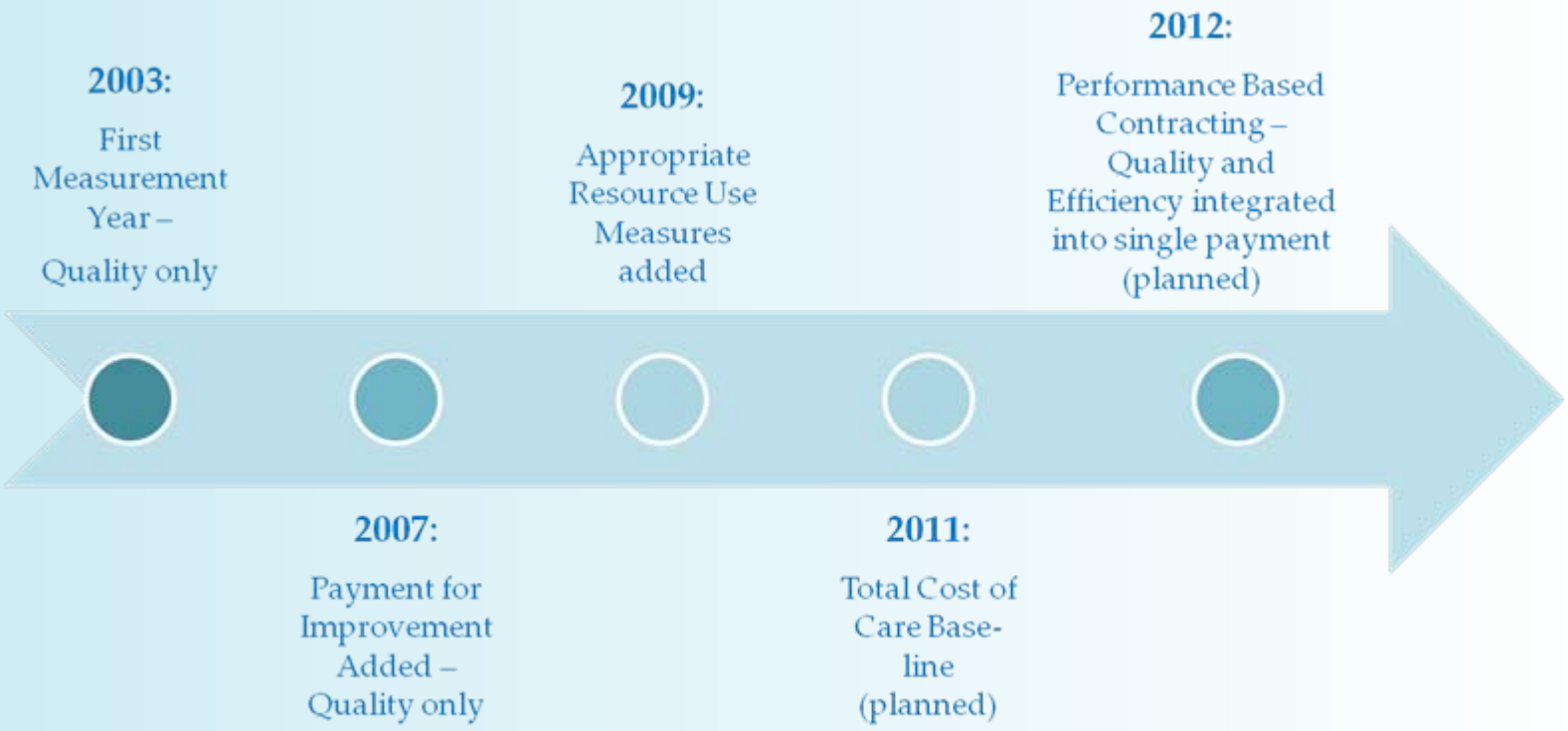
Agenda

- California P4P Background
- California Environment
- Efficiency Measures Tested/Considered
  - Potentially Avoidable Hospitalizations
  - Episode-based measures, standardized costs
  - Appropriate Resource Use
  - Total Cost of Care
- Performance Based Contracting: The Road Ahead

California P4P Background

California P4P Program Evolution Timeline



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:

- 221 Physician Organization
- 35,000 Physicians
- 10 million commercial HMO/POS members

** Kaiser medical groups participate in public reporting only, starting 2005*

Original Goal of California P4P

To create a compelling set of incentives that will drive breakthrough improvements in clinical quality and the patient experience through:

- Common set of measures using aggregated results
- A public report card
- Health plan payments to physician organizations

Evolution of Payment Reform

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Where Knowledge Informs Change

Past and Emerging Models of Accountability in Provider Payments

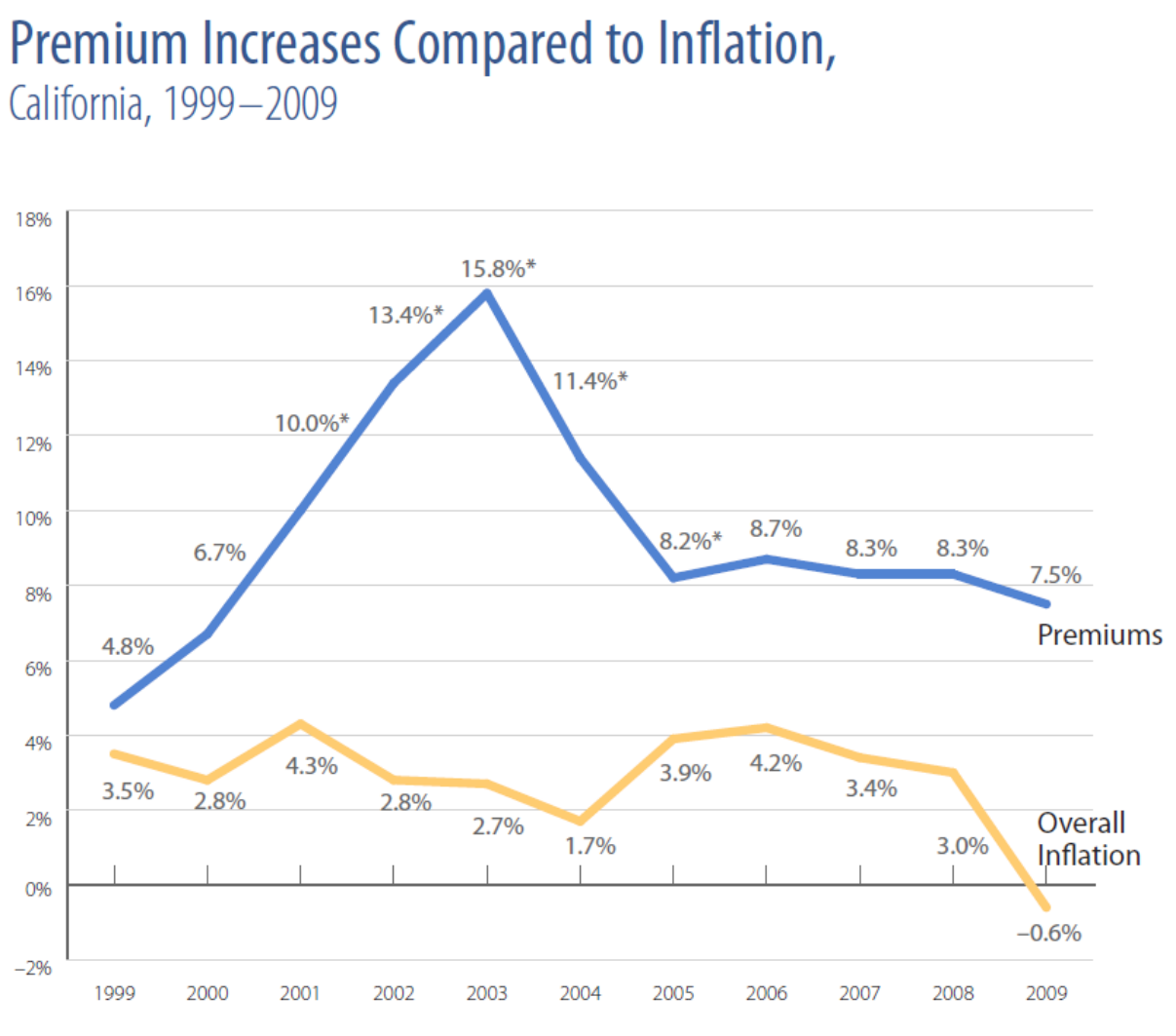
Supporting Better Performance		Paying for Better Performance		Paying for Higher Value	
Pay for reporting. Payment for reporting on specific measures of care. Data primarily claims-based.	Payment for coordination. Case manage-ment fee based on practice capabilities to support preventive and chronic disease care (e.g., medical home, interoperable HIT capacity).	Pay for performance. Provider fees tied to one or more objective measures of performance (e.g., guideline-based payment, nonpayment for preventable complications).	Episode-based payments. Case payment for a particular procedure or condition(s) based on quality and cost.	Shared savings with quality improvement. Providers share in savings due to better care coordination and disease management.	Partial or full capitation with quality improvement. Systems of care assume responsibility for patients across providers and settings over time.

Current California Environment

California Environment

- Affordability problems dramatically worsened since P4P started
  - HMO premium increased 142% since 2000 and now exceed PPO premium in multiple California markets
- HMO enrollment decreasing
  - Enrollment covered by P4P decreased 3-4% annually since program inception
- CA incentive payments already weighted toward efficiency
  - IHA P4P incentive payments average ~1% of compensation
  - Non-IHA shared risk/gain sharing payments average ~2%
- Risk sharing, as currently structured, has not yielded affordability

California Environment



California Environment: 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

California Environment: 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

Efficiency Measures Tested/Considered

Evolution of Efficiency Measurement in P4P

- Original Intent:
  - Episode and population-based measures
  - Standardized and actual costs
- Initial Episode Measurement Findings/Conclusions:
  - Data limitations
  - Small numbers issue
  - Data does not support episode measures for payment
- New Analytic Method for Episode Measurement:
  - Interesting, but not actionable without further drill down
- Current Measure Strategy:
  - Start with Appropriate Resource Use measures
  - Move to Total Cost of Care as part of Performance Based Contracting

Potentially Avoidable Hospitalizations

- Used AHRQ Prevention Quality Indicators
- Added risk adjustment to account for prevalence of condition in population
- Measured specific conditions as well as roll-up across conditions
- Findings:
  - Physician group level denominators are too low to provide reliable results
  - Use of composite does not ameliorate problem

Episode-Based Measures – Version 1

	Episode Type	Percent of Cost	Percent of Group 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%

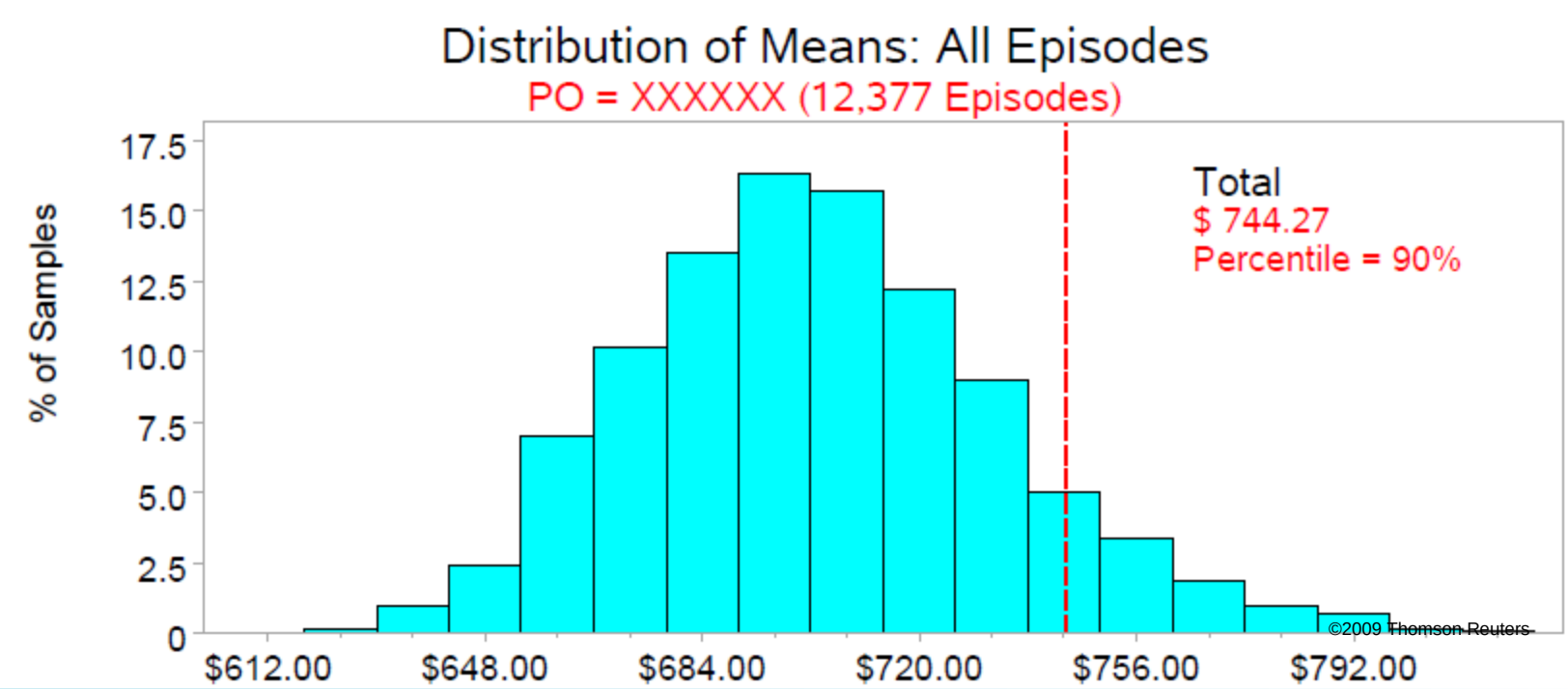
Episode-Based Measures – Version 2

- New analytic method published in MedPAC report

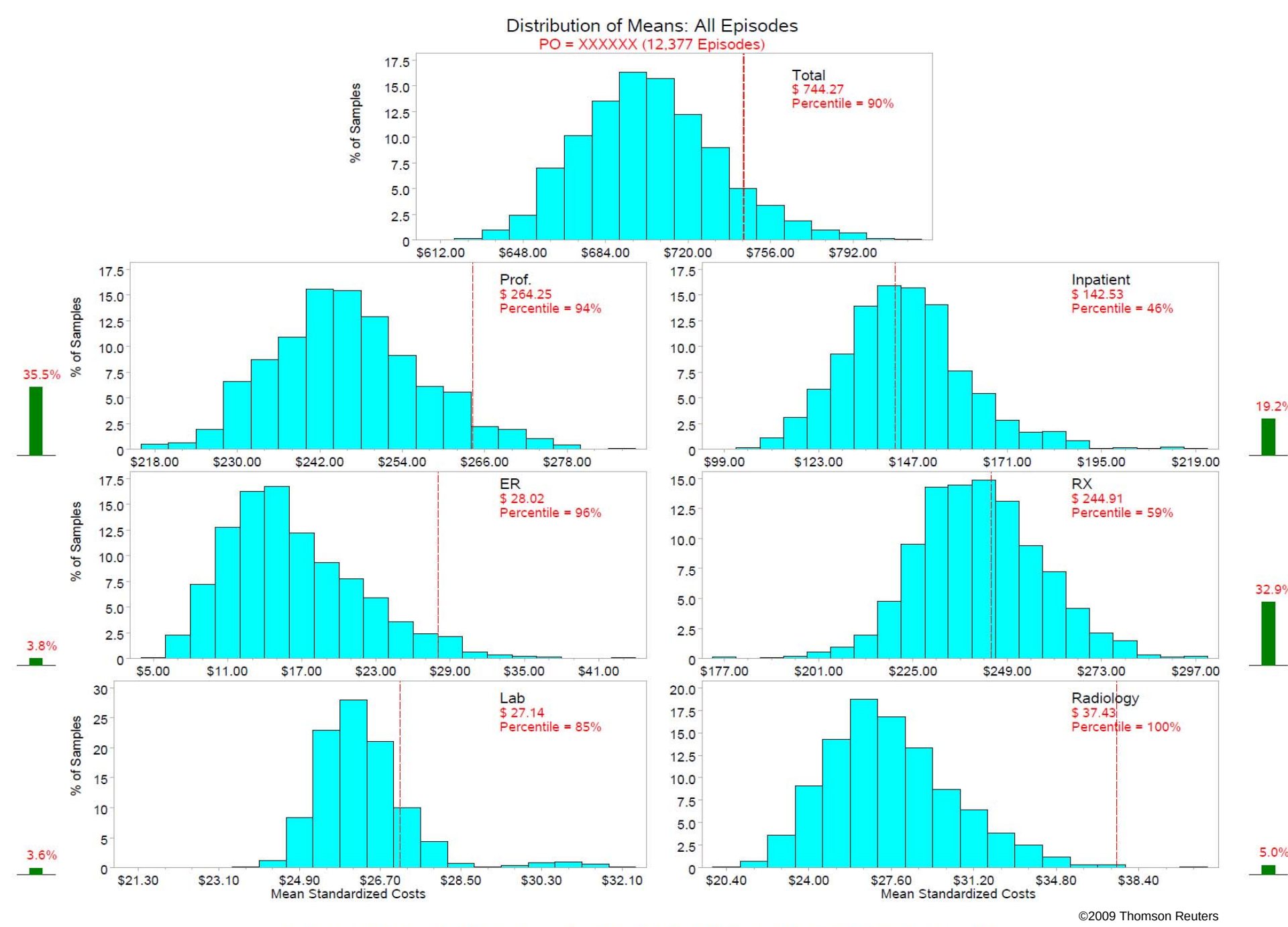
  "Are resources used by a group to treat its mix of patients more or less efficient than average resources used in California to treat patients with the same characteristics?"

- Overall Efficiency (across patients & episodes)
- Efficiency by Selected Episode Group
- Drill-down to service categories
  - Inpatient
  - Office visit
  - Drug
  - Lab
  - Radiology
  - ER

Episode Based Measures – Version 2 (cont.)

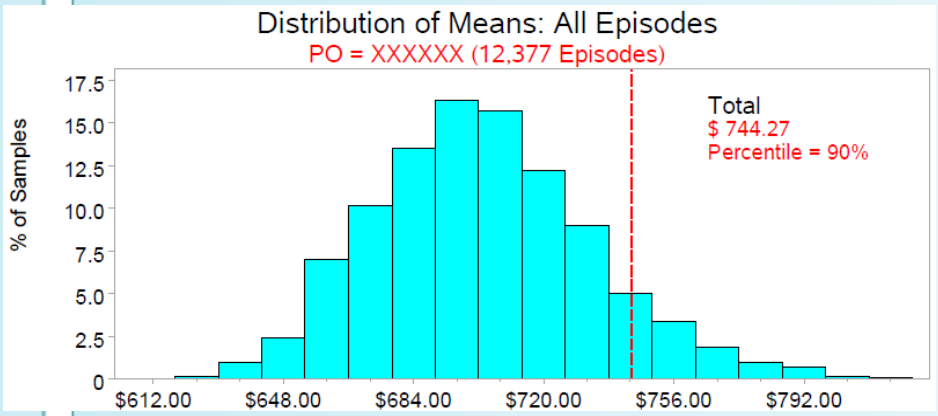


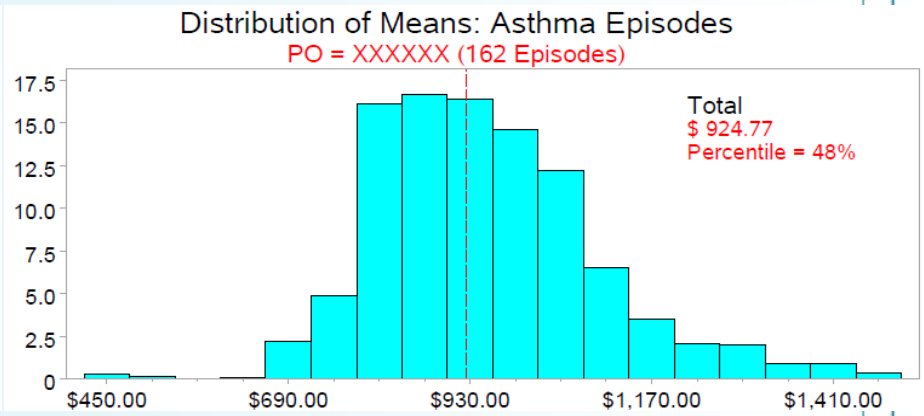
- Physician group has a total of 12,377 episodes
- Average standard cost per episode is $ 744
- Compare to distribution of mean costs based on samples of comparable episodes from CA-based physician groups (range: $600 - $800)
- Observed mean costs falls at the 90th percentile of mean costs for comparable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

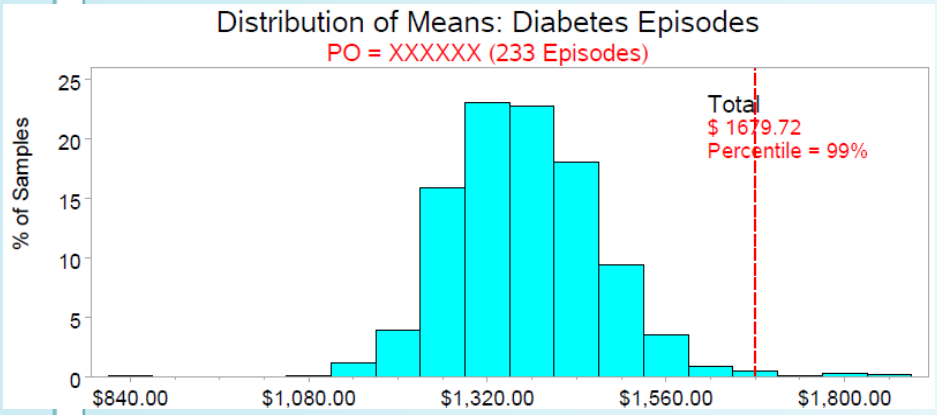


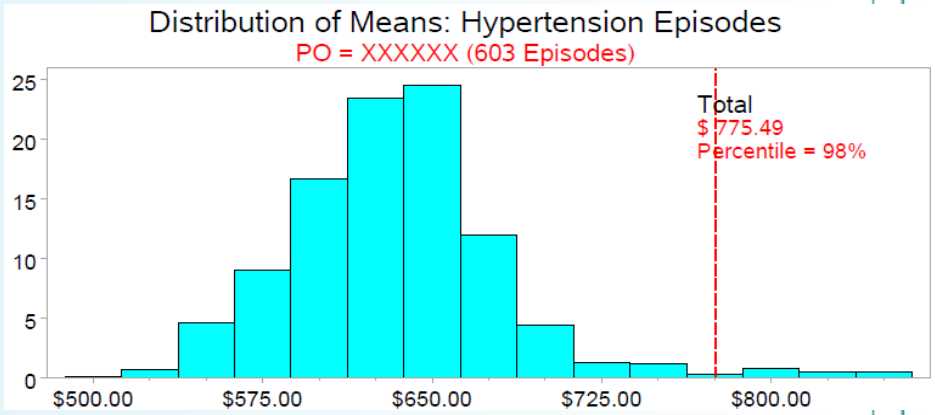
Note: The green bar next to each histogram indicates the percentage of total dollars represented by that service category.

Episode-Based Measures – Version 2 (cont.)









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 (ARU) measures and implemented for MY 2009
  - Inpatient acute care discharges PTMY
  - Bed days PTMY
  - Readmissions within 30 days
  - ED Visits PTMY
  - % Outpatient Procedures in Preferred Facility
  - Generic prescribing – 7 therapeutic areas

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

Total Cost of Care Measure

- Description: Total amount paid to any provider (including facilities) to care for all members of a physician group for a year
- Risk adjustment: Concurrent DCG Relative Risk Score with $100K truncation for health status
- Other adjustment: CMS Hospital Wage Index GAF for geographic pricing differences
- Outliers: Costs above $100,000 per member per year
- Exclusions:
  - Mental health or chemical dependency services
  - Acupuncture or chiropractic services
  - Dental or vision services
  - P4P incentive payments

Total Cost of Care Measure (cont.)

- Specifications developed by P4P Technical Efficiency Committee
- Timeline: test in 2010/2011, baseline for MY 2011, use for incentive payments for MY 2012
- Provide underlying key indicators to inform physician groups about their performance relative to peers in specific aspects of care
- Growing national consensus supporting measurement of total costs
  - NQF Call for Resource Use Measures

Total Cost of Care 2009 Testing Results

- Strong positive correlation between Observed Cost PMPY and Relative Risk Score
- Substantial variation across physician groups in Observed Cost PMPY and O/E ratio
- Regional variation in risk-adjusted total cost
  - Add geographic pricing adjustment
- Truncating costs above $100,000 PMPY narrowed std dev and increased year to year stability
- Physician group O/E ratios generally consistent across years
  - Larger groups tend to have more stable rates

Performance Based Contracting: The Road Ahead

Performance Based Contracting

Purpose: to revitalize/retool the P4P program against the backdrop of affordability

Objectives:

- Expand priorities to include cost control (affordability)
- Continue to promote quality
- Standardize health plan resource use measures and payment methodology
- Increase the amount of incentive potential and include in contract/agreement

Integrate Quality and Utilization Incentives

- Incentive amount determined by performance on both cost and quality
- Different views of cost will be examined
  - Total cost attainment: *How does physician group's Total Cost of Care (TCC) compare to TCC of other groups?*
  - Trend attainment: *Does group's TCC trend over previous year meet the P4P target of CPI+1%?*
- Quality measured by composite of Clinical, Patient Experience, Meaningful Use of Health IT
  - Consider attainment and improvement

Engage Other Stakeholders

- Hospitals
  - Bring hospitals to the table to partner
  - Create financial benefits for bending cost trend and improving quality
- Consumers
  - Provide information on cost and quality performance
  - Engage consumers to consider network options and out-of-pocket costs based on value (i.e., value-based benefit design)

Performance Based Contracting Summary

- P4P must continue to evolve
- Performance measurement/incentives must include cost and quality
- Alignment of measures and incentives across health plans will maximize impact
- All stakeholders must be engaged

California Pay for Performance

For more information:

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