Pre-Conference I: Perspectives on the Way to Value-Based P4P

National P4P Summit
San Francisco, CA
February 19, 2013

Speakers

- Juan Davila, Blue Shield of California
  - Health plan perspective
- Bart Wald, MD, Providence Health & Services
  - Provider perspective
- Dolores Yanagihara, IHA
  - Convener and program administrator perspective

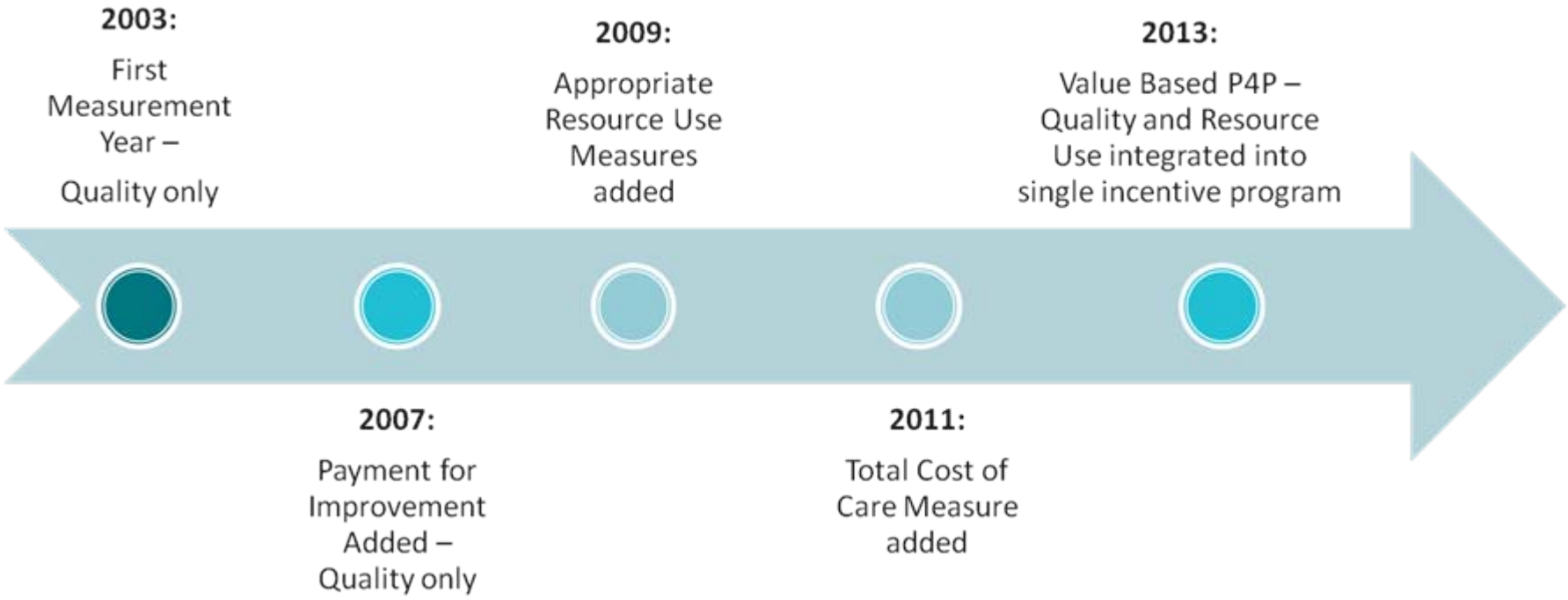
Agenda

- Overarching Goals – Why are we doing this?
- The Program – What are we doing and how did we get there?
- Making it Happen – How do we expect to roll this out?

Overarching Goals

- Why are we doing this?
- What do we hope to accomplish?
- What happens if we don't do this?

California P4P Program Evolution Timeline



Program Participants

Eight CA Health Plans:

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

Medical Groups and IPAs:

- 200 Physician Organizations
- 35,000 Physicians
- 10 million commercial HMO/POS members

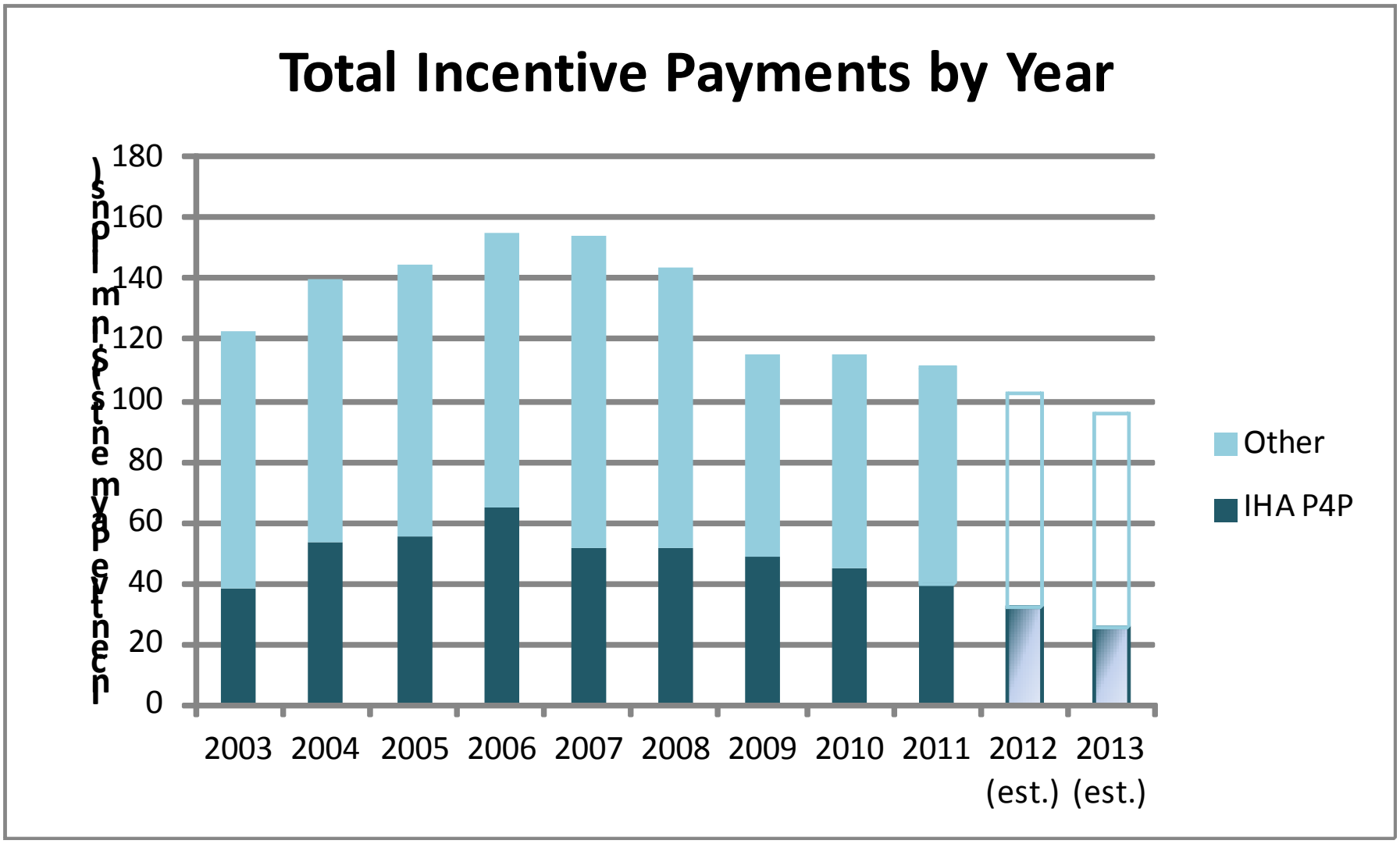
** Kaiser Permanente medical groups participate in public reporting only, starting 2005*

Why Value Based P4P?

- Days of quality-only incentives quickly coming to an end
- HMO premium increases continue to far outstrip general inflation
- HMO enrollment has steadily declined
- As currently structured:

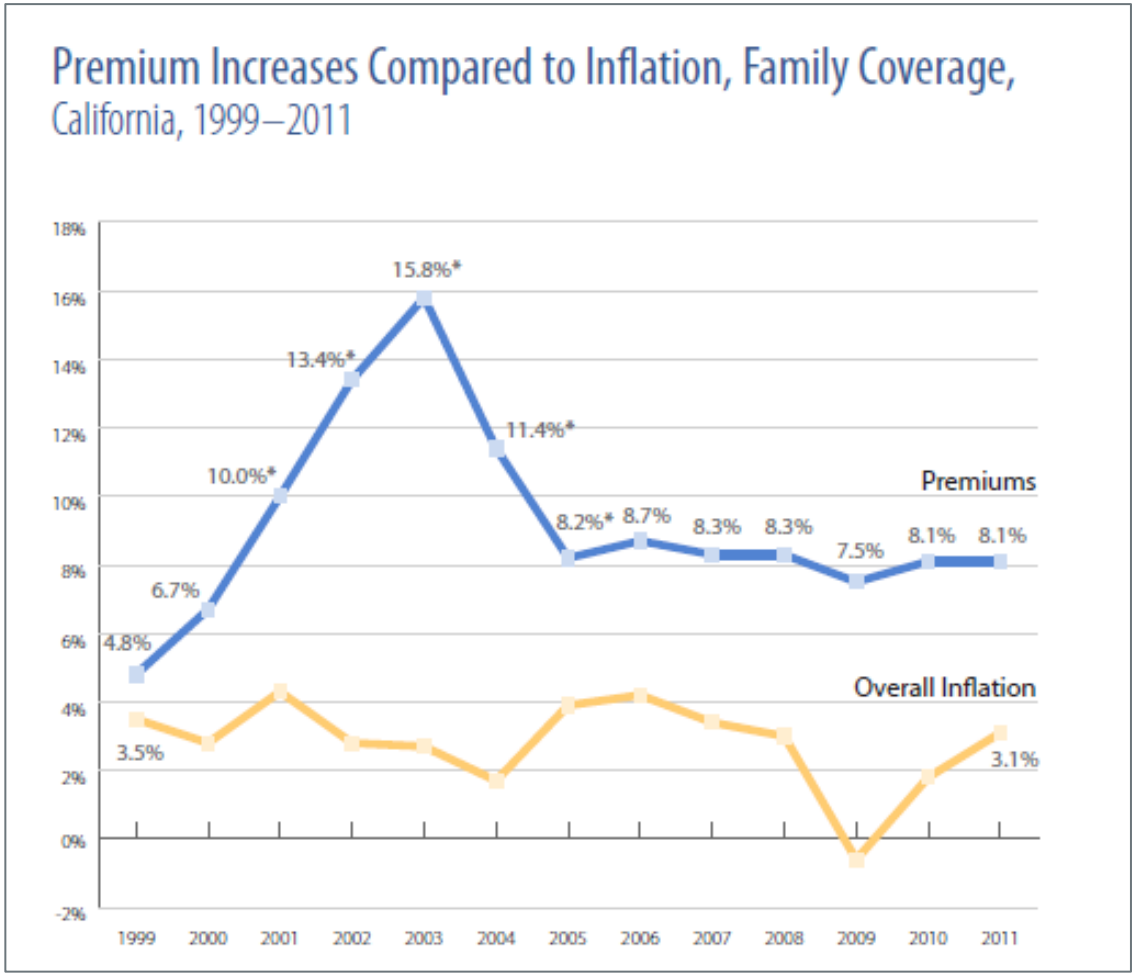
  Quality-only incentives + risk sharing ≠ affordability
- Opportunity to collaboratively design statewide value based program

Quality Incentive Payments Dropping



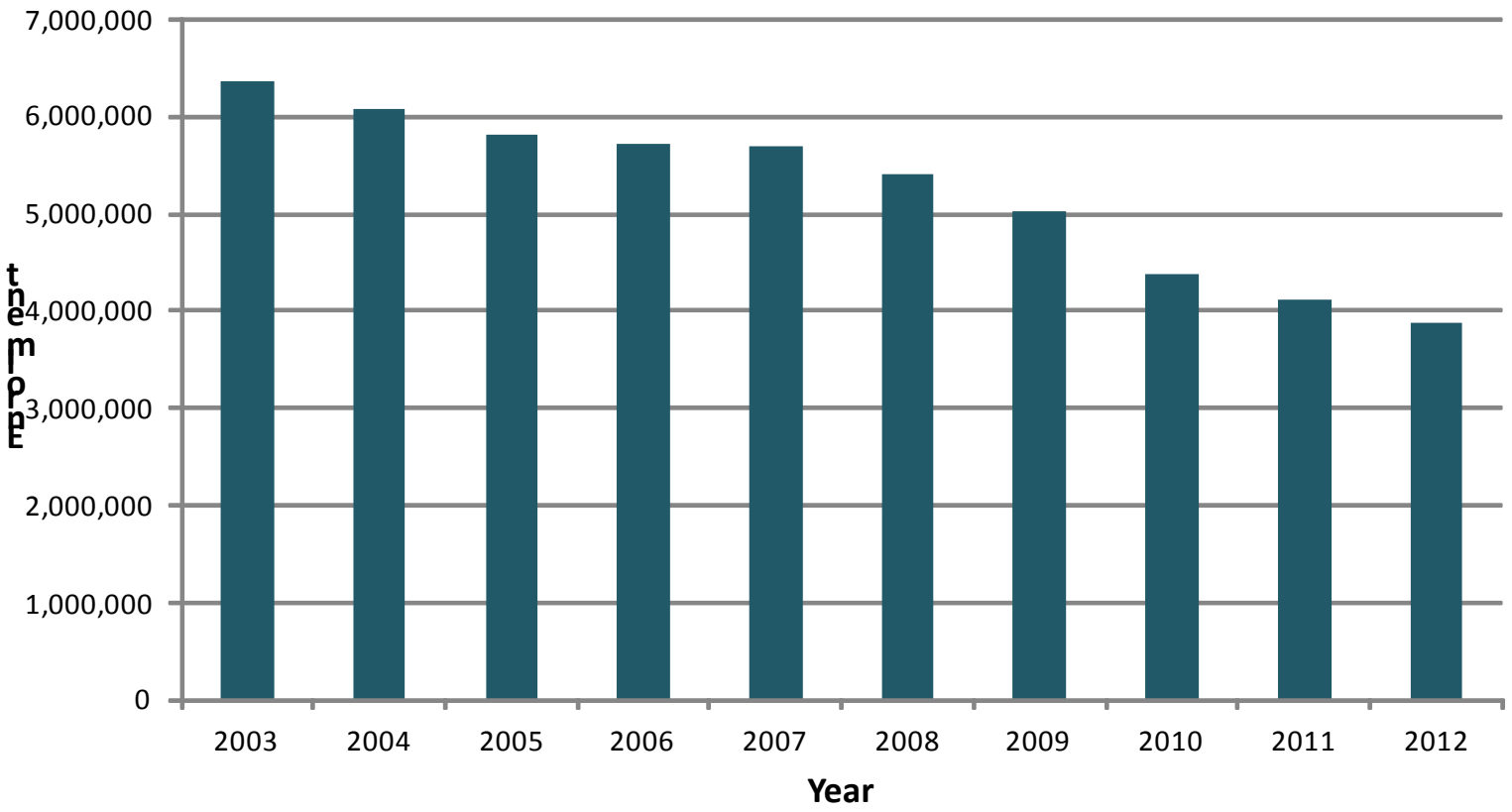
HMO Affordability Suffering

- HMO premiums in California have increased more than 150% over the life of the P4P program



Source: California Employer Health Benefits Survey, CHCF, December 2011

HMO/POS Enrollment Declining



*Enrollment includes Aetna, Anthem, Blue Shield, Cigna, Health Net, United and Western Health Advantage

P4P Program Goals and Objectives for 2012-2015

Goal #1: Continue to achieve meaningful quality improvement

Goal #2: Bend the cost trend

Objectives:

- Reorder priorities to emphasize cost control (affordability)
- Continue to promote quality
- Standardize health plan efficiency measures and payment methodology
- Increase funding to the incentive program using a shared savings model

Overarching Goals: Health Plan Perspective

- Why are we doing this?
  - Plans and purchasers have moved beyond paying for quality only
  - Consumers want transparency on quality and cost
  - Change was required in order to maintain an incentive program
- What do we hope to accomplish?
  - Reinforce message regarding quality, efficiency, and cost
  - Continue a collaborative effort to improve health care in California
  - Keep cost of health care trend in check and at a sustainable level

Overarching Goals: Provider Perspective

- Why are we doing this?
  - HMO model and Delegated Groups threatened by waning economic competitiveness
  - Purchasers and Health Plans losing faith in the Quality P4P
- What do we hope to accomplish?
  - Improve economics of HMO products
  - Retain Multiparty Engagement in Quality Metrics
- What happens if we don't do this?
  - Commercial Enrollment Dwindle – Impact
  - Trickle Down to Medicare Advantage?

The Program

What are we doing and how did we get there?

- Where we started and where we landed
- Controversial issues we grappled with along the way
- Critical obstacles and how we addressed them

The Program: Convener Perspective

- *"Value in Healthcare"* grant from Robert Wood Johnson Foundation
- Technical design team
  - Representation from each health plan
  - Monthly in-person meetings for 6 months
  - "Homework" assignments
- Plug-n-play model to assess impact of design elements
  - Number crunching and analysis
  - First design cost additive

What is Value Based P4P?

- Single performance incentive program intended to drive value
  - Incentivize physician organizations (PO) to eliminate waste and unnecessary utilization and deliver high quality care
- Holds PO accountable for cost and quality without downside risk
  - Worst PO can do is earn no incentive
- Intended to replace current incentive programs that focus separately on quality and resource use
- May be redundant for POs already in accountable care contracting arrangements

What is Value Based P4P?

- Integrates performance on quality, cost, resource use
- Uses measures already included in P4P
- Standardizes measurement and basic incentive payment methodology
- POs compete against themselves on cost, resource use
  - Total cost *trend*
  - Year-over-year improvement on resource use
- POs compete against themselves and other POs on quality
  - Quality scored on both attainment and improvement

Measures Used in Value Based P4P

1. Quality Measures
   a. Clinical Quality
   b. Patient Experience
   c. Meaningful Use of Health IT
2. Appropriate Resource Use Measures
   a. Inpatient Bed Days PTMY
   b. Readmissions within 30 Days
   c. ED Visits PTMY
   d. % Outpatient Procedures done in Preferred Facility
   e. % Generic Prescribing – 7 therapeutic areas
3. Total Cost of Care Measure

Measures Used in Value Based P4P: Quality Measures

- Quality measures combined into single Quality Composite Score
- Higher of attainment or improvement for measure
- Weighted by recommended P4P payment weighting

Quality Composite Score Example Calculation

P4P Quality Domain	P4P Domain Score	P4P Recommended Payment Weighting	Domain Score Weighted Average
Clinical Quality	72	.50	36
Patient Experience	29	.20	5.8
Meaningful Use of Health IT	67	.30	20.1
Quality Composite Score			61.9

Measures Used in Value Based P4P: Appropriate Resource Use Measures

	Inpatient Discharges/ Bed Days	Readmissions	ED Visits	Outpatient Procedures/ Generic Rx
Risk Adjustment	Concurrent DxCG Relative Risk Score	CMS DRG case mix	Concurrent DxCG Relative Risk Score	None
Exclusions	• Maternity/newborn • Mental health & chemical dependency • Discharge from SNF • Discharge to other acute care facility • Readmissions	• Maternity/newborn • Mental health & chemical dependency • Discharge to SNF • Discharge to other acute care facility • Discharge deceased	• Mental health & chemical dependency • Admissions	• Injectibles (for Generic Rx)
Outliers	• <15 discharges PTMY • Days Winsorized at 3 SD from mean/DRG	None	• <60 or >250 ED visits PTMY	None

Measures Used in Value Based P4P: Total Cost of Care Measure

- Total amount paid to any provider (including facilities) to care for all members of a PO for a year
- Risk adjusted for age, gender, and health status
- PO results for each contracted health plan, and aggregated across all contracted health plans
- Specifications developed by P4P Technical Efficiency Committee; very similar to NQF-endorsed measure
- Reported internally starting with MY 2011
  - No PO-level public reporting

Total Cost of Care – Data Inclusions and Exclusions

Inclusions:

- All capitation and FFS amounts
- Professional, facility (inpatient and outpatient), pharmacy, and other costs (e.g., DME)
- Other payments and adjustments
  - Shared risk payments, stop loss payments, etc.
- Member co-pays

Exclusions:

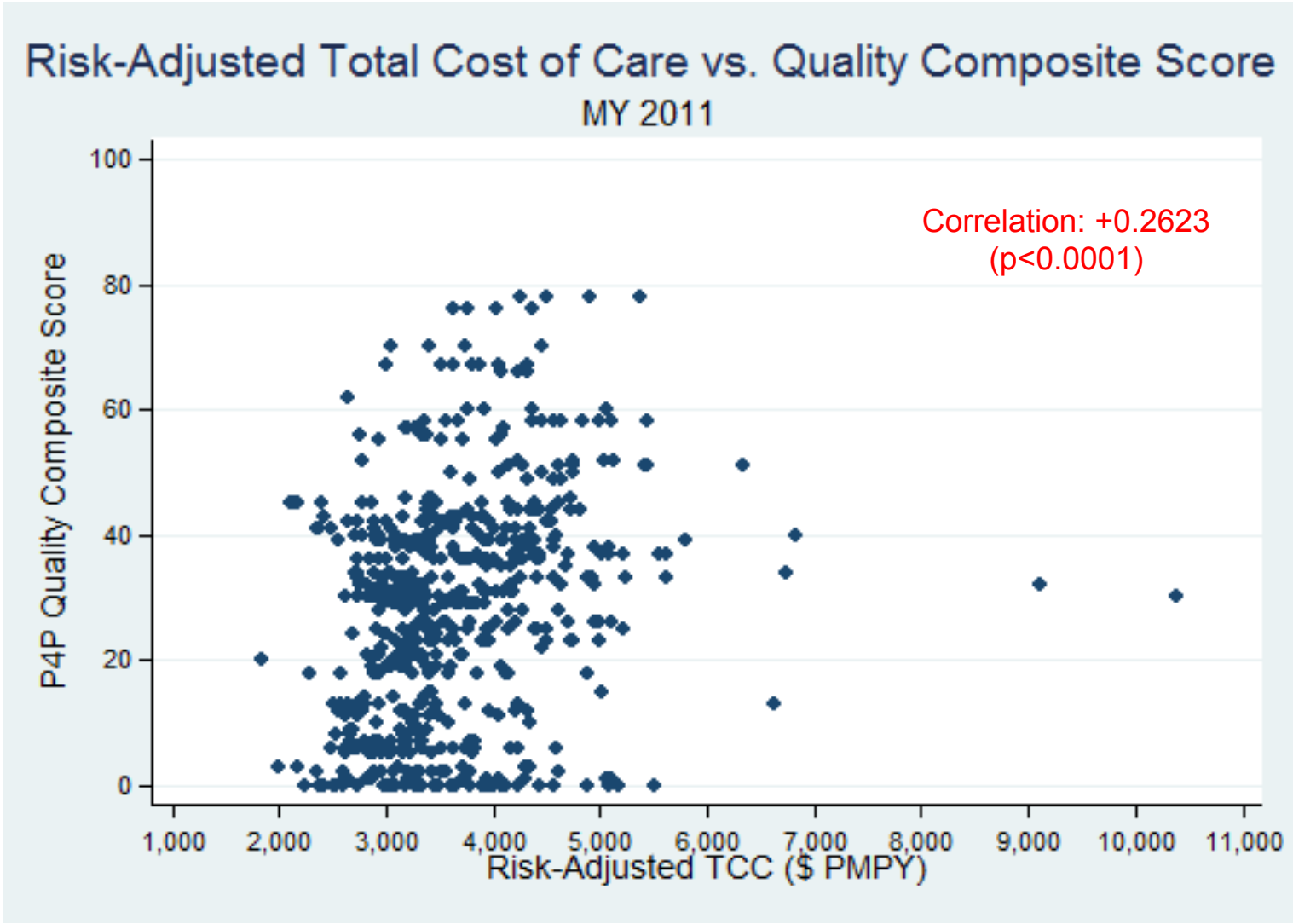
- Mental health, chemical dependency, dental, vision, chiropractic, acupuncture
- P4P quality incentive payments
- Costs above $100,000 per member per PO truncated
  - Retain all eligible members and their costs up to $100,000, but truncate costs at $100,000 per member per year per PO

PO-Level Total Cost of Care by Region

Region	POs	Total Member Years	Average MY 2011 TCC	Average MY 2010 TCC	Average 2010-2011 PO Trend
Bay Area, Sacramento	99	593,761	$4,441	$4,203	6.4%
Central Coast, Central Valley, North	67	233,425	$4,045	$3,689	7.7%
Inland Empire	80	288,872	$3,294	$3,028	8.9%
Los Angeles	201	728,968	$ 3,282	$3,104	6.9%
Orange County, San Diego	134	468,238	$3,600	$3,465	8.2%
P4P Population	***581***	***2,313,265***	***$3,642***	***$3,433***	***7.5%***

Note: Results for plan-PO combinations for four plans submitting member level data

Total Cost of Care vs. Quality Composite Score



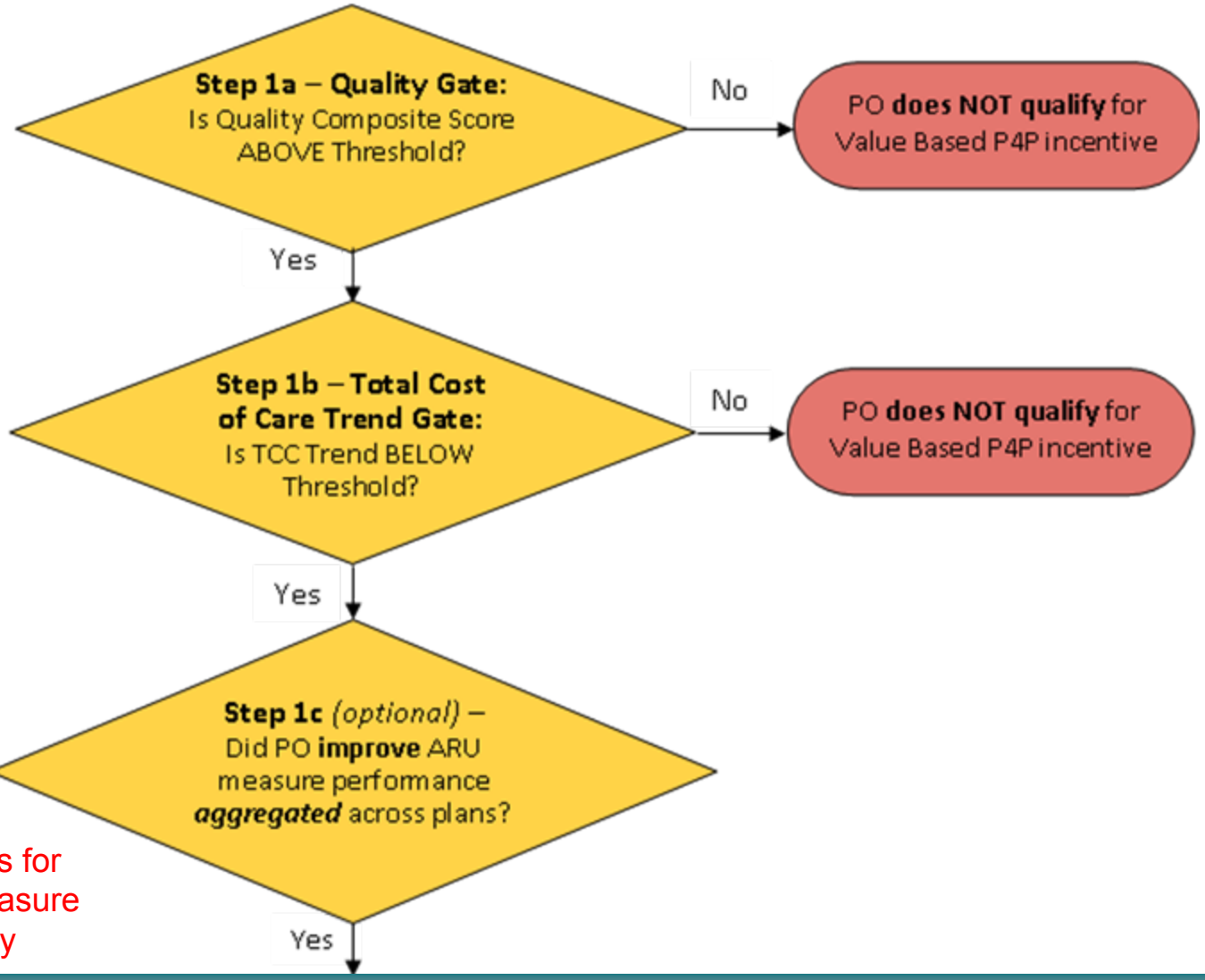
How Measures Used in Value Based P4P

Measurement Domain	Performance Gate	Basis of Shared Savings	Adjustment to Shared Savings Amount
Quality	✓		✓
Appropriate Resource Use		✓	*optional*
Total Cost of Care Trend	✓		

Value Based P4P Design

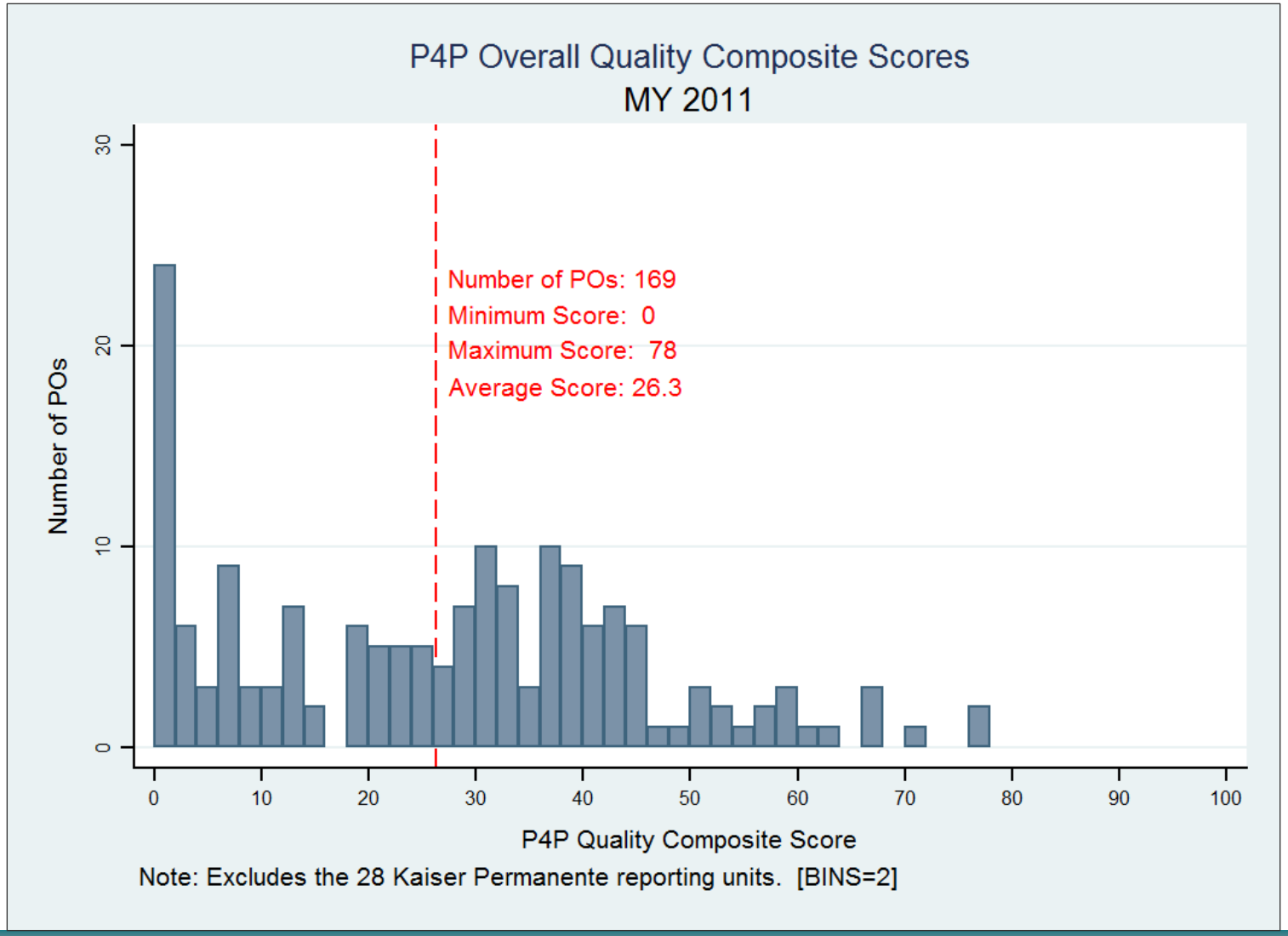
1. Apply Performance Gates
   a. Quality Gate
   b. Total Cost of Care Trend Gate
   c. *Optional:* Improvement on aggregated ARU measure
2. Calculate Shared Savings Base Incentive Amount
   a. Calculate separately for each ARU measure
3. Make Adjustments to Base Incentive Amount
   a. Quality adjustment
   b. *Optional:* ARU attainment adjustment
   c. *Optional:* ARU improvement adjustment
4. Sum Incentive Amounts Across Measures

Value Based P4P Basic Design Construct: 1. Performance Gates

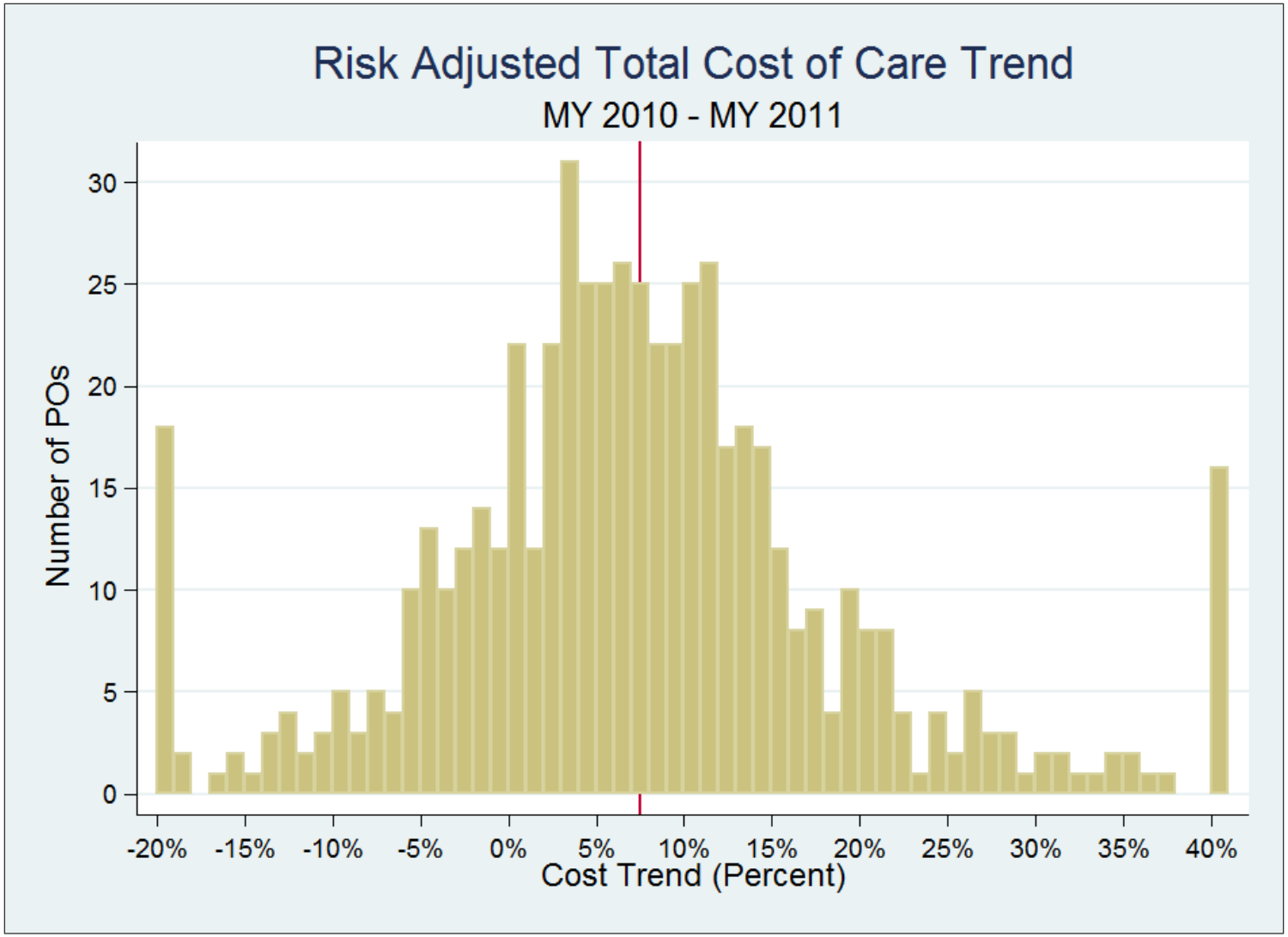


Note: Assess for each ARU measure individually

1a. Quality Gate

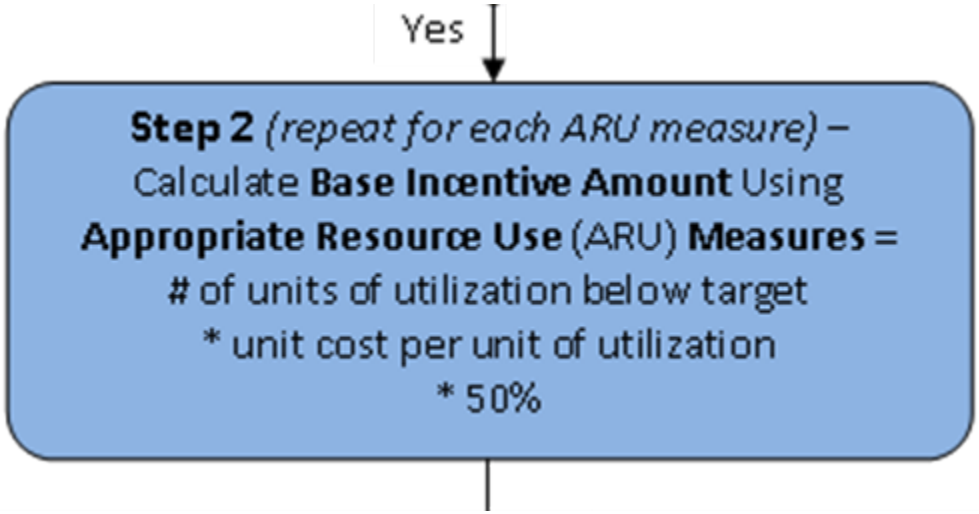


1b. Total Cost of Care Trend Gate



Value Based P4P Basic Design Construct: 2. Base Incentive Amount Calculation

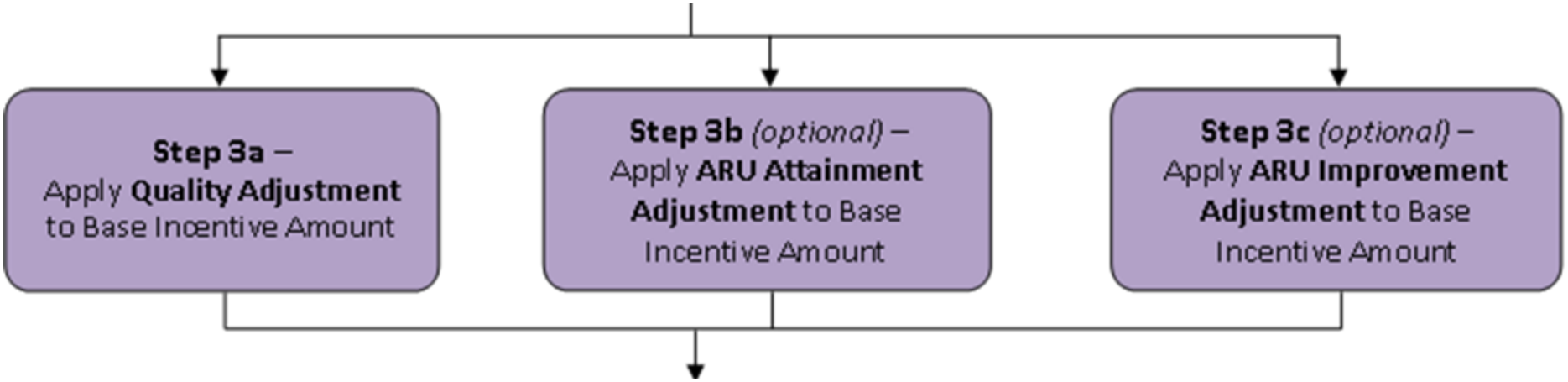
Note:
Incentive amount can be positive or negative



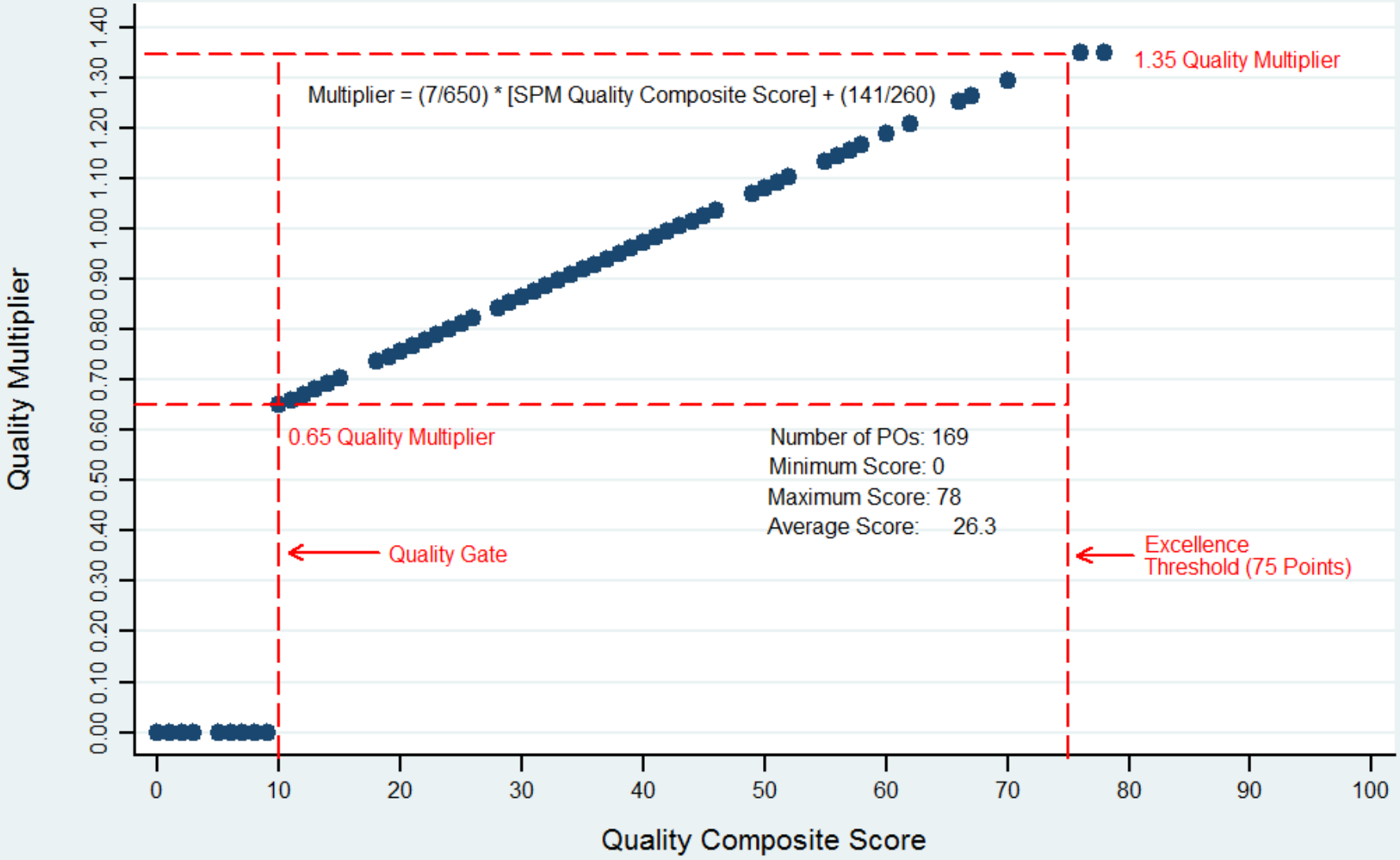
Appropriate Resource Use Measures

- Inpatient Bed Days PTMY
- Readmissions within 30 Days
- ED Visits PTMY
- % Outpatient Procedures done in Preferred Facility
- Generic Prescribing
  - Anti-ulcer
  - Cardiovascular/Hypertension
  - Diabetes (oral)
  - Nasal Steroids
  - SSRI/SNRI
  - Statins

Value Based P4P Basic Design Construct: 3. Adjustments to Incentive Amount

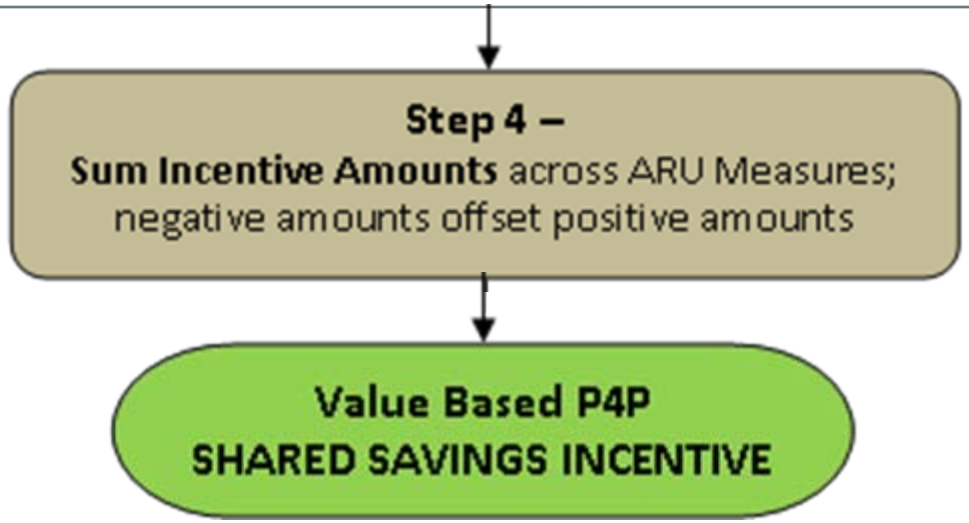


Quality Multiplier by Overall Quality Composite
MY 2011



Note: Excludes 28 Kaiser groups.

Value Based P4P Basic Design Construct:
4. Sum Incentive Amounts Across Measures



$$\$ IPBD + \$ IRN + \$ EDV + \$ OSU + \$ GRX_{1-7}$$

Notes:

- Individual ARU measure incentive amounts can be positive or negative
- Negative amounts offset positive amounts
  - If sum of all measures >$0, PO earns incentive
  - If sum of all measures <$0, PO earns no incentive, but bears no risk

The Program: Convener Perspective

- All-or-none P4P participation policy
  - Same rules for all POs
- Negotiations with large health system to gain participation
- Plug-n-play model to assess impact of design elements
  - First design cost additive
- Multiple individual meetings with executives from each health plan
- Presentations to CAPG
- Public comment
- Executive panel at P4P Stakeholders Meeting

The Program: Health Plan Perspective

- Issues along the way
  - Performance based - contracting
  - Relative risk of different HMO populations
  - Benefit design impacts
  - Market definitions and differences
  - Data quality
  - Transparency with date sharing and modeling results
  - Inclusion of incentive payouts in cost data
- Critical obstacles
  - The program could not be cost additive
  - The TCC trend gate
  - The inclusion of high-cost outliers in the program

Blue Shield of California's (BSC) Position on IHA's VB P4P Program?

- BSC is the **first** and **only** health plan to adopt IHA's Value Based P4P Program for 2013
  - Smartest or dumbest health plan?
- BSC has adopted all of the core design elements
  - Use of the P4P Quality, ARU, and TCC measures
  - Application of a Quality gate and a TCC trend gate
  - Application of a Quality adjustment
  - Shared savings calculation based on ARU measures
- BSC has adopted these optional design elements
  - Threshold / gate values and multiplier range / values
  - Application of ARU attainment and ARU improvement adjustments

The Program: Provider Perspective

- What are we doing and how did we get there?
  - Individual PO performance vs. Industry performance
  - Acknowledge emphasis shift from Quality to Affordability
- Where we started and where we landed
  - Value Based “Contracting”
  - TCC vs. Utilization Metrics
    - High Prices vs. High Utilization
    - Choice of Metrics
  - Health Plan issues/conflicts and PO reactions
  - Market Differences

The Program: Provider Perspective (cont.)

- Controversial issues we grappled with along the way/ Critical obstacles
  - Trust
    - Health Plan Use of Savings
    - Data Integrity
    - Population Adjustment
    - Health Plan Demands for Customization
    - Health Plan Demand for “Budget Neutrality”
    - Likelihood and Sufficiency of Payouts
    - Fairness of Allocations

The Program: Provider Perspective (cont.)

- Controversial issues we grappled with along the way/ Critical obstacles (cont.)
  - Role of Quality scores
  - Agreeing on the benchmarks and thresholds
  - Identification and Disposition of Outliers
    - Who gets to play?
  - Impact of Utilization trends on Costs
  - Inclusion of “Full Risk” POs
  - Role of Hospitals

The Program: Convener Perspective

- Controversial issues
  - Balancing tension between stakeholders
    - Guiding Principles
  - Don't lose focus on quality
  - Improvement vs. attainment model
  - Appropriate level of accountability
  - Plan specific vs. aggregated results
    - Request for mutual indemnification among health plans
  - Inclusion of consistently high cost POs

The Program: Convener Perspective

- Controversial issues (cont.)
  - Consistency vs. flexibility to meet business needs
    - Core and optional design elements
  - Creating a budget neutral design
    - No downside risk for POs
    - Off-set across measures
    - Payment contingent on overall plan financial performance
  - Design elements
    - Performance by market vs. geography adjustment
    - Role of TCC vs. ARU
    - Setting Trend Gate – balance bending trend with PO engagement

Value Based P4P Guiding Principles

- Savings generated contribute to lower cost trends and more competitive, value-based HMO product
- Available to all POs, including full risk POs; all health plans and POs are encouraged to participate
- POs that contribute to HMO price competitiveness and demonstrate quality should be rewarded
- Value Based P4P should not increase a health plan's total cost trend
  - Balance appropriate rewards for POs that achieve quality and cost targets, with potential overruns by other POs

Value Based P4P Core Design Elements

- Elements considered essential to the Value Based P4P design
- Deviation from these elements perceived as not adhering to recommended Value Based P4P program
  - Standardized measures
  - Quality Gate
  - Total Cost of Care Trend Gate
  - Shared Savings Calculation
  - Quality Adjustment

Value Based P4P Optional Design Elements

- Elements that can be modified or waived while still complying with the spirit of program
- Fine tune the methodology and help channel variability
  - Threshold/gate values
  - Multiplier ranges/values
  - Aggregated Performance Improvement Gate
  - ARU Attainment Adjustment
  - ARU Improvement Adjustment

Making it Happen

- How do we expect to roll this out?
- Critical factors for success
- Meeting stakeholder needs

Making it Happen: Blue Shield of California's Perspective

- Communication plan
  - Internal communications: 3rd and 4th Qs 2012
  - External communications: 4th Q 2012; 1st Q 2013
- Quality data measurement and reporting -- annual basis
  - Based on IHA's data specifications
  - Payout based on aggregated data
- ARU data measurement and reporting -- quarterly basis
  - Based on IHA's data specifications
  - Payout based on BSC-only data

Making it Happen: Provider Perspective

- Critical factors for success
  - Awareness and Education
    - Reality Check
  - Getting Buy in
  - Clarity and Credibility
  - Managing Health Plan “Quirkiness”
  - Can we “KISS”
  - Feedback and Sharing of Best Practices
  - Impact on Costs
    - Too little too late” ?
    - What are the Alternatives?
    - Health Plan Follow Through to Reduce Premiums
  - Impact on Networks and Markets

Making it Happen: Convener Perspective

- Special PO reports and webinars
- Advanced Notice of Intended Methodology and Amount
  - Adoption timeline
    - 2013: 1 plan full adoption, 2 plans partial adoption
    - 2014: 4 additional plans full adoption
  - Transition approaches
    - Distribute quality P4P budget amount based on Value Based P4P output
- Stakeholder engagement
  - Voluntary adoption by health plans
  - PO requests to contract out and keep “legacy” program

Q&A