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Peter Lee, Executive Director
California Health Benefit Exchange
2535 Capitol Oaks Drive, Suite 120
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Dear Peter:

We greatly appreciate the attention the California Health Benefit Exchange has given to the Value Based Pay for Performance (P4P) program of the Integrated Healthcare Association (IHA). This letter will discuss some of the key issues surrounding the potential use of provider-level quality and value measurement information by the Exchange in ways that could complement plan-level accreditation and measurement tools (e.g., NCQA, eValue8). Background information on our P4P program and the transition to Value Based P4P is provided below, followed by our general view of the applicability of these measures and reporting to the California Health Benefit Exchange.

Pay for Performance

IHA's P4P program is now in its tenth year. It is the largest non-governmental quality measurement and physician incentive program in the United States. IHA is responsible for collecting data, deploying a common measure set, and reporting results on behalf of eight health plans and 200 physician organizations comprised of approximately 35,000 physicians that care for almost 10 million members.

The early success of this program in orchestrating collaboration across a wide range of stakeholders was an achievement that attracted national attention. The program helped break cultural barriers underlying the long-held belief that it is impossible to measure quality in healthcare, and its approach has been replicated in a variety of forms and settings across the country. The measure set has evolved to include nearly 100 measures of performance in clinical quality, patient experience, use of health information technology, appropriate resource use, and total cost of care (included below). The clinical quality and patient experience results are reported publicly by the California Office of Patient Advocate.

IHA added Medicare Advantage physician organization measurement and reporting in 2009 and initiated a Medi-Cal physician organization pilot in 2012; furthermore, many of the Accountable Care Organizations created by the Affordable Care Act use P4P measures.

Critically, this is a measurement and reporting program that has earned the trust of physicians and physician organizations. It will be important for the Exchange, as it works to fulfill its mission of creating an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value, to build on what works within the market. The use of

established performance metrics encourages providers to partner in this effort, which will be an important key to success.

Adding Value to Quality Measurement: Value Based P4P

Value Based P4P is a strategic initiative that the California P4P program has undertaken to moderate the commercial HMO cost trend in California, while continuing to improve quality of care. Value Based P4P is a shared savings incentive model that incorporates the quality, cost, and utilization of health care services. The purpose of Value Based P4P is to revitalize/retool the P4P program against the backdrop of affordability. The objectives of this strategic initiative are as follows:

- 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

The Value Based P4P program design was developed in collaboration with the state's major commercial health plans, physician organizations, and the California Association of Physician Groups (CAPG), and is intended to go into effect starting in 2013. We believe that this is a testament to the careful work that we have done over the years to stimulate the close engagement of both plans and physician organizations in our process. Moving from quality measurement to the incorporation of new measures such as the Total Cost of Care is a challenging process and one that we have had to navigate slowly and through an extensive collaborative process.

One note of caution from this process is that the Exchange avoid, at least in the immediate term, attempting to measure quality at the level of the individual physician. As we and others have discussed in some detail elsewhere, there are a number of methodological concerns about this process that are both practical and substantive.[1] First, there is a sample size issue. It is an industry standard to require a minimum denominator of thirty for a performance result to be considered reliable enough to use for public reporting. Individual physicians generally would not have enough patients to reach that minimum denominator size for a particular payer for most performance measures. To achieve reliable results, alternative methods such as combining multiple years of data or creating composite measures, would be required. In addition, there are significant issues with the attribution of individual patients to individual physicians, as patients' care is often and increasingly managed by multiple providers. These factors make data about individual physicians extremely unreliable.

Recognizing that individual physician measurement plays a critical role in quality improvement, IHA has developed measures and incentives to encourage physician organizations to measure the performance of their individual physicians, and to use this information to facilitate and reward quality improvement. This approach can yield considerable benefit while avoiding significant disputes and distractions over individual physician measurement reliability.

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[1] See e.g., Vicki Fung, et al., "Meaningful Variation in Performance," *Medical Care* 48, no. 2 (February 2010): 140–148; Sarah Scholle, et al. "Benchmarking Physician Performance: Reliability of Individual and Composite Measures," *The American Journal of Managed Care* 14, no. 12 (December 2008): 833–838.

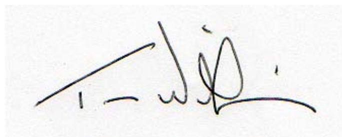
The Use of Value-Based Performance Measurement and Reporting in the California Health Benefit Exchange

As the Exchange is focused on creating a marketplace in which consumers are able to make value-based decisions on both quality and price, it is important for them to have high-quality information on the providers that they may be accessing. One of the major advantages of IHA's approach is that it has an existing data collection and aggregation process in place that can be leveraged. The current process is scalable and there are already efforts underway, as discussed above, to expand performance measurement and reporting to more health plans and physician organizations in California, with increased emphasis on providers serving commercial PPO, Medi-Cal, and Medicare populations.

It is our understanding that the Exchange is planning to offer a broad range of products through its new marketplace, including HMOs and both broad and narrow network PPOs. It is conceptually possible to create a series of quality measurement for the "virtual physician organizations" formed by these networks. There are challenges to this project, though, that we would want to discuss with you in greater detail. Nevertheless, the project of measuring provider-level quality within the PPO environment may be even more important since those data are not available elsewhere.

Thank you again for your hard work on this vital public project and for your commitment to build on existing efforts within the state. We look forward to a long and productive partnership to improve the quality and value of care for Californians. Please do not hesitate to contact me if you have any questions about the Pay for Performance program or quality measurement in general.

Sincerely,



Tom Williams, DrPH
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Oakland, CA

cc: Kim Belshé, Public Policy Institute of California
Diana S. Dooley, California Health and Human Services Agency
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Pay for Performance Measurement Year 2012 Measure Set

	Measurement Year 2012/ Reporting Year 2013 Measures
PO Encounter Threshold[2]	Encounter Threshold to be removed as a clinical reporting requirement
CLINICAL DOMAIN *MEASURES TO BE COLLECTED, REPORTED AND RECOMMENDED FOR PAYMENT*	Cardiovascular 1. Annual Monitoring for Patients on Persistent Medications—ACEI/ARB, Digoxin, and Diuretics 2. Cholesterol Management—LDL Screening 3. Cholesterol Management—LDL Control <100 4. Proportion of Days Covered by Medications—ACEI/ARB 5. Proportion of Days Covered by Medications—Statins Diabetes Care 1. HbA1c Testing 2. HbA1c Poor Control >9.0% 3. HbA1c Control <8.0% 4. HbA1c Control <7.0% for a Selected Population 5. LDL Screening 6. LDL Control <100 7. Nephropathy Monitoring 8. Blood Pressure Control <140/90 9. Optimal Diabetes Care Combination 1— LDL<100, HbA1c <8.0%, Nephropathy Monitoring 10. Proportion of Days Covered by Medications—Oral Diabetes Medications Musculoskeletal 1. Use of Imaging Studies for Low Back Pain Prevention 1. Childhood Immunization Status—24-mo Continuous Enrollment: Combination of all Antigens 2. Immunizations for Adolescents—Tdap 3. HPV Vaccination for Female Adolescents 4. Chlamydia Screening in Women—Ages 16-24 5. Evidence-Based Cervical Cancer Screening—Appropriately Screened 6. Breast Cancer Screening—Ages 50-69 7. Colorectal Cancer Screening Respiratory 1. Asthma Medication Ratio–Ages 5-50 2. Appropriate Testing for Children with Pharyngitis 3. Appropriate Treatment for Children with Upper Respiratory Infection 4. Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis
Clinical Weighting	50%

[2]PO Encounter Threshold refers to the average number of encounters per member per year required for data to be included in clinical data aggregation and public reporting.

	Measurement Year 2012/ Reporting Year 2013 Measures
MEANINGFUL USE OF HEALTH IT DOMAIN *MEASURES TO BE COLLECTED, REPORTED AND RECOMMENDED FOR PAYMENT*	1. Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines 2. Implement drug-drug and drug-allergy interaction checks 3. Maintain an up-to-date problem list of current and active diagnoses 4. Generate and transmit permissible prescriptions electronically (eRx) 5. Maintain active medication list 6. Maintain active medication allergy list 7. Record demographics 8. Record and chart changes in vital signs 9. Record smoking status 10. Report ambulatory clinical quality measures 11. Implement one clinical decision support rule relevant to specialty or high clinical priority, along with the ability to track compliance with that rule 12. Provide patients with an electronic copy of their health information 13. Provide clinical summaries for patients at each office visit 14. Capability to exchange key clinical information 15. Protect electronic health information created or maintained by the certified EHR technology 16-20. Any (5) CMS/ONC Menu set measures 21. Chronic Care Management for Diabetes, Depression, and one other Clinically Important Condition 22. Within-PO Performance Variation
Meaningful Use of Health IT Weighting	30%
PATIENT EXPERIENCE DOMAIN *MEASURES TO BE COLLECTED, REPORTED AND RECOMMENDED FOR PAYMENT*	1. Doctor-Patient Interaction Composite for PCPs 2. Doctor-Patient Interaction Composite for Specialists 3. Coordination of Care Composite 4. Timely Care and Service Composite for PCPs 5. Timely Care and Service Composite for Specialists 6. Overall Ratings of Care Composite 7. Office Staff Composite 8. Health Promotion Composite
Patient Experience Weighting	20%

	Measurement Year 2012/ Reporting Year 2013 Measures
APPROPRIATE RESOURCE USE DOMAIN *MEASURES TO BE COLLECTED, INTERNALLY REPORTED AND RECOMMENDED FOR PAYMENT*	1. Inpatient Utilization: Acute Care Discharges PTMY 2. Inpatient Utilization: Bed Days PTMY 3. Inpatient Readmission Within 30 4. Emergency Department Visits PTMY 5. Outpatient Procedures Utilization: % Done in Preferred Facility 6. Generic Prescribing: SSRIs/SNRIs 7. Generic Prescribing: Statins 8. Generic Prescribing: Anti-Ulcer Agents 9. Generic Prescribing: Cardiac—Hypertension and Cardiovascular 10. Generic Prescribing: Nasal Steroids 11. Generic Prescribing: Diabetes—Oral 12. Generic Prescribing: Anxiety/Sedation—Sleep Aids 13. Total Cost of Care (baseline)
Appropriate Resource Use Weighting	Shared savings
OTHER MEASURES *MEASURES TO BE COLLECTED AND REPORTED INTERNALLY*	1. Optimal Diabetes Care Combo 2—LDL <100, HbA1c <8.0%, Blood Pressure Control <140/90 2. Childhood Immunization Status—Individual Antigens (DTaP, IPV, MMR, Hib, Hepatitis B, VZV, PCV, RV) 3. Immunizations for Adolescents—Meningococcal and Combination of Tdap and meningococcal 4. Chlamydia Screening in Women—Ages 16-20 and Ages 21-24 5. Evidence-Based Cervical Cancer Screening—Not Screened and Screened Too Frequently 6. Breast Cancer Screening—Ages 40-49 and Ages 70-74 7. Asthma Medication Ratio—Ages 5-11, Ages 12-18, Ages 19-50, and Ages 51-64 8. Inpatient Utilization: Average Length of Stay 9. Maternity Discharges 10. Maternity Average Length of Stay 11. Overall Generic Prescribing Rate 12. Frequency of Selected Procedures—Back Surgery 13. Frequency of Selected Procedures—Total Hip Replacement 14. Frequency of Selected Procedures—Total Knee Replacement 15. Frequency of Selected Procedures—Bariatric Weight Loss Surgery 16. Frequency of Selected Procedures—PCI 17. Frequency of Selected Procedures—Carotid Catheterization 18. Frequency of Selected Procedures—CABG 19. Frequency of Selected Procedures—Cardiac Endarterectomy
TESTING MEASURES *MEASURES TO BE COLLECTED FOR TESTING AND ANALYSIS*	1. HPV Vaccination for Male Adolescents 2. Healthy Term Newborn 3. <1500gm NOT delivered at a Level III Center 4. Cesarean Section Rate (NTSV) 5. VBAC Rate 6. Episiotomy Rate