



# IHA Pay for Performance Report of Results for Measurement Year 2009

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## Executive Summary

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This report outlines results from the 2009 measurement year of the California Pay for Performance (P4P) Program, which is the largest non-governmental physician incentive program in the United States, and includes eight health plans and over 200 physician organizations. In 2009, the program measured performance on 76 measures in five domains: Clinical Quality, Coordinated Diabetes Care, Patient Experience, IT-Enabled Systemness, and Appropriate Resource Use.

2009 saw continued improvement on all but one P4P measure. Performance variation between top and bottom performers has continued to decrease, although there is still variation that is seemingly correlated with socioeconomic and geographic factors, as well as with use of health IT. Top performers in California are out-performing national HEDIS 90<sup>th</sup> percentile benchmarks on a number of measures.

California's P4P program has established a platform of trust which will be key to its future transformation into a value-based incentive program, where both high quality and efficient resource use will be rewarded. P4P has also helped to pave the way to broader payment reform in the state.

## I. Introduction

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### A Snapshot of the Evolving Physician Performance Measurement Landscape in California

This report outlines results from the 2009 measurement year of the California Pay for Performance (P4P) program, the largest non-governmental physician incentive program in the United States. Since measurement began in 2003, the performance of California's physician organizations (POs) has continually improved across a number of clinical, patient experience, and health IT measures. 2009 results show a continued narrowing in performance variation across measures, and top performers meet or exceed national HEDIS 90<sup>th</sup> percentile performance on a greater number of measures than in previous years.

California's P4P program continues to evolve and incorporate lessons from both its own experiences and the experiences of similar programs across the country; in 2011, the program will place a greater emphasis on resource use measurement with the addition of a Total Cost of Care metric to its measure set, and will also be working to implement value-based incentives that address both cost and quality concerns.

## A Solid Foundation: The California P4P Program

Founded in 2002, the California P4P Program represents the longest-running U.S. example of data aggregation and standardized results reporting across diverse regions and multiple health plans. The Integrated Healthcare Association (IHA) administers the P4P program on behalf of eight health plans: Aetna, Anthem Blue Cross, Blue Shield of California, CIGNA HealthCare of California, Health Net, UnitedHealthcare/PacifiCare, Western Health Advantage, and Kaiser Permanente (who participates in public reporting only). Together, these plans represent about 10 million commercial HMO/POS members. IHA is responsible for collecting data, deploying a common measure set, and reporting results for over 200 participating POs.

A primary strength of the program has been its commitment to collaboration between POs and health plans, who work together to create and use uniform measures. This has helped to enhance the validity of the measurement set, which is key to physician engagement. Data aggregation across multiple health plans enhances measurement reliability, and also engenders trust on the part of the organizations being measured. Participating POs have actively engaged in quality improvement and given the program an average rating of 4 out of 5 when asked about its importance to their organization.<sup>1</sup>

The number of measures used has expanded year-after-year within the program: in 2003, the first measurement year, there were 25 measures, which expanded to 76 in 2009, and is to increase to 85 in 2010. In 2009, measures were divided into five domains:

*Clinical Quality:* this domain includes 14 preventive, 5 chronic, and 4 acute care measures. The measures are a mix of both process and outcomes measures and incorporate standardized national measures.

*Coordinated Diabetes Care:* this domain was developed to promote process redesign and encourage POs to take a systematic approach to diabetes care; it includes 10 clinical process and outcomes measures for diabetes care, as well as population and care management measures.

*Patient Experience:* this domain measures patient ratings of the care received from their POs using a standardized survey tool administered by the California Cooperative Healthcare Reporting Initiative (CCHRI) and derived from the national standard CG CAHPS survey. POs are scored on nine measures, including “communication with doctors,” “timely access to care,” “care coordination,” and others.

*IT-Enabled Systemness:* this domain includes structural measures that evaluate the support and infrastructure that POs use for systematic care processes, including population management, point-of-care activities, care management processes, and individual physician-level measurement and incentives. There are a total of 18 Systemness measures. In 2011, this domain will be renamed the “Meaningful Use of Health IT” domain and will closely align with CMS measures of Meaningful Use, which will allow for national comparisons of California’s performance.

*Appropriate Resource Use:* 2009 was the first year for collecting measures to assess the use of key health care resources in order to identify variation and promote efficiency. 2009 results will be used as a baseline for 2010. As the program moves forward, more resource use measures will be added to reflect the importance of healthcare cost alongside healthcare quality.

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<sup>1</sup> Cheryl L. Damberg, Kristiana Raube, Stephanie S. Teleki, and Erin dela Cruz, “Taking Stock of Pay-For-Performance: A Candid Assessment from the Front Lines.” *Health Affairs* 28.2 (March/April, 2009): 521.

Aggregated P4P results are used by health plans as the basis for incentive payments and are publicly reported on the website of the Office of the Patient Advocate ([www.opa.ca.gov](http://www.opa.ca.gov)) in order to inform consumer decision-making. IHA also uses the annual results to publicly recognize top-performing POs, as well as those who demonstrate meaningful performance improvement. On top of this, POs rely on these results to develop internal strategies to improve their care quality and patient satisfaction.

## II. 2009 Results

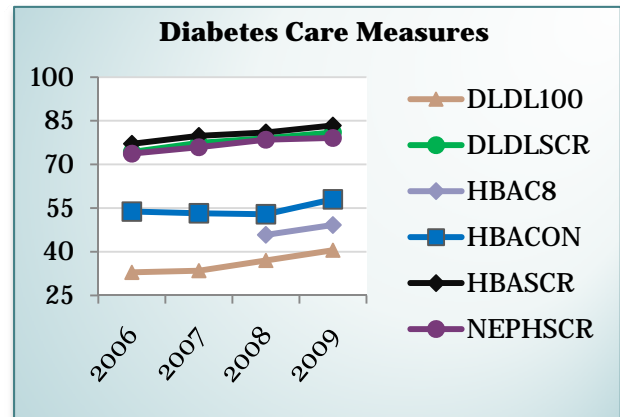
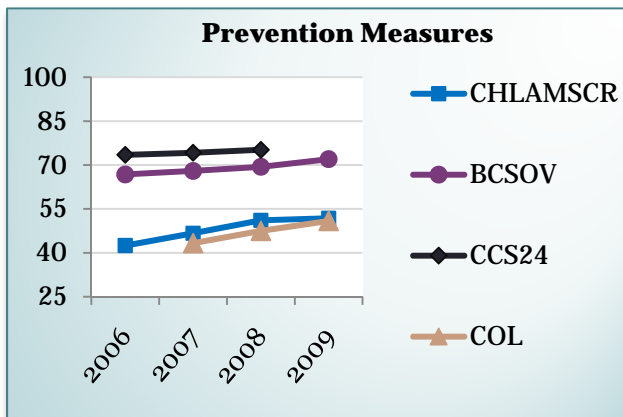
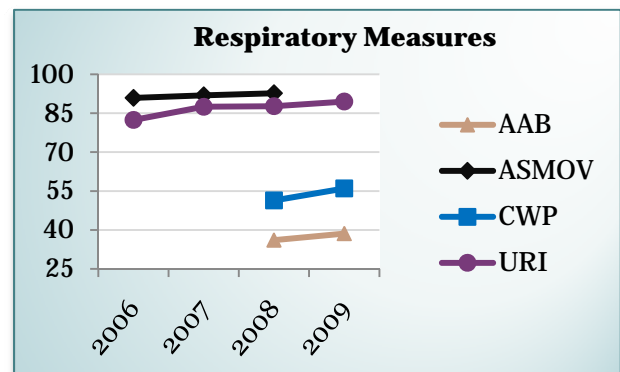
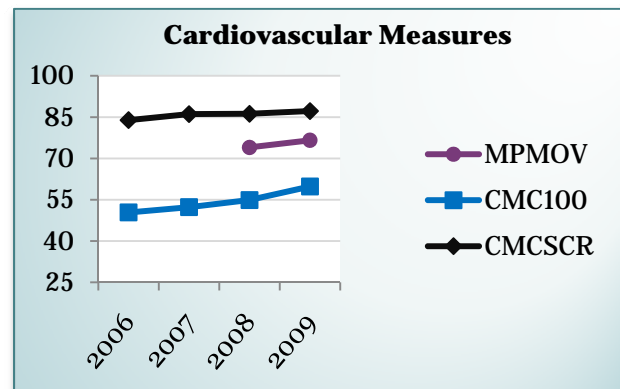
### Program Participants Continue to Improve Performance

There was improvement on all but one measure in the Clinical, Coordinated Diabetes Care, and Patient Experience domains in 2009, although the Patient Experience measures improved at a slower rate than measures in the other two domains.<sup>2</sup>

Between 2006 and 2009, average improvement per clinical measure per year was two percentage points, although some measures have seen more dramatic improvement.

For example, rates for Colorectal Cancer Screening showed average annual improvement of almost four percentage points over this time period.

The four charts below illustrate change over time for seventeen measures grouped by type of care. (See page 7 for meanings of chart acronyms.)

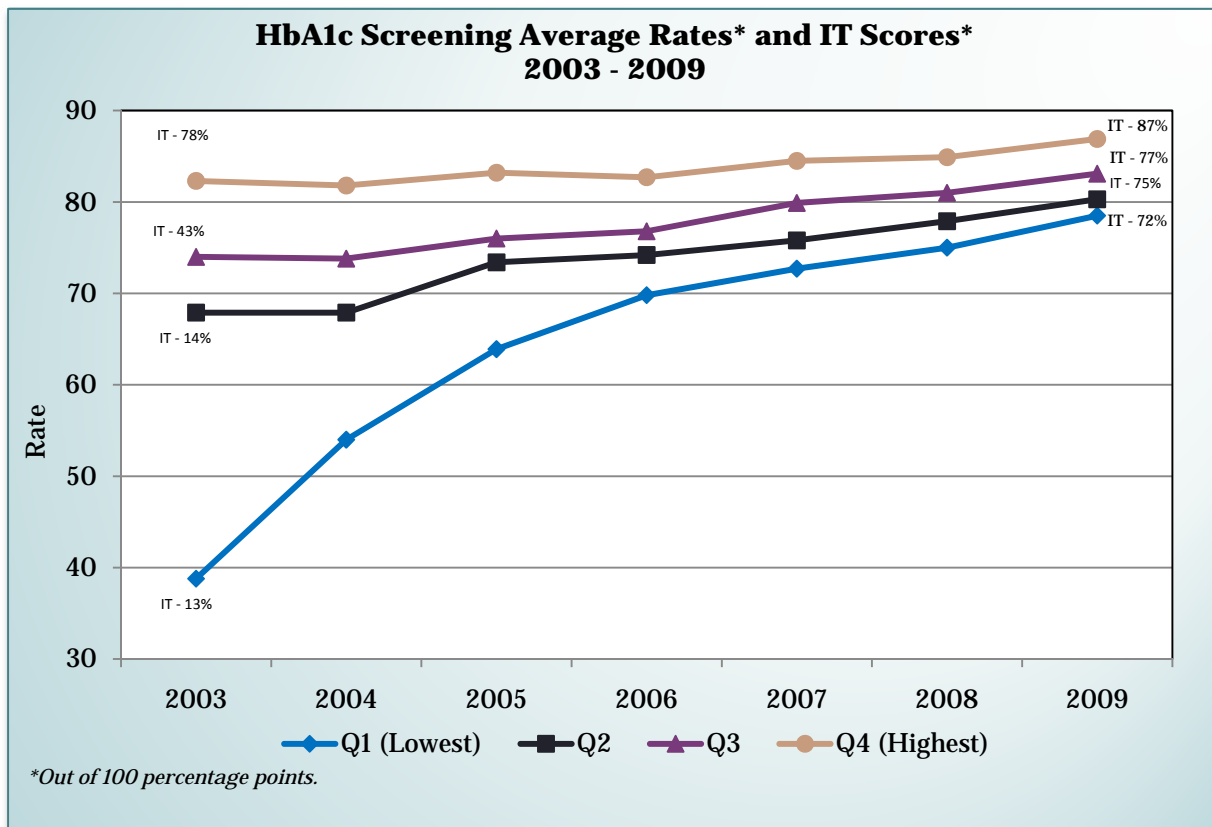


<sup>2</sup> On average, Patient Experience measures increased by about a half-percent per measure per year between 2006 and 2009.

## Variation in Performance across POs is Narrowing

When POs are assigned to performance quartiles based on their baseline performance, the gaps between the highest and lowest quartiles have narrowed on almost all measures since 2003, which has decreased overall performance variation. For example, between 2003 and 2009, highest quartile performance for HbA1c Screening increased an average of one percentage point per year, while lowest quartile improvement was an average of seven percentage points per year, as can be seen in the chart below.

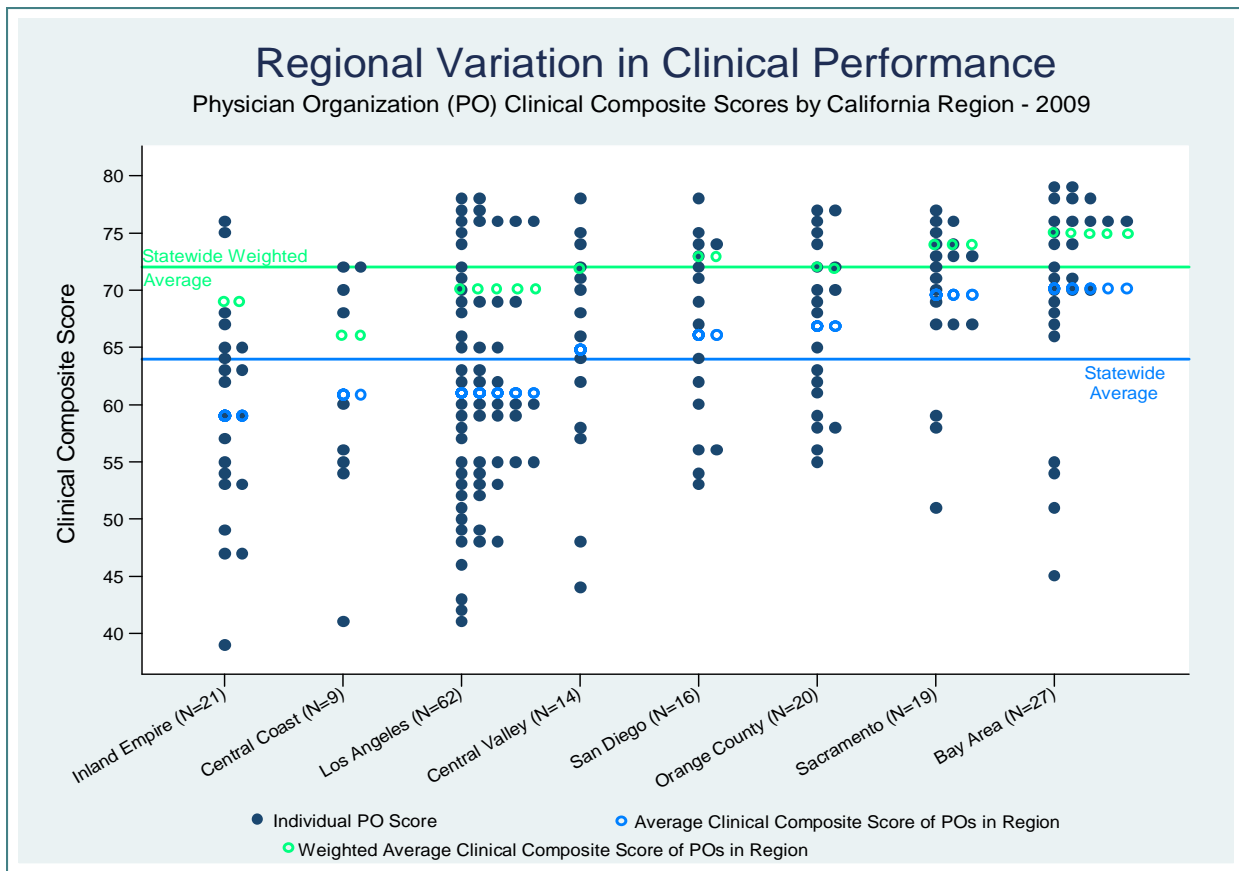
In the chart below, the difference in performance and improvement by quartile on the HbA1c Screening measure is displayed alongside POs' IT-Enabled Systemness scores. In 2003, POs in the highest quartile had Systemness scores 65% higher than those of POs in the lowest quartile. By 2009, this difference in Systemness scores narrowed to about 15%. When PO characteristics (such as geography, size, self-reporting status, medical group vs. IPA status, and Medicaid and uninsured as a percentage of business) are held constant, groups with high IT scores have significantly higher clinical performance than those with low or no IT scores.



## Variation in Performance within California Persists, and Correlates of Poor Performance Go Beyond the Practice Setting

Despite the overall decrease in variation on many measures, variation in overall clinical performance persists, and is especially evident when POs are broken down by geographic region. The difference in performance between top- and bottom-performing regions is striking: in 2009, the Bay Area and Sacramento regions consistently performed at the top of the distribution for all measurement domains, whereas the Inland Empire consistently occupied the bottom of the distribution. The chart below illustrates this regional variation, but also showcases the fact that there is significant within-region variation.

This regional variation has alerted program stakeholders to the possibility that there are factors behind performance that go beyond the clinical setting, as the Bay Area and the Inland Empire vary along a number of socioeconomic and demographic dimensions which could have an impact on PO performance, such as average income, the number of residents covered by Medi-Cal, and the number of physicians per 1000 population. It has also prompted two research studies looking at the impact of socioeconomic and geographic factors on PO performance. These two studies – conducted by researchers at the RAND Corporation and Weil Cornell Medical Center – are forthcoming.

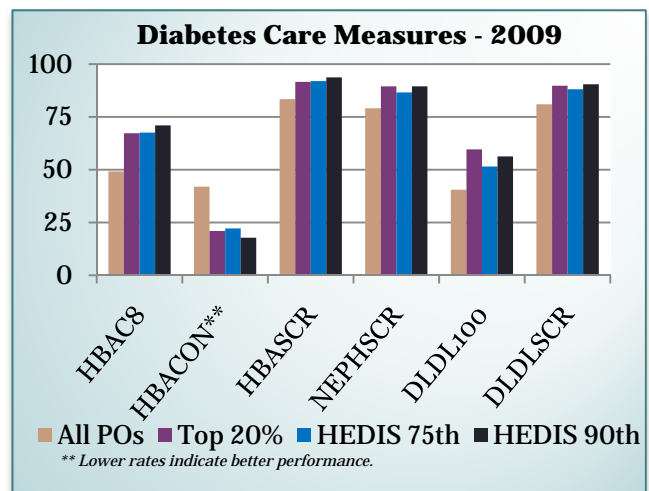
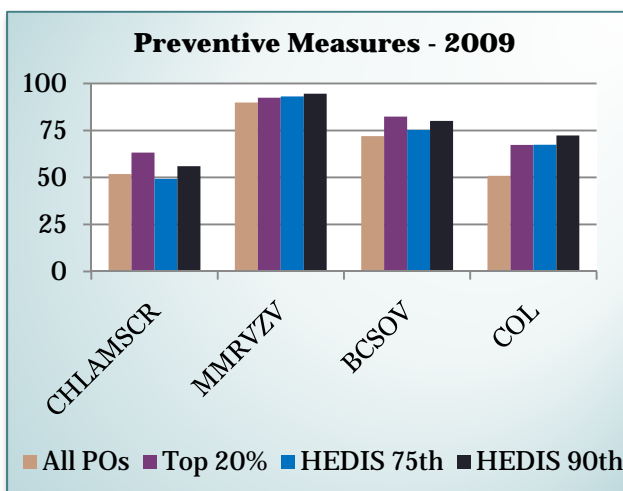
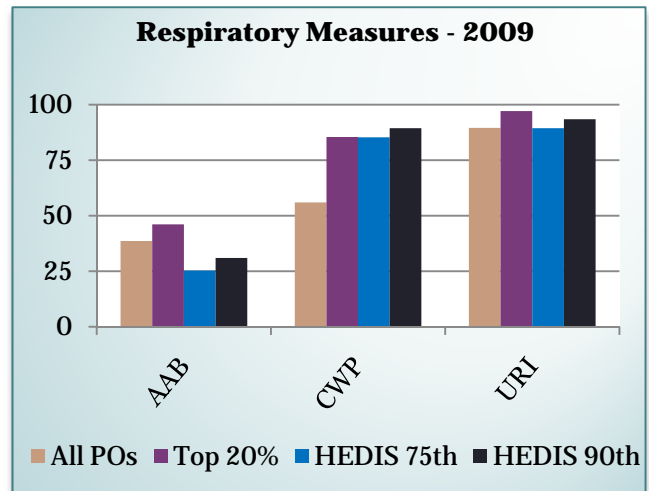
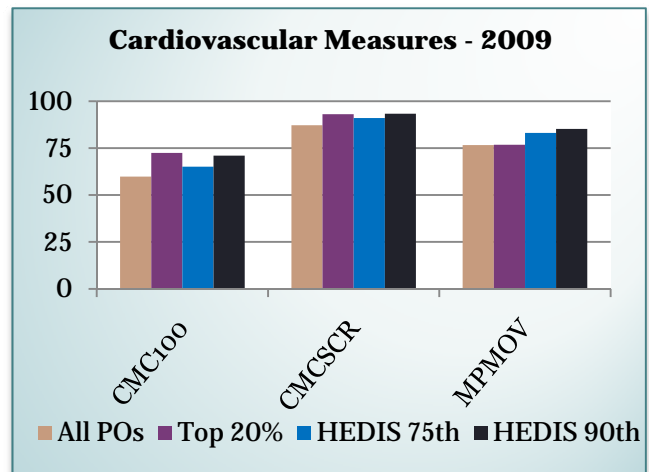


## California's Performance Relative to National HEDIS Benchmarks is Mixed

When California P4P results are compared to national healthcare performance using HEDIS<sup>3</sup> benchmarks, the results are mixed. Despite statewide performance improvement, the average performance of P4P participants is below HEDIS 75<sup>th</sup> percentiles for the majority of measures.

However, when looking at only the top performers – those in the top 20 percent of POs in California – the scores are comparable to the 90<sup>th</sup> HEDIS percentile. For some measures, such as Appropriate Treatment for Children with Upper Respiratory Infection (URI), Breast Cancer Screening (BCSOV), and Diabetes Care: LDL-C Control <100 mg/dL (DLDL100), P4P top performers are outperforming the 90<sup>th</sup> HEDIS percentile benchmarks.

Some of these differences may be driven by data sources; HEDIS measurements at the national level are based on Hybrid data (Administrative and medical chart data) reported by health plans, while the P4P program uses health plan and PO-reported Administrative data only. (See page 7 for meaning of chart acronyms.)



<sup>3</sup> HEDIS stands for Health Effectiveness Data and Information Set, which is a tool that was developed by NCQA and is used by health plans to monitor and report performance.

### III. Conclusion and Plans for the Future

California’s P4P Program has established a robust platform for meaningful quality measurement that involves collaboration between healthcare stakeholders and is trusted by those subject to measurement. Since measurement began in 2003, there have been steady, incremental gains in physician organization quality across all domains in California’s P4P Program. However, some stakeholders have expressed concern with the lack of ‘breakthrough’ performance gains, as well as the continued escalation of the cost of care delivered to commercial HMO/POS enrollees in California.

These concerns have prompted a move toward value-based incentive payments that are designed to bend the cost trend while continuing to improve quality. Currently, P4P program stakeholders are developing a shared savings arrangement based on Total Cost of Care performance, adjusted for quality performance. The Total Cost of Care measure reflects the amount paid to any provider to care for members of a PO during a year. It will allow POs to understand their risk-adjusted cost relative to their peers, and, together with appropriate resource use measures, to focus on the underlying drivers of total cost of care in order to increase affordability. In the short term, P4P quality incentive payments will continue to be made alongside this shared savings arrangement.

The transition to value-based incentive payments aligns with the national movement toward accountability for both quality and cost of care, and has the potential to moderate the cost trend and create a foundation for broader healthcare payment reform in California.

#### **Chart Acronyms:**

<b>AAB:</b> Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	<b>DLDL100:</b> Diabetes Care: LDL Control <100
<b>ASMOV:</b> Use of Appropriate Medications for People with Asthma	<b>DLDLSCR:</b> Diabetes Care: LDL Screening
<b>BCSOV:</b> Breast Cancer Screening	<b>HBAC8:</b> Diabetes Care: HbA1c Control (<8.0%)
<b>CCS24:</b> Cervical Cancer Screening	<b>HBACON:</b> Diabetes Care: HbA1c Poor Control (>9.0%)
<b>CHLAMSCR:</b> Chlamydia Screening in Women	<b>HBASCR:</b> Diabetes Care: HbA1c Testing
<b>CMC100:</b> LDL Control <100 for Patients with Cardiovascular Conditions	<b>MMRVZV:</b> Childhood Immunization Status
<b>CMCSCR:</b> LDL Screening for Patients with Cardiovascular Conditions	<b>MPMOV:</b> Monitoring for Persistent Medications
<b>COL:</b> Colorectal Cancer Screening	<b>NEPHSCR:</b> Diabetes Care: Nephropathy Monitoring
<b>CWP:</b> Appropriate Testing for Children with Pharyngitis	<b>URI:</b> Appropriate Treatment for Children with Upper Respiratory Infection