The California Pay For Performance Program

The Second Chapter
Measurement Years 2006 - 2009

EXECUTIVE SUMMARY

Innovation Through Collaboration

June 2009

The Integrated Healthcare Association's Pay for Performance (P4P) program is now in its seventh year. It has grown to include eight health plans, 35,000 physicians, and 11.5 million HMO enrollees, establishing it as the largest private P4P program in the country. Its early success in orchestrating collaboration across a wide range of stakeholders was a remarkable 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 major achievement is bringing large health plans, medical groups, NCQA and PBGH together to produce a statewide state-of-art quality report card based on best of class features."

- Michael Belman, M.D., M.P.H., F.A.C.P., Medical Director, Quality and Innovation, Anthem Blue Cross of California; IHA P4P Steering Committee Member

However, in recent years, the achievements of the California P4P program have fallen short of expectations despite steady incremental improvements in quality. In many respects, the program has both over- and under-achieved. "The California Pay for Performance Program: The Second Chapter" covers measurement years 2006 – 2009. In this report, we provide a complete, objective account of program results and lessons learned.

PROGRAM EVOLUTION

The original measurement set, comprised of three domains and 25 measures, has more than doubled to 68 measures in five domains. As the measurement set has evolved, it has also become more sophisticated. Measures have been added for systematic care processes and coordinated diabetes care. The introduction of the efficiency measures marks an important step toward integrating cost and quality of care.

Measurement Set Development 2003 – 2009

Measurement Domain	2003	2009
Clinical – Preventive	8	13
Clinical – Chronic	3	6
Clinical – Acute	0	4
Patient Experience	6	9
Information Technology (IT)	8	11
Systemness	0	8
Coordinated Diabetes Care	0	11
Efficiency / Resource Use	0	6
Total	25	68

KEY POINTS:

- Creation of a single performance-based measure set and public report card was a major step forward.
- The use of aggregated data from multiple payers to score results significantly increased measurement reliability and the trust of physicians.
- P4P has created a collaborative environment between health plans and physician groups, which serves as a platform for other initiatives.
- Physician groups have accepted the challenge of performance measurement and actively engaged in quality improvement efforts.
- Steady, incremental quality improvements have been realized, but breakthrough improvement has not been achieved.
- Dramatic regional/geographic variations in quality have surfaced.
- Payments represent a small percentage of compensation relative to other programs, which likely contributed to program performance.
- Wide variability in payments by health plans raised concerns about "free riders" motivating plans with higher payments to reduce payment levels.

RESULTS

Performance

Clinical Results

Average P4P clinical performance has steadily improved every year at a level comparable with national rates of improvement. However, there remains a slight gap between California plan Health Effectiveness Data and Information Set (HEDIS) results and national average HEDIS results. On top of this, there is significant regional variation in clinical results across the state. This geographic variation is a primary factor in the overall mediocre performance of California despite the presence of many nationally recognized physician groups and institutions.

Patient Experience Results

After an initial encouraging jump between 2003 and 2004, patient experience gains have been marginal. The geographic variation in scores for patient experience follows the same general pattern as those for clinical quality, although the performance gap is smaller between regions.

Information Technology Results

Information Technology (IT) to support better care has seen the most substantial improvement since the start of the program. Since 2003, the number of groups demonstrating clinical IT capability has more than doubled. These results are especially encouraging given the correlation identified between advanced IT capabilities and performance on clinical measures.

Payment

In 2006, it was resolved that incentive payments should reach 10% of total compensation by 2010, but little progress has been made towards this goal. In 2007, total incentive payments equaled less than 2% of physician group compensation. This contrasts to P4P programs nationally with average incentives ranging from 5% to 6% of compensation.

"Looking back it seems obvious, but there was unequal attention to measurement and payment. While the total amount of incentive dollars paid seemed high, they were at best 2% of total revenues to physician groups, insufficient to generate breakthrough improvement."

- Steve McDermott, CEO, Hill Physicians Medical Group; IHA P4P Executive Committee Chair

Stakeholder Engagement

Physician Group Engagement

Over the life of the program, physician group engagement has strengthened. P4P has inspired groups to increase quality initiatives and data collection efforts and to invest in infrastructure. Physicians have also responded favorably to the ability to collaborate with the health plans in the formulation of the measurement set. This in turn helped to strengthen the relationships of health plans and physician groups in California.

"P4P raised awareness and subsequent acceptance for objective measures for quality performance assessment. It has also contributed to cultural change – increased accountability, behavioral changes and transparency."

- Jerry Penso, M.D., Associate Medical Director, Quality Programs, Sharp Rees-Stealy Medical Group; IHA P4P Executive Committee Member

Health Plan Engagement

Health plan executives have pledged their continued participation in the program, although they have significant concerns about the rate of improvement, "teaching to the test," and the lack of a clear, positive return on investment. These concerns have led to calls for fundamental program changes by health plans, including the addition of efficiency measures.

Affordability

The California P4P program was not originally designed with costs in mind, but in retrospect, including costs as a component of performance measurement should have been an earlier consideration. Efforts to integrate cost into the measurement set have been both politically and technically challenging, but progress has been made.

FINDINGS

The P4P program has yielded a number of lessons, including an understanding that attention to payment and measurement needs to be balanced. In order to drive breakthrough changes, there must be sufficient incentive, which has not been the case with California's P4P experience to date.

The geographic variations outlined above may be symptomatic of underlying payment disparities between physician groups. The correlation between performance variation and socioeconomic status has led to a greater emphasis on pay for improvement.

In addition, the P4P experience has led to some general conclusions about data, including the importance of electronic clinical registries as a tool for data collection, measurement, internal reporting, patient monitoring, and outreach. Merging clinical and administrative data streams has also greatly enhanced performance reporting capabilities.

Finally, the initiative has illustrated that measuring appropriate use, overuse, and cost efficiency is a difficult proposition.

LOOKING FORWARD

California's P4P program has created a foundation for meaningful performance measurement, but the program must evolve to be relevant going forward.

In the future:

- Cost must be integrated with quality to address affordability.
- Performance measurement and reward need to migrate from incremental "bonuses" into performance-based compensation.
- Strategies for encouraging consumer engagement and marketplace competition need to be developed.
- Efforts to improve and merge electronic administrative and clinical data sources will continue in conjunction with regional efforts toward interoperable data exchange, yielding gradual improvements.
- Outcomes and specialty physician services will be incorporated into performance measurement as clinical data collection methods mature and new measures are developed and tested.
- The issue of low performing physician groups and geographic variability must be addressed.

Finally, P4P itself is not the answer; rather, it is an important step to building a foundation of accountability, continuous quality improvement, and effective payment reform in health care. Incorporating the above components will create a more robust program, and aid in the realization of breakthrough improvements that have thus far been elusive.

ABOUT IHA

The Integrated Healthcare Association (IHA) is a statewide leadership group that promotes quality improvement, accountability, and affordability of health care in California. The IHA P4P program is the largest non-governmental physician incentive program in the U.S. It includes 8 health plans and over 200 medical groups representing 35,000 physicians providing care for 11.5 million HMO members. Other IHA programs include: medical technology value assessment and purchasing; the measurement and reward of healthcare efficiency; and healthcare affordability.

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