CIN Partners Share:

Pay for Performance

Main Takeaway: Many health care organizations agree on P4P as a strategy to improve quality and reduce costs, even though individual programs show mixed levels of success.

The California Improvement Network (CIN) partners — public and private-health care organizations actively engaged in improving care delivery — meet quarterly to share experiences and to learn from one another. Following are highlights from the partners' November 2014 meeting, which focused on pay for performance (P4P). The meeting included presentations from the Partnership HealthPlan of California, Integrated Healthcare Association (IHA), and Monarch HealthCare.

Background

Partnership HealthPlan of California www.partnershiphp.org

Who: Partnership HealthPlan of California (PHC) is a nonprofit, community-based health care organization. It contracts with the state to administer Medi-Cal benefits through local providers to ensure that Medi-Cal recipients have access to high-quality, cost-effective care. PHC provides health care to over 480,000 members. Beginning in Solano County in 1994, PHC now serves 14 Northern-California counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo.

What: PHC's four distinct P4P quality improvement programs (QIPs) are focused on primary care, hospitals, pharmacies, and specialty care. The organization started its QIP work in 1995.

PHC's overall philosophy and approach to the QIPs is based on the following principles:

- Pay for outcomes, exceptional performance, and improvement.
- Pay sizeable incentives.
- Distribute 100% of fixed pool per member, per month (PMPM) funds.
- Use measures that are actionable, meaningful, and stable.
- Use measures based on data that are reasonable for providers to collect.
- Collaborate with providers.
- Keep it simple: Use the fewest number of measures possible.

What Is P4P?

The concept of pay for performance, or P4P, emerged in the early 2000s to address health care quality deficits and rising costs through financial bonuses or payments to providers based on a set of performance measures. While traditional fee-for-service payment mechanisms reward volume, P4P programs provide incentives for outcomes. The Affordable Care Act (ACA) expanded the use of P4P through a number of mechanisms, including the introduction of accountable care organizations (ACOs) — groups of providers who coordinate care for a group of patients and who are held financially accountable for quality, and often financial, outcomes.

The **Primary Care QIP** uses two types of incentives: fixed pool and unit-of-service incentives. The fixed-pool budget is $5 per member, per month and contributes 20%-40% of the average capitation rate paid to primary care physicians (PCPs) in the program. The fixed pool measures fall into four categories: clinical, use of resources, operations and access, and patient experience. There are specific goals for each category, and providers receive points if they meet these targets. Incentives are then paid based on these point totals.

Unlike fixed-pool measures, unit-of-service measures are based on the completion of a specific task or the provision of a service. PHC often uses unit-of-service measures with new programs. Examples include incentives for providers who have advance care planning conversations with patients, or provider organizations that extend office hours so patients have access to providers outside of normal business hours.

After realizing that measures alone were not resulting in significant change, PHC launched a technical assistance program to help organizations meet their quality goals. For example, only 53 unit-of-service incentives were paid to providers for advance care planning conversations, but this number jumped to more than 1,000 after PHC implemented a consumer and provider education program, which included webinars on understanding the importance of advance care planning and incorporating it into a practice.

Another key component of the technical assistance program is data support. PHC developed an online reporting tool (eReports) for participating sites to easily enter data. This tool also allows sites to view their performance on specific measures and to print reports at the member level. PHC also organizes teleconferences to facilitate conversations between provider organizations on topics related to P4P, such as how to improve immunization rates or encourage end-of-life care discussions.

In addition, PHC invites providers to participate in the Partnership Improvement Academy, which includes in-person presentations on quality improvement techniques, and workshops on topics such as pain management and clinic access. The academy's offerings on quality improvement range from one-day programs and conferences to a 10-month, intensive program called ADVANCE. Fifteen PHC sites are participating in ADVANCE's in-person trainings, weekly coaching, and monthly webinars. A dyad of a clinical and administrative leader from each site participates in the program and is trained on QI methods, change management, data analysis, and team-building skills. Participants are also coached to help put changes into practice.

Examples of fixed-pool measures:

- **Clinical**
  - Adolescent and childhood immunization rates
  - Cervical cancer screening rates
  - Percentage of patients with high blood pressure in control
- **Use of Resources**
  - Hospital readmission rates (unplanned readmissions to acute care facilities)
  - Acute bed days/1,000 (number of inpatient days in acute care per 1,000 people)
  - Pharmacy utilization — formulary compliance and rate of use of generics
- **Operations and Access**
  - Practice available to accept new PHC members
  - Time to third next available appointment (average length of time between when a patient makes a request for an appointment and the third available appointment)
  - Avoidable emergency department visits
- **Patient Experience**
  - Patient satisfaction — implement a survey with specified measures, analyze results, implement changes, and resurvey
  - Training option — participate in an external patient experience learning collaborative or program approved by PHC

Partnership has seen improvement across many of the selected measures. See Figure 1 on page 3.

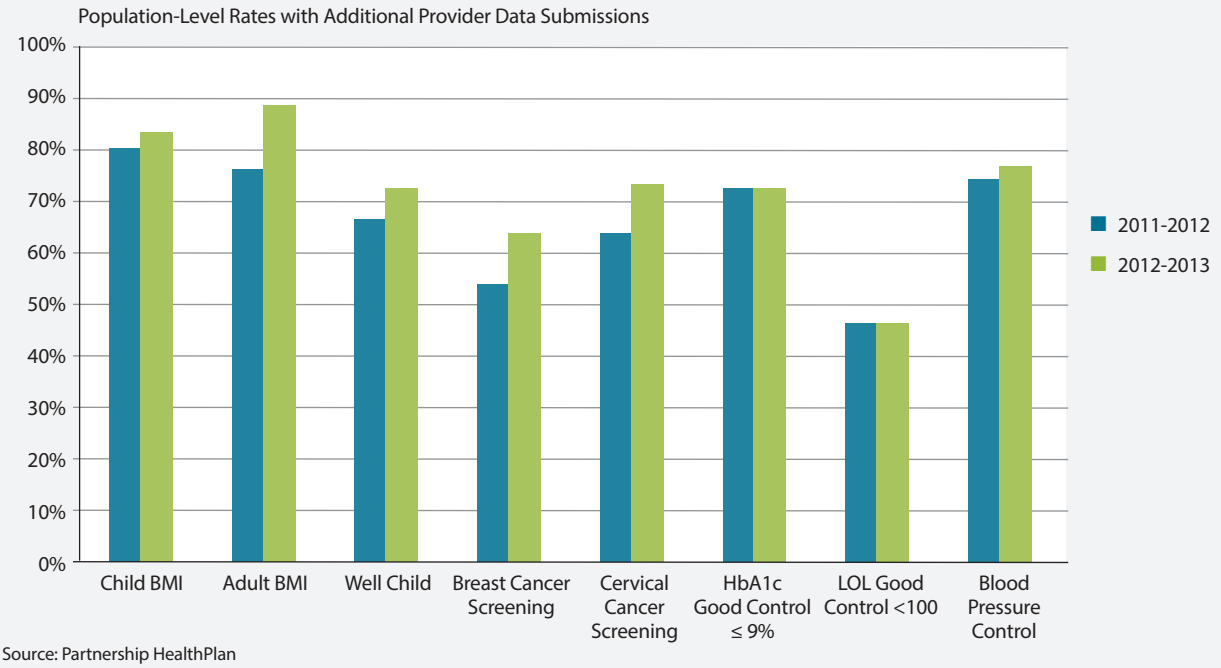
In addition to the QIP for primary care, PHC has implemented P4P programs for hospitals and pharmacies. (The organization only recently initiated a QIP for specialty care, so information about that program was not shared at the meeting.)

"Quality measures by themselves don't change behavior. You need to provide the infrastructure to help meet these goals."

For its **Hospital QIP**, PHC provides incentives equal to an average of 4.5% of average hospital income based on a specified set of measures, which include elective c-section rates before 39 weeks, hospital readmission rates, and rate of breastfeeding upon newborn discharge.

PHC's **Pharmacy QIP** includes an incentive pool that is approximately $1 per prescription filled. Examples of measures include generic refill rates and the availability of a medication delivery service, extended hours, and blood pressure machines at the pharmacy.

Figure 1. Partnership HealthPlan: Percentage of the Patient Population Meeting Quality Measurements, 2011-2013



Source: Partnership HealthPlan

Integrated Healthcare Association www.iha.org

Who: Integrated Healthcare Association (IHA) is a statewide, multi-stakeholder leadership group that promotes quality improvement, accountability, and affordability in the health care arena. IHA convenes stakeholders for cross-sector collaboration on health care issues, administers regional and statewide programs, and serves as an incubator for pilot projects.

What: IHA has developed and led P4P programs in California since 2003 with provider groups that serve commercially insured patients. The organization has helped P4P evolve from a program based solely on quality measures to one that is based on value and accounts for both quality and costs. More recently, IHA has focused on Medi-Cal managed care and the safety net with two projects: (1) a pilot project with Southern California Medi-Cal managed care plans aimed at performance measurement and reporting at the physician organization level and (2) an inventory of P4P programs in the safety net.

Running from July 2013 to October 2014, **IHA's Managed Medi-Cal pilot project** explored the feasibility of collecting and reporting data on a set of standardized measures for provider organizations serving Medi-Cal enrollees. Collection and reporting of this nature already occurs on the commercial side through California's statewide P4P program, which is administered by IHA. This standardized approach is not currently in place for the Medi-Cal market. Many provider sites find it difficult to manage different measure sets from different health plans. The plans that participated in the program were Anthem Blue Cross, CalOptima, Health Net, Inland Empire Health Plan, and LA Care.

"The alternative to paying for quality is paying for activities."

The Managed Medi-Cal pilot used a measure set that was developed collaboratively by the leadership and technical staff from participating plans and chosen from measures that Medi-Cal managed care plans are already required to report to the National Committee for Quality Assurance, the state, or both. The set consisted of 22 clinical measures (e.g., preventive screening rates for breast cancer, cervical cancer, and chlamydia), three resource use measures (e.g., number of emergency department visits), and one health information technology measure (the percentage of physicians meeting Stage 1 "meaningful use" requirements, a CMS incentive program to encourage the appropriate and effective use of electronic health records).

IHA collected and reported results from participating health plans at the physician organization (PO) level. In this project, an organization was considered a PO if it contracted directly with the Medi-Cal managed care plan. These organizations included community clinics and their networks, medical groups, independent practice associations (IPAs), and county entities representing county health systems. The PO was chosen as the unit of measurement to allow organizations to track their own performance, to compare that performance to that of their peers, and to identify areas for improvement. This level of measurement also allows health plans to have a full picture of performance among their contracting partners, identify low performers for QI activities, and identify and reward high performers. (See Resources on page 6 for a link to an issue brief describing results of the pilot.)

Highlights of the pilot project's findings include:

- The data reported by the POs passed validity checks, and aggregating results across plans at the physician organization level reduced the number of measures with denominators too small to report.
- Although the project tested PO-level reporting, measurement at the community health center or physician practice level may be a logical next step, as results may be more relevant and actionable at these levels.
- Many physician organizations across California contract with multiple Medi-Cal managed care plans. A core set of metrics and consistent measure specifications would benefit all participants in performance measurement, and enhance comparability while still giving plans the flexibility to tailor programs to local needs.

To describe the types of P4P programs that already exist among providers delivering care to Medi-Cal beneficiaries across the rest of the state, IHA also conducted a **survey of all Medi-Cal managed care plans**. Of the 20 Medi-Cal managed care plans interviewed, 16 had P4P programs in place (80%), 7 of which started in 2003 or before (35%).

Preliminary findings from the survey include:[1]

- Plans reported using measures from the following categories: clinical, utilization, encounter submission, access, and patient experience.
- Most plans pay incentives for attainment and improvement. Several include incentives for population-based measures, as well as per-activity payments (such as completing a child immunization form).
- Most plans provide regular feedback reports and conduct trainings and orientations to engage providers.
- Plans commonly rely on encounter and claims data to measure performance. This approach is used in an attempt to minimize the reporting burden on providers, but it may not capture the full story; provider organizations may still need to provide extra documentation to show that they have met a specific measure for an individual patient.
- Plan representatives identified the types of support they need, including opportunities to share best practices among plans, access to P4P experts, help with standardizing measures, and assistance to use data effectively.

Monarch HealthCare www.monarchhealthcare.com

Who: Monarch HealthCare, which was acquired by OptumHealth in 2011, is the largest IPA in Orange County. Monarch consists of more than 2,500 physicians who care for more than 200,000 managed care and Medicare ACO patients. The organization contracts with most major health plans in California and has relationships with most Orange County hospitals.

What: Monarch has been involved with IHA's commercial P4P program since the program's inception. As the program shifted to be more value-based, Monarch has worked to help its provider network transition to a new measure set. These measures track appropriate resource use and include rate of inpatient use and readmissions, rate of emergency department use, generic prescribing rate for specific conditions, and outpatient procedures use (e.g., the percentage of procedures performed in a preferred facility, as determined by the health plan).

1. An issue brief on the survey findings will be published by IHA in spring 2015.

While Monarch has taken steps toward improvement in each of these measures, its most concrete activities have focused on increasing use of ambulatory surgery centers (ASCs) as one tactic to increase the percentage of outpatient procedures performed in a preferred facility.

There are currently over 5,000 ASCs in the county, where more than 23 million surgeries are performed each year. ASCs are required to have Medicare certification, and many are accredited by The Joint Commission. Many ASCs have a patient-centric approach and can offer accommodative scheduling. The procedure cost is also usually lower at an ASC than at a hospital.

Monarch's initial strategy focused on educating providers about ASCs, securing facilitation privileges to allow providers to perform procedures at ASCs, and working with health plans to ensure appropriate reimbursement. Monarch enlisted a general surgery associate medical director (AMD) to facilitate peer discussions regarding ASCs, implemented ASC project team monthly meetings, and increased the staff focus on identifying procedures that would be appropriate for ASCs.

Monarch encountered some barriers in this work, including physicians' preference to perform procedures in the hospital setting, as the environment they are accustomed to and comfortable in. In addition, the reimbursement rate for operations that require an implant, such as many orthopedic procedures, often does not cover ASC facility expenses. This remains a contracting challenge.

Procedures commonly performed in the ASC setting are GI endoscopy, cataracts, laparoscopic cholecystectomy, and select ENT and gynecologic operations. Each requested procedure at a Monarch ASC goes through a utilization management process that includes RN and physician review for medical necessity and for appropriateness of venue for the service. If necessary, the general surgery AMD will deny and redirect the request. This process may include direct peer-to-peer conversations between the AMD and requesting provider. Monarch has increased its rate of ACS use for eligible procedures from 68% in 2011 to 79% in 2014. Its goal is to increase this percentage to 80%-81% in 2015.

Quick Takes

- **P4P can be the fuel to start improvement work.** It can provide the activation energy and the framework for change in this area.
- **Collaboration helps.** P4P programs that are codesigned or have features that are codesigned with participating organizations can lead to better buy-in and participation.
- **Support providers with training and technical assistance.** Organizations cannot jump immediately to outcomes without adequate technical assistance and infrastructure support. Without support, P4P may be a distraction to providers.
- **Motivate providers with peer data.** Generally, providers respond to data that compares them to their peers.
- **Focus on the care team, not just the individual provider.** Measures and technical assistance that encourages team-based care, and that changes the behaviors of physicians, nurses, MAs, and frontline staff, may lead to longer-lasting improvements. Incentives passed on to office staff can also contribute to quality improvements.
- **Ensure that financial incentives are substantial enough to be meaningful.** Have enough money in the incentive pool to have an impact on provider behavior.
- **Add "per-activity" measures to the mix.** Adding measures such as participating in a leadership program or learning collaborative can help organizations build capacity and build an audience to test innovative ideas or programs. These types of measures can balance out more straightforward clinical and utilization measures.

Quick Takes (cont.)

- **Tailor organizations' improvement measures to their biggest opportunities for improvement.** Doing so can help organizations prioritize where improvements can have the most impact. For example, San Francisco Health Plan's P4P program is rewarding providers for improvement only on the five lowest-performing measures.
- **Reward improvement.** Offering organizations rewards for attaining a specific target and for making substantial improvements in pursuit of the target can motivate organizations at different levels of performance.
- **The lack of standardized measure sets across different health plans can present challenges to provider organizations.** Since many provider organizations contract with multiple health plans, the lack of standardized measures can be difficult from an operational perspective. In the face of multiple measure sets, provider organizations may need to choose those that are most relevant for their patient population. On the other hand, organizations that contract with only one plan do not necessarily see the benefit of statewide P4P standardization.
- **Offload tasks from providers.** Organizations that support providers in meeting P4P measures may need to be creative in offloading tasks from providers who are juggling multiple demands. For example, Monarch offers alternative venues of care for patients for routine screening or preventive care to increase access for patients and lighten the load of PCPs.
- **Regular meetings with health plans can help provider organizations track progress against measures.** Monthly meetings to review gap reports with health plans can allow organizations to compare their data with the plan's data and conduct follow-up to address discrepancies.

Resources

Integrated Healthcare Association, "Value Based Pay for Performance: Results for Measurement Year 2013," (September 2014). www.iha.org/pdfs_documents/p4p_california/VBP4P-Results-Presentation-20141010.pdf

Integrated Healthcare Association, "Piloting Performance Measurement of Physician Organizations in Medi-Cal Managed Care: Findings and Implications," (January 2015). www.iha.org/pdfs_documents/resource_library/Medi-Cal-Performance-Measurement-Issue-Brief-Final-20150112.pdf

Julia James, Health Policy Brief on Pay-for-Performance, *Health Affairs* (October 11, 2012). www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78

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California Improvement Network Better Ideas for Care Delivery