

From Concept to Practice: Early Experience with P4P

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PacifiCare Health Systems

- ❑ Major U.S. health insurance plan with more than 2 million members across several states
- ❑ Typically contracts with large multi-specialty medical groups using professional capitation
- ❑ PacifiCare has tracked quality of care among medical groups in California for a decade
- ❑ These data have been public since 1998

Design of PacifiCare P4P

- ❑ P4P contracts cover 163 large multi-specialty medical groups in California: beginning 1/2003
- ❑ PacifiCare accounts for an average of 15% of patients in groups
- ❑ P4P targeted 5 technical/5 satisfaction measures
- ❑ Set targets at 75 percentile of 2002 performance (absolute standard)
- ❑ Payments began 7/2003; \$0.23 per member per month per measure (potential quarterly pay off per target with 10,000 members=\$6,900)

PacifiCare Evaluation

- In 2003, the Quality Incentive Program (QIP) was launched in CA only (WA/OR control)
- First year targets included five clinical quality measures, 5 patient satisfaction measures and indicator of IT adoption
- PacifiCare's QIP rewards high performance, not improvement (fixed target)

Overview of Analysis

- Comparison of the change in quality in CA vs. WA/OR after the QIP was introduced using quarterly performance reports
- Focus on 3 continuously reported measures (cervical cancer screening, mammography, HbA1c testing)
- Three questions:
 - Did the QIP improve quality?
 - How much did PacifiCare spend in bonuses?
 - How were bonuses distributed relative to improvement?

Key Findings

- Only cervical cancer screening rate improved more in CA than the OR/WA (by 3.6 percentage points)
- In total, PacifiCare distributed about \$3 million in the first year of the program; 129/172 groups received some \$, only 15 groups hit more than half of the targets
- Those with high baseline performance (\geq targeted level) received 75% of \$\$ and improved little (about 1-2 percentage points)

Table 1. Improvement in Clinical Quality Scores for QIP Measures

	Pre-QIP	Post-QIP	Row Difference (Post – Pre)
Cervical Cancer Screening			
California	39.2%	44.5%	5.3% (1.6%)*
Pacific Northwest	55.4%	57.1%	1.7% (0.9%)
Column Difference (CA-NW)	-16.2%	-12.6%	3.6% (1.8%)*
Mammography			
California	66.1%	68.0%	1.9% (1.1%)
Pacific Northwest	72.4%	72.6%	0.2% (1.1%)
Column Difference (CA-NW)	-6.3%	-4.6%	1.7% (1.5%)
HbA1c Testing			
California	62.0%	64.1%	2.1% (1.0%)*
Pacific Northwest	80.0%	82.1%	2.1% (3.3%)
Column Difference (CA-NW)	-18.0%	-18.0%	0.0% (3.5%)

Source: Authors' analysis of PacifiCare physician group performance reports 2001-2004.

Notes:

(1) Predicted values obtained from GEE models of performance.

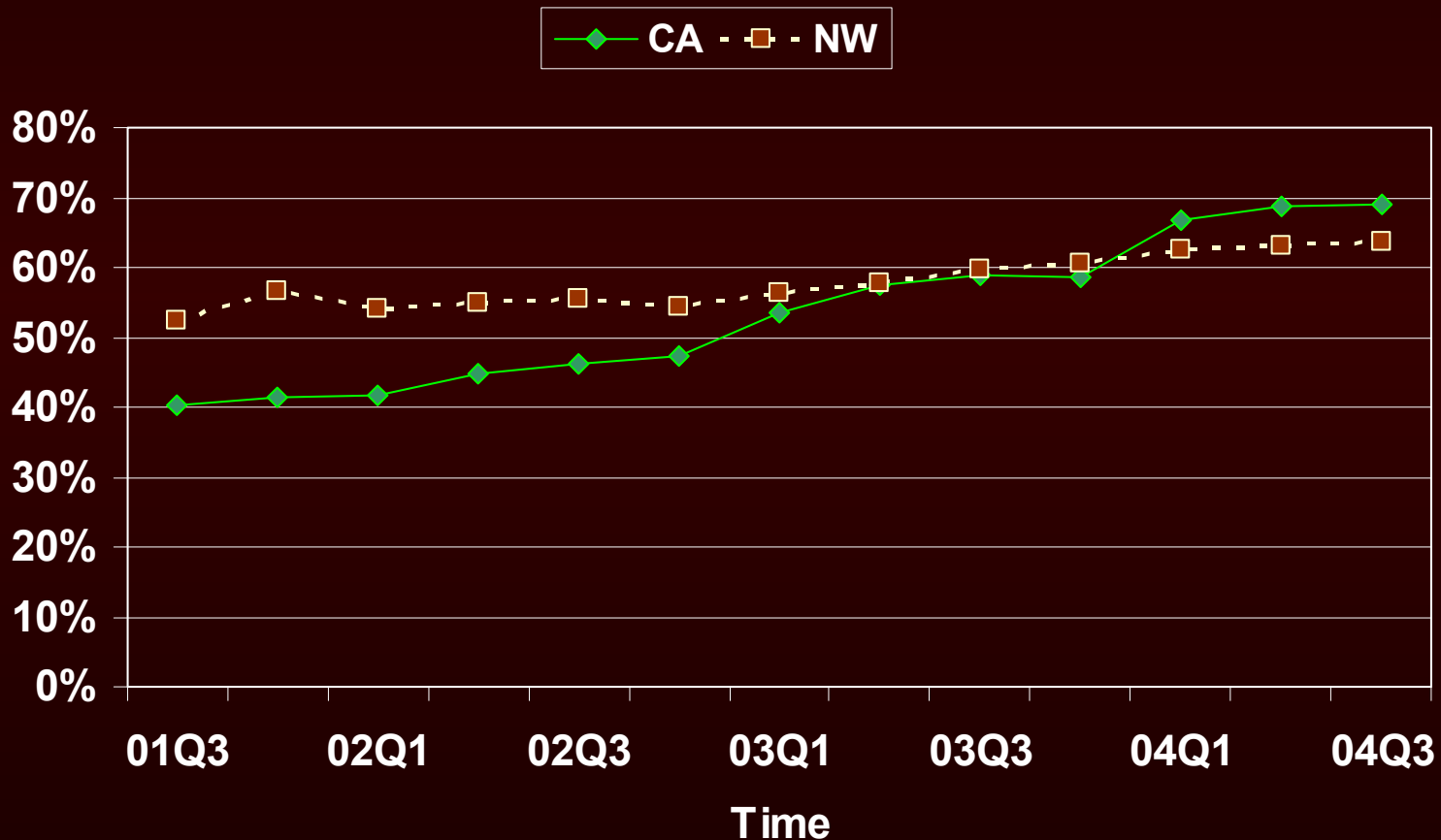
(2) Bootstrapped standard errors for row differences in parentheses. We indicate with a star (*) a p-value of <.05.

(3) For the purposes of this analysis we define the post-QIP period as beginning with the data reported for the first quarter of 2003.

Table 2. Quality Improvement after the QIP and Bonus Payments to California Groups with High, Middle or Low Baseline Performance

Quality Domain	Total PacifiCare Members	Pre-QIP Rate	Post-QIP Rate	Improvement (Post-Pre)	Bonuses Paid in Year 1
Cervical Cancer Screening					
Group 1	597,091	53.6%	56.0%	2.5% (0.8%)	\$ 436,618
Group 2	287,610	40.8%	48.1%	7.4% (2.4%)	\$ 127,632
Group 3	305,041	23.0%	34.1%	11.1% (3.9%)	\$ 26,859

Performance Over Time on Cervical Cancer Screening, California and Pacific Northwest



Conclusions

- In P4P where payments are made on: absolute performance; within a fragmented financing system; with modest payments levels—QI response was weak
- A large share of payments were made to practices that did not improve making initiative costly
- Changes in unmeasured outcomes not considered

Implications

- Paying for improvement AND performance may yield better results
- P4P on large scale to overcome fragmentation is likely important
- Multi-tasking must be studied carefully