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The Pay for Performance Planning Committee which produced the Five Year Plan was led by Steve McDermott, Hill Physicians, and included: Ron Bangasser, M.D., Beaver Medical Group; David Joyner, Blue Shield of California; Lance Lang, M.D., Health Net; Arnie Milstein, M.D., Pacific Business Group on Health; and Pauline Yan, GlaxoSmithKline.

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ADVANCING QUALITY THROUGH COLLABORATION: THE CALIFORNIA PAY FOR PERFORMANCE PROGRAM

A Report on the First Five Years and a Strategic Plan for the Next Five Years

INTRODUCTION

It has been five years since the conception of the California Pay for Performance ("P4P") program sponsored by the Integrated Healthcare Association ("IHA"). During this time, the program has matured to become the largest and most prominent Pay for Performance program in the country. The program helped launch national and international interest in the use of performance measurement and financial incentives to promote healthcare quality in all sectors of the healthcare industry.

This IHA sponsored program has achieved its initial goals: a uniform performance measure set, significant incentive payments to physician groups, and a public report card. Progress has also been made toward performance improvements in clinical quality, patient experience, and the use of information technology to support population management and patient care.

This report was prepared in conjunction with the development of a strategic plan for the next five years (2006-2010) of the California Pay for Performance program. Program stakeholders face new challenges: evolution of performance measures, increased incentives, enhancing the business case for quality, and expansion of the program to new populations. These challenges are no less daunting than those faced at the program's onset, yet one key advantage exists today: an underlying spirit of collaboration, created by the commitment of a core group of dedicated stakeholders and hundreds of organizations to an idea that is larger than the interests of any single participating individual or group.

I. EXECUTIVE SUMMARY

The IHA-sponsored California Pay for Performance program is an ongoing testament to the power of collaboration. It also reflects California's unique confluence of healthcare delivery, reimbursement, and financing which contributed to both the opportunities and challenges presented by this initiative. Responding to the consumer backlash against managed care in the 1990s, California health plans and physician groups added quality-based financial incentives and public report cards. However, these efforts were frustrated by inconsistent performance metrics, contradictory public reporting, insufficient sample sizes, and minimal funding. Leading physician groups

appealed to the health plans to develop a uniform set of quality performance measures and a single public report card. California's health plans responded favorably to this challenge, and despite seemingly insurmountable logistical problems, a successful Pay for Performance program emerged through the synergy of timing, leadership, and cooperation.

The Integrated Healthcare Association, a unique collaboration of key California stakeholders, and particular individuals within this organization took the lead. By emphasizing innovation through collaboration and setting core guiding principles, they successfully designed and implemented a Pay for Performance program with one overriding goal: *to create a business case for quality improvement through a compelling set of incentives that would drive breakthrough improvements in the quality and experience of healthcare.*

Key to the program's success is the use of uniform measures to evaluate performance across multiple health plans, physician groups, and patient populations. The initial performance measurement set has three domains: clinical, patient experience, and information technology. The weighting of these domains is dynamic, and measures within each domain are evolving each year.

Incentive payments are an essential ingredient. However, it has been difficult to arrive at a uniform approach to incentive payment in the absence of standards for payment methodologies and due to anti-trust concerns. Transparency is also a key element.

Program oversight is provided by the IHA Board, with program management and governance provided by Steering, Planning, and Technical Committees, and a technical team including experts from the Pacific Business Group on Health, the National Committee on Quality Assurance, and IHA staff. Additionally, a team of researchers from the RAND Corporation and U.C. Berkeley are currently evaluating the program.

Looking ahead, the Planning Committee revised the program's original mission and priorities and developed a set of recommendations to guide development and implementation over the next five years. These recommendations include:

1. Increase incentive payments proportional to improvements in performance outcomes;
2. Aggressively develop and expand the performance measurement set;
3. Strengthen Pay for Performance administration to support an increasingly sophisticated program; and,
4. Further develop public reporting, research, and public relations.

California's Pay for Performance program is the largest in the country, and a potential model for other regional programs, as well as for adoption by the Center for Medicare and Medicaid Services.

II. A STORY OF COLLABORATION

"Collaboration is the new frontier of human creativity."[1]

A. A Moment of Truth

It was time to bring to a close a meeting in Northern California during the fall of 2001, and the CEO of the California HealthCare Foundation ("CHCF"), Mark Smith, M.D., was asking the question, "Are you in or out?"

CHCF had agreed to fund the technical development of a statewide quality incentive program, but only if the major health plans in the state agreed to participate. Senior executives from the plans were present at the meeting, and they each had to take a position. The dynamics of the meeting suddenly became more serious.

Each health plan had its own set of considerations. Some had already developed quality-based incentives and were in a leadership position. To commit their organizations to collaboration with a uniform approach to quality measurement would mean forsaking their position, yielding a potential competitive advantage. Still other plans had not yet developed a program. Participation could bring them parity; however, agreeing to meet the recommended minimum financial incentive targets would be a challenge.

To date, the potential participants had been able to negotiate parameters without fully committing to the program, but Mark was not allowing them any more wiggle room. It was a yes or no question. The tension in the room was palpable as each plan executive gave an answer. As one by one they said "yes," the California Pay for Performance program was born.

However, to tell the story only from this point forward would leave out half the tale. California's Pay for Performance program has been built through the collaboration of otherwise unlikely partners. How they arrived at the pivotal meeting which launched the program and the roles played by key actors are among the most relevant aspects of this story, important to anyone considering a similar collaborative effort.

B. The Stage is Set

During most of the 1980's and the entire decade of the 1990's California rode the wave of managed care with particular vigor, embracing HMOs and delegating many aspects of medical management to its elaborate system of physician groups. When consumers and providers across the United States bristled against the perceived vagaries of utilization management, both California health plans and physician groups were forced to reexamine many

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1. Michael O. Leavitt, Sec. of Health and Human Servs., U.S. Dep't of Health and Human Servs., June 5, 2005, HIMSS Summit: Achieving National Healthcare Transformation.

of their traditional managed care practices. One practice under particular scrutiny was financial incentives based solely upon utilization management.

In the late 1990's, several California health plans began to shift to quality based incentives, in a move well received by physician groups and purchasers. These plans, and a key purchaser, also began to publish report cards comparing physician groups and announcing top performing groups with great fanfare.

Despite the best intentions of the health plans, these actions began to raise the ire of the physician community. Each health plan had a different set of performance metrics, making it difficult for physician groups to focus sufficient attention on any one set of measures. A cause of even more consternation was the "dueling report cards." A physician group might be touted as the top performer in a category (e.g. asthma management) by one plan, but rated as an average or below average performer in the same category by another plan. On top of these problems, funding for incentives was minimal.

Early efforts to measure and report quality also faced the challenge of obtaining a sufficient sample size to lend credibility to both publicly reported results and financial incentive payments. No single health plan had more than twenty-five percent of the managed care membership. Consequently, each plan's ability to measure and report across multiple measures and physician organizations was limited.

California's unique organization of healthcare delivery and financing contributed to both the opportunities and the challenges faced. A prevalence of larger, multi-specialty groups and independent physician associations ("IPAs") offered a more unified voice for physicians than typical in most communities. The delegation of financial responsibility (capitation) under the organized group model offered the ability to implement quality improvement initiatives. At the time, however, the physician community was just emerging from a period of underpayment driven by several years of health plan pricing wars and declining premiums.

For all these reasons, the community of physician groups and their leading statewide organization, the California Association of Physician Groups ("CAPG"), posed a challenge to the health plans: "Please cooperate with us to develop a uniform set of quality performance measures and one public report card."

The logistical challenges seemed insurmountable. Just engaging the health plans in a conversation about uniform business practices raised anti-trust concerns. Furthermore, the powerful Pacific Business Group on Health ("PBGH"), a statewide association of employers, had pitched a similar idea a few years earlier but it had not been implemented. It was viewed as an idea ahead of its time.

So why was the IHA effort successful? The answer lies in a combination of timing and leadership, guided by a spirit of cooperation and a vision larger than the personal interests of any one stakeholder or set of stakeholders.

C. Call to Action

Between the late 1990's, when the concept of a California Pay for Performance program began to take shape, and the critical meeting in 2001, a tremendous amount of important work and activity took place. As physician group leaders sought to advance the idea of collaboration, an important question was raised: "What group of leaders or organization should take the lead?"

Each major stakeholder group had a substantial trade association representing its interests: the Pacific Business Group on Health for employers and other purchasers of health benefits; the California Association of Physician Groups for physician organizations; and the California Association of Health Plans ("CAHP") for health plans. Each was a well-respected advocate for its constituency, which undermined their ability to maintain the neutrality, or the appearance of neutrality, required to navigate a complex set of political and technical challenges.

The Integrated Healthcare Association, a statewide leadership organization, was created in 1996. Committed to the development of innovative public policy, healthcare industry dialogue, and related projects, its member organizations include balanced representation from all the major healthcare stakeholder groups in California. By virtue of its member organizations, IHA is able to convene leaders from all sectors of healthcare statewide to fulfill its mission of "innovation through collaboration." IHA was a unique organization ideally suited to sponsor pay for performance.

The leaders of prominent California physician groups approached IHA with the notion of developing a uniform program of quality incentives for physicians. IHA accepted a leadership role in this process. A small band of dedicated leaders expended considerable time and political capital on behalf of this effort. The board chair of IHA in 2000 was Steve McDermott, the CEO of a large, successful California IPA. He was captivated by the notion of improving healthcare quality through a Pay for Performance program. In partnership with the IHA Executive Director at the time, he organized a process of consensus building, assuring adequate dialogue and input from all key stakeholders. He then pushed the process forward, ensuring that sufficient support existed among key decision makers, and that member organizations committed publicly and collectively to the program.

Other IHA board members also played important roles. Tom Davies, an IHA board member representing Verizon, played an active and key part. He reminded the health plans and physician organizations that the non-healthcare sectors of business had embraced quality improvement and felt they were not receiving value for their healthcare premium dollars.

Pauline Yan, another board member representing GlaxoSmithKline, was a steadfast supporter of a uniform performance measurement set, and helped to push the initiative forward by funding the action plan and pressing the

actors to "do something," not just talk. Arnie Milstein, M.D., another board member representing large employers and members of PBGH, advocated that incentives drive affordability of care, as well as quality. He laid out a vision of "breakthrough," rather than incremental improvement.

A number of health plan leaders also played critical roles, including Cora Tellez, head of Health Net of California at the time, who helped build essential support among the plans.

The efforts of many other individuals, too numerous to enumerate, contributed to the initial organizational success of the California Pay for Performance program. Those mentioned represent both important contributions and the diversity of stakeholder involvement.

D. Overcoming Roadblocks and Suspicion

The potential for failure was a constant reality. Physician leaders welcomed the prospect of additional incentives, but were adamant that they not undermine existing reimbursement levels. They demanded that incentives be funded with "new money." Purchasers, however, were not prepared to pay additional premiums specifically for incentives, arguing that they were already overpaying for healthcare, and that quality improvement should lower costs. Health plans were wary of any initiative that might undermine their ability to innovate.

To collaborate means putting the group ahead of the individual for the collective good. It requires that everyone give something up in the hope of realizing an uncertain gain. Each major stakeholder group experienced its own "moment of truth" before setting aside self-interest to move forward.

Ironically, the physician community almost undermined the program before it was launched. Despite the initial call to action by physician group leaders, suspicion began to develop in the physician community following agreement by the health plans to proceed. Less informed about the impetus and details of the initiative, some physician leaders were apprehensive about the project. A raucous meeting of the state's largest association for physician groups almost resulted in defeat of the proposed program. Only a passionate plea led by key leaders pushed the vote to proceed. Today this same association is a steady and strong program supporter.

Purchasers were less organized in their participation, but generally supportive until the discussion turned to the question of increased premiums to fund incentive payments. A resounding "no" was the common response, deflating enthusiasm for program organizers. Eventually, employer leaders endorsed the program, encouraging organizers to proceed.

Ultimately, health plans committed to budget incentive payments without reductions in existing reimbursement levels. To date they have honored this commitment, and Pay for Performance incentives have been funded by health plans through a combination of premium rate increases,

administrative efficiencies, offset to capitation increases, and re-allocation of incentive payments from other programs.

Moving key decision makers forward required incremental agreement on the nature of the program and basic organizing principles. This early step was helpful in clarifying the purpose and boundaries of the program, thereby allowing organizations to clearly understand their potential role and commitment.

The overall program goal of the initial Pay for Performance plan was straightforward: *To create a business case for quality improvement through a compelling set of incentives that will drive breakthrough improvements in the quality of healthcare and patients' experience.*

The effort to achieve this goal was guided by several organizing principles:

- Participation is voluntary.
- Physician organizations will be accountable through a publicly reported scorecard based on common clinical and patient satisfaction measures.
- Participating health plans will offer significant financial incentives to physician groups based on their scorecard performance.
- Pay for Performance is accomplished through a collaborative model involving purchasers, health plans, physician organizations, and consumers.

E. Creating Guiding Principles

Once the decision had been made to proceed with the program, a series of tough questions immediately emerged. What exactly would be measured? How would data be collected? How would the program be administered? How much would be paid in incentives? Could quality really be measured and improved?

To prevent backpedaling and loss of support, it was essential that the program goal and operating principles be expanded to provide guidance to the individuals charged with building the components of the program. A significant effort was made at this point to expand the initial organizing principles into a more fully developed set of guiding principles. This exercise began the process of collaboration, with stakeholders beginning to move beyond the notion of coordination and cooperation to building something together in a collaborative manner.

The importance of the guiding principles cannot be overstated. They have been instrumental tools for decision making and stakeholder engagement. For example, the measure selection criterion calls for the use of administrative (electronic) data only for measurement. This principle allows the program to continue at its current large scale without extensive manual data collection

effort and cost. However, it imposes a trade-off: the current availability of measures which move beyond process to outcomes is limited; therefore, evolution of the measure set has been slower than some would like.

The existence of this guiding principle has proven extremely helpful as the ongoing debate about new measures continues. At times when trades-offs become difficult and even contentious, revisiting the guiding principles provides an important check for decision makers.

The guiding principles that have guided development of the program are presented on the following page.

Vision

The achievement of breakthrough improvement in healthcare performance.

Central Goal

The overall goal of Pay for Performance is to significantly improve physician group performance in quality of health care and patient experience through public recognition and financial reward.

Core Principles

Collaboration
P4P is accomplished through purchasers, health plans, physician groups and consumers working together.
Measurement
The measurement set is comprehensive and dynamic, including measures of clinical quality, patient experience, and infrastructure to support patient care. Continuous evaluation will ensure alignment, relevance and effectiveness, raising the bar on performance over time.
Reward
Health plans will offer financial incentives tied to performance results. The financial incentives will be significant and sustained to promote performance driven organizations and justify investment in system reengineering.
Accountability
All stakeholders have a role:

- Purchasers will promote health plan participation in P4P.
- Physician organizations will implement appropriate internal performance measurement systems, including individual physician measures.
- A public scorecard will report physician group performance for consumers and providers making informed choices.

Program Objectives

1. **Strategic selection criteria**

Include measures that are:

a. Clinically relevant
b. Affect a significant number of people
c. Scientifically sound and tested before implementation
d. Feasible to collect using administrative data

e. Physician groups and health plans can impact
f. Capable of showing improvement over time
g. Are important to California consumers
h. Aligned with national measures (when feasible)

2. System reform

Encourage system re-engineering over incremental improvement. Move from an individual disease management approach to cost-cutting measures and reward better outcomes, customer service, structure and efficiency for greater change and consumer relevance. Apply risk adjustment so that payment reflects population mix and rewards better performance with patients who require special care.

3. Consumer-relevant

Add customer service and other credible measures that evaluate better service to members, administrative efficiency and quality-related utilization.

4. Predictability and stability

Ensure predictability and stability in the measurement set. Phase-in multiple part measures, moving from process to outcomes as appropriate. Leave each measure in the set for at least three years. Evaluate annually to adjust based on experience, including weighting and specifications. Consider testing for one year when measures have not been used before.

5. Standardize for comparison

Provide the greatest comparability between physician groups and enhance consumer and provider benefit by having participating health plans use a standardized measurement set.

6. Align what matters

Work to better align Pay for Performance measures among plans, providers and purchasers with the measures required by accreditation, Health Employer Data Information System ("HEDIS"), public and private purchasers and regulators, including movement to individual physician level performance.

F. Moving from Pilot to Implementation

In late 2001, an organizational structure was developed to design and operate the program. A Steering Committee was organized to provide program governance, along with a Technical Committee to design the measurement set and manage issues related to data collection, analysis and reporting. The Technical Committee, which was chaired by Stephen Shortell, Ph.D., the Dean of the School of Public Health at U.C. Berkeley, developed an initial performance measure set in 2002.

Technical development of a meaningful, credible set of performance measures is one of the most important roles that IHA plays in the Pay for Performance program. Selection of appropriate practice guidelines that are both clinically relevant and administratively feasible requires a significant amount of technical work.

IHA formed a prestigious Technical Committee of experts and stakeholders to lead this work. Enhancing this effort are individuals from the National Committee for Quality Assurance ("NCQA") and the Pacific Business Group on Health, who provide staff support to the committee. NCQA was also awarded the task of data collection and aggregation. A California based company, Diversified Data Design, which has been engaged in collecting and consolidating information for California physician organizations for over a decade, contributes to the data collection effort.

Dean Shortell's impartiality was crucial in guiding the stakeholders through the difficult process of measure selection. By the end of 2001, the initial measure set was approved by the Steering Committee and released for public comment, an important process step allowing all the affected stakeholders a chance to voice an opinion. By early 2002 the measure set was completed. At this point it was time to move forward with testing and implementation.

A key guiding principle of the program is a test period for new measures before they are incorporated into the actual measure set for reporting and payment. This required the initial measure set to be tested in its entirety before implementation. In 2002, forty-nine physician groups agreed to participate on a voluntary basis in a pilot involving clinical data collection for the recommended measure set. Groups submitted data for a single measure or multiple clinical measures. Although many groups had data collection systems in place, forty-three percent had never previously captured information for these clinical measures.

The profile of the physician groups participating in the pilot included thirty-nine percent IPA, twenty-nine percent medical group, fourteen percent mixed medical and IPA, and eighteen percent groups managed by a sub-contracted management service organization ("MSO"). The participating test groups had patient enrollments ranging from 7,500 to 225,000 patients. The results of the first year pilot revealed that the top performers were spread out among many groups; in fact, forty-four percent were in the top performing quartile for at least one measure. Following testing and analysis of the pilot results, the Technical Committee made final recommendations for the measure set. Physician group performance was measured both individually and in aggregate in 2003, with incentive payments and public reporting following in 2004.

Today, three program measurement years (2003-2005) have been completed, with incentive payments and reporting for the first two years of the program. Many key challenges have been addressed during this time and adjustments have been required, including an occasional reversal due to new

information or technical difficulties. Throughout the process, participating health plans and physician organizations have shown commitment, flexibility and a steady spirit of collaboration.

III. THE POWER OF MULTIPLES

An organizing force behind the development of the Pay for Performance program is the uniform evaluation of a physician group's performance across multiple health plans and measures. To maximize the leverage of this approach, each participating health plan is encouraged to use a uniform measure set to examine performance based on the physician group's *overall, combined* patient population.

This concept is in contrast to more traditional approaches in which an individual health plan evaluates and rewards physician group or individual physician performance in isolation. By creating a multiple of combined payment from seven health plans, physician groups can invest capital and staff attention in specific aspects of care management and data collection, knowing their efforts will receive meaningful and reliable measurement and reward.

A. Data Aggregation

Physician engagement is fostered by active participation in measure selection, assuring the validity of the measures. Equally important is the aggregation of data by physician groups across all participating health plans, enhancing the reliability of the reported results. The power of aggregated data is an underappreciated concept. It dramatically enhances the sample size and credibility of results.

This concept is best understood with examples. The largest participating plan in the IHA program has about 1.4 million members, less than twenty-three percent of the entire 6.2 million patient population. Even a plan of this size using its own data often lacks sufficient sample size to allow for statistical reliability. Furthermore, data from a single plan often cannot provide an accurate picture of the group's entire patient population. Herein lies the basis of the complaint regarding "dueling report cards," which motivated groups to push for a uniform program.

The use of aggregated data provides demonstration of the power of multiples. To illustrate this point, compare the number of measures and groups a plan can confidently report using its own data versus aggregated data. For the 2004 measurement year, those plans with less than 500,000 HMO enrollees could on average report against all clinical measures for only sixteen percent of its contracted physician groups using their own data, versus seventy percent using the aggregated dataset. Those plans with more than 1 million HMO enrollees on average could report against all clinical measures for thirty percent of its contracted physician groups using their own data, versus sixty-five percent using the aggregated dataset.

Health plans participating in the program have come to appreciate the practical advantages of using aggregated versus individual plan data. For measurement year 2004, six of the seven participating health plans based their incentive payments on the aggregated dataset which incorporates the results of the entire 6.2 million patient population. This not only allows for more extensive reporting, but gives the physician organizations much greater confidence in the reliability of the results and incentive payments.

B. Use of the Recommended Measurement Set

The power of multiples is only valid to the extent that participating plans use the recommended uniform measure set. A variety of issues, primarily philosophical and contractual, have caused plans to adopt the uniform measure set in varying degrees and with different timing. In 2003, some plans adopted the IHA recommended measure set in its entirety and exclusive to other quality performance measures, while other plans partially implemented the recommended measure set and/or added their own measures. By 2005 most of the plans had largely adopted the IHA recommended measure set and had added other measures of special interest.

IV. PERFORMANCE MEASUREMENT

The performance measurement set has three domains: clinical, patient experience, and information technology. There has been an ongoing debate concerning the relative weighting of these domains for the purpose of calculating incentive payments. Initially, the measurement domains were weighted clinical at fifty percent, patient experience at forty percent, and IT investment at ten percent. In the second and third years weightings were adjusted.[2] The current weighting is:

- Clinical at fifty percent
- Patient experience at thirty percent
- Information technology at twenty percent

The recommendations for payment weightings remains dynamic and will be adjusted in conjunction with performance measure set changes.

In the clinical measurement domain, about half of the indices are for preventive measures. The remaining clinical measures are in chronic care management. The current clinical measures are primarily focused on process measurement, but the use of outcome measures, such as control for HbA1c and LDL level, is an increasing focus of measure development.

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2. *See generally, e.g.*, Cheryl L. Damberg et al., *Paying for Performance: Implanting a Statewide Project in California*, 14 QUALITY MGMT. HEALTH CARE 66 (2005).

In the patient experience measurement domain there were initially four areas: communication with doctors, overall rating of care, specialty care, and timely access to care. In the 2005 measurement year, care coordination was added to this domain to focus on the efforts of physician groups to improve patient and population care management. This domain is currently measured and collected through the Consumer Assessment Survey ("CAS"). Many physician groups participated in the CAS and were familiar with the survey tool at the onset of the Pay for Performance program, but many more have been inspired to join CAS. In 2002, eighty physician groups participated in the CAS. By 2005, this figure more than doubled to 179 groups involving 35,000 physicians.

The existence of an established consumer/patient survey provides the advantages of a ready made tool with longitudinal data that can feed quality improvement efforts. It also minimizes the practical, operational challenges of launching a new survey. These advantages must be considered in the context of conflicts that naturally result as the original purpose and goals of the survey intersect with the objectives of Pay for Performance measurement.

At the onset of the Pay for Performance program development, information technology was not a consideration for the measurement set. Ultimately, it was decided that if truly "breakthrough improvements" were to be achieved, structural investments in information technology were essential. This resulted in the decision to reward groups for making this investment. Therefore, the information technology measurement domain was added.

Groups must be able to show capabilities in either of two categories to earn incentive payment rewards in the information technology measurement domain. They are: clinical data integration at the group level and clinical decision support at the point of care. An example of clinical data integration is the creation of data registries which integrate physician encounter, pharmacy and other data sources for specific chronic care patient populations at the physician group level. Clinical decision support at the point of care includes a number of qualifying activities such as telemedicine applications and wireless point of care e-prescribing.

Table 1: Evolution of IHA P4P Clinical Measures

2003 Measurement Year / 2004 Reporting Year	2004 Measurement Year / 2005 Reporting Year	2005 Measurement Year / 2006 Reporting Year
1. Childhood Immunizations (w/ 12-month continuous enrollment)	1. Childhood Immunizations (w/ 24-month continuous enrollment)	1. Childhood Immunizations (w/ 24-month continuous enrollment)
2. Cervical Cancer Screening	2. Cervical Cancer Screening	2. Cervical Cancer Screening
3. Breast Cancer Screening	3. Breast Cancer Screening	3. Breast Cancer Screening
4. Asthma Management	4. Asthma Management	4. Asthma Management
5. HbA1c Screening	5. HbA1c Screening	5. HbA1c Screening
6. LDL Screening (patients with cardiac event only)	6. HbA1c Control	6. HbA1c Control
	7. LDL Screening (patients w/ cardiac event & diabetics)	7. LDL Screening (patients w/ cardiovascular conditions & diabetics)
	8. LDL Control <130 (patients w/ cardiac event & diabetics)	8. LDL Control <130 (patients w/ cardiovascular conditions & diabetics)
	9. Chlamydia Screening	9. Chlamydia Screening
		10. Appropriate Treatment for Children with Upper Respiratory Infection
Encounter threshold: ≥2.7 enc./member year*	Encounter threshold: ≥3.25 enc./member year*	Encounter threshold: ≥3.25 enc./member year*
Payment weighting: 50%	Payment weighting: 40%	Payment weighting: 50%

* To ensure that reasonably complete data is used to create clinical scores, data streams with fewer than the specified number of encounters per member year will not be used to create the clinical rates from aggregating plan-supplied data.

Table 2: Evolution of IHA P4P Patient Experience Measures

2003 Measurement Year / 2004 Reporting Year	2004 Measurement Year / 2005 Reporting Year	2005 Measurement Year / 2006 Reporting Year
1. Specialty care	1. Specialty care	1. Specialty care
2. Timely access to care	2. Timely access to care	2. Timely access to care
3. Doctor-patient communication	3. Doctor-patient communication	3. Doctor-patient communication
4. Overall ratings of care	4. Overall ratings of care	4. Overall ratings of care
		5. Care coordination
Payment weighting: 40%	Payment weighting: 40%	Payment weighting: 30%

These measures are composites based on questions from California's Consumer Assessment Survey. For measurement year 2004 and beyond, the composite construction was modified to be consistent with the composites reported publicly in the consumer scorecard posted by the State Office of the Patient Advocate.

Table 3: Evolution of IHA P4P Information Technology Investment Measures

2003 Measurement Year / 2004 Reporting Year	2004 Measurement Year / 2005 Reporting Year	2005 Measurement Year / 2006 Reporting Year
1. Integrate clinical electronic data sets at group level for population management	1. Integrate clinical electronic data sets at group level for population management	No change from previous year
Activities include: • patient registry • actionable reports • HEDIS results	Activities include: • patient registry • actionable reports • HEDIS results	
2. Support clinical decision making at point of care through electronic tools	2. Support clinical decision making at point of care through electronic tools	
Activities include: • electronic prescribing • electronic check of prescription interaction • electronic retrieval of lab results • electronic access of clinical notes • electronic retrieval of patient reminders	Activities include: • electronic prescribing • electronic check of prescription interaction • electronic retrieval of lab results • electronic access of clinical notes • electronic retrieval of patient reminders • accessing clinical findings • electronic messaging	
Requires two activities, at least one in each Measure; each activity is worth 5%	Requires four activities of which at least two are in Measure 2; each activity is worth 5%	
Payment weighting: 10%	Payment weighting: 20%	Payment weighting: 20%

V. THE "PAY" IN PAY FOR PERFORMANCE

The Institute of Medicine report, *Crossing the Quality Chasm*, outlined a business case for quality which included broad recommendations for incentives to enhance quality.[3] California stakeholders attempting to implement these recommendations had a variety of standardized performance measures to draw upon, such as the NCQA HEDIS measures. However, standards for physician incentive payment methodologies were lacking. Individual health plans had experimented with incentive payments, but a broadly accepted standard for payment methodology had not emerged.

The absence of any uniform approach to incentive payment was further complicated by concerns about anti-trust. Collaborating on a uniform set of performance measures was allowable, but any agreement on a specific payment amount or payment methodology raised potential risks. Expert anti-trust counsel was engaged to provide guidance and establish boundaries for IHA and its stakeholders. The result was a decision to avoid specific recommendations by IHA about payment amounts or specific payment methodology. Rather, recommendations were made for a payment timeline, measure set weightings and general payment methodology. To preserve its financial autonomy, each respective plan considers these recommendations and individually determines its own methodology for incentive payment eligibility and amount of payment.

A. Timeline for Data Collection and Payment

Payment is typically made directly by health plans to physician organizations within six to nine months after completion of a measurement year. Payments for measurement years 2003 and 2004 have been completed, and payments for measurement year 2005 are expected to be completed by the end of October 2006. The lag between completion of the measurement year and payment reflects the time needed to complete data collection, required audits, and the aggregation of data sets across participating health plans and physician groups.

NCQA contracts with IHA to act as intermediary to aggregate information across health plans and physician organizations. Physician organizations can rely solely on health plan data or supplement this data through self-reporting. If performance for a specific measure is reported by both a health plan and a self-reporting group, NCQA will accept the more favorable score. Self-reporting groups totaled forty-two for the 2003 measurement year, increasing to eighty-two groups for the 2004 measurement year. All data

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3. *See* INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001).

submitted requires an independent audit prior to acceptance by NCQA, and these audits must be performed by an NCQA approved auditor.

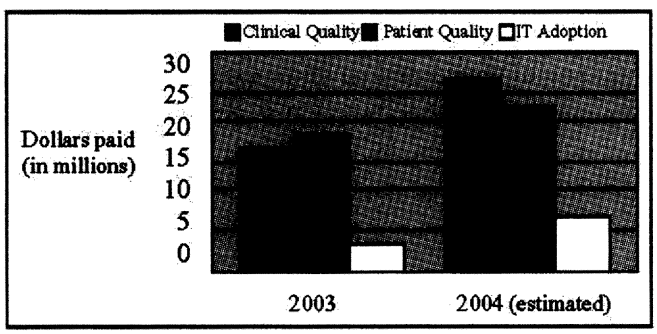
While self-reporting was initially expected to be an interim approach, it will most likely continue for the foreseeable future due to the nature of data collection in California's capitated, delegated environment.

B. Payment Amounts

Total incentive payments to physician groups equaled $37.4 million for the IHA metrics in the 2003 measurement year. For this first year, payouts for the clinical and patient experience domains were relatively equal at about $17 million each, with the balance of about $3 million paid for information technology. Payouts varied considerably by health plan. This variation reflects both the differences in enrollment and maximum payment thresholds of participating health plans. An average per member per month ("pmpm") amount provides a benchmark to compare payment amounts across health plan. These average amounts ranged from a low of $ .09 pmpm to a high of $.84 pmpm.[4]

As we go to press, total payments in 2005 for the second measurement year, 2004, are estimated to be about $54 million, reflecting substantial payment increases by several plans and the addition of a plan.

Table 4: Total Incentive Payments by Domain by Year



Payments are estimated at about $26 million for the clinical measures, approximately $22 million for the patient experience and the balance of about $6 million for information technology. Variation in average payment by plans

4. Integrated Healthcare Ass'n, *Transparency Report on 2004 Payouts (revised)*, http://www.iha.org/ftransp.htm (last visited Apr. 4, 2006). The reports were developed by the Rand Corporation and University of California, Berkeley, Hass School of Business.

continued, estimated to range from $.05 pmpm to $1.59 pmpm across the entire physician group population.[5]

Payments to individual physician groups ranged from none to $4.50 pmpm. Across all groups average incentive payment for the second program year equaled about 1.5% of total physician group compensation. This is relatively low compared to average pay for performance payments reported in a national survey. [6] The subject of active debate, the Five Year Plan presented later in this document recommends increasing payment up to ten percent of total physician compensation. At the onset of the program, the intention was for health plans to fund incentives without lowering base physician group reimbursement. Increasing incentive payments up to ten percent of total compensation will require alternative approaches which have not been resolved.

The Pay for Performance incentive payments do not represent the total incentive amounts paid by plans to physician groups. Health plans also pay incentives for non-IHA sponsored quality measures and to promote better data collection, generic pharmacy utilization, and other purposes.

At the request of its stakeholders, IHA engaged the RAND Corporation to develop a "Transparency Report" on payment amounts and methodology by health plan. This report is available for measurement year 2003 at http://www.IHA.org.

C. Payment Methodologies

Health plans have progressively adopted the recommendations developed by IHA during the measurement years 2003 through 2005. Table 5 presents an overview of the general payment methodology implemented by participating health plans for measurement year 2004.

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5. Integrated Healthcare Ass'n, *Transparency Report on 2005 Payouts*, http://www.iha.org/ftransp.htm (last visited Apr. 4, 2006). The reports were developed by the Rand Corporation and University of California, Berkeley, Hass School of Business.

6. Geof Baker, National Webcast on Pay for Performance Issues and Trends (Nov. 17, 2005) (on file with Integrated Healthcare Ass'n).

Table 5: Payment Methodology by Participating Health Plans

Use absolute threshold to qualify for payment	No	No	No	No	No	Yes, thresholds based on pervious years experience.	No
Use relative percentile ranking to determine payment	Yes, for each measure only groups performing in top quartile eligible.	Yes, groups in the 20th to 100th percentile paid on sliding scale.	Yes, groups in 30th to 100th percentile paid on sliding scale.	Yes, groups in 50th to 100th percentile paid on sliding scale.	Yes, for each groups in 50th to 100th percentile paid on sliding scale.	No	Yes, groups in 50th to 100th percentile paid on sliding scale.
Pay for all IHA recommended Clinical Measures	Yes	Yes	Yes	Yes	Yes	No, pay for most IHA Clinical Measures	Yes
Pay for IHA recommended Patient Experience Measures	Yes	Yes	Yes	Yes	Yes	No, pay for patient satisfaction using own survey.	Yes
Pay for IHA recommended Information Technology (IT) Measures	Yes	No, do not pay for IT.	Yes	Yes	Yes	No, do not pay for IT.	Yes
Pay using aggregated data set	Yes	Yes	Yes	Yes	Yes	No	Yes
Pay using IHA recommended weightings	Yes	No, pay for additional measures and exclude IT.	Yes	Yes	No, weights adjusted for Patient Experience and IT.	Yes	No, weights adjusted slightly.

VI. PUBLIC REPORTING AND PROGRAM RESULTS

Transparency via public reporting of physician group performance is a key part of the Pay for Performance program. To avoid creating yet another "dueling report card," IHA explored existing reporting efforts for potential collaboration. The California State Office of the Patient Advocate ("OPA") creates an annual, consumer-focused public score card for HMO performance, so it was a likely place to begin. OPA agreed, and the result is a clinical scorecard for California physician groups.

IHA provides the clinical Pay for Performance aggregated data to OPA for its public score card of physician groups. The use of the data is governed by the Pay for Performance Steering Committee. The layout and statistical underpinnings of the report format are the responsibility of OPA, with input from IHA.

The physician group public score card is available in multiple media and languages. A web-based version is located on the OPA website at http://www.opa.ca.gov (Figure 1). Consumers select a county to see the overall performance of all the groups that provide services in their area. They can then scroll down to see performance on each measure for each group. Print versions are available in English, Spanish and Chinese, and are distributed through major drug store chains and public libraries. Physician groups have reported that they are in favor of public reporting and that it provides strong motivation for improvement.

Figure 1: Sample of web-based physician group public score card

Rating Key Excellent ★★★ Good ★★ Fair ★ Poor ☆

Medical Group Ratings

California Medical Group	Getting the Right Medical Care	Patient Rating of Care Experiences
Medical Group A	★	★★
Medical Group B	★★	★★
Medical Group C	★★	★
Medical Group D	★★★	★★
Medical Group E	★★	☆
Medical Group F	★★	★★

Although Kaiser Permanente does not participate in the financial incentive portion of Pay for Performance, the Kaiser medical groups expressed interest in participating in the public score card. The Steering Committee was in favor, on the condition that the extensive Kaiser medical groups be reported in service areas comparable to other participating physician groups. As a result, Kaiser Northern California reported five service areas on the 2005 score card, and Kaiser Southern California plans to report twelve service areas starting with the 2006 score card. Consequently, consumers have a more complete picture of the quality and patient satisfaction ratings for all of the physician groups in their geographic area.

A. Program Results

Two complete years of results are now available. "Breakthrough improvement" has not been achieved, but physician groups have collectively improved across each measure in all three domains from Year 1 to Year 2. Undoubtedly, some of the improvement is due to better data collection, as this has been a major focus of the physician groups. However, program evaluators indicate that there were also true gains in quality improvement based on both the improved results and interviews with leadership at representative physician groups.

Table 6: Sample of Improvements in Clinical Measures

Measure	Number of Groups Scored	Number of Groups Improving	Pct of Groups Improving	Average Pct Point Change in Performance
Clinical				
Clinical Average	46	40	87.0	5.3
Breast Cancer Screening	167	94	56.3	1.1
Cervical Cancer Screening	168	130	77.4	5.4
Asthma Overall	132	94	71.2	2.6
HbAlc Screening	166	100	60.2	3.5
Cholesterol Screening (Cardiac Patients)	46	41	89.1	10.2

Table 7: Patient Experience: Improvement across Many Physician Groups

Measure	Number of Groups Scored	Number of Groups Improving	Pct of Groups Improving	Average Pct Point Change in Performance
Patient Experience				
Survey Average	108	71	65.7	1.2
Rating of Doctor	115	62	53.9	0.5
Rating of All Health Care	115	73	63.5	1.4
Specialist Problems	109	64	58.7	2.2
Rating of Specialist	108	63	58.3	0.8

B. Clinical Results

Eighty-seven percent of the groups reporting all clinical measures improved their overall clinical score by an average of 5.3 percentage points from Year 1 to Year 2. Performance on the individual clinical measures improved between 1.1 and 10.2 percentage points (Table 6). Actual rates are still slightly lower than the national average, but the gap is decreasing.

C. Patient Experience Results

In the second year, improvement also occurred in overall patient experience performance, with sixty-six percent of groups increasing by an average of 1.2 percentage points. Improvement was seen in each of the survey questions used in both 2003 and 2004 that comprise patient experience measures of overall ratings of care and specialty care, as presented in Table 7.

Many physician groups decided to participate in the Consumer Assessment Survey ("CAS") used to measure patient experience after Pay for Performance began. Participation increased thirty-eight percent, from 130 groups in 2003 to 179 groups in 2005. Looking only at groups who have participated in CAS since the beginning of Pay for Performance, their improvement ranged from three to five percentage points, substantially higher than the improvements for the entire population of physician groups. This suggests that continued participation promotes greater improvement.

D. IT Adoption Results

The most dramatic improvements were seen in IT Adoption. From Year 1 to Year 2, there was a fifty-four percent increase in the number of groups qualifying for at least partial IT credit. In Year 2, over half of the groups reported some IT capability, versus only one third for Year 1. Of the groups who received no credit for IT in Year 1, thirty-four percent demonstrated some IT capability in Year 2.[7]

In general, physician groups have demonstrated a greater ability to integrate electronic clinical datasets for population management than to use decision support technology at the point of care (Table 8). Nearly forty percent of physician groups are able to integrate datasets to generate actionable reports or HEDIS results, and over a quarter have a disease registry or data warehouse. Compare this to the approximate ten percent of groups that produce electronically generated prescriptions, automatically check drug to drug interactions before prescribing, or generate preventive or chronic care reminders electronically.

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7. T. Williams et al., *Pay for Performance and its Influence on the Use of Information Technology in Physician Organizations*, 21 J. MED. PRAC. MGMT. (forthcoming 2006).

Table 8: Improved 2004 IT Adoption Results

IT Measures	Pct of Groups	Pct of Groups	Pct Increase in Groups Qualifying from 2003 to 2004
Integration of Electronic Clinical Datasets			
Actionable Reports	24.7%	39.1%	58.7%
Registry or Data Warehouse	16.7%	25.8%	54.0%
HEDIS Results	11.2%	37.3%	234.4%
Point of Care Decision Support Technology			
Electronic prescribing	4.7%	8.9%	91.1%
Electronic drug checks	4.2%	12.9%	207.9%
Electronic retrieval of lab results	16.7%	27.1%	61.9%
Accessing clinical notes of other practitioners	11.6%	21.3%	83.5%
Physician Preventive & Chronic Care Reminders	7.0%	12.0%	72.0%

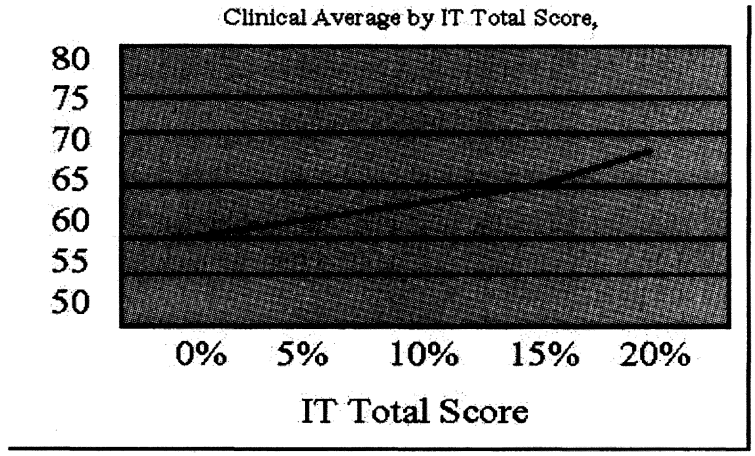
Although there has been a remarkable acceleration in the adoption of IT to support care management, the reality remains that nearly half the physician groups in California have not demonstrated any capacity in this area.

E. Correlation between Clinical and IT Performance

Adoption of IT systems for purposes such as building patient registries for at-risk or chronically ill patients and use of electronic decision support systems at the point of care offer potential improvements in the quality of care. The physician groups who received full credit on the IT measures had average clinical scores that were nine percentage points higher than physician groups who showed no evidence of IT adoption.

Further progress toward the ultimate objective of breakthrough improvement will require adoption of many program enhancements outlined later in this report, including increased incentive payments as the measure set becomes more comprehensive and performance expectations escalate.

Figure 2: Correlation between Clinical and IT Performance



VII. MANAGEMENT OF THE PROGRAM

Management of the program has naturally developed over time, and is not static. At present, the organizational and administrative structure is as follows:

A. Governance

The IHA Board provides oversight and stewardship of the program, delegating active program governance to a Steering Committee composed equally of members from three classes: health plans, physician organizations and at-large. The at-large member class includes purchaser and consumer representatives, plus individuals from organizations that contribute technical and policy expertise to the committee, such as the Center for Disease Control, local Quality Improvement Organizations ("QIO"), and state government. The Steering Committee meets quarterly and determines policy (e.g. changes to measurement set) and strategy (e.g. program expansion to new populations).

A Planning Committee was recently formed, reporting to the Steering Committee, composed of two members from each member class for a total of six members. This group meets monthly to consider key policy and strategic issues and to make recommendations to the Steering Committee.

A Technical Committee provides oversight of development of the measurement set, data collection and related technical issues. This committee includes representation from health plans, physician organizations, purchasers and technical experts. It is charged with developing the measure set, measure specifications and approaches to data collection. This committee meets quarterly.

The Five Year Plan includes a recommendation to form a new Payment Committee to focus on issues related to payment amount and methodology, subject to creation of a "safe haven" to allow discussion to occur without risk of anti-trust concerns. This important step is needed to allow an active dialogue about the proper alignment of measures, rewards and expectations.

B. Administration

A team of technical staff supports the work of all the governing committees and includes IHA staff and staff contracted by IHA from the PBGH and NCQA. This team plays a critical role in supporting the governing committees and program administration.

The evaluation team consists of researchers from the RAND Corporation and U.C. Berkeley's Haas School of Business. They are conducting a five year evaluation of the program with funding provided by the CHCF.

The following components of program activity require funding:

1. Technical Support—measure development and testing
2. Data Aggregation—collecting, aggregating and reporting performance data
3. Governance Committees—meeting expenses and consulting support services
4. Stakeholder Communication—web casts, newsletters and annual meeting
5. Program Administration—direct and indirect IHA staff and related expenses
6. Evaluation Services—program evaluation and consultative services

Initial grant funding provided by the CHCF was critically important to support performance measure set development and testing. Because the program was ground breaking, new measure development for the information technology domain was required, and extensive testing was needed prior to the use of existing HEDIS measures at the physician group level. A large pilot was conducted during 2002 involving voluntary data collection for forty-nine physician groups before launching the program.

The CHCF also funded a five-year program evaluation (2003 – 2007) and ongoing technical support on a step-down basis through 2007. Total grant funding provided by CHCF for various aspects of the program exceeds $1 million to date, with total funding committed through 2007 projected to exceed $2 million.

The program-specific and evaluation funding by CHCF was done in partnership with the Robert Wood Johnson Foundation as part of the national Rewarding Results initiative. This initiative supported seven unique pay for performance programs around the country and fostered communication between the respective programs.

GlaxoSmithKline (GSK) has provided on-going financial support for activities related to governance committees and stakeholder communication.

The participating health plans have funded data aggregation through annual fees based upon a pro-rata share of program population membership. As grant funding begins to step down, program stakeholders have sought a mechanism to provide ongoing program funding. To accomplish this, an "administrative surcharge" was adopted. This is a surcharge against bonus amounts paid by the health plans to the physician organizations. The initial surcharge equals 7.5 cents per member per year or $465,000 annually (7.5 cents x 6.2 million program members). As grant funding diminishes, the intention is to increase the surcharge to incorporate total annual program expenses.

It is important to note that the program uses only electronic data for clinical measurement, avoiding the high costs of patient chart review, and an already existing survey instrument for patient experience measurement.

VII. LOOKING AHEAD: THE NEXT FIVE YEARS (2006 – 2010)

In 2004 the Steering Committee formed a Planning Committee to develop a Five Year Plan for the program. The committee developed initial recommendations and received stakeholder feedback that was ultimately incorporated into a set of recommendations formally adopted in late 2005.[8]

During the course of this process, a number of recommendations put forward by the Planning Committee were adopted and are in various stages of implementation. Examples include: the decision to expand Pay for Performance into Medicare Advantage, development of efficiency measures, development and testing of overuse measures, action to implement a surcharge to fund program administration, steps to strengthen program governance, and development of a national Pay for Performance conference.

The final product of this process was a revision of the program mission, priorities, and recommendations.

Program Mission

Create breakthrough healthcare performance by promoting an integrated, organized, and efficient delivery system through alignment of incentives amongst all stakeholder groups.

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8. Integrated Healthcare Ass'n, *Pay for Performance Five Year Plan*, http://www.iha.org/wpapers.htm (last visited Apr. 4, 2006).

Program Priorities

The Planning Committee possesses a strong sense of urgency to drive an aggressive agenda, particularly over the next two to three years. An increased pace of program development is deemed necessary for the following reasons:

- Concerns by purchasers and health plans that continuing the current narrow measure set will promote "teaching to the test," rather than advancing quality improvement.
- Potential lack of engagement by plans and purchasers if efficiency measures are not adequately emphasized.
- Potential lack of engagement by providers if incentive payments are deemed inadequate.
- Rapid advances in measurement science.

Three major priorities identified by the Planning Committee include:

1. Aggressive expansion of the measure set, which promotes integrated and efficient care delivery and leverages advances in measurement science.
2. Increased financial incentives to facilitate performance breakthrough.
3. Strengthened administration to support an increasingly sophisticated program.

It became clear as input was received from various stakeholder groups that expansion of the measure set should not be based solely on a target number of measures. Rather, expansion should be based on the right selection and a manageable number of measures each year, with increasing focus on healthcare outcomes, introducing them at a pace that encourages physician groups to carefully design efforts that support the goals of the program.

Input from the health plans emphasized the importance of also considering appropriate use of resources and the total cost to care for a population. Not only is this one of the Institute of Medicine's six healthcare performance domains,[9] but it is also necessary for health plans to be able to make a business case for expanding their budget for pay for performance incentive payments. This should be a two dimensional approach, with a correlation between cost and performance.

9. *See* INST. OF MED., *supra* note 3.

Recommendations

1. Increase incentive payments proportional to improvements in performance outcomes.
   a. Increase incentive payments to up to ten percent of total physician compensation by 2010.
   b. Incorporate risk adjustment into capitation.
   c. Pay for improvement on an interim basis.
   d. Create a "safe haven" to advance consistent payment methodologies.

2. Aggressive development and expansion of the performance measurement set.
   a. A comprehensive clinical domain that incorporates outcomes and specialty care.
   b. Addition of an efficiency domain, including appropriate resource use measures.
   c. Revise the patient experience domain and shift to a methodology with more meaningful results for physician groups.
   d. Expansion of the information technology domain to a broader IT-enabled "systemness" domain that fosters integrated care processes.
   e. Expansion of the measurement set to incorporate Medicare Advantage.

3. Strengthen P4P administration to support an increasingly sophisticated program.
   a. Use the "administrative surcharge" as an initial step to develop a self-sustaining business model by 2008.
   b. Use of the common, aggregated dataset by all participating plans for incentive payment calculation by 2006.
   c. Incorporate mechanisms to speed the consensus-based decision making process, while maintaining multi-stakeholder governance.

4. Public Reporting, Research and Public Relations
   a. Continue OPA collaboration.
   b. Support use of aggregated dataset.
   c. Approve use of data for selective research projects.
   d. Develop public relations capability.

IX. LESSONS LEARNED

IHA and California Pay for Performance program stakeholders are often asked, "What lessons have you learned?" This important question generates a variety of responses, but consensus on some key points has emerged.

Begin by developing a set of guiding principles upon which all stakeholders can agree, and look to them when faced with disagreements.

- Set ambitious long-term performance improvement objectives, but modest short-term process goals.
- Trust is the glue that binds collaboration, and it is best developed through mutual achievement.
- Start with a limited number of measures at the program's onset. All stakeholders have limited capacity and will respond if expectations are reasonable.
- Performance measures are the "tip of the iceberg," with unending detail beneath in the form of measure specifications, barriers to data collection, and inevitable inconsistencies requiring practical solutions. Therefore, test measures prior to implementation.
- Seek ways to leverage the "power of multiples" through uniform measurement, common reporting, data aggregation, and payment by multiple sources of funding. Especially seek to measure, pay and report at the highest organizational level (e.g. physician group vs. individual physician) and with the largest population (e.g. multiple payers/purchasers vs. individual).
- Payment incentives are indeed a powerful catalyst and motivator. Public and peer recognition are also important incentives for performance not to be underestimated.
- A neutral conveyor that represents all stakeholder groups equally is important for building trust and collaboration.
- Consensus decision making can be painfully slow, but essential. Physicians must believe measurement is fair, and payers and purchasers must believe payments can be justified.
- Transparency in all aspects of the program, including governance and reporting, enhances trust among participants.
- There is no substitute for actively engaged leaders in the decision making and governance process.

X. APPLICATION BEYOND CALIFORNIA

California has unique characteristics in the organization of its medical delivery system. Most notable is the prevalence of organized, capitated

physician groups and the multitude of large commercial payers, with no one dominating the market. These factors might dissuade observers from attempting to replicate the California Pay for Performance model or similar approaches in other communities. However, many key elements of the program are independent of delivery system characteristics. This is evidenced by the alignment of many of the program's guiding principles and "lessons learned" with recent attempts to develop national guidelines for pay for performance programs.[10]

The purpose of this report is to promote pay for performance. We have demonstrated that in our highly fragmented U.S. healthcare system, broad-based quality initiatives can be operated successfully. Fundamental components of the California Pay for Performance program are replicable in most communities, and the success in California should serve as an inspiration for any group attempting to advance healthcare quality improvement in their community.

This report is also meant to inspire policy makers and leaders both locally and nationally to consider the opportunities that begin with collecting community-wide population data and using it to measure and incentivize performance. Why not collaborate to collect and aggregate data across payers, both public and private, and use that information in combination with uniform measures to create incentives, reward performance and report results publicly?

Why not use organizations and structures that pre-exist in communities, whether they are health plans, employers or physician organizations, to lead such efforts? Why not utilize existing capabilities, such as Quality Improvement Organizations, to gather data on a community, state, or regional level from all payers? Why not begin to build local infrastructure and capacity to collect data, measure performance, pay and report while the national efforts to develop uniform measures evolve?

Hopefully, this report and the dialogue at the National Pay for Performance Summit (Los Angeles, February 2006) will inspire other communities to raise these questions and help to advance understanding of the practical realities involved in creating a community-wide pay for performance program. It is our sincere hope that this will contribute to the groundswell effort emerging in this county to "do something" to realize the potential of our system of healthcare.

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10. Christopher B. Forrest, Victor V. Villagra & James E. Pope, *Managing the Metric Versus Managing the Patient: The Physician's View of Pay for Performance*, 12 AM. J. MANAGED CARE 85, 85-87 (2006).