



## **Integrated Healthcare Association (IHA) Pay for Performance (P4P) Program**

### **Overview**

#### ***About the IHA Pay for Performance (P4P) program***

The IHA P4P program is the largest non-governmental physician incentive program in the United States to provide medical groups with financial rewards based upon performance against quality and efficiency benchmarks. The goal of the program is to create a compelling set of incentives that will drive breakthrough improvements in clinical quality, efficiency and the patient experience through: (1) a common set of measures; (2) a public report card; and (3) health plan incentive payments. The adoption of a common measure set of performance measures used by all health plans as the basis for reward and recognition allows the P4P stakeholders to use collective market forces to drive excellence in patient care. The aggregation of data across all participating health plans significantly improves the validity and reliability of measurement.

The physician groups benefit by being rated by one common rating system, rather than by competing and conflicting systems used by their various health plan partners. Having a standardized measure set also benefits consumers, since California consumers are able to get comparable information on the clinical performance of the 221 physician groups, and a public report card is published on the website of the state's Office of the Patient Advocate ([www.opa.ca.gov](http://www.opa.ca.gov)).

#### ***Participants***

221 medical groups, representing approximately 35,000 physicians, participate, providing care for about 10 million HMO members. Seven California health plans participate in incentive payments and public reporting – Aetna, Anthem Blue Cross, Blue Shield of California, CIGNA, Health Net, PacifiCare/UnitedHealthcare, and Western Health Advantage. Kaiser Permanente participates in public reporting only.

#### ***P4P Common Measure Set***

The IHA P4P common measure set is designed to include measures that are evidence-based and relevant to California consumers. The measure set is dynamic, with new measures added each year and an increasing focus on outcome measures.

There are five domains of measures:

- ***Clinical quality:***

Measures preventive care – breast, cervical, and colorectal cancer screening, Chlamydia screening, and childhood immunizations; treatment of acute conditions – upper respiratory infections, bronchitis, pharyngitis, and low back pain; plus treatment of chronic conditions – asthma, diabetes and coronary artery disease. The measure set incorporates process and outcome measures, using standardized national measures wherever possible.

- ***Patient experience:***

Measures patient ratings of care they received from their doctor and other providers in the physician group (e.g., communication with their doctor, timely access to care, access to specialist, and overall ratings of care). The ratings are based on California's Patient Assessment Survey, in conjunction with the national CAHPS survey tool.

- ***IT-Enabled Systemness:***

Recognizing the essential contribution of IT to making care systematic, the goal of the domain is to measure and reward physician groups that provide support and infrastructure to their physicians for systematic processes of care that affect all patients. The domain builds on the foundation of the P4P IT measures of population management (e.g., patient registries for those with chronic illness) and point of care activities (e.g., use of an electronic medical record, or using physician or patient reminder systems at the point of care), and expands to include measures of care management processes, access and communication standards, and individual physician-level measurement and incentives.

- ***Coordinated Diabetes Care:***

Promotes focused efforts to redesign processes and create a systematic approach to diabetes care in order to achieve truly breakthrough clinical improvement. Measures in this domain are all diabetes-related and include process and outcome clinical measures; population management activities such as registries, actionable reports and individual physician level measurement; and care management processes.

- ***Efficiency:***

Responding to soaring healthcare costs and double-digit health insurance premium increases, IHA is adding efficiency measures to its P4P program, starting with generic prescribing for measurement year 2007. The new measures, for the first time, add information on cost and resource use alongside existing P4P quality measures. Total resources used to treat a specific patient population over a specific period of time, as well as resource utilization in particular areas, will be compared across physician groups, and will be risk-adjusted. This will give a more comprehensive assessment of physician group performance and allow an appraisal of the value of healthcare spending. The new efficiency measures support the goal of delivering reliable, consistent, evidence-based clinical care at an affordable cost by reducing waste and thus systematically improving the quality of patient care.

### ***P4P Results***

P4P program results for measurement year 2008, the sixth year of the P4P program, showed continued modest improvement in most clinical measures. Patient Experience scores showed a slight upward movement across all measures. Adoption of most IT activities continued to increase, and more than two-thirds of physician groups demonstrated some health IT capability.

Of the 229 physician groups participating in the IHA 2008 P4P program, those whose overall performance score was in the top 20 percent statewide were selected for recognition as top performers. An overall performance score was used to determine award winners. For each physician group, composite scores in each of the four P4P measurement domains were calculated and then weighted according to the recommended P4P payment weightings: Clinical Quality – 55% (including 15% for Coordinated Diabetes Care Clinical measures), Patient Experience – 25%, Coordinated Diabetes Care Registry – 5%, and IT-Enabled Systemness – 15%. This resulted in an overall performance score.

For the fourth year, the 2008 P4P results included scores for Kaiser Permanente’s physician groups serving both Northern and Southern California. However, these scores are used for the purpose of public reporting and performance awards, and are not used for bonus payments.

### ***Financial Rewards***

The 2008 measurement year results were used by health plans to calculate the 2009 bonuses distributed during the third and fourth quarters of 2009. Each plan determines its own budget and methodology for calculating bonus payments to the physician groups.

Total payouts from health plans to California physician groups are noted below:

<b>Payout Year</b>	<b>Measurement Year</b>	<b>Total Payout</b>
2004	MY 2003	\$ 38M
2005	MY 2004	\$ 54M
2006	MY 2005	\$ 55M
2007	MY 2006	\$ 65M
2008	MY 2007	\$ 52M
2009	MY 2008	\$ 52M

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For more information, see these IHA white papers:

*The California Pay for Performance Program: the Second Chapter* at [iha.org/P4P\\_WP\\_2](http://iha.org/P4P_WP_2) and *Advancing Quality through Collaboration: the California Pay for Performance Program* at [iha.org/P4P\\_WP](http://iha.org/P4P_WP).