Value Based Pay for Performance in California
Using Alternative Payment Models to Promote Health Care Quality and Affordability

VALUE BASED P4P—CALIFORNIA STYLE
Across the United States and California, health care costs and quality vary a great deal. Many experts believe piece-meal, volume-based fee-for-service payment encourages fragmented and inefficient care that not only costs more but is lower quality. Public and private payers are developing alternative payment models to encourage providers to integrate care and be accountable for both the quality and cost of patient care. Many alternative payment models, including IHA's Value Based P4P program, share savings—known as upside risk—between payers and providers tied to the cost and quality of patient care. Based on both quality and cost benchmarks for enrollees in commercial HMO and POS products in California, IHA's Value Based P4P program has four key components:

- A common set of measures and benchmarks.
- Health plan incentive payments.
- Public reporting.
- Public recognition awards.

COMMON MEASURES
The adoption of a common set of performance measures and benchmarks by all health plans and physician organizations helps harness collective market forces to drive improvements in patient care. Additionally, aggregation of data across participating health plans significantly improves measurement reliability and validity and decreases reporting burden for physician organizations by eliminating competing and conflicting health plan rating systems. The IHA Value Based P4P common measure set relies on evidence-based measures in four areas:

- Clinical Quality
  Measurement focuses on six priority areas: prevention, cardiovascular, diabetes, maternity, musculoskeletal and respiratory conditions and includes process and outcome measures, using standardized national measures when possible.

- Patient Experience
  Patient ratings of care received from their doctor and other providers in the physician organization—for example, communication with their doctor, timely access to care, coordination of care and overall ratings of care—based on the national Clinician & Group CAHPS survey tool.

- Meaningful Use of Health Information Technology (HIT)
  To align with federal electronic health record (EHR) initiatives, IHA's Value Based P4P methodology gives credit to physician organizations based on the percentage of their primary care physicians successfully attesting to Stage 1 or 2 meaningful use under the Medicare and Medicaid EHR Incentive Programs. Promoting HIT adoption and use also will advance the use of electronic clinical quality measures.

- Resource Use and Total Cost of Care
  Appropriate resource use (ARU) measures are based on inpatient readmissions, inpatient and outpatient utilization, emergency department visits and generic prescribing. Since 2011, a measure of Total Cost of Care (TCC), based on actual payments for each HMO/POS enrollee's care, including professional, pharmacy, hospital and ancillary services, and consumer cost-sharing has been calculated and risk adjusted for each physician organization.
IHA partners with the California Office of the Patient Advocate to publicly report Value Based P4P results annually. The online quality report card compares physician organization performance within a county, showing overall performance and topic areas, as well as scores on individual measures. Starting with 2014 results, physician organizations’ performance on total cost of care also will be reported.

**P4P PUBLIC RECOGNITION AWARDS**

Each year, IHA recognizes physician organizations that have achieved strong results. The Excellence in Healthcare Award winners must attain performance rankings in the top 50 percent for clinical quality, patient experience and cost performance. And, in memory of his contributions and dedication to quality improvement, the Ronald P. Bangasser Memorial Award for Quality Improvement recognizes the physician organization in each of eight California regions that demonstrated the greatest relative year-over-year improvement in quality performance.

**HEALTH PLAN INCENTIVE PAYMENTS**

Working with health plan and physician organization representatives, IHA developed a recommended design for Value Based P4P incentive payments; each health plan is free to adapt the design and is solely responsible for making any payments. The incentive design incorporates all of the measurement areas: clinical, patient experience, meaningful use of HIT, resource use, and total cost of care.

At its core the Value Based P4P incentive design is based on shared savings, adjusted for quality performance. Savings are generated by improvements in resource use: inpatient care (including readmissions), emergency department use, outpatient procedures, and generic prescribing. Any net savings are shared between the health plan and the physician organization. Without shared savings, there are no incentive payments. Further, to be eligible to earn any share of savings, physician organizations must first meet minimum quality standards, as well as demonstrate a total cost of care trend of no more than the consumer price index (CPI) plus 3 percentage points.

The first health plan paid incentives using the value-based design in 2014, and health plans representing the majority of non-Kaiser membership have committed to adopt the design for 2015. In its initial implementation, some physician organizations have raised concerns that resource use reductions are the only path to incentives, because high-performing physician organizations—those producing strong quality results with low resource use—receive no financial incentive for maintaining their outstanding performance. As a result, an attainment incentive is under consideration that would reward physician organizations that reach targeted levels of resource use—even if no savings are generated.

**PUBLIC REPORTING**

Standardized measures also allow consumers to compare the performance of participating physician organizations.