

# Value Based Pay for Performance (P4P) for Physician Groups: Key Design Decisions

*Initially aimed solely at quality improvement when launched in 2001, the Integrated Healthcare Association (IHA) California-based P4P program now emphasizes value by including utilization (resource use) and cost measures alongside quality measures. By merging quality, patient experience, resource use, and total cost of care measures into a single incentive program across multiple health plans, the program is now one of the country's largest alternative payment models. Value Based P4P relies on shared savings from more efficient care delivery to reward physician organizations (POs) that perform well on both quality and cost metrics. Today, participation in IHA's Value Based P4P program includes 10 health plans and more than 200 California POs caring for about 9.6 million Californians enrolled in commercial health maintenance organization (HMO) and point of service (POS) products; over \$550 million has been paid out since inception. As purchasers, payers, and providers work to advance high-quality, affordable, patient-centered care—or high-value care—examining key design and implementation decisions in the IHA Value Based P4P program can inform similar efforts across the country.*

## Five Key Design Decisions

Gaining critical mass across public and private payers in holding providers accountable for both the quality and cost of care through aligned performance measures, incentives, and public reporting is essential to scaling the triple aim of better care, better health, and smarter spending. While local market priorities and conditions vary, the IHA Value Based P4P program experience to date can be instructive on some of the most important—and challenging—design decisions in the shift to reward value, including:

- Rewarding performance improvement vs. attainment.
- Basing incentive payments on total cost of care vs. utilization.
- Setting meaningful benchmarks.
- Developing tools to enable performance improvement.
- Fostering broad and public use of results.

## Rewarding Improvement, Attainment or Both?

Incentives that reward performance can focus on improvement or attainment. The initial IHA value-based incentive design focused on improvement for two reasons. First, rewards based on improvement motivate broader participation than

rewards tied to attainment of specific thresholds, which focus on top performers. With attainment awards, lower-performing POs are likely to disengage if they perceive that targets are out of reach. Second, an improvement approach allows the program to generate incentive dollars from shared savings—a major advantage from the health plan perspective.

While the decision to focus the Value Based P4P design on improvement (shared savings) was carefully considered and vetted, the first year of implementation and payments surfaced concerns that top-performing POs would be ineligible for incentive payments under the new design. POs that had already achieved substantial reductions in inpatient bed days and readmissions—key drivers of shared savings under the improvement-oriented design—faced a high bar for continued reductions and were at risk of disengaging. Commitment to the guiding program principle of retaining broad participation led to the incorporation of an attainment incentive in 2015. Now, there are two pathways to incentive payments: improvement incentives that reward year-over-year gains and attainment incentives that reward continued excellence in resource stewardship relative to population benchmarks. The incentives are then combined; POs that both improve and meet attainment benchmarks are eligible to earn both incentives.

## Basing Incentives on TCC vs. Utilization

The two main candidates for incorporating cost into the incentive design—utilization and total cost of care—pose tradeoffs along four main dimensions:

- **Aim:** How strong is the link between performance measures and desired outcomes? At a system level, the goal is higher value—better quality at lower or comparable costs. Total cost of care is directly tied to value, while utilization is an intermediate step. In fact, because cost is the result of both utilization and price, reductions in utilization may be insufficient to drive cost reductions.
- **Control.** How much control do POs have over what is being measured? Pricing—facility and drug—is a key factor in total cost, but POs often have little price information to factor into referral decisions because of confidential negotiated rates between plans and hospitals. In contrast, POs have more control over such decisions as whether a patient is admitted to a facility at all or whether a brand or generic drug is prescribed.

- **Engagement.** Are providers motivated to perform well? Most providers believe that strong primary care coordination can potentially reduce admissions, emergency department visits, and readmissions. Improving patient care and quality is highly motivating from a clinician perspective, and reducing unnecessary utilization has a beneficial side effect: lower costs. By contrast, the goal of reducing total cost of care is less compelling to clinicians.
- **Feasibility.** How difficult is it to get accurate results? Technically, tracking TCC is much simpler and less costly than relying on resource use measures for a variety of reasons.

While early Value Based P4P design discussions favored TCC as the basis for shared savings, the decision to use utilization measures was driven by the need to engage POs in a meaningful way. The rationale for selecting utilization as the basis for incentive payments at the time was clear, but the pendulum is now swinging back toward total cost of care. TCC is in use for awards and public reporting, prompting renewed interest in reconsidering the role of TCC in the Value Based P4P incentive.

### Setting Meaningful Benchmarks

Development of any incentive design requires benchmarks to assess performance. Value Based P4P stakeholders initially leaned toward external benchmarks. Using comparison data separate and distinct from participants' experience has natural appeal: The independence of the benchmarks from the measured population prevents rewarding performance improvement that is part of—but no better than—secular trends.

In practice, however, external benchmarks are frequently impractical—they may not be available, timely, comparable, or applicable to the need. Another obstacle is that the specifications may be proprietary, making it impossible to assess comparability. Benchmarks based on the participants' patient population are an alternative to external benchmarks. While using benchmarks based on participants' patient population may seem like a compromise of necessity, they are often more meaningful and credible from a provider perspective. Benchmarks based on “peer” performance represent attainable, though perhaps challenging, targets.

### Investing in Performance Improvement

An important component in the transition from a quality-only to value-based incentive design has been developing tools to help participating POs and health plans understand and use the results to improve their performance—the ultimate goal of any P4P program. To support participants' ability to understand their results and make them actionable, the program has invested in developing modeling and reporting tools, including an online reporting portal and interactive modeling tools. The reporting portal visualizes and communicates performance to

POs and health plans on quality, utilization, and cost metrics collected in Value Based P4P. POs see performance for each plan they contract with, as well as in aggregate; health plans see PO-specific breakdowns for POs they contract with, as well as in aggregate. Additionally, underlying measure-specific data, aggregated data, and thresholds are available as .csv downloads so participants can manipulate and visualize their own data. The program also provides spreadsheet-based interactive modeling tools to all participants that allow both POs and health plans to assess the impact of “moving the dial” on each design component.

### Fostering Public Use of Results

From inception, performance results were used for public reporting and PO recognition. To signal the change in philosophy that quality alone is no longer sufficient, it was critical to incorporate cost into these nonfinancial incentives. IHA partners with the [California Office of the Patient Advocate](#) to create the Medical Group Report Card, which is the largest statewide multi-payer public report card to provide side-by-side assessments of physician organization performance on all three key aspects of value: clinical quality, patient experience, and costs.

In 2014, the first IHA Excellence in Healthcare award was presented to high-performing physician organizations. To earn the award, POs must perform in the top 50 percent for clinical quality **and** patient experience **and** total cost of care. Out of more than 200 participating POs, only 23 met the standard in measurement year 2014.

### Additional Information

Along with [online](#) information about the overall IHA Value Based P4P program, an IHA issue brief—[Charting a Course to Value in Physician Group Payment: Key Pay-for-Performance Design Decisions](#)—provides more detail about the transition of the California P4P program from focusing solely on quality to a value-based focus that incorporates quality and costs.

#### About IHA

Based in Oakland, Calif., the nonprofit Integrated Healthcare Association (IHA) convenes diverse stakeholders—including physicians, hospitals and health systems, purchasers and health plans—committed to high-value, integrated care that improves quality and affordability for patients across California and the nation.

Lindsay Erickson, Director, Value Based P4P Program  
lerickson@iha.org

500 12th Street, Suite 310 • Oakland, Calif. 94607  
(510) 208-1740 • [www.iha.org](http://www.iha.org)

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