History of IHA's Pay For Performance Initiative

The Integrated Healthcare Association (IHA) formed a high-level working group of purchasers, health plan medical directors, and physician group executives and medical directors in July 2000 to work on the concept of a new statewide initiative for California that would pay physician groups for documented performance. The strategic building blocks underpinning the initiative were:

- Expected premium increases in high single digits or more for at least another three years
- A window of opportunity in the next 12-18 months to build a "pay for performance" system that could be funded in part out of those coming increases
- The need to build a "business case for performance" on all fronts
- Commitment to an initiative that was bold, not incremental, and involved real money

IHA's perspective at the outset was that although public and private purchasers continued to talk about the need for "value-based purchasing" and the commitment to quality as well as price, to date that commitment had been expressed in relatively self-contained, incremental projects and without any significant economic rewards at the *provider* level. Health plans, for their part, had varied in their own approaches to performance measurement and reward; and, until recently, only a very few plans had provided a financial reward for performance.

The IHA Working Group, including a technical subcommittee to design the actual performance measures, completed the planning phase for the initiative in late 2001. Steve Shortell, Ph.D. from the UC Berkeley School of Public Health (since appointed as Dean) served as facilitator for both groups, which were staffed by IHA and underwritten by seed money from GlaxoSmithKline. Mark Smith, MD, President and CEO of the California HealthCare Foundation, facilitated a special "mini Summit" on September 28, 2001 and a follow-up meeting on October 31, 2001 to clarify and confirm specific commitments by all the parties.

The official announcement of Pay for Performance was made January 15, 2002. Six California health plans agreed to launch the collaborative initiative -- Aetna, Blue Cross of California, Blue Shield of California, CIGNA HealthCare of California, Health Net, and PacifiCare.

The fundamental principles of Pay for Performance are (1) common performance measures for physician groups, developed collaboratively by health plan and physician group medical directors, researchers, and other industry experts; and (2) significant health plan financial payments based on that performance, with each plan independently deciding the source, amount, and payment method for its incentive program. The first full year for Pay for Performance will involve 2003 data and health plan payments in mid-2004.

The measures represent a balance of patient satisfaction, prevention, and chronic care management, together with an information technology (IT) investment measure. Patient satisfaction will cover four key areas -- communication with the doctor, specialty care, timely care and service, and an overall rating of care. Six clinical measures cover mammograms, pap smears, and childhood immunizations, plus a measure for asthma, diabetes, and coronary artery disease. The clinical measures are weighted at 50% of the overall score, with patient satisfaction at 40% and the IT measure at 10%. The draft measurement set was sent to all delegated

California physician groups in July 2002 for review and comment. The final clinical and patient satisfaction measures for the first year of the program were adopted in September 2002. A draft of the IT measure was presented for comment at IHA's statewide "readiness" conference on October 16. That event, underwritten by GlaxoSmithKline, was designed to ensure that all parties (especially physician groups) understood the Pay for Performance program. The final IT measure was approved in January 2003.

Data will be a combination of lab, pharmacy, and administrative data, some from the participating physician groups and some from the health plans. Patient satisfaction data will come from the joint Consumer Assessment Survey (CAS). An independent entity selected through a competitive RFP will receive audited health plan and physician group data and prepare the consolidated scores for the public scorecard. Groups that are committed to managing care well but are simply less sophisticated can still do well under the initiative by showing improvement from year to year, which will also be rewarded beginning in Year 2.

As of January 2002, an expanded Steering Committee, augmented by three new consumer representatives and two additional physician group members, replaced the Work Group and is guiding the effort. IHA Board chair-elect Tom Davies, manager of managed care for the West Region of Verizon, chairs the Steering Committee. Steve Shortell chairs an expanded Technical Committee, which is supported by staff from the P-GO (Provider Group Oversight) initiative, a joint effort of the Pacific Business Group on Health (PBGH), the National Committee for Quality Assurance (NCQA), and the California HealthCare Foundation.

In May 2002 IHA submitted a Pay for Performance grant proposal to the national *Rewarding Results* demonstration program (see www.nhcpi.net for information) funded by the California HealthCare Foundation and the Robert Wood Johnson Foundation. The proposal was funded for three years beginning in September 2002, covering core project costs and a rigorous evaluation.

Beginning in 2003, IHA will be providing e-mail updates on Pay for Performance. Interested parties may sign up to receive the e-Updates by writing to P4Pcomments@iha.org. Questions regarding the initiative should be directed to Ann Bowers of the Integrated Healthcare Association, at 49 Quail Court, Suite 205, Walnut Creek, CA 94596 -- telephone 925/746-5100, FAX 925/746-5103, e-mail abowers@iha.org.

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For More Information:
E-mail: twilliams@iha.org or abowers@iha.org
Phone: (925)746-5100 Fax: (925)746-5103
Mail: 49 Quail Court, Suite 205, Walnut Creek, CA 94596