

# Physician Pay for Performance (PFP) Initiatives

*Pay for performance (PFP) is a method of linking pay to a measure of individual, group or organizational performance, based on an appraisal system. These types of bonus incentive schemes are based on the idea that work output, determined by some kind of measuring system, varies according to effort and that the prospect of increased pay will motivate improved performance.<sup>1</sup>*

A growing health care “quality movement” has combined with the continuing increase in health care cost pressures to create a separate identifiable movement to “measure performance” and subsequently pay for it, primarily at the hospital and physician levels. The goals and implementation of the “quality movement” and the “pay for performance movement” have intersected, some might say clashed, resulting in the exploding growth in programs aimed at promoting quality or paying for performance, or in most cases attempting a combination of both. The market is moving towards “exclusivity” in terms of physician networks and hospitals. Methods to differentiate physicians and other health care providers can be expected to continue to proliferate.

What follows is an American Medical Association (AMA) staff analysis of the state-of-the-art in what has come to be called “pay for performance.” Staff has not attempted to make value judgments about the merits of the PFP concept, but rather to provide an historical perspective on the evolution of these programs and their likely future growth, with, of course, special emphasis on their impact on physicians and the practice of medicine. The intent of this document is to advance discussions within the AMA and provide a roadmap to identify various aspects of PFP that might be addressed in anticipation of the need for AMA policy to guide our future deliberations on PFP.

## Table of Contents

	Introduction.....	4
I.	Background.....	5
	A. Growth in Health Care Costs.....	5
	B. The Quality Environment.....	5
II.	AMA Efforts to Address Patient Safety and Clinical Quality.....	7
	A. The National Patient Safety Foundation (NPSF).....	7
	B. Physician Consortium for Performance Improvement.....	7
III.	AMA Policy Related to Incentive Programs.....	8
IV.	What is Pay for Performance (PFP)? .....	9
V.	Current Status of PFP in the Private and Public Sectors.....	11
	A. Private Sector Initiatives.....	11
	i. Health Plan Involvement.....	11
	ii. Employer Involvement.....	13
	iii. Employer Scorecards.....	13
	iv. Physician Organization Incentive Program.....	14
	B. State Initiatives.....	14
	i. Maine.....	14
	ii. Florida.....	15
	iii. Minnesota.....	15
	C. Federal Initiatives.....	15
	i. CMS & Physician Consortium for Performance Improvement.....	16
	ii. MedPAC.....	16
	iii. Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).....	17
	iv. Physician Group Practice Demonstration.....	19
VI.	Key Components of PFP Programs.....	20
	A. Participation Criteria.....	20
	B. Level of Physician Involvement.....	20
	C. Measurements of Physician Performance.....	21
	i. Evidence-based Clinical Quality Measures.....	21
	ii. Non-clinical Performance Measures.....	21
	iii. Other Related Performance Measures.....	22
	D. Data and Technology Issues.....	23
	i. Corroborating PFP Data.....	23
	ii. Claims Data.....	24
	iii. Related Data Issues.....	24
	iv. Information Technology.....	25
	E. Rating Physicians and Physician Groups.....	25
	i. Use of Outcomes Measures.....	25
	ii. Individual and Group Ratings.....	26
	F. Bonus Pools.....	27
	G. Use of Data and Reporting Results.....	27
	H. A Tool for Negotiating.....	28

VII.	Assessing Overall Program Opportunities and Challenges.....	29
	A. Health Plan and Employer PFP Programs.....	29
	B. Physician Group and Physician Organization PFP Programs.....	31
	Appendix A: The Leapfrog Group’s Listing of PFP Programs.....	32
	Appendix B: Minnesota’s 27 Adverse Health Care Reporting Events.....	45
	Bibliography.....	47

# Physician Pay for Performance (PFP) Initiatives

The PFP movement has been described as a powerful force operating in a sea of stakeholder unrest threatening those who are not well prepared.<sup>2</sup> This movement features a model of payment that proponents say heralds the end of an era of automatic revenue for healthcare services as health plans and purchasers link revenue to verifiable performance.<sup>3</sup> The PFP wave is sweeping over the practice of medicine. Characterized by complex goals to provoke physicians to redesign systems of care and invest in health information technology,<sup>4</sup> one set of goals for PFP proposed to:

- reward quality by creating financial incentives large enough to motivate structural change;
- effectuate health care system changes needed to reduce error and improve quality, to reduce the cost and improve the efficiency of care;
- encourage physicians to broaden their delivery of patient care beyond the office visit (population management); and,
- put greater direct responsibility on physician practices to “get it right the first time.”<sup>5</sup>

The expectation of PFP proponents is clear: as quality increases, the nation’s health will improve and health care costs will decrease.

This paper is intended to provide information about the increasing expansion of PFP programs and to lay out for consideration important issues to begin addressing the development of AMA policy in this area. To frame the context in which PFP programs operate, this paper includes the following:

- 1) overview of the health care environment including cost and quality factors that are driving the PFP movement;
- 2) description of AMA collaborative efforts addressing the crisis in patient safety and clinical quality improvement;
- 3) summary of existing AMA policy positions regarding physician incentive programs;
- 4) description of PFP;
- 5) review of the current status of PFP programs within the private and public sectors;
- 6) examination of key components of PFP; and
- 7) concepts and questions that AMA should consider in evaluating PFP strategies.

## I. BACKGROUND

### **Growth in Health Care Costs**

Over the past several years, there has been growing concern regarding the rise in health care costs. National health expenditures increased to \$1.6 trillion in 2002, a 9.3% increase from 2001, and a substantial increase over the 5.5% annual increase that occurred during the mid to late 1990s.<sup>6</sup> The health care share of the gross domestic product (GDP) increased to 14.1% in 2001 and 14.9% in 2002, after nearly a decade in the 13.1-13.4% of GDP range.<sup>7</sup> Furthermore, the number of uninsured rose to 45 million in 2003, or 15.6% of the non-elderly population.<sup>8</sup>

The rising rates of the uninsured population correspond with rising health and insurance costs. One of the most common reasons cited for being uninsured is high cost.<sup>9</sup> Since 2001, health insurance premiums have increased 59%, employee contributions have grown by 57% for single coverage and 49% for family coverage, and the percentage of workers covered by their own employer's health plans has fallen from 65% in 2001 to 61% in 2004.<sup>10</sup> Approximately one in seven American families (14%) report having difficulty paying medical bills, and 68% of families with such problems have health insurance.<sup>11</sup> As a result, The Congress, other governmental bodies, employers, health insurers, and others are continuing to examine strategies for slowing the rise in health care costs and demanding comparison data on quality on which to base decisions for health care choice.

### **The Quality Environment**

In 1998, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry completed its final report, calling for a "national commitment to improving health care quality" and the creation of a national forum as part of an integrated national quality improvement strategy. Subsequently in 1999, leaders from consumer, purchaser, provider, health plan, and health service research organizations established the National Quality Forum (NQF), a not-for-profit membership organization with broad participation from across the health care system. The NQF has endorsed over 100 quality indicators and performance measures encompassing a broad array of health care topics including hospital care, patient safety, diabetes, cardiac surgery, nursing services, and nursing home care and is in the process of endorsing measures in ambulatory care, behavioral health, prescription medication use, deep vein thrombosis, and measures of care in academic health centers.<sup>12</sup>

As early as 1999 in *To Err is Human*, and as recently as 2004 at the 1st Annual Crossing the Quality Chasm Summit: A Focus on Communities (the Summit), the Institute of Medicine (IOM) has asserted that reinforcing accountability is requisite to implementing and sustaining safety and quality. *To Err is Human* generated unprecedented public awareness of patient safety but also encouraged public and private purchasers to consider safety issues in contracting decisions and to provide relevant information on quality and safety to their employees or beneficiaries.<sup>13</sup> *Crossing the Quality Chasm* (2001) recommended that purchasers create an environment that rewards improvement by aligning quality to payment incentives.<sup>14</sup> The January 2004 Summit frankly addressed

the concept of considering safety and quality in contractual decisions and identified strategies to change the way the public and private sectors pay for health care.<sup>15</sup> Summit participants accepted a definition of finance that supports quality improvement by directly aligning payment incentives with quality improvement:

- 1) implement performance-based payment models;
- 2) employ evidence-based benefit design;
- 3) provide payment for proven quality support services; and
- 4) engage consumers with information and incentives.<sup>16</sup>

A number of national entities have developed health care quality measures and are engaged in various improvement projects. Although quality measurement in the health care industry predates the IOM reports, efforts by health care accrediting bodies, major purchasers, and organized medicine were spurred into further action following publication of these reports.<sup>17</sup> Examples of these efforts are described below. A more detailed discussion, identifying and describing these organizations, is included in Chapter VI.

Heightened public reaction to the IOM reports served to galvanize major employers to form business coalitions such as the Leapfrog Group and *Bridges to Excellence* to extract value for health care spending through use of “informed decision-making” in the purchase of health care. These initiatives focus on creating incentives to providers by rewarding and recognizing improvements in safety, quality, and affordability. The Centers for Medicare & Medicaid Services (CMS) formed a partnership with hospitals to launch the Hospital Quality Alliance. CMS also re-organized its Quality Improvement Organization (QIO) program to assist providers to measure and improve quality for inpatient and outpatient Medicare beneficiaries, and embarked on a number of demonstration projects to test the feasibility of data collection and the effectiveness of measurement to address health care variation, cost, and quality (e.g., the Doctors Office Quality Projects). Many of these private and public efforts are more fully explained in Chapter V.

In 2000, the American Board of Medical Specialties (ABMS) and its member boards developed requirements for maintenance of certification (MOC) that include, among other areas, practice performance measurement on a continuous basis. Member boards have until the end of 2004 to submit MOC plans to assess physician performance and quality improvement.<sup>18</sup>

## II. AMA EFFORTS TO ADDRESS PATIENT SAFETY AND CLINICAL QUALITY

The AMA has supported several long-standing activities in patient safety and quality improvement. These activities are currently encompassed in two organizations founded by the AMA.

### **The National Patient Safety Foundation (NPSF)**

Recognizing the need to promote patient safety research and educational activities, the AMA, with CNA/HealthPro and 3M, established the National Patient Safety Foundation in October 1996, preceding the IOM Report “To Err Is Human” by three years. The AMA continues to advance NPSF’s mission—to improve the safety of patients—and participates at the highest levels of NPSF governance. Safety and quality efforts include support for research activities and implementation through transferring research results to physician practice.

### **Physician Consortium for Performance Improvement**

The AMA has supported several initiatives to address quality since the early 1990s. These initiatives culminated in 1996 with the establishment of the American Medical Accreditation Program (AMAP<sup>®</sup>). Although AMAP<sup>®</sup> was discontinued in 1998, the program served as a catalyst for organized medicine to focus directly on evidence-based medicine and the establishment of performance measurement for physicians. Activities of the AMAP<sup>®</sup> advisory committees, charged with the development of measures and resources for physicians, coalesced in 1998 with the formation of the Physician Consortium for Performance Improvement (the Consortium). Convened to promote physician leadership in clinical performance measurement, the Consortium’s mission is “to improve patient health and safety by identifying and developing evidence-based clinical performance measures that enhance the quality of patient care and that foster accountability by promoting the implementation of effective and relevant clinical performance improvement activities thereby advancing the science of clinical performance measurement and improvement.”<sup>19</sup>

A national, physician-led initiative, the Consortium is comprised of methodological and clinical experts representing more than 60 national medical specialty societies, state medical associations, the Agency for Healthcare Research and Quality (AHRQ), CMS, and other national organizations engaged in health care quality evaluation. To date, the Consortium has developed 69 measures encompassing 13 clinical topics and is committed to collaborating with its members to develop measures for two or three additional topics annually. The primary objective of the Consortium is to drive industry adoption of its measures by emphasizing the clinical relevance and feasibility of its measures so that they become the *de facto* standard for measurement. The Consortium believes that its measures may be used effectively for quality improvement and, if used appropriately, for accountability. Towards that end, the Consortium supports wide testing of its measures through demonstration projects.

The Consortium believes its measures can become the industry standard because they are:

- relevant to clinical practice by taking into consideration medical reasons and patient factors that impact the delivery of care through specific inclusion and exclusion criteria for numerator and denominator populations;
- developed and vetted by clinical experts from throughout the field of medicine and therefore have cross-specialty support; and
- undergoing testing by CMS and the AMA for integration into electronic health record systems.

Consortium measures have been submitted to the NQF under an expedited review process for endorsement of ambulatory care measures. It is anticipated that CMS and others will seek to identify a subset of the NQF-endorsed ambulatory care measures for use in the CMS pay for performance programs, paralleling the selection of a subset of NQF-endorsed hospital measures that are now used by the Hospital Quality Alliance.

### **III. AMA POLICY RELATED TO INCENTIVE PROGRAMS**

Although the AMA has not established policy directly referencing PFP, a number of policies and principles related to PFP program components exist. For example, Policy H-140.978[1] (AMA Policy Database) states that physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward or the avoidance of financial penalties. Similarly, Policy H-285.951[1] states that patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the health care system in which physicians practice, or the methods by which they are compensated.

In addition, the AMA has established principles to guide the use of financial incentives in the management of medical care (Policy H-285.951); quality assessment programs (Policy H-450.995); the development and use of performance standards and measures (Policy H-450.966[6]); the development and use of physician profiles (Policy H-406.994); and the collection, analysis, use, and release of physician-specific health care data (Policies H-406.996, H-406.997, and H-406.998). The Council on Ethical and Judicial Affairs also has established ethical opinions on the use of financial incentives (E-8.054 and E-8.13[3]).

Among the key AMA principles to guide the use of financial incentives in the management of medical care are the following:

- Financial incentives should enhance the provision of high quality, cost-effective medical care (Policy H-285.951[3]).
- Financial incentives should not result in the withholding of appropriate medical services or in the denial of patient access to such services (Policy H-285.951[4]).

- Any financial incentives that may induce a limitation of the medical services offered to patients, as well as treatment or referral options, should be fully disclosed by health plans to enrollees and prospective enrollees (Policy H-285.951[5]).
- Financial incentives should not be based on the performance of physicians over short periods of time, nor should they be linked with individual treatment decisions over periods of time insufficient to identify patterns of care (Policy H-285.951[7]).
- Financial incentives generally should be based on the performance of groups of physicians rather than individual physicians. However, within a physician group, individual physician financial incentives may be related to quality of care, productivity, utilization of services, and overall performance of the physician group (Policy H-285.951[8]).
- The appropriateness and structure of a specific financial incentive should take into account a variety of factors such as the use and level of "stop-loss" insurance, and the adequacy of the base payments (not at-risk payments) to physicians and physician groups (Policy H-285.951[9]).

As previously noted, the AMA has undertaken a number of initiatives consistent with policy calling for active involvement with members of the Federation in the development of performance measurement systems (Policies H-410.964 and H-410.965[3]); oversight of a clearinghouse of performance measurement systems (Policy H-165.907[3]); and the establishment of principles to guide the use of performance measures and standards (Policies H-410.976[2] and H-450.966[6]). In addition, the AMA encourages all physicians to be open to the development and broader utilization of evidence-based quality improvement guidelines and indicators for measurement of quality practice (Policy H-410.960).

#### **IV. WHAT IS PAY FOR PERFORMANCE?**

PFP is a term that is being applied to incentive programs that provide monetary bonuses to participating entities that make progress in achieving or attaining specific quality and/or efficiency benchmarks or standards that are established by the program. PFP programs can apply to health plans, hospitals, or other entities, but increasingly physicians and physician groups are being targeted. Most physician PFP programs are sponsored by major health plans with a large market share and significant influence over physicians. Some large employer groups and coalitions have taken the initiative, bypassing health plans, to offer incentives directly to physicians who care for their employees.

Most physician PFP programs provide financial bonuses to physicians or physician organizations that meet the programs' performance criteria. The size of incentive payments typically is modest — usually about 1 to 5% of a physician's total revenue from

a given health plan.<sup>20</sup> Since bonuses are frequently paid at the group level, some physician organizations have devised internal PFP programs to determine bonus allocations to their individual physician members. These programs operate similarly to health plan and employer PFP programs, but they have the added dimension that all decisions made about the design and operation of the program are made by physician members of the group in conjunction with the group administrator.

PFP programs collect vast amounts of data about specific physician interactions with patients and use that data to try to measure physician quality and cost of patient care with little standardization from one program to the next. Most programs focus on the use of process measures of quality, but lately there has been movement towards using outcome-based approaches. Process measures are indicators related to the methods and procedures used to provide health care. Outcome measures are used to assess the results of treatments for a particular disease or condition in terms of mortality, morbidity, health status, and quality of life. Process measures differ from outcome measures because they describe interventions that are related to the delivery of care and not the results of treatment.<sup>21</sup>

Many PFP programs are also now using non-clinical measures to rate physician quality of care. Patient satisfaction, the use of information technology (IT), and efficiency in providing care are all being used in PFP programs as measures to determine whether bonuses should be awarded. Some PFP programs are also using these data to provide listings of physician rankings to employers and the public. A variety of different PFP program designs and strategies abound and are only limited by the number of PFP programs in existence.

According to a study commissioned by the National Health Care Purchasing Institute,<sup>22</sup> effective incentive strategies must include a number of key elements, including:

- trust between physicians and the organization(s) implementing the incentives;
- a recognized need for change;
- peer and/or patient knowledge of performance;
- confidence in the data upon which incentives are based;
- perceived fairness and value of the incentives; and
- support of the medical leadership for the incentive program.

A recent study by Med-Vantage,<sup>23</sup> a health care consulting company, explored employer expectations for PFP programs. According to the survey, employers are concerned with:

- reducing clinical practice variation;
- encouraging the use of strategies to increase patient compliance;
- reducing errors and acute exacerbations; and
- motivating employees to take better care of themselves.

Employers also expressed a desire that PFP programs provide tools to help employees understand physician performance on price and quality, and they expect innovation so that health plans compete on and invest in quality initiatives.<sup>24</sup>

## V. CURRENT STATUS OF PFP IN THE PRIVATE AND PUBLIC SECTORS

PFP initiatives, still in their infancy and primarily located in the private sector, are expected to see many changes as they evolve. As of September 2004, approximately 35 health plans, covering more than 30 million patients have some kind of program tying bonuses to physician performance (Appendix A contains a listing that was compiled by The Leapfrog Group of more than 70 incentive programs targeted at physicians, hospitals, health plans, and other health care providers). The number of incentive programs is expected to more than double by next year.<sup>25</sup> In addition, several other health care associations and health care related organizations, including the American Academy of Family Physicians, the American College of Cardiology, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the NQF, and others, have approved or draft guidelines related to standards for PFP programs.

Some new developments that are evolving in the health care industry, as a result of the incentive movement, may have far-reaching effects on the practice of medicine in the future and how physicians are reimbursed, or not, for the services they provide to their patients.

### **Private Sector Initiatives**

#### Health Plan Involvement

The Integrated Healthcare Association's (IHA) "Pay for Performance" program is unique in that it reaches across multiple health plans and attempts to coordinate the plans' individual PFP efforts using uniform methodologies as a basis for arriving at physician ratings. The program involves six of California's largest health plans, more than 200 physician groups and nearly 7 million enrollees. The health plans that are participating in the program include: Aetna, Inc.; Blue Cross of California; Blue Shield of California; CIGNA Healthcare of California, Inc.; HealthNet, Inc.; and PacifiCare Health Systems, Inc.<sup>26</sup>

The initiative involves collecting performance data from participating health plans and physician groups and using it to produce reports and public scorecards that will be used by individual health plans to determine physician group incentives. The concept of using uniform performance measures and scoring methodologies across all six health plans demonstrated partial success; however, variations among the plans occurred. Physician bonuses vary by plan, but awarding uniform bonuses is not a part of the plan strategy. Between \$50 million and \$60 million in incentives are being issued this year although original expectations exceeded \$100 million. The average group bonus is expected to be about \$200,000 and the bonuses will cover 24,000 primary care physicians.<sup>27</sup> Some, but not all, of this bonus pool represents new, additional money for the program. For more

information on the first year results of this program, please consult the paper [A Report on the Integrated Healthcare Association's "Pay for Performance" Program](#), which was distributed to the Board this past July.<sup>28</sup>

As compared to the previous year, the IHA attributes this program with achieving the following health care improvements in 2003:

- almost 150,000 additional women received cancer screenings;
- 35,000 more women were screened for breast cancer;
- 10,000 additional children received two needed vaccinations; and
- an additional 18,000 people were tested for diabetes.<sup>29</sup>

Most early PFP programs focused on primary care specialists, but increasingly, these incentive programs are targeting other specialists in an effort to associate costs of in-hospital care with physician performance on selected indicators. Some major insurers have launched new specialty physician networks that are often half the size of the previous networks. Physicians can be selected to participate in these new, smaller networks based on their volume of work, quality outcomes, practice efficiencies including overall health care costs, or other factors. Most health plans and employer groups do not offer physicians in these specialty networks direct financial incentives or other forms of increased reimbursement; instead, the health plans and employers encourage patients to seek care from these selected physicians by loosening plan restrictions such as waiving the need for referrals or lowering patient copayments or coinsurance. These new networks are being promoted to specialty groups as a way to increase their business through higher volumes of patients that may generate more income for these specialists.<sup>30</sup>

Minnesota legislation, the “Adverse Health Care Events Reporting Act of 2003 (Act),” became effective July 1, 2003 and was fully implemented July 1, 2004. This legislation, which now impacts the private as well as public sectors, created a confidential, non-punitive hospital reporting system for 27 never events (Appendix B). The serious errors were identified by the National Quality Forum (NQF) as events that should never happen and are associated with surgical, environmental, criminal, and other patient care events including patient injury from the use of defective products and devices.<sup>31</sup> Similar to the aviation industry’s “Aviation Safety Reporting System (ASRS),” this law established a mandatory reporting system to collect and aggregate data for the purpose of identifying, fixing, and learning from these 27 system errors.

HealthPartners, a Minnesota health insurer, announced in early October 2004 that beginning on January 1, 2005 their plan would withhold payment for these 27 serious errors called “never events.” According to a Minnesota Medical Association (MMA) “draft” press release, the Association strongly supported the original law; however, it does not support HealthPartner’s use of these 27 adverse health events to withhold hospital payments. MMA stated that withholding hospital payment is “a use of the new

reporting system that was never intended.” MMA also issued grave concerns about possible negative repercussions of using this system for purposes other than improving quality and safety.

#### Employer Involvement

The Bridges to Excellence effort, which is backed by large employers such as General Electric Company, Ford Motor Company, United Parcel Service, Procter & Gamble, Raytheon, Verizon Communications and others, offers physicians incentive payments of \$50 to \$160, per patient per year, for treating the employers’ qualifying diabetic and cardiac patients. Physicians qualify for this program by gaining recognition for their diabetic patient care from the NCQA and recognition for their cardiac care from the Heart Stroke Recognition Program. This program also incentivizes physicians for utilization of certain IT systems recognized by the IOM. This program is only operational in Boston, New York State’s Capital District and the Cincinnati/Louisville area. Participation has also been limited by the number of physicians possessing the necessary recognitions.<sup>32</sup>

Known for its hospital survey and public reporting initiative recognizing hospitals’ use of computerized physician order entry systems, use of intensivists, and achieving volume thresholds in treating certain serious conditions, The Leapfrog Group will launch its first rewards program for hospitals in 2005. The *Leapfrog Hospital Rewards Program* will measure hospital performance on five clinical conditions for effectiveness and five for affordability. Hospitals that demonstrate excellence or show improvement along both dimensions will be rewarded. The program claims to have a minimal reporting burden. All the measures, apart from certain efficiency measures, are currently collected through the *Leapfrog Hospital Quality and Safety Survey* or through the JCAHO’s ORYX vendors.<sup>33</sup>

#### Employer Scorecards

In an effort to enter the incentives movement, 28 large employers, covering two million employees and their dependents, have teamed up to develop “scorecards” to assist their employees in choosing physicians based on how well the physicians care for patients, and how cost-effective they are. The scorecard effort, *Care Focused Purchasing*, includes rewarding physicians and hospitals for providing higher-quality care at a “reasonable” price and offering patients financial incentives to use these more cost-effective physicians and hospitals. Under the scorecard system, insurance and pharmacy claims data will be used to measure whether accepted, standard treatment practices are being followed. So far, the group has commitments from Humana, Inc., based in Louisville, Ky., Cigna Corp. of Philadelphia, and Empire Blue Cross Blue Shield of New York to contribute their data. Discussions are also underway with Aetna, Inc., which has its own pilot, *Aexcel* network, rating physicians in six specialties, using quality and cost measures.

The employers are expected to offer employee incentives, such as lower co-payments and deductibles for choosing the high quality and low cost physicians and hospitals. The scorecard format is still in the development phase, but the employers in the program hope to provide, within a year, something as simple as a Consumer Report guide, ranking physicians and hospitals with easy-to-understand points and stars. However, some health

care experts are extremely skeptical about the use of physician scorecards and the potential harm that can be caused by *Care Focused Purchasing* when physicians are publicly misclassified.<sup>34</sup>

#### Physician Organization Incentive Program

As previously mentioned, some physician groups and organizations have instituted their own PFP programs. One such program is being launched by multiple physician organizations and networks of physicians and hospitals, *Physician Direct*. This program rewards both physicians and patients for following a set of 117 “evidence-based” guidelines. The program will use a software application created by HealthGate Data Corp., which includes an interactive “decision tree” that walks the physician through steps to consider when treating patients. Physicians in the program will receive higher reimbursement for using the system. If physicians do not adhere to the guidelines, they must indicate one of several acceptable reasons for not using them. Patients are also incentivized with lower co-pays or co-insurance when they comply with their treatment regimens.<sup>35</sup>

#### **State Initiatives**

Pay for Performance incentive proposals have yet to take hold in the state legislatures. Rather, many states such as Connecticut, Florida, Kentucky, Michigan, Minnesota, North Carolina, Oklahoma, Tennessee, Texas, and Wisconsin, have enacted or have pending legislation to create programs to study quality or patient safety measures or to promote best practice measures and encourage evidence-based medicine within the states’ Medicaid programs. The intent of these programs appears to be cost-based. There is no specific indication that the studies will be used to create physician incentive programs. Following are summaries of three noteworthy programs:

#### Maine

Maine established the Primary Care Physician Incentive Program (PCPIP) which is part of Maine’s Dirigo Health Plan. Dirigo Health Plan arranges health coverage through private insurance carriers to individuals, small business (less than 50 employees), and self employed persons. This program is the first of its kind, and it established the Maine Quality Forum to:

- collect and disseminate research;
- adopt quality and performance measures;
- coordinate quality data;
- issue quality reports in conjunction with the Maine Health Data Organization;
- conduct consumer education and technology assessment reviews;
- encourage the adoption of electronic technology;
- make recommendations for the State Health Plan; and
- issue an annual report.

The PCPIP program established a pool of funding that is distributed to individual providers who show the best performance based on a series of measures. In particular, Maine uses provider profiling as part of its incentive payment system for physicians in its

PCPIP. On a quarterly basis, pediatricians, family practitioners, internists and OB/GYNs receive scores on measures related to specific goals: reducing disincentives associated with high-risk Medicaid patient panels; reducing inappropriate emergency room utilization; and increasing the utilization of preventive services. They are then ranked with other members of their provider group. Quarterly payments are made to physicians within the top 20<sup>th</sup> percentile within each provider group. Many legislatures are looking closely at PCPIP to determine if the program would be advantageous to their Medicaid programs in the future.<sup>36</sup>

### Florida

Florida moved closer to establishing a PFP program by creating the Florida Patient Safety Corporation (FPSC). The FPSC was created to identify best practices to ensure patient safety. By January 2005, the FPSC must report to Florida's governor and others on its ability to develop a system to measure and reward providers who implement evidence-based medical practices.<sup>37</sup>

### Minnesota

Minnesota took steps towards creating a PFP program by passing a patient safety bill in the House that would encourage the adoption of "best practice" guidelines and participation in "best practice" measurement activities. This legislation also directs the state commissioner of health to facilitate the use of "best practice" guidelines and quality of care measurement information for providers, purchasers, and consumers by:

- identifying and promoting local, community-based and physician-designed best practices across the Minnesota health care system;
- disseminating information on adherence to best practices; and
- educating consumers and purchasers on how to effectively use this information in choosing their health care providers and making purchasing decisions.<sup>38</sup>

Of greatest concern was Minnesota's Senate version of the bill which mirrors the House version with one major difference; it would tie payment withholds to compliance with best practices. It appears that the Senate bill will not be passed in this session.

### **Federal Initiatives**

CMS Administrator Mark McClellan, MD, PhD has stated that, in the next five to ten years, pay for performance-based compensation could account for 20% to 30% of what the Medicare program pays providers.<sup>39</sup> While current CMS projects are primarily in a demonstration phase, there is keen interest in expanding pay for performance as rapidly as possible. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) was the first in what is expected to be numerous Congressional salvoes to move the Medicare program towards rewarding quality while reducing costs.

Government action is widely supported by quality leaders from around the country. In an open letter published in *Health Affairs* (November/December 2003), leading quality experts including Donald Berwick, MD, Nancy-Ann DeParle, Elizabeth McGlynn, Uwe E. Reinhardt, PhD, John Wennberg, MD, and others reiterated the call for Medicare to lead on PFP:

*“Our recommendation—to the executive branch; to Congress; to employers and health plans; and to hospitals, physicians, nurses, and other health professionals—is that payment for performance should become a top national priority and that Medicare payments should lead in this effort, with an immediate priority for hospital care. Sustained leadership within Medicare will be a crucial ingredient. The current CMS administrator has shown aggressiveness and commitment. His successors must follow suit to assure that quality improvement becomes a priority throughout the agency, year in and year out. A major initiative by Medicare to pay for performance can be expected to stimulate similar efforts by private payers, just as Medicare’s adoption of prospective payment for hospitals did two decades ago. We call on the administration and congressional leaders of both parties to act in a bipartisan spirit on health care quality and to join the campaign to rally our underperforming health care system by empowering Medicare to take the further necessary and decisive steps to make pay-for-performance a national strategy for better quality. We should settle for nothing less.”<sup>40</sup>*

As a result of this and other political pressures calling for quality improvement and cost containment, Congress looked to hospitals, in the MMA, for its first major Medicare PFP initiative. The MMA linked the hospital Medicare payment update for three years to hospital public reporting of ten quality measures. Hospitals that do not report data will receive a 0.4% reduction on their annual Medicare market basket increases over the period. Within a year, 98% of the nation’s hospitals began reporting data. Decision makers are taking note of these results and will likely use this as a model for physicians in the future.

#### CMS and the Physician Consortium for Performance Improvement

The Consortium has developed a set of measures that can be used to measure quality of care in physician offices. CMS worked with the Consortium to validate these measures, and both organizations worked with NCQA to align the measures with those which NCQA had developed for purposes of health plan accreditation and physician recognition. The result is a measure set that is about to enter an expedited review process by the NQF. Upon completion of a successful review, this will be the first ambulatory measure set endorsed by NQF. CMS has indicated it will only use NQF endorsed performance measures and plans to use this measure set for its ambulatory pay for performance programs.

#### Medicare Payment Advisory Commission (MedPAC)

MedPAC recommended that CMS move towards using financial incentives for all types of providers and plans participating in Medicare. It also developed the following criteria for choosing the most promising settings for introducing payment for quality performance:

- to be credible, measures must be evidence-based, to the extent possible, broadly understood, and accepted;
- most providers and plans must be able to improve quality by using the measures; otherwise care may be improved for only a few beneficiaries;
- incentives should not discourage providers from taking riskier or more complex patients; and
- information to measure the quality of a plan or provider should be collected in a standardized format without excessive burden on the parties involved.<sup>41</sup>

Building on this analysis, MedPAC reported in March 2004 the development of a general design principle that a system linking payments to quality should:

- reward providers based on both improving the care they furnish and exceeding thresholds;
- be funded by setting aside a small proportion of total payments; and
- distribute all payments that are set aside for quality to providers achieving the quality criteria.

In the 2004 report, MedPAC makes additional recommendations on linking payment to quality for two sectors it judged the most ready for financial incentives – providers of dialysis services and private plans in Medicare.<sup>42</sup>

Most recently at its October 28, 2004 meeting, MedPAC discussed the issue of individual physician profiling. Commissioner Arnold Milstein, MD, predicted that profiling would inevitably be part of the Sustainable Growth Rate (SGR) dialogue. According to Milstein, because the target applies to overall spending, “no one individual feels accountable,” which wouldn’t be the case with individual profiling.<sup>43</sup>

#### Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003

On December 8, 2003, President George W. Bush signed the MMA into law. This landmark legislation provided for a prescription drug benefit, additional private sector plan options for beneficiaries, as well as a host of studies and pilot projects related to quality improvement under Medicare. MMA provisions related to PFP are outlined below:

#### *Section 238 – IOM Report on Health Care Performance Measures*

This provision requires the Secretary of the Department of Health and Human Services (HHS) to enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences will conduct an evaluation of leading health care performance measures in the public and private sectors and options to implement policies that align performance with payment under the Medicare program.

### *Section 646 - Medicare Health Care Quality Demonstration Program*

The HHS Secretary is required to establish a five-year demonstration program to examine factors that encourage the delivery of improved patient care quality including:

- financial incentives;
- appropriate use of best practice guidelines;
- examination of service variation and outcome measurement;
- shared decision making between providers and patients;
- appropriate use of culturally and ethnically sensitive care; and
- related financial effects associated with these factors.

In the demonstration, Medicare may provide benefits not otherwise covered, but may not deny services that are otherwise covered against the wishes of beneficiaries. The demonstration is required to be budget neutral.

### *Section 649 - Medicare Care Management Performance Demonstration Program*

The Medicare Care Management Performance (MCMP) Demonstration will establish a PFP three year demonstration with physicians to promote the adoption and use of health information technology to improve quality and reduce avoidable hospitalizations for chronically ill patients. Doctors who meet or exceed performance standards (the Consortium and NCQA ambulatory measures) will receive a bonus payment for managing the care of eligible Medicare beneficiaries. The demonstration must show it does not cost Medicare more than the program would have spent on the beneficiary otherwise. The MCMP demonstration is built upon the framework of the Doctors' Office Quality Information Technology (DOQ-IT) project, a two-year special study demonstration designed to improve quality of care, patient safety, and efficiency for services provided to Medicare beneficiaries by promoting the adoption of electronic health records and information technology in primary care physician offices. Implementation of the Sec. 649 demonstration is expected shortly in the same DOQ-IT project states: California, Utah, Massachusetts, and Arkansas.

CMS is working to coordinate its MCMP demonstration with private sector pay for performance programs. It has been actively engaged in developing it to fit with the *Bridges to Excellence* (BTE) program. BTE is likewise committed to using the Consortium/NCQA measure set. CMS staff indicates they will continue to look for opportunities to align Medicare and private sector PFP initiatives.

### *Section 721 - Voluntary Chronic Care Improvement Under Traditional Fee-For-Service Medicare*

As part of the MMA, the Secretary is required to provide for phased-in development, testing, evaluation, and implementation of chronic care improvement programs in the traditional Medicare fee-for-service program. Phase I is the developmental phase in which the Secretary is required to enter into three year contracts with chronic care

improvement organizations (CCIOs) to develop, test and evaluate chronic care programs using randomized clinical trials in areas meeting specific criteria. Chronic care improvement programs must be budget neutral. The Secretary is required to submit an interim Report to Congress not later than two years after implementation of the program, and an update Report not later than 3 ½ years after implementation. Two additional biennial Reports to Congress are required beginning two years after the update Report.

Approximately ten regional CCIOs will serve about 15,000 to 30,000 Medicare beneficiaries each, in regions where at least 10% of Medicare beneficiaries reside. Organizations will be required to refund some or all of their fees to the federal government if they do not meet agreed-upon standards for quality improvement, cost savings to Medicare (at least a five percent), and increased satisfaction levels in their assigned beneficiary populations. Some of the chronic care models may use bonus payments to physicians for participation.

#### Physician Group Practice Demonstration

The Physician Group Practice (PGP) Demonstration tests a hybrid payment methodology for paying physician-driven organizations that combines Medicare fee-for-service payments with a bonus pool derived from savings achieved through improvements in the management of patient care and services. Mandated by Section 412 of the Benefits Improvement and Protection Act of 2000, the PGP demonstration seeks to:

- encourage coordination of Part A and Part B services;
- reward physicians for improving health outcomes; and
- promote efficiency through investment in administrative structure and process.

Under the three year demonstration, physician groups will be paid on a fee-for-service basis and may earn a bonus from savings derived from improvements in patient management. Annual performance targets will be established, for each participating physician group, equal to the average Part A and Part B expenditures of beneficiaries assigned to the group during a base period, adjusted for health status and expenditure growth. Bonuses may be earned if the average Medicare expenditure on beneficiaries assigned to the group is below the group's annual performance target. Bonus payments will be allocated between efficiency improvements and measurable improvements in patient care processes and outcomes. Bonus payments will be made to the physician group. The group is then responsible for allocating bonus payments among its physicians and any affiliated health care professionals. Aggregate expenditures under the demonstration must be budget neutral.

Eligible organizations include freestanding multi-specialty physician group practices (200+ Physician FTEs), faculty group practices, and physician groups that are part of health care systems/medical centers or that have affiliations with hospitals and/or other providers. Program implementation will begin in early 2005.

## VI. KEY COMPONENTS OF PFP PROGRAMS

The most consistent aspect of differing incentive programs is the inconsistency that exists in the operation of one program as compared to another. These inconsistencies are particularly prevalent in PFP programs, which can make it difficult for physicians to know what criteria and which sets of treatment guidelines apply to patients covered by different PFP programs. Responding to programs with similar, yet different measures and requirements can lead to duplication of effort and increased physician frustration. Although no two programs are alike, there are still many common operational components and strategies that can be combined in a variety of ways to comprise each program. This chapter of the report takes an in-depth look at numerous PFP components and strategies including:

- participation criteria;
- level of physician involvement;
- measurements of physician performance;
- data and technical issues;
- physician rating systems;
- bonus pools;
- use of data and reporting results; and
- PFP as a negotiating tool.

### **Participation Criteria**

PFP programs that are initiated by health plans, employers, employer coalitions, and the government can be either voluntary or require mandatory participation by physicians and other health care providers choosing to treat the program's patient base. Participation can also be tied to a participatory fee, such as in the BTE program.<sup>44</sup> In this case, physicians are financing their own bonuses. Participation can also be tied to contract provisions requiring the physician to participate in other incentive programs that are sponsored by a health plan, similar to health plans use of "all payer" clauses. Some PFP programs require certain technologies, which may have to be purchased by the participating physician or physician group. Increased labor costs, inherent to program participation, can also impact physician or physician group participation in a program.

### **Level of Physician Involvement**

A key aspect to the eventual success of any physician PFP program is the involvement of physicians in the program's design, development, and implementation. Physician involvement throughout all phases of the program is important, but never more so than in the design and selection of the performance measures that are used in the program.<sup>45</sup>

Physicians are frequently involved in the overall design and implementation process of PFP programs. Programs, which are "championed" by leading physicians in the community, are likely to be embraced more quickly by the general physician population. Inclusion of practicing physicians in all phases of PFP program development helps assure that appropriate conditions and diseases are targeted, that there is a probability of good

physician participation in the program, and that the means exist for adequate physician feedback to address changes that may be needed for the continued success of the program.

### **Measurements of Physician Performance**

At the heart of any PFP program are the measures that will be used to judge the performance of physicians and physician groups. Most PFP programs ostensibly focus their primary attention on these evidence-based clinical quality of care measures. Other common performance measures focus on patient satisfaction, efficiency/productivity, and the infrastructure of the practice including the use of information technologies.

#### Evidence-based Clinical Quality Measures

The clinical quality measures used to rate physician practice performance can be process measures or outcome measures or a combination of both. Both of these types of performance measures are intended to be indicative of quality and evidence-based care for both inpatient and outpatient settings and are used as a vehicle to more rapidly translate the strongest clinical evidence into practice. Meaningful and trusted performance measures are subject to change based on new evidence and are tested for reliability, validity, and feasibility to ensure that they correctly measure what was intended, and that they provide essential information for tracking changes in patient care to the physician.<sup>46</sup> The primary purpose of performance measures is to support sound clinical decisions by aiding physicians with quality improvement activities for the care they provide to patients. A clinical performance measure is used to track “whether or how often a process of care or outcome of care occurs.”<sup>47</sup>

In response to increased employer demands to verify improved quality of care for enrollees, there is considerable pressure on many health plans and PFP programs to transition their use of process measures to outcome-based measures. Comparing outcomes requires large numbers of equally matched patients, based on factors such as age, severity of disease, concomitant and co-morbid conditions, etc. Most data analysis systems currently in use are incapable of accurately comparing the degree of case-mix severity required to accurately and effectively use an outcomes-based approach.<sup>48</sup>

#### Non-Clinical Performance Measures

PFP programs also commonly use the following non-clinical measures in an effort to judge physician performance:

- **Structural measures** are indicators of the infrastructure of a physician practice. Measures can be used to evaluate aspects of the physical plant of a practice, although these are more commonly used in assessing the IT capabilities of a practice. These measures frequently do not consider, or attempt to evaluate, the effectiveness of a practice in its utilization of these technologies.

- **Efficiency and productivity measures** are used to determine a physician's ability to treat patients in a manner that is cost-effective. This can be reflective of a physician's charges and prescribing patterns (e.g. use of generic drugs and pharmaceuticals) or of his/her ability to diagnose and treat patients in a cost-effective manner. Productivity measures that evaluate a physician's ability to treat large numbers of patients in a proscribed time frame are most frequently used within physician groups that have their own incentive programs to determine physician compensation.
- **Patient satisfaction measures** are increasingly being used by PFP programs. These data can be easily collected; however, patient satisfaction measures are qualitative and subjective and often influenced by factors beyond a physician practice's direct control. Patients may register dissatisfaction with the type or timing of care received from a physician when the problem is actually attributable to conditions imposed by the patient's health care plan. Across most illness conditions, patient satisfaction research has been consistently hampered by serious measurement problems.<sup>49</sup> Lack of comparability of patient satisfaction data remains an obstacle to the data's use as a valid instrument of measurement. Measured by different entities, for different purposes, using different instruments, patient satisfaction data is far from uniform. Even some health plans are skeptical of satisfaction-based pay and often de-link the correlation between patient satisfaction and the quality of health care.<sup>50</sup>

#### Other Related Performance Measures

Although a substantial number of quality measures have been developed by organizations with broad scope and expertise in quality measurement and assessment for rating performances within the health care industry, some of these measures may or may not be appropriate for physician performance rating. Other organizations developing their own measure sets include:

- The Health Plan Employer Data and Information Set (HEDIS®) is developed by the NCQA. HEDIS is a set of standardized measures that specifies how health plans collect, audit, and report on their performance in areas such as breast cancer screening and cholesterol control. Although these measures were designed to rate health plans, they are commonly used by PFP programs to rate physician performance.
- The JCAHO created performance measures (ORYX), which are used in its hospital accreditation process.
- Through the CMS's Quality Improvement Organization (QIO) program, CMS has developed numerous quality measures, including measures that could be used in PFP programs.

- The NQF was incorporated as a not-for-profit public benefit corporation to adopt and coordinate the use of nationally accepted uniform health care quality standards and performance measures. This organization was previously discussed in Chapter II.
- The Agency for Healthcare Research and Quality (AHRQ) has developed quality indicators for use for use in quality improvement and national tracking. The indicators are currently used in hospital reporting and relate to disease prevention, hospital care, and patient safety.<sup>51</sup>
- RAND Health has developed a set of quality indicators, known as the RAND Quality Assessment (QA) Tools system to support a much publicized two-year study on the quality of health care delivered in the US. The study encompassed 30 clinical areas representing the leading causes of illness, disability, and death.<sup>52</sup>

### **Data and Technology Issues**

Perhaps there is no area of greater importance to physicians participating in PFP programs than the myriad of issues that surround the proper collection and use of physician data. To ensure compliance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, all entities handling the data must take stringent measures to assure the confidentiality of the data. PFP programs that use third parties to collect and interpret the PFP data have an inherent credibility advantage with physicians over those programs that perform these functions internally.

#### Corroborating PFP Data

Recreating the data that many PFP programs collect, collate, and analyze is beyond the technical capabilities of many physician practices. Unless a physician practice has the ability to mirror the PFP program's data collection and analysis capabilities, the practice is largely forced to accept the results as presented by the PFP program. Physician practices that try to corroborate PFP program results still face problems collecting and formatting the data.

According to survey results from physicians participating in the IHA's 2003 "Pay For Performance" program, the greatest data problems concerned the availability and completeness of the data. In addition to the information contained in their own record keeping systems, physicians still needed to collect pharmacy and lab data, which were often incomplete and needed considerable reformatting. Physicians particularly noted difficulty in obtaining the lab data and expressed a lack of confidence in its accuracy.<sup>53</sup>

In order to have the ability to assess the validity of the data, physicians need data reports on a regular and timely basis. If physicians want to modify their own behavior to become more closely aligned with a PFP programs' quality agenda, they need access to actionable data results on which to base that change.<sup>54</sup>

### Claims Data

Performance data can be derived from administrative or claims data (the coded invoices that physicians submit for reimbursement) or encounter (clinical) data from physician practices. Many PFP programs use administrative or claims data as the basis for rating physician performance.

Claims data may reflect some of the services a physician performs or does not perform. These data are not considered in conjunction with the complexity of the patient's disease(s) or co-morbidities. The fact that a patient may be a poor candidate for a screening procedure or class of drugs that might otherwise be appropriate often cannot be factored into these data. Data on patients who decide, for a variety of reasons, to reject recommended treatments or to become non-compliant with their drug regimens, should be, but are often not, excluded from the data set. For these reasons many experts feel that the use of claims data often leads to flawed results or judgments.<sup>55</sup>

### Related Data Issues

Through the use of valid quality performance measures, variation in data between different physicians or physician groups can indicate a difference in the quality of care being delivered. At the same time, variation of these data may be the result of measurement methodology problems, differing risk pools of patients, chance variability, and poor data quality.<sup>56</sup>

The data source and the methods used to obtain data may influence the accuracy of the results that are reported in PFP programs. There are generally two approaches to data collection for rating physician performance using clinical measures: electronically collected administrative data (data used for other purposes; such as, billing, diagnoses, and laboratory results) and data that are abstracted from medical records. The cost and, unfortunately, the reliability of electronic data is minimal compared to data that is abstracted from medical records.<sup>57</sup>

According to a recent NCQA study, *Rewarding Quality in Physician Office Practices*, "Often, the greatest challenge to measurement is to achieve an optimal balance between the accuracy of the health care quality reflected by a measure and the overall cost of data collection and analysis...Physicians and others being measured usually demand high levels of accuracy...(but) those paying for measurement are affected by the cost of data collection and thus may opt for reduced accuracy while maintaining relative comparability."<sup>58</sup>

Other data concerns include the lack of uniformity in analyzing the data from one PFP program to another. One PFP program may look to incentivize physicians for the increased use of a diagnostic test to detect a treatable condition while another PFP program might use the same data to identify physicians over utilizing that same test. Even within the same health plan, payment systems may reward physicians for opposing behaviors.<sup>59</sup>

Small groups and physicians in solo practice can face the problem of having sample sizes that may be too small to result in accurate data measurement.<sup>60</sup> The smaller the sample size the more likely that one outlier can dramatically affect an entire data set. Size of the data set can also be proactively addressed by allowing physicians and physician groups the opportunity to select the type and number of measures that will be used in the PFP programs in which they participate. Physician practices can assess their size, IT capabilities, internal quality improvement activities, and patient population characteristics to determine how many and which measures could be used to ensure a rich yield of high quality data.

### Information Technology

It is generally believed that the introduction of sophisticated IT into most medical practice settings has the potential to improve the quality and safety of care. A dilemma that often faces the solo or small group practitioner is the lack of IT, which can make participating in some PFP programs difficult if not nearly impossible. According to a California Health Care Foundation survey, 85% of the medical groups and clinics in California indicated that IT systems are too expensive.<sup>61</sup> Many physician practices, particularly the solo and small group practices, neither have the initial capital nor the support staff that is required to implement and maintain significant IT into their offices. Although physicians must frequently bear the brunt of IT adoption, the Center for Studying Health System Change (HSC) notes that cost advantages linked to IT still accrue more directly to health plans, employers, and patients than to physicians.<sup>62</sup>

Providing financial incentives from new pools of money for IT implementation can benefit physicians, as well as greatly benefit the PFP program sponsor. When use of IT results in an increase in more cost-efficient electronic claims submissions or improved patient diagnoses or treatments, it can result in reduced overall treatment costs. The extent of the financial benefits to employers and health plans is closely tied to having significant employee or member market penetration within the incentivized physician practices.<sup>63</sup>

There is little argument that physician practices that have successfully installed and implemented advanced IT systems can potentially improve clinical care for patients and create efficiencies for the practice.<sup>64</sup> In an effort to spur the adoption of IT among physicians, some employers and health plans have incorporated IT measures, a type of structure measure, into their PFP program to rate physician performance. Structure measures are designed to determine whether a practice has certain tools and IT systems – not to determine a measure of clinical quality.

### **Rating Physicians and Physician Groups**

#### Use of Outcome Measures

As was previously noted, there are two types of clinical performance measures that are used in rating physicians and physician groups – process measures and outcome measures. Because outcome measures only assess a patient's health status at a given

point in time, these measures cannot look at the care that is administered to the patient by a particular physician. This can result in a physician being rated based on the results of care that was provided by other member(s) of the patient's health care team.<sup>65</sup>

### Risk Adjustment

When outcome measures are used, risk adjustment is often added to the rating process to help ensure accurate results. Risk adjustment assesses the disease burden and assigns a risk score to a physician's patient base. The risk score reflects the expected use of medical resources by that patient base. The risk score is then used to adjust, up or down, the results of that physician's patients' outcomes as measured against the standards established by the PFP program.<sup>66</sup> Physician practices that treat a disproportionate number of high-risk patients typically will be at risk of having poorer outcomes than the average physician practice. Absent risk adjustment, physicians can be unfairly penalized for treating sicker and higher-risk patients. Some experts believe that programs lacking accurate risk adjustment are actually creating disincentives for the care of the acutely and chronically ill population. Many are concerned about the possibility that PFP programs will adversely affect physicians serving disadvantaged and uninsured populations and treating patients in academic medical centers and safety-net hospitals. JCAHO's ORYX is just one example of a program that includes risk adjustment.<sup>67</sup>

### Individual and Group Ratings

PFP programs can either rate or categorize physicians individually or collectively. A drawback to assessing the work of a group of physicians is that many physicians prefer being rated only on their own work. One of the problems that PFP programs encounter when trying to judge a physician's individual work is the lack of a sufficient volume of data upon which to make an evaluation. One significant patient outlier can significantly skew the physician's results when they are based on outcome measures. Even when process measures are used, it can take relatively few outlier patients to produce unacceptable results if the physician's pool of patients for a particular condition is small.<sup>68</sup> Using performance measures to look at group or organizational compliance rates may be far more productive. The patient pool is much larger and less subject to the effects of several outlier patients or of a few adverse events. The group also can serve as a support system to encourage more uniform behavior, which can lead to improved quality of care.

Some type of physician rating or stratification of physicians into groups when awarding physician incentives is inevitable. Unfortunately, this can result in winners and losers and is conducive to creating a negative attitude towards the PFP program on the part of physicians who do not receive an incentive award. These concerns can be somewhat negated by creating dual avenues for qualifying for an incentive. Incentives are usually given to physicians who achieve certain goals or levels. Those physicians who do not qualify for these incentives can still be compensated for showing progress or improvement in reaching their goals or achieving certain standards. It has been suggested that perhaps it is these lower rated physicians who health insurers and employer groups should be most interested in incentivizing to raise their overall quality of practice.<sup>69</sup> Some PFP programs incentivize all physicians who participate in their programs.

### **Bonus Pools**

Participatory fees, up-front capital expenditures, and labor costs are all factors in assessing the overall beneficial economic aspects of physician participation in a PFP program. A thorough examination of the bonus pool is also warranted. Ultimately, the prospective likelihood of receiving a bonus and its size will be determining factors in the level of physician participation in PFP programs. The potential size of a bonus may be substantial, but it should be considered in the context of the total resources required for participation in the program. The attractiveness of such a program to a physician organization can vary greatly depending on the current availability and sophistication of the group's information technology systems. Other PFP programs may be more modest in scope, but offer correspondingly easier program compliance requirements that can be met by most physician practices.

The source of funds in the bonus pool is also of integral interest. Is the bonus pool funded by new money, by funds that were previously designated towards a different physician payment pool, or by dollars from an unknown source? Health plans maintain most of the bonuses will have to come out of regular pay increases that all doctors would have received because the plans and employers do not wish to increase overall spending.<sup>70</sup> Funds often appear to come from new sources when, in actuality, they are taken from accounts that would have been used to pay physicians and other health care professionals in a different manner. The case for health plans, employers, coalitions, and the government to reward the practice of quality medicine with additional compensation should work "hand in glove" based on these entities' belief that the practice of quality medicine results in lower health care costs.<sup>71</sup>

As previously mentioned, the IHA's P4P program is paying physicians \$50 – 60 million dollars in bonuses. Part of these bonuses are funded by the physicians themselves from their physician program participation fees, and a portion comes from dollars that had been earmarked to provide larger 2003 physician fee increases.<sup>72</sup> This latter case is an example of a common funding strategy to initially provide new monies for a bonus pool and then gradually fund the bonuses from dollars that were to have been used to fund fee increases that either become non-existent or decreased in size over time. This also results in compensation shifting with the bonus pool being partially funded by dollars that were previously earmarked as some form of compensation to all member physicians including those physician practices that will not be receiving a bonus.

### **Use of Data and Reporting Results**

The demands for increased transparency in the health care system are growing stronger. Patients, employers, health plans, hospitals, and physicians all want to have greater access to fees, payment, quality, and cost information across virtually all aspects of the health care delivery system. The AMA has longstanding policy encouraging physicians to disclose their fees for commonly performed services to their patients.<sup>73</sup> Health plans should disclose their fee schedules and medical payment policies to physicians. Transparency becomes decidedly more complicated when it is focused on physician profiling and physician report cards as a result of data collected from physician PFP programs.

When clinically significant evidence-based data are available as a result of a PFP program, important decisions need to be made regarding the further use of the data. This data can be used internally with physicians in an effort to improve quality of care, and/or it can be used to influence patients' choice of physicians or to exclude physicians from participating in certain networks.

Some PFP programs not only use the results of these programs to educate physicians and to determine physician reimbursement, but also to provide public physician rankings, tiers or physician report cards. A physician report card is a document that reflects physician ratings or rankings in relation to physician performance relative to some combination of performance measures. These ratings/rankings can take a variety of forms, but they generally designate a type of rank order within the physicians and physician groups being measured. Report cards can be used for internal physician educational purposes, but they are more frequently used to inform employers and the public about individual or physician group performance. Physician report cards are also often used to report on efficiency or cost information instead of quality information.

As previously mentioned, many physician groups are collecting and analyzing their own data on the performance of the physicians in their organization. The results of these data analyses are used for reimbursement decisions as well as for quality enhancement programs. These internal programs may be better equipped to accurately drill down through sufficient individual data to more accurately assess individual physician performance within a group of physicians.

### **A Tool for Negotiating**

Besides encouraging the members of a physician organization to constantly aspire to meet the organization's quality standards and to facilitate equitable compensation among its physicians, incentive plans implemented within a physician organization can have another residual benefit. Establishing a PFP program may allow independent physicians to jointly negotiate contracts, according to a recent report issued by the Department of Justice (DOJ) and Federal Trade Commission (FTC). Because physicians continue to be extremely frustrated with the limited opportunities to jointly negotiate, absent forming a fully integrated group practice, this is an important point.

Statement 8 of the 1996 DOJ/FTC Joint Statements on Antitrust Enforcement sets forth antitrust safety zones for exclusive and non-exclusive physician joint ventures that the agencies are unlikely to challenge. One of the safety zones is for physician joint networks sharing "substantial financial risk." The 1996 Statements included capitation, percent of premiums, global fees, and withholds as examples of financial incentive arrangements that may constitute the sharing of substantial financial risk. If a physician organization satisfies this requirement, it should not be challenged for violating antitrust statutes, absent extraordinary circumstances.<sup>74</sup>

In the report *Improving Health Care: A Dose of Competition*,<sup>75</sup> the DOJ and FTC indicated that they will consider whether a particular pay for performance program developed by a physician joint venture constitutes the sharing of substantial financial risk such that it falls into the safety zone established in Statement 8. It is far too early to predict the significance of this statement, but it may provide the impetus for physicians to develop their own PFP programs.

## VII. ASSESSING OVERALL PROGRAM OPPORTUNITIES AND CHALLENGES

### Health Plan and Employer PFP Programs

As the number and scope of new PFP programs emerge, opportunities and challenges are presented that need to be addressed by the physician community. Just as there is no perfect PFP program, there are also no perfect criteria to assess exactly what should and should not be present in a PFP program. Every PFP program entails potential financial rewards and certain risks to the sponsors of the program and the participating physicians. Some global concepts and questions that physicians need to consider when evaluating a health plan or employer PFP program are as follows:

- The PFP program is constructed in a way so that physicians want to participate.
  - What role did physicians have in the design and implementation of the program?
  - What are the financial and technological barriers to physician participation in the program?
  - Is physician participation mandatory? Is non-participation economically feasible?
  - Is program participation tied to other factors such as participation in other incentive programs?
  - Does the program provide tools to assist physicians' participation in the program?
- The PFP program is assessed for its potential impact on the patient/physician relationship.
  - Are there aspects of the program that could impact this relationship?
  - If physicians meet the goals of the PFP program, will patients benefit?
  - Are there any aspects of the program that could pit physician adherence to PFP program parameters against the best interests of the patient?
  - Could the program promote patient de-selection?

- The stated goal of the PFP program is a focus on quality of care issues.
  - Is improved quality of care the foundation of the PFP program?
  - Are evidence-based quality of care measures the primary measures used by the program?
  - Is the primary data source administrative data or data that are abstracted for medical records?
  - Are the quality measures being used process- or outcome-based?
  - Are there provisions to change the measures when evidence changes?
  - Are the Consortium's performance measures being used?
  - Are appropriate risk adjustment methods being used?
  - Is the use of quality parameters a convenient ruse to find ways of decreasing the cost of care?
  - Is patient care likely to improve if all participating physicians follow the basic tenets of the program?
  
- The financial, and other, incentives of the PFP program are available and fair to the vast majority of affected physicians.
  - Are the financial incentives sufficient in scope to warrant any extra work and expense required to achieve them?
  - Does the program offer true bonuses in the form of new dollars or does it merely reallocate resources among physicians?
  - Is this program likely to create winners and losers or is it designed to "raise all boats?"
  - To qualify for a bonus, do physicians have to:
    - ◆ merely participate in the PFP program;
    - ◆ show increased use of performance measures or improved patient outcomes; or
    - ◆ attain specific goals or standards?
  - Is the program based on rewards rather than penalties?
  - Will physicians be publicly rated? What are the chances that some physicians will be misclassified?
  - What are the likely results of physician misclassification?
  - Are physicians provided an opportunity to review their ratings or profiles before they are publicly released?
  - Are the physicians provided the actionable data results on a regular and timely basis so they can effect changes in their practice to better meet PFP goals or standards?
  - Are the physicians incentivized and rated as individuals or groups of physicians?

- The PFP program is based on achieving quality and safety improvement rather than merely meeting arbitrary program standards, which may be cost-based.
  - Are physician participants going to be held to the rigid standards of the program?
  - Can deviation from the standards be cause for retribution?
  - Do physicians have an opportunity to comment on and effect changes in program and physician rating results?
  - Can the parameters of the program be used to establish standards that can be used against physicians in other venues such as credentialing and professional liability actions?

### **Physician Group and Physician Organization PFP Programs**

This paper has primarily focused on PFP programs that are sponsored by health plans, employers, and employer coalitions; however, it also discusses internal PFP programs that are sponsored by physician groups and physician organizations for their physician members. Consideration might be given to questions about these types of PFP programs.

- Should support for and/or operational recommendations about internal PFP programs be given by the AMA?
- Can such programs be positively structured so that they can be used to foster quality improvement and a reduction in practice variations as well as to determine appropriate allocation of financial resources?
- Should any information or cautionary statements be provided to physician organizations intending to use internal PFP programs as a means of staying within the antitrust “safety zone” for the purpose of conducting fee negotiations with health plans?

## Appendix A

### The Leapfrog Group for Patient Safety

<u>Initiator(s)</u>	<u>Program Name</u>	<u>Program Target/Focus</u>	<u>Target</u>	<u>Location</u>
Aetna	Quality Enhancement	In 2002, Aetna rejuvenated its physician incentive program, the Quality Enhancement (QE) program. The quality measures employed by Aetna's QE program reflect the nationwide and regional aspect of the insurer. The program rewards primary care physicians for their scores on several measures intended to evaluate the quality of care and service physicians provide to members.	Physicians	Multi-State
Aetna		In January, 2004, Aetna launched new networks of doctors that the company says have better outcomes in high-cost specialties. Aetna said the program could reduce health-care costs for employers, improve care of patients and possibly increase volume and income for physicians. The team includes specialists in cardiology, cardiothoracic surgery, gastroenterology, general surgery, orthopedics and obstetrics/gynecology, which are some of the highest cost-drivers for the company. Aetna offers the program in Jacksonville, Dallas and Seattle areas.	Physicians, Consumers	FL, TX, WA
American Academy of Family Physicians		Two group practices are participating in a University of Florida College of Medicine pilot, which uses a tracking program to collect data on what the physicians look up when they do their weekly sync between their handhelds and office computers. The system allows doctors to perform keyword searches by symptom, diagnosis or ICDA code. To receive CME credit, doctors must also record the question they were answering on a form from the university. The American Academy of Family Physicians is cooperating with the project but has not yet determined how much credit physicians will be awarded for their participation.	Physicians	FL
American Academy of Family Physicians		The American Academy of Family Physicians has entered a deal with eight companies, including General Electric and Siemens, to offer its members discounts on systems to manage electronic medical records.	Physicians	Nationwide
American College of Physicians	ACP PDA Pilot	The idea behind the ACP pilot is to give CME credit to physicians for changing their behavior and improving patient outcomes, not just answering questions using PDAs.	Physicians	Nationwide
Anthem Blue Cross and Blue Shield Midwest	Hospital Quality Program	Agreement between Anthem and 38 hospitals (5 in KY and 33 in OH and IN) which links reimbursements to quality measurements. The hospitals involved in this project do not have to record lots of data and release it to Anthem. This is something they do already under Anthem's Hospital Quality Program, in which 346 Kentucky, Indiana and Ohio hospitals take part.	Hospitals	KY, IN, OH

Anthem Blue Cross Blue Shield of NH	Quality Improvement Incentive Program	Anthem Blue Cross and Blue Shield of New Hampshire (BCBSNH) launched a Quality Improvement Incentive Program, rewarding primary care physicians (PCP) for the provision of quality care.	Physicians	NH
Anthem Blue Cross Blue Shield of OH		This program focuses on rewarding physicians for excellence in both quality and cost efficiency. The program involves MaternOhio, a cooperative that includes 30 obstetrical and gynecological group practices and Anthem.	Physicians	OH
Anthem Blue Cross Blue Shield of VA	Virginia Quality-In-Sights Hospital Incentive Program	Virginia Quality-In-Sights Hospital Incentive Program- This program is a three year collaborative program with Virginia hospitals that focuses on patient safety, patient outcomes, and patient satisfaction.	Hospitals	VA
Blue Cross Blue Shield of Michigan (University of Michigan and Michigan Health and Hospital Association) (Rewarding Results)	Blue Cross Blue Shield of Michigan Hospital Incentive Program	BCBS of MI implemented a hospital incentive program aimed at continuously improving quality that: promotes accepted and best clinical practices, promotes best medication and patient safety practices, achieves measurable improvements in community health, encourages patients' participation in their care, and rewards hospitals for desired outcomes.	Hospitals	MI
Blue Cross of CA (Wellpoint)		In July of 2001, Blue Cross of CA introduced a revised Quality Score Card, and with it, an innovative dimension to their relationships with HMO medical groups. The enhanced monitoring process rewards physician groups for improving the quality of care given to HMO patients using health outcomes and patient satisfaction information from a number of clinical and service categories. Acting upon the feedback of physician partners and with the endorsement of their external Physician Relations Committee, Blue Cross of California has added a new measurement category, Primary Care Physician (PCP) Quality Measurement and Bonus Systems, to its Quality Score Card. The category awards points to physician groups who have an internal process for measuring the quality and clinical performance of each doctor and a system for disbursing award bonuses to those practitioners who score well.	Hospitals	CA
Blue Cross of CA (Rewarding Results)	Physician Quality and Incentive Program	In October 2002, Blue Cross of California introduced its PPO Physician Quality and Incentive Program (PQIP). PQIP includes the following: (1) an online PPO Physician Report Card that allows physicians to benchmark their performance on key clinical processes to that of their, (2) a Physician Recognition Program that provides payment rewards for superior performance on clinical, administrative and pharmacy indicators, and (3) the provision of information resources to our network of PPO physicians to support quality improvement efforts. The Report Cards and information resources are available statewide; the payment rewards are currently limited to a pilot area.	Physicians	CA

Blue Cross Blue Shield of IL	HMO QI Fund	In 2000, BCBSIL implemented a new performance-based compensation approach for medical groups and IPAs participating in either of its two HMO products. By meeting annual performance targets for selected clinical measures, practices can increase their income from the health plan. BCBSIL includes the performance expectations in the groups' HMO contracts. Measurement is conducted annually.	Physicians	IL
Blue Cross Blue Shield of IL	Promoting Hospital Patient Safety: The BCBSIL Hospital Profile	BCBS of IL collects data on multiple indicators of hospital performance. Hospital-specific results are compiled into the BCBSIL Hospital Profile. The first profiles were sent to Illinois hospitals in April, 2003. Public reporting of some profile indicators is scheduled for 2004. Profile-related performance measures are being incorporated into hospital contracts.	Hospitals	IL
Blue Cross Blue Shield of MA	Primary Care Physician Incentive Program	The Primary Care Physician PCP Incentive Program is a quality-based incentive program that BCBSMA launched in 2000 to increase the number of BCBSMA members receiving important preventive and disease management services.	Hospitals	MA
Blue Cross Blue Shield of MA	Health Quality Improvement Incentive Program	The Health Quality Improvement Incentive Program (HQIIP), launched in 2003, rewards hospitals that demonstrate a commitment to data-driven, outcomes oriented performance improvement.	Hospitals	MA
Blue Cross Blue Shield of MA	Group Practice Incentive Program	The Group Practice Incentive Program (GPIP) was launched in 2003 for groups of specialists.	Physicians	MA
Blue Cross Blue Shield of MN	Recognizing Excellence and Assisting Smokers to Quit	The Recognizing Excellence and Assisting Smokers to Quit programs reward clinics that achieve superior, measurable outcomes in specific predefined areas. They represent a fundamental shift in Blue Cross' approach to provider reimbursement; moving it away from rewarding process improvement activities to rewarding provider performance relative to proven clinical outcomes.	Physicians	MN
Blue Cross Blue Shield of MO (RightChoice)	Physician Group Partners Program	The Physician Group Partners Program has 13 medical groups (560 physicians) under contract for its HMO and over 400 individual physicians under contract for its PPO plans.	Physicians	MO
Blue Shield of California	Network Choice	Blue Shield of California developed and continues to evolve a hospital tiering program called Network Choice. Using a risk and severity adjusted methodology incorporating relative costs and quality information, our hospital network is divided into two categories, "Choice" and "Affiliate". With Choice hospitals, members do not pay additional out-of-pocket expenses. With Affiliate hospitals, members may be subject to higher copayments or coinsurance when accessing the hospital for non-emergency care. Currently Network Choice covers all HMO, POS and PPO products in small and medium-sized employer accounts, and individual and family plans.	Hospitals, Consumers	CA

Blue Shield of California	Pay for Performance	The goal of the Pay for Performance incentive program is to reward physician groups for performance in clinical care and patient experience by providing a clear set of health plan expectations, use of common metrics, and public reporting. Scoring is based on performance metrics, which include clinical measures, patient satisfaction, and IT/Infrastructure investment.	Physicians	CA
Bridges to Excellence (NCQA, Tufts, Verizon, General Electric, Harvard Pilgrim, and United) (Rewarding Results)	Bridges to Excellence-Diabetes Care Link	Diabetes Care Link (a program modeled on an existing American Diabetes Association/National Committee for Quality Assurance effort) provides annual bonus payments to physicians who demonstrate good control of their patients with diabetes. An optional patient reward program is available to encourage employees and family members to take an active role in managing their condition.	Physicians	MA, OH, KY
Bridges to Excellence (NCQA, General Electric, Ford, Humana, Procter and Gamble, UPS, BCBS of KY, OH, IL, AL, Tufts, United, Aetna) (Rewarding Results)	Bridges to Excellence-Physician Office Link	The Physician Office Link program rewards physicians for investing in information systems and care management tools to help them provide more customized and integrated care over time, rather than simply responding to a patient's symptoms during office visits.	Physicians	MA, OH, KY
Buyers' Health Care Action Group		BHCAG rewards hospitals annually. To be eligible for an award, care systems must meet or exceed minimum performance thresholds for: patient safety, delivery of preventative services, and development and implementation of an improvement program in an area chosen by the care system.	Hospitals	MN
CalPERS		CalPers approved an 11-point strategic plan aimed at rewriting the book on health benefit purchasing for its 1.2 million members. The plan includes incentives for doctors and hospitals to improve the quality of care.	Physicians, Hospitals, Health Plans, Consumers	CA
Chicago Business Group on Health	Health Purchasing Initiative	CBGH sponsors the Health Purchasing Initiative (HPI) to bring area employers together to evaluate and purchase HMO services.	Health Plans	IL
CMS/Medicare	PGP Demonstration	CMS expects six physician group practices to participate in the three (3) year PGP Demonstration. Participating physician groups will be paid on a fee-for-service basis and be eligible to earn a bonus from the savings resulting from improvements in patient management.	Physicians	Nationwide

CMS/Medicare	Premier Demonstration	Centers for Medicaid and Medicare intend to pay a total of \$7 million a year in bonuses to select Premier hospitals that score well on 35 quality measures.	Hospitals	Nationwide
CMS/Medicare	End-Stage Renal Disease Management Demonstration	The End-Stage Renal Disease (ESRD) Disease Management Demonstration will increase the opportunity for Medicare beneficiaries with ESRD to join integrated care management systems. The demonstration is designed to test the effectiveness of disease management models to increase quality of care for ESRD patients while ensuring that this care is provided more effectively and efficiently.	Physicians	Nationwide
CMS/Medicare		Pilot program to award continuing medical education credits to physicians who participate in quality improvement projects with Medicare's Quality Improvement Organizations. The pilot project aims to boost the number of physicians in outpatient and office settings participating in quality improvement efforts.	Physicians	Nationwide
CMS/Medicare/Modernization Act 2003/Hospital Quality Reporting	Hospital Quality Incentive Data Demonstration	The agreement includes a powerful incentive for hospitals to participate in CMS' Hospital Quality Incentive Data initiative.	Hospitals	Nationwide
CMS/Medicare/Modernization Act 2003/Demonstration Program		The Secretary shall establish a 5-year demonstration program to examine health delivery factors that "encourage the delivery of improved quality in patient care." Medicare will pay a per-beneficiary amount to each participating physician who meets or exceeds specific performance standards regarding clinical quality and outcomes measures. CMS will contract with Quality Improvement Organizations (QIOs) or such other entities, as the Secretary of HHS deems appropriate to enroll and evaluate participating physicians.	Physicians	Nationwide
CMS/Medicare/Modernization Act 2003/Grants to Physicians (electronic prescribing)		HHS is authorized to make grants to physicians to assist them in implementing electronic prescription drug programs. Grants would help pay for the purchasing, leasing and installing of software and hardware – including handheld computer technology – making upgrades to existing systems; and training staff.	Physicians	Nationwide
Empire Blue Cross, IBM, PepsiCo, Verizon and Xerox	Leapfrog Initiative	IBM, PepsiCo, Inc., Verizon Communications and Xerox Corporation joined Empire in an innovative program designed to save lives by providing financial incentives to hospitals that rapidly achieve proven patient safety standards.	Hospitals	NY
Employers' Coalition on Health		The program provides incentives to physicians for monitoring diabetes patients.	Physicians	IL

Excellus Health Plan, Inc. (Rewarding Results)	Rochester Rewards Results	Excellus Health Plan, working in partnership with the Rochester Individual Practice Association (RIPA), will implement a performance improvement system which will consist of 1) clinical, service, efficiency measure reports for practitioners, 2) patient-specific detail for practitioner office follow up, 3) patient engagement tools, 4) physician and patient education and communication methods tied to a 5) financial incentive. The objective of the program will be to improve care in the Rochester community and to develop a model that will be transferred to other communities in upstate New York.	Physicians, Health Plans	NY
St. Louis Area Business Health Coalition		(1) St. Louis Area Business Health Coalition (BHC), a St. Louis area, purchasing coalition measures and rewards its health plans for good quality performance. In addition, BHC publicly recognizes hospitals for participation in the Leapfrog Group national patient safety survey.	Hospitals, Health Plans	MO
General Electric		GE's health plan incentive program involves a detailed and competitive bid process designed to assess the relative value of health plans, ongoing measurement of plan performance, incentives, and accountable contract management related to performance. Since 1998, a centerpiece of these efforts is the Sigma Scorecard. GE uses the Scorecard as a contract management tool. GE also links financial and non-financial incentives to scorecard results. The Scorecard assesses how a plan is doing in four areas: member satisfaction, controllership, cost, and quality.	Health Plans	Multi-State
General Motors	Activecare	General Motors (GM) and the University of Michigan Health System developed a direct contracting relationship that includes financial incentives for providers to improve patient care. The program is called Activecare.	Health Plans	MI
General Motors		GM adjusts premium contributions for employees based on each plan's cost and quality performance. GM annually reviews the efficiency, quality, and benefit designs of health plans to determine which are providing the best value for the price. Cost and quality scores are equally weighted to determine the plan's overall score.	Physicians	MI
Group Insurance Commission		The GIC has agreed to give their health plans financial bonuses if they meet standards for increasing admissions to Leapfrog-compliant hospitals.	Health Plans	MA
Hannaford Brothers		Hannaford applies an additional co-pay if an employee of theirs attends a hospital that does not meet the volume criteria for 5 out of the 7 high-risk procedures identified by the Leapfrog Group	Consumers	ME
Harvard Pilgrim Health Care/ Partners Hospitals		HPHC and Partners HealthCare/PCHI (Partners) engaged in extensive rate negotiations in 2000, when Partners demanded substantial rate increases at a time when the health plan was struggling to recover financially. The two organizations ultimately reached a four-year agreement, beginning in 2001, that includes sizable rate increases over the term of the contract, relative to historic rate increases. A portion of the rate increase each year is dependent on Partners' performance on specific quality measures, as well as other performance measures.	Physicians	MA

Hawaii Medical Service Association (State's Blue Cross Blue Shield plan)	Practitioner Quality & Service Recognition Program Provider Quality & Service Recognition Program	Enrollment in Hawaii Medical Service Association's Practitioner Quality and Service Recognition (PQSR) Program is voluntary. Practitioners who enroll share in a multimillion dollar budget earmarked to recognize practitioners for adhering to recognized standards of quality and clinical practices proven by research to improve clinical outcomes. Each PQSR Program participant receives an award based on his or her scoring in each of the program components: - Quality indicators - Patient satisfaction - Business operations with HMSA - Practice patterns.	Physicians	HI
Health Net	Performance Incentive Program	The Performance Incentive Program, launched in October 1999, sets four criteria for submission of information to Health Net.	Physicians	CA
Health Net of California	QCIP	Hospital Comparison Report This tool on the plan web site, www.health.net, provides information about hospital performance support member decisions.	Hospitals	CA
HealthPartners	Outcomes Recognition Program	HP's Outcomes Recognition Program (ORP) offers annual bonus awards to primary care clinics that achieve superior results in effectively promoting health and preventing disease. Eligible primary care groups are annually allocated a pool of bonus dollars that is awarded if a group reaches specific performance targets.	Physicians	MN
HealthPartners	Pay For Performance	HealthPartners works with primary care groups, specialty care group and hospitals in its contracted network to provide a performance-based reward system. This program is the first quality-performance-based program for hospitals in Minnesota. HPs calls this program Pay for Performance (PFP).	Physicians, Hospitals	MN
Highmark Blue Cross Blue Shield	Quality Incentive Payment Program Two Programs: Physician (QIPS) Hospital (HPIP) initiated 07/01/2001	Highmark Blue Cross Blue Shield's Quality Incentive Payment System (QIPS) rewards physicians in the W. PA region for improvements in measures based on the Health Plan Employer Data and Information Set (HEDIS) for preventive screenings and treatment for chronic conditions. Additional quality and service performance measures include a patient satisfaction survey, generic versus brand prescribing patterns, electronic submission of claims, and member access. Highmark Blue Cross Blue Shield's Hospital Performance Incentive Program rewards select hospitals in the W. Region of PA for improvements in quality of care/service, patient safety and medication safety. Core program quality indicators and measures have historically aligned with industry quality imperatives (Pennsylvania Health Care Containment Council, Pennsylvania Regional Healthcare Initiative, JCAHO, AHA, AHRQ, Impact, Leapfrog Group (Leapfrog "leaps"), National Quality Forum, CMS Quality Improvement Organization, etc).	Physicians, Hospitals	PA
Independence Blue Cross of PA		Independence is creating new financial rewards for hospitals that can deliver specific performance quality standards.	Hospitals	PA
Independent Health Association	QUALITY MANAGEMENT INCENTIVE AWARD	The goal of Independent Health's award program is improve our membership's health through improved: access/timeliness of care, preventive health screening, and adherence to best science guidelines for the treatment of chronic health conditions.	Physicians	NY

Integrated Health Association (Aetna, Blue Cross/Blue Shield of CA, CIGNA Healthcare of California, Inc., HealthNet, and Pacificare) Pay for Performance (Rewarding Results)	IHA- Pay for Performance	Under this plan, participating physician groups will be measured on quality indicators for the calendar year 2003, but not receive any actual bonus payments until mid-2004. Under the IHA plan, physician groups will receive a consolidated performance scorecard. The annual score will be evaluated by an independent firm and made public.	Physicians	CA
Center for Health Care Strategies - Medi-Cal Healthy Family Project (Local Initiative Rewarding Results)	CHCS - Local Initiative Rewarding Results Project	CHCS works in partnership with seven Local Initiative health plans that serve low-income families and children enrolled in the State's Medi-Cal (Medicaid) and Healthy Families (S-CHIP) programs to develop financial and non-financial incentives for providers as well as member incentives to improve the quality of and access to pediatric preventive care services.	Physicians	CA
Iowa Medicaid		Iowa ties financial incentives for its contractor to nine performance measures and financial penalties to 10 measures. In a few cases, the state ties both a financial incentive and a penalty to the same performance indicator, depending on the contractor's level of performance.	Health Plans	IA
Permanente Medical Groups, Kaiser Foundation Health Plans	Kaiser Permanente Medical Care Program	The majority of payment by Kaiser Foundation Health Plan (KFHP) to the Permanente Medical Groups (PMG) for medical services is through medical group capitation. Small additional amounts may be paid directly to the PMG by KFHP for specific clinical quality achievements in some regions. In turn, the PMG compensates its individual physicians through a unique formula for each region that includes both fixed and variable pay. Fixed payments in the form of salary make up the largest part. Variable payments are based on quality-related contributions by physicians in three areas: specific clinical quality processes and outcomes, member and/or patient satisfaction measures, professional contributions to the medical group.	Physicians	CA, CO, DC, GA, HI, MD, OH, OR, VA
Massachusetts Health Quality Partners (a coalition of health plans, state health agencies, medical and hospital trade associations and consumers)(Rewarding Results)	MHQP Rewarding Results	The Massachusetts Health Quality Partners (MHQP) has received a \$1 million dollar grant from the Robert Wood Johnson Foundation to conduct a pilot program demonstrating how quality performance can be aggregated across payers to produce comparative clinical quality reports at the practice site, medical group and large physician network level. MHQP will evaluate the effect of financial and non-financial incentives established by 5 local health plans on quality of care. The project will evaluate whether rewards for quality affect physician adherence to evidence-based clinical practice guidelines for preventive care and management of common chronic medical conditions and if so, which types of records combined with which types of organizational structure have the largest effect.	Physicians	MA

Massachusetts Medicaid		In 1992, Massachusetts became the first state to implement a statewide single vendor managed behavioral health carve-out program for Medicaid. The state required reporting of performance indicators by its contractor, but financial incentives were not linked to performance targets in the initial behavioral health contract. In fiscal year 1997, the state contracted with the Massachusetts Behavioral Health Partnership (MBHP) to manage the behavioral health program. At the same time, Massachusetts embarked on an outreach campaign related to its newly implemented 1115 waiver. The new eligibility rules, combined with the outreach campaign, significantly increased enrollment in Medicaid managed care overall, and in the behavioral health contract.	Health Plans	MA
Pacific Business Group on Health	Quality-based Provider Payment	Quality-based Provider Payment: As early as 1998, PBGH recognized that quality improvement was needed at the delivery system level and that physician groups, in particular, were getting mixed and sometimes contradictory messages from plans regarding their performance. Financial incentives were inadequate and lacked a single focus. Accordingly, PBGH worked with a group of health plan representatives and several leading medical groups to devise a mechanism for rewarding quality performance at the medical group and hospital level through performance-based incentive payments. Subsequently, the program was put into effect by the Integrated Healthcare Association (IHA Pay-for-Performance).	Physicians	CA
Pacific Business Group on Health		On behalf of employers in its Negotiating Alliance, PBGH jointly negotiates health plan rates and contract requirements. Ultimately, however, each employer elects which of the health plans to offer and contracts directly with plans. As part of the annual rate negotiations, PBGH establishes performance targets with each health plan. Plans must place two percent of their premiums from Negotiating Alliance members at risk. If a plan does not achieve all of its designated performance targets, it must reimburse each employer a specified amount for each missed target. The coalition negotiates premium rates with an expectation that the plans will meet all the performance thresholds.	Health Plans, Consumers	CA
Pacific Business Group on Health		In 1997, PBGH began awarding a blue ribbon to one health plan each year based on performance.	Health Plans	CA
PacifiCare		PacifiCare began disclosing information to their HMO enrollees on the quality performance of groups of physicians. Both current and new members opted for higher quality performers.	Physicians	CA
PacifiCare		The nation's first health plan to publicly release wide-ranging data on the performance of academic and community hospitals in its networks in terms of quality of care and level of service.	Hospitals	CA
Patient Choice Healthcare, Inc.		Patient Choice Healthcare, Inc., which develops health care programs that enable value-based health care purchasing, has enhanced its method for differentiating provider performance with the addition of a "quality credit." The company's revolutionary program helps consumers better understand and easily evaluate variations between health care systems, thereby spurring providers to continually improve performance and contain costs.	Physicians, Hospitals, Consumers	MA, MN, WA, WI

Premera Blue Cross	Pay For Performance	Premera's Pay for Performance program is intended to develop provider reimbursement models that link performance to compensation. This is done by embedding performance measurement rewards (in the areas of quality, satisfaction, prescribing and actual outcomes) into contract negotiation. It's hoped that this program will promote improvements in the quality of care and better control health-care cost trends. Quality Scorecards are the core of our Pay for Performance program. Starting in 2002, Premera worked with six leading clinics in Washington State to develop the Quality Scorecard. The effort was expanded in 2003 to include a total of 10 clinics, accounting for approximately 20 percent of all care received by Premera members in 2003. The 10 clinics were compared to each other and to the statewide Premera network average. The Quality Scorecard, which has no financial incentive attached to it, feeds into Premera's incentive plans for Pharmacy and Quality. The Pharmacy Incentive Plan focuses on improvement in the generic fill rate and in decreasing the average ingredient cost of drugs. The Quality Incentive Plan focuses on HEDIS measures, pharmacy metrics, quality improvement projects and clinical outcome metrics. Participation in the Pharmacy Incentive Program is limited to groups of at least 20 to 50 providers who meet a certain threshold for pharmacy claims each quarter. Participation in the Quality Incentive Program is limited to groups that provide care to at least 1,000 Premera members and also meet a certain threshold for annual claims.	Physicians	WA
Regence BlueShield	Regence BlueShield Hospital Reimbursement Leapfrog Differential	Regence BlueShield incents hospitals if fully compliant with two of the Leapfrog patient safety initiatives. Hospitals can earn a component of their inpatient APDRG conversion factors by meeting the Intensive Care Unit (ICU) Intensivist Staffing and Computerized Physician Order Entry (CPOE) criteria as stated by The Leapfrog Group.	Hospitals	WA
Rhode Island Medicaid		Rhode Island Medicaid focuses on its plans' performance using various outcomes and process measures.	Health Plans	RI
Texas Medical Association		Texas Medical Assn. has a CME project that gives credit for tracking the use of best-practice guidelines for cardiac patients.	Physicians	TX
Tri-Rivers Healthcare Coalition		A Quality Council, comprised of purchasers, practitioners, health system representatives, and consumers, governs Tri-River Healthcare Plan incentive program. The Quality Council determines the provider performance areas and targets on which to focus. The Tri-River incentive program has two basic components: 1. a bonus pool for medical groups that meet specific quality performance thresholds, and 2. new fee-for-service reimbursement for care planning activities conducted by physicians, such as completing an annual health risk assessment for a patient and creating an action plan.	Physicians	OH
Tufts Health Plan/Partners		Contract with Partners' hospitals to provide financial bonuses for implementing "electronic systems" that improves the safety and efficiency of drug ordering.	Hospitals	MA
Tufts Health Plan and Blue Cross Blue Shield of MA		In this program, two of MA largest health insurers are jointly investing \$3 million dollars over the next year to persuade their doctors to use hand held devices when prescribing medications.	Physicians	MA

Utah Medicaid		In Utah, EPSDT is referred to as the Child Health Evaluation and Care (CHEC) program. In 1996, Utah included a financial incentive in its HMO contracts to improve CHEC participation rates. In part, the state developed the incentive program to reach the CMS goal of 80 percent of Medicaid children receiving appropriate EPSDT screens. The state data indicated that approximately 67 percent of all eligible children in Utah Medicaid program in FFY 1994 received at least one initial or periodic screen. The state's HMO contract specifically indicates that the HMO agrees to use any financial bonus to reward its employees responsible for improving the CHEC participation rate. This employee directed bonus is a unique feature of the Utah incentive program. The state staff working on the CHEC program came up with the employee-directed financial incentive as a mechanism to focus HMO attention on improving well-child care using limited state dollars.	Health Plans	UT
WellPoint Health Networks, Inc.		WellPoint seeks to include a provision in medical group agreements that rewards physicians for improving the quality of care given to patients, using health outcomes and patient satisfaction information in a number of clinical and service categories.	Physicians	CA
Wisconsin Employee Trust Funds		The State of Wisconsin Department of Employee Trust Funds, administrator of the state's group health insurance program, plans on changing its current health plan premium contribution to a tiered approach. Tiering criteria will include quality and safety standards.	Health Plans, Consumer	WI
Wisconsin Medicaid		In 1991, Wisconsin began to set its HMO capitation rates with the assumption that 40 percent of enrolled children would receive the recommended number of EPSDT screens and related services over the course of the year. Currently, under the program, named "HealthCheck," if health plans deliver fewer than 80 percent of the expected screens, the state recoups the money that it paid for the undelivered services.	Health Plans	WI
Hawaii Medical Service Association [Blue Cross Blue Shield of Hawaii]	Hospital Quality and Service Recognition Program	HMSA's Hospital Quality and Service Recognition (HQSR) Program recognizes and rewards excellence in the areas of patient care quality, service satisfaction, business operations, and resource use. Created by the Hawaii Medical Service Association in collaboration with Health Benchmarks, Inc., a health care research company, the HQSR Program encourages the delivery of high-quality and cost-effective patient care and helps hospitals identify opportunities for quality improvement. The program is intended for acute general-medical-surgical-maternity hospitals and is similar in purpose and design to HMSA's Physician Quality and Service Recognition Program for participating physicians and psychologists.	Hospitals	HI
Maine Health Management Coalition	Pathways to Excellence - Primary Care		Physicians	ME
Memphis Business Group on Health	Leapfrog Leadership Awards	Hospitals that have fully met at least one Leapfrog patient safety initiative are recognized publicly through an awards ceremony and through placement of an advertisement in the daily newspaper with the broadest distribution in the marketplace.	Hospitals	TN

Savannah Business Group	The Gold Standard	This is a hospital performance measurement program.	Hospitals	GA
Savannah Business Group and The Care Network	The Platinum Standard Program	This is physician pay for performance program.	Physicians	GA
Anthem Blue Cross and Blue Shield West Region	Promoting Healthcare Quality (PHQ)	Anthem West's Promoting Healthcare Quality (PHQ) program was designed to drive change in the health care delivery system and improve outcomes with Anthem network providers. The program provides financial incentives to primary care physician groups and hospitals for implementing, measuring and reporting on evidence-based, industry accepted quality metrics. The PHQ program is voluntary for Anthem network providers and is contracted independently through Anthem West's Quality Department. There are no disincentives or penalties associated with participation. Providers are rewarded for developing the processes, systems and practice patterns to ensure all patients receive the very best health care available.	Physicians, Hospitals	CO, NV
INTEGRIS Health	Executive Incentive Plan	Beginning with fiscal year 2004 (July 1, 2003 - June 30, 2004), INTEGRIS Health incorporated measures of clinical quality and patient safety into its system wide incentive program, tying executive rewards to quality measures.	Hospitals	OK
Physician Direct ePPO of Oklahoma	ePPO Program	Physician Direct ePPO of Oklahoma is a statewide network of over 4,500 doctors and 120 hospitals. Physician Direct is the first network in the U.S. to incorporate the ePPO Program, a patent pending program that was developed to improve the quality of care to make healthcare more affordable. The ePPO Program incorporates evidence-based medicine with a per occurrence pay-for-performance program for doctors and their patients. Each time a doctor follows an evidence-based medicine guideline and prescribes Information Therapy (Ix), the doctor is paid a higher fee. Each time a patient responds to the Ix, they earn a financial reward. This patent pending model will soon be available to payors, networks, etc. outside of Oklahoma as the next version of technology is implemented 8/1/04.	Physicians, Hospitals, Health Plans, Consumers	OK
Piedmont Clinic	Piedmont Clinic Performance Improvement Plan (PIP)	400 MD multispecialty group practice (made of 86 DIFFERENT independent practices and 1 50 MD hospital owned practice). Every six months several quality metrics are measured and MDs are subjected to financial bonus or payback based on a combination of system wide metrics and individual metrics.	Physicians, Hospitals	GA
MVP Health Care	MVP Pay-4-Performance	The MVP Pay-4-Performance program recognizes individual physicians based on the outcomes of the care provided to our members. Our intent is to at least in part, help to offset the cost to develop practice based quality improvements, and at the same time communicate to each physician the value MVP places on the care she or he provides.	Physicians	NY, VT

State of Tennessee	Volunteer eHealth Initiative	The Volunteer eHealth Initiative will provide a framework for hospitals, physician groups, clinics, health plans and other healthcare stakeholders to work together to establish regional data-sharing agreements. The initial focus of the Project will be in a three-county area including Memphis. The project is being prompted by long-term efforts to reform TennCare but has the potential to benefit the entire community in the three-county region. If the pilot project is successful, it eventually could be expanded to other parts of the state. The project is being managed for TennCare through Vanderbilt University's Center for Better Health.	Physicians, Hospitals, Health Plans, Consumers	TN
The Boeing Company Regence BlueShield	Hospital Safety Incentive (Traditional Medical Plan)	The Hospital Safety Incentive uses a Direct to Consumer model. It is intended to encourage members of Boeing's largest unions (IAM 751 and SPEEA) to use hospitals that meet the patient safety standards. It is also intended to encourage hospitals to accelerate their efforts to meet the patient safety standards in order to protect or increase their market share of Boeing patients.	Hospitals, Consumers	Nationwide
The Boeing Company	Patient Safety Performance Guarantees	The Boeing Company includes two patient safety performance guarantees among its standard set of performance guarantees for its medical plans.	Health Plans	Nationwide
Preferred Plus of Kansas, Inc.	2004 Kansas Health Plan Hospital Safety Incentive Program	The 2004 incentive program focus is on patient safety and is based upon measures that are self-reported in the Leapfrog Group Hospital Safety Survey.	Hospitals	KS

## Appendix B

### List of 27 Reportable Events

#### Under Minnesota's 2003 Adverse Health Care Events Reporting Law

*These have been adopted from the National Quality Forum's list of serious reportable events. See the [legislation](#) for the full text of each event's definition.*

#### SURGICAL EVENTS

1. Surgery performed on a wrong body part
2. Surgery performed on the wrong patient
3. The wrong surgical procedure performed on a patient
4. Retention of a foreign object in a patient after surgery or other procedure
5. Death during or immediately after surgery of a normal, healthy patient

#### PRODUCT OR DEVICE EVENTS

6. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility
7. Patient death or serious disability associated with the use or function of a device in patient care in which the device used or functions other than as intended
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility

#### PATIENT PROTECTION EVENTS

9. An infant discharged to the wrong person
10. Patient death or serious disability associated with patient disappearance for more than four hours
11. Patient suicide or attempted suicide resulting in serious disability while being cared for in a facility

#### CARE MANAGEMENT EVENTS

12. Patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration
13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility
15. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a facility
16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life
17. Stage 3 or 4 ulcers acquired after admission to a facility
18. Patient death or serious disability due to spinal manipulative therapy

#### ENVIRONMENTAL EVENTS

19. Patient death or serious disability associated with an electric shock while being cared for in a facility
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
21. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility
22. Patient death associated with a fall while being cared for in a facility
23. Patient death or serious disability associated with the use or lack of restraints or bedrails while being cared for in a facility

#### CRIMINAL EVENTS

24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
25. Abduction of a patient of any age;
26. Sexual assault on a patient within or on the grounds of a facility
27. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility

## Bibliography

- <sup>1</sup> ERI Distance Learning Center. Available at: <http://www.eridlc.com/onlinetextbook/index.cfm?fuseaction=textbook.chpt17>.
- <sup>2</sup> Denham CR, Chair, Texas Medical Institute of Technology. *The No-Outcome, No-Income Tsunami: Surviving "Pay 4 Performance."* Focus on Patient Safety. The National Patient Safety Foundation 2004; 7: 1.
- <sup>3</sup> Denham CR, *The No-Outcome, No-Income Tsunami: Surviving "Pay 4 Performance."*
- <sup>4</sup> Epstein AM, Lee TH, Hamel MB, *Paying Physicians for High-Quality Care.* N Engl J Med. 2004;350:406-410.
- <sup>5</sup> Epstein AM, Lee TH, Hamel MB, *Paying Physicians for High-Quality Care.*
- <sup>6</sup> Centers for Medicare & Medicaid Services, *National Health Expenditures, 2002.* Available at: <http://www.cms.hhs.gov/statistics/nhe/historical/highlights.asp>.
- <sup>7</sup> Centers for Medicare & Medicaid Services, *National Health Expenditures, 2002.*
- <sup>8</sup> DeNavas-Walt C, Proctor B, Mills R, *Income, Poverty, and Health Insurance Coverage in the United States, 2003.* Washington, DC: US Department of Commerce; 2004. Current Population Reports. Available at: <http://www.census.gov/prod/2004pubs/p60-226.pdf>.
- <sup>9</sup> Kaiser Family Foundation. *Health Insurance Survey, 2003.* Available at: [http://www.kff.org/healthpollreport/archive\\_April2004/15.cfm](http://www.kff.org/healthpollreport/archive_April2004/15.cfm).
- <sup>10</sup> Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits 2004 Annual Survey.* Available at: <http://www.kff.org/insurance/7148/index.cfm>.
- <sup>11</sup> May J, Cunningham P. *Tough Trade-Offs: Medical Bills, Family Finances and Access to Care.* Washington, DC: Center for Studying Health System Change; 2004. Issue Brief 85. Available at: <http://www.hschange.org/CONTENT/689/689.pdf>.
- <sup>12</sup> Available at: [www.nqf.org](http://www.nqf.org).
- <sup>13</sup> Institute of Medicine. Executive Summary: *Setting Performance Standards and Expectations for Safety*, Recommendation 7.1. In: *To Err is Human.* Washington, DC, National Academies Press; 2000: 11.
- <sup>14</sup> Institute of Medicine *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington DC, National Academies Press, 2001: 18-19.
- <sup>15</sup> Institute of Medicine. Chapter Six: *Finance in 1st Annual Summit Crossing the Quality Chasm: A Focus on Communities.* Washington, DC, National Academies Press, 2004: 67.
- <sup>16</sup> Institute of Medicine. Chapter Six: *Finance in 1st Annual Summit Crossing the Quality Chasm: A Focus on Communities.* Washington, DC, National Academies Press, 2004: 69.
- <sup>17</sup> Rosenthal M, et al., *Paying for quality: Providers Incentives for Quality Improvement,* Health Affairs Vol 23, number 2, March/April 2004, 127-141.
- <sup>18</sup> Brennan TA, et al., *The role of physician specialty board certification status in the quality movement.* JAMA. 2004;292:1038-1043).
- <sup>19</sup> Introduction to Physician Performance Measurement Sets, American Medical Association, 2001.
- <sup>20</sup> Strunk B, Hurley R, *Paying for Quality: Health Plans Try Carrots Instead of Sticks,* HSC Brief No. 82, May 2004.
- <sup>21</sup> Available at: [www.ahrq.gov](http://www.ahrq.gov).

- <sup>22</sup> *Provider Incentive Models for Improving Quality of Care*, Bailit Health Purchasing, LLC, March 2002.
- <sup>23</sup> Baker J, Houghton J, Mongroo P, *Pay for Performance Incentive Programs in Healthcare: Market Dynamics and Business Process*, Research Report, ViPS, Inc. in partnership with Med-Vantage, 2003. Available at: [http://www.leapfroggroup.org/media/file/Leapfrog-Pay\\_for\\_Performance\\_Briefing.pdf](http://www.leapfroggroup.org/media/file/Leapfrog-Pay_for_Performance_Briefing.pdf)
- <sup>24</sup> Sipkoff M, *Will Pay for Performance Programs Introduce a New Set of Problems?*, Managed Care Magazine, May 2004.
- <sup>25</sup> Landro L, *Booster Shot: To Get Doctors to Do Better, Health Plans Try Cash Bonuses*, The Wall Street Journal, September 17, 2004.
- <sup>26</sup> Integrated Healthcare Association. Available at: <http://iha.org>.
- <sup>27</sup> Landro L, *Booster Shot: To Get Doctors to Do Better, Health Plans Try Cash Bonuses*.
- <sup>28</sup> Private Sector Advocacy, *A Report on the Integrated Healthcare Association's Pay for Performance Program*, August 3, 2004 memo to the AMA Board of Trustees.
- <sup>29</sup> Wolfson B, *Support gaining for standards to evaluate medical groups*, The Orange Register, November 11, 2004.
- <sup>30</sup> Skidmore S, *Incentives for Physicians*, The Florida Times-Union, October 23, 2003.
- <sup>31</sup> Chen MY, *HealthPartners to withhold payment for errors*, Star Tribune, October 6, 2004.
- <sup>32</sup> *Bridges to Excellence*. Available at: <http://www.bridgestoexcellence.org/bte/>.
- <sup>33</sup> Leapfrog Hospital Rewards Program. Available at: [http://www.leapfroggroup.org/about\\_us/other\\_initiatives/incentives\\_and\\_rewards/rewards\\_program](http://www.leapfroggroup.org/about_us/other_initiatives/incentives_and_rewards/rewards_program).
- <sup>34</sup> Landro L, *Doctor Scorecards Are Proposed in a Health-Care Quality Drive*, The Wall Street Journal, March 25, 2004.
- <sup>35</sup> Landro L, *A Carrot for the Right Prescription*, The Wall Street Journal, May 6, 2004.
- <sup>36</sup> 2003 Me. Laws 469.
- <sup>37</sup> FLA. STAT. Ch. 2004-297.
- <sup>38</sup> H.F. 1681, S.B.1915.
- <sup>39</sup> Landro L, *Booster Shot: To Get Doctors to Do Better, Health Plans Try Cash Bonuses*.
- <sup>40</sup> Berwick D, et al., *Paying For Performance: Medicare Should Lead*, Health Affairs, Vol 22, Issue 6, 8-10.
- <sup>41</sup> Report to the Congress: Variation and Innovation in Medicare (June 2003). Available at: [http://www.medpac.gov/publications/congressional\\_reports/June03\\_Entire\\_reportv3.pdf](http://www.medpac.gov/publications/congressional_reports/June03_Entire_reportv3.pdf)
- <sup>42</sup> Report to the Congress: Medicare Payment Policy (March 2004). Available at: [http://www.medpac.gov/publications/congressional\\_reports/Mar04\\_Entire\\_reportv3.pdf](http://www.medpac.gov/publications/congressional_reports/Mar04_Entire_reportv3.pdf).
- <sup>43</sup> Reichard J, *Cost Profiles of Doctors Appeal Powerfully to MedPAC*, CQ Healthbeat News, October 28, 2004.
- <sup>44</sup> *Bridges to Excellence*. Available at: <http://www.bridgestoexcellence.org/bte/>.
- <sup>45</sup> Berberabe T, *Can Physician and Health Plan Get Together Over Guidelines?*, Managed Care Magazine, September 2004.
- <sup>46</sup> Introduction to Physician Performance Measurement Sets, American Medical Association, 2001.

- <sup>47</sup> Performance Measurement Coordinating Council. Desirable Attributes of Performance Measures. A Consensus Document from the AMA, JCAHO, and NCQA. 1999. <http://www.ama-assn.org/ama/pbu/category/2946.html>.
- <sup>48</sup> Powell A, Davies H, Thomson R, *Using routine comparative data to access the quality of health care: understanding and avoiding common pitfalls*, Qual Saf Health Care 2003; 12: 122-128.
- <sup>49</sup> Sitzia J, *How valid and reliable are patient satisfaction data? An analysis of 195 studies*. International Journal for Quality in Health Care 1999;11:319–328.
- <sup>50</sup> Jackson C, AMNews staff, *California HMO: Doctor bonuses based on patient satisfaction*, July 30, 2001.
- <sup>51</sup> Available at: <http://www.qualityindicators.ahrq.gov/documentation.htm>
- <sup>52</sup> Available at: <http://www.rand.org/publications/RB/RB9053-1/>
- <sup>53</sup> California Cooperative Healthcare Reporting Initiative, *P4P Clinical Measure Pilot Final Report*, September 5, 2003. <http://www.pbgh.org/programs/cchri/documents/CCHRIP4PClinicalMeasurePilot.pdf>.
- <sup>54</sup> California Cooperative Healthcare Reporting Initiative, *P4P Clinical Measure Pilot Final Report*, September 5, 2003.
- <sup>55</sup> Landro L, *Booster Shot: To Get Doctors to Do Better, Health Plans Try Cash Bonuses*.
- <sup>56</sup> Powell A, Davies H, Thomson R, *Using routine comparative data to access the quality of health care: understanding and avoiding common pitfalls*.
- <sup>57</sup> Paulson G, et al., *Rewarding Quality in Physician Office Practices*, written by NCQA for *Rewarding Results*, 2004.
- <sup>58</sup> Paulson G, et al., *Rewarding Quality in Physician Office Practices*.
- <sup>59</sup> Skrunk B, Hurley R, *Paying for Quality: Health Plans Try Carrots Instead of Sticks*, HSC Issue Brief No. 82.
- <sup>60</sup> Safavi K, *Pay for Performance: Fad or Forever?* Available at: [www.HCTProject.com](http://www.HCTProject.com).
- <sup>61</sup> California Cooperative Healthcare Reporting Initiative, *P4P Clinical Measure Pilot Final Report*, September 5, 2003.
- <sup>62</sup> Reed M, Grossman J, *Limited Information Technology for Patient Care in Physician Offices*, HSC Issue Brief No. 89.
- <sup>63</sup> Baker J, Houghton J, Mongroo P, *Pay for Performance Incentive Programs in Healthcare: Market Dynamics and Business Process*.
- <sup>64</sup> Groman R, *The Use of Performance Measurements to Improve Physician Quality of Care*, A Position Paper of the American College of Physicians, 2004.
- <sup>65</sup> Hofer T, Wagner E, et al., *The Unreliability of Individual Physician "Report Cards" for Assessing the Costs and Quality of Care of a Chronic Disease*, JAMA, June 9, 1999—Vol 281, No. 22.
- <sup>66</sup> California Cooperative Healthcare Reporting Initiative, *P4P Clinical Measure Pilot Final Report*, September 5, 2003. Available at: <http://www.pbgh.org/programs/cchri/documents/CCHRIP4PClinicalMeasurePilot.pdf>.
- <sup>67</sup> Hofer T, Wagner E, et al., *The Unreliability of Individual Physician "Report Cards."*
- <sup>68</sup> Hofer T, Wagner E, et al., *The Unreliability of Individual Physician "Report Cards."*
- <sup>69</sup> Rosenthal M, et al., *Paying for Quality: Providers' Incentives for Quality Improvement*.
- <sup>70</sup> Landro L, *Booster Shot: To Get Doctors to Do Better, Health Plans Try Cash Bonuses*, The Wall Street Journal, September 17, 2004.

<sup>71</sup> *A Conversation with Margaret O’Kane*, *Managed Care Magazine*, September 2004.

<sup>72</sup> California Cooperative Healthcare Reporting Initiative, *P4P Clinical Measure Pilot Final Report*, September 5, 2003.

<sup>73</sup> AMA Policy H-385.989 *Payment for Physicians Services*.

<sup>74</sup> US Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care (1996).

<sup>75</sup> A Report by the Federal Trade Commission and the Department of Justice. *Improving Health Care: A Dose of Competition*, July 2004.