AHIP
America's Health Insurance Plans

Innovations in Recognizing and Rewarding Quality

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AHIP Innovations Monograph: Recognizing and Rewarding Quality

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Recognizing and Rewarding Quality: A National Priority

By Karen Ignagni
President and CEO, America's Health Insurance Plans

Almost a decade has passed since the Institute of Medicine (IOM) issued "Crossing the Quality Chasm," its landmark report that found many patients consistently fail to receive high-quality health care. Despite the IOM's urgent call for change, wide variations in care across the country still exist, and significant resources continue to be spent on sub-optimal care. Poor performance in our health care system costs the nation up to 79,000 avoidable deaths, 66.5 million sick days, and $1.8 billion in excess medical costs each year.

These challenges have been heightened by payment systems that create disincentives to improve quality and efficiency. Until recently, most health care in the United States has been paid for on a fee-for-service basis; a service is provided and a fee (or, in the case of a typical hospitalization, a multitude of fees) is charged. These fees, for the most part, have been paid without regard to whether the services provided were appropriate and effective.

As our nation faces the crushing burden of health care costs, health insurance plans are delivering new payment models that are showing results in making the system more affordable and improving value and safety. Health insurance plans have been at the forefront of efforts to pay not just for services rendered, but for performance achieved—a long-overdue approach called "pay for performance," or "P4P." A *2006 New England Journal of Medicine* article reported that at least half of the nation's health insurance plans, representing 80 percent of all enrollees in such plans, included some P4P incentives in their provider contracts. Of those, 90 percent had programs for physicians and 38 percent had programs for hospitals. For patients, this progress means greater safety and improved outcomes. For providers, it means being recognized and rewarded for practicing to the highest professional standards.

Our report highlights some of the most innovative approaches that regional and national health insurance plans have taken to advance quality of care and efficiency through the recognition and reward of physicians and hospitals for achieving national benchmarks, demonstrating outstanding performance, and making measurable improvements over time. Some involve rewarding physicians for making structural changes such as adopting electronic health record systems. Others involve rewarding practitioners for measuring and reporting on improved patient care, such as, by more actively monitoring and coordinating care for patients with chronic illnesses. Some of the programs described here focus on physicians, while others focus on hospitals. Many involve multi-stakeholder collaborations.

In this report, you also will find the views of physicians who observe that P4P has the potential to increase provider use of best practices and promote access to appropriate and timely care. Recognizing their crucial role in redesigning payment models, health insurance plans are committed to engaging physicians, hospitals, and other health care professionals in the design and implementation of P4P programs. They also are working with various stakeholders to make measurement more consistent—so that conscientious health care providers do not find themselves burdened by complex reporting requirements.

This report also includes views of leading consumer advocates who are working tirelessly in support of policies that can ensure delivery of the right care, at the right time, for the right reason, and at the right cost, with positive consequences for the national goals of reform.

The potential of paying for quality programs to transform the health care system is demonstrated through the insight and success of these case studies. We offer this report with the hope that it will be informative and useful for policymakers and thought leaders as they seek to address the three challenges of improving quality, reducing cost, and promoting access to care.

Physician Programs

The case examples in this section illustrate the breadth and depth of innovation being used by health insurance plans to design and test ways to change the current physician reimbursement paradigm from payment for *volume* to payment for *value*.

Health insurance plans are recognizing and rewarding physicians for high levels of clinical quality and patient satisfaction; for efficiency measures such as controlling potential hospital overutilization or increasing the use of generic and low-cost, name-brand prescription drugs; for the adoption of health information technology; and for investing in infrastructure and process improvements. These programs offer financial incentives and support to physician groups—and in some cases to individual primary care physicians and specialists—for meeting or exceeding absolute performance standards, for being top performers compared with peers, and for making improvements over time. In addition to earning bonus payments, high-performing physicians are being publicly recognized on health insurance plan web sites and with plaques or certificates that can be displayed in their medical offices.

Most of the clinical quality standards for physician pay for performance programs are based on HEDIS®*, the Healthcare Effectiveness Data and Information Set, which was developed by the National Committee for Quality Assurance (NCQA) to measure performance on important dimensions of care and service. HEDIS® is widely accepted as the gold standard for measuring and reporting clinical performance in preventive care, early detection of illness, and the treatment and management of chronic conditions like diabetes and heart disease. Health insurance plans that reward efficiency, information technology (IT) adoption, or infrastructure improvement typically develop their own, customized standards, and some programs offer incentives for the reporting of nationally recognized clinical data in areas such as cardiology and surgical outcomes.

Several of the health insurance plans profiled participate in Bridges to Excellence®, which incorporates NCQA's Physician Recognition Program into its pay for performance approach. As Dr. Edward J. Bujold, a family practice physician representing Granite Falls Family Medical Center in North Carolina, indicates in his perspective beginning on page 8 of this publication, there is a growing interest in using quality rewards and recognition to encourage physician groups to adopt attributes of the patient-centered medical home model.

Whether they are well-established or still in the pilot stage, the pay for performance programs summarized in this publication share some key characteristics: all have been developed in close collaboration with participating physicians and other stakeholders; their results are being tracked and measured over time; and they are being continually evaluated for their effectiveness and for ways to make them better.

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Edward J. Bujold, MD

Family Physician—Family Medical Care Center Granite Falls, North Carolina

Dr. Edward J. Bujold, a practicing family physician, manages the Family Medical Care Center in Granite Falls, North Carolina, which is associated with Blueridge HealthCare System (Grace and Valdese Hospitals), Carolinas HealthCare System, and Frye Regional Medical Center. He specializes in family medicine and has particular interests in information technology and integration into the medical office.

Bujold obtained his medical degree from Wayne State University and completed residencies at Malcolm Grow Medical Center, Walter Reed Army Hospital, and Bethesda Naval Hospital and is certified by the American Academy of Family Practice. He has published two books: An Odyssey of Primary Care Research and The Fifteen Minute Office Practice Manager.

In 2006, Blue Cross and Blue Shield of North Carolina approached my small family practice about participating in a new program that would allow us to receive recognition and financial rewards for meeting quality-of-care standards that have been established by the National Committee for Quality Assurance (NCQA). I was concerned about the amount of administrative work and expense involved, but as a long-time advocate for quality measurement and improvement within the American Academy of Family Physicians, I was cautiously optimistic, so I signed on.

After some initial bumps in the road, we began receiving bonus payments for doing right by our patients—payments that more than covered our additional costs. More importantly, our practice has become part of a movement that could transform medical care. In fact, I believe that we may be on the cusp of a real revolution in reforming health care in the United States, and that pay for performance is a small but essential step along the way.

Providing Better Care for Patients

In order to qualify for the performance bonus, we had to meet the requirements for one of NCQA's Physician Recognition Programs in disease management. We chose diabetes management because our practice was already aligned with the program's performance standards, and we knew we could do even better in some areas. What's more, many of the NCQA guidelines for diabetes are the same as those targeting heart disease and stroke, which we see as another area where we can have a positive effect on the health and well-being of our patients.

The benefits of the program are obvious: If we keep a patient's numbers within certain parameters, then the complications go away or become much less significant, and patients are less likely to need doctor visits or hospital admissions. Until recently, however, there was no incentive for physicians to perform tests and to work with patients on compliance except for our own innate sense that it is the right thing to do.

Some physicians still balk at the use of clinical guidelines, claiming that they are nothing but "cookbook medicine." It is a conveniently demeaning term, but let's look at the reality. The Institute of Medicine has estimated that the number of preventable deaths in our health care system is the equivalent of a jumbo jet crashing several times a week, with everyone aboard dying. We would never stand for that kind of abysmal safety record in the airline industry, but for years we have tolerated unnecessary death and morbidity in health care. Evidence-based clinical guidelines are equivalent to aviation protocols: Properly applied, they allow doctors to do what they were trained to do while reducing the chance of undertreatment, overtreatment, and mistreatment.

Making Pay for Performance Work

Whatever the type or size of medical practice, embracing evidence-based guidelines and pay for performance is not enough, however. Substantial amounts of time, resources, and training are required to integrate them into the practice, clinically and administratively; to gather, analyze, and report data; and to engage and communicate with patients. This means much more than just having a physician leader as champion. Other clinicians need to provide patient education and check vital signs; administrative staff need to send out reminders to patients, gather data, and prepare reports; and the office has to be well-managed.

To maintain a commitment to quality improvement, practices need a stable workforce, which means people must be paid well, with good benefits like health and disability insurance. But many primary care offices are struggling just to cover their overhead, which means they need to see as many patients as possible. This leaves staff maxed out, with little time or energy to take on quality improvement.

Also, without proper information systems, you cannot make a dent. Despite our small size, my practice adopted a completely automated office with electronic medical records in 2000, which was unheard of at the time. The cost was substantial—$150,000 plus training and the time needed to get buy-in—and no one paid me an extra dime. I believed the pay-off in terms of making medicine safer and easier to practice would be well worth the investment, and so far so good.

Clearly, pay for performance at its current levels will not remedy the financial pressures or the other underlying problems in primary care—like the growing shortage of new primary care physicians, as more and more medical trainees choose sub-specialties instead, and the continuing bias toward paying far more for procedures than for prevention, disease management, and time with patients—but as part of a much larger puzzle, it's a start.

Building Medical Homes

The larger puzzle—the real opportunity to reform and revolutionize health care delivery, reduce unnecessary mortality and morbidity, tame health care spending, and shift the balance back toward primary care and prevention—is the medical home.

My home state has been a pioneer in encouraging the medical home concepts of personal, coordinated care management, disease prevention and quality improvement. The overall goal is to develop local disease management and care coordination systems that encourage efficient and appropriate health care utilization, improve health outcomes, and reduce spending by keeping people out of emergency rooms; reducing their use of multiple providers; increasing compliance with clinical guidelines for conditions like asthma, diabetes, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD); and encouraging them to switch to generic drugs.

The results have been dramatic, with substantial reductions in asthma-related emergency department visits and hospital admissions, and some $250 million in overall savings. In order for real reform to take hold, stakeholders need to quickly embrace the medical home, expand pay for performance based on disease management and the adoption of clinical guidelines, and find ways to increase payment to primary care specialties who provide true medical homes for their patients.

As for physicians, I say enjoy the science and the challenge of taking care of patients who are really sick, the complex cases, the people with multiple conditions. Grasp the life and the profession, and be all that you are trained to be.

Aetna—
Physician Incentive Programs

Giving physician groups maximum flexibility to improve based on self-selected quality measures

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Background

Aetna's physician incentive programs identify and target areas of opportunity for quality improvement to help improve the overall quality, safety, and cost-efficiency of health care. The programs set targets for improvements and deliver performance measurement results for Independent Practice Associations (IPAs), Physician-Hospital Organizations (PHOs), and physician groups. Data are provided at both the group and physician level and incorporate online and other tools that provide actionable, patient-level information to the physicians.

The cornerstone of Aetna's provider incentive programs is Pathways to Excellence℠, an array of initiatives that recognize and reward providers who improve the quality, safety, and cost-efficiency of health care. The initiatives also contribute to Aetna's value-based purchasing strategy on behalf of members and plan sponsors. Pathways to Excellence℠ programs use evidence-based, transparent measures and credible data to recognize and promote quality and to engage providers in achieving demonstrated improvements in care for members.

Pathways to Excellence programs for physicians include Aexcel®, a designation within Aetna's Performance Network identifying physicians who have shown that they deliver efficient, effective care; physician reimbursement demonstrations such as the Patient-Centered Medical Home; Aetna's Provider Quality Performance, or pay for performance (P4P) programs; and High Performance Provider Initiatives.

Aetna's P4P arrangements with physicians can be:

- Integrated into Aetna's contractual reimbursement methodologies;
- Negotiated into agreements with specific reimbursement for performance achievement for large multi- or single-specialty groups, IPAs, or PHOS;
- Based on national recognition program such as Bridges to Excellence® (BTE), where nationally recognized measures are voluntarily reported by physicians to achieve agreed-upon results and incentive payments;
- Integrated into an overall program using BTE and Aetna-specific measures; or
- Based on participation in statewide multi-payer collaboratives where aggregated payer data are used to recognize and reward physicians.

Aetna believes critical success factors for P4P programs include the use, wherever possible, of national, consensus-based measure definitions, such as those endorsed by the National Quality Forum (NQF), and full transparency on how each measure is defined and used. Aetna also supports existing statewide multi-payer initiatives where there is a commitment to both national standardized measures and the Consumer-Purchaser Disclosure Project's Patient Charter. The Patient Charter creates a national set of principles to guide measuring and reporting to consumers about physician performance. These principles are agreed upon by leading physician groups, health insurers, employers, consumer groups, and labor unions.

Measurement

Aetna's P4P programs apply the strengths of the company's data aggregation and national data repository resources to local market initiatives to allow for customized measures and goals. Aetna's national data repository currently holds 40 NQF-based measures of physician practice, with new measures added each year. In addition, Aetna's performance programs for physicians can readily integrate national performance results through National Committee for Quality Assurance (NCQA), BTE and other recognition programs. In the sample below, the clinical measures are based on standardized definitions from national organization; (e.g. HEDIS®, NQF). The formulary measure is transparent to physicians and focuses on opportunities where use of the formulary is both clinically and financially appropriate for the patient.

The following sample P4P scorecard is an example of the summary report for an IPA's pay for performance program with Aetna. Aetna reports on whether or not there has been improvement over the baseline during the measurement year and whether agreed-upon annual goals have been achieved. Annual goals are negotiated agreements between the provider group and Aetna based on market position and previous-year measurements. Benchmark results are provided for the marketplace, and detailed information on each individual physician's results on each measure is provided.

Reports may also be used to illustrate variations in performance among peer groups by comparing a group's scores with the aggregate performance on each measure of other groups of the same specialty in their sub-market. For the group in the example below, the performance incentive was fully earned for the cervical cancer screening measures, and progress was made toward the formulary compliance goal, resulting in a partial payment.

Physician Pay for Performance Scorecard Results for Measurement Period Ending June 30, 2008

Measure		Results				
Description	**Baseline**	**Numerator**	**Denominator**	**Score**	**Goal**	**% Achieved**
Medical Cost Effectiveness						
Effective Use of Formulary	71.4%	49,935	67,945	73.5%	73.9%	84%
Clinical Performance						
Cervical Cancer Screening	80.8%	5,599	6,735	83.1%	83.0%	106%
Diabetes Care—Hemoglobin A1c Test	80.4%	432	537	82.4%	83.0%	77%
Statin Use in Members With Ischemic Heart Disease (IHD)—Cardiologists	77.1%	380	503	75.5%	79.1%	0%

Results

In reviewing the results for a subset of about 2,500 physicians in multiple practices across three states (Connecticut, New Jersey, and New York), improvements were consistently seen for diabetes care[1], appropriate medications following an asthma event, formulary compliance, and emergency visits per thousand. For these same physician groups, some improved while others showed no improvement in areas such as cervical cancer, breast cancer, and colorectal screening. Improvements ranged from less than one percentage point to more than 40 percentage points, depending on the group and the measure.

These results reflect measurement data from 2005 through 2007, but there is significant lag time in reporting of the data. Since physician groups need time to disseminate information and work with their patients, the numbers may not capture all improved results.

[1] Measures include: Annual Hemoglobin A1c, Annual Lipid Screening, Annual Microalbuminuria Screening, and Annual Retinal Exam

A Sample of Measures in a Physician Group Pay for Performance Scorecard

Clinical Effectiveness: Make up the majority of measures and rewards availability

- Appropriate Treatment for Children with URI
- Asthmatics Receiving Inhaled Corticosteroids
- ACE Inhibitor or Angiotensin Receptor Blocker with heart failure
- ACE Inhibitor or Angiotensin Receptor Blocker with congestive heart failure
- Annual Monitoring for Members on Persistent Anticonvulsants (multiple drugs)
- Annual Monitoring for Members on Persistent Digoxin
- Annual Monitoring for Members on Persistent Diuretics
- Annual Monitoring for Members on Persistent ACE Inhibitors or Angiotensis Receptor Blockers
- Beta Blocker Treatment After AMI
- Beta Blocker Therapy—Prior to AMI
- Lipid-Lowering Drug for Prevention of IHD
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Diabetes—Annual HbA1c
- Diabetes—Annual Lipid Screening
- Diabetes—Annual Microalbuminuria Screening
- Diabetes—Annual Retinal Exam
- Drug Therapy for Lowering LDL Cholesterol in Members with Coronary Artery Disease
- NCQA Diabetes Recognition
- NCQA Heart/Stroke Recognition
- NCQA Physician Practice Connections®
- Osteoporosis Management in Members who have had a Fracture

Access, Efficiency and Resource Use: Less than half of measures and rewards opportunity, generally used as a suite of measures

- Open Panel Status (availability to new patients)
- Formulary Use Rate
- Generic Substitution Use Rate
- Bed Days per 1,000 Members
- 30-day Readmission Rate
- Sleep Studies Site of Service
- Episode of Care Efficiency Index
- Ambulatory-sensitive ER-visits/1,000 members

Critical Elements of Success

Two features of Aetna's program that are especially valuable to physician groups are the use of data measures and methodologies that are transparent and consistent with national standards, as well as the ability to obtain actionable information and data. In addition, Aetna works with the physician community to select measures and to obtain physician feedback on the measures that are applicable in their markets.

More broadly, Aetna believes that P4P's success requires:

- Clear and specific understanding between payers and providers on the parameters of the program's measurements, incentive opportunities and targets;
- National, consensus measures;
- A focus on continuous quality improvement;
- Commitments to retire measures after there have been several periods of top-level performance (e.g. 95 percent and above) and replace them with new measures that have new opportunities for improvement;
- Collaboration to identify new sources of actionable information and creative ways to encourage and engage with physicians and physician groups effectively;
- A commitment across all commercial payers to include performance incentives in the overall reimbursement strategy, recognizing that when physicians improve their practices all patients benefit;
- The integration of performance measurement activities with health information technology adoption initiatives; and
- The integration of national performance incentive programs such as BTE into the plan's overall pay for performance strategy.

As we work together to support improvements in adherence to evidence-based outcomes and achieving the best possible outcomes for patients, evaluating results and return-on-investment are critical priorities for pay for performance and related incentive programs. Learning from physician practices, the tools and strategies that help achieve results and sharing that information will promote more rapid diffusion of improvements. In addition to expanding Aetna's programs' depth and breadth, this evaluation and information sharing are key priorities for Aetna's Pathways to Excellence activities.

Plan Description:

Aetna is one of the leading diversified health care benefits companies in the United States, serving approximately 37.2 million people with information and resources to help them make better informed decisions about their health care. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, and medical management capabilities and health care management services for Medicaid plans. Its customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units and government-sponsored plans in the U.S. and internationally. www.aetna.com

Anthem Blue Cross and Blue Shield—Anthem Quality Insights–Primary Care Quality Incentive Program

Creating an interactive Web portal to empower physicians, simplify administration, and foster collaboration

Background

Anthem Blue Cross and Blue Shield's Quality Insights (AQI) quality recognition and health improvement programs are designed to redefine the relationship that health care providers traditionally have had with insurers by creating a mutually beneficial, patient-focused collaboration.

The Primary Care Quality Incentive Program rewards participating primary care physicians and provider groups throughout Anthem's Northeast region (Connecticut, Maine, and New Hampshire) that meet or exceed identified performance metrics. These metrics are based on industry standards of quality, clinical outcomes, patient safety, and administrative processes that enhance patient care. The program rewards qualifying physicians and providers through an adjustment to fee schedule-based payments over the period July 1 through June 30 annually.

The AQI Primary Care program includes a secure Web portal for provider groups that is updated on a monthly basis with administrative paid claims and that provides practitioners an opportunity to enter specific supplemental information based on a patient's medical record. Provider groups can monitor their performance on an ongoing basis using a balanced scorecard approach that includes the following components:

Program Component	Points
Chronic Disease and Preventive (Process)	40
Chronic Disease (Outcomes)	10
Pharmacy: Generic Drug Utilization	25
Technology: • EMR/EHR, e-Rx, Electronic Disease Registry	20
• Use of the AQI Web portal	5
Provider's/Group's Total	100

For providers that are part of a multi-specialty group, only those providers in the group that have been designated as primary care providers by Anthem Blue Cross and Blue Shield are included in the program. Scoring and any compensation increases are limited to those physicians and providers who are eligible to participate in the program.

Program Design

AQI has been developed to engage Anthem's primary care practitioners and specialty care physicians in a collaborative quality improvement program. Eligible practitioners who meet program requirements and targets are awarded with a two-, four-, or six-percent fee schedule increase.

Provider Web Portal

The AQI interactive Web portal allows eligible practitioners to access and submit secure information required as part of the program and to monitor the practice's progress toward meeting specific clinical performance goals. They can view performance reports that allow provider groups to monitor their monthly progress; member lists that identify members who may need specific tests or immunization reminders; clinical outcome worksheets that assist offices with medical record review; and generic pharmacy reports that compare the provider group's performance to the network. All are available to assist practices in maintaining or improving the quality of care they provide, as well as to help them optimize their incentive opportunities.

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Measurement

PCP Program Measures—2008

Primary care provider (PCP) measures include a combination of chronic disease and preventive measures evaluating process and clinical outcomes, as well as measures focusing on technology and pharmacy utilization. The measure specifications are similar to those used for HEDIS® (Healthcare Effectiveness Data and Information Set) reporting.

Component	Minimum Number of Unique[2] Anthem Members Required for Eligibility*
Process Measures Diabetes, Asthma, Cardiovascular conditions (CVC), Childhood and Adolescent Well Care, Appropriate Testing for Children with Pharyngitis	25 Members (large group) or 15 members (small group), in total, for all process measures combined (members are counted only once)
Pharmacy Generic Utilization	1 member with prescription drug coverage administered by WellPoint NextRx
Technology EMR/EHR, e-Rx, Electronic Disease/Patient Registry	1 member
Clinical Outcomes Childhood and Adolescent Immunizations, Diabetes, Cardiovascular conditions	25 members (large group) or 15 members (small group), in total, for all eligible outcomes measures combined.[3]

* A group must have at least five members eligible for a particular measure in order for that measure to be included in the eligibility count and scoring of the clinical outcomes component.

Results

Throughout the development and evolution of the program, there has been ongoing collaboration with the Anthem Quality Department to develop member outreach programs that support the AQI Primary Care measures. For example, the Population Health Department sent out a mailing to remind diabetic members to have their Dilated Retinal Exams and Hemoglobin A1c tests.

Rates for several measures were greater than 80 percent in 2007. For example, the Diabetes LDL-cholesterol (LDL-C) rate increased from 84.91 percent to 85.49 percent in 2006; the CVC rate increased from 84.31 percent to 84.56 percent; and the Adolescent Well Visits rate increased from 68.39 percent to 70.23 percent.

The AQI Generic Pharmacy program resulted in an increase in generic prescribing from 47.25 percent in 2004 (Pre AQI) to 58.70 percent in 2007. Forty-five percent of the AQI network provider groups have generic rates equal to or above that of the state wide network rate for the same specialty.

Forty-one percent of provider group responders have adopted all three technologies in 2007—electronic medical record, e-prescribing and a patient registry—compared to 30 percent in 2006. The increase in provider adoption of technology will ultimately contribute toward reducing errors, improving clinical quality, and promoting administrative and cost efficiencies in providers' offices.

Lessons Learned

The initial design of the program in 2005 involved a large internal project team, Anthem also used a variety of external resources, including physician committees, clinical researchers, and data analysts in the development of evidence-based, standardized program measures and goals.

Two key concepts that were critical to the program were:

- Developing provider tools with concurrent, actionable information to help providers improve patients' health status; and
- Minimizing the administrative burden to providers through an interactive Web portal that allows data entry.

A unique feature of the AQI portal is that it allows physicians or groups to supplement information found in the patient's medical chart to create a complete record for measurement. In 2007, AQI collaborated with provider relations to reach out to targeted provider groups, resulting in an increase in the percentage of network providers using the AQI web site from 55 percent to 61 percent.

Plan Description:

Anthem Blue Cross and Blue Shield is the trade name of: In Connecticut: Anthem Health Plans, Inc. In Maine: Anthem Health Plans of Maine, Inc. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Virginia: Anthem Health Plans of Virginia, Inc. (serving Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123.). Independent licensees of the Blue Cross and Blue Shield Association.® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

[2] Each member is counted once for the provider.

[3] Members are counted only once.

Blue Cross and Blue Shield of Florida—Recognizing Physician Excellence Program

Community physicians instrumental in choosing performance metrics that benefit members, physicians, physician groups, employers, and the health insurance plan

Background

Blue Cross and Blue Shield of Florida (BCBSF) designed its physician recognition program, *Recognizing Physician Excellence* (RPE), to recognize and reward physicians who are committed to delivering high-quality care and excellent service to their patients. Eligible physicians include primary care specialists (family practice, general practice, internal medicine, pediatrics, geriatrics, and obstetrics and gynecology) who participate in NetworkBlue.

Developed in 2004, RPE is a voluntary program offered to primary care physicians who participate in NetworkBlue, a network for all BlueOptions PPO point-of-service health insurance plans. In 2008, more than 4,000 physicians participated in the program. These physicians make up more than 50 percent of eligible physicians and care for 52 percent of the BCBSF membership. As BCBSF's pay for performance program, RPE rewards physicians for the delivery of high-quality care and recognizes the important role primary care physicians play in providing comprehensive health care to their patients.

The key objectives of the RPE program are to:

- Improve the delivery of care to members for preventive services and chronic conditions
- Increase physician and member satisfaction
- Provide enhanced service levels to participating physicians
- Foster adoption and use of information technology
- Align with national quality measures such as those of the Centers for Medicare & Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), and others
- Increase compliance with evidence-based guidelines
- Improve patient safety
- Enhance the cultural competency of physicians

Measurement

For 2009, the program design continues to focus on two categories: Clinical Quality (75 percent) and Process Improvement (25 percent). The Clinical Quality component is comprised of 22 metrics in six areas of quality: preventive health screenings, diabetes management, asthma management, pediatric care, cardiovascular care, and, new for 2009, orthopedic care. The Process Improvement section encourages practices to focus on members' safety and satisfaction, use of health information technology, and participation in continuing education programs. A distinct section for pediatric care also has been added.

Clinical Quality

The clinical quality metrics are derived from evidence-based guidelines, are clinically actionable, impact a large patient population, and align with BCBSF quality initiatives. Individual physicians responsible for influencing patient care are given credit for claims data linking them to a service.

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

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Preventive Health Screenings
- Mammography Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Colorectal Cancer Screening
- Osteoporosis Screening for Women over 50 with Fractures
- Prenatal Screening for HIV

Pediatric Care
- Childhood Vaccinations: Measles-Mumps-Rubella (MMR)
- Childhood Vaccinations: Shingles (VZV)
- Childhood Vaccinations: Hepatitis B
- Treatment of Children with Upper Respiratory Infection (URI)
- Appropriate Testing for Children with Pharyngitis

Cardiovascular Care
- Treatment of hyperlipidemia
- Post Myocardial Infarction (MI): beta blocker persistence

Diabetes Management
- Hemoglobin A1c
- Retinal exam
- Emergency Room (ER) avoidance—informational only
- Lipid panel
- Screening for diabetic nephropathy

Asthma Management
- Long term control Rx use
- ER avoidance—informational only

Orthopedic Care
- Use of Imaging Studies for Low Back Pain

Process Improvement (25 percent)

RPE program points are awarded for a variety of activities related to e-Capability Adoption, such as electronic medical records, e-prescribing tools, patient safety and satisfaction, and training and education, based on a combination of actual data and physician-supplied measures gathered through the completion of an online survey. In addition, some specific pediatric measures have been added, such as sending reminders for immunizations and well-child visits, and maintaining separate waiting areas for well children and children suspected of having an infectious disease.

Results, Challenges, and Lessons Learned

Early results of several key quality metrics show participating physicians perform at rates of two to three points higher than their non-participating peers. BCBSF believes that over time, this will translate to fewer complications from chronic diseases and more early detection of cancers and other chronic conditions.

External physician involvement in the design, development, and growth of the program has been critical to the success of the RPE program. The performance metrics utilized in the RPE program were chosen to provide benefits for members, physicians, physician groups, employers, and BCBSF. Pay for performance programs such as RPE encourage the more efficient consumption of health care resources, which in turn will lower employers' overall health care costs and improve the quality of health care received by members and their dependents.

The RPE program obtained endorsement and/or input from several external constituents, including the Florida Academy of Family Practice (FAFP), the Florida Medical Association (FMA), and the Clinical Advisory Group (CAG). The CAG is a committee of 16 multi-specialty BCBSF participating physicians from across the state with whom the RPE program team meets regularly to discuss program design and obtain feedback and recommendations.

Plan Description:

Blue Cross and Blue Shield of Florida is a leader in Florida's health industry. BCBSF and its subsidiaries serve more than 8.3 million people. Since 1944, the company has been dedicated to meeting the diverse needs of all those it serves by offering an array of choices. BCBSF is a not-for-profit, policyholder-owned, tax-paying mutual company. Headquartered in Jacksonville, Fla., BCBSF is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies. For more information visit, www.bcbsfl.com.

Blue Cross Blue Shield of Massachusetts—Group Performance-Based Incentive Program

Collaborating with medical groups to focus on the greatest opportunities for success

Background

The Blue Cross Blue Shield of Massachusetts (BCBSMA) Group Performance-Based Incentive Program (GPIP) focuses on engaging medical groups in quality improvement initiatives and promoting medical efficiency with particular focus on the role of specialty care physicians.

The goals of the program are to:

- Improve performance based on selected quality, safety, and efficiency measures by providing physicians with actionable data at the group level and HMO Blue members with health improvement tools.
- Reimburse primary and specialty care physicians at a level above the HMO Blue fee schedule for demonstrating improvements in quality and affordability.

BCBSMA collaborates with participating groups, using BCBSMA-provided utilization reports, to identify areas that offer each GPIP organization the greatest opportunity to succeed. Key areas of collaboration may include radiology, pharmacy, specialty, and outpatient management, inpatient utilization, and involvement in BCBSMA's health management programs, such as Case and Disease Management. The program provides group leaders with actionable data, tools, and incentives to reward physicians for achieving excellence in quality of care, patient satisfaction, access, and effective management of medical services.

Measurement

Group performance is measured in three areas: Clinical Quality and Patient Safety, Utilization/Resource Allocation, and Patient Experience of Care. While the general program framework remains consistent from year to year, the individual measures may change to reflect current quality or financial opportunities.

Clinical Quality and Patient Safety

For the 2008 measurement year, each GPIP organization is eligible to receive financial incentives for reporting cardiology and surgical outcomes as part of the quality and safety component of the program. These measures are based on national evidence-based quality measures developed by the Centers for Medicare & Medicaid Services (CMS). A GPIP organization can earn incentive payments independent of the efficiency component of the incentive program.

Utilization Resource Allocation

Efficiency is measured based on whether the GPIP organization's medical expense trend is lower than the overall network trend on four medical utilization measures: high-technology radiology, pharmacy, laboratory, and all other medical utilization. GPIP organizations that achieve a lower trend than the network average from the base period to performance period, adjusted to account for changes in relative health status, are eligible to share in the savings.

Patient Experience of Care

Participating groups are measured using the Patient Experience Survey administered by Massachusetts Heath Quality Partners (MHQP). This survey, which is sent annually to patients of primary care physicians and periodically to patients of certain other specialty physicians, incorporates statistically valid composites from the survey into GPIP and other P4P programs at BCBSMA.

MASSACHUSETTS

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Results, Challenges, and Lessons Learned

Out of 21 participating groups caring for approximately 318,000 HMO Blue members in 2007 (approximately 27 percent of total HMO Blue membership), 16 groups met some or all the efficiency measures, and four met all of the efficiency measures. The 21 groups received a total payout of $15.9M for 2007, for an average payout per group of $758,000.

GPIP has evolved since its inception in 2003 based on the feedback received from participating groups. Efficiency measures have been broken down into the four medical utilization areas to enable groups to direct their efforts to areas that offer the maximum opportunity for improvement in managing medical services. The program engages groups in quality activities that represent opportunities for greater efficiency in keeping trend growth below established benchmarks and continues to move from measuring clinical quality with process measures to self-reported clinical outcome measures such as lipid and blood pressure levels.

The measures for 2008 are summarized in the following table:

GPIP	Measure
Clinical Outcomes	Cardiology (coronary artery disease (CAD): Blood pressure, smoking screening, Low-density lipids (LDL), Statin history; Atrial fibrillation (AF): Coumadin management)
	Surgical (Antibiotic and Deep vein thrombosis (DVT) Prophylaxis)
	Coumadin Management
Patient Experience	Specialist Patient Experience Survey (Reporting Only)
Efficiency	High-Tech Radiology Trend
	Pharmacy Trend
	All Other Medical Services Trend
	Lab Trend
Other	Business Plan for GPIP Program

Plan Description

Blue Cross Blue Shield of Massachusetts (www.bluecrossma.com) was founded more than 70 years ago by a group of community-minded business leaders. Today, headquartered in Boston, BCBSMA provides coverage to more than 3 million members, 2.5 million in Massachusetts. BCBSMA believes in rewarding doctors and hospitals for delivering safe and effective care, and in empowering patients to take more responsibility, become educated health care consumers and become stronger partners with their doctors. Blue Cross Blue Shield of Massachusetts is an independent licensee of the Blue Cross Blue Shield Association.

Blue Cross Blue Shield of Massachusetts—Primary Care Physician Incentive Program

Supporting and building on physicians' commitment to provide safe and effective patient-centered care

Background

The Blue Cross Blue Shield of Massachusetts (BCBSMA) Primary Care Physician Incentive Program (PCPIP) offers incentives for achieving quality goals and provides physicians with the data and tools they need to reach these goals.

BCBSMA is committed to collaborating with physicians to provide safe and effective care to its members, with an emphasis on patient-centered care that reduces overuse, underuse, and misuse of health care services. PCPIP has created a mechanism by which physicians are rewarded for providing evidence-based, high-quality care that is efficient and effective. The program has been successful in improving members' health and providing them access to excellent care.

Measurement

PCPIP measures and thresholds are reevaluated annually to ensure that there is continued room for improvement. The program's 2008 measures are as follows:

Adult process and outcome measures:

- Preventive care: Mammography and Cervical Cancer Rates
- Chronic care
  - Process measures: Diabetes- Hemoglobin A1c testing (2x in a year), monitoring for nephropathy and low-density lipids cholesterol (LDL-C) testing (all or nothing composite measure)
  - Outcomes reporting:
    - Hypertension: Blood Pressure values
    - Cardiovascular patients: LDL-C and blood pressure values
    - Diabetes: Hemoglobin A1c, LDL-C and blood pressure values
- Reporting only (not tied to incentives; "opportunity lists" of patients shared with practices))
  - Colorectal cancer screening
  - Converting non-covered or non-preferred drugs to tier one or two equivalents
  - Cholesterol management for patients with cardiovascular conditions
  - Medication adherence
  - Eye exams for diabetics
  - Asthma management
  - Appropriate antibiotic use for viral conditions

Pediatric process and outcome measures:

- Well child visits
- Well teen visits
- Weight control in ages three to 17 with preventive visit to assess weight, height, body mass index (BMI), BMI percentile, BMI plotted and nutrition counseling if BMI is above the 85th percentile.

MASSACHUSETTS

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Reporting only

- Attention deficit and hyperactivity disorder (ADHD) management
- Converting non-covered or non-preferred drugs to tier one or two equivalents
- Asthma management
- Appropriate treatment for upper respiratory infection
- Appropriate testing for pharyngitis

Utilization/Resource Allocation

The percentage of generic prescriptions written by the primary care provider (PCP) must be 2 percent above the network rate to receive an incentive payment. Rates for the PCP and the network are based on the following formula:

$$\text{Rate (percent)} = \frac{\text{Number of generic prescriptions}}{\text{Number of all prescriptions written}}$$

The numerator is defined as a generic drug that is chemically and therapeutically equivalent to a brand-name drug with an expired patent. The denominator includes all eligible pharmacy claims.

Business Operations

- Technology adoption through electronic medical records or e-prescribing.
- PCP's provide information on their practice infrastructure and care systems through an on-line survey. This allows those PCP's who do not meet sample-size requirements for chronic care process and outcome measures to still receive incentive payments.

Results

Currently, 99 percent of PCPs (5,300) in the HMO Blue network participate in the incentive programs. In 2007, 89 percent of PCPs earned an incentive through the PCPIP program, and 6 percent of PCPs earned the maximum payment for which they were eligible. The average payment per PCP based on 2007 results was $7,514, and more than 900 PCPs earned over $10,000 in incentive payments. The introduction of incentives has correlated with improvements in quality of care. For example, well adolescent visits improved[4] from 56 percent in 2000 to 76 percent in 2007, and diabetic HbA1c tests improved from 85 percent in 2000 to 93 percent in 2007. Data is reviewed on a yearly basis in order to evaluate the progress of the program.

PCPIP is evolving from HEDIS® and process-based measurements to measures of reported outcomes. These outcome-driven measures will help transform the health care system by rewarding the highest quality providers based on the care they are delivering to their patients. BCBSMA remains committed to both transparency and continuous quality improvement.

Plan Description:

Blue Cross Blue Shield of Massachusetts (www.bluecrossma.com) was founded more than 70 years ago by a group of community-minded business leaders. Today, headquartered in Boston, BCBSMA provides coverage to more than 3 million members, 2.5 million in Massachusetts. BCBSMA believes in rewarding doctors and hospitals for delivering safe and effective care, and in empowering patients to take more responsibility, become educated health care consumers and become stronger partners with their doctors. Blue Cross Blue Shield of Massachusetts is an independent licensee of the Blue Cross Blue Shield Association.

[4] HEDIS® Well Child Exam Measures for Ages 0-15 months, 3-6 years, and 12-21 years

CIGNA and Dartmouth-Hitchcock Healthcare System—Medical Home Collaboration

Employing clinical information, clinical collaboration, and a blended payment model to improve both quality and affordability of care

Background

CIGNA and Dartmouth-Hitchcock Healthcare System launched a medical home pilot program in New Hampshire with the goal of improving quality, affordability, and patient satisfaction through collaboration and aligned incentives. The program is focused on the 17,000 CIGNA members who receive care from Dartmouth-Hitchcock primary care providers practicing in family medicine, internal medicine, and pediatrics. Patients, especially those with chronic illness or ongoing medical needs, will have access to enhanced care coordination, appointment availability communications, and education to help them navigate their health care system, while physicians receive additional reimbursement for providing enhanced services and a supportive infrastructure.

The patient-centered medical home model of care is designed to provide patients with a comprehensive, coordinated approach to primary care, which in turn leads to improved quality and lower medical costs. This pilot is intended to help CIGNA gather additional data about the effectiveness of this model in improving quality of care, improving patient satisfaction, adhering to treatment plans, and reducing medical costs. Dartmouth is seeking formal recognition for these capabilities through the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home program™ [5].

The program has three key components: clinical information, clinical collaboration, and a blended payment model. CIGNA provides Dartmouth-Hitchcock with lists of high-risk patients identified according to mutually agreed-upon criteria. Dartmouth-Hitchcock then provides case management services (for example, a nurse who helps to coordinate care with the goal of improving quality and reducing avoidable emergency room visits and hospitalizations for at-risk patients). CIGNA also provides Dartmouth-Hitchcock with electronic feeds that identify gaps in care in areas such as medication compliance and needed preventive health care, which can be addressed at the time of the patient's next visit.

Measurement

The program's bonus model is based on both the quality and affordability of care. CIGNA evaluates the quality of physician care using 39 evidence-based-measure rules derived from measures endorsed by the National Quality Forum (NQF), AQA Alliance (formerly known as the Ambulatory Care Quality Alliance), and HEDIS®. In this initiative, the incentive is based on a subset of these measures focused on diabetes, cardiac, and pulmonary measures in year one, with additional measures in neurology, cardiac and diabetes added in years two and three. The quality results must be improved or maintained at a better-than-market average for physicians to be eligible for a bonus. Dartmouth-Hitchcock physicians can benefit from a portion of medical savings with the potential to receive up to 3 percent of medical costs paid to the group. The potential bonus pool is determined by measuring the age, sex, case mix-adjusted trend in total medical costs for the members cared for by Dartmouth-Hitchcock compared with those cared for by other New Hampshire physicians. Patient satisfaction measures will be added in the second year of the program based on mutually agreed-upon parameters.

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Affordability is measured by a review of the total medical cost trend as compared to the local medical community on an age, sex, case mix-adjusted basis. The physician group must improve its trend compared with the market average to be eligible for any bonus, and the amount of bonus depends upon the extent of the improvement.

Results, Challenges, Lessons Learned

CIGNA will be evaluating improvement on measures, patient satisfaction, and total medical costs saved. Initial results will be available in the fourth quarter of 2009. In the interim, the participants believe that clinical collaboration, supporting informatics, and enhanced care coordination will enable Dartmouth-Hitchcock to improve quality, affordability, and patient satisfaction. Dartmouth-Hitchcock has a tradition of pursuing these objectives, and both organizations believe the pilot program will help to accelerate existing efforts.

Plan Description:

CIGNA, a global health service company, is dedicated to helping people improve their health, well-being and security. CIGNA Corporation's operating subsidiaries provide an integrated suite of medical, dental, behavioral health, pharmacy, and vision care benefits, as well as group life, accident, and disability insurance, to approximately 47 million people throughout the United States and around the world. To learn more about CIGNA, visit www.cigna.com.

[5] The NCQA Patient-Centered Medical Home program consists of three levels of set point values and must-pass elements that need to be obtained in order to achieve recognition.
– Level 1 is achieved by obtaining between 25 and 49 points and passing 5 of 10 must-pass elements, with a performance level of at least 50%.
– Level 2 is achieved by obtaining 50-75 points and passing 10 of 10 must-pass elements with a performance level of at least 50%.
– Level 3 is achieved by obtaining 75 points or more and passing 10 of 10 must-pass elements with a performance level of at least 50%.
Detailed information on the NCQA Patient-Centered Medical Home program can be found at www.ncqa.org

Geisinger Health Plan—ProvenHealth Navigator

Applying the patient-centered medical home concept through team care, improved access, and comprehensive chronic disease management

Redesigning primary care is critical to delivering high-quality, more efficient care. The ProvenHealth Navigator (PHN) program encompasses the principles of patient-centered primary care with an emphasis on enhancing the member experience and quality-of-care while maximizing efficiencies. The program was implemented in January 2007 with three primary care sites in central and northeastern Pennsylvania that care for 3,000 Medicare and 1,100 commercial members. In 2008, the program expanded to an additional nine primary care sites, covering more than 12,000 Medicare Advantage members.

The core strategy of PHN is to offer patients a delivery system that provides integrated, clinical care coordination and support management, 24 hours a day, seven days a week. Success is defined by achieving quality, member-experience, and efficiency targets for the entire primary care practice.

PHN has five key components, including:

- Patient-centered primary care team practice—physician led, team-based care with a focus on total access, enhanced in-office capabilities and chronic disease optimization
- Integrated population management—moving typical health insurance plan functions out to the primary care site including population profiling and segmentation, onsite case management, disease management, health prevention activities, pharmacy management, and telemonitoring
- Care systems management—including inpatient, skilled nursing, home care, and emergency department management
- Quality outcomes program—defined quality management strategies around diabetes, heart failure, hypertension, heart disease and preventive care
- Value reimbursement model—pay for performance was added to the plan's existing fee-for-service reimbursement structure; stipends provided to physicians, as well as, the practice for support of infrastructure improvements; results are shared, based on efficiency and quality achievement

Results, Challenges, and Lessons Learned

Quality criteria were agreed upon with the providers at the PHN sites. Baseline levels were measured, and targets were established for each quality indicator based either on defined targets or improvements over the baseline measure. The chart on page 22 shows a sampling of baseline measures compared with results after 12 months of participation in PHN, demonstrating significant improvements in a number of key metrics.

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Indicator	Office 1 – Pre	Office 1 – Post	Office 2 – Pre	Office 2 – Post
Increase over baseline – Diabetes Bundle[6] Score (must meet all criteria)	9.2%	10.9%	5.3%	9.2%
Increase over baseline – Coronary Artery Disease (CAD) Bundle[7] Score	11%	15.7%	15%	21%
Increase over baseline – Pneumococcal Vaccine	82%	85.7%	87.4%	91%
Increase over baseline – Influenza Vaccine	1,452	1,477	511	513
Inpatient Follow-up after hospital/ Emergency Department – > 75% w/in 7days	Not measured	84.2%	Not measured	92.6%
Risk Evaluation – > 90%	0	100%	0	100%
Documented Care Plan – > 90% for those in Care Management	0	99%	0	97.6%
Ability to get desired appointment	84.4%	83.7%	85.2%	85.5%
Satisfaction with care received at visit	91.0%	92.4%	90.1%	91.8%

PHN efficiency metrics include per-member-per-month expense, total admissions, inpatient admissions, and 30-day readmission rates, all of which demonstrated statistically significant improvements since implementation. In addition, a patient satisfaction measurement tool has recently been developed that better evaluates the goals of patient-centered care.

A core component of the program that is popular with both physicians and patients has been the placement of case managers directly in the primary care sites to help with coordination of care for members with chronic and complex medical conditions. Early lessons demonstrated that a key opportunity lies in transitions of care, and focusing on case management outreach within 24 to 48 hours post-discharge is critical to driving down readmissions. Phone access was difficult early in the program, so direct phone lines to the case managers were installed to help improve access.

Two of the most significant challenges Geisinger has encountered are access for acute care and the number of members continuing to seek care at emergency departments without contacting their primary care physicians. In response, efforts were undertaken in each site to realign provider schedules in order to "save" appointments for acute needs or for post-discharge follow-up. Access for acute care and follow-up appointments is now available consistently. Work continues around emergency department utilization, including enhanced communication to members about primary care access, as well as magnets with the clinic phone numbers.

While the PHN program demonstrates that it is possible to improve patients' health outcomes and reduce costs, success requires significant changes in the primary care delivery model, which is by no means easy. Some of the key lessons learned so far, include:

- Providers must be engaged, empowered and active.
- Patients with very complex conditions need very close follow-up, whether they are at home, in the hospital, or in a skilled nursing facility.
- Transitions between systems of care often highlight significant gaps as well as opportunities for improvement.
- A critical success factor has been the embedding of case managers in the PHN primary care sites.

Geisinger Health Plan continues to expand the number of practice sites participating in the PHN model and has added commercial members, as well as Medicare, in the model. In addition, to improve continuity of care and coordination of services across the spectrum of care, greater emphasis is being placed on enhancing collaboration with specialists and hospital systems, and strategies are being created to further develop a more comprehensive approach to the management of patients receiving skilled nursing care in nursing homes.

Plan Description:

Based in Danville, Geisinger Health Plan provides insurance coverage to residents in 42 counties in Pennsylvania. GHP offers a wide range of products at affordable rates for employer groups, individuals or families, and Medicare beneficiaries. Plan options include HMO, PPO, employer self-funded, high deductible plans.

GHP was ranked the top commercial health plan in Pennsylvania and #5 among health plans in the nation in the 2008-09 U.S. News & World Report/NCQA America's Best Health Plans list*. The Medicare plan, Gesinger Gold, was also ranked the top health plan in Pennsylvania and #3 in the nation. GHP's programs for members with chronic conditions such as diabetes, heart failure, and asthma have been accredited by the National Committee for Quality Assurance.

*America's Best Health Plans is a trademark of U.S. News & World Report.

[6] The Diabetes bundle measures include:% w/ pneumococcal vaccination,% w/ influenza vaccination,% w/hemoglobin A1C order in past 6 months,% w/hemoglobin A1C < 7%,% w/ LDL order in past 12 months,% w/ LDL < 100,% w/ microalbumin order in past 12 months,% documented non-smokers,% BP < 130/80.

[7] The Coronary Artery Disease (CAD) bundle measures include:% LDL < 100 or < 70 for high risk (i.e. past MI, diabetes, etc),% documented non-smokers,% BMI documented,% BP < 140/90,% on antiplatelet therapy,% with history of MI or ACS on beta blocker,% with indication for ACEI or ARB on therapy,% with influenza vaccination,% with pneumococcal vaccination.

Geisinger Health Plan—Physician Quality Summary

Using standard measures, transparency, and generous reward potential to boost participation and results

Background

Geisinger Health Plan's Physician Quality Summary (PQS) program measures clinical quality, service and value for participating primary care physicians (PCPs), posts performance results on its public web site, and offers physician groups the opportunity to earn significant financial rewards. The program was initiated in 2005 and has already demonstrated that a pay for performance program can help to improve clinical quality as measured by standard national metrics. If the physician groups have the means to make process improvements, then the program provides a generous reward potential.

Participating primary care physician groups are able to achieve three overall performance levels in the PQS program. The overall measure of the program's success for Geisinger Health Plan is the percent of its membership cared for by the highest performing PCPs. The Web-based PQS categorizes the performance of each primary care physician's group as either good (one-star), meaning its overall score equaled Geisinger's basic standards; very good (two-star), meaning its score was above the basic standards; or excellent (three-star), meaning its score significantly exceeded the basic standards The specific target that determines whether a site achieves a one-star, two-star, or three-star level is a composite score of clinical quality, service, and resource utilization measures. High-performing groups can earn an award of up to $4 per-member-per-month (PMPM), based on scores assigned for meeting patient-level measures, for meeting population-level measures, and for the group's efficiency ranking relative to peer groups. Rewards are paid biannually, approximately three to six months after the measurement period ends.

Measurement

For clinical performance measures, the PQS uses HEDIS® results divided into two broad categories—Preventive Health and Chronic and Acute Care. The Preventive Health category includes breast cancer, colon cancer, and cervical screening measures; well-child visit rates; adolescent visit rates; and the childhood immunization combination rate. The Chronic and Acute Care bundle includes cholesterol screening; appropriate medications for asthma patients, (aged 5-56); hemoglobin A1c, lipid testing, and eye exams for diabetics; appropriate testing for children with pharyngitis; and appropriate medications for children with upper respiratory infections. Geisinger also considers board certification status and whether or not the physician has had any Geisinger Health Plan peer-reviewed medical care concerns.

The PQS also incorporates a member satisfaction survey report, evaluating the office hours available for patient visits, and the rate of disenrollment from a practice for reasons of dissatisfaction. Geisinger's key measure of resource utilization is the efficiency index, a case-mix-adjusted, episode-of-care-based index that compares physicians to their specialty peers in the health insurance plan's network. The PQS also measures generic drug utilization and emergency department utilization rates.

GEISINGER HEALTH PLAN®

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Results, Challenges, and Lessons Learned

The percentage of Geisinger Health Plan membership in the highest performance level (three-star) primary care provider (PCP) sites has improved from 22 percent in the PQS October 2005 data to 50 percent in the October 2008 data. Geisinger chose this as its primary metric because it can be impacted by both components of the program: P4P leading to improvements in physician performance and web site transparency leading to consumer activation and selection based on quality indicators. In fact, Geisinger found that the upward trend in its primary metric is primarily due to physician improvements in clinical quality scores on page 22, with some improvement in generic drug utilization rates and emergency department use rates. Geisinger has found that very few members changed their PCP sites, so patient selection was not a significant contributing factor to the increase. Accordingly, it appears that a positive impact on patient care occurred as physicians successfully developed ways to improve those specific HEDIS® measures.

The program's greatest challenge has been the low penetration of Geisinger Health Plan members in many PCP practices. Geisinger has found that a physician needs to care for between 300 and 350 members before that physician is interested in the incentives offered, and a large portion of its primary care network does not have that volume of Geisinger membership in their practices. Thus improvement in quality scores that accounted for the overall increase in overall scores primarily occurred in a smaller number of practices that have large Giesinger Health Plan patient panels.

Plan Description:

Based in Danville, Geisinger Health Plan provides insurance coverage to residents in 42 counties in Pennsylvania. GHP offers a wide range of products at affordable rates for employer groups, individuals or families, and Medicare beneficiaries. Plan options include HMO, PPO, employer self-funded, high deductible plans.

GHP was ranked the top commercial health plan in Pennsylvania and #5 among health plans in the nation in the 2008-09 U.S. News & World Report/NCQA America's Best Health Plans list*. Our Medicare plan, Gesinger Gold, was also ranked the top health plan in Pennsylvania and #3 in the nation. GHP's programs for members with chronic conditions such as diabetes, heart failure, and asthma have been accredited by the National Committee for Quality Assurance.

*America's Best Health Plans is a trademark of U.S. News & World Report.

Harvard Pilgrim Health Care—Quality Advance Program

Supporting group infrastructure development while improving group quality and efficiency

Background

Harvard Pilgrim Health Care (HPHC) offers a variety of pay for performance and recognition programs for clinical excellence to eligible provider groups in its network, with the type of program dependent upon the group's size and practice type, its available clinical infrastructure, and its financial contract model. These programs are designed to recognize and reward performance at the group level, which HPHC calls the Local Care Unit (LCU), rather than at the individual provider level.

The most comprehensive of these, the Quality Advance Program (QAP), is based on a recognition by HPHC that Independent Practice Associations (IPAs) and Physician-Hospital Organizations (PHOs) need support for building their administrative infrastructures and developing more advanced clinical information systems, as well as financial rewards and recognition for efficiency and clinical quality. Another key principle behind QAP is that physicians will be more engaged and outcomes will improve if groups are rewarded not only for meeting a performance target ("excellence criteria"), but also for showing significant improvement during the year ("improvement criteria").

Measurement

The QAP includes funding for the LCU Administrative Infrastructure, Shared Savings, Investment in Health Information Technology, and Rewards for Excellence (based on performance on HEDIS® measures).

LCU Administrative Infrastructure

The LCU medical director is the primary clinical liaison between HPHC and the LCU physicians and is in a position to identify opportunities for the LCU to improve its performance and act as a champion of change for the LCU. HPHC's LCU medical director stipend compensates the LCU for the medical director's time and efforts in the oversight of HPHC's quality programs with the LCU, alignment of LCU physicians with HPHC's improvement objectives, and the execution and overall of the QAP.

The entire LCU administrative team serves an important role in promoting quality improvement within the local practice through communication and management of local performance improvement initiatives, so the QAP includes a stipend related to the LCU's efforts in describing, reporting, and improving performance.

Shared Savings

The efficiency measures in QAP focus on making cost-efficient selections in three areas: prescription drugs, laboratory and pathology, and hospital utilization.

QAP shares cost savings with the LCU for optimal use of lower-cost Tier 1 drugs, rewarding high rates of Tier 1 prescribing (where overall HPHC is already high performing) or rewarding performance improvement beyond the average change in performance observed for the HPHC network due to changing prescribing practices.

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QAP rewards performance in directing clinical laboratory and pathology services to cost-effective, preferred providers. This element includes a process component for ongoing management of this steerage program, an incentive for the LCU to use computerized physician order entry, and recognition of performance excellence in using preferred laboratory/pathology providers.

QAP rewards appropriate selection of community hospitals (typically lower-cost), using a metric of "weighted admissions per thousand," where admissions to tertiary facilities have large weight. This measure is designed to encourage the LCU to treat members in a community setting when appropriate and avoid unnecessary admissions for conditions that are best managed in an effective ambulatory setting.

Health Information Technology

Measurement in this area is a semi-annual Health Information Technology (HIT) survey tool, which is aligned with recommendations and standards from the Institute of Medicine, Bridges to Excellence and the National Committee for Quality Assurance (NCQA). The point value and payment for each domain is noted in the electronic survey tool, which totals 100 points. In order to promote practice participation in other regional and national initiatives, HPHC will accept the certification of the Bridges to Excellence Physician Office Link (POL)[8], NCQA Physician Practice Connections® (PPC)[9], or other state-based initiatives, so long as the elements in the review are substantially similar to the HPHC survey.

Rewards for Excellence

QAP rewards excellent performance relative to national percentiles using select HEDIS® measures that are relevant to the population served by the practice. Measures include:

- Diabetes: Hemoglobin A1c Control >9.0 percent
- Diabetes: Low-density lipids cholesterol (LDL-C) < 100 mg/dL
- Asthma management, ages 5–56
- Appropriate Use of Antibiotics in Adults with Acute Bronchitis
- Antidepressant: Effective, Continuation Phase (six months)

In order to even participate in the Rewards for Excellence program, an LCU must exceed the national 50th percentile in three "threshold" measures , as a way of holding the gains in clinical domains that had previously been in the Rewards for Excellence program but were retired for consistently high performance across the network. These threshold measures are Breast Cancer Screening, Cervical Cancer Screening, and Diabetic Nephropathy.

Quality Grants Program

In addition to the QAP, HPHC developed the Quality Grants program in 2000 to provide an opportunity for all contracted physicians to apply for a grant to aid in the optimization of network quality and improve member health. The topics are identified by a menu designed by HPHC to align with its overall clinical plan. HPHC considers this program as a "living lab" where the leadership of LCUs bring together their administrative team, clinical champions, local experts, and thought leader to design care improvements and measure their impact. It is through this program that many LCUs learn the skills necessary to shift practice behavior toward improvement. The successes (and challenges) of these projects become the topics of medical director meetings, where peers can hear experiences of others who are blazing the path toward improvement.

Over the past nine years, HPHC has funded more than 140 LCU-based quality initiatives, which have totaled over $11 million dollars. These projects have advanced the use of quality improvement methods and tools, the development of enduring practice-based quality infrastructure and the transfer of best practices. HPHC particularly welcomes proposals from smaller practice settings that may have fewer infrastructure, supports, but the potential to benefit from HPHC clinical consulting and quality project funding.

[8] The Bridges to Excellence Physician Office Link (POL) program promotes the use of information systems to enhance the quality of patient care to reduce errors and increase quality care. Participating offices can earn up to $50 for each patient covered by a participating health insurance plan and/or employer. The Physician Office Link program is designed to include three levels, or tiers, of recognition. For more information, please visit: http://bridgestoexcellence.org/PhysicianOffice.

[9] Physician Practice Connections® (PPC®) recognizes practices that use systematic processes and information technology to enhance the quality of patient care through establishing connections to information, patients, and other providers. There are nine PPC® standards and three levels of recognition. Practices seeking PPC® Recognition will complete a Web-based data collection tool and provide documentation that validates responses. For more information, please visit: www.ncqa.org.

Successes Observed in the HPHC Program

As part of its annual cycle of performance measurement, HPHC has observed several improvements related to its pay for performance program:

- In 2007 (last year of payment completion), over 94 percent of the available infrastructure funding was paid out (groups are engaged)
- 100 percent of eligible practices participated in the HIT survey, where $2M was paid out (84 percent of max)
- Secure server access for patient registry files (which can be downloaded and merged with other payers' data in locally managed registries) was accessible by over 100 LCUs
- Overall scores on the HIT survey rose from approximately 40 percent of maximum when the program was launched in 2004 to about 75 percent on latest survey. Areas of greatest improvement are the use of technology for order/entry and results management and use of data for internal administrative processes and reporting.
- Use of Tier 1 agents rose from 59 percent in 2006 to 69 percent currently. The use of Tier 1 agents is greater in LCUs with the QAP than those without this incentive.
- Percentage of patients who were not in hemoglobin A1c control went from 22.1 percent in 2006 to 21.5 percent in 2007. Similar comparative information on the other diabetes outcome measure used in Rewards for Excellence, low-density lipids (LDL) control, cannot be given as HPHC changed the clinical target from 130 m/dL to 100 m/dL.

Challenges

Harvard Pilgrim annually evaluates its pay for performance program to identify points of measurable success, to address the challenges, and to make improvements in program design and scope. Several themes emerge when considering the challenges of implementing and managing a pay for performance program. Some of these are common to any pay for performance program, and some reflect the complexity of the local HPHC market.

- Narrow range of nationally accepted measures beyond primary care (e.g., non-HEDIS® measures)
- Lack of nationally accepted measures of efficiency or even definitions of efficiency (resource efficiency or cost efficiency)
- Funding levels affordable by the health insurance plan (and its purchasers) do not match what physician groups (and others) feel is necessary to engage physicians and patients in behavior change
- Small units of measurement become unreliable, particularly if the program wants to move down to the individual physician level
- Complexity of the HPHC network structure, where the same physicians are participating in different LCUs and movement across contract entities occurs year to year.
- Significant leverage of parts of the HPHC network, who require modifications to the pay for performance program and adding complexity to the administration of the program with limited resources
- An overall high level of performance in the northeast market (where many plans are considered the top performers in the nation)
- Agreement that coordination among health insurance plans to endorse the same set of measures and tools requires a level of constituent coordination not yet observed in the Massachusetts Market.

Plan Description:

Harvard Pilgrim is a not-for-profit health plan that provides a variety of health benefit options and funding arrangements to more than one million members in Massachusetts, Maine and New Hampshire. Harvard Pilgrim is the #1 commercial health plan in America, for the fourth consecutive year, according to a joint ranking by U.S.News & World Report and the National Committee for Quality Assurance (NCQA)*. Health Plans, Inc, a Harvard Pilgrim subsidiary offers employers health, dental and short-term disability benefits through self-insured plans in Maine, Massachusetts and New Hampshire. Harvard Pilgrim's Maine headquarters is located on Market Street in downtown Portland. For more information, please visit www.harvardpilgrim.org

* "America's Best Health Plans" is a trademark of U.S. News & World Report. The source for this data is Quality Compass® 2005, 2006, 2007 and 2008 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass is a registered trademark of NCQA. NCQA is a private, non-profit organization dedicated to improving health care quality.

HealthPartners®

HealthPartners—Partners in Quality

Rewarding quality performance and improvement across the spectrum of care

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Background

In 1997, HealthPartners was the first health insurance plan in Minnesota, and one of the first in the nation, to launch a pay for performance program. The Partners in Quality program rewards providers in 76 primary care and 40 specialty groups (cardiology, orthopedics, obstetrics and gynecology (OB/GYN), behavioral health, emergency medicine, and *ear, nose and throat* (ENT)), 16 hospitals, retail pharmacies, and physical therapy practices for meeting the program's quality measures. Together, these groups provide care for more than 90 percent of HealthPartners' 690,000 members. Partners in Quality includes two major components, Partners in Excellence and Partners in Progress.

Partners in Excellence

Partners in Excellence provides bonus payments and public recognition to providers who meet targets related to health, experience, and affordability. A distinctive element is that clinical targets are comprehensive rather than limited to only one or two measures per disease state. For example, providers are rewarded for meeting all five targets for optimal diabetes care. In addition to giving bonuses, HealthPartners hosts an annual celebration to publicly acknowledge groups that met quality goals and honor winners of the HealthPartners Innovation Award. In addition, HealthPartners issues a news release announcing the winners.

Partners in Excellence measurement components include:

- Providing optimal care (Hemoglobin A1c<7 percent; low-density lipids (LDL)<100/mg/dL; blood pressure <130/80;daily aspirin use over age 40; non-tobacco user) or at least 25 percent of patients with diabetes)
- Preventive services up to date for more than 45 percent of adult primary care patients, including recommended screenings met for cholesterol, colorectal, breast, cervical cancer, Chlamydia, flu vaccine, blood pressure, and vision screening.

Partners in Progress

Partners in Progress provides financial incentives for quality improvement that are built into specific provider contracts for primary care, specialty, hospital, retail pharmacies, and physical therapy practices. HealthPartners collaborates with each provider to set individual goals from a menu of health, experience, safety, cultural competence, and pharmacy and health information technology process measures. Health insurance plan payments are set aside and paid if providers meet their individual targets. Partners in Progress target measures are agreed on by HealthPartners and each provider.

Partners in Progress allows groups to focus on a particular area for improvement, so a provider group can work toward and be rewarded for improving care to a higher percentage of patients. The stretch goals in Partners in Excellence encourage groups that are doing well to do even better. For example, the average clinic in Minnesota provides optimal care to about 17 percent of patients with diabetes. HealthPartners, goals for 2007 rewarded providers who delivered optimal care for 25 percent (excellent) or 30 percent (superior) of their patients.

Provider performance is publicly reported every year in the *HealthPartners Clinical Indicators Report*, which is available on the HealthPartners web site. www.healthpartners.com. Consumers also have access to cost and quality rankings of the medical clinics they are considering so that they can make informed health care decisions. Clinics are ranked based on results for a range of conditions so that consumers can know which clinic groups do the best job delivering high-quality care for the health needs that are most important to them.

To ensure that improvement is ongoing and applied to other areas, program criteria may be added or changed each year. For instance, in the past few years HealthPartners has added targets

for depression care, body mass index (BMI) assessment, and pharmacy services. Achieving goals requires system and work-flow changes within health care settings. The result is that improved care continues to be delivered to all patients (not just HealthPartners members) even after a criteria is removed from the pay for performance program.

Measurement

HealthPartners collaborates with the Institute for Clinical Systems Improvement (ICSI), an independent, non-profit organization whose membership represents about 75 percent of the physicians in Minnesota. ICSI defines the evidenced-based clinical practice guidelines upon which many of the measurements are based.

Partners for Quality program includes measures for:

- Diabetes (Hemoglobin A1c<7 percent, LDL<100/mg/dL, blood pressure<130/80, daily aspirin use for patients>40 and documented non-use of tobacco)
- Cardiovascular disease (LDL<100/mg/dL, blood pressure<140/90; daily aspiring use, no tobacco use, depression (document five or more symptoms at initial visit, document follow up of three or more symptoms within three months, continued anti-depressant use for 180 days)
- Preventive care
- Patient satisfaction
- Generic prescribing (greater than 72 percent),
- Pharmacy services
- Health information technology
- Congestive heart failure
- Cervical cancer screening (greater than 45 percent patients meet recommended screenings)
- Physical therapy
- Body mass index (BMI) assessment
- Low back pain care
- Asthma
- Tobacco treatment
- Orthopedics

While some of the target measures reward the delivery of care, others require improved clinical outcomes. For example, optimal delivery for diabetes care requires meeting goals to manage all five risk factors: hemoglobin A1c<7 percent, LDL<100/mg/dL, blood pressure<130/80, daily aspirin use for patients>40 and documented non-use of tobacco.

In addition to providing financial rewards and recognition for quality improvement, HealthPartners supports physicians in care improvement by providing access to electronic registries and by providing members with health improvement, disease management, and medical and behavioral health care management support.

Results

HealthPartners awarded $21 million to 180 providers for goals met in 2007. Nearly $678,000 of that comprised bonuses for meeting the stretch goals in the Partners in Excellence program. The remainder was paid out under the Partners for Progress component for achieving goals set in provider contracts.

Significant quality improvements have been measured in a number of important categories of care, including:

Optimal diabetes care: Since 2002, the number of members who received all of the recommended care for diabetes has climbed from 8 percent to 17 percent in 2007 for the 5 targeted optimal care components: blood sugar (hemogrlobin A1c)<7 percent, cholesterol (LDL)<100/mg/dL, blood pressure <130/80, daily aspirin use for patients >age40 and documented non-use of tobacco.

Diabetes, heart care: Average hemoglobin A1c among HealthPartners members surpasses treatment recommendations, falling in the last ten years from 7.8 percent to 7.2 percent. Similarly average LDL cholesterol in members with heart disease decreased from 109 mg/dL in 1999 to 82 mg/dL in 2007 also surpassing current treatment recommendations. Average systolic blood pressure in members with diabetes dropped from 134 mmHg in 1999 to 126 mmHg in 2007. Compared to the 1994 baseline, improving care for HealthPartners, 25,000 members with diabetes prevents an estimated 162 amputations, 118 heart attacks, and 656 cases of retinopathy every year.

Coronary artery disease (CAD): HealthPartners all-or-nothing composite measure for CAD encompasses four targets: controlled cholesterol and blood pressure, daily aspirin, and documented non-tobacco use. In 1999, only one in five HealthPartners members with coronary artery disease received optimal care. By 2007 that rate increased to 45 percent.

Generic drug use: Since 2003, generic drug use among HealthPartners members has increased from 47 percent to 71 percent. Every one percent increase in the generic rate among HealthPartners members decreases costs by $9 million annually.

Smoking cessation: In 1997, no group met the tobacco target of 80 percent of patients asked about tobacco use at every visit. Two years later, 10 groups reached that goal. In 2005, 27 of 32 groups met the higher target of 95 percent of patients asked about tobacco use. Currently 96 percent of members are asked about tobacco use, and 65 percent of smokers received help quitting. Tobacco use has fallen to an all-time low of 13 percent, and children's exposure to secondhand smoke fell from 23 percent to 5 percent.

Plan Description:

Founded in 1957, the HealthPartners (www.healthpartners.com) family of healthcare companies serves more than one million medical and dental health plan members nationwide. It is the largest consumer-governed, nonprofit healthcare organization in the nation, providing care, coverage, research and education to improve the health of members, patients and the community. For the third year in a row, HealthPartners is rated one of the best commercial health plans in the nation by U.S. News & World Report, NCQA's America's Best Health Plans 2007.

HIGHMARK
An Independent Licensee of the Blue Cross and Blue Shield Association

Highmark Blue Cross Blue Shield—QualityBLUE Physician Pay for Performance Program

Applying health insurance plan medical management consulting resources to primary care quality improvement initiatives

The Highmark QualityBLUE Physician Pay for Performance Program offers primary care physicians an opportunity to earn an additional reimbursement for providing efficient, high-quality health care. This fee-for-service incentive is based on a fixed flat dollar amount of $3, $6, or $9 paid as an add-on to select Evaluation & Management (E&M)[10] services billed by the primary care physician practice. Physician practices are scored based on 115 total points. A physician earns points based on performance in program indicators and is then compared with the network's physician specialty average.

In order to help participating physicians achieve the mutual goal of improving patient care, Highmark has dedicated the resources of more than 15 medical management consultants[11], with backgrounds in a variety of health care services, to work with the physician practices on implementing quality improvement methods and utilizing quality improvement tools.

The QualityBLUE Program measures physician performance in key clinical areas and also strives to incorporate innovative stretch goals that encourage physician practices to continuously grow and improve quality. The following tables illustrate the program components and the clinical quality improvement indicators for measurement.

Program Components	Description		Possible Quality Score
Clinical Quality	Expected Quality Guidelines—Uses a one-to-four-year defined measurement period		65
Generic / Brand RX	Prescribing Patterns—Uses three months of drug claims data in measurement period		20
Member Access	Weekly office hours—Non-traditional hours[12]		5
Best Practice	Clinical Practice Improvement Activity[13]		15
Electronic Health Record	Uses evidence of implementation progress		5
Electronic Prescribing	Uses evidence of implementation progress		5
Total Quality Score			115
Clinical Quality Measures	**Family Practice**	**Internal Medicine**	**Pediatrics**
Acute Pharyngitis Testing	√	√	√
Adolescent Well Care	√		√
Appropriate Medications for People with Asthma	√	√	√
Beta Blocker Treatment After MI	√	√	
Breast Cancer Screening	√	√	
Cervical Cancer Screening	√	√	
Cholesterol Management For Patients With Cardiovascular Conditions	√		
Comprehensive Diabetes Care	√	√	
Congestive Heart Failure Annual Care, Advanced Standard	√	√	
MMR Vaccination Status	√		√
Varicella Vaccination Status	√		√
Well Child Visits in the First 15 Months	√		√
Well Child Visits in the Third, Fourth, Fifth and Sixth Year	√		√

Results, Challenges, and Lessons Learned

Highmark's medical management consultants have worked with physician practices for more than 11 years, solely focusing on improving quality and efficiency. They routinely obtain physician feedback on program design, and they are viewed as a valuable resource and important benefit from the health insurance plan.

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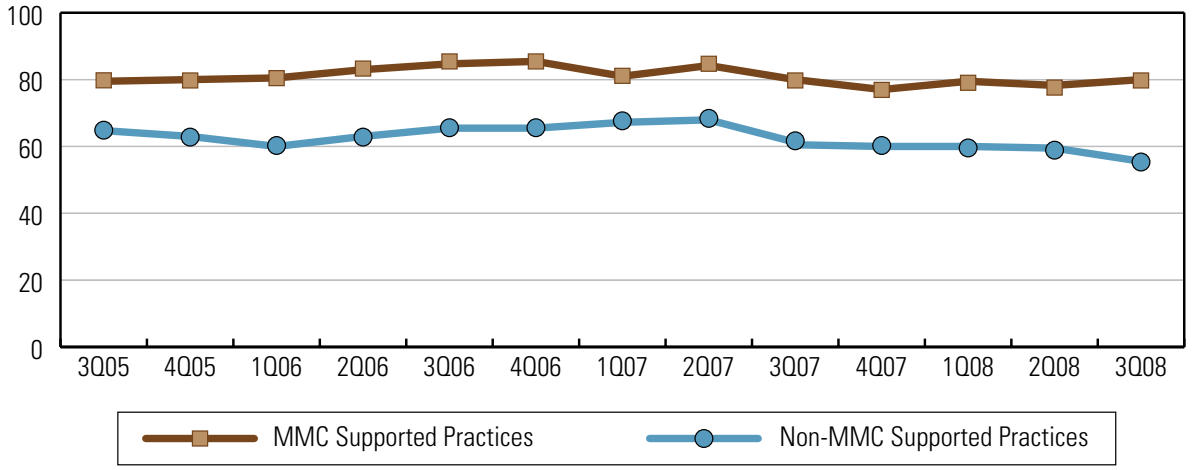
These well-established relationships with physicians and their staff, combined with the incentives offered through QualityBLUE, have resulted in significant improvements in clinical care. The following graph shows that the program's medical management consultants (MMC) have a positive impact on practices' QualityBLUE performance results:



Total Quality Scores from 3Q2005 – 3Q2008

In addition to the medical management consulting resources, Highmark provides QualityBLUE performance results and incentive reimbursements quarterly to its physicians, allowing them to assess their performance as close to "real time" as possible.

In 2007, Highmark Blue Cross Blue Shield launched an additional pilot program aimed at supporting 370 network physicians in their efforts to enhance practice processes, improve the delivery of care to their patients, and achieve the National Committee for Quality Assurance (NCQA) recognition programs in Diabetes, Heart/Stroke or Physician Practice Connections®.[14] Four hundred and thirty (430) physicians completed Level 1 of the program that required them to complete a program pre-survey on 25 Highmark members in their practice to determine where their gaps in care existed: 93 percent or 400 physicians, completed Level 2, which required the physicians to complete a chart review of at least 25 to 35 patients per physician for all payer types in their practice; and 86 percent or 370 physicians, completed Level 3, which required them to submit their application to NCQA and achieve NCQA recognition. The program was successful in increasing the number of physicians in the Highmark Western Pennsylvania network with NCQA recognition in diabetes from 25 to 232 and those with NCQA recognition in Heart/Stroke from 0 to 113. The support of medical management consultants was critical to the success of the program.

Annual QualityBLUE Physician Best Practice Forums are held (with CME credit offered) throughout the Highmark network as an opportunity to share best practices and innovative improvement strategies with other practices. The Partners in Quality Newsletter is sent to network providers quarterly, highlighting improvement strategies, success stories, and industry trends.

Plan Description:

As one of the leading health insurers in Pennsylvania, Highmark Inc.'s mission is to provide access to affordable, quality health care enabling individuals to live longer, healthier lives. Based in Pittsburgh, Highmark serves 4.6 million people through the company's health care benefits business. Highmark contributes millions of dollars to help keep quality health care programs affordable and to support community-based programs that work to improve people's health. Highmark exerts an enormous economic impact throughout Pennsylvania. A recent study states that Highmark's positive impact exceeded $2.5 billion. The company provides the resources to give its members a greater hand in their health.

Highmark Inc. is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. For more information, visit www.highmark.com.

[10] This fee-for-service incentive is based on a fixed, flat-dollar amount of $3, $6, or $9 paid as an add-on to 106 Evaluation & Management (E&M) services billed by the primary care physician practice.

[11] Medical management consultants consist of consultants with a variety of backgrounds: nursing, Respiratory Therapy, Medical Lab Technology, Pharmacy, and Healthcare Administration.

[12] The member access measure is derived from the practice's office hours and nontraditional hours of service available to our members.

[13] A practice-derived clinical quality improvement project where the practice identifies a clinical area in need of improvement (high-risk, problem-prone, high-volume) and then uses the Plan-Do-Study-Act process for improvement. They submit the final study with baseline and post-intervention measures for evaluation.

[14] Physician Practice Connections® (PPC®) recognizes practices that use systematic processes and information technology to enhance the quality of patient care through establishing connections to information, patients, and other providers. There are nine PPC® standards and three levels of recognition. Practices seeking PPC® Recognition will complete a Web-based data collection tool and provide documentation that validates responses. For more information, please visit: www.ncqa.org.

Horizon
Horizon Blue Cross Blue Shield of New Jersey
Making Healthcare Work

Horizon Blue Cross Blue Shield of New Jersey—Physician Recognition Program

Expanding physician recognition to surgical and medical specialties

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Background

At a time when most pay for performance programs were focused almost entirely on primary care, Horizon Blue Cross Blue Shield of New Jersey developed one of the first quality recognition programs designed to objectively measure, report, and recognize physician performance related to quality and clinically effective management of care for a broad array of medical and surgical specialties. Physicians who score in the highest percentiles by specialty, as compared to their specialty peers, receive a financial reward along with non-financial recognition and a listing on Horizon's corporate web site, which is accessible to its members.

While the Horizon BCBSNJ Physician Recognition Program relies primarily on nationally accepted evidence-based measures, there are some specialty areas where metrics based on administrative data sources (claims, lab reports, prescriptions, etc.) were not available, so Horizon BCBSNJ moved forward to develop and test new metrics, such as risk-adjusted post-operative event measures, with input from participating physicians, health care consultants, and national organizations that develop evidence-based guidelines.

Horizon BCBSNJ currently includes 14 specialties in the program—pediatrics, internal medicine, family practice, obstetrics and gynecology (OB/GYN), cardiology, pulmonary medicine, gastroenterology, nephrology, endocrinology, general surgery, orthopedics, urology, otolaryngology, and multi-specialty practice. The program's goals are to recognize and reward participating physicians whose objectively measured performance is amongst the highest of their peers; to improve relationships with the physician networks; and to demonstrate Horizon's commitment to high performance by their network.

Measurement

Physician Recognition Program Clinical Quality Measures

Horizon BCBSNJ produces Physician Performance Reports based on HEDIS® measures, as well as other guideline-supported measures that Horizon developed for specialties where few quality metrics were available. The specialty criteria cover a wide array of clinical practices, including:

Prevention and screening, such as: childhood immunization rates (diphtheria, tetanus and acellular pertussis (DTaP); polio (IPV); measles, mumps and rubella (MMR); H influenza type B (HiB); chicken pox (VZV), and pneumococcal conjugate immunizations); cervical cancer screening; breast cancer screening; colon cancer screening; screening for asymptomatic bacteriuria during pregnancy; chlamydia screening; osteoporosis screening for women at increased risk.

Respiratory, such as: assessment of allergy triggers and need for immunotherapy, anti-inflammatory medication for asthma; appropriate use of short-acting beta agonists for persistent asthma; follow-up care after emergency room visit for diagnosis of bronchial asthma, use of step-up therapy for patients with exacerbations of chronic obstructive pulmonary disease (COPD), diagnostic accuracy with spirometry for patients with newly diagnosed COPD; follow-up X-ray after pneumonia; appropriate avoidance of antibiotics for viral upper respiratory infections.

Cardiovascular, such as: angiotensin-converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs) for high risk patients; ACE inhibitor and ARB treatment for congestive heart failure; beta blocker treatment for congestive heart failure; congestive heart failure readmission rate; percentage of patients enrolled in Horizon's congestive heart failure health and wellness program; echocardiography in new diagnosis of congestive heart failure; LDL-cholesterol controlled.

Endocrine and metabolic, such as: monitoring of hyperlipidemia in diabetics; retinal eye examination; medical attention to nephropathy; LDL-cholesterol screening in diabetics; rate of hemoglobin A1c tested and controlled; LDL-cholesterol controlled; follow-up of benign thyroid nodule

Musculoskeletal, such as: trial of conservative treatment prior to carpal tunnel surgery; intra-articular steroid injection for osteoarthritis with effusion; central bone density testing after vertebral, rib, hip or distal forearm fracture for women 50 or more years of age.

Gastrointestinal, such as: esophagogastroduodenoscopy (EGD) rate for patients 55 years or older for a diagnosis of gastro-esophageal reflux disease; EGD rate for patients for a diagnosis of gastroesophageal reflux disease (GERD) with alarm features (melena, persistent vomiting, dysphagia, hematemesis, anemia, abnormal weight loss); percentage of patients with GERD who had a trial of conservative therapy with proton pump inhibitors for 8-12 weeks prior to EGD; percentage of patients age 50 years and older with newly diagnosed irritable bowel syndrome who had a colonoscopy; testing for H. pylori in newly diagnosed gastric ulcer, duodenal ulcer of dypepsia patients by stool antigen test, urea breath test or endoscopic biopsy.

Urinary, such as: appropriate work-up for microhematuria; upper tract imaging for hematuria; appropriate staging for kidney malignancy.

Ear, nose, and throat, such as: appropriate use of antibiotics for acute otitis media in children; percentage of children with otitis media with effusion persisting for at least 3 months who had an audiologic evaluation; if a decision was made to treat with an antibacterial agent, the percentage of a first line antibiotic having been dispensed for an acute sinusitis episode; if a decision was made to treat with an antibacterial agent, the percentage of a first line antibiotic having been dispensed for sore throat episodes.

Additional measures cover aspects of patient safety such as the adverse post-operative event rate for general surgeons, orthopedic surgeons, obstetricians/gynecologists, otolaryngologists and urologists, and birth and obstetrical trauma rates.

Results

After results have been analyzed, it is expected that the Physician Recognition Program, will mark a significant leap forward in the pay for performance concept. Physicians who score in the 85th percentile or higher, as compared to their specialty peers, receive a financial reward, non-financial recognition in the form of a plaque or certificate to display in their office, and a listing on the Horizon BCBSNJ corporate web site. The anticipated impact is the increased compliance of physician practices with evidence-based medicine resulting in high quality of patient care.

Plan Description:

Horizon Blue Cross Blue Shield of New Jersey is the oldest and largest health insurer in the state serving over 3.6 million members. Horizon BCBSNJ is New Jersey's only not-for-profit, health services corporation and is headquartered in Newark with offices in Wall, Mt. Laurel, and West Trenton.

Horizon BCBSNJ provides a broad array of health and dental insurance products and services for individuals and small and large companies, including national companies headquartered in New Jersey. Horizon BCBSNJ is committed to improving the health care experience for all the communities it serves as well as helping its members become and stay healthy.

Independence Blue Cross

Independence Blue Cross—Primary Care Physician Quality Incentive Payment System

Raising the bar for quality and patient satisfaction using comparative reporting and payment

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Background

The Quality Incentive Payment System (QIPS) is a unique reimbursement system developed in 1995 by Keystone Health Plan East HMO, (now part of Independence Blue Cross (IBC)), for participating Pennsylvania primary care physicians after discussions with providers, recognized experts in the field, and other HMOs across the country.

The QIPS program provides incentives for high-quality care; member service and convenience; certain electronic transactions; and health data submission. Quality performance is the most important determinant of variable compensation, and as meaningful measures of quality continue to be developed and improved, new indicators may be added, or indicators no longer relevant or meaningful may be dropped. There are two parts to QIPS: a monthly High Quality Capitation Premium described in detail below, and a bimonthly premium payment related to the use of electronic connectivity, after-hours care availability, use of generic drugs, and other measures. Measurement and payment take place at the individual practice level.

Measurement

The Practice Quality Assessment Score (PQAS) is an annual assessment of quality that serves as a basis for payment of the High Quality Capitation Premium. There are two parts to PQAS: quality performance measures (QPMs) and member satisfaction survey results. Each part accounts for 50 percent of the overall rank and subsequent incentive payment. QPMs are based on HEDIS® standards, some with minor modifications[15], and include:

- Childhood immunization
- Adolescent immunization
- Breast cancer screening
- Cervical cancer screening
- Asthma care: appropriate medications
- Diabetic care: members age 18 to 75 with diabetes (Type 1 and Type 2), who had all of the following:
  - Hemoglobin A1c testing in the measurement year
  - LDL-cholesterol screening in the measurement year
  - Dilated retinal eye examination in the measurement year or a negative retinal exam in the previous year
- Colorectal cancer screening
- Osteoporosis management in women who had a fracture
- Cholesterol management for patients with cardiovascular conditions
- Well-Child visits in the first 15 months of life
- Well-Child visits in the third, fourth, fifth, and sixth years of life
- Adolescent Well-Care visits

[15] While Independence includes "immunization rates" as part of its Practice Quality Assessment Score (PQAS), it choose to measure only four of the six separate components of the immunization rate specifications.

Member satisfaction is measured at the practice level, using a standardized telephone survey for each practice's member list.

In general, members must be enrolled in the practice for the entire 12-month study period to be counted in the quality measures. Practices are compared against other practices of the same specialty. Many practices adopt new administrative processes to better ensure patient compliance. With this great interest in the program, average scores have increased over time, and practices must improve overall performance to keep the same level of incentive payment. New measures are added from time to time, always with advance notice and considerable input from participating providers.

Results

There are currently more than 1,400 practices eligible for the QIPS program; they cover over 80 percent of the HMO population. The Quality Incentive Payment System offers comparative quality performance information and payment to 85 percent of eligible practices. The lowest 15 percent of practices are required to review their PQAS performance and submit action plans for improvement in quality and service measures. Payments, on average, are 15 percent to 18 percent of a primary care practice's total income.

Lessons Learned

The data collection process is extensive and intense. Independence Blue Cross uses a statistics program to run the data, and identifies and continuously monitors provider number changes, member eligibility changes, physicians changing practice locations, member non-compliance, systematic data losses, reporting errors, etc. The program issues preliminary results in the third quarter so participating physicians have an opportunity to reach out to members in need of services. Physicians are allowed to submit additional data from their records after the close of the 12-month (January through December) study period, and then Independence Blue Cross performs a final claims run in April to ensure Independence has all pertinent administrative data. Each year, a physician advisory panel composed of participating physicians from the network reviews statistical results, recommends additional measures, and proposes changes in reporting for the coming year. This enhances physician participation, not only to promote care improvement, but also to involve physicians in the pay for performance and quality improvement initiative. Over time physicians can submit additional data and increase their participation each year.

IBC plans to expand QIPS to include more measures and PPO members (although IBC believes that quality-related behavior change is carried across to all patients seen by participating physicians). Although IBC does not plan to add a measurement of cost of care/efficiency to either of the incentive programs in the near future, the health insurance plan is educating physicians on how they assess the cost of care, since it would like to include this component in an incentive program at some time in the future.

Plan Description:

Independence Blue Cross is a leading health insurer in southeastern Pennsylvania. Nationwide, Independence Blue Cross and its affiliates provide coverage to nearly 3.4 million people. For 70 years, Independence Blue Cross has offered high-quality health care coverage tailored to meet the changing needs of members, employers, and health care professionals. Independence Blue Cross's HMO and PPO health care plans have consistently received the highest ratings from the National Committee for Quality Assurance.

To fulfill its commitment to the communities and people it serves, Independence Blue Cross contributes millions of dollars each year to improve access to quality, affordable health care in the region by funding clinics for the uninsured, increasing the supply of nurses, fighting hospital-acquired infections, and promoting community wellness.

Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association.

MVP Health Care—
Primary Care Pay for Performance Program

Incorporating P4P into comprehensive transparency and improvement strategies

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Background

MVP Health Care initiated its primary care pay for performance (P4P) program in 2003 to recognize both individual physicians and physician groups. The success of the program hinges on collaboration and commitment from the plan's Independent Practice Associations (IPAs) and provider organizations and on transparency in reporting results. Performance measures are selected for each geographic region, based on improvement opportunities that are considered to be most relevant to that area's providers and members.

The program's goals are established annually through MVP's Quality Improvement Committee structure so providers know in advance what they need to achieve in order to receive incentive payments. Performance results are posted on MVP's web site for providers and members, and each round of clinical reports is followed with site visits that are used to share best practices and ensure that provider groups that are not top performers are given the tools they need to help them improve. Since 2006, the health insurance plan has paid out $3 million in incentives to more than 850 primary care physicians who have achieved quality performance goals.

All of MVP's stakeholders benefit from the program's comprehensive approach to improvement. For example:

- Physicians receive education, recognition, and financial rewards for their successes.
- Members receive reliable information with which to make informed health care choices, along with coordinated quality improvement efforts that are relevant within their region.
- MVP's gains include strengthened collaborative relationships with participating providers and increased confidence among its members that their best interests are being served.

Measurement

MVP's P4P program allows their independent practice associations (IPAs) to choose from a menu of clinical quality measures based on HEDIS®, New York State's Quality Assurance Reporting Requirements (QARR), and other national and regional sources. Access and service data are produced from member satisfaction survey responses, and communication and coordination of care measures have been developed by MVP with physician input for specialty providers and hospitals based on primary care physician (PCP) surveys and medical record reviews. Since 2005, MVP has added process measures including technology adoption (ePrescribing and health information exchange[16]) and the National Committee for Quality Assurance (NCQA)/Bridges to Excellence® (BTE) recognition. In 2009, practice transformation towards a Primary Care Medical Home will become a key focus.

Rewarding Individual Physicians

For established HEDIS® measures, P4P goals are determined by analyzing the rates of MVP's competitors as well as the 90th percentile nationally as reported in Quality Compass®. The highest of those rates is chosen as MVP's goal. For new HEDIS® measures, goals are calculated by computing statistically significant improvements over MVP's performance in NCQA's annual State of Health Care Quality Report. In the case of non-HEDIS® measures where there is no external benchmark, such as member satisfaction, goals are set at an "achievable benchmark" level, based on percentile rankings (e.g. a level of performance that is being achieved by at least 30 percent of MVP's network).

A separate per-member-per-month bonus payment may be earned for each measure, with payments made annually at the individual physician level. The objective is to present with clarity what each physician did to earn an incentive payment and what he or she might do in the future to increase their reward.

Rewarding Practice Improvements

In 2005, MVP collaborated with NCQA, Bridges to Excellence® and the Mohawk Valley Medical Associates (MVMA) IPA to design a P4P program for primary care physicians in its East region[17] who achieve recognition by NCQA's Physician Practice Connections® (PPC®) Program. MVP staff were available to assist the offices directly with the NCQA process. Upon completion, rewards were sent to providers from a total of 28 group practices: two pediatric groups, two large provider groups, one cardiology group, and several family practice and internal medicine groups. The practices' feedback has been positive, with many indicating that their incentive payments would be directed toward additional practice improvements.

In 2006 and 2007, MVP's provider relations staff worked with its Taconic region IPA[18] practices to submit 103 applications and survey tools for evaluation against NCQA standards, and, as a result, more than 400 Taconic IPA physicians have received PCC recognition.

Additional Quality Improvement Initiatives

MVP Health Care's Pay for Performance (P4P) program is part of an integrated suite of quality improvement initiatives that are housed within MVP's Quality Improvement department. An overview of these programs follows:

Provider Quality Profiling

MVP's Physician Quality Report (PQR), which is produced for primary care physicians with a panel of at least 150 HMO members, contains HEDIS® and QARR-based[19] measures of member satisfaction, access to care, and quality of care information at the individual physician level. Comparative data from the provider's region and the entire HMO are included, as well as MVP's goal for each measure. A combination of administrative (claims) data and medical record review data is used for measures requiring laboratory values; several other measures are based solely on medical record review.

Resource Management Reporting

Resource Management Reports (RMR) compare primary care physician utilization to that of peers within the same specialty throughout the health insurance plan. Measures are designed to examine key areas of utilization each year, such as specialist visits, advanced radiology referrals, urgent and non-emergent emergency room visits, and generic drug prescriptions. Goals are designed to safeguard against both under- and over-utilization and are based on plan averages and expected utilization levels. A case mix adjustment is applied to account for diagnosis-related group (DRG) severity and the type of specialty. Overall efficiency is reported as a Resource Consumption Index, which is the ratio of a physician's total resource use over the expected resource use, adjusted for the physician's panel severity.

Focused Physician Visits

MVP Clinical Reporting staff travel to physician practices to discuss PQR and RMR results, offer targeted education, and share best practices that have been identified for both quality and utilization. The visits help to establish positive relationships between the health insurance plan and providers' practices.

Transparency

MVP's transparency reports allow members to see specific performance information from primary care groups on MVP's web site. Updates to the reports are posted initially to MVP's physician web site, and after physicians have had an opportunity to review the reports and provide comments, a link is added to the member web site as well.

NCQA Physician and Hospital Quality Program

In 2007, MVP was one of some 50 plans nationwide to become "early adopters" of NCQA's Physician and Hospital Quality (PHQ) standards. This program tracks health insurance plans' measurement of the quality and cost of care provided by physicians and hospitals, and how effectively this information is shared with consumers. MVP's PHQ certification, with distinction, demonstrates a commitment to helping its members make reliable comparisons and informed decisions about their health care.

Results

From 2005 to 2007, statistically significant improvements were seen in diabetic monitoring and control, measles-mumps-rubella (MMR) and varicella (VZV) immunization rates and asthma management. Over the same measurement period, smaller improvements were noted in cervical cancer screening rates and measurement of low-density lipids (LDL).

Plan-wide decreases were seen in diabetic eye exams, sexually transited disease (STD) screening, and mammography rates. These results may represent opportunities for improvement projects, including practitioner education and incentives. Outcome measures are analyzed at the plan-wide level and also by region to uncover any significant differences across MVP's service area.

[16] This information includes member-specific data, such as prescription information, labs, radiology, consultations and clinical notes.

[17] MVP's East region encompasses the Capital District area of NY, including the 12-counties served by the Mohawk Valley Medical Associates IPA: Albany, Columbia, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington.

[18] The Taconic IPA, is a 2,300-member physician independent practice association (IPA). The Taconic region includes Columbia, Greene, Sullivan, Ulster, Dutchess, Orange, Rockland and Putnam counties of New York.

[19] QARR stands for New York's Quality Assurance Reporting Requirements. It includes many HEDIS® measures as well as some specific to New York.

2007 Physician Quality Report—Measurement Outcome Trending

Percent Change from 2005 by Independent Practice Association (IPA) and Measure							
Measure	**IPA-1**	**IPA-2**	**IPA-3**	**IPA-4**	**IPA-5**	**IPA-6**	**IPA-7**
Mammography	1%	7%	(2%)	(3%)	(1%)	1%	4%
Cervical Cancer Screening	1%	4%	1%	(1%)	0%	(1%)	(1%)
Drug/Alcohol Screening	4%	(18%)	5%	47%	12%	(2%)	13%
Preg/STD	(30%)	(9%)	(18%)	108%	5%	(5%)	19%
Hemoglobin A1c	5%	2%	6%	7%	2%	5%	2%
Hemoglobin A1c level<7	3%	(9%)	25%	47%	18%	27%	4%
LDL Test	4%	(9%)	1%	2%	1%	(1%)	5%
LDL-c	61%	(13%)	14%	24%	15%	(6%)	15%
Retinal Eye	5%	(1%)	(1%)	(5%)	(7%)	(4%)	6%
Asthma	2%	(3%)	4%	5%	5%	1%	(1%)

Lessons Learned

Primary Care

Once MVPs' Physician Quality Reports and Resource Management Reports became generally accepted, the challenge became how to wrap incentive programs around achievable results. Initially, points were awarded based on measured performance, and rolled up to a score that earned payment based on comparisons to other providers' total scores. This methodology was confusing to physicians, leaving them questioning its relevance to their actual performance. In order to develop trust in the methodology and more effectively engage the physicians, the program was re-engineered to report and pay for each measure independently. Goals were re-engineered to incorporate transparent processes based on external benchmarks and network experience. Reports are now developed and presented to highlight achievement, rather than failure. Payments are delivered annually to physician groups and mailed with reports that explain the breakout by individual physician.

The greatest challenge is to keep this program's focus on rewarding quality rather than simply distributing funds. This requires active participation by the leadership of each IPA, especially to earn the program's acceptance by physicians whose performance may not warrant rewards in the short term. Collaboration between MVP and its IPAs was identified early on as key to this program's development and success.

MVP Health Care's Primary Care P4P program is well established, with buy-in from the practitioner community and a confirmed record of performance improvement from 2005 to 2007, showing statistically significant improvements among seven measures from 2005 to 2007 (see chart above). Future measures will target opportunities that are identified for advances in primary care, accessibility, service, and member satisfaction, including further development of the patient-centered medical home and improved information systems. MVP will continue to pursue reliable measures related to actionable goals, with appropriate recognition and rewards distributed to top-performing physician practices.

Plan Description:

Founded in 1983 MVP Health Care is a regional, not-for-profit health insurer based in Schenectady, N.Y. Through its operating subsidiaries, it provides fully-insured and self-funded employer health benefits plans, dental insurance and ancillary products, such as flexible spending accounts to 700,000 subscribers in New York state, Vermont, and New Hampshire. For more information visit www.mvphealthcare.com/press.

Tufts Health Plan—Provider Network P4P Program

Using Web-based data sharing to improve quality of care

Background

Over the past eight years, the strategy used by Tufts Health Plan (THP) to improve quality of care has evolved from quality profiling and public reporting to an approach based on pay for performance (P4P). A key to the P4P program's success is the timely sharing of data with provider organizations (POs) through an innovative, Web-based member registry that is available to all provider organizations in the THP network.

The Provider Network P4P Program has been designed to recognize and reward physicians who achieve outstanding performance in quality of care, patient safety, and appropriate utilization management, as well as physicians who make great efforts and demonstrate meaningful improvement. Hospitals and physicians are objectively measured for the quality of care they provide and the amount of resources they use to provide it.

Tufts Health Plan uses three types of financial incentives to reward provider organizations for the performance of their physicians in the incentive program:

- Incremental rate increase—additional unit cost increases per fee schedule for the upcoming calendar year. These additional increases are built into the following year's physician fee schedule and are therefore available to both primary care providers (PCPs) and specialists.
- Bonus dollars—additional money paid to the provider organization at the end of the measurement period. Distribution of these monies to individual physicians (PCPs and/or specialists) is determined by provider organization.
- Withhold dollars—For some PCPs and specialists, Tufts Health Plan withholds or retains a percentage of each claim reimbursement amount and sets it aside in an account for each provider until year-end. Based upon performance in the incentive program, the withheld amount will be returned either directly to the PO or individual physicians within the PO depending on the contract arrangement.

Measurement

Tufts Health Plan's physician quality measures include several HEDIS® measures that are reported for HMO- and PCP-based Point of Service members. Since both Tufts Health Plan and the provider organization must agree on which measures will be included in their incentive program, the measures can vary among providers. Prior to agreement on measures, THP evaluates a PO's performance across the suite of available HEDIS® measures to identify those for which there is opportunity for improvement. This determination is based upon a comparison of the PO's performance to a number of benchmarks: 1) Best in Class for all health insurance plans nationally[20], 2) Best in New England, 3) Quality Compass® 90th percentile and 4) Tufts Health Plan's performance.

The benchmarks utilized for HEDIS® measure selection are also used to develop targets that will be the basis for determining a provider's performance at the end of the year. The reward structure can include a graduated framework, which allows a provider organization to achieve partial rewards when improvement is realized but the target itself is not met.

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Web-based Member Registry

During the development of clinical quality metrics for P4P, Tufts Health Plan and its physician network identified the lack of coordinated clinical data-sharing among care providers as a barrier to improvement. Until 2005, the secure medium for this clinical information sharing had been via paper reports or diskettes mailed annually to physician offices. While some providers found this process to be helpful, others found the paper reports to be cumbersome and the data not timely enough for subsequent intervention.

Working in collaboration with its network of physicians, THP developed a Web-based registry that can provide real-time clinical data. The purpose of the registry is to collect all relevant clinical markers from providers and claims data sources and to organize them into one information set that reflects patients' care status based on HEDIS® specifications and evidence-based clinical practice guidelines. An online report shows whether the physicians have met the clinical practice guidelines for suggested care, if patients are due for services in the near future, or are overdue for certain services.

Clinical Quality Reports

As an incentive for primary care physicians and physician groups to maximize the potential value of their program, THP also publishes Clinical Quality Reports on its provider portal. The reports include three core P4P measures: Comprehensive Diabetes Care, Breast Cancer Screening, and Asthma Medication Management. The report for PCPs includes member-level information about recommended health screenings and/or medications, while the reports for provider organizations and integrated delivery networks include summary results for the group. The content of the reports is updated every month.

This reminder system has had a significant impact on guideline compliance and continuity of care for patients with chronic conditions. The early data show a five percentage-point increase in compliance rates for diabetes care within the first year of implementation. Based on these outcomes, the registry has been expanded from the initial three conditions (diabetes, asthma, and breast cancer screening) to eight conditions including both chronic and preventive care. THP also received very positive feedback from its network physicians. One comment states:

> "Today, health insurance plans possess the most comprehensive source of electronic data on patients. In addition to using this for claims payment and retrospective quality measurement this is a rich source of information to improve patient care. Tufts Health Plan has recognized this and is using this information in a Web-based, near real-time manner to allow primary care physicians as well as medical directors to access information and conduct outreach to patients. The Massachusetts Medical Society sees value in this and is encouraging other plans to adopt a similar model so that all patients can benefit from such an approach. We feel that this model is innovative, benefits patients, and makes conducting outreach by physicians easier."[21]

Measurement and Results

The Provider Network P4P program has shown a positive overall impact on patients and patient care through increased patient compliance using preventive health and informed clinical care. A key assumption in developing the program was that if physicians were provided with timely and actionable clinical information, an increase in compliance with recommended care management would result. In order to test this hypothesis, THP measured diabetes care compliance rates pre- and post-implementation.

Composite measures for four diabetes indicators—hemoglobin A1c, low-density lipids (LDL) cholesterol, eye exam and nephropathy screening rates—were compared over time, beginning in October 2004 when the program began. The diabetes compliance rate increased from 65 percent in October 2004 to 70 percent in October 2005, and to 79 percent by 2007.

Another measure of success is the extent to which providers are using THP's Web reports. The first usage report in May 2005 showed that 24 percent of provider units had used these reports. By 2006, 60 percent had used the registry, and by 2008, usage had increased to 65 percent of all provider units.

Tufts Health Plan has created a supplemental database to use in conjunction with the Web reports to capture cervical cancer screening (hysterectomy) and breast cancer screenings (bilateral mastectomies) rendered by other health insurance plans so THP physicians can receive maximum rewards by excluding those members from the cancer screening denominators. The additional data is not used for utilization comparison. This supplemental database has helped make the Web reports more useful for the providers, and more than 20 percent of the provider groups have sent in additional information. This information is reviewed by qualified nurses and then combined with claims information to make THP's Web reporting more complete. This collaboration has helped the provider community understand and feel more comfortable with the data in the Web reports.

[20] "Best in class" is defined as "the best performance rate in the NCQA Quality Compass® national data".

[21] Statement was given by a PO (IPA) medical director and vice president of the State Society®.

Challenges and Lessons Learned

There are many operational barriers for the implementation of the Web-based reports, so effective communication with external and internal stakeholders is an essential element in its success. Key challenges and THP's approach to solving them have included:

Lack of Web access: There are some physician groups with no Web access, or that do not utilize the Web for managing their PCPs' performance. By working with those POs' leaders to assess the root causes and feasibility to utilize the Web-based registry, participant numbers showed an increase. If needed, technical and financial assistance is provided by THP.

Secured Web site registry: Early on, about one-third of POs were not registered for secured Web access, and others had concerns about the registration process. Involving network contracting and provider services encouraged POs to register on the secured web site and created an expanded project team consisting of the medical director, e-business director, quality director, Web designer and information technology director to work with practice physicians and plan Health Insurance Portability and Accountability Act (HIPAA) officials as advisers.

HIPAA privacy and confidentiality concerns due to sharing protected health information over the Web application: Plan HIPAA officials were involved early in the project development stage to help build the system in a way that will meet HIPAA requirements and reduce concerns.

Development cost (initial investment): The development of the Web data system is costly and time-consuming. The development cost can be justified as value added or an operational efficiency enhancement, and as potential marketing value for expanding the data sharing with members.

THP's Web-based member registry has been recognized by the National Committee for Quality Assurance (NCQA) as a best practice for HEDIS® improvement and received "Actuate Excellence Awards" for its innovative technology. Future plans include collaborating with the physician network to integrate the Web reminder system into providers' electronic medical records. Since the success of pay for performance requires involvement by members as well as providers, THP is planning to make a user-friendly quality of care reminder system available to its members in support of its overall member engagement strategy.

Plan Description:

Tufts Health Plan, a not-for-profit Physician Organization-model managed care organization located in Watertown, Massachusetts, has a contracted network of 5,000 primary care physicians, 18,000 specialists, and 80 hospitals in Massachusetts, New Hampshire, and Rhode Island. It provides a variety of products including HMO, POS, PPO and Medicare Advantage, covering more than 700,000 members. Tufts Health Plan was recently named second in the nation among "America's Best Health Plans" by NCQA and *U.S. New & World Report*, based on criteria that measured clinical performance and member satisfaction among 287 of the nation's health plans.

UnitedHealthcare®
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UnitedHealthcare/PacifiCare—Quality Incentive Program

Encouraging quality competition among physician groups through a pioneering pay for performance approach

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Background

The Quality Incentive Program (QIP) at PacifiCare, A UnitedHealthcare Company, is designed to financially reward physician groups that demonstrate superior performance based on selected quality measures. The goal of the program is to improve overall quality of care by encouraging competition among physician groups and rewarding the highest performers.

Introduced in 2002, the QIP was the first pay for performance (P4P) program targeting physician organizations in the California marketplace, and many of its quality measures have been adopted by the Integrated Healthcare Association (IHA), a not-for-profit organization that launched a P4P physician group incentive program a year later (Table 1). IHA's membership includes purchasers, physician groups, hospital systems, and seven major health insurance plans, including UnitedHealthcare/PacifiCare, plus academic, consumer, purchaser, pharmaceutical, and technology representatives. (See the IHA case study on page 75 of this publication.)

Measurement and Rewards

The QIP measures and reports physician groups' performance in four areas: Clinical Quality, Patient Satisfaction/Service Quality, Utilization/Efficiency and IT-Enabled Systemness.

Clinical quality measures are reported using administrative claim data. Clinical measures that overlap with IHA P4P are calculated using the aggregated data from the seven participating health insurance plans or from physician groups' administrative data. Other clinical quality measures are calculated using UnitedHealthcare/PacifiCare's administrative claim data.

Patient satisfaction measures are derived from the Patient Assessment Survey (PAS), administered annually in California. The PAS measures patient experience at the physician group level, and the publicly reported results are used by physician groups for quality improvement, by consumers for physician group selection, and by health insurance plans for determining quality-based payments through the P4P initiative.

Utilization/efficiency measures are calculated using UnitedHealthcare/PacifiCare's claim data. Improvement is measured by trending the measure's performance from year to year at both the physician group level and the overall contracted network level.

IT-enabled systemness is based on a physician group survey. It was originally built on the foundation of the P4P IT measures of population management (e.g., using patient registries for those with chronic illness) and point of care activities (e.g., using an electronic medical record or using physician or patient reminder systems) and was expanded to include measures of care management processes, access, communication standards, and individual physician-level measurement and incentives.

The current QIP (measurement year 2008) has 41 measures (Table 1), with each measure assigned an incentive pool based on a per-member-per-month (PMPM) allocation of funds. Each physician group is compared to other physician groups and ranked by percentile based on performance in each measure. Physician groups ranked at the 85th percentile or higher receive 100 percent of the incentive based on the PMPM allocation. Physician groups ranked from the 75th to the 85th percentile receive 50 percent of the PMPM allocation. The first incentive payments were made in July 2003 and have continued since then on an annual basis.

Table 1. UnitedHealthcare/PacifiCare Quality Incentive Program Metrics	
Measure	**Clinical Quality**
	LDL Cholesterol Screening (Cardiac)
	LDL Cholesterol Control (Cardiac)
	Breast Cancer Screening
	Cervical Cancer Screening
	Childhood Immunization—VZV
	Childhood Immunization—MMR
	Use of Appropriate Medication for Asthma
	Appropriate Treatment for Children with URI
	Chlamydia Screening
	Appropriate Testing for Children with Pharyngitis
	Colorectal Cancer Screening
	Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis
	Use of Imaging Studies for Low Back Pain
	Medication Monitoring (ACE/ARBs, Digoxin, Diuretics, total)
	Anti-depressant Medication Management Option 3
	Persistent Beta Blocker Usage After Heart Attack
	Coordinated Diabetes Care
	Hemoglobin A1c Screening
	Hemoglobin A1c Poor Control (>9)
	Hemoglobin A1c Good Control (<8)
	LDL Cholesterol Screening
	LDL Cholesterol Screening (<100)
	Nephropathy Monitoring
	Diabetes Registry and Related Activities
Measure	**Patient Satisfaction/Service Quality**
	Specialty Care—Problems Seeing Specialist (PAS)
	Specialty Care—Rating of Specialist (PAS)
	Timely Access to Care (PAS)
	Doctor-Patient Communication (PAS)
	Overall Rating of Care—Rating of Personal Doctor or Nurse (PAS)
	Overall Rating of Care—Rating of All Health Care (PAS)
	Office Staff Composite (PAS)
	Health Promotion Composite (PAS)
	Overturned Appeals (Medical Group Initiated)
Measure	**Utilization/Efficiency**
	Potentially Avoidable Hospitalizations
	Inpatient Readmission
	Use of Appropriate Antibiotics
	Risk-adjusted Inpatient Bed Days PTMPY
	Risk-adjusted Outpatient Surgeries PTMPY
	Risk-adjusted Emergency Room Visits PTMPY
	Risk-adjusted Laboratory Tests PMPY
	Risk-adjusted X-ray PMPY
Measure	**IT-Enabled Systemness**

Results, Challenges, and Lessons Learned

Overall, improvement has been observed for measures related to clinical quality and the adoption of health care technology. From 2006 to 2008, the average clinical quality score has improved by 6.0 percent. The percentage of medical groups achieving full credit on IT Systemness has increased from 36.6 percent in 2004 to 53 percent in 2007. No significant improvement has been observed in patient experience or utilization/efficiency. The improvement observed in clinical quality areas might not be solely attributed to the QIP given the coexistence of other national quality improvement programs. Some of the improvements, such as Chlamydia screening, may be more likely due to the result of better documentation and data capture.

The major challenges the QIP has encountered include:

- The definitions for measures accepted as industry standards change over time, make trending difficult and program effectiveness difficult to quantify.
- Data completeness for services provided under capitated and sub-capitated contract arrangements is inconsistent across physician groups.
- Physician groups want incentive payments that are five to ten percent above capitation payment arrangements. The payments are viewed as a guarantee for performance given that the payment is in addition to payments based on "at-risk" capitation payments.

Despite these factors, it is important to note that clinical quality measures in the QIP have shown consistent movement in a positive direction in the health insurance plan's California contracted HMO network, with some physician groups showing much more movement than others. Likewise, although the overall patient experience for California physician groups did not show noticeable improvements, there are still many groups showing substantial improvement from 2006 to 2008, with the changes in some patient experience categories as high as eight percentage points.

Plan Description:

UnitedHealthcare (www.unitedhealthcare.com) provides a full spectrum of consumer-oriented health benefit plans and services to individuals, public sector employers and businesses of all sizes, including more than half of the Fortune 100 companies. The company organizes access to quality, affordable health care services on behalf of more than 26 million individual consumers, contracting directly with more than 570,000 physicians and care professionals and nearly 4,900 hospitals to offer them broad, convenient access to services nationwide. UnitedHealthcare is one of the businesses of UnitedHealth Group (NYSE: UNH), a diversified Fortune 50 health and well-being company.

UCare—
Minnesota Health Care Programs P4P Plan and Medicare P4P Plan

Recognizing and rewarding providers regardless of practice size

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Background

For a decade, UCare has offered incentives to clinics and care systems that deliver improved quality of care to its members, initially recognizing and rewarding providers serving Medicaid beneficiaries enrolled in Minnesota Health Care Programs (MHCP), and later expanding pay for performance (P4P) to include providers serving Medicare members.

Rather than rewarding providers in an all-or-nothing fashion for reaching certain benchmarks, UCare's MHCP Pay for Performance Plan and Medicare Pay for Performance Plan reward providers who show any improvement over the previous year in the targeted areas of measurement. This feature enables every practice, no matter how few UCare members it serves, to be eligible for an incentive, and ensures that the program does not penalize physicians who accept patients with complex and difficult conditions.

Measurement and Rewards

UCare analyzes its members' health outcomes each year using mostly HEDIS® quality measures, as well as a key Minnesota Department of Human Services quality measure[22], and evaluates areas where quality improvement incentives are warranted.

For UCare's MHCP population, 2007 P4P payments were made based on the achievement of goals for:

- Two-year-olds up-to-date on immunizations
- Blood lead testing
- Diabetes care: Dilated Eye Exams, Low-density lipids cholesterol (LDL-C) screening, Urine Microalbumin Tests
- Mammography
- Colon cancer screening
- Chlamydia screening

For *UCare for Seniors* Medicare Advantage members, 2007 P4P payments were made based on the achievement of goals set for:

- Mammography
- Diabetes care: Dilated Eye Exams, LDL-C screening, Urine Microalbumin Tests
- Cardiovascular Disease Care: LDL-C screening

In 2008, UCare's P4P program for MHCP providers continued most elements from the 2007 program and added several measures related to children and women's preventive services. In addition, UCare will reward performance that demonstrates good control of blood sugar (hemoglobin A1c<7 percent), blood pressure (<130/80), and LDL-C (<100 mg/dL) for members with diabetes.

For Medicare Advantage providers, UCare added rewards for performance that demonstrates the control of blood sugar, blood pressure, and cholesterol for members with diabetes, and

[22] Blood lead screening (9- to 30-month-olds)

cholesterol and blood pressure control for patients with heart disease.

UCare establishes a payment rate for each measure, and the rates vary by measure. For 2008, a clinic or care system with performance above the network 50th percentile for a measure will get a full payment for each member up-to-date for that measure. If care system performance shows improvement from the previous year, but is not above the network 50th percentile, the group will receive half of the full payment for each member up-to-date for that measure. The threshold will be raised to the network 60th percentile for 2009.

Results, Challenges, Lessons Learned

UCare's Medicaid and Medicare HEDIS® scores have been improving since 2004, when the expanded P4P program was launched. Qualifying clinics and care systems receive a check annually at the end of the measurement period. In 2008, UCare paid $1,544,750 to clinics and care systems across Minnesota for their performance in key quality-of-health measurements achieved in 2007.

UCare made P4P payments to 60 percent of the eligible care systems serving MHCP members. Thirty-one percent of the eligible care systems and independent clinics serving about 70 percent of the *UCare for Seniors* Medicare Advantage plan members received P4P payments totaling $519,700.

UCare works closely with clinics and care systems to help them meet measures used for P4P. Action lists are produced for each clinic that has eligible members for at least one measure. All members qualifying for a measure are included on the action list, which shows if they are compliant for the measure or not. Lists are available six times per year so that providers can take steps to make improvements in a timely fashion; a year-to-date list is published in May for the January to May time period and in November for January through November.

Each measure has its own tab on the action list, as well as a combined sheet that encompasses all measures, and while action lists only look at administrative measures, the diabetes and cardiovascular tabs show which members are eligible for the lab submission portion of the P4P process. Clinics that request the lists are provided with a user name and password to log in to a folder on the UCare secure web site. In addition, to simplify the administrative process, lab submission is done using a form that is available to download from the UCare web site and that is also sent to an e-mail contact list. Clinics or systems may complete the form and upload it back to a separate folder on the UCare web site.

There are still operational issues to work out, and UCare would like more providers to participate and qualify for the reward. In 2009, providers caring for dual-eligible Medicare and Medicaid beneficiaries under the Minnesota Senior Health Options program will also be eligible for a P4P plan.

UCare periodically surveys its providers for improvement suggestions and acts on those suggestions as feasible. For instance, providers find the inconsistency between measures and program structures among different health insurance plan programs in Minnesota confusing, so UCare is working with other health insurance plans to adopt a common measurement set and a streamlined data collection process in order to reduce the administrative burden on providers.

Plan Description:

UCare (www.ucare.org) is an independent, nonprofit health plan providing health care and administrative services to more than 160,000 members. UCare partners with health care providers, counties, and community organizations to create and deliver innovative health coverage products for a wide range of Medicare, Special Needs Plans, and State Public Programs members.

UCare for Seniors, UCare's Medicare Advantage plan, is ranked by Medicare in the top 13 percent of health plans nationwide for outstanding performance. UCare addresses health care disparities and care access issues through its UCare Fund grants and a broad array of community initiatives.

Hospital Programs

Hospitals and hospital systems across the country have taken up the Institute of Medicine's challenge to "build a safer health system"[23] since its groundbreaking reports on medical errors and inadequate health care quality, and an increasing number of health insurance plans are supporting these efforts by recognizing and rewarding top performers.

This section focuses on a variety of approaches that health insurance plans are using to reward hospitals for performance related to clinical quality, patient safety, and patient satisfaction. As is the case with physician pay for performance, health insurance plans are offering incentives to hospitals for achieving absolute performance levels, for being top performers relative to their peers, and for making improvements over time. Health insurance plans are also rewarding hospitals for investing in technology that supports clinical quality improvement initiatives such as computerized physician order entry, electronic medical records, electronic alerts that prevent medical errors, and administrative simplification initiatives such as online payment and remittance.

Health insurance plans typically derive their hospital performance data from a number of private and public sources, including:

- The Leapfrog Hospital Rewards Program™, which measures hospital performance on five medical conditions using data submitted by hospitals via the Leapfrog Hospital Survey.
- The Centers for Medicare & Medicaid Services (CMS), which has collaborated with the hospital industry and public sector stakeholders to develop Hospital Compare core measures for heart attack, heart failure, pneumonia, surgical care, and pediatric asthma care.
- The Agency for Health Care Research and Quality (AHRQ), which uses hospital administrative data to develop AHRQ Quality Indicators for prevention, inpatient care, patient safety, and pediatric care. CMS and AHRQ have also developed a standardized survey of patient perspectives on their hospital care, known as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®).
- The American College of Surgeons (ACS), National Surgical Quality Improvement Program which collects data on 135 variables, including preoperative risk factors and 30-day postoperative mortality and morbidity outcomes for patients undergoing major surgical procedures.
- The Society of Thoracic Surgeons (STS), which has published clinical guidelines that provide evidence-based recommendations for patient care in cardiothoracic surgery. As Dr. Fred Edwards, professor of surgery and chief of cardiothoracic surgery at the University of Florida, Jacksonville, points out in his expert perspective beginning on page 50 of this publication, a number of health insurance plans use the STS National Database as the source of cardiac surgery metrics for their physician and hospital pay for performance programs.
- The Institute for Healthcare Improvement (IHI), 5 Million Lives Campaign, which asks hospitals to introduce up to 11 evidence-based health care interventions, and to engage their trustees in the effort, in order to protect patients from 5 million incidents of medical harm.

The largest hospital pay for performance pilot initiative in the country by far is the CMS/Premier Hospital Quality Incentive Demonstration Project, which includes more than 250 participating hospitals. These hospitals have raised their quality performance scores for heart attack, heart failure, coronary artery bypass graft, pneumonia, and hip and knee replacement by an average of 15.8 percent over three years, during which time CMS has awarded more than $24.5 million to top performers.

[23] Kohn,Linda and Corrigan, Janet, et .al.2000.To err is human: building a safer health system. Washington, D.C. : National Academy Press.

Fred H. Edwards, MD

Professor and Chief of Cardiothoracic Surgery, University of Florida/Shands, Jacksonville

Dr. Fred H. Edwards is professor and chief of cardiothoracic surgery at the University of Florida/Shands Jacksonville and chairman of The Society of Thoracic Surgeons (STS) National Database.

Edwards has been involved with the STS National Database for over 15 years and was appointed chairman of the database in 2004. He developed the first national risk-adjustment models in cardiac surgery and has had a key role in all subsequent STS risk models. He has published over 120 papers in the peer-reviewed literature, most of which deal with some aspect of outcomes analysis. His present research is directed toward outcomes analysis, the use of national performance measures in quality assessment, and statistical techniques to objectively determine surgical quality.

Edwards is active in several national quality organizations. He now serves on the Quality Alliance Steering Committee, the Steering Committee of the AQA Alliance, the Executive Committee of the American Medical Association (AMA) Physician Consortium for Performance Improvement, and the Standards Maintenance Committee of the National Quality Forum (NQF). He is chairman of the NQF Surgery/Anesthesia Technical Advisory Panel and is vice-chairman of the Surgical Quality Alliance, which is a quality organization of the American College of Surgeons.

A decade has passed since a presidential commission recommended that health care stakeholders develop a means to standardize health care quality measurement and reporting in the United States. The National Quality Forum, a public-private partnership created in 1999, has since endorsed more than 500 measures, indicators, events, practices, and other products to help assess health care quality.

At the same time, the American Medical Association-convened Physician Consortium for Performance Improvement has been developing, testing, and maintaining evidence-based clinical performance measures and measurement resources for use by physicians. Physicians representing many medical specialties have forged consensus on more than 200 physician performance-measure descriptions and specifications using the best available scientific and clinical evidence.

Nevertheless, there is still resistance within the health care community on the question of whether we can measure quality. People say, "You can't put a number to it," but that is an outdated point of view. I am sure that when we look back a decade from now, the ways we measure performance today will look very primitive, but you have to start somewhere.

Overcoming the Opposition to Measurement

In order to break down the resistance and get physician buy-in, performance measures must resonate with those at the sharp end of medicine. Clinicians need to believe that the measures and guidelines being used to judge their performance are fair and valid, and they need to know that if they adhere to clinical guidelines, they will be better doctors than if they do not.

Quality measurement and reporting face several major barriers. One is face validity: Does a clinical guideline pass the reality test? If a clinician adheres to a particular guideline, will it really improve quality? I think for some of the measures currently being used, the answer is, at best, maybe.

A second barrier is the low-bar problem: Some guidelines are seen as nothing more than competency standards. Failure to meet them may indeed compromise quality, but they are so obvious to (and universally practiced by) physicians that they undermine the credibility of the whole measurement system.

A third barrier is the perception that quality is already good. Most health care workers on the "sharp end" seem to believe that they are compliant with national guidelines and best practice protocols. When objective data are examined, however, it often becomes clear that what providers know they should do—and what they think they are doing—is quite different from what actually happens.

Physicians must work with other stakeholders and quality improvement organizations to develop valid measures that have a direct link to results, a standardized means for data collection, and an effective feedback to providers. If we do that, and we see quality really improve, the opposition will soon fade away.

We Can't Improve Quality Without Data

Over the last decade, the demand for accountability, quality measurement, and public reporting in health care has fueled a sustained movement toward evidence-based care, local collection of clinical information, national analysis, and benchmarking. My specialty, cardiothoracic surgery, has responded in a number of ways. The Society of Thoracic Surgeons (STS) has published clinical guidelines that provide firm, evidence-based recommendations for patient care in cardiothoracic surgery—not dictating, but rather suggesting patient management strategies. Most practices are now data-driven, with The Society of Thoracic Surgeons (STS) National Database serving as the major vehicle for data collection and analysis.

Data collection is expensive and time-consuming, but physicians need to make it part of the way they do business. We have done this in thoracic surgery for years. The STS National Database has been molded into one of the "gold standard" clinical data registries that allows the physician to report and thoughtfully analyze clinical information to optimize patient care. Keep in mind, however, that data collection is much easier in surgery than in a medical practice where you are dealing with a much broader range of clinical issues.

Reward Quality Performance, Not Quantity

The medical profession is one of the few that pays based on the number of services you provide, with little regard to the quality of the services you provide. Each year more and more evidence demonstrates that there is a fundamental misalignment between financial incentives and quality of care. There is also ample evidence that there is no easy solution. The complexity and fragmentation of our health care delivery and financing systems make it nearly impossible to fine-tune incentives in a way that avoids unintended consequences, resulting, for instance, in too little care instead of too much care, or encouraging physicians to avoid caring for high-risk patients.

So, how do you begin to realign incentives to encourage high levels of performance? One way is to offer financial incentives for physicians to do things that are most definitely associated with quality. Pay for performance, if done correctly, is advantageous for patients, physicians, payers, and health insurance companies alike. If quality guidelines are adhered to, the number of complications is reduced, the cost of care goes down, the quality of care goes up, and people are more satisfied with their physicians, so it's a win-win for everybody.

Some of the most innovative health insurance plans are using the STS Database as the source of cardiac surgery metrics for their physician and hospital pay for performance programs. For instance, physicians and hospitals may be rewarded for performing above the national average for the risk-adjusted mortality rate for coronary artery bypass grafting (CABG) or for the rate of post-operative complications. This encourages the adoption of techniques, practices, and processes that improve surgical outcomes and patient safety.

Pay for performance is in its infancy in the United States, so there is insufficient evidence to allow us to calculate how much of a financial incentive is needed to influence physicians' behavior, but it is certainly much more than the 1.5 percent Medicare payment add-on that physicians can receive for reporting on the quality measures in the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting Initiative. It is anticipated that pay for reporting will soon be followed by pay for performance.

Getting Past the Tower of Babel

Today, we are faced with a daunting proliferation of different reports, measures, definitions, and requirements—a Tower of Babel that leads to wasteful duplication of effort for physicians and hospitals. Health insurers, in particular, need to speak with one voice and work with other stakeholders to reduce duplication of effort and try to harmonize the various measures. Physicians must do their part as well, of course, but until there is more uniformity, there will continue to be a strong disincentive to embrace the use of performance measures.

The AQA Alliance, a coalition that includes the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans, and the Agency for Healthcare Research and Quality, is one group working on the problem. There are others, but the complexity of what we are dealing with is likely to require a central source of authority, guidance, and priority-setting in order to standardize comprehensive quality measurement. Widespread acceptance of quality measurement is probably contingent upon having the major quality organizations operate in a coordinated, harmonized effort, with a leadership structure that can streamline our national quality enterprise. Once this is in place, it seems likely that we will see an accelerated pace to achieve our ultimate goals of quality improvement and reduction in cost trends.

Aetna—
Pathways to Excellence℠
Hospital Incentive Programs

Encouraging customized quality and safety improvement using national standards

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Background

Aetna's hospital incentive programs identify and target areas of significant opportunity to improve the quality and costs of health care for our members through performance measurement and ongoing collaboration with hospitals.

The cornerstone of Aetna's provider incentive programs is Pathways to Excellence℠, an array of initiatives that recognize and reward health care providers who improve the quality, safety, and cost efficiency of health care. The initiatives also contribute to Aetna's value-based purchasing strategy on behalf of members and plan sponsors. Pathways to Excellence programs use evidence-based, transparent measures and credible data to recognize and promote quality and to engage providers in achieving demonstrated improvements in care for members.

Pathways to Excellence includes:

- Aetna Institutes™ Program publicly recognizes and promotes use of health care facilities and services that deliver quality and cost-efficient care for specific conditions based on evidence-based measures of clinical performance, cost efficiency, and member access;
- High Performance Provider Initiatives, in which Aetna collaborates with hospitals, medical groups, and other health care organizations to create breakthrough solutions to quality and cost issues;
- Patient safety improvement initiatives;
- Aetna's Provider Quality Performance, or pay for performance (P4P), programs for physicians and hospitals, including Aetna's support and expansion of Leapfrog Reward programs.

Aetna's hospital incentive, or pay for performance (P4P), arrangements may be based on:

- A negotiated agreement with a hospital or hospital system (in some cases an integrated delivery system may have both physician- and hospital-related performance measures in their agreement);
- A national recognition program such as the leapfrog group rewards program™ where nationally recognized measures are voluntarily reported by providers to achieve agreed-upon results and incentive payments; or
- A multi-payer collaborative where aggregated payer data is used to recognize and reward providers.

Measurement

Aetna uses national, all-payer data sources and measures wherever possible in its hospital P4P programs. These may include, for example, Centers for Medicare & Medicaid Services (CMS)-reported data, Leapfrog Rewards data, and/or other publicly available data sources. In addition, Aetna has developed a suite of efficiency and resource utilization measures[24] and is working in conjunction with a limited set of hospitals to assess additional measures of potentially preventable emergency room visits and hospitalizations. For any measures that are developed by Aetna, there is full measure transparency, as well as transparency and discussion of risk-adjustment methodologies, where relevant. The details of the measurements, such as inclusions and exclusions, have been developed in collaboration with hospitals.

[24] These measures include risk-adjusted average length of stay, risk-adjusted readmission ratio, and risk-adjusted one-day length of stay.

Results

All hospitals that have P4P relationships with Aetna have experienced improvements in one or more measures during the program period. In particular, all participating hospitals improved processes of care, such as preventive use of antibiotics. There is a significant lag in the data results, however, and there is no systematic way to isolate the effects of incentive payments from the effects of transparency and public reporting (e.g., CMS Hospital Compare) in achieving hospital improvements. Hospitals do report that the availability of P4P dollars increases the ability of systems to more rapidly achieve results in publicly reported measures.

Below is a sample of hospital-specific performance from January 2005 to June 2007 in a multi-year hospital P4P arrangement using CMS and Leapfrog clinical quality measures and Aetna's efficiency measures. The data illustrate that significant improvements occurred for several measures, but not for all. For heart failure measures, community-acquired pneumonia, and surgical infection prevention, significant improvements occurred during the incentive period. For acute myocardial infarction (MI)/beta blocker at discharge, where high levels were already present at the beginning of the program period, the focus was on maintaining high performance levels rather than on significant additional gain. In Aetna's programs, such measures that are already at high levels may be included in the P4P arrangement for several cycles but will be retired and replaced with new measures in collaboration with the facility. A retired measure may still be monitored, but is no longer eligible for payment. New measures enable P4P dollars to be targeted toward improvement opportunities. The hospital scorecard below also demonstrates that progress was also made on Leapfrog and efficiency measures. While readmission rates did not improve significantly, the rates are low and again, demonstrate the potential for retiring a measure.

In addition to evaluating whether a hospital is improving its performance, Aetna's systems can generate market, state, regional, and national benchmarks. The hospital's performance is also evaluated in comparison to its peers. For example, in the scorecard below, this hospital's achievement of 90.9 percent for initial antibiotic timing surpasses the market average in all measurement periods. In another hospital pay for performance arrangement, after three measurement periods there was some improvement, but the hospital was still far below the market and average statewide performance. In that case, the hospital did not earn performance awards. In setting the targets, both the hospital's performance and the hospital's performance within the marketplace and state are assessed to establish targets that provide meaningful value to members.

Hospital Pay for Performance Scorecard Measurement Period: January 2005 to June 2007

Measure Name	Numerator	Denominator	Score	1st Prior Period	2nd Prior Period	3rd Prior Period
Acute Myocardial Infarction—CMS	**July 2006–June 2007**			**Jan 06–Dec 06**	**July 05–June 06**	**Jan 05–Dec 05**
Beta Blocker at Discharge	138	146	94.4%	99.0%	98.0%	99.0%
Heart Failure—CMS	**July 2006–June 2007**			**Jan 06–Dec 06**	**July 05–June 06**	**Jan 05–Dec 05**
ACE Inhibitor or Angiotensin Receptor Blocker (ARB) for Left Ventricular Systolic Dysfunction (LVSD)	89	113	79.0%	85.0%	77.0%	75.0%
Community Acquired Pneumonia—CMS	**July 2006–June 2007**			**Jan 06–Dec 06**	**July 05–June 06**	**Jan 05–Dec 05**
Initial Antibiotic Timing	30	33	90.9%	77.0%	71.0%	69.0%
Surgical Infection - CMS	**July 2006–June 2007**			**Jan 06–Dec 06**	**July 05–June 06**	**Jan 05–Dec 05**
Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision	608	635	95.7%	95.4%	96.2%	91.7%
Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	518	611	84.8%	74.1%	69.7%	49.6%
Leapfrog	**Jan 2006–Dec 2006**			**Jan 05–Dec 05**	**Jan 04–Dec 04**	**Jan 04–Dec 04**
Computerized Physician Order Entry (CPOE) Leap	2.00	2	100.0%	100.0%	100.0%	50.0%
Intensive Care Unit (ICU) Intensivist Leap	2.00	2	100.0%	100.0%	100.0%	50.0%
National Quality Forum (NQF) Safe Practices Leap	0.75	2	37.5%	0.0%	0.0%	50.0%
Never Events	0.50	2	25.0%	n/a	n/a	n/a
Efficiency Measures	**Jan 2007–Dec 2007**			**July 06–June 07**	**Jan 06–Dec 06**	**July 05–June 06**
	Total Admissions					
Risk-Adjusted Average Length of Stay	7298	1749	4.2	4.1	4.3	4.6
Risk-Adjusted Readmission Ratio	72	1749	4.1%	2.6%	2.5%	3.1%

Lessons Learned

A hallmark of Aetna's hospital P4P programs is its flexible, collaborative approach, which engages both the clinical and financial leadership of participating provider organizations. One of the most valuable lessons is that the nature of the contractual relationship between the hospital and the payer makes a positive shift when the discussion is about encouraging and rewarding quality. Payers and hospitals are more likely to bring their clinical experts to the table; literature is reviewed; best practices and innovations are actively discussed; and the challenges of quality improvement in complex health care settings are openly acknowledged and addressed.

In addition to the important lessons on collaboration for change, within the hospital performance program we have learned to work effectively with the data, despite a lengthy delay between the end of the measurement period and the availability of the data, and to focus on continuous improvement. In addition, we are committed to working with national all-payer data, and wherever possible, hospital self-reported data. Aetna promotes reporting data to the Leapfrog Group and includes these vital patient safety measurements in our pay for performance program. In 2009, Aetna will continue to focus on working with the Leapfrog Group to evaluate the return-on-investment for patients and payers. We will also continue to work with hospitals to identify and promote effective programs to improve outcomes, patient safety, and the efficiency of hospital care.

Plan Description:

Aetna is one of the leading diversified health care benefits companies in the United States, serving approximately 37.2 million people with information and resources to help them make better informed decisions about their health care. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, and medical management capabilities and health care management services for Medicaid plans. Its customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units and government-sponsored plans in the U.S. and internationally. www.aetna.com

Anthem Blue Cross and Blue Shield—Quality-In-Sights®: Hospital Incentive Program and Quality Physician Performance Program

Using incentives to align hospital and physician goals and foster collaboration across the health care system

Background

The Quality-In-Sights®: Hospital Incentive Program (Q-HIP℠) and Quality Physician Performance Program (Q-P3℠) are Anthem Blue Cross and Blue Shield in Virginia's performance-based reimbursement programs for participating Virginia hospitals, cardiologists, and cardiac surgeons.

Q-HIP and Q-P3 reward hospitals and physicians for practicing evidence-based medicine and for implementing other nationally recognized best practices. By aligning hospital and physician goals, these programs foster collaborative efforts to improve care across the health care system.

Focused on the principles of patient safety, health outcomes, and patient satisfaction, the program is continually evolving, adopting new metrics and areas of focus as they come to the national forefront, leading to the inclusion of innovative programs such as the Institute for Healthcare Improvement (IHI) 100,000 Lives and 5 Million Lives Campaigns and the adoption of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®) survey as a satisfaction measurement mechanism.

A foundation of the programs is the use of an independent third party, designated as a Patient Safety Organization (PSO)[25], to collect, review, validate, and score all materials and information submitted by participants. Use of this trusted intermediary provides an unbiased evaluation of participant performance and allows for a unique level of trust and cooperation between participants and Anthem.

In 2006 Anthem followed up on Q-HIP's success in engaging hospitals by introducing accompanying physician programs (Q-P3) for both cardiologists and cardiac surgeons in the Virginia market. Q-P3's scoring methodology ties physician scores to those achieved at Q-HIP facilities where they practice. Using metrics from the American College of Cardiology's National Cardiovascular Data Registry (ACC-NCDR®) as a part of Q-HIP and The Society of Thoracic Surgeons National Database as the source of cardiac surgery indicators creates a unique opportunity to align hospital and physician performance goals in these two key areas of care. During the first measurement period, cardiologist participation accounted for 83 percent of eligible physicians in Anthem Virginia's network, while cardiac surgeons achieved a 100 percent participation rate.

Measurement

Performance is measured in three broad areas: patient safety, health outcomes, and member satisfaction. These measures and reporting have led to improvements observed by Q-HIP facilities and have contributed to a decrease in mortality and morbidity rates.

Patient Safety

- Joint Commission National Patient Safety Goals
- Computerized Physician Order Entry (CPOE) System
- ICU Physician Staffing (IPS) Standards
- NQF Recommended Safe Practices
- IHI 5 Million Lives Campaign (measures may be rotated annually)
- CDC/ Advisory Committee on Immunization Practices (ACIP)—Flu and Pneumonia Vaccine Guidelines

Patient Health Outcomes

- American College of Cardiology National Cardiovascular Data Registry (ACC-NCDR™) Section
- Seven ACC-NCDR Indicators for Cardiac Catheterization and PCI

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- Joint Commission / CMS National Hospital Quality Measures
- Acute Myocardial Infarction (AMI) Indicators
- Heart Failure (HF) Indicators
- Pneumonia (PN) Indicators
- Surgical Care Improvement Project (SCIP)
- CABG Indicators
- Five Society of Thoracic Surgeons Coronary Artery Bypass Graft (CABG) Measures

Member Satisfaction

- HCAHPS® Survey Results

Results, Challenges, and Lessons Learned

The improvements realized by participating facilities and physicians thus far are impressive. The eight facilities that submitted a full set of data during Q-HIP's 2003 pilot have observed:

- A 52 percent improvement in Door-to-Balloon in 90 minutes or less (DTB-90)[26] rates, improving from a weighted average of 49.8 percent during Q-HIP 2003 to a rate of 75.9 percent during Q-HIP 2006 (the measurement period most recently completed).
- A 50 percent reduction in Serious Complications[27] for Percutaneous Coronary Intervention (PCI-Comp), moving from a weighted average of 5.4 percent during Q-HIP 2003 to a rate of 2.7 percent during Q-HIP 2006.
- A 51 percent reduction in Serious Complications[28] for Diagnostic Catheterization (CATH-Comp), dropping from a weighted average of 3.0 percent during Q-HIP 2003 to a rate of 1.4 percent during Q-HIP 2006.

Improvement has not been limited to early Q-HIP adopters. The six additional facilities that submitted a full set of data during Q-HIP 2004 have observed:

- A 102 percent improvement in DTB-90 rates, improving from a weighted average of 37.2 percent during Q-HIP 2004 to a rate of 75 percent during Q-HIP 2006.
- A 43 percent reduction in PCI-Comp, moving from a weighted average of 4.4 percent during Q-HIP 2004 to a rate of 2.5 percent during Q-HIP 2006.
- An 18 percent reduction in CATH-Comp, dropping from a weighted average of 1.7 percent during Q-HIP 2003 to a rate of 1.4 percent during Q-HIP 2006.

Even as these results highlight the successes of hospitals participating in Q-HIP since its implementation, the beneficial results of introducing Q-P3 have only just begun to be realized. Comparing data from Q-HIP 2005 (the measurement period immediately prior to Q-P3 introduction) to that of Q-HIP 2006 (the first measurement period that aligned physician and hospital goals), the 18 facilities submitting during both measurement periods have observed a 21.4 percent improvement in DTB-90; an 8.3 percent reduction in PCI-Comp; and a 12 percent reduction in CATH-Comp.

One of the most important achievements of Q-HIP and Q-P3 is the collaborative approach to quality improvement that the programs have encouraged. With shared performance goals, hospitals and physicians are encouraged to work together to improve results. Indicators are no longer solely hospital or physician based; instead they become joint responsibilities. Furthermore, Q-P3's collective achievement approach means that multiple, often competing, physician groups at any given facility share the same metric results: The hospital and physicians succeed or fail as one. This makes communication and collaboration fundamental to both programs and encourages all participants to ask the question, "How can we work together to improve?"

Since its inception in 2003, Q-HIP has grown from a 16-hospital pilot program in the state of Virginia into a multi-state program with participating Anthem and affiliated health insurance plans that includes more than 150 participating hospitals in California, Connecticut, Georgia, Maine, New Hampshire, New York, and Virginia. In Virginia alone, the 69 hospitals currently participating represent over 95 percent of Anthem's inpatient admissions in the state. The Q-HIP and Q-P3 programs were recently recognized by the National Quality Forum and The Joint Commission in 2008 as one of the recipients of the annual John M. Eisenberg Awards for Patient Safety and Quality Award for the program's development and implementation of performance-based reimbursement for Virginia hospitals, cardiologist, and cardiac surgeons and its innovation in patient safety and quality at the local level.

Plan Description:

Anthem Blue Cross and Blue Shield is the trade name of: In Connecticut: Anthem Health Plans, Inc. In Maine: Anthem Health Plans of Maine, Inc. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Virginia: Anthem Health Plans of Virginia, Inc. (serving Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123.). Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

[25] Patient Safety Organizations are unbiased third-party entities (trusted intermediaries) used by the health care community for quality improvement, peer review, etc. For Q-HIP, Anthem utilizes Virginia Health Information (VHI).

[26] Door-to-balloon in 90 minutes, as defined by the American College of Cardiology and the American Heart Association is the "gold standard", recommending that the interval between arrival at the hospital and intracoronary balloon inflation (door-to-balloon time) during primary percutaneous coronary intervention should be 90 minutes or less.

[27] Serious complications are defined as cardiogenic shock, congestive heart failure, cerebrovascular accident (CVA)/stroke, tamponade, contrast reaction, and renal failure.

[28] Serious complications are defined as cardiogenic shock, congestive heart failure, cerebrovascular accident (CVA)/stroke, tamponade, contrast reaction, and renal failure.

Blue Cross Blue Shield of Massachusetts—Hospital Performance Incentive Program

Accelerating change by rewarding hospitals for achieving key metrics and for demonstrating progress

Background

The Blue Cross Blue Shield of Massachusetts (BCBSMA) Hospital Performance Incentive Program (HPIP) is designed to reward hospitals for achieving specific quality improvement project goals. Hospitals are rewarded financially for demonstrating improved quality, data-driven process and outcome-based performance improvement efforts, and for the implementation of electronic quality improvement tools.

The improvement goals of the program include:

- Accelerate performance improvement activities in hospitals by identifying opportunities that represent shared priorities for BCBSMA and the hospital.
- Financially reward hospitals by using quality performance incentives to support and recognize hospitals' active participation in data-driven, outcome-oriented performance improvement processes.

Hospitals are rewarded either for meeting absolute performance or demonstrating improvements in quality over a three-year period. For each outcome measure, upper and lower targets are set in the first year and held constant. The upper and lower targets represent the maximum achievable performance and the minimum threshold of performance at which the hospital begins to receive financial rewards. Measures are combined into a summary result with equal weight for each measure, and hospitals are paid for demonstrating results that fall anywhere along a continuum of performance. Specific measures that present the most opportunity for improvement are collaboratively determined by the hospital and the plan, making the program highly individualized.

Measurement

Hospital performance is measured in four areas:

Clinical Quality/Patient Safety

Measurement of clinical quality and patient safety is an integral part of the program, and measurements are based on nationally accepted process and outcome measures.

- The Clinical Outcome measures used in HPIP are derived from the Agency for Health Care Research and Quality (AHRQ) and the National Surgical Quality Improvement Program (NSQIP). Hospitals select four out of 13 AHRQ measures or four NSQIP "post-operative occurrences."
- Clinical process measures are rooted in the hospitals' participation in the Institute for Healthcare Improvement's (IHI's) 5 Million Lives Campaign where they are to implement and report on the 10 IHI clinical bundles by the end of the three-year period. In addition, they have incentives tied to performance on the Centers for Medicare & Medicaid Services (CMS) Hospital Quality Alliance (Hospital Compare) measures.

Patient Experience of Care

Using the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®) survey, the hospital is measured on the scores of four composite measures: Communication with Doctors, Communication with Nurses, Responsiveness of Hospital Staff and Discharge Planning. These four composite measures were chosen because they are based on specific, clinically important aspects of the patient's hospital care experience that are actionable. In addition, these measures were rigorously tested and validated to ensure that they are statistically reliable and stable before they were used in payment, tiering, or public reporting.

MASSACHUSETTS

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Governance and Business Operations

The governance component of HPIP requires that the hospital board and other key leaders are equipped and fully committed to incorporating quality and patient safety strategies into their work and performance plans. At the inception of the program, at least 75 percent of the board must complete a quality and safety governance education program approved by BCBSMA and adopt a written, data-driven quality and patient safety improvement program plan. Over the following three years, the board must implement a plan to address significant quality and safety gaps, starting with three areas (such as eliminating medication errors and pressure ulcers) in the second year and expanding to five areas in the third year. The areas targeted for improvement and identified within the improvement and program plan are decided upon by the individual hospital and reflect nationally recognized quality and safety improvement measures. The hospital CEO's performance review must include consideration of the facility's progress on its quality and safety plan.

Utilization and Resource Allocation

In program years prior to fiscal year 2007, hospitals were eligible to be rewarded for implementing and investing in hospital-specific technology aimed at improving and supporting quality improvement initiatives. They selected a minimum of two technologies (clinical and/or administrative) per measurement period. E-technology supporting clinical projects may include computerized physician order entry (CPOE), electronic medical records, bar coding, patient portals, and clinical alerts and reminders that prevent medical errors. Administrative simplification projects may include online payment and remittance, such as electronic funds transfer (EFT) and online electronic remittance advices (ERA), offered through PaySpan® for providers.

Hospitals were initially required to complete the Technology Hospital Form and eHealth Roadmap, and provided progress reports on projects planned and implementation of the IT infrastructure with estimated delivery time frames in order to receive incentive payments.

Beginning with fiscal year 2008, these measures have been replaced by the governance and business operations requirements above.

Results, Challenges, and Lessons Learned

The program has expanded from 14 hospitals in 2003 to 65 hospitals in 2008, now representing approximately 93 percent of BCBSMA network hospitals participate.

Of the 51 percent of hospitals reporting in FY2006, 67 percent, or 34 hospitals, met both improvement goals, while 25 percent, or 13 hospitals, met one of the two goals set in the second year.

All of the eligible hospitals achieved their IHI outcome, process, and patient experience goals. In FY2006, nearly $70 million was paid to 55 hospitals, representing 2.5 percent of an average hospital's BCBSMA payments.

BCBSMA has incorporated feedback from participating hospitals and its own evolving measurement approach into the HPIP program to ensure that measurements for payment, public reporting, and tiering are scientifically sound by rigorously testing and validating the results to ensure reliability, spreading incentives across more measures, and building on areas that are already priorities for hospitals. Performance is now measured against a continuous, absolute scale where available, and payment may be awarded for either absolute performance or improvement along the continuum. New components critical to quality improvement programs have been added to the hospital incentive program, such as governance and a greater focus on clinical outcomes. The program continues to be well-received by senior leaders and hospital quality improvement teams, while there is variable but slowly improving acceptance of purely claims-based measures within the provider community.

BCBSMA conducts an annual hospital quality educational forum, as well as working sessions with the majority of hospitals represented. These educational opportunities, along with a communication tool built by the plan, have facilitated sharing of successful strategies, interventions, and lessons learned among hospitals. In addition, opportunities have been created for alliances with other organizations, such as the Massachusetts Coalition for the Prevention of Medical Errors and the state's Division of Health Care Finance and Policy, among others, to align quality and patient safety initiatives.

Plan Description

Blue Cross Blue Shield of Massachusetts (www.bluecrossma.com) was founded more than 70 years ago by a group of community-minded business leaders. Today, headquartered in Boston, BCBSMA provides coverage to more than 3 million members, 2.5 million in Massachusetts. BCBSMA believes in rewarding doctors and hospitals for delivering safe and effective care, and in empowering patients to take more responsibility, become educated health care consumers and become stronger partners with their doctors. Blue Cross Blue Shield of Massachusetts is an independent licensee of the Blue Cross Blue Shield Association.

CIGNA HealthCare and Methodist Healthcare—Hospital Rewards Program

Collaborating to help network hospitals improve the health and well-being of the individuals we serve and to achieve top-tier performance

Background

In 2005, CIGNA HealthCare and Methodist Healthcare in Memphis collaborated to develop a three-year, pay for performance pilot program based on Leapfrog Group hospital measures. The goal was to recognize and reward the Methodist Hospital System if it showed year-over-year improvements or sustained top-tier performance in quality and/or cost efficiency.

The Methodist Healthcare Hospital System includes five adult hospitals and one children's hospital. Combined, they provide 70 percent of the hospital care for CIGNA members in the Memphis area. The pay for performance program was developed for the adult hospitals with the encouragement and strong support of one of CIGNA's employer accounts and the local employer purchasing coalition, the Memphis Business Group on Health.

Measurement

CIGNA's Hospital Rewards Program for the Methodist Hospital System was based on five high-risk, high-cost diagnosis categories for which the Leapfrog Group has endorsed specific process improvement measures:

- Community Acquired Pneumonia
- Acute Myocardial Infarction (MI)
- Percutaneous Coronary Intervention (PCI)
- Coronary Artery Bypass Graft (CABG)
- Deliveries/Newborn Care (NICU)

CIGNA discovered that there was insufficient Leapfrog data to track the hospitals' progress and compare results to national benchmarks, so the health insurance plan also incorporated data from its Hospital Value profile. The CIGNA Hospital Value profile uses data on mortality and complication rates, plus Centers for Medicare & Medicaid Services (CMS) data and Leapfrog data, to assess quality and patient safety, and it uses the average cost per admission, adjusted for age, sex and case-mix, to assess utilization and resource allocation. The program allowed for the Leapfrog Hospital Rewards Program's™ maximum potential reward per diagnosis category, with 60 percent of the reward for improvements and/or sustained top-tier performance for quality and 40 percent for improvements and/or sustained top-tier performance for cost efficiency.

Results

The results of the pilot program are summarized in the table on the following page, where three stars indicate performance in the highest tier and one star indicates the lowest tier. Each hospital's index score is compiled for quality and cost-efficiency, then ranked with approximately the top third in each category assigned three stars, the middle third two stars, and the lower third one star. A hospital that attains the highest number of stars (3) in both categories for any condition is considered a CIGNA Center of Excellence for each condition for which the performance goal was achieved.

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Overall, the hospitals either improved or maintained their star ratings from the beginning to the end of the pilot. Methodist Healthcare was not able to report the Deliveries/Newborn Care (NICU) quality measures at the outset of the pilot, so CIGNA awarded a grant to help the hospitals develop reporting for 2006. The hospital system was then eligible for a performance bonus in 2007 for 2006 improvement over 2005, results, and again in 2008 for improvement in 2007 over 2006 initial results.

Leapfrog Category	Methodist Hospital System Performance Star Rating 2005		Methodist Hospital System Performance Star Rating 2006		Methodist Hospital System Performance Star Rating 2007	
	Quality	Efficiency	Quality	Efficiency	Quality	Efficiency
Pneumonia	**	*	***	**	**	**
Acute Myocardial Infarction (MI)	*	**	***	**	*	**
Percutaneous Coronary Intervention (PCI)	**	***	***	***	***	***
Coronary Artery Bypass Graft (CABG)	***	***	***	***	***	***

A study published by The Joint Commission in 2008[29] examined patient outcomes in hospitals that adopted three sets of Leapfrog's patient safety practices (computerized physician order entry, the use of intensivists staffing in intensive care units, and evidence-based referrals) for acute myocardial infarction (AMI), congestive heart failure (CHF), and pneumonia. Results showed better quality of care for all three conditions, and those hospitals that had implemented Leapfrog practices had lower risk-adjusted mortality rates than hospitals that did not for at least two of the conditions.

Lessons Learned

This was a relatively simple approach that rewarded the hospital system for improvement and/or sustained top-tier performance in quality and/or cost efficiency in five important clinical areas that represent high volume and high costs for most commercial health insurance plans. The pilot program was strongly supported by one of the health insurance plan's employer accounts and its primary hospital network in the Memphis area. The pilot demonstrated the impact that a strong collaborative effort can have in leveraging each participant's dedication to improving patient care. Because there was insufficient data to compare this hospital system with others in the Leapfrog Hospital Rewards Program (LHRP) at the initiation of the pilot, the participants also used other established third-party measures and data for quality and cost efficiency measurement to compare this hospital system with other CIGNA contracted hospitals. The results show improvement and/or sustained top-tier performance in most of the diagnosis categories evaluated and provide the basis for further development of recognition and reward initiatives.

Plan Description:

CIGNA, a global health service company, is dedicated to helping people improve their health, well-being and security. CIGNA Corporation's operating subsidiaries provide an integrated suite of medical, dental, behavioral health, pharmacy and vision care benefits, as well as group life, accident and disability insurance, to approximately 47 million people throughout the United States and around the world. To learn more about CIGNA, visit www.cigna.com.

[29] Jha, Ashush K., et al. Does the Leapfrog program help identify high-quality hospitals? Journal on Quality and Patient Safety 34 (June):318-325.

Highmark Blue Cross Blue Shield—QualityBLUE Hospital Pay for Performance Program

Aligning evidence-based practices and national quality measures to advance clinical outcomes

Background

The Highmark QualityBLUE Hospital Pay for Performance Program aligns with recognized, evidence-based practices to ensure that quality measures reflect sound industry guidelines and standards. It is offered to providers as a component of provider contracting, and hospitals agree to place a portion of their contracted reimbursement at risk based upon performance. It currently includes 41 facilities, including health care organizations from both the western and central regions of Pennsylvania. Hospitals are required to improve the quality of patient care for identified clinical indicators, and their program performance is evaluated and scored. Facilities are evaluated either on performance compared to a baseline or demonstrated improvement throughout the performance year, and reimbursement is based on total program scores.

The program builds on traditional publicly reported measures, such as the Centers for Medicare & Medicaid Services (CMS) Hospital Compare Core Measures,[30] by incorporating additional clinical indicators, from national improvement initiatives. Ninety percent of a hospital's overall program score is attributed to the clinical indicators, and 10 percent to its performance on the CMS Core Measures. Each indicator is scored separately on a 100-point scale and is composed of three parts: measurement, results, and a critical analysis. The critical analysis includes information on the hospital's improvement initiatives, an analysis of the data, and an evaluation of the economic impact associated with each indicator.

At the close of the performance year, a comprehensive report of aggregate hospital clinical outcomes is distributed to all QualityBLUE hospital participants, group accounts, and the public.

Measurement

The program's performance measures include two mandatory indicators and the opportunity to choose from a menu of additional indicators. Participants are challenged to improve[31] on non-traditional pay for performance indicators, such as reducing the transmission of health care-associated infections and improving care to stroke patients.

Mandatory indicators:

- Methicillin Resistant *Staphylococcus aureus* (MRSA): prevention and reduction of MRSA
- Central-line associated bloodstream (CLAB): prevention and reduction of CLAB infections

Menu of optional indicators:

- Catheter-associated urinary tract infections (CAUTI): Prevention and reduction of CAUTI and implementation of evidence-based practices
- *Clostridium difficile* Associated Disease (CDAD): Prevention and reduction of Clostridium difficile infections
- Surgical Care Improvement Project: Infection prevention and reduction of surgical site infections
- Surgical Care Improvement Project: Venous thromboembolism (VTE) and a medical intensive care unit prevention and reduction of venous thromboembolism.
- Get with the Guidelines℠ (GWTG)—Stroke: Programmatic implementation of the American Heart Association's GWTG—Stroke to improve stroke patient care and patient/community education
- Perinatal Elective Induction: Working with the Institute for Healthcare Improvement's IMPACT project to reduce elective induction prior to 39 weeks gestational age

To add rigor into the program, QualityBLUE hospitals select up to four performance indicators (depending on their program participation level) to concentrate on improving throughout the program year.

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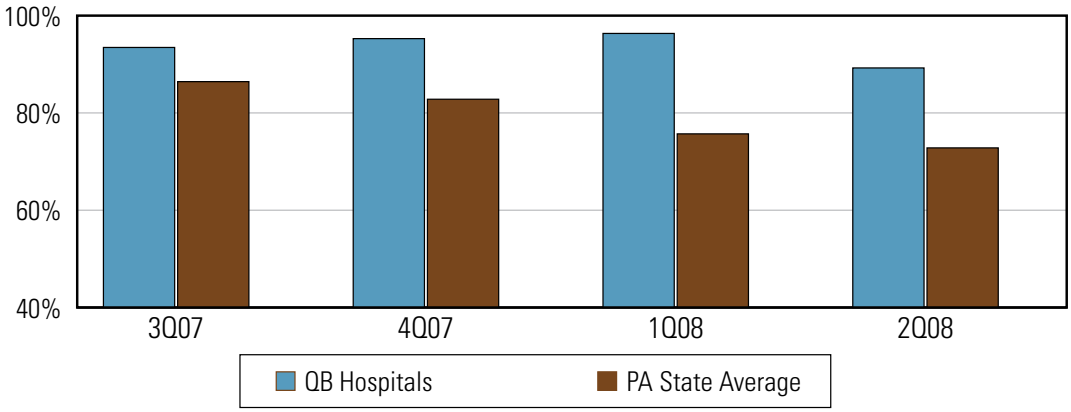
Results, Challenges, and Lessons Learned

With the QualityBLUE Hospital Pay for Performance Program, Highmark has established a strong and distinctive collaborative relationship with participating hospitals. Highmark staff members are readily available to address questions and concerns posed by the hospitals' staff and to offer consultative support to program participants covering QualityBLUE program indicators, current industry standards, evidence related to the program indicators, discussion of performance, and sharing of best practices among other program partners or connecting two QualityBLUE program participants for rapid learning. Over the years, Highmark has established itself as a leader in the pay for performance movement and strongly believes that communication and collaboration with its hospital partners are important to the advancement of improved clinical outcomes throughout the network.

The following chart illustrates the high level of performance among QualityBLUE hospitals, compared with the Pennsylvania state average, on one key measure of hospital quality, the administration of defect-free care to coronary artery disease (CAD) patients.

QualityBLUE FY08: Get With The Guidelines℠ CAD Defect-Free Care*

QualityBLUE vs. Pennsylvania State Average by Quarter

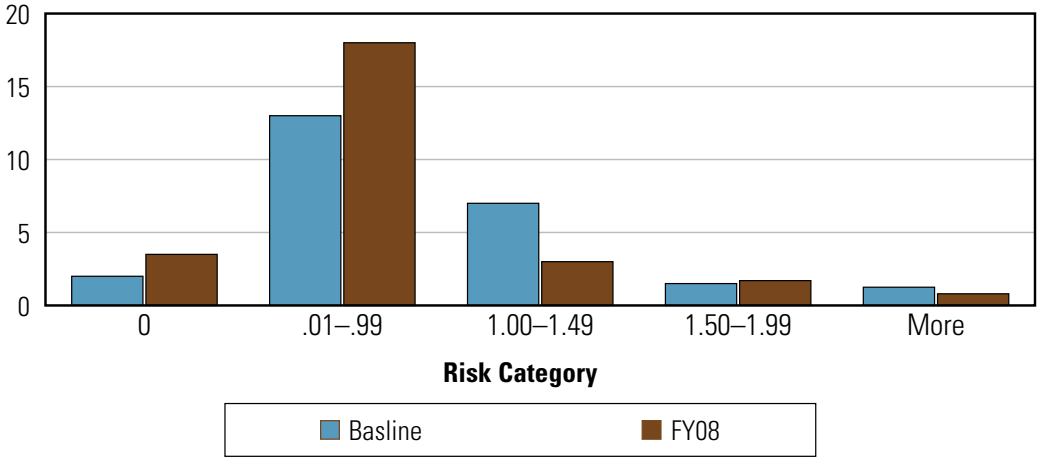


*Data from the Get With The Guidelines℠ Patient Management Tool™, developed by Outcome Sciences, Incl of Cambridge, MA.

For the central line associated bloodstream (CLAB) infection indicator, the number of hospitals in CLAB rate categories for baseline and FY 2008 are depicted in the graph that follows. At baseline, 17 hospitals had fewer than 1.0 CLAB per 1,000 central line days; for FY 2008, this number increased to 23 hospitals. Through this reduced incidence of central line infections, hospitals saved more than $22 million and up to 142 lives.

FY 2008 vs. Basline

Contribution Hospital-Wide CLAB Rates, per 1,000 central line days



[30] The CMS Hospital Compare Core measures include: eight measures related to heart attack care, four measures related to heart failure care, seven measures related to pneumonia care, five measures related to surgical infection prevention, two measures related to asthma care for children only. For further details on these measures please visit, www.hospitalcompare.hhs.gov

[31] All of the QualityBLUE measures compare a hospital to their baseline or improvement throughout the performance year. At the end of the program, all QualityBLUE hospital performance is aggregated, and hospitals are provided profiles that display their program performance compared to their peers in the program.

Through a collaborative relationship between the QualityBLUE team and participating programs, the QualityBLUE Hospital Pay for Performance Program advances the adoption of a culture of quality by expecting a commitment to the program from each hospital's executive leadership. The QualityBLUE clinical team meets twice yearly with hospital executive leadership and quality improvement team members to review program performance. Highmark is also committed to bringing its hospital partners together to share and learn from each other in many venues throughout each performance year. Following are some of the program's collaborative engagement strategies:

Partners in Quality Newsletter

The Partners in Quality Newsletter is a quarterly publication used to communicate with QualityBLUE hospital partners regarding program highlights. It covers topics of interest related to the QualityBLUE program, as well as interviews with physician champions, articles submitted by QualityBLUE hospital participants, and information on important dates related to the program.

Best Practice Forum

Annually, the QualityBLUE Program holds a Best Practice Forum where all network providers are invited to share their positive clinical improvements identified through participation in the program. The day-long event includes poster presentations, clinical breakout sessions, and nationally renowned speakers in a wide range of clinical topics. In November of 2008, 275 hospital staff attended this event.

Lunch and Learn Program

Prior to the beginning of the new program year, a Lunch and Learn is held with QualityBLUE hospital participants to provide clinical staff and administrators an opportunity to learn more about the upcoming program year's QualityBLUE requirements and ask questions regarding the program. At the Lunch and Learn, hospital participants learn about the upcoming program year and have the opportunity to discuss concerns related to data collection and analysis with the QualityBLUE team.

Focus Groups

To ensure that the QualityBLUE Program is addressing relevant clinical opportunities for improvement, focus groups are conducted throughout the year. Several representatives from QualityBLUE hospitals participate in the meetings, which are designed to solicit ideas from hospital staff regarding future indicators and to discuss other pay for performance issues. Incorporating focus group activities provides the opportunity for hospitals to discuss opportunities for program growth with the QualityBLUE team and fosters acceptance of the program requirements.

The QualityBLUE Hospital Pay for Performance collaborative engagement strategy affords hospital program participants with an opportunity to network and share quality improvement approaches among the health care team, facilitates inter-facility communication, provides consultative support, and encourages implementation of best practices. As an example, at the November 2008 Best Practices Forum, hospital attendees had the opportunity to learn about "hardwiring excellence" from Pam Beitlich of the Studer Group and shared best practice strategies around efforts to reduce MRSA infections, central line infections, Clostridium difficile infections, and surgical site infections to name a few.

Plan Description:

As one of the leading health insurers in Pennsylvania, Highmark Inc.'s mission is to provide access to affordable, quality health care enabling individuals to live longer, healthier lives. Based in Pittsburgh, Highmark serves 4.6 million people through the company's health care benefits business. Highmark contributes millions of dollars to help keep quality health care programs affordable and to support community-based programs that work to improve people's health. Highmark exerts an enormous economic impact throughout Pennsylvania. A recent study states that Highmark's positive impact exceeded $2.5 billion. The company provides the resources to give its members a greater hand in their health.

Highmark Inc. is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. For more information, visit www.highmark.com.

Horizon
Horizon Blue Cross Blue Shield of New Jersey
Making Healthcare Work

Horizon Blue Cross Blue Shield of New Jersey—Hospital Recognition Program

Developing flexible quality and safety measurement options to encourage participation by all network hospitals

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Background

The Horizon Blue Cross Blue Shield of New Jersey Hospital Recognition Program (HHRP) was designed to recognize and reward hospitals for sustained, outstanding performance and improvement in the areas of patient safety, clinical process, and patient satisfaction.

The program is based on the Leapfrog Hospital Rewards Program™ (LHRP), a nationally recognized, standardized hospital pay for performance program developed and used by purchasers of health care. Recognizing that not all hospitals would be prepared for participation in the LHRP, however, Horizon developed an alternative program with separate performance criteria for Patient Safety, Clinical Process, and Patient Satisfaction for interested hospitals.

While many of the performance measures of the two programs overlap, the LHRP criteria and comparison standards are somewhat more robust than the Horizon Program Option. The Leapfrog program measures hospital performance in clinical outcomes and resource efficiency, as well as the level of patient safety in the hospital, based on performance against the National Quality Forum endorsed measures and safe practices. Each hospital's performance is compared nationally to other participating hospitals. The Horizon program does not measure resource efficiency and utilizes the Joint Commission National Patient Safety Goals and performance in the Institute for Healthcare Improvement's 5 Million Lives Campaign as the measure for patient safety.

In developing the program for its network hospitals, Horizon BCBSNJ sought input from the New Jersey Hospital Association, the New Jersey Healthcare Quality Institute, a public advocacy group, and an advisory group with representatives from Horizon's network hospitals. The result was a program that gives hospitals the option of participating through the Leapfrog program or through compliance with Horizon's performance criteria; requires that all network hospitals participate; uses nationally recognized data sets, such as the Centers for Medicare & Medicaid Services (CMS) core measures for Heart Attack, Heart Failure, Community Acquired Pneumonia, and Surgical infection prevention and the Leapfrog Group's Hospital Safety and Quality Survey, to minimize the administrative burden of participation; and includes meaningful financial and non-financial recognition to hospitals.

Measurement

Horizon BCBSNJ hospitals selecting the Horizon Program Option are recognized for performance in Clinical Process (40 percent of maximum available recognition), Patient Safety (50 percent of maximum available recognition), and Patient Satisfaction (10 percent of maximum available recognition). As an example, a hospital of 400 beds or more is eligible for a maximum recognition value of $150,000 for each category. In the Clinical Process category, a maximum reward would be 40 percent or $60,000; Patient Safety, 50 percent or $75,000; and Patient Satisfaction, 10 percent or $15,000.

The following hospital performance measures are being used for the 2008 program. These measures have demonstrated improved outcomes in patients with the associated disease states.

Clinical Process

- Heart Attack
  - Aspirin at Arrival
  - Beta Blocker at Arrival
  - Aspirin at Discharge
  - Beta Blocker at Discharge
  - Angiotension-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blockers (ARB) at Discharge
  - Adult Smoking Cessation Advice/Counseling
  - Fibrinolytic Medication within 30 Minutes of Arrival
  - Percutaneous Coronary Intervention (PCI) within 90 Minutes of Arrival

- Heart Failure
  - Discharge Instructions
  - Assessment of Left Ventricular Function
  - ACE Inhibitor or ARB at Discharge
  - Adult Smoking Cessation Advice/Counseling
- Community Acquired Pneumonia
  - Oxygenation Assessment
  - Pneumococcal Vaccination
  - Initial ER Blood Culture Performed Prior to Administration of the First Dose of Antibiotic
  - Adult Smoking Cessation Advice/Counseling
  - Initial Antibiotic Received within 4 Hours of Arrival
  - Appropriate Initial Antibiotic(s) Selection
  - Influenza Vaccination Status
- Surgical Infection Prevention
  - Preventative Antibiotic(s) One Hour Before Incision
  - Appropriate Preventative Antibiotic(s) for the Surgery
  - Preventative Antibiotic(s) Discharged within 24 Hours
  - Doctor Ordered Treatment to Prevent Deep Vein Thrombosis (DVT)
  - Treatment to Prevent DVT within 24 Hours

Patient Safety

- Agency for Healthcare Research and Quality (AHRQ) Culture of Safety Survey or Johns Hopkins Safety Attitudes Questionnaire
- Hospital Acquired Conditions (as defined by CMS)
- Electronic Surveillance Capability for the Detection and Prevention of Hospital Acquired Infection
- IHI 5 Million Lives Campaign (8 of 12 required)
  - Deploy Rapid Response Teams
  - Prevent Adverse Drug Events/High Alert Medications
  - Prevent Central Line Infections
  - Reduce Surgical Complications
  - Prevent Ventilator Associated Pneumonia
  - Prevent Pressure Ulcers
  - Get Boards on Board
  - Prevent MRSA

Patient Satisfaction

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®)

Results, Challenges, and Lessons Learned

The Horizon Hospital Recognition Program was implemented in mid-2006, the results of the 2006 program established the baseline from which improvements be measured, and hospitals had little time to initiate changes that would affect their 2007 results. The 2008 program will be evaluating data for the first full year in which the real impact of hospitals' improvements can be measured. However, early results found that improvement in clinical processes can lead to improved outcomes and reduce the potential for adverse events by focusing on patient safety and identifying problems in quality and gaps in care. Other early results found that:

- Of the seven hospitals that selected the Leapfrog option in 2006 and 2007, one hospital received the maximum available recognition in both years. The remaining six hospitals showed an average rate of improvement of 3.7 percent.
- Of the 52 hospitals that selected the Horizon option in 2006 and 2007, 21 showed more that 10 percent improvement with an average rate of improvement of 20.7 percent; 16 showed improvement between 0 percent and 10 percent with an average rate of improvement of 5.2 percent; and 15 hospitals showed results lower than the previous measurement period.
- The average rate of improvement for all hospitals using the Horizon option was 8.5 percent
- The weighted average improvement of the hospitals in both the Leapfrog and the Horizon options was 7.5 percent.

Horizon learned several valuable lessons during the design and implementation of its Hospital Recognition Program. While the health insurance plan was able to overcome concerns by state regulators that a pay for performance program of this type might create incentives for hospitals to reduce beneficial care or increase practices such as denials of care or the premature discharge of patients, earlier involvement of regulators would have made the approval process simpler and faster. In addition, Horizon created a Hospital Advisory Council to assist in the selection and implementation of program measures and to provide valuable feedback, but the intent of the program and the selected measures would have been more easily communicated if the Hospital Advisory Council had been in place during the initial stages of the program's development.

Horizon BCBSNJ was the first payer to adopt the Leapfrog Hospital Rewards Program on a statewide basis, and the selection of this option by New Jersey hospitals has grown threefold since the implementation of the HHRP, with 23 hospitals currently selecting the LHRP option out of 60. Hospitals that are either reluctant or not prepared to participate in the LHRP have an alternative that is built on nationally recognized data sets for the measurement of patient safety, clinical process, and patient satisfaction, so the Horizon program is able to positively affect quality and patient safety in all of its New Jersey hospitals.

Program Description:

Horizon Blue Cross Blue Shield of New Jersey is the oldest and largest health insurer in the state serving over 3.6 million members. Horizon BCBSNJ is New Jersey's only not-for-profit, health services corporation and provides a broad array of health and dental insurance products and services for individuals and small and large companies, including national companies headquartered in New Jersey. Horizon BCBSNJ is committed to improving the health care experience for all the communities it serves as well as helping its members become and stay healthy.

Independence Blue Cross

Independence Blue Cross—Hospital Quality Incentive Payment System

Rewarding hospitals for active participation in quality improvement initiatives through improved internal processes

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Background

The Independence Blue Cross (IBC) Hospital Quality Incentive Program System (HQIPS) was piloted in three hospital systems from 2002 to 2007. The current HQIPS is a new program that has been offered to most of the health insurance plan's acute care hospital network during the recontracting process, since 2007. So far, 13 hospital systems with 33 hospitals are participating, and collectively, they represent well over 60 percent of IBC's admissions. HQIPS rewards hospitals for active participation in local and national quality improvement initiatives and for developing improvements in internal processes related to quality measures. The initiatives cover a wide range of possible quality targets, including several that are focused on the reduction of medical errors. In addition, every HQIPS contract includes a focus on reducing hospital-acquired infections. To date, seven of the hospital systems have reported success with implementing initiatives or improving quality metrics and have been rewarded for developing improved processes, reporting improved quality data, or both. Some hospitals have changed their patient care processes to reduce pressure ulcers; others have developed rapid response teams; others have instituted procedures to reduce infections around catheter placements or surgical sites.

Measurement

IBC uses the following measures for HQIPS:

In the first year of the program, the hospital must

- Participate in initiatives from a joint effort with the local hospital council, the Partnership for Patient Care (PPC). The PPC is a quality and patient safety effort led by southeastern Pennsylvania hospitals and one of the region's largest health care insurers, Independence Blue Cross, Its initiatives have included efforts to reduce health care-acquired infections and prevent bloodstream and surgical site infections, patient falls, and life-threatening blood clots that can develop during hospitalization.
- Participate in initiatives from the Institute for Healthcare Improvement's (IHI) 5 Million Lives Campaign. The 5 Million Lives Campaign was a national initiative of the IHI that aimed to protect patients from five million incidents of medical harm in U.S. hospitals between December 2006 and December 2008. Some of its initiatives were prevention of pressure ulcers, reduction of MRSA infections, deployment of rapid response teams, and reduction of surgical complications.
- Implement initiatives to improve antibiotic-related or Surgical Care Improvement CMS measures;
  1) Percent of immunocompetent pneumonia patients given the most appropriate initial antibiotic(s)
  2) Percent of pneumonia patients whose initial emergency room blood culture was performed prior to the administration of the first hospital dose of antibiotics
- Surgical Care Improvement/Surgical Infection Prevention Process of Care Measures
  3) Percent of surgery patients who received preventative antibiotic(s) one hour before incision
  4) Percent of surgery patients who received the appropriate preventative antibiotic(s) for their surgery
  5) Percent of surgery patients who received treatment to prevent blood clots within 24 hours before or after selected surgeries to prevent blood clots
  6) Percent of Surgery Patients Whose Doctors Ordered Treatments to Prevent Blood Clots (Venous Thromboembolism) For Certain Types of Surgeries

- Implement initiatives to reduce hospital-acquired infections, currently measured by Pennsylvania state agencies for:
  - Hospital Acquired Infection—Urinary tract infection (HAI 1 - UTI) cases with a device-related infection for in-dwelling catheter-associated urinary tract infection per total admissions;
  - Hospital Acquired Infection—Surgical-site infection (HAI 2 - SSI) cases with a surgical-site infection per total surgeries;
  - Hospital Acquired Infection—Central-line infection (HAI 3 - CLI) cases with a device-related infection for central-line associated bloodstream infection per total admissions;

In the second and subsequent years of the program, the hospital must show improvement (e.g. increase in required clinical processes or reduction in undesirable clinical outcomes) in the clinical measures associated with these initiatives. For PPC and IHI, the participating hospitals develop appropriate measures. For the rest of the program, the hospital must show improvement on the CMS measures, as well as on the state-reported measures of hospital-acquired infections.

During contract negotiations, hospitals have a limited opportunity to modify or replace some of these measures. Hospitals focus on quality and making changes to improve patient error rates and other process and outcome measures. Reports are prepared for each hospital's performance.

Results, Challenges, and Lessons Learned

The HQIPS system will continue to be rolled out across the network of recontracting hospitals, and by 2011, IBC expects nearly every hospital in its network to have an HQIPS contract. Each participant can choose which areas of improvement to focus on which provides flexibility from year to year.

Plan Description:

Independence Blue Cross is a leading health insurer in southeastern Pennsylvania. Nationwide, Independence Blue Cross and its affiliates provide coverage to nearly 3.4 million people. For 70 years, Independence Blue Cross has offered high-quality health care coverage tailored to meet the changing needs of members, employers, and health care professionals. Independence Blue Cross's HMO and PPO health care plans have consistently received the highest ratings from the National Committee for Quality Assurance.

To fulfill its commitment to the communities and people it serves, Independence Blue Cross contributes millions of dollars each year to improve access to quality, affordable health care in the region by funding clinics for the uninsured, increasing the supply of nurses, fighting hospital-acquired infections, and promoting community wellness.

Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association.

Collaborative Programs

Without the close collaboration that has taken place among private and public health care stakeholders, quality measurement and pay for performance would have a limited chance of success.

In December 2002, for example, the American Hospital Association, the Federation of American Hospitals, and the Association of American Medical Colleges formed the Hospital Quality Alliance, a national public-private collaboration to encourage hospitals to collect and report quality-of-care data on a voluntary basis.

Two years later, America's Health Insurance Plans joined forces with the American Academy of Family Physicians, the American College of Physicians, and the Agency for Healthcare Research and Quality to form what is now called the AQA Alliance, focused on improving health care quality through a process in which key stakeholders agree on a strategy for measuring, reporting, and improving performance at the physician level. Stakeholders involved represent physicians, consumers, employers, government, health insurance plans, and accrediting and quality organizations.

One result has been the Alliance's approval of an extensive set of physician and other clinician performance measures that include not only HEDIS® measures, but also measures developed by the American Medical Association's Physician Consortium for Performance Improvement® and other professional groups. The Alliance was named by Centers for Medicare & Medicaid Services (CMS) as an entity able to review and approve measures for CMS' Physician Quality Reporting Initiative (PQRI). The Alliance's breadth of stakeholders and ability to respond quickly to review measures ensured the PQRI program had a sufficient set of measures for providers to report.

This section profiles four pay for performance initiatives that give competing health insurance plans within their respective states the opportunity to support systemic improvements on behalf of patients, providers, and public and private payers. They are:

- A Massachusetts program offers providers a free, comprehensive e-prescribing solution, with the goal of reducing medication errors and drug interactions while improving efficiency and reducing costs.
- A Minnesota program involves the establishment of a single quit smoking referral line that is used by all organizations within the state to refer patients to receive smoking cessation assistance.
- A California program is based on the use of common performance measures, developed collaboratively by health insurance plans, physician groups, researchers, and other industry experts, with public reporting of results and with each health insurance plan independently deciding the source, amount, and payment method for its incentive program.
- A Rhode Island program's overarching objective is to make value-based purchasing of high-quality, accessible, and timely health services the standard for families enrolled in the state's managed Medicaid program.

Initiatives that involve multiple health insurance plans increase the amount of data available for tracking and measuring results, which means evaluations can be more timely and accurate. This, in turn, enables the various stakeholders to make needed adjustments and improvements as the pay for performance concept continues to evolve and collaboration within a market yields gains beyond what could be achieved if acting alone.

Debra L. Ness

President, National Partnership for Women & Families Washington, D.C.

Debra L. Ness is the president of the National Partnership for Women & Families. Her extensive background in health and public policy make her a remarkably effective advocate with a deep understanding of what women and families need at home, in the workplace, and in the health care arena. She is a highly respected expert who testifies frequently before Congress, speaks before a variety audiences, and is quoted regularly in leading print and broadcast media.

Ness serves on the boards of some of the nation's most influential organizations working to improve health care. She sits on the Boards of the National Committee for Quality Assurance (NCQA), the National Quality Forum (NQF), and the American Board of Internal Medicine (ABIM) Foundation. She co-chairs the Consumer-Purchaser Disclosure Group and sits on the Steering Committee of the AQA Alliance and on the Quality Alliance Steering Committee (QASC), co-chairing the QASC Cost/Price Transparency Working Group. Ness also serves on the board of the Economic Policy Institute (EPI) and on the Executive Committee of the Leadership Conference on Civil Rights (LCCR), co-chairing LCCR's Health Task Force.

The National Partnership for Women & Families has been working for three-and-a-half decades to make life better in this country. Our work to expand access to high-quality, affordable health care becomes more urgent each day, because health care is a key determinant of families' quality of life, their economic security, and their ability to thrive, prosper, and participate in our society. No one has a bigger stake in the health care system than consumers, and when an idea comes along that can drive the system to give better care, we need to press for action. Realigning our payment system to reward better care is one of those ideas.

Current Incentives Are All Wrong

While the United States has some of the brightest, best trained, and most committed health care professionals in the world, we know that Americans are not getting the best care in the world. Quality and safety problems are rampant; costs are out of control; and we are faced with historic levels of Americans who lack health insurance, are underinsured, or live in fear of losing the coverage they have.

Unfortunately, our current payment system is making these cost, quality, and coverage problems worse by rewarding volume regardless of quality or outcomes and paying for procedures and services regardless of whether they are appropriate or needed. It is a system that values expensive technology over patient-centered care and pays richly for acute care but not for the primary and preventive care that keeps people healthier in the first place.

There is ample evidence that access to good primary care keeps people healthier, improves patients' experience with the health system, and reduces overall health spending.[32] Because traditional primary care services are woefully undervalued by our current payment system, we need a new model of payment and care delivery that is anchored in primary care and focused on ensuring that every patient gets the right care, at the right time, for the right reason.

The good news is that we can realign payment incentives to drive quality improvement and foster better use of our health care resources. To get to better quality, we don't need to pay more: We need to pay smarter, and by paying smarter, we can change the way care is delivered, improve quality, and have more resources to expand coverage.

We Need To Measure, Report, Reward

Measurement and public reporting can drive significant gains in quality of care, and rewarding high performance accelerates those gains. In most segments of our economy, these principles are taken for granted as the norm, but in health care there has for too long been distrust of quality measurement, fear of reporting, and resistance to changing the financial incentives.

Today, the first two obstacles to change—the idea that quality cannot be measured and the reluctance to publicly report—are quickly sinking under the weight of evidence. For example, in 1996, only about 62 percent of eligible heart attack patients received beta-blockers upon discharge from the hospital. Then health insurance plans began to measure and report on beta-blocker use, and the rate has improved to well over 90 percent through 2007.[33] The National Committee for Quality Assurance (NCQA) estimates that the resulting reduction in second heart attacks has saved 24,000 to 30,000 lives over that same period of time, along with millions of dollars of avoided health care spending. In Pennsylvania, hospitals' inpatient mortality rates plummeted from above the national average to well below the national average after implementation of hospital-specific public performance reports.

Now we need to more concertedly take the next step—realigning payment incentives and rewarding quality. Some progress is being made, but so far it's not enough. Both public and private purchasers can help drive dramatic improvements in cost and quality by adopting the principles of value-based purchasing. As the nation's largest single purchaser of health services, the Medicare program serves as a key lever in driving payment changes. As the Medicare program moves away from simple fee-for-service, and towards paying for the delivery of appropriate, high-quality, efficient, equitable, and patient-centered care, others will follow.

A Medicare-run demonstration project with Premier Hospital System has provided groundbreaking evidence that changing payment incentives can generate better patient care, reduce costs, and save lives.[34] Hospitals in the demonstration were required to report their performance on a series of quality measures for patients with conditions such as heart disease and pneumonia, and those hospitals that performed the best received a higher payment than others. The results were dramatic. Participating hospitals improved clinical quality and outcomes by an average of 17.3 percent and saved over $1,000 per patient over the first three years. In just one clinical area—heart attacks—the hospitals estimated they saved an additional 2,500 lives.

Private payers can be even more flexible and agile than public payers, as they are not dependent on legislative authority to implement payment changes. As the case studies in this publication demonstrate, health insurance plans can take the lead in collaborating with physicians and hospitals to develop innovative programs that reward better performance, then track results, quickly make adjustments and refinements to maximize their positive impact, and disseminate them broadly through local or national networks. Consumers benefit from being able to get better care for their dollars, and employers benefit from a healthier workforce, lower health care costs, and greater productivity.

Putting Patients First

As we move forward with a national dialogue on reforming our health care system, we must find common ground on the path to changing the way we pay for and deliver care. The good news is that we can change the system in ways that both improve quality and reduce costs. This will require significant changes on the part of all stakeholders—payers, providers, and consumers. But ultimately, we must all work together to forge a system that delivers the right care, at the right time, for the right reason, and at the right cost.

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eRx collaborative
Blue Cross Blue Shield of Massachusetts
Neighborhood Health Plan
Tufts Health Plan

Blue Cross Blue Shield of Massachusetts, Neighborhood Health Plan, and Tufts Health Plan—eRx Collaborative

Moving e-prescribing into the mainstream with financial incentives, collaboration, and training

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Background

The e-prescribing (eRx) Collaborative was formed in 2003 by Blue Cross Blue Shield of Massachusetts (BCBSMA), Tufts Health Plan, and Neighborhood Health Plan (NHP), with technology partners DrFirst and ZixCorp, in order to promote and enable the use of electronic prescribing in Massachusetts. Prior to the collaboration, BCBSMA and Tufts Health Plan had previously conducted independent pilot studies of e-prescribing as early as 2000. By combining efforts and sponsorship, the collaboration offers Massachusetts physicians a tool that harnesses technology, bringing together scientific evidence and information to support physicians and patients in the safe delivery of care. According to publicly reported data, the eRx Collaborative is one of the nation's largest e-prescribing programs with the highest rates of adoption and utilization.

The eRx Collaborative believes that e-prescribing enhances patient safety, improves office efficiency, simplifies the prescription process, increases physician and member satisfaction, and accelerates formulary compliance. Furthermore, there is a growing national consensus that e-prescribing has the potential to greatly reduce the portion of health care costs related to unnecessary medications, duplicative medications, and medication errors that may result in hospitalizations. On January 1, 2009 the Centers for Medicare & Medicaid Services (CMS) initiated a 2 percent physician payment incentive for e-prescribing. This is the first step towards total adoption of electronic prescribing by 2014.

As an incentive to increase adoption, the eRx Collaborative offered providers a comprehensive e-prescribing solution, free of charge, including the following:

- Hand-held device loaded with e-prescribing software
- One year license fee and support
- Six months of Internet connectivity where applicable
- Deployment, including training and a one-time patient data download where feasible
- Access to a browser version of the software from any PC with Internet connectivity

E-prescribers have access to enhanced information when prescribing for patients in participating plans, such as patient eligibility and formulary information. In addition, the program enables prescribers to:

- View patient-specific drug histories to determine the patient's current and past prescriptions
- Create new and renew prescriptions electronically
- Send prescriptions for non-controlled substances directly to the pharmacy via fax or by Electronic Data Interchange (EDI) and/or print the prescription to paper
- Receive renewal requests from the pharmacy electronically
- Check for drug-drug and drug-allergy interactions
- View a drug reference guide

The eRx Collaborative has worked to promote e-prescribing across the state. The Collaborative has also created an advisory panel that includes representatives from major pharmacy chains and other key players in the prescribing process in order to develop strategies to increase end-to-end electronic prescribing.

Measurement

The program's performance is measured in three areas:

Clinical Quality and Patient Safety

Clinical metrics include the impact of e-prescribing on health care delivery and quality of care through features such as drug and allergy interaction messages at the point of care.

Utilization

E-prescribing allows the Collaborative to follow the number of prescriptions being sent electronically, as well as the number of prescribers active in the program. Year-to-year trends, as well as overall utilization since the program's inception, can be followed.

Operational

Surveys are sent yearly to prescribers (both physicians and non-physicians) in order to evaluate prescriber adoption and perceptions of e-prescribing. Changes in administrative efficiency can be assessed through these surveys, as well as prescriber satisfaction with the program.

Results, Challenges, and Lessons Learned

Clinical Quality and Patient Safety

E-prescribing improves safety because it removes the risk of errors due to illegible handwriting, which is said to cause 9 percent of medication errors. It also alerts prescribers to potential adverse drug events. As of the end of 2007, approximately 104,000 prescriptions had been changed or cancelled as a result of e-prescribing messages that flag possible safety issues. Newly published research has demonstrated that this prevented an estimated 724 potential adverse drug events (ADEs). An estimated $630,000 in cost savings is attributable to ADEs prevented by the eRx Collaborative.

The Vioxx® recall in October 2004 highlighted another aspect of e-prescribing's ability to improve patient safety. E-prescribing applications can generate instant reports of all patients on a particular drug, allowing the prescriber to quickly identify and contact patients and prescribe an alternative without having to dig through patient charts. Through this capability, e-prescribing systems helped 292 prescribers with a total of 1,889 patients avert the potential adverse effects of Vioxx.

Utilization

As of December 31, 2008, e-prescribing technology had been rolled out to over 5,600 prescribers through the Massachusetts Collaborative. Overall, 25 percent of Massachusetts physicians e-prescribed in 2007, up from 16 percent in 2006. Over 10.5 percent of all new BCBSMA prescriptions were sent electronically, up from 7.9 percent in December 2005. Eighty-two percent of Massachusetts retail pharmacies are able to receive scripts electronically. More than 17.8 million prescriptions have been sent electronically since the start of the program.

Operational

Electronic prescribing has brought implications to improve quality and efficiency of care. Operational impacts of e-prescribing include time-savings for the physician and office staff resulting from fewer phone calls, and the availability of plan information at the point of care. In a 2007 survey, 66 percent of respondents agreed or strongly agreed that e-prescribing had resulted in a reduction in office calls from pharmacies, up from 55 percent in 2006. Similarly, 71 percent of prescribers said that e-prescribing saves time, with the majority saving at least 1 to 2 hours per day. Eighty one percent of prescribers would recommend e-prescribing to a colleague.

The program has reduced costs for participating health insurance plan members, as well. Every time a physician identifies and prescribes a lower-tier drug, the member saves approximately $20 per prescription. In 2006, BCBSMA prescribers who used an e-prescribing device had drug costs that were 5 percent lower than BCBSMA prescribers who did not use the technology. Of that amount, BCBSMA members saved approximately $800,000 in copayments associated with their prescriptions. In addition to encouraging the use of lower-tier drugs, e-prescribing has proven its ability to reduce the volume of paperwork between physician offices and pharmacies.

The table below summarizes the major challenges encountered by the eRx Collaborative and the strategies used to overcome them:

BARRIERS TO ADOPTION	OVERCOMING BARRIERS
Getting physicians interested in eRx can be difficult (reasons include: skepticism, competing priorities)	Collaboration among health insurance plans to unify message and clarify process Target Office Staff because: • Fewer time pressures • Receptivity to new procedures that benefit them by reducing patient and pharmacy phone calls related to prescriptions • Helpful in reinforcing the value of eRx to their physicians and encourage them to consider it
Upfront costs, lost productivity, and long-term costs	• Providing program subsidy is key to initial adoption • Additional incentives can further support adoption • Ensure prescribers can quickly realize benefits from e-prescribing
Technological infrastructure	• Conduct site surveys prior to deployment to ensure prescriber has the appropriate technological infrastructure to support e-prescribing in large organizations • Engage IT team early on in the deployment process and obtain buyin from the top • Ensure technology is consistent with organization security standards and requirements
Change in practice management process	• Fully immerse office into the new process and make e-prescribing mandatory • Acknowledge that there will be growing pains; emphasizing efficiency of full compliance of e-prescriptions • Remove prescription pads from patient rooms • Identify a champion within the office and work with them to address concerns within the practice around change
Waiting for all in one solution	• Select solutions capable of integrating with current or future technology • Highlight value of e-prescribing and how it can be the gateway to an electronic medical record (EMR)
Training	• Provide staff and physicians ample time to adapt work flow and fully understand the functionality of e-prescribing applications before they begin achieving maximum value • Obtain provider commitment for initial training and continuing education • Keep training focused • Ensure onsite support and/or a site champion to provide support and answer questions during rollout
Not using the technology once implemented	• Support from administration is fundamental • Ensure utilization monitoring • Provide outreach when issues are detected • Reward and recognize successful utilization

Program Description:

The eRx Collaborative was formed by Blue Cross Blue Shield of Massachusetts (BCBSMA), Tufts Health Plan and Neighborhood Health Plan (NHP) with technology partners DrFirst, Inc and Zix Corporation (ZixCorp®), (Nasdaq: ZIXI), to collaboratively promote and enable the use of electronic prescribing in Massachusetts to improve patient safety, health care affordability, quality and delivery. In 2009, the eRx Collaborative will continue to promote the adoption and use of electronic prescribing in Massachusetts but will no longer sponsor new or renewal licenses. It will become a central educational resource for e-prescribing stakeholders in MA, focusing on physician, consumer, and vendor education and engagement. For more information, visit our website www.erxcollaborative.org or contact the individual plans.

Blue Cross and Blue Shield of Minnesota—Minnesota Clinic Fax Referral Program

Connecting patients and physicians by rewarding telephonic coaching and expedited fax referral for smoking cessation

Background

On October 1, 2007, Minnesota enacted a law that prohibits smoking in all indoor workplaces, including bars and restaurants. This milestone legislation protects all Minnesota workers from the harms of secondhand smoke. On the same day, the Minnesota Clinic Fax Referral Program was launched by Call it Quits, a unique collaboration between all Minnesota organizations that offer quit smoking helplines. Call it Quits is a collaboration among seven of Minnesota's major health insurance plans (UCare, HealthPartners, Metropolitan Health Plan, Medica, PreferredOne, MMSI, Blue Cross and Blue Shield of Minnesota) and ClearWay Minnesota℠ (the state-funded quitline, smoking cessation hotline, for uninsured and underinsured).

Telephone coaching for smoking cessation is available and free to all Minnesotans and is an effective alternative to face-to-face counseling with a physician in a busy clinical setting. When medical professionals encourage their patients to stop smoking and help connect them to evidence-based treatments, patients respond. However, only a fraction of tobacco users took advantage of the quitlines, and few physicians were referring patients to this valuable resource.

Prior to the Minnesota Clinic Fax Referral Program, health care providers were required to identify a patient's insurance in order to direct them to the correct quitline service, find the quitline phone number, and give it to the patient. The process was time consuming and the patient still had to call to initiate coaching

Now, when a patient indicates interest in stopping smoking, the clinic physician faxes a single, HIPAA-compliant quitline referral form to a central triage system. If the clinic uses electronic health records, the physician can create an order for tobacco cessation instead of filling out a consent form. In addition to establishing a single quitline number, participating physician groups modify their electronic health record system to enable an automated electronic transmission of the referral. After receiving the referral, a trained coach from the quitline, appropriate to that patient's health care coverage, contacts the tobacco user within three days to enroll him or her in cessation services. Those who are uninsured or underinsured are referred to the state-run quitline. (The program recommends that when patients say they are not interested in using the quitline, practitioners should recommend other tobacco cessation strategies such as pharmacotherapies, or discuss strategies that the patient might continue or resume.)

Measurement

Although there is evidence that smoking cessation programs are effective at helping people stop smoking, one study shows that without specific programs, referral rates are very low. A 22-month pilot program from 2005 to 2006 funded by Blue Cross and Blue Shield of Minnesota tested the feasibility of implementing the program and the effect of using pay for performance incentives to encourage physician referrals of tobacco users to quitline services.

A total of 49 clinics from a large, multi-specialty group that provides primary and specialty care participated in the pilot program and a randomized trial of incentives. In the first group, 25 "usual care" clinics received tobacco cessation referral information, and their electronic medical record systems were modified to allow for electronic fax referral. The intervention group of 24 pay for performance clinics received a launch meeting, monthly updates of their referral numbers, modification of their electronic medical record systems, and financial incentives based on the number of referrals to quitlines. Financial incentives of $5,000 were available to intervention clinics that referred at least 50 patients during the 22-month study.

BlueCross BlueShield of Minnesota
An independent licensee of the Blue Cross and Blue Shield Association

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The study demonstrated that an integrated fax referral system is relatively simple to establish and maintain, and that providing incentives to clinics increased referral rates by seven percent. An article in *Archives of Internal Medicine*, October 2008, reports that the pay for performance clinics referred 11.4 percent of smokers compared with 4.2 percent for usual care clinics. The differences were especially dramatic among clinics that had little history of involvement with quality improvement initiatives. The rate of patient contact after referral was 60.2 percent and among those contacted, 49.4 percent enrolled, representing 27.0 percent of all referrals. The marginal cost per additional quitline enrollee was $300.

While the use of financial incentives appears to have resulted in a greater referral rate, the study included two other important factors that may have contributed to increased referral rates. The establishment of a single quitline number and modifications to the electronic medical record may also have contributed to improved referral rates. As the study authors acknowledge, despite the limitations from confounding factors, the study still showed an increase in referral of smokers to a state tobacco quitline.

Challenges and Opportunities

Following the study, the program was offered to all primary care clinics in the state. Overall, during the first year of the statewide Minnesota Clinic Fax Referral Program:

- More than 600 clinics registered to participate
- All clinics combined generated more than 4,000 referrals to stop-smoking coaching
- Referrals resulted in a 27 percent enrollment rate in stop-smoking programs (nearly 1,200 people)

Given these indicators of success, expansion to medical clinics across the state is the main priority of Call It Quits. Maintaining awareness and increasing usage are current challenges. Future plans include collaboration on promoting and raising awareness of the program.

So far, Blue Cross is the only collaborator offering P4P to clinics that participate in the Minnesota Clinic Fax Referral Program. In order to be eligible for performance incentives, clinics must meet a minimum threshold of 25 people a year enrolled in stop-smoking programs. A third party data administrator provides the verified number of enrollees via the fax program. The Blue Cross pay for performance metrics include all patients seen by the medical clinic, not just Blue Cross members, which eliminates the need to determine each patient's insurance and ensures that the program will be more broadly adopted by clinicians.

Medical and dental clinics in Minnesota have been the target group for the fax referral program so far, and there are plans to explore the feasibility of adding more behavioral health, chiropractic, and optical clinics. Such groups have expressed interest in the program and have registered and participated with some success.

This project has succeeded because all members of Call it Quits have been committed to removing barriers and improving systems in a coordinated fashion, and patient-centered care is at the core of the effort. The Minnesota Clinic Fax Referral Program has created a win-win situation for patients and caregivers by helping clinicians easily connect their patients to the effective stop-smoking assistance they need.

Plan Description:

Blue Cross and Blue Shield of Minnesota was chartered in 1933 as Minnesota's first health plan and continues to carry out its charter mission today: to promote a wider, more economical and timely availability of health services for the people of Minnesota. A nonprofit, taxable organization, Blue Cross is the largest health plan based in Minnesota, covering 2.9 million members in Minnesota and nationally through its health plans or plans administered by its affiliated companies. Blue Cross and Blue Shield of Minnesota is an independent licensee of the Blue Cross and Blue Shield Association. Go to www.bluecrossmn.com to learn more about Blue Cross and Blue Shield of Minnesota.

Integrated Healthcare Association—California Pay for Performance Program

Creating a collaborative business case for quality improvement through public reporting and payment incentives

Background

California's pay for performance (P4P) program, sponsored by the Integrated Healthcare Association (IHA), is the nation's largest quality incentive initiative and a potential model for other regional programs. By emphasizing innovation through collaboration and setting core guiding principles, IHA successfully designed and implemented a P4P program with one overriding goal: to create a business case for quality improvement through a compelling set of incentives that would drive breakthrough improvements in the quality and experience of health care. Measurable quality improvements demonstrate that P4P has provided important benefits for patients, as well as physicians and health insurance plans.

IHA is a statewide collaborative of California health insurance plans, physician groups, and hospital systems, plus academic, consumer, purchaser, pharmaceutical, and technology representatives. IHA promotes quality improvement, accountability, and affordability of health care in California. One of IHA's principal projects is pay for performance.

California's P4P program involves 235 physician groups representing approximately 40,000 doctors who provide care for 11 million commercial HMO patients in California. Seven California health insurance plans—Aetna, Anthem Blue Cross of California, Blue Shield of California, CIGNA Healthcare of California, Health Net of California, UnitedHealthcare/PacifiCare (California), and Western Health Advantage—offer both public reporting and incentive payments, and Kaiser Permanente participates in public reporting. P4P incentive payments are not the only incentive amounts paid by plans to physician groups. Plans also pay incentives for non-IHA-sponsored measures to promote better data collection, administrative processes, generic pharmacy utilization, and medical management.

The fundamental principles of P4P are (1) common performance measures for physician groups, developed collaboratively by health insurance plan and physician group medical directors, researchers, and other industry experts; (2) public reporting of results; and (3) significant health insurance plan financial payments based on that performance, with each plan independently deciding the source, amount, and payment method for its incentive program. The first full year for P4P involved 2003 data, and the first health insurance plan payments were awarded in mid-2004.

Health insurance plans distributed more than $265 million in payments to physician groups for meeting P4P quality measures from 2003 through 2007. Each health insurance plan currently develops its own formula to determine payments based on its physician groups' performance in relation to clinical quality and patient experience measures and the adoption of information technology to support systematic, evidence-based care.

Measurement Set for Measurement Year 2009

IHA's P4P measures represent a balance of clinical, patient experience, information technology investment, and resource use measures.

Clinical Measures (based on HEDIS®)—payment weighting: 40 percent.

- Childhood Immunization Status—24-Month Continuous Enrollment
- Appropriate Treatment for Children With Upper Respiratory Infection
- Breast Cancer Screening
- Evidence-Based Cervical Cancer Screening
- Chlamydia Screening in Women
- Cholesterol Management for Patients With Cardiovascular Conditions—low-density lipids (LDL) Screening and Control
- Use of Appropriate Medications for People With Asthma
- Colorectal Cancer Screening
- Appropriate Testing for Children With Pharyngitis
- Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis
- Use of Imaging Studies for Low Back Pain
- Annual Monitoring for Patients on Persistent Medications

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Patient Experience Measures (taken from Clinician-Group Consumer Assessment of Healthcare Providers Survey (CG-CAHPS))—payment weighting: 20 percent
- Specialty care
- Timely access to care
- Doctor-patient communication
- Overall ratings of care
- Care coordination
- Helpful office staff
- Health promotion

IT-Enabled Systemness Measures (adapted from Physician Practice Connections®)—payment weighting: 20 percent
- Data Integration for Population Management—integrating data to create registries and actionable reports
- Electronic Clinical Decision Support at the Point of Care—use of e-prescribing, e-messaging, e-lab results, etc.
- Care Management—systematic care processes for patients with chronic conditions or who have been hospitalized
- Interoperability—using standard data exchange format
- Physician Level Measurement and Reporting

Coordinated Diabetes Care Measures (based on HEDIS® and Physician Practice Connections®)—payment weighting: 20 percent
- Hemoglobin A1c Screening and Control
- Low-density lipids (LDL) Screening and Control
- Nephropathy Monitoring
- Diabetes Registry, including Blood Pressure
- Physician Level Measurement on Diabetes Care

Appropriate Resource Use Measures—payments based on shared savings approach
- Inpatient Readmissions within 30 Days
- Inpatient Utilization — Acute Care Discharges
- Inpatient Utilization — Total Bed Days
- Percent of Outpatient Surgeries Performed in ambulatory surgery centers (ASCs)
- Emergency Department Visits
- Generic Prescribing

Results

The California P4P program now has five years of results. The most recent results are for measurement year 2007, and measurement year 2008 results will be available in July 2009.

A survey of participating physician groups revealed that the P4P program has increased accountability for quality, accelerated IT adoption, improved data collection for quality management, and created greater focus and support for quality improvement within their organizations. Quality improvement, as determined by better performance on the P4P measures, translates into a greater number of patients receiving care that has been shown to improve health outcomes and save lives.

Clinical measures continue to show incremental but steady improvement. Performance has improved 5.1 to 12.4 percentage points since inception of each clinical measure.

Patient experience scores have remained stable but show no significant improvement.

IT-Enabled Systemness has seen significant uptake in adoption of most IT measures. Of the 235 physician groups serving commercial HMO members in California, almost two-thirds of the groups demonstrated some IT capability, and almost one-third of the groups demonstrated robust care management processes.

Lessons Learned

Some of the program's lessons learned are as follows:
- Systemic improvements are critical for generating breakthrough improvement, and the program is considering the use of multiple chronic care measure domains or a comprehensive clinical measurement system (e.g., Rand QA Tools[35]).
- Wide variation across regions exists, which contributes to the overall "mediocre" statewide performance. Big gains may be possible with focused attention on certain regions. Paying for and recognizing improvement is intended to allow potential bonus dollars for lower-performing groups that are improving.
- Incentives may not be properly targeted or structured to achieve the desired outcomes. A Payment Committee was formed to develop recommendations on standardized payment methodology and amount.
- Health insurance plan commitment is wavering in the absence of a clear return on investment. The supplemental clinical data being collected by groups needs to be accessible to the plans to support improved HEDIS® performance.

The fundamental components of California's program can be replicated in Medicare and other P4P programs. The program emphasizes uniform measurement, common reporting, data aggregation, and payment by multiple sources of funding. The program also uses public reporting and peer recognition, as well as payment incentives, to motivate good performance. Trust among participants is enhanced by ensuring transparency in all aspects of the program, including governance and reporting.

Plan Description:

Integrated Healthcare Association (IHA) is a statewide leadership group that promotes quality improvement, accountability, and affordability of health care in California. IHA membership includes major health plans, physician groups, and hospital systems, plus academic, consumer, purchaser, pharmaceutical and technology representatives. IHA's mission is to create breakthrough improvements in health care services for Californians through collaboration among key stakeholders. Principal projects include pay for performance, medical technology assessment and purchasing, the measurement and reward of efficiency in health care, and prevention programs directed at obesity.

[35] RAND Health has developed and tested the Quality Assessment (QA) Tools system, a comprehensive, clinically based system for assessing quality of care for children and adults. For more information visit http://www.rand.org/health/surveys_tools/qatools/index.html

Rhode Island Department of Human Services, Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, and UnitedHealthcare of New England

Using pay for performance to improve health care quality and access for children and families enrolled in Medicaid health insurance plans.

Background

RIte Care is the name used for Rhode Island's Medicaid Managed Care Program, which provides comprehensive health care for children and families. As of mid-2008, approximately 106,000 low-income Rhode Island residents were enrolled in the three participating RIte Care health plans—Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island and UnitedHealthcare of New England. The goals of RIte Care are to improve access to care, quality of care, and health outcomes while containing costs.

A decade ago, the Rhode Island Department of Human Services (RI DHS) started the RIte Care Performance Goal Program, which established benchmark standards for health care quality and access. Rhode Island was the second state in the nation to implement a quality-based purchasing initiative, also known as pay for performance, for its Medicaid managed care program. Health insurance plans can earn incentives for achieving specific performance goals.

RIte Care Health Plans are required to conduct an annual member satisfaction survey as a Rhode Island Department of Human Services contract requirement. Each participating Health Plan uses the CAHPS® Health Plan Survey 4.0H methodology. These findings are submitted by the health insurance plans annually to the National Committee for Quality Assurance (NCQA) and to the RI DHS.

The DHS contracts with an External Quality Review Organization (EQRO) to perform an independent annual review of quality and access in RIte Care's health plans. The most recent EQRO report concluded that: "… the RIte Care Program, including each of the three Health Plans, has had a positive impact on the accessibility, timeliness, and quality of services for Medicaid recipients that each of the Plan's Excellent NCQA accreditation status would imply."

Measurements

DHS currently uses both Rhode Island-specific standards and standards based on national benchmarks (HEDIS® and CAHPS® measures) to determine performance awards. The following table shows the percent allocation of incentive payments available to health insurance plans by performance measure category in 2008.

Percentage of Performance Award Available by Category

2008 Performance Goal Program Performance Measures—Categories	Percent of total performance award available	Type of Measure
Member Services	15%	State-specific
Medical Home/Preventive Care	45%	HEDIS® & CAHPS®
Women's Health	10%	HEDIS® & CAHPS®
Chronic Care	20%	HEDIS® & CAHPS®
Behavioral Health	5%	HEDIS® & CAHPS®
Cost Management	5%	State-specific
TOTAL	100%	

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Results, Challenges, and Lessons Learned

RIte Care Performance Goal Program Results 2006 - 2008

In the Medical Home Preventive Care Performance goal category, all three health insurance plans reached or exceeded the 90th percentile on almost all preventive/ambulatory visit measures. These results indicate that members have a medical home and access to care, and that they are getting recommended preventive visits. The plans have consistently done well on these measures scoring greater than or equal to the 90th percentile compared with Medicaid health insurance plans nationally[36].

Performance Category and Measures	Type of Measure	Statewide Average 2006	Statewide Average 2007	Statewide Average[37] 2008	75th Percentile[38]	90th Percentile[39]
Medical Home Preventive Care						
Members were satisfied with access to urgent care	CAHPS®	86	84	87	84	86
Adults with an ambulatory or preventive care visit (20-44 yrs.)	HEDIS®	87	88	89	85	88
Adults with an ambulatory or preventive care visit (45-64 yrs.)	HEDIS®	89	89	90	89	90
Infants had well-child visits in first 15 months of life	HEDIS®	83	84	81	64	75
Children had well-child visits in 3rd-6th year of life	HEDIS®	79	78	78	75	80
Adolescents receive 2nd MMR before 13th birthday[40]	HEDIS®	88	85	N/A	N/A	N/A
Adolescents receive 3rd HepB before 13th birthday	HEDIS®	83	83	N/A	N/A	N/A
Adolescents receive 1 VZV before 13th birthday	HEDIS®	N/A	81	N/A	N/A	N/A
Children receive immunizations by 2nd birthday	HEDIS®	83	81	76	71	74
Children receive periodic PCP visits (12-24 mos.)	HEDIS®	99	98	99	97	98
Children receive periodic PCP visits (25 mos.-6 yrs.)	HEDIS®	93	93	93	89	91
Children receive periodic PCP visits (7-11 yrs.)	HEDIS®	94	94	95	91	93
Children receive periodic PCP visits (12-19 yrs.)	HEDIS®	91	92	92	89	91
Members over 18 yrs received advice on smoking cessation	CAHPS®	70	69	74	72	76
Members received timely prenatal care	HEDIS®	87	89	88	89	91
Members received timely postpartum care	HEDIS®	66	66	64	65	71
Adolescent well care visit	HEDIS®	57	58	59	51	59
Frequency of ongoing prenatal care	HEDIS®	67	67	66	72	79
Lead screening for children (baseline)[41]	HEDIS®	80	82	85	N/A	N/A
Produced by the NCQA and published in *Quality Compass 2007® for Medicaid*. Scores which met or exceeded the Medicaid 90th percentile are shaded in blue; those which met or exceeded the Medicaid 75th percentile are shaded in gray.						

[36] For specific details as to which of the HEDIS® scores met or exceeded the respective 90th percentiles within the Medical Home/Preventive Care component of RIte Care's Performance Goal Program, please refer to the October 2008 report produced by the Rhode Island Department of Human Services, entitled *Monitoring Quality and Access in RIte Care* (www.ritecare.ri.gov/reports)

[37] Satewide average = the average of the three RIte Care Health Plans' score for each measure.

[38] Scores from 2008 that are > the 75th percentile are highlighted in grey (as reported for HEDIS® 2007 & CAHPS® 2007, Quality Compass 2007®).

[39] Scores from 2008 that are > the 90th percentile are highlighted in blue (as reported for HEDIS® 2007 & CAHPS® 2007, Quality Compass 2007®).

[40] The Adolescent Immunization Status (AIS) series of measures was retired from the HEDIS® 2008 Technical Specifications. The NCQA will include a revised AIS measure in its HEDIS® 2010 specifications.

[41] This is a first-year HEDIS® 2008 measure that does not have Quality Compass 2007® comparison data available.

In the Women's Health performance goal category, the health insurance plans did very well on the Cervical Cancer Screening[42] measure, exceeding the 90th percentile for all three years reported. The health insurance plans did less well on the Chlamydia Screening measure, where the score for both groups, ages 16 to 20 years and 21 to 25 years, did not reach the 75th percentile for Medicaid plans nationally; however, the scores did improve slightly from the previous year. DHS has required each RIte Care Health Plan to develop a Quality Improvement Plan focusing upon interventions to enhance Chlamydia Screening.[43]

In the Chronic Care category, the health insurance plans did very well on the Appropriate Use of Asthma Medications for Children measure in children aged 5 to 9. They also improved on the asthma measure for children aged 10 to 17 from a score of 90 in 2007 to a score of 93 in 2008. For Hemoglobin A1c Screening for diabetics, the health insurance plans just reached the 75th percentile. Comprehensive diabetes care remains a targeted area of focus for performance improvement. There are five HEDIS® measures included within the Performance Goal Program's Chronic Care component. For three of the five measures, RIte Care's performance met or exceeded the Medicaid 90th percentile; the score for one of the measures met or exceeded the Medicaid 75th percentile; and the remaining measure's score met the Medicaid mean.

Performance Category and Measures	Type of Measure	Statewide Average 2006	Statewide Average 2007	Statewide Average 2008	75th Percentile	90th Percentile
Chronic Care						
Children with asthma use appropriate medications (5-9 yrs.)	95	97	97	97	95	96
Children with asthma use appropriate medications (10-17 yrs.)	88	90	90	93	91	93
Adults with diabetes had hemoglobin A1c testing	81	85	85	84	84	89
Antidepressant Rx management (acute phase)	37	44	44	43	48	51
Follow-up for children prescribed ADHD medication—initiation phase	N/A	37	37	44	39	44

Produced by the NCQA and published in *Quality Compass 2007® for Medicaid*. Scores which met or exceeded the Medicaid 90th percentile are shaded in blue; those which met or exceeded the Medicaid 75th percentile are shaded in gray.

The HEDIS® Antidepressant Medication Management measure, specifically the effective follow-up of members during the acute phase of treatment for major depression, was piloted as a baseline metric in RIte Care's 2006 Performance Goal Program and subsequently incorporated into the program, beginning in 2007. This measure is a challenging one, requiring health insurance plans to calculate the percentage of adult members who were diagnosed with a new episode of major depression; who were treated with antidepressant medication; and who remained on an antidepressant drug during the acute (first 12 weeks) phase of treatment. During 2007, scores for scores for the Acute Phase component of the Antidepressant Medication measure were reported to the NCQA by only 38 Medicaid managed care plans nationally, including each of the three health insurance plans participating in RIte Care (Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island and UnitedHealthcare of New England).

Seeking to further emphasize the importance of access to behavioral health services for children and youth, the HEDIS® Follow-up for Children Prescribed ADHD Medication measure was added as a baseline metric in 2007. In 2008, this measure was scored and treated as an active measure, and overall performance exceeded the 90th percentile.

Rhode Island continues to have a dynamic relationship with its RIte Care health insurance plans. The program's external quality review augments the work of the state by providing an objective analysis of quality improvement initiatives within and across RIte Care's participating managed care plans.

The RIte Care Performance Goal Program's overarching objective is to ensure the value-based purchase of high-quality, accessible, and timely health services for families in Rhode Island. The program has demonstrated that it is flexible enough to refocus improvement efforts from year to year, and it has also contributed to strengthening an ongoing partnership with RIte Care's health insurance plans.

Description:

RIte Care is Rhode Island's Medicaid managed care program, which provides eligible uninsured children, families, and pregnant women with comprehensive health care through one of three participating health plans: Blue Cross & Blue Shield of RI, Neighborhood Health Plan of RI, and UnitedHealthcare of New England. Families enroll in a health plan of their choice. RIte Care is administered by the RI Department of Human Services and operates under a Section 1115 Waiver from the Centers for Medicare & Medicaid Services (CMS).

[42] According to NCQA's State of Health Care Quality 2008 report (2007 data), the mean Cervical Cancer screening score for Medicaid was 64.7%, the 90th percentile for this measure was 77.5%.

[43] According to NCQA's State of Health Care Quality 2008 report (2007 data), the mean Chlamydia screening (ages 16-20) score for Medicaid was 48.8%, the 90th percentile for this measure was 65.3%; the mean score for Chlamydia screening (ages 21-25) was 54.2% and the 90th percentile was 69.6%.

Frequently Used Acronyms

ACE/ARB – Angiotensin-Converting Enzyme/ Angiotensin Receptor Blockers
ACIP – Advisory Committee on Immunization Practices
ADHD – Attention Deficit Hyperactivity Disorder
AF – Atrial Fibrillation
AHIP – America's Health Insurance Plans
AHRQ – Agency for Healthcare Research and Quality
AMA – American Medical Association
AQA – AQA Alliance, originated as Ambulatory Care Quality Alliance
BMI – Body Mass Index
BP – Blood Pressure
BTE – Bridges to Excellence
CABG – Coronary Artery Bypass Graft
CAD – Computer-Aided Detection, or Coronary Artery Disease
CAHPS® – Consumer Assessment of Healthcare Providers and Systems
CATH – Diagnostic Catheterization
CAUTI – Catheter Associated Urinary Tract Infection
CDAD – Clostridium Difficile Associated Disease
CDC – Centers for Disease Control and Prevention
CG-CAHPS – Clinician-Group Consumer Assessment of Healthcare Providers Survey
CHF – Congestive Heart Failure
CLAB – Central Line Associated Bloodstream Infections
CLI – Central Line Infection
CME – Continuing Medical Education
CMS – Centers for Medicare & Medicaid Services
COPD – Chronic Obstructive Pulmonary Disease
CPOE – Computerized Physician Order Entry
CVC – Central Venous Catheter
DRG – Diagnosis Related Group
DTaP – Diphtheria, Tetanus & Pertussis
DTB-90 – Door-to-Balloon in 90 Minutes
DVT – Deep Vein Thrombosis
E&M – Evaluation & Management Services
ED/ER – Emergency Department / Emergency Room
EMR/EHR – Electronic Medical Record/ Electronic Health Record
ENT – Ear, Nose, and Throat
e-Rx – Electronic Prescribing
GERD – Gastroesophageal Reflux Disease
HAI – Hospital Acquired Infection
HbA1c – Hemoglobin A1c
HCAHPS® – Hospital-Consumer Assessment of Healthcare Providers and Systems
HEDIS® – Healthcare Effectiveness Data and Information Set
HF – Heart Failure
Hib – *Haemophilus influenzae* Type b (Hib) Vaccine
HIPAA – Health Insurance Portability and Accountability Act of 1996
HMO – Health Maintenance Organization
HPPI – High Performance Provider Initiatives
ICU – Intensive Care Unit
IHD – Ischemic Heart Disease
IHI – Institute for Healthcare Improvement
IOM – Institute of Medicine
IPAs – Independent Practice Associations
IPV – Inactivated Polio Vaccine
IT/HIT – Information Technology/ Health Information Technology
LDL/LDL-C – Low-density lipids/ Low-density lipids Cholesterol
MI/AMI – Myocardial Infarction/ Acute Myocardial Infarction
MMR – Measles, Mumps and Rubella
MRSA – Methicillin resistant *Staphylococcus aureus*
NCQA – National Committee for Quality Assurance
NICU – Neonatal Intensive Care Unit
NQF – National Quality Forum
OB/GYN – Obstetrics/Gynecology
P4P/PFP – Pay for Performance
PAS – Patient Assessment Survey
PCI – Percutaneous Coronary Intervention
PCP – Primary Care Provider
PHOs – Physician Hospital Organizations
PMPM – Per-member-per-month
PN – Pneumonia
PO's – Provider Organizations
POS – Point of Service
PPC® – Physician Practice Connections
PPO – Preferred Provider Organization
PTMPY – Per Thousand Members Per Year
SCIP – Surgical Care Improvement Project
SSI – Surgical Site Infection
STS – Society of Thoracic Surgeons
URI – Upper Respiratory Infections
UTI – Urinary Tract Infections
VAP – Ventilator Associated Pneumonia
VTE – Venous Thromboembolism
VZV – Varicella Zoster Virus

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