

MMA's Principles for Pay for Performance

1. Pay-for-performance programs must be designed to drive improvements to health care quality and the systems in which quality care is delivered.

- Pay-for-performance programs should measure quality across the full continuum of care. Quality should be measured comprehensively considering the six aims as defined by the Institute of Medicine (i.e., safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity).
- Pay-for-performance programs must demonstrate improvements to health care quality.
- Pay-for-performance programs must offer increased value to health care consumers.
- Pay-for-performance programs should improve systems of care by encouraging use of health information technology (HIT), promoting collaboration among all members of the health care team, supporting implementation of evidence-based clinical guidelines, and increasing patient access to care that is high-quality and appropriate e.

2. Pay-for-performance programs must promote and strengthen the partnership between patients and physicians.

- Physicians are ethically required to use sound medical judgment and hold the best interests of the patient as paramount. Programs should respect patient preferences and physician judgment.
- Target goals should reflect the need for patient-centered care; therefore, performance goals should not be set at 100%. Thresholds for any P4P program should also reflect the role of patient adherence to treatment plans.
- Programs must make sure that access to care is not limited. Systems must be in place to ensure that physicians are not discouraged from providing care to patients who are members of underserved and high-risk patient populations).
- Patient privacy must be protected during all data collection, analysis, and reporting. Data collection must be consistent with the Health Insurance Portability and Accountability Act (HIPAA).

3. Pay-for-performance programs should support and facilitate broad participation and minimize barriers to participation.

- Pay-for-performance programs must work to include physician groups across the continuum of health care as soon as possible.
- Participation in P4P programs must not create undue financial or administrative burdens on physicians and/or their practices (i.e., implementation, data collection, and reporting of data).
- Elective P4P programs should allow clinics to take into account their ability to participate based on resources, patient population, and number of patients affected by the condition being measured. Physician groups, regardless of size, specialty, or HIT capability, should have the opportunity to participate in P4P programs if they have the resources and patient population needed to do so.
- Groups should be aware of P4P programs and clearly understand what the rewards will be relative to their level of participation so that they can accurately assess the cost/benefit of participation.
- Individual physician information must be protected. Data collected as part of P4P programs must not be used against physicians in obtaining professional licensure and certification.

4. Pay-for-performance program design and implementation must be credible, reliable, transparent, scientifically valid, administratively streamlined, and useful to patients and physicians.

- Practicing physicians from the appropriate specialty should be integrally involved in the design and implementation of accountability and performance-improvement measures.

- Clinical performance measures must be objective, transparent, reliable, evidence-based, current, statistically valid, clinically relevant, and cost-effective; the methodology should be prospectively defined.
 - Clinical performance measures should be selected for diseases that create a great burden on the health care system and for areas that have significant potential for clinical improvement.
 - Pay-for-performance programs should collect, report upon, and link payment to both process and outcome measures.
 - Statistical validity is essential to measurement and reporting. Data collection, data analysis, and public reporting must utilize sample sizes large enough to ensure statistical validity, whether at the facility, group, or individual physician level. If valid sample sizes are not possible at the individual physician level, measurement and reporting must occur at the medical group or facility level.
 - Risk adjustment is complex, and current methodology has serious limitations. To date, risk adjustment does not adjust adequately for confounding factors. Developers should use the best available methods for risk adjustment and update statistical methodology as the science of risk adjustment advances. Risk adjustment should account for factors that are outside the physician's control (i.e., pre-existing conditions, demographics, and co-morbidities).
 - Pilot testing should not be disregarded in order to introduce a program into the marketplace quickly. Developers of P4P programs and performance measures must allow for pilot testing that will adequately assess the reliability and validity of the measures. Measures should be reviewed at regular intervals and revised as needed to reflect changes in the evidence base.
 - A clear description of the quality measures and methods used to assess and reward physician performance should be provided prior to implementation.
 - The American Medical Association's Physician Consortium for Performance Improvement incorporates these characteristics (What characteristics) into clinical measure sets that can be used across specialties. Developers of P4P programs should consider using AMA measure sets.
 - Public reporting must reflect the full scope of the health system, and must be useful to both patients and physicians.
 - Programs must allow physicians to review the data collected and its analysis prior to using it for public reporting, rating or rewards programs. Results should be reported back to individual physicians and physician groups to facilitate process and systems quality improvement.
 - When comparing and reporting among clinical groups or across hospitals, public reports should include a clear notation on the complexity and limitations of risk adjustment.
 - Clinics should know about any changes in program requirements and evaluation methods as they occur. In order to compare data, changes should occur no more often than annually.
 - Pay-for-performance programs should make an effort to reduce or eliminate duplicative measurement and reporting. A common data set should be adopted across communities, and data pertaining to a patient's care should be collected only once.
5. **Pay-for-performance programs should reward those physicians and clinics that: 1) show measurable improvements to the process of providing quality care; 2) show measurable improvements in patients' clinical outcomes; 3) meet or exceed stated clinical goals; 4) make efforts to improve the systems in which they practice; or 5) work to successfully coordinate patients' care among providers.**
- There is value in selecting a target then rewarding physicians who meet or exceed it (absolute value) and in rewarding physicians who make significant improvements to the quality of care they provide, regardless of whether they make relative improvements or reach the desired threshold.

- The MMA supports rewards, bonuses, and systems improvements as opposed to withholds as a more effective incentive for improving quality and building systems of care.
- Programs ought to reward groups that build systems capacity in order to deliver high-quality care (e.g., providing telephonic care, installation of HIT, computerized pharmacy-order entry and clinical decision-support systems, disease and case management, and team-based care). Pay for performance programs should make efforts to help transition clinics from manual to electronic patient data collection.
- There are significant costs associated with data collection and reporting. Rewards should sufficiently cover the added practice expenses and administrative costs associated with collecting and reporting data.
- Pay-for-performance programs should reward physicians for providing effective disease management services (e.g., telephone care, care that is not provided in person) and coordinating treatment efforts among primary care physicians and hospitalists or specialists. Programs should recognize and reward groups that successfully get patients to adhere to agreed-upon treatment plans.
- Funding for P4P programs ought to be obtained through generated savings or new investments.