A Review of Pay for Performance In Minnesota

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MMA
Minnesota Medical Association

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The MMA expresses appreciation to Blue Cross and Blue Shield of Minnesota, Bridges to Excellence (Buyers Health Care Action Group), HealthPartners, Medica, PreferredOne, and UCare for their cooperation and willingness to share information that strengthened the value of this document.

Note: Much of the information contained in this document represents information provided by the Minnesota health plans identified above and/or obtained from public Web sites. While the information is correct to the best of our knowledge, it is possible that updates or changes to the programs described within this document have been made since initial research began; therefore, such changes may not be reflected in this document and we regret any unintentional omissions or inaccuracies.

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Executive Summary

In order to improve health care quality, insurers, purchasers, and policymakers are increasingly using financial incentives to reward physicians and medical groups that meet specific performance goals. Although research on the efficacy of these pay-for-performance (P4P) programs to improve the quality of care is increasing, there is little evidence about their value that is statistically significant or convincing.

The Minnesota Medical Association (MMA) is supportive of new and innovative ways to improve health care and recognizes that linking financial incentives to system performance measures in order to promote the delivery of safe, effective, timely, and patient-centered care may be an effective approach. Financial incentives alone, however, are insufficient to systematically improve quality. A comprehensive approach to quality improvement is critical and should include elements such as the implementation of health information technology (HIT), greater adoption of evidence-based decision-making, implementation of systematic care coordination, and the adoption of a culture of quality improvement in practice settings.

Between 2006 and 2007, the MMA Quality Committee, which includes MMA members who are practicing physicians, health plan medical directors, and physicians who work for Minnesota's quality improvement organizations, developed a set of guiding principles for P4P programs that were outlined in "Pay for Performance: MMA's Principles for the Effective Application of Performance Measurement to Physician Payment Incentives." The MMA Board of Trustees adopted the principles to guide MMA policy and advocacy regarding the use of financial incentives to improve health care quality.

Using those principles as a guide, the MMA sought to assess the degree to which existing P4P programs in Minnesota drive improvements to health care quality; promote and strengthen the partnership between physicians and patients; support and facilitate broad participation; and incorporate credible, reliable, transparent, and valid measures of performance.

The MMA found that most P4P programs in Minnesota align with key MMA principles. In general, the measures are reliable, evidence-based, useful, and support the physician-patient relationship. In addition, existing P4P programs are expanding to include more non-primary care specialties. There are, however, aspects of the programs that deviate from MMA principles. For example, few programs support the work of health care teams, encourage implementation and use of health information technology or care coordination, and many impose substantial administrative burdens. The P4P programs that received lower "scores" based on the MMA assessment tend to require participation, withhold payments, add administrative burden, fail to reward HIT infrastructure, and ignore the need for risk adjustment.

The MMA believes there is an opportunity to refine current P4P programs so that they better serve the community and more effectively link performance measurement to physician payment incentives. In order to improve programs, the MMA recommends that Minnesota P4P programs:

1) recognize and reward physicians for systems improvements, including HIT adoption, care coordination, and use of evidence-based medicine;
2) decrease the administrative burden and work toward a coordinated and cohesive measurement effort, specifically concerning measurement sets, specifications, and data collection methodologies;
3) use risk-adjustment methodologies that account for variations in patient populations; and
4) not place physicians in situations that create ethical conflicts that could jeopardize patient safety or limit shared patient decision-making.

Introduction

WHAT IS PAY FOR PERFORMANCE, AND WHAT ARE ITS GOALS?

Public and private health insurers, employers and other health care purchasers, policymakers, physicians, and patients acknowledge the need to increase both the quality and value of health care. In response, many payers and purchasers are implementing payment strategies that more explicitly encourage high quality, cost-effective care. One strategy that is finding traction is pay for performance (P4P).

Pay-for-performance programs reward medical groups and physicians based on their ability to meet or improve upon identified goals for clinical performance. This strategy represents a significant departure from traditional payment arrangements. Traditionally, Medicare and other third-party payers have paid physicians based on the procedures performed and specific services rendered, rather than for improvements in patient health outcomes.

The fundamental assumption behind P4P is that by offering incentives to physicians for following evidence-based processes or obtaining specified clinical outcomes—as defined by the best available medical literature—health care quality improves, efficiency increases, and health care dollars are saved. Some P4P programs award bonuses to physicians for meeting specific goals; others withhold payment from physicians until defined targets are met.

Payers and purchasers of health care initially implemented P4P programs because health care costs were becoming unmanageable and because they felt they were not getting optimal value (i.e., high-quality care at a reasonable cost). In addition, payers and purchasers believed that transparency—making the public aware of the quality of care delivered by physicians and the cost of their services—would lead to greater competition in the health care marketplace as patients select physicians who deliver higher quality, more efficient care.

Although P4P to date has been used more commonly by private payers, many state Medicaid programs are now beginning to explore similar models. For example, in 2006 the state of Minnesota created QCare to reward physicians who provide health care to enrollees in publicly funded health care programs as well as state employees. The QCare P4P program is designed to reward physicians for high-quality diabetes care, preventive services and screenings, cardiac care, and hospital care. To date, the state has yet to implement QCare as intended, but has rewarded providers for optimal diabetes care through the Bridges to Excellence P4P program, a program initiated by employers.

With approximately 44 million beneficiaries, the Medicare program has great influence over health care policy, and its strategies are often adopted by other payers. The Tax Relief and Health Care Act of 2006 (TRHCA) authorized the Centers for Medicare and Medicaid Services (CMS) to establish a physician quality reporting system, known as the Physician Quality Reporting Initiative (PQRI). PQRI is a voluntary quality reporting program. Eligible professionals who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for covered Medicare physician fee schedule services.

Performance Measurement

The foundation of any P4P program is the selection of specific metrics of performance and the subsequent data collection and analysis. Many physicians and medical groups have been involved for years with quality measurement, benchmarking, and improvement activities within their practices. Health plans, too, have performed data analyses to provide physicians and medical groups with feedback on their practice styles, often providing relative comparisons to peer groups. Only recently, however, have there been concerted and coordinated efforts to publicly report performance data with the hope of spurring continued improvement as well as generating greater competition and patient value. Given the high stakes associated with performance measurement used in public reporting and for payment purposes (i.e., P4P), it is no surprise that physicians regard the accuracy of measurement as critical.

While the evidence regarding quality measurement and public reporting suggests that these efforts improve the quality of health care, an unpublished survey conducted by a Minnesota collaborative of continuing medical education providers, of which the MMA is a member, revealed that physicians still have a number of concerns about performance measurement, including the following:

- Sample sizes may be small. Often, individual physicians do not have an adequate number of patients with a particular condition on which to assess their performance accurately. This leads to a lack of confidence in the reliability and validity of the performance measures and the results.
- Focus of performance measurement is limited. Some physicians are concerned that performance measurement applies to a limited number of clinical areas (e.g., diabetes, preventive screening) diverting attention from other important but unmeasured aspects of patient care.
- Physicians will practice medicine to meet the measure. There is concern that measurement may encourage physicians to devote their limited patient time to those activities that are measured, focusing attention too narrowly and not on the comprehensive needs of the patient.
- Administrative burdens are real and significant. Some primary care practices are already incurring additional expenses associated with data collection and reporting. These costs can affect the economic viability of physician groups, especially small practices and those located in rural communities, as they often need new or updated health information technologies and additional staff to participate fully.
- Patient populations can influence physician results. Physicians are concerned that those who treat seriously ill patients may be at a disadvantage when compared with others who do not care for large numbers of such patients. Differences in patient populations could lead to "cherry-picking" patients, resulting in decreased access to care for the seriously ill.
- Many specialties and subspecialties lack the evidence upon which to base performance measures, resulting in little or no opportunity to collect data for improving care for their patients.

The sources of specific measures of performance likewise cause physicians concern. To date, the architects of P4P programs generally have relied on existing measures such as HEDIS (Healthcare Effectiveness Data and Information Set) to develop their programs. However, many other organizations are also working to develop, standardize, endorse, disseminate and implement measures for quality-improvement activities and P4P programs. Of particular note are the following:

MEASURE DEVELOPERS

American Medical Association (AMA) Physician Consortium for Performance Improvement

Recognizing its responsibility to promote quality health care, the AMA began developing physician performance measures in 1998. In 2000, the AMA officially convened the Physician Consortium for Performance Improvement (PCPI). Today, the consortium is made up of more than 100 national medical specialty and state medical societies, accrediting councils and boards, experts in methodology and data collection, public and private quality-improvement organizations, and public and private payers.

While some national medical specialty societies independently make an effort to translate evidence-based guidelines into performance measures, many choose to work through the consortium. Specialty societies are aware that the

consortium can serve as a means to build consensus across multiple organizations and physician groups, can provide legitimacy to the quality of the metrics, and can serve as a respected source through which measures are submitted to national endorsing and implementing organizations.

The consortium has gained respect among physicians for a variety of reasons: PCPI develops performance measures that are evidence-based, statistically valid, and reliable. Established clinical recommendations are available for the measures; the measures are clinically relevant; and feasible data sources exist for the measures.

The consortium has also gained respect in Congress. In 2006, it was selected to develop 150 specialty measures for the CMS P4P program initiated in July 2007. It is expected that CMS will continue to look to the consortium to develop measures for performance and quality-improvement and accountability activities.

For a complete list of AMA measures, visit www.ama-assn.org.

National Committee for Quality Assurance (NCQA)
The National Committee for Quality Assurance (NCQA) is an independent, private nonprofit organization that has been accrediting health plans and developing performance measures for accreditation since 1990. The performance measurement sets used in NCQA's accreditation process and most frequently reported to purchasers and the public are HEDIS measures.

HEDIS measures, which are used by more than 90 percent of health plans in the United States, measure performance on various dimensions of care and service. Several of Minnesota's P4P and public reporting programs initially used HEDIS measurement sets as their measure of quality.

The Joint Commission
The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), also creates measures of performance for the organizations that it accredits—hospitals, freestanding ambulatory care centers, office-based surgery centers, and long-term care facilities. The Joint Commission standards measure the degree to which facilities conform to patient safety, patient rights, patient care, and infection control goals and guidelines. The Joint Commission accreditation is recognized nationwide and its power lies in its comprehensive accreditation process and evaluation of an organization's compliance with standards and accreditation requirements.

MEASURE ENDORSERS

National Quality Forum (NQF)
Although the NQF does not develop measures, it is charged (through a provision in the National Technology Transfer and Advancement Act of 1995 [Public Law 104-113]) with endorsing national "rules" for measurement and public reporting and a national standardized measures set. The NQF has endorsed quality measures developed by the AMA's Physician Consortium, which have then been adopted for use by both CMS and private-sector payers and purchasers.

The power of NQF is significant. Developers of performance measures that want their measures to become the national standard must submit them to the NQF's technical review and consensus process. Measures that are endorsed by the NQF are likely to be broadly adopted in the marketplace. For example, if CMS wants to measure the quality of diabetes care and the NQF has endorsed a set of measures for evaluating diabetes care, CMS is required to use those measures.

MEASURE DISSEMINATORS AND IMPLEMENTERS

MN Community Measurement
MN Community Measurement is a nonprofit organization founded by seven Minnesota health plans and the Minnesota Medical Association to improve care and support quality improvement efforts in Minnesota, to reduce quality-reporting expenses for medical groups, health plans, and regulators, and to publicly communicate findings in a fair, useful, and reliable way. MN Community Measurement provided the community with a more efficient approach to data collection and public reporting by aggregating quality data and communicating the findings to medical groups, regulators, purchasers, and consumers. Today, MN Community Measurement reports results of health care quality measures and works to increase the efficiency of reporting.

LeapFrog
In 1998, a group of large employers came together to discuss how they could influence quality and affordability via their purchasing strategies. The Leapfrog Group was officially launched in November 2000. Leapfrog works with employers to encourage easy access to health care information and rewards hospitals that have a record of providing high-quality care. Working with Bridges to Excellence, the Leapfrog Group's goal is to develop and implement reward programs for health care providers, standardize performance measures, and improve public reporting.

Agency for Healthcare Research and Quality (AHRQ)
AHRQ funds research to support evidence-based clinical practice, develops and tests measures, and promotes the use of measures through dissemination of clinical practice guidelines, measures, and measurement tools and resources. Additionally, AHRQ developed the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey, which assesses the experience of patients in both the ambulatory and inpatient settings.

Ambulatory Quality Alliance (AQA)
AQA was founded by the Ameri-

can Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans, and the Agency for Healthcare Research and Quality. Its mission is to bring together stakeholders in an effort to improve performance measurement, data aggregation, and reporting in the ambulatory care setting. AQA has been able to identify those elements that are critical to public reporting of quality data and has gained consensus on a set of measures for use in private health insurance plan contracts and with government purchasers.

MINNESOTA MEASURES

Table 1 displays the 117 measures used in the nine P4P programs in Minnesota (as of August 2007). The programs assess 63 domains of care or disease states. The diseases/conditions most frequently measured in P4P programs in Minnesota are diabetes care (six programs), chlamydia screening (five programs), cervical cancer screening (four programs), breast cancer screening (four programs), childhood immunization (four programs) and generic drug use (four programs).

It should be noted that few of the P4P initiatives implemented by Minnesota's payers use MN Community Measurement's panel of measures, data collection methodologies, or data analysis when determining provider group or physician rewards. Instead, Minnesota's P4P programs tend to collect data independently.

For complete list of measures, specifications, data sources, and providers measured, visit the MMA website http://www.mmaonline.net/quality/pay-incentives.htm.

Table 1: Measures used across Minnesota's P4P programs[1] (August 2007)

	P4P programs									Measure developers and implementers	
Measure name	Blue Cross Blue Shield MN [2]	Bridges to Excellence [3]	HealthPartners Partners in Progress [4]	HealthPartners Partners in Excellence [5]	Medica Performance based incentive [6]	Medica Choice Care QIP [7]	PreferredOne [8]	UCare [9]	CMS PQRI [10]	Used by MN Community Measurement [11]	Part of the AMA Physician Consortium set [12]
1. Acute Myocardial Infarction for ED - Aspirin at arrival									x		x
2. Acute Myocardial Infarction for ED - Beta blocker									x		
3. Advanced care plan for patients 65+									x		x
4. Anticoagulation protocol			x								
5. Asthma - Assessment									x		x
6. Asthma - Optimally managed					x	x					
7. Asthma - Pharmacotherapy	x						x		x	x	x
8. Body Mass Index (BMI)			x								
9. BMI and weight management plan (preventative services)	x			x							
10. Breast cancer - Hormonal therapy									x		
11. Breast cancer - Radiation therapy									x		

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12. Cardiovascular - Recurrent atrial fibrillation	x										
13. Carpal tunnel release			x								
14. Cataracts - Presurgical documentation									x		x
15. Cataracts - Presurgical dilated fundus evaluation									x		x
16. Cataracts - Visual function status									x		x
17. Chemotherapy - Documented plan									x		
18. Child and teen check up						x					
19. Chronic lymphocystic leukemia - Cytometry									x		x
20. Chronic obstructive pulmonary disease - Bronchodilator									x		x
21. Chronic obstructive pulmonary disease - Spirometry									x		x
22. Colon cancer - Chemotherapy									x		
23. Community acquired bacterial pneumonia - Vital signs									x		x
24. Community acquired bacterial pneumonia - O2 saturation									x		x
25. Community Acquired Bacterial pneumonia - Mental status									x		x
26. Community acquired bacterial pneumonia - Empiric antibiotic									x		x
27. Comprehensive inpatient cardiology - AMI and CHF				x							
28. Congestive heart failure program			x	x							
29. Coronary artery disease - Optimal cardiac care	x	x		x						x	
30. Coronary artery bypass graph - Pre op beta blocker									x		
31. Coronary artery bypass graph - Use of IMA									x		
32. Coronary artery bypass graph - Oral antiplatelet therapy									x		x
33. Coronary artery disease - Beta blocker therapy									x		x

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34. Coronary artery disease - Lipid profile, (with lab submission UCare)								x			x
35. Depression care - Medication therapy							x		x	x	
36. Depression - Optimal care			x								
37. Depression - Diagnosis and monitor	x										
38. Diabetes - Optimal diabetes care composite (with lab submission UCare)	x	x		x	x		x	x		x	
39. Diabetes - Hemoglobin A1c control									x		x
40. Diabetes - BP control									x		x
41. Diabetes - LDL Control									x		x
42. Diabetic retinopathy - Dilated macular or fundus exam									x		x
43. Diabetic retinopathy - Communicate with diabetes MD									x		x
44. Discectomy			x								
45. Drug Safety			x								
46. End stage renal disease - Dialysis dose									x		x
47. End stage renal disease - Hematocrit level									x		
48. Functional status				x							
49. Gastro esophageal reflux disease - Alarm symptoms									x		x
50. Gastro esophageal reflux disease - Upper endoscopy									x		x
51. Gastro esophageal reflux disease - Biopsy									x		x
52. Gastro esophageal reflux disease - Barium swallow									x		x
53. Generic drug use	x		x	x	x						
54. Glaucoma - Optic nerve evaluation									x		x
55. Headache Study			x								

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56. Health information technology	x									x	
57. Heart failure - ACE or ARB	x								x		x
58. Heart failure - Beta blocker									x		x
59. Hypertension - Blood pressure							x			x	x
60. Immunization protocol registries			x								
61. Immunization and vaccination rates: Adolescents							x			x	
62. Immunization and vaccination rates: Children				x		x	x	x		x	
63. Low back pain imaging			x								
64. Low back pain management			x								
65. Macular degeneration - AREDS									x		
66. Macular degeneration - Dilated macular exam									x		x
67. Medication reconciliation									x		x
68. Melanoma - Medical history									x		x
69. Melanoma - Skin exam									x		x
70. Melanoma - Counseling self exam									x		x
71. Meniscectomy Arthroscopy			x								
72. Multiple myeloma - Treatment bisphosphonates									x		x
73. Myelodysplastic syndrome and acute leukemias - Baseline									x		x
74. Myelodysplastic syndrome -Document iron stores									x		x
75. Non urgent chest pain for ED - EKG, ECG									x		x
76. Non urgent syncope for ED - EKG, ECG									x		x
77. Osteoporosis - Screening and therapy									x		x

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78. Osteoporosis - Communicate w/ PCP of post fracture care									x		x
79. Osteoporosis - Management of post fracture care									x		x
80. Osteoporosis - Pharmacotherapy									x		x
81. Osteoporosis - Counseling for diet and exercise									x		x
82. Otitis media, acute - Systemic antimicrobial therapy	x										
83. Patient satisfaction/experience			x	x							
84. Peri-op - Timing antibiotic prophylactic order									x		x
85. Peri-op - Timing antibiotic prophylactic administration									x		x
86. Peri-op - Selection antibiotic prophylactic									x		x
87. Peri-op - VTE prophylaxis									x		x
88. Peri-op - Discontinue prophylactic antibiotic in cardiac patients									x		x
89. Peri-op - Discontinue prophylactic antibiotic in non-cardiac patients									x		x
90. Pharyngitis - Testing children									x	x	
91. Quality profile					x						
92. Radiology imaging program					x						
93. Screening - Standardized alcohol abuse screen	x										x
94. Screening - Breast cancer screen (mammography)				x		x	x	x		x	x
95. Screening - Cancer composite screen	x									x	
96. Screening - Cervical cancer screen				x		x	x	x		x	
97. Screening - Chlamydia screen	x				x	x	x	x		x	
98. Screening - Colorectal cancer screen										x	x
99. Screening - Falls risk screen									x		x

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100. Screening - Blood lead screen			x					x			
101. Stroke - CT MRI reports									x		x
102. Stroke - Carotid imaging reports									x		x
103. Stroke - DVT prophylaxis									x		x
104. Stroke - Discharge on antiplatelet									x		x
105. Stroke - Anticoagulant at discharge									x		x
106. Stroke - t-PA considered									x		x
107. Stroke - Screen for dysphagia									x		x
108. Stroke - Consider rehab									x		x
109. Tobacco assessment (Identification)			x								x
110. Tobacco - Assisting smokers to quit clinic fax program	x										x
111. Total hip and knee replacements	x										
112. Total joint replacement - Antibiotic prophylaxis	x										
113. Upper respiratory infection - Treatment for children									x	x	
114. Urinary incontinence - Assessment									x		x
115. Urinary incontinence - Characterization									x		x
116. Urinary incontinence - Plan									x		x
117. Well child						x	x	x		x	

Pay for Performance

EVIDENCE FOR PAY FOR PERFORMANCE

Despite a lack of statistically significant and convincing evidence about whether P4P programs actually improve care and reduce costs, they have taken hold. A 2006 article in the New England Journal of Medicine found that of the 252 HMOs in 41 metropolitan areas surveyed, more than half of the HMOs use P4P in their provider contracts. Of those HMOs implementing P4P, almost 90% had programs for physicians and 38% had programs for hospitals. [13]

Prior to 2006, there were few published, peer-reviewed, empirical studies assessing the efficacy of incentives to promote quality in health care.[14] In fact, Rosenthal and Frank, who authored a 2006 meta-analysis of empirical data on the efficacy of P4P, found little evidence to suggest paying for quality is effective.[15] Their review of the literature found relatively minor improvements to patient care processes or patient outcomes as a result of P4P and they suggest that any impact on quality of care may have been the result of substantially large bonuses, improved documentation, or physicians' awareness of bonus programs and the measures used to earn those rewards. Their review included studies that yielded the following findings:

- Cancer screenings increased among provider groups, regardless of whether they received awards. There were no significant differences in the increases between the reward and non-reward groups.[16]
- Rewards had no impact on rates of childhood influenza immunization when comparing providers who received performance feedback with those who received performance feedback and incentives.[17]
- Per-patient provider rewards increased immunization rates in a statistically significant way over control groups that did not receive rewards. However, this study's methodology and the differences among practice settings might have influenced the results.[18]
- No real gain in quality of care was found when assessing the impact of financial incentives and performance feedback on childhood immunization rates. While the groups receiving a sizable bonus did improve their immunization rates, it may have been because of better documentation of immunizations children received both in and outside of the practice.[19]
- Providers who were paid for assessing smoking status, had a higher rate of documented smoking status than providers who were not eligible for rewards. However, there was no significant impact on smoking cessation rates.[20]
- Physicians' "ask and advise" rates increased if they received a bonus when more than 80% of their patients were asked if they smoked and subsequently counseled to quit smoking. However, there was no control group to determine the cause of the increase. [21]

Since 2006, research on the efficacy of P4P to improve care and patient outcomes has increased dramatically. A growing body of evidence suggests that in some cases P4P has resulted in slight changes in patient care and outcomes. However, the data remain mixed, and results are not always statistically significant. Recent studies include the following:

- Seeking to determine whether P4P is associated with improved care for acute myocardial infarction at hospitals participating in a Centers for Medicare and Medicaid Services P4P pilot project, researchers saw a slightly higher rate of improvement at hospitals participating in the P4P program compared with control hospitals that did not. The improvements, however, were not statistically significant.[22]
- Measuring changes in adherence to measures over a two-year period at hospitals voluntarily reporting quality data, including hospitals participating in a Centers for Medicare and Medicaid Services P4P demonstration project, investigators found that the hospitals participating in both public reporting and P4P showed greater improvement in the quality metrics used.[23]
- Looking at whether diabetic patients from varying ethnic backgrounds would achieve treatment targets for HbA1c, blood pressure, and total cholesterol after the implementation of new P4P contracts for general practitioners, British researchers found that patients' targets for HbA1c, blood pressure, and total cholesterol increased significantly after implementation of P4P contracts and that those targets were met uniformly across all ethnic groups.[24]

PHYSICIAN PERCEPTIONS OF PAY FOR PERFORMANCE

Little research has been done on how practicing physicians perceive P4P. Based on comments received by the MMA from its members, there are vast differences of opinion about P4P as it relates to professional responsibility and its potential for unintended consequences.

Opinions appear to be mixed elsewhere, as well. A 2007 national survey of general internists found growing support for the use of financial incentives for quality improvement among respondents.[25] That said, the authors of the study concluded that physicians remain cautious about P4P. The survey found the key concerns were that P4P could prompt physicians to avoid high-risk patients and the scope of care provided would be diminished as physicians focus the physician-patient interaction on disease states for which they are measured.[26]

Minnesota physicians have raised similar concerns. In the survey conducted by the Minnesota continuing medical education collaborative, many Minnesota physicians expressed skepticism about P4P and indicated they are waiting for convincing evidence that P4P programs improve health outcomes. In addition, they have questioned whether P4P programs define quality care too narrowly, force physicians to provide care to meet what is measured, and that P4P programs assume all physicians require improvements to the care they provide. Minnesota physicians are also concerned about the statistical validity of measures used and they fear that inaccuracies in statistical comparisons may jeopardize their reputation and livelihood. Some also view P4P as an attempt simply to reduce their payments and they believe that these programs favor mid-sized to large clinics that have the staff and resources to collect data accurately.

During MMA's member-at-large comment period on its draft principles for the effective use of P4P, physicians also raised the issue of the potential conflict between providing care tailored to their patients' needs and care that could enhance their own earning potential. One example gleaned from the comment period was the measurement of generic prescribing practices in P4P programs. Physicians raised concerns that using the percentage of generic drugs prescribed as a measure of cost-efficient care could create a conflict of interest for physicians who must weigh patient care along with drug safety and efficacy against their own financial incentives.

PAY-FOR-PERFORMANCE PROGRAMS IN MINNESOTA

Several types of P4P programs are in place throughout the country. In Minnesota, P4P initiatives currently are either performance-based incentive programs or performance-based withhold programs. In performance-based incentive programs, third-party payers and purchasers pay extra money or bonuses to physicians who meet certain practice goals. The best performers get the highest bonus, while the lowest performers receive little or no bonus. Performance-based withhold programs hold back a certain percentage of reimbursement dollars and release them at the end of the year based on the physician's ability to reach certain performance thresholds.

As of August 2007, nine payer- or purchaser-initiated P4P programs were operating in Minnesota. They included programs used by Blue Cross Blue Shield of Minnesota, Bridges to Excellence (implemented through the Buyers Health Care Action Group, a coalition of large employers), HealthPartners (two different programs), Medica (two different programs), PreferredOne, UCare, and the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative. Table 2 provides a summary of these programs.

Table 2: Key Elements of Minnesota's P4P Initiatives (August 2007)

	Number of measures used	To whom measurement results are attributed	Participation	Who is measured	How data are collected	Bonus or withhold	Reward based on meeting defined thresholds or for showing relative improvements
BCBS MN [27]	17	Clinic group level	Voluntary	Family practice, internal medicine, OB/GYN, pediatrics, cardiology, orthopedics, all specialty care	Self-report on generic drug claims, direct data submission with in-clinic chart review	Bonus	Thresholds
Bridges to Excellence (BHCAG) [27]	2	Clinic group level	Voluntary	MN Community Measurement-reporting on primary and non primary care clinics that treat employees and covered dependents of BTE participating employers and beneficiaries in Medicaid managed care programs.	MN Community Measurement data through direct data submission only. Additional in-clinic auditing required	Bonus	Thresholds
HealthPartners Partners in Progress [28]	17	Clinic group level	Voluntary For select groups program is part of provider contract.	Primary care, cardiology, orthopedics, emergency medicine, OB/GYN, ENT, behavioral health	Self-report, administrative data, chart review, and member survey	Withhold	Thresholds & relative improvements
HealthPartners Partners in Excellence [30]	12	Clinic group level	Voluntary For groups with large enough patient populations	Primary care, behavioral health, OB/GYN, physical therapy	Administrative data, chart review, and member survey	Bonus	Thresholds
Medica Performance based incentive [31]	6	Clinic group level	Voluntary	Primary care, family practice, internal medicine, pediatrics, OB/GYN, and other specialty care	Chart review, administrative data	Bonus	Thresholds
Medica Choice Care Quality Improvement Program (QIP) [32]	7	Clinic group level	Voluntary	Primary care, family practice, internal medicine, pediatrics, OB/GYN, and other specialty care	Chart review, administrative data	Bonus	Thresholds & relative improvements
PreferredOne [33]	10	Clinic group level	Voluntary	MN Community Measurement participating providers	MN Community Measurement data	Bonus	Thresholds
UCare [34]	8	Clinic group level	Not voluntary Participation is automatic for primary care groups.	Primary care	Data collected using administrative data, Minnesota Immunization Information Connection (MIIC) registry, and lab submissions	Bonus	Thresholds & relative improvements
CMS PQRI [35]	74 [36]	Provider	Voluntary	Medicare providers	Administrative data (via Medicare claims)	Bonus	Thresholds

MMA POSITION ON PAY FOR PERFORMANCE

In 2007, the Minnesota Medical Association defined P4P as "financial incentives (bonuses) to physicians and/or health care groups to promote quality improvement, systems improvement, and to recognize the delivery of safe, effective, timely, efficient, equitable, and patient-centered care."

As early as 2004, the MMA addressed P4P in its policies, stating that the MMA "acknowledges and supports the concept of linking financial incentives and system performance measurement to promote quality improvement and to recognize the delivery of safe, effective, timely, and patient-centered care." (Board of Trustees Policy 160.26, 05/2004)

Then, in 2005, as part of its report "Physicians' Plan for a Healthy Minnesota," the MMA supported incentives as components of a comprehensive approach to reforming health care and improving quality. This MMA health care reform plan states, "reforms must also include implementation of health information technologies, evidence-based decision-making, restructuring the existing payment system, care coordination, use of non-financial incentives, and continued advances in the practice and science of medicine."

The MMA recognizes and appreciates that there are diverse opinions surrounding P4P. Debate often occurs over the ability of P4P to improve health outcomes, the validity of the measures used, the ability to change physician care patterns with incentives, the ethical implications, and patients' responsibility for their own health outcomes.

Between April 2006 and April 2007, the MMA Quality Committee, which consists of MMA members who are practicing physicians, health plan medical directors, and physicians who work for Minnesota's quality-improvement organizations, discussed pay for performance extensively. As a result, a set of guiding principles was developed titled, "Pay for Performance: MMA's Principles for the Effective Application of Performance Measurement to Physician Payment Incentives." In May 2007, the policy was approved by the MMA Board of Trustees. These principles guide MMA advocacy regarding the use of financial incentives to improve health care quality. Key elements of the MMA's position are that P4P programs:

1. must be designed to drive improvements to health care quality and the systems in which quality care is delivered;
2. must promote and strengthen the partnership between patients and physicians;
3. should support and facilitate broad participation and minimize barriers to participation;
4. must, in their design and implementation, be credible, reliable, transparent, scientifically valid, administratively streamlined, and useful to patients and physicians;
5. should reward physicians and clinics that: a) show measurable improvements to the process of providing quality care; b) show measurable improvements in patients' clinical outcomes; c) meet or exceed stated clinical goals; d) make efforts to improve the systems in which they practice; or e) work to successfully coordinate patients' care among providers.

(For the complete document, see Appendix A.)

EVALUATION OF PAY FOR PERFORMANCE IN MINNESOTA

The MMA sought to assess the degree to which P4P programs in Minnesota align with its principles. For this evaluation to be meaningful, the MMA sought to understand how consistent existing P4P programs are on measures from all five domains of the MMA guiding principles: driving improvements to health care quality; promoting and strengthening the partnership between physicians and patients; supporting and facilitating broad participation and minimizing barriers to participation; promoting credibility, reliability, transparency, validity; and rewarding improvements in care, clinical outcomes, and coordination of care (Table 3).

For each P4P program, across all five domains, a numeric score was assigned, with zero indicating no alignment with MMA's principles for effective P4P programs and the highest number on the scale indicating high alignment with the MMA's principles. A validation of the criteria upon which the assessment is based was completed by a subgroup of MMA Quality Committee members, including practicing physicians, quality improvement specialists, and medical group leaders.

Table 3: Evaluation of program alignment with MMA principles (August 2007)

			HealthPartners	
MMA Principle	BCBS MN Recognizing Excellence Program	Bridges to Excellence	Partners in Progress	
Must drive improvements to health care quality and the systems of care delivery.				
Measures should include both processes of care and patient outcome measures. What the program measures: 0 = Outcome measures 1 = Process measures 2 = Both process and outcome measures	Process measures -14 Outcomes measures - 3	Process measures - 0 Outcomes measures -2	Process measures -16 Outcomes measures -1	
Alignment with MMA principle	2	0	2	
Should support implementation of evidence-based clinical guidelines: Percent of the measures based on evidence (excluding measures for care coordination or systems improvements): 0 = 0% of measures 1 = 1-25% of measures 2 = 26-50% of measures 3 = 51-74% of measures 4 = 75-100% of measures	95% of measures based on evidence Generic drug use measure not evidence based	100% of measures based on evidence	87% of measures based on evidence Generic drug use and imaging services not evidence- based	
Alignment with MMA principle	4	4	4	
Should encourage use of health information technology. If/how the program rewards or supports the acquisition and implementation of HIT: 0 = Does not cover HIT 1 = Encourages HIT with binary (Yes/No) measure of HIT adoption 2 = Encourages HIT by measuring and rewarding providers with HIT systems	Yes/No measure of HIT system implementation	Does not measure, reward or support acquisition, implementation, and use of HIT systems	Does not measure, reward or support acquisition, implementation and use of HIT systems	
Alignment with MMA principle	1	0	0	
Should promote care coordination such as provider use of registries, care planning, and communication with other providers. Number of patient/population disease states for which the program measures care coordination: 0 = Does not measure care coordination processes 1 = At least one patient population/disease state 2 = At least two patient populations/disease states 3 = At least three patient populations/disease states 4 = Four or more patient populations/disease states	Does not measure or reward care coordination	Does not measure or reward care coordination	Measures, rewards use of registries (immunization and headache) and care management for low back pain.	
Alignment with MMA principle	0	0	3	

	Medica					
	Partners in Excellence	Performance-Based Incentive	Choice Care Quality Improvement Program	PreferredOne	UCare P4P program	CMS Physician Quality Reporting Initiative (PQRI)
	Process measures -10 Outcomes measures -2	Process measures - 5 Outcomes measures-1	Process measures -7 Outcomes measures - 0	Process measures - 8 Outcomes measures -2	Process measures - 6 Outcomes measures -2	Process measures - 74 Outcomes measures - 0
	2	2	1	2	2	1
	92% of measures based on evidence Generic drug use measure is not evidence based clinical measure	50% of measures based on evidence Generic drug use and imaging services measures are not evidence based clinical measure	100% of measures based on evidence	100% of measures based on evidence	100% of measures based on evidence .	100% of measures based on evidence
	4	2	4	4	4	4
	Does not measure, reward or support acquisition, implementation and use of HIT systems	Does not measure, reward or support acquisition, implementation, and use of HIT systems	Does not measure reward or support acquisition, implementation, and use of HIT systems	Does not measure reward or support acquisition, implementation, and use of HIT systems	Does not measure reward or support acquisition, implementation, and use of HIT systems	Does not measure reward or support acquisition, implementation, and use of HIT systems
	0	0	0	0	0	0
	Does not measure or reward care coordination	Does not measure or reward care coordination	Does not measure or reward care coordination	Measures, rewards use of registries (immunization)	Measures, rewards use of registries (immunization))	Measures, rewards for advanced care planning, care plan for cataracts, chemotherapy plan, diabetes care coordination, medication reconciliation care plan, osteoporosis care coordination, urinary incontinence plan
	0	0	0	1	2	4

Table 3: Evaluation of program alignment with MMA principles (August 2007)

			HealthPartners
MMA Principle	BCBS MN Recognizing Excellence Program	Bridges to Excellence	Partners in Progress
Programs should promote and strengthen the partnership between patients and physicians.			
Should encourage patient-centered care. How frequently clinical measures allow for variation based on patient adherence, patient preferences, literature or evidence-based rationale and physician clinical judgment (i.e., targets or thresholds are not set at 100%, documented variation is allowed): 0 = Never 1 = Rarely 2 = Sometimes 3 = Often 4 = Always	All allow variation due to medical reasons; thresholds/ targets not set at 100%	All allow variation due to medical reasons; thresholds/ targets not set at 100%	All allow variation due to medical reasons; thresholds/ targets not set at 100%
Alignment with MMA principle	4	4	4
Program should support and facilitate broad participation and minimize barriers to participation			
Should include physician participation across specialty and primary care. Percentage of measures that assess non-primary care specialties: 0 = None of measures 1 = 1-25% 2 = 26-50% 3 = 51-74% 4 = 75-100%	65% assess non-primary care specialties	50% assess non-primary care specialties	47% assess non-primary care specialties
Alignment with MMA principle	3	2	2
Minimize administrative burdens by such methods as minimal methods of data collection; • providing data collection processes; • aligning with MN Community Measurement measures; • collecting data using existing MN Community Measurement data (MNCM data set); • aligning with P4P across the community; • taking advantage of existing processes, clinically and administratively (billing); • streamlining audit and validation process; providing additional clinic staff to assist in implementation Administrative burden on clinics: 0 = High 1 = Medium 2 = Low	Direct data submission Self-report Database on CD-ROM Additional in-clinic auditing is required	MN Community Measurement processes Direct data submission Additional in-clinic auditing required. All measures aligned with MN Community Measurement	Administrative reporting Chart review Self report Patient survey
Alignment with MMA principle	1	1	0
Participation should be voluntary. Whether program participation is voluntary: 0 = Not voluntary 1 = Voluntary	Voluntary	Voluntary	Voluntary For select groups program is part of provider contract
Alignment with MMA principle	1	1	1

	Medica				
Partners in Excellence	Performance-Based Incentive	Choice Care Quality Improvement Program	PreferredOne	UCare P4P program	CMS Physician Quality Reporting Initiative (PQRI)
All allow variation due to medical reasons; thresholds/targets not set at 100%	All allow variation due to medical reasons; thresholds/targets not set at 100%	All allow variation due to medical reasons; thresholds/targets not set at 100%	All allow variation due to medical reasons; thresholds/targets not set at 100%	All allow variation due to medical reasons; thresholds/targets not set at 100%	All allow variation due to medical reasons; thresholds/targets not set at 100%
4	4	4	4	4	4
50% assess non-primary care specialties	33% assess non-primary care specialties	0% assess non-primary care specialties	0% assess non-primary care specialties	0% assess non-primary care specialties	93% assess non-primary care specialties
2	2	0	0	0	4
Administrative reporting Chart review Self report Patient survey	For diabetes - MN Community Measurement processes Administrative reporting HealthHelp reports Chart review	For diabetes - MN Community Measurement processes Administrative reporting Chart review	MN Community Measurement processes Administrative reporting All measures are aligned with MN Community Measurement	Administrative data MIIC registry Clinics submit lab data to UCare All measures aligned with HEDIS 2007 and MDH specifications	Administrative reporting Data collection forms provided
0	1	1	2	1	2
Voluntary For groups with large enough patient populations	Voluntary	Voluntary	Voluntary	Not voluntary Participation is automatic for primary care groups	Voluntary
1	1	1	1	0	1

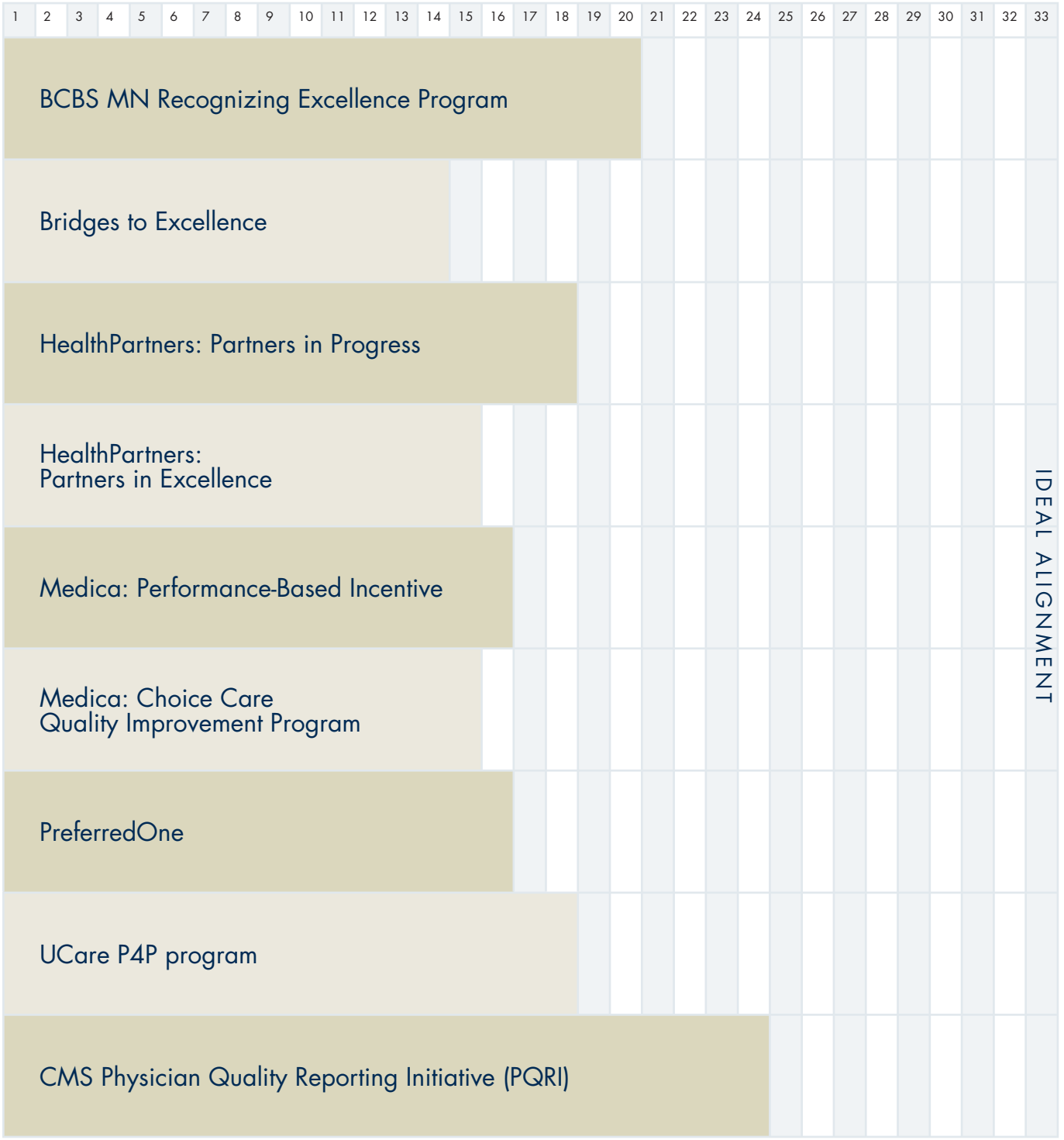
Table 3: Evaluation of program alignment with MMA principles (August 2007)

			HealthPartners
MMA Principle	BCBS MN Recognizing Excellence Program	Bridges to Excellence	Partners in Progress
Design and implementation must be credible, reliable, transparent, scientifically valid, administratively streamlined, and useful to patients and physicians.			
Measure specifications should be clearly defined, transparent, and accessible via website. Availability and detail of measure specifications: 0 = Not available 1 = Available, but lack necessary detail to fully understand measure 2 = Available and sufficiently detailed for full understanding of the measure	Specifications available and sufficiently detailed for full understanding of the measure	Specifications not available	Specifications not available
Alignment with MMA principle	2	0	0
Measures should apply risk adjustment methods to account for co-morbidities, patient-related attributes, case mix, etc. How frequently analysis uses quality risk adjustment methodology: 0 = Never 1 = Rarely 2 = Sometimes 3 = Frequently 4 = Always	High-quality risk adjustment methods not applied	High-quality risk adjustment methods not applied	High-quality risk adjustment methods not applied
Alignment with MMA principle	0	0	0
Program 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; 5) work to successfully coordinate patients' care among providers.			
Should use rewards, bonuses, and systems improvements. Type of rewards: 0 = Rewards are entirely monies withheld from regular reimbursements 1 = Rewards are a combination of supplemental monies and monies withheld from regular reimbursements 2 = Rewards are always supplemental monies	All rewards supplemental	All rewards supplemental	All rewards withheld from regular reimbursements
Alignment with MMA principle	2	2	0
Should reward for thresholds (absolute value) AND for significant improvements (relative improvements). Basis of rewards: 0 = Reaching targeted thresholds 1 = Improvement over previous results 2 = A combination of improvements over previous results and meeting thresholds	Thresholds	Thresholds	Thresholds/ targets and improvements over past performance
Alignment with MMA principle	0	0	2

	Medica				
Partners in Excellence	Performance-Based Incentive	Choice Care Quality Improvement Program	PreferredOne	UCare P4P program	CMS Physician Quality Reporting Initiative (PQRI)
Specifications not available	Specifications available and sufficiently detailed for full understanding of the measure	Specifications not available	Specifications not available	Specifications available, but lack necessary detail to fully understand measure	Specifications available and sufficiently detailed for full understanding of the measure
0	2	0	0	1	2
High-quality risk adjustment methods not applied	High-quality risk adjustment methods not applied	High-quality risk adjustment methods not applied	High-quality risk adjustment methods not applied	High-quality risk adjustment methods not applied	High-quality risk adjustment methods not applied
0	0	0	0	0	0
All rewards supplemental	All rewards supplemental	All rewards supplemental	All rewards supplemental	All rewards supplemental	All rewards supplemental
2	2	2	2	2	2
Thresholds	Thresholds	Thresholds/ targets and improvements over past performance	Thresholds	Thresholds/ targets and improvements over past performance.	Thresholds
0	0	2	0	2	0

OVERALL ALIGNMENT WITH MMA PRINCIPLES

A tally of overall "scores" shows the degree to which the programs align with MMA's principles. The MMA believes there is an opportunity to increase program alignment with its principles.



Conclusions

The demand for quality measurement, public reporting, and linking payment to quality has grown dramatically in recent years. For that reason, P4P is now part of the common discourse on health care reform and quality improvement. However, it remains to be seen whether financial rewards will change physician behavior and, if so, what size reward is most effective. Further understanding is also needed to clarify to what degree merely reporting performance data publicly changes practice and whether the relative gains in quality justify the investment in P4P.

Minnesota's largest payers, the state legislature and a segment of the employer community have made significant investments in P4P programs—an indication that the P4P movement is growing and will most likely continue to affect quality, access, and the cost of health care. Therefore, it is necessary for physicians to be wholly and integrally involved in the design, implementation, and evaluation of P4P initiatives in order to make sure that they are fair, promote quality care, protect patients, allow physicians to use their clinical judgment and provide ethical care, minimize administrative burdens, create the proper incentives, and ensure the economic viability of clinical practices.

It is clear from MMA's evaluation that there is an opportunity to refine existing P4P programs so they are more responsive to the needs of physicians, purchasers, and payers. The MMA's evaluation of these programs shows the following:

- P4P programs in Minnesota are quite diverse in that they define measures of quality for specific disease states differently and are implemented inconsistently.
- The programs evaluated did align on several components of the MMA's P4P principles. Specifically, most of the measures used in Minnesota are reliable, evidence-based, and useful. Measures support the physician-patient relationship and existing initiatives are beginning to expand measurement to more specialties.
- Programs that fared better when compared to MMA principles are those that reward systems improvements, encourage implementation across non primary and primary care, and minimize the burden of data collection and reporting.
- Programs that received lower "scores" of alignment with MMA principles were those that require participation, withhold money, add to administrative burdens, do not reward investments in HIT infrastructure, and do not employ risk-adjustment methodologies.
- Administrative burdens remain substantial. To their credit, select programs, namely CMS PQRI, the Bridges to Excellence, UCare, and PreferredOne programs, have made efforts to streamline data collection in order to minimize administrative burdens and intrusions on clinical practice.
- Programs rarely support systems improvements such as working in teams, using health information technology, or coordinating care.
- Although Medicare's Physician Quality Reporting Initiative is in its early stages, it may garner more physician support than other programs once it is up and running. In particular, the measures used are evidence based and were developed by physicians for physicians; the measures support the overall care of the patient through care coordination activities; and the program ensures broad physician participation as care is measured across the health care continuum.

Recommendations

The MMA understands that money will continue to be invested in P4P in both the public and private sectors. However, the MMA believes there is an opportunity to refine the current programs so that they better serve the community and more effectively link performance measurement with physician payment incentives. The MMA offers the following recommendations based on its assessment and evaluation of P4P in Minnesota.

1) Minnesota P4P programs must recognize and reward physicians for systems improvements, including HIT adoption, care coordination, and use of evidence-based medicine.

The MMA believes P4P programs will be more effective if, in addition to using clinical measures, they assess and reward physicians for managing populations of patients, promoting disease prevention, implementing best clinical practices, coordinating care, and building the health information technology infrastructure necessary to support quality improvement efforts. Program administrators must realize that physicians will require additional financial and technical assistance in implementing quality improvement strategies and that making resources more readily available will improve the quality of patient care.

P4P programs in Minnesota should begin to reward physicians who improve their infrastructure (EMR systems, patient registries, patient monitoring devices, care coordinators, integrated teams of primary and specialty care) and the way they deliver care (daily monitoring, case management, medication management, written feedback between primary and specialty physicians regarding treatment changes and referrals, multi-specialty treatment plans, patient self-management training).

2) Minnesota must work toward developing a coordinated and cohesive measurement effort, specifically with regard to measurement sets, measure specifications, and data collection methodologies. This would decrease the administrative burden associated with participating in multiple P4P programs.

The sheer number of measures used in the existing P4P programs, the diversity of methods used to collect data, and the variations in measure specifications lead to administrative and data overload. This ultimately will distract physicians and patients.

The MMA does not propose the creation of common payment methodologies; instead, the measures by which quality is defined should be consistent and coordinated, and data reporting should be streamlined. P4P programs in Minnesota should strive for a standardized approach to measuring quality by adopting a set of reliable and valid measures to be used by all participants and a common method for statistically valid data collection, aggregation, and reporting.

3) Minnesota P4P programs must begin using risk-adjustment methods immediately in order to make sure that variations among patient populations are considered. As risk-adjustment methods are developed further, they must be incorporated into the analysis of comparative data.

Clinicians and patients need to be assured that measures of performance adequately adjust for differences in patient populations served. Currently, Minnesota's P4P programs do not adjust for these factors. Patients with multiple co-morbidities, as well as those who are poor or members of minority groups, tend to have worse health outcomes. Failing to adjust for such factors could place clinics that care for such patients at a disadvantage and unintentionally limit access to care for these patients.

As programs begin to include more outcomes measures, risk-adjustment methods will become an increasingly significant issue for physicians. The development of good risk-adjustment methodologies has been slow, but methods, however imperfect, do exist. P4P programs in Minnesota must begin to employ these existing risk-adjustment methods in order to factor variations in patient populations into outcomes. This is especially important when measures are compared and reported publicly, when the data are analyzed on a more granular level, and when physician payment is tied to results.

4) Minnesota's P4P programs must not present ethical dilemmas for physicians by jeopardizing patient safety or limiting shared decision-making.

Physicians across Minnesota understand the need for improvements in the delivery of care. P4P programs should never a) encourage physicians to avoid high-risk and socially disadvantaged patients; b) encourage over- or under-utilization of services in order to reach a target; c) set physicians up to do what may not be in the patient's best interests because of the reward system; d) encourage physicians to focus treatment on only those clinical indications and conditions for which there are measures; e) reduce access to care for patients; f) threaten implementation of HIT systems because of decreased reimbursement; or g) prompt physicians to engage in "gaming" strategies in order to receive rewards.

NEXT STEPS

As P4P proceeds, the MMA will continue to expect P4P programs to drive quality improvements across the health care continuum, promote and strengthen the partnership between the patient and physician, support and facilitate broad participation and minimize barriers to participation, use measures that are reliable and valid, and reward physicians and clinics for achievements towards quality.

To further strengthen its leadership role and prepare for the next steps in the P4P movement, the MMA plans to pursue the following activities:

- Meet with health plan medical directors, P4P program designers, and community leaders to encourage them to include incentives for investments in HIT, practice redesign, and implementing effective strategies for managing chronically ill patients.

  Strategies to increase the funding for health information technology implementation will help ensure Minnesota meets the goal set by the 2007 Legislature for implementation of health information technology that is 100% interoperable by 2014.
- Initiate community discussions to explore: whether P4P is working, what lessons have been learned to date in Minnesota, how to make P4P more effective, how best to align measure sets and measurement specifications across Minnesota's P4P programs, ways to streamline data collection, and ways to create the most effective models for payment redesign and quality improvement;
- Initiate discussions among Minnesota physicians about the relationship between P4P and professionalism to: assess whether the measures used place physicians in unethical positions, consider the risks and benefits of select performance measures, and determine the likelihood of inappropriate care being provided in attempt to reach performance targets.

Although it is unclear whether P4P will make a significant difference in improving quality, P4P represents the first attempt to pay physicians based on the quality of care they provide. The MMA believes physicians must come together to respond thoughtfully and effectively to pay-for-performance programs. The MMA will continue to monitor these programs as they become more robust. Additionally, in an effort to seek alignment with the MMA's principles for effective P4P, the MMA will work to alleviate the possible unintended effects P4P may have on the quality of health care.

Appendix A

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 the patient and physician.

- 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.
  - o Clinical performance measures must be objective, transparent, reliable, evidence-based, current, statistically valid, clinically relevant, and cost-effective; the methodology should be prospectively defined.
  - o 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.
  - o Pay-for-performance programs should collect, report upon, and link payment to both process and outcome measures.
  - o 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 the characteristics of being credible, reliable, transparent, valid, streamlined, and useful 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.

References

1) See MMA website www.MMAonline.net/quality/payincentives.html
2) Information provided by BCBS staff and website. Reviewed for accuracy August 2007.
3) Information provided by Bridges to Excellence staff and website. Reviewed for accuracy August 2007.
4) Information provided by HealthPartners staff and website. Reviewed for accuracy August 2007.
5) Information provided by HealthPartners staff and website. Reviewed for accuracy August 2007.
6) Information provided by Medica staff and website. Reviewed for accuracy August 2007.
7) Information provided by Medica staff and website. Reviewed for accuracy August 2007.
8) Information provided by PreferredOne staff and website (December 2006). August 2007 Review sought, with no response. Based on 2006 PreferredOne program
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36) Providers need only report on 3 or more measures

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