GETTING REWARDS FOR YOUR RESULTS: PAY-FOR-PERFORMANCE PROGRAMS

More and more health plans are paying physicians for quality. Here's what you need to know about these programs, and how to get involved.

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CME Covered in *FPM* Quiz

FPM Tool inside

Donald Robinson, MD, is a family physician in private practice in Hamburg, N.Y., a blue-collar suburb of Buffalo, and has been practicing medicine since 1977. For the past five years, he has participated with the three largest HMOs in the Buffalo area in pay-for-performance programs. From one managed care plan alone, Independent Health, he earned $20,000 in incentive bonus payments in 2002 for achieving targets in five areas: patient satisfaction, access to care, emergency room utilization, mammography rates and colorectal cancer screening rates.

To meet the quality targets of the managed care plans with which he works, Robinson has had to shift his way of practicing medicine and cultivate a new mindset and skill set. He has developed computerized patient registries to track his patients. He employs two part-time staffers to send reminder notices to patients and maintain his patient registry. He has also partnered with his managed care plans, which provide him with lists of his patients in need of services as well as flow sheets, guidelines, patient education materials and other tools. Robinson monitors his own preventive care outcomes, such as colonoscopy and mammography rates, and has dedicated special attention to improving the

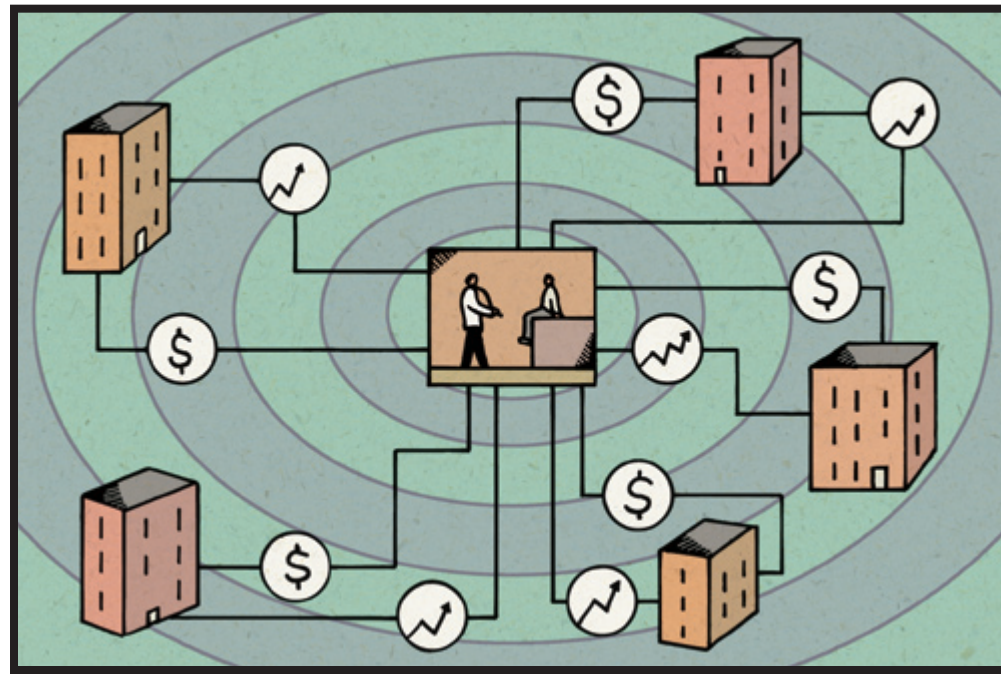

ILLUSTRATION BY RANDY LYHUS

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Pay-for-performance programs helped family physician Donald Robinson earn $20,000 in bonuses for achieving specific quality targets.

Improving quality of care requires a shift in the way physicians are accustomed to practicing medicine.

Current payment methods provide physicians with little incentive to improve quality of care and may even prevent such actions, according to the Institute of Medicine.

More than 35 health plans representing 30 million members now offer pay-for-performance programs, and those numbers are expected to grow.

outcomes of his adult patients with diabetes and his pediatric patients with asthma.

These changes in his practice have paid off. He receives bonuses from his managed care plans that have increased his earnings by approximately 6 percent. This additional money has enabled him to hire more staff, build and maintain a patient registry (the centerpiece of his practice improvement efforts), conduct a series of quality improvement projects in his practice and take home more money each year. He admits practice improvement is hard work, but it's worth the effort. "It's not the profit that interests me," he says. "It's the quality. I feel like I am stamping out disease."

The basics of pay for performance

Current payment methods provide physicians with little incentive to improve quality of care. "Even among health professionals motivated to provide the best care possible, the structure of payment incentives may not facilitate the actions needed to systematically improve the quality of care, and may even prevent such actions," according to the Institute of Medicine (IOM).[1] The IOM has called for broad-based reform of the health care payment system and strengthening of existing payment methods that provide physicians with greater financial incentives for quality improvement.

> **Current payment methods provide physicians with little incentive to improve quality of care.**

More than 35 health plans representing 30 million members now offer pay-for-performance programs (see the table on page 47). Based on current growth trends, at least 80 health plans are expected to offer such programs by 2006, covering some 60 million members.[2]

Pay-for-performance programs have four essential elements that physicians should be aware of before participating. (See the tool for evaluating pay-for-performance programs on page 49.) The first element is the set of performance measures being used. Performance measures fall into several categories:

- Utilization/cost management (e.g., average number of emergency department visits per patient per year),
- Clinical quality/effectiveness (e.g., the percentage of patients with asthma on controller medications),

KEY POINTS

- Thirty-five health plans covering some 30 million patients now offer pay-for-performance programs.
- Participating physicians receive an average of 10 percent of annual income by meeting specified quality measures.
- Practices that succeed at pay-for-performance programs continuously experiment with new ideas for improving their care, service and efficiency.

- Patient satisfaction (e.g., the percentage of patients who would recommend the physician to a family member or friend),
- Administrative (e.g., the practice's level of information technology),
- Patient safety (e.g., the percentage of patients questioned about allergic drug reactions).

These measures may be developed locally by the health plan or purchaser or may come from nationally recognized sources, such as Health Plan Employer Data and Information Set HEDIS (http://www.ncqa.org/programs/hedis/index.htm) or the Consumer Assessment of Health Plans (http://www.ahcpr.gov/qual/cahps/dept1.htm). A recent study by Med-Vantage found that 71 percent of health plans with pay-for-performance programs use some subset of HEDIS measures.[2]

The second element to be aware of is how the health plan collects the performance data. Performance data can be derived from the health plan's administrative data, claims data for medical services or encounter data from the physician's practice. Administrative and claims data have the advantage of ease of collection for the health plan; encounter data has the advantage of greater clinical detail, which improves validity of the measurement but can be difficult for physician offices to supply. Web-based electronic health records would enable family physicians to engage health plans more actively in performance measurement; however, some groups are finding creative solutions even without fully functioning electronic health records. For example, the Employers Coalition on

HEALTH PLANS OFFERING PAY-FOR-PERFORMANCE PROGRAMS

More than 35 health plans, covering some 30 million members, now offer pay-for-performance programs.

Plan Name	Program Name
Aetna	IHA Rewarding Results, Bridges to Excellence and Quality Enhancement
Anthem Blue Cross Blue Shield of New Hampshire	N/A
Anthem Blue Cross Blue Shield of Ohio	Bridges to Excellence
Anthem Blue Cross Blue Shield of Kentucky	Bridges to Excellence
Blue Cross Blue Shield of Alabama	Bridges to Excellence
Blue Cross Blue Shield of Hawaii (HMSA)	Quality and Service Recognition Program
Blue Cross Blue Shield of Illinois	Bridges to Excellence
Blue Cross Blue Shield of Massachusetts	HMO Blue Group Performance Incentive Program and Bridges to Excellence
Blue Cross Blue Shield of Michigan	Rewarding Results
Blue Cross Blue Shield of Missouri	Physician Group Partners Program
Blue Cross Blue Shield of Western New York	Quality Incentives
Blue Cross of California	IHA Rewarding Results and PPO Physician Quality and Incentive Program
Blue Shield of California	IHA Rewarding Results
Care First Blue Cross Blue Shield of the Mid-Atlantic	Primary Care Physician Recognition Program
Cigna Healthcare of California	IHA Rewarding Results
Empire Blue Cross Blue Shield of New York	N/A
Excellus Blue Cross Blue Shield of Rochester	Rewarding Results and Value of Care (IPA)
Harvard Pilgrim Healthcare	Quality Incentives and Bridges to Excellence
Health Partners (Minnesota)	Outcomes Recognition Program
Health Net of California	IHA Rewarding Results
Highmark Blue Cross Blue Shield of Pennsylvania	Quality Incentive Payment System
HIP of New York	PCP Incentive Plan
Horizon Blue Cross Blue Shield of New Jersey	N/A
Humana	Bridges to Excellence
Independence Blue Cross of Pennsylvania	Quality Incentive Payment System
Independent Health of Buffalo, N.Y.	Quality Management Incentive Awards Program
Massachusetts Health Quality Partners	Rewarding Results
PacifiCare	IHA Rewarding Results
Presbyterian Health Plan of New Mexico	N/A
Priority Health	Physician Incentive Program
Promina Cigna (Georgia)	Reward for Quality
Touchpoint Healthplan of Wisconsin	N/A
Trigon Blue Cross Blue Shield of Virginia	Performance Extra
Tufts Health Plan of Massachusetts	Bridges to Excellence
United Healthcare	Bridges to Excellence
Univera/Excellus Blue Cross Blue Shield of Buffalo	N/A
Western Health Advantage	IHA Rewarding Results

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Common performance measures focus on utilization, clinical quality, patient satisfaction, administrative issues and patient safety.

A majority of health plans with pay-for-performance programs use some subset of HEDIS measures.

Performance data can be derived from the health plan's administrative data, claims data for medical services or encounter data from the physician's practice.

Encounter data offer greater clinical detail, which improves validity of the measurement, but can be difficult for physician offices to supply.

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Health plans compare physicians either to others participating in the program or to national benchmarks.

The two most common incentives are quality bonuses and reimbursement at risk (or withholds).

Quality bonuses are preferable for physicians, as they involve no financial risk.

Payments for performance range from 1 percent to 40 percent of a practice's total annual revenue, with an average of a 10-percent bonus or withhold.

Health (ECOH) in Rockford, Ill., has distributed to physicians a software system called "Project in a Box," developed by the Illinois quality improvement organization (http://www.ifqhc.org). The software helps standardize the collection of data on diabetes and preventive care, which are used in ECOH's pay-for-performance program.

Third, physicians should understand how the health plan determines its performance targets or benchmarks. Some compare the participant group to itself and establish a defined subset as the target (e.g., two standard deviations from the mean, the top quartile or the 90th percentile). Others compare the participant group to an external benchmark (e.g., data from other health plans, national surveys or specialty society goals).

Finally, physicians should understand how the health plan will reward them for meeting or exceeding performance targets. Typically, health plans combine a physician's performance ratings on individual measures into a single value to determine whether the physician qualifies for rewards. A number of financial incentives exist,[3] but the two most common incentives are quality bonuses (in which physicians receive an annual payment for meeting performance targets) and reimbursement at risk (in which the health plan withholds 5 percent to 10 percent of reimbursement and pays it back to the physician for meeting minimum requirements). The most desirable programs will use bonuses, which physicians prefer because no financial risk is involved. The Med-Vantage study of pay-for-performance programs found that payments for performance ranged from 1 percent to 40 percent of a practice's total annual revenue, with an average of a 10-percent bonus or withhold.

IMPROVEMENT IDEAS FROM THE *FPM* ARCHIVES

To achieve the required outcomes for pay-for-performance programs, your practice may need to improve its current care processes. You can find improvement ideas through the *Family Practice Management* archives, available online at http://www.aafp.org/fpm.

Quality improvement

"Holding the Gains in Quality Improvement." Giovino JM. May 1999:29-32.

"A Team Approach to Quality Improvement." Schwarz M, Landis SE, Rowe JE. April 1999:25-30.

"Quality Improvement: First Steps." Coleman MT, Endsley S. March 1999:23-26.

System redesign

"The KISS Principle in Family Practice: Keep It Simple and Systematic." Solberg LI. July/August 2003:63-66.

"Starting a Revolution in Office-Based Care." White B. October 2001:29-35.

Chronic disease care improvement

"Thirteen Months of Quality Improvement: Did it Work?" White B. January 2001:55-57.

"Making Diabetes Checkups More Fruitful." White B. September 2000:51-52.

"Using Flow Sheets to Improve Diabetes Care." White B. June 2000: 60-62.

"Helping Patients Take Charge of Their Chronic Illnesses." Funnell MM. March 2000:47-51.

"Building a Patient Registry From the Ground Up." White B. November/December 1999:43-44.

"Improving Chronic Disease Care in the Real World: A Step-by-Step Approach." White B. October 1999:38-43.

Practice measurement/assessment

"Putting Measurement Into Practice With a Clinical Instrument Panel." Endsley S. February 2003:43-46.

"The *Family Practice Management* Practice Self-Test." Edsall R, Backer L, Bush J, White B, Maresh O, Hocker K. February 2001:41-48.

National demonstration projects

Currently, two high-profile national demonstration projects are in the early stages of testing whether pay-for-performance programs significantly contribute to improved health care outcomes.

Rewarding Results is an $8.8 million initiative of the Robert Wood Johnson Foundation and the California HealthCare Foundation. The grantees include Blue Cross Blue Shield of Michigan, Blue

PAY-FOR-PERFORMANCE EVALUATION TOOL

The spreadsheet shown here can help you evaluate pay-for-performance programs available to you. The best programs will offer financial bonuses of adequate size to be worthwhile, incentives based on well-tested and valid measures, and assistance in collecting data and improving care. To download a working copy of the spreadsheet, visit this article online at http://www.aafp.org/fpm/20040300/45gett.html.

FPM Tool

Endsley performance tool.xls

Pay for Performance Evaluation Tool

INSTRUCTIONS: Type only in the yellow fields. In row 3, enter the names of the health plans with pay-for-performance programs that you are evaluating. Beginning in cell B4, enter a "1" for each statement that is true; otherwise leave blank.

HEALTH PLAN	Quality Health Plan	Budget Health Plan	Middle Road Health Plan	Other	Other	Other	Other	Other
A health plan rep can explain the compensation formula and how it was derived.	1	1	1					
The program offers a "bonus" rather than a "withhold."	1							
Family physicians were involved in the program's design (e.g. selecting the measures).	1							
The performance measures are nationally recognized (by Medicare, the NCQA, etc.).	1	1	1					
The program offers non-financial assistance, such as guidelines, flowsheets and patient ed materials.	1		1					
The plan uses encounter data, not claims data.	1							
If encounter data is used, the health plan provides technical assistance for data collection.	1							
The potential incentive is 5 to 10 percent of income from the plan.	1		1					
TOTAL POINTS	8	2	4	0	0	0	0	0
EVALUATION	Go for It	Forget It	Possible	Forget It	Forget It	Forget It	Forget It	Forget It

KEY
0-2 points = Forget It
3-4 points = Possible
>4 points = Go for It

Cross of California, Excellus Health Plan, Integrated Healthcare Association (IHA) and Massachusetts Health Quality Partners. The largest of these is IHA, a coalition of seven health care plans (Aetna of California, Blue Cross of California, Blue Shield of California, CIGNA Healthcare of California, Health Net of California, PacifiCare and Western Health Advantage). In early 2003, participating physicians submitted data on patient satisfaction, investment in information technology and six clinical indicators: childhood immunization status, cervical cancer screening, breast cancer screening, use of appropriate medication for people with asthma, LDL-C screening after cardiovascular event, and A_{1c} testing in diabetes. The first bonuses will be paid in mid-2004.

Bridges to Excellence, funded by Robert Wood Johnson and supported by the Center for Medicare & Medicaid Services, is an initiative of large employers (General Electric Company, Procter and Gamble, Verizon Communications, Raytheon Company, UPS, Humana, Ford Motor Company and Cincinnati Children's Hospital Medical Center), health plans (Aetna, Anthem Blue Cross Blue Shield of Ohio and Kentucky, Blue Cross Blue Shield of Illinois, Alabama and Massachusetts, Tufts Health Plan, United Healthcare, Harvard Pilgrim

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Two high-profile national demonstration projects are testing whether pay-for-performance programs contribute to improved health care outcomes.

The author's pay-for-performance evaluation tool can help you judge whether a program is worth your consideration.

The best pay-for-performance programs will include financial incentives of adequate size to be worthwhile, incentives based on well-tested and valid measures, and health plan assistance in improving care.

Your decision to participate in pay-for-performance programs will also depend on whether you have the commitment, staff and resources to devote to improving quality of care in your practice.

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If your health plans do not currently offer pay-for-performance programs, let them know you are interested and look for opportunities to shape these programs in your area.

Pay-for-performance programs are not "one size fits all."

To reach your performance goals, look for improvement opportunities sponsored by reputable organizations or initiate your own.

Most importantly, start improving your practice right now; don't put it off until tomorrow.

Healthcare and Humana) and physician groups in the three large urban markets of Boston, Cincinnati and Louisville. It seeks improvements in three areas: diabetes care, cardiovascular care and patient care management systems. The diabetes component of this initiative is modeled on the American Diabetes Association/National Committee for Quality Assurance's Physician Recognition Program. Incentives of up to 10 percent of annual income will be paid to physicians who achieve targets in these three areas.

Getting involved with pay for performance

If you are ready to change your mind-set and skill set, pay-for-performance programs are a rapidly growing opportunity to work on your practice, deliver the highest attainable quality of care to your patients and strengthen your financial performance. As Dr. Robinson described, attaining new levels of performance in your practice can be hard work but well worth the effort.

When you find good ideas, steal shamelessly and share openly.

Step 1: Decide whether pay for performance is right for you. Do you have the commitment, staff and resources to devote to improving quality of care in your practice? Is your practice free from relationships that would impair your improvement efforts (e.g., being owned by a larger health system not committed to quality improvement)? Are the typical pay-for-performance measures applicable to your patient population (e.g., pneumococcal immunization rates in a younger population)? Does your practice have adequate information systems or data collection capacity, or are you willing to acquire it? Do you have the patience to achieve the outcomes that reap higher financial bonuses? Don't underestimate how much hard work it will take.

Step 2: Look for health plans offering pay-for-performance programs. The table on page 47 lists more than 35 health plans that reported pay-for-performance programs in the Med-Vantage study. Discuss these programs with representatives from the health plans with which you currently contract, and talk with your colleagues about their experiences. If your health plans do not currently offer pay-for-performance programs, let them know you are interested and look for opportunities to shape these programs in your area.

Step 3: Evaluate the pay-for-performance programs available to you. Pay-for-performance programs are not "one size fits all." Available programs in your local health care market may vary and may not fit your practice's needs and capabilities for performance improvement. Use the spreadsheet tool shown on page 49 to assess how a health plan's pay-for-performance program fits with your practice's needs. The key criteria to look for include financial incentives of adequate size to be worthwhile, incentives based on well-tested and valid measures, and health plan assistance in improving care.

Step 4: Find improvement opportunities to help you reach your performance goals. Opportunities include improvement projects and collaboratives sponsored by local health plans, national health care organizations such as the AAFP (http://www.aafp.org/x36890.xml) or the Institute for Healthcare Improvement (http://www.ihi.org), or your state quality improvement organization (for a directory, visit http://www.medqic.org/content/qio/qio.jsp?pageID=4).

You can also initiate your own improvement projects. Continuously look for new ideas that will help you improve patient care, service or efficiency. (See the *FPM* reading list on page 48 for some ideas.) Test the ideas on a small scale, adapt them as needed and keep only what works. When you find good ideas, steal shamelessly and share openly.

Step 5: Get started now. FPM

Send comments to fpmedit@aafp.org.

1. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: The National Academies Press; 2001.

2. *2003 National Study of Provider Pay-for-Performance Programs: Lessons Learned.* San Francisco: Med-Vantage Inc.; 2003.

3. Bailit Health Purchasing, LLC. *Provider Incentive Models for Improving Quality of Care.* Washington, DC: National Health Care Purchasing Institute; 2002.