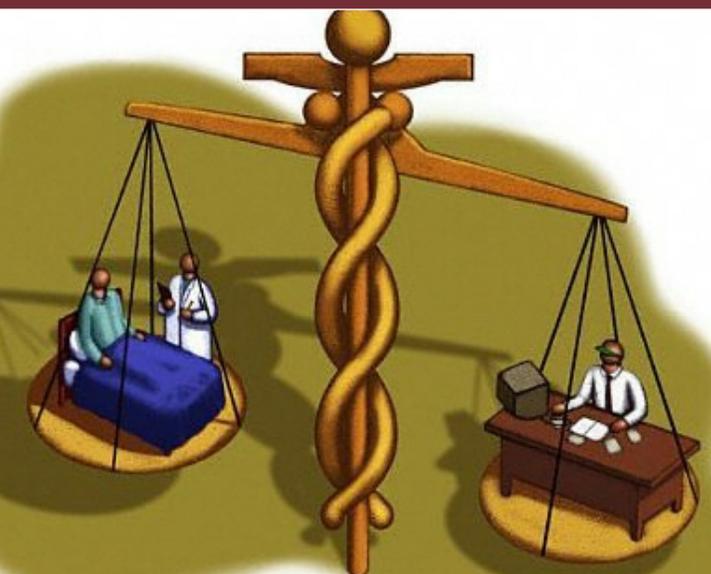




NATIONAL
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T O O L K I T

Ensuring Quality Health Plans: A Purchaser's Toolkit for Using Incentives

Bailit Health Purchasing, LLC

About the National Health Care Purchasing Institute and Rewarding Results

Mission The National Health Care Purchasing Institute was founded to improve health care quality by advancing the purchasing practices of major corporations and government agencies, particularly Fortune 500 companies, Medicare, and public employers. The Institute also operates the Rewarding Results program, which helps align incentives with high-quality health care.

Institute Objectives and Offerings Our objectives are to help purchasers buy higher quality health care, save lives, and empower consumers to choose higher quality health plans and providers. Institute offerings include courses and workshops, convening of experts and working groups, research, and information on tools and best practices.

Rewarding Results Program Rewarding Results helps employers, health plans, state Medicaid / SCHIP agencies, and others design and implement incentives to reward physicians and hospitals for higher quality. Offerings include demonstration grants, technical assistance, web seminars, and publications.

Sponsors The Robert Wood Johnson Foundation (www.rwjf.org) sponsors the Institute. The Robert Wood Johnson Foundation and the California HealthCare Foundation (www.chcf.org) co-sponsor Rewarding Results. The Institute is part of the Academy for Health Services Research and Health Policy (www.academyhealth.org).

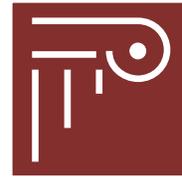
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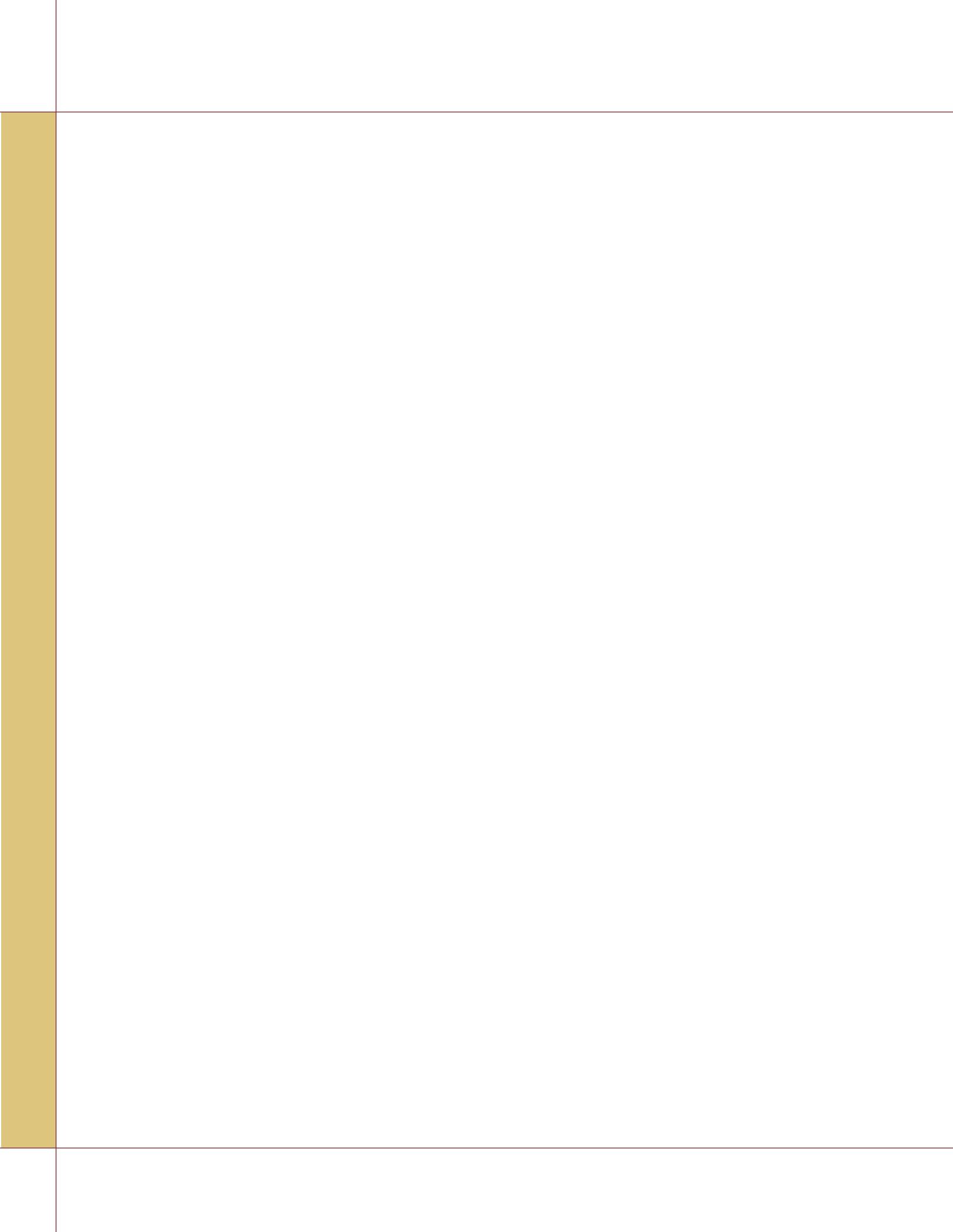
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BAILIT HEALTH PURCHASING, LLC (BHP) IS A FIRM DEDICATED TO ASSISTING PUBLIC AGENCIES, PRIVATE PURCHASERS, AND PURCHASING COALITIONS IN THE DEVELOPMENT AND EXECUTION OF EFFECTIVE HEALTH CARE PURCHASING STRATEGIES. BHP IS DRIVEN BY THE BELIEF THAT ONLY SOPHISTICATED AND DEMANDING PURCHASING EFFORTS CAN CREATE ACCOUNTABILITY FOR QUALITY, COST-EFFECTIVE CARE.

CONTENTS

Executive Summary	3
Why Use Health Plan Incentives?	4
How Does A Purchaser Get Started?	
Step 1: Assessing the Health Care Marketplace	5
Step 2: Targeting Performance Areas	7
Step 3: Developing Performance Measures	8
Step 4: Establishing Performance Targets	9
Step 5: Determining the Incentive	10
How Are Incentives Targeted?	11
Implementing an Incentive Program	12
Challenges and Ways to Overcome Them	13
Examples of Health Plan Incentives	14
Insights and Advice from a Leading Purchaser and Consultant	19
Who Has Experience with Health Plan Incentives?	22
Appendices	
A. Purchasers with Experience Using Health Plan Incentives	23
B. Consultants and Other Resources	24
C. Selected Literature on Purchasers' Use of Health Plan Incentives	25
Endnotes	26



EXECUTIVE SUMMARY

WHILE THERE ARE MANY FACTORS THAT ADVERSELY AFFECT HEALTH CARE, ONE OF THE MOST TROUBLING IS THE VARIATION IN HEALTH PLAN PERFORMANCE FROM REGION TO REGION. THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) FINDS THAT HEALTH PLANS IN NEW ENGLAND PERFORM BETTER, WHILE PLANS IN THE SOUTH CENTRAL, MOUNTAIN, AND WEST NORTH CENTRAL REGIONS TYPICALLY SCORE LOWER ON MANY QUALITY PERFORMANCE MEASURES.¹

The effects of this disparity can have dire consequences. For example, proper treatment after a heart attack can mean the difference between life and death. Health plans performing at NCQA's 90th percentile show 98 percent of people suffering heart attacks are given beta blockers. In contrast, those operating at the 10th percentile administer beta blockers to only 76 percent of heart attack patients.²

The current marketplace does not typically reward high performing health plans with more enrollees or higher reimbursement. So where, then, is the motivation for health plans to strive for excellence?

It is critical for purchasers to guarantee health plan value and quality through a variety of motivational incentives. Health plan incentives can be effective in improving performance in a variety of areas, such as:

- > Clinical quality
- > Access to care
- > Patient satisfaction
- > Administrative services

Purchasers can use financial rewards or bonuses to encourage significant improvements in performance or use financial penalties to discourage performance from falling below an acceptable level. But they should not overlook the potential impact of non-financial incentives, such as offering special awards and recognition for exceptional performance.

Creating the incentive, though, is only one component of a complete change strategy. Effective incentive programs are labor-intensive, data-dependent, and involve significant collaboration. Purchasers need to be prepared to devote the necessary resources to an incentive program and allow significant time for results to be seen.

Research sponsored by the National Health Care Purchasing Institute (NHCPI) has found that a successful incentive program will:

- > Target clear and valid measures of performance.
- > Focus on demonstrated opportunities for improvement.
- > Create incentives that are significant enough to motivate plans to improve.
- > Possess enough leverage to warrant attention from health plans.
- > Remain a priority for purchasers and plans.
- > Sustain open and constructive communication throughout all stages of the program.
- > Focus on areas within the health plan's control.
- > Provide plans with timely feedback and rewards or penalties directly related to performance.
- > Maintain a good working relationship between purchasers and plans.
- > Reinforce joint responsibility for the incentive program's success.

WHY USE INCENTIVES WITH HEALTH PLANS?

ALTHOUGH U.S. COMPANIES SPEND HUNDREDS OF BILLIONS OF DOLLARS EACH YEAR ON HEALTH PLAN PREMIUMS, NOT ALL PLANS PROVIDE THE SAME LEVEL OF QUALITY OR VALUE. IN FACT, RESEARCH AND EXPERIENCE HAS SHOWN THAT PERFORMANCE AND PATIENT OUTCOMES CAN VARY DRAMATICALLY.

For example, technology has made cancer screening for women and eye exams for people with diabetes effective preventive measures. But the number of people receiving these routine screens at appropriate intervals fluctuates significantly across health plans. Even in the top performing plans, many individuals still do not receive preventive screens.

Currently, there is no guarantee that health care is safe and effective or provided in a timely and efficient manner. According to the Institute of Medicine (IOM), up to 98,000 Americans die each year from medical errors during hospitalizations.³ In fact, there are more deaths in hospitals each year from medical errors than there are from motor vehicle accidents, breast cancer, or AIDS.

Reviewing health plan performance regularly enables you to better assess what you are buying with your health

care dollars. And incentives, when used effectively with health plans, make a business case for quality.

In recent interviews, Bruce Bradley from General Motors (GM) and Dr. Arnold Milstein of the Pacific Business Group on Health (PBGH) and William M. Mercer, Inc. (Mercer) explain why investing time and effort to create performance incentives for health plans can pay off in quality care and financial savings. Bradley is the Director of Managed Care Plans at GM, which contracts with 134 health maintenance organizations (HMOs), providing health benefits for more than 1.25 million people nationally. Milstein is the National Health Care Thought Leader for Mercer and the Medical Director for PBGH, the largest health care purchasers' coalition in the United States. PBGH purchasers represent 3 million employees, retirees, and their families.

WHY CREATE PERFORMANCE INCENTIVES FOR HEALTH PLANS?

Bruce Bradley, General Motors:

"Like most employers, GM evolved from paying premiums to selecting and negotiating health plan contracts. We believe we can only control costs through improvements in quality of care—that's why we took the next logical step and implemented incentives.

We know that best practices in care delivery are not being implemented as broadly or as quickly as they should be. So we began using incentives to create a business case for quality and get better value.

GM's incentives with health plans are an extension of our general approach to working collaboratively with suppliers to improve the quality of our products. Our role as a purchaser includes stimulating improvements in performance through better contracts and incentives."

Dr. Arnold Milstein, Pacific Business Group on Health:

"As a large coalition of public and private purchasers, PBGH believes it is part of our job to make the business case for quality more explicit and visible through performance-based incentives. Quality improvement in our health care system is not only feasible and necessary, but also long overdue.

Unfortunately, poor quality and its costs are invisible to most purchasers, patients, and providers. According to research cited by the IOM, the chances of a patient getting what's going to help them—and avoiding what's more likely hurting them—is about 50 percent. Consequently, the magnitude of the problem is under-addressed."

HOW DOES A PURCHASER GET STARTED?

ALTHOUGH CREATING AN EFFECTIVE INCENTIVE PROGRAM FOR HEALTH PLANS CAN BE A TIME-CONSUMING PROCESS, THE RESULT IS WELL WORTH THE EFFORT.

Getting started requires first considering four variables:

- > What are the environmental factors in the marketplace?
- > What type of incentive strategies are available to you?
- > What are the areas of performance you wish to target?
- > What are the available data on health plan performance?

Step 1 features a series of questions. The answers will steer you toward finding the specific information you need to create a successful health plan incentive program.

STEP 1

ASSESSING THE HEALTH CARE MARKETPLACE

Before determining which types of performance incentives to use, consider environmental factors in the health care marketplace, including: your financial situation, as well as that of each contracted health plan; your leverage with each plan; and the overall health care marketplace.

THE FINANCIAL ENVIRONMENT

You can use financial or non-financial incentives with health plans. A good idea is to use a combination of incentives and make changes to your program over time based on your experience and the marketplace environment.

How financially solvent is the health plan? Is the health plan making or losing money on my line of business?

Financial incentives that are small, or that involve downside risk for the health plan, are unlikely to be effective if the plan believes the contract is underfunded or is concerned about financial solvency.

Similarly, if health plans are losing money on your business, an incentive strategy that focuses on financial penalties is more likely to create animosity than positive change. When dealing with a plan that has significant financial concerns, you may be more effective using non-financial incentives or financial awards with no downside risk for the health plan.

Since a plan will need to increase administrative expenditures or re-allocate existing resources, you should first consult with plans when designing incentive programs. Health plans sensitive to operating margins will weigh the upfront costs against financial rewards or savings before determining their level of commitment.

Am I able to provide additional funding as an incentive?

When contemplating financial incentives, you should be certain you have the financial resources to support and maintain an incentive strategy over time. In short, establishing an effective incentive approach requires a multi-year financial commitment.

Remember, incentive programs do not typically result in immediate improvements. In the initial year of an incentive program, you and the health plan are on a learning curve.

If you do not have the cash flow, you may want to consider a strategy involving withholding a portion of premiums or using non-financial incentives. Examples of incentives with only marginal administrative costs for you include:

- > Sharing administrative data and plan profiles with health plan staff.
- > Publicizing plan performance to key stakeholders and employees.

- > Reducing administrative burdens on high performing plans.
- > Terminating contracts or freezing enrollment in poorly performing plans.

How would a health plan respond to a financial penalty or withholding as an incentive to improve performance?

Depending on the health plan's profit or loss on your business—and their interest in retaining that business—incentive strategies with significant financial penalties could result in a decision to no longer compete for your business.

Financial penalties can be effective in maintaining a floor for health plan performance and obtaining more complete and timely data from health plans. However, financial penalties and withholds may be less effective if plans budget for the potential loss or make it up when negotiating premiums.

LEVERAGE WITH YOUR HEALTH PLAN

Before embarking on a specific incentive-based strategy, you should consider the leverage you have with existing and potential health plans.

What portion of the health plan's business do I represent?

Incentive programs are more likely to be effective when you or a purchasing coalition represent a significant portion of a health plan's business. You may also have significant leverage if the plan perceives your business to be desirable (e.g., prestigious or influential).

If you lack individual leverage to obtain plan participation on your terms, consider soliciting other employers' participation in the program. You may also leverage local efforts to improve performance by coordinating with community-wide improvement projects. Additionally, focusing on projects that are visible and meaningful will increase the likelihood of plan participation.

How many competing health plans are in the marketplace?

In markets with meaningful competition, you typically have more leverage and your strategies have a greater likelihood of being effective at motivating change. Many markets have consolidated recently and employers are faced with few choices and less competition than ever. If you have a small number of health plans in your market, you may want to explore joining or developing a coalition of local purchasers to create sufficient leverage with the dominant health plans.

How do incentives affect my relationship with the health plan?

Your relationship with a health plan is crucial to the development and maintenance of any successful program. Incentives are more effective when you have a good working relationship, including open and regular communication. In the absence of a good relationship, an incentive program can result in contentiousness without adding value.

THE OVERALL MARKETPLACE

Because marketplace conditions can fluctuate, it is important to consider impending changes on the health care horizon before selecting an incentive approach and performance area to target.

What significant changes, mergers, or acquisitions are likely in the next year?

When anticipating marketplace and health plan changes, consider the effect these changes will have on incentives. For example, marketplace changes can have a significant effect on the availability of reliable performance data.

You can minimize the impact of these changes by focusing on performance measures, time periods for measurement, and membership characteristics that are less likely to be affected by change. Consult with contracted health plans to establish a feasible approach for collecting comparable data for pre- and post-merger or acquisition time periods.

Do I anticipate significant changes in health benefits?

Examine the potential effect of benefit design changes on health plan incentives. In particular, consider the likely impact of new mandated health benefits such as behavioral health parity.

Benefit changes can affect the availability of comparable health plan data over time and the utilization of services by employees. You can minimize potential challenges by taking changes into account when selecting areas to target and identifying data sources.

STEP 2 TARGETING PERFORMANCE AREAS

In developing health plan incentives, you must select specific areas of performance to target for improvement. For example, you may identify administrative measures—such as customer service telephone line response indicators—or clinical measures relating to access to care.

When considering areas to focus on, you should carefully review performance data and the limitations of readily available data. Effective incentive programs are dependent on reliable data that accurately reflect performance. Staff expertise and resources are also important when determining which performance areas to target.

The following checklist will help identify potential areas of performance that may link effectively with incentives:

- [] Review the demographics of the members enrolled in health plans and available data on their prevalent health conditions.
- [] Identify performance areas where valid measures can be obtained.
- [] Use standardized measures such as those from the Health Plan Employer Data and Information Set (HEDIS)⁴ including the Consumer Assessment of Health Plans (CAHPS), where applicable.
- [] Obtain information on local and national performance benchmarks from NCQA and other sources to identify which health plans are not meeting achievable benchmarks.
- [] Examine available data on plan performance and carefully consider areas where performance varies considerably.

If you have not previously measured health plan performance or tried to assess the health care and service needs of your employees, compiling the information for the checklist items may be time-consuming. However, this process is a critical step in developing an incentive program that is meaningful and effective.



Based in part on the health care needs of your employees, consider exploring a range of topics for performance incentives, including:

- > Improving care for people with diabetes.
- > Increasing early detection of cancer in women.
- > Increasing the use of beta blockers after heart attacks.
- > Reducing preventable errors in hospitals.
- > Reducing claims processing errors.
- > Improving response on health plan customer service telephone lines.

When you prioritize potential areas, you should consider the following criteria:

- > Importance of the targeted area for the purchaser and the plans.
- > Ease of measuring plan performance and the availability of data.
- > Potential to coordinate with other purchasers, health plans, and community improvement efforts.
- > Likelihood that the plan's performance would not be affected by confounding factors during the evaluation period.
- > Availability of required staff and resources.

After prioritizing the potential improvement areas, consider the amount of leverage your incentive program is likely to have with the health plans. To effectively motivate health plans to improve, the number, range, and difficulty of targeted performance areas must be comparable to the power of the incentives being offered.

STEP 3 DEVELOPING PERFORMANCE MEASURES

Once you have identified the performance areas that can be linked to incentives, the next step involves examining data and calculations to measure results.

You should be aware that existing measures may meet your needs. When seeking to improve diabetes care, for example, you could refer to diabetes care measures in HEDIS and the Diabetes Quality Improvement Project (DQIP)⁵ as indicators of plan performance.

From these already established measurement sets, you could then select measures identifying the percentage of members with diabetes who had:

- > Blood sugar (hemoglobin A1c) tested
- > Poorly controlled blood sugar (hemoglobin A1c over 9.5 percent)
- > Lipid profile blood test performed
- > Controlled lipid levels (LDL levels less than 130 mg/dL)
- > Dilated eye exams performed
- > Kidney disease (neuropathy) monitored
- > Blood pressure controlled

Some of these measures can be calculated from the health plan's claims data. Other measures require purchasers or health plans to review medical records to collect data on health plan performance. The advantage of using established standardized measures is that they are very clear on how data should be collected and used in calculating plan performance measures.

In a case with no standardized performance measures, the onus is the purchaser—in consultation with providers—to develop the indicators and the processes by which data will be collected and analyzed.

Performance measures must be explicit and agreed upon at the start of the incentive program. Indicate exactly how health plan performance will be measured, the measurement period, and what sources of data will be used.

When developing an incentive program, consider readily available data such as:

- > Administrative data (from the purchaser and the health plan).
- > HEDIS or other standardized clinical care data.
- > CAHPS or other standardized member satisfaction data.
- > Medical records.
- > Data collected as part of specific quality improvement projects.

In reviewing potential data sources, determine if relevant performance data can be comparable, complete, and accurate across contracted plans and over time. Also, consider the likely cost and difficulty of obtaining reliable data and whether the burden falls on the plans or on you to obtain it.

You need to create a mutually acceptable mechanism for verifying provider performance. Options for verification include:

- > Independently collecting and analyzing data on performance.
- > Auditing a sample of data collected by each contracted health plan.
- > Using data sources that are audited by other organizations.

STEP 4 ESTABLISHING PERFORMANCE TARGETS

After selecting the measures of performance, you then need to set clear targets for each measure. For example, if you were seeking to increase the percentage of people with diabetes receiving annual eye exams, you could establish incentives to reach an absolute performance target of 65 percent of all diabetic patients receiving documented eye exams.

Alternatively, you could create an incremental performance target. In this scenario, a plan must

HOW PBGH EMPLOYERS DECIDE WHICH PERFORMANCE AREAS TO TARGET

Dr. Arnold Milstein, Pacific Business Group on Health:

“At PBGH, we identify opportunities for improvement on cost, quality, and customer service performance measures. Every year, PBGH employers review their wish list for performance changes and identify top priorities. The employers make tradeoffs keeping in mind the number of performance initiatives that PBGH and the health plans can support at a given time, and the relative importance of any individual initiative.

PBGH also considers the availability of data. Generally, we attempt to use performance data that the health plans already collect and use standardized reporting formats where they exist. We use a mix of ‘off the shelf’ national standards of plan performance such as HEDIS, and customized measures based on specific goals.”

increase the percentage of people with diabetes receiving annual eye exams by at least 10 percent above the plan’s baseline performance level in order to receive a financial award.

You should also consider whether to use plan-specific performance goals or uniform standards across all plans. Consider an employer that contracts with three plans. Documentation suggests that one plan provides retinal eye exams to 30 percent of people with diabetes, another provides exams to 45 percent, and a third plan provides to 50 percent.

An incentive approach that rewards plans reaching a benchmark of 60 percent in the following year is

unlikely to provide an incentive to the first or second plan since the goal will appear unattainable. But if the employer selects a lower performance target, the third plan will be rewarded for very little or no improvement.

As an alternative, the employer may want to set plan-specific thresholds for performance or link the award to achieving a specific percentage increase. In determining performance targets with multiple health plans, consider factors such as the relative size of enrollment in each plan and the population differences across plans. For certain insurers, risk adjustment methods may need to be applied to plan data to ensure equity.

**STEP 5
DETERMINING THE INCENTIVE**

Not all types of incentives are appropriate for all types of performance measures. For example, penalties may be most appropriate to establish a floor for acceptable performance or to encourage plans to submit timely and accurate data. An incentive can be created to discourage delayed or inaccurate data submissions, with penalties accruing on a daily basis.

If an organization is developing an incentive to promote quality improvement in disease management, a financial incentive may be more effective than publicizing a plan's performance. Health plans would be concerned about adverse risk selection resulting from being publicly recognized as having the best disease management program.

HOW THE NEGOTIATING ALLIANCE DECIDES WHICH INCENTIVES TO USE

Dr. Arnold Milstein, Pacific Business Group on Health:

“Purchasers have a variety of tools or ‘levers’ to promote improved performance by health plans. PBGH considers both incentives and disincentives, and assesses which are most likely to promote better value. We consider financial and other resources available to PBGH employers, as well as to the health plans. And we assess the extent to which employers and health plans are willing to take financial risk to ensure improvements.

PBGH's requires health plans to place 2 percent of premiums at risk, based on meeting specific

levels of performance. When we identify the performance requirements, we seek health plan areas that can be reliably measured and determine which goals could be met within one year.

Since health plans agree to place a portion of their premiums at risk based on performance, there is no downside for employers. But employers also need to consider health plans' perspective.

One thing is for sure: we know we are trying to encourage health plans to make difficult changes in the way they do business.”

HOW ARE INCENTIVES TARGETED?

WHETHER YOU'RE TRYING TO STIMULATE CHANGE IN CLINICAL CARE, ADMINISTRATIVE SERVICES, CUSTOMER SATISFACTION, OR ACCURATE DATA REPORTING, YOU MAY WISH TO LINK INCENTIVES TO PERFORMANCE MEASURES INCLUDED IN THE HEDIS. NCQA SPECIFIES HOW HEALTH PLANS SHOULD COLLECT, AUDIT, AND REPORT ON THEIR PERFORMANCE FOR EACH HEDIS MEASURE. AN NCQA COMMITTEE OF PURCHASERS, CONSUMERS, HEALTH PLANS, PROVIDERS, AND POLICYMAKERS REVIEWS AND UPDATES HEDIS ANNUALLY.

Many purchasers use HEDIS results to identify opportunities to prioritize measures. HEDIS results are available directly from your contracted plans or from NCQA publications (www.ncqa.org). HEDIS includes more than 50 health plan performance measures across the following eight domains:⁶

1. Effectiveness of care
2. Access/availability of care
3. Satisfaction with the experience of care (based on CAHPS surveys)⁷
4. Health plan stability
5. Use of services
6. Cost of care
7. Informed health care choices
8. Health plan descriptive information

To start, you should select a subset of measures and consult with your contracted health plans on the number and range of measures selected. Clinical measures applied to incentives are often from the Effectiveness of Care and Use of Services domains. In this scenario, you may develop incentives to increase the percentage of heart attack patients receiving beta blockers and the percentage of women receiving cancer screenings.

In addition to standardized performance measures, you may also use incentives to stimulate quality improvement in areas that are unique to your needs. These purchaser-specific measures may focus on aspects of plan performance not addressed by HEDIS or may require the plan to complete a specific set of process steps.

In light of the IOM's recent series on the negative impact of medical errors, some purchasers have begun to develop health plan incentives to specifically improve patient safety. The Leapfrog Group (www.leapfroggroup.org), initiated by leading purchasers from the Business Roundtable, is promoting the use of three patient safety measures focusing on inpatient hospital performance. Many purchasers are trying to create incentives for health plans to work with hospitals on these and other patient safety initiatives.

IMPLEMENTING AN INCENTIVE PROGRAM

WORKING COLLABORATIVELY WITH HEALTH PLANS THROUGHOUT THE PROCESS WILL GO A LONG WAY TOWARD ENSURING A SUCCESSFUL OUTCOME. YOU MUST FIRST OFFER HEALTH PLANS SUFFICIENT NOTICE OF YOUR INTENT TO USE PERFORMANCE-BASED INCENTIVES. YOU SHOULD ALSO REVISE YOUR CONTRACTS TO REFLECT THE NEW INCENTIVE PROGRAMS AND THE PERFORMANCE EXPECTATIONS.

Prior to initiating an incentive program, both you and the health plan should have the same understanding as to what performance is going to be measured, how performance is going to be assessed, and which data and calculations are involved.

Creating the Timeline

Once the type of incentives and the targeted performance areas are decided on, develop a reasonable timeline for achieving measurable results.

When developing a timeline, you should:

- > Consult with health plans to ensure the timeline is realistic and achievable.
- > Talk to both the operational and clinical staff, since each group is likely to have different perspectives and competing priorities.
- > Clearly establish baseline performance and the period of time during which performance will be measured.
- > Consider major changes in your health plan contracts likely to affect performance or data over time.
- > Minimize potential challenges by coordinating measurement periods with other key events such as open enrollment periods.

Developing a Process

To ensure a well-defined, collaborative process, you should convene routine meetings and ongoing discussions with health plans throughout developing, implementing, and evaluating your incentive program.

To facilitate the program, you can:

- > Designate a work group of health plan staff and your own staff to roll out the incentive program.
- > Establish an advisory committee of key stakeholders to assist in designing and implementing the program.

Agenda items for the work group or advisory committee may include:

- > How best to assess baseline performance for each health plan?
- > Which data sources to use?
- > What methodology is best for calculating performance?
- > How long the time period of measurement should last?

While there are advantages to not changing the incentive program dramatically every year, you should at least consider modifications in the approach based on your experience.

CHALLENGES AND WAYS TO OVERCOME THEM

IN DEVELOPING AND USING HEALTH PLAN INCENTIVES, YOU SHOULD EXPECT TO FACE A NUMBER OF CHALLENGES. THE FOLLOWING LIST IDENTIFIES THREE COMMON PROBLEMS AND OFFERS SUGGESTIONS FOR AVOIDING THEM.

PROBLEM 1 UNREALISTIC EXPECTATIONS FOR HEALTH PLANS AND/OR PURCHASERS

You should select performance measures and thresholds for health plans that are a stretch, but still achievable. By reviewing national and local health plan performance results, you can better assess the extent to which your expectations are feasible.

Also consider the resource commitment necessary to support and manage an incentive program. By working collaboratively, consulting with clinical and operational staff and talking to experienced employers and consultants, you can better gauge the effort necessary on both sides.

To keep expectations in check:

- > Focus on just a few performance areas at first.
- > Consult with key plan and purchaser staff in setting timelines, performance targets, and overall scope of program.
- > Keep in mind that resources are limited; explore competing priorities and adjust targeted areas and timelines accordingly.
- > Solicit feedback from involved staff and identify roadblocks throughout.
- > Prepare to make modifications to targets or timelines if original assumptions appear unrealistic.

PROBLEM 2 DELAYED IMPLEMENTATION AND FEEDBACK

When feedback or an award is distant from the performance measurement period, it's less likely to be successful over time. That's why you should plan ahead to make resources available and promptly evaluate performance and implement incentives. A timeline for

key action steps should be developed and distributed in advance to accountable staff.

To ensure timely application:

- > Start small with a manageable number of performance measures.
- > Keep evaluation of performance and calculation of incentives simple.
- > Determine in advance exactly who will collect data, which data calculations and validations will be performed, and how data will be presented.
- > Assess resources promptly and identify if more are required to provide timely feedback and application of incentives.

PROBLEM 3 INCENTIVES BECOME STALE OVER TIME

By routinely using the same performance measures, thresholds, and incentives year after year, health plans may begin to lose interest. You should regularly assess your programs and make modifications based on lessons learned.

Incentive arrangements should also reflect important health plan changes or new purchasing priorities. Strike a balance between not changing the incentives at all and altering the program every time the plan undergoes a change.

To maintain health plan interest:

- > Evaluate the incentive program routinely and make modifications as needed.
- > Solicit recommendations from employees, health plans, and other stakeholders at least once a year.
- > Reassess whether incentives are linked to measures that are important to your employees and meaningful to health plans.

EXAMPLES OF HEALTH PLAN INCENTIVES

CREATING A SUCCESSFUL PROGRAM CAN BE A COMPLICATED PROCESS. THE FOLLOWING EXAMPLES OF DIFFERENT TYPES OF INCENTIVES—AND SUCCESSFUL APPLICATIONS—GIVE A CLEARER IDEA OF HOW TO FORM AN EFFECTIVE PROGRAM.

PERFORMANCE GUARANTEES

A performance guarantee is a financial incentive that involves making a portion of your health plan's premium contingent on achieving specific thresholds in targeted areas. For self-funded plans, you could use a similar approach that puts a portion of the administrative fee at risk, based on performance.

Example: PBGH

PBGH, a prominent employer coalition representing 45 major purchasers with employees in California and Arizona, has significant experience using performance guarantees to successfully improve administrative and clinical quality performance.

On behalf of its Negotiating Alliance members,⁸ PBGH issues a joint request for proposals and negotiates annual performance targets with each health plan that contracts with its members. PBGH requires plans to place 2 percent of their premium at risk for achieving designated performance targets. The individual employers hold the contracts with the health plans, with the employer receiving any refund for a plan not meeting its target.

Annual performance areas are identified by PBGH and the individual thresholds for plan performance are developed collaboratively. The performance areas do not change rapidly; many initiatives are carried over from the previous year. PBGH negotiates premium rates with an expectation that plans will continue to meet the thresholds.

PBGH targets emphasize areas of performance that can be reliably measured and include customer service, member satisfaction, and clinical quality. They set

performance targets according to the overall performance of each plan, not performance specific to PBGH or individual employer members.

In addition to HEDIS measures, PBGH also develops unique plan performance measures. For example, a portion of the performance guarantee is based on health plan participation in specified PBGH projects, such as:

- > A collaborative effort to measure member experience and satisfaction among major California medical groups.
- > A diabetes quality improvement project that promotes “best practices” and clinical guidelines, jointly endorsed by PBGH and participating health plans.

In 2001, PBGH began targeting plan performance related to patient safety initiatives promoted by The Leapfrog Group. PBGH's initiatives have focused on two distinct efforts. The first is to educate consumers about patient safety initiatives. The second fosters a joint commitment among health plans to encourage hospitals to publicly self-certify their status on the three patient safety measures from Leapfrog.

Over time, PBGH has chosen to negotiate fewer performance targets, believing that plans will be more effective by focusing their limited quality improvement resources. The coalition has also added new measures and dropped other ineffective measures over the years. In the initial year of implementing a new performance target, PBGH may require health plans to submit baseline data, but not link plan performance results to financial incentives.

PERFORMANCE BONUSES

Performance bonuses offer a financial incentive for health plans directly tied to achieving specific thresholds in targeted areas. Gateway Purchasers for Health and The Rhode Island Department of Human Services offer each contracted health plan a 1 percent premium bonus based on the plan's performance relative to selected quality measures. These two purchasers use slightly different approaches in their bonus incentive programs.

Example: Gateway

Gateway accounts for approximately \$100 million in annual health care expenditures in the St. Louis area. The coalition offers health plans a bonus of up to 1 percent of health care premiums, contingent on achieving specific performance targets. The coalition pays plans the additional 1 percent up front and recoups funds at the end of the year based on performance.

Gateway uses five health plan performance indicators, including two member satisfaction measures and three clinical quality measures. The coalition coordinates the administration of the CAHPS survey, the standardized instrument for gathering member satisfaction data. All contracted plans are required to submit the clinical measures from a certified HEDIS auditor.

For each of the five performance measures, Gateway assesses the plan's performance compared to a pre-negotiated target. Health plans reimburse the coalition for any measures that do not achieve their targets. Gateway then distributes the money back to the employers in the coalition.

Gateway has only recently begun linking plan performance to financial incentives. Previously, the coalition measured plan performance and negotiated contract language requiring them to meet specific performance targets. However, in a number of health plans, the negotiated contract language never made

its way through the organizational structure to the quality departments and medical directors with responsibility for implementing improvement initiatives.

In the first year that Gateway linked plan performance to financial incentives, all plans had to return at least some amount to the employer coalition. According to executives at Gateway, the new financial implications of the performance incentives seemed to get the health plans' attention. In Gateway's experience, the negotiation of performance measures did not appear to have a noticeable impact until the plans had to pay for not achieving their targets.

Example: Rhode Island

Rhode Island leverages a pool of bonus money that puts a spotlight on key performance areas for health plans participating in RIte Care, the state's Medicaid managed care program. In 1997, the state selected performance targets with a long-term view by establishing thresholds for a three-to-five-year period.

To assess plan performance, the state uses 21 performance measures in three general categories: administrative services, access to care, and clinical quality.⁹ The indicators and the thresholds for performance were determined through extensive collaboration between the state and the health plans. Since state fiscal year 1999, each RIte Care plan is eligible to receive a bonus of up to 1 percent of premiums annually, based on performance relative to these measures and to target thresholds.



WHY GM USED EMPLOYEE PREMIUM CONTRIBUTIONS AS INCENTIVES

Bruce Bradley, General Motors:

“Most employers link payroll contributions to a set dollar amount or a specific percentage of health care premiums. Unfortunately, this approach does not create a business case for quality.

The cost of the premium is not the only element that GM wants employees to consider. We want them to think about the overall value of the health plan—are they getting more for their money or not?

Employees that select higher performing plans pay less toward their premiums than if they select a lower rated plan with comparable benefits. By using a payroll contribution strategy that reflects performance on cost and quality, we’ve successfully shifted enrollment to higher value plans.”

Rhode Island attempts to make the administration of the incentive program as simple as possible for health plans and the state. They use encounter data to measure health plan performance on two access measures and all seven clinical measures, which account for more than 70 percent of the total points for calculating bonuses.

The other measures are assessed as part of annual site visits to each health plan. Financial awards are based on plan performance, as well as accuracy and completeness of the data submission. In the administrative area, financial awards are based on the plan’s structural capacity to perform the tasks and track the results, as well as their ability to demonstrate actual performance relative to the standards.

In all three areas, the plans’ actual performance is the main driver of the amount of any financial award. In state fiscal year 2001, Rhode Island paid bonuses totaling more than \$830,000. On average, health plans obtained 62 percent of the maximum bonus.

ADJUSTING PREMIUM CONTRIBUTIONS

Adjusting the premium contributions for employees to reflect differences in health plan performance is another type of financial incentive. General Motors has used this premium approach effectively.

Example: GM

In the 1990s, GM began adjusting premium contributions for employees based on each plan’s cost and quality performance. GM annually reviews the efficiency, quality, and benefit designs of health plans to determine which are providing the best value for the price. Cost and quality measures are equally weighted to determine a plan’s overall score. To develop the cost score for each HMO, they compare HMO premiums to the premiums for local indemnity plans. An HMO’s quality score is developed based on:

- > Response to a request for information and related site visits by GM.
- > HEDIS and CAHPS scores for quality and member satisfaction.
- > NCQA accreditation status.

Over time, GM has refined its scoring methodology to more accurately assess the efficiency, quality, and overall value. In addition, they recently added components on medical errors and patient safety measures.

Based on the overall score, GM assigns health plans to a performance category such as benchmark, strong, good, average, or poor. They then establish employee premium contributions so that HMOs with the highest scores have the lowest cost to employees. In 2001, employee contributions for a family plan ranged from \$35 for enrollment in a

top-ranking “benchmark” plan to \$190 for enrollment in a health plan ranked “poor.” This gives employees a financial incentive to select the higher value plans, and gives plans an incentive to perform better in order to increase their enrollment.

At open enrollment, GM provides each plan’s category ranking and its premium contribution rates. The benefit plan description also provides comparative quality and member satisfaction data on area plans. By adjusting premium contributions and sharing performance data with employees, GM increased enrollment in benchmark health plans by 55 percent between 1996 and 2000. Poorly rated plans lost 59 percent of GM enrollment during this same period.

PUBLICIZING HEALTH PLAN PERFORMANCE

An effective method of non-financial incentives is to use a variety of publicity approaches to educate employees, providers, and other stakeholders about the relative performance of different health plans and publicly distribute the results as part of open enrollment information.

You could also distribute a health plan report card or comparison charts for employees making enrollment selections. HEDIS measures and member satisfaction survey results are often the types of quality indicators used in report cards. Often, health plans and purchasers indicate that the simple act of distributing comparative performance data in a public forum creates an incentive for plans to improve.

Some public purchasers have also used stakeholder meetings to publicize plan performance. For example, the Iowa Medicaid agency requires its behavioral health contractor to report to the advisory council regarding the contractor’s performance on 16 quality and access indicators. The state and the contractor indicate that mandatory face-to-face presentation by accountable contractor staff is an effective incentive for improvement.

PBGH uses another incentive approach involving publicizing performance. Each year since 1997, PBGH has presented a “Blue Ribbon Award” to a plan that has demonstrated leadership in delivering high quality, affordable health care in California. PBGH promotes the Blue Ribbon awardees in a press release on the HealthScope website (www.healthscope.org) and encourages employers to also publicize the winners of the awards.

SHARING INFORMATION WITH HEALTH PLANS

Large employers can also share comparative performance information with health plans as a means of instilling more competition in a marketplace. Verizon shares comparative cost, member satisfaction, and membership data with contracted managed care plans. The company compares each plan to local competitors and examines membership trends. This assists plans in understanding their performance and also provides a significant incentive for improvement.

GM uses a similar data-sharing philosophy with its contracted health plans in providing information on how cost and quality scores are calculated. To foster more collaborative relationships, they have established a “Top 11 HMO Project”—an innovative approach to diabetes management, pharmacy management, and patient safety initiatives—as a means for driving more rapid improvements.

In GM’s experience, plans will work together and learn from each other. Most plans want to improve their performance and appreciate GM’s efforts to assist them in their efforts. They’ve successfully created a forum for plans to share best practices and agree on areas to work on together.

Example: DMA

The Division of Medical Assistance (DMA) in Massachusetts uses a different type of information-sharing approach with its Medicaid managed care

plans. DMA jointly negotiates annual quality improvement goals with each health plan. Goals are related to contractual performance expectations and achievement of best practices.

Some improvement goals are common to all plans. Other improvement goals are specific to certain plans that have greater opportunity than others for improvement or have different enrolled populations. Each goal and measure is negotiated and well-documented. The process, method, and timeline for measuring performance are also clearly established.

Semi-annually, the health plan reports on its progress toward the negotiated goals during quality improvement status meetings. DMA scores health plans on performance toward the goals and measures and shares the scores with key stakeholders and all contracted plans.

PENALTIES FOR POOR PERFORMANCE

There a variety of approaches to create disincentives for poor performance including freezing health plan enrollment, sanctioning plans using financial penalties, and terminating contracts with underperforming

plans. You should use these types of disincentives sparingly; they should create a floor for minimally accepted performance, rather than be used as a mechanism to improve performance. For example, some large public purchasers have imposed financial sanctions on plans for late payment of claims and for incomplete or delayed submission of encounter data.

Purchasers such as GM have terminated contracts or frozen enrollment in health plans that performed poorly on the company’s designated measures. GM has also stipulated with poor performing plans that their contract is dependent on the plan’s efforts and demonstrated ability to improve within a specified time period. If the plan does not improve sufficiently, it will no longer be offered. In GM’s experience, most plans put in the necessary effort.

In another example, PBGH recently warned a health plan that its members would take a range of actions—from notifying members to freezing enrollment to terminating contracts—if the plan proceeded with its intent to let its NCQA accreditation lapse. The health plan subsequently altered its position and decided to work toward retaining its NCQA status.

INSIGHTS AND ADVICE FROM A LEADING PURCHASER AND CONSULTANT

THE FOLLOWING TWO INTERVIEWS WITH INDUSTRY INSIDERS PROVIDES GREATER INSIGHT INTO THE OVERALL HEALTH CARE MARKETPLACE.

BRUCE BRADLEY OF GENERAL MOTORS CORPORATION

Bruce Bradley became Director of Managed Care Plans for GM Health Care Initiatives in 1996 after five years as Corporate Manager of Managed Care for GTE. He also spent nearly 20 years in health plan management. He was formerly Executive Director of the Matthew Thornton Health Plan in Nashua, N.H., as well as President and CEO for the Rhode Island Group Health Association. Bradley was co-founder of the HMO Group, a national corporation of 15 non-profit, independent group practice HMOs, and the HMO Group Insurance Co., Ltd.

Bradley has gained national recognition for his work in achieving health plan quality improvement and for his efforts in developing HEDIS measurements and processes. He is a board member of the National Forum on Health Care Quality Measurement and Reporting, a member of the board of the Foundation for Accountability (FACCT), a board member of the Academy for Health Services Research and Health Policy, and a founding member of The Leapfrog Group steering committee.

Q: How has GM's multi-faceted incentive approach motivated health plans to improve performance?

A: We evaluate the cost and quality of health plan services and rank plans annually. Over time, GM has seen most health plans improve and move up in the categories we use to adjust employee premium contributions. In one region, for example, we've seen health plans move up one category for each of the past three years. In Michigan, two plans recently moved up to national benchmark status, the highest ranking possible.

In recent years, GM has been more successful in obtaining health plan improvements in the quality component of the scoring, as opposed to the cost component. This is partly reflective of the overall financial conditions in the marketplace. But improvements in quality still translate into improved value for employers and employees.

Health plans clearly see that GM employees have migrated to higher value plans. Consequently, plans take our evaluations seriously and generally want to improve performance. We share our findings and our methods and we use an 'open book' approach to promote collaboration.

In our experience, motivation to improve is at the high end of the scale. The better performing plans are also the plans that improve faster. 'Underdog' success stories do occur, but are less frequent and usually can be linked to a leadership or cultural change that promotes breakthrough improvement at a particular health plan.

GM has also frozen enrollment and ultimately terminated contracts with plans that continue to rank very low. Those are incredibly effective disincentives for health plans to improve performance.

Q: GM is a very large company, covering more than 1.25 million lives. What advice do you have for smaller employers?

A: As a first step, employers interested in using health plan incentives should contact their local business coalition and the National Business Coalition on Health (www.nbch.org). Business coalitions that are active in health care purchasing can provide useful advice and can be a great source for identifying available data.

Employers should use tools and information already available rather than re-invent the wheel. For example, by using the standardized ‘Managed Care Request for Information’ measures established by the V8 group, now part of the NBCH, employers can save time and avoid unnecessary burdens on health plans.

I also encourage employers to look to accreditation organizations such as the NCQA (www.ncqa.org). NCQA is also a good source for employers to obtain quality and patient satisfaction data on health plans in their area and comparisons to national standards.

Consider both cost and quality when creating incentives for health plans. An employers’ credibility with employees and health plans depends on the employer’s attention to quality performance by health plans. Without the focus on quality, it looks like the employer only cares about the bottom line.

Q: What lessons have you learned?

A: Employers must link health plan quality performance measures with financial measures. We miss the boat when we focus exclusively on costs or on only one dimension of quality.

Employers should use a range of incentives and disincentives, but the primary emphasis should be on positive incentives for improvement. With extensive use of penalties, employers risk putting health plans in a defensive position. Instead, selective use of sanctions—such as freezing enrollment or terminating contracts with poor performing plans—is an effective tool for employers seeking better value from their health plans.

**DR. ARNOLD MILSTEIN
OF WILLIAM M. MERCER, INC. AND PBGH**

Dr. Arnold Milstein is a Worldwide Partner and National Health Care Thought Leader at William M. Mercer, Inc. Milstein is also the Medical Director of the Pacific Business Group on Health (PBGH), the largest health care purchasers’ coalition in the United States.

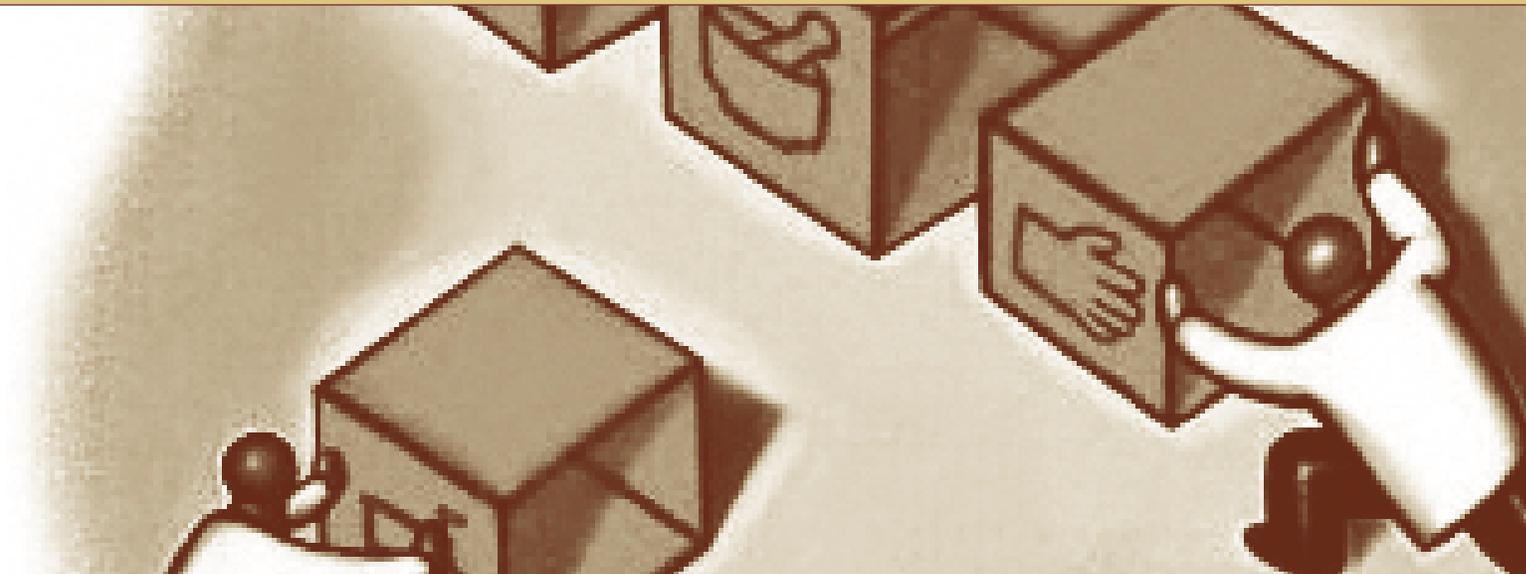
Business Insurance magazine selected Milstein as “one of the 20 people who has made a difference in employee benefits management in the past 20 years.” And the *New England Journal of Medicine* described him as a pioneer in efforts to advance the quality of health care.

Milstein’s work focuses on improving health care programs for large purchasers, providers, and government. His 30 book chapters and published articles have centered on managed care program design. He is also a member of NCQA’s national committee to develop HEDIS.

Q: What advice would you give employers for using incentives with health plans?

A: Employers should actively consider, and strategically apply, the full range of levers available for affecting health plan performance such as: performance guarantees, enrollment freezes, plan termination, publicizing plan performance, and creating incentives for employees to switch to higher performing plans.

In using health plan incentives, employers should work collaboratively and creatively with other employers and purchasers to leverage their strength. They should use standardized performance measures where available, such as NCQA accreditation and HEDIS results for health plans.



I would advise employers not to tie too many performance measures to a single incentive with health plans; it dilutes the emphasis and importance on any single measure. Employers should also balance health plan quality improvement initiatives with cost considerations.

Q: What should benefit managers do to make the business case for quality?

A: My advice is to first get the CEO and senior management on board. Give them the published numbers on the rate of quality failures in our health care system. Use information from the Institute of Medicine and The Leapfrog Group. Make sure that the CEO and other key management leaders understand that problems with quality of care do not just apply to hourly workers. It applies to them, too.

Second, I would educate consumers and unions about the economic and human cost of poor quality.

I would also highly recommend that purchasers review the variety of levers available and apply them to health plans and providers. Only with purchasers using their leverage in the marketplace can we make the business case for quality more explicit.

Q: What lessons have you learned?

A: Employers need to consider a variety of mechanisms to leverage their power. Purchasers within a coalition can use different types and levels of incentives for sending consistent messages to health plans to collaboratively promote better performance.

Benefit managers typically do not have enough freedom to use performance incentives. Support is needed from the CEO all the way to the unions. That's the only way they will effectively leverage their power to achieve and sustain desperately overdue performance improvements.

WHO HAS EXPERIENCE WITH HEALTH PLAN INCENTIVES?

LARGE EMPLOYERS AND EMPLOYER COALITIONS PIONEERED THE DEVELOPMENT AND USE OF INCENTIVES WITH HEALTH PLANS. MORE RECENTLY, A NUMBER OF PUBLIC SECTOR PURCHASERS HAVE USED PERFORMANCE INCENTIVES WITH CONTRACTED HEALTH PLANS.

Purchasers with experience using health plan incentives are listed below. Additional contact information can be found in **Appendix A**.

A list of experienced consultants and other resources is provided in **Appendix B**.

Selected articles on health plan incentives are listed in **Appendix C**.

Employer Coalitions

- > Midwest Business Group on Health
- > Gateway Purchasers for Health
- > Pacific Business Group on Health

Large Employers

- > General Electric
- > General Motors Corporation
- > Verizon Communications

Public Purchasers

- > Iowa, Division of Medical Services (Medicaid)
- > Massachusetts, Group Insurance Commission (state employees)
- > Massachusetts, Division of Medical Assistance (Medicaid)
- > New Jersey, Department of Treasury (state employees)
- > New York, Department of Health (Medicaid)
- > Rhode Island, Department of Human Services (Medicaid)

APPENDIX A

PURCHASERS WITH EXPERIENCE USING HEALTH PLAN INCENTIVES

PURCHASERS AND PURCHASING COALITIONS:

Midwest Business Group on Health

8765 West Higgins Road, Suite 280
Chicago, IL 60631
(773) 380-9090 phone
www.mbgh.org

Gateway Purchasers for Health

8888 Ladue Road
St. Louis, MO 63124
(314) 721-7800 phone
(314) 721-6784 fax
e-mail: gp4health@aol.com

General Motors Corporation

GM Global World Headquarters
300 Renaissance Center
Detroit, MI 48265
(313) 975-5000 phone

Pacific Business Group on Health

221 Main Street, Suite 1500
San Francisco, CA 94105
(415) 281-8660 phone
(415) 281-0961 fax
e-mail: info@pbgh.org
www.pbgh.org



APPENDIX B

CONSULTANTS AND OTHER RESOURCES

CONSULTANTS EXPERIENCED WITH USING HEALTH PLAN INCENTIVES

Bailit Health Purchasing, LLC

120 Cedar Street
Wellesley, MA 02481
(781) 237-5111 phone
(781) 237-5006 fax
e-mail: mbailit@bailit-health.com
www.bailit-health.com

Mercer Human Resource Consulting

c/o Arnold Milstein, MD, MPH
3 Embarcadero Center, Suite 1500
San Francisco, CA 94111
(415) 743-8700 phone

OTHER RESOURCES

The Agency for Healthcare Research and Quality

2101 East Jefferson Street, Suite 501
Rockville, MD 20852
(301) 594-1364 phone
e-mail: info@ahrq.gov
www.ahrq.org

American Accreditation HealthCare Commission/URAC

1275 K Street, NW, Suite 1100
Washington, DC 20005
(202) 216-9010 phone
www.urac.org

The Foundation for Accountability

1200 NW Naito Parkway, Suite 470
Portland, OR 97209
(503) 223-2228 phone
e-mail: info@facct.org
www.facct.org

The Institute for Medicine, The National Academies

2001 Wisconsin Avenue, NW
Washington, DC 20007
e-mail: jomwww@nas.edu
www.iom.edu

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

One Renaissance Blvd.
Oakbrook Terrace, IL 60181
(630) 916-5600
www.jcaho.org

The Leapfrog Group

c/o the Academy
1801 K Street, NW, Suite 701-L
Washington, DC 20006
(202) 292-6713 phone
(202) 292-6813 fax
e-mail: info@leapfroggroup.org
www.leapfroggroup.org

The National Business Coalition on Health

1015 18th Street, NW, Suite 450
Washington, DC 20036
(202) 775-9300 phone
(202) 775-1569 fax
e-mail: info@nbch.org
www.nbch.org

The National Committee for Quality Assurance

2000 L Street, NW, Suite 500
Washington, DC 20036
(202) 955-3500 phone
(202) 955-3599 fax
www.ncqa.org

The Washington Business Group on Health

50 F Street, NW, Suite 600
Washington, DC 20001
(202) 628-9320 phone
(202) 628-9244 fax
e-mail: wbgh@wbgh.org
www.wbgh.org

APPENDIX C

SELECTED LITERATURE ON EMPLOYERS' USE OF HEALTH PLAN INCENTIVES

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Dyer, M.B., M.H. Bailit, and C. Kokenyesi, *Are Incentives Effective in Improving the Performance of Managed Care Plans?* Center for Health Care Strategies, Lawrenceville, NJ, March 2002.

"Employer Coalitions Demand Value in Health Plan Negotiations for Quality and Efficiency Guarantees, More Oversight." *Managed Care Week*, November 29, 1999.

Maxwell, J., et al., "Managed Competition In Practice: 'Value Purchasing' By Fourteen Employers," *Health Affairs*, May/June 1998, Vol. 17, No. 3, pp. 216-225.

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Schaffler, H., et al., "Raising The Bar: The Use of Performance Guarantees By The Pacific Business Group on Health," *Health Affairs*, March/April 1999, Vol. 18, No. 2, pp. 134-142.

ENDNOTES

- 1 National Committee for Quality Assurance, *The State of Managed Care Quality*, 2000.
- 2 National Committee for Quality Assurance, *The State of Managed Care Quality*, 2001.
- 3 Kohn, L.T., et al., *To Err is Human: Building a Safer Healthcare System*, Institute of Medicine, 2000.
- 4 HEDIS is a nationally recognized set of standardized measures that can be used to evaluate health plan performance. NCQA developed and maintains HEDIS.
- 5 DQIP is sponsored by a coalition including the American Diabetes Association, the Centers for Medicare and Medicaid Services, the Foundation for Accountability, and the National Committee for Quality Assurance.
- 6 NCQA does not require that health plans report on all 50 HEDIS measures annually; a number of measures are on a rotation schedule and collected every other year.
- 7 CAHPS refers to the Consumer Assessment for Health Plans Study, which created standardized adult and child satisfaction survey tools and sampling methods to assess health plan performance. These health plan satisfaction surveys are now part of HEDIS.
- 8 To join the Negotiating Alliance, a purchaser must have at least 2,000 benefits-eligible employees in areas where PBGH provides services (currently, California and Arizona).
- 9 M.B. Dyer, M.H. Bailit, and C. Kokenyesi, *Are Incentives Effective in Improving the Performance of Managed Care Plans?* Center for Health Care Strategies, Lawrenceville, NJ, March 2002.



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