



NATIONAL
HEALTH CARE
PURCHASING
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Ensuring Quality Providers: A Purchaser's Toolkit for Using Incentives

T O O L K I T

Bailit Health Purchasing, LLC

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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.

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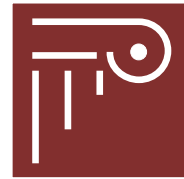
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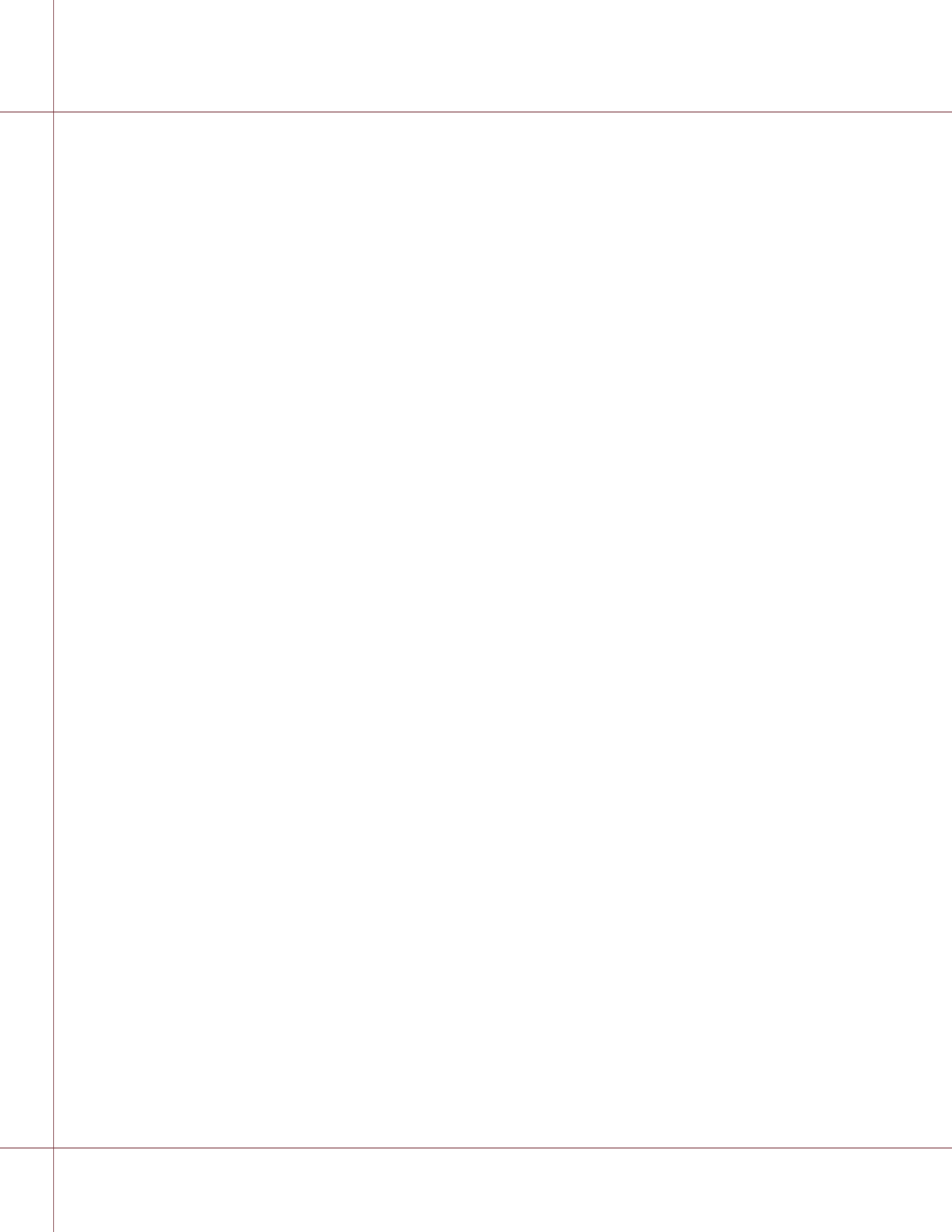
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BAILIT HEALTH PURCHASING, LLC (BHP) IS A FIRM DEDICATED TO ASSISTING PUBLIC AGENCIES, PRIVATE PURCHASERS, AND PURCHASING COALITIONS IN THE DEVELOPMENT AND EXECUTION OF EFFECTIVE HEALTH CARE PURCHASING STRATEGIES. BHP IS DRIVEN BY THE BELIEF THAT ONLY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

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EXECUTIVE SUMMARY

ALTHOUGH AMERICANS SPEND MORE MONEY ON HEALTH CARE THAN ANY OTHER INDUSTRIALIZED NATION, THE QUALITY LAGS FAR BEHIND THE EXORBITANT COSTS. IT'S A SAD FACT THAT WE CANNOT COUNT ON RECEIVING CARE THAT'S CONSISTENT WITH OUR RAPIDLY ADVANCING SCIENTIFIC KNOWLEDGE.

The result? A health care system that is often unsafe, inefficient, or ineffective.

But if providers are the drivers of quality care, what can a purchaser do?

The Institute of Medicine (IOM) and employer coalitions are strongly encouraging purchasers to create provider incentives that ensure quality care.

Innovative purchasers are using a variety of incentives for hospitals, medical groups, and individual physicians. Financial incentives for providers include performance-based reimbursement, performance bonuses, and monetary awards for specific quality improvements. Non-financial incentives recognize high performing providers, put public pressure on lower performing providers, and encourage patients to switch to higher quality or lower cost providers.

A significant obstacle is that most purchasers do not have experience with quality improvement incentives for health care providers. We've created this toolkit to give you practical tips for developing a provider incentive program, along with common challenges and ways to overcome them. We've also interviewed the President and CEO of the Central Florida Health Care Coalition (CFHCC) as well as the co-founder and first Executive Director of the Buyers Health Care Action Group (BHCAG). Both CFHCC and BHCAG possess valuable experience in developing provider incentives for improving care delivery.

WHY USE PROVIDER INCENTIVES?

MEDICAL BREAKTHROUGHS ARE HAPPENING AT TREMENDOUS SPEED, BUT THE AMERICAN HEALTH CARE SYSTEM FREQUENTLY FAILS TO APPLY NEW TECHNOLOGY EFFECTIVELY. CAN WE FIND A WAY TO TRANSLATE KNOWLEDGE INTO PRACTICE? AND CAN WE AVOID THE SHORT-TERM FIXES THAT GENERALLY END UP DOING MORE HARM THAN GOOD?

To bring about any overall change in the system, we must first look at how health care services are paid. In the current situation—with no incentives for providers to improve—purchasers continue to accept an inefficient system. There is no guarantee that care will be timely, effective, or safe. That's why purchasers must now take a more active role in developing ways to ensure that health care quality is realized.

Provider incentives are a smart option for improving health care quality because:

- > Providers are the drivers of quality care and are in a position to respond to incentives.
- > Quality varies across the nation, sometimes resulting in less effective, more costly, or more risky treatments.
- > There is no guarantee of safe health care; more than 98,000 deaths occur each year from medical errors during hospitalizations.¹
- > Providers are not rewarded for quality or improved efficiency.
- > Encouraging effective use of provider resources can help employers reduce costs for inappropriate, ineffective, delayed, and unsafe care.
- > Employees are more likely to make health care decisions on provider comparisons than on health plan comparisons.

HOW DOES A PURCHASER GET STARTED?

DESIGNING AN INCENTIVE PROGRAM FOR OPTIMAL EFFECTIVENESS CAN SEEM DAUNTING. THIS THREE-STEP PROCESS WILL GUIDE YOU THROUGH THE MANY FACTORS AND CONSTRAINTS WITHIN THE HEALTH CARE MARKETPLACE.

Each step features a series of questions. The answers will steer you toward finding the specific information you need to create a successful provider incentive program.

STEP 1 NARROWING THE TARGET

When beginning an incentive program, purchasers should start small and keep it simple. The first step in developing a provider incentive program involves deciding where to focus your quality improvement efforts.

What is my goal for an incentive program?

Prior to creating your provider incentive program, there needs to be a consensus on the program's overall goals. Shared goals that are agreed upon at the outset are critical to maintaining support for an incentive program over time.

Remember, you must be patient and expect a reasonable amount of time before seeing significant improvements. It's essential to remain focused on your goals and not be distracted by competing priorities.

What performance areas do I need to target?

With numerous opportunities for improvement in our health care delivery system, it may be hard to focus your incentives on just a few areas. For incentives with medical groups and individual primary care providers, purchasers often target clinical quality of care, access to care, and/or patient satisfaction. Incentive programs for hospitals are more likely to focus on patient safety initiatives.

Even within one general area, such as clinical quality of care, purchasers have a wide range of choices. For example, you may consider incentives that include improving care for people with diabetes, increasing early detection of cancer in women, or increasing the use of beta-blockers after heart attacks.

The following checklist will assist you in identifying potential areas of performance to target:

- Identify prevalent health conditions in your insured employees and carefully consider areas where provider performance varies.
- Obtain information on local and national performance benchmarks for providers.
- Examine areas where contracted providers are performing below expectation or below levels achieved locally or nationally.
- Identify improvement areas important to your employees such as specific health concerns, access to quality care, and patient safety.
- Look for areas where you are more likely to obtain buy-in from providers.
- Coordinate with local quality improvement initiatives.
- Identify areas where you can clearly measure provider performance.
- Rule out performance areas outside of providers' control.

If you have not previously measured provider 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 critical in developing an incentive program that is meaningful and effective.

What type of provider should I focus on?

To determine which providers to include in an incentive program, you should first identify key suppliers in your marketplace. You can target a number of different types of providers and provider organizations, including:

- > Integrated delivery systems
- > Physician-hospital organizations
- > Hospitals
- > Medical groups
- > Individual physicians

Keep in mind that common goals, mutual trust, and a good working relationship with providers will increase the likelihood of developing an effective program. Without these elements, an incentive program can create animosity between purchasers and providers, without adding any significant value.

Here are six questions to consider when looking at provider types:

1. Which types of providers drive quality in the areas most important to me?
2. Do these providers work independently or in multi-disciplinary teams?
3. Among which types of providers does competition exist?
4. With which providers am I likely to have a collaborative relationship?
5. With which providers am I likely to have the most leverage?
6. With which providers am I likely to share common objectives?

Can I increase leverage by collaborating with other purchasers?

Incentive programs are more effective when a purchaser or purchasing coalition represents a significant portion of a provider's business. You could consider joining or developing a coalition of local purchasers to create sufficient leverage with the dominant providers.

Alternatively, you can obtain additional leverage by coordinating with other local initiatives. As shown in a later case study, the Employer's Coalition on Health (ECOH) in northern Illinois elected to focus on diabetes—in part because a local initiative to increase providers' use of care flow sheets for diabetic patients was already underway.

If you do not represent a sizable portion of a plan's business, you may still have significant leverage if the provider perceives your business to be desirable (e.g., if your account is considered prestigious or influential). Focusing on quality improvement projects that are visible for and meaningful to providers will also increase their motivation to participate.

STEP 2 MEASUREMENT AND DATA DECISIONS

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

How do I measure provider performance?

Measures should be agreed upon in advance and state explicitly how provider performance will be measured, the exact measurement period, and what sources of data will be used. Potential measurement challenges can be avoided by taking benefit changes into account when selecting areas to target and when identifying data sources.

To keep the incentive program simple and clear, select only a few performance measures in a targeted area. For example, if you decide to target improved

diabetes care as a clinical goal, you should identify a few specific indicators that would enable you to measure performance in this area.

You should also be aware that existing measures may easily meet your needs. When seeking to improve diabetes care, you could refer to diabetes measures in the Health Plan Employer Data and Information Set (HEDIS)² or the Diabetes Quality Improvement Project (DQIP).³ From these already established measurement sets, you could identify 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.

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

How do I collect the data to measure performance?

Effective incentive programs are dependent on reliable data that accurately reflect provider performance. Some measures can be calculated from claims data, such as the percentage of diabetics having their blood sugar tested, lipid profiles conducted, and eyes examined. Other measures, such as whether diabetics have controlled blood sugar, lipid levels, and blood pressure, typically require purchasers or providers to review medical records or other data sources to collect information on test results.

When developing an incentive program, you could consider:

- > Administrative data (from the purchaser and the provider).
- > Clinical care data.
- > Member satisfaction data.
- > Medical records.
- > Data collected as part of specific quality improvement projects.

In reviewing potential data sources, you should thoroughly explore the advantages and limitations that could affect your approach. For example, determine if relevant performance data are likely to be comparable, complete, and accurate across providers and over time. Also, consider the likely cost and difficulty of obtaining reliable data and whether the burden will be on you or the providers.

You need to create a mutually acceptable mechanism for verifying provider performance. This is particularly important if you are concerned about the validity of the data. Options for verification include:

- > Working with an independent entity to collect and analyze data.
- > Requiring providers to submit data based on standardized criteria for data collection and auditing a sample.
- > Using claims and other administrative data sources from involved health plans.

How do I define performance expectations for providers?

To establish performance targets, you should set clear quantitative measures to minimize confusion and disputes over whether a provider met the target. This is particularly true when using financial incentives.

For each measure, you should set improvement targets that are a stretch, but still achievable. Consider factors such as the relative size and demographics of each provider's patient panel. In some cases, you may need to use risk-adjustment methods to ensure equity in evaluating provider performance data.

You may also consider whether to use provider-specific performance goals or uniform standards across all providers. This will depend, in part, on variation in the baseline performance of the providers. The sidebar offers a clear example of setting performance thresholds.

Here are three ways you can define performance thresholds:

Absolute benchmark—A provider receives an incentive payment if performance equals or exceeds an absolute benchmark, such as 65 percent of diabetic members receiving annual eye exams.

Incremental target—A provider receives an incentive payment by meeting a targeted increase from current performance, such as a 10 percent increase in diabetic members obtaining annual eye exams compared to a baseline measurement. Providers that do not fully meet the increase may also receive a portion of the incentive payment based on their percentage of improvement.

Relative performance improvement—In this case, the purchaser creates a series of provider-specific performance targets, or bands, related to the baseline performance of each provider. Higher performing providers would have to achieve a smaller relative percentage increase than providers with lower baseline performance.

**STEP 3
DESIGNING THE INCENTIVE**

Defining the specific incentives and identifying the necessary resources is the third step in creating a successful program.

SETTING PERFORMANCE THRESHOLDS: AN EXAMPLE

Consider three physicians: one who annually tests the hemoglobin A1c level of 40 percent of diabetic patients, a second who conducts these tests on 45 percent of diabetic patients, and a third who tests 55 percent. An incentive approach that rewards providers reaching an absolute benchmark of 60 percent in the following year is unlikely to provide an incentive to the first or second physician, since the goal will appear unattainable. But if the employer selects a lower performance target, the third physician will be rewarded for very little or no improvement.

If the employer links the incentive award to each physician achieving a specific percentage increase, such as 10 percent, the highest performing physician may consider the incentive unrealistic given his current high level of

performance and the amount of effort needed to achieve a further increase.

Alternatively, the employer could create a series of provider-specific performance targets that relate to the baseline performance of each provider. In this example, the first provider would be expected to improve the most in order to obtain an incentive payment, while the third provider would need the least increase in performance. With three providers at very different baselines, relative performance improvement is most likely to create meaningful incentives for all providers. However, these types of measures are also more complex to implement and the administrative tradeoff may not be worth the extra precision in the incentive.

What type of incentives will I use?

To effectively motivate providers to improve, the number, range, and difficulty of targeted performance measures must be comparable to the power of the incentives being offered.

You can use financial incentives, non-financial incentives, or a combination of both to stimulate improvements. For more detail in determining what type of incentives to use, please review the National Health Care Purchasing Institute's report titled, "Provider Incentive Models for Improving Quality of Care."

Financial incentives include:

- > Quality bonuses or penalties.
- > Provider compensation, based on performance.
- > Performance-based fee schedules.
- > Grants to providers for targeted quality improvement projects.
- > Reimbursement for prevention-focused services, such as care planning.
- > Variable cost-sharing for patients.

Non-financial incentives (which have indirect financial implications for providers and only administrative costs for purchasers) include:

- > Provider performance profiling.
- > Publicizing provider performance to key stakeholders and consumers.
- > Technical assistance for quality improvement.
- > Reducing administrative burdens on high performing providers.
- > Practice sanctions such as restricting a provider's panel size for poor performing providers.

Not all types of incentives are appropriate for all situations; you should consider environmental factors in the health care marketplace, your financial situation, as well as your leverage and relationship with the providers.

For example, incentives with significant downside risk for providers will be difficult to implement in markets characterized by mistrust between providers and purchasers, negative operating margins on a purchaser's line of business and providers' lack of interest. What's more, providers generally perceive strategies involving withholding or recouping funds as financial penalties, even if you build additional financing into their base rates.

Incentives with upside potential work best when attempting to motivate providers to achieve higher levels of performance. Relatively small penalties or rewards may also be used to encourage providers in submitting timely and accurate data for assessing their performance.

Non-financial incentives can be as powerful as financial incentives in motivating improvement. In Iowa, for example, the Medicaid managed behavioral health care vendor attributed the effectiveness of the state's incentive program to two non-financial incentives. These incentives focused on a limited number of clearly defined performance measures and had the vendor publicly present performance results to a stakeholder work group.⁴

Additionally, you should consider the potential for increased market share and adverse risk selection in any program that incorporates publicizing provider performance results. For example, if an organization is developing an incentive to promote better diabetes care, providers may be concerned about adverse risk selection resulting from being publicly recognized as having the best performance on diabetes measures.

What funding and other resources are needed to implement my incentive program?

Incentive programs require a multi-year financial commitment, and available staff expertise, data, and resources are critical factors when designing a program.

Carefully consider what internal resources will be designated to the program and what types of external assistance you might need. Local quality improvement initiatives, other purchasers, coalitions, and health plans can be potential resources for effective collaboration.

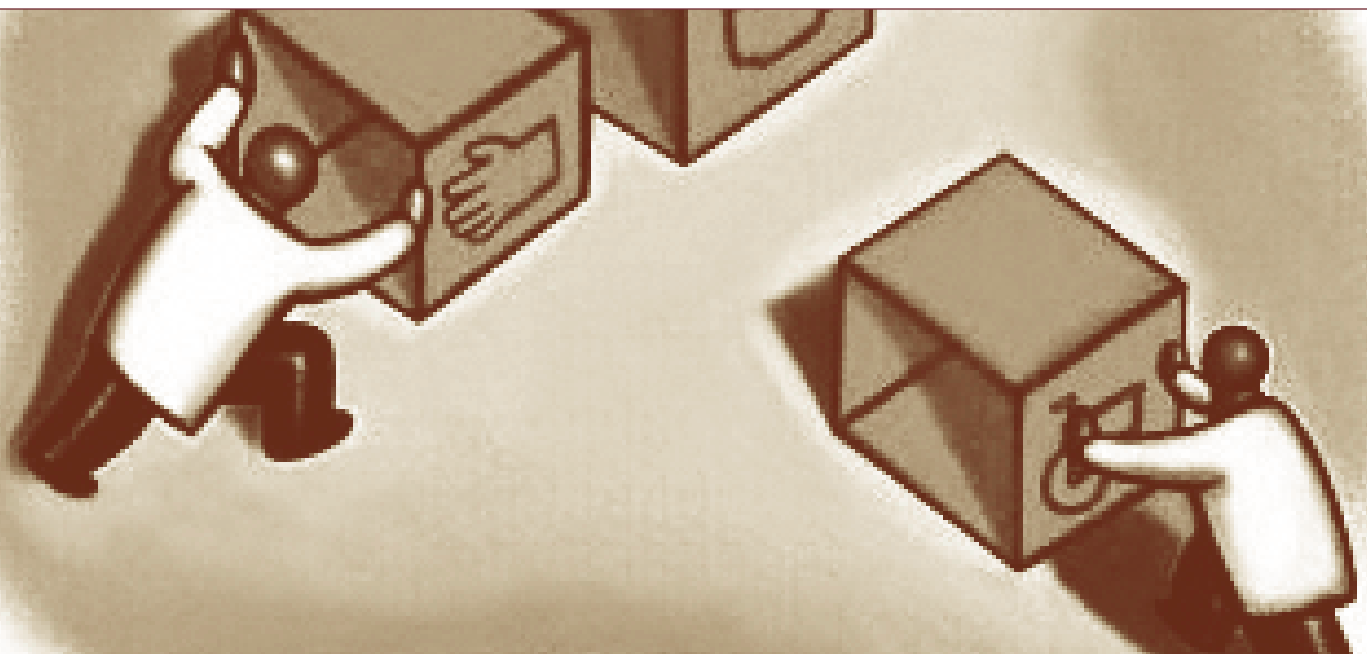
When contemplating financial incentives, you should have the financial resources to support and maintain an incentive strategy over time. In the initial year of an incentive program, everyone is on a learning curve. If you and your providers do not have shared experience collecting and analyzing performance data in the targeted area, the process for establishing baseline performance can be time-consuming.

Without the cash flow to sustain an approach, you could instead consider a strategy involving withholding a portion of provider payments or using non-financial incentives, such as publicizing provider performance.

What resources will my providers need?

A provider will need to increase administrative expenditures, re-allocate existing resources, and make changes that incorporate best practices into their care delivery processes. In addition to meeting the performance thresholds, providers will often assess the likelihood of upfront costs exceeding any rewards or savings before determining their level of commitment.

You should seek advice from providers when designing incentive programs to minimize additional reporting burdens and to understand the time, effort, and expense involved in meeting performance thresholds. Confer with local health plans and other leaders of local quality improvement initiatives to identify opportunities to reduce providers' administrative burden and related expenses.



IMPLEMENTING A PROVIDER INCENTIVE PROGRAM

When it's time to implement your incentive program, keep four general rules in mind:

- > Keep it simple.
- > Be realistic and clear about the process, the resources required, and your expectations.
- > Document the incentive approach including goals, timelines, measures, and data sources.
- > Maintain a two-way dialogue with providers throughout the process.

You must first offer providers sufficient notice of your intent to use performance-based incentives. You should also revise your provider contracts to reflect the new incentive programs and the performance expectations.

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 providers to ensure the timeline is realistic and achievable.
- > Talk to both the operational and clinical staff at provider organizations, since each group is likely to have different perspectives and competing priorities for their time.
- > Clearly establish baseline provider performance and the period of time during which provider performance will be measured.
- > Consider major changes in your provider contracts and networks 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

A well-defined, collaborative process is key to developing a successful incentive program. You should convene routine meetings and have ongoing discussions with providers throughout the process of developing, implementing, and evaluating your incentive program.

To facilitate the program, you can:

- > Designate a work group of provider staff and your own staff to roll out the incentive program in the first year.
- > Establish an advisory committee of key stakeholders including providers and health plans (if appropriate) 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 provider.
- > Which data sources to use.
- > What methodology is best for calculating provider performance.
- > How long the measurement time period should last.

In the work group model, participants have more responsibility to make and implement decisions jointly. With the advisory committee approach, key stakeholders can make recommendations and share opinions but are not ultimately responsible for designing and implementing the program.

During the Course of the Incentive Program

Successful incentive programs also require that you:

- > Offer providers timely feedback on their performance.
- > Promptly apply incentive rewards or penalties related to performance.
- > Create forums for open and constructive communication with providers and other stakeholders throughout all stages of the incentive program.

It is a good idea to solicit feedback from providers regarding the program, the performance expectations, and the process throughout implementation. While there are advantages to not changing the program dramatically every year, you may consider modifications in your approach based on experience, plus input from providers, health plans, and other stakeholders.

CHALLENGES AND WAYS TO OVERCOME THEM

IN DEVELOPING AND USING PROVIDER INCENTIVES, YOU SHOULD EXPECT TO FACE A NUMBER OF CHALLENGES. HERE ARE THREE COMMON PROBLEMS AND SUGGESTIONS FOR AVOIDING THEM.

PROBLEM 1 EMPLOYERS DO NOT STAY ENGAGED

Provider incentive programs may not produce dramatic results in the first year. Employers can become impatient with incentive strategies and distracted by other priorities or promises of short-term savings.

To keep employers and senior management personnel engaged, you should:

- > Achieve consensus on clear and realistic program goals, timelines, and necessary resource commitments.
- > Show the IOM findings on the significant quality and patient safety problems in our current health care system and emphasize that by doing nothing, purchasers are part of the problem.
- > Remind key stakeholders that there is no quick fix for changing incentives or improving quality of care.
- > Invite other purchasers or coalitions to speak about successful results from their own incentive programs.

PROBLEM 2 PROVIDERS DO NOT STAY ENGAGED

If an incentive program becomes routine and is not improved or modified, providers can become less engaged over time.

To continue to engage providers, you should:

- > Recalibrate performance thresholds periodically to maintain incentives for improvement.
- > Publicize provider performance results with consumers and other key stakeholders in a format that is meaningful.
- > Solicit provider recommendations for ways to improve the incentive program.

- > Emphasize the importance of the incentive program through words and actions.

PROBLEM 3 PURCHASERS HAVE INSUFFICIENT MARKET LEVERAGE

Even large employers often represent only a small portion of a provider's business. With limited market share, it is sometimes difficult to be effective at creating meaningful incentives.

To obtain sufficient market leverage, you should:

- > Join or create local purchasing coalitions to work collaboratively on provider incentives.
- > Establish a partnership approach with local health plans with similar interests in quality improvement and provider incentives.
- > Link incentives to quality-improvement initiatives that are broadly supported by the local community.
- > Target a goal that resonates with consumers and demonstrates to providers that consumers care about results.

INSIGHTS AND ADVICE FROM A LEADING PURCHASER AND CONSULTANT

WE CONDUCTED TWO INTERVIEWS WITH INDUSTRY INSIDERS TO HELP GIVE YOU GREATER INSIGHT INTO THE HEALTH CARE MARKETPLACE.

BECKY CHERNEY OF THE CENTRAL FLORIDA HEALTH CARE COALITION

Becky Cherney is the President and CEO of The Central Florida Health Care Coalition (CFHCC). This innovative coalition directly contracts with health care providers and consists of approximately 120 private and public sector employers, representing more than 1 million covered lives. Prior to joining CFHCC in 1994, Cherney was a consultant to Florida's Agency for Health Care Administration under Governor Lawton Chiles. Cherney has also held senior human resources positions at Holiday Inns International and other Fortune 500 companies.

Q: How did CFHCC get started and why do you focus on quality improvement?

A: The coalition formed in 1984 because businesses in Central Florida saw that we were spending a lot of money on health care, but did not know exactly what we were buying. Our employer members are a diverse group who try to do something new and are willing to commit time, talent, and resources. From day one, CFHCC stated that discounts do not heal patients. While others sought discounts, we sought data.

Our mission continues to be purchasing the highest quality health care at the lowest possible price, while also educating health care consumers. Our key focus is on health care outcomes. If we can improve the quality of care, our experience shows the costs will also improve.

Q: What are some of the first lessons you learned?

A: After several years of gaining providers' trust, CFHCC realized we would have to get into some

measurements if we were going to move our clinical quality agenda forward. Providers often did not have good information on their performance or how it compared to their peers. You can only work with the information you have.

We learned that if we gave providers good information on their performance, they would be willing—and even eager—to make changes. I have yet to meet a doctor who wants to practice bad medicine. It became obvious to CFHCC that the employers were going to have to be brokers of information on provider performance.

Q: When did you start profiling performance in hospitals?

A: In the late 1980s, CFHCC asked all of our hospitals to use Medi-Qual's Atlas system for measuring care provided in specific diagnostic-related groups (DRGs). Initially, hospitals were reluctant to make the financial investment and commitment. We continued to emphasize the importance of this initiative through negotiations, and one leading hospital agreed to pilot the Atlas system. After a year of sterling progress, other hospitals adopted the same system. We now have over 10 years experience profiling provider performance related to hospital care.

Q: How is performance data shared with individual physicians?

A: Hospitals use the Atlas system to compare performance for facilities and individual providers, and to rank specialists by outcome. All doctors receive a profile of their performance on the selected DRGs and information on the facility's performance compared to national standards.

Each hospital has its own way of distributing the provider profiles. In the beginning, another doctor or a member of hospital administration presented the profiles. Now that doctors are comfortable with the profiles, nurses or administrative staff generally deliver them.

Q: Has the hospital profiling initiative been successful in improving care?

A: Absolutely. We've had many successes, including C-sections, joint replacements, hysterectomies, treatment of chest pain, and other procedures that have been vastly improved by physicians after reviewing the DRG data.

One of the largest hospital systems had all cardiology surgeons attend a meeting to review information on coronary artery bypass graft (CABG) procedures. Using the outcome data from Atlas, the cardiologists agreed on changes that improved the quality of care and reduced the cost of CABG by more than \$5,000 per case. That was in 1991, and savings have continued to accrue for over 10 years.

Most recently, a group of vascular surgeons reviewed the literature on endarterectomies.⁵ They noted that some studies suspected over-utilization of angiograms prior to the surgery. Some other articles hinted there was overuse of the Intensive Care Unit (ICU) following the procedure.

The surgeons established a study and closely monitored its progress. As a result, the use of angiograms before the procedure went from 23 percent to 3 percent over the course of a year. The use of ICU went from 77 percent to 2 percent over the same period. The length of stay was cut in half and the costs per case were lowered by more than \$6,000, all while the quality of care improved.

Progress occurred because physicians are bright, competitive, and want to do the right thing. We gave this group a community service award at our annual meeting. The personal recognition, media coverage, and genuine appreciation of their work were like gold to the doctors.

Q: In what other ways is CFHCC profiling used to reward providers?

A: Hospitals and physicians have used the profiling results to reward physicians. For example, when the hospitals listed specialists according to their outcomes, the word spread quickly. Needless to say, the doctors who scored the best were quick to let their colleagues know. Once primary care doctors learned which specialists had recorded the best outcomes, referral patterns changed and the best doctors were rewarded with more referrals—all independent of CFHCC, but based on data.

A second 'reward' was in malpractice insurance premiums. Many doctors were able to negotiate lower premiums based on their data. If they get sued—and it's sad to say that nearly every doctor will if they practice long enough—the big cost is preparation of a defense. There is no better defense than a solid record of performance. The doctors with the data were able to use it as a bargaining chip for lower malpractice premiums.

Q: How are CFHCC's performance initiatives evolving?

A: Initially, we didn't have a clear vision of exactly how the performance initiatives would play out. We knew the first step was measurement. But we also wanted to have a second step that went beyond providing information for improvement and directly rewarded providers for better performance. Not everyone would readily recognize the increased referrals and

lower malpractice premiums as paying providers for quality performance, but that's what they are.

The next step is for CFHCC to directly reward providers for their performance. We refer to our new model as 'Pay for Performance.'

Q: Can you tell us more about this Pay for Performance model?

A: The Pay For Performance model is focused on rewarding physicians for providing better outcomes. To complement the inpatient data we already collect, CFHCC researched firms that manage data for outpatient care and contracted with MeDecisions of Santa Monica, California. MeDecisions has a severity-adjusted tool that provides clinical profiling for doctors who make a living in their office, as opposed to doctors whose base of earnings comes from a hospital setting (e.g., surgeons).

Physicians will be grouped into one of three categories (platinum, gold, or silver) based on their performance compared to national standards. Physicians that qualify for platinum will receive over 100 percent of the Medicare fee schedule. Physicians at the gold level will be paid at a fee schedule below platinum and above silver. Similarly, patients will face differential co-payment levels depending on the level of the provider. Physicians in the platinum level will have the lowest co-pays and physicians in the silver category will have the highest.

We are working with actuaries to help define the appropriate percentage and co-payment differences between the three physician fee schedules. Getting the data to the point where it is ready for actuarial analysis is a huge task and a major barrier to implementation of this type of approach.



Q: Are there non-financial incentives in the Pay for Performance model?

A: Yes. Physicians in the platinum level would have less administrative oversight of their treatment decisions. For example, a platinum physician may not be required to use a formulary or obtain pre-certifications or pre-authorizations for care. On the other hand, platinum providers would have to agree to attend mini-residencies every two years and agree to use a handheld computer to submit prescriptions, order lab tests, and track referrals.

Q: How have physicians responded to Pay for Performance?

A: I have met with hundreds of physicians in our area to discuss our plans. The doctors have, for the most part, been cheerleaders. It's unsettling because it simply means they all think they are platinum. Why wouldn't they?

Remember, no doctor has ever said he or she went to medical school to practice bad medicine. They get out of school with huge student loans. They have to work very hard to build a practice. They get very little rest or recreation. So when they have to get continuing medical education (CME) credits, they sometimes

look for a nice place to vacation since they really don't have any information about practice areas where an educational update would help them.

Q: What overall advice do you have for employers?

A: You can start your quest for quality anywhere. You can use recognition and awards to notify your provider community of your dedication to quality. You can select a disease and work on one thing.

The only thing you cannot do is ignore clinical quality. That's where danger and higher costs reside. You can pay now or pay later but you can't avoid paying. The sooner you focus on paying for performance, the sooner you will get lower costs and safer health care built around evidence-based medicine.

**STEVE WETZELL
OF WETZELL HEALTH CARE STRATEGIES**

Steve Wetzell is a nationally recognized health care purchasing and market reform leader. He is an independent consultant and speaker on advancing value-based health care purchasing principles and market reforms. Wetzell is a founding member of The Leapfrog Group and previously served as a founding employer and Executive Director of The Buyers Health Care Action Group (BHCAG). Prior to joining BHCAG, Wetzell worked in human resource management for 14 years in the areas of compensation, benefits, and labor relations.

Q: When you were at BHCAG, why did you create a new reimbursement and reward program for care systems in Minnesota?

A: There was so much overlap with health plans and provider networks, there was no way to distinguish between plans' or providers' performance in a meaningful way. BHCAG believed that the real solution for addressing quality and cost issues was at the provider level, not at the health plan level.

Providers are the drivers of quality, and consumers are more interested in information on providers than health plans. BHCAG wanted to introduce new incentives to overcome financial barriers to improving care. We also wanted to address adverse incentives for health plans and provider organizations to avoid higher risk and higher cost populations.

Q: Can you give an example of how financial incentives can inhibit quality improvement?

A: A good example is a local provider who created an improved care protocol for treating women with routine bladder infections. As part of BHCAG's initial purchasing strategy, the plan encouraged providers to develop collaborative, community-wide best practice protocols for care. The result was that they successfully reduced the cost to treat routine bladder infections in women by 70 percent.

For quality and patient satisfaction, the protocol was successful; patients were happier and the care was better. From the providers' financial perspective, the protocol was problematic. The reduction in revenue for treating bladder infections resulted in a very significant drop in their income. Instead of being financially rewarded, they were actually financially punished for improvements in care delivery.

Q: How did BHCAG's desire to change incentives evolve into a specific purchasing strategy?

A: We started with four principles driving our group purchasing strategy. First, the purchasers agreed to create competition in the marketplace based on quality and efficiency, not price or risk selection. Second, we decided to focus on providers as the drivers of quality and care delivery. Third, we agreed to a purchasing principle of focusing on employees as the true consumers of health care. Finally, we sought to streamline administration and improve customer service.

Based on these principles, BHCAG developed a multi-faceted incentive approach that focused on consumer-driven competition among integrated care systems. The reimbursement structure takes risk selection into account. It also creates incentives for care systems to deliver care efficiently by charging lower employee premiums for lower cost systems. BHCAG also offers annual quality awards to create additional financial incentives to improve care.

Report cards and employee payroll contribution adjustments provide consumers with information and financial incentives to select higher quality, lower cost care systems. Consumer involvement rewards high value care systems with greater volume of patients. These incentives restructure the health care market to produce better outcomes for employees and employers.

Q: Do purchasers have to contract directly with care systems or other provider organizations to create effective provider incentives?

A: No. Direct provider contracting is not essential as long as employers work collaboratively with health plans that engage consumers in rewarding provider performance. Employers generally prefer to work with health plans as their change agents for creating meaningful provider incentives.

BHCAG would have preferred to work with a health plan to create the type of incentive and reward system that we envisioned. BHCAG originally put out a request for proposals (RFP) to health plans but did not receive any response, which was disappointing. I think the reaction was partly due to viewing us as a competitive threat rather than a change agent and potential customer. At the point the RFP was released, BHCAG had already received extensive press coverage emphasizing the direct contracting approach with providers, creating a misconception that employers were out to ‘eliminate the middleman.’

Q: What is the first thing employers should do?

A: Employers should first agree on common principles for their incentive program—and stick with them. They should reach consensus on key questions such as:

- > Do we believe in competition?
- > Are we trying to create competition among providers based on performance?
- > For which types of providers do we want to create incentives—individual physicians, hospitals, medical groups, or other provider organizations?
- > How do we engage consumers to change their behavior in response to provider performance?
- > Are we willing to stay the course financially?

Employers should also talk directly to their suppliers—the health care providers—to learn about barriers to quality improvement and solicit recommendations for the types of incentives that might be meaningful.

Finally, employers must generate purchasing power in support of a common incentive approach. Employers should start by working with health plans to see if they can come together on a set of standards to create provider incentives. A good example of this approach is the collaborative efforts between Empire Blue Cross and Blue Shield of New York and member employers of The Leapfrog Group to create incentives for hospitals to improve patient safety.

Q: How should employers decide which type of incentives to use?

A: Purchasers first should identify their priorities. Are they trying to control costs, improve service, or improve quality? These are not mutually exclusive goals, but incentives will vary based on the primary objective.

Purchasers should also focus on performance incentives



that are easily understood by the supplier (the provider) and the end consumer (the employee). Most approaches used by employers are buried in contract language and are not clear to the community or the market.

Without publicly visible incentives that ultimately impact their bottom line, providers will not remain engaged and consumers will not use performance information to make more educated decisions. Employers should also directly consult with providers and consumers to better understand the types of incentives that would be meaningful to them.

Q: What about the use of financial versus non-financial incentives?

A: Employers should not overlook non-financial incentives such as the distribution of performance results. Non-financial incentives on performance appeal to providers' sense of professionalism and have marketing value that will likely increase as more employers adopt consumer-driven models.

When used effectively, non-financial incentives can also have financial benefit by affecting a provider's market share. For this to happen, performance information needs to be very public and presented in a meaningful way to consumers.

Over time, incentive programs are not sustainable unless there is a financial stake for providers directly related to their performance. Bonuses and penalties

offer financial incentives to providers. But non-financial incentives also create financial risk for providers when incentives affect their bottom line by moving market share.

Q: What are the key factors for successfully using incentives with providers?

A: Successful provider incentives will likely have a disproportionate influence over the provider market. When a significant volume of employers offer proper incentives, it will likely lead to permanent and sustainable improvements in performance.

Employers have the bully pulpit and should be willing to use it for quality improvement. However, an incentive program needs to be more than just talk. Employers are much more likely to be successful if they and their health plans work collaboratively with local providers and provider organizations.

A level of trust and commitment among key stakeholders is essential to a program's success. Stakeholders need to remain aligned with the incentive strategy over time and not be distracted by the potential for short-term gains or savings.

Q: What are the challenges of creating incentives and how can they be overcome?

A: The biggest challenge is the length of time it takes to obtain meaningful results in the face of intense

pressure to reduce short-term costs. It's challenging for employers to stick with programs long enough to reap the benefits. Up front, employers need to understand the tradeoffs involved in a provider incentive program and realize there is no quick fix for quality improvement.

Benefit managers need to get their CEOs and CFOs to buy into the principles behind the incentive program and remain committed, regardless of short-term opportunities. Benefit managers must make a persuasive case for purchasers to remain focused on long-term gains in quality and savings.

Employers also need to get consumers involved in actively selecting providers, plans, and treatments based on their relative quality, service, and efficiency. The Leapfrog Group's approach to using purchaser influence to engage consumers in patient safety is a good start. By focusing on outcomes that are important to consumers, Leapfrog has helped build a clear business case for purchasers and providers to improve patient safety.

Q: What are the most important lessons you've learned?

A: Everyone shares responsibility for the current flawed system, employers included. It's important to not blame other individuals or organizations for our current problems. Purchasers should look for win-win solutions for employers, providers, health plans, and other stakeholders.

Financial risks and rewards for providers are essential for improving health care quality. Appeals to professionalism will only go so far. There are too many countervailing forces working against quality improvements in the current system.

It's important for private and public purchasers to take responsibility for changing the health care marketplace and obtaining better outcomes for patients and payers.

We must be smarter buyers and take a long-term point of view. We must recognize that how we spend our money will have direct impact on shaping the behavior of the health care delivery system.

If purchasers do not accept this responsibility, we will continue down the path toward a heavily regulated environment driven by the public's growing concern over health care. And that would be an unfortunate outcome.

CASE STUDIES

FOLLOWING ARE FIVE CASE STUDIES OF PROVIDER INCENTIVE INITIATIVES THAT PRESENT A VARIETY OF APPROACHES TO PROMOTING QUALITY IMPROVEMENT. THE FIRST THREE REPRESENT INCENTIVE PROGRAMS OPERATED BY EMPLOYER COALITIONS; THE FOURTH DESCRIBES A GROUP OF FORTUNE 500 COMPANIES WORKING WITH AN INSURER TO CREATE PATIENT SAFETY INCENTIVES FOR LOCAL HOSPITALS; AND THE FIFTH SHOWS HOW A JOINT INITIATIVE BETWEEN PAYERS, PROVIDERS, AND EMPLOYERS CAN CREATE POWERFUL INCENTIVES FOR MEDICAL GROUPS.

THE BUYERS HEALTH CARE ACTION GROUP (BHCAG)

BHCAG, a coalition of Minnesota's largest employers, contracts directly with groups of hospitals and physicians, called "care systems." BHCAG's reimbursement approach eliminates negative incentives to treat only healthy patients and rewards quality treatment given to the sickest patients. BHCAG uses a discounted fee schedule with enhancements, including an overall "claim target" and risk adjustment for the health status of patients in each care system. Care systems with sicker patients can exceed their claim target⁶ without penalty and care systems with healthier patients are expected to expend less than their claim target.

Annually, BHCAG presents gold (\$100K) and silver (\$50K) awards to care systems for performance on quality improvement projects. The objective is to financially reward and publicly recognize demonstrated excellence and improvement. At the outset they asked physicians what amount of money would be meaningful to motivate them and set the quality awards at those levels.

In 2001, one care system received a gold award for improving immunization rates; another was awarded for improving treatment of chronic heart disease. A silver award went to a care system that improved tobacco cessation counseling. The care systems define their own projects and self-report on their performance.

To be eligible for a quality award, care systems must meet or exceed minimum performance thresholds for: patient satisfaction, delivery of preventive care services, and development and implementation of an improvement program in an area chosen by the care system.

A committee reviews each care system's application for depth and breadth of impact. BHCAG evaluates performance based on the following questions:

- > How engaged is the care system in the quality improvement initiative?
- > Is the initiative system-wide?
- > How many people does the initiative attempt to affect?
- > Does the care system demonstrate improvement in the defined area?

Care systems that receive awards are recognized on the annual BHCAG report card. This consumer report card provides a non-financial incentive for care systems to improve performance on cost and quality. From the report card consumers can identify each care system's cost tier (high-, medium-, or low-cost) and how they performed on patient satisfaction measures.

BHCAG employers have adjusted employee contribution strategies to encourage enrollment in care systems of relatively lower cost. They have been

pleased to observe that the highest quality care systems tend to fall into the lowest cost group. This bolsters their assertion that it costs less to provide good quality care.

THE CENTRAL FLORIDA HEALTH CARE COALITION (CFHCC)

With experience using financial and non-financial incentives, CFHCC serves more than 120 private and public sector employers, including the Walt Disney Company, Lockheed Martin, and the Orange County Government. The coalition represents just over 1 million covered lives.

CFHCC first started using non-financial incentives with hospitals and physicians. Beginning in the 1980s, CFHCC asked all their hospitals to use Medi-Qual's Atlas system⁷ to collect and analyze data on diagnosis-related groups (DRGs). The information for Atlas is abstracted from patients' clinical records, which physicians consider more reliable than other data sources. The Atlas system enables hospitals and purchasers to compare performance against national benchmarks and examine the practice patterns of individual physicians. The software makes adjustments for the severity of illness and demographic variables.

Currently, hospitals on the Atlas system abstract 15 DRGs and distribute comparative performance information to individual specialists practicing at their facility. The performance data analysis has proven very helpful in identifying and addressing practice pattern differences and helping eliminate inefficiencies, improve productivity and outcomes, and reduce costs. The hospitals report their progress directly to the CFHCC Board, which CFHCC recognized early on as a simple form of recognition that was inspiring great projects.

According to analysis by William M. Mercer, Inc., between 1989 and 1995, CFHCC saved 40.1 percent in health care increases compared to the state of Florida. This translates to \$300 million in savings for employers in the CFHCC over the same period.

CFHCC plans to implement financial incentives for physicians' performance on specific DRGs in the near future. The coalition will compare local practice patterns with national standards. Based on this comparison, the employer coalition will designate physicians as being in one of three performance levels: platinum, gold, and silver. Physicians that achieve the highest threshold of performance, the platinum standard, will receive the highest fee schedule. Physicians at the gold level will be paid a lower fee schedule but above that of physicians at silver. The exact levels of the differential provider fee schedules will be based on a complex actuarial analysis that is currently underway.

THE EMPLOYERS' COALITION ON HEALTH (ECOH)

ECOH, based in Rockford, Illinois, uses financial incentives with 85 primary care physicians (PCP) in four medical groups as part of a strategy to improve care for diabetic patients.⁸ Their goal is to move physicians toward a "best practice" model for diabetes care by creating financial rewards in their contracts with medical groups.

ECOH based their decision to focus on diabetes care on:

- > The growing prevalence of diabetes in the United States and its costly economic and quality of life implications.⁹
- > The evidence that improving diabetes care could have a meaningful impact in a relatively short time (e.g., one year).¹⁰

- > The ability to minimize additional burdens on physicians by collaborating with a community initiative to improve care.
- > The ability to collect data and analyze results of the incentive program.

ECOH established multi-year goals at the outset of the diabetes initiative, prior to determining the amount of the financial incentive to be tied to achievement. ECOH worked closely with local physicians to develop specific performance targets for the contracted medical groups.

ECOH will make incentive payments to each physician group based on whether the group completes care flow sheets on 95 percent of its diabetic encounters and maintains hemoglobin A1c levels below 7.5 in the majority of its diabetic patients. Between 2001 and 2002, the targeted percentage of patients with hemoglobin A1c levels equal or below 7.5 increased from 60 percent to 65 percent.

While the 2001 results are not final, ECOH believes that all four of the physician groups have met the two goals. If this is the case, they will make incentive payments to the medical groups of approximately \$28,000, roughly \$3.60 per member per year. A medical group must achieve both goals in order to be eligible for the incentive payment.

While ECOH's incentive payments only apply to members enrolled in their capitated contracts with the hospital-based groups, Sam Schmitz, Executive Director of ECOH, indicated the program appears to have had a positive spillover in their other lines of business, such as PPO and indemnity products. Physicians in the groups are reportedly using care flow sheets with all their diabetic patients, not just those in the capitated arrangement.

To evaluate their diabetes initiative, ECOH is comparing results with their baseline data. Based

on the first six months of data, average total charges for diabetes patients, average charge per admission and average charge per inpatient day all appear to have decreased. At the same time, all three of these cost measures increased for non-diabetic ECOH patients compared to the baseline.

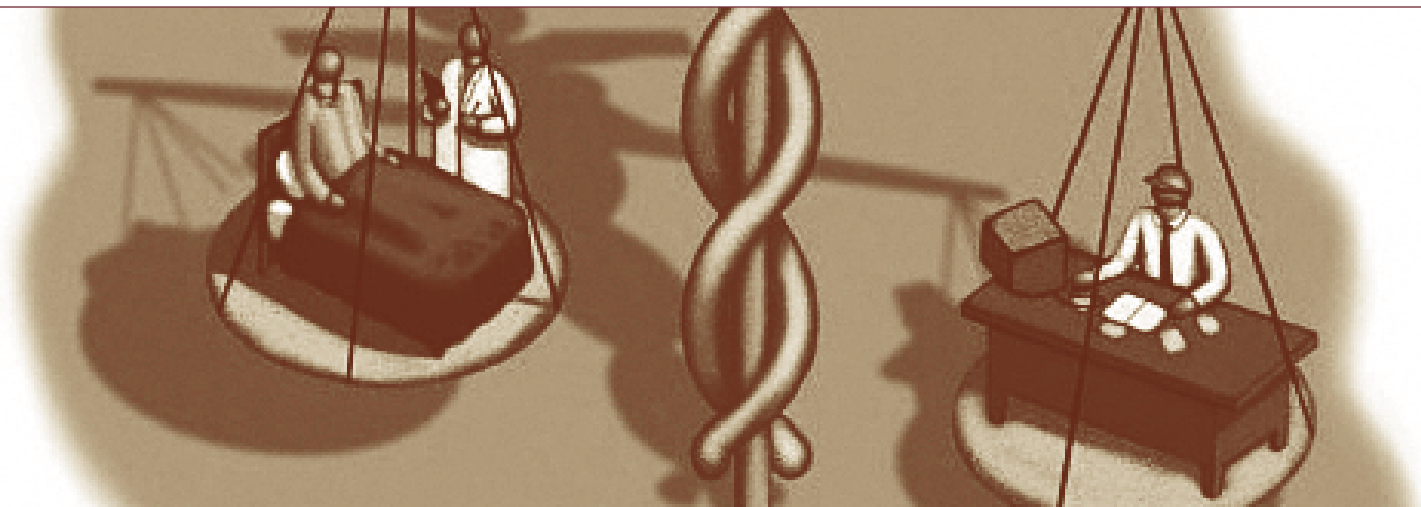
In addition to the financial incentives, ECOH negotiated with contracted hospital-based providers to increase diabetic screening and educational services offered. They also encouraged member companies to enhance their benefit packages for diabetic patients to include educational visits, an annual eye exam, and test strips for monitoring glucose levels.

EMPIRE BLUE CROSS AND BLUE SHIELD (EMPIRE BCBS)

Empire BCBS recently joined forces with IBM, PepsiCo, Verizon Communications, and Xerox Corporation to offer financial incentives to network hospitals that achieve patient safety standards.¹¹ Beginning January 1, 2002, hospitals can obtain bonuses depending on how quickly the hospital implements the following two patient safety standards:

- > Using computerized physician order entry (CPOE) systems for prescription drugs.
- > Staffing intensive care units (ICUs) with physicians that are board certified or board eligible in critical care medicine.

The Leapfrog Group, a national coalition of employers focusing on patient safety, developed these patient safety standards in response to the IOM report on medical errors. Researchers at Dartmouth Medical School have projected that 522,000 serious medical errors could be avoided and more than 53,850 lives could be saved nationally each year if all urban hospitals met these two safety standards. Empire BCBS and the four companies involved in this initiative are all Leapfrog members.



To recognize advances in patient safety, hospitals in the Empire BCBS network that meet both standards will be rewarded with a bonus. The bonuses will be paid by the four purchasing partners. The purchasers are committed to paying these bonuses based on their belief that hospital safety improvements will result in overall net health care savings and improved quality of care.

Hospitals meeting the two safety standards in 2000 will receive a 4 percent bonus, where the percentage is based on the hospital expenditures for all employees of the four purchasers participating in the initiative, as well as the employees of Empire BCBS. Facilities meeting the safety standards in 2003 will receive a 3 percent bonus and those implementing these standards in 2004 will receive a 2 percent bonus. To be eligible for the bonus, a hospital must self-certify that it meets both safety measures on the Leapfrog website (www.leapfroggroup.org).

The companies involved in this initiative will share information with employees about which hospitals meet these two safety standards. By sharing information, purchasers hope to help employees make more informed decisions about selecting hospitals for non-emergency care.

INTEGRATED HEALTHCARE ASSOCIATION (IHA)

In January 2002, six health plans serving more than eight million Californians announced their agreement on quality improvement incentives for physician groups. The initiative, referred to as “Pay for Performance,” is led by IHA, a statewide leadership group of health plans, physician groups, and health care systems with at-large academic, purchaser, consumer, and pharmaceutical industry representatives.

The health plans—Aetna, Blue Cross of California, Blue Shield of California, CIGNA Healthcare of California, Inc., HealthNet, and PacifiCare—will use a common scorecard to measure the performance of physician groups. Most of the health plans previously used different measurement methods for evaluating and rewarding physician groups. To increase their leverage, the plans agreed to collaboratively develop a common performance measurement system on which to base their quality incentive rewards.

The common scorecard will measure prevention, chronic care management, and patient satisfaction for physician groups. An independent entity will validate the data and publish the results. Some health plans will implement the incentive in 2002, with the remaining plans implementing it in 2003. Each health plan will separately distribute incentive

payments to physician groups based on the scorecard results. The amount of the payments, and how they are distributed, will vary across plans.

The Pay for Performance initiative will be managed by an IHA steering committee of business, health plan, physician group, and consumer representatives. A technical committee will work to continually improve the performance measures used in the scorecard. The technical committee includes experts from the National Committee for Quality Assurance, the University of California Berkeley Center for Health Research, and the University of California San Francisco Institute for Health Policy Studies.

WHO HAS EXPERIENCE WITH PROVIDER INCENTIVES ?

Purchasers with experience using provider 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 provider incentives are listed in **Appendix C**.

Employer Coalitions

- > Buyers Health Care Action Group (Minneapolis, Minnesota)
- > Central Florida Health Care Coalition (Orlando, Florida)
- > Employers' Coalition on Health (Rockford, Illinois)
- > The Leapfrog Group (Washington, DC)
- > Pacific Business Group on Health (San Francisco, California)
- > Tri-Rivers Health Care Coalition (Dayton, Ohio)

Large Employers

- > General Motors Corporation (Detroit, Michigan)

Insurers (In Collaboration With Purchasers)

- > Empire Blue Cross and Blue Shield (New York)
- > Integrated Healthcare Association (California)

APPENDIX A

PURCHASERS WITH EXPERIENCE USING PROVIDER INCENTIVES

PURCHASERS AND PURCHASING COALITIONS:

Buyers Health Care Action Group

Wells Fargo Plaza
7900 Xerxes Avenue South, Suite 900
Bloomington, MN 55431-1136
(952) 896-5185 phone
(952) 896-5184 fax
www.bhcag.com
e-mail: bhcag@isd.net

Central Florida Health Care Coalition

4401 Vineland Road
Orlando, FL 32811
(407) 425-9500 phone
(407) 425-9559 fax
e-mail: CFHCC@netpass.com

Employers' Coalition on Health

Edgebrook Court
1639 North Alpine Road
Rockford, IL 61107-1449
(815) 397-0790 phone
(815) 397-2790 fax
www.ecoh.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 WITH EXPERIENCE USING PROVIDER 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

Wetzell Health Care Strategies

3639 Elmo Road
Minnetonka, MN 55305
(952) 938-1788 phone
(952) 932-0822 fax
e-mail: swetzell@msn.com

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, N.W., Suite 1100
Washington, DC 20005
(202) 216-9010 phone
www.urac.org

The Centers for Disease Control and Prevention

Division of Diabetes Translation
National Center for Chronic Disease Prevention
and Health Promotion
e-mail: ccdinfo@cdc.gov
www.cdc.gov/diabetes/projects/business.htm

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 Clinical Systems Improvement

8009 34th Avenue South, Suite 1200
Bloomington, MN 55425
(952) 814-7060 phone
e-mail: icsiinfo@icsi.org
www.icsi.org

The Institute for Healthcare Improvement

375 Longwood Avenue, 4th Floor
Boston, MA 02215
(617) 754-4800 phone
e-mail: info@ihi.org
www.ihi.org

The Institute for Medicine

The National Academies

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

Integrated Healthcare Association

45 Quail Court, Suite 302
Walnut Creek, CA 94596
(925) 746-5100 phone
e-mail: bcarter@iha.org
www.iha.org

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

One Renaissance Blvd.
Oakbrook Terrace, IL 60181
(630) 916-5600 phone
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

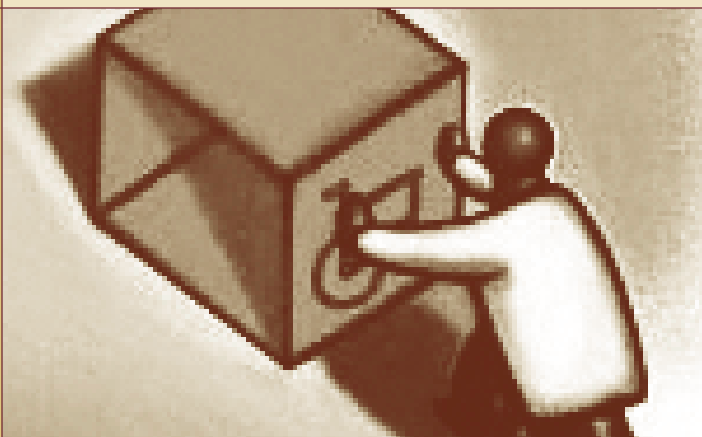
2000 L Street, NW, Suite 500
Washington, DC 20036
(202) 955-3500 phone
(202) 955-3599 fax
www.ncqa.org

PatientChoice

Parkdale Plaza
1660 South Highway 100, Suite 250
St. Louis Park, MN 55416
(800) 303-0542 phone
(952) 582-7020 fax
e-mail: info@pchealthcare.com
www.patientchoicehealthcare.com

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

- Bailit Health Purchasing, *Provider Incentive Models for Improving Quality of Care*, the National Health Care Purchasing Institute, March 2002.
- Bailit Health Purchasing, *Recommended Health Care Markets for Provider Incentive Demonstrations*, the National Health Care Purchasing Institute, March 2002.
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- "Employer Coalitions Demand Value in Provider Negotiations For Quality and Efficiency Guarantees, More Oversight," *Managed Care Week*, November 29, 1999.
- Goff, Veronica, *Advancing Patient Safety: The Leapfrog Group*, the National Health Care Purchasing Institute, December 2001.
- 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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- Milstein, A., "Mobilizing Employer Purchasing Power to Advance Quality of Care," *Viewpoint*, Marsh and McLennan Companies Inc., Summer 1998.
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- Robinson, J., "Theory and Practice in the Design of Physician Payment Incentives," *The Milbank Quarterly*, November 2, 2001, Vol. 79.

ENDNOTES

- 1 Kohn, L.T., et al., *To Err is Human: Building a Safer Healthcare System*, Institute of Medicine, 2000.
- 2 HEDIS is sponsored and maintained by the National Committee for Quality Assurance (NCQA) and designed for measuring health plan performance.
- 3 The Diabetes Quality Improvement Project (DQIP) began under the sponsorship of a coalition including the American Diabetes Association, the Centers for Medicare & Medicaid Services (CMS), and NCQA. The goal of the DQIP is to create consensus around a single set of diabetes measures for performance reporting.
- 4 Dyer, M.B., et al., *Are Incentives Effective: A Selective Study of Medicaid Managed Care Programs*, Center for Health Care Strategies, Inc., Princeton, NJ, forthcoming 2002.
- 5 An endarterectomy is a surgical excision of the inner lining of an artery that is clogged with atherosclerotic buildup.
- 6 Bodenheimer, T. and K. Sullivan, "How Large Employers are Shaping the Health Care Marketplace," *The New England Journal of Medicine*, April 2, 1998, Vol. 338, No. 14; pp. 1003-1007 and April 9, 1998, Vol. 338, No. 15; pp. 1084-1087.
- 7 Medi-Qual is a unit of Cardinal Health Information Companies and Atlas is one of the hospital performance systems approved by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO).
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