Incentives and Rewards Best Practices Primer:

Lessons Learned from Early Pilots

PRODUCED BY

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I. EXECUTIVE SUMMARY

A growing body of practical experience exists regarding the design, implementation, and evaluation of incentive and reward (I&R) strategies in health care. This primer describes the following issues to consider when pursuing an I&R strategy:

- Contemplation;
- Program design;
- Program implementation; and
- Evaluation and program refinement.

This primer discusses lessons learned from 13 pilot I&R initiatives, all of which show that it is not easy to make an I&R strategy successful. An extensive design and development process is required. If an I&R strategy fails, it is often because of a misstep that could have been avoided had purchasers and payers only known some of the lessons that this report describes.

Contemplation

When contemplating an I&R program, potential sponsors should:

- Invest time to develop and articulate the vision, goals, and guiding principles for the program;
- Understand what drives the cost of care and the gaps in quality of care for the relevant consumer population; and
- Identify other internal, local, and national efforts to address cost and quality concerns.

Incentive programs are all about behavior change. Program sponsors must consider whose behavior must change to improve quality and contain costs. Possible answers include purchasers, physicians, hospitals, and consumers. Program sponsors must engage and sustain involvement from all key stakeholders throughout I&R program development, design, and implementation.

Early in the process, successful I&R programs develop a communication strategy that includes core messages for stakeholders. These messages explain the benefits of the I&R strategy and describe why the commitment of time and resources is a good business decision. Multi-level communication strategies are even more important in collaborative I&R initiatives that involve multiple purchasers, payers, and providers.

Before designing an I&R program, sponsors should assess their resources and limitations and begin to build a team, internally and externally, to lead program development and implementation. Successful I&R programs have physicians, purchasers, payers, and consumers as key stakeholders, and they promptly identify stakeholder champions in each category. Effective I&R programs identify potential collaborators and I&R models, without overlooking the potential for collaboration with public purchasers.

Program Design

Choosing appropriate measures and measurement strategies is one of the most important issues to address. Sponsors should focus on standardized measures that are already in use. By doing so, sponsors can more easily garner support for the program from necessary stakeholders, shorten the length and cost of I&R design and development, make it easier to process decisions with providers, and lessen the need for testing and auditing data.

Successful programs solicit provider feedback on measures and measurement strategies and consider ways to minimize the administrative burden and cost of data collection.

Programs have a wide range of financial and non-financial rewards at their disposal, and using more than one approach can have a bigger impact. Programs should align incentives and rewards across a market to ensure maximum impact. Doing so simplifies the message to providers (and, sometimes, to consumers) and makes it more likely that desired behavior changes will be achieved.

Program Implementation

Begin the program with a plan and a timeline to guide how the work will proceed. Clearly define staff resources and assign responsibilities. Effective communication is essential during this period, especially with those who are receiving incentives to change their behavior — typically providers. Provider communications must address:

- The rationale behind the incentive;
- The science behind the measures and the reward algorithm;
- The providers who have endorsed the incentive;
- The behavior change expected of the providers; and
- The rewards the providers may receive.

Evaluation and Program Refinement

After the first reward period, I&R program sponsors should answer the following questions:

- Are targeted providers aware of the program?
- Did providers change their behavior in response to the incentives? If so, how?
- Did consumers change their behavior as a result of the incentives? If so, how?
- Did any undesired provider or consumer behaviors result from the I&R strategy?

For many incentive and reward sponsors, ongoing investment depends on learning that the cost of the incentives have not exceeded the cost of the rewards.

Although sponsors often initiate I&R program evaluations to assess the program's effectiveness, they will also learn important lessons that can guide them in refining the program.

The growing body of practical experience enables those contemplating new initiatives or considering refinements or expansions of existing programs to learn from the experiences of others.

II. INTRODUCTION

Provider incentive and reward (I&R) strategies are a widely accepted method used in the United States to improve health system performance. Over the period of approximately a decade, these strategies have moved from the fringe into the mainstream.

This relatively rapid change in the use of I&R strategies occurred for two main reasons. First, leading employer and employer coalition purchasers began to call for health system accountability. These purchasers were willing to structure contractual and non-contractual strategies to motivate health plan and provider performance change. In time, state agencies joined these private sector purchasers. Finally, so did the Center for Medicare and Medicaid Services (CMS) — in an important and powerful way.

Second, the Institute of Medicine's seminal report *Crossing the Quality Chasm: A New Health System for the 21st Century* specifically addressed the problem of misalignment between payment strategies and the delivery of evidence-based health care. This attracted wide attention and spurred action on the part of many health care system stakeholders, including foundations and federal government agencies.

III. FORMAT

This primer describes the steps involved in making an incentive and reward strategy successful. This primer uses examples from actual I&R initiatives. Some of the pilots were funded by the Robert Wood Johnson Foundation, under the "Rewarding Results: Aligning Incentives for Quality" initiative. Those sponsors included:

- Blue Cross of California;
- Bridges to Excellence (BTE);
- Excellus/Rochester Individual Practice Association (RIPA);
- Integrated Healthcare Association (IHA);
- Medi-Cal Local Initiative Rewarding Results (LIRR);
- Massachusetts Health Quality Partners (MHQP); and
- Michigan Blue Cross Blue Shield (BCBSM).

Other pilots received assistance from the federal Agency for Healthcare Research and Quality. Those sponsors included:

- The Boeing Company;
- Blue Shield of California;
- Buyers Health Care Action Group;
- GE, Verizon Communications, and Hannaford Brothers Collaborative;
- Healthcare 21 (HC21) Business Coalition Incentives and Reward Program; and
- the Maine Health Management Coalition (MHMC).

For more information on the pilots, see Appendix A and the Incentives and Rewards section on the Leapfrog Group's Web site at www.leapfroggroup.org.[1]

Readers should use this primer in conjunction with "The Leapfrog Group Incentives and Rewards Toolkit – 101," which walks purchasers through envisioning, designing, implementing, evaluating, and refining an I&R strategy. The toolkit does this is by posing key questions for the sponsor to consider along the way. This primer and the toolkit both break the process down into the same phases: contemplation, program design, program implementation, and evaluation and program refinement. This primer illustrates how these phases play out in

1. For the Incentives and Rewards section on the Leapfrog Group's Web site go to: www.leapfroggroup.org/about_us/other_initiatives/incentives_and_rewards.

established incentive and reward programs. The case studies target specific issues presented in each section of the toolkit. The case studies show both successes and failures — and the valuable lessons that can be drawn from each.

Appendix B to this document includes resources for purchasers and other potential I&R sponsors. For example, purchasers may want to consult, "Pay for Performance: A Decision Guide for Purchasers," which is available from the Agency for Healthcare Research and Quality (publication number 06-0047), available at www.ahrq.gov.

This primer is designed for organizations that have decided to develop I&R programs. Potential sponsors of I&R programs interested in developing a business case for incentive and reward programs should also consider reviewing a related Leapfrog document, "Assessing the Value of Incentives and Rewards Programs: A Primer."[2]

2. The HSM Group, Ltd, "Assessing the Value of Incentives and Rewards Programs: A Primer", for The Leapfrog Group, supported by funding from the Commonwealth Fund, September 2005, accessible at www.leapfroggroup.org.

IV. CONTEMPLATION

Creating a successful incentive and reward strategy is not easy, and it is rarely accomplished without an extensive development process. As in the Leapfrog I&R Toolkit, this primer divides the development process in this contemplation phase into pre-program development considerations and then specific I&R program design considerations.

When I&R strategies fail, the failure is often the result of a misstep that could have easily been avoided if only the purchasers and payers had known some of the best practices described in this primer.

When contemplating an I&R program, potential sponsors should understand what factors drive the cost of care and the gaps in quality of care for the relevant consumer population. Sponsors should know what activities are being undertaken internally, and in the local and national marketplace, to address health care cost and quality concerns. Refer to the "contemplation" and "vision" sections of the Leapfrog I&R Toolkit for initial questions to consider.

Program Vision, Goals, and Guiding Principles

At the outset of the I&R development process, sponsors must identify in concrete, measurable terms what they want to accomplish. As one sponsor of a Rewarding Results pilot noted, "Be clear about what you are trying to achieve and keep your focus." Another recommended that purchasers "Be vigilant, do not get distracted."

The I&R development and implementation process can be lengthy. Obtaining measurable clinical and financial results will also take time. Therefore, it is wise for purchasers to identify I&R goals for the near-term, as well as goals that reflect a longer-term vision. Failure to be specific at this starting point can result in internal organizational confusion and disagreement in the design and implementation phases. It can also lead to future conflicts with necessary partners and stakeholders.

The California Pay for Performance Program is a collaboration of physician organizations, purchasers, and insurers that is facilitated by the Integrated Healthcare Association (IHA), one of the Rewarding Results grantees. In a 2006 self-assessment of lessons learned, IHA wrote: "Set ambitious long-term performance objectives, but modest short-term process goals. Trust is the glue that binds collaboration, and it is best developed through mutual achievement."[3]

3. Advancing Quality Through Collaboration: The California Pay for Performance Program," Integrated Healthcare Association, February 2006, accessible at www.iha.org.

Lessons learned from the collaborative Rewarding Results initiatives indicate that I&R programs benefit if the goal statements are accompanied by project parameters or operating principles that set forth the general agreements achieved among the collaborating parties relative to the incentive and reward initiative. These parameters or principles serve as guideposts in the development process and help avert or manage future conflict. This type of approach was essential to the success of collaborative Rewarding Results initiatives, including IHA and Bridges to Excellence.

According to IHA, "The importance of the guiding principles cannot be overstated…. At times when trade-offs become difficult, and even contentious, revisiting the guiding principles provides an important check for decision makers."[4] The case study below provides more detail on the IHA goals and guiding principles. IHA has posted considerable information on its Web site—www.iha.org—that is helpful for purchasers considering, developing, and implementing I&R programs.

CASE STUDY: Setting Goals and Guiding Principles

The California Pay for Performance Program is a collaboration of physician organizations, purchasers, and insurers that is facilitated by the Integrated Healthcare Association (IHA). Initiated in 2001, IHA established a vision statement and a central goal statement:[5]

VISION: The achievement of breakthrough improvement in health care performance.

CENTRAL GOAL: To improve physician group performance significantly in quality of health care and patient experience through public recognition and financial reward.

As IHA noted, a series of tough questions emerge once a decision has been made to develop an I&R program. In a collaborative model, it is essential to create principles to guide the development and management of the I&R program effectively and to avoid loss of time and support at critical decision points.

The California Pay for Performance Program established core principles addressing collaboration, measurement, reward, and accountability. The participants established SIX PROGRAM OBJECTIVES:

1. Strategic measurement selection criteria ensure that the measures chosen would be: clinically relevant; effect a significant number of people; scientifically sound; feasible to collect; impacted by those being measured; capable of showing improvement over time; important to consumers, and aligned with national standards.
2. Encourage system change and reengineering rather than incremental improvement.
3. Include measurements of customer service and administrative efficiency.
4. Keep the measurement set predictable and stable.
5. Provide comparability across physician groups.
6. Align pay for performance measures with those required by accreditation, HEDIS, and other standards.[6]

These objectives address both short- and long-term goals. For example, the objective addressing measurement set predictability states "Phase-in multiple part measures, moving from process to outcomes as appropriate."

4. Ibid.
5. "Advancing Quality Through Collaboration: The California Pay for Performance Program," Integrated Healthcare Association, February 2006, accessible at www.iha.org.
6. Ibid.

Program Focus

Incentive programs are all about behavior change. Sponsors must assess who should be the focus of the incentive and reward program and whose behavior must change in order to improve quality and contain costs. Possible answers include physicians, hospitals, and consumers. The Leapfrog I&R Toolkit includes questions for sponsors to answer when contemplating the program focus.

I&R sponsors should consider both provider behaviors and consumer behaviors. Don't attempt to change too many behaviors at once. Be sensitive to the administrative burden that complex I&R programs can impose on providers.

Sponsors often focus on cash incentives to motivate behavior change. Although experience shows that these are effective, there is a wide array of other financial and non-financial rewards that can serve as effective incentives for behavior change. Examples of some of the non-financial business cases that might apply for a payer or for a larger provider organization include the following:[7]

- A regulatory or contractual requirement;
- Image, reputation, or product differentiation;
- Relationship development with key stakeholders;
- Relevance to an organization's mission; and
- Impact on internal culture.

Using more than one incentive might be necessary to motivate behavior change within the same organization. For example, in an incentive and reward program employed by the state of Iowa with a Medicaid-managed behavioral health contractor, a large bonus incentive payment was a strong motivator for behavior change for the contractor's corporate management, but the state-level executive director was more motivated by the obligation to present at a large public forum with providers and consumer advocates regarding her attainment of contractual quality improvement goals.[8]

Target incentives to the people who have the ability to affect change. Consider the use of incentives with a physician group practice. It's fine to award a bonus to the physicians, but if much of the work required to achieve the bonus is performed by the practice's administrative staff, those individuals should also get an incentive.

Understand the impact of existing and dominant benefit designs on providers and consumers when developing an I&R program.

CASE STUDY: Successful Focus on the Dominant Benefit Design—the PPO

Blue Cross of California, a Rewarding Results grantee, stands out for implementing an I&R program in a complex preferred provider (PPO) network in the San Francisco market. Despite the fact that 60 percent of the insured market in the United States is enrolled in a PPO, Blue Cross is a rare example of an I&R initiative focusing on individual primary care physicians in a PPO product. Developing an I&R program for its PPO physicians made sense because of the dominance of the PPO product and the insurer's simultaneous involvement with the California Pay for Performance Program focused on provider groups in the HMO market. Blue Cross' innovative strategy required the insurer continually to assess and respond to the differences in its PPO product and its relationship with providers that affected the design and implementation of a successful I&R program.

7. Bailit M and Dyer MB. "Beyond Bankable Dollars: Establishing a Business Case for Improving Health Care", *Issue Brief*, The Commonwealth Fund, September 2004.
8. Dyer MB and Bailit MH, "Are Incentives Effective in Improving the Performance of Managed Care Plans?" The Center for Health Care Strategies, March 2002.

Current Health Care Improvement Efforts in the Organization

Health care incentive and reward strategies do not exist in a vacuum. Sponsors must understand other internal initiatives that are in place or are being planned that could affect the incentive and reward strategy. These potentially interacting initiatives could have implications for resource availability or could confuse internal and external communication efforts to describe the goals of the strategy and to obtain necessary support.

Understanding the Local and National Health Care Markets

The Local Health Care Market

Understanding the local health care market is important, because things such as market dynamics, the strength of the I&R purchasers and payers, and the burden on the providers will determine what is possible.

Some previous incentive and reward initiatives failed because of faulty assessments of the relative market power that existed among purchasers, payers, and providers. These failures make it clear that sponsors must identify at the outset the interests of all of the entities that might be involved in the incentive and reward initiative, how much influence they have relative to one another, and how likely they are to respond to the short- and long-term goals around which the strategies will be designed.

Most often, purchasers and payers need to partner with multiple stakeholders, including similar purchasers and payers, as well as providers, in order to create a successful incentive and reward program. Examples of a variety of collaborative efforts are found in the Rewarding Results initiative, such as: Bridges to Excellence, Excellus/RIPA, IHA, the Medi-Cal Local Initiatives for Rewarding Results, and the Massachusetts Health Quality Partnership. The following two case studies of collaborations are from entities participating in AHRQ I&R programs.

CASE STUDY: Successful Use of Strong Market Power and Provider Self-interest

The Buyers Health Care Action Group (BHCAG) is a purchaser coalition located in the Twin Cities area, but with a statewide presence. BHCAG sought to redefine competition within the Minnesota marketplace by driving competition to the provider level. BHCAG envisioned provider systems competing with one another on explicit measures of cost and quality, with member employers varying their employee contributions based on the bid premiums of the provider systems. Because of the number, size, and prestige of participating employers; their commitment to the benefit design, and the desire of the provider systems to work directly with employers, BHCAG was able to implement and sustain over time this innovative design.[9]

CASE STUDY: Successful Partnerships When Lacking Dominant Market Power

Maine is a largely rural state with few insurers and a small number of dominant health systems. There are few large purchasers in the state. These purchasers, however, have been vocal proponents for system transparency and for quality improvement. They formed a multi-stakeholder organization, the Maine Health Management Coalition. The coalition is governed by purchasers, physicians, hospitals, and insurers that have worked together for many years, developing considerable trust with each other. When it initiated its I&R strategy, hospitals were invited to participate in the design process as full-fledged partners. Because of this trust and shared values, the coalition has been able to advance an incentive and reward program, with modest participation and support from the state's largest private insurer, Anthem.

9. Christianson J. et. al. "Early experience with a new model of employer group purchasing in Minnesota" *Health Affairs,* 18:6, November/December 1999. Christianson J and Feldman R. "Evolution in the Buyers Health Care Action Group purchasing initiative" *Health Affairs,* 21:1, January/February 2002.

If the incentive and reward strategy is to be led by a group of purchasers working together in a formal or informal coalition, it is essential to determine each purchaser's level of commitment and resolve to changing behavior through the strategy. It is quite difficult, if not impossible, for purchasers to initiate an incentive and reward strategy if they lack both dominant market power and strong resolve. There are many examples of strategies that failed because when it came time for the purchasers to assert their commitment to motivating behavior change, they failed to do so.

In the rare instance that a payer or purchaser has dominant market power, it may be able to dictate an incentive and reward strategy. Purchasers rarely exercise such market power over payers or providers, with the possible exception of the federal Medicare program and some state Medicaid programs. Below is a case study related to a proactive public purchaser in Massachusetts.

CASE STUDY: Successful Use of Strong Market Power

The Massachusetts Group Insurance Commission of the Commonwealth of Massachusetts is responsible for administering benefits to employees and retirees in the state. The commission's executive director is an outspoken proponent of system change. The size of the state employee and retiree group, coupled with the high profile of the commission's executive director, has given the commission considerable market power. Therefore, when the commission implemented a tiered benefit health insurance product for active employees, with providers tiered based on provider quality and cost (or efficiency), it was able to solicit responsive proposals from Massachusetts insurers. The commission was successful despite outspoken opposition from influential integrated delivery systems.[10]

The National Health Care Market

Regardless of the opportunities for collaborations at the local health care market level, purchasers and payers developing I&R programs should not overlook I&R models in other parts of the country that they might build upon locally. For example, both the Leapfrog Hospital Reward Program™ and Bridges to Excellence are nationally standardized programs that private health care purchasers and payers can license and implement.

The Leapfrog program focuses on five clinical areas that account for a significant share of inpatient hospital admissions and cost for private purchasers:

- Acute myocardial infarction;
- Coronary artery bypass graft;
- Percutaneous coronary intervention;
- Community acquired pneumonia; and
- Deliveries and newborn care.

Bridges to Excellence recognizes and rewards physicians who deliver safe, timely, effective, efficient, equitable, and patient-centered care. The Bridges to Excellence initiative comprises three individual physician recognition programs operated by the National Committee for Quality Assurance:

- Diabetes Care Link;
- Cardiac Care Link; and
- Physician Office Link.

Physicians who demonstrate high levels of performance in these areas are eligible for incentive bonuses paid by participating Bridges to Excellence employers.

In addition to these private programs, there are public purchasers who have either used or developed

10. Kowalczyk L. "Health plans set care surcharges. Tiered system tied to provider costs." *The Boston Globe*, March 25, 2004.

I&R models, including the Center for Medicare and Medicaid Services' Medicare P4P initiatives and demonstrations.

Building the Team and Identifying Resources

Building the Team

The team that designs and implements the incentive and reward strategy must consist of purchaser, provider, and payer representatives. The team may also include outside technical experts, consumers and consumer advocates, and governmental agencies. For many purchasers, close coordination with participating health plans is essential. In addition, purchaser-sponsored teams need sustained visibility of the purchaser sponsor while the team is being formed and afterwards. In design teams, sponsors should include both technical experts and those who can champion the effort within the organization, such as those who have significant stature in their organization or among their constituents.

The team also needs expertise in the following areas: program management, quality improvement, law, accounting/finance, clinical, communications, and information technology.

Resources — both external and internal — are also important. The corresponding section of the Leapfrog I&R Toolkit provides key questions for potential sponsors to consider when building the team and identifying resources.

Rarely will one organization have both the resources and the market leverage to implement an I&R program without significant outside resources or collaboration. With I&R programs becoming mainstream, there are more opportunities to collaborate with existing I&R efforts and to identify experienced plans and vendors that can help. I&R program design and implementation involves a learning curve, and experienced partners can help sponsoring organizations through this process.

I&R teams develop best when there are existing relationships and trust among the participants. When an independent organization can be trusted to convene and facilitate development, this adds significant credibility to a collaborative effort. The Integrated Healthcare Association (IHA) and the Maine Health Management Coalition each serve these roles. As another example, Massachusetts Health Quality Partners has become a trusted independent organization that has earned the highest praise from providers for its willingness to listen to, consider, and respond to their concerns. Below is a specific case study example in team building from Bridges to Excellence.

CASE STUDY: Building a Team With Those Who Support the Mission

At times it is possible to assemble a team by selecting those who support the principles and mission underlying the incentive and reward strategy. One example of this approach is Bridges to Excellence's decision to work with leading provider groups in Boston during the early developmental period of the project. These providers included Partners Health Care System and Lahey Clinic. These prominent delivery systems in metropolitan Boston have a strong market position and solid reputation for quality care. These providers were an excellent choice for collaboration with the Bridges to Excellence employer purchaser leaders from General Electric and Verizon on incentive and reward strategy design. The participation of these prominent providers led to program design discussions and changes that were more acceptable to the providers that were targeted for recognition.

Identifying Resources

The development and implementation phase for a large scale incentive and reward strategy typically lasts two to three years—far longer than is ever desired. One employer coalition executive director reported: "It takes a lot more time than you think." For the Rewarding Results grantees, most of whom had some past experience with performance measurement and incentives, the development phase after the grants were awarded and prior to implementation averaged about ten to 12 months. This prolonged initial period means that a significant commitment of resources must be made at the outset to see the initiative through to successful implementation.

Resource requirements include the following:

Content expertise: Incentive strategy design inevitably leads to highly technical discussions of measurement design, data collection and aggregation, statistical analysis, and award distribution policies. Those participating on the design team must bring with them clinical and statistical knowledge.

Organizational commitment: In order to proceed on firm footing, each of the participants must commit to the goals of the incentive and reward strategy before work moves to the development phase. In addition, each organization's representative must be vested with authority to make commitments on behalf of the organization.

Financial and staff resources: Significant staff time and data analysis will be required before the development and implementation phases are complete. Sometimes, organizations developing incentive and reward strategies have been able to obtain foundation funds, federal grants, or in-kind services to help defray these costs. Whatever the source of the funds, there needs to be a sober assessment of what will be required and where it will come from before proceeding with development. In addition, it is wise to anticipate what the ongoing costs after implementation might be and how those costs will be funded. Don't forget to include costs for evaluation in this assessment.

Communication Strategy

When participants in a development and implementation phase are asked what they learned, they frequently cite the need for effective

CASE STUDY: Insufficient Market Power, Poor Team Development, and Insufficient Resources

The New Hampshire Health Care Purchaser Partnership (NHHPP) was a coalition of public sector and private sector employer purchasers. It set out to develop a benefit design incentive and reward strategy that would tier providers based on an aggregate assessment of their quality and efficiency and then vary copayments accordingly.

The NHHPP convened a number of work groups to design the measures for tiering, the data collection and analysis strategy, and the new benefit design. Hospitals, physicians, and the state's three health insurers participated in these work groups, which reported their recommendations to a purchaser steering committee. However, only one of three insurers committed to develop the product, and then that insurer retracted that commitment. What went wrong?

FIRST, the purchasers designed the process as if they had dominant market power, but they did not. If providers and insurers had been given equal governing roles with the purchasers, the effort might have succeeded.

SECOND, the work commenced without a commitment from the insurers to see the project through.

THIRD, one purchaser financed the development work. Lacking a commitment from others to share the cost, the purchaser decided to end its investment.

communication, both to providers and to other stakeholders, such as consumers and the general public, through the media.

Prior to the development phase, communication must focus on obtaining understanding and buy-in. Poor communication may lead to inadequate commitment, and later to failure.

- Sponsors and stakeholders must be told what the expected benefits of the incentive and reward strategy are and why committing their time and resources is a good business decision.
- A thoughtful communication strategy is essential within sponsoring organizations and across partners and stakeholders involved in an I&R program.
- Multi-level communication strategies are even more important in collaborative I&R initiatives that involve multiple purchasers, payers, and providers.

CASE STUDY: Best Practice in Provider and Patient-Specific Communication

Excellus and the Rochester Individual Practice Association (RIPA) is a collaboration between a health plan and a provider group. RIPA physicians were involved in the development of the I&R program right from the beginning. Physician communication and outreach was a key component of the program's success. Excellus/RIPA has improved the management of patients with sinusitis, otitis, diabetes, asthma, and heart disease by giving doctors timely measures of quality, affordability, and satisfaction. The state-of-the-art program has become a national model by providing doctors with performance reports that contain actionable information to improve patient care. The actionable information is delivered to the doctor, the office, and the patient in the form of status reports that encourage follow-up with the physician. Excellus/RIPA was also the first Rewarding Results project to identify a positive return on investment.

V. PROGRAM DESIGN

Determining Measures and Measurement Strategies

Appropriate measure selection is key to a successful I&R program. For help in doing this, refer to the "program design" section of the Leapfrog I&R Toolkit.

Sponsor's review of measures and measurement strategies related to specific types of providers is an important part of the design process, which involves:

- Defining the criteria for an acceptable measure;
- Determining the source of the measure;
- Determining how the measurement results will be generated;
- Processing decisions with providers; and
- Testing and auditing measurement data.

Although early I&R strategies often needed to develop their own measures because of the lack of standardized measures, there has been a proliferation of national and regional provider performance measurement sets in the past decade, as well as an expansion of the measurement sets that already existed.

Sponsors should start by reviewing the menu of measures endorsed by national bodies, including the National Quality Forum, Centers for Medicare and Medicaid Services, the American Hospital Association's Hospital Quality Alliance, the Ambulatory Care Quality Alliance, and the National Committee for Quality Assurance. Sponsors can also look to standardized measures endorsed and collected at state and regional levels. I&R program sponsors should select measures from these standardized consensus measurement sets unless it is absolutely necessary to do otherwise.

Sponsors should also consider the "Guidelines for Purchaser, Consumer, and Health Plan Measurement of Provider Performance" developed by the Consumer Purchaser Disclosure Project.[11] This coalition of consumer, employer, and labor organizations encourages the selection of standardized measures with scientific grounding, transparent provider rating methods, and coordinated data collection.

Many of the Rewarding Results initiatives used measures and measurement strategies that were either already in use by sponsoring organizations or being used by other organizations to report provider performance publicly.

11. See http://healthcaredisclosure.org/.

In summary, sponsors should initially:

- Focus on standardized measures that are already in use for the type and level of provider being considered for the I&R program; and
- Consider ways to minimize the administrative burden and costs of data collection by coordinating with or using publicly available data.

In this way, sponsors can shorten the length and lessen the cost of the I&R design and development process, more efficiently process decisions with providers, and lessen the need for testing and auditing of data.

Sometimes, the initiative's sponsors may not be able to find applicable measurement sets, or they might need to modify existing measurement sets to address the assessed patient population or to meet local provider concerns. Still, it is best that sponsors first make certain that existing consensus measurement sets cannot address all of the team's concerns before considering developing unique measures.

The integrity of a measure rests in part on the integrity of the data used to generate the measure. For example, many I&R strategies rely upon administrative data derived from provider claims submissions. This type of date is attractive because it is relatively inexpensive to obtain when compared to medical chart abstraction. Yet administrative data can be problematic because of inaccurate coding and data entry errors. This type of data also sometimes fails to account for services that were delivered but not billed.

Time and again, providers point to provider input and measurement integrity as the key to the successful development of an I&R strategy. Physicians who are satisfied with a development process speak to having been "heard" and "listened to."

A sponsor's I&R development process needs to include adequate time for iterative discussion to evaluate issues of data quality and the clinical and statistical integrity of measures. For example, recent provider I&R initiatives have experienced extensive provider debate on accounting for variability in illness severity and complexity and accounting for variation in socioeconomic status.

On a related topic, potential measures and measurement data must be tested until providers participating on the development team feel comfortable. This testing is particularly important for non-standardized measures or measures that are being used in a new situation, such as measurement at the individual provider level rather than at the medical group practice or health plan level.

The testing of new measures or new measurement strategies involves generating the data, providing it to affected providers along with supporting case detail so that the provider can study instances of non-compliance with a measure's criteria (such as an evidence-based protocol), and then discussing findings and any desired modifications to the incentive and reward strategy prior to implementation. Physicians attain a greater level of trust and comfort with the data and the process when this level of collaboration occurs. The process can be tedious and frustrating. It is necessary, however, and it can avert subsequent problems during performance reporting or reward payout.

There is sometimes a consensus decision that data used in I&R programs need to be audited. The need and procedure for any auditing should be debated and decided upon during the development process with input from key sponsors, providers, and other stakeholders.

Sponsors need to get champions and key stakeholders together on a regular basis, to understand, develop, and endorse key program design elements.

CASE STUDY: Effective Collaboration With Providers on Measure Development

A large Michigan health system reported that Blue Cross and Blue Shield of Michigan (BCBSM) was good at listening to the provider's concerns. At the initiation of the I&R program, BCBSM invited the state hospital association to appoint representatives to a provider technical advisory group specifically related to the I&R program. BCBSM's strategy involved getting providers to buy into the I&R program by giving them a key role in helping to build it. BCBSM's willingness to work with hospitals to revise measures helped develop trust and confidence in the incentive and reward system. For example, one large health system expressed concern with a measurement of discontinuation of antibiotics 24 hours after surgery, particularly for patients receiving prosthetic devices. BCBSM suspended its use of the measure until the question was resolved. BCBSM was able to obtain participation of 100 percent of the eligible hospitals in this voluntary program—a positive refection on BCBSM's efforts to engage providers.

Financial Resources

A significant number of incentive and reward strategies are developed and implemented out of a simple desire to improve the quality of health care delivery and to achieve improved clinical outcomes. For the sponsors of these initiatives, a positive net financial return from the incentive and reward strategy is desirable but not necessary to justify the strategy. For others, the general belief that "quality costs less" is enough to justify an incentive and reward strategy.

However, for many I&R sponsors and participants, there must be a sound financial basis for supporting any financial incentive and reward strategy before it proceeds. They want to see an evidence-based calculation of projected return on investment or savings.

Further complicating the challenge is the need to sometimes demonstrate the financial return not only to those who will be funding the costs associated with the incentive, but also to the providers who will be investing time and resources in order to obtain the rewards.

CASE STUDY: Calculating the Business Case for an Incentive and Reward Strategy

Because most businesses need to see a strong business case to finance an incentive and reward program, Bridges to Excellence generated detailed, evidence-based calculations to project the savings that would accrue from the provider office systems and practices prescribed by its programs:

- DIABETES PROVIDER RECOGNITION PROGRAM: 10 to 15 percent savings per patient per year;
- HEART STROKE RECOGNITION PROGRAM: up to $350 savings per patient per year; and
- PHYSICIAN PRACTICE CONNECTIONS PROGRAM: up to $110 savings per patient per year.

Bridges to Excellence attributed the savings to the quality and efficiency of the recognized practices. Bridges to Excellence based its findings on reliable information on the cost of services received by patients. Bridges to Excellence provides the detailed data sources and calculations used to reach the estimated savings amounts within its publicly available operations manual.[12]

At this point in the process, sponsors should reassess the degree of financial commitment necessary to administer the incentive and reward strategy and to fund any reward payments. Although sponsors will

12. Bridges to Excellence Operations Manual, www.bridgestoexcellence.org/employers_hp/emp_toolkit.htm, accessed May 24, 2006.

have already made this assessment during the pre-development stage, it is necessary to consider this question again as the reward methodology becomes better defined and the prospects of implementation grow more likely.

Sponsors will also need to decide upon the size of the reward. Bridges to Excellence and others estimate that an incentive should be roughly 5 to 10 percent of total provider annual income. The IHA intends to increase the size of its financial bonus to 10 percent of physician group income by 2010. It is clear, however, that the necessary size of a financial incentive will vary depending upon the following:

- The incentive's target (for example, individual PCP, small specialty group practice, large multi-specialty group practice, hospital). Some believe that small cash payments can be quite effective with primary care physicians, whereas hospitals require larger rewards to change behavior.
- The level of resource investment required to attain the reward.
- Other incentives that might be influencing provider behavior relative to the desired behavior change.

Although most provider incentive and reward strategies involve purchaser or payer financing of rewards, there are instances in which providers are in some manner at risk for earning their reward. There are also some creative incentive and reward strategies that finance reward payments with funds that come from a payer or from purchasers in tandem with financing from providers. This type of partnership arrangement is sometimes seen as more equitable than having one party fund reward payments. This type of arrangement can also be an important symbol of the commitment that the participating organizations are making to one another.

Examples of this type of partnership funding include the following:

Excellus/Rochester Individual Practice Association: These organizations structured their incentive strategy such that Excellus committed a certain sum to financing rewards, while RIPA agreed to place a fixed percentage of its payments at risk based upon performance.

Maine Health Management Coalition: The employer purchaser and hospital members of the coalition formed a similar arrangement. The employers committed to contribute a fixed percentage of their spending to a pool, while the hospitals agreed to contribute a fixed percentage of their total revenue from the nine participating employers to the same pool.

LIRR: One of the Medi-Cal plans, LA Care, held a provider summit to discuss strategies to improve encounter data submission, identify ways to help more medical groups meet the encounter data benchmarks, and hear best practices from groups/IPAs that have been successful in earning the incentives. Technical assistance from LA Care staff and its encounter data consultant was offered to the groups/IPAs to assist them in better success with the incentive program.

Selecting the Incentive and Reward Design

Selection of measures and measurement methodologies, and confirmation of the business case and resources for the incentive strategy, leads sponsors to determining the mechanism for allocating rewards.

Research reveals great variety and creativity across the United States in the application of incentive and reward models. The table on the following page is a

summary of some of the incentive and reward models that are currently in use.[13] These approaches are often not mutually exclusive. For ease of comparison, all examples are presented relative to a single primary care physician. The concepts are, however, transferable to physician practice sites, group practices, networks, and hospitals, as well as to other provider organizations and aggregations.

Using multiple reinforcing incentives enhances the likelihood changing provider behavior. For this reason, many incentive and reward strategies include

INCENTIVE AND REWARD MODEL SUMMARY

FINANCIAL REWARD	EXAMPLE
Bonus for achievement of a predetermined threshold	A primary care physician (PCP) receives a bonus payment if 80 percent or more of age-appropriate female adult patients received a mammogram in the past two years.
Bonus for delivery of a desired service	A PCP receives an automatic payment of $50 every time one of the PCP's age-appropriate female adult patients receives a biannual mammogram. A PCP is paid $25 for every telephone call to a patient who is due for a mammogram.
Bonus for demonstration of improvement	A PCP receives a bonus payment if the PCP demonstrates a statistically significant increase in the percent of age-appropriate female adult patients receiving a mammogram in the past two years. PCPs with rates over 90 percent also receive the bonus.
Compensation at risk	A PCP forfeits a fee schedule increase unless the PCP achieves the national mean on several performance metrics.
Performance-based fee schedule	A PCP is paid 105 percent of the fee schedule if strong performance on several performance metrics distinguishes the PCP from other PCPs.
Quality grant	A PCP may apply for a grant to implement a patient registry system to facilitate tracking of patients in need of a routine mammogram.
Tiered bonus for achievement of predetermined thresholds	A PCP receives a bonus payment if 80 percent or more of age-appropriate female adult patients received a mammogram in the past two years, but a larger payment if more than 90 percent did so.
Tiered bonus based on comparative ranking	A PCP receives a bonus payment if ranked in the top 50 percent of PCPs for delivery of mammograms to age-appropriate female adult patients in the past two years, but a larger payment if ranked in the top 25 percent.
Variable cost sharing	A member pays a lower copayment when receiving services from a PCP if strong performance on several performance metrics distinguishes the PCP from other PCPs.
NON-FINANCIAL REWARD	**EXAMPLE**
Performance profiling	The percentage of a PCP's age-appropriate female adult patients who received a mammogram in the past two years is compared to regional averages and shared with the PCP.
Practice sanctions	The PCP is not made available to new patients until the PCP demonstrates improved and acceptable performance on several performance metrics.
Public recognition	The percentage of a PCP's age-appropriate female adult patients who received a mammogram in the past two years is published on a web site in conjunction with other measures and compared to regional averages. The PCP is recognized with a distinguished provider rating.
Technical assistance	The PCP is offered free practice consultation on how to increase the percentage of the PCP's age-appropriate adult female patients receiving prescribed mammograms.

13. Bailit Health Purchasing, LLC, "Provider Incentive Models for Improving the Quality of Care", National Health Care Purchasing Institute, March 2002 and Dudley R.A. and Rosenthal M.B. "Pay for Performance: A Decision Guide for Purchasers", Agency for Healthcare Research and Quality, April 2006.

more than one incentive:

Bridges to Excellence gives physicians both bonus payments and public recognition.

Excellus/Rochester Individual Practice Association gives physicians both bonus payments and technical assistance in the form of data and tools to make it easier for physicians to achieve the rewards.

Integrated Healthcare Association gives physician groups both bonus payments and public recognition through a state-issued report card.

Alignment with Other Market Activity

Consider the extent to which the selected measures and incentives may relate to existing market requirements and incentives, both locally and nationally. Building upon existing efforts makes an I&R strategy more powerful.

Assess the market on an ongoing basis to identify both opportunities and threats to the strategy. Successful change is often predicated upon timing. If circumstances are not right, the best-intended and best-designed initiative will not succeed. See the table below for examples of incentive and reward strategies that struggled at times because of concurrent market activities.

Concurrent market activities do not always create barriers, however. They can also develop into new opportunities. Consider the following case studies.

CASE STUDIES: Aligning Incentive Strategies With Existing Market Activities

Blue Cross and Blue Shield of Michigan (BCBSM) implemented an I&R strategy addressing quality indicators for treatment of heart failure. Two of the participating hospitals aligned themselves with BCBSM's initiative. BCBSM developed the incentives with the input of the health systems around existing measures established by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS). The BCBSM I&R program reinforces existing hospital requirements and incentives from other sources and is aligned with initiatives that the other health systems were already pursuing.

In California, the Integrated Healthcare Association-led effort decided that transparency was an important part of its pay for performance program. Rather than compete with a report card already published by the California State Office of the Patient Advocate, it offered its data to the Office for Patient Advocate for its own use. The offer was accepted, and this collaboration on a medical group report card for consumers in California has worked successfully.[14]

INCENTIVE AND REWARD STRATEGIES

STRATEGY	SPONSOR	CONFOUNDING MARKET ACTIVITY
Physician bonus	Local Initiative, Rewarding Results, and Integrated Healthcare Association	Concurrent multi-HMO initiatives affecting common providers with separate measures for their incentives.
Tiered benefit design	Buyers Health Care Action Group	Hospitals were distracted by the national 100,000 Lives Campaign.
	HealthCare 21	Election year made public employers timid about implementing a change that faced political opposition. Health plans are developing high performance networks as a form of incentive and reward.

Evaluation Design Strategy

Incentive and reward strategies all too often suffer because of the failure to develop an evaluation plan prior to the implementation period. Because there is frequently a desire to determine whether the incentives and rewards have affected the desired behavior change, it is necessary to identify how this assessment will be made. The team should work together to identify a methodology and data sources for doing so. Possible questions to consider in developing an evaluation design strategy are included in the Leapfrog I&R Toolkit.

The evaluation process will be imperfect, for it will not be able to hold constant all of the other factors influencing provider behavior while the incentive is introduced. Still, sponsors should develop a reasonable method for assessing impact—both clinical and financial. Successful evaluation may not be possible if the need for an evaluation is not thoughtfully considered in the I&R program design phase prior to strategy implementation. Ongoing evaluation can also help implementers decide whether to continue the program or refine it.

VI. PROGRAM IMPLEMENTATION

Implementation should proceed with a well-established work plan and timeline as well as clearly defined staff resources and responsibilities.

Operational Planning

Development of an incentive and reward strategy is not all conceptual and methodological. I&R sponsors must attend to concrete operational details that can mean the difference between success and failure. I&R sponsors should develop and use a detailed work plan and timeline to address the various operational and resource issues identified in the program design phase. In addition, sponsors should use the work plan to address assigned roles and responsibilities and to manage complex timelines.

Feedback

Typically the team that met to develop the design will continue to work together in a project oversight capacity, addressing operational and methodological issues that arise during the implementation. There should be a clearly defined process for sharing feedback from stakeholders and from assigned project staff with the design team during the implementation period. Communications with all stakeholders—and not just those stakeholders that participated in the development phase—is important throughout the process.

Communication: Consumers, Providers, Media, and the Public

One-third of the work involved in creating a strategy is design, and two-thirds is communication. The most important communication is to those who are receiving incentives to change their behavior. With the exception of benefit design strategies involving tiered provider networks and cost sharing and public recognition strategies, most provider incentive strategies exclusively target providers.

Provider communications must address all of the following:

- The rationale behind the incentive;
- The science behind the measures and the reward algorithm;
- The names of the providers who have endorsed the incentive;
- The expected behavior change; and
- The reward.

Communicating with providers is challenging because of the volume of information they receive daily. Although the efforts of the provider representatives on the design team can help considerably, those efforts may not be sufficient. In some cases, the communication can be directed to management personnel who have some control over clinical and management systems that can influence achievement of the rewards. In other cases, communications have to be directed toward individual professionals. Provider communication strategies typically have hard copy, e-mail, and web components, as well as varying forms of face-to-face meetings with practitioners and practice administrators, including town meetings.[15]

As noted in the contemplation phase, the foundations of effective provider communication need to be established early in the I&R program development. The Excellus and the Rochester Individual Practice Association (RIPA) Rewarding Results initiative included physician communication and outreach as a key component. As mentioned in the case study in the contemplation phase, Excellus/RIPA developed a state-of-the-art program by providing performance reports to the doctor, the office, and the patient in a variety of forms. Another example of effective provider communication for an I&R program is from the Kern Family Health Care Plan in California, as described in the following case study.

CASE STUDY: Effective Communication to Providers

The health plans participating in the Local Initiative Rewards Results (LIRR) program in California took a number of approaches to provider communication. Kern Family Health Care required physicians to attend a mandatory learning session in order to become eligible to receive incentives. This strategy was a success: 99 percent of eligible physicians attended a learning session.

For Kern and all of the LIRR health plans, raising awareness of the incentive and reward program "required creativity and sustained effort throughout the project."[16]

Although effective communication with providers during implementation is essential to I&R program success, I&R program sponsors should also communicate with other interested stakeholder throughout this period.

15. Young GJ et. al. "Conceptual Issues in the Design and Implementation of Pay for Quality Programs" *American Journal of Medical Quality,* 20:2, April 2005.
16. Highsmith N and Rothstein JR. "Rewarding Performance in Medicaid Managed Care", *CHCS Brief,* Center for Health Care Strategies, Inc., March 2006.

VII. EVALUATION AND PROGRAM REFINEMENT

If an evaluation strategy has been devised during the project's development phase, then it should be possible to answer key questions of interest to the sponsors of the incentive and reward strategy after its first reward period.

Provider Engagement

Because all provider incentive strategies, including those involving employee benefit design, seek to motivate changes in provider behavior, it is necessary to evaluate whether providers did, in fact, change their behavior as a result of the incentives.

Therefore, before assessing the clinical and financial effectiveness of the incentive and reward strategy, it is important to answer basic questions such as:

- Do providers know about the incentive and reward program?
- Did providers change their behavior in response to the incentives? If so, how?

This form of evaluation can use quantitative methods as well as qualitative methods, such as interviews and surveys. It need not be extensive or expensive.

CASE STUDY: Qualitative Evaluation of Provider Behavior in Response to an Incentive and Reward Strategy

Massachusetts Health Quality Partners released a public report card on physician group performance using the following sources: a multi-payer administrative database to develop HEDIS measures and a common consumer experience survey. The results were released to the public with front-page coverage in the region's leading newspaper.

In order to assess provider experience with this non-financial incentive strategy, we conducted interviews with a sample of physician groups participating in this Rewarding Results project. Providers were asked to assess the impact of the public data release on performance within their organization. Responses included the following:

- One organization reported that one-time media newspaper recognition was okay, but that their organization prioritizes quality investments based on what is at stake. Projects with financial incentives attached get higher priority than those with just public recognition.
- Another organization reported that publication of the comparative data sparked a number of new organization-wide initiatives, as well as increased scrutiny and accountability for improvement at individual practice sites found wanting on particular measures.
- A third organization reported that physicians took notice of the data, but did not implement systemic changes in response to the information.

CASE STUDY: Quantitative and Qualitative Evaluation of Provider Behavior in Response to an Incentive and Reward Strategy

An evaluation of Bridges to Excellence found that when the program was introduced, there was a flurry of physician applications for reward recognition. These applications tended to be from physicians who believed that their current practices already met the criteria for the reward.

Subsequently, there was a dramatic decrease in the volume of applications for several months, then the volume began to rise again. The evaluators attributed this phenomenon to timing. Raising awareness about the program takes awhile. Once providers know about it, they still have to complete the application, which can take months. For those who need to change practice patterns and make office system improvements first, the process may take months or years.[17]

BTE staff noted that one lesson learned was to highlight the first physicians in a region who achieve recognition. These physicians receive calls from their colleagues as to the process and their success. Word spreads among the relevant provider community and the applications from that region increase.

Consumer Engagement

Even though not all incentive strategies specifically seek to motivate changes in consumer behavior, it is important to evaluate whether consumers changed their behavior as a result of the incentives.

Sponsors should answer basic questions about consumer awareness of consumer and provider incentive and reward components as well as about consumer behavior changes.

To the extent that the I&R strategy uses public reporting of provider performance, sponsors should assess the effectiveness of the methods and the manner in which performance data was shared with consumers. Transparency of health care performance from a consumer perspective is different than transparency from a provider perspective. It is essential to evaluate the effectiveness of any public disclosure to consumers.

As with evaluations of provider engagement, evaluations of consumer behaviors can be both quantitative and qualitative.

Cost/Benefit and Business Case

For many incentive and reward sponsors, ongoing investment in the strategy depends on a positive retrospective financial assessment of the strategy. Such analyses are never simple because other changes may have occurred concurrent with the incentive and reward strategy. Nonetheless, organizations conduct such evaluations and use them to inform future strategic decisions.

CASE STUDY: Retrospective Evaluation of the Business Case for an Incentive and Reward Strategy

Excellus BlueCross Blue Shield and the Rochester Individual Practice Association (RIPA) collaborated on an incentive and reward program for RIPA's physician members. Excellus actuarial staff did a careful evaluation of the program and found at least a three-to-one return on investment for diabetes and heart disease patient populations. RIPA reported the following:[18]

	EXPENSES	SAVINGS	RETURN ON INVESTMENT
2003:	$1,148,597	$1,894,471	1.7:1
2004:	$1,148,597	$5,869,515	5.1:1

17. Draft BTE Program Evaluation, Thomson Medstat.
18. Beckman H. "Advanced PFP Studies: The RIPA/Excellus Experience", National PFP Summit, February 7, 2006.

Provider organizations will sometimes need to confirm that the costs they expended to address an incentive have not exceeded the rewards they have received. In some cases this assessment is quite formal, while in others it is less so. For example, one health system reasoned that because the Blue Cross and Blue Shield of Michigan incentives were tied to JCAHO requirements and because the reward payments equated to approximately 25 percent of the system's operating margin, there was no question of the business case of the incentive and reward strategy. This is one example of how I&R programs create an opportunity for forging new relationships between payers and providers, one that is focused on collaboration to improve performance and results.

As discussed earlier, however, there are many instances where a purchaser, payer, or provider will not feel that a cost/benefit calculation is necessary to justify continuing participation in the incentive and reward strategy. In these cases, the business case is a broad and perhaps multi-dimensional set of considerations. A retrospective qualitative assessment of whether these other considerations have been meaningfully addressed is an important part of an evaluation. This assessment might best be conducted through interviews with key purchaser, payer, and provider leaders for whom a non-return-on-investment business case has been identified.

Unintended Consequences

Incentive strategies often motivate changes in behavior. The changes, however, are not always those that were intended. As provider incentive and reward strategies grow nationally in number and in financial impact, they are likely to create more profound changes in provider behavior. Some of these changes may be troubling to the sponsors of the strategies.

For example, some disincentive strategy evaluations have raised the following concerns regarding unintended consequences:

- Providers may be jettisoning sick or poor patients in order to score well against performance standards and earn a reward.
- Providers are applying their performance improvement resources to only those aspects of care delivery that earn them rewards and are giving little attention to other areas of potential concern.

Finally, some worry that if there is excessive focus on rewarding those who are high performers and insufficient attention to those who lag behind, the poor performers will fall farther behind the rest of the market.[19]

Qualitative evaluation activity should probe for potential unwanted provider behavior in these two areas of concern and should also inquire about any other unintended behavior changes or other consequences that might call for modification of the incentive and design strategy.

Program Refinement

Although I&R program evaluations are often initiated to assess overall program effectiveness, their greatest long-term value may be their ability to inform refinement of the I&R program. Even the most well-planned and well-conceived program will confront unexpected barriers and challenges during the implementation phase. I&R sponsors should establish mechanisms to identify these challenges and their root causes, thereby providing a platform for modifying existing I&R programs.

19. Rosenthal MB et. al. "Paying for Quality: Providers' Incentives for Quality Improvement", *Health Affairs,* 23:2 March/April 2004.

CASE STUDY: Program Refinement Based on Evaluation Findings

The Bridges to Excellence initiative is a best practice example of program evaluation and refinement. Bridges to Excellence conducts a thorough evaluation of the implementation of its strategy from both an operational and financial perspective. It uses the operational findings to make incremental changes to the existing program as well as changes to the implementation of the program in new markets. Two examples of evaluation results that led to program refinement are the following:

- The application process was too confusing for some providers, leaving many uncertain about their eligibility. This, in turn, inhibited providers from pursuing recognition. Bridges to Excellence streamlined the process so that it could be more effectively communicated to providers, and participation levels increased.
- It was important to showcase the first recognized provider in a market. Doing so demonstrated that the program was real, that recognition was attainable, and that it provided positive exposure for the recognized provider.[20]

20. Draft BTE Program Evaluation, Thomson Medstat.

VIII. CONCLUSION

There is a growing body of practical experience regarding the design, implementation, and evaluation of incentive and reward strategies in health care. This primer has reviewed the process steps for I&R contemplation, design, implementation, evaluation, and refinement that practical experience has shown to result in successful programs. In addition, this primer has made an important contribution by presenting specific examples that demonstrate how the I&R concepts move into real world application.

Purchasers and payers contemplating new I&R initiatives, or considering refinements or expansions of existing strategies, have a tremendous opportunity to learn from the experience of others. Learning where others have stumbled can be as informative as learning about the experiences of those who have succeeded. Those seeking to initiate or modify an I&R strategy are advised to invest some time in studying these examples and in reaching out to organizations with experience sponsoring and supporting I&R programs. Doing so will improve the efficiency and effectiveness of future I&R programs, expedite the implementation of future programs, and reduce the likelihood of avoidable mistakes in the design and implementation of I&R programs.

APPENDIX A: Rewarding Results Incentive and Reward Pilots

Blue Cross of California

www.bluecrossca.com

The California-based health insurer stands out for implementing P4P in a complex and popular health insurance model—a preferred provider (PPO) network in the San Francisco market in which a loose network of physicians are not directed by any one health plan. The plan worked through some operational and implementation challenges, including effectively engaging physicians and determining the optimal way to pay financial rewards. Blue Cross provides health care services to approximately 6.6 million Californians and has the second largest share (22 percent) of the private health insurance market in California. Of these 6.6 million Blue Cross members, nearly 3.9 million were enrolled in Blue Cross PPO plans.

Through its PPO products, Blue Cross contracts with 89 percent of the 464 hospitals in California and with 58 percent of the 74,000 primary care physicians and specialists. The program targeted approximately 15,000 physicians of the following specialties in the Blue Cross PPO network: family practice, general practice, internal medicine, obstetrics/gynecology, pediatrics, cardiology, pulmonology, gastroenterology, and psychiatry. The program's goal is to provide effective health care to reduce the burden of illness and mortality associated with prevalent chronic conditions (such as cancer, diabetes, asthma, heart failure, and mental health conditions), and to assure the delivery of preventive care services. The program also works to improve patients' ability to access care and maintain continuous doctor-patient relationships with the quality physicians of their choice.

Blue Cross Blue Shield of Michigan (BCBSM)

www.bcbsm.com

Blue Cross Blue Shield of Michigan (BCBSM) provides health care benefits to 4.8 million members through a variety of programs. BCBSM implemented an incentive and reward program to improve hospital care. It partnered with the majority of hospitals in Michigan and focused on standardized measures that promote accepted and best clinical practice. The program has financial rewards for hospitals that achieve high performance and focuses on continuously improving quality, and promoting accepted and best clinical practices. Financial incentives also target promoting best medication safety practices, encouraging medically appropriate utilization and achieving measurable improvements in community health. The program encourages patients' participation in their care and rewards hospitals for desired outcomes. The program affects approximately 4 million traditional and PPO members receiving services at more than 90 acute care hospitals in Michigan.

Bridges to Excellence (BTE)

www.bridgestoexcellence.org

Bridges to Excellence (BTE) is a multi-state, multi-employer coalition developed by employers, physicians, health care services researchers, and other industry experts to reward quality across the health care system. BTE is a not-for-profit organization created to encourage significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they deliver safe, timely, effective, efficient, and patient-centered care. BTE's initial focus is on cardiac care, diabetes care, and the appropriate use of information technology in physician offices. In addition to National Business Coalition on Health (NBCH), Bridges to Excellence participants include large employers, health plans, the National Committee or Quality Assurance, MEDSTAT, and WebMD Health, among others. These organizations are united in their shared goal of improving health care quality through measurement, reporting, rewards, and education.

BTE rewards and recognizes physicians for meeting specific quality benchmarks and has doubled the number of diabetics seeing physicians in its target markets. BTE has found that physicians who are recognized for providing high quality and more efficient care deliver it at a 15 to 20 percent lower cost than physicians who don't participate. The BTE model is now in several markets throughout the country.

Excellus/Rochester Individual Practice Association (RIPA)

www.excellusbcbs.com
www.ripa.org

The Rochester Individual Practice Association (RIPA) and Excellus Blue Cross Blue Shield partnered to develop a physician reimbursement program based on the community care guidelines for chronic conditions developed in collaboration with the Rochester Health Commission. RIPA provides physician services to members of Excellus' Blue Choice managed care plan. RIPA physicians received reports every four months allowing them to benchmark their practice against the community care guidelines, and Excellus' Blue Choice members will receive an annual summary of their care.

The Excellus/RIPA partnership has improved the management of patients with sinusitis, otitis, diabetes, asthma, and heart disease by giving doctors measures of quality, affordability, and satisfaction. The program has become a national model by providing doctors with performance reports that contain actionable information to improve patient care. The actionable information is delivered to the doctor, the office, and the patient in the form of status reports that encourage follow up with the physician. Excellus/RIPA is the first Rewarding Results project to identify a return on investment under P4P.

Integrated Healthcare Association (IHA)

www.iha.org

A California-based coalition of health plans, physicians, health care systems, purchasers, and consumers, IHA has issued a public scorecard, comparing actual physician group performance. Through its efforts, it has seen an increase in improvement across the board in every quality measure it is using. Some health plans have seen a 40 percent increase in patient visits, with reduced hospitalizations, especially in patients with diabetes. Technology has proven to be a key to the success of the program. IHA has data to show a direct correlation between the use of tracking technology and improved quality care. The six participating health plans pay financial incentives directly to their contracted groups based on performance but in accordance with individually designed and independently operated health plan bonus programs.

Local Initiative Rewarding Results (LIRR)

www.chcs.org/publications3960/publications_show.htm?doc_id=359986

LIRR is the largest collaborative P4P effort to improve the health of babies and teens in Medicaid. It found that simple targeted incentives can improve children's health. The California-based project involved seven health plans, paid out $5 million, engaged 3,300 physicians, and touched the lives of 350,000 babies, teens, and parents. Five of seven plans improved the rate of well-baby visits, with increases from 4 to 35 percent. Visits to the doctor by teens increased from 7 to 14 percent at six of seven plans. LIRR demonstrated that P4P can help Medicaid improve care without costing more money. Among the eight participating health plans, the financial incentives included a combination of enhanced fees for certain services and bonus payments on higher capitation rates for superior performance. The non-financial incentives included provider recognition, in-kind staff assistance, and age-appropriate incentives for adolescents completing a well visit. All were in collaboration with participating providers.

Massachusetts Health Quality Partners (MHQP)

www.mhqp.org

Massachusetts Health Quality Partners, Inc. (MHQP) is a coalition of health care providers, health plans, purchasers, government, and academic representatives working together to improve the quality of health care services in Massachusetts. MHQP seeks to leverage the value of collaboration by tackling quality improvement initiatives that are more effectively addressed by a coalition than by any single organization. Working with five health plans and physician organizations in the state, MHQP designed and implemented a performance report that enables comparison of physician organization performance on a common set of quality measures. The performance report features information on preventive care measures such as breast cancer screening and chronic disease care, such as control of diabetes. By showing doctors how they stack up against one another and identifying areas for

improvement, this statewide collaborative is affecting provider performance and, in some cases, accelerating physician adoption of electronic medical records to improve patient care. MHQP is also engaged in an evaluation of the effect of financial and non-financial incentives on physician performance. Among physician groups in Massachusetts, surveys show that physicians are more likely to focus on quality improvement when health plans include P4P incentives with specific quality measures then when they don't.

AHRQ Incentive and Reward Pilots

Blue Shield of California

www.mylifepath.com

Blue Shield chose to focus its pilot evaluation on developing a *Physician Informational Tiering Project,* which will give Blue Shield the insight it needs from the physician and member populations it serves to help shape benefit design products around provider choice going forward. The project's objective is to create awareness of cost and quality differences between hospitals and use of ambulatory facilities and to learn more about how to influence the behavior of physicians and members when choosing hospitals for elective care.

The Boeing Company—Creating Differential Hospital Insurance for Employees

Through this pilot program, the Boeing Company adopted a benefit differential to encourage members of its PPO plan, the Traditional Medical Plan (TMP), to use hospitals that meet the Leapfrog quality and patient safety practices. As part of this benefit differential, which became effective on July 1, 2004, employees and early retirees represented by the International Association of Machinists and Aerospace Workers (IAM) 751 and Society of Professional Engineering Employees in Aerospace (SPEEA) ("hourly employees") and enrolled in the TMP can obtain 100 percent coverage after deductible for inpatient and outpatient services provided by a "Leapfrog-compliant" hospital. Hourly employees hospitalized in facilities that do not meet the Leapfrog safety practices obtain 95 percent coverage after deductible. This benefit incentive was in place until July 1, 2006, when a new collective bargaining agreement became effective. The incentive applies IAM 751 and SPEEA TMP members who use any network hospital in the U.S. that meets the patient safety standards.

Buyers Health Care Action Group (BHCAG)

www.bhcag.com

As the Minnesota Leapfrog Regional Roll-Out Leader, BHCAG serves the interests of approximately 85 Leapfrog members who purchase health care on behalf of more than one million Minnesota residents. The goal of the BHCAG pilot is to test the following hypotheses:

1. Dissemination of baseline plan and market level opportunity rate (rate of admittance to Leapfrog-compliant hospital per opportunity) scores across many purchasers will accelerate provider actions in implementing the leaps.
2. Linking the opportunity rates with the specific patient safety health plan score on the NBCH eValue8 tool to demonstrate the relationship will increase health plan participation in the process of improving scores.

There are two primary initial interventions proposed by BHCAG based on research that shows that even when hospital patient volume shifts do not occur as a result of incentives or quality information, measurement and public dissemination of performance data improves performance by creating a competitive environment. The first intervention is to measure and publicly disseminate market, employer, and plan specific opportunity rates scores. The second to link these opportunity rate scores to the "buy" decision by tracking plan performance on the eValue8 tool in relation to the opportunity rate.

GE, Verizon Communications, and Hannaford Brothers Collaborative Incentive and Reward Program

GE, Verizon, and Hannaford Brothers, who collectively have 46,500 lives in the Albany-Schenectady market, worked together in that region of New York to develop a bonus program for hospitals and financial incentives for consumers to reinforce the efforts of hospitals that are both efficient and effective in the care that they deliver. No specific strategy was identified.

Healthcare 21 (HC21) Business Coalition Incentives and Reward Program

www.hc21.org

HC21 is a diverse coalition that includes representatives from hospitals, providers, insurers, and employers that is trying to improve the quality of care in eastern and central Tennessee. HC21 proposed a "tier and steer" framework for their pilot model implementation. HC21 staff identified high performing hospitals based on whether the hospitals adhere to Leapfrog's fourth leap, the National Quality Forum 27 Hospital Safe Practices. HC21 recently released its 2005–2006 Consumer Guide, which rank orders those hospitals and their score on the NQF leap. To compliment this report, HC21 has been working with a few employers to design new benefit designs to steer patients to high performing hospitals (those that score well on fourth leap). They plan to strengthen the criteria by adding the clinical measures from the Leapfrog Hospital Rewards Program in the next report.

Maine Health Management Coalition (MHMC)

www.mhmc.info/index.php

MHMC's Hospital Incentives and Rewards program involves nine purchasers and ten hospitals from within MHMC's membership that have committed to funding a bonus pool of approximately $1,000,000. The core concept of the model they are piloting is that both hospitals and purchasers contribute to a bonus pool with providers at risk for losing their contribution if certain performance thresholds are not met. A complex weighting algorithm has been developed by the hospital medical directors and purchasers involved factoring in patient satisfaction, patient safety, clinical measures, and efficiency. The performance threshold for a hospital to receive a return of its contribution (the performance guarantee) was set at the 60th percentile of national or state performance depending upon the metric. The performance threshold for a hospital to receive any of the purchaser contribution (the performance bonus) was set at or above the 90th percentile of national or state performance. The total hospital reward will depend on the number of individual metrics that they exceed either the 60th or 90th percentile of performance.

APPENDIX B: Resources

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