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THE ROLE OF PERFORMANCE ASSESSMENT IN A REFORMED HEALTH CARE SYSTEM

American College of Physicians
A Position Paper
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A Position Paper of the
American College of Physicians

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Executive Summary

In their influential 2001 report *Crossing the Quality Chasm*, the Institute of Medicine stated that the nation's health care system was in need of fundamental change. The IOM found that quality of care was compromised because of the proliferation of new and complex medical technologies, growing chronic care needs, limited use of information technologies, and a fragmented and disorganized health care system that failed to coordinate care across providers and payers.¹ A decade later, the nation's health care system continues to confront these challenges, in part because of reimbursement models that fail to reward high-quality care. The dominant health care reimbursement model, fee-for-service, inadvertently promotes volume-based rather than value-based care and reactive care rather than preventive care.

The American College of Physicians has offered myriad recommendations on how the health care system can be transformed to deliver high-value care, better patient satisfaction, improved health outcomes, and lower costs.² If executed properly, the performance assessment-based payment model, which ties reimbursement to a physician or other health care professional's ability to meet specified performance measures, is one payment system that may help to achieve these goals. Performance assessment-based payment programs have proliferated since ACP published 2005's *Linking Physician Payments to Quality Care*. This paper will review payment reform efforts over the last 6 years and offer recommendations on how such models can effectively serve the health care system in the wake of the landmark Affordable Care Act.

In addition to improving access to health insurance, the Patient Protection and Affordable Care Act (ACA)—the comprehensive health reform legislation signed into law by President Obama in March 2010—seeks to initiate reform of the nation's health care delivery system. The law will test a number of health care delivery innovations, such as patient-centered medical home models and accountable care organizations. The intent of the delivery system reform initiatives is to move toward a more integrated and collaborative health care infrastructure where physicians and other health professionals work with hospitals, payers work with providers, and payers and providers engage patients toward leading a healthy lifestyle focused on prevention.

The ACA will test a number of new delivery systems to determine which will achieve the goals of enhancing the patient experience (including the Institute of Medicine-based elements of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity), improving population health, and reducing per capita health care costs.³ This “triple aim”—a phrase and program developed by the Institute for Healthcare Improvement formally led by former CMS Administrator Dr. Don Berwick—requires structural changes that move the current broken health care model to an aligned health care system that emphasizes prevention, evidence-based care, use of technology that reduces administrative costs and improves delivery, collaboration among providers, and reformed payment initiatives that incentivize such changes.

This paper will examine the evolving role of performance assessment to help achieve the triple aim of improved patient experience, improved population health, and reduced per capita costs, including how such assessments may be linked to physician compensation (often referred to as pay for performance or P4P). The paper will consider the direction in which performance assessment-based payment will be headed, and how it can be used in a reformed system that emphasizes team-based care and seeks to achieve the goals of improved patient experience, better population health, and reduced per-capita health care costs.

To effectively change the current fragmented, reactive health care landscape to one that fosters health professional collaboration, patient engagement, and preventive care, stakeholders will need to adopt a “pay-for-improved-population-outcomes” mindset that attends to population health outcomes rather than only the performance of individual physicians and other health professionals. According to Don Berwick, “measurement of and fixed accountability for health status and health needs of designated populations (and) improved standardized measures of care and per capita costs across sites and through time that are transparent” will help achieve the triple aim.⁴ This broader focus on population health could be utilized to facilitate the evolution of the nation’s health care system.

While this paper will focus on the evolving roles of performance assessment efforts within the realm of medical care, non-health care factors affecting health status—such as smoking, poor nutrition, and lack of physical activity—must also be addressed. This could potentially be achieved using financial incentives, accelerating development of outcomes measures that gauge population health improvement, and enabling system integrators to improve evaluation of and direct providers in medicine and the community to improve health status.⁵

Part I. The Use of Incentives to Promote Care

Position 1: ACP supports payment and delivery system reforms that promote high-value care, improved patient experiences, better population health, improved patient safety, and reduced per capita spending. Assessment of the value of the care provided may include reporting on evidence-based measures of outcomes, patient experience, population health, safety and effectiveness, and cost of the care provided. Such measures should be evaluated through and collected in a consistent, reliable, feasible, and transparent manner; thoroughly tested prior to full implementation to the extent possible; and applied as part of overall payment and delivery system reform emphasizing collaborative system-based health care. To the extent that such reforms include linking payments to reporting and performance on specific quality measures, such incentives must take into consideration the conflicting evidence on the effectiveness of performance assessment-based payment programs and potential adverse consequences. Specifically, ACP believes that payment and delivery system reform to promote high-value care should:

- Be integrated into innovative delivery system reforms such as the patient-centered medical home and other payment reform efforts that promote systems-based collaboration and health care delivery;
- Demonstrate improved quality patient care that is safer and more effective as the result of program implementation;
- Support an environment where all physicians—in both primary care and specialty practices—are supported in their efforts to perform better, continually raising the bar on quality;
- Develop, or link closely to, technical assistance efforts and learning collaboratives so that physicians and other health professionals are motivated and helped to improve their performance;
- Engage physicians in all aspects of program development including determination of standard measure sets, attribution methods, and incentive formulas; and

- Reflect national priorities for strengthened preventive health care, quality improvement, quality measurement, and reducing health disparities.

Position 2: To the extent that payment and delivery reforms include financial rewards and/or penalties linked to performance, the reward framework (i.e., type and magnitude of incentives) should be incorporated into systems-based payment reforms designed to permit and facilitate broad-scale positive behavior change and achievement of performance goals within targeted time periods. Potential rewards should be:

- Significant enough to drive desired behaviors and support continuous quality improvement;
- Reflective of the cost and other resources needed to participate in a performance assessment-based payment program, including the cost to measure and design improvements that will take, for example, system supports and program management;
- Balanced between rewarding high performance and rewarding substantial improvement over time;
- Graduated to create stronger incentives for physicians to participate in performance improvement programs and to ensure that a physician's level of commitment to quality improvement activities is recognized;
- Directed at positive rather than negative rewards;
- Timely and followed closely upon the achievement of performance;
- Designed to encourage physicians and health care systems to care for vulnerable patients with complex health care needs, reflect the level of care required, and avoid adverse, unintended consequences resulting from performance assessment-based payment program implementation; and
- Adjusted as the complexity of performance measure requirements change.

Part II. The Need to Fundamentally Redesign the Physician Payment System

Position 3: Programs to link payments to performance assessment must not exist in isolation and must be coordinated with concurrent efforts to improve evidence-based primary and specialty care. Programs should be integrated into other innovative delivery system reform initiatives that seek to promote care coordination across the health care sector and emphasize preventive rather than reactive care, reduce geographic disparities in quality of care, and nurture the patient–physician relationship, such as through apatient-centered medical home.

Public and private payers should work with the medical profession on a fundamental redesign of physician payment methodologies that include the following reforms:

- Physician reimbursement should encourage system- based care, promoting collaboration among payers, physicians, and other health care practitioners, and be structured to achieve the goals of improved population health, patient experience, physician and other health care clinician coordination, and reduced costs.

- The physician payment system should fairly compensate physicians for work and practice expenses, and payment updates should fairly reflect inflation.

Part III. Transparency and Oversight

Position 4: Physicians should have a key role in determining methods used to develop and select measures (including the measurement evidence and any evidence grading methods used), collect data from physicians, aggregate and score performance, and report performance data internally and publicly. These processes should be transparent so that physicians, consumers, and payers know that methods, expectations, rationale, and results are valid and reliable. Sponsors of programs that link payment to assessment of performance should collaborate with physicians who are potential participants regarding program implementation, educate physicians about the potential risks and rewards inherent in program participation, and immediately inform physicians of any changes in program requirements and evaluation methods and newly identified risks and rewards. Payers should inform patients at time of enrollment of such efforts, potential risks, and physician participation.

Position 5: Programs that link payment to assessment of performance should incorporate periodic, objective assessments of measurement, data collection, scoring, and incentive systems to evaluate their effects on achieving improvements in quality, including any unintended consequences. The programs and, where appropriate, their performance thresholds should be readjusted only when there is compelling evidence and a justifiable reason to do so.

Part IV. Selection of Measures

Position 6: The College reaffirms and expands upon the qualities of a good performance measure as reported in the ACP policy paper, *Linking Physician Payment to Quality Care*, and the position paper, *Healthcare Transparency—Focus on Price and Clinical Performance*:

Performance measures used to evaluate physician performance should be:

- Reliable, valid, and based on sound scientific evidence
- Clearly defined
- Based on up-to date, accurate data
- Adjusted for variations in case mix, severity, and risk
- Based on adequate sample size to be representative
- Selected based on where there has been strong consensus among stakeholders and predictive of overall quality performance
- Reflective of processes of care that physicians and other clinicians can influence or impact
- Constructed to result in minimal or no unintended harmful consequences (e.g., adversely affect access to care)
- As least burdensome as possible
- Related to clinical conditions prioritized to have the greatest impact on improving patient health

- Developed, selected, and implemented through a transparent process easily understood by patients/ consumers and other users

Position 7: ACP supports the use of structure, process, and outcome measures in programs that link payment to assessment of performance as long as they meet ACP’s criteria for measures used to evaluate physician performance.

Position 8: Measure sets must primarily focus on improving patient outcomes, gauging the patient-centeredness of a practice, and improving the coordination of care across all providers. The College maintains that efficiency—or “value-of-care” measures—must be based on an objective assessment of evidence on the effectiveness of particular treatments, with both cost and quality taken into consideration. Value-of-care measures must appreciate the nuances of physician care and must not compromise the patient–physician relationship. Stakeholders must also work to develop population health measures designed for specific populations.

Position 9: The development, validation, selection, refinement, and integration of performance measures should be a multilevel process that takes advantage of the most recent scientific evidence on quality measurement and has broad inclusiveness and consensus among stakeholders in the medical and professional communities. This entire process should be transparent to the medical community. Measures should be field-tested prior to adoption to ensure their viability in the medical setting. Once in use, performance measures that have not been shown to improve value to include higher quality, better outcomes, and reduced costs (and higher patient and physician satisfaction) should be removed from performance–based payment programs.

Position 10: ACP supports a national strategy for quality improvement that will establish national goals, attend to high-leverage priority areas that will lead to significant gains in quality and value of care (such as care coordination), fill gaps where few performance measures exist, develop universal terminology for measurement developers, and harmonize measure sets to improve coordination and reduce duplication and confusion. Such a strategy should also lead to determination of a single core measure set to provide data for benchmarking and ongoing quality improvement. The strategy should be updated as performance measures and programs to link payments to assessments of performance evolve. The College supports directing adequate financial resources to this and other related activities outlined in the Affordable Care Act.

Part V. Data Collection and Minimizing Physician Burdens

Position 11: To alleviate the administrative burden of performance assessment-based payment programs, measurement sets, payment models, and data collection should be standardized across programs; HIT and EHR systems should be enabled to recognize and report performance assessment–based payment data; and audit and validation processes should be facilitated. Data collection and physician reporting

required to support programs to assess performance should be administratively feasible, reliable, practical, and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

- Prospective data collection should be encouraged whenever possible to minimize burdens and to reduce measurement error.
- Data collection methodology should be consensually determined by national health care stakeholders and standardized across P4P programs.
- Data collection and analysis must not violate patient privacy.
- Physicians should not be required to purchase or lease proprietary models of data collection.
- Programs must consider the unique practice challenges faced by safety-net providers, physicians in small practices, and physicians who are just entering practice, among others.

Position 12: Information technology tools should be used whenever possible to facilitate data acquisition for performance measures and to minimize any manual data extraction to support such measurement. Incentives and best practices for incorporation of electronic health records should be developed, pilot-tested, provided, and disseminated to improve data collection on clinical outcomes.

Part VI. Data Accuracy, Data Aggregation, and Scoring

Position 13: Analysis and reporting of physician and system performance should include the application of statistical methods that provide valid and reliable comparative assessments across populations.

- Data should be fully adjusted for case-mix composition (including factors of sample size, age/sex distribution, severity of illness, number of comorbid conditions, patient compliance, patient health insurance status, panel size/patient load, and other features of a physician's practice and patient population that may influence the results).
- To the extent possible, data analysis should accurately reflect all units of delivery that are accountable in whole or in part for the performance measured.
- Scores should relate care delivered (numerator) to a statistically valid population of patients in the denominator.

Position 14: Performance measure developers must incorporate socioeconomic status adjustments or other variables to ensure vulnerable patients receive the care they need. Programs that link payment to assessment of performance must monitor participants to identify and address unintended consequences, such as exacerbation of racial and ethnic health disparities. This may be achieved by including incentives to care for underserved or complex-needs patients in such programs.

- Measuring, scoring, and incentivizing physician and system performance should result in better patient care. It must not compromise patient access to care through such mechanisms as “deselection” or lead to increased attention to or manipulation of documentation.

Part VII. Public Reporting and Other Appropriate Uses of Analyzed Data

Position 15: The College reaffirms the importance of physicians and other health care professionals having timely access to performance information prior to public reporting and the availability of a fair and accurate appeals process to examine potential inaccuracies as reflected in the ACP policy paper, *Developing a Fair Process Through Which Physicians Participating in Performance Measurement Programs Can Request a Reconsideration of Their Rating*.

Position 16: Educational feedback should be provided to physicians, other stakeholders in the system, and consumers on a timely, routine basis. Educational feedback should include a discussion of the physician's individual performance, as well as his or her performance relative to other physicians. Reports should be user-friendly, easily accessible, standardized, and based on recommendations of relevant health care stakeholders. Physicians and other health care clinicians in the system should have the opportunity to review prior years' performance data at any time.

Position 17: The results of programs to link payments to assessment of performance should not be used against physicians in health plan credentialing, licensure, or certification. Such programs must have defined security measures to prevent unauthorized release of physician ratings and patient data.

Part VIII. Program Implementation

Position 18: As physicians and other health care clinicians, payers, and affiliated community health organizations begin to establish a more collaborative infrastructure, stakeholders must work together to:

- Maintain a cooperative vision to achieve a team-based practice to reach the goals of improved patient experience, better population health outcomes, and reduced costs;
- Harmonize performance measures and data collection through a transparent, collaborative process;
- Improve access to health information technology and electronic medical records;
- Maintain timely and clear feedback to providers and other health care providers in the system;
- Provide ample incentives that at a minimum reflect the financial and practice costs of participation;
- Recognize the complex needs of small practices and physicians serving highly vulnerable populations, such as patients with multiple chronic conditions and the elderly; and
- Strengthen patient-centered primary care.

Position 19: It is crucial that any programs that link payments to performance assessment be subjected to ongoing research and monitoring to ensure that they support the patient-physician relationship, contribute positively to adoption of best practices, and do not unintentionally undermine patient care, such as by contributing to ethnic and racial disparities by penalizing or denying resources

to clinicians, hospitals, and other providers who care for poorer and sicker patients. There must be timely reconfiguration of performance-based payment programs if such adverse effects are recognized. A Medicare value-based purchasing program and other initiatives to pay physicians based on performance assessment should meet the principles outlined in this paper.

Background

ACP Efforts Since 2005

Position Papers

ACP embraced the concept of performance measurement in the 2004 policy paper, *The Use of Performance Measurements to Improve Physician Quality of Care*, establishing policy that provided guidance for the research, development, and implementation of performance measures as well as support for demonstration projects that reimbursed physicians and other health professionals for reporting on quality measures. A subsequent policy paper released in 2005, *Linking Physician Payments to Quality Care*, offered more detailed positions and provided guidance for implementation of pay-for-performance programs. The College has also released papers on the reconsideration of physician ratings related to performance measurement and a conceptual model for a clinical performance measurement framework. In September 2010, ACP published *Healthcare Transparency—Focus on Price and Clinical Performance Information*, which discusses publication of price and performance measure data.

Response to IOM's Rewarding Provider Performance Report

ACP also commented on the IOM's 2006 report *Rewarding Provider Performance: Aligning Incentives in Medicare*. The College noted its support for P4P efforts in Medicare but stressed that performance measures be evidence-based, focused on services over which physicians have direct control, validated by a multi-stakeholder group and crafted to ensure they achieve desired patient and systemic outcomes. Further, the College iterated that the pay-for-performance reporting requirements place as little administrative burden on physicians as possible, that efforts be made to incorporate performance measurement reporting capability in health information technology and emphasize use of such equipment, and that data collection ensure patient privacy and consider the unique patient profiles of physicians working in underserved areas and/or safety-net facilities.

The College also stated that physicians should be permitted to comment on data before it is publically reported. Implementation, the College stated, should be phased in to allow physicians sufficient time to prepare. Later implementation stages would allow for voluntary participation in reporting clinical measures followed by graduated bonus payments based on meeting evidence-based performance measures. The College also outlined recommendations for creating and funding bonus rewards based on performance as well as continuous monitoring and evaluation to consider the impact and effectiveness of P4P on the quality of patient care.

Patient-Centered Medical Home payment structure

ACP collaborated with a number of medical societies and quality improvement interests to develop a payment structure in the patient-centered medical home (PCMH) model. A joint statement of principles was developed that outlines a three-tiered payment structure for PCMHs to include a care coordination fee (to reflect the additional administrative and staff time cost that is not reimbursed under Medicare Part B); the existing fee-for-service payment for the encounter; and a performance-based payment related to efficiency, quality, and patient experience measures.⁶

Other advocacy and policy efforts

Other efforts include participation in the Friends of NQF coalition, which advocated for establishing the National Quality Forum as a national coordinator of performance measure efforts. Such support reflects ACP's active participation in the multi-stakeholder, consensus-based process of developing, evaluating, and endorsing performance measures. Additionally, ACP has remained active as a founding member of the AQA. The College also sent a letter to the Centers for Medicare & Medicaid Services expressing concern about the agency's Performance Measurement and Reporting System and in 2007 submitted a Congressional statement for the record advocating that Congress, among other things:

- Eliminate the SGR and provide stable, positive, and predictable updates combined with performance-based additional payments for reporting on quality measures relating to care coordination and patient-centered care, and
- Revamp the Physicians Quality Reporting Initiative to focus on clinical and structural measures related to coordination of chronic diseases and other "high-impact" interventions.

Government Efforts Since 2005

Over the past 6 years, the federal government has aggressively tested and initiated pay-for-performance and broader value-based purchasing efforts, in an effort to encourage high-quality evidence-based care, promote high-value care, and reform the inefficient fee-for-service reimbursement model. Perhaps most relevant for physicians participating in the Medicare program is the Physicians Quality Reporting Initiative (PQRI).

Established in 2006, PQRI is a voluntary program in which physicians report to CMS on a number of quality measures. The program has been labeled a starting point for future pay-for-performance efforts and value-based purchasing efforts.^{7,8} Physicians that successfully report data on the quality measures receive a bonus payment. In 2010, physicians who report on measures receive an incentive payment of 2% of their total Medicare Part B Physician Fee Schedule during the reporting period.⁹ Group practices are also eligible to participate, starting with the 2010 PQRI period. For the 2010 program, participants submit data on 179 quality measures categorized in 13 measure groups, such as diabetes mellitus, preventive care, and heart failure. Participants submit data on measures most relevant to their practice.¹⁰ Physicians who participate in the program receive feedback reports that are intended to inform and guide them to provide better care.

PQRI measures intend to influence various elements of physician practice. Over 100 of the measures reported on in 2010 are related to clinical effectiveness, either based on process or patient outcomes. Safety, patient-centeredness, and timeliness-related measures are also reported. The measures are developed by stakeholder groups, including those representing physicians, such as the AMA Physicians Consortium for Performance Improvement, and most are endorsed or under review by the NQF.¹¹ However, participation in the PQRI has been sparse as only 16% of eligible physicians submitted data on at least one PQRI measure in 2007.¹²

The federal government has also developed a number of demonstration and pilot projects to test pay-for-performance systems across the health care system. Notably:

- The Physician Group Practice Demonstration, which rates integrated group practices on their ability to meet quality standards and coordinate care. The program used a gain-sharing framework where participating groups were able to share savings if costs were reduced below a target threshold. In the fourth year of the project, all 10 participants met benchmark performance for at least 29 of the 32 measures, while 3 groups met all performance measures.¹³ A number of groups were able to achieve cost-savings in addition to meeting quality measure goals. Five groups created Medicare savings of \$38.7 million, with one participant generating over \$16 million in shared savings payments.¹⁴
- The Medicare Care Management Performance Demonstration sought to encourage the goals of evidence-based care and greater adoption of health information technology. Participating practices that met clinical process and outcomes performance measures received a bonus payment and those that submitted measurement data using electronic health records received a greater reward.¹⁵ The demonstration project was required to be budget-neutral. Beginning in 2007, the demonstration was established in 4 states. One year after implementation, 640 physicians in 4 states were participating in the demo, serving 177,000 Medicare beneficiaries. An evaluation of first-year participants found that the majority of surveyed practices met most of the quality thresholds and viewed the program as effective in aligning payment with performance.¹⁵ However, some participants felt the data-reporting process was time-consuming and outweighed the financial incentive. The report also noted a general concern among some participants that the payment structure may inadvertently lead physicians to avoid sicker patients because they may negatively affect their performance score. The demonstration was completed June 30, 2010.¹⁶
- Medicare Health Care Quality Demonstration tests participating physician groups, integrated delivery systems, and regional health care consortia on measurements geared toward improving patient safety, enhancing quality, increasing efficiency, and “reducing scientific uncertainty and the unwarranted variation in medical practice that results in both lower quality and higher costs.”¹⁷ Participating physicians/groups are expected to meet the “Six Aims of Improvement” recommended by the IOM, which includes increasing the effectiveness of the health care delivered through use of best practices guidelines and other measures.¹⁸ Current participants are the Indiana Health Information Exchange, the North Carolina Community Care Networks, and the Gundersen Lutheran Health System. Payments under the demonstration are tied to cost savings and improvement in meeting process and outcome measures, among other factors. The demonstration project is scheduled to end in 2014.

In addition to physician-focused performance assessment-based payment initiatives, the Medicare program also supports the Hospital Quality Initiative, which provides full reimbursement to hospitals that successfully submit data on 10 quality measures upon patient discharge. Of the hospitals eligible to participate in the initiative, 98.3% comply with the requirements.¹⁹ Other pilots have been driven by chronic care management organizations. For example, the Medicare Health Support Pilot Program ran from 2005 to 2008. The objective was to test new models to improve care for the chronically ill. Participants were evaluated on a range of such factors as quality improvement measures, beneficiary and provider satisfaction, health outcomes, and financial outcomes.²⁰ The program was discontinued in 2008 in part because of poor evaluation process design, population selection issues, and unreliable feedback reporting.^{21,22}

Medicaid programs across the nation are also using performance measure and pay-for-performance schemes to improve care quality and efficiency. Many Medicaid programs use performance incentives to emphasize use of primary care. In FY2010, 34 states indicated that they had a pay-for-performance program in place for managed care organizations and/or other providers, such as physicians.²³ In Maine, the Medicaid program ties monetary rewards to whether a physician meets a number of quality measures related to access, emergency room utilization, and prevention. Results are made public and physicians who score in the top 80% of their provider peer category receive a quarterly bonus.²⁴

Related to the realm of performance assessment-based payment, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized the federal government to contract with a single entity to help determine a national strategy for performance measurement. The federal government contracted with the National Quality Forum to make recommendations on a quality measurement national strategy and priorities, to endorse a standardized set of performance measures, to establish a process to update existing measures, and to promote the use of electronic health records that are equipped with the ability to collect, aggregate, and transmit performance information.²⁵ As a member of the Friends of NQF coalition, ACP had supported NQF's federal government contract. MIPPA also created an initiative where confidential quality and resource use information is reported to physicians.

Private Sector Initiatives Since 2005

Most commercial health plans use pay-for-performance incentives in their contracts with providers.²⁶ Among the significant programs are Bridges to Excellence, a long-running employer-led initiative that rewards physicians and other health practitioners for improving the quality of care to the chronically ill. Its coordinating organization, Health Care Incentives Improvement Institute, has also established the Prometheus Project, which focuses on reimbursing providers on episodes of care.²⁷ One of the largest private P4P efforts is the Integrated Health Association, which includes 8 health plans and 35,000 physicians covering 11.5 million HMO enrollees.²⁸ Other notable private sector efforts include the Hawaii Medical Service Association's Practitioner Quality and Service Recognition program, which rewards physicians and other health practitioners on their ability to meet clinical best-practice targets. In 2009, the program paid \$8.5 million in financial rewards to 2,899 practitioners.²⁹

Health Care Reform and Performance Assessment-Based Payment

The Affordable Care Act of 2010, signed into law by President Obama on March 23, 2010, includes a number of provisions related to pay-for-performance initiatives. Among the more significant provisions are:

PQRI

The ACA extends bonus payments to physicians who successfully report on quality measures through PQRI. The law extends and maintains such bonus payments from 2011 to 2014. The bonus payment for 2011 is 1% and 0.5% in 2012-2014. However, in 2015, physicians who fail to successfully report on PQRI measures will be penalized and receive a reduced Medicare payment. Also, physicians are eligible for an additional 0.5% bonus payment, in addition to the standard PQRI bonus, from 2011-2014 for meeting Maintenance of Certification Program requirements.³⁰

The law makes a number of improvements to the PQRI program. For instance, CMS is now required to give timely feedback to physicians who report data, so they can better gauge their success in meeting quality goals and areas that need improvement. An appeals process is also established, permitting physicians to address errors in reporting determinations. The law would also mandate CMS to develop a plan for merging PQRI reporting requirements with “meaningful use” requirements for electronic health records allocation incentives.³¹

Section 3003 requires the Secretary to develop and disseminate confidential reports to physicians on resource use based on claims data. Data on quality of care may be included, and the government may provide methodologies to attribute episodes of care to physicians.

National Strategy to Improve Health Care Quality and Quality Measurement

Section 3011 of the ACA requires HHS to develop a national strategy for improving quality in health care. Among the elements related to performance assessment-based payment, the strategy will have to ensure improvement in “federal payment policy to emphasize quality and efficiency” and enhance the use of health care data to improve health care quality, efficiency, transparency, and outcomes. The Secretary is required to take into consideration the recommendations of a consensus-based entity (e.g., NQF).

The legislation authorizes the formation of the Interagency Working Group on Health Care Quality that would assist in collaborating quality improvement activities among federal agencies, mitigate duplication of quality efforts, and provide assessment of private and public quality improvement harmonization.

Section 3013 of the ACA would require the Director of AHRQ to identify and address gaps where no quality measures exist, determine quality measures that need to be improved and/or updated, and ensure that quality measure development reflects the national strategy for quality improvement.³² The federal government will consider recommendations of the NQF and quality measures identified through the Medicaid Quality Measurement Program, among other sources, and is required to fund or enter into agreements with appropriate entities to develop, update, and expand quality measures in identified gap areas. Prioritized measurements are those that allow assessment of health outcomes and functional status of patients, management and coordination of health care across episodes of care, health disparities, information used to facilitate shared decision-making, meaningful use of health IT, patient-centeredness of care, efficiency of care, and patient experience. Further, the section requires the federal government to develop and update provider-level outcomes measures for hospitals and physicians, including measures related to chronic disease care outcomes and primary and preventive care. Risk adjustment, accountability, and sample size; full scope of services during the cycle of care; and

multiple dimensions must also be addressed when developing measures. Section 3013 authorizes \$75 million for each of FY 2010 through 2014.

Section 3014 would require a consensus-based entity (likely NQF) to convene a multi-stakeholder group (possibly the National Priorities Partnership) to provide guidance on developing quality and efficiency measures, including those used in reporting performance information to the public with the exclusion of data sets used to determine payment rates. The review process is required to be transparent.^{32,33,34} Authorized funding for this section is \$20 million for each of FY 2010 through FY 2014.

Section 3015 requires the federal government to create and implement a framework for the publication of performance measure data and activities for the collection, analysis, and aggregation of performance data. The law also requires that performance information be made public on standardized websites and that information be provider-specific. A consensus-based entity (likely NQF) and multi-stakeholder groups will provide input.

Value-Based Payment Modifier Under the Physician Fee Schedule

Section 3007 requires the federal government to develop and implement a quality measures-based, budget-neutral payment modifier to the Medicare physician fee schedule. This separate payment modifier is based on the quality of care furnished compared with cost during a performance period. The federal government is charged with establishing appropriate measures of quality of care provided by physicians (e.g., health outcomes) and such measures will be risk-adjusted. A consensus-based entity (likely NQF) will be consulted. Costs – based on expenditures per individual—are evaluated based on measures including the ability to eliminate geographic adjustments in payment rates and the ability to account for differences in, for example, socioeconomic characteristics and the health status of individuals.

By January 1, 2012, the federal government will publish related quality and cost measures as well as specific implementation dates and other guidance. During the initial performance period the federal government is required to provide input on performance and value of care to physicians, and by 2017 the modifier will be implemented for all physicians and groups of physicians. The modifier will be implemented in a manner that encourages systems-based care.

Delivery System Reform Projects

The ACA also establishes a number of demonstration projects that contain elements of performance assessment-based payment. The Medicare Shared Savings Program would gauge accountable care organizations on their ability to report on and meet quality standards and would direct a portion of cost-savings from improved care outcomes to participants. A pilot project to test reimbursement of bundled services would charge the Secretary (or his or her designee) to develop quality measures for an episode of care and postacute care.

Comprehensive Primary Care Initiative

In September 2011, CMS announced a new program called the Comprehensive Primary Care Initiative (CPCI), a delivery system reform project that would reward primary care clinicians for achieving goals related to chronic care management, patient engagement, improved accessibility, delivery of preventive care, and care coordination with other clinicians in the patient’s “medical neighborhood.”³⁵ In addition to existing fee-for-service payments, participating

primary care clinicians will receive risk-adjusted, per-beneficiary, per-month bonus payments for providing care management services to patients covered by traditional Medicare. As the initiative progresses, primary care practices will have an opportunity to share in Medicare savings garnered from the program. Medicaid and private payers will also be invited to participate and at first, the initiative will be established in 5 to 7 markets where Medicaid and private payers have applied and been accepted into the program, aligning payer efforts to bolster comprehensive, patient-centered primary care. Over time, the CPCI may expand beyond these markets and may become integrated into the Medicare program.

While currently in the nascent stages of development, the model may help reduce administrative burden by aligning existing quality measures across payers within their market. Measures related to PQRI, the Shared Savings Program, Medicaid Health Home Initiative, and others will be merged with CPCI to reduce duplication. Shared savings payments will be based on 25 measures within the domains of patient experience, care coordination, preventive health, and care of at-risk populations. Such payments will be calculated at the market level and then distributed to individual practices based on such metrics as performance on practice-level quality and utilization.

Evidence supporting and questioning the efficacy of performance incentives to improve quality and value

While most physicians are engaged in some form of performance assessment-based payment, the effect of pay-for-performance on quality is unclear.^{36,37,38} However, a 2006 literature review by Petersen et al. concluded that 12 of 15 studies of physician and provider group-level P4P programs yielded partial or positive effects on quality measures.³⁹ A more recent literature review concluded that while results vary significantly based on measures and other program design factors, pay-for-performance efforts improve quality of care by about 5%.⁴⁰ Still, evidence also demonstrates that pay-for-performance initiatives may not improve quality of care. A review of performance assessment initiatives failed to find substantial evidence supporting or not supporting pay-for-performance effectiveness and expressed concern that such programs did little to address for selection bias. The authors suggested that quality improvement-based payment models should be carefully designed prior to implementation to ensure effectiveness.^{41,42} A study of a hypertension care performance program conducted in the United Kingdom found that even significant financial incentives did not lead to better quality. The study authors speculated that most doctors may have already been delivering the recommended services, limiting the potential for large gains.⁴³ A review of physician cost-profiling initiatives in Massachusetts found that the measures produced inaccurate conclusions and that the average misclassification rate for internists was 25%.⁴⁴ Additionally, a comprehensive literature review found pay-for-performance-connected improvement in the quality of diabetes care management but little effect on acute care effectiveness.⁴⁰ Some conclude that while the data on performance-based incentives is generally positive, considerably more research needs to be conducted to ensure effectiveness and patient and population health outcomes.⁴⁵

Among the P4P programs that have been shown to improve health outcomes is the HealthSpring/Sumner Medical Group pay-for-quality initiative. The program centered on Medicare Advantage-enrolled patients and provided free nursing assistance to engage patients between office visits and facilitate disease management. Participating doctors who met quality targets were paid a 20% performance bonus. After the disease management and performance bonuses were provided, “patient outcomes improved across the board” and

more preventive screenings were performed.^{46,47} Patient outcome improvements of at least 30% were achieved for diabetes control, prostate and breast cancer screenings, and cholesterol screenings.⁴⁶ Evidence also demonstrates that systems-based payment reforms can improve patient experience. A review of a California performance incentive program showed that adherence to physician communication, care coordination, access to care, and office staff interaction measures improved greatly, demonstrating that performance assessment-based payment may improve the patient-physician relationship.⁴⁸

Further, P4P is seen as the initial step toward encouraging evidence-based quality care over the volume-promoting fee-for-service payment structure used by Medicare and most private payers.⁴⁹ Surveys show that although general internists have reservations about public reporting of quality data, most support the concept of performance-based incentives as long as quality measures are accurate.⁵⁰ According to CMS, the number of physicians reporting on PQRI quality measures has expanded and evidence indicates that recommended care is being delivered more frequently since the program's launch.⁵¹ Among the reported quality improvements, CMS found that in 2009, 93% of physicians told diabetes patients about potential eye-related complications, an increase of 41% compared with 2007 reports.⁵² Despite modest gains, some physicians remain frustrated with the program, particularly because of Medicare's slow feedback-response time.

Where is assessment of performance headed?

The ACA created a number of new demonstration and pilot projects that will test infrastructure reform plans to determine which will achieve the goals of better patient experience, improved patient outcomes, and lower per capita costs. This focus on value in health care (e.g., paying for improved health outcomes over volume) may include elements of performance assessment-based reimbursement.

The Center for Medicare and Medicaid Innovation (CMMI) is testing many of these fundamental changes and the new system's development occurs within the framework of the National Health Care Quality Strategy and Plan. The Plan includes input from public and private stakeholders and criteria for priorities selected based on their ability to improve "federal payment policy to emphasize quality and efficiency."⁵³

Among the nearly two dozen payment models to be tested by the CMMI are a few that incorporate aspects of linking payment to assessment of performance, including incentives for physicians and other health care providers who provide evidence-based cancer care services, global payments for accountable care organizations, and patient-centered medical homes for vulnerable patients.⁵⁴

Some health care stakeholders are taking the initiative to change the way they deliver care to achieve the triple aims of better population outcomes, improved patient experience, and reduced costs. The triple aim concept requires the designation of an "integrator" to provide oversight and facilitate collaboration at the system and provider/patient level. Payers also work with physicians and other health care providers to develop incentives and other reimbursement details that include "rewarding providers for their contribution to better health for the population."⁵⁵ Integrators also identify a population on which to focus (e.g., low-income Medicaid enrollees), shifting attention from individual health care institutions outcomes to population health outcomes.⁵⁵ Care plans are determined at the individual and family level, and basic services are provided by a primary care team, including the physician, nurse, mental health clinicians, pharmacists, nutritionists, and others, which are coordinated with specialists, hospitals, and community practitioners.⁵⁶

The five principles of the triple aim largely reflect ACP policy.² They include “a focus on individuals and families, redesign of primary care services and structures, population health management, a cost-control platform, (and) system integration and execution.”⁵⁷

Recommendations

Part I: The Use of Incentives to Promote Physician Quality Care

Position 1: ACP supports payment and delivery system reforms that promote high-value care, improved patient experiences, better population health, improved patient safety, and reduced per capita spending. Assessment of the value of the care provided may include reporting on evidence-based measures of outcomes, patient experience, population health, safety, and effectiveness and cost of the care provided. Such measures should be evaluated through and collected in a consistent, reliable, feasible, and transparent manner; thoroughly tested prior to full implementation to the extent possible; and applied as part of overall payment and delivery system reform emphasizing collaborative system-based health care. To the extent that such reforms include linking payments to reporting and performance on quality measures, such incentives must take into consideration conflicting evidence on the effectiveness of performance assessment-based payment programs and potential adverse consequences. Specifically, ACP believes that payment and delivery system reform to promote high-value health care should:

- **Be integrated into innovative delivery system reforms, such as the patient-centered medical home and other payment reform efforts, that promote systems-based collaboration and health care delivery;**
- **Demonstrate improved quality patient care that is safer and more effective as the result of program implementation;**
- **Support an environment where all physicians—in both primary care and specialty practices—are supported in their efforts to perform better, continually raising the bar on quality;**
- **Develop, or link closely to, technical assistance efforts and learning collaboratives so that physicians and other health professionals are motivated and helped to improve their performance;**
- **Engage physicians in all aspects of program development, including determination of standard measure sets, attribution methods, and incentive formulas; and**
- **Reflect national priorities for strengthened preventive health care, quality improvement, quality measurement, and reducing health disparities.**

Physician engagement is very important in forming trust and encouraging participation. The IHA P4P program sought physician group insight on such issues as quality measurement sets and the collaborative process helped to raise program awareness and acceptance of measures.³⁶ However, performance assessment-based payment initiatives must be established and connected across the health care delivery system; many current efforts are primary care-focused and more needs to be done to integrate specialists into such programs and facilitate care coordination.^{lviii} To ensure that primary care physicians are not punished (either

by reduced financial rewards or rating methods) for outcomes for which they have little control, performance assessment–based payment programs must ensure that specialists are also held accountable for quality measures and develop and use performance measures that encourage and test care coordination among all physicians and other health care providers.^{59,60} Further, performance assessment-based payment initiatives must adjust for variables that affect health status but cannot be attributed to medical care, such as environmental stressors, lack of access to nutritious food, and limited opportunities for physical exercise.⁶¹ Attribution techniques must also be improved to ensure the correct health professional is held accountable for the care of the patient. Efforts to incentivize coordinated care across various health care settings, including primary care and specialty physicians, hospitals, long-term care providers, and others, pose additional problems related to attributing responsibility for the patient among the care team. For instance, a single attribution method, which holds one physician or other health care provider responsible for the patient’s health outcomes, would not be appropriate for a patient with multiple chronic conditions who would be under the care of several physicians; a multiple attribution method would better integrate a number of providers across the system.⁶² Different attribution methods may be necessary depending on the goals of the performance measurement initiative and the types of providers involved. Determining which patients are assigned to a physician is another important consideration when establishing a performance assessment-based payment program. In testing new health care delivery systems, such as accountable care organizations, prospective attribution methods, where physicians know which patients are assigned to them before implementation, may facilitate use of risk-adjustment methods and expedite feedback on performance, allowing physicians to address any issues that impede delivery of quality care.⁶³ Attribution methods should be tested prior to implementation and, as with all aspects of performance measurement, physicians and other health care professionals must be engaged in the attribution method development process to ensure consensus on which patient assignment methods are appropriate to achieve stated goals.⁶⁴

Linking payments to performance assessment is essentially the first step toward incentivizing improved population health. This is no easy task. Among the challenges of establishing performance assessment–based payment schemes is determining which mortality and health-related quality measures should be considered and for what population, incorporating population health measures in a multiprovider/stakeholder collaboration, and addressing potential exploitation of quality incentives for financial gain.⁶⁵ Despite these challenges, some stakeholders are initiating broad system reforms within the triple aim framework to encourage population health improvements. The Vermont Blueprint for Health facilitated alliances with providers throughout the state, forged reimbursement agreements with private payers and the Medicaid program, and accelerated development of the enhanced patient-centered medical home to promote coordination and team-based primary care.⁶⁶ The initiative is also in the process of developing an accountable care organization framework to further strengthen health care system collaboration.

Although ACP reaffirms its qualified support for performance assessment–based payment efforts that align with College policies, it is concerned that participation in the PQRI will essentially be mandated beginning in 2015. Given the low PQRI participation rates, the dearth of research supporting its effectiveness, and its administrative burdens, CMS should consider extending the implementation period for “hardship providers”—that is, small or safety-net practices that lack the financial resources to acquire the equipment, staff, and expertise to participate.

Position 2: To the extent that payment and delivery reforms include financial rewards and/or penalties linked to performance, the reward framework (i.e., type and magnitude of incentives) should be incorporated into systems-based payment reforms designed to permit and facilitate broad-scale positive behavior change and achievement of performance goals within targeted time periods. Potential rewards should be:

- **Significant enough to drive desired behaviors and support continuous quality improvement;**
- **Reflective of the cost and other resources needed to participate in a performance assessment-based payment program, including the cost to measure and design improvements that will take, for example, system supports and program management;**
- **Balanced between rewarding high performance and rewarding substantial improvement over time;**
- **Graduated to create stronger incentives for physicians to participate in performance improvement programs and to ensure that a physician's level of commitment to quality improvement activities is recognized;**
- **Directed at positive rather than negative rewards;**
- **Timely and followed closely upon the achievement of performance;**
- **Designed to encourage physicians and health care systems to care for vulnerable patients with complex health care needs, reflect the level of care required, and avoid adverse, unintended consequences resulting from performance assessment-based payment program implementation; and,**
- **Adjusted as the complexity of performance measure requirements change.**

Financial incentives must encourage team-based collaboration among all health care stakeholders. In *Reforming Physician Payments to Achieve Greater Value in Health Care Spending*, ACP outlined potential solutions toward improving collaboration among hospitals and physicians by, among other methods, providing rewards for avoiding hospital readmissions compared with an established baseline.⁶⁷ Such incentives would help achieve the triple aim by improving collaboration among providers, improving patient experience by preventing readmission, and lowering costs by avoiding subsequent hospital stays. Again, Vermont's Blueprint for Health brought together physicians and other health care practitioners and health insurers (including private insurance and Medicaid) to mutually construct an integrated financial structure to achieve collaboration across the health care spectrum. CareOregon, a triple aim site, rewards participating clinics on meeting improvement goals (such as better scores on access or HEDIS measures) and meeting outcome targets (such as rewards for decreasing emergency department visits).⁶⁸

As performance assessment-based payment programs become more sophisticated and gauge not only adherence to process measures but also health outcomes and efficiency, physician incentives must evolve to reflect the significant investment providers must make to participate in such initiatives. As physicians are encouraged to report on process, health outcomes, HIT adoption, patient-centeredness, and other complex measure sets, incentive payments must also increase to reflect the additional administrative burden, medical inflation, additional staff, and HIT investment required to participate. Without proper incentives, performance assessment-based payment programs can stagnate.

The IHA P4P program recommended in 2006 that by the end of the decade, performance incentives should reach 10% of compensation. However, in 2007, average incentive payments equaled only 2% total of physician group's reimbursement. By 2008, incentive levels were reduced as some payers began focusing financial resources on other non-P4P-related gain-sharing efforts.³⁶ This led one physician group CEO to opine that the 2% payment incentive was "insufficient to generate breakthrough improvement."³⁶ While half of the physician organizations reported that the P4P incentive payments were greater than the amount they spent to facilitate participation, 6 of the 35 organizations reported that the incentives were "barely enough to cover investments the group had to make to measure and manage the processes."⁶⁹

The appropriate level of incentive is difficult to ascertain. How much money is needed to reflect the cost of program participation? A study of commercial HMO P4P efforts found that about 41% of survey respondents estimated that potential bonus payments were around 5% or more of total plan payments.⁷⁰ The United Kingdom's National Health Service implemented its own pay-for-performance program for general practitioners in 2004. Performance payments make up 25% of family physician's income.⁷¹ An evaluation of the Massachusetts Health Quality Partners P4P program concluded that the average annual performance incentive of \$1000 per physician may have been insufficient to drastically improve quality measure adherence and that incentives may have to exceed \$2000 per primary care physician to achieve desired results.⁷²

Incentives must also be strongly aligned with meeting quality-of-care goals at the individual and population levels. Health care utilization measures do need to be established to minimize wasteful use of resources, but not at the expense of quality care measures. Some physician groups who participated in the IHA P4P program expressed concern that the financial incentives encouraged participants to focus on meeting resource use rather than quality care measures. The AMA expressed similar concern about the CMS Physician Group Practice demonstration project.⁷³

Payment policies should intend to reward all physicians who improve clinical performance (i.e., "lift all boats") rather than simply target those who are already considered "high-performing." The majority of P4P programs instituted by HMOs reward physicians based on ability to attain a predetermined performance threshold (62%), while only 20.4% explicitly rewarded improvement and many plans provided bonuses only to top performers. About 14% offered rewards for meeting predetermined thresholds as well as improved performance.⁷⁰ The Physician Group Practice demonstration, for instance, requires physicians and other providers to satisfy at least one of three targets: two based on meeting performance thresholds and one based on improvement over time.⁷⁴ Performance assessment-based payment programs must be structured to encourage all participants, including those considered high-performing prior to program implementation, to improve rather than to simply maintain the status quo.⁷⁵ Incentives must also be significant enough to encourage under-performing physicians and other health professionals within the health care team to meet quality measures. Eventually, incentives based on improvement should be gradually phased out to encourage all providers to meet high-performance benchmarks. Finally, payers should work to align financial incentives connected to a standard set of evidence-based, physician-developed and tested set of quality measures to reduce administrative burden and maximize program potential.⁷⁶

Part II: The Need to Fundamentally Redesign the Physician Payment System

Position 3: Programs to link payments to performance assessment must not exist in isolation and must be coordinated with concurrent efforts to improve evidence-based primary and specialty care, should be integrated into other innovative delivery system reform initiatives that seek to promote care coordination across the health care sector and emphasize preventive rather than reactive care, reduce geographic disparities in quality of care, and nurture the patient–physician relationship, such as through a patient-centered medical home.

Public and private payers should work with the medical profession on a fundamental redesign of physician payment methodologies that include the following reforms:

- **Physician reimbursement should encourage system- based care, promoting collaboration among payers, physicians, and other health care practitioners, and be structured to achieve the goals of improved population health, patient experience, physician and other health care clinician coordination, and reduced costs.**
- **The physician payment system should fairly compensate physicians for work and practice expenses, and payment updates should fairly reflect inflation.**

Efforts to add an additional portion of reimbursement tied to physician performance on top of the current payment system will be inadequate to materially change the current level of physician performance. Performance assessment–based payment initiatives must be integrated into broad reimbursement reform efforts that promote coordinated, team-based care and patient-centeredness through models such as the medical home.

Assigning patients to a medical home and incentivizing team-based care across all health care providers may be necessary to achieve the coordination and improved quality of care goals set for performance assessment–based payment programs. Since fee–for–service payment models used by Medicare and many private payers do little to promote coordination of care, many patients receive care from multiple primary and specialty care providers. A study by Pham et al. found that P4P implementation in a fee–for–service–based system will be difficult, particularly since many patients—especially those with chronic illnesses—have more than one primary care provider, making it difficult for a single physician to direct (and be largely responsible for) the care of a patient.⁷⁷ The uncoordinated nature of the fee–for–service structure makes it difficult to influence quality through performance measures and incentives. The patient-centered medical home model seeks to provide care that better meets the needs of patients and rewards physicians and other health care providers for continuous quality improvement.⁷⁸ One solution is to reimburse primary care physicians for acting as the primary care provider in a patient-centered medical home model and provide additional bonus payments for meeting performance measurements.⁷⁹

In creating its own statewide effort to achieve the goals of the triple aim, the Vermont Blueprint for Health establishes enhanced medical home at the base level, facilitating physician and other health care provider partnerships through patient registries and a compatible health information technology infrastructure.

Part III: Transparency and Oversight

Position 4: Physicians should have a key role in determining methods used to develop and select measures (including the measurement evidence and any evidence grading methods used), collect data from physicians, aggregate and score performance, and report performance data internally and publicly. These processes should be transparent so that physicians, consumers, and payers know that methods, expectations, rationale, and results are valid and reliable. Sponsors of programs that link payment to assessment of performance should notify potential participating physicians of program implementation, educate physicians about the potential risks and rewards inherent in program participation, and immediately inform physicians of any changes in program requirements and evaluation methods and newly identified risks and rewards. Payers should inform patients at the time of enrollment of such efforts, potential risks, and physician participation.

Position 5: Programs that link payment to assessment of performance should incorporate periodic, objective assessments of measurement, data collection, scoring, and incentive systems to evaluate their effects on achieving improvements in quality, including any unintended consequences. The programs and, where appropriate, their performance thresholds should be readjusted only when there is compelling evidence and a justifiable reason to do so.

Physicians must be engaged at all levels to ensure complete understanding of the types of quality measures used, reporting requirements and intervals, data collection methods, distribution of progress reports, administrative requirements, payment structure, and other issues involving pay-for-performance schemes to guarantee understanding and engender confidence in the program. Evidence shows that while a majority of general internists support the idea of P4P, many do not believe that performance measures are accurate and that private and public payers will not do enough to ensure accuracy.⁵⁰ Another survey showed that physicians harbor negative views of the level of understanding of the details of P4P programs and concluded that physicians studied were “neither disaffected from nor fully engaged” in the P4P programs studied.⁸⁰ Measure developers, payers, medical societies, and patient/consumer advocates must work together in a transparent manner to ensure that all stakeholders understand how they may be affected by performance assessment-based payment efforts.

Better ongoing collaboration with medical societies and physicians may help to build trust and understanding during the design stage as well as implementation. The ACA would require a multi-stakeholder group to determine gaps in areas where few quality measures exist and provide recommendations on measure development. Physicians and other health practitioners must be involved in this and other related processes to ensure validity and understanding among the medical community. Collaboration and transparency has helped strengthen existing programs; an evaluation of the IHA P4P effort noted “the value of collaboration among health plans and physician groups to create and use uniform measures cannot be overstated.” It also found wide physician support for payment incentives, clinical IT adoption, and data collection methods.³⁶

Patients should also be aware of performance assessment–based payment program participation and whether physicians are receiving bonus payments for quality care. According to ACP’s *Pay-for-Performance Principles That Promote Patient-Centered Care: An Ethics Manifesto*, “transparency increases the risk that patients will not trust their physician, but secrecy would have far worse consequences. Patients must also know how their physician performs on quality measures and what financial incentives he is subject to.”⁸¹

Periodic assessments of measure sets, data collecting, incentive models, and other performance assessment–based payment facets should occur on a regular basis to ensure such initiatives do not lead to unintentional consequences, such as “practicing to the measure” or deselecting patients with complex health care needs. The IOM’s *Rewarding Provider Performance: Aligning Incentives in Medicare* suggests charging HHS to periodically review Medicare P4P programs to correct program errors, determine progress in clinical outcomes and effect of incentives, and identify and widely establish best practices that may help to improve overall program performance among other duties.⁸²

Within the triple aim framework, the macrointegrator may engage physicians and other health care clinicians in developing, sharing, and testing services to improve primary care delivery. An evaluation of triple aim site CareOregon noted that “by partnering with health care providers to create and pursue a common vision for improving primary care delivery, CareOregon is transforming its role from a payer to an integrator of care on behalf of its members.”⁵⁵

Part IV: Selection of Measures

Position 6: The College reaffirms and expands upon the qualities of a good performance measure as reported in the ACP policy paper, *Linking Physician Payment to Quality Care*, and in ACP’s position paper, *Healthcare Transparency—Focus on Price and Clinical Performance*:

Performance measures used to evaluate physician performance should be:

- **Reliable, valid, and based on sound scientific evidence**
- **Clearly defined**
- **Based on up-to date, accurate data**
- **Adjusted for variations in case mix, severity, and risk**
- **Based on adequate sample size to be representative**
- **Selected based on where there has been strong consensus among stakeholders and predictive of overall quality performance**
- **Reflective of processes of care that physicians and other clinicians can influence or impact**
- **Constructed to result in minimal or no unintended harmful consequences (e.g., adversely affect access to care)**
- **As least burdensome as possible**
- **Related to clinical conditions prioritized to have the greatest impact**
- **Developed, selected, and implemented through a transparent process easily understood by patients/ consumers and other users**

Position 7: ACP supports the use of structure, process, and outcome measures in programs that link payment to assessment of performance as long as they meet ACP’s criteria for measures used to evaluate physician performance.

Position 8: Measure sets must primarily focus on improving patient outcomes, gauging the patient-centeredness of a practice, and improving the coordination of care across all providers. The College maintains that efficiency—or “value-of-care” measures—must be based on an objective assessment of evidence on the effectiveness of particular treatments, with both cost and quality taken into consideration. Value-of-care measures must appreciate the nuances of physician care and must not compromise the patient–physician relationship. Stakeholders must also work to develop population health measures designed for specific populations.

Position 9: The development, validation, selection, refinement, and integration of performance measures should be a multilevel process that takes advantage of the most recent scientific evidence on quality measurement and has broad inclusiveness and consensus among stakeholders in the medical and professional communities. This entire process should be transparent to the medical community. Measures should be field-tested prior to adoption to ensure their viability in the medical setting. Once in use, performance measures that have not been shown to improve value to include higher quality, better outcomes, reduced costs (and higher patient and physician satisfaction) should be removed from performance–based payment programs.

Position 10: ACP supports a national strategy for quality improvement that will establish national goals, attend to high-leverage priority areas that will lead to significant gains in quality and value of care (such as care coordination), fill gaps where few performance measures exist, develop universal terminology for measurement developers, and harmonize measure sets to improve coordination and reduce duplication and confusion. Such a strategy should also lead to determination of a single core measure set to provide data for benchmarking and ongoing quality improvement. The strategy should be updated as performance measures and programs to link payments to assessments of performance evolve. The College supports directing adequate financial resources to this and other related activities outlined in the Affordable Care Act.

To achieve the goal of collaboration across the health care spectrum, macrointegrators, such as health insurers, and microintegrators, such as physicians and clinics, must work to develop evidence-based quality measures to improve individual patient and population health. Further, patient experience (or patient-centeredness) should be measured to ensure that the patient–physician relationship is not harmed as a result of performance assessment-based payment programs. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) model, for example, is a patient survey framework where patients report on such questions such as whether they received a timely response to their medical inquiry.⁸³

According to the Institute for Healthcare Improvement, outcome measures should be developed for each of the triple aims. Meeting these aims requires disparate and disconnected providers, hospitals, payers, and patients to come together and agree on controversial aspects of health care delivery, such as standardized performance measure sets and how much reimbursement should be based on meeting certain performance thresholds. Focusing on a specific population, and developing measures for that population, may help smooth

the collaborative process since it is easier to target policies to a single group with similar health care needs. A review of three triple aim sites found that the population-based focus helped achieve consensus between macrointegrators and microintegrators, since resources can be designated to meet the needs of the specific population. Many performance measure sets, such as HEDIS, already measure efficiency, which intends to avoid “waste of equipment, supplies, ideas and energy.”⁸¹ The PCPI measure set includes measures intended to avoid inappropriate use of antihistamines or decongestants.⁸⁴ Further, ACP has acknowledged the need for measures that improve quality and efficiency.⁸⁵ The ultimate goal of efficiency measure-related payments should be to promote “value of care,” which considers the quantity of health care services used, cost-effectiveness of services delivered, and clinician or patient preferences.⁸⁷

Performance measures must also be aligned with PQRI-related measures and HIT meaningful use requirements. The MIPPA law required HHS to contract with an entity to make recommendations on a national strategy and priorities for performance measurement, endorsement of standardized health care performance measures, maintenance of measures, and promotion of development of electronic health records. The harmonization of measures is an important goal. The 2009 National Healthcare Quality Report included such a recommendation while acknowledging that the current uncoordinated performance measurement field creates competing and sometimes conflicting measures related to the same process or outcome goal.⁸⁶

Part V: Data Collection and Minimizing Physician Burdens

Position 11: To alleviate the administrative burden of programs to report on performance metrics, measurement sets, payment models, and data collection should be standardized across programs; HIT and EHR systems should be enabled to recognize and report performance assessment– based payment data; and audit and validation processes should be facilitated. Data collection and physician reporting required to support programs to assess performance should be administratively feasible, reliable, practical, and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

- **Prospective data collection should be encouraged whenever possible to minimize burdens and to reduce measurement error.**
- **Data collection methodology should be consensually determined by national health care stakeholders and standardized across P4P programs.**
- **Data collection and analysis must not violate patient privacy.**
- **Physicians should not be required to purchase or lease proprietary models of data collection.**
- **Programs must consider the unique practice challenges faced by safety-net providers, physicians in small practices, and physicians who are just entering practice, among others.**

Position 12: Information technology tools should be used whenever possible to facilitate data acquisition for performance measures and to minimize any manual data extraction to support such measurement. Incentives and best practices for incorporation of electronic health records should be developed, pilot-tested, provided, and disseminated to improve data collection on clinical outcomes.

With hundreds of performance assessment–based payment programs currently initiated across the nation, the wide variety of quality measure sets, data collection requirements, and auditing and validation hassles adds to an administrative burden that can compromise the patient–physician relationship. A Minnesota Medical Association report on P4P programs concluded that the multitude of uncoordinated quality measures, data collection methods, and measure specifications “ultimately will distract physicians and patients.”⁸⁷ The success of these programs may hinge on their efficiency; a complex array of performance assessment–based payment programs may create confusion among physicians, undermining any gains in health status among patients and limiting the prospect of cost-savings for payers. Payers and stakeholders should explore means to standardize payment systems (e.g., all payers increase payments to physicians who meet a standard set of quality measurement goals) without violating antitrust law to mitigate confusion and strengthen the prospect of improved patient outcomes and cost-savings.⁸⁸

Performance assessment–based payment data collection methods should not create an onerous financial or time burden on physicians and their staff. A survey of PQRI-participating physicians found that 57% described data capture and submission activities to be “difficult” or “very difficult.”⁸⁹ As performance measurement activities become more complex, efforts should be made to ensure that participation does not create an undue financial or practice burden. For instance, during the initial stages of the performance assessment–based payment program, physicians should be exposed to little or no financial or performance-related risk.

Manual chart abstractions can accurately determine clinical outcomes, but it is an expensive and time-consuming option.⁹⁰ Less resource-intensive data collection methods, such as patient exit surveys, may be appropriate depending on the service measured.⁹¹ Health information technology, including electronic health records, has the ability to greatly enhance performance assessment–based payment efforts and make participation more worthwhile for physicians. Practices that are EHR-enabled can more efficiently collect and transmit data, and EHR-based tools like electronic reminders can help performance improvement.⁹² As with other aspects of performance assessment–based payment programs, HIT systems and electronic health records must use harmonized data elements, be interoperable throughout the health care system, and allow for real-time data collection. The federal government has authorized funding for HIT investment. The American Recovery and Reinvestment Act of 2009 included a provision providing funds for investment in health information technology. Physicians and other health care professionals that serve a high volume of Medicaid patients will receive federal funding to assist with the purchase, implementation, and operation of health information technology infrastructure.⁹³ To qualify for funds under this provision, physicians must demonstrate that their health IT is for “meaningful use.” By 2012, HHS will devise a plan to integrate the PQRI with the HIT meaningful use requirements.⁹⁴

In developing a larger collaborative framework, integrators and physicians and other health care providers should mutually determine a means of data collection. In Vermont, Blueprint for Health pilot sites used a common clinical tracking system to enter patient data and track community health needs. Such technology was used to maintain collaboration and information sharing at PCMH sites and with community health teams.^{66,95}

Part VI: Data Accuracy, Data Aggregation, and Scoring

Position 13: Analysis and reporting of physician and system performance should include the application of statistical methods that provide valid and reliable comparative assessments across populations.

- **Data should be fully adjusted for case-mix composition (including factors of sample size, age/sex distribution, severity of illness, number of comorbid conditions, patient compliance, patient health insurance status, panel size/patient load, and other features of a physician’s practice and patient population that may influence the results).**
- **To the extent possible, data analysis should accurately reflect all units of delivery that are accountable in whole or in part for the performance measured.**
- **Scores should relate care delivered (numerator) to a statistically valid population of patients in the denominator.**

Position 14: Performance measure developers must incorporate socioeconomic status adjustments or other variables to ensure vulnerable patients receive the care they need. Programs that link payment to assessment of performance must monitor participants to identify and address unintended consequences, such as exacerbation of racial and ethnic health disparities. This may be achieved by including incentives to care for underserved or complex-needs patients in such programs.

- **Measuring, scoring, and incentivizing physician and system performance should result in better patient care. It must not compromise patient access to care through such mechanisms as “deselection” or lead to increased attention to or manipulation of documentation.**

Despite the growing support and mainstreaming of pay-for-performance initiatives over the last several years, the idea is not without great controversy. A host of ethical issues surround the idea of incentivizing physician behavior, and evidence shows that even though initiatives to link payments to performance assessment may be established with the best intentions, numerous unintended consequences can develop when programs are poorly designed. In 2007, ACP’s Ethics Committee released a paper expressing concern that pay-for-performance efforts could lead to adverse effects, such as:

- “Deselection” of difficult patients with complex health care needs;
- “Gaming of the system” or providing services based solely on performance measures rather than evidence-based services that might not be measured;
- Undermining trust between the patient and physician; and
- Unjustified increases in unnecessary or costly care.⁸²

To combat unintended consequences, ACP suggested improving transparency between patients and physicians, developing measures based on patient-centeredness, and utilizing administrative procedures and oversight to prevent deselection and other negative consequences. Adverse effects are an important consideration, leading one commentator to suggest that bioethicists be consulted when developing and researching P4P efforts.⁹⁶ In one study,

health care providers sought to attract substance abuse patients with less severe health care needs to more easily qualify for performance inducements; as a result, the number of patients with severe health problems seen by the practice decreased after the performance-based contracting program was established. The author suggests that severity be considered in performance measure development.⁹⁷ Among the more troubling negative consequences of performance assessment-based payment is the potential to exacerbate racial/ethnic and socioeconomic health care disparities. One study by Friedberg et al. found that primary care physicians who already serve a high number of vulnerable patients would receive lower performance incentives than other practices.⁹⁸ Additionally, Medicaid, elderly African American, and Hispanic patients are often treated in hospitals that deliver poor-quality, high-cost care and are often served by a limited number of geographically concentrated providers; if such providers were unwilling or financially unable to serve this population, access to care would be reduced.^{99,100,101}

Some studies, particularly those focused on the United Kingdom, have shown that performance assessment-based payment has not negatively affected equity of care.⁴⁰ One study concluded that such programs had not undermined chronic disease management efforts among various socioeconomic populations.¹⁰² A study of hospitals participating in the Premier Hospital Quality Initiative Demonstration program concluded that payment programs based on performance assessment did not have a negative effect on poor patients and noted that such programs may show promise in improving quality of care for hospitals that serve poor patients.¹⁰³ Still, safeguards need to be implemented to ensure that patients are not adversely affected by implementation of performance assessment-based payment. One possible way to avoid such unfavorable effects is to risk-adjust process and outcomes measures to account for patient socioeconomic status, race and ethnicity, or both.^{103,104,40} Similarly, risk stratification methods permit comparison of patients with similar characteristics and may help ensure care equity; for instance, comparing mammography rates among African American women and white women across multiple health insurance plans may help highlight disparities in the receipt of services.¹⁰⁵ Another way to potentially ensure equity is to use aggregate reporting at the large physician group level to limit risk for those individual physicians who treat a disproportionate share of complex patients.⁶⁰ Incorporating measures designed to evaluate mitigation of disparities, such as use of interpreters for patients with limited English proficiency, may also help to close the disparity gap.

There is some indication that risk-adjustment mechanisms are becoming more prevalent in performance assessment-based payment schemes.¹⁰⁶ For example, the United Kingdom's National Health Service adjusts performance-based incentives according to community demographics and the health system of New Zealand establishes different pay-for-performance goals for providers serving a high proportion of the aboriginal population, a group found to exhibit health disparities compared to the white patients.¹⁰⁷

Part VII: Public Reporting and Other Appropriate Uses of Analyzed Data

Position 15: The College reaffirms the importance of physicians and other health care professionals having timely access to performance information prior to public reporting and the availability of a fair and accurate appeals process to examine potential inaccuracies as reflected in the ACP policy paper, *Developing a Fair Process Through Which Physicians Participating in Performance Measurement Programs can Request a Reconsideration of Their Rating.*"

Position 16: Educational feedback should be provided to physicians, other stakeholders in the system, and consumers on a timely, routine basis. Educational feedback should include a discussion of the physician's individual performance, as well as his or her performance relative to other physicians. Reports should be user-friendly, easily accessible, standardized, and based on recommendations of relevant health care stakeholders. Physicians and other health care clinicians in the system should have the opportunity to review prior years' performance data at any time.

Position 17: The results of programs to link payments to assessment of performance should not be used against physicians in health plan credentialing, licensure, or certification. Such programs must have defined security measures to prevent unauthorized release of physician ratings and patient data.

Feedback reports should be easily accessible and standardized and physicians should be able to view performance data from prior years. This recommendation reflects the frustration many PQRI-participating physicians have expressed in receiving timely and actionable feedback from CMS. An MGMA survey found that nearly 37% of physicians were unable to download their 2008 PQRI feedback report and the average practice spent nearly 9 hours to successfully download the report.¹⁰⁸ Nearly 70% of physicians surveyed stated that they were dissatisfied or very dissatisfied with the “effectiveness of the report in providing guidance about how the practice can improve patient care outcomes.” Effective, regular communication between payer and physician is vital to a successful P4P program. A study of Medicaid P4P efforts found that payers who provided timely, clear technical assistance and feedback were more successful in meeting their goals.^{109,110}

Part VIII: Program Implementation

Position 18: As physicians and other health care clinicians, payers, and affiliated community health organizations begin to establish a more collaborative infrastructure, stakeholders must work together to:

- **Maintain a cooperative vision to achieve a team-based practice to reach the goals of improved patient experience, better population health outcomes, and reduced costs;**
- **Harmonize performance measures and data collection through a transparent, collaborative process;**
- **Improve access to health information technology and electronic medical records;**
- **Maintain timely and clear feedback to providers and other health care providers in the system;**
- **Provide ample incentives that at a minimum reflect the financial and practice costs of participation;**
- **Recognize the complex needs of small practices and physicians and other health professionals serving highly vulnerable populations, such as patients with multiple chronic conditions and the elderly; and**
- **Strengthen patient-centered primary care.**

Position 19: It is crucial that any programs that link payments to performance assessment be subjected to ongoing research and monitoring to ensure that they support the patient–physician relationship, contribute positively to adoption of best practices, and do not unintentionally undermine patient care, such as by contributing to ethnic and racial disparities by penalizing or denying resources to clinicians, hospitals, and other providers who care for poorer and sicker patients. There must be timely reconfiguration of performance-based payment programs if such adverse effects are recognized. A Medicare value-based purchasing program and other initiatives to pay physicians based on performance assessment should meet the principles outlined in this paper.

The College supports initiatives to encourage delivery of high-value care to achieve the goals of incentivizing best practices and improving patient health. Such efforts must be combined with a movement toward fostering health system integration, either through formal integrated health systems, such as the Geisinger Health System, or informal collaborations, such as accountable care organizations. At the root of such a collaborative effort is the patient-centered medical home, and the principles of the triple aim support the growth of primary care and preventive health. Performance assessment-based payment can be integrated into such a system but measures and reimbursement structures must be aligned and created in a collaborative process involving integrators at the patient and system-wide level. With improved integration, the current fragmented health care landscape can evolve into a cohesive system working toward the shared goals of better population health and patient experience while reducing health care costs.

Regarding current initiatives, the ACA authorizes CMS to financially penalize physicians who are not participating in PQRI beginning in 2015. This is an ambitious timeline, especially considering the related delivery system reforms facing physicians, such as ICD-10 implementation and the value-based payment modifier. Since the ACA will greatly expand coverage to the uninsured and underinsured beginning in 2014, physicians and other health professionals—particularly primary care physicians—may face larger patient loads, leaving less time for adhering to the administrative requirements of performance assessment-based payment and other delivery system reform programs. This reality highlights that more needs to be done to accelerate use of health information technology and standardize performance measure sets and data collection methods, among other facets of performance assessment-based payment. Further, as Medicaid and private payers cover more people, new measures will have to be developed to reflect the needs of various newly insured populations. Physicians and stakeholders must work together in a transparent process to develop, test, and endorse performance measures that meet the recommendations of the IOM by improving safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

In ACP's 2006 response to the IOM's *Rewarding Performance* report, the College recommended that Medicare P4P programs be gradually phased-in to incentivize reporting on structural measures (such as HIT development), followed by voluntary reporting on evidence-based measures, and finally graduated bonus payments based on a physician's ability to meet evidence-based measures. Although many physicians have some experience with such efforts, participation rates in PQRI are very low, and CMS should consider adjusting the PQRI bonus requirements to improve participation or delay penalties for nonparticipation prior to 2015.

While performance assessment–based payment programs have proliferated over the last 5 years, evidence is sparse on the effectiveness of such initiatives to improve the quality and value of health care. Ongoing research is needed to determine best practices and aspects of performance assessment–based payment that lead to negative consequences. Although the ACA authorizes funding for performance measurement improvement efforts, developing national quality improvement plans, providing incentives, and other quality improvement activities, there is no guarantee that such funds will be appropriated.

Conclusion

The principles of medical professionalism dictate that doctors always deliver evidence-based care to all patients (where such evidence exists), regardless of the opportunity for financial or other gain. Given that doctors are already motivated by such professionalism, it would seem that paying physicians and other health professionals to deliver quality care would conflict with the doctrine of professionalism. However, as the College has noted, the two concepts do not have to be mutually exclusive, provided that such efforts do not detract from ethical delivery of care.⁶⁰ While evidence supporting the use of performance assessment–based payment is mixed, there is some indication that it can lead to better physician performance and patient health outcomes.

The College reiterates its support for payment and delivery system reforms to promote high-value care, and recognizes that such reforms may include measures of performance linked directly or indirectly to payments to physicians, hospitals, and other providers. Such reforms should facilitate patient-centered care that is prevention-based, improves the patient–physician relationship and is highly coordinated across the health care system. Health information technology infrastructure must be established to facilitate the exchange of information, improve the collection and reporting of measure data, reduce waste, and minimize the administrative burden. Thorough and extensive ongoing research must be conducted to determine which evidence-based performance measures and payment systems achieve desired results. Finally, physicians must have the opportunity to provide input on the design, implementation, and operation of such models to ensure that delivery of high-quality, equitable care is not compromised.

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