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## Rewarding Performance in Medicaid Managed Care

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*Pioneering private, and more recently public, sector purchasers are increasingly turning to incentive-based reimbursement to reward better health care at the provider, plan, and consumer levels. As one of the largest health purchasers in America, Medicaid can play a leadership role in testing the viability of pay-for-performance strategies to improve health care quality for low-income, racially diverse, and chronically ill individuals.*

**P**rovider pay-for-performance programs are on the rise nationally, with approximately 107 programs currently in operation.<sup>1</sup> Although far more prevalent in the commercial sector and increasingly so in Medicare, incentive programs are emerging in Medicaid as a way to improve health care services and outcomes.<sup>2</sup> Whereas reimbursement in health care traditionally has focused on volume — the more patients a physician sees, the more he or she gets paid — pay-for-performance programs attempt to better align payment and quality with the goal of improving the efficiency, timeliness and quality of care. Through these programs, providers who deliver high-quality, patient-centered and efficient care are reimbursed at a higher rate than their lower-performing counterparts.

Medicaid, with 52 million beneficiaries and more than \$300 billion in annual expenditures, has a responsibility to ensure that it is getting value for the dollars it spends. Because more than 60 percent of beneficiaries are enrolled in managed care,<sup>3</sup> Medicaid plans can lead the pay-for-performance movement by aligning payment and quality and “raising the bar” for providers,

regardless of the population being served. While much still needs to be evaluated, pay-for-performance programs represent an opportunity to test whether incentive-based reimbursement can improve the delivery of care for those who need it most.

This issue brief summarizes trends in pay-for-performance and outlines eight key considerations for rewarding quality in the Medicaid program. In addition, the paper presents the experiences of seven Medicaid managed care plans in California that implemented incentive programs through the Local Initiative Rewarding Results (LIRR) program.

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### Fundamental Lessons for Medicaid Pay-for-Performance

1. Promote Access and Preventive Care
2. Engage Providers
3. Select Clear Measures
4. Pay Attention to the Structure of Incentive Programs
5. Be Mindful of Data Challenges
6. Remember: Money is Not Everything
7. Consider Member Incentives
8. Coordinate with Other Payors

## Lessons from the Local Initiative Rewarding Results Project

The Local Initiative Rewarding Results project, funded by the California HealthCare Foundation, is the largest pay-for-performance collaborative conducted within Medicaid. Its goal is to improve the health of babies and teens. It is one of seven initiatives within the Rewarding Results Program, a national initiative of the Robert Wood Johnson Foundation and the California HealthCare Foundation (with evaluation funding from the Agency for Health Care Research and Quality) to test provider performance incentive strategies. Over the past three years, 3,300 physicians have been involved in the LIRR project touching the lives of 350,000 babies, teenagers and parents. Preliminary results from the project show that simple, targeted financial incentives can make a difference.

The experiences of the seven California plans provide new insight into the unique cross-cutting challenges and opportunities in rewarding performance in Medicaid managed care. Issues such as the significance of provider feedback, the systems and infrastructure needed to support improvement, and the importance of provider and member engagement are all being addressed. While the lessons learned through this project overlap with the experiences of many of the other Rewarding Results grantees and commercial incentive programs, the LIRR demonstrations suggest how traditional pay-for-performance efforts can be adapted to serve the goals of publicly financed care. Following are key lessons learned from LIRR and other health plan incentive programs.

### 1. Promote Access and Preventive Care

All pay-for-performance endeavors, whether in the commercial or public market, face challenges. For example, are incentives perceived as just paying doctors for what they should already be doing? Do providers view plans/purchasers as simply withholding money that is due to them anyway? How can the costs and difficulty of data collection be mitigated? Programs designed for the public sector, and particularly within Medicaid, must not only answer these questions, but must also address the unique attributes of the beneficiary and provider population.

The first step in delivering health care to Medicaid beneficiaries is simply getting them “in the door.” Medicaid patients can be transient, so

outreach (by a provider, health plan, or other agency) requires an organized and sustained effort. Other factors, such as language barriers, lack of transportation, and conflicting work schedules also threaten a Medicaid beneficiary’s ability to access needed health care services.

Thus, incentives in Medicaid often initially focus on access measures (e.g., getting moms in for prenatal care and newborns in for well-baby visits), rather than on clinical measures (e.g., the number of members with diabetes with an HbA1c less than eight or the number of members with asthma prescribed a controller medication). The plans in the LIRR project recognized that poor preventive care for children can be extremely expensive — in both human and financial terms — and thus targeted incentives for well-baby and adolescent well-care visits. Providers involved in the project have noted that the additional incentive dollars allowed them to do more outreach to the patients most in need of care.

As incentive programs that initially focus on access and prevention become more sophisticated, rewards for improvements in chronic care and specific clinical outcomes can be added. For example, some health plans have promoted certain aspects of the Chronic Care Model<sup>4</sup> by reimbursing for quality improvement efforts in the area of registry development and the implementation of evidence-based guidelines for chronic care. One LIRR participant, Inland Empire Health Plan, currently has an incentive program focused on appropriate asthma care. The plan reimburses providers for clinical processes, such as the completion of an asthma progress note at every visit. Provider incentive programs that set targets for specific clinical outcomes (e.g., number of members meeting LDL or HDL cholesterol goals) are commonly used to promote quality in the management of chronic diseases. (Further discussion of “next generation” pay-for-performance programs can be found later in this brief.)

### 2. Engage Providers

Medicaid health plans often struggle to secure buy-in and gain leverage with providers around pay-for-performance efforts. The maintenance of provider networks in Medicaid can be challenging — low Medicaid payment rates, provider shortages in rural areas, and lack of infrastructure for things like billing and scheduling can make network stability tenuous. In many cases, Medicaid beneficiaries may not constitute a large percentage of a medical group’s or individual

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## LOCAL INITIATIVES REWARDING RESULTS: TESTING INCENTIVES IN MEDICAID

The seven managed care organizations participating in the Local Initiative Rewarding Results project are working to improve the quality of and access to preventive care services for children and adolescents enrolled in Medi-Cal, California's Medicaid program. The primary incentives target well-baby and adolescent well-care visits. A complimentary measure rewards medical groups based on the volume, timeliness, and quality of electronic encounter data.

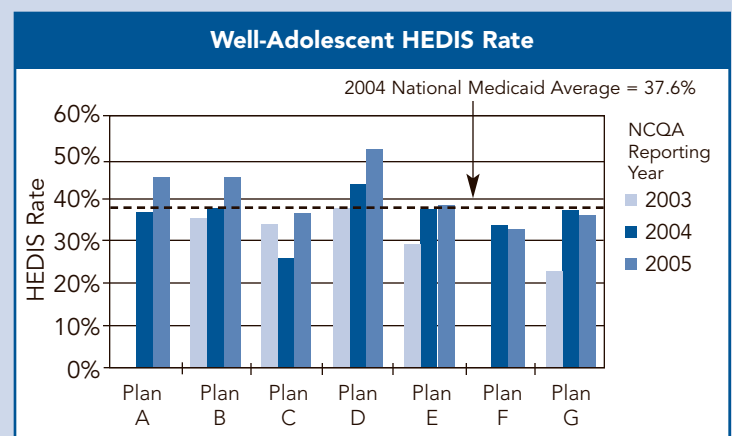
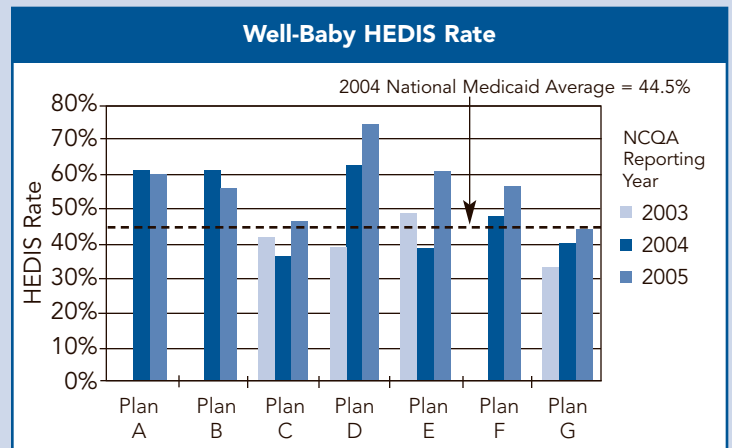
The participating plans are:

- Alameda Alliance for Health
- Health Plan of San Joaquin
- Inland Empire Health Plan
- Kern Family Health Care
- L.A. Care Health Plan
- San Francisco Health Plan
- Santa Clara Family Health Plan

Since the project's implementation, the majority of plans have had mostly positive results in their HEDIS rates.

- Four of the five plans with new incentives for timely well-baby visits improved their score on the relevant HEDIS measure; improvements ranged from four percent to as high as 35 percent.<sup>5</sup>
- All four plans with new incentives for well-adolescent care increased their score on the relevant HEDIS measure; improvements ranged from eight percent to 12 percent.
- Six out of seven plans are at or above the HEDIS Medicaid national average for well-baby visits, and four out of seven are at or above the HEDIS Medicaid national average for well-adolescent visits.

The participating plans combined serve close to one million children and adolescents in nine counties throughout California. The project, which began in September 2002, is funded by the California HealthCare Foundation and managed by the Center for Health Care Strategies. The key state agency payors — the Department of Health Services and the Managed Risk Medical Insurance Board — are participating in its Steering



Committee. The project is part of Rewarding Results, a three-year national initiative of the Robert Wood Johnson Foundation and the California HealthCare Foundation to test whether financial performance incentives for providers can improve health care quality.<sup>6</sup>

Provider incentives for well-baby and adolescent well-care visits include bonus payments, risk pool distribution, and, for one health plan, in-kind staff assistance. Plans also are experimenting with member incentives: a few plans are offering incentives to adolescent members for well visits and one plan is offering incentives to parents upon completion of well-baby visits.

A rigorous evaluation by Mathematica Policy Research, a national health policy research firm, will determine the effectiveness of provider and member incentive strategies and compare the different models, taking into account the delivery and payment environment.

physician's patients. A health plan starting a new incentive program might have difficulty creating awareness and achieving buy-in from enough practitioners to make the program effective.

Demonstrating that a performance gap exists between actual (what is provided) and *ideal* (what should be provided) care can be a real hook in getting providers to participate in pay-for-performance projects. According to a recent study, only 33 percent of physicians receive data about the quality of care they provide.<sup>7</sup> The San Francisco Health Plan, a participant in the LIRR project, structured incentive payments to recognize physician accomplishments and, at the same time, to show that opportunities to improve still exist. Along with an actual payment check based on goals met, the health plan sends a voided check with an amount the provider *could have received* had performance been better.

The LIRR health plans used various approaches to alert providers to incentive programs. Kern Family Health Care required physicians to attend a mandatory learning session to become eligible to receive incentives. Approximately 99 percent of eligible providers attended the sessions and became familiar with Kern's program. Other plans sent letters or visited practices to explain the program and inform providers about their current performance and incentive performance targets. Working through medical group administrators provided a valuable channel to inform providers about incentives. For almost all of the LIRR health plans, "getting the word out" about incentive programs and gaining providers' attention required creativity and sustained effort throughout the project.

### 3. Select Clear Measures

Measures used to evaluate physician performance should be based on solid clinical or practice-based evidence that is accepted by the provider community and for which a change in behavior or practice will result in measurable change. A variety of resources and tools are available to help health plans select measures that best fit the needs of their programs.<sup>8</sup>

Standardized measures, such as HEDIS, are often adopted in pay-for-performance programs because they are widely used and because such measures make it possible to compare the performance of one organization to others. In the LIRR

project, HEDIS rates for well-baby and well-adolescent visits were chosen to measure improvement for all the plans. Because the state requires HEDIS data from Medi-Cal health plans, data collection for LIRR was not an added burden for the plans. Using HEDIS also allowed plans to examine trends in rates before, during, and after the LIRR demonstration.

The downside of this type of standardized measure is that criterion may not be available to gauge performance on select services or processes. For Medicaid this is particularly true because not all clinical areas and populations (e.g., mental health, substance abuse, children with special health care needs) are represented in national measurement sets. While specialized measures allow plans to gather information on specific populations, clinical processes, and areas of interest, these unique measures are not widespread and may require extra effort to collect.

### 4. Pay Attention to Incentive Program Structure

An incentive program should reflect a plan's specific goals and objectives. In designing an incentive program, health plans must decide how to target the clinical outcomes or processes, how to measure improvement, and how to structure payment. The health plans in the Local Initiative Rewarding Results project collectively decided to emphasize HEDIS rates for well-baby and well-adolescent visits, as well as the submission of encounter data. Well-baby and well-adolescent visits were targeted because the plans all recognized the importance of preventive care and felt that substantial opportunity for improvement existed. Improving the submission of encounter data was stressed because without such data, plans have difficulty achieving accurate HEDIS rates. In California, HEDIS measures are monitored by the state and used to auto-assign members to Medi-Cal health plans, so accuracy is of paramount importance to plans.

Plans can choose and customize incentives based on a number of criteria including: administrative burden (to the plan and to providers); the plan's ability to estimate payout; whether the plan wants to emphasize relative improvement versus hard targets; and the degree of control that a physician or practice has in reaching goals. Following are four different options:

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### *Per Service Bonus*

This type of bonus distributes additional dollars for each specified service that is performed or type of visit that occurs. Many plans in the LIRR project used this type of incentive to reward doctors for completing the well-baby and well-adolescent visits (e.g., \$50 bonus when an adolescent is seen for a well-care visit). Plans using this reward structure need to consider whether payment can be based on administrative data or if additional provider documentation is needed. To ease administrative burden associated with rewarding providers for each well-baby visit (six are required in the first 15 months of life), many of the LIRR plans consolidated payments for these visits. San Francisco Health Plan, for instance, paid \$50 per child if four or five visits were completed by 15 months, plus an extra \$100 if six or more visits took place.

### *Tiering Bonus*

Under a tiering bonus model, a health plan evaluates participating providers and arrays them on a normative scale. The top third of the group receives the highest payment, the middle tier receives a smaller incentive, and the bottom tier may receive nothing.<sup>9</sup> Since physicians are not able to know how their peers are performing, they cannot know if their efforts to improve will result in any rewards. While hospitals and medical groups respond to tiering, the inherent lack of transparency may make this kind of reward structure less viable when the target is an individual physician.<sup>10</sup>

### *Risk (Quality) Pool Distribution*

In this arrangement, a health plan sets aside a pool of money that is distributed semi-annually or annually to providers based on a range of quality scores. This structure differs from a tiering bonus because providers are not necessarily being benchmarked against their peers.

One LIRR participant, the Health Plan of San Joaquin, traditionally had a risk pool that was distributed to providers based solely on enrollment. The plan found it difficult to get providers to accept a change in the payout methodology from volume to quality. Some of the providers had begun to view the pool as additional compensation for simply serving Medicaid members and were concerned with

the idea that payment could possibly disappear overnight. To quell provider anxiety, the plan decided to slowly (over several years) increase the percentage based on quality. This strategy prevents providers from suddenly losing large amounts of expected income, but also educates them about the possibility of future losses if quality does not improve.

Santa Clara Family Health Plan is also working to transition its pool incrementally. For the 2005 fiscal year, the plan will send providers a rating sheet showing how each provider scored on a variety of measures compared to others in his or her group. The plan will also send a letter of explanation outlining the percentage of the risk pool that will be based on quality the next year, and the percentages expected in future years. This letter will introduce the model and potentially encourage providers to improve the targeted measures before full implementation of the quality bonus.

### *Threshold Bonus*

Under a threshold bonus model, a provider receives a reward when a specified performance target is met. In the LIRR project, L.A. Care used a threshold bonus to encourage Independent Practice Associations and medical groups to submit encounter data. The plan examined historical performance and set reimbursement on a per member, per month basis at \$0.16 for 110 submissions per thousand and \$0.32 for 130 submissions per thousand.

*Ensuring Quality Providers: A Purchaser's Toolkit for Using Incentives*, a report by Bailit Health Purchasing, explains that thresholds can be defined in a number of ways:<sup>11</sup>

1. Absolute Benchmark – A provider receives payment when performance meets or exceeds a defined, fixed benchmark. For example, if 80 percent of the women on a provider's panel have received their mammogram screening, the provider is paid.
2. Incremental Target – A provider receives an incentive payment if he or she meets a percentage increase goal, such as a 10 percent increase in diabetic members receiving annual eye exams.

3. Relative Performance Improvement – The plan uses baseline performance to set specific improvement goals for each provider. In this scenario, a high-performing provider would have to achieve a relatively smaller percentage increase than would his or her peer who started with a lower baseline.

### 5. Be Mindful of Data Challenges

Timely and accurate data on process and outcome improvements are the basis for any incentive program designed to reward quality. The collection of such information, however, is not always simple.

An interim report on the LIRR project produced by Mathematica Policy Research found that a number of the plans faced challenges in the areas of performance feedback and payout.<sup>12</sup> Because administrative data is not always accurate, the miscoding of well-adolescent visits was cited as a problem by both plans and physicians. To resolve this problem, Kern Health Plan instituted billing forums to instruct providers on how to get credit for the services they provide. L.A. Care, which had problems getting encounter data from capitated providers, began offering technical assistance on how to submit data. Systems changes, such as switching data warehouses, can also contribute to the difficulty of collecting timely and accurate data. While the LIRR plans were able to work out most of the bugs associated with collecting data, any health plan beginning an incentive program should allow time to test the data collection methodology.

Health plans should also recognize the cost associated with collecting data to both plan and provider. While chart reviews afford access to information that may not otherwise be available, medical record abstraction can be expensive. One estimate puts the cost of collection at \$30-\$50 per chart (with 30-50 charts required per office).<sup>13</sup> The health plans in the LIRR demonstration relied on administrative data, which is less costly to collect than chart review data.

### 6. Remember: Money is Not Everything

Health plans wishing to implement incentive programs for their Medicaid providers must consider that many publicly financed providers (county hospitals and clinics) may not legally be allowed to accept monetary incentive payments. Health plans wishing to engage these providers need not abandon incentives entirely. San Francisco Health Plan donated incentive payments to a foundation, from which the publicly funded

provider could draw. Non-monetary incentives, including in-kind staff for specific projects, technological equipment or training, and the referral of new members can also be used in lieu of cash.

Several LIRR plans offered non-financial provider supports while concurrently rolling out financial incentives. Five plans provided feedback to providers on performance, two plans provided in-person consultation to low-performing providers, and three plans provided training on how to submit encounter data. A number of plans assisted providers by notifying them when a member was due for needed care or by directly contacting the member to suggest that they make an appointment. LIRR plans found that providers appreciated the non-financial assistance in improving care for babies and teens. One provider noted: “Since we got the list of kids missing visits, the nurse practitioner in my office goes through the charts, and calls 30-40 patients per month. We made this change for all our patients, not just [this plan’s] patients...”

### 7. Consider Member Incentives

Member incentives can play a vital role by encouraging Medicaid consumers to seek necessary care. The implementation of member incentives can be important in engaging consumers in their own health care and may address provider concerns about hard to reach and “non-compliant” members.

For Medicaid beneficiaries, monetary incentives may be counted as “income” and therefore have the potential to disqualify someone from eligibility. Therefore, plans need to be aware that even a small incentive could push someone over the income limit. States often regulate the nature of member incentives — in California state approval is needed before a plan can distribute incentives to members. One LIRR plan waited six months for state approval for a movie ticket incentive — the state had concerns that the incentive was not health related and wanted assurance that the incentive would not amount to more than \$50 per year. In other states, member incentive specifications are written into the state’s Medicaid managed care contract.

In the LIRR project, several plans experimented with member incentives. L.A. Care Health Plan used member incentives for well-baby visits (\$10 for each series of three visits, and an additional \$25 for completion of all six) and adolescent well-care visits (one movie ticket per annual visit). Although L.A. Care was surprised at the low rate of members redeeming the rewards, the

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plan saw a noticeable increase in both well-baby and well-adolescent visits. This discrepancy may be because members intended to redeem their reward (to do so they had to mail a form to the health plan), but simply forgot to do so. San Francisco Health Plan coupled member incentives (movie tickets) with intensive outreach (through advertising in high schools, phone calling campaigns, etc.) to encourage adolescents to visit their doctors. Between 2002 and 2005, the plan saw HEDIS rates for adolescent well care rise from 29.4 percent to 45.1 percent.

### 8. Coordinate with Other Payors

Many of the physicians receiving performance-based reimbursement in California are eligible for quality incentives from more than one health plan or payor. As one expert suggested in testimony to Congress, “if only a few of the many payors that a provider contracts with are paying for performance, or if each payor focuses on a different measure set, the effects of pay-for-performance may be diluted.”<sup>14</sup>

Medicaid health plans have shown that incentive payments to providers can improve access to and the quality of care that is delivered to patients. Moving forward, further collaboration among health plans and the state Medicaid agency is needed, both to raise provider awareness about the Medicaid population and to encourage the sharing of best practices. In late 2005 the state began to auto-assign Medi-Cal members to health plans in a given county based on comparative plan performance on seven measures. While some plans have expressed concerns that the ensuing competition may reduce collaboration among health plans, the focus on quality measures for the Medicaid population is a step in the right direction. More coordination means that providers receive a clear message about the kind of care that is needed and what actions will improve performance.

The opportunities for payors to align measures increase as national organizations, such as the Ambulatory Care Alliance and the National Quality Forum, endorse sets of physician performance measures. While standardized measurement sets may not entirely meet the needs of Medicaid payors and providers, they at least provide common ground from which to begin.

### Evolving Pay-for-Performance: Issues to Consider

As health plans get more sophisticated, many are working to design incentive programs that recognize improvements in chronic care processes and specific clinical outcomes. Many of these “second

generation” pay-for-performance programs seek to simultaneously educate and reward providers. These programs use composite measures that reflect a myriad of office-based activities and health outcomes and involve providers more fully in evaluation and assessment of their own performance.

Independent Health Association of Western New York uses a multi-dimensional *Adherence-to-Guideline* score in its “Performance Excellence Program” for asthma. Provider performance is measured along eight dimensions:

1. History;
2. Severity Assessment;
3. Correct Severity;
4. Right Medication for Severity;
5. Office Pulmonary Function Test;
6. Review of Pulmonary Function Test History;
7. Action Plan in Chart; and
8. Administration of the Influenza Vaccine.

These measures require a comprehensive review of the medical record, which can provide more information about clinical processes and outcomes than administrative claims data. The assessments, however, are not made by the health plan; each provider reviews a random sample of his or her own charts. By doing the chart reviews, these providers are learning, first hand, about the performance gap that may exist in the care they are giving. The providers are also collecting valuable data, which at an aggregate level, helps the plan understand trends in care. In the first years, providers are reimbursed simply for reviewing the chart (pay-for-participation). As providers grow more familiar with the structure and process of the incentive program, payment depends more on their score.

Partnership Health Plan of California, a Medi-Cal managed care plan in Northern California, has also implemented an incentive program based on composite measures of performance. Partnership’s Quality Incentive Bonus (QIB) Program accounts for just over 50 percent of the plan’s risk pool. The QIB dollars that are available to physicians and practices are based on a 100-point scale. Up to 25 points can be earned in each of the following areas.

- Chronic Condition Management — Comprehensive Diabetes Care
- Preventive Services — Well Infant Visits, Mammogram Screening
- Chronic Disease Management — Asthma Medication Management
- Practice Site Quality Improvement (QI) Project

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 “Second generation” pay-for-performance programs seek to simultaneously educate and reward providers regarding improvements in chronic care processes and specific clinical outcomes.  
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The Practice Site QI Project is selected by a team at the practice site and must be approved by the health plan. The QI project can focus on improving access to care, patient satisfaction, or improved clinical information systems (manual or electronic chronic disease registry, electronic health or medical records). Practice sites select measures and implement interventions that are relevant to their project and patients.

In the Institute of Medicine's landmark report, *Crossing the Quality Chasm*,<sup>15</sup> issues around health care quality were examined along three dimensions: overuse, underuse, and misuse. One Rewarding Results grantee, the Excelsior/Rochester Individual Practice Association (RIPA) used the IOM's paradigm of appropriate utilization to frame its quality improvement efforts, including its pay-for-performance program. The RIPA model proposes that "high-quality care means doing the right thing," whether that is by increasing appropriate but underused services or by reducing the use of unnecessary treatments and tests. As explained by Howard Beckman, MD, RIPA's Medical Director, "Because our fee-for-service environment directly rewards overuse and inadvertently often rewards misuse, addressing overuse and misuse leads to quality improvement efforts and cost savings at the same time." To

meet the quality improvement and cost saving goals, areas targeted in pay-for-performance efforts must include overuse and misuse measures that could generate significant savings because there is considerable room for improvement. Using this methodology, RIPA has demonstrated a return on investment for its provider incentive program.

## Conclusion

Across the country Medicaid programs are facing budgetary constraints and pressure to cut costs, benefits, and beneficiaries. But we know that poor quality health care (or no health care at all) can be very expensive in the long term. Pay-for-performance programs in Medicaid, with their focus on preventive, high quality, and efficient care may be one way to ensure that we as a nation are getting value for our dollars spent, while ensuring that health care remains available to those who need it the most. While issues around provider engagement, data integrity, and cross-payor alignment have not been fully resolved, preliminary results from projects such as LIRR and other health plans give reason for optimism about the potential of rewarding provider performance in Medicaid.

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## Endnotes

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The Center for Health Care Strategies is a nonprofit health policy resource center that promotes high quality health care services for low-income populations and people with chronic illnesses and disabilities. We achieve this objective by providing training and technical assistance to state purchasers of publicly financed care, health plans, and consumer groups.

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