Pay for Performance in the Individual Physician World

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Chief Medical Officer
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Medical Director/Quality Management
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AGENDA

• Introduction
• History of P4P at Blue Cross of California
• PPO Physician Quality and Incentive Program Version 1
• Disparities in Quality
• Challenges and Changes Version 2
• Summary & The Future
Physician Incentive Programs

“There are three ways to pay a physician - fee for service, capitation and salary, and they are all bad”.

James Robinson. UC Berkeley, 2000
Influencing Physician Practice (Behavior)

How to influence physician behavior

• Not effective
  – Lectures, review articles, grand rounds

• Partially effective
  – Practitioner feedback
  – Physician leader education-one on one Patient incentives and reminders

• Very Effective
  – System changes-Nursing Assistants to do preventive health, dedicated clinics

• Promising but limited data
  – Above plus physician incentives

What Do Physicians Think of Incentives?

• Many physician organizations use a variety of financial incentives for Primary Care Physicians to influence behavior

• Incentives that limit referrals and incentives to increase productivity have a potential negative influence that could compromise quality of care

• Incentives to improve quality and those linked to patient satisfaction are more tightly linked to greater PCP satisfaction

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History of P4P at BCC

- 1994 HMO Report Card
- 1995 Incentive added for top performers
- 1997 Incentive for 80% of network
- 2001 Incentive increased to mean > $2.00 pmpm - $66m awarded in 2005
- 2002 Incentive Program for PPO – awardee of RWJF “Rewarding Results”
Quality broadens the dialogue beyond fees to building a foundation of trust.

Alignment of Health Plan and Physician Goals

- Long Term Goals
  - Value
  - Improve Member Health
- Short Term Goals
  - Outcomes
  - Structure / Process
- Foundation
  - Build Trust / Collaboration
Quality Score Card HMO
Physician Internal Program

• 99% of membership in delegated groups
• Incentive paid to group management
• Introduced scoring for incentive paid to practitioners
  – Scoring System 20 points
  – Member Satisfaction - 5 points
  – HEDIS or at least one chronic disease (e.g. MS, CC, asthma) 5 points
  – Physician Profile - 5 points
  – Physician Bonus - 5 points
# Internal Bonus Trends

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>Overall (N=180)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Bonus</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction w/ PCP</td>
<td>5</td>
<td>112</td>
<td>115</td>
<td>133</td>
</tr>
<tr>
<td></td>
<td>2.5</td>
<td>10</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>34</td>
<td>22</td>
<td>19</td>
</tr>
<tr>
<td>Clinical Measures</td>
<td>5</td>
<td>101</td>
<td>106</td>
<td>146</td>
</tr>
<tr>
<td></td>
<td>2.5</td>
<td>10</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>45</td>
<td>34</td>
<td>18</td>
</tr>
<tr>
<td>PCP Feedback</td>
<td>5</td>
<td>71</td>
<td>67</td>
<td>104</td>
</tr>
<tr>
<td></td>
<td>2.5</td>
<td>26</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>59</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>Incentive Program</td>
<td>5</td>
<td>39</td>
<td>67</td>
<td>114</td>
</tr>
<tr>
<td></td>
<td>2.5</td>
<td>5</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>112</td>
<td>72</td>
<td>57</td>
</tr>
</tbody>
</table>

*Bold = sign. Pr<0.05*
AGENDA

- Introduction
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Physician Quality Incentive Program Goals

- Improve the quality of care delivered to members
- Create a more transparent health care system
- Improve affordability through generic prescribing and quality of care improvements
- Reduce costs through simplified and timely transactions
PQIP Program Ver 1.0

- PPO Physician Scorecard available on-line
  - Physicians can compare performance to peers

- Physician Recognition Program
  - Financial reward based on Scorecard results
  - Introduced in pilot area in October 2002
  - First payout in 1st Quarter 2004
  - New fee schedule introduced in July 2005
Clinical Measures Goal 1. Improve Care

- ACE Inhibitor use in CHF
- Breast cancer screening
- Cervical cancer screening
- Childhood immunizations: MMR
- Childhood immunizations: VZV
- Long-term control drugs for asthma
- Compliance with lipid lowering drugs
- Diabetes: retinal exam
- Diabetes: HbA1c measured
- Follow-up after ER visit for asthma
- Lipid panel for stroke
- Colorectal cancer screening
- Follow-up after mental illness hospitalization
- Major depression acute phase treatment
- Major depression optimal contacts
- Major depression continuation phase treatment
<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Primary/Secondary</th>
<th>Your Rate</th>
<th>Average Rate</th>
<th>How You Compare</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE Inhibitor use in CHF</td>
<td>Primary</td>
<td>100%</td>
<td>N/A</td>
<td>100%</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>Primary</td>
<td>82%</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>Primary</td>
<td>29%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Compliance with lipid lowering drugs</td>
<td>Primary</td>
<td>82%</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>Diabetic retinal exam</td>
<td>Primary</td>
<td>21%</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Follow-up after Emergency Department visit for asthma</td>
<td>Primary</td>
<td>0%</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>
Goal 2: Improve access to physician of choice

• MEASURES
  – Practice open to new patients
  – Length of time provider has contracted with BCC’s PPO
  – Provider contracts with other BCC products
  – Board certification
Goal 3: Improve affordability through generic prescribing

- Generic prescribing rates for:
  - Antibiotics
  - Antidepressants
  - Hypercholesterolemia
  - Hypertension
  - NSAIDs
  - Ulcer medications
Goal 4: Reduce costs through simplified and timely transactions

• MEASURES
  – Proportion of claims submitted electronically
  – ProviderAccess participation
  – Timely response to re-credentialing materials
Distribution of Eligible Physicians

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th># of MDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract with BCC PPO</td>
<td>45,000</td>
</tr>
<tr>
<td>Targeted specialties</td>
<td>20,000</td>
</tr>
<tr>
<td>Score for 1 or more “key” clinical measure</td>
<td>12,281</td>
</tr>
<tr>
<td>Practice in Bay Area</td>
<td>1,984</td>
</tr>
<tr>
<td>$12,000 or more in BCC paid claims</td>
<td>~1,700</td>
</tr>
</tbody>
</table>
# Incentive Program Ver 1.0

<table>
<thead>
<tr>
<th>Score</th>
<th>Reward</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 40</td>
<td>1 year subscription to SKOLAR MD</td>
</tr>
<tr>
<td>41-60</td>
<td>2% of Paid Claims, up to $2,000 + 1 year subscription to SKOLAR MD</td>
</tr>
<tr>
<td>61-80</td>
<td>4% of Paid Claims, up to $3,000 + 1 year subscription to SKOLAR MD</td>
</tr>
<tr>
<td>81-90</td>
<td>7% of Paid Claims, up to $4,000 + 1 year subscription to SKOLAR MD</td>
</tr>
<tr>
<td>91-100</td>
<td>10% of Paid Claims, up to $5,000 + 1 year subscription to SKOLAR MD</td>
</tr>
</tbody>
</table>

Incentives are based on a percent of previous calendar year paid claims (> $12,000 in claims)
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Corporate Region Classification
PPO Clinical Trends 2004

Bay Area 55% vs. Rural East 28%

ACE Inhibitor Use in CHF
Bay Area 69% vs. Inland 53%
Long-term Control Rx in Asthma

PPO Clinical Trends 2004

Specialist
Primary Care
Others
Colorectal Cancer Screening

PPO Clinical Trends 2004

GI

IM

FP

OBG

PLM

ALL

CRD

END

Specialist

Primary Care

Others
Glycosylated Hemoglobin for Diabetics

PPO Clinical Trends 2004

Specialist  Primary Care  Others

END  IM  FP  PED  PLM  CRD  GI

60%  70%  80%  90%
Teaming with Physicians to Improve Disparities

Practice Rates by Gender – PQIP Cardiac Based Indicators

Differences for these indicators were statistically significant to the 0.05 level
Interim Summary

- Builds on BCC experience with quality reports and incentives in HMO market
- Combines unique web-based report card with feedback and educational material
- State-wide data provides view of variation in adherence to good practice guidelines
- Differences found by region, specialty, gender and age
- Drill down allows for development of targeted interventions to improve guideline adherence
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Evaluation Components

- RAND performing external evaluation of PQIP
- Process evaluation to document development and implementation of PQIP
- Assessments of physician and plan performance
  - Baseline performance
  - Changes over time in performance scores with and without financial reward
- Analysis of dollars paid out for financial reward
  - Characterize “winners” and “losers”
- Focus groups with physicians to assess their perspective of PQIP
Program Focus on Individual Physicians

Year 1 Challenges

• Measurement
  – Low eligibility for most measures
  – To attribute care, submitted claims must include physician license number
    • License number not required for payment

• Communication and Outreach
  – Large target audience – over 12,000 physicians

• Who makes improvement happen?
  • physician, office staff, group structure/management?
Web Based Platform

Year 1 Challenges

- **PQIP Scorecard located on new ProviderAccess® site**
  - The good - one on-line site to communicate with physicians
  - The bad – slow transition to new Web site; limited capacity to promote PQIP use

- **The need to log on**
  - Internet use in office, by physicians, is unknown
  - Mailing hard copy reports stirred more response
Measurement Issues

- Provider attribution (who provides care?)
- Services outside plan system
- Plan members not 100% of physician practice
- Lack control over patient compliance
- TIN is contracting entity, physician is measured
- Physician data contains all / multiple specialties
- Physician demographic information out-of-date
Physician Active Participation

<table>
<thead>
<tr>
<th>Logged Inquiries</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique Inquiries</td>
<td>59</td>
<td>282</td>
<td>14</td>
<td>3%</td>
</tr>
<tr>
<td>Check Re-Issues / Questions</td>
<td>0</td>
<td>204</td>
<td>0</td>
<td>49%</td>
</tr>
<tr>
<td>General Info on Program or Methodology</td>
<td>15</td>
<td>53</td>
<td>5</td>
<td>17%</td>
</tr>
<tr>
<td>Administrative Measures</td>
<td>21</td>
<td>39</td>
<td>0</td>
<td>14%</td>
</tr>
<tr>
<td>Accessing Web</td>
<td>32</td>
<td>2</td>
<td>5</td>
<td>9%</td>
</tr>
<tr>
<td>Scorecard/Data/Measures/Specialists</td>
<td>7</td>
<td>31</td>
<td>1</td>
<td>9%</td>
</tr>
<tr>
<td>Contract Amendments</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>329</td>
<td>14</td>
<td>100%</td>
</tr>
</tbody>
</table>

|                      |      |      |      |     |
| Phone Calls          | 212  |      |      | 75% |
| E-Mails              | 62   |      |      | 22% |
| Letters and Faxes    | 8    |      |      | 3%  |

* Note: 120, or 7%, of 1,700 checks were thrown away
### Physician and Group Feedback

- Low web utilization
- Busy schedules
- Aware of P4P but still contentious and in early stages

<table>
<thead>
<tr>
<th>AWARENESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- May not trust health plan</td>
</tr>
<tr>
<td>- May believe financial incentive is money already owed to them</td>
</tr>
<tr>
<td>- Seemingly distrustful of measures</td>
</tr>
<tr>
<td>- Feel performance is sometimes out of their control</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACCEPTANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Seemingly resistant to change</td>
</tr>
<tr>
<td>- Intrinsically concerned with “doing the right thing” and extremely competitive by nature</td>
</tr>
<tr>
<td>- May be motivated by financial incentives but what is sufficient to change behavior?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADOPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Note: Of those offered fee schedule increases less than 50% accepted.
Going Forward with PQIP

• Modify Scorecard
  – Focus on Clinical Quality and Generic
  – Revise Administrative Measures
  – Change Financial Reward Structure

• Revise Pilot Program
  – Confirm Timeline
  – Develop PQIP fee schedule(s)
  – Re-contract physicians on standard fee schedule in Pilot area

• Communicate
The Communication Challenge

A. Single Group Only – 57%
B. Multi-Groups – 17%
C. Solo Only – 14%
D. Solo and Group – 7%
E. Solo and Multi-Groups – 1%
Communication Next Steps

**communications**

- Increase the frequency and quality of physician communications, hone in on key motivational messages and improve quality of printed materials to increase response rates and improve usability

**program design**

- Augment web-based scorecard efforts with other communications (mail, fax, calls) in the short term to increase physician adoption; seek to legitimize scorecard and measurements; and provide tools to aid physicians in their goal to improve patient care
PQIP Measures

- Clinical Measures
  - Preventive Composite (Primary Care Specialty)
  - Care Management Composite (Primary Care Specialty)
  - Specialty Composite (Endocrinology, Cardiology, OB/GYN, Psychiatry)

- Pharmacy Measures
  - % Generic (Generic Select Composite)

- Administrative Measures
  - EDI
  - Provider Access Usage
  - Open for New Patients
Program Modifications Scoring

• Composites rather than percentile ranking on individual indicators
• Score reflects 2 years of data
• Physician performance classified as Above Peer Mean, At Peer Mean, or Below Peer Mean
  – Mitigates problem of low patient sample
• Increased weight of clinical measures
• Eliminated some administrative/structural measures
  – Board certification
  – Tenure with PPO product
  – Contracts with other products
• Payment approach
  – Variable fee schedule rather than lump sum
• Updated Web site
Changes to PQIP

- Larger Bonus to Fewer Physicians
  - Fewer Specialty Physicians are included
  - PCPs preferentially rewarded
  - Award only the physicians whose better performance can be assessed statistically.
  - Estimated Bonus Difference
    - From $1,551 (3.9% of annual reimbursement) to $2,091 (5.3%), an increase of 33%
    - 7% of physicians receive $3,000 or more in 2004
    - 26% of physicians receive $3,000 or more in 2005
### Who Qualified for new PQIP?

<table>
<thead>
<tr>
<th>Criteria</th>
<th># of MDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract with BCC PPO</td>
<td>45,000</td>
</tr>
<tr>
<td>Targeted specialties – CA</td>
<td>21,369</td>
</tr>
<tr>
<td>Targeted specialties – Pilot</td>
<td>2,550</td>
</tr>
<tr>
<td>Score in clinical composite – CA</td>
<td>11,655</td>
</tr>
<tr>
<td>Score in clinical composite – Pilot</td>
<td>1,349</td>
</tr>
</tbody>
</table>

* For measurement through 2004

Scorecard

---

*For the measurement through 2004.*
**PQIP 2.0 “Scorecard”**

### Scorecard

<table>
<thead>
<tr>
<th>Measurement Period End</th>
<th>Specialty Care</th>
<th>Care Management</th>
<th>Generic Prescribing</th>
<th>Administrative*</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/15/2003</td>
<td>Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Your Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peer Mean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>93%</td>
<td>75%</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meets All Standards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/15/2003</td>
<td>Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Your Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peer Mean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>93%</td>
<td>75%</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meets All Standards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Above Mean**

*Meet or be below the mean or *Meet or be below the mean.

**Performance Trend**

<table>
<thead>
<tr>
<th>Specialty Care</th>
<th>Care Management</th>
<th>Generic Prescribing</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

To read some ways to improve your score, [click here](#).
New Composite Ratings
Clinical and Rx

Your Score
Practice Rate

Confidence Interval – based on the number of observed cases for the physician, the range within which one can be 95% confident of the actual performance. Statistically, takes into account that observed cases are considered a sub-set of a larger population of performance events for a physician. The more observed cases, the narrower the confidence interval i.e., increased certainty that the observed performance rate is the actual performance rate.
### Specialty Care

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Observed Care</th>
<th>Eligible Cases</th>
<th>Your Rate (Confidence Interval)</th>
<th>Peer Mean</th>
<th>Composite Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Control Drugs for Asthma</td>
<td>39</td>
<td>42</td>
<td>93%</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>Composite Total (Confidence Interval)</td>
<td>39</td>
<td>42</td>
<td>93% (85% - 101%)</td>
<td>72%</td>
<td></td>
</tr>
</tbody>
</table>

### Core Management

<table>
<thead>
<tr>
<th>Clinical Indicator</th>
<th>Observed Care</th>
<th>Eligible Cases</th>
<th>Your Rate (Confidence Interval)</th>
<th>Peer Mean</th>
<th>Composite Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>49</td>
<td>58</td>
<td>84%</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>68</td>
<td>84</td>
<td>81%</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>26</td>
<td>45</td>
<td>58%</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td>Compliance with Blood Lowering Drugs</td>
<td>11</td>
<td>22</td>
<td>50%</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Diabetes: Diabetic Retinal Eye Disease</td>
<td>5</td>
<td>11</td>
<td>45%</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>Diabetes: Glycosylated Hemoglobin for Diabetes</td>
<td>10</td>
<td>11</td>
<td>91%</td>
<td>71%</td>
<td></td>
</tr>
<tr>
<td>Composite Total (Confidence Interval)</td>
<td>169</td>
<td>231</td>
<td>73% (67% - 79%)</td>
<td>65%</td>
<td></td>
</tr>
</tbody>
</table>
### Generic Prescribing

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Generic Prescriptions</th>
<th>Eligible Prescriptions</th>
<th>Your Rate</th>
<th>Peer Mean (Confidence Interval)</th>
<th>Composite Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-depressants</td>
<td>4</td>
<td>21</td>
<td>15%</td>
<td>46%</td>
<td></td>
</tr>
<tr>
<td>Anti-hyperlipidemics</td>
<td>8</td>
<td>54</td>
<td>15%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>Anti-hypertensive agents</td>
<td>86</td>
<td>107</td>
<td>80%</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>Antibiotics</td>
<td>25</td>
<td>44</td>
<td>57%</td>
<td>46%</td>
<td></td>
</tr>
<tr>
<td>Composite Total</td>
<td>123</td>
<td>226</td>
<td>54%</td>
<td>44%</td>
<td></td>
</tr>
</tbody>
</table>

**Click Here** for an explanation of how ratings are calculated.
# PQIP 2.0 Administrative Composite

## Administrative Composite

- **POIP Home**
- **Scorecard**
  - Clinical Quality Composite
  - Generic Prescribing Composite
  - Administrative Composite
- **Benchmarks and Comparisons**
- **Indicator Specifications**
- **How to Improve Your Score**
- **Frequently Asked Questions**

## Change Physician

- **Physician:**
- **Specialty:** GASTROENTEROLOGY

### Administrative Composite

<table>
<thead>
<tr>
<th>Tax ID Number (TIN)</th>
<th>Submit Claims Electronically</th>
<th>Provider Access Use</th>
<th>Practice Open</th>
</tr>
</thead>
<tbody>
<tr>
<td>77-0139017</td>
<td>75%</td>
<td>192</td>
<td>Yes</td>
</tr>
<tr>
<td>77-0324655</td>
<td>94%</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

- **Indicator Standard**
  - > 85% in any TIN
  - > 0 hits in any TIN
  - Yes

- **Your Performance**
  - Standard Met

## Meeting Standards

- **Meets All Standards**
- **Meets Some Standards**
- **No Standards Met**

[Click Here](#) for an explanation of how ratings are calculated.

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## Fee Schedule Methodology

<table>
<thead>
<tr>
<th>Composite Ratings</th>
<th>Associated Fee Schedule Adjustment</th>
<th>Maximum Possible Fee Schedule Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Composites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Above Peer Mean&quot; in each composite scored</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>One &quot;Above Peer Mean&quot; and</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>One &quot;At Peer Mean&quot; Clinical Composite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;At Peer Mean&quot; in each composite scored</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Generic Prescribing Composite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Above Peer Mean&quot;</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Administrative Composite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;All Standards Met&quot;</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>TOTAL PQIP INCENTIVE POSSIBLE</td>
<td>Prudent Buyer +</td>
<td>12%</td>
</tr>
</tbody>
</table>
Payout Comparison 1.0 vs 2.0

PQIP Financial Incentive Comparison

% of Physicians in Category

Est. $ (Based On Std Contract)

- 2005
- 2004
AGENDA

• Introduction
• History of P4P at Blue Cross of California
• PPO Physician Quality and Incentive Program Version 1
• Disparities in Quality
• Challenges and Changes Version 2
• Summary & The Future
Performance Measurement Challenges

• How big should an incentive be and how much of a practice should it impact
• Right mix of quality measures – danger that unmeasured areas will be neglected
• Resistance from participants-physicians who do not receive incentives at risk of lower payment
• Risk adjustment of process measures- non-compliant patients or lower SES
• Threat to sense of professionalism amongst physicians
Future Enhancements

- Web-based patient registries and performance profiles
  - Provide real time information to physicians
  - Provide specific patient information to physicians
- Add measures to enhance scoring and add more specialties
- Find methods to reward improvement as well as performance
- Find affordable methods to measure customer satisfaction
- Report physician performance to our members
- Develop network designs based on physician performance
Today’s Big Picture

- In our experience incentives and rewards work in organized health care systems
- The return on investment must be proven
- Efficiency measures will become an important part of our reward programs
- Incentives for quality must be financed through existing health care dollars – there is no “new money”
- Further work is needed in PPO systems to prove their value
- Pay for performance must be linked with other strategies to improve performance
- We must understand and manage the influence of disparities due to race and culture on physician performance measures
Looking forward

- Improve resources for performance improvement
  - Incorporate patient registries
- Deeper internal analysis of data to target interventions
- Expanding program beyond pilot area
  - Roll out to a High Performance Network
Why the Interest in Healthcare Quality?

- Healthcare dollars are not limitless and must be spent wisely
- Members depend on us to structure the best arrangements
- There are major opportunities for improvement
- Our global competitiveness depends on a healthy, productive, satisfied workforce
- Collaboration amongst purchasers, payors, providers is essential for success
Summary

• P4P is needed to reduce the clash between “medicine, money and morals”

• P4P is no panacea… offers the potential to balance the autonomy critical to the practice of medicine

Millenson M. Quality and Safety in Health Care; 2005
Conclusion

- Builds on BCC experience with quality reports and incentives
- Combines unique web-based report card with feedback and educational material
- Grant funding enables detailed and comprehensive evaluation of program
- High potential to provide critical information on which future incentive programs can be designed