"Update: The State of Pay-for-Performance and the Status of Fee-for-Condition Pilots"
Oregon Health Policy Commission
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I. Overview
Chairman Barnett, Vice-Chairman Ater, members of the Oregon Health Policy Commission and Director Morley, thank you for inviting us to be here with you today. When we last met with you in June of 2004, we suggested that medical hyperinflation and sub-par quality are man-made, not intrinsic to health care; that our predicament is the result of unintended and ill-conceived incentives that reward all the wrong behaviors. And that policymakers working in an era of Incrementalism could best achieve the goals of stabilized medical inflation and continual quality improvement by reshaping health care's incentives. In turn, we indicated that we planned to cultivate pilot programs to validate the same. Today, in no more than fifteen minutes, we will update you on the state of incentives and our pilot efforts.

A consensus is emerging in our community, and in our country, that may transform American health care. It consists of three interwoven ideas – the pillars of this consensus. You know them. They are:

- First, health consumers should have ***income-appropriate*** financial incentives to be sensitive to the cost and quality of their health care options.
- Second, the prices and performance of doctors, hospitals and drugs should be made available to health consumers – that is, transparency.
- And third, doctors and hospitals should be paid for performance rather than merely for tasks.

Implementation of the first two pillars, consumer incentives and transparency, are underway. The third pillar – payment for performance – the subject of this update, is in a formative stage. However, it is the lynchpin that determines success of consumer incentives, transparency and indeed the entire school of thought, itself. It is the lynchpin for two reasons: the method of payment defines the method of care and the method of payment determines the efficacy of transparency.

First and foremost, again, the method of payment defines the method of care. And of course, the method of care determines the cost and quality of the care itself. That the method of payment defines the method of care has not always been appreciated. Yet it is the underlying premise of pay-for-performance. Today's predominant payment system, fee-for-service really means "fee-for-task" and rewards providers for producing the highest-compensated tasks in lieu of the highest-value tasks and absolves providers of accountability for results – let alone cost.

Second, the method of payment determines the unit of payment and it is the unit of payment that answers the question: "Transparency of what?" Transparency is only as constructive as the relevance of what is made transparent. Naturally, under fee-for-task

transparency would surface the price and performance of tasks like office visits or laboratory tests, which would be useless to the public.

In contrast, if pay-for-performance, known as P4P, is done well, it will reward providers for superior price and performance of a meaningful unit of care, and serve up consumer-friendly price and performance information at a low administrative cost.

Let's now see how P4P is being done today.
So far, thirty-five commercial health plans and Medicare have initiated P4P pilots. In general, these pilots continue to rely on fee-for-service but superimpose a system of bonuses for performing preferred tasks and/or desired clinical outcomes. Unfortunately, disturbing early reports are now appearing, which suggest that to the degree these programs rely primarily on preferred tasks rather than clinical outcomes, the cost of care actually increases without a clear return on the investment. There are three reasons. First, the high performers get paid more for doing what they were already doing. But the low performers who fulfill performance tasks that are only weakly linked to long-term value are also paid more. Second, these programs are expensive to administer particularly when based on an extensive list of tasks. Finally, neither consumers nor providers can readily relate the processes of care to the outcomes people care about. The latest literature continues to point to the need to emphasize clinical results over preferred processes or tasks.

In this vein, we have proposed a provider payment method which we call fee-for-condition, which is rooted in the philosophy of pay-for-performance. We have described this method in multiple venues including in tomorrow's issue of the *British Medical Journal.*

We suggest that the fundamental economics of health care are driven at the level of medical conditions and in turn, that the underlying costs, quality and health outcomes of health care occur between doctor and patient.

We propose that the condition may serve as the *optimal* unit of payment. By paying for conditions instead of for tasks we would shift the locus of health care competition from the trivial to the meaningful – from tasks to conditions. We propose fee-for-condition: the comprehensive care of a condition for a fixed fee. Fee-for-condition has three advantages over other payment methods. First, it aligns providers and patients. Fundamentally, patients want their providers to efficiently and effectively prevent, diagnose and treat their conditions. In a sense, the condition is the epicenter of health care. Second, condition-based outcomes are the ideal unit of measurement and comparison. And third, conditions are readily risk-adjusted so that provider compensation and liability closely approximate each other.

At this time, Dr. DiPiero will describe the status of our fee-for-condition pilot efforts.

II. Pilot Progress Report

Arnold Millstein, physician and chief actuary for Mercer, consultant to the Pacific Business Group on Health and the founder of the Leap Frog Group, recently explained how *we all know* the problems and have a good idea regarding the *elements* of a potential solution, but both insurers and providers are stuck pointing to each other and saying, "You go first." The good news today is that a couple of Oregon institutions are going first together.

Last year, we set out to validate condition-based payment for performance, which we call fee-for-condition. In doing so, we met with Oregon's insurers which led to conducting half-day workshops with senior management on implementing a fee-for-condition pilot. In these workshops, we addressed topics including methodologies to define conditions based on severity; to determine the fee-for-condition; and to determine the information exchange. Throughout we emphasized how to conduct a pilot without disrupting current operations. We have also acted as sort of a dating service, trying to bring together insurers and providers we knew to be interested in pursuing fee-for-condition.

I will now describe the status of one fee-for-condition pilot.

The participants are Regence BlueCross BlueShield of Oregon and the Oregon Health Sciences University. Initially, this will be focused on a chronic illness management program I co-direct dedicated to the care of patients with diabetes, hypertension, and elevated cholesterol

Before I delve into details, let me answer the question: What's the big deal?

For the first time, a payer will pay a provider for caring for a condition. To receive payment the provider must not only demonstrate that a patient meets defined clinical criteria but must also report evidence of clinical results. In other words, for the first time, anywhere, the discussion over what we spend will be based explicitly on agreed-upon criteria of value and results. This is very good news for patients and purchasers of care. And this is very good news for the providers of care -- they now get to control a pool of resources to allocate to care for a patient's condition rather than having resources parsed out task by task.

Here's how the pilot will work.

A. Phases, Goals and Metrics

The pilot is in a planning phase.

We foresee a three phase pilot. The phases are 1-Feasibility, 2-Validation and 3-Replication. I'll describe the Phase One goals, methods of care and metrics.

The goals of Phase 1–Feasibility are:

- First, to define a condition – really a continuum of conditions – that will serve as the unit of payment.
- Second, to determine the fee-for-condition adjusted for severity.

- Third, to demonstrate that a payer can pay for a condition and that a provider can bill and get paid for a condition.
- And fourth, to demonstrate that a provider report clinical metrics that reflect the quality of care and the results of care.

How will fee-for-condition positively impact the method of care?

This program is based on a system of chronic disease management which has been well described in the literature and national meetings. It provides intensive monitoring and the proactive delivery of preventive services and care support to patients with diabetes, hypertension and high cholesterol and kidney, eye, and vascular disease related to diabetes.

For a fixed fee, patients will receive the following services:
- Evidence-based preventive services
- Structured education to enable the patient to set goals and achieve self-management of their conditions
- Remote case-management support
- Constant monitoring of clinical metrics related to short-term and long-term health
- High risk patients are identified and receive intensification of therapy including:
    - Referral to specialists for intensification of therapy.
    - Intensification of primary care physician interventions
    - Intensification of case-management support and education

What will be measured and compared to the old fee-for-service method?
- Health care utilization by patients
- Clinical processes provided versus evidence-based guidelines
- Clinical outcomes adjusted for severity
- Costs under fee-for-condition versus fee-for-service

How will the fee in the fee-for-condition be set and how will it reward superior results?

Again, Phase 1 is about feasibility not price. In Phase 1, the insurers and providers will settle on a negotiated comprehensive fee-for-condition, and may reconcile the payment so that neither side is at risk. But in Phase 2, the fee-for-condition would be based on performance. We anticipate that each fee will include a variable portion which will either be built into the fee reflecting past performance relative to peers or it may be paid as a bonus.

To summarize, the condition is the optimal payment unit to align the incentives between patients, providers and payers to stimulate sustainable care improvement and innovation. Fee-for-condition is the comprehensive care of a condition for a fixed fee. It is rooted in the philosophy of pay-for-performance. Now, for the first time, anywhere, major Oregon institutions will evaluate the feasibility of this method. We welcome others and stand ready to help.

III. Conclusion

In conclusion, as health care in America continues its seemingly slow evolution away from the era of managed care to an era of incentives, provider payment methods will emerge as THE issue. Now that Medicare and major insurers have begun testing various applications of pay-for-performance, today is THE best moment for Oregon policymakers to consider whether and how to proactively shape the debate.

In our opinion, the Commission, in focusing on consumer behavior, transparency, delivery systems and information systems has focused on four of the key levers available in 2005. So, should the Commission also somehow address what will clearly be a key lever in the years ahead – provider payment methods? Could it have an influence? What would it do? We suggest that Commission could be helpful in four ways:

First, purchaser, payer and provider communities are sensitive to a certain degree to signals of inevitability of trends. The Commission may be in a position to heighten awareness, signaling at once safety in movement and the risk of standing on the sidelines.

Second, standards will be required for success. The Commission may be in a position to support adoption of standards in our community.

Third, purchasers, payers and providers are sensitive to the plans of public purchasers. The Commission may be in a position to inform public purchaser transition from fee-for-service to pay-for-performance.

Fourth, and finally, while it is highly unlikely that we will experience a near-term sea change in who pays for care, it is inevitable that we will experience a sea change in how we pay for care. And since deciding how we pay for care will determine how we spend one-fifth of our annual income, it is altogether fitting that our State's health policy commission inform this debate.

Thank you.

PUBLIC EMPLOYEES' BENEFIT BOARD (PEBB)
FOCUS ON QUALITY

HEALTH POLICY COMMISSION
MARCH 17, 2005

BACKGROUND

In late 2002, Board adopted its Vision for 2007. The Vision focused on a new state of health for members, with these key components:

- An innovative delivery system in communities statewide that provides **evidence-based medicine** to maximize health and utilize dollars wisely;
- A focus on **improving quality and outcomes**, not just providing healthcare;
- The promotion of **consumer education and informed choices**;
- Appropriate **market and consumer incentives** that encourage the right care at the right time;
- System-wide **transparency** through explicit, available and understandable reports about costs, outcomes and other useful data; and
- Benefits **affordable** to the state and employees.

TRANSLATING THE VISION TO REALITY

- Board engaged Dr. David Lansky of the Foundation for Accountability (FACCT) in spring 2004 to lead a process to establish recommended purchasing criteria based on the Vision.
- FACCT in turn established a Technical Advisory Committee (TAC) of experts to advise FACCT on suggested criteria.
- Process first focused on potential criteria for specific service categories (e.g. primary care, specialty care, hospital, pharmaceuticals, etc.).
- Process included initial input from Board, research by FACCT, review and feedback by TAC on suggested criteria, further review by Board, sharing and discussion at stakeholder forums (primarily carriers, representatives of delivery systems), then further refinement and review by the Board.
- Final recommendations then identified themes (domains) cross-cutting specific service categories, as well as suggested weighting of those domains (attached).
- For each domain, recommendations included minimum criteria vendors would need to meet to have proposals considered; suggestions of what might constitute high, medium and low scoring of proposals; guidance on how to assess the credibility of the proposal; and guidance on a realistic phase-in, assuming beginning implementation in 2006 (attached).
- Full report is available at: http://oregon.gov/DAS/PEBB/facct.shtml

REQUEST FOR PROPOSAL (RFP) PROCESS

Timeline

- Met with stakeholder groups in November 2004 to review quality criteria to be included. Full report from FACCT was made available on PEBB website.
- Issued RFP January 10, 2005. Closing date was March 4, 2005.
- Received fifteen proposals.
- Evaluation process will occur March-June, with decisions on 2006 contractors scheduled to be finalized at June 21 Board meetings.

Weighting of criteria

- Initial evaluation of proposals meeting minimum criteria will be weighted 80% on quality and 20% on administration.

- Weighting of quality criteria:

  Medical home = 25%
  Evidence-based care = 20%
  Member self-management = 15%
  Service integration = 10%
  Infrastructure = 10%
  Transparency = 10%
  Managing for quality = 10%

- After finalists are chosen, negotiations will occur on cost and other issues. Proposals will then be scored again. Final weighting:

  Quality = 60%
  Administration = 20%
  Cost = 20%

Weighting system – Medical Home

Minimum requirements/benchmarks

- Willing to implement standardized patient survey (ACES-SF or ambulatory CAHPS) for each PEBB primary care provider (across all patients, not just PEBB members) in 2006.
- Willing to report how many PEBB members have medical home, based on claims or survey results.
- Willing to report how many PCPs in network have EMR.

Otherwise: non-responsive.

Guidance for evaluating proposals:

- **High rating:** Bidder can document (offer of) medical home for each member; provides reports and can hold each provider accountable (and has incentives) for screening, preventive services, chronic care and coordination services; able to measure outcomes for patients with target conditions (i.e., asthma, diabetes); can produce patient satisfaction scores for each PCP; > 60% of PCPs have EMR and permit patients to access own EMR.

- **Moderate rating:** Bidder can document which members have source of routine care; produces provider-level reports of utilization/HEDIS-type wellness services, including immunizations, screenings, smoking cessation; has system to encourage members to select PCP.

- **Low rating:** Bidder can document which members have source of routine care; produces population-level utilization/HEDIS reports; can document population-level delivery of chronic and wellness services.

Assessing the credibility of the proposed approach:

Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for medical home:

- Bidder can provide patient satisfaction survey results that show high proportion of patients reporting a current, positive relationship with PCP
- Bidder can provide sample reports of individual provider quality profiles (not just utilization)
- Bidder has a system in place for tracking patient assignment to PCP
- Bidder has provider contracts in place reflecting PCP obligation to coordinate all care.

If contract is awarded initially, acceptable phase-in schedule for contract renewal:

- 2006: Produce provider-level reports; implement system for PCP assignment
- 2007: Demonstrate that each patient has had opportunity to select "medical home" provider
- 2008: Fulfill <u>all</u> of the high-rating criteria.

Weighting system – Evidence-based Care

Minimum requirements/benchmarks

- Able to conduct retrospective data analysis to identify potentially inappropriate test and procedure use
- Able to identify members with asthma or diabetes and create patient registry.
- Willing to report population-level HEDIS measures for asthma and diabetes.
- Able to implement evidence-based drug formulary or willing to work with selected prescription drug plan to implement evidence-based formulary.
- Able to document appropriate provider use of SAMSHA evidence-based practices.

Guidance for evaluating proposals:

- **High rating:** Bidder supports implementation of evidence-based formulary through education, e-prescribing, pricing and incentives, feedback systems. Uses retrospective data analysis to profile high-variation procedures. Network providers have EMR and/or registries that allow protocols to be implemented and supported, with feedback to providers. For diabetes and heart disease, network has established guidelines, can report HEDIS and Bridges to Excellence measures for population and by provider; for asthma, reports HEDIS measures for population and by provider. Network documents adherence to SAMHSA evidence-based practices. Network hospitals adopt Leapfrog practices for Computer Physician Order Entry, evidence-based referrals, and intensivists. Network has training system and information infrastructure in place to support evidence-based practice.

- **Moderate rating:** Bidder supports evidence-based formulary, develops asthma and diabetes registries and reports HEDIS measures. Bidder identifies and supports practice guidelines for asthma, diabetes, heart disease. Network generates management and provider feedback reports on high-variation procedures, such as back surgery, hysterectomy, c-section.

- **Low rating:** Bidder only meets minimum criteria above.

Assessing the credibility of the proposed approach:

Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for evidence-based care:

- Bidder can identify recommended practice guidelines and has systems for training, measurement, and feedback.
- Bidder can provide data showing performance against guideline indicators for selected conditions, tests, procedures (e.g., imaging, back care, asthma, diabetes, heart disease).
- Network providers have EMR with decision-support programs enabled.

If contract is awarded initially, acceptable phase-in schedule for contract renewal:

- 2006: Implement evidence-based formulary support; generate HEDIS measures for population.
- 2007: HEDIS measures at provider level. Guidelines training in place for provider network. Baseline measures collected
- 2008: Fulfill all of the high rating criteria.

Weighting system – Member Self-Management

Minimum requirements/benchmarks

- Able to acquire and distribute health risk assessment and health screening information to providers
- Provides members with access to shared decision-making tools
- Offers chronic care management, disease management, and/or medication adherence programs in support of primary care role
- Willing to coordinate health education and outreach programs with PEBB-sponsored (e.g., worksite) programs

Guidance for evaluating proposals:

- **High rating:** Bidder offers patients access to electronic medical record (personal health record) including email contact with providers, automated reminders, alerts, remote monitoring links (e.g., blood glucose monitors). Providers receive health risk assessment and screening data, develop personal health maintenance plan with patients, generate annual data on health risk reduction per provider. Patients with chronic illness have personal care plan, telephone support, routine measurement of relevant outcomes. Medication adherence program in place. Providers actively refer to and work with shared decision-making tools.

- **Moderate rating:** Bidder has ability to share health risk assessment data with providers and evaluate behavior changes. Telephone support and related educational tools are in place for chronic care management and medication adherence.

- **Low rating:** Bidder only meets minimum criteria above.

Assessing the credibility of the proposed approach:

Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for member self-management support care:

- Bidder has strong disease management program in place with high participation levels and well-defined outcomes data.
- Bidder has significant HRA data collection and system for sharing with providers.
- Bidder has strong wellness programming, including smoking cessation, cardiac risk reduction, nutrition and exercise.

IF contract is awarded initially, acceptable phase-in schedule for contract renewal:

- 2006: Implement HRA data collection and distribution, chronic care education and outreach systems. Shared decision-making tools available.
- 2007: Medication adherence program in place; 20% or more of patients have personal health record. Physicians refer to shared decision-making tools.
- 2008: Fulfill <u>all</u> of the high rating criteria.

Weighting system – Service Integration

Minimum requirements/benchmarks

- Has arrangement with behavioral health specialty network that includes 24/7 support to primary care
- Has capacity to share health risk assessment data with primary care providers
- Has capacity to share formulary information with prescribers in real time
- Willing to require primary care providers to complete ACIC or similar chronic care assessment tool
- Has internal capability or willing to collaborate with third-party predictive modeling and case management systems
- Requires new IT acquisitions to conform to Federal Consolidated Health Informatics (CHI) data standards (http://www.whitehouse.gov/omb/egov/gtob/health_informatics.htm)

Otherwise: non-responsive.

Guidance for evaluating proposals:

- **High rating:** Bidder has close relationship with behavioral health network, including co-located behavioral health specialists in major primary care clinics, 24/7 telephone consultation, and tight data feedback systems; uses PHQ-9 or similar depression screening tool. Has implemented e-prescribing including real-time formulary information to prescriber. Most PCPs have standards-compliant EMR, can acquire lab and pharmacy data electronically, permit multiple providers and patients to access EMR as appropriate. Primary care providers have completed ACIC and are taking steps to implement chronic care model. Bidder has system in place to identify and intervene with high-risk patients, including multiple chronic disease, polypharmacy, underserved.

- **Moderate rating:** Bidder has established relationship with behavioral health network, including 24/7 telephone consultation and data feedback to providers. New IT acquisitions are standards-compliant. E-prescribing systems being deployed. Bidder has established program for identifying and intervening with high-risk patients.

- **Low rating:** Bidder only meets minimum criteria above.

Assessing the credibility of the proposed approach:

Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for service integration:

- Bidder has established behavioral health network relationship.
- Has implemented standards-compliant, interoperable EMR and e-prescribing.
- Has implemented predictive modeling and case management services.

IF contract is awarded initially, acceptable phase-in schedule for contract renewal:

- 2006: Implement behavioral health consultation, referral, and feedback system; implement predictive modeling and case management; administer ACIC.
- 2007: E-prescribing, behavioral health measurement system, data on case management, chronic care outcomes.
- 2008: Fulfill all of the high rating criteria.

Weighting system - Infrastructure

Minimum requirements/benchmarks

- Information technology plan addresses primary care EMR, adoption of CHI data standards, common patient identification approach, patient e-mail, clinical registries, CPOE, e-prescribing, predictive modeling.

Otherwise: non-responsive.

Guidance for evaluating proposals:

- **High rating:** Bidder has high proportion (>60%) of primary care providers with EMR; all hospitals (>150 bed) with CPOE. Patient-provider email in place. Network policies address use of CHI data standards. Master patient index or equivalent patient identification algorithm in place. E-prescribing, including formulary and pricing access, in place. Capability to import HRA, screening, pharmacy, lab data to EMR and share with providers. Patient ability to access medical record and input personal health information (PHR).

- **Moderate rating:** Bidder has high proportion (>60%) of primary care providers with EMR; most hospitals with CPOE; significant percentage of PCPs using patient-provider email; network policies address use of CHI data standards.

- **Low rating:** Bidder only meets minimum criteria above.

Assessing the credibility of the proposed approach:

Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for infrastructure development:

- Network has high standards-compliant EMR use in place.
- Network has master patient index.
- Network has clinical registries (e.g., diabetes, coronary, stroke, asthma).
- Network provides patients with on-line access to lab results, medication lists, clinical e-mail, EMR.
- Network has significant capital allocated to further IT development and a clear IT plan.

IF contract is awarded initially, acceptable phase-in schedule for contract renewal:

- 2006: High primary care EMR penetration; standards defined, registries for diabetes, asthma, risk assessments.
- 2007: E-prescribing, patient clinical email, and patient portal or PHR implemented.
- 2008: >60% of PCPs using EMR and e-prescribing.

Weighting system - Transparency

Minimum requirements/benchmarks

- Bidder requires participating hospitals to report data to the Oregon Public Safety Commission, Leapfrog criteria, procedure volumes, and participate in the HCAHPS survey in 2005.
- Bidder requires participating primary care providers to report HEDIS-like measures and cooperate with patient satisfaction survey program.

Otherwise: non-responsive.

Guidance for evaluating proposals:

- **High rating:** Bidder reports chronic disease outcomes (particularly asthma, depression and diabetes) for the population as a whole and by provider or clinic. Bidder develops and shares provider report cards, for hospitals, medical groups, and individual providers. Participating hospitals report Leapfrog, Oregon Patient Safety Commission, and CMS data, as well as procedure volumes. Network conducts and publishes annual primary care patient satisfaction survey, with scores for each primary care physician. Network has on-line capability to share formulary, pricing, and performance data with patients.

- **Moderate rating:** Bidder requires hospital participation in Leapfrog, Oregon Patient Safety and CMS. Can report chronic disease outcomes for overall population.

- **Low rating:** Bidder only meets minimum criteria above.

Assessing the credibility of the proposed approach:

Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for transparency:

- Hospital and medical group performance reports.
- Patient satisfaction surveys with public results of physician and hospital performance.
- On-line provider selection tools.
- Chronic disease outcomes measurement and reporting.
- Adverse event reporting, to JCAHO and to Oregon Patient Safety Commission.

If contract is awarded initially, acceptable phase-in schedule for contract renewal:

- 2006: Hospital report card and on-line tools for members.
- 2007: Physician ratings available. Chronic disease outcomes reported.
- 2008: Fulfill all of the high rating criteria.

Weighting system – Managing for Quality

Minimum requirements/benchmarks

- Bidder has a provider payment system in place that rewards high performance on quality, outcomes, or clinical systems (could include chronic disease process measures, health outcomes, patient satisfaction, and/or adoption of EMR and related technology).
- Bidder has management information system that permits periodic assessment of provider performance and qualification for incentive payment.
- Bidder has plan with specific implementation schedule for providing patient economic incentives for risk assessment and reduction, chronic disease outcomes, and/or medication adherence.

Guidance for evaluating proposals:

- **High rating:** Bidder has shared incentive system in place tied to clinical outcomes, similar to Bridges to Excellence or Integrated Healthcare Association (Calif.) pay for performance systems. Both managers and clinicians receive reporting and compensation tied to performance. Parallel system is available to reward members' achievement of health goals. Bidder has management information system such as predictive modeling that permits rapid identification of high-risk patients, and case management system to support those patients. Information system can track utilization and outcomes. System has capital and implementation plans to support quality improvement and incentive systems.

- **Moderate rating:** Bidder has pay for performance system for providers based on HEDIS and other process measures. Bidder has predictive modeling or equivalent systems and case management capability.

Low rating: Bidder only meets minimum criteria above.

Assessing the credibility of the proposed approach:

Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for managing for quality:

- Pay for performance already in place.
- Some member/patient incentives already in place.
- Chronic care outcomes already measured and available via registries.
- Clinical performance (not utilization) feedback reports are routinely provided to clinicians with medical director follow-up.

If contract is awarded initially, acceptable phase-in schedule for contract renewal:

- 2006: Provider pay-for-performance tied to outcomes, satisfaction, process indicators.
- 2007: Member and patient incentives implemented.
- 2008: Fulfill <u>all</u> of the high rating criteria.