

PHYSICIAN INCENTIVE PROGRAMS:

Is it possible to develop incentive programs that provide financial incentives for primary care physicians while balancing quality medicine and utilization controls?

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Dedication

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INTRODUCTION

Health care costs in the United States have risen drastically in the last thirty years. The rise in health care costs started in the 1960s with the introduction of Medicare and Medicaid programs. By the 1970s, healthcare expenditures were increasing at an alarming rate, and became a major concern for reform. President Nixon called on experts to reorganize health care to include health maintenance organizations (HMO). The Nixon administration argued that HMOs increase the value of services a consumer receives for each healthcare dollar. Finally, by December 1973, the HMO Act was adopted. The main purpose of the HMO Act was to create a competitive market for healthcare with the aim of solving the problem of rising health care costs with an emphasis on maintenance of health through prevention and education.

Health Maintenance Organizations have grown in popularity since the 1970's with enrollment in the United States increasing from approximately six million in the mid- 1970s to more than fifty million in 1995.¹ The years prior to 1987 saw rapid expansion in the number of HMOs followed by industry consolidation, and since 1993 expansion again in the number of HMOs.

Cost has become a very important factor in the health care system. There is only x amount of dollars allocated for health care, thus the need for a check and balance process in managed care organizations. Cost-efficient medical care can enhance the population's health by eliminating duplication of services and directing patient care to an appropriate medical service level. Reducing medical costs reduces premiums, enabling the allocation of more resources to those that need it most thereby increasing access to health care. Additional medical resources allocated to preventative medicine should also improve the quality of medical care delivered in the community over the long run. However, there is a line beyond

which health maintenance organizations (HMOs) can contractually deliver to the patient without causing a conflict of interest.

PROBLEM/ ISSUE

Managed care organizations have focused on utilization controls through the use of managed care techniques as a manner of containing costs. Managed care techniques such as selective contracting, risk sharing and risk adjustment, gatekeepers, medical management and utilization review have presented a more measurable means of financially incentivizing the primary care physician. However, has the focus on utilization controls been at the expense of practicing quality care medicine?

Compensation that rewards physicians for withholding care can interfere with physicians' loyalty to patients and ultimately their candor and trust. Structural incentives to reduce cost can be effective if they are not so direct and substantial to influence medical decisions. Thoughtful incentive structures can use measures of quality and patient satisfaction instead of rewarding less costly treatment decisions. How do we develop and balance these incentive structures and what other issues need to be taken into consideration?

Thus, in order to find a solution for such a complex issue, the complexity needs to be analyzed and defined. My research will utilize information already available on utilization controls and quality incentives to help better understand the existing relationships and structure. Additionally, my research will include gathering and analyzing data on two existing quality incentive programs to determine the effectiveness of using financial incentives for practicing quality medicine. The findings of this research will provide health care administrators with a cost / benefit analysis of the development of similar and more extensive models.

Major questions related to the development of quality incentive programs

- 1. How does the payment method for physician services impact the quality of care delivered?**
- 2. What do we know about the relationship between managed care techniques and quality of care?**

OPERATIONAL DEFINITIONS

Budgeted Capitation – Arrangement where provider accrues a budgeted capitation per member per month (pmpm) but receives fee-for-service (FFS) payments that are applied against the “budget”.

Capitation – A per-member, monthly payment to a provider that covers contracted services, and are paid in advance of the delivery of the service. In essence, a provider agrees to provide specified services to HMO members for this fixed, predetermined payment for a specified length of time (usually a year), regardless of how many times the member uses the service.

Case Management – The comprehensive management of a member’s health problems wherein the chronically ill or otherwise impaired individual may require long term and/or costly care.

Catastrophic Threshold – A pre-determined amount of fee for service payments that when reached (per member per year), changes the risk arrangement between the providers and the plan.

Concurrent Review – A method of reviewing patient care, during hospital confinement, to validate the necessity of current care and to explore alternatives to inpatient care.

Days Per Thousand (per 1000) – A measurement of the number of days of hospital care used in a year per 1,000 HMO members.

Fee-For-Service (FFS) – A system of payment for health care whereby a fee is rendered for each service delivered. This traditional method contrasts with that used in the prepaid sector where services are covered by a fixed payment made in advance that is independent of the number of services rendered.

Health Care Financing Administration (HCFA) – The agency within the Department of Health and Human Services which administers federal health financing and related regulatory programs, principally the Medicare, Medicaid, and Peer Review Organization.

Health Maintenance Organization (HMO) – A legal corporation that offers health insurance and medical care. HMOs typically offer a range of health care services at a fixed price. Types of HMOs:

- Staff Model – Organization owns its clinics and employs its doctors.
- Group Model – Contract with medical groups for services.
- IPA Model – Contract with an IPA that in turn contracts with individual physicians.
- Direct Contract Model – Contracts directly with individual physicians.
- Mixed Model – Members get options ranging from staff to IPA models.

Managed Care – A relatively new term coined originally to refer to the prepaid health care sector where care is provided under a fixed budget and costs are therein capable of being

“managed”. Increasingly, the term is being used by many analysts to include Preferred Provider Organizations (PPO) and even forms of indemnity insurance coverage that incorporate preadmission certification and other utilization controls.

Member Months – A unit of measurement that counts the number of months a member is assigned to a primary care physician (a member for 12 months would have 12 member months).

Per Member Per Month (PMPM) – A measurement of any kind that is calculated by taking the total (revenue, expenses) and dividing by member months.

Physician Hospital Organization (PHO) - It is owned jointly by a hospital and a physician group. The PHO, in turn, contracts with hospitals and physicians for the delivery of services to payers under contract to the PHO.

Stop-loss – The practice of an HMO or insurance company of protecting itself or its contracted medical groups against part or all losses above a specified dollar amount incurred in the process of caring for its policy holders.

TIMELINE FOR MANAGED CARE AND NATIONAL STANDARDS

HMO

In December 1973, the Health Maintenance Organization (HMO) Act was adopted. Health Maintenance Organizations were given legal recognition by the Public Health Service Act, Amendment Title XIII – Health Maintenance Organizations, also known as the Health Maintenance Act of 1973. The HMO Act authorized expenditures of federal dollars, for the purpose of providing assistance and encouragement for the establishment of HMOs. Subsequent amendments to this act were Health Maintenance Organizations Amendments of 1976, Health Maintenance Organizations Amendments of 1978, and Omnibus Budget Reconciliation’s Act of 1981. Since 1986, growth in HMO enrollment has been considerable, both nationally and under Medicare.

JCAHO

Since 1951, The Joint Commission on Accreditation of Healthcare Organizations has been evaluating and accrediting over 19,000 healthcare organizations and programs in the United States. JCAHO is an independent not-for-profit organization and is the nations’ predominant standards setting and accrediting body in healthcare. Joint Commission has developed state of the art, professionally based standards and evaluated the compliance of healthcare organizations against these benchmarks. The Joint Commission evaluates and accredits services for the following types of organizations: hospitals, healthcare networks, home care organizations; long-term care facilities, assisted living, behavioral healthcare, ambulatory care and clinical laboratories.

Accreditation by Joint Commission is recognized nationwide as a symbol of quality that indicates an organization meets certain performance standards. To earn and maintain

accreditation an organization must undergo an on-site survey by a Joint Commission survey team at least every three years.

In 1997, Joint Commission launched ORYX (outcome results) to integrate the use of outcomes and other performance measures into the accreditation process. Requirements for ambulatory care organizations and long-term care facilities under ORYX have not yet been established.

NCQA

The National Committee on Quality Assurance was established in 1990 as an independent not-for-profit organization based in Washington D.C. The NCQA has worked with consumers, healthcare purchasers, state regulators and the managed care industry in developing standards that evaluate the structure and function of medical and quality management systems in managed care organizations.

NCQA's standards for accreditation of managed care organizations evaluate a managed care plan's performance in the areas of quality management and improvement, utilization management, credentialing, members' rights and responsibilities, preventative health services and medical record keeping. NCQA Accreditation is an example of a managed care organizations commitment to principles of quality and continuously improving the clinical care and services it provides.

HEDIS

In 1992, NCQA took over responsibility for the management and evolution of the Health Plan Employer Data and Information Set (HEDIS), a performance measurement tool initially developed by The HMO Group. HEDIS is a set of standardized performance

measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking and childhood immunizations. HEDIS also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS is sponsored, supported and maintained by NCQA

In 1997, NCQA released its first annual addition of *The State of Managed Care Quality – Quality Compass, 1997*. Quality Compass uses only standardized, independently audited information from NCQA's Health Plan Employer Data and Information Set (HEDIS) and offers an overview of the performance of the nation's HMOs.

HCFA

On March 27, 1996, Health Care Financing Administration (HCFA) issued the final rule on requirements for Physician Incentive Plans in Prepaid Health Care Organizations. The regulations govern physician incentive plans operated by federally qualified health maintenance organizations and competitive medical plans contracting with the Medicare program, and certain health maintenance organizations and health insuring organizations contracting with the Medicaid program. The regulations were effective January 1, 1997.

QUALITY MEASUREMENT

To define quality, one needs to examine both health policy and health economics. Over the past decade, health policy has emphasized the importance of improving outcomes desired by consumers, as well as the challenge of distinguishing the effect of the medical care process from the many other factors that influence outcomes. Health policy organizations have defined the quality of medical care as the degree to which health care increases the probability of outcomes desired by consumers given current medical knowledge.² Some of the health economics literature has similarly identified quality with a greater intensity of treatment such as the length of time spent with a physician during an office visit, number of visits per episode of illness. However, other analyses have recognized that more care is not necessarily better or worse.

The Institute of Medicine (IOM) defines quality of care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”²

The literature therefore implies that “quality of care is measured by the production of improved health of a patient after adjustments for the constraints of existing technology and severity of the patients illness. Avedis Donabedian describes three sources of data for measuring quality of healthcare: Structure, Process and Outcome (SPO) (Donabedian, 1980, p. 82-86). Structural data describes features of healthcare facilities, equipment, professional and nonprofessional staff and organizations for delivery of care. Process data describes the things actually done to or for a patient. Outcome data describes the change in health status of a patient that is attributable to healthcare.³

For purposes of this research and my organization (a large PHO), we will utilize the Institute of Medicine's definition measured against the desired clinical outcomes as established by the National Committee for Quality Assurance (NCQA). Additionally, my research will include data from The State of Managed Care - Quality Compass, 1999 and Quality Compass, 2000. The NCQA's Compass 1999 and 2000 contain information on clinical performance, accreditation and member satisfaction. It also uses only standardized, independently audited information from HEDIS and includes results on the performance (averages, benchmarks & specific measures of care and service) of the nation's HMOs. The report tells us that the good news is managed care quality is improving, at least in those health plans that are willing to release their results.

LITERATURE REVIEW

Impact of Increased Competition on Quality of Care

Numerous studies have been conducted to assess the growth of HMOs and their impact on health care costs and quality care. A survey of recent studies by Robert H. Miller and Harold S. Luft entitled “Does Managed Care Lead To Better Or Worse Quality Of Care?” reviewed the quality of care rendered by HMOs compared with the traditional system. It is equally important to look at the financial relationship between the primary care physician and the HMO and what implications that arrangement may have on quality care. My research will look at existing relationships and attempt to assess whether those relationships steer physician behavior. Additionally, the research will examine the current incentives or dis-incentives and build upon them or develop new incentives for primary care physicians.

The goal behind the development of the HMO was to form an alternative form of health care that focused on the maintenance of health through prevention and education. The theory is that future medical problems can be avoided or reduced by practicing preventative medicine. Additionally, reducing the impact of future medical problems may help decrease overall health care costs. If the HMO is unable to decrease costs because of additional preventative expenses, hopefully the process will at least improve the overall health of the community. In a health maintenance organization, the member must choose a primary care physician, who agrees to manage all of the members’ health care needs. The physician will act as a “gatekeeper” for services including the necessity of referring patients to specialists and hospitalization.

The growth in health maintenance organizations during the period between 1992 and 1996 seems, in part, to have eased the increase in health care spending. As HMO enrollment and growth increased, market penetration increased and, over the past decade, the

number of physicians employed by HMOs or at least contracted with health maintenance organizations increased. HMO market structure is based on the interaction of HMO penetration (the proportion of the population in a given market enrolled in HMOs) and the number of HMOs operating in a market. The HMO Enrollment Growth for 1990 -- 2000 is as follows:

HMO Enrollment Growth from 1990-2000

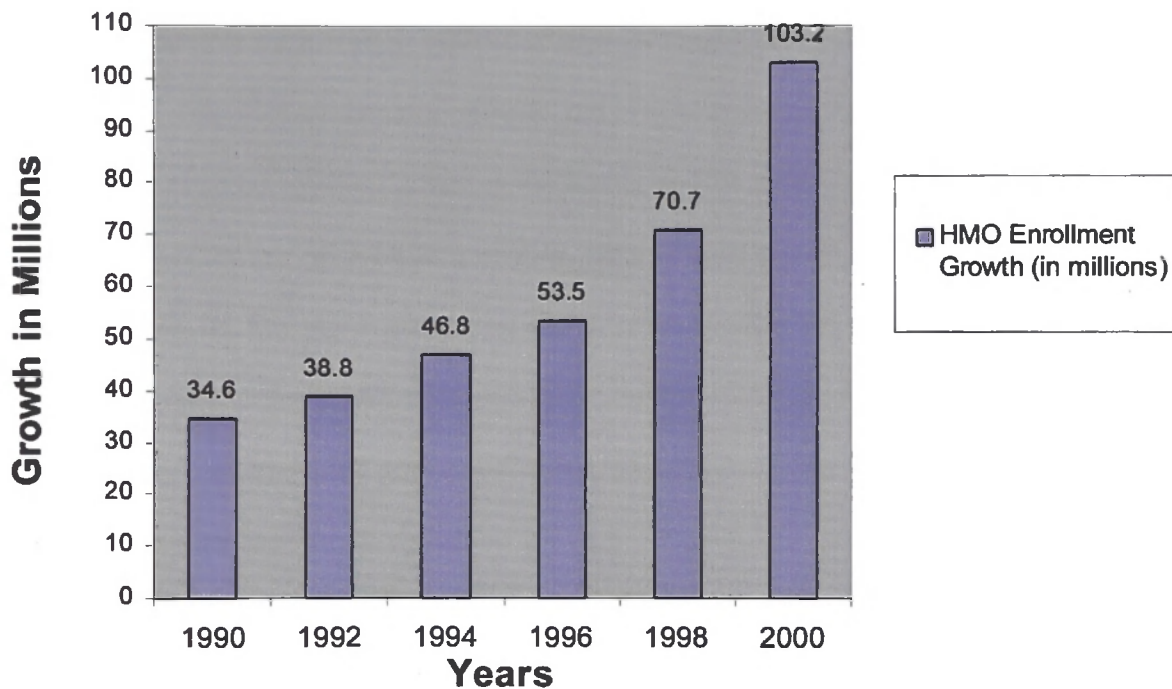


Figure 1: *HMO Enrollment Growth from 1990 – 2000*

Source: The author's summary of the studies included in this paper

The data used to identify the population of HMOs is the InterStudy HMO Census. It describes the organizational structure of HMOs in terms of model type (Independent Physician Association, Group or Staff); profit status; headquarter location and federal

qualification. In one study designed to assess the impact of HMO market penetration on premiums, the research looked at average premiums, hospital use and ambulatory visits.

Average premiums were constructed by dividing private HMO premium revenues by private HMO member months. Hospital use is the number of inpatient days per thousand enrollees per year; ambulatory visits are the number of physician and non-physician encounters per enrollee per year.¹

The research shows that as HMO penetration and the number of HMO competitors increase, group model HMOs reduce premiums, hospital use and increase ambulatory service use. It suggests that such HMOs achieve at least some of their cost savings by substituting outpatient and drug therapy for inpatient care, not simply by reducing payments to providers. Theoretically, price competition occurs in the health insurance market when HMOs compete amongst themselves and with other insurance plans to gain market share. In theory, price competition can lead to lower premiums, which in turn can result in lower fees, provider profits and/or use a different mix of medical care resources such as substituting outpatient for inpatient care. With increased price competition, the quality of care and its cost could either increase or decrease in some combination.

Comparisons reported by extent of HMO market share should come closer to reflecting the effects of greater competition. People in areas of medium HMO penetration were significantly less likely to report improvements in access and quality than those in areas of low penetration, but respondents reporting improvement in the two areas varied only in a range of 42 to 49 percent. About 60 percent of those in all areas considered managed care growth a good thing. The greatest impact on rates were found in high, and then in medium penetration areas with 45 to 46 percent of these respondents expecting managed care to improve quality.⁴

The characteristics of plans included breadth of provider choice, perceived access, interpersonal quality and amenities. Although these surveys were conducted in areas with growing diversity among plans, the influence of greater price competition, as opposed to public policy and other factors, cannot be discerned from the results. Proposals to create more

price-competitive conditions in health care focus on the individual consumer's selection of a health insurance plan. According to theories, consumers who are sensitive to premiums would consider the characteristics of different plans, including but not limited to, the quality of the care they offer. Policy changes were implemented in Minnesota hoping to increase price competition.

In 1985, the state's group insurance program required employees to pay the additional premiums if they did not enroll in the lowest cost plan; in 1991, a coalition of private employers in the Twin Cities instituted the same policy. Although employees may pay their share of premiums with before-tax dollars, through 1993 the lowest-cost HMO steadily gained market share, and indemnity and high-cost managed care plans lost ground.⁵

These results are consistent with consumers' choosing lower premiums and managed care as an alternative to higher premiums with unrestricted access to autonomous providers. From 1988 through 1991, greater HMO market share was associated with lower HMO premiums.⁶

Thus, the past decade has brought increased managed care market share and more recently that growth seems to be associated with lower HMO premiums. How have those two characteristics affected how HMO's pay physician organizations, and how do physician organizations pay physicians? The literature examines quality and cost-based risk-sharing, percent of premium, capitation and in-patient case rate with capitation being the most prominent for primary care physicians.

Relationship of Physician Payment Method on Quality

My research examines two local managed care plans' financial risk arrangements with a large primary care physician group (PHO). The financial risk is the arrangement that makes the individual provider, group of providers, hospital and/or insurance plan responsible

for a certain percentage of the difference between fee for service payments and the budgeted capitation. The research will examine only the commercial HMO product for both plans. It is important to examine the risk sharing arrangements in each plan to assess those arrangements or potential incentives that the primary care physician can control and those which are not within their control. For both plans, the average funding level is derived from the single- person premium rate multiplied by a loading ratio. That funding level or budgeted capitation is adjusted based on age, sex and benefit level for each member annually. In analysis of the contracts, the negotiated funding levels and age/sex adjustment is critical because it determines how much money the physician has, based on their risk arrangement, to spend on the patients care. Details of the plans are as follows:

PLAN A – DIRECT HEALTH CARE FUNDS

- COMMERCIAL – Percent of premium (a risk arrangement that shares the risk of the entire premium dollar among the primary care physicians, the hospital and the plan.
- PRIMARY FUND – Fee-for-service (FFS) payments made to primary care physicians for services they provide.
- SPECIALIST FUND – FFS payments made to specialists + certain FFS payments made to the hospital that can be performed in the physician office + certain FFS payments made to ancillary service providers (excludes payment for psych/ substance abuse expenses)
- DRUG FUND – FFS payments made to pharmacies for prescriptions written by the PCP and/or specialist physician (excludes Rx for psych/ substance abuse)

- INSTITUTIONAL FUND – FFS payments made to hospital for inpatient & outpatient services – FFS payments charged to specialist fund (excludes psych/ substance abuse)
- PSYCH/ SA FUND – FFS payments made to physicians, pharmacies, hospital and other psych/ substance abuse providers for services.
- GROUP - The large primary care physician group committed to the risk sharing arrangement.

PLAN A – CATASTROPHIC THRESHOLD TIERS (Once the pre-determined amount of FFS payments has been reached, per member per year, the risk arrangement changes between the providers and the plan). Threshold tiers may also be termed Stop/Loss arrangements where the physician is capped from additional expenses beyond that threshold tier amount.

- PRIMARY FUND – No catastrophic threshold tiers.
- SPECIALIST FUND
 - * TIER 1 \$0 - \$4,000
 - * TIER 2 \$4,000 +
- DRUG FUND
 - * TIER 1 \$0 - \$1,000
 - * TIER 2 \$1,000 +
- INSTITUTIONAL FUND
 - * TIER 1 \$10,000
 - * TIER 2 \$10,000 +
- PREMIUM FUND – Not applicable
- PSYCH/ SA FUND – No catastrophic threshold tiers

- PLAN REINSURANCE LEVEL - \$200,000 any combination of FFS payments made from each fund.

Table 1: *Plan A Risk Model*

FUND	PCP	GROUP	HOSPITAL	PLAN
Primary	100%	0%	0%	0%
Specialist				
Tier 1	33.33%	0%	33.33%	33.33%
Tier 2	0%	33.33%	33.33%	33.33%
Drug				
Tier 1	33.33%	0%	33.33%	33.33%
Tier 2	0%	33.33%	33.33%	33.33%
Institutional				
Tier 1	33.33%	0%	33.33%	33.33%
Tier 2	0%	33.33%	33.33%	33.33%
Premium	0%	33.33%	33.33%	33.33%
Psych/ SA	0%	33.33%	33.33%	33.33%
Plan Reinsurance	0%	0%	0%	100%

Source: This author's summary of Plan A's Financial Risk Sharing Contract with local Physician Hospital Organization (PHO).

PLAN B – DIRECT HEALTH CARE FUNDS

- COMMERCIAL – Capitation and Budgeted Capitation
- PRIMARY FUND – Full capitation for services provided by the primary care physician.
- SPECIALIST FUND - FFS payments made to specialists + certain FFS payments made to the hospital that can be performed in the physician office + certain FFS payments made to ancillary service providers.
- DRUG FUND – FFS payments made to pharmacies for prescriptions written by the primary care and/ or specialist physician.

Table 2: *Plan B Risk Model*

FUND	PCP	GROUP	HOSPITAL	PLAN
Primary	CAP	0%	0%	0%
Specialist				
Tier 1	45%	0%	45%	10%
Tier 2	0%	0%	0%	100%
Drug	0%	25%	25%	50%
Institutional				
Tier 1	35%	0%	35%	30%
Tier 2	0%	0%	0%	100%
Plan				
Reinsurance	0%	0%	0%	100%

Source: *This author's summary of Plan B's Financial Risk Sharing Contract with local Physician Hospital Organization (PHO).*

It is important to note the risk sharing arrangement in Plan A, is such that the physician group begins to function as an insurance vehicle for the individual provider once costs have reached the threshold. The risk sharing arrangement with catastrophic thresholds eliminates the incentive to withhold care because of cost as it limits the exposure to individual primary care physicians by shifting the risk exposure to a group of physicians. In both plans, the total premium revenue plays a significant role in the amount of funds allotted for the primary care physician.

Both plans are utilizing capitation to align financial incentives among the network providers with the goal of reducing health care costs by risk sharing. Capitation payment arrangements can range from individual productivity- oriented approaches, based on volume, to salary-oriented models based on group performance. Plans A and B are a combination of productivity-oriented approaches based on group performance. The use of capitation can create powerful economic incentives to move the focus of care away from high-cost settings and treatment to community-based services that can better prevent or control the incidence. One of the keys to properly managing the risk is reducing the need for medical care without denying access to needed care or undermining the quality of care.

In both Plans A and B, not only does the primary care physician have financial responsibility for the primary fund, they are responsible for guiding the member through the network. Therefore, the primary care physician will utilize several managed care techniques to keep utilization and health care costs down. Utilization of the gatekeeper role, maintenance of a tight specialist referral panel as well as, medical management programs and utilization review are tools that primary care physicians use to maintain and/ or reduce cost. Utilization tools are designed to be used for the healthy or temporarily ill member. The member that is seriously ill or has a long-term illness tends to be managed by their illness.

The primary care physician can only really control the first group and should not be worried and/or concerned about the costs associated with the second group especially with proper risk sharing arrangements in place. Therefore, these utilization controls or tools become the only incentives that are within the physicians' control.

Managed Care Techniques and Quality

Gatekeeper

Physicians may perceive that utilization controls, such as the gatekeeper, serve as incentives or dis-incentives for practice patterns. The “gatekeeper” system was initially set up to manage large networks of physicians with little incentive to cooperate and work together. As the gatekeeper, the primary care physician must authorize all medical services, (e.g. hospitalization, diagnostic work-ups, and specialty referrals) for a member. According to research by the American Academy of Family Physicians, as many as 90 percent of patients can be safely managed by a primary care physician. A gatekeeper system sends patients along a route they should probably take anyway. In one focus group study among primary care physicians in Massachusetts, primary care physicians stated that they naturally see their role as a gatekeeper; however, they feel the process puts them in an administrative role that has little to do with their clinical responsibilities.

According to Bilodeau (1996), researchers from Duke University Medical Center found that if the gatekeeper system isn't set up properly, primary care physicians may end up managing too many tricky specialist cases, with unfortunate results for everyone concerned. Researchers found that three-fifths of emergency department patients arriving with chest pains remained in the care of a primary care physician. The patients were more likely to die within a year of the onset of symptoms than patients managed by a cardiologist.⁷

Disease Management

Another approach and/ or alternative to the ‘gatekeeper’ system is the medical or disease management. This approach gives primary care physicians control of routine cases; in turn the care of patients with certain disease states and conditions are turned over to specialists. This sends each patient to the professional best able to care for them, while keeping referrals under the supervision of the cost-efficient primary care doctor. According to Bilodeau (1996), in her article “Trying Out Alternatives to the ‘Gatekeeper’ System,” PRIMUS, a Miami based physician-owned HMO established a disease management system, rather than traditional gatekeeper, to use treatment protocols and care maps to guide patients along. Patients will go through a comprehensive primary care assessment, which will collect baseline data and prepare a plan of care, which requires any diagnoses that require ongoing treatment. The patient then will be seen by whichever specialists are called for in the protocol.⁷

Disease management seems to be too complex to operationalize because of the inherent issues in monitoring and tracking protocols. Additionally, there is a gap in the literature as to whether plans and/ or physician groups can be financially successful with these programs. However, some form of medical management appears to be necessary in maintaining control within the managed care organization and in keeping with quality care. United HealthCare of Minnesota, a large managed care organization, has found success with ‘gatekeeper’ and disease management systems. They feel their success has been attributed to capitation (primary care physicians are paid on a FFS basis and specialists are capitated), mutual guidelines development process, and a sophisticated management information system to keep close tabs on their physicians.

Risk Adjustment

Meaningful assessment of patients' outcomes generally requires a measure of the outcome itself and a way to adjust for patients' risk for various outcomes.⁸ Given the personal stakes, decisions about health care especially require weighing risk of good versus bad outcomes, variously defined. There are generally four factors accounting for observed differences in patient outcomes: 1) differences in significant risk factors among patients, 2) differences in how well available data sources represent reality and these risk factors, 3) random variation, 4) differences in the effectiveness of the health services provided or the quality of care.

The purpose of risk adjustment is to account for one potential cause of observed difference in outcomes- intrinsic patient characteristics that increase risk. The goal of risk adjustment is to account for pertinent patient characteristics before making inferences about the effectiveness of quality of care based on patient outcomes. When determining funding levels in capitated payment arrangements, risk adjustment is extremely important because sicker patients are more likely to require health services that cost more over time. Risk adjustment should improve fairness of payment, reduce the likelihood of withholding medical care and reduce the risk of exclusion from the plan.

There are several dimensions of risk:

- Age
- Sex
- Race and ethnicity
- Principle diagnosis
- Severity of principle diagnosis
- Extent and severity of co-morbidities
- Cultural and socioeconomic attributes
- Health status and quality of life
- Patient attitudes and preferences for outcomes

Lisa Iezzoni, M.D. a professor of medicine at Harvard Medical School and the author of *Risk Adjustment for Measuring Health Outcomes*, says the feasibility of using a risk-adjusted system depends on two issues: data collection and the difficulty of predicting health care costs.

“You can’t do risk adjustment without data. Under the Medicare program, HCFA has the authority to tell managed care plans to submit the data. However, this could require costly changes in plans’ information systems, and some plans could leave Medicare because of this.” There would be no such directive bolstering any risk-adjusted methodology attempted in the private sector. “Non-Medicare participating plans,” says Iezzoni, “would have to voluntarily produce the data. You really can’t separate the issue of risk adjustment from information-gathering capabilities.”⁹

Effective January 2000, HCFA planned to use the new risk adjusted methodology in the Medicare + Choice program which will use inpatient hospital utilization in one year to predict the cost of all services in the following year.⁹ The new payment system proposes that managed care plans will receive extra funds for those Medicare patients that have been hospitalized in the previous year for specific conditions. Conditions such as breast cancer, lung cancer and Aids will be given bonus funds per beneficiary. Medicare officials estimate that this new payment plan could save Medicare \$11.2 billion dollars over the next five years. However, the question that remains is will HMOs survive with Medicare plans and is the payment method sufficient to care for the more seriously ill? As we have seen over the past year, many HMOs are no longer providing Medicare Risk programs.

Properly designed risk adjustment models will be a combination of clinical judgment and empirical modeling. Clinicians should be involved in identifying and specifying the risk variables and reviewing the empirical models for clinical face validity and plausibility. If properly developed, the model could discourage cream skinning and encourage physicians and health plans to be much more rigorous in their management of specific cases. Additionally, it can provide an incentive for physicians to be more conscientious and look after patients in the most cost effective manner.

Physician Perception of Utilization Controls

Part of the problem when assessing utilization controls and their effect on physician incentive is a percent of the data represent self-reporting from the physicians' perspective. The study from this 1997 Resurvey of Young Physicians (sample size 1549), examines if contractual arrangements with health plans are associated with physician perception of financial incentives, i.e., will these incentives increase or decrease the service to patient ratio.

The survey collected information on current practice structure, practice operations, arrangements with managed care plans, amount and methods of compensation, utilization review, gatekeeper arrangement, communications from insurance plans and indicators of satisfaction. The dependent variable, perceived financial incentive, is an ordinal measure constructed from two survey questions:

1. How would you describe your overall personal financial incentives in your practice? On balance, do the incentives: a) favor reducing services to individual patients, b) favor expanding services to individual patients, or c) favor neither?"

2. If the physician answered either a or b, the follow up question was: Have these incentives reduced (or expanded, as appropriate) services: a) a little, b) a moderate amount or c) a lot?"

The variable constructed from the physician's responses has four ordered values: 1) a strong incentive to reduce services; 2) a moderate incentive to reduce services; 3) no incentive to either increase or decrease services; and 4) an incentive to increase services.¹⁰

In general, the study found several statistically significant relationships that affected perceived financial incentives. Gatekeeper arrangements with compensation effects, high risk of exclusion from health plans, patient referrals dependent on costs, being subject to gag clauses prohibiting disclosure of financial incentives, and participation in one or more capitated insurance plans all significantly increased the odds that physicians would report perceived financial incentives to reduce services to patients. Physicians who are not paid by straight salary are more likely to say their incentives favor increasing services to patients compared with physicians who receive a straight salary. Physicians who are paid a salary

with a bonus based on performance are also more likely to report an incentive to increase services. Physicians who contract with one or more capitated insurance plans are more likely to report an incentive to reduce services to patients when compared with those who treat only fee-for-service patients.

Conversely, we found that physicians who are paid a salary with bonus incentives, and those who are not salaried tend to report having an incentive to increase services to patients. Self-employed physicians or those employed by a non physician-owned corporation are more likely to report incentives to reduce services rather than those physicians employed by another physician or a physician owned group.

The goal of the study was to determine whether specific aspects of physician's direct arrangements with health plans, their compensation arrangements and their employment settings have systematic and significant effects on physicians' assessments of their overall financial incentives in their practices. The study tells us there is a relationship between compensation and physician perception but because of the complexity of the study, it is difficult to determine the specific impact in each of the compensation variables on that relationship. The following factors contribute in making it difficult to measure physicians' financial incentives:

- Contracts may incorporate several types of financial and other incentives to influence behavior.
- The influence of any particular arrangement may depend on the proportion of a physician's practice that is devoted to caring for patients covered by that plan.
- The physician's method of compensation by his practice may be independent of the practice's contractual arrangement with various health plans.

- Health plans themselves may offer several distinct insurance products under the same general name.

The above study tells us physicians' perceptions are altered by their compensation arrangement and their financial arrangement with the payer or plan. Additionally, there are good theoretical reasons to believe that financial incentives do have an impact on quality however the constant flux in the relations between payers, plans and providers makes it difficult to determine the specific variables and their impact on quality. Based on the literature reviewed by R.A. Dudley, R.H. Miller, T.Y. Korenbrot and H.S. Luft a gap exists in the inability to objectively measure variables indicating risk of exclusion or compensation adversely affected by the number of referrals. Also, if overall financial incentives are highly correlated with actual contractual incentives, it could also be affected by various attitudinal variables.

The impact of incentives to provide more services when those services are small or unknown has been shown in several studies of medical appropriateness and shown apparent over utilization. Additionally, traditional fee for service can create quality problems for those patients who need preventative or "mundane" services that may be ignored resulting in "under-utilization" of preventive or routine services.

Hypothesis

The implementation of quality incentive programs, such as Performance Recognition Program and Health Maintenance Grids by two Genesee County health maintenance organizations has been a positive financial incentive for primary care physicians. More importantly, the implementation of quality incentive programs has improved the overall health of the Greater Flint community.

METHODOLOGY

The purpose of the study is to determine if Quality Incentive Programs are successful in providing financial incentives to primary care physicians and maintaining the practice of quality care medicine. The results of the two Genesee County programs were compiled utilizing billing data that was confidentially compiled from physician numbers and can't be identified by patient.

In Program 1, the raw data was analyzed and a comparison of means was conducted to identify whether there was an increase or decrease from year to year. The reimbursement dollar amount to the physician group was provided by Plan A in an introduction to the program.

In Program 2, Plan B compiled the raw data from utilization summary reports and claims paid data. The summary reports were provided to the group practice (PHO) with percentage compliance per each clinical indicator in the formats displayed in Appendices I - VI. My research focused on the overall program results and the four qualities of care and patient satisfaction measures that were consistent in both years. A comparison of means was performed to determine whether there was an increase and/or decrease in financial payments and quality care provided.

This analysis is based on the review of the secondary data compiled by the health plans for the purpose of their programs, books and articles. By performing such studies, my research will attempt to determine whether Quality Incentive Programs financially incentivize the primary care physician and improve the health of the community.

STUDIES AND FINDINGS OF QUALITY INCENTIVE PROGRAMS

Literature

In January 1997, Health Care Financing Administration (HCFA) issued the final rule on requirements for physician incentive plans in prepaid health care organizations. The regulations govern physician incentive plans operated by federally qualified health maintenance organizations and competitive medical plans contracting with the Medicare program as well as certain HMOs and health insuring organizations contracting with the Medicaid program.

As documented by the Department of Health and Human Services, Rules and Regulations, Federal Register: December 31, 1996, an organization must meet the following requirements if it operates a physician incentive plan:

- 1) That it not directly or indirectly makes specific payments to a physician or physicians group as an inducement to limit or reduce medically necessary services to a specified individual involved with the organization.
- 2) That it will disclose to HCFA its physician incentive plan arrangements in detail that is sufficient to allow HCFA to determine whether the arrangements comply with departmental regulations.
- 3) If the plan places a physician or group at substantial financial risk for services not provided directly, the prepaid health care organization:
 - a) Provide the physician or group with adequate and appropriate stop-loss protections.
 - b) Conduct surveys of currently and previously enrolled members to assess the degree of access to services and the satisfaction with the quality of services.

- c) Requires that organizations with physician incentive plans disclose information about those plans to us and to any Medicare beneficiary who requests it.
- d) Specifies that HCFA may apply intermediate sanctions if it's determined that an HMO or competitive medical plan (CMP) fails to comply with the physician incentive plan requirements.¹¹

In 1987, U.S. Healthcare developed a quality-based compensation model through which its primary care physicians, hospitals, and specialists can earn additional compensation based on quality and cost-effectiveness of the care they provide to their patients. U.S. Healthcare is an independent practice association (IPA) model managed care organization that contracts with approximately 15,000 primary care physicians, 45,000 specialists and 400 hospitals. The Quality Care Compensation System (QCCS) was designed to transition the traditional incentives of FFS payments to the creation of incentives for quality. As described in a journal article:

Their model was implemented with the following contractual relationships between each of their participating providers. The primary care physicians were capitated by per member per month (pmpm) and age and/ sex adjusted; the hospital was paid on fee for service basis which generally includes a per diem rate paid for each hospital day. Most specialists were capitated in a gatekeeper arrangement.¹²

These compensation arrangements formed the foundation upon which U.S. Healthcare introduced its quality-based compensation model. Prior to the implementation of QCCS, primary care physicians were capitated on a “withhold” model where they would receive 80% of the capitated rate bi-monthly. Based on the total costs of care provided throughout the year, a portion of the total aggregate withheld amount across all PCPs would

be returned at the end of the year in the form of a distribution. The withheld amount is an incentive to discourage over utilization of inappropriate medical care.

After the introduction of QCCS, primary care physicians had the opportunity to increase their capitated payment and receive additional distributions based on their measured performance in providing improved quality of care and service and appropriate resource utilization for members. The four standards of measurement include:

Quality of care was measured through focused medical chart reviews of compliance with various health-maintenance performance standards. Quality of service was measured through member satisfaction and rates of transfer between physicians. Medical directors assessed philosophy of managed care and professional service coordinators based on the PCP's participation in various managed care programs. Utilization was determined through hospital inpatient days, specialist costs, and emergency department costs.¹²

The capitation payments and the eligibility for additional distributions are driven by the primary care physicians' overall quality factor, which is derived from three components on a semiannual basis: quality review, comprehensive care and utilization.

Table 3: U.S. Healthcare's Compensation Model for Primary Care Physicians.

TOTAL PAYMENT= BASE CAPITATION x QUALITY-FACTORED AND DISTRIBUTION ENHANCEMENT		
Depends On:		
Quality Review Components	Comprehensive Care Components	Utilization Components
* Member Surveys	* Membership size	*Hospital Days
* Focused medical care reviews	* Scheduled office hours	* Specialist Costs
*Member transfer rates	* Available office procedures	* Emergency department costs
* Philosophy of MC	* Continuing medical education	

Source: *U.S. Healthcare, Inc., Blue Bell, PA, 1996.*

The QCCS has been successful in improving quality within U.S. Healthcare's medical delivery system. Medical chart evaluations have shown demonstrated improvement in quality review measures (Figure 2) and audits have shown steady improvement in the quality of care.

Improvement in Quality-Review Measures Under the Quality Care Compensation System Selected Years 1988-94

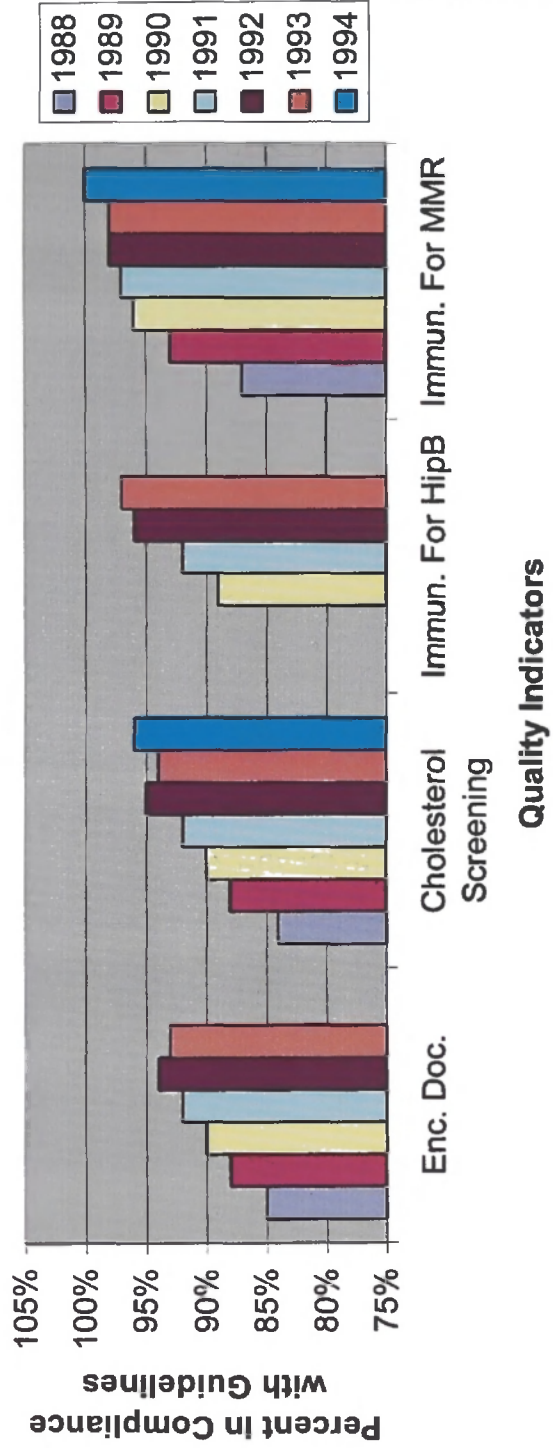


Figure 2: Improvement in Quality-Review Measures Under the Quality Care Compensation System: Selected Years 1988-94

Source: U.S. Healthcare, Inc., Blue Bell, PA, 1996.

PROGRAM 1 – HEALTH MAINTENANCE GRIDS

The managed care organization (Plan A) established a Clinical Practice Guidelines Binder. The binder includes the guidelines and protocols for fifteen different topics and each guideline includes a one page summary sheet (grid), which may be removed for easy reference. The guidelines and protocols are the product of careful consideration of nationwide recommendations, and present the health plans best effort at outlining prevention, wellness, and disease management strategies. The goal of the program is to improve patient care and the value of the health plan product by developing, implementing, and monitoring scientifically sound, evidence-based guidelines and protocols.

The primary care physician is to code and bill each patient visit for the services rendered. Additionally, they are to fill out the Health Maintenance Grid (Appendices I-V) for each patient visit. Annually, the physician may bill the Health Maintenance Code for \$100 reimbursement for each patient who received the appropriate health maintenance measures over the course of the year. Chart reviews are conducted by a Quality Improvement Nurse to verify proper use of the Health Maintenance Code and appropriate charting.

The primary care physicians' utilization of the Health Maintenance Code is displayed in Figure 3. In the initial year, 1999, the physicians utilized the code 554 times for a reimbursement of \$55,400. In the next year, 2000, the number of codes rose to 683 for a total of \$68,300 and an overall increase of 8%.

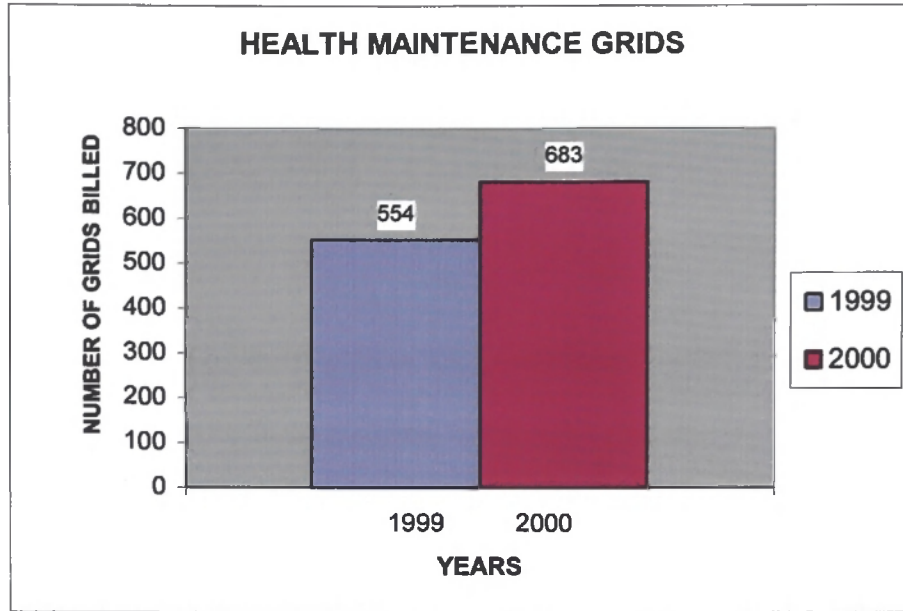


Figure 3: *Comparison of Health Maintenance Grid Codes*

Source: *The author's summary of the Health Plan Practice Activity Report on procedure code 9216A.*

PROGRAM 2 – PERFORMANCE RECOGNITION PROGRAM

The managed care organization (Plan B) developed the Performance Recognition Program as a tool to recognize and reward physicians for providing quality care and service to members in a cost-effective manner. The two main categories of incentive in the 1999 and 2000 PRP are:

- Quality of Care, as measured by Health Employer Data Information Set (HEDIS) and other quality indicators.
- Member Satisfaction, as measured by members' survey responses.

The indicators were chosen based on a process developed by a cross-functional team to determine major health issues that are important to their members and purchasers. For Quality of Care measurements, the health plan utilized 1) Breast Cancer Screening, 2) Cervical Cancer Screening and 3) Childhood Immunization. For the Member Satisfaction measurements, the health plan is using 1) Satisfaction with Ability to Make an Appointment, 2) Satisfaction with Office Waiting Time and 3) Satisfaction with Primary Care Physician. The health plan is using the same scale and wording required in Consumer Assessment of Health Plan Survey (CAHPS), a member survey tool mandated in its format and administration by HCFA. Primary care physicians are credited for services provided to members assigned to him/her as of the 31st day of the year regardless of whether the primary care physician provided the service. The final report on 1999 Performance Recognition Program is available in Appendix VI. Appendix VII contains the 2000 Performance Recognition Program result for the large group practice by physician number.

Following is a summary of the scoring method used in the 1999 and 2000 programs.

- A) Determine each primary care physician's total score.
 - 1. PCPs with 75 or more members
 - Determine the rate for each PCP indicator
 - Compare the rate for each indicator to the goals and award 0, 5, or 10 points.
 - Tally all the points to obtain Total Points Received.
 - Divide Total Points Received by Total Points Possible to arrive at a percent, or the PCPs Total Score.

2. PCPs with less than 75 members

- Determine the member-weighted average of the Total PCP Scores for the PCPs with 75 or more members. This result is the Total Score assigned to PCPs with less than 75 members.

B) Determine the payment earned by each PCP using the following formulas:

For a PCP Total Score of:	The PCP's Payment Is: (mm= member months)
0% to 49%	Zero
50% to 79%	$(\text{Score}) \times (\$2.25) \times (\text{mm})$
80% to 100%	$(100\%) \times (\$2.25) \times (\text{mm})$

Source: *This author's summary of the Health Plans' program definition*

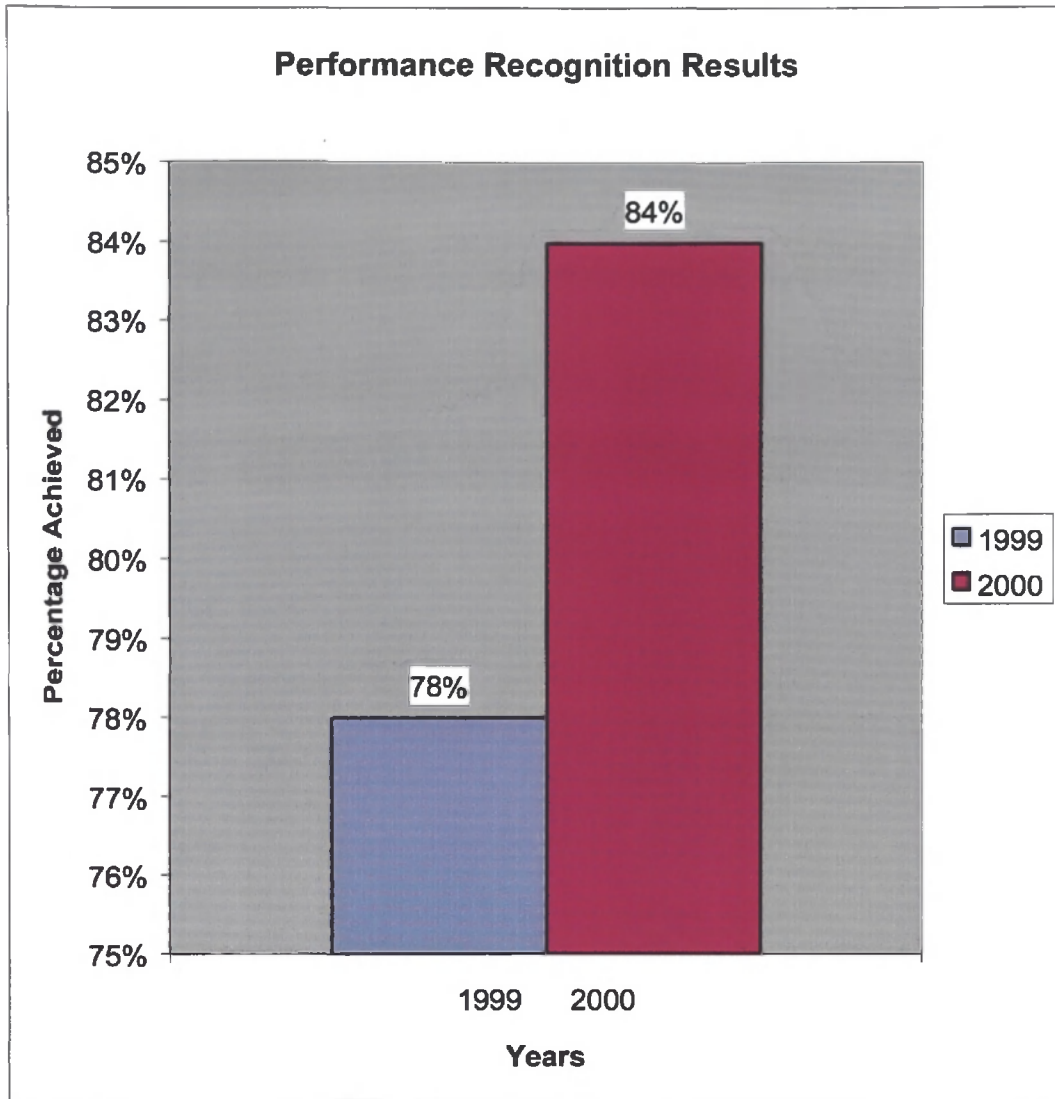


Figure 4: *Performance Recognition Program Results for Years 1999 and 2000*

Source: *This author's summary of Plan B's Program Results in 1999 and 2000*

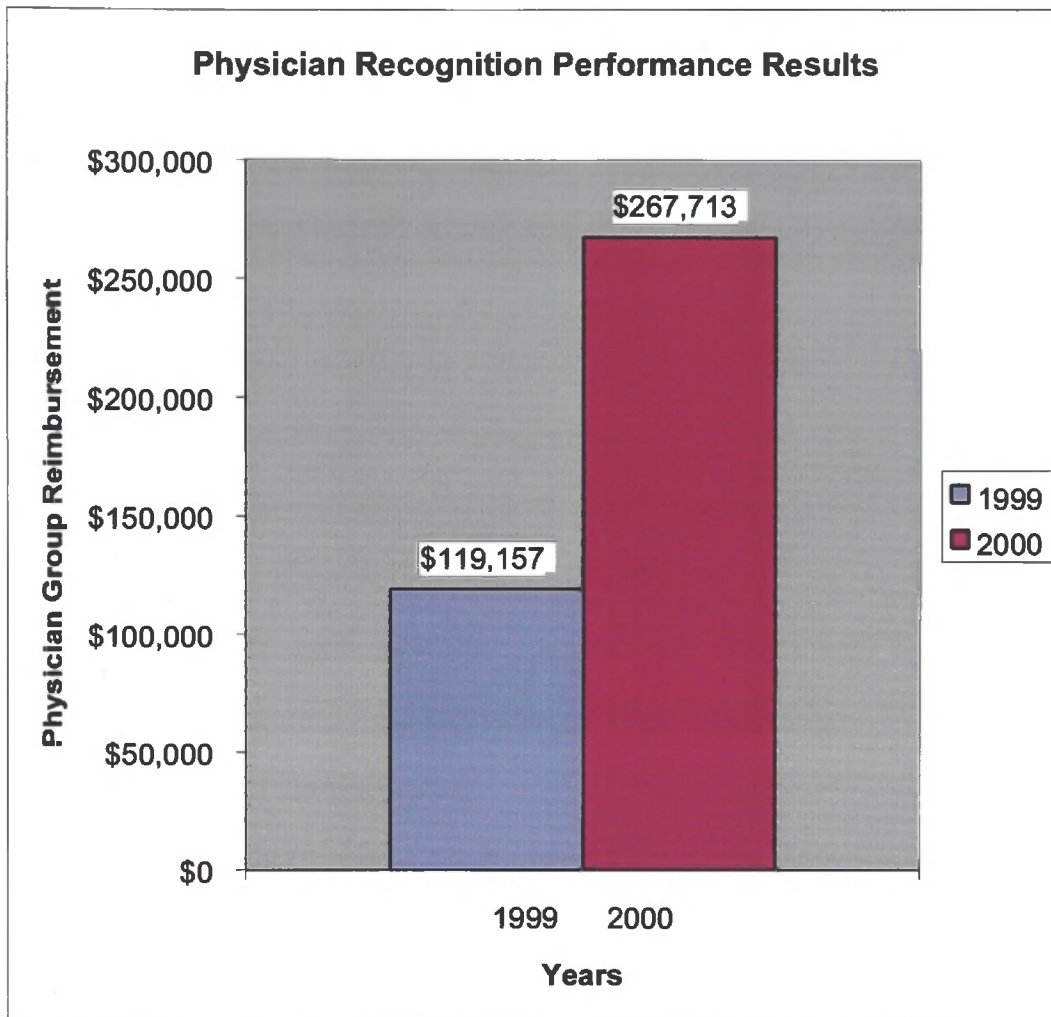


Figure 5: *Comparison of Health Plan B's Performance Recognition Program Physician Reimbursement Results for 1999 and 2000.*

Source: This author's summary of Health Plan B's Physician Recognition Program Reimbursement Results.

DISCUSSION

There is a reasonable body of literature that has attempted to evaluate the effect of different payment methods on the quality of care, and the overall conclusion in the majority of these studies is that the quality of care in managed care is equal to or better in health maintenance organizations (HMOs) than in fee-for-service sector.¹² Nevertheless, there have been on-going concerns about balancing incentives in managed care. Therefore, incentives for practicing medicine appear to have intrinsic value. The studies listed above have examined three different types of programs designed to promote financial incentives for the primary care physician to practice quality care. Each of these studies suggest that primary care physicians have been motivated to improve their performance in the clinical standards measured from the inception of the programs to the next year. Additionally, each program proved financially beneficial to the primary care physician.

As described in a journal article, U.S. Healthcare states that the actual payment to primary care physicians and frequency of their distributions has improved significantly since the implementation of their program.

An analysis of Program 1, Health Maintenance Grids shows that the number of grids billed increased 8% in the first year of implementation. The total reimbursement to the primary care physician group in year 2000 was \$68,300, which was up \$12,900 from the previous year. The most important factor in the implementation of this program is the overall improvement in those clinical standards that were measured and were part of the health maintenance grid, during the course of this program. For example: the Pediatric Health Maintenance Grid (Appendix 1) focuses on age's birth through five years. Aside from basic development assessment (height, weight, and head circumference) and safety violence issues, the guideline focuses primarily on childhood immunizations. Those clinical measures that

my research was able to analyze included: Breast Cancer Screening, Cervical Cancer Screening and Childhood Immunizations. As seen in Figure 6, the PHO's compliance in cervical cancer screening (4.1%) and childhood immunizations (7%) increased from 1999 to 2000. There was a slight decrease (.4%) in breast cancer screening. Of the three clinical measures, the PHO group reported only childhood immunizations as greater than Plan A's overall market. However, it is important to note that all three clinical measures were significantly higher than what the state of Michigan reports and even more importantly, greater than current national reports.

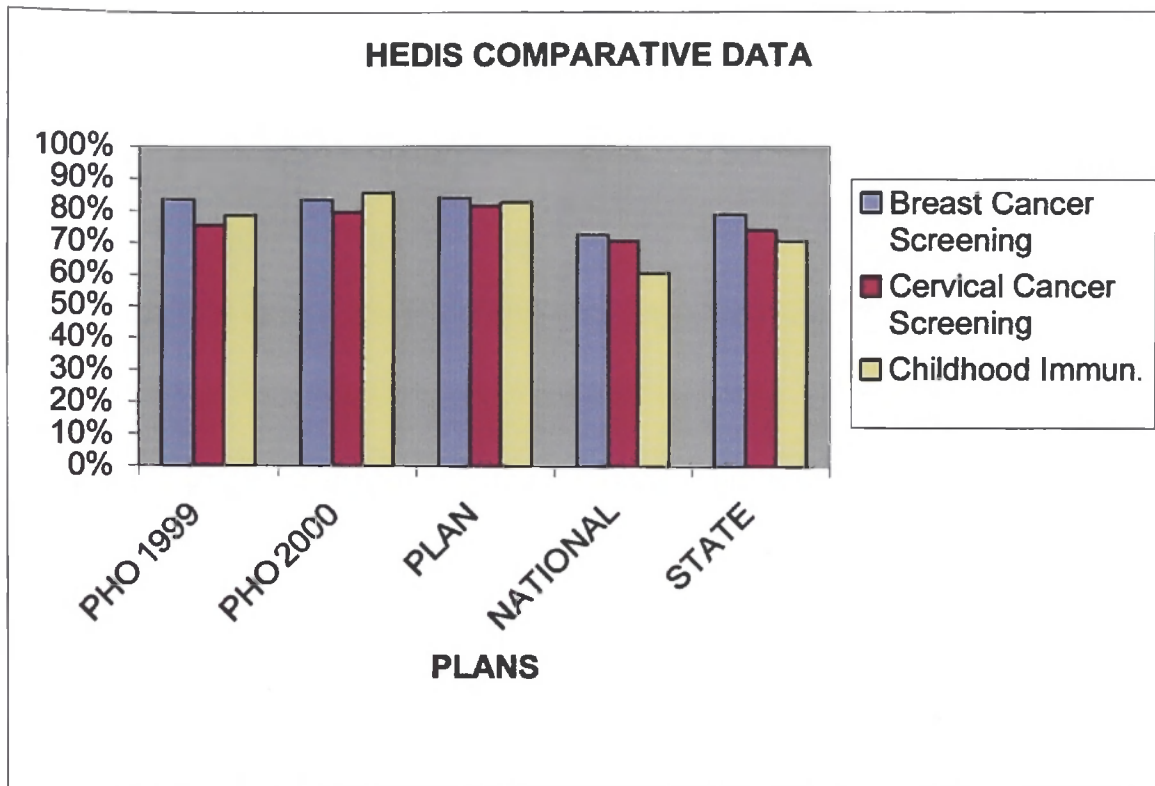


Figure 6: HEDIS Comparative Data for Plan A, 1999 Group Practice, 2000 Group Practice and State of Michigan.

Source: The author's summary of the Comparative Plan A Data.

Although the results were similar, Plan B implemented a much more complex program in Program 2, Performance Recognition Program. The program was similar to that of U.S. Healthcare's Quality Care Compensation System in that it was a "withhold" model. Plan B withheld \$2.25 pmpm (per member per month) to be returned to the primary care physician through annual distribution pending the results of the physician's performance in the program. During the program's first year (1999) quality of care measures included: Breast Cancer Screening, Cervical Cancer Screening, Retinal Exams for Diabetics, and

Childhood Immunizations. The patient satisfaction measures were Satisfaction with PCP, Satisfaction with Ability to Make an Appointment and Satisfaction with Office Waiting Time. In the year 2000, quality of care measures included: Breast Cancer Screening, Cervical Cancer Screening, Childhood Immunizations, Formulary Compliance, and Generic Rate. The patient satisfaction measures included: Satisfaction with PCP, Ability to Make an Appointment and Advice to Quit Smoking. For purposes of consistency between the two years, this research analyzed the year end results for plan effectiveness and the following four measures of quality of care and patient satisfaction for measurable impact on the greater community:

- Breast Cancer Screening
- Cervical Cancer Screening
- Satisfaction with Ability to Make an Appointment
- Satisfaction with Primary Care Physician

The total scores in the four measures and overall program are identified in the graph below. Unfortunately, Childhood Immunizations could not be included in this study due to lack of measurable data in both years.

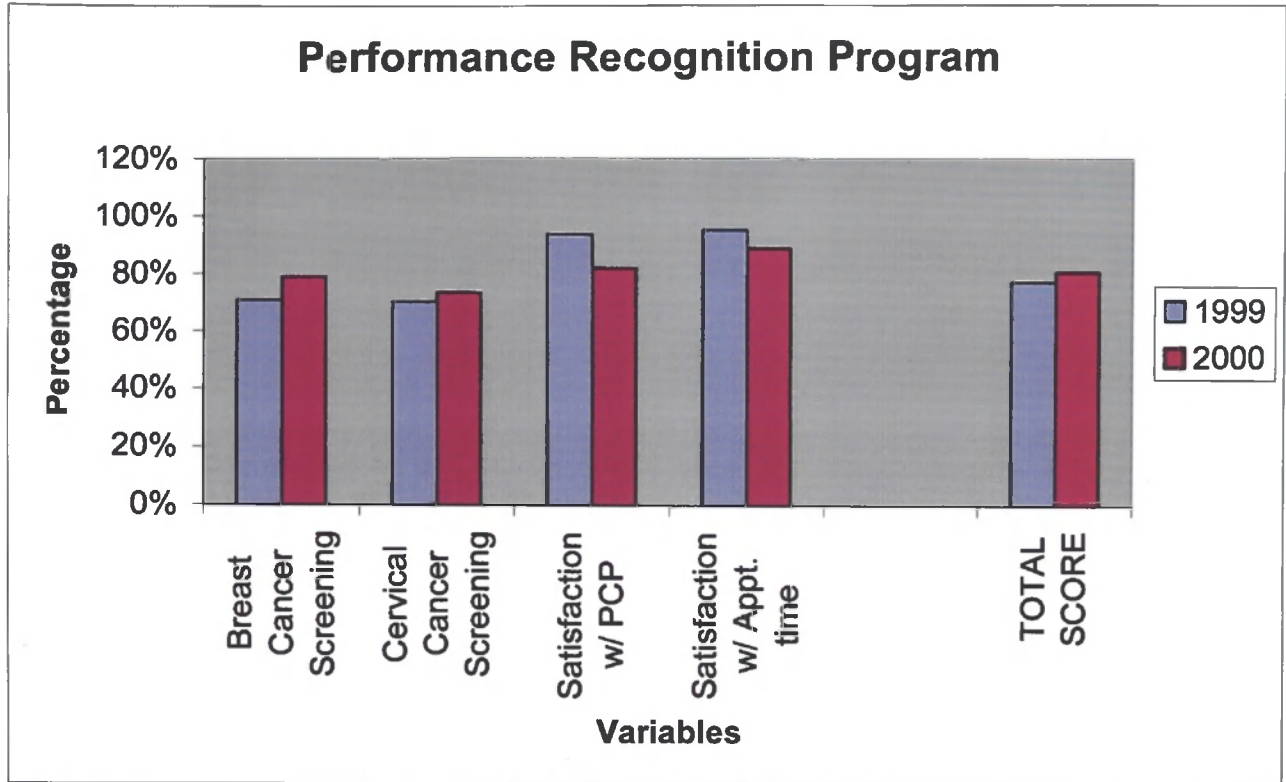


Figure 7: 1999 and 2000 Performance Recognition Program Results

Source: The author's summary of Plan B's Program Results

Figure 7 shows that compliance for Breast Cancer Screening rose from 70% in 1999 to 79% in 2000. Cervical Cancer Screening demonstrated an increase from 70% in 1999 to 74% in 2000. However, Satisfaction with PCP decreased from 94% in 1999 to 82% in 2000. Satisfaction with Ability to Make an Appointment also decreased from 95% in 1999 to 89% in 2000.

A difference of means test was conducted on the overall total score and the two quality of care measures to compare the mean values of both groups (1999 and 2000) to determine if the difference is sufficiently large to conclude that a difference exists between

the two groups. The difference between the means was measured in terms of standard deviation. The following formula uses the t distribution:

$$t = \frac{(\bar{x}_1 - \bar{x}_2)}{((\sigma_1^2 / N_1 - 1) + (\sigma_2^2 / N_2 - 1))^{.5}}$$

The difference of means test on the overall total score shows that the improvement from 78% in 1999 to 84% in 2000 is statistically significant at the 1% level. The t-statistic from the difference of means test is 4.38 and the critical value at the 1% level is 2.576, so the improvement is statistically significant at the highest level (1%). The t-statistic from a difference of means test on Breast Cancer Screening is 3.03 demonstrating that the improvement from 70% in 1999 to 79% in 2000 is statistically significant at the 1% level. The t-statistic from a difference of means test on Cervical Cancer Screening is 2.06, so the improvement from 70% in 1999 to 74% in 2000 is statistically significant at the 5% level. These results show a positive relationship between physician incentive programs and the increase in quality improvement measures in Genesee County.

Additionally, the payment distribution to the primary care physician group in 1999 was \$119,157. In 2000, that performance improvement represented a payment distribution of \$267,713, an approximate 45% increase in capitation reimbursement. It is also significant to note that Plan B's capitated reimbursement level rose from \$1.05 pmpm in 1999 to \$1.60 pmpm as a direct result of the success of the Performance Recognition Program and the physician group distribution payment.

CONCLUSIONS

There is little doubt that managed care organizations can have an impact on the quality of care and service delivered in the community. As we have seen from the literature and the three studies examined, it is possible for managed care organizations to balance their need to contain costs and produce quality care medicine. A strategic physician incentive program should include:

- appropriate financial motivation of physician productivity
- managed care efficiency
- A group citizenship component
- A patient satisfaction component and
- A group profitability component.

The intent of a physician incentive program is to remove the temptation for physicians to “over doctor” while ensuring that they are nevertheless motivated to provide quality care within a framework of finite resources.

The three studies examined demonstrate increased compensation for the primary care physician. The compensation arrangement may vary by Plan as to whether it is a percent of the premium or capitation or in the case of Plan B have a positive influence on the amount of reimbursement. Regardless of the compensation arrangement, there is only one healthcare dollar for distribution and in each program the primary care physician has increased their piece of the healthcare dollar.

Of even greater significance is the overall impact the improvement generated from the quality of care measures implemented in these programs. The cost/ benefit analysis associated with the impact of these increases in quality care are essential for health care

administrators in developing future risk arrangement models between physician groups and plans. Additionally, these measure improvements have a profound impact on the health of our community now and in the future as we look to Healthy People 2010 to project our national targeted goals. Healthy People 2010 is a set of national health promotion and disease prevention objectives developed in the United States with two overarching goals for the nation: (1) increase years of healthy life and (2) eliminate health disparities. It is partially based on health statistics and projections developed by the Bureau of the Census and the National Center for Health Statistics.¹⁴

According to NCQA's The State of Managed Care Quality, Quality Compass, 2000, the national average Breast Cancer Screening rate increased from 73.4% in 1999 to 74.5% in 2000. This 1.1% increase means that an additional 35,000 of the 3.5 million women who were eligible for the measure were screened in 2000. This increase in performance translates to approximately 130 lives saved. The United States' goal for the year 2010 is that 70% of women aged 40 years and older will have received a mammogram within the preceding 2 years.

The national average for Cervical Cancer Screening rate dramatically increased from 72% in 1999 to 78% in 2000. This increase of more than 6% is so significant because cervical cancer is nearly 100% preventable if detected early. Estimates of the incremental cost-effectiveness of conventional Pap screening every three years compared with no Pap screening is \$4,097 per life-year saved.¹⁵ Healthy People 2010 target 90% women aged 18 years and older who received a Pap test within the preceding 3 years.

NCQA reports national improvements in Childhood Immunization rates for every vaccine measured between 1999 and 2000. The overall rates in participating managed care plans averaged between 70% and 88% for each of the six HEDIS status vaccinations. In the

United States, vaccine-preventable diseases are rare but, do occur and can be costly to treat as well as have severe quality of life consequences. Healthy People 2010 target 95% children under age 6 years who participate in fully operational population-based immunization registries.

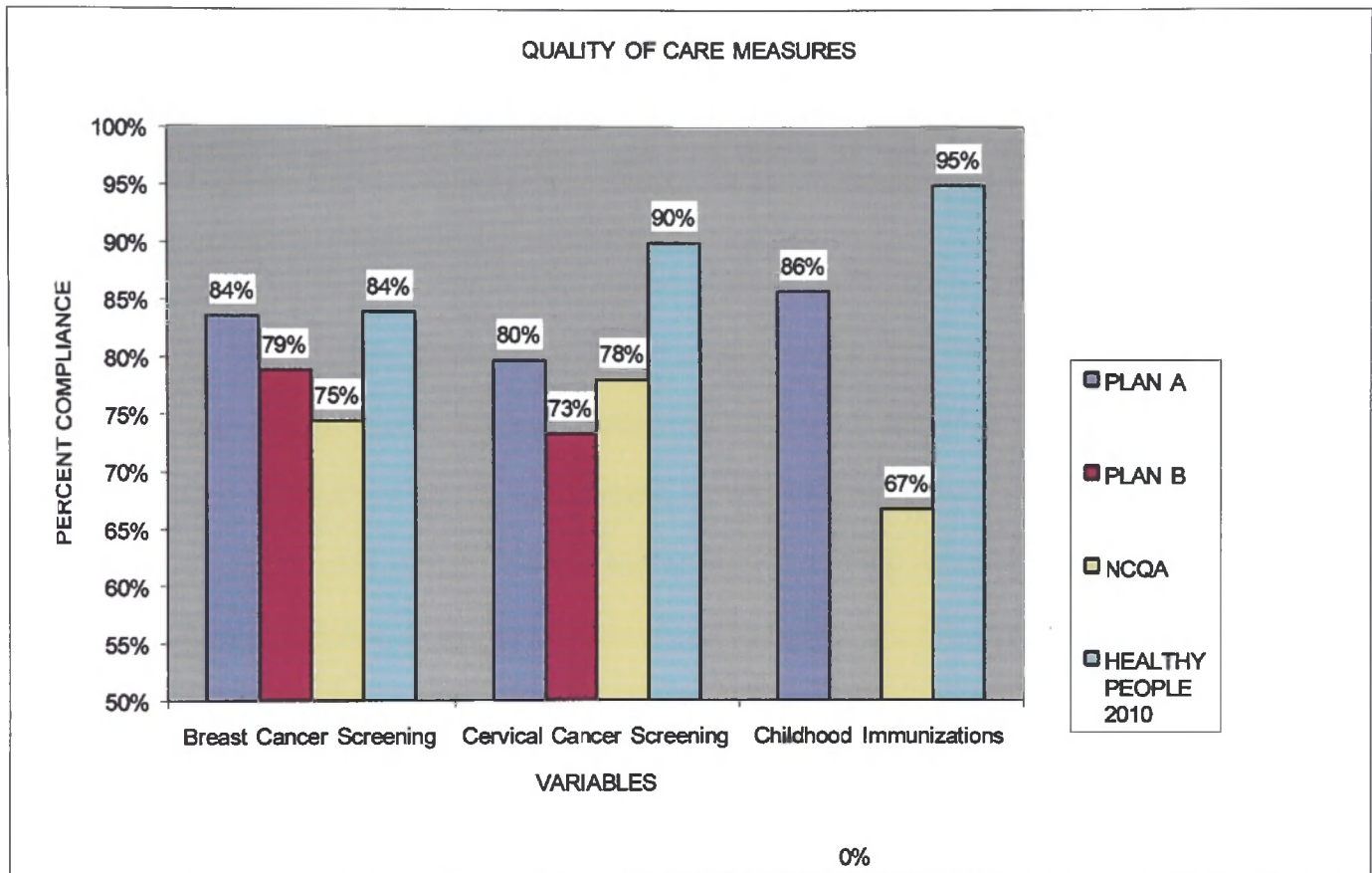


Figure 8: *Quality of Care Measures for the Group and Plans A & B in Comparison to NCQA and Healthy People 2010.*

Source: *This author's summary of the studies included in this paper.*

The models and Quality Incentive Programs examined in this paper show positive results for the quality of care delivered in this community and progressive movement toward the goals of our country in improving the overall health. Quality Incentive Programs do work in both incentivizing the primary care physician and improving the quality of care delivered. It is not determined from the research exactly what the motivation behind the improvement process is but, only that there are financial incentives and improvement in quality care measures.

My research also shows that plans need to continually improve their collection of data and effectiveness of their measurement processes in order to continue to incentivize physicians to fully participate in Quality Incentive Programs. Consistent analysis and monitoring of Quality of Care measures can be further improved through the utilization of an electronic medical record. Additionally, further research is needed on risk adjustment based on severity of illness and could be implemented as a strong component in future risk arrangement models that would also enhance the overall quality of care in the community.

Finally, my research shows that primary care physicians can benefit financially by practicing quality medicine while maintaining costs. I believe that my research will help to eliminate some of the myths about balancing quality care medicine and financial incentives for physicians. However, society needs to continually improve the perception of managed care organizations and their delivery of quality care in our communities.

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**GENESYS PHO-1997
PEDIATRIC HEALTH MAINTENANCE GRID
AGES BIRTH-5 YEARS**

PATIENT NAME: _____

PATIENT DOB: _____

Highlighted areas = Services not required at that time.

AGE	Birth	2 mths	4 mths	6 mths	9 mths	12mths	15 mths	18 mths	24 mths	3 yrs	4 yrs	5 yrs	
Safety/ Violence <i>Car Seats, etc.</i>													
PE & Develop. Assessment, (Ht., Wt., Head circ. Birth-2years) Ht., Wt., birth-5yrs.)													
Blood Pressure													
DPT						Once in this age group							
HIB* (see footnote)						Once in age group							
POLIO* (Injectable/Oral)				Once in this age group—OPV								OPV	
MMR						Once in this age group							
HEPATITIS B				Once in this age group									
VARICELLA						Once in this age group							
TB TEST													
CBC/HH				Baseline					Once in this age group				
Cholesterol (If family Hx.)													
Lead				Once in this age group									
Sickle Cell													
Thyroid, PKU													
Urinalysis				Once in this age group					Once in this age group				
Hearing Screen													
Vision Screen													

*Children who receive Pedvax HIB at 2 and 4 months do not require a dose at 6 months. 18 month dose is still needed.

*Injectable polio is recommended, by the CDC, to be given at 2 and 4 months, and oral is recommended at 6-18 months and 4 years of age.

Resources:

AAFP—American Academy of Family Physicians
AMA—American Medical Association
USPSTF—U.S. Preventive Services Task Force
(See reverse side for explanation of Safety/Violence)

CHPS—Clinician's Handbook of Preventive Services
AOA—American Optometric Association
AAP—American Academy of Pediatrics

GENESYS PHU-1997
ADOLESCENT HEALTH MAINTENANCE GRID
AGES: 6 To 17 Years

PATIENT NAME _____

PATIENT DOB _____

Highlighted areas= Services not required at that time

	6 Yrs.	7 Yrs.	8 Yrs.	9 Yrs.	10 Yrs.	11 Yrs.	12 Yrs.	13 Yrs.	14 Yrs.	15 Yrs.	16 Yrs.	17 Yrs.
Safety/Violence <i>Seatbelts, Helmets, Firearms</i>												
Behavioral Assessment <i>Depression</i>												
Risk Evaluation <i>Alcohol/Tobacco Drugs/Sexual Risk</i>												
PE (B/P, Ht., Wt., every 2yrs.) (Including testicular exams.)												
Developmental- Clinical breast exam Education on exams							(Sexually active or 18 & older—every 1-3 yrs.) (Physicians discretion)					
MMR	Once 4-6yrs					If not done @ 4-6 Yrs.						
Td						(At 11-16 Yrs. If 5 yrs. have elapsed since last dose)						
Varicella (If lack of reliable Hx.)						Once in this age group if lack of Hx.						
Hepatitis B (If not previously immunized)						Series in this age group						
CBC/HH	Once in this age group								Once in this age group			
Cholesterol	If family Hx., once in this age group											
Hearing Screen												
Vision Screen												
Urinalysis						Done with every 2 year PE and/or with sports physical						
Pap/Pelvic							(Sexually active or 18 yrs. & older—every 1-3 yrs.)					

Resources:

AAFP-----American Academy of Family Physicians
 AMA-----American Medical Association
 USPSTF----U.S. Preventive Services Task Force
 (See reverse side for explanation of Safety/Violence/Behavioral Assessment/Risk Evaluation)

CHPS---Clinician's Handbook of Preventive Services
 AOA----American Optometric Association
 AAP-----American Academy of Pediatrics

YOUNG ADULT HEALTH MAINTENANCE GRID
AGES 18-39 Years

PATIENT NAME: _____

PATIENT DOB: _____

AGES	18-19	20-21	22-23	24-25	26-27	28-29	30-31	32	33	34	35	36	37	38	39
EXAM															
Risk Evaluation <i>Tobacco, Alcohol Drugs, Sexual Risk</i>															
Safety / Violence <i>Auto Safety Helmets</i>															
Behavior Assessment <i>Depression</i>															
PE (Every 3 yrs)															
Blood Pressure (Every 2 yrs.)															
Skin Evaluation (Yearly)															
Cholesterol (Every 5 yrs)															
Breast Exam (Every 1-3 yrs.)															
Calcium/HRT Tx.															
Pap/Pelvic (Every 3 yrs.) (If sexually active or on BCP, yearly)															
Testicular Exam (Yearly)															
Td (Every 10 yrs.)															

Resources:

- AAFP= American Academy of Family Physicians
- SCF = Skin Cancer Foundation
- USPSTF=U.S. Preventive Services Task Force
- AUA= American Urological Association

- AAD= American Academy of Dermatology
- ACOG= American College of Obstetricians & Gynecologists
- ACP= American College of Physicians
- ACS = American Cancer Society

(See reverse side for explanation of Safety/Violence/Behavioral Assessment/Risk Evaluation and HPM recommendations)

~~WELLESLS FDU-1997~~
ADULT HEALTH MAINTENANCE GRID
AGES 40-64

PATIENT NAME _____
PATIENT DOB _____

Highlighted areas= Services not required at that time

AGES	40-41	42-43	44-45	46-47	48-49	50-51	52-53	54-55	56-57	58-59	60-61	62-63	64
EXAM													
Risk Evaluation <i>Tobacco, Alcohol</i>													
Safety/Violence <i>Auto safety</i>													
Behavioral Assessment <i>Depression, Sedentary</i>													
PE (Every 1-2 yrs.)													
Blood Pressure (1-2yrs)													
Breast Exam (Yearly)													
Cholesterol <i>(Every 5 yrs.)</i>													
Digital Rectal (Yearly)													
Glaucoma <i>(Every 2-4 Years)</i>													
Hemoccult (Yearly)													
Mammogram <i>(1-2yrs. 40-49)(Yearly >50)</i>													
Calcium/HRT Tx													
Pap/Pelvic (Yearly)													
Prostate Exam (Yearly)													
PSA (Yearly)													
Sigmoidoscopy <i>(Every 3-5 yrs.)</i>													
Skin Evaluation (Yearly)													
Testicular Exam <i>(Yearly)</i>													
Td (Every 10 yrs.)													

RESOURCES:

AAFP—American Academy of Family Physicians
 AMA—American Medical Association
 USPSTF—U.S. Preventive Services Task Force
 ACS—American Cancer Society

CHPS—Clinician's Handbook of Preventive Services
 ACOG—American College of Obstetricians & Gynecologists
 AUA—American Urological Association
 AAO—American Academy of Ophthalmology

(See reverse side for explanation of Risk Evaluation/Safety/Violence/Behavioral Assessment, and HPM recommendations)

**GENESYS PHO-1997
ADULT HEALTH MAINTENANCE GRID
AGES 65+**

PATIENT NAME _____

PATIENT DOB _____

AGE	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80
Risk Evaluation <i>Tobacco, Alcohol, Dental Nutrition, Physical activity</i>																
Safety/Violence <i>Falls, Auto safety</i>																
Behavioral Assessment <i>Sedentary</i>																
PE (Yearly)																
Blood Pressure (Yearly)																
Glaucoma (Yearly)																
Vision exam																
Hearing exam																
Skin Evaluation (Yearly)																
Mammogram (Yearly)																
Calcium/HRT Tx.																
Pap/Pelvic (Yearly)																
Cholesterol (Every 5 yrs.)																
Hemocult (Yearly)																
Prostate Exam (Yearly)																
Digital Rectal (Yearly)																
Sigmoidoscopy (3-5 yrs)																
Testicular Exam (Yearly)																
Td (Every 10 Yrs.)																
Influenza Vaccine (Yearly)																
Pneumococcus Vaccine	Recommended at least once over 65 years of age.															

RESOURCES:

AAFP—American Academy of Family Physicians
 AMA—American Medical Association
 USPSTF—U.S. Preventive Services Task Force
 ACS—American Cancer Society

CHPS—Clinician's Handbook of Preventive Services
 ACOG—American College of Obstetricians & Gynecologists
 AUA—American Urological Association
 AAO—American Academy of Ophthalmology

(See reverse side for explanation of Risk Evaluation/Safety/Violence/Behavioral Assessment)

**1999 Performance Recognition Program
PCG Summary Report**

APPENDIX VI

PCP ID	Last Name	First Initial	Degree	Specialty	PRP Plan Wide Mean	Average Panel Size	Accepting New Members	Childhood Immunizations	Breast Cancer Screening	Cervical Cancer Screening	Formulary Compliance	Office Waiting Time	Ability to make an appointment	Satisfaction with PCP	Advice to Quit Smoling	PCP Final Score
P87208		A	MD	FP		140	NA	NA	53%	61%		77%	100%	93%		72%
P83009		L	DO	FP		110	NA	NA	38%	61%		54%	92%	92%		59%
P64683		J	DO	FP		194	NA	NA	67%	79%		67%	79%	88%		69%
P92963		M	MD	MP		140	NA	NA	NA	NA		88%	100%	100%		72%
P84852		O	MD	FP		190	NA	NA	58%	65%		97%	97%	97%		78%
P85339		D	DO	FP		143	NA	NA	88%	85%		95%	100%	97%		78%
P73140		D	DO	FP		182	NA	NA	62%	62%		56%	86%	100%		64%
P84255		R	DO	FP		118	NA	NA	50%	65%		52%	89%	78%		60%
P91191		R	DO	FP		19	NA	NA	50%	67%		NA	NA	NA		59%
P50966		I	MD	IM		27	NA	NA	50%	78%		NA	NA	NA		51%
P65355		E	DO	FP		93	NA	NA	100%	82%		69%	100%	85%		84%
P62613		J	DO	FP		187	NA	NA	100%	83%		92%	97%	100%		84%
P60313		L	DO	FP		57	NA	NA	100%	71%		92%	100%	100%		93%
P74144		M	DO	FP		78	NA	NA	NA	67%		93%	93%	93%		87%
P87675		R	MD	FP		22	NA	NA	NA	100%		NA	NA	NA		100%
P59712		K	MD	IM		94	NA	NA	60%	44%		82%	96%	93%		68%
P101718		P	MD	FP		128	NA	NA	25%	55%		88%	94%	94%		59%
P82589		M	MD	FP		264	NA	NA	71%	78%		92%	95%	97%		79%
P59694		J	DO	FP		96	NA	NA	100%	74%		78%	89%	94%		73%
P48401		S	MD	FP		37	NA	NA	100%	77%		NA	NA	NA		59%
P64682		R	DO	FP		215	NA	NA	75%	86%		86%	95%	100%		74%
P8672		L	MD	FP		86	NA	NA	NA	100%		90%	100%	100%		98%

IEMFF-14 Genesys PHO		PCP ID	Last Name	First Initial	Degree	Specialty	Average Panel Size	Accepting New Members	Childhood Immunizations	Breast Cancer Screeing	Cervical Cancer Screeing	Formulary Compliance	Office Waiting Time	Ability to make an appointment	Satisfaction with PCP	Advice to Quit Smoling	PCP Final Score
P64681	A	MD	FP	50	NA	33%	72%	100%	98%	98%	67%						
P83935	E	MD	PE	79	100%	NA	NA	100%	NA	NA	100%						
P87758	G	MD	FP	109	NA	100%	80%	100%	100%	100%	80%						
P65341	C	DO	FP	149	NA	57%	67%	82%	93%	82%	63%						
P59516	V	MD	FP	206	NA	75%	82%	95%	95%	93%	85%						
P60319	C	MD	FP	78	NA	75%	55%	85%	85%	92%	78%						
P86088	A	DO	FP	94	NA	67%	71%	62%	94%	81%	63%						
P51333	D	MD	FP	55	NA	100%	86%	94%	100%	94%	85%						
P94450	W	MD	FP	161	NA	85%	62%	100%	98%	100%	77%						
P67513	B	DO	FP	122	NA	75%	70%	67%	93%	93%	66%						
P72356	M	DO	FP	101	NA	50%	61%	77%	87%	87%	60%						
P51096	G	MD	FP	158	NA	75%	60%	100%	97%	100%	77%						
P60328/	J	DO	FP	162	NA	75%	73%	100%	100%	97%	89%						
P73979	G	DO	FP	12	NA	NA	100%	NA	NA	NA	100%						
P52936	J	DO	FP	58	NA	67%	73%	NA	NA	NA	47%						
P101714	S	MD	FP	202	NA	73%	89%	91%	100%	96%	75%						
P60299	S	MD	FP	116	NA	57%	42%	86%	95%	91%	87%						
P65345	S	MD	IM	54	NA	67%	65%	95%	100%	94%	87%						
P50138	First	IMD	FP	223	NA	89%	66%	97%	97%	91%	76%						
P92346	D	MD	FP	109	NA	73%	72%	43%	97%	97%	64%						
P64679	K	MD	PE	131	100%	NA	NA	100%	100%	100%	100%						
P60130	D	DO	IM	104	NA	55%	65%	76%	92%	84%	69%						
P64671	T	MD	FP	128	NA	100%	30%	53%	94%	100%	71%						
P92345	J	MD	FP	79	NA	40%	57%	100%	100%	95%	70%						

PCP ID	Last Name	First Initial	Degree	Specialty	Average Panel Size	Accepting New Members	Childhood Immunizations	Breast Cancer Screening	Cervical Cancer Screening	Formulary Compliance	Office Waiting Time	Ability to make an appointment	Satisfaction with PCP	Advice to Quit Smoling	PCP Final Score
IEMFF-14 Genesys PHO															
P65335		L	DO	FP	104	NA	NA	83%	92%		86%	95%	95%		90%
P59764		P	MD	FP	317	100%	100%	89%	78%		95%	95%	100%		82%
P94455		P	MD	IM	28	NA	NA	NA	64%		NA	NA	NA		32%
P60824		G	MD	FP	286	NA	NA	80%	69%		96%	98%	100%		84%
P101713		P	MD	IM	111	NA	NA	80%	86%		96%	100%	92%		76%
P61079		P	DO	FP	23	NA	NA	NA	86%		NA	NA	NA		86%
P64678		R	DO	FP	95	NA	NA	50%	68%		NA	NA	NA		50%
P74013		N	MD	FP	187	NA	NA	90%	78%		97%	97%	92%		80%
P60536		R	DO	FP	72	NA	NA	67%	61%		92%	92%	100%		69%
P66780		T	MD	FP	87	NA	NA	83%	79%		100%	100%	100%		77%
P68048		E	DO	FP	87	NA	NA	NA	56%		75%	94%	80%		51%
P59991		S	MD	FP	133	NA	NA	83%	87%		78%	96%	96%		82%
P66781		J	DO	GP	170	NA	NA	67%	59%		88%	96%	88%		67%
P65334		B	MD	PE	81	100%	100%	NA	NA		100%	100%	100%		100%
P92967		K	DO	PE	274	100%	100%	NA	NA		94%	100%	100%		99%
P83602		C	MD	IM	86	NA	NA	100%	89%		71%	82%	73%		82%
P59933		H	DO	FP	139	NA	NA	80%	68%		70%	93%	95%		71%
P59706		L	MD	FP	277	NA	NA	75%	85%		90%	95%	98%		71%
P60484		D	MD	FP	124	NA	NA	92%	84%		52%	100%	100%		71%
P88673		M	MD	FP	123	NA	NA	75%	58%		100%	95%	100%		71%
P65336		G	DO	FP	43	NA	NA	25%	42%		NA	NA	NA		22%
P79031		M	DO	GP	34	NA	NA	33%	60%		NA	NA	NA		47%
P65337		G	MD	PE	139	100%	100%	NA	NA		100%	100%	88%		97%
P79030		W	DO	IM	44	NA	NA	50%	71%		NA	NA	NA		40%
P64677		V	MD	IM	71	NA	NA	43%	35%		96%	100%	100%		67%

**2000 Performance Recognition Program
PCG Summary Report**

APPENDIX VIII

PCP ID	Last Name	First Initial	Degree	Specialty	Average Panel Size	Accepting New Members	Childhood Immunizations	Breast Cancer Screening	Cervical Cancer Screening	Formulary Compliance	Generic Rate	Ability to make an appointment	Satisfaction with PCP	Advice to Quit Smoling	PCP Final Score	PCP Payment Earned
PRP Plan Wide Mean							69%	68%	68%	75%	45%	87%	82%	75%		
IEMFF14	Genesys PHO															
P87208		M	MD	IM	201	O	NM	61%	50%	73%	60%	96%	79%	83%	69%	\$ 3,724.13
P83009		L	DO	FP	101	L	NM	NM	82%	76%	50%	61%	24%	NM	50%	\$ 1,359.43
P64683		J	DO	GP	183	O	NM	NM	80%	77%	54%	72%	62%	67%	50%	\$ 2,470.01
P92963		M	MD	IM-P	144	O	NM	76%	72%	69%	44%	NM	NM	NM	50%	\$ 1,949.79
P84852		O	MD	FP	228	O	NM	45%	68%	73%	47%	41%	56%	100%	38%	\$ -
P85339		D	DO	FP	142	L	NM	NM	93%	71%	6%	92%	88%	100%	79%	\$ 3,013.19
P73140		D	DO	FP	189	O	NM	72%	66%	71%	52%	91%	68%	56%	50%	\$ 2,553.84
P84255		R	DO	GP	115	O	NM	NM	79%	73%	58%	77%	77%	33%	57%	\$ 1,771.88
P91191		J	DO	FP	189	L	NM	NM	85%	82%	55%	98%	95%	62%	79%	\$ 4,018.91
P50966		M	DO	PE	196	O	73	NM	NM	66%	75%	98%	95%	NM	75%	\$ 3,968.81
P65355		K	MD	IM	103	O	NM	NM	52%	78%	50%	87%	86%	83%	71%	\$ 1,984.90
P62613		P	MD	FP	143	O	NM	NM	57%	70%	56%	100%	67%	33%	50%	\$ 1,937.21
P60313		M	MD	FP	249	L	NM	75%	84%	77%	56%	90%	95%	100%	81%	\$ 6,731.30
P74144		J	DO	FP	122	L	NM	NM	75%	76%	41%	69%	76%	75%	50%	\$ 1,647.27
P87675		S	MD	FP	102	O	NM	NM	72%	80%	55%	NM	NM	NM	88%	\$ 2,766.17
P59712		R	DO	FP	202	L	NM	NM	87%	72%	52%	83%	86%	60%	64%	\$ 3,505.51
P101718		S	DO	FP	82	O	NM	NM	72%	74%	49%	NM	NM	NM	63%	\$ 1,388.03
P82589		E	MD	PE	92	O	NM	NM	NM	65%	58%	80%	60%	NM	40%	\$ -
P59694		G	MD	FP	88	L	NM	NM	94%	80%	57%	100%	100%	50%	79%	\$ 1,867.39
P48401		W	DO	FP	221	O	NM	66%	66%	75%	46%	94%	100%	70%	56%	\$ 3,358.32
P64682		C	DO	FP	155	O	NM	NM	59%	83%	61%	100%	50%	50%	57%	\$ 2,392.11
P8672		V	MD	FP	206	L	NM	100%	75%	76%	55%	90%	96%	67%	75%	\$ 4,169.12
P60654		A	DO	FP	92	O	NM	NM	70%	84%	72%	85%	85%	100%	79%	\$ 1,951.40
P51095		W	MD	FP	151	L	NM	66%	64%	78%	50%	88%	76%	75%	56%	\$ 2,297.06
P60823		C	MD	FP	128	O	NM	NM	69%	76%	51%	100%	100%	100%	79%	\$ 2,721.55
P79029		B	DO	FP	123	L	NM	NM	83%	71%	50%	76%	76%	83%	71%	\$ 2,365.62
P84478		M	DO	FP	107	O	NM	NM	66%	70%	51%	78%	47%	67%	43%	\$ -
P92007		G	MD	FP	208	O	NM	80%	77%	72%	56%	97%	89%	86%	81%	\$ 5,602.93

PCP ID	Last Name	First Initial	Degree	Specialty	Average Panel Size	Accepting New Members	Childhood Immunizations	Breast Cancer Screening	Cervical Cancer Screening	Formulary Compliance	Generic Rate	Ability to make an appointment	Satisfaction with PCP	Advice to Quit Smoling	PCP Final Score	PCP Payment Earned
ITEM#F14 Genesisys PHO																
PRP Plan Wide Mean																
							69%	68%	68%	75%	45%	87%	82%	75%		
P64681		J	DO	FP	154	L	NM	NM	65%	78%	60%	94%	100%	67%	64%	\$ 2,667.36
P83935		J	DO	FP	115	O	NM	NM	84%	77%	57%	86%	71%	67%	71%	\$ 2,213.41
P87758		S	MD	FP	211	L	NM	85%	90%	73%	55%	97%	96%	100%	88%	\$ 5,693.40
P65341		S	MD	FP	146	O	NM	NM	60%	76%	56%	89%	78%	100%	79%	\$ 3,094.21
P59516		F	MD	FP	172	L	NM	77%	68%	79%	51%	98%	92%	86%	69%	\$ 3,188.64
P60319		D	MD	FP	108	O	NM	NM	78%	80%	50%	62%	75%	100%	71%	\$ 2,084.72
P86088		K	MD	PE	147	O	NM	NM	NM	61%	56%	100%	97%	NM	80%	\$ 3,965.47
P51333		D	DO	IM	142	O	NM	69%	76%	76%	54%	75%	82%	100%	63%	\$ 2,398.87
P94450		J	MD	FP	86	O	NM	NM	56%	67%	52%	75%	50%	NM	33%	\$ -
P67513		L	DO	FP	111	O	NM	NM	86%	78%	58%	79%	100%	67%	71%	\$ 2,132.66
P72356		P	MD	FP	409	O	NM	100%	83%	76%	47%	97%	86%	100%	88%	\$ 11,044.01
P51096		G	MD	FP	270	L	NM	76%	77%	80%	47%	95%	97%	78%	75%	\$ 5,471.87
P60328/		P	MD	IM	125	O	NM	NM	87%	72%	54%	100%	68%	50%	64%	\$ 2,164.54
P73979		R	DO	FP	112	O	NM	NM	69%	76%	64%	100%	100%	100%	79%	\$ 2,378.70
P52936		N	MD	FP	173	L	NM	88%	81%	72%	60%	97%	84%	50%	69%	\$ 3,210.76
P101714		T	DO	FP	83	O	NM	NM	85%	79%	58%	NM	NM	NM	88%	\$ 2,242.91
P60299		R	DO	FP	102	L	NM	NM	94%	68%	40%	NM	NM	NM	50%	\$ 1,375.19
P65345		T	MD	FP	98	O	NM	NM	NM	75%	50%	100%	100%	100%	92%	\$ 2,636.91
P50138		E	DO	FP	83	O	NM	NM	NM	77%	37%	NM	NM	NM	50%	\$ 1,115.70
P92346		D	MD	FP	139	L	NM	NM	89%	76%	46%	80%	79%	NM	58%	\$ 2,185.88
P64679		J	DO	FP	176	L	NM	NM	55%	72%	57%	90%	70%	100%	57%	\$ 2,715.60
P60130		B	MD	PE	93	O	NM	NM	NM	72%	52%	100%	93%	NM	90%	\$ 2,519.21
P64671		K	DO	PE	316	L	75	NM	NM	69%	56%	95%	100%	NM	75%	\$ 6,392.60
P92345		C	DO	IM	94	O	NM	NM	95%	72%	46%	94%	53%	80%	71%	\$ 1,811.38
P101717		M	MD	FP	125	O	NM	NM	62%	75%	56%	NM	NM	NM	63%	\$ 2,111.53
P82967		H	DO	FP	138	O	NM	100%	65%	74%	51%	96%	85%	86%	81%	\$ 3,732.37
P60526		L	MD	FP	271	L	NM	84%	89%	78%	61%	95%	100%	100%	88%	\$ 7,312.86
P65351		D	MD	FP	110	L	NM	84%	84%	77%	54%	88%	94%	67%	81%	\$ 2,979.59
P93973		M	MD	FP	213	O	NM	92%	81%	74%	52%	81%	88%	75%	69%	\$ 3,952.96
P65346		T	DO	FP	323	O	NM	76%	78%	74%	52%	97%	94%	60%	69%	\$ 5,995.58

PCP ID	Last Name	First Initial	Degree	Specialty	Average Panel Size	Accepting New Members	PRP Plan Wide Mean										PCP Final Score	PCP Payment Earned
							Childhood Immunizations	Breast Cancer Screening	Cervical Cancer Screening	Formulary Compliance	Generic Rate	Ability to make an appointment	Satisfaction with PCP	Advice to Quit Smoling				
P65335		G	MD	PE	138	O	91%	68%	68%	75%	45%	87%	82%	75%	75%	\$ 2,789.59		
P59764		C	MD	PE	127	O	NM	NM	NM	55%	40%	100%	95%	NM	60%	\$ 2,059.91		
P94455		S	MD	FP	125	O	NM	92%	72%	75%	55%	100%	93%	67%	81%	\$ 3,366.54		
P60824		K	MD	IM	93	O	NM	NM	73%	75%	64%	79%	50%	50%	43%	\$ -		
P101713		D	MD	FP	129	O	NM	NM	69%	77%	46%	NM	NM	NM	50%	\$ 1,741.53		
P61079		B	MD	FP	122	O	NM	72%	51%	80%	56%	100%	93%	NM	79%	\$ 2,596.22		
P64678		L	DO	FP	96	L	NM	NM	NM	74%	43%	100%	100%	NM	70%	\$ 1,815.72		
P74013		D	DO	FP	99	O	NM	NM	68%	62%	38%	100%	86%	100%	57%	\$ 1,520.14		
P60536		J	MD	IM	77	O	NM	NM	56%	74%	64%	NM	NM	NM	63%	\$ 1,298.31		
P66780		W	MD	FP	130	L	NM	NM	79%	77%	43%	69%	88%	100%	57%	\$ 2,011.55		
P68048		A	DO	FP	372	O	NM	89%	84%	73%	49%	97%	97%	100%	85%	\$ 10,036.60		
P59991		K	DO	FP	130	L	NM	NM	85%	76%	49%	82%	65%	33%	36%	\$ -		
P66781		K	MD	FP	185	L	NM	80%	82%	84%	47%	90%	92%	100%	81%	\$ 4,999.50		
P65334		T	MD	FP	122	L	NM	90%	80%	72%	47%	95%	84%	100%	75%	\$ 2,474.38		
P92967		R	MD	IM	226	O	NM	81%	78%	74%	56%	96%	90%	88%	81%	\$ 6,103.85		
P83602		A	MD	FP	244	L	NM	80%	77%	75%	52%	86%	92%	80%	69%	\$ 4,532.02		
P59933		M	MD	FP	229	L	NM	83%	76%	73%	43%	82%	85%	75%	56%	\$ 3,471.72		
P59706		G	MD	FP	180	O	NM	66%	68%	75%	56%	100%	90%	78%	69%	\$ 3,349.15		
P60484		S	MD	FP	81	O	NM	NM	50%	61%	50%	100%	85%	67%	64%	\$ 1,398.23		
P88673		E	MD	FP	143	O	NM	75%	69%	77%	46%	91%	45%	100%	56%	\$ 2,166.78		
P65336		D	MD	FP	162	L	NM	86%	65%	70%	47%	100%	86%	NM	64%	\$ 2,816.66		
P79031		J	MD	IM	148	L	NM	NM	75%	77%	61%	94%	87%	100%	79%	\$ 3,138.87		
P65337		A	MD	FP	184	L	NM	60%	66%	78%	50%	82%	88%	100%	50%	\$ 2,478.96		
P79030		L	DO	FP	93	O	NM	NM	67%	73%	50%	100%	75%	50%	57%	\$ 1,433.60		
P64677		M	DO	FP	203	O	NM	NM	56%	70%	55%	71%	56%	60%	36%	\$ -		
P101310		N	MD	FP	40										68%	\$ 739.06		
P55626		D	DO	PE	66										68%	\$ 1,201.38		
P100281		D	MD	FP	64										68%	\$ 1,166.92		
P92505		R	DO	FP	22										68%	\$ 409.68		
P59707		I	MD	IM	29										68%	\$ 533.07		