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THE AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The Council on Ethical and Judicial Affairs ("Council") develops ethics policy for the American Medical Association ("AMA"). The Council consists of seven practicing physicians, a resident, and a medical student who are nominated by the American Medical Association's President and elected by the House of Delegates. With the assistance of a full time staff trained in medical ethics, the Council maintains and updates the 160-year-old AMA Code of Medical Ethics, which is widely recognized as the most comprehensive ethics guide for physicians.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS: PHYSICIAN PAY-FOR-PERFORMANCE PROGRAMS*

I. INTRODUCTION

Physician pay-for-performance ("PFP") compensation arrangements attempt to provide an economic incentive to improve health care quality by linking remuneration to measures of individual, group, or organizational performance. These programs typically offer bonus payments to physicians who either meet, or demonstrate improvement in meeting, pre-established standards of performance measure. The American Medical Association ("AMA") has issued a set of principles and guidelines that advocate for acceptable parameters.[1] The AMA states that PFP programs should strive to: ensure the quality of care; foster the patient/physician relationship; offer voluntary physician participation; use accurate and fair data reporting; and provide fair and equitable program incentives.[2] Many of these principles are closely related to core concepts of medical ethics and professionalism, including patient autonomy, conflicts of interest and trust, as well as fairness and justice. Accordingly, this report examines the tensions that may arise from physicians' participation in PFP programs and offers guidance to physicians striving to practice ethically in the face of performance-based incentive arrangements.

II. BACKGROUND

The past decade has been marked by an emerging quality movement in medicine, prompted by the Institute of Medicine's health care quality initiative, "Crossing the Quality Chasm," which proposed a new quality construct based upon safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.[3] To achieve these objectives, key health care leaders have emphasized the role of evidence-based guidelines.[4]

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* CEJA Report 3 – I-05 presented by Priscilla Ray, M.D., Chair, referred to Reference Committee on Amendments to Constitution and Bylaws (Charles J. Hickey, M.D., Chair).

1. Am. Med. Ass'n, *Board of Trustees Report 5-A-05: Pay-for-Performance Principles and Guidelines*, http://www.ama-assn.org/meetings/public/annual05/bot5a05.doc (last visited May 17, 2006).

2. Am. Med. Ass'n, *Principles for Pay-for-Performance Programs*, http://www.ama-assn.org/ama1/pub/upload/mm/368/principles4pay62705.pdf (last visited May 17, 2006) [hereinafter AMA Principles].

3. *See* INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001).

4. AMA Principles, *supra* note 2.

In turn, this has led to the establishment of market-based quality improvement mechanisms that link compensation to measurements of patient safety and clinical outcomes.[5] Among these, pay-for-performance programs provide participants with monetary bonuses to reward the achievement of predetermined quality or efficiency benchmarks.[6]

To measure performance, PFP programs must collect data on health care process and outcomes, including patient safety indicators and patient satisfaction.[7] These data are then incorporated into payment mechanisms for hospitals or physicians.[8] Physicians or physician groups, upon meeting a given program's performance criteria, are rewarded with modest financial bonuses that may constitute up to five percent of the total revenue received from a given health plan.[9]

III. ETHICAL RESPONSIBLITIES OF PHYSICIANS

Physicians are ethically obligated to provide competent, patient-centered care to each of their patients, as codified within *Principles I* and *VIII* of the *Code of Medical Ethics* ("The Code").[10] Physicians must also assume central roles in promoting patient safety by participating in the identification, reduction, and prevention of medical errors (see Opinion E- 8.121, "Ethical Responsibility to Study and Prevent Error and Harm,"[11] AMA Policy Database). Stemming from these obligations, physicians and the medical profession assume a duty to improve the safety and effectiveness of the health care that patients receive.[12]

A. Designing Appropriate Physician Incentive Programs

Compensation policies that are designed to promote optimal patient care, such as the incentives offered through PFP programs, represent one of

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5. L. Garcia, S. Safriet & D. Russell, *Pay-for-Performance Compensation: Moving Beyond Capitation*, 52 HEALTHCARE FIN. MGMT. 52, 52-57 (1998).

6. AMA Principles, *supra* note 2; Mary Piette et al., *Integrating Ethics and Quality Improvement: Practical Implementation in the Transitional/Extended Care Setting*, 17 J. NURSING CARE QUALITY 35, 35-42 (2002).

7. Bradley C. Strunk & Robert E. Hurley, *Paying for Quality: Health Plans Try Carrots Instead of Sticks, HSC Brief No. 82*, CTR. STUDYING HEALTH SYS. CHANGE (May 2004), http://www.hschange.com/CONTENT/675/ (last visited May 17, 2006).

8. AMA Principles, *supra* note 2; *see also* Piette et al., *supra* note 6.

9. Strunk & Hurley, *supra* note 7.

10. Am. Med. Ass'n, *Principles of Medical Ethics*, http://www.ama-assn.org/ama/pub/category/2512.html (last visited May 17, 2006) [hereinafter AMA Principles of Medical Ethics].

11. Am. Med. Ass'n, *Ethical Responsibility to Study and Prevent Error and Harm*, http://www.ama-assn.org/ama/pub/category/11968.html (last visited May 17, 2006).

12. Eran Bellin & Nancy Neveloff Dubler, *The Quality Improvement Research Divide and the Need for External Oversight*, 91 AM. J. PUB. HEALTH 1512, 1512-17 (2001).

many measures intended to help physicians improve health care quality.[13] However, the establishment of financial incentives may also create unintended tensions for participating physicians, as well as for physicians in leadership positions.

Most notably, the presence of economic incentives risks establishing a conflict between physicians' financial interests and the fulfillment of their professional obligations. Physicians' commitment to patient-centered care must supersede incentives offered by various compensation arrangements (see Opinion E-8.03, "Conflicts of Interest: Guidelines," [14] and Opinion E-8.054, "Financial Incentives and the Practice of Medicine" [15]). Yet, all reimbursement systems, including fee-for-service ("FFS"), capitation, and salary arrangements, establish various incentives that may adversely influence the quality of patient care.

In fee-for-service, physicians are paid for each procedure or service that they provide to the patient. Physicians have great latitude in providing necessary services, such as diagnostic tests or preventive services.[16] Some may provide more services than are medically necessary, thereby promoting the over-utilization of medical resources.[17]

Capitation plans pay physicians a fixed amount per patient over a given period of time, regardless of the quality or quantity of services rendered. While capitation has the potential to mitigate over-utilization, it creates an economic disincentive for the provision of expensive or complicated care, thus promoting underutilization.

Salaried arrangements that pay physicians a fixed sum may similarly contain costs, but also have the potential to lower productivity and discourage treatment of difficult clinical cases.[18]

In view of the shortcomings of all compensation methods, PFP programs may prove beneficial when they recognize and reward physicians who deliver optimal care to their patients. However, practicing physicians and physicians involved in the design and implementation of PFP programs must take appropriate measures to ensure that any incentives used by these programs are consistent with the ethical values of the profession.

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13. INST. OF MED., *supra* note 3.

14. Am. Med. Ass'n, *Conflicts of Interest: Guidelines*, http://www.ama-assn.org/ama/pub/category/8469.html (last visited May 17, 2006).

15. Am. Med. Ass'n, *Financial Incentives and the Practice of Medicine*, http://www.ama-assn.org/ama/pub/category/8482.html (last visited May 17, 2006) [hereinafter AMA Financial Incentives].

16. SHERMAN FOLLAND, ALLEN C. GOODMAN, & MIRON STANO, THE ECONOMICS OF HEALTH AND HEALTH CARE (3d ed. 2001).

17. Thomas Rice, *Physician Payment Policies: Impacts and Implications*, 18 ANN. REV. PUB. HEALTH 549, 549-65 (1997).

18. Bellin, *supra* note 12; Gerald B. Hickson et al., *Physician Reimbursement by Salary or Fee-for-Service: Effect on Physician Practice Behavior in a Randomized Prospective Study*, 80 PEDIATRICS 344, 344-50 (1987).

B. Responsibilities of Physicians in Leadership Positions

Physicians with appropriate professional expertise should be integrally involved in the design, implementation, and evaluation of new PFP programs.[19] Accordingly, physicians acting in this capacity should undertake efforts to ensure that any incentives and performance benchmarks established by PFP programs are designed to primarily benefit the patient and improve the quality of their health care, rather than promoting cost-containment (see Opinions E-8.021, "Ethical Obligations of Medical Directors,"[20] and E-8.054, "Financial Incentives and the Practice of Medicine"[21]).

C. Responsibilities of Practicing Physicians

Physicians participating in PFP programs should work to ensure that the incentives provided by PFP programs preserve their ability to promote patient well-being. This may require negotiating the removal of any contractual terms that might compromise professional values, impede their ability to act as patient advocates, or obstruct the provision of medically necessary care (see Opinion E-8.0501, "Professionalism and Contractual Relations"[22]).

D. Promoting Evidence-Based Practice and Preserving Patient-Centered Care

All physicians who strive to practice ethically are committed to the provision of competent patient care through the exercise of their professional expertise. However, due to differences in training and practice styles, equally competent and dedicated physicians may provide divergent treatments for like medical conditions.[23] This has led to system-wide variations in the use of medical services, medical expenses, and patient outcomes.[24]

Such inconsistencies in physician practice become ethically problematic when they prevent patients from deriving adequate benefits from medical care. To promote fairness, individual physicians must be sensitive to variations in

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19. AMA Principles, *supra* note 2.

20. Am. Med. Ass'n, *Ethical Obligations of Medical Directors*, http://www.ama-assn.org/ama/pub/category/8468.html (last visited May 17, 2006) [hereinafter AMA Ethical Obligations].

21. AMA Financial Incentives, *supra* note 15.

22. Am. Med. Ass'n, *Professionalism and Contractual Relations*, http://www.ama-assn.org/ama/pub/category/15457.html (last visited May 17, 2006).

23. John E. Wennberg et al., *Professional Uncertainty and the Problem of Supplier-Induced Demand*, 16 SOC. SCI. MED. 811, 811-24 (1982).

24. Mark R. Chassin & Robert W. Galvin, *The Urgent Need to Improve Health Care Quality: Institute of Medicine National Roundtable on Health Care Quality*, 280 JAMA 1000, 1000-05 (1998).

patient care that are not explained on the basis of medical need (see Opinion E- 2.095, "The Provision of Adequate Health Care" [25]).

Collectively, physicians should implement quality improvement activities as a means of ensuring competent medical care and reducing unwarranted variations in patient outcomes.[26] One such approach is the promotion of evidence-based practice guidelines, which define standards for the safe and effective delivery of medical care.[27]

Pay-for-performance arrangements can strive toward this goal by establishing performance incentives incorporating evidence-based practice guidelines. When doing so, the AMA has advised that PFP programs should utilize current peer-reviewed evidence-based performance measures that have been accepted by physicians with appropriate practice expertise.[28]

The benefit of practice guidelines resides in their promise to improve aggregate outcomes at the population-level. However, the adoption of practice guidelines is not intended to eliminate all practice variations. It should be noted that the degree of benefit derived from a given intervention remains variable at the individual-level due to patient-specific factors. Moreover, over-reliance upon disease-specific practice guidelines can potentially diminish the quality of care delivered to patients with multiple comorbid conditions.[29] For this reason, physicians must retain the ability to customize care for each individual in order to meet the specific needs of patients when participating in PFP programs.

E. Responsibilities of Physicians in Leadership Positions

Physicians involved in the design and implementation of PFP programs should contribute their professional expertise to ensure that the practice guidelines that are used are fair and objective, and consistent with the ethical values of the profession (see Opinion E-8.021[30]). Moreover, physicians working in this capacity must also ensure that all practice guidelines allow for sufficient variation to enable physicians to accommodate the specific needs of individual patients (see Policy H-320.949, "Clinical Practice Guidelines and Clinical Quality Improvement Activities" [31]).

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25. Am. Med. Ass'n, *The Provision of Adequate Health Care*, http://www.ama-assn.org/ama/pub/category/8429.html (last visited May 17, 2006).

26. INST. OF MED., *supra* note 3.

27. Alan M. Garber, *Evidence-Based Guidelines as Foundations for Performance Incentives*, 24(1) HEALTH AFF. 174, 175-79 (2005).

28. AMA Principles, *supra* note 2.

29. Cynthia M. Boyd et al., *Clinical Practice Guidelines and Quality of Care for Older Patients with Multiple Comorbid Disease: Implications for Pay for Performance*, 294 JAMA 716, 716-724 (2005).

30. AMA Ethical Obligations, *supra* note 20.

31. Am. Med. Ass'n, *Clinical Practice Guidelines and Clinical Quality Improvement Activities*, http://www.ama-assn.org/apps/pf_new/pf_online (last visited May 17, 2006).

Once evidence-based practice guidelines have been established, their designers have a responsibility to make these guidelines available to participating physicians, along with an explanation of any intended purposes and uses not related to patient care (see Policy H-410.980, "Principles for the Implementation of Clinical Practice Guidelines at the Local/State/Regional Level" [32]). If possible, PFP program designers should also inform practicing physicians of the expected benefits associated with specific evidence-based recommendations.[33] By doing so, the implementation of clinical guidelines can improve health care quality by helping physicians to select among multiple evidence-based recommendations in order to best benefit the individual patient.[34]

F. Responsibilities of Practicing Physicians

Practice guidelines are ethically acceptable when they are primarily designed to promote the well-being of patients. Practicing physicians should familiarize themselves with current evidence-based findings and clinical practice guidelines that arise from them. This commitment is consistent with *Principle V* of the Code, which directs physicians to "continue to study, apply and advance scientific knowledge [and] maintain a commitment to medical education" in order to serve patients in accordance with professional standards of excellence.[35]

Physicians also should share this knowledge with their patients in order to better inform patients' medical decision making and to improve their adherence to prescribed treatment (see Opinion E-8.08, "Informed Consent"[36]). Physicians must not allow practice guidelines or performance-based compensation arrangements to create unrealistic expectations among patients (see Opinion E-6.01, "Contingent Physician Fees" [37]). Therefore, physicians should inform patients that evidence-based practice guidelines are based on clinical findings aggregated at the population level, meaning that individual treatment options and outcomes may vary in practice.

Physicians must also ensure that their focus on relevant practice guidelines does not inappropriately infringe upon patients' autonomy.

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32. Am. Med. Ass'n, *Principles for the Implementation of Clinical Practice Guidelines at the Local/State/Regional Level*, http://www.ama-assn.org/apps/pf_new/pf_online (last visited May 17, 2006).

33. Patrick J. O'Connor, *Adding Value to Evidence-Based Clinical Guidelines*, 194 JAMA 741, 741-43 (2005).

34. H. Gilbert Welch et al., *Estimating Treatment Benefits for the Elderly: The Effect of Competing Risks*, 124 ANNALS INTERNAL MED. 577, 577-84 (1996).

35. AMA Principles of Medical Ethics, *supra* note 10.

36. Am. Med. Ass'n, *Informed Consent*, http://www.ama-assn.org/ama/pub/category/8488.html (last visited May 17, 2006).

37. Am. Med. Ass'n, *Contingent Physician Fees*, http://www.ama-assn.org/ama/pub/category/8364.html (last visited May 17, 2006).

Practicing physicians must inform their patients about the full range of available treatment options, as required by Opinion E-8.053, "Restrictions on Disclosure in Health Care Plan Contracts." [38] Physicians must then provide appropriate services in accordance with their patients' medical needs and personal preferences, even if such treatments conflict with the guidelines used to determine the physicians' performance.[39] However, physicians are not ethically required to cater to all patient demands and may decline to deliver medical care that they do not believe has a reasonable chance of benefiting the patient (see Opinion E-2.035, "Futile Care" [40]).

IV. MITIGATING POTENTIAL ADVERSE IMPACTS ON PFP PROGRAMS

A potential ethical concern regarding the long-term effects of pay-for-performance programs is the impact that these efforts may have upon patients' access to health care. Should PFP programs publicize performance ratings or link physicians' compensation to patient outcomes without making appropriate case-mix adjustments, some physicians may be motivated to preferentially seek out and treat healthier patients.[41] This practice allows physicians to improve their prospects for achieving pre-determined performance measures by treating only those patients presenting the best anticipated health outcomes. As this occurs, it may become increasingly difficult for some patients to access appropriate health care.

The negative effects of patient selection could be especially problematic for patients belonging to vulnerable population groups. Patients from these groups tend to enter the health care system in more advanced disease states,[42] and may be faced with limited financial and social resources or more severe communication difficulties, which can impede their ability to adhere to treatment recommendations.[43] As a result, treatment outcomes for these patients may be sub-optimal. This may systematically disadvantage physicians who treat patients from such vulnerable populations because their aggregate performance outcomes may not meet the benchmarks established by PFP programs. As a result, poorly designed PFP incentive structures could

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38. Am. Med. Ass'n, *Restrictions on Disclosure in Health Care Plan Contracts*, http://www.ama-assn.org/ama/pub/category/8480.html (last visited May 17, 2006).

39. Louise C. Walter et al., *Pitfalls of Converting Practice Guidelines into Quality Measures: Lessons Learned from a VA Performance Measure*, 291 JAMA 2466, 2466-70 (2004).

40. Am. Med. Ass'n, *Futile Care*, http://www.ama-assn.org/ama/pub/category/8389.html (last visited May 17, 2006).

41. E. Haavi Morreim, *Result-Based Compensation in Health Care: A Good, but Limited Idea*, 29 J.L. MED. & ETHICS 174, 174-81 (2002).

42. Kendra L. Schwartz et al., *Race, Socioeconomic Status and Stage at Diagnosis for Five Common Malignancies*, 14 CANCER CAUSES & CONTROL 761, 761-66 (2003).

43. Rajesh Balkrishnan, *Predictors of Medication Adherence in the Elderly*, 20 CLINICAL THERAPEUTICS 764, 764-71 (1998).

dissuade physicians from serving vulnerable patient populations in favor of catering to comparatively healthier patients.

In the face of such pressures, all physicians must uphold the mandates of *Principle IX*[44] and work to support access to medical care for all people. Practicing physicians can promote equitable access by continuing to treat patients on the basis of need. In addition, physicians participating in the design and implementation of PFP programs should ensure that these programs are structured in a way that does not discourage the treatment of patients belonging to vulnerable population groups. This can be accomplished by avoiding the use of performance benchmarks based upon factors beyond the control of individual physicians, by the incorporation of appropriate risk-adjustment mechanisms, and through the use of risk-pooling strategies. [45] If PFP program administrators choose to make data on physicians' performance publicly available, physicians should advocate for the incorporation of risk-adjusted performance ratings, characterized by adequate review and appeal mechanisms.[46]

V. CONCLUSION

Physician pay-for-performance programs may benefit patients by improving the effectiveness and safety of medical care. These goals are consistent with physicians' obligations to provide competent patient care. However, physicians participating in these incentive programs must continue to uphold all ethical obligations to their patients and avoid conflicts of interest stemming from PFP arrangements. Participating physicians must ensure that all care is delivered on the basis of patients' individual needs and preferences. Physicians must also continue to treat each of their patients without bias and avoid further disadvantaging vulnerable patient populations. In addition, physicians should work collectively to ensure that the goals and incentives utilized by PFP programs promote patients' best interests.

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs of the American Medical Association recommends the following:

> Physician pay-for-performance compensation arrangements should be designed to improve health care quality and patient

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44. Am. Med. Ass'n, *Principles of Medical Ethics*, http://www.ama-assn.org/ama/pub/category/2512.html (last visited May 17, 2006).

45. David A. Hyman & Charles Silver, *Just What the Patient Ordered: The Case for Result-Based Compensation in Health Care*, 29 J.L. MED. & ETHICS 170, 170-73 (2002).

46. Am. Med. Ass'n, *Guidelines on Pay-for-Performance Programs*, http://www.ama-assn.org/amal/pub/upload/mm/368/guidelines4pay62705.pdf (last visited May 17, 2006).

safety by linking remuneration to measures of individual, group, or organizational performance. To uphold their ethical obligations, physicians who are involved with PFP programs must take appropriate measures to promote patients' well-being.

(1) Physicians who are involved in the design or implementation of PFP programs should advocate for:
   (a) incentives that are intended to promote health care quality and patient safety, and are not primarily intended to contain costs;
   (b) program flexibility that allows physicians to accommodate the varying needs of individual patients;
   (c) adjustment of performance measures by risk and case-mix in order to avoid discouraging the treatment of high-risk individuals and populations;
   (d) processes to make practice guidelines and explanations of their intended purposes and the clinical findings upon which they are based available to participating physicians.

(2) Practicing physicians who participate in PFP programs while providing medical services to patients should:
   (a) maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives;
   (b) support access to care for all people and avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes;
   (c) be aware of evidence-based practice guidelines and the findings upon which they are based;
   (d) always provide care that considers patients' individual needs and preferences, even if that care conflicts with applicable practice guidelines;
   (e) not participate in PFP programs that incorporate incentives that conflict with physicians' professional values or otherwise compromise physicians' abilities to advocate for the interests of individual patients.

AMERICAN MEDICAL ASSOCIATION

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAM

Physician pay-for-performance programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

(1) Ensure quality of care—Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians, across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.

(2) Foster the patient/physician relationship—Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

(3) Offer voluntary physician participation—Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers, including costs of start-up.

(4) Use accurate data and fair reporting—Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

(5) Provide fair and equitable program incentives—Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the

incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

A. Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality of care measures must be the primary measures used in any program.
  1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
  2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
  3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
  4. Performance measures should be scored against both absolute values and relative improvement in those values.
  5. Performance measures must be subject to the best-available risk-adjustment for patient demographics, severity of illness, and co-morbidities.
  6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
  7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.

- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

B. Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care. (1) Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients. (2) Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-compliance, and sponsors of PFP programs should attempt to minimize non-compliance through plan design.

C. Physician Participation

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.

- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology ("IT"). (1) Programs should provide physicians with tools to facilitate participation. (2) Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

D. Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner. (1) Programs should use accurate administrative data and data abstracted from medical records. (2) Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices. (3) Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients (denominator).
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting. (1)

Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives. (2) Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and / or certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

E. Program Rewards

- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.