MACRA Analysis by Dr. David McKalip, President of the Florida Chapter of the AAPS.

*Author's note. I prepared this document prior to the passage of MACRA by Congress. The document was a white paper created for the leadership of the Florida Medical Association (FMA). At the time there was intense interest by the AMA in getting all state and national medical associations (the "federation of medicine") to sign on to a letter supporting MACRA. I was an officer (Vice-Speaker) at the time. The President, (Alan Pillersdorf, M.D.) was planning to sign the FMA on in support and was being encouraged to do so by the Florida delegation chair, Dr. Corey Howard. I prepared this document to demonstrate that the FMA was not able to sign on to this since the law violated policies of the FMA and AMA policies endorsed by the FMA. Ultimately Dr. Pillersdorf, without a vote of the FMA executive Committee and acting as President, signed the FMA on to support MACRA. This violated his role as president and that was also pointed out to him in a separate analysis of FMA policy as it relates to Presidential power. This analysis and the analysis of the abuse of FMA Presidential power by Dr. Pillersdorf substantially contributed to the effort to have me removed from office by running two other candidates against me when I was up for FMA Vice-speaker later that year (July 2015). (this was an updated analysis of the bill that included the budget neutrality provisions of MACRA. The analysis began in March of 2015 and continued through May 2015).*

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This is an analysis of HR2, the "Medicare Access and CHIP Reauthorization Act of 2015", referred to as the "doc fix" bill. The bill does end SGR permanently and provide 0.5% payment increased for a few years. However it vastly expands the pay for performance control structure over Medicare patients and their doctors. This expansion is done in ways that violate large amounts of FMA and AMA policy. There is far more harm contained in this bill than benefit. Some may describe this bill as a "reality" we must accept. They may say that we must be "pragmatic" and that we can minimize the impact on doctors later in rule making. However, the FMA has never merely accepted bad legislation and bad health care policy as a "reality" we must "pragmatically" accept and hope to address through damage control later on.

We have proudly stood against Obamacare because of many of the pay for performance policies in it that violate FMA policy and our FMA policy on health system reform. I provide this grid for review to show just how bad this bill is (HR2). There is nothing to fear from failure of passage of this bill in the Senate. Congress would not allow the full SGR cut to go into effect for fear of Medicare patient backlash (that is why they have patched it 18 times). The House of medicine will suffer far more greatly under this policy than policy as it exists. Further, if the FMA is seen as endorsing HR2, we will lose much of our ability to oppose these onerous programs in the future.

The main concerns with this bill, those that stand opposed to FMA policy and our approach on health system reform, are as follows:

- Doctors are penalized for putting their patients first above so-called "guidelines" that have rarely proven effective and often hurt patients and the population.
- Bonuses for the programs will only come if enough penalties are paid. Dr. Peter must be robbed to pay Dr. Paul in this scenario.

- These programs (PQRS, Meaningful use, value based modifiers) are already failing to provide any meaningful bonuses to doctors and most doctors spend great deals of money to comply and get no bonus.
- Doctors who do not participate will simply get a 9% payment cut and this can be scaled to higher amounts (27%) to meet budget neutrality requirements to pay for bonuses.
- Even participating doctors will get a penalty, if they don't reach ¼ of the threshold for compliance.
- Threshold compliance levels will be "rigged" by the Secretary of HHS to meet CMS budgetary goals.
- Doctors will have their practice data reported publicly on the web, opening them up to persecution and causing them to avoid high risk patients to get a better report card.
- Doctors will face higher tax penalties than other Americans.
- Doctors will lose all appeal rights, due process and access to the courts in disputing their rating, bonus or penalty.
- Doctors will be coerced into "risk-based" programs that will cause many to put their bottom line above the interest of their patient.
- More doctors will leave private practice and become employed – constantly subject to coercion by employers to cut costs to increase employer profits.
- Surgeons will have a 5% payment delay to coerce them into submitting detailed data on activity during global period.

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| **Bonuses are funded by Penalties!**<br>**BUDGET NEUTRAL!!** | "..the Secretary shall increase or decrease such adjustment factors by a scaling factor in order to ensure that the budget neutrality requirement of clause (ii) is met."<br>''(ii) **BUDGET NEUTRALITY REQUIREMENT.—**<br>''(I) IN GENERAL.—Subject to clause (iii), the **Secretary shall ensure that the estimated amount described in subclause** | Page 60, lines 21-25<br>Page 61 lines 6-11 | Violates AMA PFP principle that rewards must be paid for with ADDITIONAL money, not financed with money from Penalties!<br>"**5. Provide fair and equitable program incentives** - Fair and ethical PFP programs provide **new funds for positive incentives** to |

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| | **(II) {{Ed note: "INCREASE"}} for a year is equal to the estimated amount described in subclause (III) {Ed note: "DECREASE"}} for such year.** | | physicians for their participation |

| **Issue** | **Law Language** | **Bill reference HR2 114th Congress** | **Comments** |
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| Would impose a FULL penalty (loss of ALL incentives) for failure to report requested data or comply with MIPS - 9% cut to fees<br><br>--PLUS—<br><br>Loss of access to $500 million "extra" bonus annually. | ""the Secretary shall provide that in the case of a MIPS eligible **professional who fails to report on an applicable measure or activity** that is required to be reported by the professional, **the professional shall be treated as achieving the lowest potential score applicable to such measure or activity**." | Page 41, lines 1-13 (9% penalty)<br><br>Page, lines 9-24 (annual $500 million "additional" bonus money). | Violates AMA PFP Principles and guidelines (w/ are the FMA standard).<br><br>Cut pay is Simply not voluntary.<br><br>Principle 3 "**voluntary physician participation** …do not undermine the economic viability of non-participating physician practices" |
| **PENALTIES for DOCTORS who Don't Reach ¼ of the threshold level**<br><br>Doctors with lower performance scores will get NEGATIVE ADJUSTMENT FACTORS – **PENALTIES** | "…below such performance threshold for such year **receive negative payment adjustment** factors for such year in accordance with clause (iv), with such professionals having lower composite performance scores receiving lower adjustment factors;…"<br><br>"Professionals with composite performance scores that are equal to or greater than 0, but not greater than **¼ of the performance threshold.."**<br><br>"Receive a negative payment adjustment factor | Pg 54, lines 6-12<br><br>referring to page 55 lines 5-10)<br><br>referring to page 55 lines 14-17<br><br>Referring to page 55 lines 20-22<br><br>referring to Page 56 lines 1-5 | Violates AMA/FMA Principles and guidelines on PFP.<br><br>**"Programs must be based on rewards and not on penalties.**<br><br>**HR2 penalizes doctors 4-9% for not meeting 25% of arbitrary thresholds set by Secretary of Health and Human Services.**<br><br>**Thresholds of a 4-point composite score** |

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| | that is **equal to the negative of the applicable percent** specified in subparagraph (B) for such year."<br><br>(B)...''(i) for 2019, 4 percent;<br>''(ii) for 2020, 5 percent;<br>''(iii) for 2021, 7 percent; and<br>''(iv) for 2022 and subsequent years, 9 percent." | | **on "quality", "Meaningful use"**<br>**"Resource Use" and Clinical Improvement Models"** |
| **Appeal and Judicial review rights DENIED to physicians on Pay for Performance.**<br><br>**No due process.**<br>**No review by court.**<br>**Full, unchallenged power of the Executive branch.**<br><br>**Rule of MAN, not Rule of Law.** | ''(B) **LIMITATION.**— there shall be **no administrative or judicial review** ….of the following:**''(i) The methodology used to determine the amount of the MIPS adjustment factor** … **the amount of the additional MIPS adjustment factor under paragraph** …<br>''(ii) **The establishment of the performance standards under paragraph (3)**<br>''(iii) **The identification of measures and activities and information made public or posted on the Physician Compare Internet website**<br>''(iv) **The methodology .. to calculate performance scores** | Pg 74 | **PFP #4 4. Use accurate data and fair reporting**<br>Physicians are allowed to review, comment and **appeal results prior to the use of the results for Programmatic reasons and any type of reporting**. |
| **Would impose a 5% payment delay on surgeons who don't report additional data** on services provided within the global period. | ''(C) IMPROVING ACCURACY OF PRICING FOR SURGICAL SERVICES.—For years beginning with 2019, the Secretary shall use the information reported under subparagraph (B)(i) as appropriate and other available data for the purpose of improving the accuracy of valuation of surgical services under the physician fee schedule under this section.''. | Page 256, lines 16-24 | |
| **Forces doctors to Share patient information** | ''(2) PREVENTING BLOCKING THE SHARING OF INFORMATION.—(A) FOR MEANINGFUL –<br>that the professional has not **knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology**''. | Page 149 line 20-21<br><br>&<br><br>Page 150 lines 4-8 | **Doctors will BREAK LAW if they do anything that prevents the sharing of patient information with the Federal government!**<br><br>How much jail time will go with that? |

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| **Public reporting of physician composite scores**<br><br>The reporting will not be fully compensated even with the "bonuses" .Further the reporting will alter physician behavior to ensure good scores, harming access to care for those with more complicated issues. This has been proven many times over in scientific literature. | ''(9) **PUBLIC REPORTING.—**<br>''…make available on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services the following:<br>''(I) shall include the composite score for each such MIPS eligible professional and the performance of each such MIPS eligible professional with respect to each performance category; | Page 65 lines 10-24<br><br>Page 66 lines 1-5 | **The Physician Compare Website is already an inaccurate mess that reports data unfairly and inaccurately. It can't be trusted.**<br><br>**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.<br><br>**Further, even with the "bonuses" there is NOT full reimbursement for time and resources necessary to report the data to Medicare.**<br>:<br>PFP guidelines:<br>"• Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program." |

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| | | | Violates "ACCESS TO CARE" impact.<br><br>PFP Principle states:<br><br>"**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."** |
| **NO appeal on Publicly reported data**<br><br>Can "submit correction" for review, but no right to APPEAL to even an administrative law judge here! | "''(C) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for a professional described in subparagraph (A) to review, and **submit corrections for, the information to be made public** with respect to the professional under such subparagraph prior to such information being made public. | Page 66 line 22-24 | Violates AMA PFP principle #4<br><br>**"4. Use accurate data and fair reporting** …Physicians are allowed to review, comment **and appeal results** prior to the use of the results for programmatic reasons and any type of reporting." |

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| **Makes Physician/patient practice data for sale to highest bidder.**<br><br>Will be used by insurance companies, big corporations and others to further control care of patients by doctors to impose rationing. | "(a) EXPANDING USES OF MEDICARE DATA BY QUALIFIED ENTITIES.—<br>…to conduct additional **non-public analyses** (as determined appropriate by the Secretary) and provide or **sell such analyses to authorized users for non-public use** (including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including **developing new models of care).** | Pg 132 lines 12<br>&<br>Pg 133 lines4-11<br><br>Referring to 42 USC 1395KK(e) | **Violates: PFP preamble to principles:**<br>"Fair and ethical PFP programs are **patient-centered** and link evidence-based performance measures to financial incentives."<br><br>This is not PATIENT-Centered. **This is PAYOR CENTERED**. |
| While Still in Appeals Process….<br><br>Medicare can LEVY 100% if ALLEGED delinquent taxes from Medicare payments to doctors.<br><br>This is an increase from the 30% currently allowed under law. | **SEC. 413. LEVY ON DELINQUENT PROVIDERS.**<br>(a) IN GENERAL.—Paragraph (3) of section 6331(h) of the Internal Revenue Code of 1986 is amended by striking ''30 percent'' and inserting ''100 percent''. | Pg 213, lines 20-23. | Physicians will be subject to greater abuse by IRS than others in society. A convenient way to minimize deficit impact on paper, while further controlling doctors through intimidation. |
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| **Programs for REMOTE PATIENT MONITORING will be studied for later implementation.**<br><br>**In order to save money for Medicare, the government will seek to monitor "activities of daily living" and other information of patients.**<br><br>**Are you, as a patient, acting in a way that costs the government too much?** | **"REMOTE PATIENT MONITORING SERVICES.—…**<br>a coordinated system that uses one or more home based or mobile monitoring devices that automatically transmit vital sign data or **information on activities of daily living and may include responses to** | Page 155 line 15-25<br>and<br><br>Page 156 lines 1-5 | What sort of data could the government want on patients besides the obvious (vital signs). Will patients' eating habits, smoking habits and more be monitored?<br><br>Technology is available to be VERY invasive.<br><br>Violates protections against patient privacy. |

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| | **assessment questions collected on the devices wirelessly or through a telecommunications connection to a server"** | | |
| Composite score subject to "weighting" by Secretary based on High performers…<br><br>Can also arbitrarily reduce a weight to ZERO. (Designed to give more weight to areas where more improvement is "needed" and less weight to areas where improvement is "achieved". So, once the doctors achieved the "goals", the weight given to that achievement goes down to encourage them to constantly strive to meet other goals set by Secretary of HHS.<br><br>This creates an arbitrary system that is unpredictable for providers. | | Pg 44 lines 14-21<br>and<br>pg 48 | |
| MIPS providers receive a differentially higher "bonus" based on higher composite scores based on arbitrary thresholds set by Sec. HHS. | "professionals having higher composite performance scores receiving higher adjustment factors; and" | Pg 54, lines 1-3 | Violates AMA/FMA Principles and guidelines on PFP.<br><br>Guidelines on Program rewards:<br>"- Programs must **not reward physicians** |

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| | | | **based on ranking** compared with other physicians in the program. " |
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| **Arbitrary "EXCEPTIONAL PERFORMANCE" awards**<br><br>Secretary of HHS will give even more bonus money to those who perform exceptionally in a way she determines.<br><br>This is an ARBITRARY methods that is **NOT FULLY EXPLAINED to participating physicians** in advance (now) and **does not promote quality improvement across ALL** participating physicians. Only those who are **RANKED arbitrarily higher by the Sec of HHS.** | "…professional with a composite performance score for a year at or above the additional performance threshold under subparagraph … Secretary shall specify an additional positive MIPS adjustment factor for such professional 18 and year."<br><br>And<br><br>professionals having higher composite performance scores above the additional performance threshold receive higher additional MIPS adjustment factors. | Pg 56 lines 6-24 | Violates AMA/FMA PFP Principle #5<br>"**5. Provide fair and equitable program incentives** - The eligibility criteria for the incentives are **fully explained to participating physicians**. These programs support the goal of **quality improvement across all participating physicians**.<br><br>AND<br>Guidelines on Program rewards:<br>"- Programs must **not reward physicians based on ranking** compared with other physicians in the program. " |
| **"Consultation" by Sec HHS for measure development**<br><br>"Good" PFP have the physicians groups creating the measures and having final approval. That is NOT the case here where the Sec. of HHS merely "consults" before making a final decision on their own. | "The Secretary shall consult with stakeholders in carrying out the MIPS, including for the identification of measures.." | Pg 67 ln 11-12 | **Violates AMA PFP Principle 1:** "Evidence-based quality of care measures, created by physicians across appropriate specialties, **are the measures used** in the programs. |
| **Raids $100 million from Medicare Trust fund for "technical assistance" money for creation of medical** | ''(B) FUNDING FOR TECHNICAL ASSIST20 ANCE.—… the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund | Page 68-69 lines 19-4 | Takes $100 million away from patient care to pay for an unnecessary administrative |

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| **practice control structure.** | established under section 1841 to the Centers for Medicare & 25 Medicaid Services Program Management Account of $20,000,000 for each of fiscal years 2016 through 2020. " | | imposition on small physician practices. |
| **Raids $400 million Medicare Trust fund for overall implementation of command and control structure (Pay for Performance)** | (3) FUNDING FOR IMPLEMENTATION.—For purposes of implementing the provisions of and the this section ({Editors note: Pay for Performance Command and control bureaucracy}}, the Secretary of Health and Human Services shall provide for the transfer of $80,000,000 for each of the fiscal years 2015 through 2019. | Page 79-80 lines 20-6 | Takes $400 million away from patient care to pay for an unnecessary administrative imposition on all of medicine and patients. All to create a command and control (incentive/penalty) program in Medicare called Pay for Performance. |
| **Raids $75 million Medicare Trust fund for "measure development" of command and control structure (Pay for Performance)** | "FUNDING.—… the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $15,000,000 …for each of fiscal years 2015 through 2019." | Page 126, lines 18-24 | Takes another $75 million away from patient care to pay for an unnecessary administrative imposition on all of medicine and patients. All to create a command and control (incentive/penalty) program in Medicare called Pay for Performance. |
| **Turning Physician practices into HMO's**<br><br>**Creates rationing incentive for doctors who will have to choose to spend money on patient or lose money in their own practice.**<br><br>**According the politicians and the** | (2) INCENTIVE PAYMENTS FOR PARTICIPATION **IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—**<br>"(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures" | Page 88 line 7-8<br><br>&<br><br>Page 98 | Violates PFP principle #1 "**1. Ensure quality of care** – Fair and ethical PFP programs are committed to improved patient care as **their most important mission.**<br><br>**Doctors will be given a bonus if the overall** |

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| **media, physicians can't be trusted with a "fee for Service" model, since they will abuse the system to make money? How can these same people trust physicians to be even MORE trustworthy in a system where they must deny care to earn a bonus or avoid losing money?** | | | **"aggregate" spending on patients is Lower than what the government wants to spend. As doctors struggle to make ends meet in the massive regulatory environment, will their most important mission remain their patients' well-being or their financial survival?** |

**FMA Policy preventing compromise of our Principles on PFP in exchange for an SGR fix.**

**P 325.016 REPEAL OF SUSTAINABLE GROWTH RATE IN MEDICARE PAYMENT TO PHYSICIANS**

The Florida Medical Association, through the Florida AMA Delegation, continuously seeks to achieve the repeal of the unjust Sustainable Growth Rate (SGR) purportedly proposed to achieve budget neutrality which is imposed upon physicians without compromising AMA Principles of Pay for Performance. *(Res 06-40; HOD 2006)*

**P 365.001 PAY-FOR-PERFORMANCE**

The Florida Medical Association adopts as policy the American Medical Association's Principles and Guidelines for Pay-for-Performance programs and opposes policies or programs of any public or private entity relating to the medical quality, patient safety and reporting of medical process and outcome data if they are not compliant with the AMA Principles and Guidelines for Pay-for-Performance. *(Res 05-7, HOD 2005) (Reaffirmed HOD 2013)*

**P 365.004 TRANSPARENCY OF PHYSICIAN RATING PROGRAMS**

The Florida Medical Association (FMA) supports legislation on transparency of physician rating programs only if it is substantially compliant with FMA policy on physician rating, pay for performance, public reporting and payer measures (including but not limited to Resolutions 05-5, 05-7, 05-58, 06-1, 06-11, and 07-15) giving significant leeway to the FMA legislative team to achieve our FMA mission. *(BOG October 2008)*

**P 235.005 FMA HEALTH SYSTEM REFORM POLICIES**
The Florida Medical Association adopts the following health system reform policies:

2. That the FMA opposes the following as health system reform policy:

C Value Based Purchasing and Pay for Performance programs that are not compliant with the AMA's Principles and Guidelines on Pay for Performance.

E. Reducing physician and hospital payments to fund incentive programs for value based purchasing.

**P 195.003 PRESERVE CORE VALUES OF TRANSPARENCY AND INCLUSIVENESS**
Prior to taking action that is inconsistent with or contrary to established policy of the Florida Medical Association (FMA), the FMA Board of Governors will uphold and respect the governance of the House of Delegates by first providing full, honest and open disclosure of the risks and benefits of such action as they relate to the FMA and the affected Stakeholder Organizations along with alternative actions that could mitigate any adverse impacts to the affected Stakeholder Organizations and patients, and further, the **FMA shall immediately abandon pursuit of any policy inconsistent with or contrary to established HOD policy, unless in the specific interest of public safety.** ***(Res 12-308, HOD 2012)***

## H-450.947 PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) 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.

June 21, 2005

## Guidelines for Pay-for-Performance Programs

Safe, effective, and affordable healthcare for all Americans is the American Medical Association's (AMA) goal for our healthcare delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) 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.

Quality of Care

• The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the healthcare 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 riskadjustment for patient demographics, severity of illness, and comorbidities.
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 healthcare 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.

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 noncompliance, and sponsors of PFP programs should attempt to minimize noncompliance through plan design.

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.

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 in the 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 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.

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 prespecified 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.