"Who Stole My Plan" and "Pray for Performance": Current Bestsellers for Contracting Physicians[1]

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Several recent and ongoing developments within the healthcare industry have created major challenges for physicians and physician organizations contracting with health plans and payors. Two of the most challenging developments are consolidation of health plans ("Plans") through mergers and acquisitions and the increasing prevalence of pay-for-performance ("PFP") reimbursement methodologies (and publication of related rankings). Both developments pose hidden traps for less experienced physician counsel and new areas of concern which even more experienced counsel may not have previously addressed in their clients' managed care agreements.

Note On Terminology: For ease of reference, this paper will refer to an individual physician or mid-level provider as "Physician" and to a physician practice or group as "Group." Participation agreements and similar Plan-Physician contracts are referred to as "Contract" or "Agreement."

I. "Who Stole My Plan": Dealing With Health Plan Consolidation

The past seven years have witnessed tremendous consolidation of Plans. Between 2000 and 2007, the nation's two largest Plans, WellPoint Inc. and UnitedHealth Group each acquired 11 insurers to reach a combined total of 67 million covered lives, a whopping 36 percent of the U.S. health insurance market.[2] By contrast, the two largest

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[2] American Medical Association. (2007). *Competition in health insurance: A comprehensive study of U.S. markets | 2007 update* (Public Sector Advocacy Unit), Chicago: Author (hereinafter, "AMA Study") (available at http://www.ama-assn.org/ama1/pub/upload/mm/368/compstudy_52006.pdf).

Plans in 2000, Aetna and UnitedHealth Group, had a combined total of 32 million covered lives.[3] Moreover, the trend shows little sign of ending any time soon. In March 2007, UnitedHealth Group announced its intent to purchase Sierra Health Services. If the acquisition is completed, UnitedHealth Group would obtain more than 630,000 additional covered lives.[4]

The AMA Study clearly reflects the impact of Plan consolidation on relative bargaining power between Plans and physicians. It found that in 96% of surveyed MSAs, at least one plan had a combined HMO/PPO market share of 30% or more, while 24 % had at least one Plan with a combined HMO/PPO market share of 70% or more.[5] Further evidence of the potential negative impact of consolidation upon physicians can be found in California, where physicians saw fee cuts of 20-30% after the PacifiCare – UnitedHealth and WellPoint – Anthem mergers.[6]

Given this continuing trend, what can we as physician counsel do to assist our clients? As with many issues, an ounce of prevention is worth a pound of cure. The potential for consolidation must be considered and factored into negotiation of several portions of the Agreement.

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[3] *Id.* at 1.
[4] AHLA (March 13, 2007). UnitedHealth's acquisition of Sierra would build its strength in West. *Health and Life Sciences Law Daily*
[5] AMA Study, *supra* note 2, at 5.
[6] American Academy of Family Physicians (October 25, 2007). *Statement Concerning the Impact of Health Insurance Consolidation On Small Business*. Submitted to the Congressional Committee On Small Business. Washington, D.D. (Available at: http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/congresstestimony/healthinsur.Par.0001.File.tmp/SmallBusinessImpactHealthInsConsol.pdf).

A. Contracting Measures To Protect Physicians In The Era Of Plan Consolidation

Before getting into the so-called "substantive" portions of the Contract, careful attention should be given to the Contract's definitions. Among others, the definitions of "Payor," "Plan" and "Affiliate" can all materially impact the parties' respective rights with respect to Plan consolidation.

1. Payor

The Agreement must clearly identify the "Payor," being the entity that is ultimately liable for payment. This is particularly critical for PPO Contracts where one must guard against "Silent PPO" problems, where the Group's discounted rates under the Agreement are accessed by unintended third parties. The same provisions that protect against Silent PPOs can also provide some protection against Plan-consolidation problems. Consider how the following definition falls short in that regard:

> **"Payor"** is an entity obligated to a Participant to provide reimbursement for Covered Services under the Participant's Benefit Plan, and authorized by Plan to access the services of Group's Physicians under this Agreement.

The modified versions below more effectively protect the Physician's interests:

> **"Payor"** is an entity obligated to a Participant to provide reimbursement for Covered Services under the Participant's Benefit Plan, and authorized by Plan to access the services of Group's Physicians under this Agreement. No entity which contracts directly with Physicians or Physician Groups within Group's service area to serve as members of its primary health care provider network shall be deemed a Payor under this Agreement. Nor shall any entity which contracts, directly or indirectly, with Plan for access to health care providers solely for its members, participants or beneficiaries while outside of either their primary health care provider network or the service area of such network. The parties agree that the definition of Payor shall be narrowly construed.

2. Plan

Many Contracts do not use or define the term "Plan" or use and define it only in the context of a "Benefit Plan" or other document which specifies the coverage and financial terms applicable to a particular Member, Enrollee or Participant. Problems can occur, when "Plan" is instead, used to refer to the entity or party to which the Contract with the Group applies. For example, rather than "Untied and Group agree that …," the Contract might read "Plan and Group agree that …" Many of those problems relate to the "Plan" definition's use of the term "affiliate," e.g., "CINAG and its affiliates (collectively, 'Plan') hereby agree…" Where the term "Plan" is used to refer to both a document and an entity, separate definitions should be carefully drafted for each.

3. Affiliate

In addition to the Group and the Plan as the named parties to the Contract, Plans frequently draft the Contract as also applying to "any of Plan's affiliates." The problems posed by a complete failure to define "affiliate" in such a case should be self-evident. An inappropriate definition of "Affiliate" can also be troublesome, particularly as it may give the Group a false sense of security. Consider the following definition:

> **"Affiliate"** means an entity that directly or indirectly owns or is owned by Plan, and any entity which is, directly or indirectly, under common ownership with Plan.

While the above example defines Affiliate broadly, it applies to only the Plan and not the Group. Hence, a Contract provision permitting its assignment to "a party's Affiliate," would benefit only the Plan. The Group's counsel might propose the following alternative language in an attempt to make the provision more even-handed:

> **"Affiliate"** means an entity that directly or indirectly owns or is owned by a Party, and any entity which is, directly or indirectly, under common ownership with a Party. Upon

> execution of this Agreement, each Party shall provide to the other a current list of Affiliates. Each such list will be updated not less than quarterly and each Party shall provide a copy to the other, upon its request.

As discussed further in the following section of this outline, the above change, while beneficial, may be inadequate to protect the Group in the event of the Plan's merger or acquisition.

4. Assignment

Almost all Plan-provider Contracts include a section captioned "Assignment," and even today, it is not uncommon to find that the "General Terms" or "Miscellaneous" articles of a Contract includes a provision stating that the Contract is "binding upon the parties and their successors and assigns" (or "permitted assigns").[7] In the past, the parties typically gave little thought to the long-term obligations or consequences created or posed by such clauses. In the current era of Plan consolidation, however, physicians and their counsel must carefully analyze both the "Assignment" and other sections of their Contracts with regard to their impact upon a future merger or acquisition involving that Plan.

The "standard" Contracts of many Plans expressly prohibit either any assignment, whatsoever, by the Physician or Group, or any assignment without the Plan's prior written consent, but conversely, permit assignment by the Plan, either with or without limitations. The following is an example of the latter:

> This Agreement shall be binding upon and inure to the benefit of the respective legal successors and assignees of the parties. However, neither this Agreement, nor any rights or obligations hereunder may be assigned, by operation of law or otherwise, delegated, transferred in

[7] Such provisions are often found in paragraphs captioned "Binding Effect," "Interpretation and Construction" or "Complete Agreement."

> whole or part, without the prior written consent of the other party, except that Plan retains the right to assign, by operation of law or otherwise, delegate, or transfer in whole or part, this Agreement to an Affiliate.

The above example underscores the importance of carefully defining the term "Affiliate" and also illustrates why many "Assignment" clauses are inadequate: they specify who can and can not assign the Contract, but fail to specify just what constitutes an "assignment." As noted in the preceding section of this outline, Plans' standard Contracts frequently define "Affiliates," if at all, as those "entities controlling, controlled by, or under common control with Plan [or "a Party"]." Given that the Contract "assignment" situations most commonly faced now involve mergers and acquisitions of one of the parties, the Assignment clause quoted above could easily result in the Group encountering, and being bound to the Contract with, a previously unanticipated Affiliate of the Plan.

As a result of the extensive Plan consolidation that has already occurred, Plans today often have the market power or leverage to demand such one-sided clauses. Larger physician groups and those with members in high-demand specialties may be able to obtain more balanced Assignment clauses and should negotiate for them.

Physicians have legitimate reasons for wanting to restrict the Plan's ability to assign the Contract or the Plan's rights under it without the Physician Group's consent. A Group would not, for example, want the Plan to assign the Contract to another Plan in connection with a merger or acquisition if the assignee Plan was one with which the Group has had a long history of payment or operational problems. The Group may therefore, wish to negotiate a so-called "Mutual Assignment" clause, such as this:

> This Agreement can not be assigned by either party without the prior written consent of the other party.

Many Mutual Assignment clauses also add include a proviso that "such consent shall not be unreasonably withheld." While it is inherently difficult to argue for unreasonableness, or against a "reasonableness" requirement, such a proviso may prove problematic by injecting uncertainty. For example, an arbitrator might conclude that it was "unreasonable" for the Group to withhold its consent to the Plan's proposed assignment of the Contract to a financially sound, nationally established Plan, despite the proposed assignee's horrendous track record of administrative hassles. Unfortunately, the uncertainty likely can not be eliminated by drafting additions to the "reasonableness" proviso, as it is doubtful that the parties will be able to agree upon in advance will and will not be deemed "reasonable" grounds for withholding consent to a proposed assignment.

As alluded to above, absent very specific language in the Assignment section of the Contract, arguments can and have developed as to whether an "assignment" of the Contract actually occurred if the Plan was wholly acquired by another entity during the Contract's term. The following real-life scenario demonstrates that such arguments can become particularly sticky if the Group has a separate, pre-existing Contract with the acquiring Plan, i.e., the alleged "assignee."

Scenario:

(a) Group negotiates Contract #1 with Plan #1, a well-established regional PPO that sells its network to a wide variety of self-funded customers/Payors. Because of its market share, Plan #1 is able to negotiate a 30% discount, whereby it pays Group's Physicians only 70% of charges for services they furnish to its enrollees.

(b) Group also negotiates Contract #2 with Plan #2, a national Plan for both fully-insured and self-funded products. Because Plan #2 is new to the Group's market area and is attempting to rapidly create a network, it

agrees to pay the Group's physicians 87% of charges for services they furnish to its enrollees.

(c) Eighteen months later, Plan #2 has built up its membership and life is good…until Plan #2 acquires Plan #1 outright. Plan #2 then informs Group that it is not terminating Contract, but will no longer access the Group's physicians though Contract #2 at 87% of charges. Instead, despite the fact that it now owns Plan #1, Plan #2 will proceed to function as simply one more of Plan #1's PPO customers/Payors and thereby access the Group's physicians through Plan #1 at the steeper 30% discount.

(d) Result: The Group's physicians lose 17% of their charges on the "Plan #2 business."

Was there an "assignment" of Contract #1 under this scenario? The Group and the Plans clearly disagreed on the answer to that question.

Attempting to define "assignment" by specifying in the Contract, in advance of its execution, all of the myriad transactions into which the Plan could possibly engage would not be a realistic solution. However, even without a specific, detailed definition of "assignment," the Group's problems under the scenario could have been avoided if it had previously negotiated into its Contracts with both Plans a provision such as this:

> Anything in this Agreement to the contrary notwithstanding, at no time shall this Agreement apply to the following: (a) any Payor or entity with which Group already has a then-existing contract or participation agreement, even if such other Payor or entity becomes an Affiliate of Plan. This Agreement and Group's then-existing contract with the other Payor or entity will each remain in effect and will continue to apply as they did prior to the Payor or entity becoming an Affiliate of Plan, unless all parties to both agreements agree otherwise in writing.

5. Options in the Event of Consolidation

One must know of events before one can respond to them. As such and given the lag time between (a) the agreement to merge/acquire/be acquired, (b) closing of the

merger or acquisition, and (c) implementation of the transaction's results, both Plans and Physicians can and probably should agree to Contract provisions mandating advance notice of any proposed assignment, merger, acquisition or other event of similar type and impact. For example:

> **Notice**. Each Party shall give the other Party written notice of a proposed assignment, merger, acquisition or Change of Control (as defined in Section X) of or involving the notifying Party not less than 120 days' prior to the closing of such transaction.

Whether due to human nature, business model or both, Plans are generally more hesitant to agree in advance to limitations on what they can do (e.g., "Plan can not assign…"), than to agree that Physicians will have certain options or remedies in the event that the Plan takes a particular action (e.g., "If Plan assigns, then Physician may…"). One such option is termination of the Contract. It may, therefore, be beneficial to negotiate a provision that expressly grants and delineates the parameters of such a post-event termination right, separate and apart from the Contract's main "Termination" provisions. For example, the parties may wish to require a different advance-notice period for a termination due to the Plan's merger, than for a termination unrelated to a merger or acquisition. They might also wish to grant an unrestricted post-merger/acquisition termination right even if the Contract does not otherwise permit without-cause termination. Below are two examples of post-event termination clauses:

> 1. In the case of a merger or acquisition involving a Party, the other Party can at its option, terminate this Agreement, effective upon any date before or after the effective date of the merger or acquisition, by giving the involved Party written notice of termination within sixty (60) days after receipt of notice of the proposed merger or acquisition. Such termination shall have no effect upon the rights and obligations of the Parties arising out of any transactions occurring prior to the effective date of such termination.

> 2. Plan and Group may each terminate this Agreement in the event of the other party's acquisition of or by, or joint venture, partnership or merger (statutory or otherwise) with, any entity that the terminating party determines, in its sole discretion, to be unacceptable. Such termination right shall be exercised, if at all, within sixty (60) days after the terminating Party receives notice of the event pursuant to Section X, by giving at least one hundred twenty (120) days' prior written notice to the other Party. Provided, however, that this section shall not apply to any merger for which Plan or Group, as the case may be, is the surviving entity.

Given the nearly limitless number and combinations of business transactions in which a Plan might participate, it is important that the Group's counsel carefully and specifically draft the terms of any exceptions to the Group's termination rights, such as the final clause of example #2, above. Sloppy drafting of a termination exception can result in the exception swallowing the rule.

Either in addition to, or as an alternative to, a simple all-or nothing termination right, the Group may wish to negotiate for election rights in cases where it has a pre-existing Contract with Plan #2. Below is an example of a clause that grants such rights in addition to outright termination. Note how it also more thoroughly specifies the "Transfer Events" that will trigger such rights, rather clumping them together by using only the word "assignment."

> **X. Assignment; Notice And Election**.
> X.1 Neither Plan, nor Group can assign this Agreement or any of its respective rights or obligations under this Agreement, without the prior written consent of the other party.
>
> X.2 Plan and Group (each a "Transferring Party") shall notify the other party (the "Notified Party") at least one hundred twenty (120) days before the Transferring Party engages in any of the following "Transfer Events": (a) sells all or substantially all of its assets; (b) transfers control of its management or operations to any third party entity (regardless of whether such entity is or is not related to the

> Transferring Party); or (c) acquires or assumes control of, or is acquired or controlled by, any other entity (regardless of whether such entity is or is not related to the Transferring Party), whether by sale, purchase, merger (whether statutory or by any other means), consolidation, alliance, joint venture, partnership, association, or any other means, and regardless of whether the Transferring Party will or will not be the surviving entity after the Transfer Event.
>
> X.3 At any time within the one hundred eighty (180) days after its receipt of notice of the Transfer Event, the Notified Party can, in its sole discretion, elect to terminate this Agreement by giving written notice of termination to the Transferring Party, such termination to be effective on the sixtieth (60th) day after the date upon which such written notice of termination was given.
>
> X.4 If Group is the Notified Party and elects to not terminate this Agreement as permitted by Section X.3, and the entity (other than the Transferring Party) involved in the Transfer Event is a health plan, contracted provider network, or payor, in or with which Group or a Group Physician participates pursuant to a participation agreement or similar contract between Group or Group Physician and such entity (the "Other Contract"), then at any time within the one hundred eighty (180) days after its receipt of notice of the Transfer Event, Group can, in its sole discretion, elect to be governed by the terms and conditions of that Other Contract, rather by the terms and conditions of this Agreement, by giving written notice of such election to the Transferring Party. Any such election shall be effective on the sixtieth (60th) day after the date upon which Group's written notice of such election was given. If Group does not terminate this Agreement as permitted by Section X.3, and also does not make the election permitted by this Section X.4, then this Agreement shall remain in effect, in accordance with its terms, after the Transfer Event.

B. Tactics For Responding To Changes Due to Plan Consolidation

Many times, the Physician or Group will lack adequate leverage to force its preferred result in the event of a change due to Plan consolidation. As such, the best course is to attempt to avoid unanticipated changes. Contract maintenance includes

keeping one's ear close to the ground, closely monitoring the industry, and being aware of discussions and rumored changes. If a problematic rumor seems sufficiently credible, a Group may, for example, refuse to renew its current contract or to renew the Contract only if its terms are modified to adequately address the concern. How to proceed if despite those efforts your client is confronted with a Plan change?

First, you should attempt to ascertain Plan 2's intended course of action. Will it operate Plan 1 as a separate operating division of Plan 2 keeping Plan 1's existing contracts in place? Probably not, but, if so, the consolidation may pose no problems, at least initially. Even if that is Plan 2's initial course of action, does it intend to convert to its own, Plan 2 contract forms when the existing, Plan 1 contract expires or comes up for renewal?

Does the Group already have in place a contract with Plan 2, in addition to the Plan 1 Contract, and, if so, which Contract does Plan 2 intend to utilize with the group? In such a case, you should carefully analyze each of the Contracts to determine which would be preferable or more beneficial to the Group. Note that in conducting such analysis, one can not focus solely on the Contracts' terms in a vacuum. Rather, one must also consider the impact or potential impact of having those terms in a Contract with the new Plan/entity. For example, the existing Contract's terms may be that loosely worded or vague, but never posed a problem due to Plan 1's positive attitude toward physicians and its cooperative approach to Contract implementation. That same loose or vague language in a Contract with Plan 2 could pose significant trouble for the Group if Plan 2 has a long track record of poor provider relations or is known for exploiting every vague clause or term in its provider Contracts. (Example: "The Contract does not specify that

we must pay claims within 30 days, merely that claims must be paid 'promptly.' We believe that payment within 60 days is 'prompt.' End of discussion.")

What impact will the post-consolidation changes have on the Group's overall payor mix? If the Group is unable to negotiate or otherwise implement its desired changes with Plan 2, does it have Contracts with other Plans to which changes might more easily be negotiated? If, for example, the Group has greater leverage with Plan #3 because its network lacks other physicians of the same specialty, the Group may be able to achieve some or all of its desired payor-mix adjustments through negotiation of changes to its Plan #3 Contract.

The ultimate action to be taken will, of course, depend upon the results of your analysis and your client's decisions made after receiving your counsel. Below are three potential courses of action which, in some cases, may be combined. This short list is by no means exhaustive.

Option 1: Terminate one or both Contracts under their respective terms. As discussed above, there may be provisions permitting termination in the event of an improper assignment or other consolidation-related "triggering event," in addition to those in the Contract's main "Termination" section. The definitions of "Assignment" and "Affiliate" may also determine or significantly impact your client's options with regard to termination.

Physicians will quickly and correctly tell you that, for virtually every Group, there is a certain percentage of patients which, if covered by a single Plan, makes termination of that Plan's Contract financially impracticable. Physicians sometimes forget, however, that market forces can also operate in their favor. In evaluating its termination options,

therefore, the Group must also take into account what, if any, alternatives the Plan would have if the Group was to terminate the Contract. Are there sufficient participating physicians of like specialty(ies) in the same service area that could, and would be willing to, absorb the Group's patients? If the answer is anything short of a definite "yes," merely raising the possibility of the Group's termination might provide the Group sufficient leverage to negotiate desired Contract changes.

Option 2: Request voluntary re-opening of negotiations to address problematic portions of the Contract. Yes, the request may be promptly denied or rejected, particularly by a mega-Plan, but the request certainly will not be granted if the Group does not even make it. You may have to make the request more than once (in some cases, many times) and make it to more than one representative of the Plan.

In addition to exploiting any physician-favorable market forces noted under Option 1, the negotiations should also focus on what makes your Group unique. For example: (a) Is it the #1 performing Group in the state for diabetic care? (b) Has it developed unique patient registries that are valuable to the Plan? (c) Is the Group willing to partner with that particular Plan on initiatives to increase the Plan's presence in the Group's service area and thereby enhance competition between Plans? (d) Do the Group's physicians regularly treat a large percentage of the employees (particularly executives) of one of the Plan's key customers/employers in the Group's service area? The key is to put forth one or more good reasons why the Plan should treat your Group differently than any of its numerous other contracted physician groups and grant your requested changes. If you can not do that, credibly and forcefully, you should not be

surprised if the Plan's provider contracting representative is not willing to go to his or her superior and argue your case for you.

Option 3: Be creative and use whatever tools you may have. For example, if the pre-existing Contract with Plan 1 is preferable, ascertain whether it contains any terms that might be used to force its continued use. If it contains what was previously thought to be a very pro-Plan, broad definition of "Affiliate," can that definition be utilized against Plan 2 with an argument along the following lines: (a) The Plan 1 Contract states "This Agreement applies to Plan and its Affiliates." (b) Plan 2, the acquiring entity, fits within the Plan 1 Contract's broadly-worded definition of "Affiliate." (c) Therefore, the existing Plan 1 Contract also applies to Plan 2, despite the fact that it has acquired ownership of Plan 1.

Another example: Does the Plan need your Group in its network for a different product, such as a new Medicare Advantage product, that is covered by a separate Contract or Contract exhibit? If so, can the Group leverage the Plan's need in that regard to obtain changes in its Contract for the problematic product?

II. "Pray-For-Performance": Performance-Based Reimbursement and Ratings

The remaining portion of this outline addresses issues related to the continuing growth and expansion of pay-for-performance ("PFP") and related physician performance rating ("PPR") programs. While such programs could easily generate enough material for an entire two-day conference, we here attempt, in the space and time allotted to: (a) outline some of the concerns posed by such programs, including new

issues of potential dispute, and (b) suggest some contracting measures designed to position physicians for PFP/PPR success and facilitate resolution of associated disputes.[8]

A. Concerns and Potential Disputes Associated With PFP and PPR

It should first be noted that PFP and PPR programs are separate and distinct types of programs. PFP programs tie a portion of physicians' reimbursement to their performance on specific measures (e.g., percentage of generic prescriptions written). Pure PPR programs rate or score physicians' performance on quality and/or economic measures and publicize those ratings to a particular audience, e.g., employers, enrollees and/or the public at large. While each type of program can exist on a stand-alone basis, PFP and PPR programs are frequently intertwined.

For example, a combined program may use physicians' performance on quality measures for both adjusting current-year compensation (the PFP component), and also use those same performance scores to publicly rank them in comparison to their peers (the PPR component).

Additionally, the results of a PPR program may have a collateral impact upon the rated physicians' overall compensation on a going-forward basis. For example, a Plan's assignment of physicians to distinct network tiers based upon their relative PPR performance scores, may be coupled with variations in fee schedules or co-payments by tier. If an enrollee has a $20 copay for an office visit with a higher-scoring Tier 1 physician and has a $35 copy for the same office visit with a lower-scoring Tier 2

[8] The growth in PPR and PFP programs has not been unaffected by Plan consolidation. As a condition of the approval of its December 2005 merger with PacifiCare Health Systems, Inc., UnitedHealth Group, Inc. agreed to pay "at least $13.7 million in pay-for-performance incentives for physicians in group practices based on quality improvements." *See* AHLA Antitrust Practice Group. (January 2006). [Member Briefing] *"UnitedHealth Group, Inc. and PacifiCare Health Systems, Inc."*

physician, the resulting enrollee steerage may have a substantial negative financial impact on the Tier 2 physicians.

As the movement toward cost and quality "transparency" progresses and the PFP-percentage of total physician compensation increases, physicians' relative scores and rankings on PFP and PPR measures play an increasingly critical role in determining their professional reputations and degree of financial success. Few physicians disagree in principle with the PFP/PPR goals of improving quality, optimizing utilization of healthcare resources, and permitting consumers to make informed decisions regarding their healthcare. As with most things in life, however, the devil is in the details.

Many, if not most, of the real and perceived problems with PFP and PPR programs can be traced to the details of their design and implementation. While "accuracy" issues are commonly raised by physicians and most often cited to the public,[9] the specific type and number of concerns posed by a particular PFP or PPR program can vary widely. Common concerns with such programs can generally be summarized into the following eight categories:

1. **Certainty –** Know in advance exactly what is being measured and how?
    a. This is one area where there is no such thing as "too much" detail
    b. There should be no "moving targets" or rules changing in midstream.
    c. Does it measure quality or cost and utilization? "Cost" vs. "Charges"[10]

[9] *E.g.,* "'The ratings have not been accurate,' says Nancy Nielsen [, M.D.], president-elect of the American Medical Association," commenting on the importance of recent health plan settlements regarding physician performance measurement, reporting and tiering programs. Mincer, J. Doctor ratings revised. (December 16, 2007). *The Wall Street Journal* (http://online.wsj.com/public/article/SB119776597524732041.html).
[10] See **Appendix 1** to this outline for an example of a dispute concerning "cost" and related discussion.

2. **Accuracy –** Is the performance accurately measured and accurately reported?
    a. Accuracy in measurement is worthless if reporting is inaccurate.
    b. Accuracy in comparisons is critical in PPR; apples to apples.
3. **Control –** Are the measured results within the physician's control?
    a. Urologists have little ability to affect mammography percentages.
    b. To "buy-in," a physician must perceive control over own destiny.
4. **Realistic –** Are the performance goals or targets realistically achievable?
    a. Little or no chance of achieving goals = no physician buy-in.
    b. If measure only raw score improvement, good performers suffer.
5. **Funding Source –** Are the at-risk dollars "new money"? adequately funded?
    a. Asked to do more in order to receive, at best, prior reimbursement?
    b. Is funding adequate to pay maximum bonuses if all achieve targets?
6. **ROI –** Is the potential financial return sufficient to justify the cost and effort?
    a. Performance improvement is costly: IT, staffing, volume reductions.
    b. If potential ROI is minimal, participants' net income may be reduced.
7. **Adequate Data –** Type, quantity and timing of necessary data adequate?
    a. Many measures are extremely data intensive; data = time = money.
    b. Without real-time tracking, little opportunity to correct and achieve.
8. **Dispute Resolution –** Are there fair and timely measures to resolve disputes?
    a. Disputes are endemic so address resolution mechanisms in advance.
    b. Untimely resolution = illusory solution.

Your physician clients' reputations and livelihoods may well depend on the results of their PFP and PPR programs. Accordingly, prudence dictates that you consider

each of the eight listed topics and carefully scrutinize all associated terms and provisions when you review, negotiate or draft any PFP or PPR program document or related Contract provisions.

B. Actual PFP/PPR Experiences and Suggested Contracting Measures

As the list of PFP/PPR concerns specified in the previous section suggests, many, if not most, physicians are extremely concerned about potential errors in the collection, analysis and publication of quality, utilization and price performance data and the potential resulting adverse impact upon their reputations and livelihoods. Unfortunately, experience has demonstrated that such concerns are often well-founded. Below are three real-world PFP/PPR scenarios and some suggested contracting measures to help avoid the types of problems experienced by the physicians discussed in each scenario.

Scenario #1: A Group of primary care physicians stood to realize a PFP payment of $0.50 per member per month ("pmpm") for each of the Plan's enrollees assigned to the Group if at least X% of the assigned female enrollees over age 50 received an annual mammogram. The Group's physicians and office staff worked diligently on the mammogram measure and, at contract year end, were confident that they had not only achieved, but exceeded the mammogram target percentage. At settlement time, however, the Plan informed the Group that it had failed to meet the target percentage and would not receive the associated PFP payment.

Attempting to determine whether and where it fell short, the Group's initial research focused on the "numerator" in the mammogram percentage, i.e., how many of their assigned female enrollees over age 50 actually did receive an annual mammogram. Surprisingly, the Group's numerator matched the Plan's. Additional research disclosed

that the problem was actually in the "denominator," i.e., the total number of female enrollees over age 50 assigned to the Group and eligible for mammograms. The Plan had erroneously included in that denominator several patients who had previously undergone bilateral mastectomies. When the Plan removed those enrollees from the denominator, the Group's mammogram percentage did exceed the performance target, and it received its PFP bonus.

Scenario #1 demonstrates that it is in both parties' interests to carefully define not only the target measures in a PFP/PPR program, but also the patient population to which each measure will apply. A provision such as the following would help avoid similar disputes:

> PFP Program Details. The final version of the Technical Manual that outlines the PFP measure definitions and data collection parameters [{is attached hereto as Exhibit X} or {was delivered to Group by Plan on or about ____ 2007, and a copy of such Technical Manual was initialed by representatives of both parties at the time of execution of this Agreement}]. All references in this Agreement to "PFP Technical Manual" shall be deemed to refer to the final version described in the preceding sentence of this section. The PFP Technical Manual shall remain in place and unchanged for Group throughout calendar year 2008 except as Plan and Group otherwise expressly mutually agree in writing, regardless of any change made to the Technical Manual or any other manual or document on Plan's website.

Also see the discussion of the 2008 Physician Quality Reporting Initiative documents in Section II.E of this outline.

Scenario #2: A Plan published on its web site a directory of all pediatricians in its network and listed for each a "diamond" score, similar to those assigned to hotels[11],

[11] In October 2007, *USA Today* reported that WellPoint "has teamed with Zagat Survey to let patients rate their doctors, just as diners rate restaurants in Zagat's burgundy-colored guides." Appleby. (October 27, 2007). *USA Today*, p.1A.

based upon their relative performance on several listed measures, including the percentage of their patients who had received required immunizations by a specified age. One Group received a low diamond score because it had failed to meet the immunizations target. Due to the potential adverse impact of the score on the Group's ability to attract and retain patients, it challenged the score. The Plan replied that it had carefully reviewed all of the claims submitted by the Group for immunizations provided to its Member patients; had compared those claims to the age of its Members assigned to the Group; and had concluded that the Group's results did, in fact, fall short of the target.

After auditing its own medical records, the Group determined that a number of its Plan patients had received one or more of the necessary immunizations from other providers, e.g., county health department clinics, for which the Plan had received no claims data. By providing the Plan with documentation of the outside immunizations, the Group was able to persuade the Plan to add an additional "diamond" to each of the individual Provider's web site scores.

Scenario #2 demonstrates why it is important that the Contract (a) carefully define the specific types and sources of documentation that will be considered or evaluated in determining whether a PFP/PPR target has been achieved and (b) provide both parties with necessary access to program calculations and documentation. Below is an example of such a provision:

> For each performance measure included in PFP program, Plan shall provide to Group, within thirty (30) days after its reasonable request, all data and supporting documentation (including all patient lists and all enrollee eligibility histories) utilized or relied upon by Plan in calculating the baseline, performance, results and achievements of each Group Physician with regard to such performance measure and any resulting financial settlement. Within thirty (30)

> days after its receipt of such data and documentation from Plan, Group may provide to Plan any additional data or documentation that Group contends leads to a different result. In such case, within thirty (30) days after its receipt, Plan will review the additional data or documentation and issue a decision on the matter in question.

Note, however, that while the above provision would help the Group dispute a PFP/PPR determination made by the Plan, its mere existence does not, alone, ensure that the relevant data or documentation (such as public health department records) will be readily available to the Plan or the Group.

Scenario #3: The members of four separate, six-person physician practices participated in a PHO. The PHO's contract with one Plan included a PFP program under which participating physicians could earn an additional $0.25 pmpm bonus for each of four PFP targets the physician met. Three of the physician groups were quite skilled at efficiently managing care from both cost and quality perspectives and consistently met or exceeded all four PFP targets. The fourth group's Members, all near retirement, didn't care for "that managed care stuff" and were extreme over-utilizers of high-cost diagnostic and treatment measures. At year-end, the Plan notified the PHO that "The PHO PFP group has failed to meet any of the four PFP targets" and that as such, none of PHO's physicians in any of the four practices would receive a PFP bonus. Review of the PHO's Contract revealed that it was silent as to whether PFP performance was to be evaluated at the individual practice level or at the PHO level, and that it contained several occurrences of the phrases "the PHO PFP Group" and "PHO's PFP Group."

Scenario #3 demonstrates why it important to carefully define the level at which performance will be measured or evaluated (e.g., individual physician, professional corporation or other practice group, entire IPA, etc.) and expressly address what impact,

if any, the performance of other Physicians covered by the Contract will have on any individual Physician. Further, if there are multiple Physician Groups whose performance is being separately judged, it is important to also specify the criteria for inclusion within each Group, when changes to the Group's membership can or will be made, and how the addition or deletion of a Physician will impact the Group's scoring.

C. PFP/PPR Dispute Resolution

In Scenarios #1 and #2 above, the existence or lack of a dispute resolution mechanism specific to the challenged PFP/PPR score or ranking could have a major impact upon whether and how meaningfully the disputes would be resolved. Traditional dispute resolution mechanisms, such as arbitration, commonly found in Contracts are often ill-suited for PFP/PPR disputes, due to both the type of relief they permit and, perhaps even more problematic, the length of time necessary to invoke and complete them.

Consider, for example, a Group seeking to challenge its low PPR scores and resulting assignment of second-tier status. Depending upon when the Group receives the challenged scores in relation to both (a) the date upon which the Plan will publish the Group's scores and tier assignment on the Plan's website and (b) the open-enrollment period for employees in the Group's service area, use of the Contract's traditional arbitration procedures could result in the Group winning the score-challenge battle, but losing the professional reputation and reimbursement war. Physicians are thus well-advised to negotiate for PFP/PPR-specific dispute resolution mechanisms, in addition to those applicable to the more "standard" types of disputes.

Due to the number of potential data and time variables commonly found in PFP/PPR disputes, Contract provisions to address their resolution must be detailed and comprehensive. However, the complexity of the task should not dissuade the Group's counsel from addressing these critical issues. The sample PFP/PPR Disclosure And Dispute Resolution clause ("Sample Clause") below illustrates the drafting complexity necessitated by the "perfect storm" combination of (i) an increased percentage of total Physician compensation received through PFP programs; (ii) the expansion of PPR programs in response to increased demands for quality and performance transparency; and (iii) technology that permits nearly instantaneous publication of PPR results data to a potentially unlimited audience of employers, patients and other providers:

> **PFP/PPR Disclosure and Dispute Resolution**
> (a) For each contractual performance measure addressed in the PFP Program the PPR Program (each as defined in Sections X and Y of this Agreement), Plan shall provide to Group, within thirty (30) days after its reasonable request, all data and supporting documentation (including all patient lists and all enrollee eligibility histories) utilized or relied upon by Plan in calculating the baseline, performance, and the settlement or results/achievements of each Group Physician with regard to such performance measure.. In addition to any other disclosure made pursuant to this paragraph, Plan shall provide to Group, without need for specific request for same, all of the above-referenced data, supporting documentation, and amounts relied upon in connection with the Annual PFP Program Settlement described in Section Z of this Agreement. This provision shall not require either party to disclose proprietary information to the other party; however, all settlements and results/achievements for PFP Program measures shall be based on data and information that is disclosed to Group.
>
> (b) No quality or efficiency performance data, rating, or ranking regarding any Group Physician, including those related to the PFP Program or PPR Program (each as defined in Sections X and Y of this Agreement) shall be published or distributed to anyone outside of Plan and the

Group, regardless of its form or format (e.g., website, printed directory, etc.) until at least thirty (30) days after Group and the Group Physician(s) in question have received both written notice of the specific performance data, rating, or ranking proposed for publication or distribution and the data, supporting documentation, and amounts relied upon in connection with the Annual PFP Program Settlement described in Section Z of this Agreement. This provision shall apply to only performance data, ratings, and rankings prepared and/or calculated by the Plan, and shall not prohibit Plan from providing links on its website to any third-party which publishes quality data or rankings (e.g., Leapfrog Group).

(c) In the event that Plan, Group, or any Group Physician disagrees with any data, rating, or ranking received from or proposed by the other party, that entity may request an in-person meeting between the Plan and the Group or the Group Physician in question in an attempt to resolve the disagreement. If, and only if, Group or the Group Physician wishes to exercise its right under paragraph (d) of this section to delay the initial publication or distribution of such data, rating, or ranking beyond the thirty-day period specified in paragraph (b) of this section, it must request such in-person meeting within ten (10) days after its receipt of both the notice and the data, etc. required by paragraph (b) of this section. Within ten (10) days after such a meeting request is made, representatives of the Plan and the Group or the Group Physician in question, having the authority to finally resolve the particular disagreement at issue, shall meet and exercise good-faith efforts to resolve the disagreement. If the disagreement is not resolved to the aggrieved party's satisfaction within ten (10) days after the initial meeting request, that party may by written notice to the other party cause the matter to be submitted for review by an independent third-party auditor in accordance with paragraphs (d) and (e) below ("Auditor Review"). If, and only if, Group or the Group Physician wishes to delay the initial publication or distribution of the data, rating, or ranking at issue beyond the thirty-day period specified in paragraph (b) of this section, it must give written notice of its request for Auditor Review within fifteen (15) days after the initial meeting request, and failure to request such Auditor Review within fifteen (15) days after the initial meeting request shall be deemed a waiver of only the right to delay the initial publication or distribution of the data, rating, or ranking at issue beyond

thirty days from the date of its receipt, but shall not constitute a waiver of its right to otherwise pursue Auditor Review.

(d) If the aggrieved party so requests, the quality or efficiency performance data, rating, or ranking at issue shall not be published or distributed to anyone outside of the Plan and the Group until the completion of the Auditor Review; provided, however that if, as a result of the Auditor Review, the Plan is precluded from initially publishing or distributing any quality or performance data, rating, or ranking beyond the thirty-day period specified in paragraph (b) of this section, then any PFP Program settlement payment otherwise payable to the requesting party shall also be delayed until the earlier of the completion of the Auditor Review or thirty-five days after the date of receipt of such data. The Auditor Review can be invoked by only the Plan or the Group (on behalf of the Group or any Group Physician), each of which is referred to in paragraphs (c) through (e) individually as a "party" and collectively as "the parties."

(e) The independent third-party auditor ("Auditor") shall be mutually agreed upon by the parties within three (3) days after the request for Auditor Review; provided, that if the parties cannot jointly agree upon the Auditor's identity, each party shall designate an Auditor and give written notice of such designation to the other party, and the two Auditors so selected will select a third Auditor and give notice of the selection to both parties within three (3) days after the request for Auditor Review. In order to be prepared for any potential Auditor Review, Plan and Group shall complete the auditor selection process specified in this paragraph as soon as reasonably possible after the Effective Date of this Agreement, and in any case not later three (3) days after a party's request for Auditor Review. The single Auditor selected in accordance with this paragraph will conduct such data audit as the Auditor deems necessary. Within five (5) days after selection of the Auditor, each party shall submit to the auditor a concise statement of its position and all of the data and information at issue in the dispute, and such other data or information as the auditor may reasonably request. If either party fails or refuses to comply with the preceding sentence, the Auditor shall rule in favor of the other party to the dispute. Upon request of either party, the Auditor shall execute a confidentiality agreement consistent with the terms of this Agreement. The Auditor shall issue a written decision within fifteen (15)

> days after his or her selection, unless both parties mutually agree upon a later date. The Auditor's decision shall be final and binding on both parties and shall be promptly implemented and effectuated by the parties. The party who does not prevail in the review shall pay the costs of the Auditor. For these purposes, "prevail" shall mean receipt of a favorable Auditor decision on at least a majority of the issues involved in the review, as determined by the Auditor.
>
> (f) If the Auditor's decision is adverse to Plan and relates to performance data, or a rating or ranking previously published by Plan, Plan shall, within ten (10) days after issuance of the Auditor's decision, both remove the data, rating, or ranking from any website to which it was published, and publish the corrected data, rating, or ranking, and notice of the correction in all media (electronic, paper, and otherwise) through which it was originally published, including all materials provided to its employer customers.

In a May 2007 presentation, the author noted that very few Contracts then contained PFP or PPR disclosure and dispute resolution provisions as detailed and complex as those in the above example, but questioned at what point such provisions would become the norm and the "standard of care," if the intensity of the "perfect storm" continued to increase. Recent events in New York and Washington suggest that we are approaching that point more quickly than many of us previously expected.

D. The New York Attorney General's Settlements With Plans Concerning Physician Performance Measurement, Reporting And Tiering Programs

As the result of an investigation by New York Attorney General, Andrew Cuomo, first publicized last summer, virtually all of the major national Plans[12] have entered into agreements with his office generally entitled "Agreement Concerning Physician Performance Measurement, Reporting And Tiering Programs." Links to copies of each of those agreements (the "NYAG Agreements") can be obtained from the "Press Releases" page of the New York Attorney General's website.[13] A copy of the NYAG Agreement with Health Insurance Plan of Greater New York and Group Health Incorporated (hereinafter "HIP/GHI Agreement") is attached as **Appendix 2** to this outline.

While there are differences between the various NYAG Agreements, they all share the following three premises:

1. "[B]ecause measuring physician performance is relatively new, complex and rapidly evolving, the need for transparency, accuracy and oversight in the process is great.
2. "[W]hen the sponsor is an insurer, the profit motive may affect its program of physician measurement and/or reporting. This is a potential conflict of interest and therefore requires scrutiny, disclosure and oversight by appropriate authorities.
3. "[A]any initiatives to measure quality and cost-efficiency of physicians have the potential to cause confusion if not conducted and communicated appropriately, and could result in a violation of law.[14]

Each of the NYAG Agreements delineates the agreement of the applicable Plan(s) to abide by what are described as "a set of best practices for the proper disclosure, attention to accuracy and oversight of physician, performance measurement, reporting

[12] CIGNA, Aetna, Empire Blue Cross Blue Shield, UnitedHealthcare, Health Insurance Plan of Greater New York, Group Health Incorporated, and Independent Health Association, Inc.
[13] http://www.oag.state.ny.us/press/agpress07.html.

and tiering (including rating, ranking or measurement designation) programs."[15] The "core principles" of all of the NYAG Agreements are identical: "accuracy and transparency of information, oversight of the process, and fairness in comparison of physicians."[16] While a detailed analysis of the NYAG Agreements is beyond the scope of this outline, several points regarding them are worth noting.

First, many key terms of the NYAG Agreements address one or more of the eight PFP/PPR concerns listed in Section II.A of this outline, and closely track the Sample Clause for PFP/PPR disclosure and dispute resolution provided in Section II.C of this outline. The NYAG Agreements require, among other things, all of the following (with citations to the applicable paragraphs in the HIP/GHI Agreement):

- Full disclosure of "[t]he basis and data used, and its relative weight or relevance to the overall rating" for both quality and efficiency measures [¶ 6];
- Quality performance measures of "that are based on nationally-recognized evidence-based and/or consensus-based clinical recommendations or guidelines;" [¶ 6]
- That in measuring cost-efficiency, Plans must use "appropriate and comprehensive episode of care software," make "appropriate risk adjustment," and "compare physicians within the same specialty within the appropriate geographical market;" [¶ 9]
- That Plans disclose to consumers, *inter alia*, that physician performance ratings "have a risk of error;" [¶ 20]
- That physicians "have the right to correct errors and seek review of data, quality and cost-efficiency performance ratings and inclusion or exclusion in any tier (including rating, ranking or measurement designation)," to "submit any additional

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[14] HIP/GHI Agreement, ¶¶ 2, 3.
[15] *Id.* at ¶ 1.
[16] *Id.* at ¶ 4.

information, including that contained in medical charts, for consideration;" [¶ 22]

- That Plans must "provide [for physicians] a reasonable, prompt, and transparent appeals process;" [¶ 22]
- That Plans give physicians a detailed notice "[a]t least 45 days before making available to consumers any new or revised quality or cost-efficiency evaluations or any new or revised inclusions or exclusions in network tiers (including rating, ranking or measurement designation);" [¶24]
- That Plans "make no change in the physician's quality and cost-efficiency rankings or designation until [a timely-made] appeal is completed;" [¶24]
- That each Plan "use its best efforts to ensure that the data it relies upon is accurate, including a consideration of whether some medical record verification is appropriate and necessary;" [¶25] and finally,
- That Plans "promptly complete and maintain in good standing a review of its physician performance measurement and reporting process by" "a Ratings Examiner ('Rx')," that is a "nationally-recognized standard-setting organization." [¶26]

The NYAG Agreements tend to focus more on general requirements that must be met or goals that must be achieved, than on specific procedures by which to meet or achieve them. Given how closely many of their terms track the Sample Clause, portions of that Sample Clause could be used or adapted to "operationalize" the NYAG Agreements. In that regard, the Sample Clause creates an enforcement mechanism (the "Auditor Review") to serve retrospectively, many of the functions that are to be served prospectively by the Ratings Examiner or "Rx" under the NYAG Agreements.

Second, like the Settlement Agreements from *In Re: Managed Care Litigation with Charles Shane, M.D., et al.*, did for many managed care contract provisions, the NYAG Agreements have essentially become the *de facto* industry standard for PPR and,

by extension, PFP programs. The NYAG Agreements were expressly adopted by virtually all of the "major player" Plans for not only themselves, but also "any subsequent owner or operator (whether by merger, transfer of control, contractual arrangements, or other means) of all or any substantial portion of" the Plan.[17] That fact makes it very difficult for any Plan to justifiably reject their terms wholesale, regardless of the Plan's service area and regardless of whether it is, or is not a named party to one of the NYAG Agreements. Despite the relative recency of the NYAG Agreements, compare the text already found on any major Plan's website regarding its PPR procedures, with the text of the HIP/GHI Agreement attached to this outline as **Appendix 2**. The degree to which the former already tracks the latter may surprise you.

Given all of the above, the NYAG Agreements have become a powerful tool for physicians' counsel in their negotiations regarding PPR/PFP program terms and related disputes. It should be noted, however, that the NYAG Agreements expressly provide that they do *not* "deprive or confer upon any consumer or other person or entity of any private right under the law."[18]

On January 9, 2008, after the deadline for submission of this outline but before its distribution, the HMOs and Health Plans Practice Group will sponsor a teleconference, entitled "Health Plan Tiering Arrangements: A New Paradigm." The teleconference is to "address the implications of this model arrangement [in the NYAG Agreements] for designing and implementing tiered provider networks based upon quality and efficiency." In addition to a high-quality source for additional information on the latest developments

[17] *Id.* at ¶ 32.
[18] *Id.* at ¶ 33.

in PPR programs, the teleconference is, in the author's opinion, one more excellent reason to purchase a subscription to the AHLA's _health law archive_.

E. The 2008 Physician Quality Reporting Initiative

As if the PFP/PPR developments with the commercial Plans were not enough, CMS is rapidly expanding previous PFP pilot programs with the 2008 Physician Quality Reporting Initiative ("PQRI"), funded to the tune of $1.35 billion. A detailed discussion of PQRI is beyond the scope of this outline, and PQRI is being addressed as part of a separate conference session ("*Reimbursement and Payment Regulatory Issues for Physicians,*" Session O).

The 119 PQRI measures for 2008 are set out in the Medicare Physician Fee Schedule Final Rule, published in the *Federal Register* on November 27, 1997 ("Final Rule").[19] (Contrast that with 148 measures listed in the Proposed Medicare Physician Fee Schedule Rule,[20] and 74 measures in the 2007 PQRI.[21]) Select excerpts from that Final Rule, and the two-page CMS summary of the PQRI portions of the 2008 Medicare Physician Fee Schedule Final Rule, are collectively attached as **Appendix 3** to this outline. All of the 2007 and 2008 PQRI measures and related documents are available for download from the CMS web site, http://www.cms.hhs.gov/PQRI.

It should be noted that the 2008 "PQRI bonuses are financial incentives to participate in a voluntary quality reporting program."[22] Under the program, bonuses are earned not by achieving substantive quality targets but by simply reporting date for a specified percentage of claims on a given number of measures. In the Medicare Physician

[19] 72 FR 66221, 66345 - 66350 (Nov. 27, 2007).
[20] 72 FR 38195 - 38202 (Aug. 15, 2007).
[21] *See* 72 FR at 66336.
[22] 72 FR at 66358.

Fee Schedule Final Rule, CMS described the financial aspects of the 2008 PQRI by comparing them to those of the 2007 PQRI. It wrote as follows:

> Section 101(c) of MIEA–TRHCA authorizes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. Eligible professionals, who choose to participate and successfully report on a designated set of quality measures for services paid under the Medicare Physician Fee Schedule and provided between July 1 and December 31, 2007, may earn a bonus payment of 1.5 percent of their allowed charges during that period, subject to a cap. In the CY 2008 PFS proposed rule (72 FR 38206), **we proposed that the physician quality initiative for CY 2008 be structured and implemented in the same manner as the 2007 PQRI, as described above**. This includes calculating the amounts of the 2008 bonus payments based upon a percentage of allowed charges, as was statutorily required for 2007 bonus payments. 72 FR 66358 (emphasis added).

Unfortunately, CMS has asserted the voluntary nature of PQRI as justification for the fact that PQRI bonuses "were not intended to cover the costs of significantly improving the infrastructure of eligible professionals."[23] Given the extraordinary pressure on CMS to reduce Medicare expenditures while improving quality of care, one can anticipate that the now-voluntary PQRI may rapidly transform into a mandatory PFP program where the dollars at stake are not "new money" bonuses, but a percentage of what had previously been the base reimbursement. At such a time, significant infrastructure improvements by physicians will no longer be luxuries, but basic requirements for financial survival.

One positive aspect of the PQRI is that, like PPR under the NYAG Agreements, the PQRI provides for full disclosure of program details in advance of the program's reporting commencement date, and ensures certainty by prohibiting mid-game rule

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[23] *Id.*

changes. Thus, CMS emphasized that the measures it had identified for 2008 were "final as of the effective date of [the] final rule, and no changes (no additions or deletions of measures) will be made after that date."[24] CMS went on to note that, while it might "make modifications or refinements, such as code additions, corrections, or revisions, to the detailed specifications for the 2008 measures until the beginning of the reporting period … No further changes to the specifications will be made after the start of the 2008 reporting period."[25]

One additional area in which the 2008 PQRI excels is the extensive detail found in the formal "specifications" for each of its 119 measures. An excerpt from the "2008 Physician Quality Reporting Initiative Specifications Document" [26] is attached as **Appendix 4** to this outline. It serves as a great example of the type, quality and quantity of detail contemplated by the sample language following Scenario #1 in Section II.B of this outline. If the contemplated manual for your client's PPR/PFP program will not be completed or attached as an exhibit to your client's Contract at the time of its execution, consider attaching an excerpt from the 2008 PQRI Specifications Document as an exhibit to the Contract, together with Contract provisions mandating that the same type, quality and quantity of detail be provided in the Plan's specifications for the measures included in its PPR/PFP program.

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[24] 72 FR 66345.
[25] *Id.*
[26] Available at http://www.cms.hhs.gov/PQRI/downloads/2008PQRIQualityMeasureSpecs123107.pdf.