

Status Report
Linking Payment to Performance:
A Joint Health Purchasing Project



From:

The Washington State Health Care Authority

As Required by ESSB 6090, Section 213(7)

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Table of Contents:

	Page
Executive Summary	1
Introduction and the Decision Making Process	2
Data and Proposed Projects	5
Other Activities and Suggestions for Legislative Support	10
Exhibit 1: L&I Project Measures	11
Exhibit 2: UMP Invited Clinics	12
Exhibit 3: UMP Measures, Reward Levels, Expected Outcomes	13

Executive Summary

Engrossed Substitute Senate Bill 6090 includes a budget proviso which directed the Department of Social and Health Services (DSHS), the Department of Labor and Industries (L&I), and the Health Care Authority (HCA) to design and implement a “joint health purchasing project” linking payment to performance, particularly where such efforts could improve outcomes, reduce variations in clinical practice, and “yield measurable and significant savings” by use of evidence-based performance measures and payment incentives. The proviso also mandates the submission of a report to the Legislature by December 1, 2006, on the status of the purchasing project, including savings projections. This report provides information on the status of interagency efforts, key accomplishments, and outlines future agency activities.

The three agencies created a joint work group to plan and carry out the work stipulated by the proviso. The work group selected prescription drugs as the focus for the purchasing project as prescription drugs have a significant impact for all three purchasers; the Prescription Drug Program allows for data gathering and analysis that is not possible without significant investment for other medical practice areas; and this focus aligns with private payers in the state providing a greater chance for success given the agencies limited resources for this project. Work done to support the proviso followed two tracks:

Development of proof of concept reports to profile individual prescribers across all three agencies. Such profiles could help with identifying shared contracting providers, prescribed medications, and differences in prescription patterns. This could add to the state’s purchasing leverage, and create additional efficiencies for administering pay for performance initiatives.

Creation of three individual incentive pilot projects to spur increased compliance with the Washington State Preferred Drug List (PDL), and increased generic prescription rates.

- L&I is working with orthopedic and neurological surgeons to increase access and appropriate care for injured workers. The initiative measures prescriber use of preferred drugs from the PDL as one of its critical performance measures.
- The HCA project creates incentives for the use of generic drugs and an increase in PDL compliance for twenty-four pilot clinics contracted with the Uniform Medical Plan
- The DSHS project plans to work with the Washington State Medical Association and the Puget Sound Health Alliance in the Quality Improvement Initiative to profile providers based on a wider pool of data than is currently available.

The projects have very different assumptions regarding expected savings. All three agencies agree that on average each one percent increase in generic fill rate can decrease pharmacy spending by an equivalent one percent. All of the projects are currently in the beginning or developmental stages. It is, therefore, impossible to accurately gauge the degree of their success. The ability of each agency to change prescription patterns will ultimately define the actual amounts of projected savings. Simultaneously, the agencies are participating in broader efforts to develop additional quality measures for use in designing effective incentive programs in the future.

Introduction and the Decision Making Process

Legislative Direction

In 2005, the Legislature passed SHB 1512 (codified as Chapter 446, Laws of 2005) which directed the Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) to collaborate with other state agencies that administer state purchased health care programs, private health care purchasers, health care facilities, health care providers, and health insurance carriers to use evidence-based medicine principles to develop common performance measures, and to incorporate purchasing strategies which would:

- Reward improvements in health outcomes for people with chronic diseases, increased use of appropriate preventive health services, and reductions in medical errors; and
- Increase, through appropriate incentives to insuring entities and providers, the adoption and use of information technology contributing to improved health outcomes, better coordination of care, and decreased medical errors.

Since the passage of this legislation, HCA and other state agencies have been working with the Puget Sound Health Alliance (the Alliance) to:

- Produce quality, efficiency, and patient experience reports comparing the performance of medical clinics and hospitals.
- Adopt evidence-based treatment guidelines consistent with national standards.
- Support the adoption of interoperable health information technology to improve efficiency and enable more accurate ways to assess health quality outcomes.

Also in 2005, the Legislature passed ESSB 6090 which includes a budget proviso [codified as Chapter 518, Laws of 2005, Section 213 (7)]. The proviso directs the Department of Labor and Industries (L&I), DSHS, and HCA to design and implement a “joint health purchasing project” linking payment to performance, particularly where such efforts could improve outcomes, reduce variations in clinical practice, and “yield measurable and significant savings” by use of evidence-based performance measures and payment incentives. In support of the proviso language, the three agencies created a joint work group. The work group evaluated current literature on incentive programs and presented an action plan. This report summarizes the work of the three agencies in fulfilling the legislative directive in this budget proviso.

Lessons, Challenges, and Opportunities

An assortment of incentive strategies targeting health plans, providers, or consumers emerged over the last decade, with mixed results. Generally, all aim to change some performance or outcome indicator by using incentives or disincentives. Strategies aimed at health plans usually focus rewards on improvements along defined process measures and assume resulting improvements in outcomes.¹ As L&I does not deliver care through health plans, the group saw

¹ Measurement scoring data sets include HEDIS® (Health plan Employer Data and Information Set) and CAHPS® (Consumer Assessment of Healthcare Providers and Systems), evaluating process measures and patient satisfaction, respectively.

this option as outside the proviso mandate for a joint project. Strategies to target consumers posed other problems. These usually steer patients to preferred providers or lower cost drugs by changing premium prices or co-pays. However, approaches based on price sensitivity are not applicable to Medicaid clients and L&I injured workers with no out-of-pocket costs for their care.

The work group, therefore, chose to target provider behavior directly. In 2005, L&I paid over 120,000 claims for work-related injuries and occupational diseases. DSHS now provides fee-for-service care to over 400,000 Medicaid clients and the Uniform Medical Plan (UMP) purchases care for over 160,000 people. Targeting providers can indeed change care delivery for these beneficiaries. Simultaneously, it poses several challenges. One big challenge is the difference in the agencies' business models. While UMP and Medicaid mainly pay for medical costs; L&I also deals with replacement of workers' income (time loss). Potential for joint focus is further narrowed due to different prevalence of medical conditions for workers' compensation and traditional medical benefit plans. Simultaneously, even were the agencies to purchase care in similar ways, they are not identical. For example, in the case of multi-specialty clinics, UMP contracts with the provider clinics while DSHS contracts with individual providers, making it challenging to apply the same tools.

Another challenge is the workload of individually targeting providers due to the variety of efforts required for proper monitoring and intervention. Purchaser interventions presume individual contacts with targeted providers to explain project goals, measures, and incentives. This requires well-developed outreach capabilities. In addition, before a purchaser contacts each targeted provider, the purchaser must be able to evaluate the provider's present behavior and any subsequent changes. Evaluations of individual behavior demand an analytic infrastructure capable of identifying, benchmarking, and analyzing change along defined measures for thousands of providers. This in turn predicates a significant additional resource commitment.

This raises a third substantial design challenge: any data obtained must be shared with providers and all participants in the process must accept its validity on multiple levels. For example, a lack of communication with, and buy-in from, affected parties can cause challenges from stakeholders and result in loss of confidence. If all participants do not accept the validity of the project's goals, measures, or data, stakeholders may ultimately see it as misguided, ineffectual, or worse, simply as another cost control effort at the expense of patient satisfaction and provider quality.

Unintended behavior changes are another potential result. Recent studies suggest that even if positive outcomes are reported, occasionally this is because of administrative changes (such as an undesired change in patient selection or a different way of bookkeeping) rather than due to positive changes in the health of the targeted population.²

² Werner, R. M., & Asch, D. A. (2005). The unintended consequences of publicly reporting quality information. *Journal of the American Medical Association*, 293(10), 1239-1244. See also, Petersen, L. A., Woodard, L.D., Urech, T., Daw, C. & Sookanan, S. (2006). Does pay-for-performance improve the quality of health care? *Annals of Internal Medicine*, 145(4), 265-272.

These examples suggest that incentives need to be developed with due care to elicit positive behavior change. The work group conducted a review of available literature and identified several prerequisites for successful program design:³

- Programs must have a clear set of desired outcomes and have resources to create incentives which providers would see as worth pursuing.
- Desired outcomes must be measurable along a set of performance indicators.
- Providers must see these as valid measures over which they have control.
- Stakeholder efforts must be proportional to the degree of expected behavior change.
- Resources to collect and analyze data must exist or be acquired.
- Programs should align with market efforts to focus provider attention.
- Programs must systematically reevaluate project measures to gauge if incentives produce desired outcomes, unintended consequences, or gaming of the system.

Using the budget proviso the work group also developed a set of operative assumptions:

- The report on the purchasing project is due December 1, 2006.
- The project has no dedicated funding.
- No data infrastructure exists to analyze provider performance across agencies.
- The project must aim for greatest impact and account for agencies' business needs.

After examining the effective program design requirements and operative assumptions, the work group evaluated several potential options for joint activity. Following a robust discussion, the work group decided to target provider prescribing behavior, for several reasons. Prescription drugs are of significant concern for all three purchasers. Analysis of provider behavior across all three agencies is necessary for establishing a practice baseline for any pay for performance project, and the existence of the Prescription Drug Program (PDP) allows for data gathering and analysis regarding prescription behavior in a way not possible without significant investment for other medical practice areas. Finally, this direction is aligned with payers in the state and the Alliance, enhancing the chances for positive results.

The work group brought the PDP into the discussion and obtained data sharing commitments from all participants. After discussing options for creating a single project, the work group agreed that agency cooperation would follow two tracks. First, an analytical infrastructure would be attempted to allow for provider evaluations across one or more agencies, and the setting of current practice baselines needed for the development of any effective incentive program. Second, independent pilots using common measures would be created by the agencies in accordance with the agencies' business practices and current priorities.

³ A primer on designing provider incentive programs is Bailit Health Purchasing, LLC (2002). *Provider incentive models for improving quality of care*. Retrieved November 7, 2006 from <http://www.bailit-health.com/articles/NHCPI-incentive-models.pdf>.

Data and Proposed Projects

Data Challenges

The goals of the pilot programs include increasing compliance with the state Preferred Drug List (PDL) and increasing provider generic prescription rates. Creating an infrastructure to evaluate provider behavior for the three agencies requires careful analysis of a staggering amount of claims data. Over the course of a year, Medicaid processes millions of prescription claims submitted by nearly twenty thousand different prescribers. Though both UMP and L&I have fewer beneficiaries and providers, the volume of each agency's drug claims data is huge and requires a concerted, focused analytical approach.

Drug claims, though available, are quite complex. Identifying a drug from claims data requires decoding an 11-digit National Drug Code from each claim. Multiple codes exist for each drug, identifying strength, dosage form, manufacturer, and package size. Nearly one-quarter million unique codes exist to track approved medications. This compares to about ten thousand diagnosis codes to categorize all known health conditions within the International Classification of Diseases. Linking claims to prescribers is yet another challenge as payment or denial of performance incentives requires accurate matching of each claim with the right prescriber. Prescribers are not identified by name on a drug claim, only by Drug Enforcement Agency (DEA) codes. Multiple prescribers (Advanced Registered Nurse Practitioners, Physician's Assistants, etc.) can write on a single DEA code. Because the codes can be used to illegally obtain prescriptions, lists of providers and their associated DEA codes are not publicly available or easily verifiable against a master list.

Data Activities

The proviso provided an impetus to attempt the creation of a framework for profiling individual prescribers. The focus on prescription drugs illuminated the potential for building a master provider database across agencies. Currently, to the extent they exist, provider profiling efforts are maintained within each agency. Combined reports could offer a framework to evaluate possible agency cooperation to profile providers by identifying shared contracting providers, prescribed medications, and differences in prescription patterns. Conversely, they may offer data to show why joint action would not be desirable. If accepted as valid by all involved parties, such reports could lead to an aggregate state purchasing data set for use in discussions with providers by any one agency. This could lead to more accurate provider profiling, add to the state's purchasing leverage, and create additional efficiencies for administering pay for performance initiatives. However, although such data may end up explaining agency-specific distinctions in provider behaviors, and offering other benefits for formulating policy, it remains unclear what practical value it has for aiding purchasing decisions until it is gathered and examined.

To try and answer some of these questions, the PDP at HCA designed a template for each agency to "pull" data on providers and prescribed drugs from their respective claims warehouses in order to profile individual providers' compliance with the PDL and overall

generic fill rate (GFR) outside of the PDL in 2005.⁴ Agencies approached this data request with two goals in mind; creation of a data processing and analytic infrastructure for exploration of future joint activity, and a view to utility for pilot projects. The agency approaches differed in terms of data priorities, claims detail availability, response times, and levels of “completeness” of submitted data.

Ultimately, the work group did not create combined provider reports across agencies. Currently, there is no standard provider number with which to electronically match L&I, UMP, and Health and Recovery Services Administration (HRSA) providers to create pharmacy reports. Without such an identifier, creating such reports is very labor intensive, requiring manual matching on name, address, and other fields. The agencies involved in the project determined that given agency priorities and the uncertain value that the resulting information may offer, such work was too resource intensive to be attempted at the current time. With the advent of the National Provider Indicator, combining prescriber-specific data across the three agencies may become easier by 2008. However, such an approach would need to be re-evaluated at that time, as similar work done by the Alliance across a wider set of payers may obviate the need for a narrower data set offered solely by the three agencies. However, the work group did utilize the submitted data to create proof of concept reports in support of the agencies’ projects.

While the work group made no practical use of the data submitted by L&I, UMP data did become the foundation for a set of proof of concept reports designed to demonstrate the feasibility of profiling provider prescribing behavior by PDL drug class. To increase the reliability of the individual provider estimates reports only named providers who had written at least 50 scripts for the specific drug class in 2005 were included in the reports. Resulting reports showed the PDL preferred percentages for each drug class, the number of “dispense as written” (DAW) claims, and the non-PDL generic percentages for selected providers. Drug class-specific reports were produced separately for “endorsing” and “non-endorsing” providers.⁵

HCA also developed provider-specific generic utilization reports using data obtained from the HRSA fee-for-service networks. HCA provided HRSA with simulations designed to estimate the potential savings to their drug program from increasing generic use by the profiled providers. Focusing on the first six months of 2006, the HRSA reports added detailed cost information on each provider’s total drug spend and clients seen for named prescribers who had written at least 250 prescriptions during the period.⁶ Simulations modeling cost reductions from increased generic substitution suggest that for every one percent increase in generic use there was a corresponding average one percent drop in drug costs (the range was 0.8 - 1.5 percent). The analysis also suggested that the potential savings per prescriber contacted was nearly twice as high for providers with the lowest rate of generic use.

⁴ See Technical Appendix A, located on the internet at <http://www.rx.wa.gov/data/>.

⁵ De-identified versions of these reports are included in Technical Appendix B located on the internet at <http://www.rx.wa.gov/data/>.

⁶ De-identified versions of these reports are included in Technical Appendix C located on the internet at <http://www.rx.wa.gov/data/>.

Project Descriptions

Labor & Industries

As demonstrated by the design and execution of pilot projects such as COHE, L&I has a well-developed track record for creating and evaluating incentive projects to improve health care outcomes and reduce costs. For the purposes of the proviso, L&I is tailoring an existing pay for performance pilot project. The project aims to increase timely access to needed care for injured workers to improve health outcomes, and reduce the time before a return to work. Incentives target orthopedic and neurological surgeons to improve practice patterns using six performance indicators. For the purposes of the proviso L&I is using the fifth of these (Measure E on Exhibit 1) to address prescription behavior. To be eligible for participation in the pilot project, providers must sign up as an endorsing PDL provider for therapeutic interchange if they have not done so previously. L&I is using 100 percent endorsement as a benchmark for all pilot participants. In addition, providers must have a DAW rate of less than ten percent for PDL non-preferred drugs to meet the goal of the prescription measure.

L&I and UMP initially agreed to focus on seven drug classes. Five of the classes are targeted for increased generic utilization by the Alliance, aligning agency efforts with those of other major payers in the region. Unlike UMP, L&I is not focusing directly on GFR with the current pilot. However, of the seven targeted drug classes, six are on the PDL with generics predominating as the preferred PDL options⁷. The other targeted class, antibiotics, also has a strong generic presence. Thus, increasing PDL compliance (or decreasing DAW rate for non-preferred drugs) will also increase GFR, further aligning agency efforts with those of other major payers in the region. The pilot started in July 2006 and will end in June 2008. An evaluation will be conducted within six months after the pilot ends.

Uniform Medical Plan

UMP developed a pilot project strategy that like that of L&I, stressed PDL compliance, but also stressed the use of generic drugs for six of the seven classes listed above. To evaluate the savings potential of increased generic drug use, UMP used a national Express Scripts, Inc. (ESI) study that estimated generic opportunities in six of the most widely used therapy classes. Six therapy classes accounted for 41 percent of 2004 drug spend and emerged as having the most potential for savings. Based on ESI estimates of current GFR for these six drug classes UMP hopes to attain savings by improving its GFR for the same six classes as well as improving overall GFR from the current 60 percent to 65 percent. For the 2007 plan-year UMP is changing its plan wide co-payment structure for prescription drugs, most importantly by exempting generic drugs from the prescription deductible. This should create an incentive for patients to ask for generic medications. Simultaneously, it is developing a pilot project to target providers directly. This approach will evaluate the effect of targeting providers for specific interventions and will also more narrowly target individual GFR rates in the six drug classes.

⁷ The PDL classes are: statins, second generation antidepressants, proton pump inhibitors, non-steroidal anti-inflammatory drugs, skeletal muscle relaxants, and long acting opioids.

UMP's project selected twenty-four clinics with a current UMP group contract for a proof of concept pilot project. Each clinic has a minimum of 20 providers and provided care to at least 300 UMP enrollees (per 2005 claims data). The clinics will be invited to join the program (list of clinics attached as Exhibit 2). Clinics will be asked to supply UMP with DEA numbers for their primary care providers on a monthly or quarterly basis and will be evaluated along several performance measures, including overall and class-specific GFR benchmarks, PDL compliance, and endorsement for therapeutic interchange.

Clinics will be rated along a three-tier system depending on their success in meeting a set of GFR or PDL compliance goals. Participants will receive quarterly incentive payments if they meet the performance goals specified for a given tier (see Exhibit 3 for a list of measures, reward levels, and expected outcomes). Subsequent to the end of the 2007 plan-year, UMP will be able to compare the GFR rates for the plan as a whole to those for 2006 (evaluation of benefit change effect) and compare pilot clinics to others not in the pilot project (evaluation of pilot effects against those of benefit change alone).

Department of Social and Health Services

DSHS plans to work jointly with the Washington State Medical Association's (WSMA) Education and Research Foundation, and the Alliance in the Quality Improvement Initiative. This initiative will combine medical and pharmacy claims data from multiple payers to create provider-specific reports to offer a performance baseline, allow comparison with peers, and identify "best practices" and outliers. Reports identify all of a provider's patients (public and private pay) to improve preventive and chronic care. The program is HIPAA-compliant in that patient-specific data is shared only with providers that have a current patient-provider relationship.

HRSA currently spends approximately \$3.5 billion in health care costs for approximately one million clients. Of these, the sickest five percent of patients incur approximately fifty percent of total medical costs. The chronic conditions addressed by the initiative represent significant agency costs and client risks. Approximately \$280 million of the HRSA medical spend is on drugs. Currently 60 percent of prescriptions are generic accounting for approximately 40 percent of the drug budget. Though the HRSA fee-for-service 2005 GFR of 61 percent exceeds the state average of 56 percent, higher rates are possible. The Everett Clinic has a very high GFR (73 percent). As previously noted, a one percent GFR increase can save between .8 and 1.5 percent of total drug costs. Medicaid's top 2,400 prescribers account for \$103 million of the pharmacy spend with a large variation of GFR (i.e., 13 to 99 percent). By comparing providers to peers and identifying best practices and outliers, the program can reduce variation, increase GFR, and reduce costs.

Collaboration with WSMA and the Alliance would lower Medicaid's risk for provider-specific profiling and increase the likelihood for success. The initiative creates synergies with current HRSA initiatives, including the medical home, case management, predictive modeling, and the PDP/PDL, and may enhance the effectiveness of each. For the proviso, HRSA will work with the initiative to support provider-specific quality reports and disease registries by:

- Providing WSMA with quarterly claims and encounter data.

- Working with WSMA to define provider-specific data, identify best practices and outliers, and form strategies for quality improvement.
- Using the data HRSA and WSMA will work toward incentives/rewards and identification of outliers.

Projects Summary

The three projects take different approaches to attain similar goals. By working with stakeholders, and tying prescription behavior to other indicators, the projects have a real potential to address some very visible cost and variability issues facing state health care purchasers. The projects also have very different assumptions regarding expected savings. All three agencies agree that on average each one percent increase in generic fill rate is estimated to decrease pharmacy spend by an equivalent one percent. In some cases, such as UMP, enrollees also pay a lower co-payment for a generic drug, saving an average of \$10 per prescription compared to a non-generic drug.

For L&I, the savings from increasing PDL compliance are only a small portion of those expected from the pilot as a whole, and are hard to predict at this time. A formal evaluation process will be conducted at the end of the pilot project. For DSHS, potential savings are also hard to quantify since the pilot project is a cooperative effort with other stakeholders and is in its initial developmental stage. However, proof of concept modeling done for DSHS as part of the work under this proviso, suggests that if the lowest quartile of HRSA generic prescribers (i.e., those writing more name brand prescriptions than anyone else) were motivated to change their behavior by just a five percent GFR increase, this would lead to savings of just over \$4 million, or \$6,034.71 per prescriber.

For UMP, the goal for the benefit changes and the generic incentive program is to increase the overall generic utilization from 60 percent to 65 percent. This could be as much as five percent of \$106 million spent on prescription drugs in CY 2005, and could reduce UMP drug spend by as much as \$5.3 million. Additional savings from the pilot clinics are unknown at this time, but can be evaluated once CY 2007 claims data is available.

Other Activities and Suggestions for Legislative Support

All three agencies strongly support the addition of incentive programs to our toolkits. L&I has a long history of pilot projects to evaluate specific incentives, improve patient care and decrease state costs. One such endeavor is the COHE pilot program. COHE demonstrates many positive features necessary for success. It combines pertinent incentives, extensive stakeholdering, widespread community involvement, and innovative use of information technology with a solid analytic infrastructure and periodic evaluations. This program is viewed as a possible model for future state incentive program pilots.

DSHS and HCA are actively working with the Alliance, health plans, providers, and major purchasers in Washington State to establish a single analytical infrastructure that could serve as a foundation for subsequent incentive-based programs. The Alliance is working to establish a common set of measures for future collection of efficiency and quality provider data.

In November of 2006, UMP will submit medical and pharmacy claims data to the Alliance for use in creating health care provider standard quality measures. UMP data will be pooled with that from other major commercial payers in the region to develop quality metrics, hopefully to be available by early 2007. As outlined in the HRSA project description, HRSA also intends to contribute data to the Alliance in conjunction with the WSMA Quality Improvement Initiative.

The work group strongly hopes that the Legislature recognizes the value of aligning incentive programs with efforts in the wider market. The work group believes that HB 1512 (Chapter 446, Laws of 2005) provides sufficient legal authority for activities in support of these goals, but that dedicated funding to support such efforts is sorely lacking.

In pursuing the worthy goal of developing incentive programs, the work group hopes the Legislature considers several factors which may contribute to future success. The Legislature, working with the Governor, could lend significant aid to future efforts by supporting:

- The Alliance in the creation of a statewide commonly agreed upon set of measures for provider quality and efficiency, and the creation of an analytic infrastructure to evaluate provider data along these measures.
- The creation of a similar structure for evaluating hospital performance.
- The availability of any resulting data to state health care purchasers.
- The creation of and adequate resource allocation to pilot projects within state government to act as laboratories for exploring effective policy options for incentive program design. The COHE project and its evaluative framework is an excellent example of efforts with the potential to significantly contribute to such exploration.
- The needs of incentive projects to develop, acquire, and maintain a strong analytical infrastructure, stakeholder involvement, and effective evaluative tools.
- Enhanced cooperation between state health care purchasers in sharing information on the design, creation, and evaluation of incentive strategies.
- Strategies that recognize the challenges inherent in cross-agency projects, given disparate agency missions, business practices, and authorizing environment.

Exhibit 1

L&I Project Measures

	<u>Indicator</u>	<u>Expectation</u>	<u>Threshold</u>
A	Timeliness of First Visit	Injured worker seen by surgeon within 7 business days of referral	70% of injured workers
B	Activity Prescription Form (APF)	Non-surgical—1 APF Surgical—minimum of 2 APF: 1 pre-surgery, 1 post-surgery	90% of injured workers
C	Intensive Rehabilitation Plan	Complete Rehabilitation section on APF	100% of APFs reviewed
D	Surgery within 3 Weeks	Provide surgery within 21 days of claim manager authorization	80% of injured workers
E	Dispense as Written Prescriptions	Prescribe preferred drugs or allow appropriate substitution	<10% non-preferred drugs
F	Occupational Health Training	Receive Continuing Medical Education training in occupational health annually	100% of participating providers

Exhibit 2

UMP Invited Clinics

Invited Clinics	
<p>King, Pierce, Snohomish Counties:</p> <ol style="list-style-type: none">1. Highline Medical Group2. Pacific Medical Center3. Providence Physician Group4. Seattle Primary Physicians5. Franciscan Medical Group6. Puget Sound Family Physicians7. Virginia Mason Medical Center8. Everett Clinic9. Pediatric Associates10. Polyclinic11. Stevens Healthcare12. University of Washington Physicians13. Multicare Health System14. Swedish Health Services15. Minor & James Medical <p>Kitsap County:</p> <ol style="list-style-type: none">16. The Doctor's Clinic	<p>Spokane County:</p> <ol style="list-style-type: none">17. Rockwood Clinic18. The Physicians Clinic of Spokane <p>Whatcom County:</p> <ol style="list-style-type: none">19. Madrona Medical Group <p>Cowlitz County:</p> <ol style="list-style-type: none">20. PeaceHealth Medical Group <p>Lewis County:</p> <ol style="list-style-type: none">21. Steck Medical Center <p>Nez Perce County, Idaho:</p> <ol style="list-style-type: none">22. Valley Medical Center PLLC-Lewiston <p>Chelan County:</p> <ol style="list-style-type: none">23. Wenatchee Valley Clinic <p>Walla Walla County:</p> <ol style="list-style-type: none">24. Walla Walla Clinic

Exhibit 3

UMP Measures, Reward Levels, Expected Outcomes

Performance Measures:

1. Overall generic fill rate of 65 percent or, for Bronze level only, incremental improvement of 3 percent over current baseline based on Alliance goals.
2. Overall PDL compliance of 90 percent in 2007, or for Silver and Bronze levels only, incremental improvement of 1 percent.
3. Minimum of 95 percent of clinic providers must endorse for therapeutic interchange.
4. Targeted drug class generic fill rates:

	Statins	Anti-depressants	PPI	NSAID	Antibiotics	Skeletal Muscle Relaxant
Baseline Rate	20%	66%	31%	70%	86%	95%
Goal	60%	87%	50%	97%	95%	100%

Incentive Reward Levels:

Gold	<ul style="list-style-type: none"> • Meets or exceeds all benchmark goals for items 1, 2, and 3. • Meets or exceeds all 6 goals in item 4.
Silver	<ul style="list-style-type: none"> • Meets or exceeds benchmark goals in items 1 and 2. • Meets or exceeds at least 4 out of 6 goals in item 4. • At least 50% of clinic providers endorse the PDL.
Bronze	<ul style="list-style-type: none"> • Meets or exceeds the benchmark goals in items 1 and 2. • Meets or exceeds at least in 3 out of 6 goals in item 4.

Expected Outcomes:

Gold	Based on UMP Neighborhood clinic performance, 1 to 4 clinics may reach the level the first year—expected average payment of \$10,000 per clinic.
Silver	About 7 clinics would receive an expected average payment of \$7,500 per clinic.
Bronze	About 5 clinics would receive an expected average payment of \$5,000 per clinic.