

# The Future in Focus

NCQA 2004 ANNUAL REPORT



# TABLE OF CONTENTS

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PRESIDENT'S LETTER <i>Quality: A Collaborative Effort</i>	01
THE FUTURE IN FOCUS	04
GOING TO THE DOCTOR: <i>Yesterday and Tomorrow</i>	12
REWARDING QUALITY IN MEDICARE: <i>Paying for Performance at CMS</i> <i>Essay by Mark McClellan, M.D., Ph.D.</i>	20
CONSUMERS AND HEALTH TECHNOLOGY: <i>Fostering the Health Care Marketplace</i> <i>Essay by David Brailer, Ph.D.</i>	22
QUALITY PLUS: <i>Raising the Bar</i>	24
2004 ACCOMPLISHMENTS	28
2004 SPONSORS	30
2005 BOARD OF DIRECTORS	30
2004 FINANCIALS	32



## PRESIDENT'S LETTER

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# Quality: A Collaborative Effort

**WE'VE LEARNED MUCH OVER THE PAST 15 YEARS ABOUT HOW TO MAKE HEALTH CARE BETTER.** We now know more about the quality of our nation's health plans, hospitals and medical groups than we ever have, and public reporting of performance data has had the impact we intended: it promotes continuous improvement.

Our national challenge going forward is to work on the things we are not yet very good at: building broad, collaborative partnerships designed to foster even greater improvements in efficiency, safety, effectiveness, patient-centeredness, timeliness, and equity—all aspects of quality identified by the Institute of Medicine.

The importance of effective partnerships in the pursuit of improved quality cannot be overstated, especially as the focus of quality measurement and reporting pushes down to the delivery system level. Collaborations between plans and providers, among care delivery organizations and physicians' offices, and even among individual doctors themselves can foster faster and more robust improvement than can any of these entities working independently. Put in terms that illustrate the issue at a very human level, the average Medicare patient sees six different physicians. If those physicians aren't working collaboratively to provide coordinated care to their patients, the patients—and the system itself—are not getting the high performance and value they deserve.

Increased collaboration is a tall order, but it is essential if health care is to behave more efficiently and effectively. Pay-for-performance—which seeks to remedy a payment environment that continues to penalize providers for doing the right things, and incentives that drive patients to high performing providers are examples of important collaborative efforts that push the quality agenda.

This report focuses on the future by profiling a number of specific features that we think are essential to the high quality health care system of today and tomorrow. The essays contributed by Mark McClellan, M.D., Ph.D., CMS Administrator and David Brailer, Ph.D., National Health Information Technology Coordinator, focus on two of the most critical trends in health care today: the broad adoption of pay-for-performance and the emphasis on health information technology investment. These and other initiatives and activities described here will require new levels of collaboration, most importantly between providers and patients, who must form working partnerships based on mutual respect and shared goals.

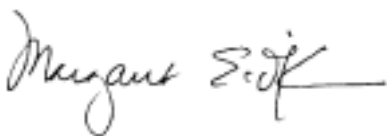
NCQA's newest program, Quality Plus, is designed to highlight innovations such as those described in this report, recognizing health plans that employ cutting-edge practices in areas such as information technology, chronic care management and physician and hospital assessment and compensation. Importantly, Quality Plus considers quality not just from a technical point of view, but from the patient's perspective as well.

The trends we are beginning to see in health care—just-in-time information at the point of patient care, information systems that send reminders to patients about tests and follow-up care, compensation that removes financial barriers to good care—are promising and must be supported. NCQA is very excited to be providing some of that support through Quality Plus.

This report provides me with the annual opportunity to publicly acknowledge and thank the many skilled and dedicated people who work tirelessly with and for NCQA to advance our mission. We have made enormous and very rewarding strides since we first began our work, but, as always, there is still much to do. I am pleased and humbled to say that we have never had a more impressive and talented group of people—staff as well as board and committee members—than we have currently assembled to move our agenda forward.

Together, we remain firmly focused on the future and the many ways in which we will continue promoting the delivery of the highest quality health care to patients throughout our nation's vast and complex health care system.

Sincerely,

A handwritten signature in black ink, appearing to read "Margaret E. O'Kane". The signature is fluid and cursive, with a long horizontal stroke at the end.

Margaret E. O'Kane  
President



*Effective partnerships*

*are critical in the pursuit*

*of improved quality.*

*Keeping patients  
skilled providers and an effective  
care system that*



*healthy requires*

*supports their work..*

NCQA 2005:

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## The Future in Focus

**THERE ARE SOME THINGS ABOUT HEALTH CARE THAT WILL NEVER CHANGE, NOR SHOULD THEY.** At its heart, health care remains one of the most personal of professional endeavors, a human interaction that requires a delicate blend of science, intuition, and compassion.

But surrounding the core skills required in every encounter between physician and patient, is a system that supports—or is supposed to support—that interaction. In today's world, often a doctor can only be as good as the system that surrounds him or her. That “support system” stretches beyond the confines of the health care delivery system itself and includes insurers, purchasers, and even patients, all of whom play a role in promoting high quality care.

Of course the delivery of top-quality care still depends largely on the skill of the provider who delivers it. But given the complexity of medical science today—the emphasis on prevention and aggressive disease management rather than episodic, reactive care; the important role that computers play in information management and communication; the perverse financial incentives still embedded in the system; and all we have learned about the value of engaging patients in their own care—the delivery of top-quality care also depends on a robust system that enables physicians to use new tools to provide better care.



*New and powerful information technology helps providers keep up with patients' preventive care.*

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Consider, for example, the use of computer technology in everything from digital imagery—enabling physicians to share X-rays or MRI images across town or across the world—to electronic medical records and patient registries that give providers immediate access to a patient's medical history, or a summary of how effectively they are taking care of all their patients with, say, diabetes, and how that compares to other physicians in their practice, or other practices across the nation.

There are a number of elements that are increasingly considered essential in the support of high quality health care in this new century. Each of these elements is changing health care as we've known it for the better. Used more widely and in concert, these ideas will be instrumental in shaping American health care into a system that consistently and reliably delivers the high quality of care that those who count on it deserve.

#### *Electronic Medical Records*

Despite the potential they hold to improve care, electronic medical records and computerized reminder systems are not yet widely used in health care. A recent report by the Centers for Disease Control and Prevention (CDC), based on surveys conducted between 2001 and 2003, says that about 31 percent of hospital emergency departments, 29 percent of outpatient departments, and 17 percent of doctors' offices have electronic medical records to support patient care.

Recognizing the important role that information technology (IT) can play in the delivery of high quality health care, in 2004 President Bush established the role of a National Health Information Technology Coordinator to promote more widespread adoption of computerized records in health care, and appointed David Brailer, M.D., Ph.D., to fill it. (See Dr. Brailer's essay on page 22 of this

report.) One of Brailer's tasks is to meet the President's goal of making electronic health records available to the majority of Americans within the next 10 years.

Information technology supports better care in a number of ways. "At the most basic level, it saves time compared to paper," says Louise Liang, M.D., Senior Vice President for Quality and Clinical Systems Support at Kaiser Permanente in California. "But more importantly, it improves care, patient safety, and service."

Computers are powerful patient safety tools. Take computerized physician order entry (CPOE) systems, for example. When orders for drugs and diagnostic tests are entered electronically rather than on prescription pads, the computer system can compare the order against standards for dosing, check for allergies or drug interactions, and warn of potential patient problems. Currently only about eight percent of physicians use CPOE, according to the CDC.

One of the most sophisticated health-related information systems is the one used in the vast Veterans Health Administration (VA) system, where computers are used for electronic health records, CPOE, laboratory test results and imaging studies, and clinical reminders. As one of the largest integrated delivery systems in the country, serving approximately 6 million patients, the VA is also one of the nation's "most wired" health care networks.

It is no coincidence that both Kaiser and the VA are quality leaders, scoring in the highest percentiles of HEDIS measures in many categories.

### *Pay-For-Performance*

As long as health care payment policies continue to reward physicians for delivering units of care, regardless of the quality of that care, there will remain serious financial disincentives for improving quality. Consider the error that necessitates further treatment and additional billing; clearly, the financial incentive in this instance is pointing the wrong way. By contrast, pay-for-performance compensation programs do just the opposite. By creating explicit incentives toward specific goals, pay-for-performance reimbursement programs drive physicians to achieve better outcomes for their patients.

"There is no debate that we should have better information technology in physicians' offices, but there is no incentive," says Tom Williams, Executive Director of the Integrated Healthcare Association (IHA), a group of top decision makers from the major health care stakeholder groups in California. IHA's mission is to promote the evolution of integrated health care, supported by financial mechanisms that align incentives of purchasers, payers, and providers.

"Building effective IT systems requires attention, money, expertise, and time, but physicians' offices are overwhelmed by the demands put on them by managed care and other factors. Unless there is some explicit incentive to invest, often those investments come more slowly than we would like," says Williams.

IHA's P4P program measures clinical quality, patient experience, and investment in and use of information technology among some 45,000 physicians participating in six health plans. First year results revealed that the program, which paid \$50 million to physician groups in 2003, does stimulate better care: HEDIS rates increased for all the P4P measures an average of two percent.

Bridges to Excellence (BTE), launched by a coalition of some of the nation's largest employers, ties compensation and incentive payments to performance in diabetes care, cardiovascular and stroke care

and office systems that support care. Launched by a coalition of some of the nation's largest employers, BTE builds upon physician recognition programs designed by NCQA in partnership with the American Diabetes Association and the American Heart Association/American Stroke Association.

Studies done by three national health plans found that physicians participating in the BTE diabetes program offered care that was substantially more consistent with best practice guidelines. These physicians also delivered care at a 10 percent to 15 percent lower cost than physicians not recognized by the program. The majority of the savings come from fewer hospitalizations and fewer patient visits to the emergency room.

Recently the Centers for Medicare & Medicaid Services (CMS) launched a new pay-for-quality demonstration project designed to explore the effectiveness of pay-for-performance in large medical group practices. The medical groups participating in the new CMS effort will have Medicare incentive payments linked to their performance on various measures developed by NCQA and the American Medical Association. The Medicare program now has seven major pay-for-quality efforts.

IHA's Williams says that while incentives are never perfect, P4P works. "P4P galvanizes change," he says. "That's why more than 100 pay-for-performance efforts are currently underway nationwide."

### *Value-Based Purchasing*

Purchasers of health care—mainly employers and government—have considerable clout in the health care marketplace, and have begun to use it to promote quality rather than simply push for lower costs. This value-based approach to purchasing care holds providers accountable for both cost and quality.

Alongside a health plan's cost structure, many purchasers also evaluate the processes and structures of the plans they offer to see how they measure the delivery and outcomes of care. This reflects a growing sophistication on the part of purchasers, who recognize that high quality care is a good value because it keeps employees healthier and more productive.

NCQA's Quality Dividend Calculator helps purchasers quantify this value by assessing the indirect costs of illness in terms of reduced productivity that results from disability and absenteeism.

### *Physician-Level Measurement*

"It's a classic business maxim: measurement is essential to management," says Brent James, M.D., M.Stat., Vice President for Medical Research at Intermountain Health Care in Salt Lake City and Executive Director of its Institute for Health Care Delivery Research. "Physicians must be able to look at their own practices and establish priorities based on how they are doing." Outcome measures at the individual practice level are the best way to do this.

Christine Sinsky, M.D., a general internist with Medical Associates in Dubuque, Iowa, says that she and her colleagues value the physician-specific data they get through NCQA's Diabetes Physician Recognition Program. "Most physicians want to be doing a good job," she says. "The data gives us feedback and shows us where we need to focus our improvement efforts."

Sinsky says that it is essential that the data given to physicians are reliable. "Poor quality data are worse than no data," she says. If the data aren't solid, Sinsky says physicians are likely to focus on the weaknesses in the data rather than the weaknesses in their practices. "But when the data are meaningful, like the feedback we get about our diabetes care, it is helpful. You can see where you need to create stronger organizational structures and system supports to facilitate better care."



*Web-based services make life a little easier for patients and their families.*

### *Leveraging the Web*

Physicians are not the only ones who are taking advantage of information technology to improve the delivery of care. For patients too, information technology is playing a new role, whether it's providing access to comparative data about health plans or hospitals, health information on their health plan's Web site, or even, in some cases, the ability to communicate with their physician by e-mail.

For years NCQA has been providing detailed comparative information for consumers about how effectively health plans take care of their members. Recently the U.S. Department of Health and Human Services launched a new Web site that allows users to compare how well hospitals care for patients with heart attacks, heart failure, or pneumonia. And many, if not most, health plans offer health-related information and healthy living tips on their Web sites.

The nation's top health plans offer their members more than just health information online. At Harvard Pilgrim Health Care in Boston, for example, members with congestive heart failure or asthma or attention deficit disorder, to name a few, can maintain an interactive personal health diary on the plan's secure Web site, join support communities and online discussion groups, and send messages to Harvard Pilgrim clinicians. Members have access to these personal health records from any location where they have Internet access.

At Group Health Cooperative in Seattle, members can use the Web for a whole host of services, from e-mailing providers to ordering prescription refills to viewing test results online. Group Health's site also links to both general health information and useful parts of patients' medical records. When it's more convenient, members can even schedule appointments online.

## *Engaging Patients in Their Care*

Perhaps one of the strongest trends in health care in recent years has been the movement to include patients more fully in health-related decision making. Sometimes called shared decision making or informed choice, the idea is for patients to be partners in their care rather than mere recipients.

“In back surgery there are a lot of options, and often it’s not clear what the ‘right’ choice is,” says James Weinstein, M.D., Professor and Chair of the Orthopedic Surgery Department at Dartmouth Hitchcock Medical Center. “The patients’ values and preferences have to play a role. It’s no longer acceptable for doctors to say, ‘you should have this procedure, I can do it Tuesday, sign here.’”

The ideal role for patients involves not only participation in decision making, but ownership of and responsibility for the lifestyle factors that influence health. Education is a key component of this new paradigm, teaching patients everything from healthy diet tips to more complicated skills such as monitoring their blood glucose levels daily if they are diabetic or their lung capacity if they have asthma.

“This is where evidence-based medicine comes in,” says Weinstein. “Care must be based on the best science and the patient’s informed preferences, not just on what the doctor thinks is best.” And today the evidence supports an aggressive, patient-centered approach to chronic care management that relies heavily on the patient to play a central role.

Top quality health plans offer patients with chronic conditions sophisticated programs designed to keep them healthy and active. Education and easy access to providers helps keep patients informed and on top of their health.

For patients with multiple needs related to different diagnoses, this support is even more important, but also trickier. “For the patient who has diabetes, a good diabetes program can usually be effective. But add a diagnosis of breast cancer or heart disease, and the care can be fractured. This is where high-risk patient care managers can step in to support the patient by coordinating care and helping patients set personal goals that require their active participation,” says Sanford Kurtz, M.D., Chief Operating Officer at Lahey Clinic in Burlington, Massachusetts. “The goal is for the caregiver and the patient to be proactive. This way, the patient can avoid needing to go to the emergency room in crisis or be admitted to the hospital, and the patient feels in control and at the center of the care team.”

Some health care organizations—including Lahey and nearby Harvard Pilgrim Health Care—are using predictive modeling to identify patients who might be at risk for hospitalization, and attempting to intervene before a crisis develops. “Sometimes these patients with co-morbidities are actually lost in the medical care system,” says Judith Frampton, R.N., M.B.A., Vice President of Clinical Quality Programs at Harvard Pilgrim. “Using an algorithm that looks at patterns of care and also absence of care, we identify patients who are at risk. We reach out to these patients, working with them to set goals and create care plans designed to optimize their health and quality of life.”



For decades, people in Washington and elsewhere have been talking about health care reform. And yet there has been little change in financing mechanisms, and an increase of about a million people a year over the past five years in the number of uninsured Americans. It’s a disturbing backdrop, to be sure, but against it there are some promising signs too—in the delivery of health care itself a quiet

revolution has been taking place. That revolution—led by purchasers, health plans, physicians, and organizations such as NCQA—is fueled by the strong desire to close the gaps in quality that the Institute of Medicine labeled a “chasm” in its landmark 1999 report.

The revolution continues to gain steady momentum as more purchasers recognize the importance of quality in their buying decisions; as health plans and physicians understand the value of performance data and experience the benefits of using information technology to foster better patient care; and as patients themselves gain confidence in their roles as partners in their care.

There is, to be sure, considerable distance to travel on the path toward a health care system that consistently and reliably delivers the best care. But the progress made so far is encouraging, and the way forward is clear, generously marked by those who have blazed the trail.



*Health care today involves  
strong partnerships between  
patients and providers.*



## GOING TO THE DOCTOR:

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### Yesterday and Tomorrow

WHAT CONSTITUTES A “TYPICAL” DOCTOR VISIT IS CHANGING. THE ELEMENTS IDENTIFIED IN THIS REPORT AS IMPORTANT COMPONENTS OF GOOD CARE ARE BEING USED INCREASINGLY ACROSS THE COUNTRY. HERE WE SHOW HOW THESE ELEMENTS WORK TO CHANGE YESTERDAY’S TYPICAL DOCTOR VISIT INTO TOMORROW’S IDEAL CARE.

*New models of care are keeping patients healthier and more engaged in their own care.*

**YESTERDAY:** Ms. G., a 61-year-old widow, has had diabetes for eight years, and was diagnosed with high blood pressure three years ago. She has a primary care physician, whom she likes but sees only when she is having trouble. She is moderately obese and smokes.

Working full time, and caring for her elderly mother, Ms. G. finds it difficult to eat properly or exercise. She attended a class to learn more about controlling her diabetes when it was first diagnosed, but has received only intermittent and occasionally conflicting information since. She knows she should quit smoking but just can't do it.

Her kitchen drawer is full of different diet sheets. She's not sure which one is the best and has stopped using them. As a result, Ms. G.'s diabetes is not well controlled, and she sometimes ends up in the emergency room or admitted to the hospital as a result. Her doctor visits are brief, focused on the problem at hand, and often don't leave time to address issues she faces in trying to manage her chronic conditions in her busy life.

Ms. G. often doesn't feel well, but tries to ignore it and just keep going. Sometimes she feels pressure in her chest and is short of breath. She decides to mention it next time she sees her doctor, but she doesn't know when that will be.

Although she receives care from competent providers and institutions, Ms. G. is clearly not doing well. Repeated surveys reveal that Ms. G. represents the majority of Americans with chronic illness, who—without optimal treatment—are experiencing morbidity and associated costs that could be prevented.



**TOMORROW:** Ms. G's care would be very different if all the elements of good care were employed by her health plan, provider, and payer. Consider the following alternative scenario—and examples of tomorrow's care improvement strategies (in blue) that are already in practice today.

Ms. G.'s doctor's staff checks its **ELECTRONIC PATIENT REGISTRY** and finds that Ms. G.'s diabetes is not well controlled, and that she hasn't had a preventive check-up in several months. The diabetes nurse educator calls her to schedule a structured visit with the doctor and the nurse educator. The nurse asks Ms. G. to **BRING ALL HER MEDICATIONS** with her to the appointment so the doctor can review them, and sends her a **WALLET CARD FOR DIABETES PATIENTS** with questions she should ask her doctor at every visit.



## ELECTRONIC PATIENT REGISTRY: *HealthPartners*

*Minnesota-based HealthPartners relies on electronic patient registries to support its Planned Care Model, which combines a team approach to patient care with a more comprehensive way of thinking about patient visits.*

*The Planned Care Model calls for a prepared practice team that actively anticipates and prepares to meet patients' needs prior to their arrival. An electronic patient registry and electronic medical records make this possible by providing information about which patients are in need of certain tests, screenings or preventive visits.*

*For example, a medical assistant reviews the records of patients with cardiac disease, chronic pain, diabetes or stroke (all known to be at higher risk for depression) prior to their visits to see if they are due for a depression screening. If they are, the record is flagged for the care team, and the nurse administers the screening prior to the patient's visit with the doctor.*

*At HealthPartners, prepared practice teams include physicians, registered nurses, licensed practical nurses, and clerical staff such as receptionists. A diabetes nurse specialist, nutritionist, and/or pharmacist are added to teams as necessary. The patient is at the center of the team.*

*The Planned Care Model is getting good results. More patients are receiving the complete set of appropriate screening tests for their age group. For patients with diabetes, more patients are achieving healthy levels for blood sugar, blood pressure and cholesterol.*

## BRING ALL HER MEDICATIONS: *Medica Health Plan*

*Some members of Medica, a health plan in Minnesota, are learning to brown-bag it and like it. But this has nothing to do with lunch. Instead, it has everything to do with medication safety.*

*Once a year, Medica mails a brown lunch bag to patients over age 55 who take five or more regular medications (about 19,000 members). On the bag is a sticker asking the patient to bring all his or her medications—including over-the-counter medications and remedies like vitamins and herbal supplements—to his or her next doctor's appointment for a "medication check-up."*

*"This program has several benefits," says Kristina Bloomquist, M.Ed., Clinical Program Manager for the brown bag project in 2004. "It helps strengthen the connection between patients and their primary care physician, and is part of our patient safety plan. It helps us make sure that patients are taking their medications correctly, that they aren't taking expired medications, or drugs that interact badly, and that generic brands are considered when appropriate." An added value of having all medications reviewed by one provider is the opportunity to coordinate dosage schedules in a way that makes it easiest for patients to follow.*

*The direct cost of the program is relatively small—printing and postage, primarily—but the value in terms of improved patient compliance and safety is potentially quite large. "We'd like to expand it to include a younger population with fewer medications," says Caroline Marks, CPHQ, Quality Improvement Program Manager.*

## WALLET CARDS FOR DIABETES PATIENTS: *Harvard Pilgrim Health Care*

*Harvard Pilgrim Health Care in Massachusetts is a leader in effective disease management, which is one reason the plan scored first in the nation in 2004 for both clinical quality and member satisfaction among plans reporting HEDIS scores.*

*"Disease management programs have to be multi-faceted," says Judith Frampton, R.N., M.B.A., Vice President of Clinical Quality Programs at Harvard Pilgrim. "We use all channels of communication at our disposal to remind both patients and providers about the essential elements of good care."*

*For diabetes patients, for example, one element of a much broader disease management program is a wallet card with seven questions they are advised to ask at every visit with their primary care physician. "These are key messages that remind both patients and providers about the importance of routinely checking cholesterol and blood pressure, taking a daily aspirin, getting a regular eye and foot exam," says Frampton.*

*Harvard Pilgrim also regularly sends patient-specific information to providers from the diabetes registry, accompanied by clinical reminders such as "Don't Forget Aspirin." The health plan also provides detailed pharmacotherapy guidelines such as the use of combination drugs when mono-therapy is ineffective.*

*Additionally, arming patients with appropriate reminders like the seven-question wallet card is a powerful and effective strategy. "We learned this from the pharmaceutical industry," says Frampton. "If they can tell patients to ask their doctor about specific drugs, we can tell patients to ask their doctor about specific tests and therapies. By educating our members we are also driving physician behavior."*

“The beauty of this effort is that when we improve care at our sites for our members, care will also improve for non-members. This helps us fulfill our mission, which is to serve all members of the **community** with high quality health care.”

*John Shematek, M.D., Quality Improvement Medical Director, CareFirst*

## ELECTRONIC MEDICAL RECORD: *Kaiser Permanente Health Plan*

*Kaiser Permanente Health Plan in California has long been an innovator in health care delivery, and its use of electronic medical records and related interactive technology is a case in point.*

*“We are rolling out a \$3 billion system that not only enables every doctor in our system to access patients’ electronic medical records, but that will soon allow patients access to their own records as well,” says Louise Liang, M.D., Senior Vice President for Quality and Clinical Systems Support at Kaiser.*

*Designed by clinicians, the system also enables physicians to order tests, write prescriptions, and make referrals via computer. Clinical guidelines built into the system provide physicians with “just-in-time” clinical information at the point of care to support the delivery of evidence-based care.*

*When fully installed by 2007, the system, called KP HealthConnect, will connect all of Kaiser’s regions, and all its facilities, including hospitals, medical office buildings, labs, and pharmacies. “If a member arrives in the emergency room of any of our hospitals, the staff will be able to access his or her medical record, which is enormously helpful,” says Liang.*

*Members, some as soon as the summer of 2005, will be able not only to view portions of their medical record on a secure Web site, but also to make appointments, look up lab tests and prescriptions, and find links to health information related to anything in their records. “This system helps us fulfill our mission, which is maintaining our members’ total health. It makes delivering good care easier for our doctors, and empowers patients to participate more fully in their care,” says Liang.*

## EXTRA COMPENSATION FOR PROVIDING TOP-QUALITY CARE:

*CareFirst BlueCross BlueShield*

*CareFirst BlueCross BlueShield took the “First” in its name seriously when it became the first health insurer to partner financially with Bridges to Excellence (BTE), a national non-profit organization that encourages significant leaps in the quality of care. CareFirst BlueCross BlueShield serves more than 3.3 million members in Maryland, Northern Virginia, Delaware, and the District of Columbia.*

*“We are working to fulfill the quality aims that the Institute of Medicine identified for health care, as well as NCQA’s goals,” says Jon Shematek, M.D., CareFirst’s Quality Improvement Medical Director. Historically, BTE programs have been funded by health care purchasers such as large employers.*

*CareFirst will pay participating doctors who meet certain criteria set by NCQA as much as an extra \$50 annually for every CareFirst patient under their care plus their costs in being recognized by NCQA. In its pilot program, CareFirst has committed funding to cover as many 58,000 of its members being served by physician practices throughout the region.*

*Bridges to Excellence rewards excellence in diabetes care, cardiovascular and stroke care, and office systems that support care. CareFirst is using the Physician Office Link Program as the basis for incentives and rewards. And while CareFirst has had financial incentives in place for years relating to satisfaction, utilization, and efficiency measures, BTE marks the beginning of recognizing those physician practices that use information and systems to improve patient care.*

*“The beauty of this effort is that when we improve care at our sites for our members, care will also improve for non-members. This helps us fulfill our mission, which is to serve all members of the community with high quality health care,” says Shematek.*

At the visit, Ms. G. receives her flu shot (thanks to a “pop-up” reminder that appears on the computer screen when the doctor retrieves her **ELECTRONIC MEDICAL RECORD**), as well as recommended tests for monitoring her diabetes. With the incentive of **EXTRA COMPENSATION FOR PROVIDING TOP-QUALITY CARE** to its diabetic patients, the practice developed a comprehensive diabetes management program that enables her doctor to schedule and print a list of her upcoming screenings and tests, including her next eye exam, cholesterol check, and foot exam.



*Patients at Group Health Cooperative in Seattle are full partners in their care. As the nation's largest consumer-governed health care organization, Group Health is all about patient involvement.*

*As a member of a consortium of local health care organizations who together received a Pursuing Perfection grant from the Robert Wood Johnson Foundation to make dramatic leaps in quality of care, Group Health helped to create the Shared Care Plan, a paper- and computer-based self-management tool that helps patients create a personalized health record to track information about their health, including their symptoms, treatments, medications, tests, and personal goals. The Shared Care Plan was designed in response to patient requests for more control over their medical information, and is the model for similar efforts in other parts of the country.*

*And as the home of the Center for Health Studies, where the widely used Chronic Care Model was developed, Group Health providers know perhaps better than most the value of involving patients in their own care. Research shows that patients are more successful at changing behaviors when they are involved in setting their goals. Providers who understand how to help patients set goals that are specific, realistic, and achievable are practicing truly patient-centered care.*

Ms. G talks with the nurse educator about her diet and exercise regimen and about quitting smoking. **TOGETHER THEY SET SOME GOALS** that Ms. G agrees are reasonable, and she signs up for a smoking cessation class the nurse recommends. The nurse gives her a copy of her goals and some clear and useful information about managing diabetes, and shows her the online health **MANAGEMENT INFORMATION AND TOOLS** on her health plan's Web site. The nurse also suggests that Ms. G join the diabetes support group offered through her health plan.

The nurse educator telephones Ms. G. a week later to see how she is doing with her new goals and answer any questions she has. Further phone calls reveal that Ms. G. has quit smoking, feels better, and her diabetes is better controlled. She is scheduled for another structured visit in two months.

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*We are grateful to Edward Wagner, M.D., M.P.H., who provided the basis for Ms. G's stories. Wagner is Director, MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative in Seattle and the creator of the Chronic Care Model, a comprehensive, coordinated model of care that is dramatically improving outcomes throughout the country for patients with chronic conditions.*

“It’s all about promoting healthy lifestyles,  
and providing tools and information  
to help people feel more informed and

# confident

in making decisions about their health care.”

*William C. Popik, M.D., Aetna, Chief Medical Officer*

## ONLINE HEALTH MANAGEMENT INFORMATION AND TOOLS:

*Aetna*

*With access to the Internet booming, Aetna saw an opportunity back in 1996 to leverage this new technology to help engage members in their care and even help change patient behavior. That is when the company began offering DocFind®, its online participating provider directory. In 2001, the company widely launched its secure member Web site—Aetna Navigator™—and ever since has continuously added health tools and content designed to help members manage a whole slew of conditions and illnesses.*

*“It’s all about promoting healthy lifestyles, and providing tools and information to help people feel more informed and confident in making decisions about their health care,” said William C. Popik, M.D., Aetna’s Chief Medical Officer. “You can deliver the same information via the Web that you can via paper, but the former is more efficient and it’s interactive too. It’s a great tool for keeping in touch with people 24/7.”*

*Aetna Navigator™, the company’s secure member Web site, is rich with tools and information that help members take care of health plan business and learn more about health topics. The company offers additional Web sites, but this one is considered the central portal. Through Aetna Navigator, members can quickly obtain information on their eligibility, review current claims status and history, print a temporary ID card and request a permanent one. In the “Take Action on Your Health” section, members can find participating health care professionals and facilities; estimate the cost of services, procedures and medications; find a wealth of information on staying healthy, including fitness, nutrition, smoking cessation and weight management programs; and review information on treating illnesses—all with a few clicks of the mouse.*

*The Web site also includes a number of links to other useful sites, such as the Aetna IntelliHealth® Web site and the Healthwise® Knowledgebase, which are resources for members who are interested in exploring health topics more thoroughly. “Health care consumers need to be engaged and knowledgeable about their health, and our Web site is one way we are working to help them feel better informed,” Popik said.*



MARK MCCLELLAN, M.D., PH.D.

*Administrator*

*Centers for Medicare & Medicaid Services*

## REWARDING QUALITY IN MEDICARE:

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# Paying for Performance at CMS

**HEALTH CARE IN THE 21ST CENTURY FACES A COMPLEX CHALLENGE:** providing the highest-quality and the most efficient health care possible. We are living in an era that can meet this challenge with breakthrough drugs and treatments targeted to specific conditions, but our future of better health through better medicine is not guaranteed. Such unfulfilled promise is why CMS is committed to improving the quality of health care, and, in particular, doing so by providing financial incentives for such improvement through pay-for-performance programs.

Too frequently, the health care industry fails to translate our knowledge into effective, efficient patient care, and it results in needless suffering, avoidable deaths, and much higher health care costs. Our health care system should support health care providers and help them make treatment decisions based on the latest scientific evidence. Poor quality health care is not only a disservice to patients, it's also expensive. In medicine, high quality care is the only kind we can afford.

Nowhere is this failure more evident than in the Medicare program, which sets the standard for medical coverage and reimbursement in the United States, but historically has struggled with out-of-date benefits and inappropriate reimbursement. Until recently, about 95 percent of Medicare spending went to treating health problems after they happen—paying for the emergency room, putting you in the hospital, or doing surgery when something goes wrong. Dealing with health problems after they happen means that hundreds of thousands of Americans die prematurely each year. That's not good medicine. And that's not efficient medicine.

But it doesn't have to be that way.

Medicare is marked by unprecedented opportunities to improve the health care system thanks to new legislation and a renewed commitment to rethink, refocus, and reform the way we deliver and pay for health care in this country. Through the Medicare Modernization Act, CMS—the Centers for Medicare & Medicaid Services—has the tools and ideas to support good medical practice, and the Agency is using those tools to create a business case for high-quality, efficient care in the Medicare program.

Specifically, CMS is using the Medicare law to change how we pay for services in order to create

a business case for high-quality, efficient care. Currently, Medicare reimburses physicians and other health care providers on the number and complexity of the services they provide. In practical terms, that means Medicare pays more for more treatments, regardless of their impact on patient health. There is a strong body of evidence suggesting that by anticipating patient needs, especially for patients with chronic diseases, health care teams—in partnership with patients—can intervene before expensive procedures and hospitalizations are required. With this prevention-oriented approach, patients stay healthier and costs are lower.

But to reach this goal, Medicare must begin to pay based on the quality of the health care provided to our beneficiaries, not simply the amount. Better care should be rewarded, and to do this, Medicare needs to pay for performance, not for services. Thanks to growing support from health care providers and other stakeholders, this is now possible.

Effective performance-based payments have shown results in the private sector, and Medicare has already started programs and demonstrations to reward quality improvement in hospitals. By bringing the same kind of enhanced support for better quality to physicians, we are reaching the providers that have the greatest impact on decisions about patient care. This approach has great potential for improving care for our beneficiaries and strengthening the Medicare program.

While there is a growing consensus throughout the health care industry to reward providers who furnish better care, there should also be agreement on how to reward those providers. Medicare's new pay-for-performance initiatives reflect hard work by providers, consumer advocates, and other health care payers and purchasers to develop valid measures of quality and efficiency, and to use them effectively to support better care. And CMS is committed to this sea change: we are working to apply this in every setting in which Medicare pays for care.

This includes initiatives for hospitals, physicians, and physician groups, as well as exploring opportunities in nursing home care, home health and dialysis providers, as well. For example, CMS is conducting a Hospital Quality Incentive demonstration with Premier, Inc., that provides bonuses to hospitals that achieve condition-specific quality scores based on a mix of process and outcome measures in the top 20 percent of all participants.

CMS is pursuing several pay-for-performance demonstrations with physicians as well. For starters, the Physician Group Practice demonstration announced in January is providing rewards to large, multi-specialty group practices for improving the quality and costs of care for their patients. Similarly, our upcoming Medicare Care Management Performance demonstration will reward small-to-medium physician offices for improvements in the care they provide to chronically ill patients.

As CMS implements these and other pay for performance programs, we are seeing changes in medical practice. The participating organizations are investing in health IT systems that help doctors manage their chronically ill patients and make sure that all their patients get preventive tests.

As the biggest health care payer in the world, Medicare should support and drive our health care system to get higher quality and lower costs. For too long, Medicare's payment incentives ran counter to this goal—but no more. Thanks to the hard work and collaboration of health system stakeholders, we are seeing the kinds of innovation that doctors and other health care experts have been saying we need to make our health care system better and more efficient—because we are beginning to pay for the kind of care we all want and deserve.



DAVID BRAILER, PH.D.  
*National Health Information  
Technology Coordinator  
U.S. Department of Health  
and Human Services*

## CONSUMERS AND HEALTH TECHNOLOGY:

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# Fostering the Health Care Marketplace

THE UNITED STATES IS EXPERIENCING A MAJOR SHIFT IN HOW CONSUMERS PARTICIPATE IN HEALTH CARE. They—or we, since we all are or will be consumers of health care services—want to ensure that we have real choices about what treatments we get, where we get them and who delivers those treatments. We want to have information that can guide our decisions in a fact-based and rational manner. We want to level the playing field so that we can have control over our health status and how we use health care services to improve it. In short, we want to be informed consumers of health care, just as we are informed consumers of other products and services.

Health information technology has demonstrated great promise in improving care delivery. It has been shown to improve preventative care, reduce medical errors, minimize duplicative and unnecessary services, and improve collaboration in care delivery. Health information technology is widely regarded as a necessary substrate to bring together numerous elements of transformation, whether at the micro level within a hospital or physician practice, or at the macro level of health care markets and the overall industry. But health information can also change the underlying fundamentals of health care, transforming it into a consumer-driven marketplace.

Informed choice of caregivers and treatment options is a defining characteristic of a health care marketplace. Many Americans can seek treatments from various providers at any point in time, but their choice is constrained by limited quality and performance information available today. Consumers do not have the information to evaluate how well any provider performs on a given procedure or disease, nor how cost-effective that provider is. Consumers often do not know what alternative treatment options they have, nor what risks and benefits various treatments bring to people like them.

We all know that competition is another fundamental of a marketplace. Health information technology can either increase or decrease the level of competition in the health care marketplace, depending on how it is used. Some practices, for example, are adopting electronic health records (EHRs), but that adoption varies with the size and resources of the organization. Large physician practices and hospitals have more resources than solo practitioners, and therefore have more ability to acquire information technologies and more capacity to make good use of it. Their investment in EHRs is strategic, intended to shift market share to them. But, for most small provider groups, the business case for EHR purchase is weak at best, and they cannot keep up. A level playing field for EHR adoption is needed across all providers to increase competition in health care.

I want to see a real marketplace for health care services, where consumers ultimately drive quality and efficiency. In this marketplace, everyone will be better off than they are today. Physicians will have access to information on the latest advances in medical science so that they can apply this medical evidence to their treatment decisions. EHRs will make their practices more efficient in handling patient workflow and decision-making. Payers will get better information about the value of treatments for the cost, and will be able to develop more specialized services and networks for their members. Most of all, consumers will have information that helps them understand their treatment options in the context of their own personal circumstances, and will know which providers give the best care for them. To achieve this vision, information tools must be in the hands of clinicians and used at the point of care. More importantly, consumers must have access to their clinical information and become actively engaged in their total health. The combination of the American consumer and health information technology is stronger than either is alone.

*Continually raising the  
keeps patients' best interests  
and improves care,*



bar on quality  
at heart,  
outcomes and quality of life.

## QUALITY PLUS:

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### Raising the Bar

AMONG THE FORCES DRIVING IMPROVEMENT IN HEALTH CARE QUALITY, ONE OF THE MOST POWERFUL IS CERTAINLY THE FOLLOWING: BRAGGING RIGHTS.

Health plans annually spend billions of dollars touting their accreditation status and other quality achievements, and with good reason—customer loyalty is closely tied to perceptions of quality. NCQA’s new Quality Plus program reinvigorates the bragging rights competition among health plans by introducing a series of new, voluntary standards to help distinguish the industry leaders in three key areas: Member Connections, Physician and Hospital Quality, and Care Management and Health Improvement.

The new standards are, in a word, tough. Many Quality Plus standards relate to activities and strategies—pay-for-performance, putting claims information online, physician-level measurement, risk assessment—that are not yet standard practice. Building requirements around such activities would be problematic in the context of NCQA’s regular MCO accreditation program—only a few plans could meet such standards. But as a voluntary program, Quality Plus gives innovators credit while encouraging others to follow suit.

“We want to drive improvement even among the top performers; Quality Plus gives something extra to health plans that go a little further in key areas,” said Phyllis Torda, Vice President, Product Development. “And Quality Plus is also a preview of where our standards are going in the future—Quality Plus will eventually get rolled into accreditation and become mandatory.”

#### *Early Adopters*

Many plans aren’t waiting for the new standards to become mandatory. Thirty-nine health plans, including four PPOs, have signed up for surveys under the first Quality Plus standards in the area of Member Connections. The Member Connections standards focus on how effectively a health plan manages and uses information such as medical records and guidelines to improve patient care; the standards also look at how a plan makes claims data and health information available to members.

Using information effectively is an incredibly important part of good medical practice, say experts; properly treating even common problems can involve sifting through medical records and family histories, cross checking prescriptions, arranging follow-up at appropriate intervals, reviewing updated guidelines and so on.

“There's no medical model anymore where it's see the patient, diagnose, treat and forget,” said Kathy Barfoot, National Manager of Accreditation, UnitedHealthcare, which has signed up six health plans as early adopters. “There are a dozen other steps that involve moving information to the doctor or to the patient to make sure that the diagnosis is correct and that the treatment works. Good medicine depends on good information.”

Another early adopter is Aetna, which is bringing all 21 of its plans through the process. In addition to helping its doctors deliver better care, Aetna sees investing in information technology as a way to keep people fully engaged in their own health care. “Our aim is to support our members with tools and information to help them feel more confident making decisions as they navigate the complex health care system,” said Charles Cutler, M.D., National Medical Director for Quality, Aetna. “Even in the middle of the night we try to provide answers right then and there; that's why our members have 24-hour-a-day access to claims data and health information. Like everything else in the real world, member service doesn't just happen 9 to 5.”

### *Employer Support*

Early participation in Quality Plus may also be in reaction to an employer community that has clearly telegraphed its intention to look favorably on plans that earn the Quality Plus distinction. “If employers have a choice between a plan that will give their employees these kinds of extra services and one that doesn't, the choice is easy,” said Peter Lee, J.D., President of the Pacific Business Group on Health. “Quality Plus focuses on activities that we believe every health plan should be pursuing because they help consumers become better partners in getting the care they need.”

Other employers and coalitions that have expressed support for the program include the National Business Group on Health, the National Business Coalition on Health, and NCR.

### *Next Steps*

The remaining two sets of Quality Plus standards, Physician and Hospital Quality and Care Management and Health Improvement, focus on wellness and prevention, management of chronic illnesses, complex case management, physician and hospital performance measurement and other proven strategies for improving health care quality.

“We're focusing on these areas because we know they drive improvements in the value of care,” said Torda. “Building standards around these activities will speed their adoption by the industry; the message to health plans is: if you're not already doing these things, start.”

The Care Management and Health Improvement standards will distinguish health plans that excel at promoting wellness and prevention. A specific focus of the standards is identification of members suitable for wellness, disease management and case management programs. The standards also look at how effectively an organization recruits members into relevant programs.

The measures were developed with the input of stakeholders from across the health care system, including purchasers, consumer groups, health plans and physicians. “Quality Plus is designed to help the industry promote the best quality improvement practices around,” said Richard Baron, M.D., a Director of the American Board of Internal Medicine. “Just as important, they encourage health plans

and doctors to work together to adopt these strategies—collaboration is the real key to driving improvement and reducing the waste of redundancy.”

The Physician and Hospital Quality standards look at how effectively a plan measures the quality of care delivered by their network doctors and hospitals. The standards also require that organizations use those results to improve the quality of patient care—by publicly reporting results, providing information about provider quality in print and online directories and by setting quality goals or designing pay-for-performance programs to reward providers that meet such quality goals.

Pay-for-performance has gained enormous traction in health care over the past two years—at last count, more than 100 demonstration projects were underway nationwide. Both the Centers for Medicare & Medicaid Services and the Institute of Medicine have called for health care payment systems that reward quality, and three major medical societies—the American Medical Association, American Academy of Family Physicians, and the Medical Group Management Association—have come out with principles for pay-for-performance efforts in the past year.

While much of the focus on pay for performance efforts tends to be on the “pay” aspect, for others, the real motivator is improving performance. “Quality Plus was built the right way from the ground up—our participating medical groups and physicians appreciated that the measures were fair and that the measurement process would give them feedback to help them deliver even better care than they do already,” said Jeff Kamil, M.D., Vice President and Regional Medical Director, Blue Cross of California. “Improvement is something we all agree on.”

## MEMBER CONNECTIONS: *Early Adopters*

1. Aetna Health, Inc., NY
2. Aetna Health, Inc., AZ
3. Aetna Health, Inc., CO
4. Aetna Health, Inc., CT
5. Aetna Health, Inc., DC, MD and VA
6. Aetna Health, Inc., DE
7. Aetna Health, Inc., FL
8. Aetna Health, Inc., GA
9. Aetna Health, Inc., ME
10. Aetna Health, Inc., MA
11. Aetna Health, Inc., MO
12. Aetna Health, Inc., Northern NJ
13. Aetna Health, Inc., OH
14. Aetna Health, Inc., OK
15. Aetna Health, Inc., PA
16. Aetna Health, Inc., Southern NJ
17. Aetna Health, Inc., TN
18. Aetna Health, Inc., TX
19. Aetna Health of California, Inc.
20. Aetna Health of Illinois, Inc.
21. Aetna Health of the Carolinas, Inc.
22. Blue Cross and Blue Shield of Massachusetts, Inc.
23. Blue Cross and Blue Shield of Massachusetts, Inc. (PPO)
24. Blue Preferred (PPO), MD
25. CareFirst BlueChoice, MD
26. Group Health Cooperative, WA
27. HealthPlus of Michigan, Inc.
28. Kaiser Foundation Health Plan of the Northwest, Inc., OR
29. Keystone Health Plan East, Inc., PA
30. Medical Mutual of Ohio
31. Medical Mutual of Ohio (PPO)
32. QCC Insurance Company (PersonalChoice) (PPO), PA
33. Rochester Area HMO d/b/a Preferred Care, NY
34. UnitedHealthcare of Colorado
35. UnitedHealthcare of New England, Inc., MA
36. UnitedHealthcare of New Jersey, Inc.
37. UnitedHealthcare of New York, Inc.
38. UnitedHealthcare of the Midwest, Inc., MO
39. UnitedHealthcare of Wisconsin, Inc.

## 2004 ACCOMPLISHMENTS:

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**DEVELOPED** and released for public comment Member Connections, the first set of voluntary Quality Plus standards. Signed up nearly 40 health plans, including four preferred provider organizations, to participate as early adopters.

**TRANSITIONED** NCQA's core programs to the Interactive Survey System, substantially simplifying preparations for organizations undergoing an accreditation or certification survey.

100 percent of respondents to a customer satisfaction survey characterized the Interactive Survey System as an improvement over the old paper-based process.

**REACHED** an agreement with the Minnesota Medicaid program to allow NCQA-Accredited Medicaid plans to apply NCQA Accreditation standards to five major areas of the state's annual quality review, thus reducing duplication of effort and overall oversight burden.

**NAMED** by the Georgia Department of Insurance as the first and only deemed health plan quality oversight organization. The deeming arrangement will guarantee that NCQA-Accredited health plans in Georgia receive significant regulatory relief.

**RECEIVED** deeming authority from CMS for preferred provider organizations (PPOs). As a result, PPOs participating in Medicare Advantage will be able to cite their NCQA Accreditation to satisfy federal regulatory oversight requirements.

**EXPANDED** the reach of both the Diabetes Physician Recognition Program and the Heart/Stroke Recognition Program through partnerships with Bridges to Excellence, individual health plans and others. Over 2,500 physicians now participate in those programs, and many more are in the application process.

**LAUNCHED** the new Physician Practice Connections program which recognizes physicians and medical groups that adopt systems and technology to help ensure top-quality care and service. More than 450 doctors from 38 practices were recognized in the first 10 months of the program.

**RELEASED** the eighth annual *State of Health Care Quality* report, focusing on pay-for-performance and provider recognition. The report received the most extensive media coverage ever; CMS Administrator Mark McClellan, M.D., Ph.D., was a featured speaker at the press conference.

**ADDED** four new performance measures to HEDIS: Persistence of Beta Blocker Treatment After A Heart Attack, Use of Imaging Studies in Low Back Pain, Glaucoma Screening in Older Adults and Physical Activity in Older Adults.

**WORKED** with the Integrated Healthcare Association in California to develop and implement the largest pay-for-performance program in the United States, covering 7 million California commercial lives across 215 medical groups and six health plans. NCQA aggregated the data and conducted analysis to support the distribution of more than \$40 million in quality bonuses to leading medical groups.

**WON** two CMS contracts to continue monitoring the quality of Medicare Advantage health plans. These contracts involve manage the Medicare Health Outcomes Survey, collecting HEDIS data from Medicare Advantage plans, and developing new performance indicators.

**ENTERED** into an agreement with the National Quality Forum (NQF) whereby NCQA submitted an extensive set of ambulatory physician performance measures to NQF for endorsement.

**RELEASED** our first ever Top 10 Medicare and Medicaid lists, naming the best health plans nationally in terms of clinical performance.

**WON** six new multi-year research grants and contracts, along with new and ongoing subcontracts on five additional research grants.

**LAUNCHED** the Efficiency Measurement Advisory Panel and began work on developing additional measures for HEDIS and other purposes focusing on misuse, overuse measures and efficiency-related issues.

**WON** major new contracts with CMS and a number of quality improvement organizations that have given NCQA a significant presence in key demonstration and pilot projects such as the Doctor's Office Quality (DOQ) Project and the Doctor's Office Quality Information Technology (DOQ-IT) Project.

**CONDUCTED** more than 200 accreditation and certification surveys, including 89 on the Interactive Survey System.

**ACHIEVED** record-low report turnaround times on all core accreditation and certification products.

**CONDUCTED** accreditation surveys of the human research protection programs of 23 Veterans Administration medical centers.

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*We gratefully acknowledge the following sponsors, whose support in 2004 furthered NCQA's mission of improving the quality of health care:*

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*Nothing is more important  
than trusting in the quality  
of care you and your family receive.*

## 2004 FINANCIALS:

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	2004	2003	2002	2001	2000
<i>Assets</i>	\$10,465,554	\$9,226,330	\$8,024,792	\$8,772,659	\$9,801,023
<i>Liabilities</i>	\$5,929,823	\$5,083,450	\$4,580,340	\$5,328,207	\$6,106,276
<i>Net Assets</i>	\$4,535,731	\$4,142,880	\$3,444,452	\$3,444,452	\$3,694,747
<i>Revenue</i>	\$24,993,280	\$24,449,560	\$23,113,962	\$22,849,414	\$24,126,957
<i>Expenses</i>	\$24,600,429	\$23,751,132	\$23,113,962	\$23,099,709	\$24,017,064
<i>Margin</i>	\$392,851	\$698,428	\$0	\$-250,295	\$109,893





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