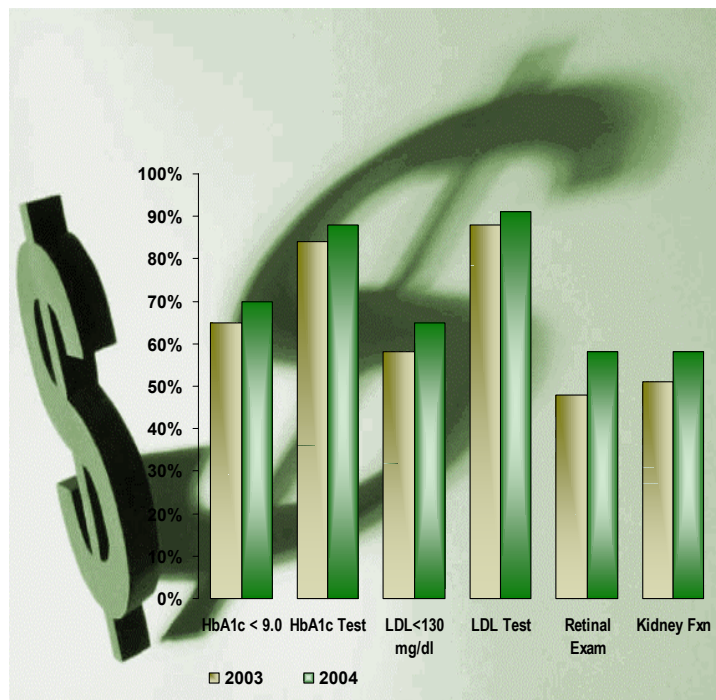


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Aligning Physician Incentives:

Lessons and Perspectives from California

A conference sponsored by the Pacific Business Group on Health, National Committee on Quality Assurance and California HealthCare Foundation in partnership with the California Medical Association, Centers for Medicare & Medicaid Services and Lumetra

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Executive Summary

Interest in physician measurement and pay-for-performance has attracted tremendous attention. Across the nation, public and private payors are adopting physician measurement and pay-for-performance programs to promote improvement in the quality of health care. A 2004 national review of pay-for-performance programs identified 47 programs rewarding physicians for the quality of care delivered to 38 million patients, or 16% of the insured population in the United States. California is often a bellwether of national health care financing trends; the same holds for physician performance-based payments. An estimated 41% of privately insured Californians receive care from physicians receiving performance-based payments. The proportion of physicians already receiving some portion of compensation based on quality performance in California is similarly high; at least one-third, and more likely one-half, or 33,000 California physicians, now receive performance-based incentives.

Momentum is building quickly in policy-making circles to promote performance-based payments for physicians. In the first half of 2005:

- The Medicare Payment Advisory Commission (MedPAC) recommended that pay-for-performance for physicians become part of the Medicare payment system. Medicare is the single largest payor of health care services in the country.
- In 2005, two national bodies endorsed sets of physician performance measures: the Ambulatory Care Quality Alliance (ACA, a collaborative composed of leading physician organizations, health plans, public and private purchasers and consumer groups) and the National Quality Forum.

- The American Medical Association endorsed pay-for-performance principles for physicians.
- The ranking members of the Senate Finance Committee (Senators Grassley and Baucus) introduced the Medicare Value Purchasing Act of 2005 which would require the adoption of a value-based purchasing program by Medicare, incorporating payments and public reporting of quality and efficiency at the physician level.

The challenge and opportunity for physicians, payors and consumers is to synchronize current and emerging incentive programs by federal, state and private payors to practicing physicians so that measurable progress can be made toward the six Institute of Medicine Aims: care that is safe, effective, patient-centered, timely, efficient and equitable.

In California, over one hundred health plans and physician organizations pay quality-based payments to physicians. Not only do a large proportion of California physicians receive performance-based payments; many contract with at least two organizations with pay-for-performance programs. To better understand the potential impact on physicians, patients and payors, California organizations creating physician incentive programs (employers, Federal and State payors, accreditors and health plans) met in November of 2004 with those affected by incentives (integrated systems, physician groups, and physicians) to:

- Explore and document the level of agreement on important elements of physician measurement and incentive programs;
- Identify where coordination among payor programs is important; and

- Clarify where consensus does not yet exist on program design and implementation.

There was unanimous agreement that making performance-based payments to physicians is the right thing to do – all stakeholders embraced physician bonus incentives as a way to introduce quality performance into physician compensation and believe coordinated action is required to make them effective. However, these programs can only realize their potential if designed and implemented in the right way. Stakeholders discovered substantial agreement on challenging issues such as measure design, payment policies and public reporting. This report describes design principles for physician incentive programs that meet the needs of physicians, consumers and payors in California:

- Programmatic alignment across payors is especially important in two areas:
 - Because most physicians receive payments from multiple sources, major payors need to agree on a core set of measures to motivate behavior change or investments in improved care delivery. Alignment is not required across all measures; in fact, some should vary based on clinical needs of the population served by the payor.
 - If multiple entities issue public reports, conflicting ratings will undermine the credibility of the information in the eyes of consumers and physicians.
- Local measures should closely follow national metrics as long as those metrics are reportable from electronic data sets, whether from administrative data or electronic health records (EHR). Otherwise, data collection on a large scale is unaffordable.
- Systemic change is accelerated by using a large set of performance metrics representing a “balanced scorecard”, including clinical performance and patient experience with care. Without a comprehensive set of measures, providers are more likely to focus just on the

rewarded measures and not on systems to improve overall performance.

- Public reporting to consumers, in the way they can easily understand and use, is essential to an effective program. Patient experience scores for individual physicians are a good place to start publicly reporting results at the individual physician level.
- Attention should be paid to the effect of these programs on physicians serving in areas where resources, including physicians, are scarce and social problems are plentiful. Whatever programs are implemented, they should not further stress a tenuous safety-net delivery system. Rewarding improvement of care over time is one method to engage physicians caring for challenging patient populations.

Other issues deserve more discussion and study to develop a common understanding:

- There remains debate about whether clinical performance is best attributed to the individual physician or to the system in which the physician practices. Meeting participants disagreed on the relative importance of the physician and the system of care on clinical outcomes. Some California programs make payments at the practice level, while others direct payments to individual physicians.
- Because Information Technology (IT) is an enabler of both measurement and improvement, it may be worth considering a short-term strategy that directly rewards adoption of clinical information systems (such as NCQA’s Physician Practice Connection Standards) and/or assures that any performance-based payments go directly into IT investments rather than operating expenses, such as salaries.

Introduction

A 2004 report on pay-for-performance programs by Med-Vantage identified 47 programs rewarding primary care physicians for care delivered to 38 million patients, which is 16% of the insured population in the United States. Pay-for-performance is more prevalent in California; 14 programs reward physicians for care delivered to 12 million patients or 41% of the state's insured population.^{1,2}

The Integrated Healthcare Association's (IHA) Pay for Performance program in California is the largest program in the country. In 2004, six health plans paid \$100 million to physician groups in performance bonuses for care delivered to 7 million HMO patients. Approximately half, or \$50 million was paid based on a common set of clinical, patient experience and IT investment metrics. In addition, results on performance metrics were publicly reported on the State of California web site (www.opa.ca.gov). A total of 215 physician groups, contracting with 45,000 of the state's 65,000 practicing physicians, were eligible for payments.

Although these payments were made to large, organized physician groups (contracting with 50 to 4,000 physicians each), IHA's program along with other California payment programs in the PPO and Medicaid markets, have gained the attention of the state's physicians. With the Congress and the Centers for Medicare & Medicaid Services (CMS) seriously considering physician level incentives, California stakeholders met to discuss the effect of

proliferating measurement and incentive programs on California's 65,000 practicing physicians and consider how best to take advantage of these multiple efforts to improve patient care.

A series of discussions between those fostering physician incentive programs (employers, Federal and State payors, accreditors and health plans) and those affected by them (integrated systems, physician groups, and physicians) revealed a surprising amount of common ground. (See list of meeting participants in Appendix A.) There was universal agreement that performance-based payments to physicians are necessary and important, as long as they are implemented thoughtfully. Stakeholders agreed on many of the toughest issues: which types of metrics to use, the importance of public reporting and the essential areas for collaboration among payors. There were several issues still unresolved: the relative importance of the physician and the systems around the physician in improving clinical performance and the recommended pace of change.

This report starts with a profile of California's physicians and a review of current physician-level incentive programs. It documents the considerable areas of agreement in program design. The report concludes with an overview of key issues requiring further consideration.

¹ Baker, G and Carter B, *Provider Pay for Performance Programs: 2004 National Study Results*, Med-Vantage Inc., 2005.

² California's insured population from The Henry J. Kaiser Foundation www.statehealthfacts.org.

Physicians and Physician Incentive Programs in California

Physicians in California

The 65,000 physicians in California practice in a range of settings, contract with different types of payors and receive revenues from a variety of sources. Practice organization, payor mix and the marketplace influence payment structures, which in turn affect the design and alignment of physician incentive programs. Key observations are:

- 40% of practicing physicians in California are primary care physicians (the same as the national average);³ the rest are office-based or facility-based specialists.
- Solo and small group practice is the predominant practice setting in California, as it is elsewhere in the United States. Two-thirds of California's 65,000 physicians practice in either solo or small single-specialty practices and bill a variety of payors for services as well as receive capitation payments through one of the over 200 Independent Practice Associations (IPA) or medical groups in the state.
- 30% of physicians are in organized group practices (such as Kaiser or Sharp Rees-Stealy), where physicians do not bill for their services. Instead, they receive all their compensation from the physician group. This style of group practice is not typical elsewhere; it is largely concentrated in California and Minnesota.
- California has the highest rate of HMO penetration in the nation (48% versus 24% nationally). However, the single largest payor is the same as in other parts of the country – traditional Medicare.⁴

³ www.statehealthfacts.org, The Henry J. Kaiser Foundation

⁴ Ibid.

Although there are differences in the structure of the health care delivery system in California, most physicians in California practice in settings similar to their colleagues in other states. The challenge in the California, and nationally, will be to foster programs that align measures and rewards across diverse payors and reach physicians practicing in a wide variety of settings. The complexity of such alignment is shown in the **Figure 1**, which illustrates the multiple streams of payments that may comprise the revenue for an individual physician.

Physician Incentive Programs in California

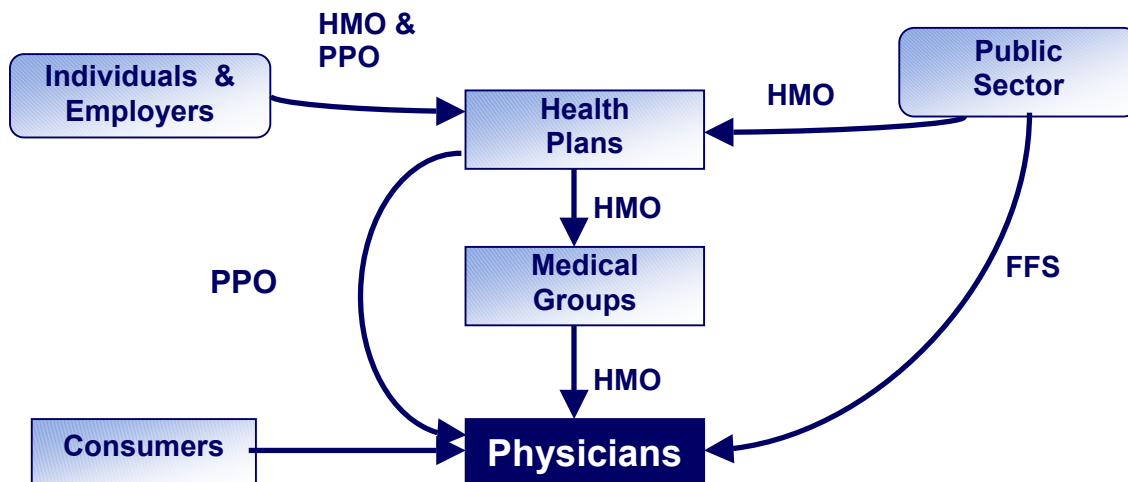
While the IHA Pay for Performance program for physician groups has garnered national attention, less visible is the extent to which many thousands of **individual** physicians are already receiving quality-based payments through contracted insurance plans and physician groups.

A study published in Health Affairs found that 35% of California physicians received performance-based bonuses in 2000.⁵ A report based on the same data found that 20% of primary care physicians and 10% of specialists received financial incentives based on clinical quality or patient experience.⁶ The survey was conducted before the launch of the IHA Pay for Performance program in 2003, which spurred proliferation of physician bonus programs by physician groups to align quality-based pay-for-performance payments to contracted physicians with

⁵ Rittenhouse D, Grumbach K, O'Neil EH, et al., Physician Organization and Care Management in California: From Cottage to Kaiser. *Health Affairs*, 2004. **23**(6): pp. 51-62.

⁶ Dower, C., et al., *The Practice of Medicine in California: A Profile of the Physician Workforce*. 2001 Center for the Health Professions, UCSF, www.futurehealth.ucsf.edu

Figure 1. Potential Payment Streams to Individual Physicians



those paid to the physician groups. Over 100 physician groups sponsor quality-based pay-for-performance programs for their physicians.⁷ For instance, the largest provider organization in California, The Permanente Medical Group, which employs 4,800 physicians, bases a portion of physician compensation on clinical quality and patient experience performance. Its counterpart, the Southern California Permanente Medical Group, includes an additional 3,500 physicians. Hill Physicians, the state’s largest IPA contracting with 2,100 physicians, pays up to 15% of physician compensation based predominantly on quality performance. In summary, up to one-half, or 33,000 California physicians, now receive performance-based incentives from over a hundred provider organizations and health plans.

To illustrate how health plans and physician groups are structuring incentive programs, four of the programs are profiled in Appendix A. The two provider group-sponsored programs include The Permanente Medical Group (part of the Kaiser-Permanente system) and Hill Physicians (largest IPA in the state). The two health plan programs include the Blue Cross of California program for PPO contracted physicians and a consortium of Medicaid

health plans collaborating as the Local Initiative for Rewarding Results.

An estimated \$34 million was paid directly to physicians by these four programs. All four programs include HEDIS-based preventive care clinical measures collected electronically, but not necessarily the same ones. Some programs include patient experience measures while others do not. The incentive structures also vary in emphasis placed on IT adoption and use. Maximum rewards ranged from 0.5% to 15% of physician compensation. At this time, these programs do not release physician-specific results to consumers or patients. Developed independently, these programs are not aligned to allow physicians to receive consolidated feedback from multiple sponsors/payors on their performance. For instance, performance information for the same physician contracting with Blue Cross PPO and Hill Physicians is not aggregated.

Despite the prevalence of physician group and health plan programs, CMS’ influence will grow significantly in the future. The CMS Doctors Office Quality – IT program, led by California’s QIO, Lumetra, has signaled CMS’s intent to at least collect data on quality performance and perhaps modify payments based on results. CMS, as the largest single payor in California and the nation, can have an enormous impact on the way quality is measured, reported and incented.

⁷ Data collected and reported by Blue Cross of California

Principles for Physician Measurement and Rewards Programs

As previously mentioned, California payors and providers alike support physician measurement and use of those measures for payment and public reporting. Many meeting participants have direct experience with these programs, either as recipients of quality bonuses or part of an organization that pays quality bonuses. Experience in California has led to the shared understanding that a portion of physician compensation will be performance-based; the challenge will be to do it right.

The following describes characteristics of physician measurement, payment and public reporting and payment programs that meet the needs of the patients, the market and the physicians in California, as agreed upon by the meeting participants.

Use the Right Measures

- Program developers should adopt widely accepted measures, starting with those endorsed at the national level, such as those from National Quality Forum, National Committee for Quality Assurance, or Ambulatory Care Quality Alliance.
- For data collection across a large number of physicians to be affordable, measures and data collection systems use electronic data sets, whether administrative or electronic health record (EHR) data. Claims-based measures can be collected universally while there is still variation in how other clinical information is stored. Some physicians use EHRs, others paper records while many use specific applications, such as e-prescribing and disease registries.
- Incentive programs should promote adoption of information technology, which improves both patient care and measurement of outcomes, with due consideration of how practices without any electronic health records can participate. One approach to reward IT-supported care processes has been recommended by MedPAC for use by Medicare is NCQA's Physician Practice Connections program (www.ncqa.org/ppc/).
- Adequate clinical measures may exist for primary care, chiefly based on HEDIS. Currently, there are not equally well-accepted clinical measures for many areas of specialty care. Physician specialty associations can play an important role in advancing such metrics.
- A common set of core measures should be shared across major payors. This is essential to gain the attention of the two-thirds of physicians with multiple payment streams. Alignment across payors is less important for physicians in multi-specialty group practice where all compensation derives from the group. However, program sponsors need not achieve complete alignment of measures. In fact, participants felt measurement priorities should differ for physicians serving different patient populations (e.g., Medicaid versus Medicare).
- A comprehensive set of measures will most effectively promote system change. Without a comprehensive set of measures, providers are more likely to focus only on the measures being rewarded and not on systems to improve all care.
- The same set of measures should be used for both public reporting and payment, although results are typically reported differently for the two purposes. Consumers need simple rankings

to make choices; providers seek detailed, statistically based results to design improvements.

- Currently, adequate measures do not exist for many important public health concerns, such as obesity and depression, or for elements of care important to consumers, such as coordination of care between physicians.

Use the Measures for Payment

- Aligning payment methods across payors, for instance weighting of measures, and timing of pay-outs, is not as important as alignment of a core measure set to achieve desired behavior change.
- When physicians are “actively engaged”, relatively small rewards appear to be sufficient to change behavior. When physicians are passively enrolled in performance bonus programs, it is difficult to create awareness, especially if a payor constitutes a small portion of the physician’s revenues. Under these circumstances, larger or more timely payments may be needed to motivate improvements in performance.
- Payments should be made as close to the performance period as possible. If physicians perceive that incentive programs are a way to delay payments, they lose trust and, therefore engagement, in the program.
- In a budget-neutral world, physicians can only earn more if others earn less. The system will have innate penalties for poor performance and may force solo and small practices to join groups that can support the infrastructure needed to participate and perform well in reward programs.
- Rewarding improvement of care over time can engage physicians serving challenging patient populations, such as those experiencing economic, social or other barriers to care.
- Population differences in health status and socioeconomic status should be recognized in

physician payment programs to address the potential danger of motivating physicians to avoid high-risk patients. Danger is heightened by the size of the incentive, how information is made public and/or by the design of the measure. Assuring adequate risk adjustment is one mechanism to counteract potential incentives to selectively treat patients.

Use the Measures for Public/Consumer Reporting

- Public accountability for performance is an essential component of physician-level incentive programs.
- Evidence supports that providers will take action to improve care if performance information is publicly reported, even without attached payments, but probably more slowly.
- Patient experience measures, collected and reported to consumers at the physician level, are good first measures to start reporting publicly.
- Consumer needs for physician performance information are complex; they vary by health status, age, social needs and many other factors. The presentation and delivery of information needs to be user-friendly and presented in a context so that it is immediately usable.
- Benefit design, if structured thoughtfully, creates an excellent opportunity to increase consumer engagement. When out-of-pocket costs are at stake – as seen in a few early examples of consumer-directed plans, consumers are more likely pay attention to cost and quality data.
- If multiple organizations issue public reports, it is essential that ratings from all reporting entities based on the same measures agree, or information will lose credibility with consumers and physicians.
- Multiple payors are already implementing their own payment formulas using their own data on

the same physicians. Measures would be more accurate if based on aggregated data. To aggregate data from multiple sources to report a single score for a physician will require establishing unique physician identifiers and gaining commitment from all program sponsors to share data and use the results.

- Providers wish to start with a small number of measures reported confidentially and expand gradually to build physician engagement and support. In contrast, purchasers and consumers desire many measures reported quickly. Guidelines for a phased release can meet both sets of needs:
 - i. Inform and educate physicians about the intentions of stakeholders to collect and use performance information, with transparency in the selection and weighting of the measures.
 - ii. Start with a small set of widely-accepted measures across multiple domains.
 - iii. Initially, share data confidentially with physicians to allow physician feedback on the quality of the data used and to provide the opportunity to improve.
 - iv. As a possible first step in public release, disclose to the public only the names of participating physicians, without scores. A second step could be disclosure of high performers, and finally, reporting scores for all physicians.

Issues for Future Consideration

Although a broad range of California stakeholders were able to agree on many principles regarding the design and implementation of physician measurement and incentive programs, other issues warrant more discussion and study to develop a common understanding. For example, some strongly support rewards directly to physicians for clinical performance. Others see the nexus of change as being the system and would therefore emphasize rewards at the practice or system level. Participants cited examples of variation in clinical performance between physicians within the same care system and other examples of variation between care systems. Perhaps the implication is that rewards are needed at both levels.

It is not clear whether clinical measures are best reported at the practice or physician level. Embedded in the debate are different views about where change needs to occur. Concerns include:

- Incenting an inefficient system and “ossifying” the one physician-one patient paradigm for care;
- Dollars and effort may be wasted if we only reward past performance; our goal should be to change the systems that deliver future performance;
- Care systems may be more likely to invest bonus payments in system improvements than individual physicians.

Because IT is an enabler of both measurement and improvement it may be worth considering a short-term strategy which directly rewards electronic functionality and assures that any performance-based payments go directly into IT investments rather than operating expenses, such as salaries. Taking this approach, however, runs the risk of disadvantaging the

physicians least able to afford the technology – those in solo practice. Many physicians (82% of PCPs and 66% of specialists in California) may get electronic access through their IPAs and medical groups, but in most cases only for the portion of their patients enrolled in managed care plans.

Although California plans and medical groups have collaborated to adopt standard metrics at the medical group level, it is unlikely that different payors will use the same methods of payment, same timetables or weight measure domains in the same way at the physician level. While it is clear that the more consistency across programs, the more physicians will invest in changes to improve performance, it is not clear how much alignment is required among these design features to promote behavior change. One challenge preventing movement toward market alignment has been the threat of anti-trust; however, some programs are finding ways to lawfully collaborate on incentive programs to providers.

Product differentiation is also occurring via plans’ efforts to develop high-performance networks. The role of benefit designs that limit access to, or “tier” physicians is unclear. There is evidence that institutions, such as hospitals and medical groups, respond to tiering by health plans. However, it is unknown whether individual physicians are aware of plan decisions and therefore may not be influenced by them. At this time, the lack of transparency in “tiering” systems may make such products less saleable to consumers and physicians, mitigating the effect of benefit design as an incentive for the consumer or the physician to change behavior. Greater transparency in physician measurement and alignment of performance incentives are necessary to make such products sustainable in the long-term.

Appendix A – Examples of California Physician Incentive Programs

This summary reflects four of the more than 115 programs in California. They are among the largest and are illustrative of how medical groups and health plans are implementing incentive programs, they do not reflect a representative sample of all programs.

		Summary of Four California Programs			
		Hill Physicians Medical Group	The Permanente Medical Group	Local Initiative Rewarding Results	Blue Cross PPO PQIP
Payments made by:		Physician Group – IPA	Physician Group – Integrated Group	Some Medi-Cal Plans	Health Plan
Results Publicly reported:		No	No	No	No
Feedback reports to physicians:		Yes	Yes	Yes	Yes
Measures	Clinical	IHA P4P measures plus other HEDIS	Specialty-specific for primary care physicians	HEDIS well-baby and adolescent well-care visits	14 HEDIS measures +2 additional
	IT Functionality	Participation in Group e-initiatives rewarded	No	No	No
	Patient Experience	Yes	Yes	No	No
	Other	Utilization Group contribution	Workload Group contribution	Electronic Claims submission	Cost efficiency Electronic transactions Access
Future Direction		Add specialties and risk adjusters	Add specialties, link to organizational improvement efforts	Add IT and chronic care measures	Move to variable fee schedule, pay more to fewer physicians

Meeting Participants

Individuals from the following organizations met on November 22, 2004 and contributed to the discussions at the meeting that subsequently form the basis of this report. Organizations are listed for identification only. Contributions by these individuals do not imply organizational endorsement of the contents of this report.

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