| **Strategy** | **Pay for Performance** |
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| **Background:** | Pay for Performance (P4P) is a strategy to facilitate quality improvement and better health outcomes by rewarding providers who have met a specified set of performance expectations. The P4P concept is being utilized in a growing number of public and private health care programs, including Medicare and Medicaid. Pay for Performance initiatives show promise for improving quality and health care outcomes for Medicaid enrollees.<br><br>Medicare has several P4P initiatives in various stages of development. A P4P demonstration project for hospitals (*Premier Hospital Quality Incentive Demonstration*) was implemented in October 2003, focusing on quality improvements related to five clinical conditions. The program rewards high quality hospitals up to 2 percent in bonus payments. There is also a penalty component to this initiative. The project includes over 260 Medicare hospitals in 38 states, including 21 Texas hospitals. Results from the first year show a significant quality improvement in the five clinical areas of focus. Over $8.8 million was paid to participating hospitals that met the quality improvement requirements in the first year of the program.<br><br>In December 2006, the Medicare program was directed by Congress to develop a P4P program for Medicare providers (physicians), in lieu of a 5 percent pay cut. Providers will qualify for a 1.5 percent bonus for reporting on quality of care, such as prescription of a particular drug following a heart attack or their success in controlling blood pressure in patients with diabetes. The program has an aggressive timeline for development with a July 2007 implementation date.<br><br>In the Medicaid program, the Centers for Medicare and Medicaid Services (CMS) provided guidance concerning P4P programs for Medicaid and the Children's Health Insurance Program (CHIP) in an April 2006 State Medicaid Director Letter. CMS is also in the process of designing a P4P demonstration project for Medicaid nursing facilities.<br><br>In 2002, The Robert Wood Johnson Foundation initiative, called *Rewarding Results,* awarded grants to private entities in several states to develop and implement P4P initiatives. The initiatives have been in place for three years and some evaluation data is now available.<br><br>The P4P programs, which included both financial and non-financial incentives, focused on gaining improvements in areas such as: access and preventive care, condition specific care (e.g., heart disease, diabetes, asthma), information technology assistance, and provider report cards and feedback.<br><br>The *Rewarding Results* initiative has provided some important considerations and lessons learned including the following.<br><br>• Early provider engagement is critical. There must be an early collaborative effort to engage providers and seek agreement on measures and expected |

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| | outcomes.<br>• Provider buy-in is more likely if data integrity is reliable and measures are valid and scientifically based. For new programs, it is generally better to establish less controversial processes and structural measures that can be more easily assessed, and move to more complex clinical measures as the program is better established and accepted.<br>• Financial incentives make a difference, but need to be fairly significant. Non-financial incentives can also be effective, such as administrative simplification, staffing assistance, and technology. These have been utilized in a number of P4P programs.<br>• Public reporting is very effective and provides an opportunity to compare performance.<br>• Provider feedback is crucial, along with tools and guidance on ways to improve.<br>• Providers already involved in managed care seem more amenable to the P4P concept. |
| Other States: | **California** has a *Local Initiative Rewarding Results (LIRR)* that has been in place for several years and includes seven Medicaid managed care plans. This program focuses efforts on promoting access and preventive care (for children and adolescents) and has seen improvement in these areas. Provider incentives for these included bonus payments, risk pool distribution, and staffing assistance.<br>California's LIRR program allows plans to customize incentives based on a number of considerations, including administrative burden, emphasis on relative improvement versus hard targets, and the degree of control that a provider has in reaching goals. The program has utilized some of the following options:<br>• Per service bonus (e.g., $50 bonus for an adolescent well-check or $50 bonus is 4-5 well-checks provided for child in first 15 months of life).<br>• Tiering bonus (e.g., providers evaluated on normative scale, where top third receives highest payment). This tends to work better for hospitals or provider groups.<br>• Risk Pool Distribution (pool of money that is distributed semi-annually or annually to providers based on achievement of quality measures).<br>• Threshold Bonus: Absolute benchmark (provider receives bonus when performance meets or exceeds a defined benchmark), incremental target (provider receives bonus if goals are partially met), relative performance improvement (baseline data used to set specific improvement goals for that provider). |

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| | **Massachusetts** Health Quality Partners includes five health plans and physician organizations in the state and has a physician performance report on a common set of quality measures focusing on preventive care measures such as breast cancer screening and chronic disease care, like diabetes. This program also appears to be accelerating physician use of electronic medical records in some cases.<br><br>**Michigan** Blue Cross Blue Shield (BCBS) has an initiative to improve care for patients hospitalized for cardiac care. The program established measures that have improved care and decreased the rate of life-threatening infections by 45 percent for patients in the intensive care unit. Michigan's BCBS is in the process of expanding the use of incentive payments for other conditions.<br><br>**New York** had the first Rewarding Results project to identify a return on investment for its P4P program. Excellus/Rochester Individual Practice Association (RIPA), showed improvement in managing patients with chronic conditions, such as sinusitis, otitis, diabetes, asthma, and heart disease. The program provided doctors with performance reports including actionable information to improve patient care. Information is also provided to patients. In 2004, Excellus/ RIPA invested $1 million on health information technology and reduced health care cost trends by almost $3 million.<br><br>**Several states** (original pilots in Massachusetts, Ohio, Kentucky, and New York) have implemented Bridges to Excellence initiatives though a RWJ Rewarding Results grant. The Medicare program is in the process of developing a P4P initiative that is modeled after Bridges to Excellence. The primary goals of the programs are to improve quality through:<br>1) Reduction of mistakes.<br>2) Reduction of waste and inefficiencies.<br>3) Increased accountability.<br><br>Bridges to Excellence includes three programs designed to reward physicians providing high quality care to their patients:<br>1) Physician Office Link rewards providers based on process improvements (e.g., electronic medical records).<br>2) Diabetes Care Link allows for rewards for providers providing high quality diabetes care. The program offers products and tools to help patients get engaged in their care.<br>3) Cardiac Care Link rewards physicians providing excellent cardiac care. Program evaluations indicate savings have been achieved.<br><br>Although until recently these programs have primarily been utilized in the private sector, there is clearly a move to include these types of incentive programs for Medicaid and Medicare enrollees. Recently, seven states (Arizona, Connecticut, Idaho, Massachusetts, Missouri, Ohio, and West Virginia) were awarded grant funds (from the Center Health Care Strategies, the Robert Wood Johnson, and The |

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<tr><th>Strategy</th><th>Pay for Performance</th></tr>
<tr><td></td><td>Commonwealth Fund) to participate in an initiative to develop and implement provider incentive programs related to Medicaid beneficiaries.</td></tr>
<tr><td>Application to Texas –<br><br>Advantages & Disadvantages:</td><td>Texas has included performance-based principles in its new Medicaid and CHIP health maintenance organization (HMO) contracts. In FY2007, the HMOs are at-risk for several contract requirements, primary focused on access to services and timely claims payment. As HHSC and the HMOs become more familiar with the value-based purchasing (pay for performance) approach, HHSC plans to include clinical measures to the at-risk performance measures. HHSC's External Quality Review Organization will begin collecting Health Plan Employer Data and Information Set (HEDIS) data on the Medicaid and CHIP HMOs for FY2008 measures in January 2007.<br><br>Additionally, in keeping with the pay for performance concept, Section 13 of Senate Bill 1188, 79th Texas Legislature, Regular Session, 2005, included direction to HHSC to "develop a proposal for providing higher reimbursement rates to primary care case management (PCCM) providers who treat program recipients with chronic health conditions in accordance with evidence-based, nationally accepted best practices and standards of care."<br><br>The report includes recommendations on payment of a variable case management fee to PCCM primary care providers (PCP). Currently, PCPs in the PCCM model are paid $2.93 per member per month. The report suggests the use of three levels of case management fee:<br><br>1) The standard $2.93 per member per month amount.<br>2) Incrementally higher rates paid to providers who do any or all of the following (open panel, extended office hours, Texas Health Steps (THSteps) providers, report immunizations to ImmTrac, participate in on-line training).<br>3) The highest level of case management fee paid to PCP providers who have received National Committee for Quality Assurance's (NCQA) physician recognition (Physician Practice Connections).<br><br>It is possible that some of these and other P4P concepts could be transferred into the PCCM program. However, because the PCCM model operates only in rural areas, special consideration should be given to the unique issues encountered in rural areas (lack of infrastructure, technology, and provider and staffing shortages).<br><br><u>Advantages</u>:<br>• P4P has been shown to motivate providers to improve quality and more aggressively monitor patient care.<br>• Facilitates partnership building with providers.<br>• Some of these initiatives have been shown to facilitate incorporation of information technology in provider practices.</td></tr>
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<tr><td>Strategy</td><td colspan="8">Pay for Performance</td></tr>
<tr><td></td><td colspan="8"><u>Disadvantages</u>:<br>• Return on investment is sometimes difficult to estimate.<br>• It is difficult to know what size financial reward would be needed to effect change.<br>• Additional appropriations would be required.</td></tr>
<tr><td rowspan="3">Meets Medicaid Reform Goal(s):</td><td>Cost Reduction or Avoidance</td><td>X</td><td>Maximizes federal funds</td><td></td><td>Improves Program Sustainability</td><td></td><td>Consumer Choice/ Responsibility</td><td></td></tr>
<tr><td>Reduces Number of Uninsured</td><td></td><td>Supports Private Market Coverage</td><td></td><td>Improves Quality</td><td>X</td><td>Improves Access</td><td>X</td></tr>
<tr><td>Benefit Options</td><td></td><td colspan="6"></td></tr>
<tr><td>Populations Affected:</td><td colspan="8">Managed care populations in Medicaid (both HMO and PCCM) and potentially CHIP enrollees.</td></tr>
<tr><td>General Revenue Impact:</td><td colspan="8">Unknown.</td></tr>
<tr><td rowspan="2">Other Considerations</td><td colspan="2">Stand Alone Option</td><td>X</td><td colspan="4">This Option should be considered in conjunction with other Medicaid Reform Strategy(ies)</td><td></td></tr>
<tr><td colspan="8">Although this strategy can stand alone, it may be more effective if considered in conjunction with strategies to encourage client responsibility (such as enhanced benefit accounts). California is currently testing the use of member incentives in its P4P program.<br><br>For the Medicaid/CHIP HMO program, this initiative might be enhanced by including an auto-assignment process that rewards HMOs default enrollments based on meeting identified quality improvement goals (improved access, provider networks), which would positively impact providers in the HMOs' network. California has adopted this approach. Auto-assignment rewards are an option in current HMO contracts, along with other value-based purchasing strategies (i.e., Quality Challenge Pool and Experience Rebate Reward).</td></tr>
<tr><td rowspan="3">State and Federal Approval(s) Required:</td><td rowspan="3">Federal</td><td colspan="2">1115 Waiver</td><td></td><td rowspan="3">State</td><td colspan="2">Rules</td><td></td></tr>
<tr><td colspan="2">Other Waiver(s), [LIST]</td><td></td><td colspan="2">Legislation</td><td>X</td></tr>
<tr><td colspan="2">State Plan Amendment</td><td></td><td colspan="3"></td></tr>
<tr><td>Implementation Considerations & Timeframes:</td><td colspan="8"><u>Affected Stakeholders</u><br>• Health care providers (PCPs, specialists, hospitals)<br>• Medicaid (and potentially CHIP) managed care enrollees<br>• Health plans<br><u>Systems and Resource Considerations</u><br>• For PCCM: Additional Staffing will be required for PCCM contractor and</td></tr>
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| **Strategy** | **Pay for Performance** |
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| | for HHSC<br>**<u>Other Considerations</u>**<br>• Provider collaboration and data integrity are critical. Time will be needed to consult with providers.<br>• It is difficult to know what size financial reward would be needed to effect change.<br>• It is unclear how well P4P would work in a PCCM setting.<br>• For HMOs, which are under a 1915(b) waiver, P4P initiatives must be budget neutral or show savings (per CMS State Medicaid Director Letter, April 2006).<br>• For PCCM, additional appropriations would be needed, unless funding comes from current PCP provider case management fee of $2.93 per member per month.<br>**<u>Implementation Timeframes (in months)</u>**<br>• Unknown at this time. Estimate at least 15-18 months. |

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