The Feasibility and Cost Effectiveness of Making Pay-for-Performance Opportunities Available to Texas Medicaid Providers

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by Bailit Health Purchasing, LLC
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Executive Summary

Introduction
Senate Bill 10 from the 80th Legislature, Regular Session, 2007 (Section 10 (d), (e), (f), (g)) directed the Texas Health and Human Services Commission (HHSC) to study the feasibility and cost effectiveness of including provisions in HMO contracts that require the HMOs to make available pay-for-performance (P4P) opportunities to contracted HMO network providers. The P4P opportunities would be designed to support quality improvements in the care of Medicaid recipients.

HHSC contracted with Bailit Health Purchasing, LLC (Bailit) to conduct the required analysis and draft this report. HHSC asked Bailit to not only assess the feasibility and cost effectiveness of requiring contracted HMOs to make P4P opportunities available to contracted providers, but also to assess the feasibility and cost effectiveness of HHSC making such opportunities available to providers who directly contract with HHSC.

The Centers for Medicare and Medicaid Services defines P4P to mean "the use of payment methods and other incentives to encourage quality improvement and patient-focused high value care." Commercial health insurers and Medicaid programs alike have adopted P4P strategies in order to promote improved quality for a wide range of services, using a variety of techniques.

Methodology
In order to perform the assessment required by Senate Bill 10, Bailit collected information in the following fashion:

- Review of the research literature regarding the use and effectiveness of P4P;
- Interviews with states that have pursued requiring Medicaid managed care plans to make P4P opportunities available to their providers (AZ, IN, and PA).
- Interviews with a sample of states that have made P4P opportunities directly available to varying types of providers with which the state Medicaid program has contracted (CT, ID, MA, MN, and OK).
- Advisory panel discussions with Texas physicians, behavioral health providers, hospitals, nursing homes and HMOs participating in the Medicaid program.
- Review of documentation and conduct a site visit to assess the Superior HealthPlan physician P4P program.

Research Findings: Cost Effectiveness
P4P programs in most cases have been implemented for reasons other than cost containment. Rather, states and managed care plans have designed P4P programs to improve access, quality of care, patient experience and to foster provider participation in the program. Where cost effectiveness has been a consideration, the P4P program sponsor is typically interested in the program being cost neutral. For this reason, there is virtually no research assessing the cost effectiveness of P4P. Still, there are opportunities for P4P to be cost effective by focusing on provider actions for which a return on investment has been demonstrated in the research literature.

Research Findings: Experience of Other States

The experience of other states indicates that only a few states have attempted to make provider P4P opportunities available through their contract health plans, and these efforts have only been implemented recently, so that the sponsoring states lack any findings relative to effectiveness at this point. Still, the states and their contracting plans generally are positive in their assessment of the programs. States have more broadly applied P4P opportunities in their direct contracting with service providers, including behavioral health providers, primary care physicians, hospitals and nursing homes. Providers universally report that the incentives have created an intensified provider focus on quality in the areas to which the incentives have been applied. In addition, regardless of the service or state, their lessons learned are fairly consistent and also consistent with that reported in the research literature.

Research Findings: Texas Perspectives

Discussions with Texas managed care organizations suggested that there is limited use of P4P strategies by these entities at present. Managed care organizations expressed some skepticism about the benefits of P4P with primary care practices, in part because of their belief that approximately 70 percent of the primary care practices with which they contract lack the management staff to respond to performance incentives and generate improvements in care. They were favorably disposed towards the notion of using financial incentives with these practices to help them transform themselves into medical homes using the following approach:

- Provide practices with training and technical assistance regarding how to implement three to five new practices that are consistent with the principles of the Patient-Centered Medical Home and with demonstrated best clinical practices;
- Utilize a managed care plan or HHSC-paid case manager who would work with the practice full or part-time depending upon the size of the practice's Medicaid patient load, and
- Utilize P4P incentives to implement the best practices, with regular reports providing feedback to the practices.

Discussions with Texas providers revealed that providers are wary but open to the creation of pay-for-performance opportunities. They worry about a P4P program being properly designed, implemented and administered, and about providers having an appropriate role in the planning activities. Their greatest concern, however, is that any new P4P initiative be funded with "new money", and that the state not siphon existing funding for this purpose, or place providers at risk for losing any existing funding. Some providers feel that P4P should not be considered until basic issues of adequate payment rates are resolved. Nursing facilities voiced this point stronger than any other provider group.

Some other important provider recommendations included:

- The program should not place any new administrative demands on providers to collect or report additional data;
- A statewide, representative advisory group should advise HHSC on program design, including representatives at the level of those doing the work for which the incentives are being designed;
- The program should provide incentives for both excellence in performance and for improvement over time, so that all providers have motivation and reasonable expectation for achieving incentive rewards;
- While financial incentives are most important, a non-financial incentive, such as waiving certain managed care plan or HHSC administrative requirements (e.g., prior authorization of services) could also be meaningful to providers, and
- There should be a sophisticated means to adjust the P4P methodology to account for differences in the patient case mix borne by different providers. Otherwise, providers, like the managed care plans, worry about "cherry picking" and the avoidance of difficult patients that may follow.

Primary care providers were favorably disposed towards the medical home concept discussed with managed care organizations, but noted that it (like other P4P strategies) might only work with practices with large volumes of Medicaid patients. Behavioral health providers favored the introduction of P4P opportunities, as did nursing homes, albeit only after base reimbursement levels were increased.

Assessment

It is operationally feasible for HHSC to make P4P opportunities available to providers through its managed care contractors. In fact, HHSC contract language currently requires managed care plans to offer motivational incentives either financial or non-financial. In order to make the resulting P4P programs effective in improving quality, HHSC needs to create guidelines for managed care plans through contract amendment or some other non-contractual vehicle. The greatest challenge to feasibility will be financial. While managed care plan margins on HHSC business are generally strong enough to fund part or all of a provider P4P program, there is some reason for concern that the imposition of such a requirement could adversely impact provider reimbursement by managed care plans. The need for state funding of a dedicated stream of funds for provider P4P, on the other hand, could pose challenges, particularly during the current downturn in the economy.

It is also administratively feasible to implement P4P directly with service providers, as several other states have done, but it would be more challenging to do so than with managed care plans. In addition to adverse reaction from some provider types (e.g., nursing homes), depending upon the measures selected, HHSC might confront internal challenges regarding: a) a valid data source for measurement with data that are reliable for fairly assessing performance; b) sufficient internal capacity and infrastructure to collect and then aggregate the data; and c) administrative provider support (e.g.,

sharing of best practices, case management, patient outreach, etc.). Still, with appropriate commitment and administrative resources, HHSC should be able to succeed relative to these challenges.

The clinical and cost effectiveness of either P4P approach (through managed care plans or directly with providers) is less certain. Despite the wide application of P4P strategies nationally, research is, at best, suggestive of its clinical effectiveness, and evidence of cost effectiveness is lacking because there has been almost no research on the topic.

Recommendations

There is broad national consensus that reforming how medical care and long-term care services are paid will be necessary if quality is to be improved and cost growth slowed. Pay-for-performance is one important step towards such reform, although it is not likely to be the final one. We find the merits of pay-for-performance to warrant its application with providers who participate in the Texas Medicaid program either through managed care plans or via direct contracts with the Texas Health and Human Services Commission. We recommend that HHSC pursue making P4P opportunities available to providers should it be fiscally feasible for the state to do so in upcoming fiscal years. We further recommend that as HHSC considers its approaches to P4P, that it take note of the evolution of payment reform methodologies and incorporate and test new ideas, such as episode-based payment, shared savings, and the Patient-Centered Medical Home. Detailed recommendations follow below.

1. Require Medicaid managed care plans to make pay-for-performance opportunities available to their network providers if sufficient funding is available.
    a. Start by making provider pay-for-performance opportunities available through the STAR, STAR+PLUS, and CHIP programs.
    b. Specify a core set of two or three high priority opportunities for improvement, by program (STAR, STAR+PLUS, CHIP), which all managed care plans statewide or within a region will be required to address. Give plans the latitude to add limited additional topics, with state approval.
    c. Establish other general parameters regarding how P4P opportunities should be offered, including:
        i. Plans must conduct thorough education of providers prior to implementation.
        ii. Plans must offer technical support to those providers being offered P4P opportunities.
        iii. Providers should have an active and meaningful role in program design, and the resulting methodology should be transparent.
        iv. Measures should be based on national standards.
        v. The program should exclude measures that would be expected to be heavily influenced by patient case mix so as not to penalize practices with more clinically complicated patients, or to create incentives for “cherry picking."

vi. Measures should include a balance of those that may not generate near–term cost savings, but are consistent with public policy objectives (e.g., Texas Health Steps exams) and those that have a greater likelihood of producing cost savings within a reasonable time horizon (e.g., reduced ER visits, improved management of diabetes, pediatric asthma and high-risk pregnancy).
vii. Measures should focus on outcomes to the extent possible. The program should control for the effects of random variation.
viii. P4P methodologies should take into account both superior performance relative to a plan-set benchmark and also statistically significant improvement over time, so that all providers have an incentive to improve.
ix. The program should include a process for providers to request review of their performance results and present information that they believe supports what they believe to be inaccurate results, with verified incorrect results then corrected by the managed care plan.

d. Require that each managed care plan routinely evaluate its program for effectiveness and unintended consequence.
e. Align the P4P financial and non-financial incentives that HHSC utilizes with its managed care plans, with those that the managed care plans are required to use with their providers.
f. Fund the P4P opportunities through a combination of additions to the capitation rate and from existing managed care plan margins. HHSC should require that 100 percent of the designated funds pass through to network providers, and audit to make sure that managed care plans comply.
g. Ensure that HHSC supports, monitors, and evaluates managed care plan efforts to help the plans succeed, ensure prudent use of state dollars, and learn which efforts succeed, and if possible, why.

2. Make pay-for-performance opportunities available to providers who directly contract with HHSC in incremental fashion, if it is financially feasible to do so.
    a. Focus initially on those providers who are amendable to the opportunity, and where the barriers to implementation otherwise appear lowest.
    b. Introduce models incrementally.
    c. Apply the same program parameters to HHSC's own P4P program design and implementation activity that HHSC would apply to managed care plans (see 1c above).
    d. Fund the P4P opportunities at a level that is deemed sufficient to motivate and achieve meaningful improvements in quality.
    e. Fund the P4P opportunities with "new money."
    f. Routinely evaluate the program for effectiveness and unintended consequences.

3. As HHSC designs its approaches to P4P, incorporate and test new ideas, such as episode-based payment, shared savings and the Patient-Centered Medical Home.

   We specifically recommend that the state consider targeting modification of the PCCM program in one region to a medical home model, and develop a model that provides technical assistance to practices to incrementally transform themselves to medical homes, supports their costs to function as a medical home, and then introduces quality and efficiency performance targets for which the practices would receive payment for their attainment. Furthermore, an evaluation plan should be introduced at the outset.

National Research on Pay-for-Performance

A. What is Pay-for-Performance?

The Centers for Medicare and Medicaid Services defines P4P to mean "the use of payment methods and other incentives to encourage quality improvement and patient-focused high value care."[1] It is of special note that despite the use of the word "pay" in "pay-for-performance" the concept is really a broad one that is inclusive of incentives that may be directly or indirectly economic but are not explicitly payment related. For this reason, at least one national purchaser organization utilizes the term "incentives and rewards" instead of P4P.[2]

P4P incentives are usually, but not always, positive in nature. In some applications, health care providers and health plans are placed at risk of losing something if their performance doesn't meet a defined threshold.

States and large employer purchasers and purchasing coalitions use P4P strategies with contracted insurers, while states and insurers employ the strategies with providers.

Why Pay-for-Performance?

P4P strategies are typically devised as a means for aligning provider or managed care plan incentives so that it is in the economic interest of the provider or managed care plan to improve access to care or quality of care. In other words, the incentives create a "business case" for pursuit of access and quality objectives.

Some observers question why incentives need to be employed for providers and plans to do what they should already be doing. The answer lays in the complex set of payment incentives that providers and managed care plans face today. Those incentives generally do not reward quality. For example, health care providers are primarily financially rewarded for treating more patients, and delivering more (and more intensive) services to them. Managed care plans are primarily financially

[1] Center for Medicaid and State Operations, Centers for Medicaid and Medicare Services. State Health Official Letter #06-003. April 6, 2006

[2] Bailit Health Purchasing (Bailit MH, Dyer MB, Joseph MS). "Incentives and Rewards Best Practices Primer: Lessons Learned From Early Pilots." The Leapfrog Group, Washington, DC, July 2006.

rewarded for enrolling more members and ensuring that their health care costs fall below the capitated premium rate.

P4P strategies are intended to mitigate some of the unintended consequences of the current payment systems. Many believe that even more is required than pay-for-performance to address the flaws of the current payment systems, particularly for providers, and call for more profound redesign of payment systems.[3]

What Does Pay-for-Performance Reward?

P4P strategies can target any type of capacity, action or result that is of priority interest to the sponsor, as described below:

1. Process measures of quality: Most often, P4P strategies have been linked to "process" measures of quality (e.g., whether an individual received recommended tests or treatments such as vaccinations and mammograms) because standardized national measures are most available in this area.
2. Outcome measures of quality: To a lesser degree, outcome measures are also utilized (e.g., controlled cholesterol levels, nursing home resident bed sores). These measures are more challenging than process measures because a) many outcomes take years to become manifested, b) it is difficult to attribute an outcome to the actions of a health plan or provider, and c) outcomes are frequently influenced by co-morbidities and other patient characteristics. For this reason, when outcome measures are used, they typically are "interim" outcome measures. For example, controlled cholesterol is used as an interim outcome measure, because it decreases the likelihood of other possible future outcomes – heart disease and premature death.
3. Structural measures of quality: Sometimes providers and health plans are rewarded for having an administrative capacity or capability. Examples include:
    a. Availability of evening and weekend office hours;
    b. Adoption of e-prescribing;
    c. Adoption of patient safety practices such as Computer Physician Order Entry (CPOE), wherein hospital staff enter medication orders via a computer linked to prescribing error prevention software, and
    d. External recognition by an independent accreditation organization, e.g., as a patient-centered medical home by a national accreditation body.
4. Satisfaction: Scores from the application of standardized satisfaction (member and patient) and experience of care surveys are used on occasion, particularly for non-financial P4P strategies.
5. Efficiency: Some managed care plans reward providers who demonstrate that they make more efficient use of health care resources in the care of a defined population or for defined conditions. The Institute of Medicine identified

[3] Rosenthal MB. "Beyond Pay for Performance – Emerging Models of Provider-Payment Reform" New England Journal of Medicine, 359;12, p. 1197-1200, September 18, 2008.

efficiency as one of the six aims of quality improvement, defining it as avoiding waste.[4]

6. Participation or reporting: Instead of paying for performance per se, some P4P programs provide incentives for plans or providers to report data or to participate in a collaborative quality improvement initiative. For example, the Medicare Physician Quality Reporting Initiative (PQRI) initially offered a 1.5-percent bonus to physicians for reporting specified measures on their Medicare claim forms.[5] L.A. Care Health Plan in Los Angeles rewards physicians for participating in a diabetes care improvement project.[6]
7. Other: There are other miscellaneous actions that are targeted through P4P programs. For example, the California Medicaid program rewards Medicaid HMOs for supporting safety net hospitals and clinics with increased patient volume.[7]

How Does Pay-for-Performance Reward?

P4P strategies are intended to confer some type of economic benefit on a managed care plan or provider as a result of the provider or plan taking desired action or achieving desired results. Some economic benefits are financial, e.g., resulting in fewer or greater dollars being allocated by the purchaser or payer. Some economic benefits are non-financial, meaning that there is no exchange of money, but the provider or plan is rewarded indirectly. Examples of financial and non-financial incentive strategies[8,9] follow below:

Financial Incentive Strategies:

1. Quality Bonuses
   - Perhaps the most common type of P4P program, this strategy involves the provision of supplemental payments based on a retrospective assessment of provider or plan performance.
2. Compensation at Risk
   - Some states place a portion of health plan reimbursement at risk for achievement of a set of performance targets. Similarly, some states and managed care plans place a portion of a provider's rate increase at risk for performance.

3. Pay for Process (Continuous Rewards)
   - There are two forms of this strategy. Conversations with Texas Medicaid HMOs indicate that some apply both forms of the strategy incentive today.

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[4] Crossing the Quality Chasm: A New Health System for the 21st Century, Institute of Medicine, March 2001.
[5] See www.cms.hhs.gov/PQRI/33_2007_General_Info.asp#TopOfPage. (accessed November 12, 2008)
[6] Interview with Elaine Batchlor, L.A. Care Health Plan, November 12, 2008.
[7] Bailit M and Dyer MB. "Putting Quality to Work: Rewarding Plan Performance in Medi-Cal Managed Care." California HealthCare Foundation, Oakland, CA, May 2006.
[8] Bailit Health Purchasing (Dyer MB, Bailit MH, Burgess LL), "Provider Incentive Models for Improving Quality of Care." National Health Care Purchasing Institute, Washington, DC, March 2002.
[9] LLanos K, Rothstein JR, Dyer MB, Bailit M. "Physician Pay-for-Performance in Medicaid: A Guide for States." Center for Health Care Strategies, Lawrenceville, NJ, March 2007.

The first form is to increase fee-for-service provider payment rates for certain services (e.g., Texas Health Steps (THSteps), after-hour office visits, etc.).
    - The second approach is to pay a bonus payment that is linked to a specific action (e.g., a primary care provider receives an automatic payment of $10 every time one of the provider's age-appropriate adult female patients receives a biannual mammogram and for every telephone call to a patient who is due for a mammogram).
4. Performance-Based Fee Schedules
    - Some commercial insurers pay a different (higher) fee schedule for better performing providers.
5. Quality Grants
    - Insurers sometimes offer grants to providers to help finance quality improvement activities or to make investments in provider site infrastructure. Minnesota Medicaid, for example provides supplemental payments to nursing homes for discrete quality improvement initiatives.
6. Variable Cost Sharing for Patients
    - Commercial insurers motivate improvement in provider performance by varying enrollee cost-sharing responsibilities based on provider performance, with lower cost-sharing responsibility for better performing providers.

Non-Financial Incentive Strategies:

1. Performance Profiling
    - States and employer purchasers frequently profile the performance of their managed care plans. Likewise, states and managed care plans profile the performance of their providers. These reports are typically fed back to the assessed entity with peer and/or benchmark comparison, and sometimes with supporting technical assistance, to inform and motivate quality improvement activity.
2. Publicizing Performance
    - Most provider profiling initiatives eventually, if not immediately, lead to disclosure of performance to interested parties (e.g., Medicaid recipients with a choice of health plans), and/or to the general public.
3. Technical Assistance for Quality Improvement
    - Some organizations provide consultative assistance to their contracted health plans and/or providers. For example, a coalition of Medicaid and commercial health plans in Pennsylvania provide training and coaching to primary care practices to help them transform themselves into "medical homes."[10]
4. Sanctions
    - Both state purchasers and health plans apply sanctions to contractors who fall below performance expectations. These non-financial sanctions can include prohibition from serving additional patients or members, and increased administrative requirements.

[10] "Transforming Primary Care Practice: The Southeast Pennsylvania Rollout." Pennsylvania Chronic Care Commission, June 17, 2008.

5. Reducing Administrative Requirements
   - Purchasers and managed care plans will sometimes exempt contractors from certain requirements should they demonstrate superior performance. For example, a health plan could waive certain service authorization requirements based on a provider's past utilization patterns.
6. Auto-assignment Distribution
   - Some states (e.g., CA, MI, and NY) assign a disproportionate percentage of members to managed care plans that perform better than their competitors on a defined set of performance measures.[11]

B. What Does Published Research Say About the Feasibility and Effectiveness of Pay-for-Performance?

There is a growing body of research regarding pay-for-performance as a strategy for improving health care quality. Some of the research has been qualitative, seeking to identify those aspects of pay-for-performance that practitioners believe are associated with success in improving quality, with the balance evaluative, seeking to answer the impact of P4P on health care quality.

Feasibility

Most of the qualitative research, by evaluating components of what are *perceived to be* successful P4P programs with providers, in many ways identifies what is required for a provider P4P program to be feasible. There is some research specific to identification of key success factors for implementing P4P with Medicaid providers[12], with much more P4P research that is not specific to Medicaid providers[13]. There is no specific research concerning the feasibility of a state implementing provider P4P through its contracted managed care plans, most likely because so few states have approached P4P in this fashion to date.

This research on feasibility suggests that provider P4P is generally feasible, and will prove most successful by adhering to the following:

1. Focus the P4P strategy on demonstrated opportunities for performance for which the targeted providers have sufficient control to generate performance improvement.

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[11] Bailit M and Dyer MB, op. cit.

[12] Kuhmerker K and Hartman T. "Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs", The Commonwealth Fund, New York, NY, April 2007, and LLanos, Rothstein, Dyer, and Bailit, op. cit.

[13] Dudley RA and Rosenthal MB. "Pay for Performance: A Decision Guide for Purchasers." Agency for Healthcare Research and Quality. April 2006. See www.ahrq.gov/qual/p4pguide.htm. (accessed September 5, 2008), "*Rewarding Results* Pay-for-Performance Initiative Ten Lessons Learned", Robert Wood Johnson Foundation, November 15, 2005. See www.rwjf.org/files/newsroom/RewardingResulstsLessons_110705.pdf (accessed November 12, 2008), and Christianson JB, Leatherman S, Sutherland K and Williams CH. "Paying for Quality: Understanding and Assessing Physician Pay-for-Performance Initiatives", The Synthesis Project, Issue 13, The Robert Wood Johnson Foundation, Princeton, NJ, December 19, 2007. See www.rwjf.org/pr/product.jsp?id=24373. (accessed November 11, 2008)

2. Performance measures should be scientifically sound and drawn from national standards.

3. Performance measures should be feasible to collect and not impose added measurement burdens on affected providers.

4. Performance measures should not be highly sensitive to patient case mix considerations that would require the use of a risk adjustment mechanism.

5. Substantial variation in physician performance metrics from year-to-year based on random effects can challenge the credibility of pay-for-performance programs. This means that design efforts should focus on common conditions, setting minimum patient volume thresholds, and measuring performance at the group level for practitioner-focused P4P programs.

6. Develop the P4P methodology in close collaboration with affected providers, and make it transparent to affected providers.

7. Provide significant education to providers so that they understand the specifics of the P4P methodology, and what actions are expected of them to attain the potential P4P rewards.

8. Provide technical support to providers to help them achieve the P4P performance targets, such as by providing timely performance feedback and comparison to benchmarks, extending treatment adherence compliance incentives to members, performing member outreach, and providing information on how to implement best practice strategies.

9. Provide incentives for excellence *and* for performance improvement over time so that the P4P program doesn't simply reward those who are already performing well, without motivating those who need most to improve.

10. Align incentives across payers within a geographic area so that providers do not face multiple unaligned P4P incentives that make it difficult, if not impossible, for the provider to focus and achieve desired improvement.[14]

11. Ensure sufficient economic reasons for physicians to engage, by making sure that financial incentives are sufficiently large, utilizing complementary non-financial strategies, and, as referenced in #10, by aligning incentives with other payers.

[14] Francois de Brantes, CEO for the employer-based P4P program Bridges to Excellence has observed that the success of physician P4P programs is dependent on "a strong willingness of health plans to collaborate" (O'Reilly KB. "P4P found to have little impact on care quality", *American Medical News*, August 4, 2008). A state can overcome this barrier by requiring alignment of programs across contracted Medicaid managed care plans, and further, if possible, by partnering with commercial insurers that contract with the same providers.

12. Dedicate adequate resources to program administration to avoid measurement error, erroneous algorithm calculations, payment delays or inaccurate payments, all of which could irreparably harm the credibility of the program.

13. Monitor, revise, and improve provider P4P programs on an ongoing basis after initial implementation.

Cost Effectiveness

Despite the broad application of P4P programs across commercial insurance, Medicaid, and Medicare, there is limited evidence of clinical effectiveness and no evidence of cost effectiveness. Where clinical effectiveness studies exist, they tend to show no impact or a small positive impact. There are several reasons for this:[15]

First, very few controlled studies have been performed on the clinical effectiveness of provider P4P. For example, it appears that fewer than 10 have been performed specifically on physician P4P.

Second, studies have difficulty disentangling the effects of multiple variables that influence provider performance. This indicates another reason for which there are so few studies; P4P program sponsors don't have the patience or ability to implement P4P in a true controlled environment.

Third, many of the early programs have been critically assessed as employing financial bonuses that were too small, in some cases, because the programs were pilots and the payers wanted to limit their financial commitment. For example, many health plans and health services researchers today believe that a physician P4P incentive must total 10 percent or more of annual revenue. A 2006 study found that most physicians average less than a 5 percent bonus, with maximum incentives averaging 9 percent of annual revenues.[16] Because most providers contract with many payers, even a substantial financial commitment by one payer may not have a significant enough impact on the provider, and mixed messages from multiple P4P programs can also limit the impact of the program.

Fourth, early programs set single high performance thresholds, which removed the incentive for poor performers to improve.

Fifth, the programs were sometimes implemented on a small scale, making it difficult to statistically discern meaningful differences.

Sixth, most of the P4P programs were added to pre-existing fee-for-service payment systems that contain such strong financial incentives for increased service volume and

[15] Christianson, Leatherman, Sutherland and Williams, op. cit., Rosenthal MB and Frank RG. "What is the empirical basis for paying for quality in health care?" *Med Care Res Rev*, 63(2):135-57, April 2006, and interview with Meredith Rosenthal, September 15, 2008.
[16] Rosenthal and Frank, op. cit.

service intensity, that P4P programs may have been unable to overcome them. Dr. Robert Galvin of General Electric described P4P as making improvements to a payment model that is fundamentally flawed.[17]

There is a much larger pool of the program evaluations of the clinical impact of provider P4P. These "real world" evaluations of P4P interventions lack the methodological rigor of controlled studies, but often are viewed as more relevant by policymakers. The evaluations address incentive programs that have been implemented primarily by health plans[18] and show more positive results than findings from controlled experiments. A recent policy synthesis examined these program evaluations and found improvement in one or more quality indicators in each evaluation. The findings cannot, however, be viewed with the same level of confidence that one would apply to a controlled study.[19]

C. What Do Other States Report About Their Experience with Pay-for-Performance?

State Medicaid programs have been employing pay-for-performance strategies with health plans and providers for many years. P4P was not commonly pursued by states, however, until the last several years. A 2006 state survey found that more than half of states were operating one or more pay-for-performance programs, and nearly 85 percent expected to do so within the next five years. Of the existing programs, more than half were targeted towards motivating improvements in managed care plan performance, with the balance employed with PCCM program administrators and a range of different types of direct service providers. [20]

Only a small number of states have implemented provider P4P through their managed care plans as envisioned by S.B. 10. Most P4P programs targeting state-contracted managed care plans are focused on plan performance, and do not attempt to use the managed care plan as a vehicle for making P4P opportunities available to the managed care plans' contracted providers.

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[17] Robert S. Galvin, MD, 2nd National P4P Summit, February 14, 2007.

[18] Amundson G, Solberg LI, Reed M, Martini EM, Carlson R. "Paying for Quality Improvement: Compliance with Tobacco Cessation Guidelines." *Joint Commission Journal on Quality & Safety,* vol. 29, no. 2, 2003; Beaulieu ND, Horrigan D. "Putting Smart Money to Work for Quality Improvement." *Medical Care Research and Review,* vol. 40, no. 5, Part I, 2005; Chung RS, Chernicoff HO, Nakao KA, Nickel RC, Legorreta AP. "A Quality-Driven Physician Compensation Model: Four-Year Follow-Up Study." *Journal for Healthcare Quality,* vol. 25, no. 6, 2003; Felt-Lisk S, Gimm G, Peterson S. "Making Pay-for-Performance Work in Medicaid." *Health Affairs Web Exclusive,* vol. 26, no. 4, 2007; Greene RA, Beckman H, Chamberlain J, Partridge G, Miller M, Burden D, Kerr J. "Increasing Adherence to a Community-Based Guideline for Acute Sinusitis through Education, Physician Profiling and Financial Incentives." *The American Journal of Managed Care,* vol. 10, no. 10, 2004; Larsen D, Cannon W, Towner S. "Longitudinal Assessment of a Diabetes Care Management System in an Integrated Health Network." *Journal of Managed Care Pharmacy,* vol. 9, no. 6, 2003; Levin-Scherz J, DeVita N, Timble J. "Impact of Pay-for-Performance Contracts and Network Registry on Diabetes and Asthma HEDIS Measures in an Integrated Delivery Network." *Medical Care Research and Review,* vol. 63, no. 1, 2006; Morrow RW, Gooding AD, Clark C. "Improving Physicians' Preventive Health Care Behaviour through Peer Review and Financial Incentives." *Archives of Family Medicine,* vol. 4, no. 2, 1995; Rosenthal MB, Frank RG, Li Z, Epstein AM. "Early Experience with Pay-for-Performance: From Concept to Practice." *Journal of the American Medical Association,* vol. 294, no. 14, 2005.

[19] Christianson, Leatherman, Sutherland and Williams, op. cit.

[20] Kuhmerker and Hartman, op. cit.

In order to learn first hand about the feasibility and cost effectiveness of state Medicaid P4P provider initiatives that either work through a managed care plan or directly with providers, we interviewed a sample of states, including both those that pursue provider P4P through managed care plans, and those that do so directly with one or more types of direct service providers. Those states interviewed, and the type of P4P programs about which we interviewed them[21], are listed below:

State	Type of P4P Program
Arizona	Primary care provider and nursing home – *through managed care plan**
Connecticut	Behavioral health provider
Idaho	Primary care provider
Indiana	Primary and acute care provider – *through managed care plan*
Massachusetts	Hospital
Minnesota	Nursing home
Oklahoma	Nursing home and primary care provider
Pennsylvania	Primary and acute care provider – *through managed care plan*

* Designed but not yet implemented.

State Managed Care Plan P4P Programs

A considerable number of states operate P4P programs with their Medicaid managed care plans – 20 as of July 2006 with 14 additional programs being planned.[22] Only a small number have attempted to use their managed care plans to implement provider P4P opportunities. We interviewed three such states – Arizona, Indiana, and Pennsylvania. Descriptions of these three initiatives follow below.

Arizona[23,24]

Arizona's Medicaid program enrolls almost all Medicaid beneficiaries in Medicaid managed care. The state contracts with 20 health plans, with one group of contractors responsible for preventive and acute care services, and with another set of managed care plans responsible for long-term care services.

The state has traditionally not required its health plans to implement P4P with its contracted providers, although it reports that four of its 20 plans currently do so of their own volition.

[21] In some cases the state administers additional P4P programs about which we did not interview the state (e.g., Minnesota has a managed care plan P4P program).
[22] Kuhmerker and Hartman, op. cit.
[23] Interview with Marc Lieb, MD, Arizona Health Care Cost Containment System, October 7, 2008.
[24] "Arizona Uses ROI Calculator for P4P Design", *States in Action*, The Commonwealth Fund, New York, NY, June/July 2008.

Arizona recently attempted to implement a statewide P4P directly with providers to address problems that would result from having plans utilizing different measures in their own provider P4P programs. Arizona supported the design with a return on investment (ROI) analysis that indicated a positive return within two years. Despite these projections, the Medicaid agency was not able to secure funding for the effort.

The state's intention was to directly make P4P payments to providers, utilizing data that the contracted health plans would be required to provide to the state. Because only 20 percent of the state's contracted managed care plans currently operate their own P4P program, this course of action seemed more sensible than requiring MCOs to each operate their own provider P4P program. The state felt a statewide initiative would be efficient and would thereby improve provider relations and participation.

Arizona preferred making payments directly to providers as opposed to prepaying provider P4P payments to MCOs in prospective capitation rates for MCO distribution. The state was concerned that, operationally, this prepayment could result in plan winners or losers due to unequal distribution of physicians qualifying for P4P payments.

Aware that CMS generally considers such payments outside of the managed care capitation to be unacceptable, state staff worked closely with CMS to clarify that these were not duplicative payments and that the system would be more efficient when payments were made directly to providers.

Unclear whether CMS would ultimately agree that these were not duplicative payments, the state developed an alternative strategy involving the use of a broker to distribute new provider P4P funds collected from the plans on a per-member per – month (PMPM) basis. The health plans would pay the incentive to a broker based on its membership. Once the state completed its analysis of plan-reported provider performance data and decided which providers earned P4P payments, the broker would disperse the funds. As a secondary alternative, the state could make a retroactive or one-time adjustment to the MCO capitation payments to reflect the P4P payment.

Arizona intended to target primary care providers and nursing homes for the P4P payments, estimating annual costs of $3.2 million for each provider type.

The state had not identified what nursing home measures it would employ, but had identified the following measures for its primary care provider P4P program:

- Diabetes Care
    - Hemoglobin A1c test (two times per year)
    - Lipid profile test (one time per year)
    - Renal panel test (one time per year)
- Immunizations
    - All required vaccinations before 2nd birthday

The state's planned incentive payment methodology was defined as follows:

Diabetes Care—$25 for every diabetic member in the practice, if:
- The practice served at least 50 diabetic members, and
- All of the prescribed measures were performed for at least 50% of the practice's diabetic members.

Immunizations—$25 for every two-year-old in the practice, if:
- The practice served at least 50 members, and
- All of the recommended immunizations were provided to at least 80 percent of the practice's qualifying members.

Nursing Home Quality Measures - $50,000 to the top 40 percent of the state's 134 licensed nursing homes contracted with the Medicaid program based on:
- One or two performance measures, such as frequency of pressure ulcers and use of restraints.

While Arizona has been unable to implement this initiative as of yet because of state budget deficits and lack of legislative support, it identified the following key success factors when developing P4P opportunities for providers contracting with managed care plans:
- Work with providers to select measures that fairly assess their performance, and specifically performance that is within their direct control (providers dislike being assessed for performance in areas where they are dependent on patient compliance);
- Measures need to be objective, available from administrative data, and not additionally burdensome to providers – especially for those providers not utilizing electronic health records (EHRs);
- Providers need to be able to review their performance data, and
- Withhold programs will be viewed negatively – the state has to make available "new" money rather than place existing payments at risk.

Indiana[25]

Indiana operates a P4P program with its contracted managed care plans. The program includes both additional budgeted bonus funds equal to 0.5 percent of premium, as well as a 1.5 percent premium withhold. The bonus fund payments are triggered by performance above the 50th percentile of national Medicaid managed care plan performance, as calculated annually by the National Committee for Quality Assurance, with payments increasing for performance above the 75th and 90th percentile levels. Because the performance thresholds to qualify for the bonus funds are high, the state is paying out only about half of the available funds for 2007 performance.

[25] Interview with Stephanie Baume, Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning, October 16, 2008.

The withheld funds are not returned if performance is both below the 50th percentile and not improving over time. This policy is based on the state's position that it does not "want to pay for mediocrity."

Indiana attached its P4P bonus and withhold to the following measures in 2008:

- Well Child Visits in the First 15 Months of Life
- Follow-up After Hospitalization for Mental Illness
  - Percent of members who received follow up within 7 days of discharge
  - Percent of members who received follow up within 30 days of discharge
- Prenatal and Postpartum Care – Timeliness of Prenatal Care

Beginning in 2007, Indiana implemented a requirement that its contracted managed care plans distribute 50% of any earned P4P funds to contracted providers and/or to members. Those funds were being distributed in the fall of 2008, and the state will be utilizing an accounting firm to confirm that the health plans actually distribute 50 percent of the bonus funds.

Indiana has not specified how the bonus payments should be distributed to providers or members. Plans have full discretion to select the performance they want to reward, and the measures need not include those used by the state in its P4P methodology with the plan.[26] Managed care plans must, however, submit a proposed methodology for state review and approval. The full set of contract guidelines that the state defined for managed care plan distribution of bonus funds is provided in Attachment C. Indiana designed its program in order to provide incentives for improved quality. It did not consider cost effectiveness in the design.

Indiana identified the following as key success factors when developing P4P opportunities for providers contracting with managed care plans:

- Clearly identify state priorities and be careful not to set too many competing priorities. Managed care plans need to be able to focus their attention in order to be effective, and
- Allow for stakeholder input into the design process.

We interviewed personnel from two Indiana Medicaid managed care plans to learn about their experience with the program.[27] One plan reported experience making provider P4P opportunities available in other states and found nothing about the state's program to be extraordinary. The other was supportive of the concept, but identified opportunities for improvement, including: a) fewer measures, and b) more attainable performance targets (Indiana rewards only excellence, and not improvement). The plan also discussed the need to support practices with data to help them achieve improvements targets, problems of small numbers, and concerns about practices

[26] The state reported that health plan proposals it had received for distribution of the 2007 bonus funds utilize the state's measures for health plan P4P, with one plan adding EHR use and use of physician extenders to their proposal.
[27] The two Indiana managed care plans included Anthem and MDwise.

"cherry picking." Finally the plan noted that a collaborative approach would be valuable for quality improvement: "I think that a lot of improvement can come through more collaboration on the community level. Aligning goals is critical. A lot of these issues are bigger than the health plan, and there is a limited amount that the health plan can do alone."

Pennsylvania[28]

Like Indiana, Pennsylvania has a history of maintaining a P4P program with its contracted managed care plans. The state has rewarded plans for achieving improvements and for demonstrating performance at or above thresholds for clinical quality indicators taken from the Healthcare Effectiveness Data and Information Set (HEDIS).

Beginning in 2008, Pennsylvania implemented a separate pay-for-performance initiative for contracted HMO network providers. Like Indiana, Pennsylvania designed its program in order to provide incentives for improved quality. It did not consider cost effectiveness in the design. However, unlike Indiana, which elected to require its health plans to distribute a portion of the plan's earned bonus to network providers and/or members, Pennsylvania provided a wholly separate funding stream for provider incentives, allowing the plans to retain whatever bonus payments they earned at the plan level.

Pennsylvania added $1 PMPM to its capitation payment rates if the state approved the plan's proposed provider P4P program. The state provided no specific parameters for how the provider P4P program should be structured, aside from informally encouraging the plans to focus upon one or more of the 13 HEDIS measures of interest to the state. The state's contract required only that the proposal include the following:

- A detailed description of the proposed plan.
- Which provider(s) are being targeted.
- Specific services or fees targeted.
- How provider success or compliance will be measured.
- How payment will be made to providers, including time frames.
- How the proposed initiative aligns with the goals of the Commonwealth's Prescription for Pennsylvania [health reform] initiative or the Department's MCO P4P Program.
- Certification, including signature by the health plan medical director, that the proposal is new or an expanded program.

The full set of contract guidelines that the state defined for managed care plan provider pay-for-performance is provided in Attachment D.

Pennsylvania reported that the seven contracted health plans designed highly divergent programs due to the latitude afforded them by the state. Still, the provider P4P

[28] Interview with Barbara Molnar, Pennsylvania Department of Public Welfare, September 15, 2008.

programs largely targeted primary care providers and OB/GYNs. Some plans have focused on diabetes care provided by both primary care physicians and endocrinologists.

Pennsylvania requires that the effectiveness of the approved provider P4P initiative(s) be evaluated by the health plan. The results of the analysis must be submitted to the state no later than one year after implementation of the initiative.

Pennsylvania further requires that all funding received from the additional $1 PMPM must be paid in incentives to network practitioners. The state will perform a plan-specific, individualized reconciliation and monitoring process based on the practitioner initiative proposed. A clinical reconciliation will inform the state whether the plan utilized the incentive methodology as proposed, and the financial reconciliation will demonstrate whether all the money tracked from the plan into the network.

Pennsylvania identified the following as the key success factor for making P4P opportunities available to providers contracting with managed care plans:

- Set more parameters for the plans than did Pennsylvania. The broad parameters utilized by the state resulted in a time consuming and administratively complex process to develop unique financial and clinical reconciliation tracking measures for each plan. Pennsylvania recommended selecting one priority topic and directing the plans to use the extra provider P4P resources in that area.

We interviewed personnel from three Pennsylvania managed care plans to learn about their experience with the program.[29] They were positive in their assessment of the program, reporting that they generally aligned the P4P incentives that the state created for the plan with those the plan created for physicians. They all spoke of the level of administrative support that needs to be provided to physician practices to understand the incentives, and then to respond to them. They liked the flexibility that the state afforded them in program design, although one plan noted that having multiple Medicaid plans in a geographic region using different incentives was problematic. They all felt that extra funding should be provided if a state institutes such requirement, with one plan stating that there should also be added administrative funding because of the increased administrative costs for developing and operating the program.

State Provider P4P Programs

States in recent years have been placing increased emphasis on creating provider-level incentives, particularly in states that do a significant amount of direct contracting with providers. Provider-level P4P programs can be more challenging for a state to administer than those directed at health plans for a few reasons[30]:

[29] The three Pennsylvania Medicaid managed care plans included AmeriChoice, Gateway Health Plan, and UPMC Health Plan.
[30] LLanos, Rothstein, Dyer, and Bailit, op. cit.

- The methodologies can be more complicated to design than those with managed care plans, and require collaboration with many providers as compared to a limited set of health plans.
- Administering the P4P program can be staff-intensive due to the number of providers profiled.
- The small number of members treated by many providers excludes many providers from participation for statistical reasons if certain common and desired measures are to be employed.
- For financial P4P strategies, there can be a high volume of provider incentive payments that need to be calculated and distributed on a regular basis.
- In a Medicaid PCCM program, it can be challenging to determine how best to assign members to PCPs due to changes in Medicaid members' eligibility and the limitations of data information systems linkages between eligibility, PCP enrollment, and clinical quality data.

We interviewed five states that have implemented P4P programs directly with their contracted Medicaid providers – Connecticut, Idaho, Massachusetts, Minnesota and Oklahoma. In so doing, we purposely selected states that have implemented such programs with a range of different provider types. Descriptions of these three initiatives follow below.

Behavioral Health Provider P4P - Connecticut[31]

Connecticut implemented a P4P program for contracted freestanding mental health clinics in June 2007, administering the program with help from an administrative services organization (ASO). The program was designed to increase access to and quality of behavioral health services. As a result, cost effectiveness was not a consideration in the program's design.

Connecticut offers the mental health clinics an incentive of a 25 percent rate increase for attainment of state-defined standards for timely access to services and for coordination with primary care. The specific standards against which clinics were assessed for the first year were as follows:

- Timely Access to Services
    - Emergent care within two hours for walk-in appointments.
    - Urgent care within two days.
    - Routine care within 14 days.
    - All of the standards are met 95 percent of the time.

Performance relative to access standards is measured through a web-based service authorization system administered by the state's contractor.

[31] Interview with Mark Schaefer, MD, Connecticut Department of Social Services, October 16, 2008.

Beginning in the fall of 2008, Connecticut added additional P4P requirements for coordination with primary care:

- Coordination with Primary Care
    - Sign memorandums of understanding (MOUs) with PCPs, and develop policies and procedures (to be submitted for state review) that demonstrate the clinics have implemented the activities provided for under the MOUs, including the circumstances under which a referral for medication management by the PCP would be pursued and administrative methods for identifying candidates for referral.
    - Provide for timely response to PCP inquiries with regard to patients currently or formerly treated by the clinic.[32]

The state has not formally evaluated the initiative, but reports that access has definitely improved. Previous waiting lists for appointments have disappeared, and the state is receiving fewer complaints regarding access. Based on the perceived early success of the initiative, the state is looking to expand the program to psychiatric inpatient and other care settings.

Connecticut identified the following key success factors when developing P4P opportunities for behavioral health providers:

- Involve providers during the design phase to garner support for the concept.
- Involve providers in the design of the actual standards upon which the P4P initiative will be based.
- Provide sufficient time to develop the program requirements.
- Ensure that the measurement activities create a low administrative burden for both the state and providers.

Primary Care Provider P4P – Idaho[33] and Oklahoma[34]

Idaho and Oklahoma are two of a number of states that operate P4P programs with primary care providers in the context of a primary care case management program. Other states with such programs include Maine and Pennsylvania. Descriptions of the Idaho and Oklahoma primary care provider P4P initiatives follow below:

Idaho initiated its effort as a pilot in 2006 with federally qualified health centers (FQHCs) after completing program planning that began in 2003. It plans to extend the program to all PCPs in the future. The P4P program targets management of care for diabetics, and is structured as follows:

- Enrollment of Diabetics into Disease Management

[32] More detailed information regarding the requirements can be found in Attachment E.
[33] Interview with Jeanne Siroky, Idaho Department of Health and Welfare, Division of Medicaid, October 1, 2008.
[34] Interview with Debbie Ogles and Kelly Taylor, Oklahoma Health Care Authority, September 30, 2008, and review of information available at www.ohca.state.ok.us. (accessed November 5, 2008)

    - $50 to enroll each diabetes member into a state-administered disease management program. This payment is meant to provide practices with some start-up funds and to motivate them to participate.
- Provision of Recommended Care to Diabetic Patients
    - $10 payment for each of the following (most payments limited to once per year):
        1. Plan of care is established and/or reviewed at least annually;
        2. Semi-annual assessment of hemoglobin A1c – if the score is greater than 7, the provider may reassess up to two more times per year for a total of four times per year;
        3. Annual serum lipid evaluation.
        4. Annual dilated retinal exam.
        5. Annual influenza immunization.
        6. Annual blood pressure evaluation.
        7. Annual micro albumin urine test.
        8. Annual foot exam by inspection.
        9. Annual foot exam by monofilament.
        10. Annual depression screening.
        11. Annual assessment/counseling regarding tobacco use.
        12. Annual assessment/counseling for weight and body mass index (BMI).

Legislatively appropriated funds were used for the program, and while there has not been a formal evaluation for clinical or cost effectiveness, indications are that providers have modified their practices in order to respond to the incentive.

We interviewed an Idaho FQHC association representative to learn about providers' experiences with the program. The interviewee reported that direct involvement of the Medical Director of the Division of Medicaid, including his going out to each FQHC, was key to the development of provider trust. She reported that FQHCs are providing input and feeling that they are being heard. Providers have been challenged to respond the P4P program, often because their practices lacked the infrastructure. She also counseled not to build an entire program in one year, but to proceed incrementally.

Idaho identified the following as key success factors when developing P4P opportunities for primary care providers:

- Ensure a reliable source of funding; the state worries that its appropriation for the P4P program could be in jeopardy as state finances weaken.
- Ensure adequate staffing to design and administer the program, including a fully dedicated medical director to work with physicians and adequate resources and infrastructure to support data collection processes on both the provider and state sides.
- Make sure that the design does not run afoul of CMS – it was quite difficult for Idaho to obtain approval for a state plan amendment.

Oklahoma's PCCM program, SoonerCare, has operated an EPSDT[35]-based P4P program for several years. Participating primary care practices are eligible for a 25 percent rate enhancement for all EPSDT recommended general health screenings that fall above the state's target compliance rate of 65 percent. These payments are made in addition to fixed monthly capitated payments for case management and a limited set of primary care services. Oklahoma reports that approximately one-third of PCPs qualify for the bonus payment. The program was designed to increase EPSDT rates and, as a result cost effectiveness, was not a consideration in its design. The state believes that the incentive may have contributed to an increase in EPSDT rates that the state has witnessed over time.

Oklahoma is transforming SoonerCare to a medical home model PCCM program with a January 1, 2009 start date. A significant number of reimbursement and program changes accompany this transformation, including a modification to the P4P program. The new P4P measures are as follows:

- EPSDT
    - All PCPs that meet or exceed the appropriate EPSDT compliance rate for medical home members for the age group (65 percent in 2009) will receive up to an additional 25 percent of the rate for the age appropriate procedure code.
- Breast cancer screening
    - The provider will be paid a rate per screen for each screen provided on a member in his or her panel. The rate will be based on the number of relative screens provided on all SoonerCare Choice members divided by the amount available for the quarter for a particular measure.
- Cervical cancer screening
    - The provider will be paid a rate per screen for each screen provided to a member in his or her panel. The rate will be based on the number of relative screens provided on all SoonerCare Choice members divided by the amount available for the quarter for a particular measure.
- Fourth DtaP screening
    - All PCPs that immunize a child with the fourth DTaP prior to age two, file a claim for the service and those claims in a paid status will be eligible to receive $3.00 per child. The payment amount is based on available funds and may be less.
- Physician inpatient admitting and visits incentive
    - All PCP's that admit and visit members in an inpatient setting (procedure codes 99221–99239) will receive up to an additional 25 percent of the rate for the procedure code according to the current fee schedule.
    - Each PCP will be compared to the average percentage of all PCPs that participate in their members' inpatient care. To qualify, any individual PCP must be above the average of all PCPs or above 20p percent,

[35] EPSDT, or Early and Periodic Screening, Diagnostic, and Treatment, is the federal designation for what Texas refers to as "Texas Health Steps", or "THSteps."

Oklahoma has budgeted an annual incentive pool for each of the P4P measures (e.g., $1M for EPSDT, $350,000 for breast and cervical cancer screening) with one quarter of the budgeted funds made available each quarter. Because of this cap on available P4P funds, the state has informed providers that actual payments may be less than those defined above.

Oklahoma identified the following as key success factors when developing P4P opportunities for primary care providers:

- Establish provider buy-in, as well as that of the advocacy groups.
- Keep the methodology simple and transparent.
- Provide enough money to make it worth providers' efforts.

Hospital P4P – Massachusetts[36]

State Medicaid agencies have not often ventured into hospital P4P initiatives historically. Massachusetts and Pennsylvania are two examples of states that have done so. We interviewed Massachusetts about its initiative.

While most state Medicaid P4P programs result from an executive branch initiative, Massachusetts implemented its hospital P4P program in 2007 in response to a legislative directive focused on quality improvement and not cost effectiveness. Hospitals can earn incentive payments two ways:

1. Demonstrate improvement from the previous year's performance, and
2. Meet data validation requirements for reporting new measures (pay-for-reporting).

The tables that follow depict the measurement categories and specific measures for which bonus payments have been made available, and the budgeted bonus funds for each in Rate Year 2009. Detailed measurement specifications can be found at http://massqex.ehs.state.ma.us/massqex/index/specs.

Quality Measure Category	Budget Allocation
Community-Acquired Pneumonia	$8,000,000
Maternity	16,200,000
Neonate	4,000,000
Surgical Care Infection Prevention	8,000,000
Pediatric Asthma	4,000,000
Health Disparities CLAS	11,250,000
Health Disparities Clinical	$6,450,000

[36] Interview with Iris Garcia-Caban, Massachusetts Executive Office of Health and Human Services, October 8, 2008.

Measure ID	Measurement Category and Name
	Maternity
MAT-1	Intrapartum Antibiotic Prophylaxis for Group B Streptococcus
MAT-2	Perioperative Antibiotics for Cesarean Section
	Neonate
NICU-1	Neonatal Intensive Care – Administration of Antenatal Steroids
	Community-Acquired Pneumonia
PN-1	Oxygenation assessment
PN-3b	Blood culture performed in ED prior to first antibiotic received in hospital
PN-4	Adult smoking cessation advice/counseling
PN-5c	Initial antibiotic received within 6 hours of hospital arrival
PN-6	Appropriate antibiotic selection for CAP in immunocompetent patients
	Pediatric Asthma
CAC-1a	Children's Asthma Care - Inpatient Use of Relievers
CAC-2a	Children's Asthma Care - Inpatient Use of Corticosteroids

Measure ID	Measurement Category and Name
	Surgical Care Infection Prevention
SCIP-1a	Prophylactic antibiotic received within 1 hour prior to surgical incision
SCIP-2a	Appropriate antibiotic selection for surgical prophylaxis
SCIP-3a	Prophylactic antibiotic discontinued w/in 24 hours after surgery end time
	Health Disparities
HD-1	Cultural and Linguistic Appropriate Service (CLAS) Standards
HD-2	All clinical measures listed above

Massachusetts reported that devising the program was technically challenging because most available inpatient hospital service quality measures have been designed for use with the Medicare population and affect only a small subset of Medicaid hospital admissions. In addition, hospitals objected to any reporting requirements beyond those to which they were already subject. The state began with pay-for-reporting incentives, and then began transitioning to pay-for-performance incentives.

Massachusetts identified the following as key success factors when developing P4P opportunities for hospitals:

- Work closely with providers and anticipate likely concerns.
- Minimize the burden on the providers to collect and store data.

- Modify the measures when it appears that a) supporting clinical evidence has changed or national measurement standards have changed, and b) providers are achieving maximum achievable performance levels.
- Utilize nationally endorsed measures.
- Maintain adequate legislative financing and staff administrative support.

Nursing Home P4P – Minnesota[37] and Oklahoma[38]

Six states currently maintain nursing home P4P programs, including Georgia, Iowa, Kansas, Minnesota, Ohio and Oklahoma, and more are exploring the concept. In addition, CMS will implement a nursing home P4P demonstration in 2009 in several states.

The six states generally pay bonus payments to high-performing nursing homes that are either a percentage of the daily rate (e.g., between 1 and 4 percent), or are paid as a fixed dollar add-on to the daily rate. We interviewed state agency representatives from Minnesota and Oklahoma.

Minnesota has been committed to paying nursing homes for performance for several years, and faced several roadblocks along the way. Its goals have been to improve quality, improve efficiency, and contribute to the re-balancing of Minnesota's long-term care system (i.e., shift towards more community-based service delivery). It first implemented a nursing home report card (www.health.state.mn.us/nhreportcard/), one of approximately 20 states to do so, before finally implementing its financial incentive program in its 2006 rate year.

Minnesota's financial P4P program was structured as a rate add-on, using a weighted scoring system utilizing the nursing home report card measures to provide nursing homes with up to a 2.4 percent add-on to the operating cost component of their rates for facilities earning scores of between 40 percent and 100 percent in rate year 2006, and a 0.3 percent add-on in rate year 2007. In rate year 2007 the weighting methodology was as follows:

- Nursing Facility Quality Measures
  - Quality of life[39] – 20 percent
  - Minnesota quality indicators[40] – 35 percent
  - Direct care staffing level – 10 percent
  - Direct care staff retention – 20 percent
  - Temporary staff usage – 5 percent
  - Minnesota Department of Health certification findings – 10 percent

[37] Interview with Valerie Cooke, Minnesota Department of Human Services, October 6 and 21, 2008.
[38] Interview with David Branson and Jason Ence, Oklahoma Health Care Authority, September 30, 2008, and review of information available at www.ohca.state.ok.us/providers.aspx?id=2999&menu=74. (accessed November 5, 2008)
[39] This information is collected by trained interviewers using a standardized state assessment tool.
[40] These are 23 indicators taken from the Minimum Data Set Assessment, some taken from CMS, and developed by researchers at the University of Minnesota and the Center for Health System Research and Analysis at the University of Wisconsin.

This program was operational for only two years, because the Minnesota legislature did not fund the program for the 2008 rate year. The legislature did fund another type of nursing home P4P program, however, for fiscal year 2008 and 2009. This financial incentive (the "Facility Performance Initiative"), however, was designed to complement the rate bonus, rather than replace it. It involves a competitive process in which nursing homes propose quality improvement projects for funding. The state instructed nursing homes to focus their proposals on innovation, collaboration, and use of the nursing home report card quality measures

Selected facilities can receive up to a 5 percent add-on to their payment rate, with 4 percent tied to the proposed quality improvement process, and 1 percent tied to achievement of improved outcomes that result from the process. The legislature made available $6.7 million in state dollars. The state reported that 68 proposals were received, and 22 nursing homes were selected to negotiate with the state.

Despite the changes that have occurred in the program over time, the state feels the program has been successful, citing positive trend lines for both quality indicator and quality of life scores, with statewide improvement seen on all measures.

We interviewed two Minnesota nursing home industry representatives[41] to learn about their experience with the program. They generally felt positive about the initial rate add-on methodology and the corresponding consumer report card, feeling that they truly focused nursing home efforts on quality. One industry representative expressed great concern that the initial rate add-on was funded by taking a portion of a budgeted cost-of-living rate increase, conveying the belief that the state should have provided new funding for the P4P incentive. The interviewees felt less positively about the newer quality improvement incentive, feeling that it was essentially a grant writing exercise that did not inspire great creativity and awarded dollars only to those nursing homes with staff time to write good proposals.

Minnesota identified the following as key success factors when developing P4P opportunities for nursing homes:

- Involve stakeholders when designing the performance measures.
- Research the performance measures and make sure they are research-based and credible (Minnesota invested over $2M in the development of its quality of life and quality of care indicators).
- Ensure adequate numbers of qualified staff to support the model's operation – in Minnesota state staff negotiate contracts and select proposals. This is very resource intensive and the state agency does so without any new appropriations.
- Obtain legislative funding support. This can be difficult even with a legislature support of P4P in concept, because the nursing homes will argue in favor of cost-of-living adjustments as a higher funding priority.

[41] The interviewees were representatives of Care Providers of Minnesota and Aging Services of Minnesota.

Oklahoma's program is named "Focus on Excellence." It was designed for three purposes: a) to enable additional Medicaid payments to nursing homes that meet or exceed any of ten separate performance targets; b) to provide information to support a public star rating system for use by consumers in evaluating facilities; and c) to give providers the technology and tools to set and meet their own quality improvement goals and compare their performance to facilities across the state and the nation. Whereas Minnesota's effort was pursued as a long-standing agency priority, Oklahoma's program was designed in response to a legislative directive strongly supported by the trade associations.

Oklahoma's program is similar to that of Minnesota in a few ways. Like Minnesota, Oklahoma uses a menu of measures to reflect different aspects of performance. Also like Minnesota, Oklahoma's P4P performance measures are almost entirely aligned with the measures used for a consumer report card.[42] Implemented in April 2008, it works much like that of Minnesota.

Unlike in Minnesota, where the state invested significant time and resources in measurement tool development, Oklahoma used an outside vendor to design its program and that vendor also performs the bulk of the data collection activity, including consumer interviews.

Oklahoma's P4P methodology allows nursing homes to earn a bonus payment of between $1.09 and $5.45 per day, with an average of $2.60. Given that the average nursing home daily rate is approximately $130, this equates to a bonus of 2%. The performance domains include:

- Quality of life
- Resident/family satisfaction
- Employee satisfaction
- CNA/NA turnover and retention
- Licensed nurse turnover and retention
- State survey compliance
- Level of person-centered care
- Clinical outcomes43
- Direct care staffing hours
- Medicaid occupancy and Medicare utilization ratio

Resident/family satisfaction receives the highest weighting (30 percent).

[42] See www.oknursinghomeratings.com/. (accessed September 30, 2008)

[43] Oklahoma uses six clinical measures, as compared to the 23 used by Minnesota. They include: percentage of residents without falls, percentage of residents without facility-acquired restraints, percentage of residents without facility-acquired pressure ulcers, percentage of residents without facility-acquired catheters, percentage of residents without use of anti-psychotic medications, and percentage of residents without unplanned weight loss or gain.

We interviewed two Oklahoma nursing home industry representatives[44] to learn about the industry's experience with the program. We were told that the P4P program, while still relatively new, has been well received and that "it is definitely getting facilities to focus on quality." One interviewee described provider reaction as "In general, they like anything that gives them more money." They emphasized the need for the use of positive incentives, and the need to support nursing homes by instructing them how to implement changes that would help them achieve the incentives. The P4P system's consumer report "star" rating system has been less well received.

Oklahoma identified the following as key success factors when developing P4P opportunities for nursing homes. Most of them are the same as those identified by the state for primary care physician P4P programs:

- Establish provider buy-in, as well as that of the advocacy groups.
- Keep the methodology simple and transparent.
- Provide enough money to make it worth providers' effort.
- Make adequate provision for collecting and analyzing performance data.

Medicare P4P Initiatives

While not specific to Medicaid, it is worth noting that CMS has exerted considerable effort to pilot P4P programs in the Medicare program.[45] Brief summaries of three prominent, provider-focused Medicare P4P initiatives follow below.

Physician Group Practice Demonstration Project

Under CMS' ongoing Physician Group Practice Demonstration Project, physician groups continue to be paid on a fee-for-service basis and are eligible for performance payments if the growth in Medicare spending for the population assigned to the physician group is less than the growth rate of Medicare spending in their local market by more than two percentage points. Performance payments are allocated between efficiency and quality, using 32 ambulatory care measures for quality. Participating physician groups have been implementing care management strategies designed to anticipate patient needs, prevent chronic disease complications and avoidable hospitalizations, and improve quality of care. For purposes of the calculations, beneficiaries are assigned to the physician group if they receive the plurality of their office or other outpatient visits at the physician group.

CMS reported that for the first year of the demonstration, two participating physician groups earned combined bonuses of approximately $7.3 million and all ten participating physician groups attained most of the quality targets.[46] The federal

[44] The interviewees were representatives of The Oklahoma Association of Health Care Providers and The Oklahoma Association of Homes and Services for the Aging.
[45] See www.cms.hhs.gov/apps/media/press/release.asp?counter=1343 for a full list of Medicare P4P initiatives. (accessed December 2, 2008)
[46] See www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PGP_Press_Release.pdf. (accessed December 2, 2008)

General Accounting Office (GAO) found that the size of the 10 participating physician groups (i.e., 200 or more physicians) is much greater than most U.S. physician practices and gave the demonstration participants certain size-related advantages. The GAO observed that this could make it difficult to broaden the model's application to other smaller practices.[47]

Premier Hospital Quality Incentive Demonstration

This demonstration was launched in 2003 to improve the quality of inpatient care for Medicare beneficiaries by giving financial incentives to approximately 250 hospitals for high quality. Under this demonstration, CMS is collecting data on 34 quality measures relating to five clinical conditions (acute myocardial infraction, coronary artery bypass graph, heart failure, pneumonia, heart and knee replacement). Hospital-specific performance is publicly reported on CMS's web site. Hospitals scoring in the top 10 percent for a given set of quality measures receive a 2 percent bonus payment on top of the standard DRG payment for the relevant discharges. Those scoring in the next highest 10 percent receive a 1 percent bonus.

Reported results thus far indicate that patients treated at demonstration hospitals are living longer and receiving recommended treatments more frequently. Over the first three years of the project (2003-2006), participating hospitals raised overall quality by an average of 15.8 percent[48] based on their delivery of patient care relative the standardized quality measures.

Physician Quality Reporting Initiative

The Physician Quality Reporting Initiative (PQRI)[49] is a program that provides a financial incentive to physicians and other eligible professionals who successfully report quality data related to covered services provided under the Medicare Physician Fee Schedule. In order to participate in the PQRI, a clinician reviews the detailed PQRI Quality Measure Specifications and selects measures applicable to his or her patient panel and the professional services furnished to his or her patients. The clinician then reports the selected measures by submitting the specified quality-data codes on claims for services paid under the Medicare Physician Fee Schedule and provided during the reporting period. This program is a pay-for-participation program, in contrast to the more clinical process and clinical and financial outcome-oriented physician group practice and hospital demonstrations described above.

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[47] "Care Coordination Programs Used in Demonstration Show Promise, but Wider Use of Payment Approach May Be Limited", U.S. General Accounting Office, February 18, 2008.

[48] See http://www.cms.hhs.gov/HospitalQualityInits/Downloads/HospitalPremierFactSheet200806.pdf. (accessed December 2, 2008)

[49] For more information on PQRI, see www.cms.hhs.gov/PQRI/. (accessed December 2, 2008)

Texas Perspectives on Pay-for-Performance

In order to evaluate the potential application of pay-for-performance strategies to the Texas Medicaid program, we solicited input from Texas Medicaid managed care plans and providers. We also examined the degree to which HHSC currently makes use of pay-for-performance strategies, and performed a case study and evaluation of the P4P program administered by one HHSC-contracted managed care plan.

A. To What Degree Does HHSC Currently Employ P4P Strategies with Contracted Managed Care Plans or Providers?

HHSC currently requires its contracted managed care plans to employ "substantive motivational incentive strategies, such as financial and non-financial incentives" with its contracted providers. The common contract used for STAR, STAR+PLUS, and CHIP states that health plans should use incentives to motivate improved performance. HHSC also utilizes P4P strategies with its managed care plans and, to a limited degree, with providers with which HHSC contracts directly. A brief summary of these initiatives is provided in the following table.

Entities with Which P4P Strategies are Employed	Description of Strategy
Managed Care Plans[50],[51] (STAR, STAR+PLUS, CHIP)	• Health Plan Performance Profiling: HHSC distributes information on key performance indicators to HMOs on a regular basis, identifying an HMO's performance, and comparing that performance to other HMOs, HHSC standards and/or external benchmarks. HHSC recognizes HMOs that attain superior performance and/or improvement by publicizing their achievements. • Performance-Based Capitation Rate: HHSC places each HMO at risk for 1 percent of the capitation rate(s). Should the HMO fall short on some or all of the quantitative performance expectations established by HHSC (e.g., member services hotline abandonment rate), the plan forfeits some or all of the 1 percent. • Quality Challenge Award: HHSC redistributes any forfeited Performance-Based Capitation Rates to a pool that is used to reward plans that demonstrate superior performance on a defined set of clinical quality indicators.

[50] 2007 HHSC/HMO contract, HHSC Uniform Managed Care Contract Terms & Conditions. The contract also states that HHSC may implement a new auto-assignment methodology that would reward those HMOs that demonstrate superior performance and/or improvement on one or more key dimensions of performance with greater numbers of members. See www.hhsc.state.tx.us/medicaid/FY2007ManagedCare.pdf. (accessed November 9, 2008)

[51] The Integrated Care Management (ICM) and STAR Health contracts have some, but not all, of the same P4P mechanisms. The ICM contract does not require the use of incentives with providers. See www.hhsc.state.tx.us/Contract/529060406/final/rfp_docs.html for the ICM RFP and www.hhsc.state.tx.us/medicaid/STAR_Health.pdf for the STAR Health contract. (accessed November 9, 2008)

Entities with Which P4P Strategies are Employed	Description of Strategy
Managed Care Plans (STAR, STAR+PLUS, CHIP) (Continued)	• Requirements to Use Incentives with Providers: HHSC's HMO contract specifies that the HMO "must employ substantive motivational incentive strategies, such as financial and non-financial incentives, to improve provider compliance with clinical practice guidelines." It separately specifies that the HMO shall "develop and implement incentives, which may include financial and non-financial incentives, to motivate Providers to improve performance on profiled measures." (pages 8-22 and 8-23)[52] In addition, the NorthSTAR contract stipulates that the contractor, "in conjunction with NTBHA and providers, shall develop performance incentives for providers, using the list described in Appendix 4a as a guide. Once developed Contractor/NTBHA shall forward incentive plan to DSHS for approval."[53] It further states "DSHS will pay Contractor performance incentive funds, if applicable, as described in Appendix 4a. Performance incentives paid to Contractor shall be passed through to providers."
Primary Care Case Management (PCCM) Program and Fee-for-Service (FFS) Program	• Disease Management: HHSC recently concluded a pilot of a PCCM P4P program specific to primary care provider support for the HHSC disease management program. Applying a model similar to that employed by Pennsylvania, and using disease management vendor funds, the model targeted 323 PCPs with 9,520 inactive disease management clients in either the HHSC PCCM or FFS programs. Physicians could earn up to $1800 each for participating. The initial pilot period ran from February 4, 2008 through October 31, 2008. An evaluation had not been completed at the time that this report was prepared.[54]

[52] The contract further requires that " If a HMO intends to include Bonus or Incentive Payments as allowable administrative expenses, the HMO must furnish a written Bonus and/or Incentive Payments Plan to HHSC so it may determine whether such payments are allowable administrative expenses in accordance with Cost Principles Document in the Uniform Managed Care Manual. The written plan must include a description of the HMO's criteria for establishing bonus and/or incentive payments, the methodology to calculate bonus and/or incentive payments, and the timing of bonus and/or incentive payments. The Bonus and/or Incentive Payment Plan and description must be submitted to HHSC for approval no later than 30 days after the Effective Date of the Contract and any Contract renewal. If the HMO substantively revises the Bonus and/or Incentive Payment Plan, the HMO must submit the revised plan to HHSC for prior review and approval." (page 8-36)

[53] "NorthSTAR Contract for Services, 11/1/07 through 8/31/09." See www.dshs.state.tx.us/mhprograms/northstarContract07/ValueOptionsSOW.pdf. (accessed November 11, 2008)

[54] Interview with Ashley Fox, Texas Health and Human Services Commission, October 16, 2008.

Entities with Whom P4P Strategies are Employed	Description of Strategy
Nursing Home Services	• Performance Bonus: HHSC does not currently offer performance bonuses to nursing homes, but it did do so in FY 2001-2002 on a pilot basis as part of the "Performance-based Add-On Payment Methodology."[55] This program used quality measures developed by the Center for Health Systems Research and Analysis (CHSRA) and survey deficiencies to assess quality performance. • Report Card: While not an HHSC initiative, the Department of Aging and Disability Services (DADS) offers information online to help consumers evaluate the quality of long-term care services, including nursing home services, through the Long Term Care Quality Reporting System.[56]

B. What Do Texas Stakeholders Think About HHSC Pursuing a Pay-for-Performance Strategy?

In order to assess Texas stakeholder reactions to the concept of an HHSC P4P program that a) required contracted health plans to make P4P opportunities available to their contracted providers, and/or b) would be implemented by HHSC with its directly contracted providers, we convened small advisory panels that in most cases met twice[57] via conference call. The panels were as follows:

- Primary care physician and hospital
- Specialty physician and behavioral health practitioner
- Nursing home
- Managed care plan

HHSC staff recruited the advisory panel participants. The primary care physician and hospital advisory panel primarily voiced the perspective of primary care practices, despite the fact that a large number of the physician representatives were from large hospitals. The names and affiliations of those who participated in the process are provided in Attachment B. The findings from the seven advisory panel calls are summarized below.

Managed Care Plans

We spoke with four managed care plans regarding the possibility of HHSC requiring the plans to implement a P4P program with their provider network. We spoke with a fifth health plan, Superior HealthPlan, about the same when we performed a site visit to assess its P4P program.

[55] For information on the methodology, see http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=355&rl=309. (accessed November 10, 2008)

[56] See http://facilityquality.dads.state.tx.us/ltcqrs_public/nq1/jsp3/qrsHome1en.jsp?MODE=P&LANGCD=en. (accessed November 9, 2008)

[57] The nursing home advisory panel convened once.

As a group, the five managed care plans make limited use of P4P strategies at present. Existing strategies focus upon enhancing fees for a) specific services for which the plan wishes to increase service use, e.g., evening and weekend office hours (to decrease ER utilization), Texas Health Steps visits, flu vaccine, or b) to support the plan's internal care management programs (e.g., notifying the managed care plan when a member is pregnant).

The managed care plans were not enamored with the notion of HHSC requiring that they implement provider pay-for-performance programs. One voiced concern was that HHSC simply should not be mandating how the managed care plan does its business in this area because doing so would remove a competitive advantage for those that were already doing so. Other plans had concerns that focused more on their assessment of the challenges in making provider-focused P4P succeed. Their perspectives are summarized as follows:

1. Most practices small, do not have many staff to concentrate on managing their practice. As a result, they lack the ability to respond to incentives and achieved desired improvements.
2. There is insufficient funding available to the plans to fund incentive payment.
3. There is not a "business case" (that is, a near-term financial return) for an investment in performance incentives for many services and populations (e.g., children).
4. Pay-for-performance will only work with large providers or with well-managed independent practice associations (IPAs) with significant Medicaid volume.
5. There is serious concern about practices "cherry picking" their patients in response to the incentive, and disenrolling non-compliant patients.
6. What some practices need in order to improve quality is not more money, but data and support services (e.g., case management) from the managed care plan.

When pressed to provide recommendations on the parameters should the legislature direct HHSC to implement a requirement for managed care to make P4P opportunities available to their contracted providers, the plans provided the following advice.

<u>Should HHSC prescribe how health plans implement their P4P programs?</u>

While one health plan felt that HHSC should allow managed care plans to submit P4P proposals for approval, but without any state specification of measures or methodology, the others felt that some degree of direction from HHSC would be appropriate and helpful. Specifically, they felt that if HHSC selected a clinical focus, or a choice of clinical foci and then left it to the plans in the region to select one, it would benefit improvement efforts. Their rationale was that a) there is great variation across the state, and the priority opportunities for improvement vary from region to region, and b) adopting a common clinical area of focus (e.g., Texas Health Steps visits, asthma care, diabetes care, etc.) across plans will increase the likelihood that the collective impact of the managed care plan P4P programs will be positive.

This model of alignment of P4P programs has been utilized for several years in California by commercial health insurers, and the organizing entity reports that it has resulted in measurable provider performance improvement.[58]

Which clinical topics are most worthy of attention in a provider P4P program?

The managed care plan representatives offered the following suggestions: Texas Health Steps visits (particularly due to the settlement agreement resulting from the Frew v. Hawkins lawsuit), immunizations, asthma, and "anything that reduces ER visits and unplanned hospitalizations." The plans were not of one mind regarding the adoption of Healthcare Effectiveness Data and Information Set (HEDIS) measures. One managed care plan medical director urged HHSC to focus on topics for which past P4P efforts with providers have been able to demonstrate effectiveness.

How should providers be assessed to qualify for P4P?

The plans urged that providers be compared to state or regional means rather than to national benchmarks, and to like providers.

What should be the form and size of any financial incentive payments?

One managed care plan representative urged the continued practice of paying enhanced fees for specific actions, since closely tying reward application to a desired action has been shown to improve effectiveness. Others thought of financial incentives in terms of a bonus payment. One individual said that the payment needed to be "in the thousands", while another cited literature that estimated a necessary range of 3-10 percent of income. All agree that between one quarter and one half of the eligible providers should receive a bonus payment.

Because the managed care plans lacked enthusiasm for an HHSC requirement that they make pay-for-performance opportunities available to their contracted providers, we asked them about other potential strategies that HHSC might pursue that could potentially achieve the same aims of a P4P program aimed at generating quality improvement. The managed care plan representatives expressed interest in two ideas:

1. Regional quality improvement goal setting

   During each of its two conference calls, the managed care plan advisory panel spoke of the potential benefit that would result from HHSC facilitating a process for establishing regional quality improvement goals. They spoke of the advantages of a consistent message from HHSC and each of the Medicaid managed care plans in a region to the providers in the area. The plans expressed the belief that in addition to setting common quality improvement goals within a region, there could also be

[58] "Advancing Quality Through Collaboration: The California Pay for Performance Program", The Integrated Healthcare Association, Oakland, CA, February 2006

coordinated efforts to implement standardized, best practice clinical interventions. The group agreed that this regional quality improvement goal setting approach could be done with or without a requirement for managed care plans to create P4P opportunities for their network providers.

2. Facilitated implementation of medical home and best clinical practices

In response to the health plan representatives reporting that the majority of primary care practices lacked the wherewithal to effectively respond to P4P opportunities, we asked the plan representatives to react to the idea of instead providing incentives to practices to transform themselves by implementing medical home concepts and best practices. Under this scenario, practices would:

- Be provided with training and technical assistance on how to implement three to five new practices that are consistent with the principles of the Patient-Centered Medical Home and with demonstrated best clinical practices.
- Utilize a managed care plan or HHSC-paid case manager who would work with them full or part-time depending upon the size of their practice.
- Be offered P4P incentives to implement the best practices, with regular reports providing feedback.

The Patient-Centered Medical Home is an approach to providing comprehensive primary care for children, youth, and adults that has gained much currency in the past two years nationally as a superior method for delivering primary care services, with better access and coordination, and more effective management of patients with chronic illnesses.[59] Many state Medicaid agencies and multi-payer coalitions across the country are currently testing or implementing medical home strategies.[60]

The managed care plan representatives noted that perhaps 30 percent of their physician practices could respond immediately to a more traditional P4P program, and that it would be possible to offer one to them, while offering the alternative approach to the remaining 70 percent. The managed care plan representatives also acknowledged that a more comprehensive approach to practice transformation could be pursued, but they worried about the ability of their contracted primary care practices to engage in such a demanding effort. One medical director observed that practices "don't have the time to study and implement", while another counseled, "make it simple and you'll get it done", adding that their recommended approach was "not trying to boil the ocean."

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[59] "Joint Principles of the Patient Centered Medical Home", American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, February 2007. Available at: www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

[60] For examples of current state and multi-payer medical home initiatives, see www.nashp.org/_docdisp_page.cfm?LID=980882B8-1085-4B10-B72C136F53C90DFB (accessed November 10, 2008) and www.pcpcc.net/content/pcpcc-pilot-projects. (accessed November 5, 2008)

Service Providers: Physicians, Behavioral Health Providers and Hospitals

We spoke with 14 non-nursing home provider representatives regarding the possibility of HHSC requiring managed care plans to implement a P4P program with their provider network, and/or implementing P4P incentive opportunities directly with providers.

The non-nursing home advisory panel participants voiced many similar messages, despite their diversity of their organizations and geographic locations. These common messages were as follows:

- Pay-for-performance offers potential, but must be carefully designed and implemented, taking special heed of the following:
    - The P4P program should offer financial incentives in the form of "new" money – providers should not be at risk of losing any existing funding.
    - The program should not place any new administrative demands on providers to collect or report additional data.
    - A statewide, representative advisory group should advise HHSC on program design, including representatives at the level of those doing the work for which the incentives are being designed.
    - Some providers will take umbrage at the program, arguing that the Legislature and HHSC should instead focus on improving the base provider payment levels, since the program's success rests more on basic reimbursement levels than on what a P4P program might produce.
    - The program should provide incentives for both excellence in performance and for improvement over time, so that all providers have motivation and reasonable expectation for achieving incentive rewards.
    - While financial incentives are most important, a non-financial incentive, such as waiving certain managed care plan or HHSC administrative requirements (e.g., prior authorization of services) could also be meaningful to providers. Providers were mixed on the attractiveness of the use of a patient volume incentive, with some feeling that added volume only caused the provider to lose more money, while others viewed added patient volume as a benefit.
- Providers, like the managed care plans, worry about "cherry picking" and the avoidance of difficult patients if there is not a sophisticated means to adjust the P4P methodology to account for differences in the patient case mix borne by different providers.
- Any incentive payments need to exceed the cost of achieving the quality target, and should be more than $10,000 per year per provider to obtain the necessary attention.

As a result of the input received from the managed care plan advisory panel, we decided to test the notion of a facilitated implementation of medical home and best

clinical practices using P4P incentives. The reception to the notion was universally positive. Some felt that the focus on supporting the practices with case management was extremely important and likely to add value. The providers offered the following recommendations as to how the strategy should be implemented:

- The case manager should ideally be hired by the provider rather than by the state or the managed care plan. This could be accomplished by providing practices with a grant. Others felt that the means for hiring the case manager might need to vary by region, and that one single model should not be adopted for the state.
- The state should recognize that this strategy will work for practices with high volumes of Medicaid patients, but will have little relevance for other practices, unless the state is able to engage commercial insurers in a multi-payer initiative.
- If this model proves not to be viable in rural regions, HHSC's PCCM and fee-for-service programs should assign case managers to certain high-need recipients.

Finally, the providers noted that there are some ongoing administrative shortcomings to the Texas Medicaid programs that make it difficult for providers to participate and, if corrected, would help providers better serve their Medicaid patients. First, providers find it too difficult to confirm eligibility and payer status for Medicaid recipients. They seek information that is timelier and more reliably accurate. Second, it is difficult for providers to get Texas Medicaid provider numbers, and then there is a burdensome need to reapply every year.

Service Providers: Nursing Facilities

We convened one advisory panel conference call comprised primarily of nursing home representatives and professional association staff. Unlike the other providers with whom we spoke, the nursing home representatives participated on the call with their professional association, the Texas Health Care Association (THCA), and provided their position on the topic of making P4P opportunities available to nursing homes in the form of the THCA's 2008 testimony to the House Human Services Committee[61]. The recommendations provided in that testimony comprised the unified message that the nursing home advisory panel participants communicated, and included the following:

1. Making P4P opportunities available to nursing homes could yield benefits, but should only be pursued after more basic concerns regarding the adequacy of nursing home reimbursement are addressed. The advisory panel participants made clear that this was their most important message.
2. Should these concerns be addressed and the state wish to pursuing making P4P opportunities available to nursing homes, the state should proceed in the following fashion:
    - Participation should be voluntary.

[61] Testimony of Tim Graves on behalf of the Texas Health Care Association, House Human Services Committee, May 1, 2008.

- At least a year should be allocated to data collection, analysis, cleaning and validation.
- All stakeholders, including providers, consumers and state legislative and executive branch government staff should participate in program development.

While the nursing home advisory panel participants primarily focused their input on the points above, they did provide a few additional recommendations that echoed the input of non-nursing home providers. First, they felt that P4P financial incentives should be funded with "new" money, and should not redistribute existing funding. Second, the collection and analysis of performance data for the program should not place any additional administrative demands on providers. Third, the financial incentive amount should exceed the cost of achieving the desired performance level. Fourth, the performance targets should be achievable for nursing homes.

Finally, on the topic of measures, the advisory panel expressed the belief that family and resident satisfaction surveys could be valuable, as would staffing measures – but again, only if adequate reimbursement rates were already in place.

C. How Have Provider Pay-for-Performance Programs Worked for Those HHSC-Contracted Managed Care Plans That Utilize Them

HHSC directed Bailit at the outset of the project to review and evaluate two HHSC-identified Texas Medicaid managed care plan P4P programs, and to consider the cost effectiveness of each pilot. The two programs were identified as being managed by El Paso First and Superior HealthPlan. With HHSC's assistance, we arranged for initial exploratory telephone calls with each plan.

We learned from El Paso First that it had just completed an initial three-month pilot of its program in the summer of 2008 with four high-volume primary care practices. Providers were offered bonus payments for a) increasing the percentage of children receiving timely Texas Health Steps exams, and b) for notifying the plan of members who declined an exam, so that the plan could provide outreach and education to the member. Because El Paso First had only conducted a small-scale P4P pilot as of the time this report was bring written, Bailit and HHSC concluded that an evaluation would not be feasible.

Evaluation of Superior HealthPlan P4P program[62]

Superior HealthPlan has a long history of utilizing performance incentives in its contracts with its Texas primary care practice network. The contracting model is one that was developed by Superior's corporate parent, Centene Corporation, but has been modified over time with input from Superior's Physician Compensation Committee. It was designed to create alignment between the state's incentive for the plan to manage costs to the capitation budget, and the plan's relationship with its providers.

[62] Information obtained from Irene Armendariz, Robert Payne, and Tom Wise of Superior HealthPlan before, during and after an October 16, 2008 site visit to Superior offices in Austin.

Beginning in El Paso in 1999, the plan has contracted on a risk basis with larger primary care practices in order to provide incentives for efficient use of health care resources. By "risk basis", we mean that contracted providers are financially responsible for the provision of both the primary and specialty services delivered to the primary care practice's assigned membership. The program is voluntary.

"Model 1" and "Model 1 Lite" Contracts

These risk contracts, referred to as "Model 1" contracts by Superior, are available only to STAR and CHIP (EPO) practices with 1,000 or more Superior members.[63] Practices have the ability to earn bonuses at the end of the year if actual physician and hospital expenditures fall below targets. The practices can see no bonus and have deficits carried forward to future years if spending exceeds targets. Smaller practices, and those larger practices which do not desire the Model 1 contract risk, are offered "Model 1 Lite" contracts. These contracts do not carry any financial risk for losses to the practices, but they also carry less potential for financial gain. Overall between one quarter and three quarters of Superior membership is served by a primary care practice operating under a Model 1 or Model 1 Lite contract, depending on the region, with the vast majority of those being served by providers with Model 1 contracts. Superior reports that practices almost always receive bonus payments, and while it has not conducted a formal evaluation of this contracting strategy, it attributes reduced ER visit rates and the plan's past positive financial performance, in part, to the strategy.

As envisioned by Senate Bill 10, Section 10, we do not find the Model 1 and Model 1 Lite contracts to constitute pay-for-performance opportunities for contracted HMO network providers, in that they were not primarily designed "to support quality improvements in the care of Medicaid recipients." While the contracts do provide incentives for efficient care, and for care to be provided in appropriate settings, they do not address the many other aspects of quality that we believe the legislation envisioned when writing of quality improvements in care.

Quality Bonus Fund

Superior augmented its Model 1 and Model 1 Lite contracts in 2005 through the creation of a P4P vehicle, the plan's "Quality Bonus Fund." This change was initiated at the corporate Centene level. Superior is planning on implementing the Quality Bonus Fund over time with all of its practices – not just those with Model 1 and Model 1 Lite contracts.

Each of Centene's managed care plans develops its own measures and criteria for earning Quality Bonus Fund payments in order to tailor the P4P program to individual state requirements. In addition to creating alignment with state non-financial performance requirements, the Quality Bonus Fund also serves as an added incentive

[63] Superior intends to introduce newly revised Model 1 contracts in 2009. Superior also anticipates that it will extend the models to its STAR+PLUS and STAR Health lines of business after it has gained more experience with each.

for physicians to participate in the Centene/Superior network. Model 1 and Model 1 Lite practices that agree to participate in the Superior Quality Program and submit clean encounter data are eligible to participate in the Quality Bonus Fund.

The Quality Bonus Fund presently works as follows:

1. Superior sets aside 1 percent of state premium to the plan for the Quality Bonus Fund.
2. Superior evaluates participating provider performance and plan financial performance. If the plan did not experience a financial deficit and if the provider met some or all of its performance metrics, Superior pays out the 1 percent set aside.
3. The performance metrics are as follows:

Topic/Measure	Threshold for Bonus Payment
Availability of Appointments	Meets availability standards
After Hours Access & Linguistic Access	System in place (Yes/No)
Member Complaints	< .75/1,000
Member Retention	> 5 months
ER visits / 1,000	50th percentile in Service Area
THSteps (EPSDT) Visit Rate	50th percentile in Service Area

Superior reported that it selected these six topics and measures, because they are easy to measure, they are not controversial with providers, and some reflect state requirements. While there is interest at the corporate level in considering the use of HEDIS quality measures, Superior believes that HEDIS measures are problematic, because physicians are likely to challenge them.

Superior reports that its pays out about 95 percent of the 1 percent that is set aside for the Quality Bonus Fund. At the plan's discretion it can pay out more than a practice has earned based on the bonus payment calculations, and it does so. Overall, when combining the Model 1 contract incentive payments for utilization and cost management with the Quality Bonus Fund payments, the latter represent approximately 20 percent of total annual bonus payments to practices.[64]

Superior has not evaluated the impact of the Quality Bonus Fund, but believes that it has helped produce a positive community image and improved provider relations, as well as improved access for members.

It is important to note that Superior makes some limited utilization of other P4P strategies in addition to the Quality Bonus Fund. These include:

1. Supplemental payments in some markets for specific services, including visits to after hours clinics in several markets to address access issues.

[64] Since one of the six Quality Bonus Fund measures is the rate of ER visits per 1,000 members, one could reasonably say that more than 80% of the total bonus payments can be attributed to management of utilization and cost.

2. A reward to the primary care practice in San Antonio that is at the top of a compilation of quality measures, including selected Quality Bonus Fund measures and some other measures.

Superior attempted to provide gift cards to practices as an incentive to inform Superior of a member's pregnancy, but has found that it has not worked well.

Superior identified the following as key success factors when developing P4P opportunities for primary care providers:

- Perform measurement activities on a timely basis.
- Select measures that are less sensitive to case mix concerns in order to avoid the need for difficult risk adjustment techniques or challenges by the affected physicians.
- Communicate effectively to physicians and educate them about the program, including its objectives and the relevant performance measures and metrics.

Efforts were made to solicit feedback from primary care practices contracting with Superior under these arrangements to learn about their experiences, but contacted practices did not respond to requests.

Assessment of Research Findings

We have performed a thorough analysis of the feasibility and cost effectiveness of making pay-for-performance opportunities available to Texas Medicaid providers, either through contracted managed care plans or directly with providers.

This section of the report provides an assessment of the feasibility and cost effectiveness of a) requiring contracted HMOs to make P4P opportunities available to contracted providers, and b) HHSC making such opportunities available to providers who directly contract with HHSC.

In this section of the report, we first evaluate the feasibility of a) requiring contracted HMOs to make P4P opportunities available to contracted providers, and b) HHSC making such opportunities available to providers who directly contract with HHSC. We then discuss the cost effectiveness of each strategy.

We utilized a formal set of criteria, developed at the outset of our work and informed by research and experience regarding P4P programs, in order to assess the feasibility and cost-effectiveness of requiring contracted HMOs to make P4P opportunities available to contracted providers.

Criterion	Assessment
1. HHSC has a means to amend HMO contracts to implement a provider P4P requirement.	HHSC's Joint HMO contract (STAR, STAR+PLUS and CHIP) and STAR Health contract currently require use of incentive strategies (P4P) to motivate improved provider performance. While the requirements are not detailed, no contract amendments are necessary for a general provider P4P requirement.
2. HHSC can modify state plan and/or CMS waivers to specify the terms of a P4P program and meet federal Medicaid requirements.	HHSC would need to design the P4P initiative so that CMS would review the initiative as part of a state plan amendment for the managed care program should HHSC provide supplemental payments to the managed care plans to be used for provider P4P. CMS supports P4P programs with managed care plans so long as the incentive payments, in total, do not result in a payment to any managed care plan above 105 percent of the managed care plan's capitation rate.[65]
3. HHSC can ensure that HMOs structure and administer their P4P programs in a fashion that would make success, in terms of improved quality and cost effectiveness, highly likely.	HHSC's Joint HMO contract (STAR, STAR+PLUS and CHIP) and STAR Health contract currently require that any plan for provider financial incentives be submitted for HHSC approval and include a description of the managed care plan's criteria for establishing bonus and/or incentive payments, the methodology to calculate bonus and/or incentive payments, and the timing of bonus and/or incentive payments.
4. HHSC can ensure that HMOs structure and administer their P4P programs in a fashion that[66]: a. Addresses a priority condition (i.e., high prevalence and/or high individual impact). • The measures relate to specific program goals (e.g., relevance to the plan's and/or the state's priorities, including those of the state legislature). • The measures center on populations of interest (e.g., maternal and child health, aged, blind, and people with disabilities, etc.). • The measures center on specific medical conditions.	HHSC's Joint HMO contract and STAR Health contract do not specify how managed care plans structure and administer their P4P programs to ensure that the programs address the criteria listed in the left column, all of which have been identified as important for program success. HHSC could require that the P4P opportunities that managed care plans make available to providers meet these criteria. This could be done in one or more of four ways: 1. Amend existing contracts. 2. Integrate the criteria into the HHSC Uniform Managed Care Manual, which is incorporated in the contracts. 3. Provide guidance to managed care plans in the form of a bulletin or policy memo. 4. Integrate the criteria into the review process used by HHSC to evaluate proposed P4P programs. Finally, demands on internal staff resources to manage the development and implementation of a provider P4P requirement of health plans could be a concern based on Pennsylvania's reported experience, and should inform program design. Decreasing the ability of managed care plans to customize their P4P strategies should decrease the administrative burden of the prior review and post-audit processes.

[65] Llanos, Rothstein, Dyer and Bailit, op. cit.

[66] Kuhmerker and Hartman, op. cit., LLanos, Rothstein, Dyer and Bailit, op. cit. and Dudley and Rosenthal op. cit.

Criterion

b. Baseline practice varies significantly from evidence-based guidelines (e.g., areas in which clear opportunities for improvement exist).

c. There is a valid and reliable data source for measurement and data are reliable for fairly assessing performance.

d. Measures have been nationally vetted and accepted by a body such as the National Quality Forum or the AQA[67] and the measures are:
   - scientifically sound, and
   - regularly reviewed and updated.

e. The measure and the measurement process are transparent to the affected provider.

f. Affected providers participated in the program's development, including agreeing on a manageable number of measures that are based on accessible data.

g. Affected providers feel motivated by the P4P program structure and reward to modify their practices in order to achieve the reward.

h. Affected providers believe that they have the means to modify their practice and achieve the reward.

i. The measures correlate with quality care and improvement, not just attainment of a target.

j. Sufficient internal capacity and infrastructure exist to collect, and then aggregate the data.

- Data already exist, which makes the program economically feasible.
- Data are easy to collect.
- Select measures whose specifications do not call for risk adjustment or ensure that the adjustment mechanism has been validated and is acceptable to those being measured.
- Resources are sufficient to manage the data and support the P4P objectives and timelines.

Assessment

See assessment for criteria 4a-j on the preceding page.

[67] See "*Guide to Quality Measures: A Compendium*" -- AQA Recommended Starter Set Clinical Measures for Physician Performance at www.ahrq.gov/qual/aqastart.htm. (accessed November 12, 2008)

Criterion	Assessment
5. HHSC has the means to fund HMOs at an adequate level to allow the HMOs to fund the P4P payments.	HHSC would either have to require contracted plans to utilize existing funding for their P4P programs, or else supplement managed care plan rates, as Pennsylvania did. It does not appear that Indiana's approach of requiring managed care plans to distribute 50% of their plan P4P bonus payments would be feasible, since HHSC does not provide its plans with a regular P4P bonus of consistent size. Based on managed care plan financial reporting to HHSC, it appears that Texas managed care plan financial margins in recent years have generated sufficient margins to fund apply .75% to 1% of premium to provider P4P opportunities.[68] Managed care plans seeking to protect their margins could respond, however, by cutting provider rate increases or actual rates in response to such a state requirement. The state could choose a hybrid approach, by funding part of the provider P4P payments with new funding, and requiring that part of the funding come of existing capitation rates.
6. HHSC is able to evaluate HMO P4P programs to assess their effectiveness in terms of improved quality and return on investment.	HHSC has limited internal evaluative resources to assess whether a managed care plan investment in P4P has yielded significant, measurable results in terms of improved quality. As a result, HHSC may need to use an external contractor for this purpose.

Assessment of the Feasibility of HHSC Making P4P Opportunities Available to Contracted Providers

Criterion	Assessment
1. HHSC can modify its regulations and/or provider agreements to specify the terms of a P4P program.	Other states have implemented provider P4P programs through regulation, and there should not be any special technical issues for HHSC to do so. Any provider concern with P4P program design and funding, however, could possibly create political challenges.

[68] HHSC internal analysis of managed care plan financial statistical reports conducted November 14, 2008 indicates an average 4.5% margin for the STAR, STAR+PLUS and CHIP programs, with CHIP contracts generating the largest margins.

Criterion	Assessment
2. HHSC can modify state plan and/or CMS waivers to specify the terms of a P4P program and met federal Medicaid requirements.	HHSC would need to design the P4P initiative so that CMS would review the initiative as part of a state plan amendment for the Fee-for-Service and/or PCCM programs. A CMS State Health Official Letter wrote: "In general, if the pay-for-performance program is part of a fee-for-service delivery system, a state may include its initiative in its state plan. A waiver under Section 1115, 1915(b) or 1915(c) of the Social Security Act (the Act) may be necessary when the initiative will not be statewide, will impact the amount, duration or scope of benefits, will affect the comparability of benefits across the eligible population; or will restrict beneficiary choice of physician."[69]
3. HHSC can ensure that it can structure and administer its P4P programs in a fashion that would make success, in terms of improved quality and cost-effectiveness, highly likely [70] (See criteria 4a-j on pages 45-46.)	HHSC should be able to select measures that meet the same criteria described for managed care plan P4P program construction. HHSC should similarly be able to convene a provider advisory group to inform measure selection and methodology development, while providing full transparency to affected providers. Depending upon the measures selected, however, HHSC might confront internal challenges regarding a) a valid and reliable data source for measurement with data that are reliable for fairly assessing performance, b) sufficient internal capacity and infrastructure exist to collect and then aggregate the data, c) administrative provider support to complement the P4P incentives. Data and staff resource capacity will be a key consideration. Another challenge to P4P program feasibility could be provider reaction. Conversations with providers indicate that all providers might express concern with the introduction of provider P4P unless base reimbursement rates are increased, with nursing homes appearing to be the most adamant on this point. This reaction might limit the application of a P4P strategy to certain provider types.

[69] CMS Dear State Health Official Letter, April 6, 2006, (SHO #06-003), signed by Dennis G. Smith.
[70] Kuhmerker and Hartman, op cit. and LLanos, Rothstein, Dyer and Bailit, op. cit.

Criterion	Assessment
4. HHSC can identify a means for funding the P4P program.	Given the widely perceived low reimbursement rates of the Texas Medicaid program, it will not be feasible to implement a P4P program that does not produce "new money." In addition, national experience shows that provider P4P programs are seldom designed with provider "downside" risk. The cost to implement a P4P program given the size of the Texas PCCM and Fee-for-Service programs could be considerable, particularly during a down period in the national economy. Financial feasibility will depend on the specific P4P program design, including the definition of the eligible providers, and upon state finances.
5. HHSC could evaluate its P4P program to assess its effectiveness in terms of improved quality and return on investment.	HHSC has limited internal evaluative resources to assess whether a P4P investment with its providers has yielded significant, measurable results in terms of improved quality. As a result, HHSC may need to use an external contractor for this purpose.

We make one more note on the feasibility of offering P4P opportunities to Texas Medicaid providers. HHSC has expressed interest in the possibility of including P4P incentives for the adoption of an electronic health record. This application of P4P is one that has been utilized elsewhere, and research suggests that such use of incentives, coupled with the broader effect of P4P on providers, can motivate increased provider investment in EHRs, albeit most noticeably in larger physician organizations[71]

We believe that HHSC could include such a focus within its P4P requirements, but anticipate that small practices would complain that the incentive is unattainable in light of the high cost of EHR systems, and the low level of reimbursements that practices receive for caring for Medicaid recipients. As a result it may be necessary to take this into consideration when designing the scope of the EHR incentive, and perhaps to offer alternatives for small practices.

[71] Williams et. al. "Pay for Performance: Its Influence on the Use of IT in Physician Organizations", *Medical Practice Management*, March/April 2006.

Assessment of the Cost Effectiveness of Requiring Contracted HMOs to Make P4P Opportunities Available to Contracted Providers

and

Assessment of the Cost Effectiveness of HHSC Making P4P Opportunities Available to Contracted Providers

Criterion	**Assessment**
1. Formal evaluations of provider-level P4P programs demonstrate either: a. A positive return-on-investment within a reasonable time period (e.g., two years), or b. A zero sum return on investment with significantly improved quality of care.	There is very limited evidence on the *clinical* effectiveness of provider pay-for-performance. Of the rigorous research that exists, most focuses on physician pay-for-performance. Some research suggests modest positive impact on quality of care as measured by process measures of quality.[72] Pay-for-performance research, where it exists, tends not to evaluate cost-effectiveness, but only effectiveness in quality improvement. Only one study to date has addressed cost-effectiveness, and it showed a positive rate of return for an HMO incentive program.[73] Therefore, we do not know if P4P generates a return on investment.
2. The formal evaluations have been performed with Medicaid provider P4P programs or there is a good reason to believe that results from evaluation of other programs would be transferable to Medicaid.	There is very little information that scientifically establishes the *clinical* effectiveness of provider-focused P4P programs with Medicaid providers, and what does exist suggests modest and mixed results.[74] The comparatively poorer quality care received by low income populations when compared to higher income populations suggests that there are clear opportunities for P4P to help foster quality improvement in Medicaid.[75] Pay-for-performance research in Medicaid does not evaluate cost effectiveness. Therefore, we do not know if Medicaid provider P4P generates a return on investment.

We make one note on the evaluation of the cost effectiveness of P4P programs. As observed earlier in this report, most pay-for-performance programs to date have been designed to improve quality, and without a cost reduction objective. While some P4P initiatives have been predicated on projected savings that will result from quality improvement (e.g., Bridges to Excellence[76], the CMS Physician Group Practice Demonstration), most have not.

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72 Rosenthal and Frank, op. cit.; Petersen et. al. "Does pay-for-performance improve the quality of health care? *Annals of Internal Medicine* 145:265-72, August 15, 2006. Christianson, Leatherman, Sutherland and Williams, op. cit.

73 Curtin K, Beckman H, Pankow G, Milillo Y, Greene R. "Return on Investment in Pay for Performance: A Diabetes Case Study." *Journal of Healthcare Management,* vol. 51, no. 6, 2006.

74 Felt-Lisk, Gimm, and Peterson, op. cit.

75 Agency for Healthcare Research and Quality, 2007 National Healthcare Disparities Report, February 2008. See http://www.ahrq.gov/qual/nhdr07/nhdr07.pdf (accessed November 12, 2008).

76 See www.bridgestoexcellence.org/ and Aston G. "Practices hit Medicare P4P quality targets, but bonuses still fall short", *American Medical News*, September 8, 2008.

Recommendations Regarding Making Pay-for-Performance Opportunities Available to Medicaid Providers

The Institute of Medicine wrote in 2001:

> "The goals of any payment method should be to reward high-quality care and to permit the development of more effective ways of delivering care to improve the value obtained for the resources expended...Private and public purchasers should examine their current payment methods to remove barriers that currently impede quality improvement, and to build in stronger incentives for quality enhancement."[77]

Based on our assessment of the research on provider pay-for-performance, the experience of other states' Medicaid agencies with pay-for-performance, the perspectives of Texas providers and managed care plans, and our knowledge of HHSC, we offer the following recommendations.

1. Require Medicaid managed care plans to make pay-for-performance opportunities available to their network providers if sufficient funding is available.

There is no question that payment practices influence provider behavior. Pay-for-performance programs cannot eliminate all of the barriers and perverse incentives that exist in the current payment system, but it can make incremental progress in aligning objectives for high quality and efficient evidence-based care with provider economic incentives. This progress can serve as an essential initial step towards longer term, farther reaching payment reform, which will be necessary to improve quality and tame cost growth.

HHSC may need to provide additional funding in order to make P4P financial incentive funds available to managed care plans. We recommend that the provider P4P opportunities be funded through a combination of additions to the capitation rate and from existing managed care plan margins. HHSC should require that 100 percent of the designated funds pass through to network providers, and audit to make sure that managed care plans comply.

Senate Bill 10 anticipated that this effort could start with a regional pilot.[78] This is a reasonable approach; although we recommend a broader implementation should sufficient funding be available.

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[77] Crossing the Quality Chasm: A New Health System for the 21st Century, op. cit.

[78] "If the commission determines that the provisions are feasible and may be cost-effective, the commission shall develop and implement a pilot program in at least one health care service region under which the commission will

a. Start by making provider pay-for-performance opportunities available through the STAR, STAR+PLUS, and CHIP programs.

These are the state's managed care programs that serve the vast majority of individuals enrolled in publicly funded capitated managed care. Further expansion to other HHSC capitated managed care programs, including NorthSTAR and STAR Health, should follow within two years.

b. Specify a core set of two or three high-priority opportunities for improvement, by program (STAR, STAR+PLUS, CHIP), which all managed care plans statewide or within a region will be required to address. Give plans the latitude to add limited additional topics, with state approval.

Interviews with other states that require managed care plans to make P4P available to their providers, conversations with Texas Medicaid providers, and published research on Medicaid and non-Medicaid managed care suggests the significant value of presenting providers with a common set of topics to focus upon in their quality improvement efforts. Yet, we also have found that if given some flexibility, plans can also innovate if the state is not too prescriptive.

Some potential topics that may be worthy of consideration include:

- Texas Health Steps exams
- Management of asthma
- Management of diabetes
- EMR adoption
- E-prescribing adoption

c. Establish other general parameters regarding how P4P opportunities should be offered.

Pay-for-performance strategies do not always succeed. Design and execution have everything to do with outcome. Managed care plans should not be given complete discretion in terms of program design if the state wants to be sure that its investment in P4P yields desired results. HHSC should develop a set of policy guidelines that all plans should be expected to meet.[79] For example:

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include the provisions in contracts with health maintenance organizations offering managed care plans in the region."

[79] These guidelines reflect the findings reported earlier in the report, as well as some of the content of "The Patient Charter for Physician Measurement, Reporting and Tiering Programs", The Consumer-Purchaser Disclosure Project, April 1, 2008. See http://healthcaredisclosure.org/docs/files/PatientCharter040108.pdf. (accessed November 11, 2008)

- **Plans must conduct thorough education of providers prior to implementation.** Communication and education efforts should result in full understanding of the P4P opportunities by those to whom they will be offered. Providers should be instructed on what aspect(s) of their performance will be evaluated, how performance will be measured, and how performance and incentives are related.
- **Plans must offer technical support to those providers being offered P4P opportunities**, e.g., timely feedback on performance, outreach to patients due for scheduled care, information on patient ER visits and admissions, consumer incentives for adherence to recommended guidelines, best practice techniques with demonstrated effectiveness, and reports that identify patients with gaps in care for the practice. P4P incentives create motivation, but they do not necessarily give providers what they need to succeed. Complementary health plan strategies can do just that.
- **Providers should have an active and meaningful role in program design, and the resulting methodology should be transparent.** This message came through interviews and from the research literature.
- **Measures should be based on national standards**. The primary source for measures should be the National Quality Forum (NQF). When NQF measures do not exist, the next level of measures that should be considered, to the extent practical, should be those endorsed by the AQA, federal agencies, and those endorsed by accrediting organizations such as NCQA and the Joint Commission. Should no such measures exist for a specific topic, the managed care plan should then be permitted to proceed with other measures provided that the plan's providers support the use of other measures.
- **The program should exclude measures that would be expected to be heavily influenced by patient case mix so as not to penalize practices with more clinically complicated patients, or to create incentives for "cherry picking."** Managed care plans and providers alike express concern about creating an incentive for this type of provider behavior.
- **Measures should include a balance of those that may not generate near–term cost savings, but are consistent with public policy objectives (e.g., Texas Health Steps exams) and those that have a greater likelihood of producing cost savings within a reasonable time horizon (e.g., reduced ER visits, improved management of diabetes, pediatric asthma and high-risk pregnancy[80]).**
- **Measures should focus on outcomes to the extent possible.** While this admittedly may conflict with the immediately preceding parameter, some recent studies have shown that some quality improvement initiatives that focus on process do not impact outcome.

[80] Greene SB, Reiter KL, Kilpatrick KE, Leatherman S, Somers SA, Hamblin A. "Searching for a Business Case for Quality in Medicaid Managed Care." *Health Care Management Review*, 33(4):350-360, 2008.

As a result, there may be increased likelihood of impact by focusing on desired outcomes.

- **The program should control for the effects of random variation** by focusing on very common conditions, setting minimum patient volume thresholds to qualify for the program, and measuring performance at the physician group rather than the individual physician level.
- **P4P methodologies should take into account both superior performance relative to a plan-set benchmark and also statistically significant improvement over time, so that all providers have an incentive to improve.**[81] P4P strategies that just reward the highest performers fail to motivate those with the greatest potential and need for improvement.
- **The program should include a process for providers to request review of their performance results and present information that they believe supports what they believe to be inaccurate results, with verified incorrect results then corrected by the managed care plan.** Providers are skeptical and concerned about the integrity of managed care plan efforts to measure their performance, particularly when claim or encounter data are the basis for the performance measurement. Such a process will provide a basis for reassurance.

d. Require that each managed care plan routinely evaluate its program for effectiveness and unintended consequences.

Managed care plans can only refine and improve their P4P programs if they study them. In addition, HHSC can only evaluate the benefits accrued through its investment in provider P4P through the provision of evaluative information from the plans. HHSC should set some basic guidelines for how evaluations should be structured to help ensure meaningful evaluations.

e. Align the P4P financial and non-financial incentives that HHSC utilizes with its managed care plans, with those that the managed care plans are required to use with their providers.

When incentives are aligned, they are more likely to produce the desired behavioral effect. Misaligned incentives can produce confusion and inaction, or many ineffective actions.

2. Make pay-for-performance opportunities available to providers who directly contract with HHSC in incremental fashion, if it is financially feasible to do so.

[81] For example, North Carolina Medicaid established a physician P4P program that introduced both financial bonuses and recognition for physicians that either reached a best practice performance goal (85th percentile of baseline performance) or improved by 20 percent and exceeded the median level of baseline performance. Dudley RA and Rosenthal MB, op. cit.

While Texas has committed to capitated managed care as a principle health care purchasing strategy, a significant percentage of state Medicaid spending occurs through direct contracts with service providers. As a result, it behooves the state to align payment incentives with performance objectives in these direct contracting activities. There are real challenges to doing so, however.

First, it is clear that the strategy would only succeed if "new" money were made available. Reallocating existing payments that are widely perceived as inadequate in the provider community would not be a viable approach.

Second, there are many more operational demands placed on a state agency to implement a P4P strategy directly with providers, rather than to do so via its contracted managed care plans. A strong data infrastructure and analytic capacity are required, as are resources to communicate with and educate providers, modify payment systems, and evaluate effectiveness. In addition, the types of technical support that practices need to complement the P4P incentives (e.g., North Carolina makes available claim data with predictive modeling software capability to contracting primary care networks) will be particularly challenging.

Third, provider dissatisfaction with base payments rates will mean that an offer to extend pay-for-performance opportunities may be rejected, as was initially the case with nursing homes in Minnesota.

a. **Focus initially on those providers who are amendable to the opportunity, and where the barriers to implementation otherwise appear lowest.** From our conversations with providers, we believe that primary care physicians and behavioral health providers would welcome this opportunity. While we did not have the opportunity to speak with hospital representatives who represented the hospital (as opposed to affiliated physician practices), we believe that it would be worth exploring opportunities there as well. We recommend against pursuing P4P opportunities with nursing homes initially, unless their position changes. While there are established models for nursing home P4P that can be drawn from other states, and a large portion of state Medicaid expenditures goes to nursing homes, the industry must be willing to engage for the strategy to be successful. Finally, we find that the lack of standardized measures and the lack of experience with P4P with community-based long-term services and supports suggests that this area of P4P application should be deferred for now, and that problems of diverse measurement sets and low volume indicate deferred consideration of specialty physician application.

b. **Introduce models incrementally**. Many national applications of P4P have started with limited measurement sets, and then expanded over time. This incremental approach allows for a safe means of testing and slowly

growing the program. Doing so will increase the chances of success by avoiding large program failures early during implementation that could create irreparable harm to the program by damaging its credibility with providers.

c. Apply the same program parameters to HHSC's own P4P program design and implementation activity that HHSC would apply to managed care plans:

- Conduct thorough education of providers prior to implementation.
- Offer technical support to those providers being offered P4P opportunities.
- Providers should have an active and meaningful role in program design, and the resulting methodology should be transparent.
- The program should exclude measures that would be expected to be heavily influenced by patient case mix so as not to penalize practices with more clinically complicated patients, or to create incentives for "cherry picking."
- Balance the measures between those that may not generate near –term cost savings but are consistent with public policy objectives (e.g., THSteps exams) with those that have a greater likelihood of producing cost savings within a reasonable time horizon (e.g., reduce ER visits, improved management of diabetes, pediatric asthma and high-risk pregnancy). Align disease management and case management programs with these areas of focus.
- Focus on outcome measures to the extent possible.
- The program should control for the effects of random variation.
- P4P methodologies should take into account both superior performance relative to a plan-set benchmark and also statistically significant improvement over time, so that all providers have an incentive to improve
- The program should include a process for providers to request review of their performance results and present information that they believe supports what they believe to be inaccurate results, with verified incorrect results then corrected by the managed care plan.

d. Fund the P4P opportunities at a level that is deemed sufficient to motivate and achieve meaningful improvements in quality.

There is no definitive rule for establishing appropriate financial incentives to be used in a pay-for-performance program. Experience does show that the available funds need to be a) sufficient to garner the attention of the provider organization, and b) greater than the costs that would need to be inquired by the provider to obtain the desired performance level. For physicians, a general rule

of thumb is that an incentive in the range of 10% is effective[82], and research suggests that programs have failed when the incentive levels have been too low.[83] For institutional providers, the percentage is frequently much less.

e. Routinely evaluate the program for effectiveness and unintended consequences.

Responsible purchasing requires ongoing assessment of strategy effectiveness, and refinement to generate continuous improvement and added value to recipients and taxpayers.

3. As HHSC designs its approaches to P4P, incorporate and test new ideas, such as episode-based payment, shared savings and the Patient-Centered Medical Home.

Other payment strategies are currently being discussed and explored nationally. For example, Massachusetts has convened a special commission on state health care system reform.[84] Congress has likewise instructed the Health and Human Services Secretary to report on proposed payment reforms by May 2010. Increasing numbers of observers view P4P as a stepping-stone on the way to more fundamental payment reform that corrects a larger misaligned system of incentives.[85,86,87]

Some of the ideas currently being considered nationally include:

- Episode-based payment: This involves a global payment for a group of condition or procedure-related services that cross provider types and settings. One promoted model, Prometheus Payment[88], offers case-payment rates for a given condition that were developed on the basis of clinical standards for appropriate care rather than through examination of current patterns of care. Payments are risk-adjusted and have accompanying P4P incentives equivalent in value to 10 to 20% of the case-payment rate.

- Shared-savings: Some believe that an achievable and effective step towards developing provider budget accountability for health care resource utilization is to work with provider organizations using a shared savings model. Shared savings models focus on overuse and misuse of services and allow providers to

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[82] Trude S, Au M, and Christianson JB. "Health Plan Pay-for Performance Strategies." *American Journal of Managed Care*, 12;537-542, 2006.
[83] O'Reilly, op. cit.
[84] Chapter 305 of the Acts of 2008, "AN ACT TO PROMOTE COST CONTAINMENT, TRANSPARENCY AND EFFICIENCY IN THE DELIVERY OF QUALITY HEALTH CARE." See www.mass.gov/legis/laws/seslaw08/sl080305.htm. (accessed November 12, 2008)
[85] Tom Williams of the Integrated Healthcare Association in O'Reilly op. cit.
[86] "Incentives For Excellence: Rebuilding The Healthcare Payment System From The Ground Up", A Summary Report of the Network for Regional Healthcare Improvement's 2007 Summit on Creating Payment Systems to Accelerate Value-Driven Health Care, Network for Regional Healthcare Improvement,
[87] Rosenthal, op. cit.
[88] De Brantes F and Camillus JA.. "Evidence-Informed Case Rates: A New Health Care Payment Model", The Commonwealth Fund, New York, NY, April 2007.

share in a portion of achieved savings. Rather than focusing on cost per se, conversations with providers focus on reviewing data on variation in practice and reducing identified incidences of care being overused and misused.

The idea has received recent support from former HCFA Administrator Gail Wilensky[89] and from the Brookings Institution, which described the strategy as one of several potential "silver BBs[90]." Shared savings were the basis for the CMS Physician Group Practice Demonstration, in which physician groups continue to be paid on a fee-for-service basis and are eligible for performance payments if the growth in Medicare spending for the population assigned to the physician group is less than growth rate of Medicare spending in their local market by more than two percentage points. Alabama similarly implemented a shared savings model in its Medicaid PCCM.

- Patient-Centered Medical Home: The payment reform initiative currently attracting the greatest national attention and action is the Patient-Centered Medical Home, which provides a means to transform primary care delivery using team-based care, proactive planned care, data analysis, enhanced access and evidence-based techniques for chronic care management. HHSC could facilitate multi-plan pilots of the concept in select markets to test its effectiveness in improving care and reducing health care costs. It could also test the concept through its PCCM program in a geographic region without capitated Medicaid managed care. North Carolina and, more recently, Oklahoma have structured their PCCM programs around the medical home model, and the strategy appears to hold promise.[91] HHSC is currently developing the concept for use with Children with Special Health Care Needs as part of the Frew settlement and therefore has a base from which to expand it planning efforts. HHSC could also partner with an existing multi-payer initiative such as the Texas Patient-Centered Medical Home Demonstration Project.[92]

  The notion of focusing new P4P initiatives on supporting practice transformation to the Patient-Centered Medical Home resonated strongly with both the managed care plan and physician advisory panels, with many feeling that it would the preferred approach to making P4P opportunities available to primary care providers. In addition, some of the managed care plans interviewed in other states voiced similar perspectives.

  We recommend that the state consider targeting modification of the PCCM program in one region to a medical home model, and develop a model that supports practices to incrementally transform themselves to medical homes,

[89] Wilensky G. et. al. "Gain Sharing: A Good Concept Getting a Bad Name?, *Health Affairs*, 26:58-67, 2007.
[90] Rivlin M. and Santos J. (Editors) "Restoring Fiscal Sanity 2007: The Health Spending Challenge", Brookings Institution, 2007.
[91] Mercer Government Human Services Consulting's evaluations of the North Carolina program have annually reported program savings. See www.communitycarenc.com/PDFDocs/Mercer%20SF05_06.pdf. (accessed November 14, 2008)
[92] See www.acponline.org/running_practice/pcmh/demonstrations/texaspc.pdf. (accessed November 12, 2008)

supports their costs in doing so, and then introduces quality and efficiency performance targets for which the practices would receive payment for their attainment. Furthermore, an evaluation plan should be introduced at the outset.

It is important to note that all of these alternative payment models require a change in service delivery organizational models, and drive towards a more integrated approach to health care delivery in which the health care system, in fact and not just name, operates as a "system."

Attachment A
Senate Bill 10 from the 80th Legislature, Regular Session, 2007
Section 10 (d), (e), (f), and (g)

(d) Subject to Subsection (f), the commission shall assess the feasibility and cost-effectiveness of including provisions in a contract described by Subsection (a) that require the health maintenance organization to provide to the providers in the organization's provider network pay-for-performance opportunities that support quality improvements in the care of Medicaid recipients. Pay-for-performance opportunities may include incentives for providers to provide care after normal business hours and to participate in the early and periodic screening, diagnosis, and treatment program and other activities that improve Medicaid recipients' access to care. If the commission determines that the provisions are feasible and may be cost-effective, the commission shall develop and implement a pilot program in at least one health care service region under which the commission will include the provisions in contracts with health maintenance organizations offering managed care plans in the region.

(e) The commission shall post the financial statistical report on the commission's web page in a comprehensive and understandable format.

(f) The commission shall, to the extent possible, base an assessment of feasibility and cost-effectiveness under Subsection (d) on publicly available, scientifically valid, evidence-based criteria appropriate for assessing the Medicaid population.

(g) In performing the commission's duties under Subsection (d) with respect to assessing feasibility and cost-effectiveness, the commission may consult with physicians, including those with expertise in quality improvement and performance measurement, and hospitals.

Attachment B
Advisory Panel Participants

Primary Care Physician and Hospital Panel

Name	Organizational Affiliation
Linda Chappell	Cook Children's Hospital, Fort Worth
Chris Greely, MD	University of Texas Health Science Center, Houston
Gilbert A. Handal, MD	Thomason Hospital, El Paso
Joseph Lopez, MD	Santa Rosa Family Health Center, San Antonio
Cynthia Peacock, MD	Baylor College of Medicine, Houston
Ray Tsai, MD, MBA	Children's Medical Center, Dallas
Jon Tyson, MD, MPH	University of Texas Health Science Center, Houston
Robert W. Warren, MD, PhD, MPH	Texas Children's Hospital, Houston
Stephen Whitney, MD, MBA	Texas Children's Hospital, Houston

Specialist Physician and Behavioral Health Practitioner Panel

Name	Organizational Affiliation
Thomas Collins	Green Oaks Psychiatric Hospital, Dallas
Douglas Denton, LCDC	Homeward Bound, Inc., Dallas and El Paso
John Holcomb, MD	San Antonio
Mark Laney, MD	Cook Children's Hospital, Fort Worth
James W. Williams	Lakes Regional MHMR Center, Terrell

Nursing Facility Panel

Name	Organizational Affiliation
Phil Elmore	Christian Care Centers, Mesquite
Ronnie Evans	Autumn Winds Retirement Lodge, Schertz
Tim Graves	Texas Health Care Association, Austin
David Hastings	Kruse Memorial Lutheran Village, Brenham
Coyle Kelly	Coyle Kelly & Associates, Austin
Greg Lentz	HealthMark Partners, LLC, Nashville, TN
Tom Plowman	Texas Health Care Association, Austin

Managed Care Plan Panel

Name	Organizational Affiliation
William Brendel, MD	Driscoll Children's Health Plan, Corpus Christi
Shonnie Conley	Driscoll Children's Health Plan, Corpus Christi
Angelo Giardino, MD	Texas Children's Health Plan, Houston
Barry Lachman, MD, MPH	Parkland Community Health Plan, Dallas
Joe McGrath	Molina Healthcare of Texas, Houston
David Valdez, MD	Molina Healthcare of Texas, Houston

Attachment C

Indiana Managed Care Plan Contract Requirements for Provider Pay-for-Performance[93]

4.11 Physician Incentives

4.11.1 Physician Pay for Performance

OMPP will require MCOs to develop a pay for performance program that focuses on rewarding physicians' efforts to improve health outcomes for Hoosier Healthwise members.

Pay for performance programs are performance-based payment systems that offer financial and non-financial incentives to health plans, providers and members for meeting quality performance targets. MCOs must establish a performance-based incentive system, at a minimum, for high volume providers. OMPP will define high-volume providers, and will identify the priority areas to be addressed by the provider incentive system. These priority areas may change from time to time and OMPP will determine these priority areas based on State and Federal priorities, and with input from the MCOs.

With State approval, the MCO will determine its own methodology for incenting providers. Incentives may be financial or non-financial. However, if the MCO offers financial incentives to providers, these payments must be above and beyond the standard Medicaid fee-for-service fee schedule. See Section 7.9.2 Incentive Program of this Attachment for additional information regarding the pay-for-performance program.

4.11.2 Disclosure of Physician Incentive Plan

The MCO may implement a physician incentive plan only if:

- The MCO will make no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and

- The MCO meets requirements for stop-loss protection, member survey, and disclosure requirements under 42 CFR 438.6.

Federal regulations 42 CFR 438.6, 42 CFR 422.208 and 42 CFR 422.210 provide information regarding physician incentive plans, and the Center for Medicare and Medicaid Services (CMS) provides guidance on its website. The MCO must comply with all Federal regulations regarding the physician incentive plan and supply to OMPP information on its plan as required in the regulations and with sufficient detail to permit OMPP to determine whether the incentive plan complies with the Federal requirements. The MCO must provide information concerning its physician incentive plan, upon request, to its members *and in any marketing materials* in accordance with the disclosure requirements stipulated in the federal regulations. Similar requirements apply to subcontracting arrangements with physician groups and intermediate entities.

[93] Indiana Office of Medicaid Policy and Planning, RFS-6-68 HOOSIER HEALTHWISE STATE/MCO CONTRACT, ATTACHMENT D: MCO SCOPE OF WORK

Attachment D
Pennsylvania Managed Care Plan Contract Requirements for Provider Pay-for-Performance[94]

B. Provider Pay for Performance Program.

The Department is implementing an additional layer to its Pay for Performance (P4P) strategy with the MCOs. The Department recognizes that the MCO's success in achieving and sustaining improvements in the quality of care provided to its Members is closely related to the performance of the Contractor's Providers or practitioners. Therefore, based on availability of funding in the SFY 07-08 budget, the Department will add approximately $1.00 to the MCO's Per Member, Per Month (PMPM) Capitation payment to fund Provider P4P programs. The additional funding will enable the MCO to implement more comprehensive or expanded P4P strategies within their Provider Networks. The MCO is strongly encouraged to align its proposed Provider P4P programs with the goals included within the Commonwealth's *Prescription for Pennsylvania* initiative as well as the quality measures included in the Department's MCO P4P program.

MCO participation in the Provider P4P program is mandatory beginning in January 2008 but may be implemented prior to January 2008. Upon execution of this HealthChoices Agreement, the additional $PMPM will be added to the 07-08 Capitation payment rates if the Department has approved the MCO's Provider P4P program. All funding received from the additional $PMPM must be paid in incentives to Network practitioners. The Department will develop an MCO specific, individualized reconciliation and monitoring process based on the practitioner initiative proposed. The MCO must cooperate with Department staff in developing the reconciliation process and any subsequent audit activities.

The MCO must submit a proposal and receive approval from the Department before implementing its Provider P4P program according to the following timeline:

1. MCO submits draft proposal to DPW by November 1, 2007.
2. DPW provides comments and changes by November 30, 2007.
3. MCO submits final approved proposal by January 1, 2008.

The proposal must demonstrate that it is a new initiative or is an expansion of a current program. The Provider P4P proposal must include:

- A detailed description of the proposed plan;
- What Provider(s) are being targeted;
- Specific services or fees targeted;
- How Provider success or compliance will be measured;
- How payment will be made to Providers, including time frames;
- How the proposed initiative aligns with the goals of the Commonwealth's Prescription for Pennsylvania initiative or the Department's MCO P4P Program; and

[94] Pennsylvania Department of Public Welfare HealthChoices Standard Agreement – Amended Effective July 1, 2008, Agreement Exhibit B – Performance-Based Contracting – Pay for Performance Program

- Certification, including signature by the Medical Director, that the proposal is new or an expanded program.

The Department will review all proposals and provide a written decision within thirty (30) days of receipt of the proposal. The Chief Medical Director, Office of Clinical Quality Improvement, as well as the Division of Quality and Special Needs Coordination will have the responsibility for the review and approval process.

The effectiveness of the approved Provider initiative(s) must be evaluated by the MCO. The results of this analysis must be submitted to the Department no later than one year after implementation of the initiative.

Attachment E
Connecticut Behavioral Health Pay-for-Performance Criteria Regarding Coordination with Primary Care Providers[95]

Each Memorandum of Understanding must provide for the following:

Protocols for referral of primary care patients to the ECC[96] to include the following:

- provisions for timely access to emergent, urgent, or routine evaluation and treatment services; and
- provisions for timely access to evaluation and management consultation visits with a psychiatric medical professional (MD or APRN);

Protocols for referral of ECC patients to the patient's primary care provider to include the following:

- Protocol for referral of stable ECC patients to the patient's primary care provider for ongoing medication and general medical management,
- Accompanying written referral summary and recommendations for follow-up care,
- Periodic written communication with the primary care provider for patients who continue to be seen by a non-medical practitioner within the ECC,
- Ad hoc telephone consultation with ECC clinician regarding the above primary care managed patients, and
- Protocols for referral back to the ECC for further psychiatric evaluation and crisis management.

Communication guidelines to support:

- ECC and primary care co-management of patients with behavioral health and physical health disorders, and
- Care of patients for whom the primary care provider has assumed responsibility for psychiatric medication management after stabilization by the ECC.

Designated agents:

- Designation of parties responsible for coordinating necessary medical and behavioral health services.

Education and Training:

- ECC conduct of annual education and training events for primary care providers and their office staff related to prevention, screening, evaluation and family-centered management of behavioral health disorders in primary care and indications for referral to ECC.

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[95] Connecticut Department of Social Services, Policy Transmittal 2008-xx (PB 2008-XX) TO**:** General Hospitals and Freestanding Mental Health Clinics SUBJECT: Primary Care/Behavioral Health Requirements for Enhanced Care Clinics under the Connecticut Behavioral Health Partnership

[96] ECCs (Enhanced Care Clinics) are specially designated Connecticut based mental health and substance abuse clinics that serve adults and/or children. They provide routine outpatient services such as individual therapy, group therapy, family therapy, medication management and other special services. See www.ctbhp.com/members/enhanced_care_clinics.htm. (accessed November 16, 2008)

Optional Components:

- Informal telephonic consultation by ECC to primary care providers regarding the management of patients with no history of treatment by the ECC;
- Protocols for early identification and intervention; and
- Streamlined access models to ensure early and effective linkage to behavioral health services such as co-location of behavioral health services within primary care.