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Resource Paper

Provider Incentive Programs: *An Opportunity for Medicaid to Improve Quality at the Point of Care*

By:
Dianne Hasselman
Center for Health Care Strategies, Inc.

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Introduction

Can there be such a thing as *too much* focus on quality? Imagine a primary care physician whose performance in diabetes care is assessed through incentive programs from multiple health plans. Each health plan uses slightly different performance indicators, requires different chronic care interventions, and provides different feedback reports for a subsection of the physician’s patient panel — an overwhelming scenario, but unfortunately all too real.

Although the purpose of pay-for-performance (P4P) programs is to use financial incentives to “move the quality needle” in a deliberate manner and to increase value-based purchasing, the proliferation of incentive programs — particularly at the individual physician or practice level — is creating a patchwork of quality efforts with negative and unintended consequences. Many providers, frustrated with the numerous and fragmented performance reports they receive, discount or simply discard the data as confusing, inefficient, inaccurate, and unhelpful.

In recent years, there has been a groundswell among health policy experts, public and private purchasers, and payers toward greater standardization of quality improvement activities. Purchasers increasingly recognize the need for standardization around evidence-based guidelines. Significant movement has occurred in adopting nationally-recognized performance indicators to assess health outcomes. The National Quality Forum and its many partners are establishing national priorities and goals around performance measurement and reporting. National initiatives like *Aligning Forces for Quality*,¹ the *Regional Quality Improvement* initiative,² and *Bridges to Excellence*³ are also helping to align public and private purchasers and payers around uniform quality improvement goals, common performance measures, and, in some instances, common payment.

By jointly developing incentive programs to improve quality at the point of care, purchasers and health plans can replace well-meaning but redundant and often conflicting pay-for-performance (P4P) programs. The resulting standardization of provider incentive programs could dramatically improve physician response to P4P efforts.

¹ For more information about Aligning Forces for Quality, visit www.forces4quality.com.

² For more information about the Regional Quality Improvement initiative, visit www.chcs.org.

³ For more information about Bridges to Excellence, visit www.bridgestoexcellence.org.

Medicaid and Provider Incentive Programs

With 63 million beneficiaries — 66 percent of whom are in managed care — and more than \$361 billion in annual expenditures, state Medicaid programs are in an excellent position to impact quality at the point of care and to foster greater alignment across health plans and delivery systems.⁴ Indeed, P4P programs are not new to states. Currently more than 25 states have P4P programs with their health plans or primary care case management (PCCM) programs.⁵ Yet, while many states use P4P programs to motivate improvements at the health plan level, few have designed effective programs at the provider level.

Historically, states delegate responsibility for provider incentive programs to their managed care partners, particularly in risk-based managed care delivery systems. States have been reluctant to micromanage managed care operations and have encouraged plans to innovate. States have also been challenged to work within the regulatory parameters established by the Centers for Medicare and Medicaid Services (CMS) including a cap on total incentive payments in risk-based systems.

In addition to acknowledging the benefits of standardization, states are increasingly aware that quality ultimately must occur at the point of care. Many states understand that in the highly competitive managed care environment, collaboration and alignment across Medicaid plans — even around quality — occurs most readily when the regulatory and purchasing authority of the state is used. As such, there is growing involvement of state Medicaid agencies in provider incentive programs.

In 2006, with funding from The Commonwealth Fund and additional support from the Robert Wood Johnson Foundation, the Center for Health Care Strategies (CHCS) launched the *Pay-for-Performance Purchasing Institute* to help state Medicaid agencies design provider incentive programs. Seven states — Arizona, Connecticut, Idaho, Ohio, Massachusetts, Missouri, and West Virginia — worked with CHCS to develop and test physician-level financial and non-financial incentives, choose performance measures, engage providers effectively, and increase alignment across incentive programs. This resource paper presents examples, including several from that initiative, of how states are becoming increasingly involved in P4P at the practice level, particularly around efforts to improve alignment and standardization.⁶

⁴ HMA projections for total spending and enrollment for federal FY 2008, based on: CBO, *Budget and Economic Outlook*, January 2008; CBO, *Medicaid Baseline*, 2008; CMS, Office of the Actuary, National Health Statistics Group, 2008; and NASBO, *State Expenditure Report*, December 2007.

⁵ K. Kuhmerker. *Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs*, The Commonwealth Fund, April 2007. Available at: http://www.commonwealthfund.org/usr_doc/Kuhmerker_P4PstateMedicaidprogs_1018.pdf?section=4039

⁶ For more about the *Pay-for-Performance Purchasing Institute* as well as information about structuring P4P programs, selecting measures, choosing financial and non-financial incentives, and engaging physicians, visit www.chcs.org.

Innovative State Models

The provider incentive program models described in this resource paper are based on the efforts of five state Medicaid programs:

- **Rhode Island** designed and implemented a provider incentive program that required Medicaid health plans to adopt standardized program goals, but allowed plans and providers to test different approaches to achieving those goals.
- **Arizona** is exploring the development of a provider incentive program that would require all Medicaid health plans to adopt common program goals, common performance measures, and to aggregate provider financial incentives across plans using a third-party broker.
- Since 2006, **Minnesota** has been participating in a provider incentive program where Medicaid and commercial purchasers and plans adopt uniform program goals and performance measures, and combine incentive dollars into “bucket” for provider payment.
- **Massachusetts** and **Missouri** are both focusing efforts around creating P4P program strategies and tools for use across different Medicaid delivery systems.

In considering the models above, a Medicaid program needs to recognize factors in its unique marketplace and circumstances, which may include:

- **Delivery system:** Will the incentive program operate in a risk-based managed care, primary care case management delivery system, or both?
- **Focus of P4P program:** Is the program targeting a chronic condition with a nationally-recognized measure set and a strong evidence base around impacting care (e.g., diabetes), or encouraging testing a new area with a less robust evidence base (e.g., reducing inappropriate emergency room utilization)?
- **Infrastructure:** Does the state have the infrastructure and staff to operate aspects of the program in house? The program design steps are consistent across models; however, “who does what” varies by state. In Rhode Island’s model, the state is responsible for establishing and funding the provider incentive program, but the plans are responsible for the remaining steps. In Arizona’s model, the state is more involved in all program design steps.
- **Political support:** Does the state have the political will and support to maximize alignment across plans? To join a multi-payer P4P program?

One size does not fit all in state-designed provider incentive programs, as illustrated by each of the following models, so states should consider their own unique circumstances when designing provider incentive programs.

Model 1: Alignment of Program Goals across Health Plans (Rhode Island)

Model 1 is based on Rhode Island's RItE Care P4P program. In 2005, the state required its health plans to implement a physician-level P4P component to compliment a health plan P4P program to reduce inappropriate emergency room (ER) use. The state had an incentive program at the plan level; however, with the prudent layperson laws and the Emergency Medicaid Treatment and Active Labor Act (EMTALA), the state and plans noted a gradual increase in ER utilization. The state decided to expand the incentive program to the point of care.

The state included a \$0.95 per member per month (PMPM) increase to RItE Care's health plan capitation rate to be used for a primary care provider (PCP) incentive program. The state required that the additional PMPM payment be used to reward PCPs based on performance. Each plan was charged with designing a provider incentive program that promoted timely access to quality care, including preventive care, urgent care, and care during evening hours. Plans were not required to adopt the same provider-level measures or aggregate data into one rate per practice.

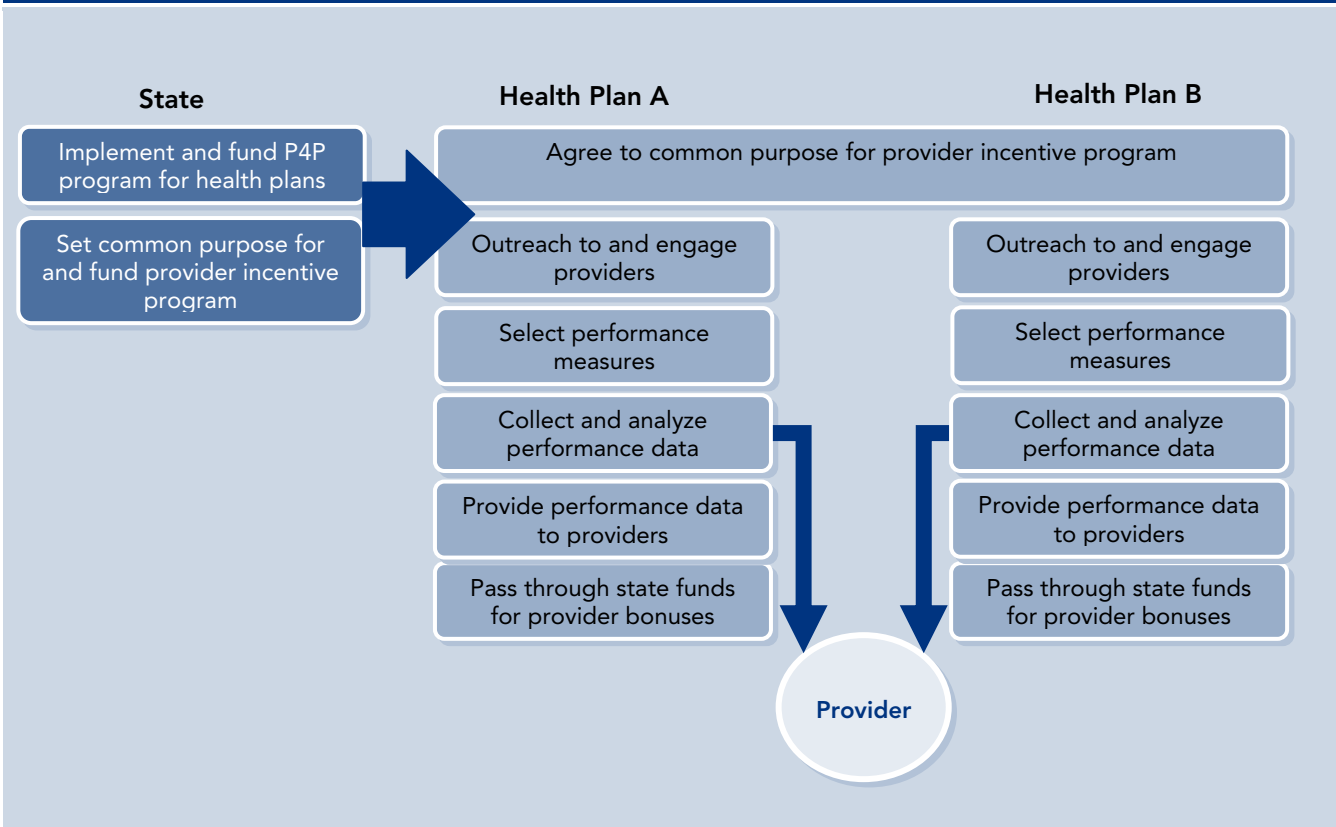
One of the plans, Neighborhood Health Plan of Rhode Island (NHPRI), targeted primary care practices with at least 200 NHPRI RItE Care members, creating a critical mass of potential new incentive dollars to "get the practice's attention." NHPRI divided the incentive payment into components. All eligible practices automatically received a payment of \$0.30 PMPM during the first year. Practices that extended business hours or were open during the weekend received an additional PMPM amount. Practices that had multilingual practitioners on call after hours received an additional PMPM amount. Finally, practices that reduced ER utilization received an increase amount. Using this strategy, all eligible practices received some funding initially to work toward expanding access. Additional funding was not guaranteed or unlimited — progress had to be demonstrated over time. A subset of high-performing practices received the maximum amount for achieving specific outcomes.

Rhode Island's approach reflects its unique marketplace and delivery system. The state has a risk-based managed care program, so it operated the provider incentive program through its health plans. The program focus — reducing inappropriate ER utilization — did not have a strong evidence base of "what works." As such, the state wanted to leave ample room for the plans and providers to experiment. Adopting such an approach allowed the state and plans to test different provider incentive program designs and to compare and contrast what worked and what did not. The state is currently assessing outcomes data and convening its health plans to review, retool, and identify best practices.

States that are interested in testing provider incentive program options but are not yet ready to require greater alignment across plans or delivery systems might consider this strategy. Comparing and contrasting outcomes from different approaches would allow states to make more informed decisions in the future about how, where, and why to create greater standardization.

The figure below, based on Rhode Island's model, illustrates how a Medicaid program might design a provider incentive program across plans.

Model 1: Alignment of Purpose across Plans (Rhode Island)



Model 2: Alignment of Purpose, Measures, and Payment across Medicaid Plans Using a Third-Party Broker (Arizona)

Model 2 presents a provider incentive program that creates significant alignment across its Medicaid plans. It is based on a provider incentive approach that the Arizona Health Care Cost Containment System (AHCCCS) is exploring.

AHCCCS is considering a P4P program to improve care for 88,000 adult Medicaid beneficiaries with diabetes. In the proposed model, AHCCCS would aggregate claims data across Medicaid plans to calculate a provider’s performance rate for all of his or her diabetic patients. In other words, the physician or practice would receive one consolidated diabetes performance report from the AHCCCS program, as opposed to a provider profile form each plan with whom the practice contracts. The proposed strategy aims to improve the validity and reliability of measurement and reduce the administrative burden on plans and providers alike.

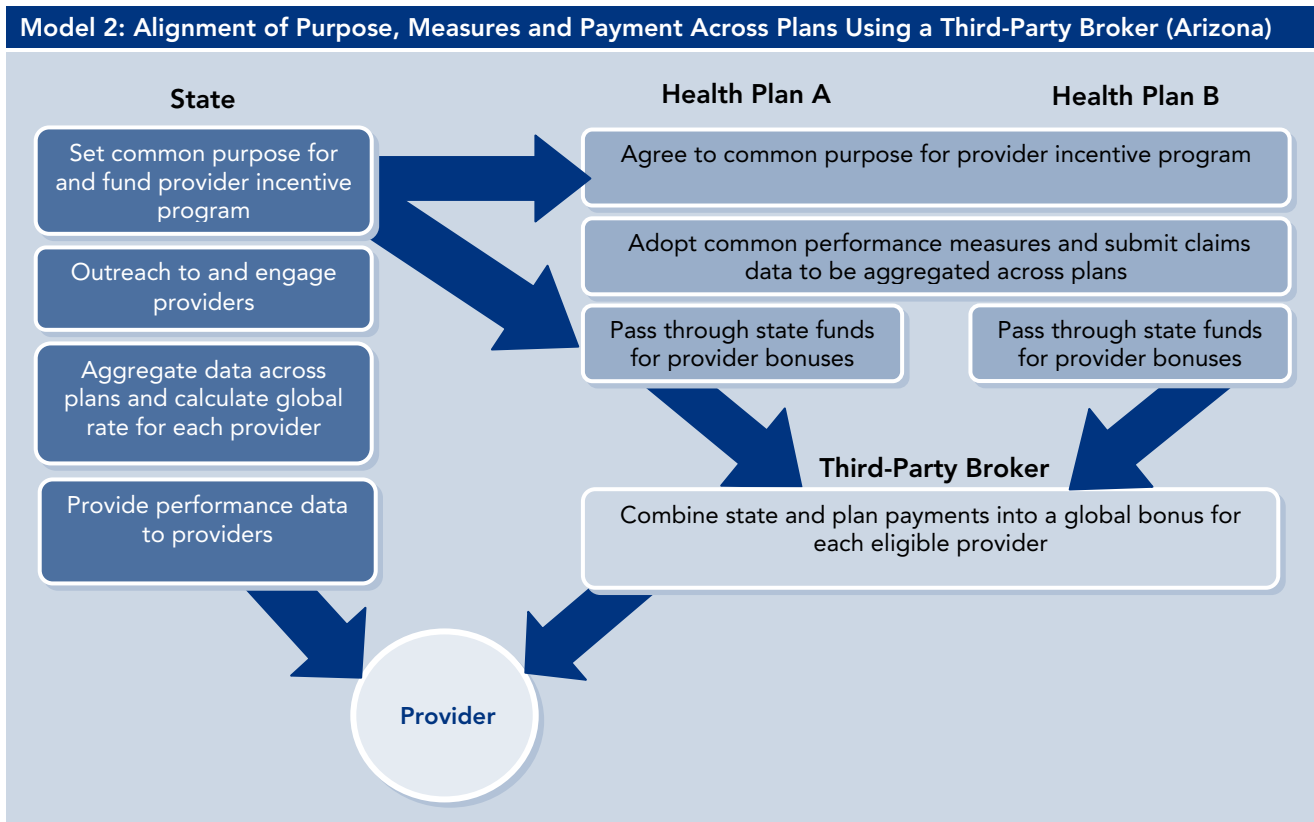
Like the Rhode Island model, funds for provider bonuses would be included prospectively in the health plans’ capitation rates. The health plans would be required to pass all state funds on to the providers. Incentive payments will be aggregated across plans into one payment per physician or practice. Thus a practice would receive one larger check, as opposed to multiple smaller checks. Because plans receive capitation rates prospectively, and provider performance would be measured and rewarded retrospectively, it

is possible that funds available for provider incentive payments might not be used in totality. Therefore, any remaining funds would accumulate and be used for provider incentive payments in the future.

The model that Arizona is exploring would use a third-party broker to receive and aggregate dollars from the plans, and to calculate and distribute bonus payments to practices. The state and CMS are currently exploring this broker model and whether and how it might be implemented.

Arizona’s approach reflects its unique circumstances and delivery system. Like Rhode Island, Arizona operates a risk-based managed care delivery system, so any provider incentive program would need to operate through its plans. The potential program’s focus — diabetes — has a nationally recognized set of measures and a strong evidence base around effective interventions. As such, the state could require plans to agree to a common set of measures. The state also has a rich source of high quality encounter data and a team of highly skilled data analysts who could calculate per practice or physician performance rates. Lastly, the large size of Arizona’s program and the competitiveness of the managed care marketplace means that the state has significant purchasing leverage to direct quality improvement initiatives, if it so chooses.

The figure below, based on the model Arizona is exploring, illustrates how a Medicaid program might design a provider incentive program that is fully aligned across plans.



Model 3: Alignment of Purpose, Measures, and Payment across Purchasers and Plans (Minnesota)

Model 3 is a cross-market collaboration that adopts a provider incentive program that is uniform across public *and* private purchasers (e.g., employers, Medicaid agencies, state employees, etc.) and plans (e.g., commercial and publicly funded). It is based on Minnesota's existing cross-payer provider incentive program. In this model, purchasers and plans use the same measures to assess provider performance and combine financial resources to reward high-performing physicians.

Such an approach has many benefits:

- Purchasers increase their buying power by banding together, focusing on value-based care, and demanding more efficient and effective health care.
- Plans must deliver value as purchasers make contracting decisions based on performance data. Plans benefit from creating economies of scale and reducing fragmentation of quality improvement activities.
- Practices are assessed by a common set of measures and a single report, which reduces administrative burden and confusion.
- When performance data is shared publicly, consumers have the opportunity to become more informed and active participants in their health care.

While public-private payer P4P programs are still in their infancy, the alignment and standardization created by this model holds great promise for Medicaid and commercial purchasers, providers, and consumers.

Minnesota's marketplace has unique characteristics that have helped accelerate innovations in quality. Its health care system is highly integrated. Hospitals and health systems own most primary care groups. As such, there is not only a strong business case to create alignment throughout a health care system, but the ability to do so.

Health care providers in Minnesota are required to serve the Medicaid population. This integration reinforces the importance of including Medicaid in cross-payer initiatives.

Lastly, Minnesota has created an infrastructure to support quality and innovation throughout its health care system. Three key building blocks have been particularly integral to Minnesota's achievements in value-based purchasing:

- **The Buyers Health Care Action Group (BHCAG)** is a coalition of private and public purchasers that seeks to promote purchasing strategies and develop tools that help purchasers buy and evaluate health care based on performance and value, not just price. BHCAG initiated Minnesota's diabetes provider incentive program in 2004.⁷
- **The Institute for Clinical Systems Improvement (ICSI)** develops evidence-based guidelines and measures for physician performance evaluation, and provides implementation support.⁸

⁷ For more information about Minnesota's Buyers Health Care Action Group, visit www.bhcag.com.

⁸ For more information about the Institute for Clinical Systems Improvement, visit www.icsi.org.

- **Minnesota Community Measurement (MNCM)** is a collaborative that receives and aggregates claims data from plans, collects clinical data from practices, and reports provider-level performance rates for conditions such as diabetes and cardiac disease.⁹

It is within this unique environment that BHCAG implemented a Bridges to Excellence (BTE) program to achieve optimal diabetes care in 2005. BTE is a national employer-led P4P program with a standard data exchange platform and performance measurements to foster cross-market collaborations in regions or states. Using evidence-based guidelines and measures developed by ICSI, MNCM collects, aggregates, and reports performance data for practices and clinics. BHCAG receives and aggregates financial incentives from purchasers, including Medicaid, and pays providers based on their performance.

In 2007, Minnesota's Department of Human Services (DHS), the state's Medicaid agency, joined BHCAG's effort and began to enroll Medicaid managed care recipients ages 18 to 75 with diabetes or cardiac disease into the initiative. DHS rewards practices based on their share of Medicaid patients, as opposed to clinical results. DHS includes dollars for provider incentives in health plan capitation rates. The plans, in turn, give those dollars to BHCAG.

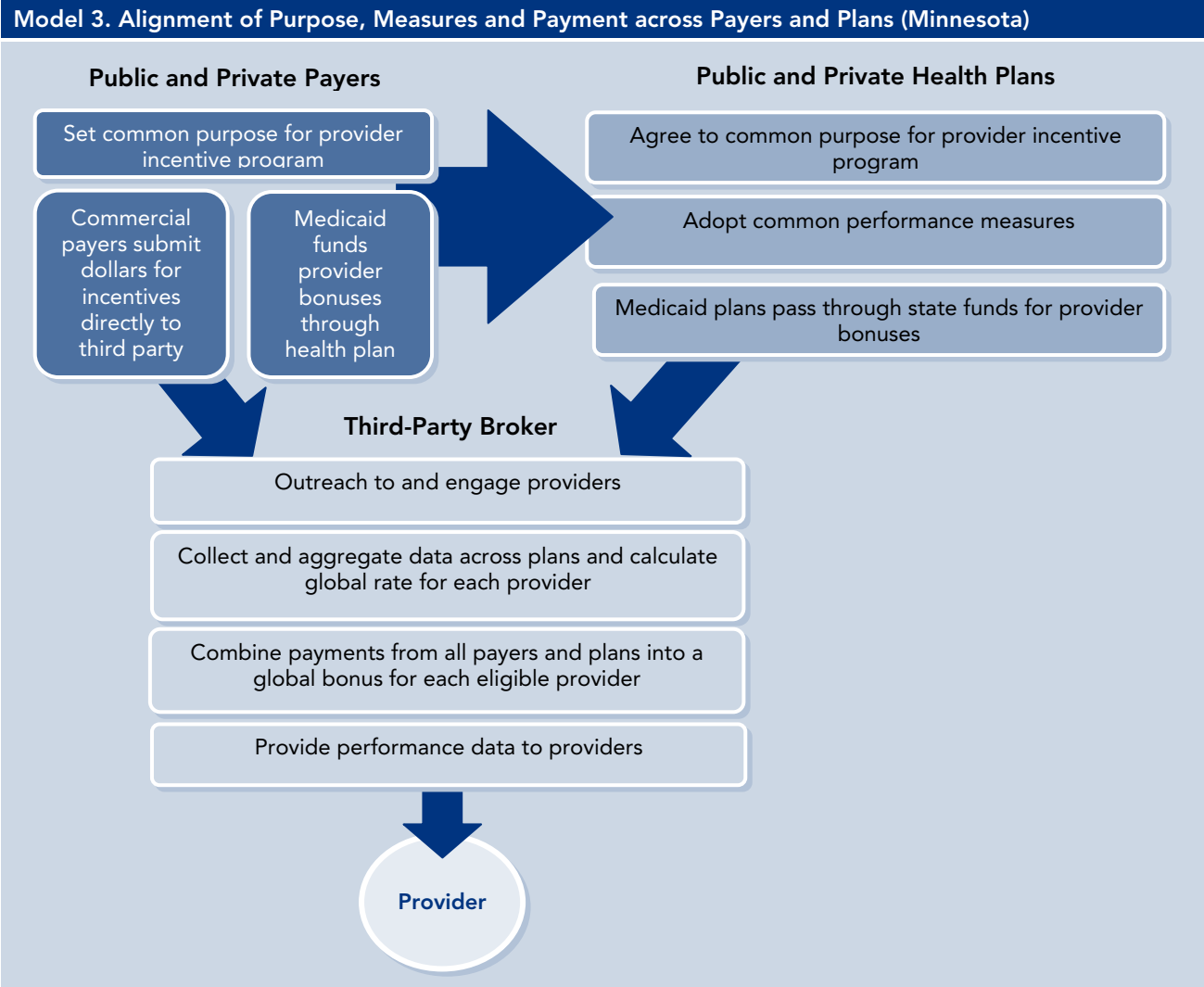
Through the BTE program, physicians providing optimal diabetes care to at least 10 percent of their patients with diabetes receive \$100 per patient. In 2006, BHCAG paid physicians \$97,000 in rewards, and rewarded \$260,000 in 2007.¹⁰ The percentage of Minnesotans receiving optimal diabetes care from providers participating in the BTE program has increased from 6 percent in 2004 to 22 percent in 2007.

DHS recently received approval from CMS for a new provider incentive program. This program will focus on Medicaid recipients remaining in fee-for-service. This population comprises 30% of Medicaid recipients, many of whom are disabled. Diabetes prevalence in this population is 10%, compared to 6% in the Medicaid managed care population. DHS will directly reward individual practices providing optimal care to Medicaid fee-for-service recipients with diabetes or cardiac disease. DHS will pay \$125 per diabetic for the first year, and up to \$500 for optimal performance in subsequent years. Practices will submit their data to DHS electronically.

The figure below, based on the model that Minnesota implemented, illustrates how to create full alignment across payers and plans.

⁹ For more information about Minnesota Community Measurement, visit www.mnhealthcare.org.

¹⁰ BHCAG March 2008 presentation at the CHCS Medicaid Purchasing Leadership Summit.



While several state Medicaid agencies have expressed interest in provider incentive programs that are aligned across purchasers and plans, Medicaid’s engagement to date has been limited. States may face multiple challenges participating in a multi-payer P4P program. States have concerns about how data will be collected and used publicly. Public-private programs work best when there is a significant overlap of providers who serve both the commercial sector and Medicaid patients. States with comparatively low Medicaid reimbursement rates often have provider networks with a less integrated patient mix. Lastly, some Medicaid programs may struggle to obtain the funding necessary to adequately support and sustain provider incentive programs.

Model 4: Alignment of Purpose, Measures, and Interventions across Delivery Systems (Massachusetts and Missouri)

Model 4 depicts provider incentive programs being designed in Massachusetts and being implemented in Missouri. Both states developed P4P approaches within a non-risk-based context (PCCM or fee-for-service), with the intent to extend select program elements to the risk-based managed care delivery system in the future.

MassHealth, the Commonwealth's Medicaid program, is designing a provider incentive program for its Primary Care Clinician (PCC) Plan based on the following principles:

- Transparency and collaboration;
- Alignment with the existing data collection and reporting system;
- Minimization of provider reporting burden; and
- Consistency with established state and national P4P programs.

The program will measure performance of individual physician practices, group practices, community health centers, hospital-licensed health centers, and hospital outpatient departments. To participate in the clinical measures portion of the incentive program, providers must have a minimum number of Medicaid patients in the denominator of each clinical measure in the P4P program and must complete a practice survey.

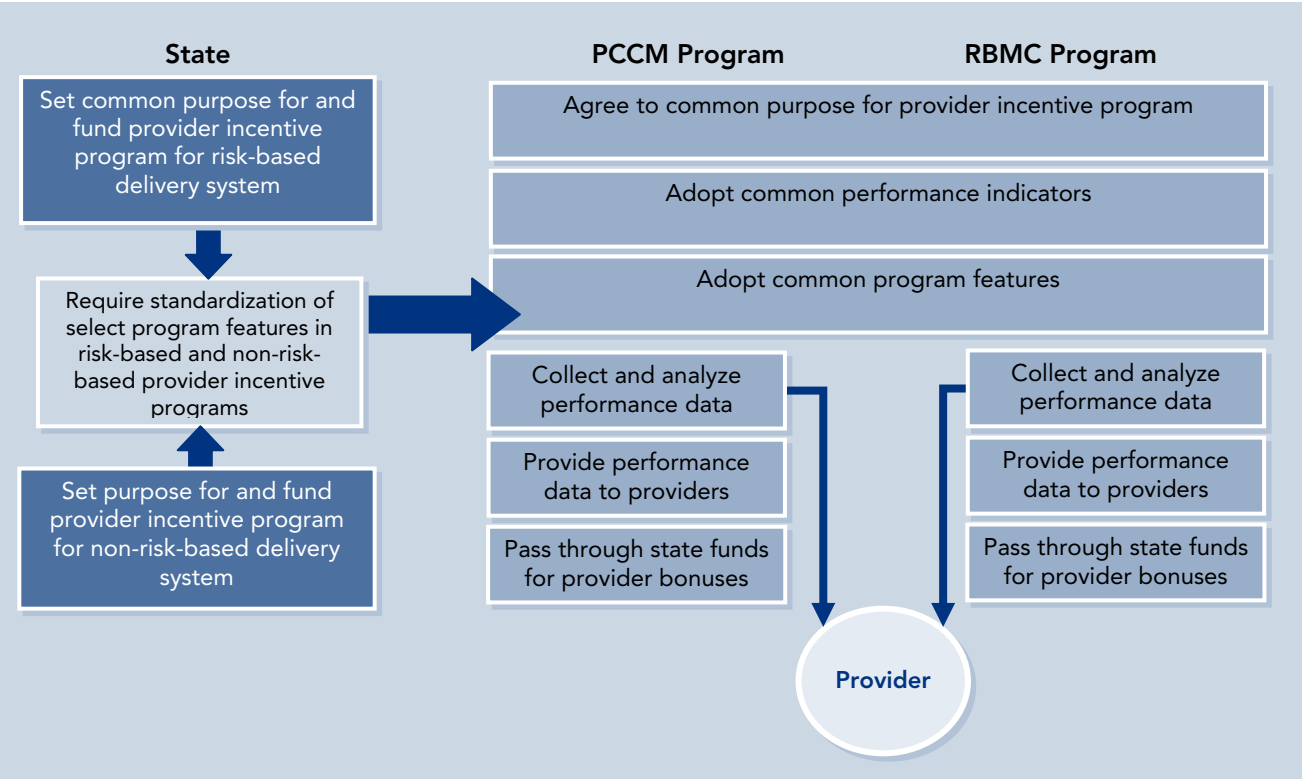
The practice infrastructure survey will be used to assess critical medical home components including: HIT capacity, follow-up from tests, referrals and acute events, guideline-based reminder systems, registries, access, and the process for gathering and tracking race and ethnicity information. During the first year of the program, practices will receive a "pay for reporting" amount if they fully complete and return the practice survey. Practices completing the survey will be assessed for eligibility for P4P funds based on their clinical indicator performance.

Provider performance around prevention and diabetes care will be assessed using HEDIS-based measures that are already collected and reported through the PCC Plan's profiling activities. MassHealth's new P4P program will allow providers to review their individual rates and submit additional information if they believe the rates are inaccurate. Payments will be based on achieving the performance benchmark for the clinical measures, or achieving improvement for clinical measures even though they do not meet the established benchmark rate. Incentives will be paid on a PMPM basis, based on the provider's total PCC Plan member enrollment. The state is still developing the specific PMPM amount.

The state is creating alignment across MassHealth's P4P programs. Specifically, all individual health plan provider incentive programs, including the new PCC Plan, will be required to use the same measures. They will also be required to use the same practice infrastructure survey tool.

The state of Missouri is also creating alignment with its fee-for-service (FFS) and risk-based managed care delivery system through a provider incentive program. Currently, physicians or mid-level practitioners in high-volume federally qualified health centers (FQHCs) in targeted geographic areas receive incentives for developing electronic care plans for patients with diabetes, asthma, gastroesophageal reflux disease, cardiovascular disease, or chronic obstructive pulmonary disease. The state pays providers \$25 for developing the initial patient assessment online, and an additional \$10 for updating web-based care plans. To assist providers with developing care plans, the state is placing care coordinators in the high-volume FQHCs to act as a liaison between the PCP and the patient. Missouri is currently revising its health plan contract to include the same provider incentive program.

Model 4. Alignment of Purpose, Measures, and Interventions Across Delivery Systems (Massachusetts and Missouri)



State Provider Incentive Program Profiles

Following are brief descriptions of additional state provider incentive programs:

Connecticut

Connecticut is working closely with its health plans to design and phase in a provider incentive program aimed at improving EPSDT rates. The first phase is to reward PCPs for completeness of EPSDT encounters. To do this, the state added payment incentives directly to the EPSDT reimbursement process so that medical practices can devote the time and resources necessary for care coordination. The state is now focusing on options for measuring and rewarding care coordination at the practice level. Specifically, the state will provide bonus payments through the health plan capitation rate to PCPs who coordinate care with specialists as appropriate based on EPSDT screening results.

Idaho

Idaho is piloting a provider incentive program within its PCCM delivery system and disease management program. Although the program will ultimately target five chronic diseases (diabetes, asthma, depression, hyperlipidemia and hypertension), the state made a strategic decision to “start small” by focusing first on diabetes. The state is targeting the pilot program to three high-volume FQHCs equipped with electronic medical records to facilitate data capture.

The diabetes program aligns with the state’s existing disease management program and targets approximately 500 diabetics within the state. While Idaho is using nationally-recognized performance measures to assess changes in outcomes, it is initially rewarding practices based on process measures. Specifically, practices receive \$50 per patient enrolled in the state’s diabetes disease management program. They also receive \$10 for each of the six diabetes measures reported. To date, the state has paid \$20,000 to the three FQHCs. The state has \$500,000 available for incentive payments as it continues to expand the P4P program. Next steps include establishing a secure web-based data submission and collection system.

Ohio

Ohio began exploring options for provider incentive programs by soliciting feedback from its health plans, provider community and other key stakeholders. A series of focus groups revealed physician frustration regarding the variety of measurement sets across different payers and plans. One medical director of a large primary care network described nine different measurement sets for which his organization is accountable. Physicians also voiced concerns with the accuracy of administrative data and were more likely to support P4P if their own data was used for measurement.

The state also surveyed health plans regarding the range of P4P methodologies, potential performance indicators, and estimated distribution of physician rewards over the various performance measurement domains. One key finding was that physician-level measurement, reporting and incentives could be complicated by the small numbers of encounters and measurable events at the physician-level. The state identified that only 12 percent of practices had a volume of 30 or more Medicaid patients — the number they estimate to sufficiently evaluate performance.

One option being considered is joining Cincinnati’s Bridges to Excellence Diabetes Care Link program. Cincinnati, one of the original BTE pilot markets, has been active since 2003. Physicians in the program who demonstrate they are top performers in diabetes care can earn up to \$100 for each patient covered by a participating employer. Employers (currently private only) fund incentives from documented savings achieved through lower health care costs and increased employee productivity that results from improved diabetes care.

Due to budgetary constraints, Ohio Medicaid has “tabled” short-term plans around developing a provider incentive program, but continues to consider its opportunities moving forward.

West Virginia

West Virginia is considering a provider incentive program that would support the state’s Mountain Health Choices program. Mountain Health Choices offers a two-tiered benefit system — beneficiaries must sign a “personal responsibility” agreement to receive enhanced benefits. Through the agreement, the beneficiary acknowledges the role he/she plays in his/her health care delivery. The state is considering implementing a provider incentive program that rewards physicians and mid-level practitioners as they encourage and work with Medicaid recipients in completing the agreements. Due to budgetary constraints and limited resources, the state plans to revisit its P4P programs — both at the plan and provider level — in the near future.

Conclusion

While the number of provider-level incentive programs is low compared to plan-level programs, provider P4P initiatives are increasing with the greater awareness that health care is local and quality ultimately occurs at the point of care when the patient meets face-to-face with the provider.

The provider P4P models highlighted herein can help states identify options for creating greater standardization in their quality improvement activities, particularly in a risk-based managed care delivery system. Alignment of P4P programs can improve the validity and reliability of performance measurement, reduce administrative burdens on plans and providers, and create economies of scale for plans and breakthroughs in quality for patients — all of which lead to reductions in future cost growth. This resource paper deliberately highlights states that have chosen different levels of alignment, recognizing that states will vary in terms of their interest in and ability to create standardization.

This resource paper reflects the growing recognition of the need to standardize quality improvement initiatives to send a stronger message to providers. Fragmentation in quality improvement efforts creates duplication and confusion for providers. Provider incentive programs offer purchasers an opportunity to become more involved in improving quality at the point of care and in achieving a greater level of standardization across P4P programs. Although P4P is just one tool in the quality improvement “arsenal,” Medicaid programs can play an important role in creating much needed alignment in P4P.

Appendix

Background on P4P

Pay-for-performance (P4P) programs are voluminous and growing throughout the public and private sectors as payers increasingly look for ways to link payment and quality. While many events have contributed to the proliferation of P4P programs, a few seminal events and initiatives are highlighted in this section.

The earliest P4P efforts were initiated by plans seeking to measure provider performance around cost and utilization, more so than quality. As employers saw their health care costs rising, they sought to link payment with health outcomes through health plans, which were responsible for a growing proportion of their employees. Plans were a logical starting place because they already collect standardized performance measures through the Healthcare Effectiveness and Data Information Set (HEDIS®) measures and customer satisfaction information through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) tool. Plans also have the capacity to collect and report data and are responsible for performance in many settings.

In 2001, the Institute of Medicine (IOM) released its groundbreaking report, *Crossing the Quality Chasm*, which revealed that up to 98,000 Americans die each year as a result of medical errors.¹¹ The IOM report stated that payers need to align payment policies to support quality improvement, as they often were paying more for poorer outcomes. This report was followed by one from RAND in 2003 that documented that patients receive the recommended care approximately half the time.¹² Both of these reports resonated deeply with health care purchasers, payers, providers, and consumers, and reinforced the need to link payment with performance.

As P4P grew in the private sector, public payers also began to link payment to performance. Medicare, for example, launched several P4P demonstration programs, targeting hospitals and physician practices. State Medicaid programs also began implementing P4P programs — some as early as the 1990s. Initial efforts focused on accountability, rather than quality or value, and targeted health plans. Because states began managed care enrollment with the Temporary Assistance for Needy Families (TANF) population, early P4P programs tended to focus on measures specific to services that mothers and children typically received, such as prenatal care visits, well-child checkups, and immunizations. Over time, as states have enrolled high-cost, high-need Medicaid beneficiaries into care management programs, P4P programs have expanded to focus on outcomes related to complex conditions and special needs.

As states have become more sophisticated purchasers of care and more proficient at collecting and using performance data and measures, P4P programs have become more advanced and targeted. As of July 2006, 28 state Medicaid agencies operated P4P programs, and half of those programs were operating for five or more years. Again, the majority of these programs were at the health plan level, followed by those targeting primary care case management (PCCM) programs, nursing homes, hospitals, behavioral health care providers, and lastly, individual physicians. In 2006, 19 states were planning to expand existing P4P programs in the next five years, and 15 Medicaid agencies were planning to start their first P4P programs.¹³

¹¹ Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy Press, 2001.

¹² RAND. *The Quality of Health Care Delivered to Adults in the United States*. McGlynn, June 2003.

¹³ The Commonwealth Fund. *Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs*. Kuhmerker and Hartman. April 2007.

The growing availability of performance data, the increasing demand for value-based purchasing, and a greater national focus on creating more alignment and standardization around quality have contributed to the proliferation of P4P initiatives, particularly to measure performance at the point of care. A few of the most notable ones are described below.

Rewarding Results: Aligning Incentives with High-Quality Health Care

Rewarding Results was a three-year effort funded by the Robert Wood Johnson Foundation, the California HealthCare Foundation, and The Commonwealth Fund. The three foundations selected seven demonstration projects that made providers eligible for financial and non-financial rewards based on the achievement of specific quality goals linked to clinical quality. The demonstration projects offered varied approaches, typically targeting primary care physicians or physician organizations, and represented several types of insurance arrangements, (e.g., health maintenance organizations (HMOs), preferred provider organizations (PPOs), and Medicaid.)

Through use of incentives, the *Rewarding Results* projects significantly increased patient visits to the doctor; pushed physicians to embrace health information technology (HIT) and electronic medical records (EMRs) at a faster pace; increased the number of patients receiving annual mammograms and other screenings; and motivated physicians to monitor patient care more aggressively, particularly for chronically ill patients. The initiative included seven experimental projects — three of which are described below — designed to test a variety of P4P models.

Integrated Healthcare Association (IHA)

Created in 1996, the Integrated Healthcare Association is a California-based, statewide coalition of health plans, physicians, health care systems, purchasers, and consumers working to create the business case for quality at the physician group level. In 2003, IHA initiated its P4P program with the goal of rewarding physician groups for performance in clinical care, patient experience, and HIT investment based on common metrics and public reporting. Key to the program's success has been the use of uniform measures to evaluate performance across multiple health plans, physician groups, and patient populations. To date, it is the largest P4P initiative in the country.

Bridges to Excellence

Bridges to Excellence (BTE) is the largest employer-sponsored effort rewarding and recognizing physicians for meeting specific quality benchmarks. For the *Rewarding Results* initiative, the BTE employer coalition focused on four locations across the country and financially rewarded physicians per patient per year for excellence in diabetes and/or cardiac care. The BTE model is now in several markets across the country and has found that physicians who are recognized for providing high-quality and more efficient care deliver it at 15 to 20 percent lower cost than physicians not participating in the program.

Local Initiative Rewarding Results

Local Initiative Rewarding Results was the largest collaborative P4P effort to improve the health of babies and teens in Medicaid. The California-based project involved seven health plans that collaborated to test the impact of financial and non-financial incentives on provider quality. The program, which ran from 2002 through 2004, ultimately paid \$5 million in provider incentives and involved 3,300 physicians touching the lives of 350,000 babies, adolescents, and parents. Five of the seven plans improved the rate of well-baby visits, with increases from 4 to 35 percent. Visits to the doctor by teens increased from 7 to 14 percent at six of the seven plans. Of the seven *Rewarding Results* projects nationwide, the *Local Initiative Rewarding Results* project was the only activity focusing on the Medicaid population and the first known collaborative effort to establish financial incentives within Medicaid among multiple plans with the same objective.

The Leapfrog Group

The Leapfrog Group was established in 2002 to mobilize employers' purchaser power in relation to health care services and to influence the quality and affordability of care. The *Crossing the Quality Chasm* report focused Leapfrog initially on reducing preventable medical mistakes, recommending that large employers provide more market reinforcement for the quality and safety of health care. The Leapfrog Group launched its Hospital Rewards Program in 2005 and continues to measure hospital cost and quality performance. Hospitals that demonstrate excellence or show improvement along both dimensions receive rewards.

Medicare P4P Demonstration Programs

The Centers for Medicare and Medicaid Services (CMS) has been instrumental in establishing demonstration projects for P4P at the point of care. Two of its key P4P demonstration projects focused on physician practices are described below.

Physician Group Practice (PGP) Demonstration

In 2005, CMS launched its two-year Physician Group Practice (PGP) Demonstration focusing on improving the quality of care delivered to patients with congestive heart failure, coronary artery disease, and diabetes mellitus. Ten large, multi-specialty group practices participated in the demonstration project and received \$16.7 million in incentive payments for improving health outcomes and coordinating the overall health care needs of Medicare patients assigned to their groups.

Physician Quality Reporting Initiative (PQRI)

A related CMS value-based purchasing initiative is the Physician Quality Reporting Initiative (PQRI), which uses a pay-for-reporting approach. Under PQRI, physicians and other health care professionals earn incentive payments for reporting measurement data about the quality of care they provide to Medicare patients. CMS is now developing a program that moves from the PQRI pay-for-reporting approach to a performance-based payment plan.

CMS Payment Policies and Federal Regulations

The Centers for Medicare and Medicaid Services provides policy guidance on provider incentive programs that states must consider as they develop P4P programs in risk-based managed care and PCCM programs.

Payments to Providers

Under risk-based managed care, because a contractual relationship exists between the state and its plans, states are prohibited from paying providers outside of the health plan contract. In other words, states are restricted from making direct incentives payments to providers. As an alternative, a state can include funds for a provider incentive program in the health plan's capitation rate, then contractually require the health plan to pass the full incentive payment on to eligible providers.

In a PCCM environment, a state can make incentive payments directly to eligible providers or have the PCCM administrator pass through the bonuses to eligible providers. The state must specify the incentives in its State Plan, and the incentives must be tied to payments for services, as specified in the State Plan.

Incentive Payment Amounts

Incentive payments from the state cannot exceed 105 percent of the payments attributable to services covered by the incentive arrangement.¹⁴ In risk-based managed care, total payments (capitation payments

¹⁴ 42 CFR 438.

plus any incentive amounts) cannot exceed 105 percent of the approved capitation rate attributable to services covered by the incentive arrangement. A state could not, for example, offer a 3 percent incentive payment to its health plans, and an additional 3 percent as a “pass through” to physicians.

In a PCCM delivery system, the 105 percent ceiling is based on services that impact the P4P program target, and may include inpatient hospital, emergency room services, and other services as well as those provided or authorized by the physician, practice, or other PCCM provider. A state should work with CMS to develop an incentive methodology that fits its PCCM program design. Research shows that incentive payments must be large enough to be meaningful in order to motivate a change in behavior. As such, limits on incentive payments may present an even greater reason to collaborate with other purchasers, particularly when Medicaid can benefit from pre-existing quality improvement programs.