

Physician Pay-for-Performance in Medicaid: A Guide for States



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CHCS
Center for
Health Care Strategies, Inc.

Physician Pay-for-Performance in Medicaid: A Guide for States



About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit organization dedicated to improving the quality and cost effectiveness of publicly financed care for people with chronic health needs, the elderly, and racially and ethnically diverse populations. CHCS works with state and federal agencies, health plans, providers, and consumers to design programs that better serve high-need and high-cost populations. Its program priorities are: regional quality improvement, racial and ethnic disparities, and adults with complex and special needs.

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The Centers for Medicare and Medicaid Services (CMS) defines pay-for-performance as “the use of payment methods and other incentives to encourage quality improvement and patient-focused high value care.”¹

Introduction



Over the past several years, pay-for-performance (P4P) programs have emerged as a promising strategy to improve the quality and cost-effectiveness of care for Medicaid and State Children’s Health Insurance Program (SCHIP) members. State purchasers and managed care plans across the country are linking physician reimbursement and non-monetary rewards to improve the quality of care for Medicaid patients.

Most P4P initiatives to date, in both the public and private sectors, have been applied at the health plan level, rewarding health plans that meet defined targets, rather than offering incentives directly to physicians. However, commercial purchasers, insurers, Medicare, and a few Medicaid agencies are increasingly using physician and hospital-level P4P initiatives to align payment and non-financial incentives with higher quality. As one of the largest health care purchasers in America, Medicaid has an opportunity to play a leadership role in testing the viability of physician-level P4P strategies to improve health care quality for low-income, racially diverse, and chronically ill individuals.

During the summer of 2006, the Center for Health Care Strategies (CHCS) conducted a 50-state survey, funded by The Commonwealth Fund and the Robert Wood Johnson Foundation, to identify innovative practices in the reimbursement of high-quality health care in the public sector. Based on the survey’s most promising responses, CHCS and Bailit Health Purchasing conducted 12 interviews with Medicaid agency officials from across the country, representatives from CMS, and other experts in health care financing. We also reviewed recent findings on various P4P initiatives in the public and private sectors.

This resulting guide for states offers lessons from a variety of Medicaid, commercial, and Medicare P4P programs to help in the development of successful Medicaid P4P strategies at the physician level. The guide also outlines 10 financial models of physician rewards and six non-financial models that states can consider in the design of Medicaid physician P4P programs.

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

Implementation of successful P4P strategies is not easy, particularly given the budgetary and regulatory challenges faced by state Medicaid agencies. We recommend that states engage in an extensive design and development process before implementing P4P strategies. States developing a P4P strategy can use this guide to help address the following questions:

1. What is P4P?
2. How does a state get started designing a physician P4P program?
3. What are the different incentive models?
4. Which incentives are best suited to the target audience?
5. What performance measures and data should be used?
6. What are the best ways to engage physicians?
7. How does a budget-conscious state finance a Medicaid physician P4P initiative?
8. What regulatory issues are unique to Medicaid physician P4P initiatives?
9. What can states learn from Medicare's experience with its physician P4P demonstration?
10. What can states learn from leading commercial-sector P4P initiatives for physicians?

State Pay-for-Performance Purchasing Institute: A CHCS Technical Assistance Initiative

Since 1995, the Center for Health Care Strategies (CHCS) has worked with state Medicaid agencies and Medicaid health plans to develop value-based purchasing strategies, including best practices in rewarding quality through financial and non-financial incentives. In early 2006, CHCS launched its *Pay-for-Performance Purchasing Institute* with funding from The Commonwealth Fund and the Robert Wood Johnson Foundation. The initiative is helping states develop physician-level P4P strategies to promote the delivery of high-quality care to low-income, racially diverse, and chronically ill individuals.

Teams from Arizona, Connecticut, Idaho, Massachusetts, Missouri, Ohio, and West Virginia were selected to participate in the 18-month Purchasing Institute. The teams were chosen based on their proposed strategies and how well they met the following criteria:

- The state is seeking to implement strategies to improve the quality of care delivered to the Medicaid population through the use of incentives at the physician level.
- The state has the resources (data and staff capacity) to select measures and targets and to evaluate the effect of physician-level incentive programs on the quality of care delivered to Medicaid beneficiaries.
- The state seeks to collaborate with key stakeholders (e.g., other branches of state government, other state purchasers such as the agency responsible for state employee and retiree benefits, other large commercial purchasers and plans, Medicaid health plans, and physician groups) to most effectively design and implement a physician-level incentive program.

For more information, including a variety of resources for states, visit www.chcs.org.

State Considerations for Physician Pay-for-Performance Strategies



1. What is P4P?

There are a number of ways that states can use incentives within Medicaid. “Pay-for-performance” can refer to a wide variety of program types, varying greatly both in what is rewarded and what constitutes a reward. The “pay” in P4P in Medicaid programs can refer to monetary payment for the achievement of pre-specified goals, the use of non-monetary incentives such as public reporting and recognition, or other incentives such as referral of members to a plan or provider. The targeted “performance” in P4P can be outcome-based (e.g., were certain clinical goals achieved?) or process-based (e.g., did the physician comply with certain quality improvement processes or protocols, or participate in a designated quality improvement activity?).

Physician reward and recognition strategies need not be mutually exclusive, and many successful P4P programs include both financial and non-financial incentives. The use of multiple reinforcing incentives can often enhance the likelihood of physician behavior change.

2. How does a state get started designing a physician P4P program?

The most common failures of P4P programs can be attributed to missteps in the design or implementation phases. States should also be patient with P4P initiatives and expect that some time will elapse before significant improvements in quality and efficiency are recognized.

Reference Materials

Resources, based on a growing body of practical experience in the public and private sectors, are available to assist state purchasers in designing performance incentive programs. “Pay for Performance: A Decision Guide for Purchasers,” an April 2006 publication by the Agency for Healthcare Research and Quality (AHRQ), outlines considerations for state purchasers, including which physicians should be targeted first, whether participation should be voluntary or mandatory, and how much money should be allocated to performance pay.² A link to the AHRQ guide as well as additional P4P resources are available at www.chcs.org (see also Appendices B and C).

Since pay-for-performance is still a relatively new approach, the research base is thin. A literature review found only nine randomized controlled trials that attempted to measure the effectiveness and outcomes of performance-based payment or public reporting in health care.³ Further research is being conducted, and rigorous evaluations of several demonstrations, including projects from the national Rewarding Results program, are underway.⁴ While few of these new initiatives are randomized controlled studies, they are likely to provide preliminary evidence from a variety of incentive designs and settings (e.g., commercial, Medicaid, and Medicare).⁵ These studies may also provide additional information about the degree to which improvement is achieved, the types and amounts of incentives that are most effective, and whether or not emphasizing certain aspects of performance influences other aspects, either for good or ill.

² R.A. Dudley and M.B. Rosenthal. “Pay for Performance: A Decision Guide for Purchasers.” Agency for Healthcare Research and Quality. April 2006. <http://www.ahrq.gov/qual/p4pguide.htm>.

³ R.A. Dudley, A. Frolich, D.L. Robinowitz, J.A. Talavera, P. Broadhead, H.S. Luft. “Strategies To Support Quality-Based Purchasing: A Review of the Evidence.” Technical Review 10. (Prepared by the Stanford-University of California San Francisco Evidence-based Practice Center under Contract No. 290-02-0017). AHRQ Publication No. 04-0057. Rockville, MD: Agency for Healthcare Research and Quality. July 2004.

⁴ Rewarding Results is a national initiative, funded by the Robert Wood Johnson Foundation and the California HealthCare Foundation, to help purchasers and health plans develop innovative incentive programs.

⁵ Dudley, Frolich, et al., op. cit.



Framing the Questions to Answer

P4P programs are all about behavior change. To develop P4P goals and a strategy for influencing physician behavior change, states should answer the following questions:

1. What aspect(s) of health care delivery do we want to improve?
2. What behaviors do we want to change?
3. Which physicians will be affected?
4. What are the pros and cons of targeting individual physicians or groups?
5. What do we desire as an outcome of our P4P initiative?

The structure of pay-for-performance programs will vary according to who is eligible for incentives (e.g., health plans, medical groups, or individual physicians), the performance required to receive an incentive payment (the performance target) and the method used to structure the incentives. Once the state has identified the target physician population and the targeted behavior change(s), it must determine a number of other interrelated design issues, including the reward structure, the measure(s) to be used, and the data collection process. For example, the purchaser can choose to implement an incentive that focuses on state or health plan priorities, demographics of the enrolled membership, or the need for improved care or access to care.

Assembling the Agency's Internal P4P Team

States should carefully assess the operational and political issues involved in specific P4P programs to determine key internal stakeholders. Building a team of technical experts and including those who can champion P4P efforts is crucial to successful implementation.⁶ During the implementation period, the P4P design team should work together in a project oversight capacity, addressing operational, methodological, and political issues that arise.

State Medicaid P4P initiatives need to involve respected leaders who can make a convincing case to the legislature for the use of incentive funds, as well as champions who can address arguments such as why physicians should receive bonuses for “doing their jobs.” External champions are also needed among physicians and other key stakeholder groups, e.g., consumer advocates. Involving consumers in P4P program design may add credibility to the initiative in the eyes of physicians and also allows consumers to play an important role in shaping quality improvement activity within the state.

States should consider the expertise and resources that will be required for P4P design, implementation, and evaluation, including program management, quality improvement, legal, accounting/finance, clinical, communications, and information technology. States should assess internal resources, potential collaborations with external initiatives and stakeholders, and services or support that might need to be obtained to allay implementation problems. Unanticipated problems, e.g., delayed payment of physician rewards or a data backlog, can dramatically reduce the effectiveness of P4P initiatives.

⁶ Bailit Health Purchasing. “Incentives and Rewards Best Practices Primer: Lessons Learned from Early Pilots.” The Leapfrog Group, July 2006. <http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=124237>.

3. What are the different incentive models?

States are using both financial and non-financial incentives to drive quality at the health plan and, more recently, at the physician level. Since access — getting people in for routine and preventive care — is a priority for many Medicaid programs, performance targets and incentives are often related to improving basic primary care.

Tables 1 and 2 (p.8 and p.12) summarize six non-financial incentive models and 10 financial incentive models that are currently in use by commercial insurers, employers, Medicare, and/or state purchasers.⁷ Many effective P4P strategies include more than one type of incentive. In fact, sponsors of P4P initiatives often start with non-financial incentives such as data profiling activities, and then phase in financial incentive components. Following the two tables, we provide examples of how several states are implementing the different types of incentive models.

For ease of comparison, all of the following incentive model examples are presented relative to a single primary care physician and are focused on preventive care services for women such as mammograms. The concepts are, however, transferable to physician practice sites, group practices, networks, and hospitals, as well as other provider organizations. The concepts are also transferable to other quality improvement goals such as preventive care for children or for care management for people with chronic illnesses.

Non-Financial Incentive Models

Non-financial incentives refer to non-monetary rewards, such as public reporting, recognition, technical assistance, and the referral of new members. Table 1 provides examples of different types of non-financial incentive models.

⁷ Bailit Health Purchasing, LLC. "Provider Incentive Models for Improving the Quality of Care," National Health Care Purchasing Institute, March 2002, at <http://www.academyhealth.org/nhcpi/models.pdf>, and R.A. Dudley and M.B. Rosenthal, op. cit.

Table 1. Examples of Non-Financial Incentive Models

Non-Financial Reward	Example
1. Performance profiling	The percent of a PCP's age-appropriate female adult patients who received a mammogram in the past two years is compared to statewide averages and shared with the PCP.
2. Public recognition	The percent of a PCP's age-appropriate female adult patients who received a mammogram in the past two years is published on a web site in conjunction with other measures and compared to statewide averages. The high-performing PCP is recognized with a distinguished provider rating.
3. Technical assistance	The state or its vendor offers the PCP free practice consultation on how to increase the percent of the PCP's age-appropriate adult female patients receiving prescribed mammograms.
4. Practice sanctions	The PCP is not assigned new patients until the PCP demonstrates improved and acceptable performance on specific performance metrics or completion of approved quality improvement initiatives.
5. Auto-assignment	The PCP is eligible to obtain member-panel assignments for female clients in mandatory programs who do not select a provider if the PCP performs above a specific threshold on women's health measures.
6. Reduced administrative requirements	If the PCP demonstrates excellent performance on mammography and other defined preventive measures, the PCP can undergo a quality audit every other year instead of annually. ⁸

Performance Profiling

The sharing and transparency of performance data is a type of non-financial incentive that can help physicians understand and improve the quality of the care they deliver. Physicians who are given relevant data can better understand and gauge their own performance and are better equipped to identify areas needing performance and efficiency improvements.

Public performance reports can affect both the public and peer image of physicians. Concern for protecting reputation tends to motivate quality improvement among physicians.⁹ Public reporting can be done through reports, newsletters, press releases, web sites, award ceremonies, and stakeholder meetings. One caveat for performance profiling is that methodological challenges (such as small sample size or aggregation of data at the individual physician level) can hinder the ease of developing such reports.

Publicly sharing physician data can also be used to promote consumer engagement in health care decision making. A growing number of states are providing consumers with “user-friendly” comparative information about physicians. Regardless of how data are used, public reports should have two main goals: informing the public and stimulating action (e.g., improving performance and sparking stakeholder interest in practice improvement).

⁸ Other possible reduced administrative requirements, depending upon the performance measure, include a) subsidized information technology, such as e-prescribing hardware and software, and b) waiver of service preauthorization requirements.

⁹ J.H. Hibbard, J. Stockard, and M. Tusler. “Hospital Performance Reports: Impact on Quality, Market Share and Reputation,” *Health Affairs*, July/August 2005, pgs. 1150-1160.

Maine

As used by states, physician profiling can be a stand-alone (non-financial) incentive, or it can be linked with financial rewards. Since 1998, Maine has used physician profiling as one part of its incentive for physicians in the primary care case management (PCCM) program. The state links the results of the physician profiles to monetary rewards. On a quarterly basis, pediatricians, family practices/group practices, internists, and OB/GYNs receive scores for measures related to targeted goals (Figure 1).

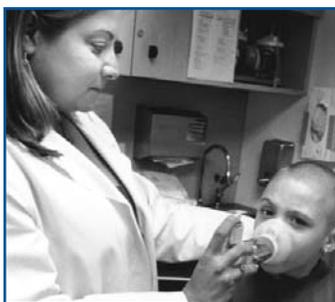
Figure 1. Examples of Types of Measures Used in Maine's PCP Profile

- Average number of EPSDT encounters (per patient per year)
- Number of EPSDT/Bright Futures forms required/number of EPSDT visits billed
- Children ages 0 to 20 with 1 or more EPSDT visits in the last year
- Well-child visits in first 15 months of life
- Well-child visits in 3rd, 4th, 5th, and 6th years of life
- Adolescent well-care visits: ages 12-21 years
- Cervical cancer screening
- Breast cancer screening
- Prenatal care in the first trimester
- Diabetes — retinal exams
- Diabetes — HbA1c tests
- Diabetes — Lipid tests
- Lead screening rates: 1st year
- Lead screening rates: 2nd year

The Maine legislature established an annual budget amount (approximately \$3 million), available for bonus payments to the MaineCare managed care primary care physicians (PCPs) who show the best performance on a series of measures related to access, emergency room utilization, and prevention/quality. PCPs are grouped by specialty and panel size so that physicians compete only with their closest peers. Those physicians whose performance is in the top 80 percent of their group receive a quarterly bonus payment. The specific amount of an individual physician's bonus payment depends on specialty and overall performance. Although payment is made at the group level, the profile reports are sent directly to each physician.

Maine Medicaid staff report satisfaction with this PCP incentive and believe that this initiative encourages physicians to improve their performance. State staff report that physicians appreciate obtaining the profile reports and note that PCPs pay close attention to the scores and rankings. It is not necessarily clear what is the primary physician motivator: the desire to improve ranking on the publicly shared profile report or the potential for a bonus payment.

Maine Medicaid staff report some difficulty in assessing the overall effectiveness of their incentive program due to difficulties aggregating PCP profile information and the potential for double-counting Medicaid members. The state is currently considering changing the way it measures PCP performance, particularly regarding how members are assigned to PCPs when developing the PCP profile, to better enable aggregate comparisons of performance in 2007.



Massachusetts

Since 1995, Massachusetts has profiled PCCM primary care clinicians (PCC) and used other non-financial incentives to promote quality improvement. The MassHealth PCC Plan staff, in conjunction with a vendor (currently the Massachusetts Behavioral Health Partnership), manages the PCCM quality improvement activities associated with the PCC Profile.¹⁰

The state profiles each provider practice with 200 or more PCCM enrollees. These practices serve 83 percent of the PCCM population. The state PCCM and vendor staff also conduct semi-annual onsite meetings with provider office staff, and work with practices to develop improvement activities based on the profiling data. The PCC profile report includes demographic data on the provider panel and comparison information. The profile includes provider rates and quartile rankings for select Health Plan Employer Data and Information Set (HEDIS®) measures¹¹ and other performance measures as compared with all other practices that have at least 200 beneficiaries in their panels. Data for the profile report are compiled using paid claims. In addition to the profile, providers receive two reports every six months, the PCC Reminder Report and the PCC Care Monitoring Registry. The Reminder Report lists PCCM members overdue for well-child care visits, cervical cancer screening, and breast cancer screening, as well members with two or more emergency department visits within the previous six months. The PCC Care Monitoring Registry report includes the most current data available on members in provider panels with asthma and diabetes, as well as data on members with high pharmacy utilization. The reports list the most currently available member addresses and telephone numbers to assist providers in reaching members.

Providers with more than 200 members are required to implement action plans based on the PCCM profile results. Common action plans include initiatives related to well-child care, asthma care, emergency department utilization, cervical cancer screening, breast cancer screening, and diabetes. As part of the PCC profile and action plan discussions, the PCCM vendor's staff share information with physicians about how other practices are addressing similar problems.

Research has not been able to attribute improvements in performance to the PCC profile and quality improvement activities.¹² However, more than one-half of the Massachusetts PCC physicians who were profiled reported redesigning aspects of their practice activities as a result of the PCC plan profile and action plan activities in 2001.¹³ PCC profiling and quality improvement challenges at the PCC practice level, the state level, and the beneficiary level, were clearly identified through the program (Figure 2).

¹⁰ E.G. Walsh, D.S. Osber, et al. "Quality Improvement in a Primary Care Case Management Program," *Health Care Financing Review*. Summer 2002.

¹¹ HEDIS, the Health Employer Data and Information Set, is a registered trademark of the National Committee for Quality Assurance.

¹² E.G. Walsh, et al., op. cit.

¹³ Ibid.

Figure 2. Early Massachusetts PCCM Profiling and Quality Improvement Challenges

Practice-Level Challenges

- Need for designated staff with responsibility for implementing changes
- Need for infrastructure and information systems to facilitate new approaches
- Multiple sites of larger physician groups have different procedures and cultures
- Varying requirements of multiple payers

State-Level Challenges

- Inherent limits of claims data decrease salience and credibility of data to physicians
- Need for up-to-date beneficiary contact information to assist physicians with outreach

Beneficiary-Level Challenges

- Lack of stability in Medicaid population
- Cultural barriers to compliance with some recommended services¹⁴

Performance-Based Auto-Assignment

Traditionally, auto-assignment methodology, used to determine where to assign beneficiaries who do not select a health plan, has been based on factors such as health plan capacity and agency goals. Over the past several years, states have developed auto-assignment algorithms that base the assignment of new members on health plan performance. Thus, higher performing health plans are rewarded by having a higher percentage of beneficiaries assigned to them. This type of performance-based auto-assignment process provides an incentive for health plans to improve for the reward of increased market share.

California

In late 2003, the California Medicaid agency was interested in creating a performance incentive for contracted health plans, but a state fiscal crisis necessitated a creative non-financial strategy. The state created a performance-based auto-assignment algorithm. California assembled a stakeholder advisory group, consisting of health plan executives as well as consumer and physician stakeholders. While consensus on the assignment algorithm among the members was viewed as desirable, it was not required. The state Medicaid agency made the final determination of the specifics of the performance-based auto-assignment policy.¹⁵

The Medi-Cal (California) managed care performance-based auto-assignment incentive program is currently using the following HEDIS quality measures:

- Childhood immunization status: Combo 2;
- Well-child visits: 3rd – 6th years of life;
- Adolescent well-care visits;
- Timeliness of prenatal care; and
- Use of appropriate medications for people with asthma.

¹⁴ Health Economics Research, Inc., interviews with Primary Care Clinician Plan providers, the Massachusetts Division of Medical Assistance, and the Behavioral Health Partnership, 2001.

¹⁵ Bailit Health Purchasing, LLC. "Putting Quality to Work: Rewarding Plan Performance in Medi-Cal Managed Care," California HealthCare Foundation. May 2006. <http://www.chcf.org/topics/medi-cal/index.cfm?itemID=121098>

Financial Incentive Models

The following section describes the types of incentive structures that link monetary rewards with the achievement of certain outcomes, adherence to certain processes or protocols, the demonstration of improved performance, or for participation in a quality improvement activity.

Table 2. Examples of Financial Incentive Models

Financial Reward	Example
1. Pay-for-participation	The PCP is reimbursed for time spent at state-sponsored collaborative quality improvement workgroup meetings focused on women's health or time spent attending meetings to review performance profiling information and developing quality improvement action plans.
2. Pay-for-process	The PCP receives an automatic payment of \$10 every time one of the PCP's age-appropriate female adult patients receives a biannual mammogram. A PCP is paid \$10 for every telephone call to a patient who is due for a mammogram.
3. Quality grant	The PCP may apply for a grant to implement a patient registry system to facilitate tracking of patients in need of a routine mammogram.
4. Bonus for achievement of a predetermined threshold	The PCP receives a bonus payment if 80 percent or more of age-appropriate female adult patients received a mammogram in the past two years.
5. Tiered bonus for achievement of predetermined thresholds	The PCP receives a bonus payment if 80 percent or more of age-appropriate female adult patients received a mammogram in the past two years, and a larger payment if more than 90 percent did so.
6. Tiered bonus based on comparative ranking	The PCP receives a bonus payment if ranked in the top 50 percent of PCPs for delivery of mammograms to age-appropriate female adult patients in the past two years, and a larger payment if ranked in the top 25 percent of PCPs.
7. Bonus for demonstration of improvement	The PCP receives a bonus payment if the PCP demonstrates a statistically significant increase in the percent of age-appropriate female adult patients receiving a mammogram in the past two years. PCPs with rates over 90 percent also receive the bonus since further improvement above 90 percent might be extremely difficult to achieve.
8. Performance-based fee schedule	The PCP is paid 105 percent of the usual fee schedule if strong performance on several performance metrics distinguishes the PCP from other PCPs.
9. Compensation at-risk	The PCP forfeits a Medicaid fee schedule increase unless the PCP achieves the statewide Medicaid mean on several identified performance metrics.
10. Variable cost sharing	The member pays no pharmacy co-payment when receiving services from a PCP if strong performance on several performance metrics distinguishes the PCP from other PCPs.



Bonus Payments

One of the most commonly used forms of financial incentives is the bonus payment — a payment that is paid to providers in addition to the usual Medicaid fee received for providing covered services. The following examples highlight how two Medicaid agencies and one health plan have designed P4P programs that pay physicians a cash bonus for completing a specified requirement or achieving a certain performance threshold.

Oklahoma

SoonerCare Choice, Oklahoma's PCCM program, provides health care for low-income Medicaid-eligible pregnant women, children, and the SSI-eligible population. The state's P4P program is targeted at improving early periodic screening, diagnosis and treatment (EPSDT) rates for children by providing bonus payments to physicians completing EPDST requirements. Each year the state sets aside \$1 million for these bonus payments. Since the program began in 1997, the state has seen its EPSDT rates improve by more than 20 percent. In 2006, the average EPSDT bonus payout per doctor was just over \$2,800.

In addition to the EPSDT bonus payment, SoonerCare Choice physicians can also qualify to receive a payment of \$3 for administering the fourth dose of DPT/DTaP before a PCCM member's second birthday. The state has allocated approximately \$50,000 annually for these DPT/DTaP payments. The state found that having physicians self-report these immunizations resulted in relatively low participation in the program. Oklahoma has changed the process to an internal review of encounter data for payment verification. This is the same process used for validation of the EPSDT bonus calculations.

Pennsylvania

Pennsylvania's Access Plus program, the state's enhanced PCCM program, was created in March 2005. The program covers about 280,000 members in 42 counties.¹⁶ Access Plus is based on a medical-home model of complex case management for adults and children. As part of the program, the state contracts with a disease management vendor for several chronic diseases, including asthma, diabetes, chronic heart failure, chronic obstructive pulmonary disorder, and coronary artery disease. Pennsylvania decided to tie incentives to the Access Plus program to encourage primary care physicians to play an active, collaborative role with the disease management program.

The incentive program is structured so that physician offices that actively collaborate with the disease management vendor for patient management receive a bonus payment. Collaboration between physician offices and the disease management program was defined as assistance with enrollment of eligible patients into disease management programs; care management of enrollees; and delivery of key clinical interventions that improve quality of care and clinical outcomes. In the short time since the program has been in place, 350 physicians out of 2,767 network PCPs have participated in the Access Plus incentive program.

Table 3 outlines how Pennsylvania ties these activities to bonus payments.

¹⁶ Dual eligibles are excluded from the Access Plus program.

Table 3. ACCESS Plus P4P Incentives

Activity	Payment Amount	Frequency
Practitioner reviews and partners in the ACCESS Plus Program	\$200	One-time payment
Practitioner contacts newly eligible high-risk patients to encourage them to enroll in the program (contact can occur by mail, telephone or in person)	\$40/patient	Once per member enrolled
Physician locates and provides contact information for selected patients (as requested by the ACCESS Plus Disease Management staff)	\$30/patient for whom the office provides requested contact information	As requested
Physician completes Chronic Care Feedback Form. This form captures key clinical information (e.g., medications, most recent vital signs, lab values, goals, and patient education needs)	\$60/per completed form	Every 6 months
Physician receives payment for each instance when patient reports taking key medications for the target condition (year 1): <ul style="list-style-type: none"> • Congestive heart failure (CHF): beta blocker • Diabetes: aspirin • Asthma: a controller medication (persistent asthma) • Coronary artery disease (CAD): aspirin 	\$17/per patient	Every 12 months
Physician receives payment for each instance of patient compliance based on claims data of one lab or prescription per 12 months (year 2): <ul style="list-style-type: none"> • CHF: beta blocker • Diabetes: Measurement of LDL-C • CAD: statins • Asthma: a controller medication (persistent asthma) 	\$17/per patient	Every 12 months

Local Initiative Rewarding Results Project

Seven managed care plans in California participated in the Local Initiative Rewarding Results (LIRR) project, the largest collaborative pay-for-performance effort to improve the health of babies and teens in Medicaid. The project was part of a three-year national initiative of the Robert Wood Johnson Foundation and the California HealthCare Foundation to test financial performance incentives for physicians.

The combined participating LIRR plans served close to one million children and adolescents in nine counties. An interim evaluation was completed by Mathematica Policy Research in 2005.¹⁷ Since the project's implementation, the majority of plans have had mostly positive results in their HEDIS rates. For the plans that implemented new physician incentives:

- Two-year average HEDIS scores for the well-baby visit measure improved by 7.5 percent, to 27 percent between the pre- and post-demonstration periods.
- Two-year average HEDIS scores for the well-adolescent visit measure improved by 2.5 percent, to 10 percent between the pre- and post-demonstration periods.¹⁸

¹⁷ S. Felt-Lisk and F. Smieliauskas. "Evaluation of the Local Initiative Rewarding Results Collaborative: Interim Report." Mathematica Health Policy Research, Inc., August 2005. www.mathematica-mpr.com/publications/PDFs/evaluationlocal.pdf

¹⁸ Ibid.

One of the LIRR participants, the Inland Empire Health Plan (IEHP), a nonprofit based in California's Riverside and San Bernardino counties, is a veteran among Medicaid health plans in its use of physician incentives. The health plan's program focuses largely on preventive services, such as immunizations, well-child visits, and Pap smears.

IEHP first started using physician incentives in September 1997 to improve immunization rates for beneficiaries age 0 to 2 by reimbursing physicians for timely vaccines. Based on initial successes, in April 2000 IEHP expanded its physician incentive program to include incentives for well-child visits, adult physical exams, perinatal services, and health education behavioral assessments. Physicians were reimbursed \$50 for each well-child visit done in accordance with the IEHP well-child visit schedule for beneficiaries age 0-18 years. Exams completed during the first 120 days of enrollment earned an additional \$50 bonus.

IEHP reviews the incentive program each year to make sure incentives remain aligned with company goals. In 2004/2005, IEHP re-focused the program to address goals related to HEDIS results, including the addition of incentives for chlamydia and Pap testing, diabetes, and asthma care. IEHP's pay-for-performance efforts have helped increase the timeliness of preventive health services and improve HEDIS results. IEHP is now in the 90th percentile nationwide among Medicaid plans for well-child visits in the first 15 months of life and for timeliness of prenatal care and postpartum care. The plan also has the highest rate in California of adolescent well-care visits, and is in the 90th percentile nationally among Medicaid plans for immunizations.

Complimentary Incentive Models

Michigan, New York, and Rhode Island have each implemented programs targeting health plan performance that make use of both financial and non-financial incentive models.

Michigan: Health Plan Bonus/Withhold and Performance-Based Auto-Assignment

Michigan's Medicaid managed care program began in 1997. For almost 10 years, the state has implemented a two-pronged incentive strategy that includes a performance-based auto-assignment algorithm and a performance-based bonus/withhold for health plans. The following is an excerpt from the Michigan health plan contract:

During each Contract year, DCH will withhold .0015 of the approved capitation payment from each Contractor until the performance bonus withhold reaches approximately \$3.0 million dollars. These funds will be used for the Contractor performance bonus awards. These awards will be made to Contractors according to criteria established by DCH. The criteria will include assessment of performance in quality of care, enrollee satisfaction and access, and administrative functions. Each year, DCH will establish and communicate to the Contractor the criteria and standards to be used for the performance bonus awards.¹⁹

¹⁹ Michigan Medicaid managed care contract: Final FY06 MHP Contract Section II-Z.



Michigan's auto-assignment process is based on three performance categories (administrative, clinical, and financial) and three auto-assignment tiers. Health plans earn points based on their performance compared to the Michigan Medicaid average and the 50th National Committee for Quality Assurance (NCQA) percentile. Scores for each health plan are based on the assigned HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS®),²⁰ and administrative measures.²¹ Plans are assigned to one of three tiers (top, middle, or bottom). More auto-assignments are given to the top than the middle tier and so on. Michigan averages a 40 percent auto-assignment rate.

New York: Health Plan Bonus and Performance-Based Auto-Assignment

New York's state Medicaid managed care P4P program was developed in 2002 to augment capitation payments for managed care plans that had high rates of quality and consumer satisfaction. New York's program has two main components: a monetary quality incentive and auto-assignment algorithm based on scores that plans achieve on quality measures and health plan satisfaction. The combination of measures was selected to represent a mix of adult and children's measures as well as a combination of preventive, prenatal, and chronic condition measures. As with other states, the vast majority of the health plan quality measures are HEDIS or HEDIS-like measures.

New York Medicaid uses a scoring methodology for its quality incentive that compares the data from two years prior to the reporting year data. The satisfaction scoring is based on the performance of plans on the most recent survey and then is compared to the statewide averages. Based on these methodologies each health plan receives a sum for both the quality score and satisfaction score. This sum is referred to as the "quality incentive score." Based on this score, which has a maximum of 150 points (10 points per measure), each health plan has the potential to qualify for one of five levels of the incentive. In April 2005, the maximum financial incentive award to plans was an additional 3 percent of the premium; prior to that, the maximum bonus was 1 percent of the premium.²²

In April 2006, the New York Department of Health issued a Request for Applications for a new initiative, the Pay for Performance Demonstration Projects. Through this initiative, New York's Department of Health is funding five regional demonstrations that "will involve collaboration between multiple insurers and physicians as they work towards developing physician incentive programs designed to promote patient safety and quality of care."²³ As only a few states offer incentives at the individual physician level, the New York demonstration will inform other state policymakers where opportunities exist for public/private collaboration and how public-sector programs can best engage physicians.

²⁰ CAHPS, the Consumer Assessment of Healthcare Providers and Systems is a registered trademark of the Agency for Healthcare Research and Quality.

²¹ Michigan Medicaid managed care contract: Final FY06 MHP Contract Section II-F-2.

²² Bailit Health Purchasing, LLC. "Putting Quality to Work: Rewarding Plan Performance in Medi-Cal Managed Care," op. cit.

²³ New York State Department of Health, Office of Managed Care Bureau of Quality Management and Outcomes Research, Request for Applications: Pay for Performance Demonstration Projects. <http://www.nyhealth.gov/funding/rfa/0603130408/0603130408.pdf>

Rhode Island: Health Plan Bonus and Pass-Through Incentive to Providers

In 1998, Rhode Island's Medicaid managed care program, RItE Care, created a performance incentive program to improve quality and access to care, improve member satisfaction, and decrease overall medical costs. The state selected performance measures that reflected key areas of health plan performance as well as the age and gender of the RItE Care population. The measures cover the areas of administrative service, access, and clinical quality. Financial rewards are based on health plan performance on measures as well as the accuracy and completeness of the submitted data.

Originally many of the measures were Rhode Island-specific. Over time, the measures (especially the clinical measures) have evolved from being “home grown” to being based on HEDIS and CAHPS measures, which are externally audited and provide the ability to compare performance to national benchmarks. As Rhode Island has redesigned its Performance Goal Program, the Department of Human Services has focused on the importance of health plans linking RItE Care enrollees with a “medical home,” in which primary prevention and disease management are core principles. A health plan meeting or exceeding the NCQA 90th percentile for Medicaid receives full payment; if the 75th percentile is achieved a partial payment is awarded; and if a plan falls below the 75th percentile no incentive payment is given. Through the incentive program, the state has been able to leverage its purchasing power to obtain better access and quality for RItE Care enrollees.

In addition to health plan-level incentives, RItE Care also created a physician-level incentive program. Beginning in January 2005, the Medicaid health plan capitation rates included a bonus payment of \$0.95 per member per month to motivate primary care physicians to increase access to primary care and reduce inappropriate emergency room utilization. The state gives the supplemental payment to the health plans and requires plans to pass the incentive through to PCPs, based on a set of objectives submitted to and approved by the Department of Human Services. The PCP incentive methodology seeks to promote timely access to care (e.g., access to preventive care, access to urgent care, access to care during evening hours). The results of this physician pass-through are not complete, but state officials have been initially pleased with the plans' implementation of PCP incentives, citing one plan that used the money to reimburse practices that began extended hours.

4. What incentives are best suited to the target audience?

Once the state has articulated its goals for the P4P program, it must determine which incentives are best suited to the target physicians and P4P objectives — keeping in mind resource and financial constraints. States should not limit their consideration to financial incentives. Other strategies, such as physician profiling and publicizing performance, can serve as effective incentives for behavior change and are important alternatives or complements to financial incentives.

Even within a single organization, different incentives might be required to motivate behavior change. For example, an evaluation of an Iowa Medicaid managed behavioral health contractor incentive program revealed that, while a large bonus incentive payment might have been a strong motivator for behavior change for the contractor's corporate management, the state-level executive director appeared to

be more motivated by the obligation to present her attainment of quality improvement goals at a large public forum with physicians and consumer advocates.²⁴

Incentives should be meaningful and targeted at those who have the ability to effect the desired change. If a bonus is awarded to the health plan, but much of the work required to achieve the bonus must be performed by physicians, either the health plan or the state purchaser might want to ensure that the incentive is extended to physicians. Physicians should view the incentive(s) as meaningful relative to the effort involved to obtain the reward or recognition. Plans and purchasers should keep in mind that an incentive that is seen as meaningful to physicians in one region might not be as motivating in another. Similarly, the same reward strategy can be less effective with a solo practitioner than with a large group.

5. What performance measures and data should be used?

The selection of appropriate measures and data collection strategies is key to a successful P4P program. Physicians need a trusted source for valid, accurate, reliable, and actionable data to understand what kind of care they provide and to identify ways to provide higher-value care. States' review of measures and measurement strategies is an iterative part of the design process. In addition to selecting performance measures, states must:

- Determine the source of the data for the measurement;
- Determine how the measurement results will be generated and shared; and
- Engage physicians and other key stakeholders when identifying the appropriate measures.

States need to identify what performance measures are priorities, what data are available, when the data are available, and the reliability of the data in fairly assessing performance. In Medicaid P4P programs, states and plans can select performance measures to use in financial and non-financial incentives based on a number of factors, including:

- Relevance to the targeted Medicaid managed care population (e.g., maternal and child health versus aged, blind, and people with disabilities);
- Availability of standardized performance data;
- The frequency with which such performance data are available;
- Areas in which clear opportunities for improvement exist;
- Areas in which performance varies; and
- Relevance to the plan's priorities and/or the state's priorities, including those of the state legislature.

A measure's integrity rests in part on the integrity of the data used to generate it. Physicians' distrust of data integrity is frequently a reason for lack of physician engagement. Many P4P strategies rely on administrative data that are obtained from physician claims submissions. These data are attractive because they are relatively inexpensive to obtain, compared to medical chart abstraction. Yet, administrative data is subject to inaccurate coding and data entry errors and may not provide a full

²⁴ M.B. Dyer and M.H. Bailit. "Are Incentives Effective in Improving the Performance of Managed Care Plans?" Center for Health Care Strategies, March 2002.

picture of the quality of medical services. This can be especially true for services that were delivered but not billed.

A measure's integrity also rests on the ability of the state to ensure that the process being measured (e.g., delivery of beta blocker medication) and the population being measured are both large enough to generate statistically valid measures for most or all targeted physicians. The problem of "small numbers" is a constant concern when measuring physician performance.

Standardized Measures

When possible, states should select P4P measures from standardized, nationally-recognized measurement sets. By using available validated measures, states can shorten the length and cost of the design and development process, face fewer challenges in terms of processing decisions with physicians, and potentially lessen the need for testing and auditing of data. Physicians will be much more accepting of measures that are evidence-based and have been developed with the approval of national professional organizations. Identifying such measures may be difficult when addressing topics related to Medicaid special needs populations and long-term services and supports. In such instances, a state may opt to develop measures that might be more appropriate for its target population.

States should review provider performance measures endorsed by the Centers for Medicare and Medicaid Services, and national bodies, such as NCQA and the National Quality Forum (NQF), as well as standardized measures endorsed and collected at the state level. In developing performance measures, CMS works with NQF and NCQA, as well as the Joint Commission on Accreditation of Healthcare Organizations, the Hospital Quality Alliance, AQA (formerly the Ambulatory Care Quality Alliance), and medical specialty societies and other government agencies.

CMS' recently released "*Guide to Quality Measures: A Compendium*" is a compilation of nationally recognized quality measures.²⁵ States can use the guide to sort measures by target population, setting of care, disease or condition, or measure type. The compendium can decrease the amount of time states spend canvassing the field to determine which measures exist.

The AQA is working to find the best way to measure performance at the physician level; to collect and aggregate data in the least burdensome way; and to report useful information to providers, consumers and purchasers.²⁶ In April 2006, the AQA, now a 140-member public-private collaborative of physicians, consumers, purchasers, health insurance plans, and others, developed a set of 26 starter measures that apply to all physicians. Appendix D includes the AQA Recommended Starter Set Clinical Measures for Physician Performance. These 26 AQA measures address areas such as prevention/screenings, heart disease, depression, diabetes management, asthma, prenatal care, and measures addressing overuse and underuse. Many of these AQA measures are from a combination of existing standardized measurement sets, including HEDIS.

²⁵ "The Guide to Quality Measures: A Compendium" (Volume 1), Centers for Medicaid and Medicare Services. September 2006.
<http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/>

²⁶ <http://www.aqaalliance.org>

No matter which measurement set the state decides to use, it must work with health plans and physicians to identify a manageable number of measures that are based on data that are accessible and acceptable to all parties. Topics of interest to the state may not be addressed by existing measure sets, or existing measurement sets' criteria may need to be modified to address the Medicaid population or concerns of local physicians.

Risk Adjustment

Physicians will understandably be concerned if the state employs performance measures that will produce misleading results. A primary concern will be whether the measurement results should be adjusted to account for the relative burden of illness experienced by each physician's pool of patients. One way states can avert this problem is by selecting measures whose specifications do not call for risk adjustment (e.g., child immunization). In fact, many nationally accepted provider performance measures do not require risk adjustment. Should the selected measures require risk adjustment, however, it will be essential that the adjustment mechanism has been validated and is acceptable to those being measured. "Black box" adjustment methodologies will generally produce concern among physicians.

Internal Capacity for Measurement and Analysis

In considering measures for a P4P program, the state must determine how much internal capacity and infrastructure it has to collect, and then aggregate the data. Whether a P4P program includes new reporting requirements for health plans and/or physicians or uses existing data (e.g., HEDIS measurement results, administrative or encounter data), the Medicaid agency must manage the data to support the P4P objectives and timelines. Once a state understands its capacity to collect data and manage the data in a timely manner, it is better positioned to decide whether and to what extent to use existing measurement sources.

Health information technology (e.g., electronic medical records, registries, health information exchanges) can assist Medicaid agencies and health plans in collecting performance data. Several states have entered into partnerships with academic institutions experienced in information technology to enhance their capacity for analyzing and using data.

6. What are the best ways to engage physicians?

Engaging physicians is essential to developing and implementing an effective P4P strategy. Involving physicians in the P4P planning and decision-making process creates an opportunity to garner feedback from those who will be most affected.

Physician input is essential in determining what type and level of incentives would be meaningful, and what barriers to participation might exist. Some barriers to participation will be easily resolved, but others will not. It is worth asking physicians directly about what incentives they would find motivating, even if the state is not able to address some of the feedback. A P4P initiative without buy-in from physicians cannot succeed.

Communication Strategies

Physician communications must address 1) the rationale behind the incentive; 2) the science behind the measures and the reward algorithm; 3) the physicians who have endorsed the incentive; 4) what behavior change is expected of the physicians; and 5) what physicians might receive as rewards.²⁷ Some have cautioned that undue emphasis on external rewards can be seen as an affront to physicians' internal professional motivation.²⁸ For this reason it is important that payers emphasize that additional payments are a means to support doctors in their efforts to provide quality care, including extra activities such as patient outreach.

The challenge of creating awareness is formidable due to the volume of information sent to physicians daily. States should consider to what extent physician communication should be directed to individual professionals and/or to practice management personnel who have some control over clinical and management systems that can influence achievement of the rewards. Physician communication strategies typically have hard copy, e-mail and web components, as well as varying forms of face-to-face meetings with practitioners and practice administrators and "town meetings."²⁹

Creative Approaches to Communicating with Physicians

The Medicaid health plans participating in a recent P4P collaborative referred to as the Local Initiative Rewards Results (LIRR) program in California took a number of different approaches to physician communication. Kern Family Health Care required physicians to attend a mandatory learning session to become eligible to receive incentives. This strategy was an absolute success: 99 percent of the eligible physicians attended a learning session. For Kern and all of the LIRR health plans, raising awareness of the incentive and reward program "required creativity and sustained effort throughout the project."³⁰

Engagement Strategies

All purchasers struggle to secure buy-in and garner support for P4P efforts from physicians. Physician engagement issues can be even more challenging for state Medicaid programs. Common goals, mutual trust, and a good working relationship with physicians increase the likelihood of developing an effective P4P program. Without these elements, an incentive program can create animosity between states and physicians, without adding any significant value. For these reasons, it is important that payers engage physicians early in the design stage of any P4P program.

States should consider the following questions when developing approaches to engaging physicians:

- Which types of physicians drive quality in the areas most important to the state?
- Which physicians have already expressed interest in performance improvement or taken improvement action in areas of importance to the state?
- With which physicians is the state likely to have a collaborative relationship? The most leverage? Share common objectives?

²⁷ Bailit Health Purchasing. "Incentives and Rewards Best Practices Primer: Lessons Learned from Early Pilots." The Leapfrog Group with support from the Robert Wood Johnson Foundation and the California HealthCare Foundation, July 2006.

²⁸ H. Beckman, et al. "Physician Reactions to Quantitative Individual Performance Reports." *American Journal of Medical Quality*, 21, no.3 (2006): 192-199.

²⁹ G.J. Young et al. "Conceptual Issues in the Design and Implementation of Pay-for-Quality Programs." *American Journal of Medical Quality*, 20, no.3 (2005): 144-150.

³⁰ N. Highsmith and J.R. Rothstein. "Rewarding Performance in Medicaid Managed Care." Center for Health Care Strategies, Inc., March 2006.

- What are the current incentives and disincentives that physicians face relative to the desired behavior?
- What will be required of physicians in order for them to affect the desired behavior change and performance improvement?
- How can the state not only introduce new incentives, but also remove existing disincentives (barriers)?

To effectively motivate physicians to improve their performance, the number, range, and difficulty of targeted performance measures must be comparable to the power of the incentives being offered. Differences in health care markets and Medicaid programs can result in different perspectives on what is a meaningful incentive.

Choose Visible and Meaningful Improvement Objectives

Focusing on quality improvement projects that are visible and meaningful to physicians increases their motivation to respond to incentives. Demonstrating that a performance gap exists between actual (what is provided) and ideal (what should be provided) care can be an important motivator in getting physicians to participate in P4P projects.³¹ It is important, also, to make sure that targets are achievable. San Francisco Health Plan, a Medicaid health plan, structured incentive payments to recognize physician accomplishments and, at the same time, to show that opportunities to improve still existed. Along with an actual payment check based on goals met, the health plan sends a voided check with an amount the physician *could have received* had performance been better.

Ensure Sufficient Economic Reasons for Physicians to Engage

Incentive programs are more effective at engaging physicians when the P4P program affects a significant portion of a physician's business. There is no formula or clear consensus on exactly what portion of a physician's business is "significant" enough for a P4P initiative to be meaningful and effective. Similarly, there is no evidence that a financial reward must equal a certain percent of total physician payments to be effective in motivating behavior change, although many insurers believe this proportion to be 10 percent.³² The importance and level of financial rewards vary across and within physician groups and health care markets and is affected by other factors, such as physician resources, physician alignment with the goals of the P4P initiative, and any other concurrent and reinforcing state incentive strategies.

Evidence from commercial P4P experiences demonstrates that small financial incentives and contradictory public report cards by different sponsors with little market leverage are unlikely to be effective. States can obtain additional leverage by coordinating with other quality improvement initiatives locally and nationally. For example, targeting incentives to the same measures that are being used by commercial insurers or employers could enhance the effectiveness of the state's incentive strategy. If a state is interested in working through its managed care organizations to reach physicians, it may wish to encourage standardization of measures, targets, and reporting across plans.

³¹ Ibid.

³² S. Trude, M. Au, and J.B. Christianson. "Health Plan Pay-for Performance Strategies." *American Journal of Managed Care*, 12(2006): 537-542.

7. How does a budget-conscious state finance a Medicaid physician P4P initiative?

One of the first questions a state grapples with when developing a Medicaid P4P initiative is how to fund incentive or bonus payments. States have been creative in coming up with funds for financial incentives. States have used a variety of approaches, including:

- Budgeting a pool of dollars for bonus payments;
- Funding “challenge pools” where unearned bonus monies or unearned withheld capitation payments are paid out to those who excel on certain performance measures;
- Reallocating monies collected as penalties and redistributing them as financial incentives for performance;
- Linking rate increases to physicians meeting certain P4P participation or performance standards; and
- Withholding a portion of the managed care organization’s capitation payment, and paying it back later, contingent on performance.

However the incentive is financed, states must ensure that the funds are protected. Some states, including Connecticut and Maryland, saw the legislature appropriate funds that had been set aside for incentive payments for another purpose. Separate identification of bonus funds for incentives can actually increase their visibility and thus their vulnerability to reallocation. Budgeting of financial incentives will vary greatly between states, based in part on a state’s Medicaid budget process and the level of specificity related to certain line items in the budget. Medicaid staff developing financial incentives should consult with the state budget and legal staff regarding various financing options early in the P4P design process.

In developing a financing approach, states should carefully review CMS rules and policies for determining the federal match rate for incentive or bonus payments. Generally, when the payment is made as a component of the Medicaid payment for specific covered services, states receive federal financial participation at the federal medical assistance percentage rate for the state’s Medicaid program. Administrative services associated with P4P programs are generally matched at the 50 percent matching rate for administrative-related payments. Administrative services related to utilization and quality improvement activities for hospitals and managed care plans and for Medicaid management information systems might be eligible for enhanced federal match rates. States also need to consider how performance-related payments relate to federal limits on physician payments. Certain Medicaid service payments are bound by upper payment limits or actuarial certification of managed care rates, which can impact the state’s ability to establish specific P4P incentive payments.

States need to consider not only the financing of the incentives themselves, but also the funding for the development, implementation, and evaluation activities related to the P4P program. Some states have been able to obtain foundation funds, federal grants, or in-kind services to help defray P4P development and implementation costs. These funding sources rarely assist purchasers with funds for the actual incentive payments, however. Whatever the source of the funds for the P4P program, it is important to make a sober assessment of what will be required and where it will



come from before proceeding. Significant staff time and data analysis are required to complete the development and implementation phases of a new Medicaid P4P program. In addition, states need to consider, and possibly fund, ongoing post-implementation costs for evaluation and program refinement.

8. What regulatory issues are unique to Medicaid physician P4P initiatives?

States should carefully assess the regulatory issues involved in specific P4P programs. CMS has implemented an increasing number of innovative P4P strategies in Medicare and is supportive of state use of P4P strategies in Medicaid and SCHIP. In August 2005, CMS announced the Medicaid/State CHIP Quality Initiative and noted that quality-based payment strategies are an important component of this CMS Quality Initiative. In April 2006, CMS released a State Health Official Letter that responds to some common questions from states about Medicaid incentive programs.³³ Three key regulatory questions are summarized below.

1) Is a demonstration or request for a waiver necessary for a Medicaid P4P initiative?

A P4P program, on its own, does not typically require a Medicaid waiver. CMS might review a state's Medicaid P4P initiative as part of a state plan amendment or a Medicaid demonstration project application or amendment, through a waiver application or amendment, or other oversight mechanisms.

As noted in the CMS State Health Official Letter: "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."

States have broad flexibility, within federal regulations, to decide on medically necessary services that will be covered and rates that will be paid to physicians or plans. However, many P4P programs are implemented as part of an existing MCO or primary care case management program that operates under some type of waiver. Depending on the nature of the waiver and incentive program, a state might need to amend its waiver when implementing a new P4P program if the state is also changing other aspects of its managed care program.

Even if a waiver is not required for a state to implement a Medicaid P4P program, the state is likely to need a state plan amendment (SPA). In the SPA Preprint, CMS includes a section that relates to incentive rules that apply to managed care contracts. CMS applies the same principles to PCCM programs operated under state plan amendments."³⁴

³³ CMS Dear State Health Official Letter, April 6, 2006, (SHO #06-003), signed by Dennis G. Smith.

³⁴ CMS-PM_10120, Attachment 3.1F, OMB No. 0938-933. January 25, 2005.

2) Does a state have to concern itself with budget neutrality or cost-effectiveness issues in a Medicaid P4P program?

States with Medicaid waivers need to consider any financial changes related to P4P programs that could affect budget neutrality or cost-effectiveness requirements in their waivers. For example, federal law requires that states demonstrate budget neutrality or cost-effectiveness for 1115 demonstration waivers and 1915(c) home and community-based waivers. Federal law also requires that 1915(b) managed care waivers demonstrate cost-effectiveness. States may need to demonstrate a return on investment for their P4P program over the waiver period in order to maintain budget neutrality or cost effectiveness for their waiver program(s).

3) Are there upper limits on financial incentive payments in a Medicaid P4P initiative?

As CMS noted in its State Health Official letter (April 6, 2006), “Medicaid service payments are tied to efficiency, economy, and quality of care standards and in some cases are also bound by upper payment limits or actuarial certification of managed care rates, all of which would impact the ability of a state to establish such a payment.”

In Medicaid P4P programs at the health plan level, if the state withholds or puts a percentage of the capitation rate at-risk related to performance, the state needs to be able to demonstrate that the MCO capitation rate is still actuarially sound. If the state P4P program allows for incentive payments above the MCO capitation rate, the incentive payments, in total, cannot result in a payment to any plan above 105 percent of the MCO capitation rate.

In the State Plan Amendment Preprint, CMS applies risk incentive rules to PCCM programs operated without waivers. These incentive rules include the following limitation: “incentive payments to the PCCM will not exceed five percent of the total FFS payments for those services provided or authorized by the PCCM for the period covered.”³⁵

States designing PCCM P4P programs should also review other CMS requirements cited in the SPA Preprint that could affect financing of P4P initiatives. For example, there is a requirement that incentives must be made available to both public and private PCCMs and that incentives cannot be conditioned on intergovernmental transfer agreements.³⁶

³⁵ Ibid.

³⁶ Ibid.

9. What can states learn from Medicare's experience with its physician P4P demonstration?

The Medicare program has piloted various demonstration projects related to the use of incentives. While the Medicare hospital P4P initiatives have been operating the longest, states can also learn from the Medicare P4P initiatives focused on the physician group practice level.

CMS' Hospital Quality Initiative links 10 core performance measures with hospital payment rates. Hospitals that submit data to CMS on the selected measures receive a full payment update to their Medicare diagnosis-related group payments (0.4 percentage points higher than those facilities that do not submit the data.) The rate of participation in the initiative has been impressive. In FY 2005, 98.3 percent of eligible hospitals in the country submitted data and received the higher payment.³⁷

Another hospital demonstration, the Medicare Premier Hospital Quality Incentive Demonstration, affects 400,000 Medicare beneficiaries served by over 270 participating hospitals nationwide. The demonstration began in mid-2003 to reward and recognize hospital performance on a variety of acute care measures. The demonstration involves a CMS partnership with Premier, Inc., a nationwide organization of not-for-profit hospitals. CMS identifies hospitals with the highest clinical performance for each of five targeted clinical areas. Hospitals in the top decile for a given diagnosis are provided with a two percent bonus, while hospitals in the second decile receive a one percent bonus. Hospitals that fall below targeted baselines after year three are at risk for up to a two percent reduction in payment. Initial results indicate that the hospitals have been successful in improving performance in all five targeted clinical areas. Medicare awarded almost \$9 million in hospital incentive payments for the first year of the demonstration. CMS expects long-term savings related to the performance improvements, but the demonstration is not required to be budget neutral.

The Medicare Physician Group Practice (PGP) Demonstration, launched in April 2005, rewards physicians in 10 large group practices for efficiency and enhanced patient management. Early indicators of the PGP Demonstration suggest that the 10 participating multi-specialty group practices are "making strides in identifying Medicare patients with chronic, high-cost conditions and closing the gaps in their care."³⁸ The Medicare PGP Demonstration uses 32 measures that focus on preventive services and chronic conditions such as diabetes mellitus, congestive heart failure, and coronary artery disease. CMS sets performance targets for each group based on the growth rate of Medicare spending in the local market. Unlike the Medicare hospital P4P incentive, the PGP demonstration is required to be budget neutral to CMS. Performance payments may be earned if actual Medicare spending for the population assigned to the physician group is below the annual target. Performance payments are allocated between efficiency and quality, with an increasing emphasis placed on quality during the demonstration. CMS worked with physician groups to develop a consensus agreement around how the measures would be captured and used to assess performance and reward quality under the demonstration.

³⁷ Testimony of Herb Kuhn to the House Subcommittee on Health, Committee on Ways and Means. March 15, 2005. <http://www.cms.hhs.gov/apps/media/press/testimony.asp?Counter=1382>.

³⁸ S. Klein. "Issue of the Month: Medicare P4P Demo Pushes Physician Care for Chronically Ill." *Quality Matters: Pay-for-Performance in Medicare*. The Commonwealth Fund, September/October 2006.



In addition to the pilot demonstrations underway, over the past several years the Medicare Payment Advisory Commission has recommended that Congress adopt pay-for-performance programs for hospitals, home health agencies, physicians, and Medicare Advantage plans serving Medicare beneficiaries.³⁹

10. What can states learn from leading commercial-sector P4P initiatives for physicians?

The commercial sector has more experience with physician-level P4P initiatives than either Medicaid or Medicare. States should examine the approaches, measures, and lessons learned from these private sector physician P4P programs. Three of the most well known and successful commercial P4P endeavors at the physician-practice level are the California Pay-for-Performance Program, the Excellus/Rochester IPA Rewarding Results Initiative, and Bridges to Excellence.

California Pay-for-Performance Program

California insurers have been active in P4P initiatives for years. In California, part of the impetus for the collaborative P4P initiative was from physicians frustrated with conflicting report cards and bonuses issued by individual insurers based solely on internal physician claims data. Insurers were also willing to try a new approach, since the conflicting data and measures used in individual plan physician P4P programs reduced the effectiveness of any one insurer's physician incentives.

The Integrated Healthcare Association's (IHA) California Pay-for-Performance Program demonstrates the power of standardization to focus attention on quality and affect change. The IHA project is the largest P4P effort in the country, a collaborative involving seven California health plans, 225 physician organizations, and over 35,000 physicians serving more than 6.2 million commercial HMO enrollees. The health plans participating in the P4P program have developed a uniform performance measure set. These agreed-upon measures, developed with physician input, are aggregated across all participating health plans to evaluate and reward physician groups. This aggregation enhances the validity of the results and provides a better view of a physician group's performance than do isolated individual health plan reports.

IHA's P4P measures cover clinical quality, patient satisfaction, and investment in information technology. For 2006, the IHA initiative is measuring medical group performance related to childhood immunization status and use of appropriate medication for people with asthma, as well as nine other HEDIS-based clinical measures. The 11 clinical measures account for 50 percent of the total score.

³⁹ MedPAC. Report to the Congress: Medicare Payment Policy. March 2005.

All but one of the participating health plans base their incentive payments on the aggregate data set (as opposed to in-house-only data).⁴⁰ Because the physician groups are being evaluated along the same criteria by multiple plans, they can make rational, informed decisions about investing time, talent, and capital “knowing that their efforts will receive meaningful and reliable measurement and reward.”⁴¹

Since implementing the collaborative medical group scorecard and related P4P incentive programs, several IHA health plans have seen a 40 percent increase in patient visits and reduced hospitalizations, especially among patients with diabetes. Performance on clinical indicators reflects improvement over time. For example, between 2003 and 2005, mean medical group performance on breast cancer screening increased by 4 percent, cervical cancer screening increased by 6.9 percent, and HbA1c screening for diabetics increased by 7.6 percent.⁴²

Table 4. Integrated Healthcare Association Clinical Measures

IHA Clinical Measures	2003 Mean	2005 Mean
Breast Cancer Screening	64.4	68.4
Cervical Cancer Screening	62.4	69.3
Diabetes Care: HbA1c Screening	65.8	73.4

Excellus/RIPA Rewarding Results Initiative

Excellus and the Rochester Individual Practice Association (RIPA) represents a unique P4P collaboration between a health plan and a physician group. Excellus covers half of the Rochester area commercial market with about 300,000 members. RIPA includes 3,200 community physicians. Excellus agreed to shared-savings programs that contribute dollars to the RIPA Value of Care Plan, a P4P program. RIPA contributes its entire withhold pool, approximately 10 percent of the capitation from Excellus, to their pay-for-performance program. The Value of Care distribution to RIPA physicians is between 50 percent and 150 percent of their withheld contribution, based on performance and shared savings. The average P4P return for a RIPA primary care physician has ranged from \$4,000 to \$12,000.⁴³

RIPA physicians were involved in the development of the P4P program from the beginning. Physician communication and outreach was a key component. In addition to financial incentives, Excellus/RIPA developed timely performance reports to physicians, offices, and patients in a variety of forms based on HEDIS measures.

The Excellus/RIPA P4P program focuses on improving the management of patients with chronic diabetes, asthma, and heart disease, and acute sinusitis and otitis media, as well as mammography screening, patient satisfaction, and cost efficiency. The program provides physicians with performance reports three times a year. The

⁴⁰ S. McDermott and D. Yanagihara. “Advancing Quality Through Collaboration: The California Pay for Performance Program.” Integrated Healthcare Association. March 22, 2006. <http://www.ihha.org/wp020606.pdf>.

⁴¹ Ibid.

⁴² “Continued Quality Improvement in California Health Care Announced by Integrated Healthcare Association,” press release July 13, 2006. <http://www.ihha.org/071306.htm>.

⁴³ H. Beckman. “Can Underuse Measures Reduce Cost? The ROI for DM Using P4P.” Academy Health Annual Research Meeting, June 26, 2006. <http://www.academyhealth.org/2006/monday.htm>.

information is delivered to physicians, offices, and patients as status reports that encourage follow-up with the physician. Physician reports include a registry of eligible patients with diabetes, cardiac disease and/or asthma. Physician profiling is linked to educational programs.

Excellus/RIPA was the first Rewarding Results project to identify a positive return on investment (ROI). Table 5 includes RIPA's annual expenses and savings compared to a two-year rolling trend and ROI for 2003 and 2004.

Table 5. Excellus/RIPA Return On Investment Calculations — Diabetes and Coronary Artery Disease

	2003	2004
Expenses:	\$1.15 million	\$1.15 million
Savings on trend:	\$1.90 million	\$5.80 million
ROI:	1.6:1	5.0:1

The diabetes improvements produced approximately \$1.9 million in plan savings in 2003 (\$10.37 per member per month) and \$2.9 million in 2004 (\$17.70 per member per month). The coronary artery disease results produced almost an additional \$3 million in savings in 2004.⁴⁴

Bridges to Excellence

Bridges to Excellence (BTE) is the largest employer-sponsored effort that rewards and recognizes physicians for meeting quality benchmarks.⁴⁵ Purchasers have implemented BTE programs to reward physicians in 11 states and the District of Columbia. While at least a few state Medicaid agencies are considering developing a BTE or BTE-like approach, such a program has not been used by any Medicaid agencies to date.

The BTE initiative includes three physician recognition programs: Diabetes Care Link, Cardiac Care Link, and Physician Office Link.

Diabetes Care Link: BTE's diabetes program consists of a set of physician performance standards associated with diabetes processes and outcomes, such as HbA1c levels and blood pressure. Physicians can earn rewards by collecting and submitting data that demonstrates that they are providing high quality diabetes care. The standards were developed by NCQA and the American Diabetes Association.

Cardiac Care Link: BTE's cardiac program consists of a set of physician performance standards, such as blood pressure and lipid testing, associated with improved outcomes in patients with cardiovascular disease or who have had a stroke. NCQA evaluates physicians to determine if they meet the standards for three-year recognition through the Heart Stroke Recognition Program. The standards were developed by NCQA and the American Heart Association/American Stroke Association.

⁴⁴ R. Greene. "Positive ROI from Provider PFP Incentives in Diabetes Care: The RIPA Experience." Disease Management Colloquium. May 11, 2006.

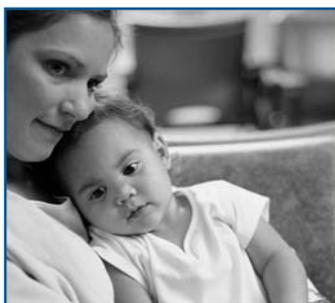
⁴⁵ http://www.bridgestoexcellence.org/about_us/home.htm

Physician Office Link: BTE's Physician Office Link is consistent with NCQA's office practice performance assessment program, the Physician Practice Connection. The program involves a set of standards associated with comprehensive systems in clinical information systems, patient education and support, and care management. Office practices are evaluated to determine if they meet the standards in each area. The program includes the following components: 1) access and communication; 2) patient tracking and registry functions; 3) care management; 4) self management support; 5) electronic prescribing; 6) test tracking; 7) referral tracking; 8) performance reporting and improvement; and 9) interoperability.

BTE has found that physicians who are recognized for providing high quality and more efficient care deliver it at a lower cost than physicians who don't participate. For the NCQA Diabetes Provider Recognition Program, BTE performed a comprehensive actuarial analysis that shows savings between 10 and 15 percent per patient per year. For NCQA's Heart Stroke Recognition Program, Towers Perrin performed an analysis that linked specific costs savings estimates to each performance measure with savings up to \$350 per patient per year. Additionally, BTE's estimates for NCQA's Physician Practice Connections measure of primary care physicians' data systems could result in savings up to \$110 per patient per year.⁴⁶

⁴⁶ BTE Operations Manual, January 2006. www.bridgestoexcellence.org.

Conclusion



As states become more sophisticated in their use of pay-for-performance strategies, many are considering not only how to motivate change at the practice site, but also how to use financial and non-financial incentives to improve the delivery of care in a variety of other settings and populations. As more states explore the use of innovative P4P incentive approaches at the physician level, Medicaid managed care programs are also expanding beyond traditional populations of pregnant women and children, giving increased attention to performance measurements for people with chronic conditions and their care management programs. Pennsylvania and Massachusetts are creating incentive programs targeting hospitals, and Oklahoma and Minnesota are exploring the use of incentives to improve nursing home care. Additionally, Medicaid health plans are beginning to use incentives to help build the infrastructure for sustaining quality by encouraging the collection of data, promoting the use of care and disease management programs, and supporting the application of health information technology.

P4P strategies should be conceived in the context of the broader quality improvement agenda. P4P is not a magic bullet and should not be used alone to motivate change. P4P, combined with other quality improvement mechanisms such as endorsing evidence-based guidelines, building multidisciplinary care management approaches, and working to engage consumers, is likely to have a greater impact on improving health care for Medicaid beneficiaries than any single approach. Similarly, a comprehensive P4P strategy should also include states, health plans, physicians, and other stakeholders working collaboratively to identify appropriate measures and to establish physician improvement goals.

The key to a successful Medicaid-focused physician-level incentive program rests in the state's ability to provide physicians with the tools and support needed to improve the quality of care for their patients. Each state has the responsibility to help physicians recognize opportunities for improvement, to develop incentives that motivate change, and to supply physicians with the support (e.g., technical assistance, health information technology) needed to improve the way health care is delivered. Medicaid, as one of the largest insurers in the country, has the opportunity to lead the field in testing various approaches to physician-level incentives and to evaluate the ability of incentives to improve care for the most vulnerable populations.

Appendix A: Pay-For-Performance in Medicaid: Selected State Activities

State	Contact Person	Program Start Date	Health Care Delivery Model				Individuals or Groups who are Eligible to Receive Financial Incentives				Non-Financial Incentive Strategies					
			Risk-Based Managed Care	PCCM	Medicaid FFS	Other	Health Plans	Hospitals	Providers	Members/Consumers	Perf Profiling	Publicizing Perf	Reducing Admin Req	Apply Sanctions	Offering Tech Assist	Other
CA	Don Fields dfields@dhs.ca.gov	2003	X				X Auto Assignment						X			
IA	Dennis Janssen djansse@state.ia.us	1999	X		X		X		X					X		
IL	Stephen Saunders steve.saunders@illinois.gov	PCCM-2007; Risk-Based Mgd. Care - 2006	X	X			X		X					X (RBMC)	X (RBMC)	
ME	Brenda McCormick brenda.mccormick@maine.gov	1998		X					X							
MI	Susan Moran morans@michigan.gov	1997	X				X						X			
MN	Vicki Kunerth vicki.kunerth@state.mn.us	Risk Based Mgd. Care - 2001; FFS-2007	X		X		X		X							X
NM	Sandra B. Chavez Sandrab.Chavez@state.nm.us	1997 with revisions in 2006	X				X							X		X
NY	Joe Anarella jpa02@health.state.ny.us	2001	X				X							X		X
OK	Lynn Mitchell lynn.mitchell@okhca.org	1997		X					X							X
PA	David K. Kelley c-dkelley@state.pa.us	Risk Based Mgd. Care - 2005; PCCM-2006	X	X			X		X					X		X
RI	Ellen Mauro emauro@dhs.ri.gov or Robyn Hoffman RMHoffman@dhs.ri.gov	Risk Based Mgd. Care - 1998; FFS-2002	X		X		X		X							X
UT	Gail Rapp GAILRAPP@utah.gov	1996	X				X						X			
WA	Barbara Lantz lantz@dhs.wa.gov	2005	X				X									X
WI	Gary Ilminen ilmingr@dhs.state.wi.us	2002	X				X							X		X

Appendix B: Agency for Healthcare Research and Quality P4P Checklist: 20 Questions for Purchasers to Consider

Phase 1. Contemplation

- ✓ Question 1. Is our community ready?
- ✓ Question 2. Should we partner with other purchasers or go it alone?
- ✓ Question 3. When and how should we engage physicians in P4P discussions?

Phase 2. Design

- ✓ Question 4. Which physicians should we target first? Hospitals or physicians? Specialists or primary care physicians?
- ✓ Question 5. For physicians, what are the advantages and disadvantages of targeting individual clinicians versus medical groups? In the case of hospitals, what are the advantages and disadvantages of targeting individual hospitals versus hospital systems?
- ✓ Question 6. Should physician participation be voluntary or mandatory?
- ✓ Question 7. Should we use carrots or sticks — bonuses or penalties — or a combination?
- ✓ Question 8. How should the bonus be structured?
- ✓ Question 9. Should we use relative or absolute performance thresholds?
- ✓ Question 10. What are our options for phasing in pay-for-performance?
- ✓ Question 11. Where do we find the money?
- ✓ Question 12. How much money should we put into performance pay?
- ✓ Question 13. What measure characteristics make them attractive candidates for inclusion in an initial measure set?

Phase 3. Implementation

- ✓ Question 14. How do we address physicians' concerns about whether risk adjustment adequately captures the severity of illness of their patients?
- ✓ Question 15. If we currently sponsor a private or public report card, will P4P offer more of an incentive? If we are considering both a public report and P4P, which should we pursue first?
- ✓ Question 16. Should we tailor pay-for-performance for subsets of a particular group of physicians, e.g., safety-net hospitals?
- ✓ Question 17. How should we think about pay-for-performance and its relationship to benefit design, including tiered networks?
- ✓ Question 18. Is there any special advice for Medicaid agencies and Medicaid managed care plans interested in pay-for-performance?

Phase 4. Evaluation

- ✓ Question 19. How can we tell if the P4P program is working?
- ✓ Question 20. What unintended consequences should we look for?

Source: "Pay for Performance: A Decision Guide for Purchasers." Agency for Healthcare Quality and Research, April 2006. <http://www.ahrq.gov/qual/p4pguide.htm>

Appendix C: Pay-for-Performance Resources

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D. Stewart. Pacific Business Group on Health. *Aligning Physician Incentives: Lessons and Perspectives from California*. September 2005.

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Appendix D: AQA-Recommended Starter Set Clinical Measures for Physician Performance

Prevention Measures	
1. Breast Cancer Screening*	Percent of women who had a mammogram during the measurement year or year prior to the measurement year.
2. Colorectal Cancer Screening*	The percent of adults who had an appropriate screening for colorectal cancer. One or more of the following: FOBT – during measurement year; Flexible sigmoidoscopy – during the measurement year or the four years prior to the measurement year; DCBE – during the measurement year or the four years prior; Colonoscopy – during the measurement year or nine years prior.
3. Cervical Cancer Screening*	Percent of women who had one or more Pap tests during the measurement year or the two prior years.
4. Tobacco Use [#]	Percent of patients who were queried about tobacco use one or more times during the two-year measurement period.
5. Advising Smokers to Quit*	Percent of patients who received advice to quit smoking.
6. Influenza Vaccination*	Percent of patients (50-64) who received an influenza vaccination.
7. Pneumonia Vaccination*	Percent of patients who ever received a pneumococcal vaccine.
Coronary Artery Disease (CAD)	
8. Drug Therapy for Lowering LDL Cholesterol [#]	Percent of patients with CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).
9. Beta-Blocker Treatment after Heart Attack*	Percent of patients hospitalized with acute myocardial infarction (AMI) who received an ambulatory prescription for beta-blocker therapy (within seven days of discharge).
10. Beta-Blocker Therapy – Post MI*	Percent of patients hospitalized with AMI who received persistent beta-blocker treatment six months after discharge.
Heart Failure	
11. ACE Inhibitor /ARB Therapy [#]	Percent of patients with heart failure who also have LVSD who were prescribed ACE inhibitor or ARB therapy.
12. LVF Assessment [#]	Percent of patients with heart failure with quantitative or qualitative results of LVF assessment recorded.
Diabetes	
13. HbA1C Management*	Percent of patients with diabetes with one or more A1C tests conducted during the measurement year.
14. HbA1C Management Control*	Percent of patients with diabetes with most recent A1C level greater than 9.0 percent (poor control).
15. Blood Pressure Management [#]	Percent of patients with diabetes who had their blood pressure documented in the past year at less than 140/90 mm Hg.
16. Lipid Measurement*	Percent of patients with diabetes with at least one low density lipoprotein cholesterol (LDL-C) test (or ALL component tests).

Diabetes (continued)

17. LDL Cholesterol Level (<130mg/dL)*	Percent of patients with diabetes with most recent LDL-C less than 100 mg/dL or less than 130 mg/dL.
18. Eye Exam*	Percent of patients who received a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the reporting year or during the prior year if patient is at low risk for retinopathy. A patient is considered low risk if all three of the following criteria are met: (1) the patient is not taking insulin; (2) has an A1C less than 8.0%; and (3) has no evidence of retinopathy in the prior year.

Asthma

19. Use of Appropriate Medications for People with Asthma*	Percent of individuals who were identified as having persistent asthma during the year prior to the measurement year and who were appropriately prescribed asthma medications (e.g. inhaled corticosteroids) during the measurement year.
20. Asthma: Pharmacologic Therapy#	Percent of all individuals with mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.

Depression

21. Antidepressant Medication Management*	Acute Phase: Percent of adults who were diagnosed with a new episode of depression and treated with an antidepressant medication and remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase.
22. Antidepressant Medication Management*	Continuation Phase: Percent of adults who were diagnosed with a new episode of depression and treated with an antidepressant medication and remained on an antidepressant drug for at least 180 days (6 months).

Prenatal Care

23. Screening for Human Immunodeficiency Virus#	Percent of patients who were screened for HIV infection during the first or second prenatal visit.
24. Anti-D Immune Globulin#	Percent of D (Rh) negative, unsensitized patients who received anti-D immune globulin at 26-30 weeks gestation.

Quality Measures Addressing Overuse or Misuse

25. Appropriate Treatment for Children with Upper Respiratory Infection (URI)*	Percent of patients who were given a diagnosis of URI and were not dispensed an antibiotic prescription on or three days after the episode date.
26. Appropriate Testing for Children with Pharyngitis*	Percent of patients who were diagnosed with pharyngitis, prescribed an antibiotic and who received a group A streptococcus test for the episode.

Source: <http://www.aqaalliance.org/performancewg.htm>

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