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PAY-FOR-PERFORMANCE IN STATE MEDICAID PROGRAMS

A SURVEY OF STATE MEDICAID DIRECTORS AND PROGRAMS

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ABSTRACT: Many health care purchasers are trying to link health care spending to quality and efficiency through pay-for-performance (P4P) programs. This report examines the current and planned P4P activities of state Medicaid programs, based on a survey and follow-up interviews with state Medicaid directors and their staffs as well as review of related documents. The authors found that more than half of states currently operate one or more pay-for-performance programs and nearly 85 percent expect to do so within the next five years. Health information technology is an important component of programs now in development. The report outlines the most common measures and incentives, discusses evaluation and reporting approaches, and provides detailed descriptions of each of the pay-for-performance programs. The findings should inform state governments and other stakeholders that are considering modifying or adopting pay-for-performance strategies.

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EXECUTIVE SUMMARY

A growing number of employers, health plans, and government programs are seeking to link their health care spending to quality care through pay-for-performance (P4P) activities. The Medicaid program is no exception: over the past several years, the number of state Medicaid pay-for-performance programs has dramatically increased, and all indications are that new programs and approaches will continue to be added.

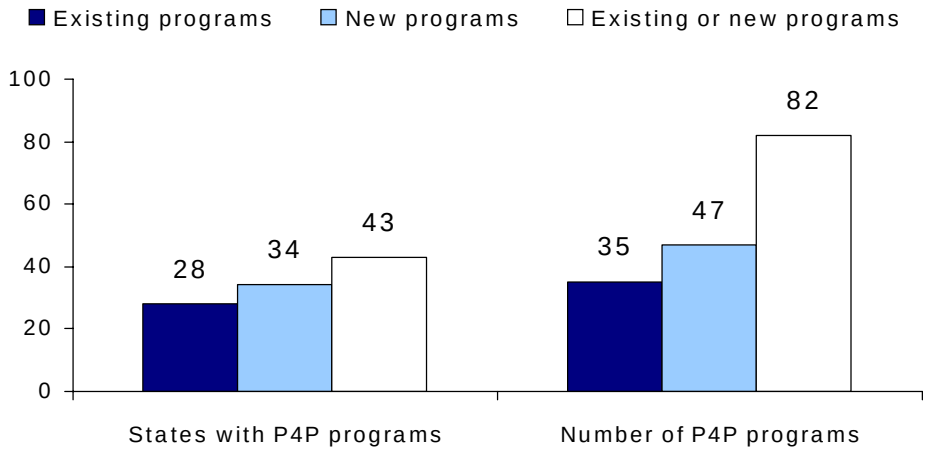
This report examines the existing and planned pay-for-performance activities of state Medicaid programs. It should inform state governments and other stakeholders that are considering modifying existing programs, implementing new ones, or coordinating their efforts. It focuses on programs that provide financial rewards not only for quality, but also for efficiency and other attributes.

The report is based on findings of a survey of all state Medicaid directors, follow-up interviews with Medicaid directors and their staffs, and review of documents received from the interviewees and on state Web sites. The study was conducted from mid-May through mid-October 2006, and reflects information that was current at the time.

Key Trends

- As of July 1, 2006, more than half of all state Medicaid programs were operating one or more pay-for-performance programs. Within the next five years, if all current plans to start new programs are realized, nearly 85 percent of states will be operating Medicaid pay-for-performance programs (Figure ES-1).

Figure ES-1. Count of States and Programs in State Medicaid Pay-for-Performance Programs



As of July 2006.

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, as well as information concerning existing and planned state Medicaid pay-for-performance programs from state Web sites.

- Medicaid is not a new entrant to the field of pay-for-performance: almost half of all existing programs are more than five years old. A similar percentage of programs began operations within the past two years. More than 70 percent of planned new programs are expected to start within the next two years.
- Seventy percent of existing Medicaid pay-for-performance programs operate in managed care or primary care case management (PCCM) environments, focusing on health care for children, adolescents, and women. While planned programs are still focused on managed care and PCCM providers, they appear to be shifting their emphasis to environments in which quality and cost issues related to chronic disease management can be better targeted. Rewarding the provision of primary care continues to be a component in the vast majority of Medicaid pay-for-performance programs.
- There are several noteworthy trends in planned new programs:

  - Nine Medicaid programs are joining with other payers, employers, consumers, and providers in statewide and regional pay-for-performance and quality improvement efforts. For example, the Oregon Health Care Quality Corporation, involving state government, health plans, medical groups, insurers, purchasers, providers, and consumers, is working to incorporate

standardized performance measures into their P4P activities. Several Medicaid directors in other states expressed an interest and willingness to join such efforts. The common principles and requirements emerging from these efforts should improve P4P programs around the nation by promoting consistency and stability. However, this movement toward the use of community and national standards may pose a significant challenge to some states, where many of the performance measures used are unique to the Medicaid program and its concerns.

- Health information technology (HIT) is a focus of numerous Medicaid pay-for-performance programs. Several Medicaid programs are "paying for participation," rather than "performance," in an effort to encourage providers to adopt electronic health records, electronic prescribing, and other technologies. For example, Alabama is offering reimbursement increases tied to provider participation in a program using technology to improve monitoring of patients with chronic diseases. HIT also has the potential to reduce data collection costs in P4P programs, which should allow P4P programs to expand into less-traditional venues.
- Several Medicaid directors were concerned that P4P activities might impinge upon beneficiaries' access to care by causing providers to leave the Medicaid program or limit the number of Medicaid beneficiaries served in their practices. This concern is shaping some of the approaches taken in pay-for-performance programs, particularly in states with large rural or sparsely populated areas. For example, South Carolina is offering increased reimbursement to providers who agree to establish a medical home for Medicaid beneficiaries.
- The vast majority of Medicaid directors reported that their priority in operating pay-for-performance programs is to improve quality of care rather than reduce costs. Some states are targeting specific aspects of care, such as the overuse of emergency department services. Maine's Physician Incentive Program ties 30 percent of a performance bonus to emergency department utilization measures.
- Few state Medicaid programs have conducted formal evaluations of their programs.

Measures and Incentives

Measures (the performance standards) and incentives (the ways in which states reward providers for good performance) used in state Medicaid programs vary widely. Some

programs include as few as one or two measures, while others include 10 or more. The complexity and number of incentives used in programs also vary, though not as substantially. Nonetheless, there are several commonalities and trends:

- Medicaid directors reported that they select measures for their pay-for-performance programs that they feel are best suited to address their specific improvement goals. It is important to them that measures are scientifically sound, feasible to collect, and regularly reviewed and updated.
- This study characterized the measures used in state Medicaid pay-for-performance programs into five types: Health Plan Employer Data and Information Set (HEDIS) and HEDIS-like measures; structural measures; cost/efficiency measures; measures based on patient experiences; and measures based on medical records. Using this categorization, the most commonly used measures in existing programs are HEDIS and HEDIS-like measures, followed by structural measures. Few programs use measures based on medical records, or review medical records in conjunction with other types of measures.
- The most common assessment methodologies in existing programs are attainment of a specified level of performance and degree of improvement. This continues to be the case with planned programs. Yet, in an effort to address shortcomings in each of these separate approaches, more than 40 percent of new programs are planning to include assessment methodologies that combine attainment and improvement goals for the same measures. To ensure a basic level of attainment is reached, Nevada established a bottom level of performance, beneath which no incentive payment is provided. Massachusetts is considering using incentives to reward attainment of specified levels of performance as well as improvement.
- This study characterized incentives into six types: bonuses; differential reimbursement rates or fees; penalties; auto-assignment of beneficiaries to a plan or provider; withholds; and grants. While not technically a financial incentive, auto-assignment is included as a pay-for-performance incentive because it drives market share and, therefore, compensation. Most Medicaid directors said that bonuses and differential reimbursement are the most effective types of incentives, and the types of incentives planned for new programs are consistent with this assessment. In existing programs, penalties are the second most common type of incentive. Medicaid directors thought that penalties were the least effective incentive and, in fact, could be detrimental to a pay-for-performance program. Only two new programs are currently planning to include penalties.

- A few states are offering grants rather than performance-based pay. New York is offering five grants for pay-for-performance demonstration projects, while Pennsylvania allows hospitals to compete for grants to support quality-related investments.
- Many pay-for-performance programs include non-financial incentives in addition to financial incentives. The most common of these is public reporting of performance.
- Some states are directly emphasizing physician performance—both primary care providers and specialists—in their pay-for-performance programs. Primary care case management programs in several states, among them Alabama, Louisiana, and Pennsylvania, provide incentives directly to participating providers.

Medicaid directors raised concerns about the potential unintended consequences of pay-for-performance programs. In particular, they feared that: providers might steer beneficiaries with complicated conditions away from their practices; providers might decide to leave the Medicaid program if the wrong kinds of incentives (primarily penalties) were included; and mandatory participation in pay-for-performance might, in and of itself, result in providers leaving the program.

Conclusions

Medicaid directors and their staffs generally report positive feedback on their pay-for-performance programs and believe that the overall quality of care being provided is improving, although they have mixed opinions about cost savings resulting from the programs. Directors are considering changing some of the measures, incentives, and even the data collection strategies to improve their existing programs and to shape planned programs. Overall, they believe that pay-for-performance is adding to their repertoire of tools to improve the care provided to their Medicaid populations.

As state governments and other stakeholders move forward with pay-for-performance activities, several challenges will need to be addressed. For example, the growing trend toward collaboration among health care purchasers and other stakeholders may present competing priorities. Medicaid programs will need to consider the particular needs in their own states—including ensuring access to care, promoting high-quality prenatal and postpartum care, and addressing the needs of beneficiaries with chronic conditions—as well as broader community and national standards. The expansion of HIT will provide opportunities for more precise and comprehensive measurement and more efficient data collection, making it easier to satisfy the demands of all stakeholders.

Ultimately, the biggest challenge facing both state Medicaid P4P programs, and those operated under other auspices, is to determine their effectiveness. Given that individuals change providers and may lose coverage altogether, and that standards of care change over time, this is difficult to do in any environment. However, Medicaid programs operate in a public setting. To the extent that Medicaid directors believe that pay-for-performance is improving care and reducing inappropriate spending, it is important that quantifiable and reliable results are available to demonstrate the value of continuing the financial investment that states are making in these programs.

PAY-FOR-PERFORMANCE IN STATE MEDICAID PROGRAMS

A Survey of State Medicaid Directors and Programs

INTRODUCTION

Historically, revenue generation in the health care system has been tied to the quantity—rather than the quality or effectiveness—of work performed. In fact, in some instances, revenue is generated when additional procedures are needed to correct previous errors or omissions.

Pay-for-performance, or P4P, is an approach to reimbursing health care providers that is designed to alter this paradigm. As costs escalate rapidly, large purchasers of health care services—employers, health plans, and government programs—are embracing pay-for-performance in an effort to link health care spending to quality and use limited financial resources more effectively. For example, a study recently published in the *New England Journal of Medicine* showed that more than half of a representative sample of commercial health maintenance organizations, covering more than 80 percent of individuals enrolled, incorporated pay-for-performance in their contracts.[1]

Among the most well-known programs in the private sector are:

- *The Leapfrog Group:* This is a nationwide group of health care purchasers dedicated to encouraging public reporting of health care quality and outcomes, rewarding doctors and hospitals for improving the quality, safety, and affordability of health care, and helping consumers make smart health care decisions. In 2005, Leapfrog initiated a hospital rewards program focusing on five clinical areas that account for a significant share of inpatient hospital admissions and costs.[2]
- *Bridges to Excellence (BTE):* Bridges to Excellence is a multi-state, multi-employer organization created to encourage improvements in the quality of care by recognizing and rewarding health care providers who deliver safe, timely, effective, efficient, and patient-centered care. BTE currently operates three rewards programs, one each in the areas of cardiac care, diabetes management, and physician office practice management.[3]
- *Integrated Healthcare Association:* The Integrated Healthcare Association (IHA), a coalition of health care purchasers and providers in California, initiated its pay-for-performance program in 2003. Working with coalition members, consumers, and

other health care experts, IHA established performance measures in three areas: prevention and chronic care, patient satisfaction, and information technology investment. Over 225 physician organizations now participate in the IHA pay-for-performance program.[4]

The Centers for Medicare and Medicaid Services (CMS) is encouraging similar efforts and has initiated several P4P programs in its Medicare program, including the following:

- *Premier Hospital Quality Incentive Demonstration:* This three-year project rewards participating hospitals for their performance on 34 measures related to five conditions: acute myocardial infarction, heart failure, community-acquired pneumonia, coronary artery bypass graft, and hip and knee replacement. Currently, more than 260 hospitals are participating. Hospitals performing in the top 10 percent in a certain area receive a 2 percent payment bonus for services provided to patients with that condition; hospitals in the second 10 percent receive a 1 percent bonus.[5]
- *Physician Group Practice Demonstration:* This is the first physician pay-for-performance program in Medicare. It rewards physicians for improving the quality and efficiency of services provided. The 10 large physician group practices included in the demonstration are able to earn financial rewards if they achieve savings in comparison to a control group and/or meet quality performance targets or improvement levels.[6] Early experience shows that the participating group practices are responding to the incentives built into the program by, for example, expanding data systems, care management programs, coordination-of-care efforts, and other interventions that are not directly reimbursed through the fee-for-service system.[7]

While Medicare is strictly a federal program, the Medicaid program is a partnership between the federal government and the states, with each state having significant independence in program design and operation. As such, many states have taken the initiative to start pay-for-performance programs unique to their situations. Moreover, CMS has been promoting quality and value-based purchasing through its Medicaid/State Children's Health Insurance Program (SCHIP) Quality Initiative.[8]

Over the past several years, the number of state Medicaid pay-for-performance programs has dramatically increased, and all indications are that new programs and

approaches will continue to be added. This report describes the activities of state Medicaid programs and the tools they are using to promote quality and efficiency of care. It can be used as a reference for states considering modifying existing programs or creating new ones; it can also be used by stakeholders that may be considering partnering with states in P4P initiatives.

For this study, we used the CMS definition of pay-for-performance as the "use of payment methods and other incentives to encourage quality improvement and patient-focused high value care."[9] We considered programs that provide financial rewards not only for quality, but also for other types of efficiencies and attributes in which state Medicaid programs have demonstrable interests.[10]

The report is based on findings of a survey of all state Medicaid directors, follow-up interviews with Medicaid directors and their staffs, and review of documents received from the interviewees and on state Web sites. It is based on a snapshot of activities at a point in time. Undoubtedly, some of the programs described will have changed—in fact, some changed during the course of the study. Moreover, some plans for new programs may have been abandoned, and new detail for others may now be available.

Of course, the depth and breadth of information available about existing programs are far greater than what is available for new or planned programs. While some state respondents were able to provide definitive information about the measures, incentives, and providers in their new programs, others were only able to report what types of program components were being considered. The tables in Appendix A make this distinction clear by identifying program characteristics that are only under consideration with a "(c)." Throughout the report, however, information on "new" programs incorporates data on programs for which there is definitive information, as well as those where aspects are only under consideration. When reporting numbers and proportions, we included states and programs for which we had information on the particular subject. Total counts ("n") are noted in the figures and tables.

Information about the number and characteristics of existing and new pay-for-performance programs can be found in the sections "Number of Current and Planned Pay-for-Performance Programs" and "Pay-for-Performance Program Components." The last section, "Perspectives on Medicaid Pay-for-Performance," focuses on the opinions of state Medicaid directors and their staffs concerning pay-for-performance. Appendix A includes summary tables that can be used for quick reference to determine which states

have pay-for-performance programs with specific characteristics. Appendix B is a compendium describing existing and new programs on a state-by-state basis.

Study Methodology

Data collection consisted primarily of written questionnaires and in-depth telephone interviews and was conducted between May 2006 and October 2006. Questionnaires were mailed as well as sent via e-mail to state Medicaid directors in 49 states and the District of Columbia in mid-May.[11] Directors who responded to the written questionnaire were then contacted for a follow-up telephone interview.

These interviews, averaging 75 minutes in length, were conducted with Medicaid directors and/or their staff members during the period mid-June 2006 through mid-October 2006. Many of the interviews were group conference calls, as initial respondents added staff members with specific expertise to the discussion. Follow-up calls and communications were conducted as necessary to clarify information. In addition, information from state Web sites and written documents were reviewed.

In total, Medicaid directors and/or their staffs in 38 states responded to the written questionnaire and 36 participated in the follow-up interviews.[12] Three state Medicaid directors, while not participating in the written survey or follow-up interview, indicated that their state was not operating or currently planning to implement pay-for-performance programs. Sufficient detail was available publicly concerning six additional states to include them in the report. State Medicaid directors were informed at the beginning of the study that a report would be published and, except where noted, the program descriptions included in Appendix B were verified by state staff. In total, data from 47 states, representing $296 billion or 97 percent of total Medicaid expenditures (FFY 2005) and 96.3 percent of the nation's Medicaid beneficiaries (as of December 2004), were incorporated in the report.[13]

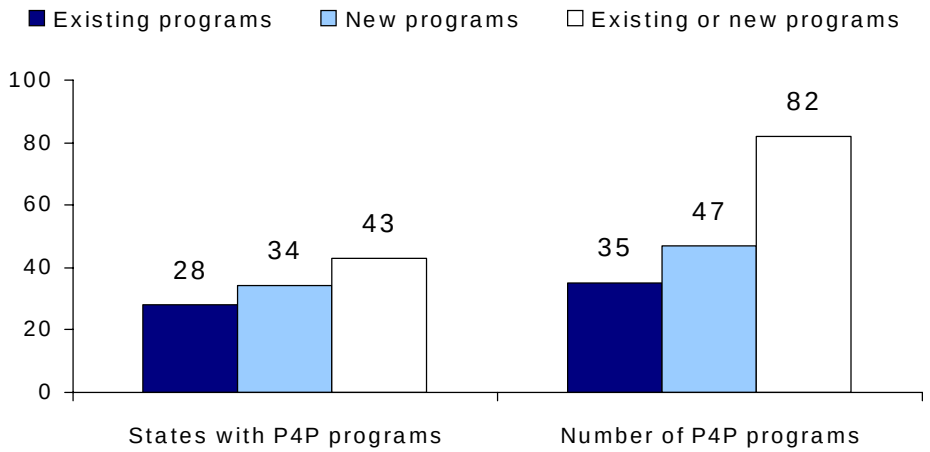
NUMBER OF CURRENT AND PLANNED PAY-FOR-PERFORMANCE PROGRAMS

Within the next five years, 85 percent of state Medicaid agencies will have incorporated pay-for-performance programs. As of July 1, 2006, 28 state Medicaid agencies are currently operating one or more pay-for-performance programs (19 of which are planning additional new ones in the next five years). Fifteen state Medicaid agencies plan to start their first programs during that same period.[14] Of the remaining eight states, state staff in

four states reported that they are not operating an existing, nor planning a new, pay-for-performance program. Information is not available for the final four.

State Medicaid programs often operate more than one pay-for-performance program. Five years from now, by 2011, if all planned programs begin, there will be a total of 82 programs (Figure 1).[15] Except for one state that eliminated the pay-for-performance component of its disease management program, states with existing programs are continuing them, and fine-tuning their measures and incentives.

Figure 1. Count of States and Programs in State Medicaid Pay-for-Performance Programs

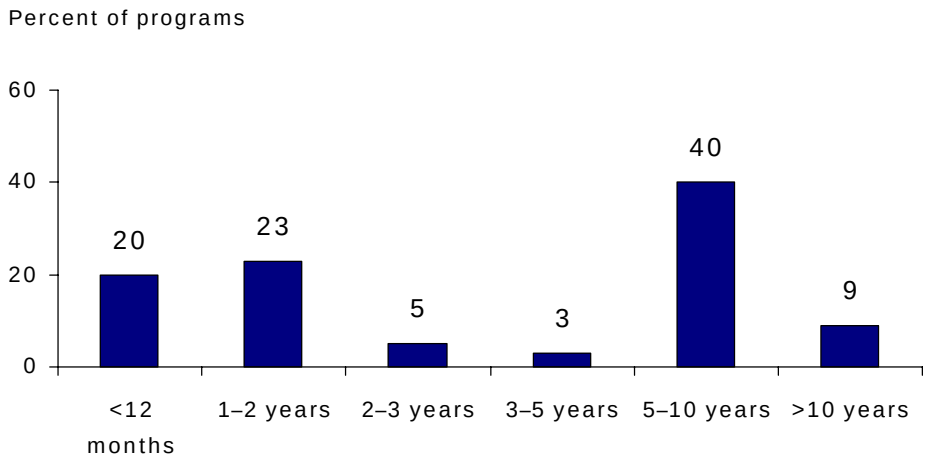


As of July 2006.

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, as well as information concerning existing and planned state Medicaid pay-for-performance programs from state Web sites.

Medicaid programs have been involved with pay-for-performance for a significant period of time, as evidenced by the fact that almost 50 percent of existing programs have been in operation for more than five years. A slightly smaller percentage of programs have started within the last two years. Only a very small number started more than two and less than five years ago (Figure 2).

Figure 2. Age of Existing State Medicaid Pay-for-Performance Programs

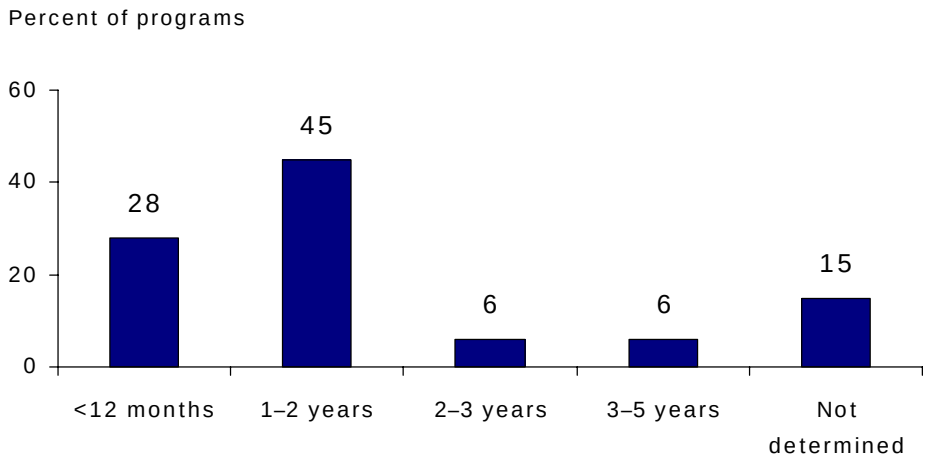


As of July 2006 (n=35).

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, as well as information concerning existing state Medicaid pay-for-performance programs from state Web sites.

Nearly three-quarters of all new programs are targeted to begin within the next two years and an additional 12 percent are targeted to start in the next two to five years. The remaining 15 percent of new programs that do not have a specific target date are largely those involving collaboration with other stakeholders and are in their early stages. The combination of these two factors makes it difficult for state staff to estimate a start date, but it is not unreasonable to assume that these programs are likely to begin operations within five years (Figure 3).

Figure 3. Targeted Start Dates for New State Medicaid Pay-for-Performance Programs



As of July 2006 (n=47).

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, as well as information concerning planned state Medicaid pay-for-performance programs from state Web sites.

PAY-FOR-PERFORMANCE PROGRAM COMPONENTS

In collecting data for this study, particular attention was paid to the three major components of pay-for-performance programs: 1) providers affected; 2) measures used; and 3) incentives incorporated. In addition, we were interested in how data were collected and validated and to what extent program evaluations had been conducted.

The following sections describe findings in these areas, combining results of the interviews held with Medicaid directors and their staffs with information concerning existing and planned state Medicaid pay-for-performance programs collected from state Web sites and written documentation provided by state officials.

Providers Included in Pay-for-Performance Programs

Managed care programs are the most common type of provider currently engaged in pay-for-performance, both in existing and new P4P programs (Table 1).

Table 1. Provider Types in State Medicaid Pay-for-Performance Programs

Provider Type	Existing Programs	New Programs
Managed care	20	14
PCCM	5	2
Nursing home	3	3
Other providers	3	2
All providers	0	2
Primary care	2	9
Behavioral health	2	3
Hospital	1	4
Clinic	0	1

Notes: As of July 2006. Some programs affect multiple provider types. Eleven new programs have not yet identified provider types. PCCM refers to primary care case management providers.

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, as well as information concerning existing and planned state Medicaid pay-for-performance programs from state Web sites.

Medicaid directors and their staffs cite a number of reasons that their states entered the pay-for-performance arena through the managed care venue:

- Most managed care organizations routinely report the type of data that can be fairly easily incorporated into a pay-for-performance program. For example, one of the most common sets of measures used in state Medicaid P4P programs is the Health Plan Employer Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA) specifically for managed care organizations.
- Most Medicaid beneficiaries are enrolled in some form of managed care delivery system, and the proportion of enrollment continues to increase. In 2000, 55.8 percent of all Medicaid beneficiaries were enrolled in managed care; by December, 2004, this percentage had increased to 61.3 percent.[16] Moreover, with many states requiring their beneficiaries to enroll in managed care programs, which can be perceived as limiting a beneficiary's choice of provider, there is frequently pressure to demonstrate that services provided in these restricted environments are of high quality, accessible, and cost-effective.
- All Medicaid directors expressed concerns about ensuring appropriate access to care. Managed care organizations are often more successful at recruiting and retaining providers to serve the Medicaid population than are states in the fee-for-service environment. In other words, providers in managed care networks may be less

likely to be driven away from participating in Medicaid due to the implementation of P4P programs than would providers in other care environments.

- It is less complicated to update a contract with one or more managed care plans to reflect pay-for-performance requirements than it is to modify the conditions of participation and individual provider agreements that affect all fee-for-service providers. Similarly, managed care organizations are more likely to have sufficient administrative staff to meet the demands of pay-for-performance measurement than are fee-for-service providers.
- Some states could afford to provide incentives only to a portion of their providers. For many of the reasons cited above, managed care organizations were, therefore, chosen to be the first to be included in P4P programs.
- Most managed care plans are quite familiar with pay-for-performance, having been involved with employer contracts containing quality of care incentives and/or operating P4P programs of their own with contracted providers.

Primary care case management (PCCM) programs are the second most prevalent provider type included in existing P4P programs. Most of these programs operate in states that either have no managed care programs or relatively small ones, and enrollment in them can be mandatory. Like managed care programs, PCCMs often have networks and related administrative capabilities that make it easier to establish pay-for-performance programs in these environments than in regular fee-for-service settings. Nonetheless, only two new programs are planned in PCCM settings, perhaps a function of the proportionately smaller number of PCCM programs and enrollees nationwide.[17]

A relatively small number of existing pay-for-performance programs operate directly with primary care physicians, hospitals, nursing homes, clinics, and behavioral health programs, although the numbers and proportions are increasing as new programs are developed. Of particular note is the fact that more states are planning to include physicians directly in their P4P programs, and several states are adding specialists in addition to primary care physicians, resulting in the number of P4P programs directed at physicians increasing from two existing programs to nine new programs.

With the type of providers to be targeted in 11 new programs not yet determined, it is difficult to discern additional reliable trends based solely on the numbers and types of programs. It does appear, however, that greater emphasis is being placed on settings other than managed care. One reason for this shift could simply be that managed care

organizations are so heavily represented in existing programs that there are fewer opportunities to initiate new ones.

However, the absolute number of new programs being planned in hospital, behavioral health program, and "all" provider settings, combined with the trend we see in the types of measures being used in new programs, appears to signal a growing interest in directing pay-for-performance programs to chronic care issues.[18] A shift from managed care to other provider types would be consistent with this trend, since the most severely disabled and chronically ill individuals are frequently exempted from managed care enrollment or have services related to their chronic conditions that are provided outside of their managed care plan. Interestingly, however, there are no existing or new programs involving home health agencies, a provider sector that provides a significant proportion of Medicaid-covered care to the chronically ill.

Several other developments should be noted:

- Medicaid programs in nine states are participating in statewide and regional efforts to promote the delivery of cost-effective, high-quality health care, and directors in several other states expressed interest in doing so. In many cases, stakeholders (governments, health care plans, providers, payers, employers, and consumers) are working to develop one set of requirements or common principles to guide health care improvement and related pay-for-performance programs. These approaches hold out the promise of having P4P programs focusing consistent attention on particular measures and, possibly, incentive types. These efforts should reduce duplicative and/or competing requirements and could reduce record keeping and result in more reliable data in the long term. However, the consensus development process that is inherent in these types of activities will probably lengthen some of the time frames needed to establish new programs (Table 2 and Table 5; Appendix A).

Table 2. State Medicaid Programs Participating in Multi-Payer Pay-for-Performance Activities

State	Program Name
Arizona	Health-e Connection Roadmap
Kansas	Multi-Payer Program
Maine	Maine Quality Forum
Minnesota	Smart-Buy Alliance
New Hampshire	Citizen's Health Initiative
New York	Regional Pay-for-Performance Grant Program
Oregon	Oregon Health Care Quality Corporation
Vermont	Vermont Blueprint for Health
Washington	Multi-Payer Program

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, as well as information concerning existing and planned state Medicaid pay-for-performance programs from state Web sites.

- One example of a program involving multiple heath care purchasers, which also incorporates measures related to health information technology, is Arizona's Health-e Connection program. By establishing an electronic health record database, this program is laying the groundwork for a possible P4P program. Moreover, the state may promote participation in the initiative by providing grant funding. Through a Web-based database, providers will be able to access consolidated information such as laboratory results, health plan enrollment data, and prescription drug usage. Built with appropriate privacy protections, this database will be available to all participating providers and will have obvious benefits, such as allowing doctors in hospital emergency departments to know what services and tests have been provided to patients in other health care settings.

- At least one state director cautioned that different patient mixes may require differing pay-for-performance approaches. For example, Medicaid programs are often more concerned about access to care than are other payers. Similarly, because Medicaid programs support almost 40 percent of all births in the United States, they are likely to be more concerned about prenatal and postpartum care than other payers. Coordinated programs that incorporate some variation within their overall framework may be needed to address such concerns.

- Health information technology (HIT) is at the core of several new pay-for-performance programs (Table 3). To promote adoption of HIT, some states are establishing "pay-for-participation" rather than "pay-for-performance" programs, often supporting the development of an HIT infrastructure that rarely exists in environments outside of

managed care. Such activities should enhance the ability of states and other payers to expand their pay-for-performance activities into these settings. In addition, HIT has the potential to increase the capability of providers to deliver better patient care.

Table 3. Health Information Technology in State Medicaid Pay-for-Performance Programs

Existing Programs	New Programs
Alabama	Alaska
Pennsylvania	Arizona
	Massachusetts
	Minnesota
	New York
	Pennsylvania
	Utah

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, as well as information concerning existing and planned state Medicaid pay-for-performance programs from state Web sites.

Alabama's Patient First program is an example of how pay-for-participation related to HIT can be incorporated in a pay-for-performance program. Through the local Blue Cross plan's electronic database, primary medical providers participating in the Alabama Medicaid program receive patient-specific drug, office visit, and laboratory result information, as well as information comparing practice patterns to those of their peers. The in-home monitoring program for chronically ill patients uses telecommunications equipment to alert medical providers that follow-up is needed either because monitoring results are outside of established parameters or were not reported at all. The monthly case management fee includes specific reimbursement increases tied to participation in these programs.

- Pay-for-participation is also being seen in other types of programs. Several states are rewarding providers for specific activities, such as reporting to immunization registries, using practice management tools, and offering patient education programs. Medicaid directors and staff reported that they incorporated these pay-for-performance approaches for two major reasons: they believe that the activities themselves should improve care and that the period between conduct of the activity and the reward can be relatively short.
- New York and Iowa are issuing requests for proposals to solicit pay-for-performance concepts from the provider industry. Under this strategy, they are widening the field from which new program ideas could be generated, creating opportunities for new programs and provider combinations they might not otherwise have considered.

Measures

Measures used in state Medicaid programs vary widely. Some programs incorporate as few as one or two measures, while others include 10 or more. Medicaid directors reported that they select measures for their pay-for-performance programs that they feel are best suited to address their particular improvement goals. These goals are frequently state-specific and can vary dramatically, depending on local conditions. Choosing measures also necessarily requires consideration of the types of data available and possible methods of collection and validation, issues that are discussed later in this report.

Types of Measures

This study categorizes the types of measures used in P4P programs into five main types: Health Plan Employer Data and Information Set (HEDIS) and HEDIS-like measures; structural measures; cost/efficiency measures; measures based on patient experiences; and measures based on medical records. The following discussion defines each type of measure and comments on the use of the measure in state Medicaid pay-for-performance programs (Figure 4).

HEDIS and HEDIS-like measures. HEDIS is a set of standardized performance measures sponsored, supported, and maintained by the NCQA, which is the major accrediting body for managed care organizations. HEDIS measures are related to significant public health issues, largely concerning preventive and primary care, and to many chronic diseases.[19]

We use the term "HEDIS-like measures" to identify measures that are similar to those maintained by NCQA. Among the measures included in this categorization are those related to the federally mandated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, Medicaid's comprehensive and preventive child health program for individuals under the age 21. EPSDT measures are unique to the Medicaid program, and are included in this category because the mandated state reporting covers many of the same areas—such as well-child and adolescent well-care visits—as do the HEDIS measures.

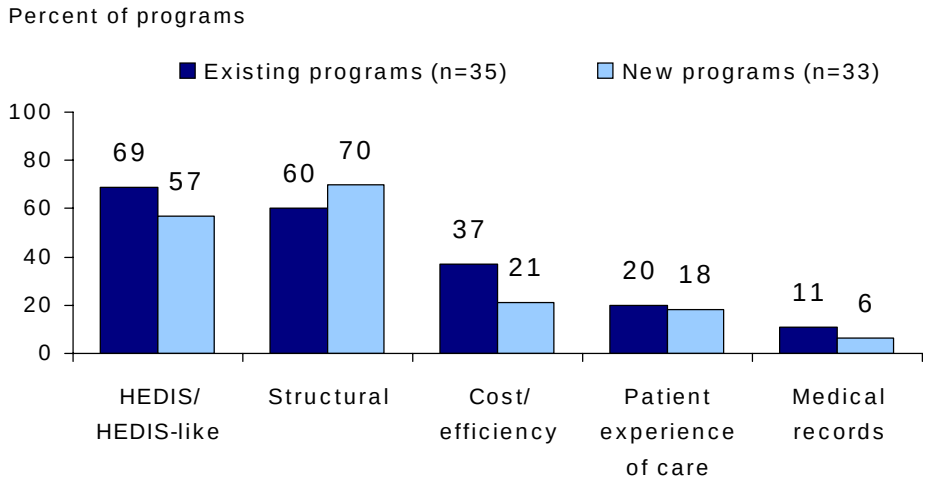
Other examples of HEDIS and HEDIS-like measures that state Medicaid programs use in their P4P programs include:

- childhood immunization rates;
- timeliness of prenatal care;
- comprehensive diabetes care measures;

- use of appropriate medications for people with asthma;
- various types of cancer screening; and
- assistance with smoking cessation.

Medicaid directors indicate that, overall, HEDIS measures are the most commonly used measures in existing and new P4P programs because such programs are mostly applied to managed care organizations. Their use is reflective of their wide acceptance, the ease with which Medicaid programs can access the data, the potential to identify a HEDIS measure that tracks to a program area in which a state has concerns, and the fact that the measures are independently audited as a requirement of NCQA accreditation.

Figure 4. Measures Used in State Medicaid Pay-for-Performance Programs



Notes: As of July 2006. Some programs include more than one type of measure. Percentages reflect measures that have been determined and identified.

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, as well as information concerning existing and planned state Medicaid pay-for-performance programs from state Web sites.

Some Medicaid programs use HEDIS-like measures, instead of HEDIS measures, even when an existing HEDIS measure appears to address the same characteristic. Directors and staff reported that this can occur for a number of reasons, including the interest of the Medicaid program in only a portion of the data used to develop the HEDIS measure, reporting of services provided by a provider that does not collect data using HEDIS-specific criteria, or to counter perceived shortcomings in the HEDIS definition. For example, the immunization data that staff reported using in several states are slightly different than those contained in HEDIS measures for both programmatic reasons and because most of the data are collected from primary care providers that do not use HEDIS

criteria. In another state, staff developed a state-specific readmission rate for individuals with behavioral health problems that they believe is a better indicator of quality care than the comparable HEDIS measures. A staff member from this state commented that measures should be "measurable, meaningful, and achievable. . . . That doesn't always mesh well with HEDIS."

Another limitation of HEDIS measures is their exclusion of beneficiaries who are not continuously enrolled for a year or more. Since the eligibility status of a significant proportion of Medicaid beneficiaries changes frequently, these individuals would not be covered by a strict application of HEDIS criteria.

Structural measures. Structural measures are those related to a specific status or activity, such as accreditation status, health information technology adoption, being open on weekends, or the time it takes to get an appointment. For example, Tennessee and Wisconsin require their managed care organizations to be NCQA-accredited to qualify for a bonus. According to another director, NCQA accreditation "breeds a culture of quality for the organization."

Structural measures are the second most common type of measure used by existing state Medicaid P4P programs. These measures are usually not specifically related to quality or outcomes, but they can indicate whether a program is providing quality care. Moreover, these measures are often used as a proxy for access to care.

Despite the prevalence of structural measures, some states expressed a desire to move from structural measures to those more focused on outcomes. One interviewee noted, "You can do P4P around structural type issues—do you or do you not have [an electronic] medical record? Who knows what you do with it? . . . That is a structural measure . . . it has nothing to do with patients, at least directly."

Cost/efficiency measures. These include measures gauging, for example, the use of generic drugs, utilization rates, and overall spending levels. Medicaid directors reported two overall approaches to using cost and efficiency measures in their pay-for-performance programs. The first approach uses a measure of overall savings from a prior period for, or an expected dollar level being spent on, a given subpopulation of Medicaid beneficiaries. Many of the states that use this type of measure engage a contractor (such as a disease management vendor) to operate a specific program, with overall cost savings being a component of the contract itself. Sometimes, the savings are shared between the vendor and the state. The second approach is to identify measures of efficiency related to a specific

process or activity. Examples of such measures include processing times for claims submitted to a managed care program, the speed with which grievances are resolved, and notification to the state that a beneficiary has third-party benefits.

Slightly more than one-third of existing programs incorporate cost/efficiency measures; the proportion in new programs is about 20 percent.

Patient experience of care. These survey measures are designed to assess the overall experience of patients and their families with the care that they receive from the health care system. The most common measures of this type are from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which was developed in a public/private partnership by the Agency for Healthcare Research and Quality.[20] Some state programs, most notably programs related to nursing homes, use non-CAHPS patient or family experience of care surveys. CAHPS measures are also part of the HEDIS data set. For purposes of this report, however, we have counted these measures only in the "patient experience of care" category.

Approximately 20 percent of existing and new programs are reported to use patient-experience-of-care measures. However, it is important to note that no programs use only this type of measure. One state specifically rejected a CAHPS-like measure for inclusion in their state's multi-payer program.

Measures based on medical records. These are developed by reviewing information contained in medical records. (HEDIS measures based on medical records are included in the HEDIS category above.) For example, the Medicare Hospital Quality Initiative is a nationwide set of measures based on medical records.

Many Medicaid directors expressed concern that collecting measures derived from medical records would be too burdensome on providers—which could reduce participation and thus access to care—and noted that using their own staff to do so was not financially feasible. Moreover, as noted above, HEDIS measures already incorporate some measures based on medical records. Thus, when states are interested in addressing issues that require medical record reviews, they may be more likely to turn to HEDIS measures than to create their own measures.

It is not surprising, then, that only four existing and two new pay-for-performance programs incorporate measures based on medical records.

We also examined whether measures used in P4P programs were developed by the state or drawn from nationally recognized or developed measure sets. We did not list this factor independently because state-developed measures are not mutually exclusive from the other measure types; in fact, the preponderance of measures developed by the states are structural. However, it is interesting to note that 18 states used one or more state-developed measure in their existing programs and 10 states are planning to use or are considering use of one or more state-developed measure in their new programs.

Examples of state-developed measures include:

- newborn enrollment notification within specific time frames;
- nursing home staffing ratios;
- use of safety net facilities;
- indicators of recovery for individuals with mental health and substance abuse issues; and
- establishment of a financial target for medical services.

As states work to develop multi-payer programs, it is not clear whether the use of state-developed measures will continue to the same extent in either existing or new programs.

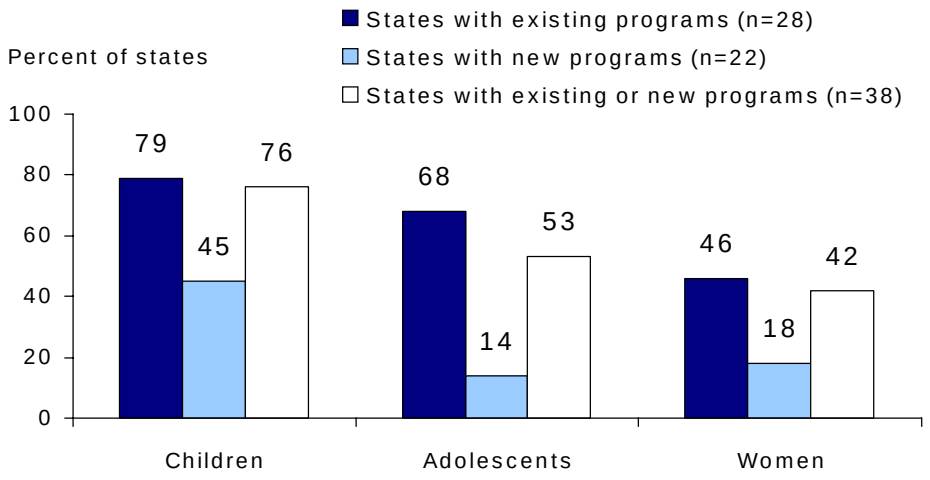
Populations, Medical Conditions, and Care Delivery

One of the areas of analysis undertaken as part of this study was a review of selected populations and medical conditions addressed in both existing and new pay-for-performance programs.

Not surprisingly, children were the most prevalent population addressed in existing P4P programs. Children represent approximately half of all Medicaid beneficiaries nationwide and, since the early days of the Medicaid program, emphasis has been placed on ensuring that children receive the care they need (note the EPSDT program). Adolescents were the second most frequently addressed population (they are also identified as an important population in the EPSDT program), and women were the next most frequently addressed population (almost 40 percent of births nationwide are financially supported by Medicaid). Considering that the most common provider type in P4P programs is managed care, and that children and low-income families are the predominant populations enrolled in Medicaid managed care programs, it is reasonable that many measures would relate to these three populations (Figure 5).

When comparing the percentages of existing and new programs that address children, adolescents, and women, it appears that the emphasis in new programs is moving away from these populations. The percentage of measures in the areas of adolescent and women's health drops significantly, while the percentage for children's measures drops somewhat less. There is a clear reduction in the number of new programs that include EPSDT measures for both children and adolescents.

Figure 5. Coverage of Selected Populations in State Medicaid Pay-for-Performance Programs

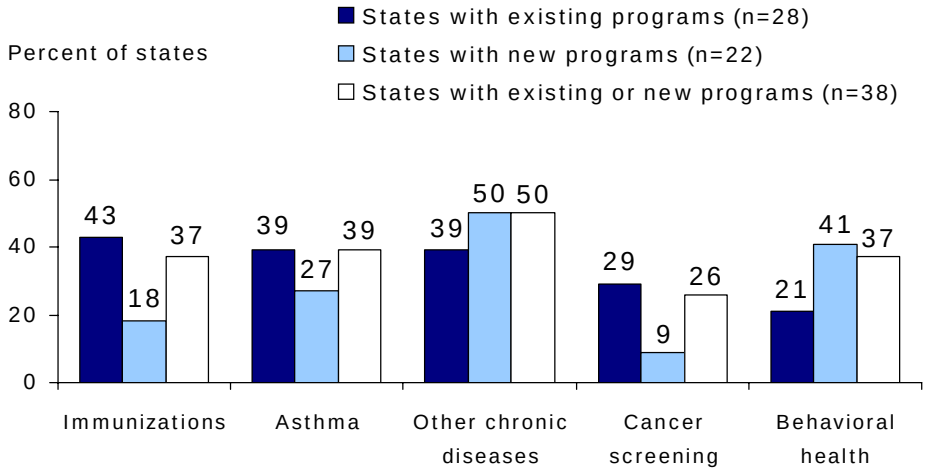


Notes: As of July 2006. Percentages reflect populations and programs that have been determined and identified.

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, as well as information concerning existing and planned state Medicaid pay-for-performance programs from state Web sites.

The apparent lessening in importance of children, adolescent, and women's health issues appears to coincide with the increased emphasis on chronic care and behavioral health issues in new programs. When analyzed in conjunction with three other selected medical conditions and procedures—immunization and vaccinations, asthma (for which data were collected separately from data for other chronic diseases), and cancer screening—it is clear that "other chronic diseases" and "behavioral health issues" are incorporated far more frequently in new programs. In fact, measures related to "other chronic diseases" are incorporated in existing and new programs in more states than any other type of measure (Figure 6).

Figure 6. Coverage of Selected Conditions and Procedures in State Medicaid Pay-for-Performance Programs



Notes: As of July 2006. Percentages reflect conditions and procedures in programs that have been determined and identified.

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, as well as information concerning existing and planned state Medicaid pay-for-performance programs from state Web sites.

Regardless of this shift in focus, primary care continues to be a major theme in pay-for-performance programs. More than 85 percent of all states with existing programs incorporate measures that relate to the provision of primary care services in their programs; with the addition of new state pay-for-performance programs, the proportion of states will increase to over 90 percent. State programs focus on primary care in a variety of ways:

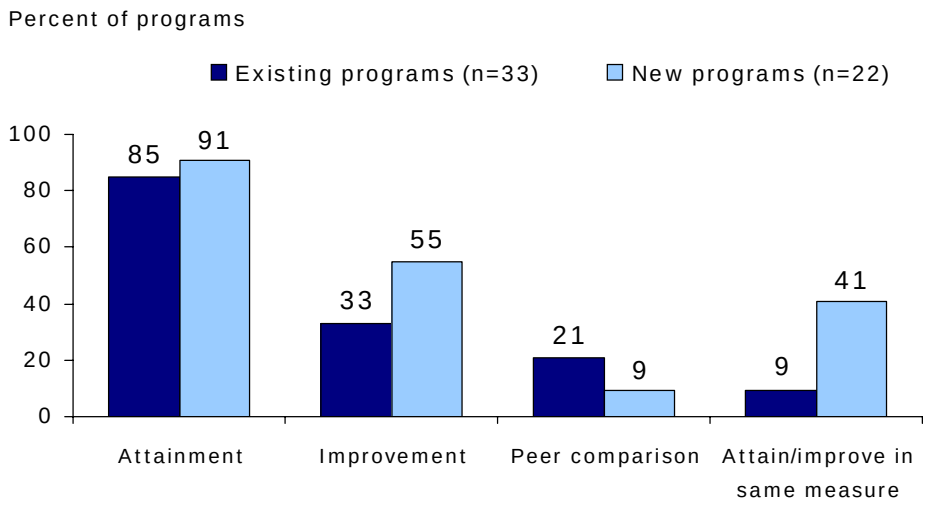
- Many states include measures such as access to preventive care visits for children and, less frequently, adults.
- Other states target specific aspects of care, such as the overuse of emergency department services. For example, individuals with high emergency department usage that is not followed by an inpatient admission are a target group in Illinois' risk-based disease management program. Another example is MaineCare's Physician Incentive Program, in which 30 percent of the bonus is based on emergency department utilization measures.
- Promoting the general availability of primary care providers is another method used by state Medicaid programs to support the provision of primary care. Some programs provide increased reimbursement to a provider who agrees to establish a medical home for Medicaid beneficiaries (as in South Carolina's Medical Homes Network program). Other programs, such as Alabama's Patient First program,

provide increased reimbursement for meeting specific standards, such as having the practice itself provide round-the-clock coverage.

Assessing Performance

A review of state Medicaid pay-for-performance programs establishes that there are three main methods of assessing performance as well as a fourth that is a hybrid of two of them (Figure 7). All have advantages in terms of rewarding performance, but each has characteristics that may discourage performance improvement under certain circumstances or result in inequitable rewards.

Figure 7. Assessment Methodologies in State Medicaid Pay-for-Performance Programs



Notes: As of July 2006. Percentages reflect assessment methodologies in programs that have been determined and identified.

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, as well as information concerning existing and planned state Medicaid pay-for-performance programs from state Web sites.

Attainment. The first and most common method—in both existing and new programs—is to establish a target level of performance and simply determine if that particular standard or benchmark, such as a designated percentage of childhood immunizations, has been achieved. This approach has the advantage of being somewhat easier to implement than a measurement approach that looks for performance improvement over multiple years because it requires only one snapshot of performance and the effects of data variations are somewhat minimized.

One risk of using this approach is that lower-level performers that have little chance of attaining the incentive level might opt out of P4P programs in cases where participation is not mandatory. On the other hand, providers who have already achieved

the required level might feel that there is little incentive to improve once they have met the goal. Furthermore, if a state does not change its performance levels or measures, the P4P program could stagnate.

States have addressed some of these concerns by:

- giving providers who have reached the goal an extra incentive for maintaining the attainment level;
- rotating the measures on which most providers have done well out of the "performance" part of the program, but retaining them as measures that are still being monitored; and
- increasing the target level when all or most providers have qualified for a reward.

Improvement. The second most common method is to reward improvement over a previous baseline or performance level, for example the achievement of a higher level of childhood immunizations over the previous year.

Using improvement as a performance assessment tool addresses one of the disadvantages of the attainment tool. Essentially, the improvement approach establishes performance improvement levels, creating an incentive to most providers to improve performance. But several Medicaid directors registered concern that recognizing only improved performance could effectively reward a provider for meeting standards that might be considered unacceptably low. Nevada addresses this issue by establishing a floor beneath which no incentive payment is given, regardless of the level of improvement.

Another disadvantage of this approach is that a relatively poor performer might be rewarded for improving from a low to a mediocre score, while a consistently superior performer, whose improvement potential is limited because it is already near the top, may not be. Pennsylvania has attempted to address this issue by proportionally increasing the amount of the incentive as provider performance improves.

Peer comparison. Peer comparison measures a provider's performance against other providers in a state or region, ranking all providers but providing incentives only to those who have reached a certain competitive level. MaineCare's Physician Incentive Program, for example, provides bonuses only to those providers who rank in the top 20th percentile when compared with other providers in their specialty.

While competitive environments can stimulate achievement, this method may discourage low performers who believe that they will not be able to achieve a level that could result in receipt of an incentive. Relatively high performers, who may do well but fall slightly below the established cutoff, may also find that they are not rewarded for what might otherwise be considered good performance.

Similarly, some respondents found that, when they structure incentives based on performance relative to other plans or providers, the results do not necessarily correlate with improvement. They may find a reshuffling in the provider order, but without actual increases in performance. One state director reported making a significant financial outlay in the program, but the results included only a very limited increase in overall measures, and a decrease in some. The remedy, we were told, would be a change in the formula the following year so that it would require at least some absolute improvement.

Improvement and attainment. A number of Medicaid programs have attempted to balance the advantages and disadvantages of these methods by establishing an assessment approach that combines improvement and attainment. This measure recognizes both a specific level of performance and gradations of improvement. The proportion of new programs planning to use this dual approach is substantially greater than that in existing programs (Table 4).

Table 4. Improvement and Attainment on the Same Measures in State Medicaid Pay-for-Performance Programs

States with Existing Programs	States with New Programs
Nebraska	Arkansas
Nevada	Delaware
	Illinois
	Massachusetts (all new programs)
	Nevada
	North Carolina

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, as well as information concerning existing and planned state Medicaid pay-for-performance programs from state Web sites.

A review of the performance assessment methods reported by state Medicaid programs also shows that states are making some small adjustments to these broad categories of measures to reward providers for moving toward state goals. For example, Maryland rewards positive ratings proportionally more than it penalizes negative ratings. In Indiana and Pennsylvania, the bonus increases as a provider approaches the desired

standard, while Illinois's managed care P4P program decreases the amount of improvement required to receive a bonus as the plans' baseline levels increase. Missouri increases the penalty as the time that the undesirable activity exists lengthens.

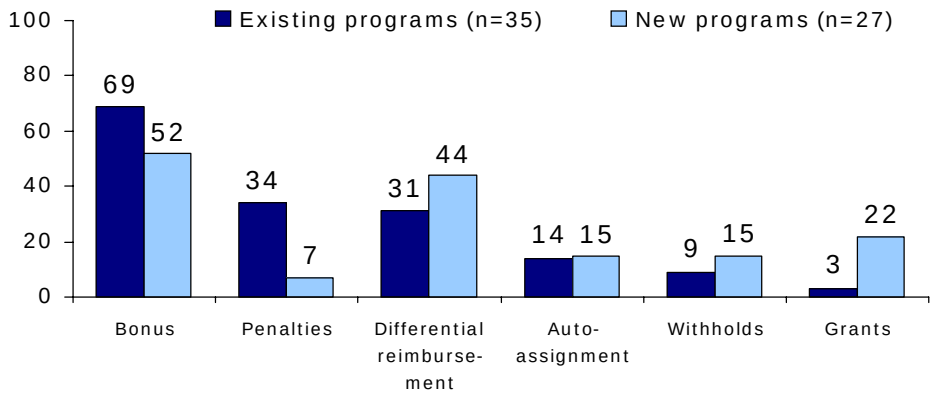
Incentives

Incentives are the third core component of any pay-for-performance program. While states can choose from many measures related to a wide array of program goals, the number and types of incentives available to pay-for-performance programs are far more limited. In addition, a state's choice of incentives can be constrained by financial considerations—limits on the resources a state is able to put into the program. Some of these constraints are state-imposed (such as having a limit on the total amount that can be distributed in bonuses or differential rates, or being unable to provide any financial incentives at all) and some are related to actuarial soundness limitations imposed on state Medicaid programs by CMS.

Types of Incentives

This study categorizes the types of incentives used in P4P programs into six main types: bonuses; penalties; differential reimbursement rates or fees; auto-assignment; withholds; and grants (Figure 8). Many state Medicaid programs also incorporate additional types of non-financial incentives into their pay-for-performance programs. A brief discussion of some of these types of incentives is included at the end of this section.

Figure 8. Financial Incentives Used in State Medicaid Pay-for-Performance Programs



Notes: As of July 2006. Some programs include more than one type of incentive. Percentages reflect incentives that have been determined and identified.

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, as well as information concerning existing and planned state Medicaid pay-for-performance programs from state Web sites.

Bonuses. The most common type of incentive in existing and new programs, bonuses are one-time or periodic financial rewards for achieving specific performance levels, making improvements over previous performance levels, or demonstrating excellence as compared with peers. Medicaid directors consider bonuses to be relatively easy to calculate, and many of the respondents to our survey felt that providers respond positively to a special payment to reward them for the delivery of quality care.

Bonuses are applied in several ways:

- a maximum pool is established. If the provider performance payments would result in bonuses greater than that amount, the bonuses are prorated. If provider performance payments would not use the complete pool, only the amount calculated is distributed;
- a pool is established and all providers meeting the necessary standard receive a proportional share based on their relative performance. The entire pool is distributed;
- a bonus amount is established per occurrence. Bonuses are paid out based on the number of occurrences and the dollar amount per occurrence;
- a bonus equal to a specific percentage of a reimbursement rate is paid when a standard is met;
- the bonus is an established share of a calculated amount saved as a result of the P4P program (for example, in shared savings situations). The share is usually included in a contract between the state and the provider or vendor;
- a bonus is calculated, but can only be used to offset any penalties; and
- in recognition of CMS guidelines in this area, states often include provisions that ensure that no plan can receive more than 105 percent of their capitation rate as a result of any redistribution of, or increase in, funds.[21]

Penalties. Widely used—they are the second most commonly used incentive in existing programs—but definitely controversial, penalties are the opposite of bonuses in that they are one-time requirements for plans or providers to repay the state (or to have the state recoup funds previously paid) to reflect the failure to meet required performance levels.[22]

Penalties are considered controversial by many Medicaid directors because they believe that positive incentives are more effective than negative ones. Based on our discussions, this perspective has been developing over several years. In fact, many

Medicaid directors now feel that penalties are actually detrimental to the operation of a good pay-for-performance program, creating ill will between the medical community and the state, which may result in decreases in provider participation. Thus, while penalties are frequently seen in existing pay-for-performance programs, their use is substantially more limited in new programs.

Implementation methods include:

- a requirement that a plan or provider pay a specific amount, often termed liquidated damages, for failing to meet standards;
- a requirement to pay back some or all of administrative fees if the plan does not meet required savings and/or quality levels;
- increasing the dollar amount of the penalty as the length of time during which the standard is not met, or as the number of penalties, increases; and
- charging a specific percentage of a reimbursement rate when a standard is unmet.

Differential reimbursement rates or fees. The third most frequently used incentive, differential reimbursement, is a change in the ongoing reimbursement rate or fee to reflect achievement of, or improvement in, required performance levels. The primary difference between differential reimbursement rates or fees and bonuses is that the payment is ongoing rather than one-time or periodic. While some Medicaid directors felt that providers responded positively to the special bonus payment, others felt that ongoing increased reimbursement, albeit smaller than any one bonus payment, was a continuing reminder to providers that their performance was being rewarded.

Some implementation methods include:

- periodically (for example, quarterly or annually) increasing a reimbursement rate or fee by a specific amount or percentage to reflect achievement of the standard;
- modifying a reimbursement rate so that a provider's rate can increase, decrease, or remain the same depending on whether the minimum standard has been met; and
- reducing the reimbursement rate to a provider when standards have not been met for a prolonged period of time and redistributing the funds to providers that are meeting standards.

Auto-assignment. Medicaid beneficiaries in many states are required to receive their care through a managed care plan or a primary care case management provider and must, therefore, choose a plan or provider. When a beneficiary fails to make such a choice within the required time frame, the state assigns them to one so that they have a medical home.

States are beginning to use quality measures as incentives to route beneficiaries in greater proportions to plans that demonstrate superior quality. Most states that incorporate quality measures in their auto-assignment algorithms do so by identifying plans that are performing well, or performing better than their peers. Missouri, however, reduces a plan's auto-assignment percentage to reflect substandard performance, effectively increasing the percentages of the remaining, and presumably adequately performing, plans.

This incentive is somewhat different than the other five incentives because it does not, in and of itself, incorporate a financial component. However, the assignment of new members to a plan can have significant implications for market share and the absolute number of members. Since many plans believe that a beneficiary who does not make a plan choice is likely to use fewer services than average, auto-assignment can be a powerful tool.

While only a few states incorporate auto-assignment in their pay-for-performance programs, Medicaid directors noted that one important advantage of this approach is that it entails no additional cost to the Medicaid program.

Withholds. Through withholds, Medicaid programs set aside performance-related funding until a provider demonstrates that a standard has been met. Once the provider meets the standard, the funds are released and returned to the provider in the form of bonuses. Similar to penalties in that they can reduce the amount of funding available to providers, imposition of a withhold does not, however, assert that the provider has not met the required standard. Use of withholds as performance incentives is found only in managed care and primary care case management P4P programs.

Despite the fact that withholds allow states to provide financial rewards without increasing their costs, they are used relatively infrequently in both existing and new programs. One reason may be that providers and plans perceive them as reductions in the payment rate that, prior to imposition of the withhold, was represented as an appropriate payment level.

Examples of how this type of incentive has been implemented are:

- funds may be initially withheld by the state or the state may require the plan to set aside a certain portion of their reimbursement. Funds are released by the state when managed care plans earn back some or all of the withheld moneys by meeting performance standards;
- withheld funds that are not earned back by the managed care plan from which they were initially withheld can either be: placed in a second pool to be distributed among plans that meet additional performance criteria; used, with state approval, by the plan to focus on other program areas needing improvement; or returned to the state; and
- the state guarantees that a specific percentage of the funds withheld will be returned, but the funds do not need to be returned to the provider from which they were initially withheld.

Grants. Grants enable states to set their priorities and reward providers for addressing them. Typically, providers are asked for quality improvement proposals, often through a request for proposals vehicle. Proposals are evaluated on established criteria and grants are awarded for specified dollar amounts.

Only one state, Tennessee, operates an existing pay-for-performance program that incorporates a grant. However, with the growing interest in targeting specific areas of performance, particularly health information technology, the number of new programs that are considering using or planning to use grants as an incentive is increasing.

Non-Financial Incentives

In addition to the six incentives described above, Medicaid directors reported that their pay-for-performance programs also included non-financial incentives, which they believed improved their programs by adding depth to their pay-for-performance activities.

Tools. Several states or their contractors offer practice management tools to providers (such as software for billing and patient management), in some instances as part of agreements to participate in pay-for-performance programs. These tools are then available to be used by the practice as a whole.

Initial bid ranking. As part of its contracting process with managed care organizations, Michigan ranks plans based on their performance. After including only those plans that meet required performance standards, the state goes down the list and contracts with enough plans to provide sufficient and appropriate access. In a recent year, this goal was achieved by contracting with the top two-thirds of the bidders.

Public and peer recognition of plans or providers. Several state respondents noted that plans and providers respond to seeing how they rate against certain standards, as well as how they rank against their peers. As a result, many state Medicaid pay-for-performance programs incorporate some type of public or peer recognition in conjunction with their other incentives. Examples of such reporting include:

- report cards are sent to Medicaid beneficiaries at the time they are required or permitted to make a plan or provider choice. Report cards can provide quality as well as cost-effectiveness information;
- public reporting of plan rankings is made available on Web sites, in public reports, or in other public forums. Public reporting can also provide quality as well as cost-effectiveness information;
- reports on a specific portion of the health care industry are provided, without specific plan or provider rankings;
- provider success is publicized on an ad-hoc basis, such as by the issuance of press releases for special performance or the provision of plaques to high-quality providers;
- good performers are recognized, without ranking them, to avoid potentially causing providers who do not believe they rank high enough to leave the program. This approach occurs most often in smaller states with few providers; and
- reports comparing individual performance to a peer group are made available to the provider. States reported use of this approach in both managed care environments and with primary care providers.

Incentive Recipients

Most incentives are provided to managed care organizations, institutional providers (such as hospitals and nursing homes), and other provider networks. However, a few Medicaid programs have structured their incentives to get closer to the actual deliverer of care. For example:

- primary care case management programs in several states, among them Alabama, Louisiana, and Pennsylvania, provide their incentives directly to participating providers;
- other state Medicaid programs require their managed care organizations to pass on a portion of the incentive to providers. Georgia will be instituting such a requirement in the second year of its managed care pay-for-performance program. Indiana will

be expanding this concept by requiring its managed care organizations to distribute a portion of their incentive not only to providers, but to members as well; and

- Utah has taken a unique approach, in which the Medicaid managed care contract language requires that managed care organizations share incentives with the employees who are responsible for achieving the performance measures.

Incentive Intervals and Payments

Due to the nature of the measures used, many of which are based on or similar to HEDIS measures, almost 70 percent of Medicaid directors reported that the measurement interval in their existing programs is one year. The next most common interval is quarterly, with slightly less than one-third of the states reporting in this category.

To accommodate billing lags, validation activities, and other calculation-related processes, the time period between the conclusion of the measurement interval and when the incentive is actually received ranges from one quarter to one year. The most common lag time is four to six months, followed by one quarter. Several programs, however, are able to provide some of their incentives early in the program because the incentives are for participation rather than for meeting a specific performance standard.

Most state Medicaid directors said that they understood the value of delivering an incentive as closely as possible to the time period being measured. However, they also recognized that the nature of the data collection, measurement, and calculation processes often makes the time period between the two far longer than they believe is optimal. Medicaid directors have learned that drawing attention to measures by including them in a pay-for-performance program yields more accurate reporting. Providing more timely incentives might improve upon the gains already made. Perhaps some of the HIT improvements will streamline these processes.

DATA COLLECTION, ANALYSIS, REPORTING, AND EVALUATION

To be effective, pay-for-performance programs need consistent, reliable, and accurate information with which to assess performance. Selecting measures, therefore, necessarily requires consideration of the types of data available and possible methods of collection.

For example, administrative data, such as that developed from claims submissions and encounter reports, are frequently used by state Medicaid programs because they tend to be easily available from fee-for-service providers and managed care organizations at minimal cost. These data, however, are only as good as the claims or encounter

information received from the providers and plans. Moreover, this type of information does not provide a complete picture. For example, the data can reveal to a program manager what activity occurred (or was billed for), but not why it was done or the outcome of the activity.

Clinical data collected through means such as medical record reviews often give program managers the what, why, and outcome information they need, but gathering these records is time-consuming and costly. Moreover, providers, who are the primary source of this information, need to devote the majority of their efforts to delivering care rather than to reporting about care.

What data are used, how it is collected, and how it is validated are important questions that states must consider as they search for the appropriate balance between the added value and the costs of delivering their pay-for-performance programs. Recognizing this, we focused on data collection methods in the follow-up interviews with Medicaid directors. Since nationally collected measures (such as HEDIS) have standard collection, validation, and auditing protocols, we focused on data collected by states or specifically for states.

Data Collection

The preponderance of data used in state Medicaid pay-for-performance programs (almost 90%) comes from providers, either directly (as in disease or condition registry information) or as part of billing and encounter data collection activities. Staff in one state reported that they collect the data themselves. In a small number of states, primarily those with disease management contractors, the vendor collects the data directly from the participating providers (in these cases, some states also collect data for comparison purposes).

Data Validation

Validation is the act of confirming that the data collected are accurate. Approximately 50 percent of state Medicaid directors reported that internal Medicaid staff conduct validation of program-related information themselves by sampling the data. Thirty percent of respondents said that their state hires consultants specifically for data validation purposes. In one state, a program contractor validates the data. A handful of state respondents indicated that their programs conducted no validation-related activities.

Several directors also noted that the data they use for their P4P programs are gathered initially for other purposes (such as maintaining a registry). In these cases, Medicaid program staff do not conduct any data validation activities but, rather, rely on the checks and balances incorporated in the originating program.

While not a formal validation protocol, about half of the state respondents indicated that their programs conduct a variety of "reasonableness" checks, including comparing other sources of information to the reported data or comparing year-to-year changes.

Data Analysis

Data analysis is most often done by internal Medicaid staff (approximately 50% of the time) or by consultants (approximately 10% of the time). In several states, data analysis is conducted both by internal Medicaid staff and consultants (approximately 35%). Some Medicaid programs work with staff in other parts of their agency or other agencies (such as public health program and health statistics staff).

Since state pay-for-performance programs are relatively new, several state managers have taken the approach of using both outside contractors and state staff in the early years of their programs, with the expectation that analysis activities will become the sole responsibility of the state as the program matures. This approach allows checks and balances to be incorporated early in the data analysis process, when such comparisons would be most valuable, while accommodating the financial limitations that exist in some states.

Some states that use consultants are considering shifting responsibility for these activities to state staff, primarily for financial reasons. Other states, however, believe that using outside consultants brings a level of impartiality to the process that assists them in their overall program management.

Medical record reviews. Consistent with the fact that very few states use measures based on medical records, medical records are seldom reviewed for pay-for-performance programs.

Use of patient surveys. Patient and family surveys, conducted independently of routine requirements for managed care organization certification, are rarely performed in pay-for-performance programs. The programs most likely to involve such surveys are focused on nursing home quality.

Payment calculation. Two-thirds of the states use their internal staff to calculate P4P payments, with the remainder using consultants, a university, or some combination of approaches. Several Medicaid directors noted that they use outside actuaries and consultants to assist them in this process because their work is likely to be viewed as impartial. The state directors reporting that payment calculations were performed by their internal staff felt that they had sufficient expertise to appropriately manage the process.

Public performance reporting. Nearly half of the state directors interviewed mentioned some level of public performance reporting. Preparation of public performance reporting documents is conducted by state staff and consultants with approximately equal frequency.

Program Evaluation

Program evaluations enable states to determine whether their pay-for-performance programs are worth their investment (in money, time, or effort), gauge whether they are delivering the desired quality and outcome improvements, and identify any unintended consequences. However, pay-for-performance programs in all sectors—regardless of who sponsors them—have not yet been sufficiently evaluated for there to be a body of evidence that demonstrates their effectiveness.[23] Our research among Medicaid directors and their staffs demonstrates that Medicaid pay-for-performance programs are no exception.

Respondents in states with existing programs reported that approximately 45 percent of pay-for-performance programs would undergo an evaluation at some point. In eight states, or approximately 30 percent, Medicaid directors reported that they had conducted or intended to conduct a formal evaluation of their programs. Less formal evaluations were reported to have occurred or to be planned in 15 percent of state programs.

The formal evaluations were or will be conducted by outside consultants, foundations, and universities. It was not clear whether the results were or would be available publicly. Not all of the reported evaluations appeared to be comprehensive. For example:

- one was performed to fulfill the cost neutrality evaluation required by CMS of all waiver programs and, thus, the pay-for-performance portion of the evaluation was a small, albeit important, part of the report;[24]
- several evaluations were focused primarily on costs so that agreement could be reached on how, or whether, to share savings between a state and a contractor; and
- in another state, the effect that incorporation of quality measures had on plan-specific auto-assignment rates was evaluated. The program itself has not been in operation long enough to know if there are going to be any quality-related improvements or unintended consequences resulting from operation of the program.

The balance of state Medicaid directors interviewed, covering 55 percent of existing pay-for-performance programs, reported that they have not conducted any formal evaluations and were not planning to do so at the time of our conversation. Among states that do not currently have evaluation plans, some have programs that started very recently,

without established evaluation protocols. Program staff, who have been focused primarily on implementing the programs, have not yet had the opportunity to consider how, what, or when to evaluate their impact.

Reported reasons that more formal evaluations of pay-for-performance programs are not occurring include:

- limited resources;
- the absence of a control group, which makes it difficult to establish a benchmark for evaluation purposes;
- the simultaneous occurrence of many other program changes, making it difficult to isolate the effects of P4P in a scientific manner;
- insufficient experience with P4P to define desired quality improvement, which is a necessary step in establishing an evaluation hypothesis;
- difficulty in designing the evaluation protocol due to varying stakeholders holding different points of view concerning what constitutes an evaluation; and
- insufficient data to conduct a thorough evaluation.

PERSPECTIVES ON MEDICAID PAY-FOR-PERFORMANCE

This section is provided to give state Medicaid directors, their staffs, and other health care professionals a better understanding of how pay-for-performance is viewed by the individuals who manage Medicaid programs. The perspectives presented should be especially useful in light of the growing trend to develop statewide and regional pay-for-performance programs, which will include Medicaid programs and other payers, providers, and stakeholders.

Characteristics of a Good Pay-for-Performance Program

With few evaluations of pay-for-performance programs, there is insufficient evidence of their effectiveness and what constitutes a high-quality pay-for-performance program. As a result, one goal of this study was to determine what Medicaid directors believed made a good pay-for-performance program. To that end, we offered a list of specific characteristics related to the operation of a pay-for-performance program and asked respondents to rate them on a 10-point scale, ranging from "10—very important" to "1—not important" (Table 5).

Table 5. Characteristics for the Operation of a Good Pay-for-Performance Program

Percent Rating "Very Important"

Very Important*	Characteristic
78%	Incorporates scientifically sound measures
73%	Uses measures that are feasible to collect
70%	Uses measures that are regularly reviewed and updated
62%	Promotes continuous quality improvement, not just attainment of a target
61%	Developed in collaboration with providers and purchasers
49%	Publicly discussed so that it can be understood by providers, consumers, and purchasers
41%	Results are reported publicly
35%	Uses nationally recognized measures
28%	Designed to improve care, but without a requirement of cost savings
24%	Uses measures other than those based on administrative or claims data, for example a program that uses processes such as medical record reviews
14%	Requires cost savings

* Percent answering 10 or 9 on a 10-point scale. 10 = "very important"; 1 = "not important." (n=37).
Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, 2006.

While there was wide variation in the answers to some of the items (such as whether a program should require cost savings), on average, Medicaid directors rated all of the characteristics on the positive side of the scale (at least "5"). To determine the most highly rated characteristics, responses of "10" and "9" were combined to form a "very important" rating.

The three characteristics at the top of the "very important" scale are reflective of respondents' concerns related to the accuracy and availability of the data that are needed to operate a P4P program. Using measures that are scientifically sound, feasible to collect, and regularly reviewed and updated led the field. Far fewer directors were concerned that the measures be nationally recognized or developed using processes such as medical record reviews. Consistent with their emphasis on the importance of measurement, Medicaid directors—who are charged with implementing P4P programs and responsible for their outcomes—commented on the absence of any mention of "measurable" in the CMS definition of pay-for-performance.

A significant portion of Medicaid directors gave a high rating to the goal of supporting continuous improvement, rather than attainment of a target. More than half of Medicaid directors felt that collaboration with providers and purchasers in development

of the P4P program and public discussion of the methodology with stakeholders were very important.

Publicly reporting the results was somewhat discounted. Cost, technical capabilities, and the concern that it might alienate providers were reasons cited as to why public reporting might not be a key component of a P4P program. One director rated public reporting of results at "0," or "damaging to the program."

Two of the three least important characteristics from this list were both related to cost. In fact, requiring cost savings is the least important general characteristic of a pay-for-performance program, despite the fact that four state respondents rated required cost savings at "10,"or being of the highest importance.

Factors that Would Be Detrimental to a Pay-for-Performance Program

In the written survey, we also posed a "sentence completion" question to Medicaid directors concerning some of the factors that could be detrimental to pay-for-performance programs. Their responses, coupled with additional comments that reflect some of the other responses that were received during other parts of the study process, follow (Table 6).

Table 6. Factors that Would Be Detrimental to a Pay-for-Performance Program

	This program won't work in my state if . . .
Agree	**Factor**
69%	**It penalizes providers.** Twelve state directors reported that they currently use penalties as incentives in their P4P programs. Consistent with this response, however, is the fact that only two new P4P programs are considering including penalties. One state director plans to change tactics, noting that this state "used to be in the sanction world. Now, we want a positive spin. . . . We're looking into outcome measures. We'd like to merge that with payments."
57%	**It could result in greater spending.** Most respondents think this would be a problem if it did occur, but we learned from the interviews that most think it will not result in greater spending.
17%	**It doesn't guarantee immediate savings.** A handful of Medicaid directors in smaller states that are starting programs think that this is very important; most other respondents tend to discount this factor. "You don't come out of the chute immediately saving money."
17%	**It applies only to certain providers and not others.** Most state Medicaid officials do not think this is important, which is consistent with their activities.
	Additional factors that would be detrimental to a pay-for-performance program (volunteered): • if there are access-to-care problems; • if there is increased fraud; • if data are not available in a timely fashion; • if we make the mistake of calling it "pay-for-performance"; • if we do not recognize obstacles and barriers in rural or frontier counties; and • if it has an impact on the largest providers of medical services.

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, 2006. (n=37)

Consequences and Outcomes Related to Pay-for-Performance Programs

Respondents were also asked to record their opinions concerning the consequences or outcomes of operating a P4P program in a state Medicaid program on an agree/disagree scale, which ranged from "10—strongly agree" to "1—strongly disagree" (Table 7).

Table 7. Consequence and Outcomes: Percent Who Agree with Statement About Medicaid Pay-for-Performance

Agree*	Statement
97%	The State will be a more informed and effective purchaser of health care
81%	The cost of care will decrease, because of reductions in unnecessary and inappropriate care
62%	Healthier enrollees will be able to get better jobs, will therefore no longer need to be in the Medicaid program or receive other state assistance
46%	Establishing a pay-for-performance program will not address our highest spending areas, such as chronic and long-term care and behavioral health
35%	Costs will increase, because enrollees will get more medical care than they did before the program was implemented
30%	The cost of care will increase, because the incentives will cost us more, while our existing health care costs will not increase
22%	Will divert attention from other activities that we must do—for example, replace our MMIS system, meet federal eligibility processing time frames
19%	Promoting quality will reduce the number of providers in the program, which could reduce access to care

* Percent answering 10 through 6 on a 10-point scale. 10 = "strongly agree"; 1 = "strongly disagree." (n=37)
Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, 2006.

There is near-unanimous agreement among Medicaid directors that, by instituting pay-for-performance programs, states will be more informed and effective purchasers of health care. Directors were similarly positive that costs might decrease as a result of the reduction in unnecessary and inappropriate utilization, and that costs also might be reduced because pay-for-performance programs could lead to healthier beneficiaries, who would qualify for better jobs and leave Medicaid and other state assistance roles.

There was significant disagreement among Medicaid directors related to the assertion that pay-for-performance programs would not address the highest spending areas, notably chronic and long-term care and behavioral health. While 46 percent agreed that their highest spending areas would not be addressed through pay-for-performance programs, 30 percent of respondents—representing primarily the largest states—strongly disagreed, believing that pay-for-performance would address these populations.

Responses were mixed in regard to the proposition that costs would increase because beneficiaries would receive more medical care under pay-for performance. Most responses clustered around the middle of the 10-point scale, indicating that there is significant uncertainty about this outcome. The majority of Medicaid directors did not

believe that the increased costs resulting from incentives would be offset by decreased health care costs.

The statement that pay-for-performance would divert attention from other activities was met with little support, although several directors from a few small states felt very strongly that they had many competing interests to juggle. Similarly, the premise that promoting quality would reduce the number of providers was dismissed by most Medicaid directors, except those representing smaller, rural states with limited numbers of providers.

Medicaid directors also offered a major cautionary note during our interviews: namely, states need to be careful of the unintended consequences resulting from pay-for-performance programs. Their concerns centered primarily on quality and access issues:

- providers might try to steer complicated or potentially noncompliant patients away from their practices to improve the likelihood that they could meet cost or delivery of care standards;
- the wrong kinds of incentives (primarily penalties) could result in providers deciding to leave the Medicaid program, thereby limiting access to needed care;
- mandatory participation in a pay-for-performance program, regardless of the incentives, might result in providers leaving the Medicaid program;
- if non-financial incentives such as public recognition and auto-assignment resulted in major increases in practice size, high-quality providers might become overloaded, and therefore no longer be able to provide the level of care that the state desires; and
- providers might focus only on quality in those areas that are being measured, ignoring other areas in which they had been performing well before or that also might need improvement. Two comments along these lines were, "You get what you pay for and you get what you measure," and "We give you exactly what you're measuring—not one thing more, not one thing less. . . . [They] will design . . . [their] whole program around what you're measuring."

The potential for these unintended consequences points to the need to not only evaluate performance on the measures included in the P4P program, but also to evaluate the program's impact on the health care system available to the Medicaid population as a whole. Moreover, including stakeholders in the development of pay-for-performance

programs, as more states are now doing, is an invaluable way to obtain the feedback that is necessary to avoid these unintended consequences.

Perspectives on Measures

As noted above, Medicaid directors gave the highest rating to measures that were feasible to collect, scientifically sound, and frequently reviewed and updated. In our discussions, they elaborated on those choices, noting that the measures they used in their programs needed to be fair, accurate, and widely accepted.

The interest in developing programs with stakeholders and workgroups, as well as the trend to partner with other members of the health care community to identify standardized measures, demonstrates their states' commitment to meeting these criteria. States are moving away from some of the earlier approaches to measurement development, when many programs used Medicaid-only measures such as EPSDT visits. Several directors noted that other payers would not be interested in participating in P4P programs that included these types of measures. As such, new Medicaid pay-for-performance programs, while still needing to address some Medicaid-specific issues, are redirecting some of their measurement activities and P4P incentives to more widely accepted measures, such as those incorporated in the Bridges to Excellence, Leapfrog, and Medicare Hospital Compare programs.

Nonetheless, given the time pressures many directors face in getting programs up and running, they recognized that sometimes measures needed to be chosen primarily to enable a quick program start (Table 8).

Table 8. Criteria for Selecting Measures

- Relate to specific program goals
- Correlate with quality care and improvement
- Center on populations of interest
- Center on specific medical conditions
- Data already exist, which makes the program economically feasible
- Data are easy to collect
- Measures are widely accepted

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, 2006.

Perspectives on Incentives

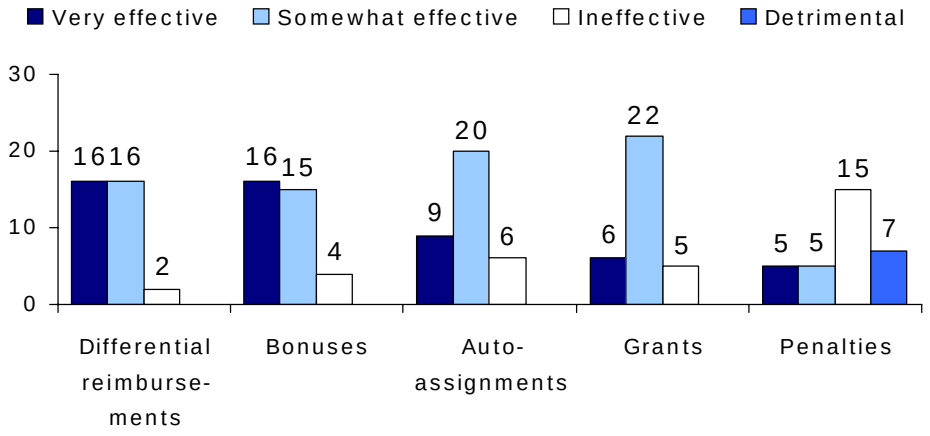
To obtain more in-depth knowledge as to why certain incentives were chosen, Medicaid directors were asked to rate the effectiveness of incentives in meeting the goals of a Medicaid pay-for-performance program in general, using a five-point scale ranging from "very effective" to "very ineffective." They were specifically asked to rate the factors

independently of whether they used or planned to use any of these incentives in their own states. As an additional response, the directors were offered a sixth ranking, which was that the incentive would be "extremely detrimental" to the development of a pay-for-performance program (Figure 9).

Differential Reimbursement Rates or Fees and Bonuses

Medicaid directors overwhelmingly responded that differential reimbursement rates or fees and bonuses were the most effective incentive types; they were rated as very effective or somewhat effective 94 and 88 percent of the time, respectively. As noted above, directors had varying opinions on whether plans and providers responded more effectively to larger, periodic bonuses or to ongoing, but smaller, increased payments. In fact, one comment on the value of bonuses was that a bonus was viewed more positively when it occurred on a regular, consistent basis. Regardless, directors all reported that increasing reimbursement was a significant and positive incentive.

Figure 9. Effectiveness Rating of Incentives Used in State Medicaid Pay-for-Performance Programs



Notes: As of July 2006. "Undecided" responses are omitted (n=37).

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC.

The question of the amount of the increased reimbursement arose with both incentive types. Some directors reported that they felt that differential reimbursement rates or fees needed to increase by a minimum of 3 to 4 percent; another reported learning about a study that stated that increases needed to range between 3 and 15 percent. Most of the states that were able to value their pay-for-performance differential payment structure

from a percentage perspective noted that their increased payments were in the 1 percent to 3 percent range.

One state director commented that many providers find bonuses ineffective because of the limited dollar amount available, noting, "[the bonus amount] is less than [the plan's] budget for sanctions." On the same theme, another state director noted that a bonus might be more effective for a smaller plan or provider than it would be for a larger organization.

Assessment of the feasibility of using either of the two incentive approaches appeared to be related to the structure of a state's payment system, with some directors reporting that bonuses were the easiest approach to implement and other directors just as emphatically reporting that differential payments were the most feasible.

Approximately half of the respondents also noted that, if differential reimbursement meant that rates or fees could be reduced, provider buy-in would be reduced, thereby decreasing the incentive's effectiveness.

Auto-Assignment

While approximately one-fourth of respondents considered auto-assignment to be a "very effective" incentive, the majority of Medicaid directors considered it "somewhat effective." One state director remarked that it is the primary incentive used in that state because it requires no additional spending. Large states with many plans were more likely to feel that this incentive could be very effective; one reason expressed was that it promotes competition between the plans for additional volume.

Again, as noted above, a respondent from a smaller state expressed concern that auto-assignment algorithms that include quality factors could overload the high-performing plans. Another respondent noted that auto-assignment could have an adverse impact on access to care if it increased volume for plans that considered their reimbursement rates to be too low, leading them to leave the Medicaid program.

One state Medicaid director disagreed with the premise of auto-assignment as an incentive entirely, saying, "Auto-assignment doesn't work. It's hard enough to get providers to participate." Finally, we were told by a respondent that changing the auto-assignment algorithm to include quality factors was unnecessary—the quality information that would be made publicly available to its Medicaid beneficiaries would be a sufficient market driver.

Grants

While few states actually provide grants to plans or providers, most state Medicaid directors still rank this incentive as "somewhat effective." Also, special grants to improve practices are a desirable tool in starting up P4P programs and supporting health information technology.

On the negative side, it might be difficult to identify a grant as a Medicaid-specific expenditure, which would enable it to receive federal financial participation. Finally, there is concern that one-time grants do not change behavior.

Penalties to Plans or Providers

As the lowest-rated incentive, penalties were the only incentive to be characterized as extremely detrimental to the development of current or future P4P plans, and it was characterized this way by more than 20 percent of respondents. Moreover, almost half of respondents felt that the incentive was simply ineffective.

Medicaid directors reported that providers already believe they are not appropriately reimbursed for the services they provide. In such situations, applying penalties because plans or providers have failed to meet performance standards may result in plans leaving the program rather than working to improve their performance.

Despite these assessments, approximately 30 percent of existing programs employ penalties. As for the incentive's effectiveness, one director noted that penalties really do get attention. A counterargument came from another director, who said that plans simply budget for penalties: "It's easier to just pay the penalty than to do the right thing." Especially for the larger plans, one director noted, the penalty is usually too small to influence behavior.

Another point of view is that penalties may be more effective when made public. But publication raises the stakes for providers, making it more likely that they will be contested through political channels or burdensome administrative proceedings. Perhaps due to these factors, the trend in new P4P programs is to move away from penalties.

Withholds

Although we did not ask respondents to rate withholds for effectiveness, these types of incentives were mentioned during the discussions as being in use. A small number of state Medicaid directors mentioned that they withheld funds initially and then permitted their

providers to recover the moneys based on performance. States appear to be using withholds in an effort to insert a performance bonus aspect into their pay-for-performance system while avoiding increased costs.

Starting New Pay-for-Performance Programs

Despite what Medicaid directors may or may not believe about the efficacy of pay-for-performance programs, there is growing interest in establishing them in state Medicaid programs. As such, part of the focus of this study was to understand the dynamics behind new program development and the differences, if any, from the environment that existed earlier.

Most existing programs were advocated for and designed by staff internal to a state's Medicaid program. The suggestion to begin a program did not usually come from a governor's office, and legislative branches were of even lesser influence. Consultant involvement was also relatively rare. Stakeholders—such as advisory groups, associations, insurers, and providers—were somewhat active from the beginning, as their constituencies were affected.

These circumstances are changing for new programs, however. Governors, and especially legislatures, are taking a greater interest in pay-for-performance as the concept has become more widely known. Consultants and vendors are assuming more significant roles in designing plans as states move from relatively simple-to-manage programs to more complex ones, and as Medicaid offices need additional programmatic support to implement their programs in short time frames. Stakeholders also are exhibiting a larger presence during the development phase, particularly as Medicaid programs are considering joining in multi-payer pay-for-performance programs.

To examine the issues that were or were not influencing their state's decision to implement a new or additional pay-for-performance program, respondents were asked to rate a series of factors on a four-point scale, where "1" was "very important" and "4" was "not important at all." Their responses, with added commentary derived from other information that became available during the course of the study, appear in Table 9.

Table 9. Factors that May Influence States in Starting a New or Additional Medicaid Pay-for-Performance Program

Important*	Unimportant**	Statement
100%	0%	**P4P has the potential to improve the quality of care provided in the Medicaid program.** The most important factor influencing the development of a new program.
79%	21%	**P4P will, at least in the short run, cost money.** A significant factor, but only 28% rated it "very important," including one director who cited this as the reason that the state did not have a financial incentive program. This concern is overridden in some instances by the belief that it will save money in the long run.
72%	28%	**Have limited staff to develop and implement a program.** To address this issue, many states use outside help, such as consultants, vendors, and universities.
64%	36%	**P4P will save money.** Most state directors are in the middle ("2" and "3" on the scale)—while hopeful, they are not sure P4P will save money and are careful in suggesting that it will.
62%	38%	**Need to respond to external pressures (such as the legislature, governor's office, contractors, or advocacy groups) to do more in this area.** Medicaid directors from large states were inclined to say that external pressures were very important; medium-size states less so. Small states were mixed.
62%	38%	**Do not have the funding to support an incentive program.** A real concern to the majority of directors.
62%	38%	**Want to be in step with what other states are doing.** Few directors are experiencing significant pressures ("very important" = 10%), but most feel some. "People are looking at pay-for-performance, so we should be looking at it too."
41%	59%	**Need to wait for more information on program outcomes before more effort is expended in this area.** Medicaid staffs would like more information, but most feel they need not or cannot wait for it to proceed.
38%	62%	**Do not have time to develop request for proposals (RFPs) to hire a contractor to implement and/or run a program.** Only one state Medicaid director reported that limited time for RFP development was "very important."
31%	69%	**Do not have the data with which to structure an effective program.** Respondents understood the need to limit their approaches to what they can do; they started with managed care, knowing that data were available. Now, they are looking at new approaches, moving to pay-for-participation and electronic health records on the practitioner side.
24%	76%	**It doesn't work.** Most respondents rejected this assertion because they believe P4P does work, although a few commented that the question had not yet been settled.

* Percent answering "very important" or "somewhat important."

** Percent answering "somewhat unimportant" or "not important at all."

Source: Surveys of Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, 2006. (n=29)

CONCLUSIONS

Medicaid directors and their staffs generally report positive feedback on their pay-for-performance programs and believe that the overall quality of care being provided is improving, although they have mixed opinions about cost savings resulting from pay-for-performance programs. Directors are considering changing some of the measures, the incentives, and even the data collection strategies to improve their existing programs and to include in new programs. Overall, they believe that pay-for-performance is adding to their repertoire of tools to improve the care provided to their Medicaid populations.

As state governments and other stakeholders move forward in this area, several challenges will need to be addressed. For example, with the growing emphasis on collaboration among stakeholders, and the use of nationwide and community-based standards, decisions will need to be made concerning how important it is to provide incentives for performance in areas that are particularly significant to Medicaid programs. These priorities include ensuring access to care, promoting high-quality prenatal and postpartum care, and addressing both the acute and long-term care needs of beneficiaries with chronic diseases and disabilities, especially since the largest per-beneficiary expenses occur for these populations. Creative solutions that still meet the goal of incorporating community standards will need to be developed. The expansion of HIT will undoubtedly assume a greater role in the process and provide opportunities for more precise and comprehensive measurement and more efficient data collection.

Ultimately, the biggest challenge facing both state Medicaid programs and those operated under other auspices is that of determining program effectiveness. Given that individuals change providers or may lose coverage altogether, and that standards of care change over time, this is difficult to do in any environment. However, Medicaid programs operate in a public setting. To the extent that Medicaid directors believe that pay-for-performance is improving care and reducing inappropriate spending, it is important that quantifiable and reliable results are available to demonstrate the value of the financial investment states make in these programs.

NOTES

[1] M. B. Rosenthal, B. E. Landon, S.-L. T. Normand et al., "Pay-for-Performance in Commercial HMOs," *New England Journal of Medicine,* Nov. 2, 2006 355(18):1895–1902.

[2] Leapfrog Group. Accessible online at http://www.leapfroggroup.org/home.

[3] Bridges to Excellence. Accessible online at http://www.bridgestoexcellence.org/.

[4] Integrated Healthcare Association. Accessible online at http://www.iha.org.

[5] CMS/Premier Hospital Quality Incentive Demonstration. Accessible online at http://www.premierinc.com/quality-safety/tools-services/p4p/hqi/index.jsp.

[6] Centers for Medicare and Medicaid Services. Accessible online at http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1343.

[7] M. Trisolini, G. Pope, J. Kautter et al., *Medicare Physician Group Practices: Innovations in Quality and Efficiency* (New York: The Commonwealth Fund, Dec. 2006). Accessible online at http://www.cmwf.org/publications/publications_show.htm?doc_id=428880.

[8] Centers for Medicare and Medicaid Services. Accessible online at http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/.

[9] Centers for Medicare and Medicaid Services, State Medicaid Director Letter #06-003, dated Apr. 6, 2006.

[10] See P. McNamara, "Foreword: Payment Matters? The Next Chapter," *Medical Care Research and Review,* Feb. 2006 63(1 Suppl.):5S–10S, for a fuller discussion of the difference between pay-for-performance and quality-based payment.

[11] All references to "states" in the body of the report include the District of Columbia and, thus, are reflective of a total of 51, except where specifically noted otherwise. New York State was not contacted due to limitations on the activities of former state employees. All information contained in this report concerning New York State is available publicly.

[12] One state did not complete the multiple choice sections on the written questionnaire.

[13] Kaiser State Health Facts, Total Medicaid Spending, FY 2005. Accessible online at http://www.statehealthfacts.org, and Centers for Medicare and Medicaid Services, Medicaid Managed Care Enrollment as of Dec. 31, 2004. Accessible online at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp.

[14] Of all 51 states (including the District of Columbia), 28 report that they currently operate programs,19 indicate that they do not have any existing programs, and information was not available from four states. With respect to state Medicaid programs operating new programs, 34 plan to do so, 12 report no plans to start new programs, and information was not available from five states.

[15] For example, a state may have one P4P program for managed care and a separate and distinct program, with its own measures and incentives, for nursing homes.

[16] Kaiser Commission on Medicaid and the Uninsured, Medicaid and Managed Care Fact Sheet; Dec. 2001; Accessible online at http://www.kff.org/medicaid/ and Kaiser State Health Facts, Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees, as of Dec. 31, 2004; Accessible online at http://www.statehealthfacts.org.

[17] CMS, Medicaid Managed Care Enrollment Report as of June 30, 2005. Accessible online at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp.

[18] There is a growing recognition that Medicaid programs spend significantly more for each chronically ill individual than they do for adults and children without disabilities (five and one-half and seven times more, respectively). See Kaiser Family Foundation State Health Facts; Medicaid Payments per Enrollee, FY 2003; Accessible online at http://www.statehealthfacts.org. As a result, many state Medicaid directors have begun focusing on how they can provide better, and, they hope, less expensive, care to this population.

[19] More information can be obtained on HEDIS and NCQA from the NCQA Web site, at http://web.ncqa.org/.

[20] More information on CAHPS can be found in the CAHPS section of the AHRQ Web site, at https://www.cahps.ahrq.gov/default.asp.

[21] This CMS limitation applies to other forms of incentives that can provide increased reimbursement such as differential reimbursement or fees and withholds.

[22] The report of the number of state Medicaid pay-for-performance programs that include penalties may be undercounted because not all program staff may have equated contractual penalties (such as liquidated damages for failure to meet a baseline) with pay-for-performance requirements.

[23] Institute of Medicine, *September 2006 Fact Sheet: Rewarding Provider Performance: Aligning Incentives in Medicare*. Accessible online at http://www.iom.edu/Object.File/Master/37/238/11723_fact_sheet.pdf.

[24] "Waiver" programs are special demonstration programs authorized by CMS that allow states to "waive" some of the underlying rules of the Medicaid program for specific purposes. One of the requirements of a waiver is that the program cannot cost the Medicaid program more than operating the program under the regular rules would cost, i.e., the program must be "cost neutral."

APPENDIX A. TABLES OF PROVIDERS, MEASURES, AND INCENTIVES

Table A-1. State Medicaid Pay-for-Performance Programs: Provider Type by Type of Measure—Existing Programs

Provider Type/State[a]	Type of Measure[b]				
	HEDIS/ HEDIS-like	Medical-Records Based	Patient Experience of Care	Cost/ Efficiency	Structural
Managed Care					
California	◆				◆
Delaware					◆
Florida					◆
Georgia	◆				◆
Maryland	◆				
Michigan	◆		◆	◆	◆
Minnesota	◆			◆	◆
Missouri	◆				
Nebraska		◆			
Nevada	◆				
New Jersey	◆				
New Mexico	◆			◆	
New York	◆		◆		
Ohio	◆		◆		◆
Pennsylvania	◆				
Rhode Island	◆		◆	◆	◆
Tennessee	◆			◆	◆
Utah	◆				
Washington	◆				
Wisconsin	◆				◆
PCCM					
Alabama				◆	◆
Louisiana	◆				◆
Oklahoma	◆				◆
Pennsylvania	◆			◆	◆
South Carolina[c]					◆
Nursing Homes					
Georgia		◆	◆		◆
Iowa				◆	◆
Utah			◆		◆

Provider Type/State[a]	Type of Measure[b]				
	HEDIS/ HEDIS-like	Medical-Records Based	Patient Experience of Care	Cost/ Efficiency	Structural
Other Providers[d]					
Florida				◆	
Illinois	◆			◆	
South Carolina				◆	
Primary Care					
Idaho	◆(c)				
Maine	◆			◆	◆
Behavioral Health					
Iowa		◆	◆	◆	◆
Nebraska		◆			
Hospitals					
Pennsylvania	◆				◆
Total number of programs using measure	24[e]	4	7	13	21

[a] Nineteen states report that they have no existing P4P programs: Alaska, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Indiana, Kansas, Massachusetts, Montana, New Hampshire, North Carolina, North Dakota, Oregon, Texas, Vermont, Virginia, West Virginia, and Wyoming. No information is available about programs in the following four states: Hawaii, Kentucky, Mississippi, and South Dakota.

[b] Use of a "(c)" denotes that a state is considering this type of measure but has not made a final determination.

[c] Although only one program, South Carolina's program is reported in two provider categories (PCCM and Other Providers) to reflect its differing components.

[d] States with providers in the "Other Providers" category include programs with "at-risk" contractors: Florida (Provider Service Networks); Illinois (disease management contractor); South Carolina (Care Coordination Service Organizations).

[e] Includes Idaho which is considering using this measure.

Source: Interviews with Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, 2006, and data from state-authorized Web sites.

Table A-2. State Medicaid Pay-for-Performance Programs: Provider Type by Type of Measure—New Programs

Provider Type/State[a]	Type of Measure[b]: HEDIS/ HEDIS-like	Medical-Records Based	Patient Experience of Care	Cost/ Efficiency	Structural	Not Yet Determined
Managed Care						
Arizona[c]	◆(c)				◆(c)	◆
Connecticut					◆(c)	◆
Delaware[d] (2 programs)	◆			◆	◆	◆
District of Columbia	◆					
Florida	◆(c)		◆(c)			◆
Illinois	◆					
Indiana	◆				◆	
Massachusetts					◆	◆
Nevada					◆(c)	◆
New Jersey					◆	
Pennsylvania					◆	
South Carolina						◆
Washington					◆(c)	◆
PCCM						
Illinois	◆		◆	◆	◆	
North Carolina	◆			◆	◆	
Nursing Homes						
Ohio						n/a
Oklahoma			◆(c)		◆(c)	◆
Utah						◆
Other Providers[e]						
Florida	◆(c)		◆(c)			◆
Vermont				◆	◆	
Primary Care/Fee-for-Service[f]						
Idaho	◆(c)					◆
Kansas	◆(c)				◆(c)	◆
Massachusetts					◆	◆
Missouri						◆
Nevada					◆(c)	◆
Ohio						n/a
Oklahoma	◆(c)					◆
Utah						◆
Washington					◆(c)	◆

Provider Type/State[a]	Type of Measure[b]					
	HEDIS/ HEDIS-like	Medical-Records Based	Patient Experience of Care	Cost/ Efficiency	Structural	Not Yet Determined
Behavioral Health						
Connecticut	◆		◆		◆	
Massachusetts					◆	◆
Montana					◆(c)	◆
Hospitals						
Arkansas		◆				
Massachusetts					◆	◆
Pennsylvania					◆	
Tennessee						◆
Clinics						
Idaho	◆(c)					◆
All Providers						
Arizona						◆
Vermont[g]	◆(c)					◆
Not Yet Determined						
Alaska						◆
Iowa						◆
Louisiana						◆
Maine						◆
Minnesota						◆
New Hampshire (2 programs)	◆(c)(2)					◆(2)
New York[h]	◆	◆	◆	◆	◆	
North Dakota[i]	◆(c)					◆
Oregon[j]	◆(c)			◆(c)	◆(c)	◆
West Virginia	◆(c)		◆(c)	◆(c)	◆(c)	◆
Total number of programs planning to use the measure	8	2	3	5	14	32
Total number of programs considering using the measure[k]	11	0	3	2	9	n/a
Total measures planned or under consideration	19	2	6	7	23	32

[a] Twelve states reported that they are not planning a new P4P program: Alabama, California, Colorado, Georgia, Michigan, Nebraska, New Mexico, Rhode Island, Texas, Virginia, Wisconsin, and Wyoming. No information is available about programs in the following five states: Hawaii, Kentucky, Maryland, Mississippi, and South Dakota.

[b] States that reported that they had not made a *decision* on the type(s) of measures, and did not report that they were *considering* any particular type(s) of measures, are identified solely in the "not yet determined" measure column. Use of a "(c)" in a measure column denotes that a state is "considering" this type of

measure, but has not made a final determination. These states are also identified as "not yet determined," except in North Dakota where the majority of decisions have been made concerning which type(s) of measures will be used. Use of an "n/a" in a measure column denotes that information is not available on the measures for the program.

[c] Arizona is considering establishing a P4P program that will affect both its managed care organizations and their contracting providers.

[d] Delaware is planning two new managed care programs. The measures to be used in the second one, focused on long-term and chronic care, are not yet determined.

[e] States with providers in the "Other Providers" category include programs with non-managed care "at-risk" contractors: Florida (Provider Service Networks); Vermont (disease management vendor).

[f] Kansas, Nevada, and Washington are developing P4P programs not only for primary care providers but for other unspecified fee-for-service providers.

[g] Vermont is developing P4P programs targeted at all providers who treat individuals with chronic conditions.

[h] New York's program is limited to primary care providers, managed care organizations, hospitals, and clinics. The specific providers will be determined following a request for proposal process.

[i] North Dakota is developing a P4P program that may include disease management vendors, fee-for-service providers, and/or primary care case management providers.

[j] Oregon is developing a P4P program that may include primary care providers, managed care organizations, or other provider types.

[k] Florida, Idaho, Nevada, and Washington are planning to implement single new programs, which are expected to affect more than one provider type. "Measure" totals count these programs only once.

Source: Interviews with Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, 2006, and data from state-authorized Web sites.

Table A-3. State Medicaid Pay-for-Performance Programs: Provider Type by Type of Incentive—Existing Programs

Provider Type/State[a]	Type of Incentive[b]						
	Auto Assignment	Differential Reimbursement	Bonus	Penalty	Withhold	Grant	Non-Financial[c]
Managed Care							
California	◆						◆
Delaware				◆			
Florida			◆				
Georgia		◆		◆			
Maryland			◆	◆			◆
Michigan	◆		◆		◆		◆
Minnesota			◆		◆		
Missouri	◆	◆					◆
Nebraska		◆					
Nevada			◆				
New Jersey				◆			◆
New Mexico	◆		◆		◆		◆
New York	◆	◆					◆
Ohio			◆	◆			
Pennsylvania			◆				
Rhode Island		◆					◆
Tennessee		◆	◆	◆		◆	◆
Utah			◆				◆
Washington			◆				
Wisconsin		◆	◆	◆			◆
PCCM							
Alabama		◆	◆				◆
Louisiana			◆				
Oklahoma			◆				◆
Pennsylvania			◆	◆			
South Carolina[d]		◆					◆
Nursing Homes							
Georgia		◆					◆
Iowa		◆					
Utah			◆				
Other Providers[e]							
Florida			◆	◆			
Illinois				◆			◆
South Carolina			◆	◆			

Provider Type/State[a]	Type of Incentive[b]						
	Auto Assignment	Differential Reimbursement	Bonus	Penalty	Withhold	Grant	Non-Financial[c]
Primary Care							
Idaho			◆(c)				
Maine			◆				◆
Behavioral Health							
Iowa			◆	◆			◆
Nebraska			◆				
Hospitals							
Pennsylvania			◆				
Total number of programs using incentive	5	11	24[f]	12	3	1	18

[a] 19 states report that they have no existing P4P programs: Alaska, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Indiana, Kansas, Massachusetts, Montana, New Hampshire, North Carolina, North Dakota, Oregon, Texas, Vermont, Virginia, West Virginia, and Wyoming. No information is available about programs in the following four states: Hawaii, Kentucky, Mississippi, and South Dakota.

[b] Use of a "(c)" denotes that a state is considering this type of incentive but has not made a final determination.

[c] Includes only non-financial incentives such as public recognition, tools, and peer recognition.

[d] Although only one program, South Carolina's program is reported in two provider categories (PCCM and Other Providers) to reflect its differing components.

[e] States with providers in the "Other Providers" category include programs with "at-risk" contractors: Florida (Provider Service Networks); Illinois (disease management contractor); South Carolina (Care Coordination Service Organizations).

[f] Includes Idaho, which is considering using this incentive.

Source: Interviews with Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, 2006, and data from state-authorized Web sites.

Table A-4. State Medicaid Pay-for-Performance Programs: Provider Type by Type of Incentive—New Programs

Provider Type/State[a]	Type of Incentive[b]							
	Auto Assignment	Differential Reimbursement	Bonus	Penalty	Withhold	Grant	Non-Financial[c]	Not Yet Determined
Managed Care								
Arizona[d]		◆(c)	◆(c)			◆(c)	◆(c)	◆
Connecticut			◆					
Delaware (2 programs)	◆(c)	◆(c)						◆
District of Columbia	◆		◆		◆		◆(c)	
Florida							◆(c)	◆
Illinois			◆		◆			
Indiana	◆(c)		◆	◆			◆	
Massachusetts		◆(c)	◆(c)				◆(c)	◆
Nevada								◆
New Jersey						◆		
Pennsylvania					◆			
South Carolina								◆
Washington								◆
PCCM								
Illinois			◆		◆		◆	
North Carolina		◆(c)					◆(c)	◆
Nursing Homes								
Ohio								n/a
Oklahoma		◆(c)					◆(c)	◆
Utah								◆
Other Providers[e]								
Florida							◆(c)	◆
Vermont				◆				
Primary Care/ Fee-for-Service[f]								
Idaho								◆
Kansas			◆(c)				◆(c)	◆
Massachusetts		◆(c)	◆(c)				◆(c)	◆
Missouri		◆						
Nevada								◆
Ohio								n/a
Oklahoma								◆
Utah								◆
Washington								◆

Provider Type/State[a]	Type of Incentive[b]							
	Auto Assignment	Differential Reimbursement	Bonus	Penalty	Withhold	Grant	Non-Financial[c]	Not Yet Determined
Behavioral Health								
Connecticut		◆						
Massachusetts		◆(c)	◆(c)				◆(c)	◆
Montana		◆(c)	◆(c)					◆
Hospitals								
Arkansas			◆					
Massachusetts		◆(c)	◆(c)				◆(c)	◆
Pennsylvania						◆		
Tennessee								◆
Clinics								
Idaho								◆
All Providers								
Arizona							◆(c)	◆
Vermont[g]						◆		
Not Yet Determined								
Alaska						◆(c)		◆
Iowa		◆(c)	◆(c)				◆(c)	◆
Louisiana								◆
Maine								◆
Minnesota								◆
New Hampshire (2 programs)								◆
New York[h]						◆		
North Dakota[i]								◆
Oregon[j]	◆(c)						◆(c)	◆
West Virginia							◆(c)	◆
Total number of programs planning to use incentive	1	2	6	2	4	4	2	31
Total number of programs considering using incentive	3	10	8	0	0	2	14	n/a
Total incentives planned or under consideration[k]	4	12	14	2	4	6	16	31

[a] Twelve states reported that they are not planning a new P4P program: Alabama, California, Colorado, Georgia, Michigan, Nebraska, New Mexico, Rhode Island, Texas, Virginia, Wisconsin, and Wyoming. No information is available about programs in the following five states: Hawaii, Kentucky, Maryland, Mississippi, and South Dakota.

[b] States that reported that they had not made a *decision* on the type(s) of incentives, and did not report that they were *considering* any particular type(s) of incentives, are identified solely in the "not yet determined" incentive column. Use of a "(c)" in an incentive column denotes that a state is "considering" this type of incentive, but has not made a final determination. These states are also identified as "not yet determined," except in the District of Columbia and Indiana where the majority of

decisions have been made concerning which type(s) of incentives will be used. Use of an "n/a" in an incentive column denotes that information is not available on the incentives for the program.

[c] Includes only non-financial incentives such as public recognition, tools, and peer recognition.

[d] Arizona is considering establishing a P4P program that will affect both its managed care organizations and their contracting providers.

[e] States with providers in the "Other Providers" category include programs with non-managed care "at-risk" contractors: Florida (Provider Service Networks); Vermont (disease management vendor).

[f] Kansas, Nevada, and Washington are developing P4P programs not only for primary care providers but for other unspecified fee-for-service providers.

[g] Vermont is developing P4P programs targeted at all providers who treat individuals with chronic conditions.

[h] New York's program is limited to primary care providers, managed care organizations, hospitals, and clinics. The specific providers will be determined following a request for proposal process.

[i] North Dakota is developing a P4P program that may include disease management vendors, fee-for-service providers, and/or primary care case management providers.

[j] Oregon is developing a P4P program that may include primary care providers, managed care organizations, or other provider types.

[k] Florida, Idaho, Nevada, and Washington are planning to implement single programs, which are expected to affect more than one provider type. "Incentive" totals count these programs only once.

Source: Interviews with Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, 2006, and data from state-authorized Web sites.

Table A-5. State Medicaid Programs Participating in Multi-Payer Pay-for-Performance Activities

State	Program Name and Description
Arizona	**Health-e Connection Roadmap** This program is a public/private partnership to promote health information technology in medical offices, hospitals, and other health care providers, as well as health information exchange among providers. The State is interested in including other payers in this initiative. The initial incentive to participate in the program is the advantage of having information available to be a more effective health care provider. Participation could be required in the future. Grant funding is available. http://www.azgita.gov/tech_news/2006/Arizona%20Health-e%20Connection%20Roadmap.pdf
Kansas	**Multi-Payer Program** The Kansas Health Care Authority, created in July 2005 to improve overall health care in the State, houses both the Medicaid program and the State employee benefits program. The Authority also collects encounter data from all non-ERISA carriers and is evaluating how to use this data to establish a quality initiative. Medicaid would be one, but not the only, participating provider.
Maine	**Maine Quality Forum** Established in 2003, the Maine Quality Forum has four main purposes: collection and dissemination of research; adoption of quality and performance measures; promotion of evidence-based medicine and practices; and public reporting on the costs and quality of care. In addition to the State's Medicaid program, Forum participants include the three major payers: physician groups, medical groups, and the State employee health program. http://www.mainequalityforum.gov/
Minnesota	**Smart-Buy Alliance** Initiated in November 2004, the Smart-Buy Alliance is a program under which the State and business and labor groups pool their purchasing power with the goal of reducing health care costs resulting from inappropriate and poor quality care. The Alliance embodies four common principles: require or reward "best in class certification"; adopt uniform measures of quality and results; empower consumers with easy access to information; and require the latest information technology. http://www.maximumstrengthhealthcare.com
New Hampshire	**Citizen's Health Initiative** Citizens, payers, businesses, medical professionals, and government leaders are joining together to develop a health care plan for the State. The overall goal of the program is to create a system of care that promotes health, assures quality, and makes care affordable, effective, and accessible. While incentives have not yet been determined, four measures have been identified by the Initiative: use of appropriate medications for people with asthma; appropriate testing and/or treatment for children with pharyngitis; and two diabetes outcome measures (HbA1c and LDL-C levels). http://www.citizenshealthinitiative.org

State	Program Name and Description
New York	**Regional Pay-for-Performance Grant Program** Regional coalitions of health care payers (managed care organizations, health insurance companies, government insurance, and self-insured employers) and providers (hospitals, clinic, and physicians) are eligible to compete for grants to support pay-for-performance, health information technology, and patient safety programs. The specific measures that can be incorporated in projects were developed through a workgroup process in which managed care plans, hospitals, provider associations, payers, labor unions, state staff, and consumers participated. Projects will be chosen through a Request for Proposal process. See http://www.nyhealth.gov/funding for the complete RFP.
Oregon	**Oregon Health Care Quality Corporation** The Oregon Health Care Quality Corporation is designed to bring measurable improvement to the quality of health care in Oregon. The Quality Corporation coordinates projects that improve health care quality through better information and increased community-wide collaboration. Participants include doctors, hospitals, insurers, providers, purchasers, government agencies, and consumers. The Medicaid program is interested in incorporating uniform, statewide standardized performance measures, perhaps developed by the Corporation, into its programs. http://www.q-corp.org/
Vermont	**Vermont Blueprint for Health** Stated in 2003, the Vermont Blueprint for Health is a collaborative public/ private partnership that includes state government, health insurance plans, business and community leaders, health care providers, and consumers. The Blueprint is focused on chronic care issues and is seeking to promote change in four areas: patient self-management, provider practice change, community development, and information systems development. The Medicaid program's Chronic Care Management Program will be participating in the Blueprint. http://healthvermont.gov/blueprint.aspx#initiative
Washington	**Multi-Payer Program** Washington's Medicaid program is talking to stakeholders in the health care system—other payers, labor, industry, purchasing consortiums, and medical groups—to develop new approaches, measures, and incentive programs to promote the provision of high-quality, affordable and evidence-based health care.

Source: Surveys of Medicaid directors & staff conducted by The Kuhmerker Consulting Group, LLC, 2006, as well as information concerning existing and planned state Medicaid pay-for-performance programs from state Web sites.

Table A-6. State Medicaid Pay-for-Performance Programs: Summary of State Activity

State	Number of Existing Programs	Number of New Programs	Total Number of Programs
Alabama	1	0	1
Alaska	0	1	1
Arizona	0	2	2
Arkansas	0	1	1
California	1	0	1
Colorado	0	0	0
Connecticut	0	2	2
Delaware	1	2	3
District of Columbia	0	1	1
Florida	2	1	3
Georgia	2	0	2
Hawaii	n/a	n/a	n/a
Idaho	1	1	2
Illinois	1	2	3
Indiana	0	1	1
Iowa	2	1	3
Kansas	0	1	1
Kentucky	n/a	n/a	n/a
Louisiana	1	1	2
Maine	1	1	2
Maryland	1	n/a	1
Massachusetts	0	4	4
Michigan	1	0	1
Minnesota	1	1	2
Mississippi	n/a	n/a	n/a
Missouri	1	1	2
Montana	0	1	1
Nebraska	2	0	2
Nevada	1	1	2
New Hampshire	0	2	2
New Jersey	1	1	2
New Mexico	1	0	1
New York	1	1	2
North Carolina	0	1	1
North Dakota	0	1	1

State	Number of Existing Programs	Number of New Programs	Total Number of Programs
Ohio	1	2	3
Oklahoma	1	2	3
Oregon	0	1	1
Pennsylvania	3	2	5
Rhode Island	1	0	1
South Carolina	1	1	2
South Dakota	n/a	n/a	n/a
Tennessee	1	1	2
Texas	0	0	0
Utah	2	2	4
Vermont	0	2	2
Virginia	0	0	0
Washington	1	1	2
West Virginia	0	1	1
Wisconsin	1	0	1
Wyoming	0	0	0
Total number of states with programs	28	34	43
Total number of programs	35	47	82

Note: "n/a" indicates that information on this state is not available.

Source: Interviews with Medicaid directors and staff conducted by The Kuhmerker Consulting Group, LLC, 2006, and data from state-authorized Web sites.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.cmwf.org.

Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care (March 2007). Allan H. Goroll, Robert A. Berenson, Stephen C. Schoenbaum et al., *Journal of General Internal Medicine,* vol. 22, no. 3 (*In the Literature* summary).

Medicare Physician Group Practices: Innovations in Quality and Efficiency (December 2006). Michael Trisolini, Gregory Pope, John Kautter et al.

Quality Matters: Pay-for-Performance in Medicare (September 2006). Newsletter.

Case Study: Improving Quality and Efficiency in Response to Pay-for-Performance Incentives Under the Medicare Physician Group Practice Demonstration (September 2006). Douglas McCarthy.

Medicare Physician Payment: Are We Getting What We Pay For? Are We Paying for What We Want? (July 25, 2006). Stuart Guterman. Congressional testimony.

Measuring, Reporting, and Rewarding Performance in Health Care (March 2006). Richard Sorian.

Can Medicaid Do More with Less? (March 2006). Alan Weil.

Early Experience with Pay-for-Performance: From Concept to Practice (October 12, 2005). Meredith B. Rosenthal, Richard G. Frank, Zhonghe Li et al., *Journal of the American Medical Association,* vol. 294, no. 14 (*In the Literature* summary).

Measure, Learn, and Improve: Physicians' Involvement in Quality Improvement (May/June 2005). Anne-Marie J. Audet, Michelle M. Doty, Jamil Shamasdin, and Stephen C. Schoenbaum. *Health Affairs,* vol. 24, no. 3 (*In the Literature* summary).

Examining Pay-for-Performance Measures and Other Trends in Employer-Sponsored Health Care (May 2005). Meredith B. Rosenthal. Congressional testimony.

Quality Matters: Pay-for-Performance in Medicaid (April 2005). Newsletter.