APPENDIX B. STATE PAY-FOR-PERFORMANCE PROGRAM SUMMARIES

CONTENTS

ALABAMA
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Patient 1st Program (June 2005): The Patient 1st Program has two major components: ▪ PCCM case management fee. Providers receive a case management fee based on participation in specific programs and activities; and ▪ Shared Sharing. Savings are shared equally between the state and participating providers based on overall costs for the provider's panel of patients. The Patient 1st Program provides patient management tools to its providers, at no cost to the providers, to help them provide higher-quality/less expensive care. Tools include: ▪ an in-home monitoring program for individuals with chronic diseases; ▪ a practice management program, which provides drug, office visit, and lab history to providers for Medicaid and Blue Cross subscribers; and ▪ a provider report card, which provides providers with 12 months of age/sex/morbidity-adjusted data on their patient panel vs. peer data.	Primary Medical Providers (PMPs) – physicians and clinics. Participation of providers is voluntary	**Differential reimbursement (case management fee):** Monthly case management fee is based on program participation. Total fee reflects payment for those activities in which a provider participates, as follows: EPSDT Provider (provides own screenings) $0.45 Vaccines for Children (VFC) Participant $0.10 Medical Home Training $0.10 24/7 Coverage (provides direct after-hours coverage) $0.85 Hospital Admitting Privileges (provider admits own patients to hospital) $0.30 In-Home Monitoring (chronic disease mgmt) $0.10 Practice Management Participant $0.50 Receives MA Program Notices Electronically $0.05 Electronic Educational Materials (receives materials and copies for patients) $0.15 Total possible PCCM Fee: $2.60 **Bonus (shared savings):** Savings will be shared equally between the state and providers. Actual definition of base and program costs, as well as the measurement period, have not been finalized (expected September 2006). Cost increases are not shared between the state and providers.	Differential reimbursement is based on participation in specific programs and activities (see Incentive Type and Methodology). These state-developed measures were chosen by the state because of their correlation with the provision of high-quality care. Savings will be shared equally between the state and providers. Actual definition of base and program costs, as well as the measurement period, have not been finalized (expected September 2006).

ALASKA
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Possible Grants-Based Pay-for-Performance Program (target start date: one to two years): State is gathering information on other programs and measurement approaches. Open to working with Blue Cross, Tribal Health Corporation, and other payers to gain purchasing power and emphasize same or similar practices for all payers.	Not yet determined.	Not yet determined. Considering grants in the area of health information technology, electronic health records, and pharmacy management. Incentives must not create access problems.	Not yet determined. Interested in adopting proven outcome measures that are not burdensome to collect.

ARIZONA
NEW PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Pay-for-Performance Program (target start date: one to two years): State is working with the provider community to develop a pay-for-performance program that would use fair, achievable, and objective measures to reward managed care plans and their providers for meeting quality standards.	Managed care organizations (MCOs) as well as providers with whom the managed care organizations contract.	Not yet determined. State is working closely with provider community to develop effective incentives. Most interested in incentives that provide increased resources to high- or improving-quality providers, not penalties for failing to meet standards. Expect incentives will also be designed to reward attainment of a standard rather than a comparison of all participants with incentive going to highest achiever. Total Medicaid program is operated through managed care organizations. As a result, state is considering designating a certain dollar amount that would need to be used for provider pay-for-performance. Examples of incentives currently under consideration: ▪ differential rates and fees; ▪ bonuses; and ▪ public recognition. Incentives may also be structured to coordinate with overall e-health initiative (see below).	Not yet determined. State is working closely with the provider community to develop fair, achievable, and objective measures. Also looking for measures that will not increase reporting obligations. Among the types of measures being considered are: ▪ Primary care providers: Looking for a small number of well-accepted HEDIS-like measures that may already be being collected. ▪ Hospitals: Examining measures that are already being reported and are well accepted. Considering adapting Leapfrog-type measures. ▪ Public recognition for certain achievements, such as designation as a center of excellence.
Health-e Connection Roadmap: ▪ Governor has a five-year roadmap, developed by a task force, for e-health adoption in the state. ▪ Program is a public/private partnership, in which Medicaid is expected to participate, to promote health information technology in medical offices, hospitals, etc. as well as health information exchange among providers. ▪ State also interested in including other payers in the e-health initiative.	All provider types	Not yet determined. Developing Web-based system that will include data from numerous sources, regardless of payer (such as laboratory results, health plan enrollment data, pharmacy benefit usage). All providers will have access, with appropriate privacy protections. Initial incentive to participate is the advantage of having information available to be a more effective health care provider and the possibility of some form of grant funding (not necessarily Medicaid funding). Participation could become required in the future.	Not yet determined.

ARKANSAS
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Hospital Inpatient Quality Incentive Payment (July 2006): Arkansas is establishing a hospital pay-for-performance incentive program using compliance measures established under the Medicare program. State Plan Amendment approval is pending at CMS.	Acute care hospitals, excluding pediatric hospitals, state-operated teaching hospitals, rehabilitative hospitals, inpatient psychiatric hospitals, and critical access hospitals. Hospital participation is voluntary.	**Bonus:** ▪ The state's methodology for incentivizing hospitals rewards both attainment of the target as well as improvement toward meeting 100% of the target. ▪ To be eligible to receive the bonus, hospitals must meet or exceed the compliance rate on two-thirds of the quality measures chosen. ◆ For 2006, the state has chosen seven measures. ◆ Hospitals, therefore, need to meet or exceed the targets on five of them. ▪ Hospitals can meet or exceed the compliance rate for each measure in one of two ways: ◆ The rate in the current rating period is equal to or higher than the 75th percentile of all hospitals in the state for the same period the year before, or 95% compliance, whichever is lower; or ◆ The rate in the current rating period is equal to or greater than the prior period rate plus 25% of the difference between the prior period rate and 100% compliance. ▪ Hospitals that meet the quality requirement during the reporting period will receive a bonus at the end of the reporting period equal to $50 per diem or 5.8% of the per diem rate, whichever is lower. ◆ The per diem bonus is calculated based on Medicaid patient days during the state fiscal year that includes the rating period. ▪ Performance is measured annually for a six-month period (two quarters). The bonus is provided approximately six months after the measurement period.	**Medicare measures:** The state will determine which Medicare quality measures it will use in its quality incentive program. For 2006, the state has chosen seven measures as follows: <u>Heart Failure:</u> ▪ HF1: Discharge instructions ▪ HF2: Evaluation of left ventricular systolic (LVS) function ▪ HF3: ACE Inhibitor or ARB for left ventricular systolic dysfunction (LVFD) ▪ HF4: Adult Smoking Cessation Advice/Counseling <u>Pneumonia:</u> ▪ PN2: Pneumococcal Vaccination Given/Screened ▪ PN4: Adult Smoking Cessation Advice/Counseling ▪ PN5b: First Antibiotic Dose within 4 Hours

CALIFORNIA
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Performance Incentive Program (December 2005): ▪ The state incorporates seven (five HEDIS and two state-developed) performance measures in its algorithm for pay-for-performance to auto-assign individuals who have failed to choose a managed care plan: ◆ The HEDIS measures are designed to measure quality of care for those populations in which the state has particular interest. ◆ The state-developed measures are designed to measure the plan's continued support for safety net providers and clients. ▪ The program also includes a public reporting component for all managed care plans.	Managed care plans Plans can opt out of accepting auto-assignments (i.e., those individuals who would have been assigned to them are distributed proportionately to the other plans in the county). Plans are required to participate in the public reporting aspects of the program.	**Auto-assignment:** ▪ The auto-assignment algorithm applies only to managed care plans in 14 counties with two or more plans: 12 counties operating under the two-plan model (one county-developed health plan and one commercial health plan) and two Geographic Managed Care counties in which all qualified managed care plans can participate. ▪ Plans are assigned points relative to their performance on the measures as compared to the other plan(s) in the same county. ▪ Each plan receives that proportion of auto-assignees equal to its proportion of total points for all plans in the county. ◆ In the first two years of the program (2005 and 2006), no plan's percentage of those auto-assigned is allowed to change by more than 10 percentage points each year. ▪ After the first year, points will also be assigned to reflect the extent to which a plan's performance on a measure has changed from the previous year. ******** **Public recognition:** ▪ Report cards on plan performance are sent to new enrollees to assist them in making plan choices. Report cards are also sent to existing enrollees during the annual eligibility redetermination process to assist them if they want to change plans. ▪ HEDIS and CAHPS measures are publicly reported. ▪ Reports are made available regardless of the number of plans in a county.	**HEDIS measures:** ▪ Childhood immunization status (combo 2) ▪ Well-child visits: 3rd through 6th years of life ▪ Adolescent well-care visits ▪ Timeliness of prenatal care ▪ Use of appropriate medications for people with asthma **Structural/State-developed measures:** ▪ % of hospital discharges at Disproportionate Share Hospitals (DSH) for Medi-Cal managed care enrollees ▪ % of Medi-Cal managed care enrollees with safety net provider Primary Care Providers ******** Public reporting is based on HEDIS measures as well as CAHPS consumer survey measures.

CONNECTICUT
NEW PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Enhanced Care Clinic Program (target start date: January 2007): ▪ Program is being developed in conjunction with an overall effort to improve and expand individualized, family-centered and community-based mental health and substance abuse services. ▪ Providers can apply through a Request for Application (RFA) process to be enhanced care clinics (ECCs). ECCs must meet a number of Sstate-developed structural requirements related to access and care delivery. ▪ In recognition of the ability of the ECC to meet those standards, fees will be increased by an average of 25%.	Behavioral Health Providers: Outpatient Mental Health and Substance Abuse Clinics for Adults and Children Provider participation is voluntary	**Differential reimbursement (increased fees):** ▪ Existing hospital-based and freestanding mental health/substance abuse clinics can apply through an RFA process to receive designation as an ECC. ▪ ECCs, which bill on a fee-for-service basis, will receive fees that are approximately 25% higher than regular fee-for-service payment levels.	Clinics will need to meet several state-developed structural measures to retain designation as an ECC and be able to receive the increased fees. Requirements are expected to be phased-in over a one-year period, in the following areas: <u>January 2007:</u> Access measures: ▪ Emergency screening and crisis assessment (95% seen within 2 hours) ▪ Urgent outpatient evaluation (95% offered appointment within 2 calendar days) ▪ Routine outpatient evaluation (95% offered appointment within 14 calendar days) ▪ Outpatient follow-up visit (95% seen within 14 calendar days) ▪ Extended hours (at least nine hours beyond 9 to 5 on business days) <u>June 2007:</u> Coordination of care measures: ▪ Agreements with other clinics for medical management, co-management, etc. Member services and support: ▪ Peer support groups meet during nine months of the year ▪ Client satisfaction survey ▪ Materials pertaining to client rights and responsibilities and education sources <u>December 2007:</u> Quality: ▪ Adoption of one evidence-based practice ▪ Effective management of individuals with co-occurring disabilities ▪ Care offered in at least two specialties (e.g., trauma, eating disorders) ▪ Cultural competence

CONNECTICUT
NEW PAY-FOR-PERFORMANCE PROGRAMS (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Pay-for-Performance Program (target start date: July 2007): State developing a pay-for-performance program that would provide bonuses to managed care organizations related to provision of specialty care, particularly for children. State is consulting with stakeholders as the program is being developed.	Managed care organizations (MCOs)	**Bonus:** State is developing a proposal to provide bonuses to managed care organizations for maintaining and/or improving their specialist networks, particularly pediatric specialists. Bonus amount could be as much as 2.5% of capitation amount. Measurement period, timing of bonus, and amount of bonus are not yet determined.	Standards not yet determined; stakeholders are being consulted. Areas being researched include: ▪ identifying any existing standards for specialist-to-patient ratios; ▪ amount of turnover in specialist panels; ▪ number of specialists who will see new patients; and ▪ membership churning.

DELAWARE
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Diamond State Health Plan Program (1996): ▪ Delaware currently contracts with one company (Delaware Physicians Care, Inc.) to manage its mandatory managed care program. ▪ The managed care organization is required to meet performance criteria or sanctions will be applied. ▪ Current performance criteria are access, data, and complaint-related, but the state has proposed expanding its pay-for-performance program to include additional quality of care indicators (see "new program" description following).	Managed care organizations	**Penalty:** ▪ The managed care organization is liable to penalties of $1,000 per day for failure to meet required performance standards. ▪ In addition, the state is authorized to withhold capitation payments if encounter data are not reported to the state as required by the contract.	Existing measures are in areas such as: ▪ time to schedule appointments; ▪ waiting times; ▪ data reporting to the state; and ▪ complaints.

DELAWARE
NEW PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Delaware Quality Strategy for the Diamond State Health Program (target start date: July 2008) ▪ Responses to Delaware's Diamond State Health Program RFP are due in December 2006. This RFP incorporates the state's Quality Strategy. ▪ The program is scheduled to begin July 1, 2007, with pay-for-performance aspects beginning July 1, 2008. ▪ The Quality Strategy will cover services provided under Medicaid and SCHIP.	Managed care organizations, primary care providers, SCHIP providers	Incentive types and methodologies are proposed to be developed jointly by the state and its contractor(s). Among the kinds of incentives being discussed are: ▪ **Auto-assignment:** The auto-assignment algorithm may reflect the completeness of EPSDT reporting. The state may also decide to only auto-assign individuals to plans which provide complete and accurate encounter data. ******** ▪ **Other incentives:** The state is interested in developing positive incentives (rather than penalties) to promote quality. While no final determinations have been made, the state is considering differential reimbursement rates or fees. Incentives are likely to be based on attainment of certain goals and improvement in meeting goals and may also include measures that reflect both attainment and improvement.	**EPSDT measures:** The contractor(s) are required to report several measures of EPSDT activity (such as providing notices of screening due dates, performing the screenings, and making referrals). It is not yet determined, however, whether the state will incorporate levels of performance in these areas, reporting only, or both, as a factor in providing incentives. ******** Delaware's Quality Strategy includes measures in the following areas. It is expected that the state's pay-for-performance program will include some, but not all, of these measures: **HEDIS-like measures:** <u>Access/Availability of Care:</u> ▪ Well-care visits (15 months; 3–6 years) ▪ Access to a primary care provider (children and adolescents; 4 age ranges) ▪ Access to a primary care provider (adults; 3 age ranges)

DELAWARE
NEW PAY-FOR-PERFORMANCE PROGRAMS (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
			Effectiveness of Care – Quality: ▪ Childhood immunizations (combo 2) ▪ Adolescent immunizations (combo 2) ▪ Breast cancer screening ▪ Cervical cancer screening ▪ Appropriate medications for people with asthma (3 age ranges and combined rate) ▪ Diabetes care (lipid, HbA1c, and retinal eye exam screening) ▪ Chronic Heart Failure – ACE inhibitors ▪ Appropriate treatment for children with upper respiratory infections ▪ Behavioral health -- appropriate antidepressant medication Utilization of Services: ▪ 5% decrease in ER admissions ▪ 5% decrease in hospital readmission rates ▪ Hospital discharges ▪ Inpatient days **State-developed specifications:** Several state-developed measures are also included in their quality strategy: ▪ Lead screening rate (<3 and <6 years of age) ▪ Lipid screening for those with hyperlipidemia **Structural measures:** ▪ Time to get an appointment ▪ Waiting time
Long-Term and Chronic Care Pay-for-Performance Program (target start date: July 2009): ▪ Delaware is considering enrolling elderly and disabled individuals needing long-term care (institutional or waivered long-term care programs) into managed care settings. A pay-for-performance program would be incorporated into this program. ▪ Establishment of a program for individuals with behavioral health needs is also under consideration.	Managed care organizations	Not yet determined.	Not yet determined.

DISTRICT OF COLUMBIA
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Pay-for-Performance Program (target start date: August 2007): The District of Columbia is planning to phase in a multifaceted pay-for-performance program for its managed care organizations. The program's components may include: ▪ auto-assignment based in part on quality measures; ▪ bonuses and withholds for meeting certain HEDIS measures; and ▪ public recognition of plan quality. The District of Columbia is developing the program with the George Washington University School of Public Health and will incorporate input from managed care organizations.	Managed Care Organizations (MCOs). Next RFP for managed care is expected to implement pay-for-performance. MCOs will be required to be NCQA accredited or working towards accreditation.	**Auto-assignment:** The auto-assignment algorithm may be structured to incorporate quality measures. **Bonus/withhold:** ▪ District expects that the program will not include any bonuses or withholds during the first year. ▪ Beginning in year 2, the District may incorporate both bonuses and withholds. Specifics on how this will be done are not yet determined. **Public recognition:** The District is evaluating how to incorporate public recognition in the program. As with the bonuses and withholds, this incentive may begin in the second year. Note: The Health Care Alliance program (health care coverage for individuals with incomes up to 200% of the federal poverty level, paid for with local funds) uses the Medicaid contracts for its programs. As such, HCA may also incorporate comparable pay-for-performance requirements as a result of the next procurement.	**HEDIS and HEDIS-like measures:** ▪ Current managed care contracts require MCO reporting on 40+ HEDIS measures. ▪ District may use between 5 and 15 measures in its pay-for-performance program. ▪ The measures may be phased in over three to four years. ▪ Measures will be targeted to the Medicaid population which includes children, adults and those with chronic diseases. ▪ Efforts will also be made to incorporate measures that reflect community standards and best practices.

FLORIDA
EXISTING PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Provider Service Networks (PSNs) (2001): ▪ Provider Service Networks are administrative entities composed of network arrangements of physicians, hospitals, and ancillary providers in certain areas of the state. PSNs are responsible for health care service provision to enrollees, as well as administrative functions such as credentialing and enrolling providers, quality initiatives, and utilization management. ▪ PSNs incorporate a pay-for-performance program that is focused on cost efficiency and savings. ▪ PSNs receive a monthly administrative fee to manage the care provided to Medicaid enrollees. ▪ Services are paid for on a fee-for-service basis. Note: Florida currently operates two other programs (the Minority Physician Network and the Pediatric Emergency Room Diversion program), which are primary care case management programs that incorporate a similar bonus/penalty component.	Participation in the pay-for-performance component of the PSN program is required as part of the contractual relationship with the state. Provider participation in the PSN is voluntary.	**Bonus/penalty:** ▪ The design of the bonus/penalty calculation is to enable PSNs to share in any savings that accrue when comparing the PSN program to contractual benchmarks. ▪ A comparison is made between the PSN's program costs and those that would have been incurred under the fee-for-service program. ▪ The PSN retains a portion of the savings. ▪ If there were no savings or the savings were less than the cost of the administrative fee, the PSN must return 50 percent of the administrative fee to the state. ▪ This reconciliation is conducted annually.	**Cost/efficiency measure:** Shared savings calculations (see Incentive Type and Methodology section)
Dental Managed Care Program (2004): ▪ Program provides bonus payments to network dentists based on client visits.	Program is mandatory for dentists participating in dental managed care program.	**Bonus:** ▪ Managed care program incorporates an incentive program which provides bonuses to dentists who see at least 60% of the children assigned to their practice. ▪ Activity is reviewed quarterly; the bonus is paid quarterly, approximately six months after completion of the quarter.	**Structural/state-developed measure:** Bonus is given to dentists who see at least 60% of the children assigned to their practice.

FLORIDA
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Enhanced Performance Reporting Program (target start date: 2007-2009): ▪ State is interested in adding additional quality indicators to Managed Care Organization and other network program pay-for-performance programs. ▪ Also interested in direct provision of quality and performance information to enrollees to assist them in making provider/plan choices.	Managed care organizations and other provider network organizations (Provider Service Networks)	Not yet determined. Also looking to expand public reporting and targeted reporting to Medicaid enrollees. Note: Public reporting on performance measures related to preventive and chronic disease care, access to care, and service utilization is currently provided. Information is also made available on the Web.	Not yet determined, but a workgroup has been established to evaluate HEDIS and HEDIS-like measures. CAHPS-like surveys are also likely to be included.

GEORGIA
EXISTING PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Nursing Home Quality Incentive Program (July 2004): ▪ Program provides for differential payments for nursing homes that actively participate in the program, which consists of two process tests (see Incentive Type and Methodology). ▪ Data on facility performance is collected by the quality contractor. Some data are directly reported to them by the nursing homes; some are MDS data; some are collected by the contractor (e.g., patient/family and employee satisfaction surveys). ▪ This information is reported back to the home, along with comparisons with peers in the state and nationwide, so that the facility can evaluate their quality performance and make appropriate changes. ▪ Aggregate performance data are provided to the state and is made public.	Nursing facilities. All nursing facilities are required to participate.	**Differential reimbursement:** Nursing facilities are provided with a 1% increase in their rate if they actively participate in the quality incentive program. Active participation is defined as: ▪ having a nurse/patient staffing ratio of greater than 2.5 hours per patient per day; and ▪ participating in data collection efforts with the state's contractor. The quality incentive payment is reviewed by the state, and can be adjusted to reflect changes in nursing facility participation, on a quarterly basis. The state expects to increase the amount of the incentive to 2% of the rate next year. **Public recognition:** Aggregate performance data on overall industry performance is made public; some information made available on Georgia Health Care Association Web site.	In addition to the nurse/patient staffing ratio indicator, quality measures developed by the contractor are collected. Examples of such measures, many of which are medical records-based, include: ▪ prevalence of acquired decubiti (occurred after patient in NH); ▪ use of psychotropics; ▪ use of physical restraints; ▪ prevalence of falls; ▪ use of catheters; ▪ occurrence of depression; ▪ survey deficiency analysis; and ▪ staff stability (RN and CNA absenteeism and turnover). The contractor also conducts and reports on family and employee satisfaction surveys focusing on quality of care/life/services (family surveys) and work environment/ training/supervision (employee surveys).

GEORGIA
EXISTING PAY-FOR-PERFORMANCE PROGRAMS (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Care Management Organization (CMO) Pay-for-Performance Program (June 2006): ▪ Program is being phased in along with overall mandatory managed care program, "Georgia Healthy Families." Emphasis in program is on care for children. ▪ CMOs are required to meet benchmark standards in a number of areas; if standards not met, CMOs may be required to pay liquidated damages. ▪ If performance exceeds standards, CMOs may receive a performance payment, which, in the aggregate, cannot be more than 105% of the capitation rate.	Care Management Organizations (CMOs) Pay-for-performance requirements are incorporated in CMO contracts with the state; as a result, all CMOs wishing to participate in the Medicaid program must participate in the performance program.	**Differential reimbursement:** CMOs may receive up to 105% of their capitation rate if they exceed standards in certain primarily primary care areas. Performance data are reviewed quarterly and the rate adjustment, if any, is reflected in the monthly capitation payments made in the following quarter. While not mandated, some of the plans pass on a portion of the incentive payment to their networks. ********** **Penalty:** CMOs are liable for liquidated damages: ▪ $25,000 if the CMO does not operate the physician quality incentive program as outlined in the RFP (see "New Pay-for-Performance" section; and ▪ $5,000 per day if the CMO does not meet certain HEDIS-type minimum standards. ******** **Incentive to Primary Care Providers:** Within one to two years, each CMO will be required to develop a Physician Quality Incentive Program, which must be approved by the state. Methodologies are not yet developed, but the state expects that the incentive could be an increase in the fee paid to primary care physicians by the CMOs.	**HEDIS-type measures:** ▪ % of Health Check (EPSDT) well-child visits in excess of the minimum 80% compliance standard; ▪ % of lead screening blood tests in excess of the minimum 80% compliance standard for children 9 to 30 months old; and ▪ % or # of dental visits in excess of the minimum 80% rate of Health Check–eligible children receiving visits. Information is obtained from encounter data. **Structural/State-developed measures:** ▪ # of newborn enrollment notifications received within 12 hours of birth; and ▪ # of follow-up calls or notices to Health Check members who have missed screening visits. ********** **HEDIS-type/structural measures ($5,000 per day liquidated damages):** ▪ initial health visit and screening requirements for Health Check (EPSDT) eligibles; ▪ periodicity schedule for 80% of Health Check eligibles; and ▪ initial visit within 14 days for newly enrolled pregnant women. ******** Measures are not yet developed but are likely to be similar to those in the pay-for-performance programs for CMOs: some HEDIS measures; some structural measures. Focus of the measures likely to be on children's health.

IDAHO
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Chronic Disease Management (July 2006): Pilot program designed to improve chronic disease management using an electronic health record as a base. Program is beginning with diabetes, and expects to expand to other chronic diseases in the future (see "New Pay-for-Performance Program").	Three providers are participating in the pilot: two university-based family residency programs (University of Washington and University of Utah) and one federally-qualified health center. Participation is voluntary.	State is endorsing the development of additional electronic health record functionality, which should improve future data collection and measurement. Type of incentive and methodology not yet determined. Measurement period likely to be quarterly. Incentive likely to be a bonus payment provided at the practice level.	Measures not fully determined, but are expected to be a subset of HEDIS diabetes measures, as well as self-management indicators that are being built into the electronic health record. Measures should be those which are easy to collect, accepted by the health care community, related to specific program goals, and reflective of appropriate action being taken by a provider.

IDAHO
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Chronic Disease Management (target start date: two to three years): Program is expected to be an expansion of existing pilot chronic disease management program to include other diseases (e.g., asthma, clinical depression, hypertension, heart disease, lipid control)	Primary care providers	Incentive type, methodology, and measurement period are not yet determined.	Measures not yet determined. Could be HEDIS-like measures for the specific diseases chosen. May use indicators similar to those used in Medicare program.

ILLINOIS
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Risk-Based Disease Management Program (July 2006): Risk-based disease management program for individuals in three categories: ▪ Non-dual eligible disabled adults (SSI/AABD population). Individual member participation is voluntary. Risk calculation includes costs for all members and all conditions, including those members who do not participate in the program. ▪ Children or adults with persistent asthma (as defined by HEDIS definition). ▪ Frequent emergency room users (defined as those who use the ER six or more times per year without a resulting inpatient hospital admission).	Contractor chosen through Request for Proposal (RFP) process. Provider participation is voluntary.	**Penalty:** 50% of per member per month fee is at risk based on the following: ▪ 80% of at-risk portion of fee is dependent on contractor meeting financial savings. Annual financial savings level was bid by contractor in response to RFP; ▪ 20% of at-risk portion of fee is based on meeting clinical performance measures for diseases/indicators; and ▪ penalty, if any, is assessed on a proportional basis to reflect success of contractor. Reconciliation target date: nine months after the end of the annual period, in recognition of billing lags and need to analyze information. Expect to do a mid-year calculation to test reconciliation process in the first year. **Public Recognition:** Currently under discussion. Provider profiles will be made available to individual providers. Public reporting, if any, will be made available only on a macro basis. **Other:** Participating providers continue to be paid on routine fee-for-service basis. Contractor incentivizes provider participation with tools to better manage their patient panel (Medicaid and non-Medicaid), such as software for chronic disease management.	**HEDIS and HEDIS-like:** State has identified several indicators in each area that are monitored; most, but not all, are used to calculate clinical performance for at-risk calculation. Successful attainment for most indicators is a specified increase (e.g., 10%) in positive actions taken from prior year's level: ▪ congestive heart failure (CHF); ▪ coronary artery disease (CAD); ▪ diabetes; ▪ asthma; and ▪ chronic obstructive pulmonary disease (COPD). **Cost/efficiency:** Guaranteed savings level is compared to actual savings (determined by comparing base year, trended forward, to actual spending in contract year).

ILLINOIS
NEW PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Primary Care Case Management Program (mandatory program target start date: December 2006): Program is being established in conjunction with a statewide mandatory PCCM program. ▪ Program withholds a percentage of the PCCM administrator's contract; the withhold can be earned back based on performance. ▪ Focus of the program is on healthy women and children, the majority of the Medicaid population in this service delivery mode.	PCCM contractor chosen through a Request for Proposals (RFP) process. Provider participation is voluntary.	**Withhold/bonus:** The state will withhold 3% of the administrator's contract in each year. The amount withheld can be earned back based on administrative, clinical, and other performance measures: year one measures are different from those applied in subsequent years. ▪ Each performance measure is assigned a percentage of the withheld amount. The performance measure must be completely met for the withheld amount related to that individual performance measure to be returned. ▪ Payment of withheld amounts related to administrative performance measures will be made by three months after the end of the fiscal year (i.e., October 1 for the SFY ending June 30). ▪ Payment of withheld amounts related to clinical performance measures will be made by nine months after the end of the fiscal year (i.e., April 1 for the SFY ending June 30). ******** **Incentive to Primary Care Providers (PCPs):** Beginning in year 2, the contractor is required to share at least 50% of the amounts withheld by the state with its PCPs, based on PCP performance in the previous year. The incentive is to be given to providers who achieve improved performance. The specific type, timing, and criteria for the incentive payments will be determined by the contractor, the state, and an advisory group.	**First year measures; administrative only; each 20% of withhold amount:** ▪ voluntary enrollment rate (70% of potential enrollees in counties without a voluntary managed care program affirmatively choose a PCP); ▪ PCP network development rate (95% enrolled); ▪ average call wait time < 3 minutes; ▪ electronic file submissions; and ▪ referral system operational by November 2006. **Subsequent year measures; administrative and clinical:** <u>Administrative measures (25%):</u> ▪ Enrollee satisfaction (10%) ▪ Voluntary enrollment rate (7.5%) ▪ Provider profiles distributed (7.5%) <u>Clinical measures (25%; 6.25% each):</u> ▪ 3 HEDIS measures related to well-child visits ▪ 10% decrease in # of hospitalizations for ambulatory-care sensitive conditions (e.g., angina, congestive heart failure) ******** <u>PCP clinical performance measures (50%):</u> ▪ To be determined by workgroup of the contractor, state, and an advisory group.

ILLINOIS
NEW PAY-FOR-PERFORMANCE PROGRAMS (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Program QI Pay-for-Performance Program (target start date: August 2006): Program being implemented in conjunction with August 2006 MCO contracts. ▪ Program withholds a percentage of monthly capitation payments in each year. ▪ Withheld moneys are returned to contractors based on demonstrated improvement over the baseline in 8 clinical measures.	Managed care organizations (MCOs) Pay-for-performance requirements are incorporated in MCO contracts with the state; as a result, all MCOs wishing to participate in the Medicaid program must participate in the performance program.	**Withhold/bonus:** The state will withhold ½% of each capitation payment in year one and 1% in subsequent years. Withheld funds will be paid to the MCO if the MCO demonstrates the required improvement in the prior years' baseline HEDIS score. ▪ Each HEDIS measure has a value of one-eighth of the withheld amount. ▪ The MCO must fully meet the improvement requirements in order to receive the withheld amount related to the specific measure. ▪ Improvement requirements vary depending upon the baseline measures: ◆ if the baseline measure is below 30%; improvement must be 15 percentage points; ◆ if the baseline measure is between 30% and 50%, the improvement must be 10 percentage points; ◆ if the baseline measure is above 50%, the improvement must be 5 percentage points; ◆ if the baseline measure is above the 50th percentile for the baseline year's HEDIS Medicaid benchmark, regardless of the percentage score, the improvement must be 2.5 percentage points; and ◆ if the baseline measure is above the 75th percentile for the baseline year's HEDIS Medicaid benchmark, regardless of the percentage score, the level must be maintained.	**HEDIS measures; all measures are one-eighth of withheld amount:** ▪ childhood immunization status (combo 2); ▪ well-child visits; first 15 months; ▪ well-child visits; 3rd through 6th years; ▪ breast cancer screening; ▪ cervical cancer screening; ▪ timeliness of prenatal care; ▪ use of appropriate medications for people with asthma; and ▪ comprehensive diabetes care (HbA1C testing).

INDIANA
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Hoosier Healthwise Pay-for-Performance Program (target start date: 2007): ▪ Indiana is establishing a pay-for-performance program in its managed care program as part of its most recent MCO contracting cycle. ▪ The program will be three-tiered. The first tier will be financial and non-financial performance incentives to MCOs. The second and third tiers will be incentives that the MCOs provide to providers and members, respectively. ▪ Indiana has incorporated graduated performance targets in its programs.	Managed Care Organizations (MCOs) Pay-for-performance requirements will be incorporated in MCO contracts with the state; as a result, all MCOs wishing to participate in the Medicaid program must participate in the performance program.	**Auto-assignment:** The state is considering revising its auto-assignment algorithm to incorporate performance measures. **Bonus:** ▪ MCOs must meet minimum eligibility criteria (such as having no areas requiring corrective action) to be eligible to receive a bonus. ▪ Bonuses are not required to be distributed if performance standards are not met. ▪ The bonus is calculated based on the two HEDIS and one HEDIS-like performance measures. ▪ The maximum bonus is 1/3rd of ½of 1% of the capitation rate for each measure, for a total bonus potential of ½of 1%. ▪ MCO bonuses are graduated so that MCOs demonstrating higher performance receive higher bonuses. ▪ MCOs will be required to reinvest at least 50 percent of the incentive amount received from the state in programs to provide incentives to providers and members. **Penalty (liquidated damages):** MCOs are liable for liquidated damages if certain operational requirements (such as meeting reporting timeframes) are not met. Liquidated damages are not assessed for failing to meet quality of care performance measures. **Public reporting:** The state will recognize MCOs that attain superior performance and/or improvement by, for example, posting information on exceptional MCO performance on its Web site.	Indiana has identified five priority areas for its performance monitoring program. Three of the areas are used in its pay-for-performance program: **HEDIS/HEDIS-like measures :** ▪ frequency of ongoing prenatal care; ▪ well-child visits; and ▪ blood lead screening. Two additional measures are monitored on an ongoing basis, but are not used in the calculation of the bonus payment: **Other/Structural measures:** ▪ appropriate emergency room utilization; and ▪ behavioral and physical health coordination.

IOWA
EXISTING PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Iowa Plan for Behavioral Health: Mental Health Access Plan (1999): ▪ State contracts with a single statewide contractor to provide mental health and substance abuse services. ▪ The single contractor receives a per-member per-month capitation amount and provides a single point of entry for all mental health and substance abuse services. ▪ Pay-for-performance program consists of both bonuses and penalties. ▪ Contract is a three-party contract between state Medicaid program, the state Department of Public Health (DPH), and the contractor. Medicaid and the DPH have separate performance indicators.	Program is mandatory for the statewide contractor. Any willing behavioral health provider who meets contractor requirements can participate.	**Bonus:** Up to $1 million is available annually to the contractor for a set of 8 performance measures. Each performance measure has a specific dollar value. Performance is measured and paid annually, approximately 6 months after the end of the measurement period. ********	**Eight performance measures for possible bonus.** Measures are state-developed, structural, and medical records–based: ▪ 30-day readmission rate of less than 15%; ▪ 97% consumer participation in joint treatment planning conferences; ▪ average time between inpatient hospitalizations not less than 60 days; ▪ percent of involuntary admissions (not exceed 15% for children; 10% for adults); ▪ 6% or more of expenditures shall be for integrated supports and services; ▪ 90% of inpatient discharges receive other treatment within 7 days; ▪ 60% of substance abuse discharges receive follow-up services within 14 days; and ▪ 90% of discharge plans are implemented. ********

IOWA
EXISTING PAY-FOR-PERFORMANCE PROGRAMS (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
		Penalty: Liquidated damages may be assessed against the contractor for failure to meet the standards for any of 13 indicators. ▪ Performance is measured, and penalties are assessed, quarterly. ▪ Liquidated damages increase as the time period the contractor fails to meet a particular standard increases: o first occurrence: failure to meet standard for 2 quarters; o 2nd occurrence: failure to meet standard for 3 quarters; and o 3rd occurrence: failure to meet standards for 4 quarters. ▪ There are two levels of performance indicators, which have different rates of liquidated damages: o level 1: $5,000; $10,000 and $15,000; and o level 2: $5,000, $25,000 and $50,000. ******** **Performance Reporting:** Quality improvement report is on Web. Comparison of contractor performance vs. the standard is also provided.	**13 performance measures for possible penalty.** Measures are state-developed, structural, and medical records–based: ▪ information packet to 95% or new enrollees w/in 10 days; ▪ 90% of discharges have discharge plans; ▪ *less than 1.5% of <18 year old discharges are to shelters;* ▪ *follow-up with 95% of enrollees who received ER care w/in3 days, but not admitted;* ▪ *20 joint treatment planning conferences per month;* ▪ 60% of inpatient substance abuse discharges receive follow up w/in 30 days; ▪ 90% of discharges from substance abuse setting have discharge plans; ▪ *Medicaid claims will be paid within certain time periods;* ▪ 95% of appeals will be resolved w/in 14 days; ▪ 95% of expedited appeals will be resolved w/in 3 days; ▪ 95% of grievances will be resolved w/in 14 days; ▪ credentialing of network will be completed within certain time periods; and ▪ provider manual changes will be distributed 30 days before effective. *Note: measures in italics are level 2 performance indicators.* ********

IOWA
EXISTING PAY-FOR-PERFORMANCE PROGRAMS (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Nursing Facilities Accountability Measures Program (June 2001): ▪ The objective of the program is to provide quality services in a cost-effective manner by measuring facility performance in areas that indicate a level of quality care, efficiency, or a commitment to care for certain types of residents. ▪ Nursing facilities receive additional reimbursement for meeting state-developed quality indicators. ▪ Program was developed by a workgroup of industry representatives, nursing facility providers, associations, advocacy groups, and state agency representatives (Survey & Certification, LTC Ombudsman & Medicaid).	Freestanding nursing facilities (Medicare-certified hospital-based facilities are not eligible to participate). Participation is mandatory for all measures except one (resident satisfaction); measures are initially collected for purposes other than the accountability program (e.g., survey and certification).	**Differential rates:** Facilities receive an increase to their daily per diem of 1%, 2%, or 3% of the direct care and non–direct care component medians used to calculate the facility's rate depending on their performance. The amount of the increase is based on a 10-measure scale, as follows: ▪ 0–2 points: no additional reimbursement; ▪ 3–4 points: 1% increase; ▪ 5–6 points: 2% increase; and ▪ 7 or more points: 3% increase. Rate changes are made annually, at the beginning of each state fiscal year, which is 6 months after the end of the reporting year.	**State-developed measures (1 point unless otherwise noted).** Measures are structural, cost/efficiency, CAHPS-like, and medical records–based (e.g., compliance-related) in nature: ▪ deficiency-free survey (2 pts); ▪ regulatory compliance with survey (1 pt; cannot also receive pts for deficiency-free survey); ▪ nursing hours at or above 50th percentile (2 pts maximum); ▪ resident satisfaction at or above 50th percentile; ▪ resident advocate committee resolution rate (at or above 60 percent); ▪ high employee retention rate (at or above 50th percentile); ▪ high occupancy rate (at or above 95%); ▪ low administrative costs (at or below 50th percentile); ▪ special licensure for residents with chronic confusion or a dementing illness; and ▪ high Medicaid utilization (at or above 50th percentile).

IOWA
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Voluntary Pay-for-Performance Program (target start date: one to two years): Program is in design stage, with no specific provider group, service package, incentives, or measures determined. State is working with University of Iowa, which is reviewing best practices in the field, advisory groups, and public health leaders. State is considering issuing a Request for Proposal (RFP) to solicit provider input on program design.	None specified, but expect that provider participation would be voluntary.	Not yet determined. Likely types of incentives that would be considered are: ▪ differential rates or fees; ▪ bonuses; and ▪ public recognition.	Not yet determined. State is considering issuing an RFP to gather proposals from providers, including measures and approaches. State is interested in using a community-based standard rather than one solely related to the Medicaid program.

KANSAS
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Possible Multi-Payer Pay-for-Performance Program (target start date: one to two years): ▪ Kansas created a Health Policy Authority in July 2005 to improve overall health care quality in the state. Medicaid and the state employee benefits programs merged with the authority in July 2006. ▪ The Authority collects encounter data from all non-ERISA carriers and is evaluating how to use these data to establish a quality initiative. ▪ Medicaid would be one, but not the only, payer participating in the program.	Primary care providers and specialists.	Not yet determined. State is considering incentive payments and public recognition (such as ranking physicians on certain criteria or credentialing). State wants to ensure that incentives do not create access problems, particularly for Medicaid clients.	Not yet determined. State is reviewing HEDIS, national standards, and other state-developed structural measures (such as measures based on claims and encounter data and others based on evidence-based practice).

LOUISIANA
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Primary Care Case Management Immunization Pay-for-Performance Program (July 2006): ▪ Program provides bonus payments to primary care providers for specific activities related to immunization rates for children 19–35 months. ▪ Medicaid program works with the Office of Public Health, which operates the Vaccines for Children (VFC) and Louisiana Immunization Network for Kids Statewide (LINKS) programs.	Primary care providers (PCPs) participating in the Primary Care Case Management program. Provider participation is voluntary.	**Bonus:** State provides a bonus to each primary care provider based on certain activities and performance criteria. The bonus is calculated monthly for all individuals under 21 who are in the provider's patient panel, as follows: ▪ $0.25 PMPM for LINKS usage and participation in the VFC program; or ▪ $0.50 PMPM if meet LINKS usage and VFC program participation and 80% of the HEDIS-like immunization rate; or ▪ $1.00 PMPM if meet LINKS usage and VFC program participation and 90% of the HEDIS-like immunization. Payments are made quarterly based on the activity for the previous three months.	Measures are HEDIS-like and structural/state-developed, as follows: ▪ meet 80% or 90% of HEDIS-like Combo 2 immunization rate for children 19–35 months; ▪ participation in state immunization registry (Louisiana Immunization Network for Kids Statewide or LINKS); and ▪ participation in Vaccines for Children (VFC) program.

LOUISIANA
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Louisiana Health Care Redesign for New Orleans area (projected start date: next 12 months): ▪ Pay-for-performance or "value-based purchasing" is being considered as a part of the Louisiana Health Care Redesign program. ▪ In addition to Medicaid, would hope to include other payers such as Medicare	Not yet determined	Not yet determined	Not yet determined

MAINE
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
MaineCare Physician Incentive Program (2000): ▪ Maine's Physician Incentive Program (PIP) provides bonuses to physicians who rank in the top 20% of their peer group on a variety of access, emergency room use, and prevention/quality-of-care measures. ▪ The program also provides profiles to each physician, which allow them to compare their practice to those of their peers.	Primary care providers, including those with specialties in family practice, general practice, pediatrics, obstetrics/gynecology, and internal medicine. Participation is required in the program since the information is collected for other purposes.	**Bonus:** ▪ Bonuses are provided to physicians who rank above the 20th percentile when compared with other physicians in their specialty. ▪ Measures are weighted as follows: o 40% for access to care measures; o 30% for emergency room utilization measures; and o 30% for prevention/quality measures which vary by physician specialty. ▪ Performance is measured every six months for the previous 12 months, after allowing for a six-month claiming lag. Bonuses are paid approximately three months later. ********	Maine calculates performance on its measures using claims data. **Measures used for the bonus payment include**: <u>Access:</u> ▪ # of patients/users who saw the provider <u>ER usage:</u> ▪ Average # of ER visits per user <u>Prevention/Quality:</u> ▪ EPSDT: # <21 who had at least 1 EPSDT procedure; ▪ adult Preventive Care: # >=21 who had at least 1 procedure; ▪ women's Health: # of women >=21 who had a Pap test; ▪ colon cancer: # >=21 who were screened; ▪ lead screening: # children <1 who were screened; ▪ lead screening: # children <2 who were screened; ▪ diabetic care: % >32 who had an HbA1c test; ▪ diabetic dare: # of HbA1c tests that screened individuals >32 received; and ▪ diabetic care: % >32 with diabetes who had an eye exam. ********

MAINE
EXISTING PAY-FOR-PERFORMANCE PROGRAM (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
		Peer Recognition: Physicians are provided a Primary Provider Profile every six months. This profile compares their practice with those of other physicians in their specialty. The profile reports on all of the measures that are used for the bonus as well as several additional measures.	**Measures used for the Peer Recognition report include:** ▪ measures used for the bonus payment (peer recognition measures are frequently changed from actual number of users to percentages and occasionally change the age cohort); ▪ average cost per member per month; ▪ % of repeat ER users; ▪ potentially avoidable hospitalizations for individuals with: o asthma o pneumonia o severe ear, nose and throat infections o kidney urinary tract infections o chronic heart failure o gastroenteritis; ▪ EPSDT measures including: o average # of encounters o # of visits o well-child visits o adolescent well-care visits; ▪ breast cancer screening: % women 52–69 years old screened with mammogram; ▪ prenatal care: % women receiving first trimester prenatal care; and ▪ diabetes care: % >18 who had an LDL-C screening.

MAINE
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Maine Quality Forum (ongoing): ▪ The Maine Quality Forum was established in 2003 with four main purposes: ◆ collection and dissemination of research; ◆ adoption of quality and performance measures; ◆ promotion of evidence-based medicine and practices; and ◆ public reporting of information about costs and quality of care. ▪ The Maine Medicaid program is a participant in the Quality Forum and its "Quality Counts" activities, as are the state's three major payers, physician and medical groups, and the state employee health program.	Not yet determined.	Not yet determined.	Not yet determined. However, the organization's intent is to identify standardized measures that can be used by all payers in the state. Pathways to Excellence measures are being reviewed.

MARYLAND
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
HealthChoice Value-Based Purchasing Program (1999): Maryland's Value-Based Purchasing Program measures plan performance in three areas: access to care, quality of care, and administration. The state has focused its program so that it is relevant to its core populations (children, pregnant women, and adults with chronic conditions) and to priority areas for improvement. The program has two main components: ▪ plans receive financial sanctions for performance below state-determined targets (note that performance above the target can be used to offset the sanction amount); and ▪ plan performance is reported on publicly.	Managed Care Organizations (MCOs) Pay-for-performance requirements are incorporated in MCO contracts with the state; as a result, all MCOs wishing to participate in the Medicaid program must participate in the performance program.	**Penalty, with bonuses used to offset penalties:** ▪ Maryland categorizes MCO performance on individual measures into three levels: ◆ above the standard (incentive); ◆ in the standard range (neutral); and ◆ below the standard (disincentive). ▪ Points are awarded to a plan for each percentage point that it is above (or below) the standard range for each measure. No points are awarded for performance in the neutral range. ▪ Plans receive an incentive or are penalized (sanctioned) a dollar amount per point, multiplied by the MCO's per-1,000 enrollment level. ◆ The dollar amount per point increases as the aggregate number of points above or below the standard grows. ◆ Incentives for performing above the target are greater than penalties for performing below the target. ▪ Note: Since 2005, no incentive moneys have been made available. Rather, incentive amounts can be used only to offset penalties or sanctions. **Public recognition:** Maryland sends a HealthChoice consumer report card to all enrollees to assist them in making a plan choice. The report card, as well as information on plan performance, is available on the Web.	**HEDIS measures:** ▪ well-child visits (3rd–6th years); ▪ timeliness of prenatal care; ▪ cervical cancer screening; ▪ eye exams for diabetics; ▪ childhood immunizations combo 2; and ▪ practitioner turnover. **HEDIS-like measures collected from encounter and other data:** ▪ dental services for children 4–20 years; ▪ ambulatory care for SSI adults; ▪ ambulatory care for SSI children; and ▪ lead screening 12–23 months.

Note: Information has not been verified by state.

MASSACHUSETTS
NEW PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Health Care Reform Bill Pay-for-Performance Programs (target start dates: one to two years): ▪ Health care reform legislation passed in the spring of 2006 requires the Medicaid program to incorporate pay-for-performance programs for hospitals and physicians in 2007. ◆ Pay-for-performance program is tied to statutorily established rate increases. ▪ The state is also interested in establishing pay-for-performance programs in its managed care and behavioral health programs (perhaps in 2008).	Hospitals (October 2007) and Physicians (July 2007). Managed care plans and behavioral health programs (2008).	Not yet determined. State is working with stakeholders to develop appropriate incentives. State is likely to consider differential reimbursement rates and fees as well as bonuses. Penalties are less likely. Incentives may be structured to reward both attainment of specified levels of performance as well as improvement. Public recognition is also likely since one of the tenets of the health care reform legislation is transparency.	Not yet determined. State is working with stakeholders to develop appropriate measures. ▪ Administration goal is to work jointly with other payers so that measures are consistent, while recognizing that the issues that need to be addressed by various payers may be different. ▪ Statutorily required to include measures related to racial and ethnic disparities and information technology improvement.

MICHIGAN
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Pay-for-Performance Program (2001): Michigan's managed care program incorporates the concepts of pay-for-performance in three distinct ways: ▪ The initial contract award process incorporates clinical outcomes and access to care indicators as factors in plan ranking. Better performance increases the chances of participating in the state's Medicaid managed care program. ▪ Plans with higher quality receive a greater proportion of auto-assigned enrollees. ▪ A small portion of the capitation premium is initially withheld to generate a pool from which a quality-based performance bonus is made.	Managed care plans (termed "Medicaid Health Plans" or MHPs). Pay-for-performance requirements are incorporated in MHP contracts with the state; as a result, all MHPs wishing to participate in the Medicaid program must participate in the performance program.	**Initial Contract Award Ranking:** ▪ MHP bidders are evaluated on four primary criteria: network capacity, demonstrated clinical outcomes, access to care, and administrative effectiveness; ▪ plans with higher quality scores rank higher on the selection list; ▪ state contracts only with those higher-quality-scoring plans that it needs to provide sufficient access; and ▪ this activity occurs only once, as part of the initial procurement process. ******** **Auto-assignment:** ▪ New managed care enrollees who do not choose a plan are auto-assigned to a MHP based on a number of clinical, administrative, and capacity criteria designed to identify plans providing high quality. ▪ The methodology reflects regional differences in plan capacity and rotates quality criteria on a quarterly basis. ▪ As a result, the auto-assignment algorithm changes on a quarterly basis. ********	**HEDIS measures (bidder's score relative to Medicaid national percentiles):** ▪ childhood immunizations; ▪ well-child visits; ▪ timeliness of prenatal care; ▪ postpartum care; and ▪ HbA1c testing. **Access to care measures:** ▪ ratio of PCPs to population; ▪ ratio of open PCPs to population; ▪ CAHPS measures of consumer satisfaction; and ▪ getting needed care and getting care quickly. **Administrative effectiveness:** Capabilities in several key areas (such as grievances and appeals, MIS capabilities) ******** **HEDIS measures:** ▪ child measures (Quarter 1); ▪ women's measures (Q2); ▪ living with illness measures (Q3); and ▪ Adult measures (Q4) **CAHPS measures:** ▪ child—getting needed care and getting care quickly (Q1); ▪ adult—getting needed care and getting care quickly (Q2); ▪ health plan rating: child and adult (Q3); and ▪ adult—customer service and health care rating (Q4). **Cost/efficiency measures:** ▪ Error-free claims processing and encounter data submissions; higher point value for higher error-free submissions. **Structural measures:** ▪ Ratio of open primary care providers to capacity; higher point value for lower ratio. ********

MICHIGAN
EXISTING PAY-FOR-PERFORMANCE PROGRAM (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures

		Withhold/Bonus Performance Award:
		▪ The state withholds .0015 of MHP capitation payments until a minimum of $3 million is collected (pool amount in 2006: $4 million).
		▪ This pool of funds is then available for redistribution to plans based on clinical and access HEDIS indicators, member satisfaction CAHPS indicators, accreditation status, and specific legislative criteria.
		▪ The proportion of funding assigned to each category is as follows:
		  ▪ clinical (HEDIS) measures: 42%;
		  ▪ access to Care (HEDIS) measures: 15%;
		  ▪ member satisfaction (CAHPS) measures: 13%;
		  ▪ accreditation status: 6%; and
		  ▪ legislative incentive: 24%.
		▪ Plan scores for each of these indicators are weighted by the percentage of Medicaid member months provided by the plan to determine the proportion of the pool that is made available to each plan.
		▪ Bonus payments are made annually. Each plan receives some portion of the bonus pool.
		
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		Performance Reporting: Managed care plan HEDIS scores are publicized.
			For all measures except the legislative incentive, the state awards a higher point value to a plan that meets a higher standard (i.e., a plan gets a higher point value if it meets the 90th percentile on a measure than if it meets the 50th percentile on the measure).
			
			HEDIS (clinical) measures:
			▪ breast cancer screening;
			▪ cervical cancer screening;
			▪ Chlamydia combined rate;
			▪ prenatal care;
			▪ postpartum care;
			▪ diabetic care;
			▪ appropriate asthma meds – combined rate;
			▪ assistance with smoking cessation;
			▪ well-child visits;
			▪ immunizations; and
			▪ children—upper respiratory infections.
			HEDIS (access to care) measures:
			▪ children: 12–24 months, 25 months–6 years, 7–11 years, 12–19 years; and
			▪ adults: 20–44 years, 45–64 years.
			CAHPS (member satisfaction) measures:
			▪ getting needed care: adult, child;
			▪ getting care quickly: adult, child; and
			▪ health plan rating: adult, child.
			Structural (accreditation) measure:
			▪ NCQA, JCAHO, or URAC accreditation status as of 12/31 of the prior year.
			Legislative incentive:
			▪ Continuously enrolled blood lead testing rate; 60% target.
			
			********

MINNESOTA
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Pay-for-Performance Program (1999): ▪ Five percent of the monthly capitation payment is withheld from the MCOs. ▪ Withheld funds are placed in a pool, which can be earned back by the MCOs based on performance on nine administrative, clinical, and structural measures. ▪ Any funds that are not earned back by the MCOs finance a bonus pool. ▪ MCOs can participate in the bonus pool if they demonstrate a 10 percentage point improvement in at least one of five HEDIS or HEDIS-like clinical indicators. ▪ No MCO can receive more than 105% of the capitation rate.	Managed Care Organizations (MCOs) Pay-for-performance requirements are incorporated in MCO contracts with the state; as a result, all MCOs wishing to participate in the Medicaid program must participate in the performance program.	**Withhold/Bonus payment:** ▪ The state withholds 5% of all MCO capitation payments and places the funds in a pool. ▪ MCOs can earn back their withhold by meeting nine performance measures. ▪ If an MCO does not meet all performance measures, it receives only the proportion of its withheld funds that is equal to the measure or measures it has met. ▪ The nine measurement areas and their respective points value are as follows: ◆ denial, termination, or reduction of services notices: 10 points; ◆ grievance and appeal reporting: 10 points; ◆ timely claims payment: 10 points; ◆ identification of the treating provider in encounter data: 20 points; ◆ no quality assurance deficiencies: 20 points; ◆ member service phone responsiveness: 5 points; ◆ access to board-certified psychiatrist: 5 points; ◆ lead screening: 10 points; and ◆ asthma medication: 10 points. ▪ MCOs receive points only for measures for which they completely meet the standards, except for the measure related to identifying treating providers, for which they can receive partial points depending on the extent of performance. ▪ 80% of the withheld funds must be returned to the MCOs. ▪ Performance is measured annually at the end of the contract year (January 1 through December 31). Bonus payments are released between July 1 and July 31of the following year. Interim reports are provided quarterly for feedback purposes. ********	**Structural/administrative/state-developed measures:** ▪ timely submission and accurate (90%) completion of the denial, termination, or reduction of services report; ▪ timely submission and accurate (90%) completion of the grievance and appeal report; ▪ accurate reporting of treating provider on encounter claims (90% or more accuracy results in full award of points; lower percentages are prorated); ▪ no quality assurance deficiencies after corrective actions taken; ▪ maintain maximum call abandonment (10%) and wait time (average 2 minute) for member services call center; ▪ MCO has access to a board-certified psychiatrist for oversight and evaluation of utilization and quality assurance activities. **Cost/efficiency measure:** ▪ timely clean claims payment (90% within 30 days; 99 percent within 90 days). **HEDIS/HEDIS-like measures:** ▪ increase lead screening rates for 9- to 30-month-old children (at least 10% of the difference between 80% target and the prior year's rate); and ▪ increase asthma medication performance rate (10% of the difference between the 90% target and the prior year's rate). ********

MINNESOTA
EXISTING PAY-FOR-PERFORMANCE PROGRAM (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
		Bonus (Outstanding Performance Pool): ▪ Any funds remaining from those initially withheld from the MCOs (limited to no more than 20% of all withheld funds) are placed into an Outstanding Performance Pool. ▪ MCOs can participate in this pool if their rate on one of the five HEDIS and HEDIS-like clinical performance measures is at least 10 percentage points higher than it was the prior year. ▪ MCOs share in the pool funds based on their proportion of total member months for the calendar year. ▪ No MCO can receive total payments that are greater than 105% of their capitation payments.	**HEDIS/HEDIS-like measures:** ▪ antidepressant medication; ▪ adult access to preventive/ambulatory health services; ▪ annual dental visit; ▪ asthma performance; and ▪ lead screening (9- to 30-month-olds).

MINNESOTA
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Smart-Buy Alliance: ▪ Minnesota Medicaid program is a participant in the Smart-Buy Alliance. ▪ The Smart-Buy Alliance is a gubernatorial initiative, beginning in November 2004, under which the state, business, and labor groups pool their purchasing power with the goal of reducing health care costs resulting from inappropriate and poor-quality care. ▪ The Smart-Buy Alliance incorporates 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.	Not yet determined.	Variable, but expect that some will be similar to those used in the Bridges to Excellence program (such as public recognition and identification of "best in class").	Variable

MISSOURI
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Pay-for-Performance Program (2000): The Missouri pay-for-performance program has two major components: ▪ EPSDT-based (began in 2000). Under this component, the state adjusts the monthly capitation premium to reflect whether a plan has met or exceeded required EPSDT well-child visit requirements. ▪ HEDIS-based (began in July 2006): Under this second component, the state reduces both the auto-assignment percentage and the monthly capitation premium to reflect poor performance on a number of HEDIS measures and publicly reports on performance.	Managed care plans Pay-for-performance requirements are incorporated in managed care plan contracts with the state; as a result, all managed care plans wishing to participate in the Medicaid program must participate in the performance program.	<u>EPSDT-based component:</u> **Differential reimbursement (monthly capitation premium can increase, decrease, or stay the same):** ▪ The portion of the premium related to EPSDT well-child visits is increased or decreased depending on the managed care plan's success in meeting the minimum standard: ◆ if a plan exceeds the minimum, the premium is increased; ◆ if a plan does not meet the minimum, the premium is decreased; and ◆ if a plan is at the minimum, there is no change in the premium. ▪ The measurement period is 12 months. Activity is measured every six months. As a result, activity in any one six-month period factors into the performance rate for two measurement periods. ▪ Premiums are adjusted every six months, beginning six months after the end of the measurement period.	**HEDIS-like measure:** ▪ 80% of required EPSDT well-child visits, based on CMS 416 report data.

MISSOURI
EXISTING PAY-FOR-PERFORMANCE PROGRAM (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
		<u>HEDIS-based component:</u> Each managed care plan's annual HEDIS performance is rated as high (3 points), average (2 points), low (1 point), not applicable (0 points), or not reported (-1 point) in relation to the statewide average of plan performance. Health plans are required to maintain an average score of 2 points. **Auto-assignment (poor performer allocation is reduced and redistributed to higher performers):** ▪ The first time a plan has an average HEDIS score of 1 point, its auto-assignment percentage is decreased by 50%. ▪ The second time a plan has an average HEDIS score of 1 point, its auto-assignment percentage is again decreased by 50%, to 25%. ▪ The auto-assignment percentages that have been removed from the poorer-performing plans are distributed to the highest-rated plans within the same region. **Differential reimbursement (monthly capitation premium is decreased and redistributed to higher performers):** ▪ The third time a plan has an average HEDIS score of 1 point, the monthly capitation amount is decreased by .25 percent. ▪ The reduction in premium payments to the poorer-performing plans is redistributed to the highest-rated plans within the same region. **Performance reporting:** ▪ Enrollment materials sent to Medicaid members include information noting specifically when a plan has failed to achieve the minimum performance standard (1 point) or when a plan's performance is above the minimum performance standard (3 points). ▪ The state publishes information on plan performance in a Consumer Guide on the Web.	**HEDIS measures:** Effectiveness of care: ▪ childhood immunization status; ▪ adolescent immunization status; ▪ cervical cancer screening; ▪ Chlamydia screening; ▪ follow-up after hospitalization for mental health disorders; and ▪ appropriate medication for individuals with asthma. Access to Care: ▪ prenatal and postpartum care; and ▪ annual dental visit. Experience of Care: ▪ CAHPS child/adult survey. Use of Services: ▪ well-child visits (15 months); ▪ well-child visits (children ages 3, 4, 5. and 6); ▪ adolescent well-care visits; ▪ ambulatory care; ▪ % receiving inpatient, intermediate, and ambulatory mental health services; and ▪ identification of alcohol and other drug services.

MISSOURI
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Chronic Care Improvement Initiative (projected start date: September 2006): ▪ Primary care providers will receive an enhanced fee for participation in the program. ▪ Focus of program is on Medicaid enrollees who are high-resource users and who have comorbidities. Program is voluntary for enrollees. ▪ Contractor (APS Healthcare) is signing up primary care providers, providing case managers, and assisting with program implementation. ▪ Contractor will also review data and will be the primary avenue for communication with providers. ▪ Web-based plans of care developed by the contractor will be available to providers.	Primary care providers Provider participation is voluntary Contractor is not at risk	**Differential reimbursement (enhanced primary care fee):** Enhanced fee is provided for participating in the program Other incentives will be added in the future to promote quality care; type not yet determined.	Not yet determined

MONTANA
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Mental Health and Chemical Dependency Pay-for-Performance Programs (target start date: three to five years): State is interested in developing a pay-for-performance program that would measure improvement in measures that demonstrate move to recovery. Expect that the measures will be state-developed and structural. State is working with the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Co-Occurring Center for Excellence (COCE).	Behavioral health programs and providers	Incentives not yet determined. Most likely types are differential reimbursement rates or fees and bonuses.	**Structural/state-developed measures:** Measures are not yet determined. However, the state is considering a number of measures that would represent markers on the road to recovery, such as: ▪ being gainfully employed; ▪ continuing to receive treatment; ▪ maintaining sobriety; and ▪ stable/independent living. It is likely that these measures would be combined with others that were derived from claims data, such as ▪ inpatient hospitalizations; and ▪ receiving counseling. Measures that reflect evidence-based practice are preferred.

NEBRASKA
EXISTING PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Prenatal Care Program (2003): ▪ Program is designed to improve pregnancy outcomes by focusing on one indicator (smoking cessation) identified as improving outcomes. ▪ MCOs receive an increase in their capitation rate based on improvement in smoking cessation counseling activities. ▪ While not pay-for-performance, Nebraska also modified its MCO reimbursement strategy in an effort to improve birth outcomes by: ◆ reimbursing only for live births; and ◆ rolling prenatal care payments into a pregnancy kicker.	Managed care organizations (MCOs) MCOs must participate	**Differential reimbursement (capitation rate):** ▪ Capitation rate is increased by approximately 2% to reflect improvement in measure. ▪ Activity is reviewed quarterly and the differential reimbursement is provided the following quarter.	**Medical records–based/state-developed measure:** ▪ MCO sampled practitioner files to determine a baseline for smoking cessation counseling and samples files quarterly thereafter. ▪ Measure used for incentive is one of improvement, not attainment of a specific level.
Behavioral Health Inpatient Documentation Program (2005; significantly modified effective July 2006): ▪ Program is designed to decrease the lengths of stay in residential behavioral health programs. ▪ Overall behavioral health program is managed by an administrative agent, which contracts with the behavioral health network providers. Providers are reimbursed on a fee-for-service basis. ▪ The pay-for-performance program provides a bonus to the administrative agent when there is improvement in documentation that each client has a treatment and discharge plan. ▪ Program is co-purchased with the Nebraska Office of Behavioral Health, which funds non-Medicaid services.	Behavioral health program administrative agent Participation is part of contract with the state.	**Bonus:** ▪ The administrative agent can earn up to $102,000 each quarter for demonstrating improvement in four measures tied to decreasing lengths of stay in residential behavioral health facilities. ▪ Each measure has an equal value ($25,500). ▪ Data will be reviewed quarterly and the bonus payment will be made the following quarter.	**Medical records-based/state-developed measures:** ▪ Four specific measures are tied to processes used to document a plan for reaching 90% compliance with the goal that each client have a treatment plan and be discharged, with a discharge plan, when the treatment goals have been met. ▪ Currently, baseline performance data are being developed against which future improvement can be measured.

NEVADA
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Pay-for-Performance Program (2004): ▪ Program provides bonus payments related to performance on three HEDIS measures. ▪ The incentive is structured to reward both high performance as well as improvement.	Managed care plans Pay-for-performance requirements are incorporated in managed care contracts with the state; as a result, all MCOs wishing to participate in the Medicaid program must participate in the performance program.	**Bonus:** ▪ The incentive is structured so that plans can receive bonus payments related to their actual performance level as well as improvement from the prior year. ▪ Actual performance level: ◆ the full incentive is provided if the plan is at or above the national 90th percentile; ◆ no incentive is provided if the plan is at or below the national mean; and ◆ the incentive payment is prorated if the plan scores between the national mean and the 90th percentile. ▪ Improvement basis: ◆ the full incentive is provided if the plan demonstrates a 10% improvement; ◆ no incentive is provided if the plan shows no improvement; and ◆ the incentive payment is prorated if the plan improves, but at less than 10%. ▪ The full amount available per measure is $.20 per member per month. The total of all bonus payments is capped at $1 million annually. If calculated payments are greater than $1 million, payments are prorated so that the total is no more than the maximum. ▪ Bonus amounts are calculated on a per member per month basis and paid in a lump sum eight months after the end of the measurement period.	**HEDIS measures (current):** ▪ annual dental visits; ▪ well-child visits (3rd through 6th years); and ▪ asthma (ages 10–17). **HEDIS measures (effective with November 1, 2006 contracts):** ▪ annual dental visits; ▪ all three well-child visit measures; and ▪ childhood immunization status combination 2.

NEVADA
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
State is examining numerous options for expanded and/or additional pay-for-performance programs (target start date: 2007): ▪ Currently consulting with stakeholders. ▪ Considering expanding activities into fee-for-service area. ▪ Considering additional program areas, including: ◆ children's behavioral health; ◆ immunizations; and ◆ care coordination. ▪ Considering outcome-based performance criteria as well as the possibility of "paying for participation."	Managed care plans Possibly fee-for-service providers	Not yet fully determined. Want to continue to structure to promote improvement, not just attainment, of specific performance levels.	Not yet fully determined, but considering "Leapfrog-like" and "paying for participation" types of measures

NEW HAMPSHIRE
NEW PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Care Coordination Pay-for-Performance Program (target start date: one to two years): ▪ Legislative mandate to institute a care coordination program, of which pay-for-performance is a component. ▪ Executive required to report back to Legislature on activities by December 2007. ▪ Care Coordination program will be managed by a vendor. ▪ State expects to develop the pay-for-performance program in conjunction with its vendor.	Not yet determined.	Not yet determined. Prefer rewards to penalties.	Not yet determined. Prefer outcome measures to those that are structural or process-oriented. HEDIS measures will be given strong consideration. Governor's New Hampshire Citizen's Health Initiative may influence the choice of measures. Under this initiative, Medicaid is joining with other payers to discuss common indicators to be used to measure performance.
New Hampshire Citizen's Health Initiative (ongoing): ▪ Citizens, payers, businesses, medical professionals, and government leaders are joining together to develop a health care plan for the state. ▪ Overall goal is to create a system of care that promotes health, assures quality, and makes care affordable, effective, and accessible. ▪ Workgroups are addressing many issues, including pay-for-performance and health information technology.	Not yet determined.	To be determined by each payer.	The following measures have been recommended: ▪ use of appropriate medications for people with asthma; ▪ appropriate testing and/or appropriate treatment for children with pharyngitis; ▪ diabetes outcomes measure: HbA1c levels; and ▪ diabetes outcomes measure: LDL-C levels.

NEW JERSEY
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Performance Standards Program (2000): Managed Care Organizations can have their capitation rates reduced if they do not meet performance standards related to EPSDT and blood lead screening. HEDIS scores are shared among plans.	Managed Care Organizations (MCOs) Pay-for-performance requirements are incorporated in MCO contracts with the state; as a result, all MCOs wishing to participate in the Medicaid program must participate in the performance program.	**Penalty (liquidated damages):** ▪ MCOs are liable for liquidated damages if they do not meet EPSDT and lead screening performance standards. ▪ MCOs that do not meet the performance standards are required to reimburse the state a dollar amount per enrollee, varying between $1 and $5 depending on the percentage of screenings that did not occur, for each enrollee who did not receive the screening. ▪ If the compliance standards are not met, MCOs are also liable for the costs incurred by local health departments to perform required screenings. ▪ Measurement is conducted annually. **Peer recognition:** State shares plan HEDIS scores among plans so that they can compare themselves with their peers.	**EPSDT Measure:** ▪ 80% compliance with required screening rates for children under 21. **HEDIS Blood Lead Screening Measure:** ▪ 80% compliance with required screening rates for children under 3.

NEW JERSEY
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Pay-for-Performance Program (target start date: next 12 months): ▪ State will provide MCOs with grants to assist them in meeting certain state-developed milestones related to adolescent access to care. ▪ Physician advisory group assisted the state in developing the milestones. ▪ Plans have responded to an RFP; responses are under review.	Managed Care Organizations (MCOs)	**Grant:** ▪ State is using funds collected from sanction levied under the existing pay-for-performance program to support the grant program. ▪ Amount of grant will depend on programs proposed and managed care organizations chosen to receive funding. ▪ Plans will be required to return the bonus funding if the milestones are not met.	▪ State developed its own milestones that plans need to meet over an 18-month period (e.g., increase adolescent access to care by 10%). ▪ Plans set their own individual goals and approaches to enable them to meet the state-established parameters. ▪ Projects are to continue after the grant funding ends.

NEW MEXICO
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Performance Measures Program (2001): ▪ MCOs are required to set aside a portion of their capitation payments in a separate account in order to establish a "Challenge Pool." ▪ The Challenge Pool can be earned back by the MCO based on meeting certain HEDIS, EPSDT, and other structural performance measures. ▪ If the MCO does not meet the required performance standards, the moneys in the Challenge Pool are not distributed to the MCO until it meets additional performance standards that are agreed to by the state and the MCO. ▪ Performance reporting data are publicized on the Web and provided to the Legislature. ▪ Plans with higher performance measures receive a larger proportion of auto-assigned members.	Managed care organizations (MCOs) Pay-for-performance requirements are incorporated in MCO contracts with the state; as a result, all MCOs wishing to participate in the Medicaid program must participate in the performance program.	**Withhold/Bonus payment:** ▪ MCOs are required to set aside 0.5% of their capitation payments in a separate account. ▪ These funds are placed in a "Challenge Pool" that can be earned back by the MCO by meeting six performance measures. ▪ Initially, if an MCO does not meet all performance measures, it receives only the proportion of the Challenge Pool that is equal to the measure or measures it has met. ▪ The six measurement areas and their respective percentage of the Challenge Pool are as follows: ◆ EPSDT preventive dental: 20%; ◆ cervical cancer screening: 15%; ◆ diabetes disease management performance: 15%; ◆ provider payment timeliness: 15%; ◆ encounter data reporting: 15%; and ◆ timely submission, accuracy, and analysis of Medicaid program reports: 20%. ▪ Performance is measured annually at the end of the contract year (July 1 through June 30). Withheld funds are released between July 1 and October 31 following the end of the contract year. ▪ If an MCO does not meet all the above standards, the state and the MCO agree on additional MCO-specific performance standards and an accompanying spending plan to achieve the standards. The state will release the remaining funds on a quarterly basis as the MCO carries out its related spending plan. **Performance Reporting:** The state publicizes MCO performance on the measures on the Web. Information on MCO performance is also routinely provided to the Legislature. **Auto-Assignment:** Plans that have higher performance measure scores receive a larger proportion of members who are auto-assigned to plans.	**EPSDT measure:** ▪ Preventive dental services: 50% of children aged 24 months to 20 years receive a preventive dental visit each year. **HEDIS measures:** ▪ cervical cancer screening: 70% of women 21 to 64 years of age are screened annually; ▪ diabetes disease management: ◆ Year 1: HEDIS measurement only; and ◆ Year 2: for individuals who were in the plan the prior year: 1% decrease in acute hospitalizations for the diagnosis of diabetic-related complications. **Cost efficiency/state-developed measures:** ▪ Claims processing: 90% of clean claims processed within 30 days; 99% within 90 days (federal regulatory requirement); ▪ encounter data: 100% submitted timely; 90% of files will have an error rate of 3% or less; and ▪ MCOs will achieve and maintain compliance with all format and content changes required by the Medicaid program.

NEW YORK
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Pay-for-Performance Program (1999): New York's managed care program has expanded its managed care pay-for-performance program since its inception. At present, it consists of two major components: ▪ Plans with higher performance measures receive a larger proportion of auto-assigned members (1999). ▪ Monthly capitation rates are increased for plans that perform well on a set of HEDIS/HEDIS-like and consumer satisfaction indicators (2002). In addition, plan performance on certain HEDIS/HEDIS-like, consumer satisfaction, and other quality indicators are reported on publicly, available on the Web, and provided to Medicaid beneficiaries.	Managed Care Organizations (MCOs) Pay-for-performance requirements are incorporated in MCO contracts with the state; as a result, all MCOs wishing to participate in the Medicaid program must participate in the performance program.	**Auto-Assignment:** Plans that have higher performance measure scores receive a larger proportion of members who are auto-assigned to plans. **Differential reimbursement rates (capitation rates):** ▪ monthly capitation rates can increase by up to 3 percent based on plan performance on a number of quality and consumer satisfaction measures; ▪ if an MCO does not meet all performance measures, it receives a proportion of the full 3% increase possible; ▪ the increased rates are effective for 12 months; and ▪ performance is measured annually. **Public recognition:** ▪ The state publishes an annual "Quality Assurance Reporting Requirement" or QARR report. ◆ This report provides comparative quality information on all Medicaid, Family Health Plus (a Medicaid expansion program), Child Health Plus (the State's Children's Health Insurance Program), and commercial managed care programs. ◆ The report is also available on the Web. ▪ In addition, the state produces Medicaid-specific consumer guides to assist enrollees in making plan choices.	The state measures performance using HEDIS/HEDIS-like, CAHPS (consumer satisfaction), and state-developed structural measures. Measures rotate annually. Performance measures for 2005 include: **HEDIS/HEDIS-like measures:** ▪ well-child visits (0–15 months) (encounter data); ▪ well-child visits (3–6 years) (encounter data); ▪ adolescent well-care visits (encounter data); ▪ breast cancer screening; ▪ postpartum care; ▪ appropriate medications for individuals with asthma ▪ diabetes care (poorly controlled); ▪ Chlamydia screening (encounter data); ▪ controlling high blood pressure; and ▪ follow-up after mental health hospitalization (30 days). **Patient Experience of Care (CAHPS) measures:** ▪ problem getting care needed; ▪ receive services quickly; ▪ rating of personal doctor or nurse; ▪ rating of health plan; and ▪ problem getting service.

Note: Information has not been verified by state.

NEW YORK
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Pay-for-Performance Demonstration Projects (target start date: November 2006): ▪ Pursuant to legislation (Chapter 58, Laws of 2005), the state is directed to provide grants to up to five regional pay-for-performance demonstration projects for two years. ▪ Projects will be chosen through a Request for Application (RFA) process. ▪ The intent of the program is to promote patient safety and quality of care through the development of pay-for-performance programs that involve multiple payers. ▪ Stakeholders participated in developing consensus on performance measures.	Regional coalitions of health care payers (managed care organizations, health insurance companies, government insurance, and self-insured employers) and providers (hospitals, clinics, and physicians). Participation is voluntary	**Grant:** ▪ Up to $9.5 million is available to fund grants for two-year demonstration projects. ▪ Medicaid funding is available to support projects related to hospital inpatient performance only. ▪ Projects can fund pay-for-performance, health information technology, and patient safety programs. ▪ During the first year of the grant, a project can provide financial support to providers for participating in the program. ▪ Grant moneys can also be used to provide financial support for performance incentives to providers if other payers also participate in such support.	Specific measures, developed by a workgroup consisting of managed care plans, hospitals, provider associations, payers, labor unions, and consumers, are included in the RFA. Projects must identify which measures they are planning to use, why they chose those measures, and what improvement they expect. Measures are provided in the following areas: ▪ ambulatory care (focused on disease management and preventive care); and ▪ inpatient care (focused on diseases responsible for a high proportion of admissions, patient safety, and efficiency).

Note: Information has not been verified by state.

NORTH CAROLINA
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Community Care of North Carolina (CCNC) Physician Incentive Plan (target start date: one to two years): CCNC is North Carolina's enhanced primary care case management program. Pay-for-Performance program components (the CCNC Physician Incentive Plan) have been drafted and approved by the CCNC clinical directors: ▪ CCNC workgroup assessed baseline information and wanted to choose measures to drive the statewide asthma and diabetes disease management programs. ▪ State has assessed information, including evaluations of its existing disease and utilization management programs, and consulted with stakeholders. The state is considering using savings from pharmacy cost containment efforts (increases in OTC prescribing for certain drugs) as a possible revenue source for the program.	Primary Care Case Management Networks (North Carolina Community Care Networks)	Not yet determined. The state is considering differential PCCM fees. The state is also considering providing incentives based on two levels of rewards, which would incorporate attainment of a standard, peer comparisons, and improvement from previous levels, as follows: ▪ excellence performance: best practice goal or top 15th percentile; and ▪ quality improvement: improvement from own network baseline by 20%. Part of the CCNC plan is also to recognize networks that have achieved excellence and notable improvement. An annual awards banquet with key senior state leadership to give recognition is being considered. Incentives are likely to be structured to give the networks the opportunity to determine how to distribute them between and among participating practices. This will allow networks the flexibility to use funding for community initiatives and improvements to their central infrastructure as well as for incentives for individual practices. The final incentive type may be limited by financial constraints.	The CCNC clinical directors chose the following measures (one for asthma and diabetes, and three for OTC prescribing): ▪ asthma ED rate per 1,000; ▪ HbA1c performed every six months (twice in one year); ▪ achieving 60% prescribing Loratadine OTC in tier one of the non-sedating antihistamines therapeutic class; ▪ achieving 60% prescribing Prilosec OTC in tier one of the proton pump inhibitors therapeutic class; and ▪ provide improvement goal for achieving a 20% increase from baseline in prescribing OTC medications. More OTC measures were chosen since this might be a funding source for the incentive program.

NORTH DAKOTA
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Disease Management Pay-for-Performance Program (target start date: one to two years): ▪ Disease management program focused on asthma, diabetes, chronic obstructive pulmonary disease, and chronic heart failure; awaiting federal waiver approval. ▪ Once approved, program will be operated by a vendor. ▪ State interested in adding a pay-for-performance component to the program once existing program is implemented.	Not yet determined. Considering disease management vendor, fee-for-service providers, primary care case management providers.	Not yet determined.	Not yet determined. Considering HEDIS and HEDIS-like measures.

OHIO
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Ohio Pay-for-Performance Program (2001): ▪ As part of the expansion of its mandatory managed care program throughout the state, Ohio is incorporating pay-for-performance into its managed care plan contracts. ▪ The applicability of the pay-for-performance criteria will be changing during the state's transition period, which is scheduled to continue through 2009. ▪ In addition, several of the performance standards that plans are required to meet increase during the term of the current contract (2006–07).	Managed Care Plans (MCPs) Pay-for-performance requirements are incorporated in MCP contracts with the state; as a result, all MCPs wishing to participate in the Medicaid program must participate in the performance program.	Ohio's pay-for-performance program includes both the potential for a managed care plan to be penalized for failing to meet certain standards as well as the opportunity for a plan to receive a bonus payment for high performance. **Penalty:** A portion of each MCP's capitation payment is at risk (on a statewide basis, the at-risk portion is slightly less than 1 percent of the monthly capitation rate). ▪ To avoid being penalized for the at-risk portion, a plan must first meet several qualifying standards: ◆ meet required minimum standards on independent review, access, and satisfaction measures; ◆ achieve certain emergency room diversion standards; and ◆ meet benchmarks for seven of nine clinical performance measures. ▪ A plan that meets the above standards is then eligible to retain one-third of the at-risk amount for each of three additional performance measures. These three measures are the same measures used for the bonus calculation, described below. **Bonus:** A total of $250,000 annually will be distributed between all plans that meet the performance standards for all three additional measures. It is possible for one plan to receive the full $250,000. Most performance periods are for the calendar year prior to the performance payment year, although several are for the six-month period prior to the beginning of the performance payment year.	**Qualifying Performance Measures:** SFY 2006: ▪ independent external quality review; ▪ primary care provider turnover; ▪ children's access to primary care; ▪ adult access to primary care; and ▪ overall satisfaction with the plan. SFY 2007: ▪ primary care provider turnover; ▪ children's access to primary care; ▪ adult access to preventive/ ambulatory health services; and ▪ overall satisfaction with the plan. **Additional Qualifying Performance Measures:** ▪ rate of emergency department use; ▪ meet performance measures or minimum benchmarks for seven of the following nine measures: ◆ 3 perinatal care measures (frequency of ongoing care; initiation of care; postpartum care); ◆ 3 well-child visit measures (15 months; 3–6 years; 12–21 years; ◆ use of appropriate medications for people with asthma; ◆ dental visits; and ◆ blood lead levels – 1-year-olds. **Measures Related to Avoiding the At-Risk Penalty and Receiving the Bonus:** Each of these measures has an "excellent" and a "superior" standard: ▪ case management of children; ▪ use of appropriate medications for people with asthma; and ▪ adult access to preventive/ ambulatory health services.

Note: Information has not been verified by state.

OHIO
NEW PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Nursing Home Pay-for-Performance Program (target start date: January 2007): No additional information available.	Nursing Homes	No additional information available.	No additional information available.
Primary Care Pay-for-Performance Program (target start date: first half of 2008): No additional information available.	Pediatricians, internal medicine providers, and family practice providers are expected to participate in this program.	No additional information available.	No additional information available.

Note: Information has not been verified by state.

OKLAHOMA
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Primary Care Case Management Pay-for-Performance Program (1998): Oklahoma's program provides bonuses to primary care providers who meet performance measures in the following two areas: ▪ EPSDT well-child visit requirements (started in 1998); and ▪ provision of the 4th DPT (Diptheria, Pertussis, Tetanus) immunization before the child is two years old (started in 2001).	Primary care providers who participate in the Primary Care Case Management program are required to participate as part of their contract with the state.	**Bonus:** ▪ EPSDT well-child visit: ◆ Providers can earn up to 20% above their annual capitation payment if they meet the EPSDT well-child visit performance measure. ◆ Annual amount available for bonuses is $1 million. ◆ Bonuses are paid approximately 7 months after the end of the year. ▪ 4th DPT immunization: ◆ Providers receive a $3 per-child bonus when the 4th DPT immunization is provided before the child's 2nd birthday. ◆ Annual amount available for bonuses is $50,000. ◆ Bonuses are paid approximately 6 months after the end of the year. **Public recognition:** Public recognition is not a standard part of this program although provider success is sometimes publicized when it is significant.	**HEDIS-like measures:** ▪ Providers must meet 65% of the EPSDT well-child visit requirements. ▪ Providers must provide the 4th DPT immunization before the child's 2nd birthday. ▪ Performance on both measures is based on encounter data.

OKLAHOMA
NEW PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Nursing Facility Pay-for-Performance Program (target start date: one to-two years): ▪ Program expected to focus on resident quality of care and quality of life, family and resident satisfaction surveys, employee satisfaction, facility certification, CNA training and education, and patient acuity levels. ▪ Program being developed by a long-term care working group consisting of providers, advocates, and state agencies, following June 2006 enactment of Medicaid reform legislation.	Nursing facilities	Incentive types and methodologies still under development, but are expected to include: ▪ differential reimbursement rates; and ▪ public recognition mechanisms, which will assist individuals and families in choosing high-quality nursing facilities that meet their needs.	Final determination on performance measures not completed. Expect, however, to include measurements in the following areas: ▪ CAHPS-like employee and resident/family surveys; ▪ structural measures such as survey and certification results; and ▪ other to-be-developed state-developed measures.
Primary Care Provider Incentives Program (start date not determined): ▪ State evaluating instituting incentive programs in several areas. ▪ First area being examined is emergency room use. Other areas under consideration for review include mammography, Pap smears, EPSDT (other than well-child visits, which are already done).	Primary care providers	Not yet determined.	▪ Not yet determined since measurements dependent on area that state determines to incentivize. ▪ ER measure likely to be rate of ER usage per patient, with rates in the lowest quartile likely to be rewarded.

OREGON
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Value-Based Purchasing (target start date: one to two years): ▪ State is a member of the Oregon Health Care Quality Corporation. Health plans, medical groups, insurers, purchasers, health care providers, and consumers are also members. ▪ The Medicaid program is interested in incorporating uniform, statewide standardized performance measures, perhaps developed by the corporation, into its programs.	Not yet determined. Primary care providers and managed care organizations are likely; other provider types may also be covered in a program.	Not yet determined. State is considering auto-assignment as a possible incentive. Administrative incentives, such as those that could reduce administrative burdens when quality measures are reached, are also being considered.	Not yet determined. Goal is to use statewide, standardized measures rather than have each payer have its own set of measures. State is considering a number of measures, including: ▪ HEDIS and HEDIS-like measures; ▪ cost/efficiency measures; and ▪ structural measures Unlikely to use patient surveys as a part of a value-based purchasing program.

PENNSYLVANIA
EXISTING PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
HealthChoices Pay-for-Performance Program (June 2005): ▪ HealthChoices is the state's mandatory managed care program, which is operated in three regions of the state. ▪ MCOs are eligible to receive bonus payments based on their performance on each of 10 HEDIS measures. ▪ Each MCO receives a specific goal for each of the measures.	Managed Care Organizations (MCOs) Pay-for-performance requirements are incorporated in MCO contracts with the state; as a result, all MCOs wishing to participate in the Medicaid program must participate in the performance program.	**Bonus:** ▪ Each of the 10 HEDIS measures has equal weight and, therefore, is able to generate a bonus equal to a portion of the average premium for a specified time period based on member enrollment. ▪ The state sets MCO-specific goals for each HEDIS measure depending on the MCO's relative ranking in comparison to national Medicaid HEDIS benchmarks or based upon statistical calculations that demonstrate continuous improvement. ▪ A plan must meet 100% of its goal to receive a bonus payment related to that measure unless the prior and current years' rates were above the 90th percentile Medicaid benchmark. Payments are prorated, depending on the actual rate that the plan achieves: ◆ at or below 50%: no incentive (i.e., no goal is met); ◆ 51% to 75%: 50% of the maximum incentive; ◆ 76% to 90%: 75% of the maximum incentive; and ◆ above 90%: between 90% and 100% of the maximum incentive, depending on whether the goal was reached. ▪ Payments are made by the end of the calendar year based on performance during the previous year.	**HEDIS measures:** 7 Core Measures: ▪ controlling high blood pressure; ▪ comprehensive diabetes care (HbA1c poorly controlled); ▪ comprehensive diabetes care (LDL control <130); ▪ cholesterol management for patients with cardiovascular conditions (LCL-C <130); ▪ ongoing prenatal care (>81% of expected visits); ▪ breast cancer screening; and ▪ cervical cancer screening. 3 Sustaining Measures: ▪ prenatal care in 1st trimester; ▪ appropriate medications for people with asthma; and ▪ adolescent well-care visits.

PENNSYLVANIA
EXISTING PAY-FOR-PERFORMANCE PROGRAMS (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
ACCESS Plus Pay-for-Performance Program (January 2006): ▪ ACCESS Plus is an enhanced primary care case management program that focuses on the establishment of medical homes for consumers as well as disease management. It is operated in those portions of the state not covered by the mandatory managed care program (Healthchoices). ▪ The program integrates primary care case management and disease management under a single contractor. ▪ The program incorporates pay-for-performance incentives for the contractor as well as for the providers who join the contractor's network. ▪ The program incentivizes the contractor to establish and maintain medical homes and to involve the patient's primary care provider. ▪ Purpose is to contain costs through care management, not cost management.	Voluntary enrollment of primary care case management providers ACCESS Plus program is managed by a state contractor; pay-for-performance requirements are integral to the contract.	<u>Medical Home Component:</u> **Bonus/penalty (to the contractor):** ▪ 5% of the primary care case management portion of the premium is at-risk based on the degree of improvement on 5 key measures. Similarly, a 5% bonus is also possible. ▪ Each of the 5 measures is worth 1%. ▪ The improvement target is based on the HEDIS percentile score of current fee-for-service performance: the lower the rank, the higher the percent improvement target. Annual improvement goals range between 1% and 10%. ▪ Performance is reviewed and bonuses/penalties are paid annually. ******** <u>Disease Management Component:</u> Disease management activities are directed toward five disease states: ▪ asthma; ▪ diabetes; ▪ chronic obstructive pulmonary disorder (COPD); ▪ chronic heart failure (CHF); and ▪ coronary artery disease (CAD). **Bonus/penalty (to the contractor):** ▪ Up to 40% of the disease management premium is at risk if guaranteed savings amount is not met; the contractor may also earn up to a 20% bonus if savings are greater than required. ▪ In the first year of the program, if actual savings are greater than 5% above or 10% below the guaranteed savings level, the bonus or penalty is proportionately scaled depending on the extent of the additional savings or costs. ▪ In the second year of the program, the penalty for failing to achieve the guaranteed savings begins to be applied when actual savings are greater than 5% below (rather than 10% below) the guaranteed level. ▪ Performance is reviewed and bonuses/penalties are paid annually. ********	Five HEDIS and HEDIS-like measures are used to assess performance in the medical home component: ▪ EPSDT screening rates (CMS 416 report); ▪ ER visits; ▪ prenatal care visits; ▪ cervical cancer screening; and ▪ adolescent well-care visits. The contractor collects the measurement data from its individual primary care case managers. ******** Contractor performance is determined using total cost data, including the disease management premium, for the segment of the ACCESS Plus population who are eligible for participation in the disease management portion of the program only. Actual costs during the performance period for this population are compared with an estimate of costs that would have been incurred had there not been a disease management program. ********

PENNSYLVANIA
EXISTING PAY-FOR-PERFORMANCE PROGRAMS (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
		Bonus (to the provider): As a result of the state's interest in promoting provider participation in the disease management program, a portion of the contractor's capitation fee is set aside to fund provider bonuses, as follows: ▪ One-time $200 payment to practitioner when practitioner reviews the disease management program, completes a survey on topics related to disease management, and agrees to allow the disease management contractor to use his/her name when recruiting patients. ▪ One-time $40 payment when the practitioner contacts a high-risk patient to discuss and promote participation in the disease management program. ▪ One-time $30 payment when the practitioner provides contact information on a high-risk patient to the disease management contractor. ▪ Semi-annual $60 payment to practitioner upon submission of updated Chronic Care Feedback form, which includes medical records–based information on high-risk participants, to disease management contractor. ▪ Annual $17 payment to practitioner for each high-risk patient who reports taking certain actions designed to manage their condition. In year two, the annual payment is made for both high- and low-risk patients; data are obtained from claims data rather than patient reporting. Activity is reviewed and paid on a quarterly basis.	**Structural/state-developed measures:** ▪ Measures with associated one-time payments reward practitioners for general program support and support for patient enrollment (see Incentive Type and Methodology). ▪ Measure associated with the semi-annual payment rewards practitioners for continued participation in the program. Information collected relates to medications prescribed, recent vital signs, lab reports, goals, and patient education needs. Payment is based on completion of form, not on appropriateness of the information contained on the form. ▪ Annual payments are based on the success of the program in getting patients to adopt evidence-based practices related to their conditions. For example: ◆ CHF: taking a beta blocker; ◆ CAD: taking aspirin (year 1 measure); taking statin (year 2 measure); ◆ diabetes: taking aspirin (year 1 measure) and controlling LDL level (year 2 measure); and ◆ asthma: taking controller medications ▪ Year 3 measures may incorporate peer comparisons and additional program metrics.

PENNSYLVANIA
EXISTING PAY-FOR-PERFORMANCE PROGRAMS (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Hospital Quality Care Incentive Program (January 2006): Disproportionate Share Hospital (DSH) rate increases can result from performance in several measures related to chronic diseases and common illnesses of the elderly. Program rewards improved management, coordination, and infrastructure investment.	Participation is mandatory because the information is collected for other purposes.	**Differential payments (DSH rates and medical education):** ▪ Hospital performance on 1) readmission rates for certain conditions, 2) assessment score for left ventricular function (LVF), and 3) antibiotic usage measures are compared with average statewide performance. Better performance receives a higher score (ranging from 0 to 2). ▪ One point is given for implementation of a single medical record, pharmacy error reduction program, or Leapfrog reporting. ▪ Maximum of 15 points result in rate increases as follows: ◆ 13–15 points: 150% of increase for inpatient DSH and medical education; ◆ 9–12 points: 125% of increase; ◆ 6–8 points: average increase; ◆ 2–5 points: 75% of increase; and ◆ 0–1 points: no increase. ▪ Children's hospitals have a slightly different scoring schedule, based on a smaller number of factors: ◆ 6 points: 150% of increase; ◆ 5 points: 125% of increase; ◆ 3–4 points: average increase; ◆ 1–2 points: 75% increase; and ◆ 0 points: no increase.	**HEDIS-like/structural/state-developed measures for acute care hospitals:** ▪ readmit rates for asthma, diabetes, CHF, and COPD; ▪ assessment score for left ventricular function (LVF); ▪ mean time to 1st antibiotic usage for pneumonia; ▪ implementation of a single medical record; ▪ implementation of a formal pharmacy error reduction program; and ▪ reporting to Leapfrog. **HEDIS-like/structural/state-developed measures for children's hospitals:** ▪ readmit rate for asthma; ▪ implementation of a single medical record; ▪ implementation of a formal pharmacy error reduction program; and ▪ reporting to Leapfrog or field testing pediatric quality measures.

PENNSYLVANIA
NEW PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Hospital Quality Care Incentive Program (awards projected to be made in 2006): Hospitals are eligible to compete for grants that support quality-related investments.	Hospitals can choose to participate in the grant program.	**Grants:** ▪ Hospitals apply through an RFP-type process. ▪ State has $1 million available for grants annually. ▪ Up to $100,000 is available per DSH hospital that has made investments in several quality-related activities; final amount per hospital is dependent on the number of hospitals that receive grants.	**Structural/state-developed measures:** ▪ Pharmacy error reduction ◆ pharmacy legibility improvement program; ◆ participation in ECRI, ISMP, and DVCH Regional Medication Safety program; ◆ completion of ISMP's Medication Safety Assessment for 2004; ◆ participation in PRHI's Medication Safety Program; ◆ use of medication error reporting tool; ◆ establishment of confidential medication error reporting system ◆ implementation of point-of-care bar coding medication administration system or CPOE; ◆ automated pharmacy system; and ◆ 24 hour pharmacist; ▪ single medical record; ▪ reporting to Leapfrog; and ▪ other investments approved by the Department of Public Welfare.

PENNSYLVANIA
NEW PAY-FOR-PERFORMANCE PROGRAMS (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
HealthChoices Behavioral and Physical Health Care Coordination (projected start date: mid-2007): ▪ Physical Health MCOs will be provided with financial incentives to promote sharing of pharmacy data with Behavioral Health MCOs. ▪ A portion of the Physical Health MCO's capitation payment will be withheld until it has demonstrated compliance with required data-sharing.	Physical Health Managed Care Organizations (PH-MCOs)	**Withhold:** ▪ Physical Health MCOs must negotiate and sign an agreement to provide each Behavioral Health MCO (within its HealthChoices zone) the appropriate pharmacy data for the common membership of the MCOs. ▪ Physical Health MCOs must regularly provide member-level files of pharmacy data to the Behavioral Health MCOs. ▪ The state will withhold the one-time sum of $1 million from a capitation payment otherwise due to the PH-MCO. ▪ The state will release $500,000 of the withheld amount to the Physical Health MCO when it provides documentation of a signed agreement related to pharmacy data-sharing with the Behavioral Health MCOs in its zone. ▪ When the Physical Health MCO has provided the second file of pharmaceutical data to each Behavioral Health-MCO in the zone, the state will release the final $500,000.	Compliance with pharmacy data-sharing requirements will trigger release of the withheld amount to the Physical Health MCOs.

RHODE ISLAND
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
RIte Care Performance Goal Program (1998): Rhode Island's Performance Goal Program rewards Health Plans for meeting certain administrative, access and clinical goals. Approximately 1 percent of total capitation payment amounts is available for the program.	Managed Care Organizations or "Health Plans" Pay-for-performance requirements are incorporated in Health Plan contracts with the state; as a result, all Health Plans wishing to participate in the state's Medicaid managed care program, RIte Care, must participate in the performance program.	**Differential reimbursement (capitation payments):** ▪ Health Plans are eligible to earn up to $1.25 per member per month above the standard capitation payment if they meet performance standards in three areas of focus: ◆ administrative; ◆ access to care; and ◆ clinical. ▪ The areas of focus are further delineated into six performance categories. The categories, and their potential percentage allocation of the differential reimbursement, are as follows: ◆ member services (20% or $0.25); ◆ medical home/preventive care (50% or $0.625); ◆ women's health (10% or $0.125); ◆ chronic care (10% or $0.125); ◆ behavioral health (5% or $0.0625); and ◆ resource maximization (5% or $0.0625). **Public Recognition:** Rhode Island prepares an annual report on the RIte Care program, including the Performance Incentive Program. The report, which is available on the state's Web site, includes information on each health plan's performance.	The measures used in the program are specific contract requirements, HEDIS measures, CAHPS measures, or other priority areas for the state. Measures that are not HEDIS or CAHPS measures are collected either from the Health Plans or encounter data. Specific measures for SFY 06 are as follows: <u>Member Services:</u> ▪ ID cards within 10 days; ▪ handbooks within 10 days; ▪ new member calls; and ▪ grievances and appeals resolved. <u>Medical Home/Preventive Care:</u> ▪ access to emergency services; ▪ member satisfaction with urgent care; ▪ adult preventive visit; ▪ well-child visits (15 months, 3rd–6th years); ▪ immunizations at 13 years; ▪ immunizations at 2 years; ▪ HEDIS access for children (12–24 months, 2–6 years, 7–11 years, 12–19 years); ▪ blood lead screening before 2; ▪ smoking advice; ▪ timely pre- and postnatal care; and ▪ adolescent PCP care.

RHODE ISLAND
EXISTING PAY-FOR-PERFORMANCE PROGRAM (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
			Women's Health: ▪ cervical cancer screening; and ▪ Chlamydia screening. Chronic Care: ▪ child: appropriate asthma medication use; and ▪ adults: HbA1c testing. Behavioral Health: ▪ follow-up after inpatient hospitalization w/in 30 days for members >/= 6 ; ▪ antidepressant compliance. Resource Maximization: ▪ 1% improvement in generic substitution rate; and ▪ notification to state of third-party liability.

SOUTH CAROLINA
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Medical Homes Network (MHN) Pay-for-Performance Program (2005): South Carolina operates a Medical Homes Network in several parts of the state through Care Coordination Services Organizations. The MHN pay-for-performance program has several components: ▪ Primary care providers who participate in the networks receive a primary care case management fee. ▪ CSOs receive claims information from the state so that they can assess provider activity and provide information back to providers to assist them in providing better, more cost-effective care. ▪ CSOs share equally with the state in any savings that are realized in the program. CSOs share their savings with their network. ▪ Providers receive feedback on their practices relative to those of their peers. ▪ MHNs are required to conduct performance improvement projects and report on certain performance measures.	Care Coordination Services Organizations (CSOs) and Primary Care Providers Participation of CSOs in pay-for-performance program is required as part of the contracting process. Provider participation is voluntary; any willing provider that meets CSO requirements can participate in the Medical Homes Network.	**Differential reimbursement (enhanced fee):** Providers participating in the MHNs receive a Primary Care Case Management fee ranging from $2.00–$4.00 per member per month. ******** **Bonus/penalty (shared savings):** The state and its CSOs share equally in any savings that accrue as a result of the MHN activity: ▪ Savings are calculated by comparing actual claims payments and administrative fees to total baseline expenditures for comparable age- and risk-adjusted populations. ▪ Reconciliation of actual versus baseline costs and payment of the resultant bonus, if any, is conducted quarterly, six months after the completion of the corresponding quarter. If costs under the MHN program are higher than adjusted baseline costs, the CSOs may be required to return up to the total amount of the administrative fee to the state. ******** **Peer recognition:** Providers are given information on their practice patterns relative to comparable practices. In particular, information is provided to them concerning emergency room usage and hospitalization rates.	The CSO determines the per month per member amount based on level of performance of enrolled provider. ******** Savings are shared equally between the state and its CSOs based on a comparison of actual costs to baseline costs. ******** Quality of care studies and performance indicator reporting focus on the following types of areas: prenatal care, newborn outcomes, childhood immunizations, EPSDT requirements, and certain indicators of hospitalization activities and drug utilization.

SOUTH CAROLINA
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Pay-for-Performance Program (target start date: one to two years): State is evaluating its options for such a program under both the Deficit Reduction Act and 1115 waiver approaches.	Managed care organizations (MCOs)	Not yet determined.	Not yet determined.

TENNESSEE
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
TennCare Pay-for-Performance Program (July 2005): TennCare's pay-for-performance program has two major components: ▪ The MCO administrative fee can be increased or decreased based on the attainment of certain benchmarks. ▪ The MCO can also earn a supplemental administrative fee for meeting disease management benchmarks. In addition, MCOs can receive reimbursement for achieving NCQA certification (prior to December 2006).	Managed Care Organizations (MCOs) Pay-for-performance requirements are incorporated in MCO contracts with the state; as a result, all MCOs wishing to participate in the Medicaid program must participate in the performance program.	**Penalty/bonus (administrative fee-related):** ▪ 10% of the administrative fee is at risk based on the MCO meeting benchmarks in the following areas: ◆ medical services target budget (2%); ◆ usage of generic drugs (2%); ◆ completion of benchmarks toward attaining NCQA certification (2%); ◆ increased EPSDT compliance (2%); ◆ non-emergency ER visits (1%); and ◆ inpatient admissions (1%). ▪ The administrative fee also can be increased by up to 15% based on exceeding benchmarks in the following areas: ◆ medical services target budget (5%); ◆ usage of generic drugs (2%); ◆ increased EPSDT compliance (2%); ◆ non-emergency ER visits (2%); and ◆ inpatient admissions (4%). ▪ Performance on all benchmarks is prorated to reflect the extent to which the MCO met, failed to meet, or exceeded the standards. ▪ Measurement is generally done quarterly, with some measures lagged to accommodate reporting periods. Payment is made twice a year (by January 1 and July 1) for the quarters ending 6 and 9 months prior to the payment due date. ********	**Structural/ state-developed measures:** ▪ medical services target budget: population-specific medical services budget target; ▪ usage of generic drugs: population-specific generic usage target; ▪ completion of benchmarks toward attaining NCQA; ▪ increase EPSDT compliance to 80% rate; ▪ non-emergency ER visits: population-specific ER visit target; and ▪ inpatient admissions: population-specific inpatient admissions target. ********

TENNESSEE
EXISTING PAY-FOR-PERFORMANCE PROGRAM (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
		Differential reimbursement (increased capitation amount related to disease management): ▪ MCOs are required to submit disease management plans to the state in four areas: ◆ maternity care; ◆ diabetes; ◆ asthma; and ◆ congestive heart failure. ▪ The plans are to include components such as the definition of the target population, clinical practice guidelines that will form the basis of the program, types of process and outcome measures, and reporting intervals. ▪ MCOs are eligible for an additional $.03 per member per month ($0.12 total) if they meet HEDIS standards and reductions in emergency room visits related to these four disease states. ******** **Reimbursement of NCQA initial certification fees:** MCOs will be reimbursed for the following fees related to obtaining NCQA certification by December 31, 2006: ▪ application and pre-survey fee; ▪ base survey fee; and ▪ additional per member fee. The state will reimburse the MCO within 30 days of receipt of proof of payment by the MCO.	**Structural/state-developed measures:** **HEDIS measures:** ▪ HbA1c testing: 50th national Medicaid percentile; and ▪ prenatal care: 75th national Medicaid percentile. **Structural/state-developed measures:** ▪ ER visit frequency: 5% reduction from the prior year for visits related to: ◆ asthma; and ◆ congestive heart failure. ******** **Structural/state-developed measures:** The amount of reimbursement that an MCO can receive is a function of the rating they receive from NCQA: ▪ excellent – 100%; ▪ commendable – 80%; ▪ accredited – 60%; ▪ provisional – 40%; and ▪ denied – 0%.

TENNESSEE
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Children's Hospitals (projected start date not known): State is working with two children's hospitals that received grants to develop interventions that would result in savings.	Children's hospitals (2)	Incentives are unknown at this time. The state has given the two hospitals data that should allow them, with technical assistance from an actuarial firm, to identify savings opportunities. The state expects the hospitals to propose areas in which there is the potential for savings.	Not yet determined

UTAH
EXISTING PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Managed Care Pay-for-Performance Program (1996): Utah's managed care program provides bonuses to plans for performance on four EPSDT, HEDIS and HEDIS-like measures. The state also provides public report cards on plan HEDIS scores and consumer satisfaction (CAHPS) surveys.	Managed Health Care Plans Pay-for-performance requirements are incorporated in health plan contracts with the state; as a result, all health plans wishing to participate in the Medicaid program must participate in the performance program.	**Bonus:** ▪ Bonuses are provided for both improvement in rates and for attainment/maintenance of a targeted rate. ▪ EPSDT rate: Plans receive $500 for each percentage point improvement above its CMS 416 participation rate from the previous year. Once a plan's rate is at or above 80%, the plan receives $10,000 if it maintains a rate of 80% or above. ▪ Immunization rates: ◆ Two-year olds: $300 is provided for each percentage point improvement, up to 50 percentage points, from the plan's prior year rate. ◆ Adolescents and adults: $300 is provided for each percentage point improvement, up to 50 percentage points, from the plan's prior year rate. ▪ Plans are required to use the incentive payment to reward those employees who helped achieve the improvement in the two-year-old, adolescent, and adult immunization rates. ▪ Measurement is generally for a 12-month period; payment occurs within approximately 10 months of the end of the contract year. **Public recognition:** The state provides public report cards on plan HEDIS ratings and consumer satisfaction (CAHPS) surveys.	Utah's measures are designed to reward attainment, maintenance, and improvement toward meeting targeted rates. **EPSDT Measure:** ▪ EPSDT CMS 416 (Utah's Child Health Evaluation and Care or CHEC program) 80% screening rate target. **HEDIS and HEDIS-like measures:** ▪ HEDIS immunization rate for two-year-olds; ▪ HEDIS immunization rate for adolescents; and ▪ state-developed influenza immunization rate for adults over 50 years of age (based on encounter data).

UTAH
EXISTING PAY-FOR-PERFORMANCE PROGRAMS (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Nursing Home Quality Improvement Initiative (2004): Nursing homes receive a bonus based on surveillance and certification data as well as operation of a quality improvement plan that involves families and residents.	Nursing homes Facility participation is voluntary	**Bonus:** ▪ $500,000 is available statewide for the bonus, between $0.50 and $0.60 per patient per day; funding is made available from provider tax revenues. ▪ Nursing homes apply annually to the state to participate in the program. ▪ Nursing homes must demonstrate that they meet quality standards and that they have a quality improvement plan in place that involves families and residents and responds to their concerns. ◆ Quality standards have become more stringent over the three-year life of the program, promoting continued improvement. ◆ Nursing homes that have substandard quality of care levels in certain categories (these criteria were added in the current year) are eligible for only 50% of the incentive. ▪ Bonus moneys are distributed at the end of the year.	**State-developed structural measures:** Surveillance and certification deficiencies: ▪ no "immediate jeopardy" citations; and ▪ no substandard quality of care citations in several categories (existence of these ratings reduces incentive by 50%). **State-developed CAHPS-like measure:** Quality Improvement Plan that includes residents and families including: ▪ plan incorporates a process to assess and measure results; and ▪ third-party entity conducts and reports on quarterly customer satisfaction surveys.

UTAH
NEW PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Physician Quality Improvement Program (target start date: three to five years): State considering a two-step process in developing a new pay-for-performance program: ▪ Supporting adoption of a system, which could include an electronic health record, to assist in providing information on health care delivery and outcomes. ▪ Using data to identify areas where the state would like to focus efforts and pay for better outcomes.	Primary care providers and specialists	Not yet determined. State recognizes the need to engage stakeholders in these discussions to enhance consensus development and adoption of agreed-upon approaches. Dependent on funding available.	Not yet determined. State recognizes the need to engage stakeholders in these discussions to enhance consensus development and adoption of agreed-upon approaches.
Nursing Home Quality Improvement Program (target start date: three to five years): State examining opportunities to implement electronic record keeping in nursing homes to: ▪ facilitate exchanges of information with hospitals and other providers; and ▪ obtain more detailed information on quality outcomes than is currently available from surveillance and certification data.	Nursing homes and related providers	Not yet determined. State recognizes the need to engage stakeholders in these discussions to enhance consensus development and adoption of agreed-upon approaches. Dependent on funding available.	Not yet determined. State recognizes the need to engage stakeholders in these discussions to enhance consensus development and adoption of agreed-upon approaches.

VERMONT
NEW PAY-FOR-PERFORMANCE PROGRAMS

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Chronic Care Management Program (target start date: next 12 months): ▪ Pursuant to legislation (Vermont Act 191 of 2005-06), the state is directed to contract with a vendor to operate a Chronic Care Management Program. ▪ The program will include: ◆ process and outcome measures to provide performance feedback on health care delivery and quality; and ◆ payment methodologies to align reimbursement and create financial incentives related to quality health care delivery. ▪ The vendor's fee is at risk if the program does not reduce costs. ▪ The Chronic Care Management Program must also be consistent with the Vermont Blueprint for Health Strategic Plan (see below).	Pay-for-performance may be incorporated in the vendor's contract with the state. Health care providers may also be included in the pay-for-performance aspects of the program.	<u>Vendor:</u> **Penalty:** Some part of the vendor's fee is statutorily required to be at risk if the vendor's program does not reduce state Medicaid costs. Initial contracting plans include putting some fees at risk for process measures (i.e., services provided by the vendor). Details on the amount and conditions of future penalty provisions are not yet determined. Note: The initial contract agreement will not include "guaranteed savings" requirements, but will hold part of the vendor's fees at risk for meeting satisfactory performance standards relative to intervention services. The state reserves the right in future years to base vendor fees on guaranteed clinical and financial outcomes. <u>Providers:</u> Not yet determined. Differential reimbursement rates or fees are possible; penalties are unlikely.	<u>Vendor:</u> **Cost/efficiency/ structural and state-developed:** State will monitor the program for changes in clinical and financial outcomes, as well as for vendor performance on intervention services such as completion of health risk assessments, telephone and face-to-face contact with beneficiaries, and provider outreach and education. <u>Providers:</u> Not yet determined, although likely that many will be structural and state-developed: ▪ Initial measures are likely to be structural ones that a vendor/provider could control, such as number of risk assessments completed; number of client provider visits; number of client contact phone calls made. ▪ Later measures are likely to be more outcome-oriented and be coordinated and consistent with the Vermont Blueprint for Health. Expect that the Chronic Care Management Vendor will participate in Blueprint discussions.

VERMONT
NEW PAY-FOR-PERFORMANCE PROGRAMS (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Vermont Blueprint for Health (ongoing): ▪ Started 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 Vermont Blueprint is focused on chronic care issues and has identified four areas in which it is seeking to promote change: ◆ patient self-management; ◆ provider practice change; ◆ community development; and ◆ information systems development. ▪ Pilot communities have been identified to test Blueprint strategies. ▪ The Blueprint's Strategic Plan is expected to be released shortly.	All providers involved in providing care to individuals with chronic conditions	The Blueprint is providing grants at the local level to help support participation as well as infrastructure required for improvement of clinical outcomes, and for sustainable system change. These include: ▪ provider and staff education; ▪ consumer self-management programs; ▪ activities and community resources for increasing physical activity and other risk-reducing behaviors; and ▪ provision of a chronic disease registry application for providers for their proactive outreach and care management. Additional incentives for process and clinical outcomes are being explored.	Not yet determined. Goal is to identify measures that are ▪ based on evidence-based practices and guidelines; ▪ accessible to providers; and ▪ easy to integrate into the day-to-day practice of providers.

WASHINGTON
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Healthy Options Pay-for-Performance Program (2004): Healthy Options is Washington's Medicaid managed care program. ▪ Medicaid's Healthy Options program, in conjunction with the state's SCHIP program, operates a managed care pay-for-performance program focused on HEDIS and EPSDT measures. ▪ The program rewards plans for current year performance as well as improvement from the prior year.	Managed Care Organizations (MCOs) Pay-for-performance requirements are incorporated in MCO contracts with the state; as a result, all MCOs wishing to participate in the Medicaid program must participate in the performance program.	**Bonus:** ▪ A total of $2 million is available annually to provide pay-for-performance incentives; $1 million for the HEDIS immunization rate measure and $1 million for the EPSDT well-child visit rate measures. ▪ For each type of measure, plans are ranked against each other based on: ◆ actual performance rate versus other plans; and ◆ improvement from the previous year versus improvement experienced by other plans. ▪ The better a plan's performance, the lower it is ranked. ▪ The four best (lowest ranking) plans share in the incentive payment as follows: ◆ #1 receives 100% of the payout per member; ◆ #2 receives 75% of the payout; ◆ #3 receives 50% of the payout; and ◆ #4 receives 25% of the payout. ▪ Performance is measured annually and payments are made to plans approximately eight to nine months after the data are reported.	Measures are evaluated to reward plans for current year performance relative to other plans, as well as improvement from the previous year, also relative to other plans. **HEDIS measure:** ▪ immunization rate for two-year-olds. **EPSDT measures:** ▪ well-child visits: birth to 15 months; 3 to 6 years; adolescents.

WASHINGTON
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Multi-payer pay-for-performance program (target start date: two to three years): 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.	Fee-for-service providers and managed care organizations	Not yet determined, but favoring incentives over disincentives.	Not yet determined. Looking at Bridges to Excellence program as well as other programs that would promote appropriate use of services and positive outcomes, including in some of the more difficult-to-manage areas such as mental health and substance abuse.

WEST VIRGINIA
NEW PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Medicaid Redesign Quality Outcomes and Measurement Program (target start date: one to two years): The state has included pay-for-performance in its Medicaid Redesign Initiative. The major components of the program will include: ▪ establishing quality benchmarks and developing incentives to promote effectiveness and responsiveness of the health system in meeting client needs; ▪ use of a measurement matrix that will allow consumers, advocacy groups, and the public to evaluate the redesign program. The program is likely to focus on low-income families and children, most of whom receive care through the state's health maintenance organization (HMO) and Physician Assured Access System (PAAS) programs. In addition, Medicaid Redesign will include client rewards for activities designed to improve or maintain health status.	Not yet determined. However, the program is likely to be directed initially to HMO and PAAS organizations and their primary care providers. Specialists are less likely to be included in the first year of the program.	Not yet determined. Incentives will be developed to encourage and reinforce the delivery of evidence-based practices. Public recognition of provider performance is likely to be a component. A stakeholder workgroup is reviewing incentives to determine those which are expected to be most effective. One area that the workgroup will be examining is whether and, if so, how to structure the incentives so that they are received at the individual provider level.	Not yet determined. Measures will combine elements from existing quality assurance and improvement monitoring activities. New measures will also be developed and are likely to be structural and state-developed. The stakeholder workgroup is also reviewing measures to be used in the program. Measures are proposed to be developed in the following areas: ▪ access to care (e.g., # days to appointment); ▪ service utilization (e.g., prevention visits; lengths of stay); ▪ effectiveness of care (e.g., improvement in condition); ▪ patient experience (e.g., patient satisfaction); ▪ safety (e.g., medical errors); and ▪ administrative (e.g., cost of care).

WISCONSIN
EXISTING PAY-FOR-PERFORMANCE PROGRAM

Program Name and Description	Providers	Incentive Type and Methodology	Measures
Wisconsin Pay-for-Performance Program (1996 for Family Medicaid program only; substantially modified in 2006): ▪ Wisconsin's Medicaid and SCHIP (or "Badgercare") programs contract with health maintenance organizations to provide managed care services. ▪ The programs are mandatory in areas of the state that have more than one HMO. (Note that Wisconsin is also implementing the rural exception provision, which permits the state to establish a mandatory managed care program in rural areas that have only one health maintenance organization. ▪ The most recent program contracts incorporate pay-for-performance components beyond the initial EPSDT provisions.	Health maintenance organizations (HMOs)	**Penalty:** ▪ Wisconsin includes funding in its capitation rates to support HMO-attainment of the federally required 80% screening rate for EPSDT (termed "HealthCheck" in Wisconsin). ▪ The state recoups funding from plans that do not meet the 80% screening rate. ▪ Plan reporting and recoupments, if any, occur annually. **Differential reimbursement:** ▪ Up to $2.5 million is available to increase capitation rates by 7% when an HMO increases enrollment in areas with limited managed care enrollment or lifts enrollment limits in targeted areas ▪ This incentive is applicable from February 2006 through December 2007. **Bonus:** ▪ Up to $1 million is available to HMOs that achieve a 10% improvement in blood lead screening levels. ◆ The improvement level is calculated by comparing a 100% screening level to the HMO-specific screening level, based on encounter data, and applying a 10% factor to the difference. ◆ Each plan receives $15,000 for administrative costs regardless of whether it meets the 10% improvement target or not. ▪ Up to $750,000 is available to increase preventive and general dental utilization for children and adults. ▪ An accreditation incentive is provided to HMOs that receive full accreditation from national accrediting organizations.	**HEDIS and HEDIS-like measures:** ▪ % of EPSDT well-child visits; ▪ 10% improvement in blood lead screening levels (1 and 2 year olds); and ▪ increased utilization of preventive and general dental care for children and adults. The state is currently developing a tobacco cessation measure, which should become effective in 2007. **Structural measures:** ▪ accreditation by national organizations such as NCQA, JCAHO, and other organizations recognized by the state; and ▪ increased enrollment in certain areas of the state.

WISCONSIN
EXISTING PAY-FOR-PERFORMANCE PROGRAM (continued)

Program Name and Description	Providers	Incentive Type and Methodology	Measures
		Public reporting: In addition to the incentives noted above, Wisconsin has an extensive public reporting protocol related to quality measures in its managed care program. The state publishes annual reports detailing how each HMO has performed on a number of measures and how performance has changed system-wide over time. Among the measures reported on by the state are: ▪ asthma care; ▪ blood lead screening; ▪ dental preventive care; ▪ diabetes care; ▪ EPSDT well-child visits; ▪ general and specialty inpatient and outpatient care ▪ childhood immunizations; ▪ breast cancer screening; ▪ maternity care; ▪ mental health/substance abuse follow-up care and outpatient care evaluations; ▪ non-EPSDT well-child visits; and ▪ cervical cancer screening.	