



Leveraging Missouri's Investments in Health Care Quality and Information Technology through Pay-for-Performance

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Executive Summary

The Missouri Health Improvement Act of 2007 advances the state's goal of transforming Missouri Medicaid into MO HealthNet, a model program for the provision of high-quality, patient-centered health care. The legislation called for creation of the Professional Services Payment Committee, also called the Pay-for-Performance (P4P) Committee, to guide MO HealthNet in the development and implementation of new incentive programs. In order to inform the deliberations of the P4P Committee and MO HealthNet stakeholders, the Missouri Foundation for Health (MFH) and the Health Care Foundation of Greater Kansas City (HCF) commissioned Health Management Associates (HMA) to examine potential P4P opportunities within MO HealthNet.

This report begins with an overview of recent quality improvement activities in MO HealthNet to provide a context in which any new P4P initiative would be implemented. For example, MO HealthNet is regarded as a trendsetter in Medicaid P4P programs for its Chronic Care Improvement Program (CCIP), which includes incentives to physicians to promote the use of new patient care technologies. P4P is more successful when well-integrated with existing quality improvement priorities and activities rather than on a separate, parallel track.

Key trends in P4P initiatives in both the public and private sector have particular relevance for the priorities that the Governor, the Legislature, and the Department of Social Services (DSS) have established for MO HealthNet. These trends are related to:

- Patient-centered care,
- Health information technology, and
- Multi-purchaser P4P collaborations.

MO HealthNet has, in fact, either contributed to or is well-positioned to advance these developments in P4P. Additionally, several trends specific to Medicaid P4P have implications for MO HealthNet incentive programs. These cover:

- Medicaid P4P initiatives targeted to hospitals and nursing homes,
- Medicaid-initiated physician P4P programs within managed care, and
- Incentive programs targeted to Medicaid beneficiaries.

P4P is evolving as a broader movement for payment reform, in recognition of its limitations as a tool for transforming the quality of care within reimbursement systems that tend to reward or discourage volume over quality. Certain approaches are being explored to promote patient-centered care that have evolved from P4P initiatives. These include the creation of "virtual" care networks to measure and compare provider performance, as well as payment schemes that promote "clinically accountable care" organizations are approaches being explored to promote patient-centered care that have evolved from P4P initiatives.

These and other developments have implications for MO HealthNet's current and future P4P initiatives, especially in the context of the state's goal to bring provider payments in line with Medicare rates.

Based on a review of P4P trends in the context of recent health care reforms in Missouri's Medicaid program, HMA recommends a five-point strategy for the consideration of the P4P Committee and those with a stake in the outcome of the Committee's deliberations:

These recommendations can be summarized as follows:

1. Increase the leverage of MO HealthNet quality and P4P initiatives through multi-purchaser alignment of performance measures, reporting methods, and incentives. This recommendation includes conducting an environmental scan of clinical performance measures used in P4P and public reporting, by provider type, among the various public and private sector purchasers in the state.
2. Use P4P strategies as experiments for broader payment reform for establishing a nationally endorsed medical home model while implementing Medicare payment parity in MO HealthNet.
3. Explore the use of incentives to promote interoperable e-health technologies across the state's health care delivery system, including MO HealthNet.
4. Incorporate measures of access, continuity of coverage, and affordability as indicators of quality in MO HealthNet.
5. Pilot a Medicaid nursing home P4P initiative.

Elected officials, agency leaders, and health care stakeholders have contributed significantly to the recent health care reforms that are transforming the Missouri Medicaid program. HMA has identified a number of opportunities for Missouri to increase the impact of these efforts by incorporating strategies that other states, the federal Centers for Medicare and Medicaid Services (CMS), and the private sector have pursued, as well as by building on the infrastructure of MO HealthNet's existing P4P initiative in its CCIP. P4P is not a "silver bullet" for improving health care quality, but it can be a valuable tool when well-integrated with other quality strategies and implemented as uniformly and broadly as possible across the state's health care delivery system.

Introduction

The transformation of Missouri's traditional Medicaid program into a 21st century quality-based health care program is being guided by the Missouri Health Improvement Act of 2007 (henceforth referred to as the 2007 Health Act), a blueprint for state health care reform. This legislation formally changed the Medicaid program's name to MO HealthNet.¹

One section of this legislation, and the topic of this report, called for creation of a Professional Services Payment Committee to develop pay-for-performance (P4P) guidelines. This committee is established within the MO HealthNet Division, the former Division of Medical Services in the Department of Social Services (DSS), which oversees the Medicaid program. The Professional Services Payment Committee (henceforth called the P4P Committee) is comprised of 18 individuals representing a geographically balanced cross-section of the state. The committee includes nine physicians, two patient advocates, the attorney general (or designee), with remaining members comprised of individuals from hospital administration, nursing home administration, dentistry, and the pharmaceutical industry.

The 2007 Health Act also called for creation of other bodies whose recommendations and actions could complement or otherwise interact with the adoption of P4P initiatives in MO HealthNet. For example:

- The MO HealthNet Oversight Committee is working with DSS to develop health improvement plans (HIPs) for all participants in MO HealthNet. Financial penalties may be applied to plans that do not comply with a 2011 deadline for full HIP enrollment. DSS will conduct an annual evaluation of MO HealthNet programs that the Oversight Committee will review.
- The Joint Committee on MO HealthNet was also established to study the resources needed to continue improvements to the program.

Other reforms in the 2007 Health Act could potentially undermine or advance quality improvement efforts that a P4P initiative might target:

- Requiring MO HealthNet participants to make new co-payments for certain medical services, permissible under the 2007 Health Act, could impede certain quality goals that a P4P program is intended to promote.
- The Healthcare Technology Fund was also established in the 2007 Health Act to support technological advances that improve patient care and administrative efficiencies. The Oversight Committee (described above) is to make recommendations about how to allocate appropriated funds. Financing from this new funding source could be leveraged with a complementary P4P initiative or could potentially duplicate efforts.²

In other words, Medicaid P4P initiatives operate in a dynamic environment of many other potentially complementary or duplicative efforts and sometimes competing interests.

The framework employed in this report for assessing P4P opportunities in Missouri Medicaid is based on the notion that performance incentives are just one of many tools available in the value-based purchasing toolbox. They are most effective when aligned with a state's health priorities and when integrated within a broad quality improvement paradigm—such as that adopted for the new MO HealthNet program (briefly described below).

With this framework in mind, this report is organized into the following topics:

- Missouri Medicaid Reform Environment and P4P Opportunities,
- Trends in Medicaid P4P and Implications for MO HealthNet,
- Evolution of P4P as a Broader Concept of Payment Reform, and
- Recommendations for the P4P Committee and MO HealthNet stakeholders.

By framing the opportunities for P4P in the context of recent health care reforms in Missouri, the intent is to present a series of options to help ensure that P4P initiatives proposed for MO HealthNet support the agency's priorities and optimize the state's scarce resources by adding value to existing quality improvement efforts.

Missouri Medicaid Reform Environment and P4P Opportunities

As recommended by the state's Medicaid Reform Commission, supported by Governor Matt Blunt and embraced by the General Assembly through passage of the 2007 Health Act, the MO HealthNet program's objectives focus on³:

- wellness,
- prevention,
- improved health outcomes,
- individual responsibility,
- evidence-based practice,
- technology, and
- efficient program operations.

These goals are to be supported with a patient-centered model of care, often called an "advanced medical home,"⁴ which, in MO HealthNet, includes the components discussed in the following sections.

A Health Care Home

Each MO HealthNet participant would choose or be offered a health care home that provides coordination of care, promotes wellness activities, and facilitates access to needed care.

Health Risk Assessment

Each MO HealthNet participant would complete a health risk assessment with his/her health care home coordinator which would be used to develop an individualized plan of care.

HealthNet Plus

MO HealthNet participants would have the opportunity to access health services that are not offered under Medicaid. These would be services that encourage participants to become more involved in their own health care and would be considered cost-effective and appropriate for the individual's health care needs.

Provider Participation

Physicians' participation in MO HealthNet and their support of its values and objectives are considered a critical factor in Missouri Medicaid's transformation.

The following three efforts are planned to promote physician participation in MO HealthNet:

1. **Parity with Medicare.** In a departure from the traditional Medicaid program, the 2007 Health Act calls for development of a plan for MO HealthNet reimbursement levels for physician and dental services to reach parity with Medicare payment rates and average third party dental payments, respectively.
2. **Access to health information technology.** Providers who participate have access to improved technology, through a web-based tool called CyberAccess,TM which provides electronic prescribing, diagnosis data, patient medical history, ability to receive alerts, selection of appropriate medications, and a means to request drug and medical prior authorizations.
3. **Performance incentives.** Performance incentives for physicians are to be implemented to promote health goals for enrollees and best practices.

Chronic Care Improvement Program

Prior to passage of the 2007 Health Act, DSS implemented an innovative disease management (DM) program for MO HealthNet enrollees with chronic conditions to improve quality of care outcomes and reduce costs. Conditions include asthma, cardiovascular disease, diabetes, chronic obstructive pulmonary disease, and gastroesophageal reflux disease. This enhanced primary care case management program combines traditional DM with electronic health records (EHRs) and web-based care plans to facilitate patient care coordination among providers and between physicians and their patients.⁵ Launched in November 2006, the Chronic Care Improvement Program (CCIP) had a target enrollment goal of 125,000 by July 2008, and may enroll up to 520,000 of the state's nearly 900,000 Medicaid enrollees by 2011.⁶

CCIP is currently available to beneficiaries in fee-for-service. However, it is the springboard for launching the health care home and health risk assessment innovations (described above) for all MO HealthNet beneficiaries. Importantly, CCIP was designed to link quality of care and evidence-based performance measures with financial incentives. For example, each participating physician receives a \$25 payment for completing an initial assessment for CCIP participants. Physicians who log on to a patient's web-based care plan at least one time per month receive a \$10 payment each month thereafter.⁷

For fiscal year (FY) 2008, \$2.9 million was budgeted for CCIP performance incentives, with a 4.5 percent increase budgeted for FY 2009. For FY 2010, \$13.6 million was budgeted to expand pay-for-performance in CCIP to the entire MO HealthNet program.⁸

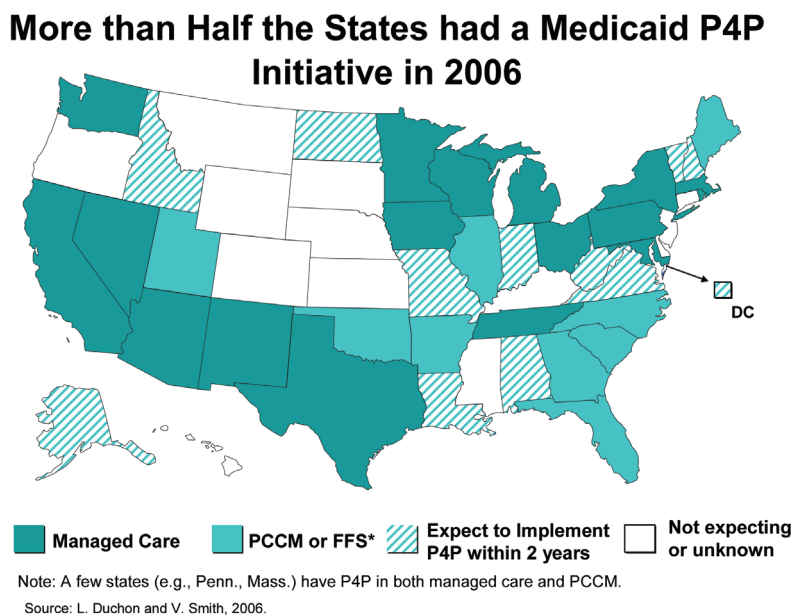
In recognition of the health care innovations promoted in the CCIP, MO HealthNet was one of only seven Medicaid programs selected to participate in a P4P initiative sponsored by the Center for Health Care Strategies' Purchasing Institute.⁹ The Institute is providing technical assistance for developing incentive structures, choosing measures, and engaging providers.

Thus, MO HealthNet already is recognized nationally as a leader in Medicaid P4P initiatives for physicians. Rather than starting from scratch, Missouri's Medicaid program is positioned to develop the next generation of incentive programs by building on the infrastructure of its existing P4P initiative in the CCIP. The state may also be well served to consider how some of the public and private sector trends in P4P could further enhance the state's vision for transformation of its Medicaid program.

Trends in Medicaid P4P and Implications for MO HealthNet

More than half of all Medicaid programs have established a P4P initiative, with the earliest programs dating back to the mid-1990s (See Figure 1).¹⁰ Seventy percent of existing Medicaid P4P programs operate in managed care or primary care case management (PCCM) environments, and the vast majority have focused on quality improvement rather than cost-containment. Within the next several years, at least 85 percent of all Medicaid programs are expected to have adopted at least one P4P initiative.¹¹

Figure 1



Early, "first generation" P4P initiatives, most of which are still in place, targeted managed care organizations (MCOs) or PCCM programs. They had the goals of improving compliance with EPSDT requirements and improving performance on Healthcare Effectiveness Data and Information Set (HEDIS) "process" measures for providing preventive care to children and women

and chronic care for people with asthma and diabetes. As P4P programs mature and expand, they are adapting to a changing health care environment and expectations. Some of the emerging strategies in private sector P4P programs that are beginning to migrate to public programs are summarized in Table 1. The following sections highlight some of the key trends in P4P.

Focus on Patient-Centered Care and Chronic Care

Measuring and rewarding aspects of care coordination, as MO HealthNet is doing through its CCIP, is an example of the growing interest in patient-centered care. The South Carolina Medicaid Medical Homes Network program provides increased reimbursement to providers who agree to establish a medical home for Medicaid beneficiaries. Additionally, Alabama's Patient First program provides increased reimbursement for practices that provide round-the-clock coverage.¹²

While states are laboratories for developing quality performance measures for their unique Medicaid programs, the trend is toward adopting measures that have been vetted by national quality organizations, such as the National Quality Forum (NQF) or the National Committee for Quality Assurance (NCQA). NQF has endorsed a framework for measuring care coordination that includes the definition of a health care home, but has not endorsed specific measures.¹³ NCQA recently developed the Physician Practice Connections – Patient-Centered Medical Home program to measure patient-centered care.¹⁴ Bridges-to-Excellence, the multi-state, multi-employer organization created to reward high quality physician care recently established a Medical Home Program.¹⁵

Health Information Technology Adoption as a Performance Measure and Reward

Information technology is a cornerstone of the advanced medical home. As described by NQF, patient-centered care is “facilitated by registries, information technology, health information exchange (HIE) and other means to assure that patients get the indicated care when and where they need and want it...”¹⁶ EMRs, e-prescribing, and other health information technologies (HIT) are being added as “structural” measures of quality and increasingly are considered part of “standard” care, with some purchasers and health plans beginning to require provider practices to be wired for connectivity as part of contractual agreements.¹⁷

Yet HIT is expensive, particularly for small medical practices that may not benefit directly from the investments and have been the least likely to adopt innovations such as EMRs. To adapt, providers may need to become more organized through independent practice associations or other group practices. The Centers for Medicare and Medicaid Services (CMS) and private purchasing groups strongly encourage more physician organization to improve care coordination. (See “Toward clinically accountable care” section below).

CMS has added structural measures related to adoption of EMRs or e-prescribing to its Physician Quality Reporting Initiative (PQRI), a pay-for-reporting demonstration program.¹⁸ Some Medicaid programs are following this strategy as well. Additionally, CMS is planning to pilot test the use of clinical data registries in PQRI. Congressional leaders are encouraging CMS to

recognize and reward physicians for “registry-based reporting of performance data that combines information regarding Medicare, Medicaid, and other patients.”¹⁹ Some Medicaid programs are using grants or technical assistance for HIT adoption as a reward for meeting other quality performance standards.²⁰

Table 1. Evolution of P4P Initiatives

Traditional Medicaid P4P	Emerging P4P
<ul style="list-style-type: none"> • Target HMOs, PCCMs, individual doctors 	<ul style="list-style-type: none"> • Expanding to physicians within managed care, multi-specialty groups, hospitals, nursing homes, other vendors (e.g., behavioral health, disease management, pharmacy benefits), and consumers/patients
<ul style="list-style-type: none"> • Incentives target greater utilization of preventive care, HEDIS measures 	<ul style="list-style-type: none"> • Incentives target reductions in over-utilization, expanding HIT infrastructure, and include pay for participation in development of new initiatives
<ul style="list-style-type: none"> • Evidence-based guidelines, by specialty; “homegrown” measures 	<ul style="list-style-type: none"> • Defining measures for value, efficiency, equity, population-based outcomes; NQF-endorsed measures
<ul style="list-style-type: none"> • Purchasers design own incentive programs 	<ul style="list-style-type: none"> • Multi-payer standardization of measures, incentives, reporting across public purchasers and private industry
<ul style="list-style-type: none"> • P4P “silos” across provider types and agencies; measures not aligned. 	<ul style="list-style-type: none"> • Aligning incentives across provider types for care coordination, continuity, medical care home
<ul style="list-style-type: none"> • Public reporting on MCOs 	<ul style="list-style-type: none"> • Provider profiling; hospital, nursing home, physician/group report cards
<ul style="list-style-type: none"> • Limited to existing claims, encounter data 	<ul style="list-style-type: none"> • Use of EMRs, e-lab, and e-prescribing to enhance clinical data collection and data aggregation across plans and providers
<ul style="list-style-type: none"> • Delayed performance feedback, often for health plans only 	<ul style="list-style-type: none"> • More point-of-care feedback: actionable information through registries, reminder alerts
<ul style="list-style-type: none"> • Expect better value for current spending level 	<ul style="list-style-type: none"> • Improve quality and attempt to “bend the cost curve” (reduce trend in cost increases)

Public-Private and Public-Public Collaboration on Performance Incentives

Standardization and interoperability are critical to electronic health information exchange, which has led public and private purchasers to collaborate, regionally, on HIT investments and standards. These efforts are typically independent of P4P initiatives, but this may change as public and private purchasers increasingly collaborate more broadly to adopt uniform health care performance measures and align their incentive programs.²¹ This standardization across purchasers can reduce reporting burdens on providers, improve the robustness of provider performance comparisons, and in fact, facilitate standardization of HIE across providers and payers. These trends pave the way for measuring and ultimately improving population-based health outcomes.

Minnesota is a model state for public-private collaboration on performance measurement. Other states are collaborating across public purchasers (e.g., Medicaid, state employee benefit, and

state employee retirement programs) on performance measurement, public reporting and incentives (see Table 2.) These multi-payer collaborations may increasingly include financial incentives and/or technical assistance to speed the adoption rate of interoperable e-health records and patient registries.

Table 2. State Medicaid Programs Participating in Multi-Payer P4P Initiatives

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

Source: K. Kuhmerker and T. Hartman, 2007.

Trends in Medicaid P4P Targets

While Medicaid P4P has primarily targeted MCOs and physicians, states have recently begun providing incentives to hospitals, nursing homes, and other providers directly, in a fee-for-service structure. These initiatives are not integrated with physician P4P initiatives and have been outside the scope of Medicaid managed care. However, some states are experimenting with incentives to physicians—and beneficiaries—within risk-based managed care. Examples of these developments are highlighted below.

Medicaid is Following Medicare Trends in Hospital P4P Initiatives

CMS has been a leader in hospital quality measurement and P4P. CMS's P4P demonstration with nearly 300 hospitals includes financial incentives for improving performance on 34 measures for five conditions (heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements).²²

Hospital P4P initiatives in Medicaid have just begun in the last several years. For example, Arkansas Medicaid's hospital P4P initiative was established in 2006 in collaboration with the state's hospital association and the state's quality improvement organization (QIO) for Medicare. The initiative offers bonuses for reaching target performance measures on CMS quality measures that hospitals were already reporting.²³ Pennsylvania's Medicaid P4P initiative measures seven-day readmission rates and rewards hospitals on structural measures that include e-prescribing and computerized physician order entry (CPOE).²⁴ Pennsylvania, Michigan, and Wisconsin

Medicaid programs also recently adopted Medicare's new practice of no longer paying for 27 "never-events" (e.g., operating on the wrong patient or body part, medication errors that result in death or disability, bad blood transfusions).^{25, 26} As of this writing, a bill pending in the state legislature would adopt this practice in Missouri as well.²⁷

States are Leading P4P Initiatives to Improve Nursing Home Care

With Medicaid programs being the largest purchaser of nursing home services, a number have implemented P4P initiatives designed to improve quality of care in their state's skilled nursing facilities. Georgia, Iowa, Minnesota, Ohio, and Oklahoma have each implemented a nursing home quality improvement initiative with financial incentives that generally include the following types of measures: minimum data set (MDS) measures on resident outcomes; staffing-level measures; certification survey deficiencies; and resident/family quality of life surveys. Virginia is also actively designing a comprehensive Medicaid nursing home P4P program.²⁸ A committee of stakeholders has researched and summarized other states' activities and developed a comprehensive "roadmap" for decision-making in designing a P4P program for nursing homes. CMS plans to launch a Medicare P4P demonstration with nursing homes that builds on these states' efforts.

Aligning Managed Care and Physician P4P Goals

Medicaid programs that have adopted a managed care P4P initiative hold health plans directly accountable for outcomes on performance measures. Health plans may or may not initiate their own performance incentives for their network providers. When they do, those initiatives may or may not promote the Medicaid program's quality improvement priorities, and physicians may be subject to multiple health plan P4P initiatives.

Perhaps over frustration with health plan performance and/or a lack of improvement on health outcomes, some Medicaid programs are targeting P4P efforts directly to physicians or physician groups, even within risk-based managed care. Arizona, Idaho, Rhode Island, and Pennsylvania are examples of states striving to aggregate physicians' performance across multiple health plans and provide those physicians with one incentive payment.²⁹

Whether these P4P experiments will become a trend in Medicaid is unclear. CMS does not allow states to make "subcontractor" payments to physicians that are under contract with a health plan in risk-based managed care. Also, any Medicaid pass-through to providers must not allow total payments to a health plan to exceed CMS's 105 percent limit on Medicaid payment of approved capitation rates.³⁰

Incentivizing Medicaid Beneficiaries Through Managed Care

A few State Children's Health Insurance Program (SCHIP) and Medicaid programs are working with their health plans to offer incentives to encourage people to take a more active role in their own care. Initiatives have generally focused on lifestyle changes related to smoking or obesity, or seeking preventive or follow up care.³¹ Through legislation, at least five states

have begun or are considering initiatives that build on the concept of “patient engagement” promoted by the U.S. Department of Health and Human Services as a way to control costs and improve health outcomes.

Incentives for the desired behavior may include reduced cost-sharing (Florida), additional benefits that are not part of the standard benefit package (Michigan, Texas), and gift certificates or movie passes (California). Pending a CMS waiver, a pilot program in Texas would allow volunteers who participate in smoking cessation or weight loss programs to receive credits in an “individual health rewards” account that could be used to purchase additional health services. These efforts may offer lessons to Missouri’s planned MO HealthNet Plus program described earlier.

Evolution of P4P as a Broader Concept of Payment Reform

P4P, to some degree, has evolved as a response to counter disincentives for providing high quality care in both fee-for-service and capitation.³² Most P4P incentives are considered “weak signals” compared to the underlying payment system on which they are layered.³³ Indeed, P4P is no substitute for payment reform, but it is easier to implement and helps to focus attention on health care priorities.

The impact of P4P in improving adherence to clinical quality guidelines or other types of performance is difficult to evaluate, in part because the effects cannot be isolated among multiple quality initiatives and there is usually not a comparison group. Studies have found mixed results on P4P initiatives—whether targeted to health plans, physician groups, or hospitals—that are difficult to interpret.³⁴ Nonetheless, two major benefits of P4P have been consistently reported: promoting a climate of accountability and improving accuracy of data reporting.

Continued rising costs in health care and concern over the affordability of health care—as uninsured rates climb—loom large. Public and private health care purchasers and others view P4P as part of a transition to broader payment reform. In fact, the patient-centered care movement is facilitating a call for new payment methods. Some experts consider P4P under current reimbursement practices as a limited if not ineffective way to achieve patient-centered medical care.³⁵ As more Medicaid programs and health plans are using P4P in chronic care management programs to achieve better care coordination, concerns are growing about how to attribute—and reward—positive clinical outcomes of patient care across a continuum of providers.

Toward Clinically Accountable Care

As evidence-based medicine advances and measures of care coordination evolve and create the potential to reduce over- and under-utilization in care, P4P incentives and reimbursement methods will likely adapt to, as well as facilitate, more change in medical practice.

Interest is building around bundling of payments that promote integrated, coordinated systems of care referred to as clinically accountable entities.³⁶ These include: a medical home (for wellness, complex pediatrics, geriatrics, cancer, HIV); coordinated specialty-group practices; a hospital-centered network; and other accountable, integrated systems.³⁷ CMS is being encouraged to develop the means of recognizing multiple physician network structures, and physi-

cian-hospital organizations (PHOs) “to encourage better collaboration in treating patients with complex illnesses.”³⁸ Greater physician organization has also been associated with higher quality and efficiency.³⁹

Virtual Care Networks

Innovative private sector P4P initiatives are creating these structures virtually, and they may evolve into broader payment reforms. A Michigan health plan has created virtual physician networks for its physician P4P program to assess physician performance among small practices.⁴⁰ A Virginia private health plan has used P4P to align incentives between hospitals/health systems and cardiac physicians by rewarding them on the same performance outcomes. The initiative uses the Society of Thoracic Surgery’s clinical database registry to measure and reward performance on inpatient cardiac care.⁴¹

MO HealthNet: Medicaid P4P Trendsetter

MO HealthNet is a trendsetter in state Medicaid P4P initiatives with regard to measuring and rewarding care coordination and giving providers incentives to use HIT through CCIP. As this P4P initiative is extended more broadly across the MO HealthNet program, there are opportunities for Missouri to increase the impact of its recent health care reforms and the value of the state’s health care spending – including planned rate parity with Medicare – by incorporating some of the strategies that other states, CMS and the private sector have pursued.

Recommendations for the P4P Committee and MO HealthNet Stakeholders

Public officials, agency leaders and health care stakeholders have contributed significantly to the recent health care reforms that are bringing about Medicaid transformation in Missouri. HMA recommends a five-point strategy for broadening the state’s purchasing leverage for producing quality of care that meets evidence-based standards and increases efficiencies in MO HealthNet and throughout the health care delivery system in Missouri:

1. Multi-payer collaboration on measurement sets
2. P4P as a transition to payment reform for health care home
3. Incentives as a tool for adoption of interoperable e-health technologies
4. Access, continuity of coverage and affordability as measures of quality
5. Targeted P4P initiative for nursing home care

Each strategy, discussed below, is offered as a set of suggestions to the P4P Committee that was created by the 2007 Health Act and MO HealthNet stakeholders.

1. Increase the leverage of MO HealthNet quality and P4P initiatives through multi-purchaser alignment of performance measures, reporting methods and incentives.

Small financial incentives and contradictory public report cards among different sponsors with little market leverage are unlikely to be effective in changing behavior and improving performance, based on P4P experiences to date.⁴²

- Commission an environmental scan of clinical performance measures used in P4P and public reporting of performance, by provider type, among the various public and private sector purchasers in the state.
- As part of an environmental scan, determine which, if any, major health plans, employers, or other large purchasers have implemented the Bridges To Excellence Physician Office Practice Management rewards program, NCQA's Physician Practice Connection program, or other national reward programs. Assess the extent of Missouri physicians' participation in either Medicare's Physician Quality Reporting Initiative or its Physician Group Demonstration P4P initiative.
- Use the results of an environmental scan or inventory of measures and reward programs in Missouri to inform decision-making about the value of establishing a multi-payer purchasing coalition (or a new entity that serves purchasers) for performance measurement and standardized reporting of performance, of which MO HealthNet would be a founding member.
- Examine other states' multi-purchaser P4P initiatives to gain insights that could be valuable for Missouri.
- Follow developments in NQF-endorsed measures of care coordination for opportunities to standardize definitions and measures of patient-centered care practices within the CCIP program and more broadly across MO HealthNet.
- Establish performance measurement and quality reporting standards across health plans that participate in MO HealthNet.
- Conversely, as the CCIP program matures and expands within MO HealthNet, leverage the state's investment in CCIP by considering which aspects may be a model for other purchasers. For example, consider how the implementation of HIPs required by 2011 for all MO HealthNet participants may be more effective as part of a multi-purchaser quality initiative.

2. Use P4P strategies as experiments for broader payment reform, to promote establishment of the medical home model of patient-centered care in the course of implementing Medicare payment parity in MO HealthNet.

Fee-for-service is noted for contributing to uncoordinated care and undervaluing primary care while rewarding expensive, procedure-based medicine.⁴³ Increasing reimbursement to providers relative to Medicare rates is an important step for expanding access to primary and specialty care to Medicaid beneficiaries. However, it is unlikely to be sufficient to transform Medicaid medical practices into coordinated system of patient-centered care.

- Recognize the limitations of P4P within current reimbursement systems to transform medical practice or reduce expenditures and set the more achievable objective of harnessing its

potential to promote a climate of accountability and focus attention on particular population groups and health priorities.

- As efforts proceed to raise Medicaid reimbursement rates to parity with Medicare, track the modifications to and results of the CMS Medicare physician P4P demonstration and PQRI for lessons about how to incorporate measures and incentives that may promote the medical home model envisioned for MO HealthNet—within a fee-for-service system that tends to reward volume over quality.
- Consider pilot testing directly, or through Medicaid managed care plans, P4P models from the private sector that align measures and incentives across hospitals or health systems and physician groups affiliated with them for a particular condition prevalent in the MO HealthNet population. Consider how a pilot program could be implemented with a comparison group.
- Monitor developments in Medicare, Bridges To Excellence, The Leapfrog Group, and national health plans for developments in payment reform that are working to transition their P4P programs into broader payment reform initiatives that promote patient-centered care.

3. Explore the use of incentives to promote interoperable e-health technologies across the state's health care delivery system, including MO HealthNet.

The Missouri Healthcare Information Technology Task Force recognized the importance of MO HealthNet's participation in achieving the state's vision for a coordinated system of HIE.⁴⁴ One Task Force recommendation was to “encourage provider adoption of electronic healthcare records by exploring incentives.” Collaboration from purchasers and providers on both performance measurement and HIT would offer Missouri significant opportunities to leverage its investment in these areas and reduce the potential for duplication of efforts.

- Ensure that the HIE organization created to coordinate HIT within the state collaborates with purchasers and provider organizations to explore development of appropriate incentives that could facilitate achievement of statewide connectivity goals.
- To the extent that structural measures of HIT adoption can be used uniformly among health care purchasers as measures of quality, they could be incorporated into public report cards of provider performance.
- Use a portion of the new Healthcare Technology Fund to finance incentives or technical assistance to providers to adopt prescribed technologies, which could include patient registries, e-health records, e-prescribing and or CPOE.
- Determine whether current HIT applications in MO HealthNet may be a platform for broader statewide implementation or whether they will likely need to adapt to be compatible with emerging HIE standards for the state. Consider how incentives could be a useful tool in either scenario.

4. Incorporate access, continuity of coverage and affordability as key measures of quality in MO HealthNet.

Policies that increase the opportunity for beneficiaries to have disruptions in coverage or make the cost of care more expensive reduce the ability of health plans and providers to achieve the

quality goals the state has established for MO HealthNet and undermine the potential effectiveness of P4P initiatives. Disruptions in coverage and unaffordable co-pays also create disincentives for individuals to take responsibility for following the health improvement plan they have established with their medical home provider.

- Adopt Medicaid policies that reduce reenrollment barriers and promote beneficiaries' compliance with doctor-prescribed care and health improvement plans.
- Develop measures related to beneficiary "churning" to add to MO HealthNet's own quality performance scorecard. This could include assessment of the numbers of beneficiaries excluded from HEDIS measures because they were not continuously enrolled for at least one year.
- Test the use of incentives for Medicaid consumers that are aligned with provider incentives that support the medical home goals established for MO HealthNet.
- Study other states' patient incentive programs in Medicaid and SCHIP for models that could be adapted for use with MO HealthNet Plus.

5. Pilot a Medicaid nursing home P4P initiative

As the largest single purchaser of skilled nursing services, Medicaid is in a strong position to use its purchasing power to promote high quality skilled nursing care and reward high achievers. The availability of national, uniform reporting standards for skilled nursing facilities makes P4P a potentially valuable strategy to support MO HealthNet's long term care quality initiatives.

- Study the Medicaid P4P initiatives that have been implemented in Oklahoma, Georgia, Iowa, and Minnesota.
- Establish goals and priorities for quality improvement in Missouri nursing homes to guide MO HealthNet in its planning process for selecting measures, incentives and scoring systems.
- Use Virginia Medicaid's planning and development process as a guide for engaging key nursing home care stakeholders in a Missouri Medicaid P4P nursing home initiative.

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