Medicaid P4P Programs: Arizona's Perspective

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Arizona Health Care Cost Containment System (AHCCCS)

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Program Overview

- Over 1 million members in AHCCCS, Arizona's Medicaid program.
- An additional 1 million uninsured.
- Over 90% of AHCCCS members are in mandatory Medicaid Managed Care with contracted health plans, including long-term care and behavioral health.

Why a State-wide Provider P4P in an MCO Environment?

- Multiple MCO P4P programs result in disjointed requirements, performance measures and payments.
- Statewide program is less burdensome and more rewarding to providers, resulting in greater provider participation.
- Alleviates “small numbers problem” when plan members aggregated in state P4P.

Initial Performance Measures

- Diabetes Care
  - Hemoglobin A1c 2X per year
  - Lipid profile 1X per year
  - Renal panel 1X per year
- Immunization of 2-year olds
  - All required vaccinations before 2nd birthday
- Nursing Home P4P, measures yet TBD

Challenges

- Physician mistrust of P4P programs
- Accurate and meaningful data collection
- Payment system that meets CMS requirements and not result in MCO “winners or losers”
- Legislative approval and adequate funding to provide meaningful rewards

Physician Mistrust

- Collaborative effort to select initial P4P measures that reflect physician performance, not patient compliance
- Outcomes measures will be added in subsequent years
- No “economic” measures; performance measures based on good medical practice, not costs
- No public reporting of first year data

Accurate Data Collection

- Encounter data may not reflect all lab tests performed on patient population
- Office lab tests or hospital lab tests difficult to collect in system
- Physicians without EMR have more difficulties in documenting performance
- State-wide EMR for AHCCCS members will facilitate more robust data collection

Payment Systems

- CMS does not generally allow direct payments to providers when capitated payments made to MCOs for care
- Working to show CMS that these are not duplicative payments and system is more efficient when made directly to providers
- Can work around this through broker or by adjusted capitation payments to plans

Payment Systems

- “Prepaying” MCOs in prospective capitation rates can result in plan “winners or losers” due to unequal distribution of physicians qualifying for P4P payments
- Retroactive or one-time MCO capitation adjustments may be possible
- Better to have CMS buy-in of payment method before proceeding with program

Legislative Approval

- Expenditure of funds for P4P Program requires legislative approval
- Estimated costs of program:
  - $3.2 million for physician P4P program
  - $4.5 million for nursing home program
- Arizona has significant budget shortfall in 2008 and 2009—close to $1 billion / year
- Use CHCS ROI tool to make “best case”

Current Environment

- Governor's budget proposal includes nursing home P4P funding but no funding for physician P4P program
- Initial legislative budget proposal does not include any funding for P4P
- Given current fiscal shortfall, the budget is unlikely to be finalized before May or June

Thank You

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Medicaid P4P Programs: Trends in 2008

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Center for Health Care Strategies

Our Mission

To improve the quality of health care services for people with chronic illnesses and disabilities, the elderly, and racially and ethnically diverse populations.

Our Focus Areas

- Improving Care for People with Complex and Special Needs
- Advancing Regional Quality Improvement
- Reducing Racial and Ethnic Disparities

Our National Reach

- 48 states
- 160 health plans

Evolution of Medicaid P4P

1st Generation	2nd Generation
Unaligned from Existing QI Efforts	Aligned Across Payers & Plans Part of a Larger QI Effort
Breadth	Depth
Focus on Accountability	Focus on Quality/ Efficiency
Health Plan Focus	Plan *and* Practice Focus
Uni-Dimensional Measures	Composite Measures and Tiering
Claims Data	Chart Data

Trend 1: P4P at the Physician Level

- Designing or implementing state-operated physician-level P4P programs within managed care systems
  - Primary care case management
  - Risk-based managed care
- Adopting physician-level measures
- Striving to aggregate data across plans and report performance at the provider level

Trend 1: P4P at the Physician Level (Continued)

- Addressing new challenges
  - Addressing the “small numbers problem”
  - Attributing patients to physicians
  - Aligning within existing QI efforts
  - Calculating the right incentive amount
- Examples: Arizona, Idaho, Rhode Island, Pennsylvania

Trend 2: P4P and Multi-Payer Alignment

- Aligning with commercial sector around P4P
  - Participating in Bridges to Excellence (BTE)
  - Aggregating performance across plans and payers
- Addressing challenges
  - Overlapping provider networks
  - Funding increased provider payments
- Examples: Minnesota, New York

Trend 3: P4P and Care Coordination

- Measuring and rewarding care coordination and the medical home
  - Rewarding care plan development and care coordination; or
  - Using NCQA's Physician Practice Connections (PPC) tool to measure the patient-centered medical home
- Examples: Rhode Island, Pennsylvania, Indiana, Missouri, Massachusetts

Trend 4: P4P and HIT

- Incenting providers to use HIT, web-based portals, or electronic care plans
- Using electronic lab data to enrich claims data information
- Moving towards web-based reporting system
- Addressing challenges
  - Expanding to all providers
  - Aligning with ongoing HIT efforts
- Examples: Missouri, Idaho

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