**Medicaid Managed Care Plan Offers Patient-Specific, Pay-for-Performance Program, Leading to Improvements in Immunization Rates and Diabetes Care**

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The program rewards providers based on their performance with individual patients, offers multiple ways to earn bonuses (beyond achievement of targeted clinical outcomes), and provides actionable feedback to help physicians improve performance. Although some program elements have been temporarily suspended for financial reasons, the initiative has improved immunization rates and diabetes care and generated a positive response from providers, without having a negative impact on health disparities.  ***Evidence Rating*** ([What is this?](http://innovations.ahrq.gov/evidencerating.aspx))  **Moderate**: The evidence consists of pre- and post-implementation comparisons of performance on various metrics between Hudson Health Plan and other New York-based Medicaid managed care plans, along with post-implementation feedback from providers. |   begin doxml  ***Developing Organizations***  Hudson Health Plan Tarrytown, NYend do  ***Date First Implemented***  2003 The immunization and diabetes programs ran from 2003 and preventive care ran from 2007 until temporarily suspended in 2010; the program continues for cervical cancer screening, appropriate use of antibiotics, and chlamydia screening.begin pp  ***Patient Population***  Age > Adolescent (13-18 years); Child (6-12 years); Vulnerable Populations > Children; Gender > Female; Vulnerable Populations > Impoverished; Age > Infant (1-23 months); Insurance Status > Medicaid; Age > Newborn (0-1 month); Preschooler (2-5 years); Vulnerable Populations > Racial minorities; Rural populations; Womenend pp | | | http://innovations.ahrq.gov/../images/spacer.gif |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | | **What They Did** | [Back to Top](http://innovations.ahrq.gov/content.aspx?id=3653#top) | http://innovations.ahrq.gov/../images/spacer.gif |  |  | | --- | | ***Problem Addressed***  **Pay-for-performance (P4P) programs (which typically offer financial incentives to physicians and other providers who meet defined quality and/or efficiency targets) can inadvertently increase health disparities or adversely affect physicians serving disadvantaged or minority populations.**[**1**](http://innovations.ahrq.gov/content.aspx?id=3653#1) **The costs of participating in these programs can often be prohibitive for small practices.**[**2**](http://innovations.ahrq.gov/content.aspx?id=3653#2)   * **Penalties for practices serving vulnerable populations:** P4P systems that award bonuses based only on population-level outcomes may end up penalizing practices that care for many vulnerable patients, such as those who have resistant disease or comorbid conditions, and those who do not follow the treatment plan for cultural, economic, or mental health reasons.[1](http://innovations.ahrq.gov/content.aspx?id=3653#1) * **Burdensome on smaller practices:** Most P4P plans pay bonuses based on aggregate performance across a group of patients. This system favors larger practices with more participating patients over which to spread risk. In addition, meeting the tracking and reporting requirements imposed by many P4P programs requires time and infrastructure that smaller practices often lack. As a result, these practices may not participate and hence miss out on the potential rewards.[2](http://innovations.ahrq.gov/content.aspx?id=3653#2) * **Negative impact on access:** Smaller practices and those serving vulnerable populations may choose not to participate in P4P programs, or may begin turning away medically complex patients who impede their ability to perform well in such programs. Either way, the end result could be reduced access to quality health care services for patients of these practices.   ***Description of the Innovative Activity***  **Hudson Health Plan tailors its P4P program to practices serving vulnerable populations by rewarding providers based on their performance in serving individual patients (rather than a group of patients), offering multiple ways to earn bonuses (beyond achievement of targeted clinical outcomes), and providing actionable feedback to help physicians improve.** Key program elements are detailed below. (Some of these elements have been temporarily suspended; see Planning and Development Process section for details.)   * **Patient-specific P4P bonuses:** Although most P4P programs base bonuses on aggregate performance across a group of patients, Hudson Health Plan ties bonuses to performance on a patient-by-patient basis. * **Multiple ways to earn bonuses (beyond outcomes):** Unlike many P4P plans that pay only if certain clinical performance targets are achieved, Hudson also pays bonuses to physicians who provide certain recommended services (e.g., immunizations, screening tests, procedures) in a timely manner and/or who improve performance over time, even if the target is not attained. Patient-specific bonuses are paid out based on claims data and clinical data. Hudson also plays a primary care bonus based on New York State’s Quality Assurance Reporting Requirements (QARR) results. (Released annually, QARR reports are available to Medicaid beneficiaries and other consumers in the state who are choosing a health plan.[3](http://innovations.ahrq.gov/content.aspx?id=3653#3)) QARR incorporates measures from the HEDIS® (Healthcare Effectiveness Data and Information Set), developed by the National Committee for Quality Assurance and adopted by more than 90 percent of health plans to track improvement efforts.[4](http://innovations.ahrq.gov/content.aspx?id=3653#4) The following are examples of how providers can earn bonuses under the program.   + **Provision of childhood immunizations:** Up until 2010, Hudson Health Plan rewarded physicians quarterly from 2003 to 2010 with $100 for every child fully immunized by his or her second birthday. Physicians received an additional $100 if the child received the immunizations according to the 2003 HEDIS-recommended schedule. The full $200 bonus represented a 15- to 25-percent increase above usual reimbursement for these services.   + **Provision of evidence-based services based on claims data:** Hudson Health pays bonuses above the standard reimbursement for the provision of certain recommended care processes, such as chlamydia and cervical cancer screenings and counseling patients on the proper use of antibiotics. These bonuses are paid automatically based on the submissions of claims data to the plan.   + **Diabetes management and outcomes:** Using standards developed by the American Diabetes Association and endorsed by the New York Diabetes Coalition, Hudson’s diabetes management program paid bonuses based on diabetes care provided from 2003 to 2009 based on the provision of recommended diabetes services and the achievement of (or improvements in) diabetes outcomes, as outlined below:     - *Provision of recommended services:* Practices received payments for each diabetes patient who received blood pressure screening, low-density lipoprotein screening nephrology consult, hemoglobin A1C tests, smoking assessment, retinal eye examination, and influenza and pneumococcal immunizations according to the recommended schedule.     - *Achievement of and/or improvement in outcomes:* Practices received bonuses for each patient who met national goals for diabetes control or who showed meaningful improvement in these measures. For example, a physician who performed all recommended tests and achieved benchmark outcomes with a patient received a full bonus of $300 per patient. Those who performed all recommended tests on a patient who did not achieve the benchmark outcome received a smaller bonus. Those caring for a patient whose outcomes improved but did not meet the target also received a smaller bonus. (This approach contrasts with that of many other P4P programs, which only reward physicians whose patients meet the clinical goal of a hemoglobin A1c level below 7.0. However, reducing a patient’s hemoglobin A1c level from 12 to 10 may be equally or more important than helping another patient achieve a more modest reduction to a level below 7.0.)   + **Provision of preventive care:** From 2007 to 2010 primary care practices received $15 to $25 above contracted visit rates for performing an annual preventive care visit.   + **Performance on QARR:** From 2001 to 2009 Hudson primary care practices also received a practice-level quality bonus (not patient-specific) based on QARR results. In 2010 this was supplanted by a New York State–sponsored bonus payment for achieving patient-centered medical home status. * **Actionable feedback on performance:** Physicians receive multiple reports designed to assist them in providing evidence-based care, as outlined below:   + **Preliminary report:** Physicians receive a preliminary diabetes report approximately 6 months before the diabetes bonus payment. The immunization preliminary reports are distributed quarterly and preventive care lists semiannually. Based on claims data submitted by providers, these reports list patients who have not received recommended services. Practices then check the reports for accuracy, send in chart data for test results for those who have actually received the service, and follow up with those who are overdue for a recommended service. (The reports include the patient’s contact information so that practices can easily follow up.)   + **Personal delivery of annual QARR-based report:** From 2001 to 2008, physicians received an annual report based on the most recent QARR report. Beginning with 2010 this report was revised to identify prospectively members in need of services to meet QARR requirements. Throughout the year, trained provider relationship representatives meet with each primary care group in person to explain the practice level reports and give out the bonus checks for the period. The reports are specific to each practice and give results for the most recent year and the previous year and compares these with planwide and New York State benchmarks. These meetings provide an opportunity for physicians to receive an explanation of the results and to ask any questions and voice any concerns they may have.   + **Awards banquet:** Annually from 2001 to 2007 and again in 2009, physicians and their spouses/significant others attend a dinner to recognize the top performing practices. Hudson’s chief medical officer provided an explanation of the programs and reviewed performance across the plan.   + **Patient outreach:** Hudson Health Plan also proactively contacts patients due for recommended services or screenings, urging them to schedule an appointment with their doctors. Each fall, Hudson representatives contact members who have diabetes to remind them of the importance of receiving a flu shot and other needed services. In 2010 and 2011 all members with diabetes in need of an eye examination received a phone call offering an incentive completing required care. To increase immunization rates, families receive a letter at the child’s second birthday urging parents to complete the immunization schedule. If a child missed an immunization or other preventive care appointment, parents receive a phone call. In October, representatives contact women who have missed their annual well woman visit.   ***References/Related Articles***  Chein AT, Li Z, Rosenthal MB. Improving timely childhood immunizations through pay for performance in Medicaid-managed care. Health Serv Res. 2010;45(6 Pt 2):1934-47. [[PubMed]](http://www.ncbi.nlm.nih.gov/pubmed/20849554)  Friedberg MW, Safran DG, Coltin K, et al. Paying for performance in primary care: potential impact on practices and disparities. Health Aff (Millwood) 2010;29(5):926-932. [[PubMed]](http://www.ncbi.nlm.nih.gov/pubmed/20439882)  Halladay JR, Stearns SC, Wroth T, et al. Cost of primary care practices of responding to payer requests for quality and performance data. Ann Fam Med. 2009;7(6):495-503. [[PubMed]](http://www.ncbi.nlm.nih.gov/pubmed/19901308)  ***Contact the Innovator***  **Janet Sullivan, MD** Chief Medical Officer Hudson Health Plan 303 S. Broadway, Suite 321 Tarrytown, NY 10591-5455 E-mail: [AHRQinfo@hudsonhealthplan.org](mailto:AHRQinfo@hudsonhealthplan.org)  ***Innovator Disclosures***  Dr. Sullivan received external support from the Robert Wood Johnson Foundation and the Commonwealth Foundation to fund the evaluation of this initiative. She also served in 2011 as the chair of the New York Diabetes Coalition, an unincorporated entity advocating for optimal diabetes management. | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | | **Did It Work?** | [Back to Top](http://innovations.ahrq.gov/content.aspx?id=3653#top) | http://innovations.ahrq.gov/../images/spacer.gif |  |  | | --- | | ***Results***  **The program has improved immunization rates and diabetes care and generated a positive response from providers. There was no negative impact on health disparities.**   * **Higher immunization rates:** Between 2003 and 2007, immunization rates among Hudson Health plan members rose from less than 60 percent to approximately 85 percent, a significantly better rate of improvement than occurred in other New York Medicaid managed care plans (62 to 79 percent).[5](http://innovations.ahrq.gov/content.aspx?id=3653#5) Hudson sustained these improvements until the immunization program was temporarily suspended in 2010. * **Better diabetes care:** When the diabetes P4P program began in 2003, Hudson Health Plan rated below average in diabetes care among Medicaid managed care plans in New York. By 2007, Hudson had improved on all measures. However, the difference between Hudson’s outcome and those of other health plans was not significant. * **Positive provider feedback:** Preliminary results from an independent evaluation suggest that most physicians are aware of Hudson’s P4P program and view it positively. * **No negative impact on health disparities:** The immunization study cited above found that the Hudson P4P methodology did not have a negative impact on immunizations in children with chronic conditions and did not otherwise increase health disparities, as compared with similar health plans that did not implement P4P programs.   ***Evidence Rating (***[***What is this?***](http://innovations.ahrq.gov/evidencerating.aspx)***)***  **Moderate**: The evidence consists of pre- and post-implementation comparisons of performance on various metrics between Hudson Health Plan and other New York-based Medicaid managed care plans, along with post-implementation feedback from providers. | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | | **How They Did It** | [Back to Top](http://innovations.ahrq.gov/content.aspx?id=3653#top) | http://innovations.ahrq.gov/../images/spacer.gif |  |  | | --- | | ***Context of the Innovation***  Launched in 1988, Hudson Health Plan is a not-for-profit managed care organization that now serves approximately 115,000 Medicaid and Children’s Health Insurance Program members residing in 6 counties north and west of New York City. Roughly half of the plan’s participating providers work in small (one- or two-physician) practices, although the network also includes community health centers and some large multispecialty practices. Roughly half of the plan’s members are Hispanic and one-fifth are African American.   The impetus for the program began in 1997, when the newly hired chief medical officer (Dr. Janet Sullivan) began looking for ways to help physicians improve performance on QARR results. To that end, Dr. Sullivan decided to break down these results into practice-specific reports, first delivered to providers in 1999. Although these reports received positive feedback from other plans and State leaders, few physicians seemed to pay attention. In 2001, Hudson received a small payment increase, which Hudson decided to share with physicians based on their respective practice’s overall QARR results. Although these reports helped doctors learn about quality measures, Hudson’s performance still rated below average for childhood immunizations and diabetes. Because most practices had only a handful of Hudson members, the practice-wide data did not give physicians enough information, nor were the practice-based bonuses large enough to motivate them to track and improve performance. To solve these problems, Hudson moved to the current patient- and physician-specific P4P program, with rewards based on more than just outcomes and the provision of actionable data to support improvement.  ***Planning and Development Process***  Key steps included the following:   * **Determining performance measures:** To the extent possible, Hudson Health relied on national standards when choosing performance measures. The plan also collaborated with local physician leaders to confirm and refine the approach to measurement. * **Developing and testing the reporting system:** Hudson administrative staff worked with internal programmers to develop a system to extract data and write the reports. This process included identifying data elements and sources, drafting the logic behind the reports, designing data input and reporting formats, coding, and testing the reports. During this process, Hudson worked with a few medical practices that reviewed and tested the reports before their release to all providers. (Going forward, Hudson will be relying on an outside vendor to manage the data collection and reporting process; see Adoption Considerations for more details.) * **Training provider representatives:** Provider representatives received training in the QARR reports and how to explain the practice- and patient-specific data to providers. The goal of the training was to ensure that representatives knew the source of the data and offer suggestions on how to improve reporting accuracy and performance on different measures. * **Scaling back program:** Hudson scaled back the incentive program during the recent financial crisis that affected New York’s Medicaid reimbursement payments to managed care plans; leaders decided to temporarily suspend the immunization and diabetes programs due to the high costs involved in creating the performance reports and paying the bonuses. The claims-based program that rewards the provision of certain evidence-based services remains in place. The impact of this reduction in Hudson’s quality bonus payment has been ameliorated for many practices by the introduction of a New York State–sponsored bonus for patient-centered medical homes.   ***Resources Used and Skills Needed***   * **Staff:** Hudson Health did not hire any additional staff for this program; existing staff incorporated it into their regular duties. Staff involved in the project included the chief medical officer, who oversees the program, along with staff from finance, marketing, provider relations, and information services. Eventually Hudson hired one full-time employee as the Supporting Excellence Coordinator to manage the programs and outreach. Data management work for Hudson staff will be reduced when the program reports transition to a new HEDIS® vendor, allowing the Supporting Excellence coordinator to concentrate on outreach and communications. * **Costs:** Upfront costs included staff time for the initial programming and training the provider representatives as well as the development and mailing of informational materials. The main ongoing costs consist of the bonuses; at the height of the program, Hudson paid out as much as $1.9 million in 2009 and $9.2 million from program inception through 2011. Other ongoing operating costs include data collection and analysis, personal meetings with physicians to deliver the reports and bonus checks, developing and mailing informational materials, and the biannual dinners.   begin fsxml  ***Funding Sources***  Robert Wood Johnson Foundation; Commonwealth Fund; Hudson Health Plan Hudson Health Plan funded operating expenses and bonus payments; the Commonwealth Fund and Robert Wood Johnson Foundation helped pay for program evaluation.end fs | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | | **Adoption Considerations** | [Back to Top](http://innovations.ahrq.gov/content.aspx?id=3653#top) | http://innovations.ahrq.gov/../images/spacer.gif |  |  | | --- | | ***Getting Started with This Innovation***   * **Position program as a partnership with providers:** Because Hudson Health Plan contracts with providers (rather than employing them), plan leaders had to make sure that the P4P program would not result in physicians dropping out of the plan or dropping nonadherent patients. Although some physicians resist P4P structures, Hudson found that most responded well when approached in a spirit of collaboration and appreciation. Hudson did not penalize practices who chose not to submit data and made payments to practices without regard to practice size or number of Hudson enrollees. Hudson Health staff go out of their way to thank providers for their service and at the dinners and in other communications staff position the program as a way to show appreciation for a job well done and to compensate for outreach and followup with patients. Many physicians especially liked the fact that Hudson’s program offered a bonus for providing better care and recognized the extra time required to track data. * **Anticipate and take provider concerns seriously:** Even with the positioning described above the team at Hudson fielded numerous phone calls from physicians about the program and how the ratings would affect their practices. Taking these comments and complaints seriously helped build trust and partnership with providers. * **Build on widely accepted standards, but also seek counsel in designing reward structure:** Whenever possible, Hudson Health used nationally recognized clinical measures and performance goals. However, plan leaders also wanted to recognize and reward providers who achieve meaningful improvements, even if performance targets are not met. The plan’s medical advisory board provided valuable guidance on how to structure the rewards in this manner. * **Make bonuses high enough to compensate extra work:** Collecting quality data is a relatively new requirement for providers and may require additional staff time. Consequently, potential bonuses must be large enough to make it worthwhile for physicians to make this effort. Originally, the incentive program rewarded physicians over and above contractual payments for services. * **Consider using a vendor for data collection and reporting:** Hudson initially used in-house programmers to develop and manage the reporting system. This proved difficult, particularly as new incentives and measures were added. Staff often ended up creating some parts of the report manually, adding to the time and expense of the program. In the future, Hudson plans to use its HEDIS® vendor to develop and manage the reporting system. With advances in health information technology and the development of statewide registries for immunizations and other measures, the reporting task should become easier, thus allowing Hudson to begin issuing the reports and bonuses again in the future.   ***Sustaining This Innovation***   * **Build the internal team needed to support the work:** It takes teamwork across departments to make a something this complex work well. Hudson’s Supporting Excellence Coordinator synchronizes efforts of different departments as needed and a cross-department “supporting excellence” committee helps enhance communication. The committee channels input from the various departments involved in the project, including administration, clinical, communications, community relations, customer care, facilities (mailroom), finance, information services, marketing, and provider relations. This structure helps all staff members take pride in Hudson's accomplishments in quality improvement. * **Provide actionable data:** By giving physicians actionable data, Hudson encouraged physicians to follow up with patients and deliver recommended care. This process helped patients get the care they need, and helped the plan improve its overall QARR scores. * **Use claims data whenever possible for rewarding bonuses:** Bonuses paid automatically based on the submission of claims data are easy to administer and inexpensive to maintain. As noted, Hudson had to suspend its diabetes and immunization P4P programs (which proved expensive to administer), but the payments continue for physicians who file a claim for chlamydia screenings, Pap smears, and other services. * **Keep total reimbursement competitive:** Total reimbursement (including P4P bonuses) needs to remain competitive with that of other health plans. Otherwise, physicians may opt not to participate in the plan. At the same time, payments well above the market rate will likely not be sustainable. This program allowed Hudson to gradually move a portion of primary care reimbursement from fee for service or capitated payments to performance-based payments. * **Be flexible on documentation requirements:** As noted earlier, Hudson pays some bonuses automatically based on the submission of claims data. Because patients frequently lose eligibility for Medicaid coverage, claims data will always be incomplete. Therefore, Hudson remains flexible with respect to documentation requirements for these services, accepting clinical records, in-house registries, and other forms of documentation. | |  |  |  | | --- | --- | | |  | | --- | |  | | | |  |  |