Payment System Reform
One State's Journey

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Abstract: In June 2011, Texas enacted Senate Bill 7, which mandates a Medicaid quality-based outcomes payment program on the basis of a common set of outcomes that apply to all types of provider systems including hospitals, managed care plans, medical homes, managed long-term care plans, and Accountable Care Organizations. The quality-based outcome measures focus on potentially preventable events (services) such as preventable admissions and readmissions that result in unnecessary expense, patient inconvenience, and risk of complications. The payment adjustments relate to a provider system's effectiveness in reducing the rate at which potentially preventable events occur. The program envisioned by Texas Medicaid is one that is administratively simple, establishes the right financial incentives to drive delivery system improvement, and does not intrude on the provider practice or the patient. Rather than imposing a series of processes that must be followed or require rigid adherence to standardized protocols, the payment adjustments are based on risk-adjusted comparisons of the rate of potentially preventable events for an individual provider systems to an empirically derived performance standard such as the state average. This article proposes a payment system design that can meet the ambitious objectives of the Texas legislation. **Key words:** *Accountable Care Organizations, managed care, medical homes, payment incentives, preventable events*

IN JUNE 2011 Texas enacted Senate Bill 7, which mandates a Medicaid "quality-based outcomes" payment program covering all types of provider systems including hospitals, managed care plans, medical homes, managed long-term care plans and Accountable Care Organizations(Senate Bill 7, 2011). The Texas legislation bases payment adjustments on a common set of quality-based outcomes that apply across all provider systems. The legislation requires that those measures that "have the greatest effect on improving quality

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of care and the efficient use of services" be used to adjust payment on the basis of "the extent to which the physician or other health care provider reduces potentially preventable events." Thus, the selected outcome measures must not only be potentially preventable but also must substantially impact the cost of care. The Texas legislation significantly expands the quality-based outcomes payment reforms enacted in other states such as Maryland and New York.

The outcomes-based performance measures will affect a significant portion of Medicaid payments. For example, 5% of Medicaid-managed care premiums are put at risk on the basis of a provider system's performance "with respect to reducing potentially preventable events and containing the growth rate of health care costs." In addition, future Medicaid budget increases will be allocated to geographic regions in part on the basis of the overall quality-based outcome performance of the provider systems in the region.

The Texas legislation is one of the most comprehensive, innovative, and clearly

communicated payment reform initiatives enacted by any state. By creating uniform financial incentives for quality improvement through the establishment of a common core set of quality-based outcome measures, the Texas legislation seeks to encourage better care coordination at the level of the individual provider and at the regional level. Indeed, the National Association of Medicaid Directors summarized the objective of the Texas legislation as a payment reform that would "hold hospitals and managed care plans accountable for any preventable event, and to thereby incentivize innovations and improvement in hospital-based care, patient management, and follow-up" (National Association of Medicaid Directors, 2012).

Moreover, the pragmatic implementation of the program envisioned by Texas Medicaid is one that is administratively simple, establishes the right financial incentives to drive delivery system improvement, and does not intrude on the patient or the provider practice. Rather than prescribe a series of processes that must be followed or require rigid adherence to standardized protocols, the payment incentives are tied to quality-based outcomes. Performance on the quality-based outcomes and the associated payment adjustments are based on risk-adjusted comparisons of individual provider systems to an empirically derived norm such as the state average. Since optimal performance cannot be achieved without integration of outpatient care, inpatient care, home care, and discharge planning, the quality-based outcome payment system also encourages care integration.

The term "outcome" typically refers to events or measures of change that have an immediate consequence for the patient, such as death, debility, discomfort, and decline in functional status. In the context of the Texas legislation, the term "quality-based outcome" differs in that it refers to potentially preventable events (services) such as preventable readmission that result in unnecessary expense, patient inconvenience, and risk of complications without necessarily leading to physical harm to the patient. These events include measures of excess care or

poor performance and as such are legitimate measures of quality that may have resulted from inadequate care, although the extent of the inadequate care often cannot be directly measured from the medical record and must be inferred. For example, infections due to poor sterile techniques cannot be directly measured from the medical record. Such infections are potentially preventable and a high infection rate may be indicative of an underlying quality problem.

The specific measures used to identify quality-based outcomes, the method of risk adjustment for comparing outcomes across provider systems, and the payment design for incorporating them into an operational payment system are crucial for the ultimate success of the Texas initiative. The objective of this article is to propose a payment system design that meets the ambitious objectives of the Texas legislation.

SELECTING THE QUALITY OUTCOME MEASURES

There are hundreds, if not thousands, of quality measures that have been identified by organizations such as the National Quality Form. The proliferation of quality measures has made profiling and identifying potential quality problems increasingly complex. Payment applications present an even greater challenge because diverse quality measures must be combined to determine the net impact on payment. For most quality measures, there is no direct link to the cost or payment associated with the aspect of quality being measured. This is especially true for quality measures that are based on adherence to care processes, such as many of those created or endorsed by National Quality Form (http://www.qualityforum.org/Home.aspx), Healthcare Effectiveness Data and Information Set (HEDIS) (http://www.ncqu.org/HEDISQuality Measurement.aspx), and The Leapfrog Group (http://www.leapfroggroup.org/). Attempts to use such process measures in a payment context typically create artificial and complex rules for associating the lack of adherence with the process measures to a

payment adjustment. For example, the Medicare Value–Based Purchase system contains a multitude of process and outcome measures combined together by an arbitrary and overly complex formula that links payment and quality (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/hospital-value-based-purchasing).

In contrast, the Texas legislation focuses on quality-based outcome measures associated with potentially preventable events that have a direct and unambiguous relationship with the payment for the care delivered instead of attempting to link a process violation to a payment penalty amount that does not inherently exist. Because there is a direct link to payment, the financial consequences of a quality-based outcome measure can be made proportionate to the size of the actual cost increase it generates. For example, a preventable readmission should generate a penalty that reflects the cost of that readmission. Because the payment system establishes the payment amount for the readmission, it simultaneously provides a measure of the financial consequence of a preventable readmission as an inherent by-product.

The financial penalties established by the Texas legislation are substantial, in addition to being proportionate to the magnitude of the financial consequences of the outcomes identified. Without sufficient financial motivation, providers are unlikely to make the investment necessary to achieve the behavioral changes needed to improve quality. For example, the Medicare Hospital-Acquired Conditions (HACs) payment adjustment impacts less than 0.02% of Medicare inpatient prospective payment system payments (Federal Register, 2007). Although the HAC payment policy has a direct link to the amount paid, the minimal financial impact of HACs is unlikely to result in any measurable impact on quality.

Quality-based outcome measures such as preventable readmissions and complications represent negative outcomes that are not only harmful to patients but also directly generate added cost through the delivery of unnecessary services. By eliminating or reducing the occurrence of such negative outcomes, quality is improved, harm to patients is reduced, and health care costs are constrained. Unfortunately, rather than causing a decrease in payment, most existing payment systems often increase payment when a negative outcome occurs by paying for the additional care required. This perverse financial incentive represents a fundamental flaw in existing payment system design, which the Texas legislation seeks to eliminate by adjusting payments to reflect the outcomes actually being achieved.

The Texas legislation specifically identifies 5 quality outcome measures that have substantial cost and a direct and unambiguous link to the payment for the care delivered:

Potentially preventable complications

Potentially preventable complications are harmful events (accidental laceration during a procedure) or negative outcomes (hospital-acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease.

Potentially preventable readmissions

Potentially preventable readmissions are return hospitalizations that may result from deficiencies in the process of care (readmission for a surgical wound infection) or inadequate postdischarge follow-up (prescription not filled) rather than unrelated events that occur postdischarge (broken leg due to trauma). Readmissions may result from actions taken or omitted during the initial hospital stay, such as incomplete treatment or poor care of the underlying problem, or from poor coordination of services at the time of discharge and afterward, such as incomplete discharge planning, or from inadequate access to care.

Potentially preventable admissions

Potentially preventable admissions (PPAs) are hospital admissions that may have resulted from the lack of adequate access to care, inadequate treatment of those with access, or insufficient coordination among specialists in the ambulatory care setting. Potentially

preventable admissions are ambulatory sensitive conditions (eg, asthma, congestive heart failure) for which adequate patient monitoring and follow-up (eg, medication management) can often avoid the need for admission (http://www.qualitymeasures.ahrq.gov/content.aspx?=27175). A higher than expected rate of PPAs suggests a failure of ambulatory care.

Potentially preventable emergency room visits

Potentially preventable emergency room visits (PPVs) are emergency room visits that may result from a lack of adequate access to care or ambulatory care coordination. Similar to PPAs, PPVs are ambulatory care sensitive conditions (eg, asthma, diabetes) for which adequate patient monitoring and follow-up (eg, medication management) should be able to reduce or avoid the need for an emergency room (ER) visit. Potentially preventable emergency room visits are inefficient and expensive either because the care could have been provided less expensively and with better coordination in the physician office or because the PPV reflects inadequate care of a chronic or subacute problem in the outpatient or hospital setting that resulted in an acute deterioration. The types of ER visit that are considered a PPV will differ if the patient is coming from a nursing home as opposed to home. For example, an ER visit for a fracture due to a fall is a PPV for patients coming from a nursing home but not for patients coming from home.

Potentially preventable ancillary services

Potentially preventable ancillary services are ancillary and interventional services ordered by physicians that may not provide useful information for diagnosis (routine use of many laboratory tests) or treatment for which there are significant questions of efficacy (eg, back surgery).

Evaluating a provider system's performance on these 5 measures simultaneously provides a relatively comprehensive picture of the quality-based outcomes (as defined by the Texas legislation) being achieved and the effectiveness of the care being provided. It of course requires a broader concept of the "provider system" responsible for care, one which is capable of coordinating care across the inpatient and outpatient settings. The provider system would be rewarded or penalized on the basis of its quality-based outcomes, while the details of the structures and processes used to achieve those outcomes would be left up to the provider system.

KEY PAYMENT SYSTEM DESIGN ISSUES

Once the quality-based outcomes have been identified, differences in relative performance must be quantified in terms of financial impact to determine a payment adjustment. In designing a quality-based outcome payment system, there are 5 key payment system design issues that must be addressed (Averill et al., 2011):

1. Case-by-case versus provider system payment adjustments
2. Rate-based determination of provider system performance
3. Establishment of reference outcomes norms
4. Quantification of the financial impact of excess negative outcomes
5. Determination of an overall provider system payment adjustment

Each of these 5 issues must be addressed in a consistent and complementary manner to create an overall effective payment system design.

Case-by-case versus provider system payment adjustments

The first issue is whether the payment adjustment should be applied on a case-by-case basis or on an overall provider system basis. With the exception of the small number of negative outcomes that are virtually always preventable, applying judgments about quality for individual cases tends to be an inefficient way to change behavior and improve efficiency. Labeling the care provided to an individual patient as explicitly substandard will, predictably and understandably, cause physicians and hospitals to respond

defensively not only in a desire to save face and protect reputations but also out of fear that the perceived failure could serve as the basis of a malpractice suit. For example, the Medicare HAC payment policy is administered on a case-by-case basis. As a result, the only complications that are included as HACs are those that can be considered practically always preventable. This limitation greatly restricts the number of conditions that can be considered HACs, thus severely limiting their payment impact. In contrast, determining the payment adjustment for quality based on overall provider system performance avoids the key problem with the case-by-case approach. It allows the determination of an overall quality payment adjustment that is applied to all patients treated by the provider system, regardless of whether the individual patient experienced the negative outcome, thereby avoiding need to designate the care of specific patients as substandard. Since negative outcomes are often the result of deficiencies in coordination and communication within a provider system, a focus on system-wide quality is more appropriate and useful. Such a focus emphasizes that the entire health care team within the provider system has the responsibility for improving quality. The payment adjustment approach for readmissions in the Affordable Care Act is an example of a rate-based determination of a quality-related payment adjustment.

Rate-based determination of provider system performance

The second issue relates to the degree of preventability for each of the quality outcomes. The 5 quality-based outcomes specified in the Texas legislation are potentially preventable but not absolutely preventable even with optimal care. Thus, there will be a residual rate at which these negative outcomes occur even in the best-performing provider systems. The assessment of quality-based outcome performance should, therefore, be based on a provider system's relative rate of negative and positive quality-based outcomes as compared with its peers. A rate-based approach explicitly recognizes that negative outcomes will occur even with optimal care. Basing payment adjustments on performance levels that depart from the outcome rates being consistently achieved by other provider systems provide an empirical basis for determining the magnitude of any payment adjustment. This avoids the need to have panels of experts, or individuals armed with criteria and guidelines, to determine what constitutes acceptable performance.

Provider systems that care for more seriously ill patients will have higher rates of negative outcomes due solely to the "case mix" of their patients and the greater inherent susceptibility of those patients. As a result, in the absence of adequate risk adjustment, a higher rate of negative outcomes for such provider systems would not necessarily reflect poor quality of care. Risk adjustment for the severity of illness of a provider system's patient population is essential to ensure a fair comparison of quality-based outcome rates and must be an integral part of any evaluation of provider system performance. Failure to perform adequate risk adjustment could unintentionally encourage provider systems to avoid seriously ill patients, resulting in problems of access for those most in need.

Evaluations of inpatient complications and readmissions relate to the care provided during a hospital admission and are, therefore, event-based relative to a particular point in time. Hospital admissions, emergency room visits, and outpatient services examine enrollees over time and are population based. Therefore, 2 different risk adjustment systems are needed. Diagnosis-related groups–based systems have been shown to be effective for risk-adjusting hospital complication and readmission rates (Goldfield et al., 2008; Hughes et al., 2006;). A separate set of risk-adjustment methods are available for population-based comparisons over time and can be used for comparing rates of admissions, ER visits, and outpatient ancillaries (Hughes et al., 2003; Pope et al., 2000).

Establishment of reference outcomes norms

The third issue relates to the outcome norm that will be used to determine performance.

In a rate-based system, the performance of a provider system is determined by comparing the expected risk-adjusted number of negative outcomes for a provider system with its actual number of negative outcomes to determine the excess. Key to this calculation is the reference population (norm) used to compute the expected risk-adjusted number of negative outcomes. By computing the expected values from a large reference population, the norm represents outcome levels that are being consistently achieved. Such an empirically based standard is likely to be more readily accepted. The policy question is whether the average performance in the reference population should be accepted as the standard. Alternatively, a quality outcome norm could reflect the best empirically derived hospital quality outcomes that are consistently being achieved (ie, best practice). One approach to computing a best practice norm would be to base it on the average performance in the subset of provider systems that are achieving the best outcomes (eg, the top 25%). This approach to defining best practice has the advantage that it creates a performance standard that has been empirically demonstrated to be readily achievable by a substantial number of provider systems. During the initial implementation, it is important to set long-term performance expectations and, therefore, a best practice norm should be considered.

Quantification of the financial impact of excess negative outcomes

Once the excess number of negative outcomes for each individual quality-based outcome measure is computed, the associated excess payment amounts can be used to quantify the financial impact of the excess negative outcomes. As an inherent by-product of the payment system, the financial consequence of each quality-based outcome is established. For example, the payment for a readmission can be used as the basis for quantifying the financial impact of excess readmissions. For inpatient complications, the marginal cost of the complication can be used for quantifying the financial impact of excess complications (Fuller et al., 2009). By relating the financial

impact of a negative outcome to its impact on payment, the contribution of each type of outcome can be made proportionate to the size of the actual cost or payment increase it generates. This provides an empirical basis for combining multiple quality-based outcomes together into a single payment adjustment amount for a provider system.

Determination of an overall provider system payment adjustment

Once the costs associated with the excess negative outcomes for each individual quality-based outcome measure are determined, they can be combined into a single provider system payment adjustment factor. Across different outcome measures, a provider system can have both good performance (less than expected negative outcomes) and poor performance (more than expected negative outcomes). As a result, there can be a mix of both positive and negative financial impacts across the different outcome measures. In general, the financial impact of good performance should be allowed to offset the financial impact of poor performance. It could be argued that a low rate of use of outpatient interventions (good performance) could lead to excess admissions (poor performance). As a result, the good performance on outpatient intervention usage should not be allowed to partially offset the poor performance on admissions. While this argument is plausible, there is by no means any direct evidence of causality. Therefore, it might be prudent to let the positive and negative financial impacts across quality-based outcome measures offset each other since the magnitude of the financial impact of each quality-based outcome is directly taken into consideration. Of course, extremely low rates of outpatient interventions, for example, should be monitored to be certain that patients are not being underserved.

After the net financial impact across outcome measures for a provider system has been computed, it can be converted into a provider system payment adjustment factor. The most straightforward way of computing the payment adjustment factor would be to divide

the net financial impact of negative outcomes by the overall payments to the provider system. The resulting fraction can then be used to adjust payments for all enrollees/patients cared for by the provider system. This calculation is essentially the same calculation used to compute the payment adjustment factor for readmissions in the Accountable Care Act. The payment adjustment would be applied to all enrollees/patients to avoid the problems of having payment adjustments for negative outcomes assessed on an individual patient basis. On a periodic basis, the payment adjustment factor would be recalculated, thereby reflecting any improved performance through the updating of the payment adjustment factor.

Overall process for determining quality-based payment adjustments

In summary, a provider system's payment adjustment would be computed as follows:

- For each outcome measure
  - Compute provider system's actual historical outcome rate
  - Compute an outcome norm
  - Compute the provider system's risk-adjusted expected outcome rate on the basis of the norm
  - Compare provider system's actual and expected risk-adjusted outcome rate to determine excess negative outcomes
  - Quantify the financial impact of the excess negative outcomes
- Consolidate across outcome measures
  - Determine overall (net) financial impact of excess negative outcomes across all outcome measures
  - Convert overall financial impact of excess negative outcomes into a provider system payment adjustment factor
- Prospectively apply the payment adjustment factor to all of a provider system's patients/enrollees.

This process provides an empirically based approach to determining quality-based outcomes payment adjustments. It uses the historical performance of providers to determine

a payment adjustment factor that is applied prospectively to all payments to a provider system.

POTENTIAL IMPACT

The proposed approach links payment adjustments to the level of excess negative outcomes in a provider system. This approach creates a realistic and achievable target for the savings from a quality-based outcome payment reform. Despite this very conservative approach, the potential savings associated with excess negative outcomes are substantial. The Medicare payments–associated excess inpatient preventable complications have been estimated to be 8.14% of Medicare inpatient payments (Fuller et al., 2011), and the payments across all payers in Florida-associated excess preventable readmissions have been estimated to be 3.73% of inpatient payments (Averill et al., 2009). Since the determination of excess negative outcomes depends on the extent of the variation in the rate of negative outcomes across provider systems, the lower percentage of payments associated with preventable readmissions versus inpatient complications suggests that there is more variation across hospitals in terms of preventable inpatient complications than in preventable readmissions.

DISCUSSION

While the Texas legislation may be the most far-reaching example of a payment reform based on adjusting payment for negative outcomes, it is just one example of a clear trend in payment reform efforts. The Deficit Reduction Act of 2005 (PL 109–171) requires Medicare to eliminate any payment increase associated with a limited number of postadmission complications. The Affordable Care Act requires Medicare to reduce payments to hospitals with high readmission rates. In 2010, New York implemented a Medicaid payment reform that mandated a reduction of $47 million in annual Medicaid payments to hospitals with high readmission rates (Public Health

Law, 2010). Maryland's Health Services and Cost Review Commission has implemented a rate-based payment adjustment for inpatient complications (Calikoglu et al., 2012). In the initial 2 years, inpatient complications in Maryland decreased by 15.26%. The cost savings over the first 2 years of the Maryland payment adjustment for inpatient complications was $110.9 million (Calikoglu et al., 2012).

The importance of effective communications

The ultimate objective of any payment reform is to motivate behavioral change that leads to better quality and lower costs. Provider systems will be better able to improve quality of care if the methodologies used to identify negative outcomes and to risk adjust the rate of negative outcomes are expressed in a clinically meaningful manner that communicates actionable information in a form and at a level of detail sufficient to achieve sustainable behavior changes. Therefore, the methodologies used for identifying negative outcomes and risk adjusting their rates must be transparent, clinically precise, and open for examination and review. Center for Medicare and Medicaid Services has emphasized the importance of the communications value of the method of payment: "The success of any payment system that is predicated on providing incentives for cost control is almost totally dependent on the effectiveness with which the incentives are communicated" (Federal Register, 2001). In order for there to be a real operational impact, the methodologies used must be able to produce information that can meet the needs of all levels of a provider system. Transparent and categorical methodologies will allow provider systems to produce meaningful data for clinicians and the entire health care team, thereby increasing the likelihood of acceptance of a quality-based outcome payment system. Indeed, the Texas legislation requires that in-depth provider system performance reports be distributed to provider systems in advance of the implementation of the quality-based outcomes payment adjustments.

Comprehensiveness of the quality-based outcomes

The financial risks associated with any quality-based outcomes payment adjustment must be substantial enough to motivate provider systems to make the investments necessary to improve outcomes. Without sufficient financial motivation, it is unlikely that delivery systems will make the investment necessary to achieve the behavioral changes needed to substantially improve outcomes. The payment adjustments for complications in the Deficit Reduction Act and for readmissions in the Affordable Care Act are very narrow in scope and have relatively minimal financial impact. In contrast, the Texas legislation envisions that any outcome included in the payment adjustment be comprehensive in its scope, ensuring that the measurable financial impact is substantial. Payment designs in which the outcomes included are narrow in scope and, therefore, occur relatively infrequently but result in an artificially large payment adjustment (payment cliffs), run the risk of being unstable and causing unreliable and unfair payment adjustments. By having the financial impact of a negative outcome relate to its impact on payment, the payment impact of an outcome is proportionate to the size of the actual payment increase it generates, thereby eliminating any artificial payment cliffs. In addition, because the Texas payment system design incorporates a complete a range of preventable outcomes, providers are encouraged to undertake a system-wide approach to quality improvement as opposed to focusing only on a narrow list of conditions that are included in the payment adjustment.

Flexibility and scalability

A quality-based outcomes payment reform as enacted by the Texas legislation provides policy maker with great flexibility in terms of the rollout of the payment system changes. The pace of implementation, the number of outcomes included, the aggressiveness of the performance norm, and imposition of any caps on the magnitude of penalties can all be used to balance cost savings and provider

ability to respond as well as policy goals and political circumstances. Portions of the saving could also be redistributed back to provider systems to achieve specific policy objective such as providing additional funding to safety net providers.

FUTURE OPPORTUNITIES AND CHALLENGES

Expanding the outcome measures

While the Texas legislation focused on 5 specific outcome measures, the general approach can be expanded to any outcome measure that has a direct impact on payment. For example, another outcome measure that could be considered is the change in enrollee health status over time. Health status measures the chronic illness burden of an enrollee and the relative severity of the enrollee's chronic illnesses. The rate at which the enrollee's chronic illness burden or severity increases provides a measure of the rate at which an enrollee's health is deteriorating and the effectiveness of the delivery system in maintaining an enrollee's health. The financial impact of the change in enrollee's health status could be quantified by the difference in the annual cost between the beginning and ending health status (Fuller et al., 2013).

Strengthening the financial incentive for provider cooperation

The financial incentives discussed so far have been focused on provider systems. The focus has been on providing consistent incentives across care settings. To further promote care coordination, the Texas legislation uses the same outcome measures to determine the level of budget increases to geographic regions. Since future budget increases are conditional upon quality-based outcome performance in each region, there is a payment incentive for all providers in each region to improve cooperation and communication within the region, leading to better care coordination.

Cooperation among payers

The ultimate success of payment system reform in controlling costs will be in part determined by the extent to which payment systems across payers are complementary and reinforce the incentive for cost control. The cost containment impact of any payment reform is greatly constrained if the payment systems across payers create financial incentives that are in conflict. If the payment gains from one payer are offset by payment losses from other payers, providers will be less likely to take necessary management action. In a multipayer system, conflicting incentive across payers is a fundamental barrier to achieving cost savings. While the Texas legislation creates uniform quality incentive across provider systems for Medicaid patients, it does not address the issue of uniform quality incentives across payers.

Long-term care—dual eligibles, nursing homes, and other types of long term care

The existing Texas legislation does not explicitly include the areas of long-term care, broadly defined, and behavioral health in the quality-based outcome payment system. The basic approach of a quality-based outcome payment system is also applicable in these areas. In fact, the Texas legislation specifically encourages the state to pursue long-term care payment reform that includes provisions for quality-based outcome payments. The New York State Department of Health is pursuing a coordinated care effort for dual eligible individuals and individuals with significant mental health disorders that over time will incorporate paying for quality-based outcomes (http://www.health.ny.gov/health_care/man aged_care/mltc/index.htm). Although the New York State Department of Health has implemented a risk-adjustment system that incorporates functional health status into the risk-adjustment classification, it should be pointed out that the risk-adjustment methods are at a much earlier stage of development for long-term care and behavioral health.

For example, factors not routinely collected, such as homelessness, will need to be taken into account as part of the risk adjustment for behavioral health. In addition, the scope of the quality-based outcomes used in the payment system will need to be altered in order to apply to these areas.

CONCLUSION

The Texas legislation has established a common core set of quality-based outcome measures for adjusting payments across all types of provider systems, thereby creating uniform financial incentives for quality improvement. By linking financial incentives to measurable quality-based outcomes, this approach seeks to not only reduce unnecessary spending but also encourage coordination within the health care system and, perhaps most importantly, reduce harm and maximize the quality of care given to patients. A comprehensive focus on the elimination of negative outcomes will directly impact the total cost of care, which is ultimately the measure of success of any health care payment reform effort.

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