Session 4: *Payment Mechanisms and Financial Incentives to Encourage Patient Safety in Alternative Payment Models*

Presenters:

Subject Matter Experts

- **John M. Hollingsworth, MD, MSc** – Urologist and Professor, University of Florida College of Medicine, and Chief Quality Officer, UF Health
- **Jennifer L. Wiler, MD, MBA, FACEP** – Professor, Department of Emergency Medicine, University of Colorado School of Medicine, Co-Founder, UCHealth CARE Innovation Center, and Chief Executive Officer, Minerva Partners
- **Jimmy Blanton, MPAff** – Deputy Director, Quality and Program Improvement, Medicaid and CHIP Services, Texas Health and Human Services
- **Susan E. Sheridan, MIM, MBA, DHL** – President and Chief Executive Officer, Patients for Patient Safety US

Session 4: *Payment Mechanisms and Financial Incentives to Encourage Patient Safety in Alternative Payment Models*

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Targeting Improvements in Patient Safety Through Alternative Payment Models (APMs):

An Academic Health System Perspective

John M. Hollingsworth, MD, MSc
Chief Quality Officer, UF Health
Professor, University of Florida College of Medicine

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Opening Reflection:
Two and a half decades after *To Err Is Human*

Fundamental Changes:

- Reframing harm as a systems problem rather than simply individual failure
- Accelerating transparency, reporting, and accountability
- Catalyzing the modern patient safety movement

Important Progress Followed:

- Reductions in selected healthcare-acquired infections
- Widespread adoption of safety checklists and standardized workflows
- Greater organizational focus on safety culture
- Development of national safety measurement and reporting infrastructure

But Over 20 Years Later:

- Preventable harm remains common
- Improvement has been uneven
- Some domains plateaued or worsened following COVID-19
- Patient safety no longer occupies the same central place in healthcare policy discourse that it once did

The patient safety movement succeeded in changing awareness. The next challenge is transforming system capability.

1999 *To Err Is Human* → **2005 - 2015** Rise of Safety Movement → **2020** COVID Disruption → **2026** What Comes Next?

Has Patient Safety Lost Momentum?

Have We Entered an Era of "Safety Drift?"

Competing National Priorities:

- Pandemic response
- Workforce shortages and burnout
- Financial instability
- Access and throughput pressures
- Digital transformation

Fragmentation of Safety Work Into:

- Compliance programs
- Dashboards
- Regulatory reporting
- Isolated metrics

Movement → Program → Metrics

Important nuance:

- These tools do matter.
  - Dashboards, surveillance systems, and checklists help operationalize safety.

But over time,

- Safety has become increasingly defined by what is easily observable,
- rather than by the full spectrum of patient harm and system vulnerability.

The First-Generation Safety Architecture:
We Measure What Is Easily Observable

The modern safety enterprise was largely built around harms that are

- Codable,
- Retrospectively identifiable, and
- Administratively extractable from claims or surveillance systems.

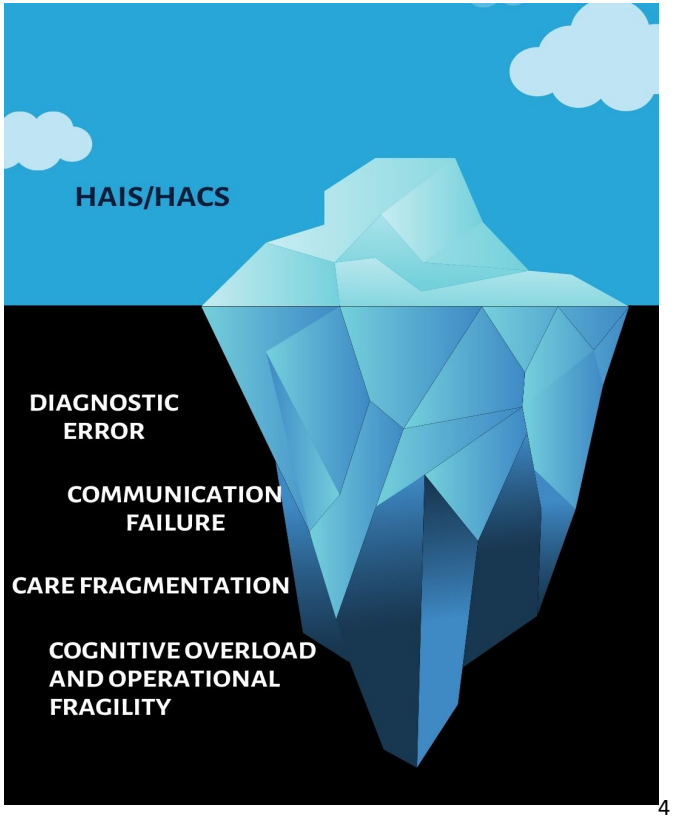
Examples:

- Central line-associated bloodstream infections, catheter-associated urinary tract infections
- Pressure injuries and falls
- Healthcare-acquired conditions

While these measures are critically important as

- They reflect real patient harm,
- They drive accountability,
- They improve transparency, and
- They focus organizational attention,

They represent only part of the modern safety landscape.



The Modern Safety Landscape:

Many Contemporary Safety Risks are Harder to Measure

Some of the most consequential modern safety threats are

- diagnostic delay and diagnostic error,
- fragmented transitions of care,
- communication failures,
- deterioration recognition failures,
- inbox/message overload,
- delayed follow-up of abnormal results,
- ambulatory safety failures,
- digital workflow hazards, and
- operational strain and staffing

These harms are often

- Longitudinal,
- Cross care settings,
- Contextual,
- Weak-signal phenomena, and
- Poorly captured through claims or other existing infrastructures.

The absence of measurable harm is not necessarily the presence of safety.

The Opportunity Ahead for APMs:

AI and Advanced Analytics May Change Safety Measurement

Historically, many important safety risks were too difficult to detect at scale.

Emerging capabilities will allow organizations to

- Identify diagnostic delays,
- Detect clinical deterioration earlier,
- Identify unsafe operational conditions,
- Recognize communication breakdowns,
- Monitor handoff reliability,
- Identify delayed follow-up, and
- Synthesize weak signals across fragmented systems.

Shift That APMS Can Catalyze:

Retrospective defect counting → Continuous system-risk sensing

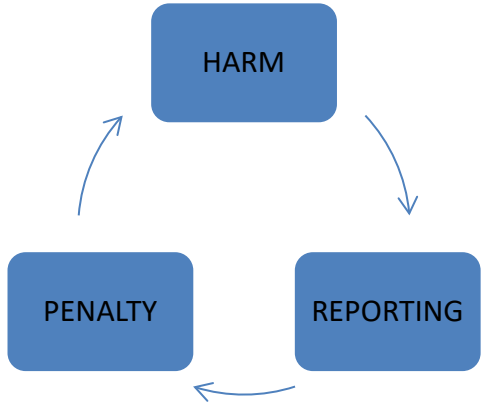
AI is enabling capability for

Earlier Detection,
Operational Awareness, and
Proactive Intervention.

Current Safety Payment Models:

Necessary, But Primarily Reactive

Examples:	These Programs:	They are Fundamentally:
CMS nonpayment policies for never events	Established accountability	Retrospective
HAC-based payment adjustments	Elevated safety nationally	Defect-oriented
Selected readmission penalties	Created financial consequences for preventable harm	Punitive



Current payment models largely finance around failure states rather than safety capability.

Next Evolution of APMs:

From Being Mainly Punitive to Rewarding Proactive Capability

The next era of patient safety should increasingly reward organizations that

- Identify risk early,
- Reduce operational fragility,
- Strengthen communication reliability,
- Improve transitions between settings,
- Proactively detect deterioration,
- Build learning systems, and
- Prevent harm before it reaches the patient.

Key shift:
From lagging indicators → toward leading indicators of safety and resilience

Potential future incentives include the following:

- Diagnostic safety infrastructure,
- Closed-loop communication systems,
- Predictive deterioration surveillance,
- Transition-of-care reliability,
- Near-miss learning systems,
- interoperability and data integration, and
- AI-enabled risk identification.

Structural Measures and the Future:

Measuring the Presence of Safety Capability

The new CMS Patient Safety Structural Measure is a signal of this important conceptual shift.

Historically,

- Safety policy focused primarily on adverse events

In the future, CMS may want evaluate whether organizations possess

- Leadership infrastructure,
- Learning systems,
- A culture of safety,
- Accountability mechanisms, and
- Patient engagement capability.

Important Distinction:

Did harm occur?

→

Does this organization possess the infrastructure necessary to reliably prevent harm?

A Broader Critique of APMs:

Voluntary Participation Creates Important Limitations

Many federal APMs remain

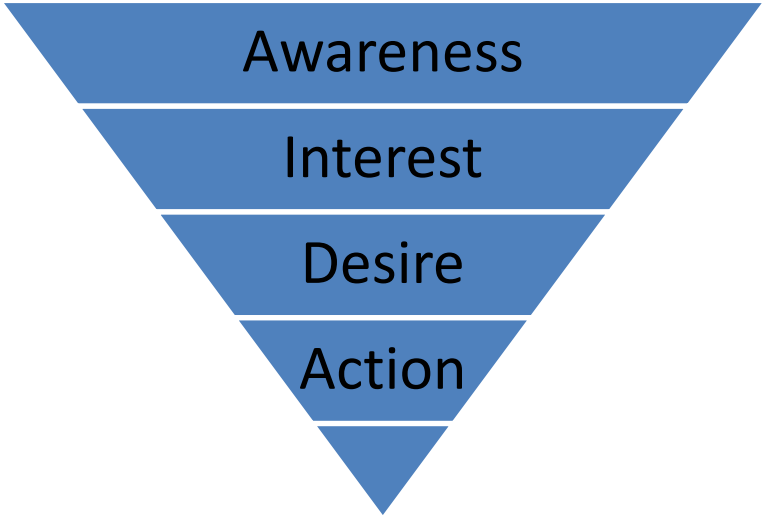
- Voluntary,
- Selectively adopted, and
- Vulnerable to participation bias.

Consequences:

- High-performing systems disproportionately participate
- Lower-performing systems often opt out
- Organizations strategically respond to incentives
- Observed “improvement” may partly reflect selection effects

Important Implication:

- It becomes difficult to distinguish **true delivery-system transformation** from **participant selection and compositional change.**



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Lessons From the Shared Savings Program:
Incentives Shape Organizational Behavior

In our evaluation of the MSSP,

- Apparent savings attenuated substantially after accounting for nonrandom clinician exit, and
- High-cost clinicians were more likely to exit participating ACOs.

Core Lesson:

- Healthcare organizations respond strategically to incentives.

Voluntary models often test

- "Can organizations already positioned to succeed perform well under alternative incentives?"

Mandatory models more directly test

- "Can the healthcare delivery system itself transform?"

Why Mandatory Models Matter:

Safety Is Not a Niche Innovation Strategy

Mandatory Models:

- Reduce selection bias,
- Generate more generalizable evidence,
- Force operational redesign,
- Expose real implementation barriers, and
- Create broader accountability

Examples:

- Comprehensive Care for Joint Replacement Model
- Transforming Episode Accountability Model

If patient safety is a foundational expectation of healthcare delivery, we should increasingly think about safety-oriented payment reform as core infrastructure, not optional participation.

Where APMs Need to Go Next:

A Second-Generation Safety Architecture

The Next Generation of Patient Safety Payment Policy Needs to Move

- Beyond retrospective defect counting,
- Beyond narrow surveillance metrics, and
- Beyond selective voluntary experimentation.

And Toward

- Proactive safety capability,
- Predictive analytics,
- Operational resilience,
- Diagnostic safety,
- Longitudinal care coordination,
- Continuous learning systems, and
- Enterprise-wide redesign.

Twenty-five years after *To Err Is Human*, the patient safety movement is not over. But it is ready for its next chapter.

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Payment Mechanisms and Financial Incentives to Encourage Patient Safety in Alternative Payment Models – Provider Perspective

Jennifer L Wiler MD, MBA

Tenured Professor, University of Colorado School of Medicine

CEO, Minerva Healthcare Partners

Summary

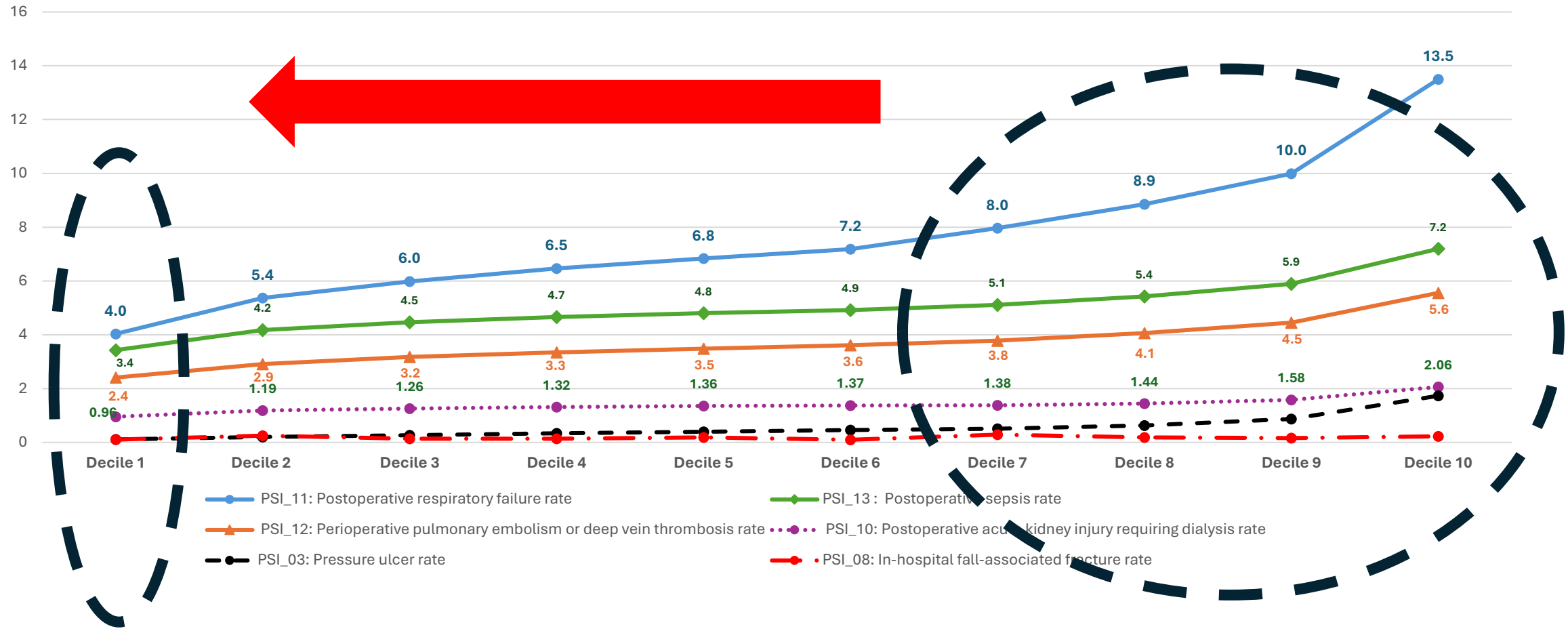
- Metric selection considerations
- Types of financial models
- Alignment of safety performance and payment
- Unintended consequences & considerations

1 - Metric Selection Considerations

- **Importance**
  - Most common AEs
    - Inpatient: Medication (43%), patient care (23%), procedures or surgery (22%), infection (11%)*
    - Outpatient: adverse drug events (63.8%), health care associated infections (14.8%), and surgical or procedural events (14.2%)*
  - Highest “impact”
    - To individual patient (morbidity/mortality), to specific population, to system (cost)
- **Largest variability in performance**
- **Avoidability**
  - No standard definition (Nabhan et al, BMC Health Serv Res, 2012)
  - “Never event”
- **Ability to accurately capture**
  - SSI definitions
- **Impact on drivers of harm**
  - 1 metric vs Holistic improvement of system

Bring Up the Bottom?

Large difference between best & worst performing hospitals



Note: Data sourced from CMS Care Compare and include measurement periods from 2014-2024. Reported statistics are weighted by total hospital discharges. Decile 1 represents the best-performing hospitals, and Decile 10 represents the worst-performing hospitals. Based on analysis by ASPE.

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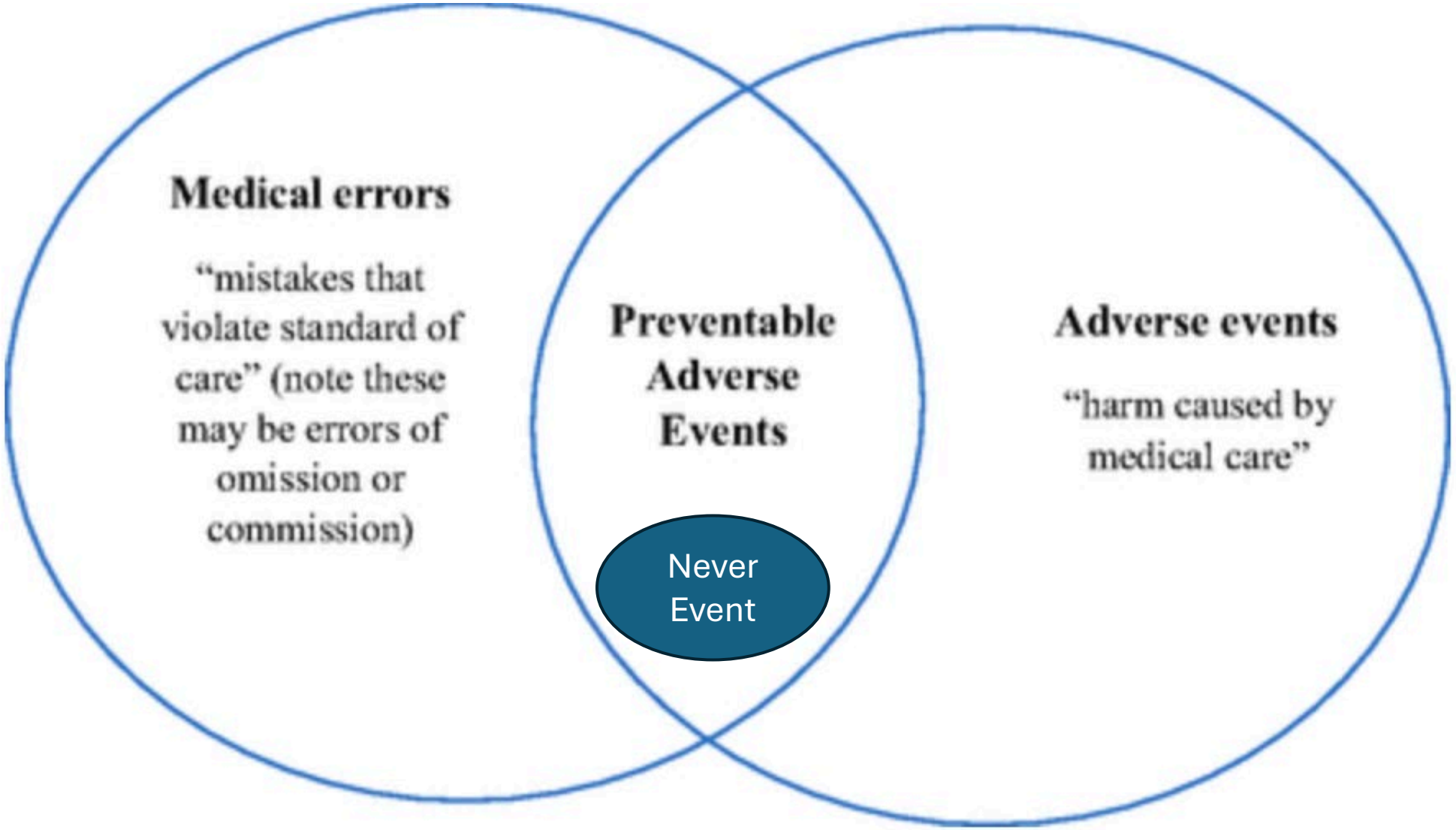
Types of Patient Safety Errors



Source: DOI: https://doi.org/10.3122/jabfm.2018.01.170247

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Strategies to Improve Patient Safety & Decrease Harm

Process Strategy	Description	Healthcare Example
Standardization **	Use consistent procedures and protocols	Surgical safety checklists **
Clear Communication	Ensure accurate information exchange among teams	SBAR handoff communication tool **
Staff Training and Education **	Regular competency training and simulations	CPR and infection-control training **
Risk Assessment	Identify and reduce potential hazards	Medication error risk analysis
Incident Reporting Systems **	Encourage reporting of errors and near misses	Anonymous patient safety reporting **
Evidence-Based Practice	Apply proven clinical guidelines	Standard protocols for sepsis treatment
Use of Technology	Implement systems that reduce human error	Electronic prescribing systems **
Double-Check Systems **	Independent verification of critical tasks	Two-nurse medication verification
Patient Involvement	Engage patients in their own care and safety	Confirming patient identity before procedures
Continuous Monitoring	Track safety indicators and outcomes	Monitoring hospital-acquired infections
Teamwork and Collaboration	Promote multidisciplinary cooperation	Daily multidisciplinary ward rounds
Safety Culture	Encourage openness, accountability, and learning	Non-punitive response to error reporting
Process Simplification	Reduce unnecessary complexity in workflows	Streamlined medication administration
Root Cause Analysis (RCA)	Investigate causes of incidents to prevent recurrence	Reviewing causes of surgical errors
Leadership Support	Management commitment to safety improvement	Hospital leadership investing in safety programs
Adequate Staffing **	Ensure sufficient skilled personnel	Safe patient staffing ratios
Environmental Safety	Maintain safe physical environments	Infection prevention and clean facilities
Regular Audits and Feedback	Evaluate compliance and provide improvement feedback	Hand hygiene compliance audits
Continuous Quality Improvement (CQI)	Ongoing review and improvement of processes	Plan-Do-Study-Act (PDSA) cycles

2 - Types of Payment Incentives for Performance

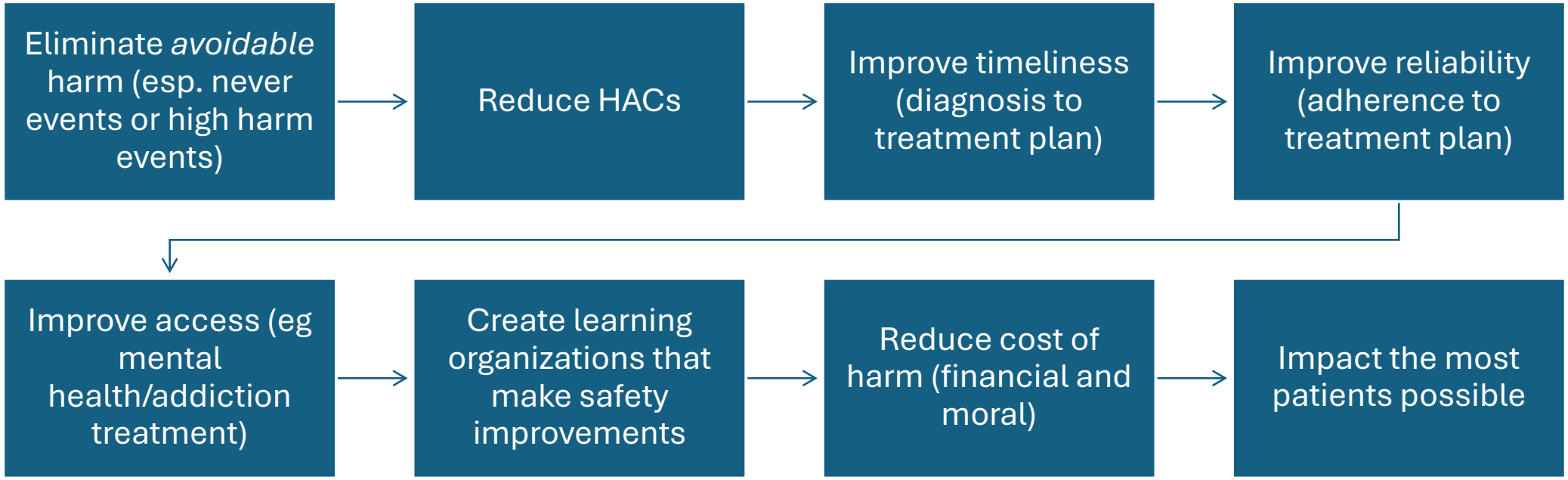
Financial Incentive	Description
Gainsharing	Service leader receive a portion of savings.
Launch bonus	One-time payments for action.
Tax incentives	Government reductions in taxes to encourage activities like investment.
Cashback / rebates	Partial refunds after performance.
Grants	Financial support for projects.
Subsidies	Financial assistance from governments or organizations.
Performance incentives	Rewards tied to productivity, KPIs, or milestones.
Bonuses	Extra pay for meeting goals or performance targets.
Discounts and coupons	Reduced prices to encourage purchases.

Financial Incentives in Healthcare

Financial Incentive Type	Description	Healthcare Example	Purpose
Pay-for-Performance (P4P)	Providers receive bonuses for meeting quality targets	Hospitals rewarded for reducing readmissions	Improve quality of care
Fee-for-Service Incentives	Higher payments for delivering more services	Physicians paid per consultation or procedure	Increase service delivery
Value-Based Payments	Compensation linked to patient outcomes and efficiency	Clinics rewarded for improved diabetes control	Promote better outcomes
Capitation Incentives	Fixed payment per patient with bonuses for efficient care	Primary care groups managing preventive care costs	Encourage cost control
Shared Savings Programs	Providers share savings from reduced healthcare spending	Accountable Care Organizations (ACOs)	Reduce unnecessary costs
Quality Bonuses	Additional payments for meeting care standards	Bonuses for high vaccination rates	Improve clinical performance
Retention Bonuses	Financial rewards for staying in underserved areas	Rural physician retention payments	Address workforce shortages
Recruitment Incentives	Signing bonuses or relocation assistance	Incentives for nurses in critical shortage areas	Attract healthcare workers
Productivity Bonuses	Rewards based on workload or patient volume	Surgeons paid extra for high procedure numbers	Increase productivity
Patient Satisfaction Incentives	Payments tied to patient experience scores	Hospitals rewarded for high satisfaction ratings	Improve patient-centered care
Preventive Care Incentives	Bonuses for preventive services	Incentives for cancer screening completion	Promote prevention
Team-Based Incentives	Rewards shared among healthcare teams	ICU staff bonus for infection reduction	Encourage collaboration
Continuing Education Incentives	Financial support for certifications or training	Tuition reimbursement for specialty training	Improve workforce skills
Loan Repayment Programs	Debt reduction for service commitments	Student loan forgiveness for rural doctors	Increase access to care
Performance-Based Grants	Funding linked to achieving healthcare goals	Public health clinics funded for immunization targets	Strengthen public health outcomes

3 - Alignment of Safety Performance & Payment

Strategy: Work Backwards from Goal



Improve Patient Safety with Payment ….What Should Be Financially Incented?

Data

Process (eg. event review)

Action

Eg. Address error found in event review

Outcome

Close a gap

Keep gap closed

Improvement efficiency

Move fast/move slowly

Improve Patient Safety with Payment ....Performance Clusters

Site of service

Disease condition

Provider specialty

Patient payor (ie Medicaid)

Geo-location

Patient

Behavioral Economics

Illustration by Ann Yun, UChicago Creative

Unintended Consequences of Financial Incentives in Healthcare

UNINTENDED CONSEQUENCE	DESCRIPTION	EXAMPLE IN HEALTHCARE
Overtreatment	Providers may deliver unnecessary services to increase payments	Ordering extra tests or procedures
Undertreatment	Cost-control incentives may reduce necessary care	Avoiding expensive treatments
Gaming the System	Manipulating reporting or patient selection to meet targets	Selecting healthier patients to improve outcomes
Reduced Quality of Care	Focus on financial targets over patient-centered care	Spending less time with patients
Inequity	Incentives may disadvantage high-risk or underserved populations	Clinics avoiding complex patients
Burnout and Stress	Pressure to meet targets can increase workload stress	Providers working excessive hours
Short-Term Focus	Emphasis on immediate measurable outcomes rather than long-term health	Prioritizing quick fixes over prevention
Data Manipulation	Misreporting performance metrics for rewards	Adjusting DRG codes to exclude patient from ”expected” denominator
Fragmented Care	Competition for incentives may reduce collaboration	Departments working independently
Loss of Professional Motivation	Financial rewards may weaken intrinsic motivation to care for patients	Providers focusing mainly on bonuses
Neglect of Non-Incentivized Areas	Services not tied to incentives may receive less attention	Mental health screenings overlooked
Increased Administrative Burden	Tracking incentives requires more paperwork and reporting	Extra documentation for quality metrics
Patient Distrust	Patients may question whether care decisions are financially motivated	Concerns about unnecessary procedures
Risk Avoidance	Providers may avoid very ill patients who could worsen performance scores	No offering high-risk surgeries

Perverse Incentive of Rewards/Penalties

Perverse Incentive	Description	Example in Healthcare	Potential Consequence
Overtreatment	Financial rewards encourage excessive services	Ordering unnecessary imaging or tests	Increased costs and patient harm
Undertreatment	Penalties for high costs discourage needed care	Avoiding expensive but necessary treatments	Poor patient outcomes
Patient Selection ("Cherry Picking")	Providers prefer low-risk patients to improve metrics	Avoiding complex or chronically ill patients	Reduced equity in access to care
Data Manipulation ("Gaming")	Metrics are altered to secure rewards or avoid penalties	Upcoding diagnoses or adjusting records	Misleading quality data
Tunnel Vision	Focus only on incentivized measures	Prioritizing blood pressure targets over holistic care	Neglect of non-measured services
Reduced Professional Motivation	Financial focus weakens intrinsic commitment to care	Providers concentrating mainly on bonuses	Lower morale and professionalism
Premature Discharge	Pressure to reduce costs or length of stay	Early hospital discharge to avoid penalties	Higher readmission rates
Avoidance of High-Risk Procedures	Fear of penalties for poor outcomes	Refusing surgery for critically ill patients	Limited care for vulnerable patients
Increased Administrative Burden	Providers spend more time documenting metrics	Excessive reporting for pay-for-performance programs	Less patient interaction time
Fragmented Care	Competition for incentives reduces collaboration	Departments optimizing separate targets	Poor continuity of care
Short-Termism	Incentives emphasize immediate measurable outcomes	Quick symptom control over long-term prevention	Weak chronic disease management
Patient Dissatisfaction	Incentives distort care priorities	Rushed consultations to increase volume	Reduced trust in providers
Overreliance on Metrics	Quality judged only by measurable indicators	Ignoring empathy or communication quality	Incomplete assessment of care quality
Cost Shifting	Savings in one area create costs elsewhere	Reduced inpatient care increasing emergency visits	System inefficiency
Defensive Medicine	Fear of penalties encourages excessive caution	Ordering extra tests to avoid complaints or lawsuits	Wasteful spending and unnecessary procedures

Final Thoughts …Provider Perspective

- Want to do the right thing for the patient
- Do not want to cause harm (physical, emotional, financial)
- Can’t be “perfect” (treatment, diagnostic, treatment) 100% sensitive/specific
- Don’t want to be sued
- Want to be paid fairly
- (Most) individual providers do not control the systems they work in & feel like many outcomes are actually out of their control

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Jimmy Blanton, MPAff

Deputy Director, Quality and Program Improvement
Medicaid and CHIP Services
Texas Health and Human Services

TEXAS
Health and Human Services

Patient Safety in Texas Medicaid Managed Care

Physician-Focused Payment Model Technical Advisory Committee, June 16, 2026

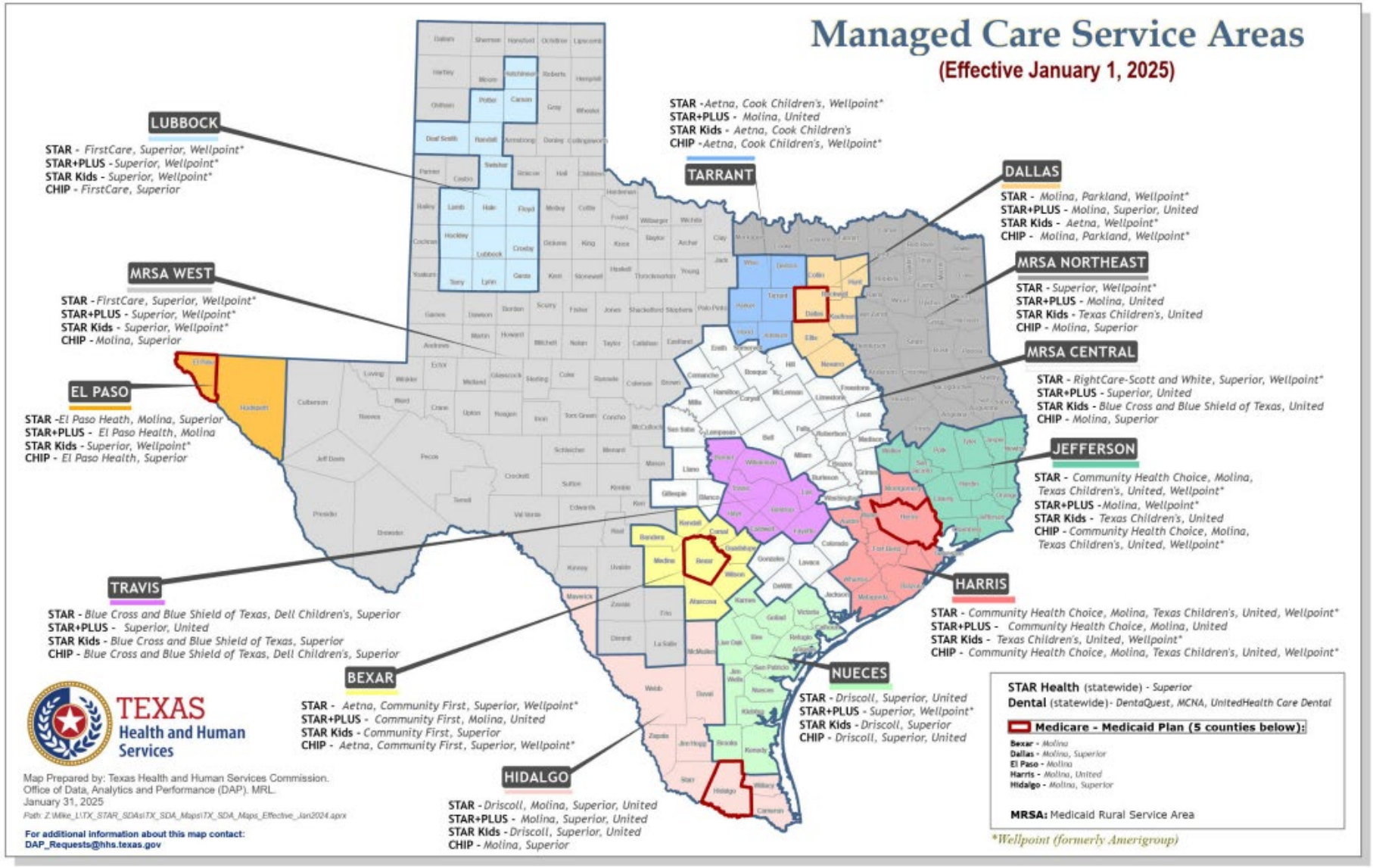
About the Speaker

Jimmy Blanton, MPAff

Deputy Director, Quality and Program Improvement
Medicaid and CHIP Services, Texas Health and Human Services Commission (HHSC)

- Over 30 years of experience in health and human services
- Expertise in value-based initiatives, data analytics, and performance improvement
- Leads efforts to improve quality and value for more than 4.5 million Texans enrolled in Medicaid and CHIP, including through Alternative Payment Models (APMs)

Managed Care Programs, Texas Medicaid



Texas Medicaid Quality Strategy Goals

- Promote optimal health through prevention and by engaging individuals, families, communities, and the healthcare system to optimize health outcomes.
- **Keep patients free from harm by building a safer healthcare system.**
- Promote effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs.
- Use high quality health information for individuals, families, communities, and the healthcare system to make data driven decisions to improve the quality of healthcare for all Texans.

Patient Safety Objectives

Texas Medicaid keeps members free from harm with reporting, quality improvement, and incentive programs that aim to:

a) Reduce avoidable complications or adverse health care events in all care settings

b) Reduce the rate of avoidable hospitalization for nursing facility (NF) residents

c) Reduce severe maternal morbidity

d) Reduce unnecessary cesarean sections

e) Promote evidence-based best practices, including antibiotic stewardship

Quality Strategy: Mapping Texas Medicaid Patient Safety Objectives, Measures, and Initiatives

TEXAS Health and Human Services

a) Reduce avoidable complications or adverse health care events in all care settings

Measure	HHSC Initiatives
Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Comprehensive Hospital Increase Reimbursement Program (CHIRP)
Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure	CHIRP
Medication Reconciliation: Number of Unintentional Medication Discrepancies per Medication per Patient	CHIRP
Pediatric CAUTI	CHIRP
Pediatric CLABSI	CHIRP
Postoperative Sepsis Rate	CHIRP
Solventum™ Potentially Preventable Complications™	Performance Indicator Dashboard, CHIRP, Hospital Quality Based Payment
% of nursing facility residents experiencing one or more falls with major injury	Quality Incentive Payment Program (QIPP)
% of nursing facility residents who have/had a catheter inserted and left in their bladder	QIPP
% of nursing facility residents with pressure ulcers	QIPP

b) Reduce rate of avoidable hospitalizations for NF residents

Measure	HHSC Initiatives
Number of hospitalizations per 1,000 Long-Stay NF Resident Days	QIPP

c) Reduce severe maternal morbidity (SMM)

Measure	HHSC Initiatives
Texas Alliance for Innovation on Maternal Health (AIM) Collaborative Participation	CHIRP
Medical and Anesthesia Obstetric Complications	CHIRP
Pregnancy-Associated Outcomes - SMM for all deliveries excluding cases identified only by transfusion (OAP)	Performance Indicator Dashboard, P4Q
Severe Maternal Morbidity (AIM)	CHIRP

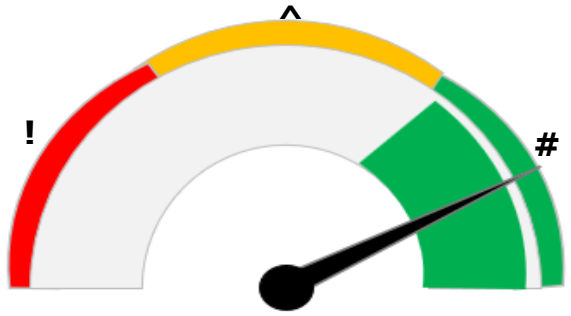
d) Reduce unnecessary Cesarean sections

Measure	HHSC Initiatives
Cesarean Sections in uncomplicated Deliveries	Performance Indicator Dashboard
PC-02 Cesarean Birth	CHIRP

e) Promote evidence-based best practices, including antibiotic stewardship

Measure	HHSC Initiatives
Appropriate Testing With Pharyngitis (CWP)	Performance Indicator Dashboard
Appropriate Treatment with Upper Respiratory Infection (URI)	Performance Indicator Dashboard, MCO Pay for Quality (P4Q)
Antibiotic Utilization for Respiratory Conditions (AXR*)	Performance Indicator Dashboard
Avoidance of Antibiotic Treatment with Acute Bronchitis (AAB)	Performance Indicator Dashboard

CHIRP Directed Payment Program - Free From Harm Quality Strategy Goal Scorecard, SFY 2022-2024 Evaluation



* indicates an EQRO Reported Measure
\# Green indicates the median and most providers improved
^ Orange indicates the median became worse, but most providers improved
! Red indicates the median and most providers became worse
\+ Gray indicates the measure is high-performing and the median rate maintained

CHIRP

Unintentional Medical Discrepancies#	
Severe Maternal Morbidity ^	
Potentially Preventable Complications*#	
PC-02 Cesarean Birth ^	
Ped. CAUTI +	CAUTI#
Ped. CLABSI#	CLABSI#
AIM Collaborative Participation#	

Alternative Payment Models (APMs): Performance Framework

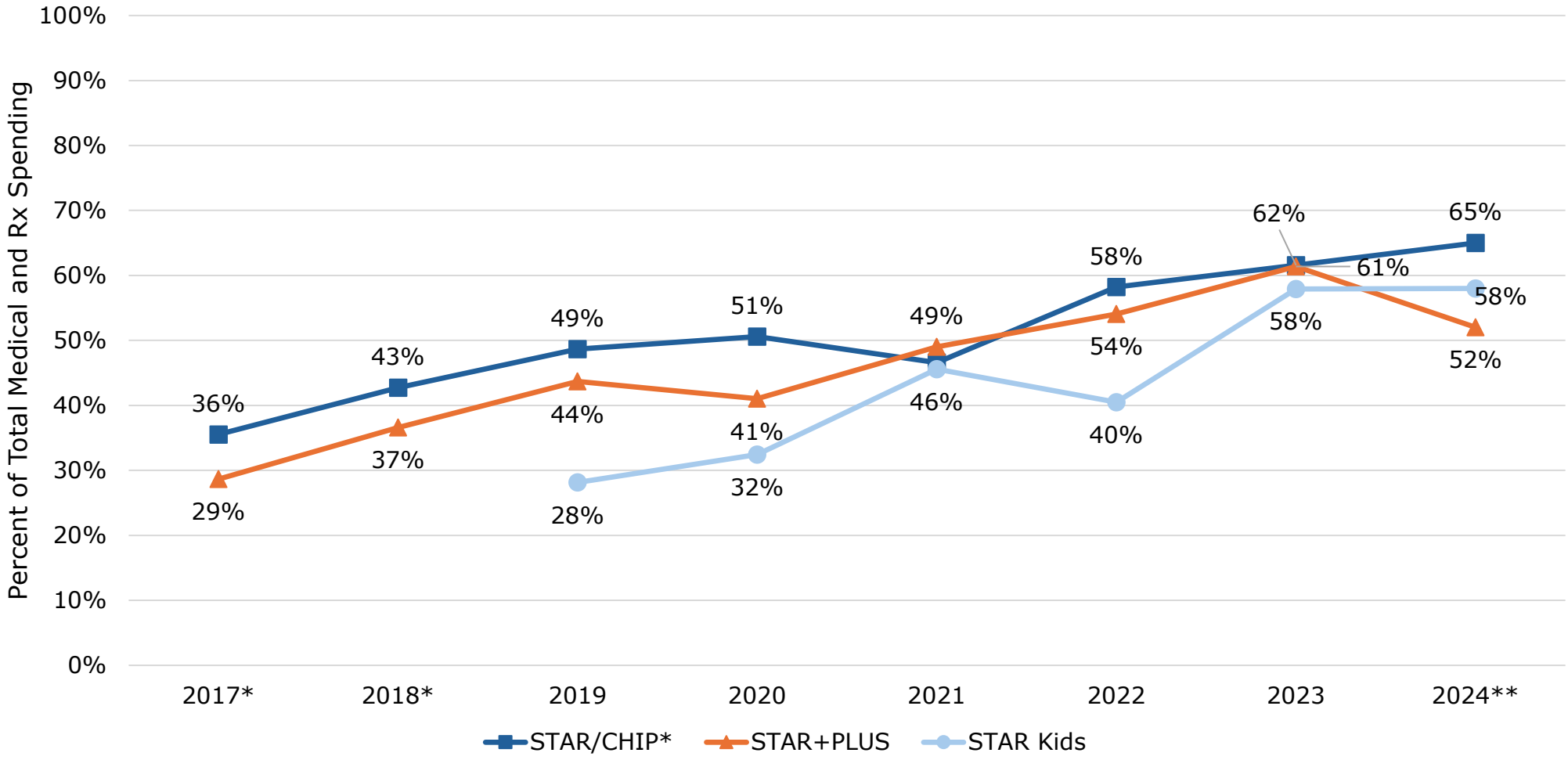
1. Alternative Payment Models (APMs) incentivize high-quality and cost-efficient care by linking a portion of provider payments to measures of value
2. Managed Care Organizations (MCOs) must meet APM Performance Framework requirements for the STAR/CHIP, STAR+PLUS, STAR Kids, and STAR Health programs

MCOs earn points across five APM Domains

1. Achievement levels
2. Quality Performance
3. APM Priorities
4. APM Pilots and/or Initiatives
5. APM Support

TEXAS Health and Human Services

Overall APM Payments by Managed Care Program



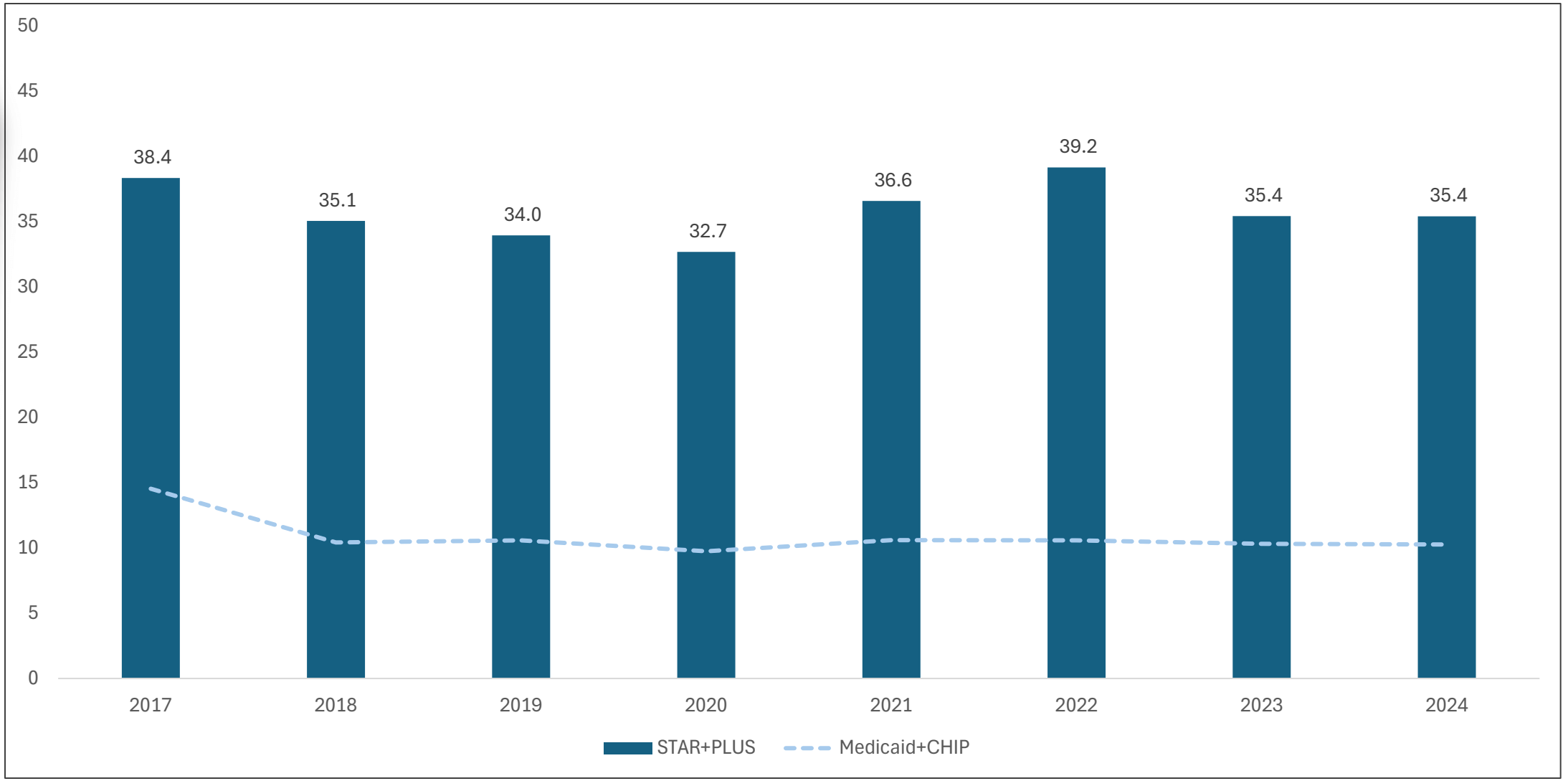
*Current analyses combines STAR & CHIP. CHIP data were not included for 2017 and 2018.
**CY 2024 data are preliminary.

Hospital Quality-Based Payment (HQBP) Program and APM

1. The HQBP Program holds hospitals and MCOs accountable for performance on risk adjusted rates of Solventum™ Potentially Preventable Complications™ (PPC) and Solventum™ Potentially Preventable Readmissions™ (PPR) in Medicaid.
2. Payment rates for lower performing hospitals are adjusted directly in fee-for-service, while MCOs receive an adjustment to capitation rates in managed care. Typically, MCOs pass their rate adjustments to hospitals through an APM.

	ACTUAL-TO-EXPECTED RATIO									
	◄ 0.84	0.85	0.90	0.91	1.00	1.09	1.10	1.25	1.26 ►	
PERFORMANCE	Distinguished			Satisfactory			Unsatisfactory			
POTENTIALLY PREVENTABLE COMPLICATIONS (PPC)	No penalty; no incentive.			No penalty; no incentive.			LOW Penalty: -2.0%		HIGH Penalty: -2.5%	
POTENTIALLY PREVENTABLE READMISSIONS (PPR)	No penalty; no incentive.			No penalty; no incentive.			LOW Penalty: -1.0%		HIGH Penalty: -2.0%	

STAR+PLUS Admissions with a PPC per 1,000 Admissions at Risk



Texas MCO APMs: Patient Safety Related Examples

APM Focus	Patient Safety Goal
Hospital quality	Reduce preventable complications and readmissions
Maternal outcomes	Reduce severe maternal morbidity
Long Term Services and Supports	Reduce harms such as falls and pressure ulcers in nursing facilities or falls in homes
Medication Management	Optimize medication use and reduce adverse events
Pediatric integrated care	Prevent crisis escalation
Children with complex care needs	Prevent errors in high-risk populations
Clinically Integrated Network	Standardize care and reduce variation in outcomes

Patient Safety in Texas Medicaid: Summary

1. The Texas Medicaid Managed Care Quality Strategy establishes patient safety as one of four overarching goals.
2. Texas Medicaid advances patient safety through directed payment programs, performance measurement, MCO accountability, and APMs.
3. Key patient safety priorities include reducing preventable complications and adverse events, improving maternal outcomes, reducing avoidable hospitalizations, and promoting evidence-based practices.
4. APMs adopted between MCOs and their network providers operationalize patient safety goals by tying financial incentives directly to reductions or prevention of avoidable harms.
5. Taken together, these efforts position patient safety as a core organizing principle of Medicaid managed care, with the aim of aligning measurement, payment, and care delivery models to reduce preventable harm.

TEXAS
Health and Human
Services

Thank you

Session 4: *Payment Mechanisms and Financial Incentives to Encourage Patient Safety in Alternative Payment Models*

Susan E. Sheridan, MIM, MBA, DHL

President and Chief Executive Officer
Patients for Patient Safety US

Patients for Patient Safety US

Sue Sheridan, MBA, MIM, DHL
President and CEO

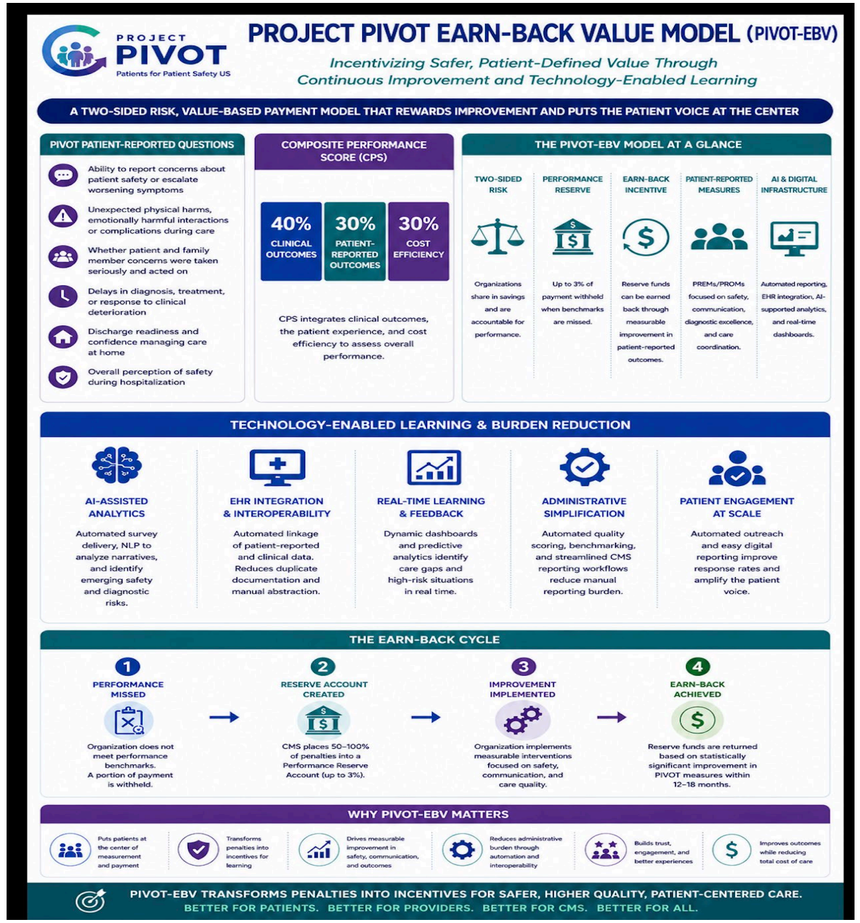
PTAC Meeting

Session 4: *Payment Mechanisms and Financial Incentives to Encourage Patient Safety in Alternative Payment Models*

June 16

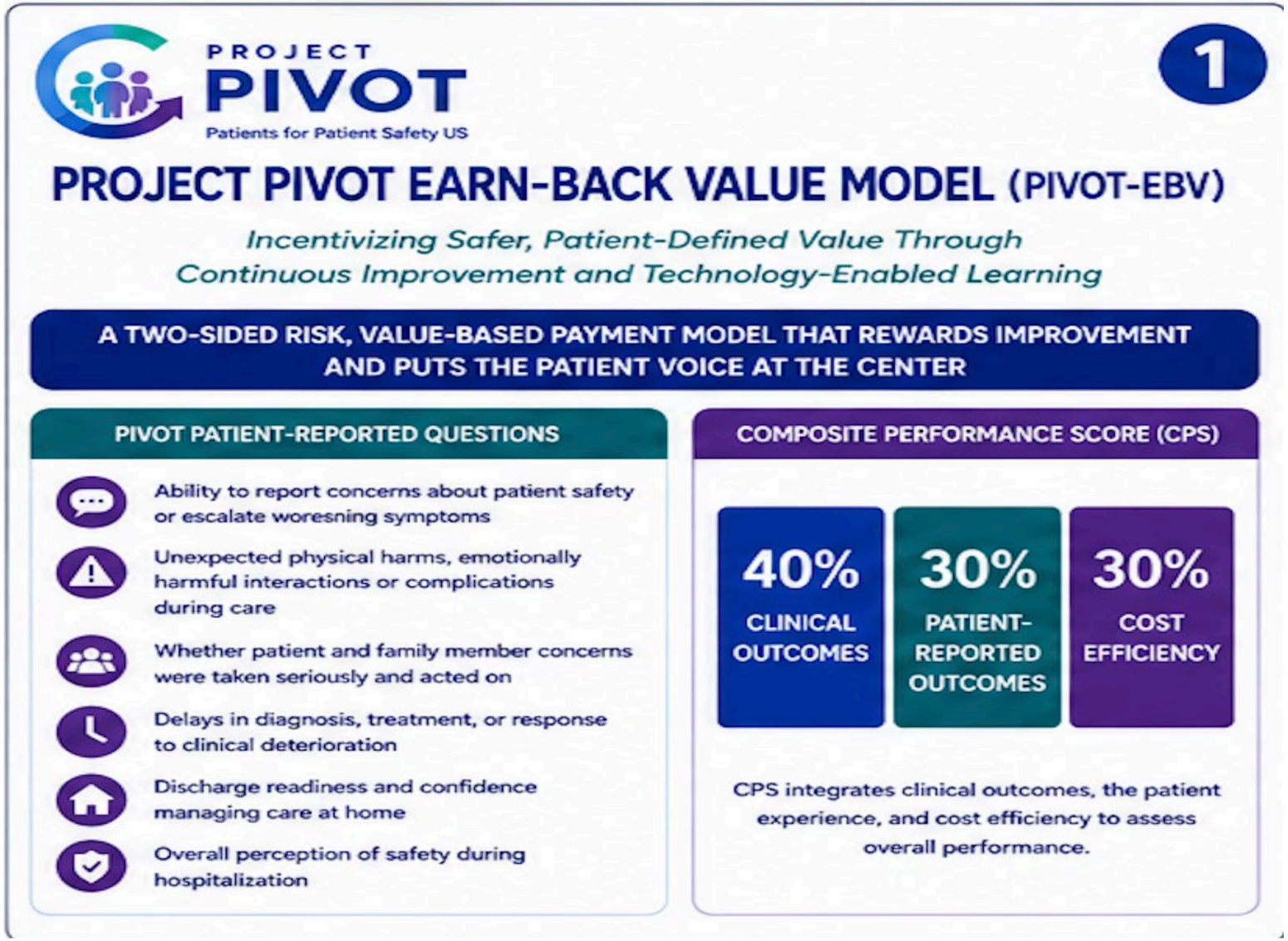
The Next Generation: Widespread incorporation of the PIVOT earn back incentive that promotes safety and diagnostic excellence

- Directly measures patient-defined/reported safety failures, diagnostic delays, communication breakdowns, and preventable harm
- Allows “second chance” to reinvest and recover performance losses through demonstrated safety improvement
- Rewards measurable improvement rather than one-time penalty cycles
- Encourages transparency and learning rather than fear and hiding harms
- Technology enabled (burden reduction)
- Better outcomes and lower cost of care



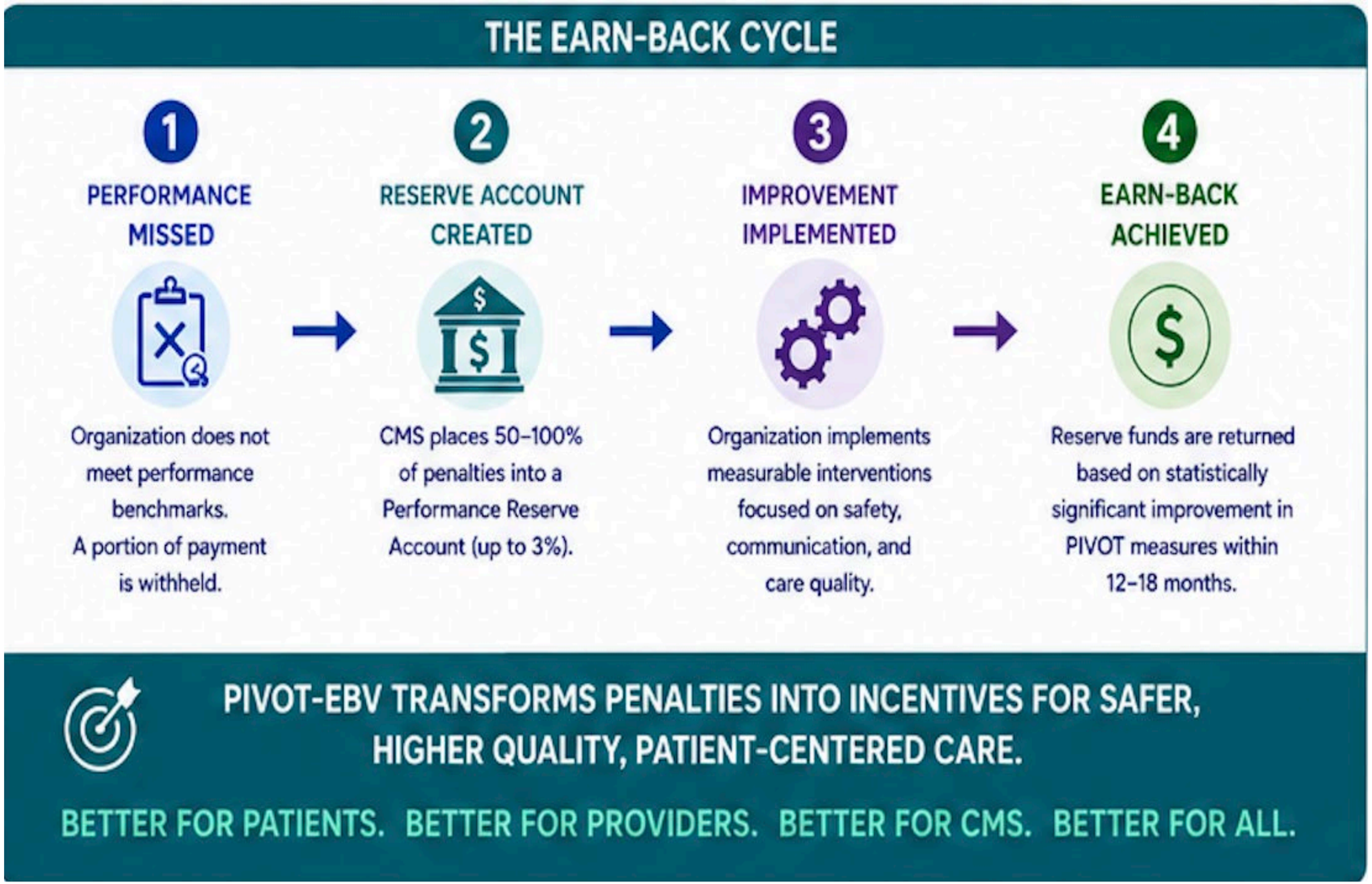
2 THE PIVOT-EBV MODEL AT A GLANCE

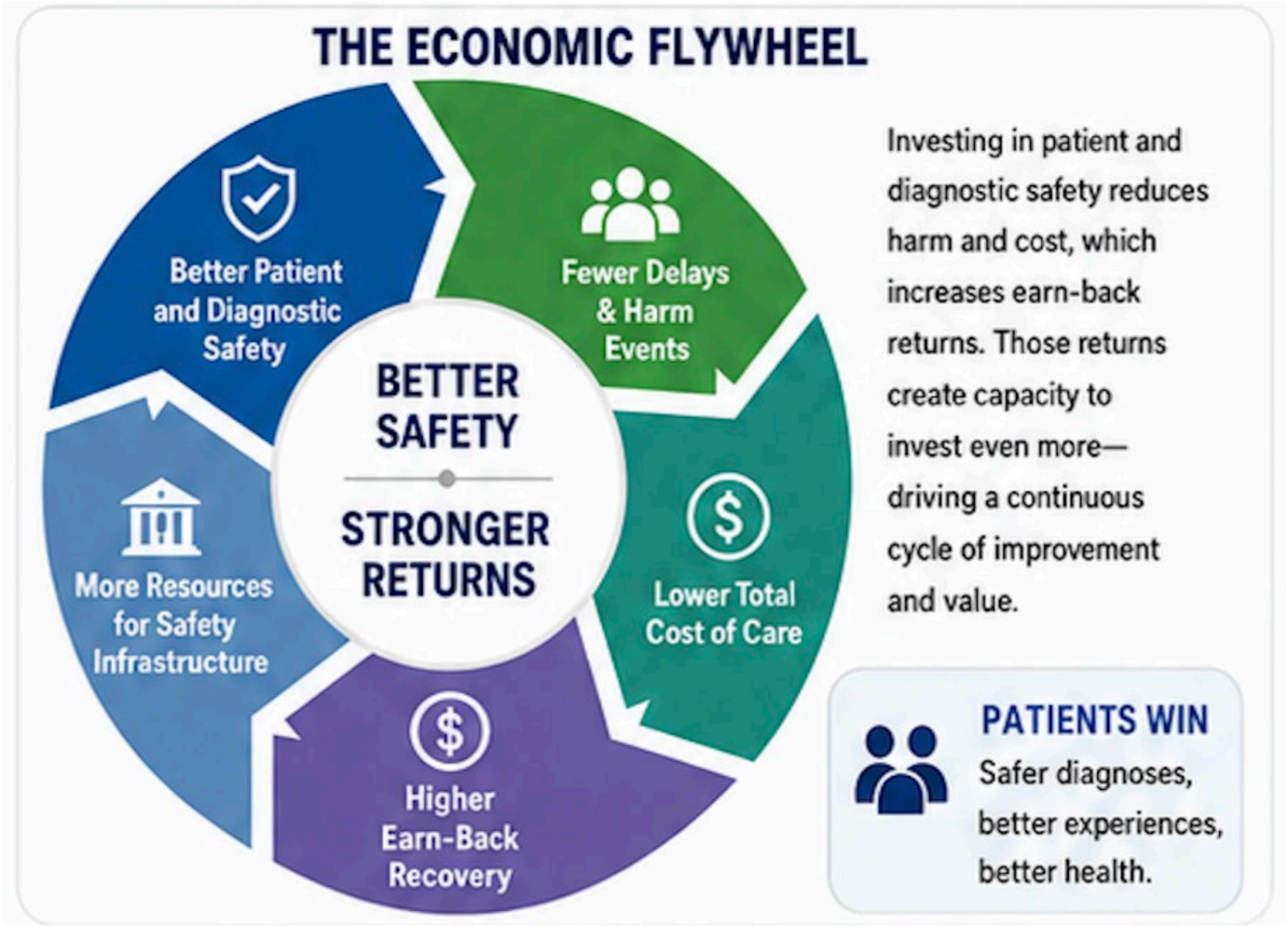
TWO-SIDED RISK	PERFORMANCE RESERVE	EARN-BACK INCENTIVE	PATIENT-REPORTED MEASURES	AI & DIGITAL INFRASTRUCTURE
				
Organizations share in savings and are accountable for performance.	Up to 3% of payment withheld when benchmarks are missed.	Reserve funds can be earned back through measurable improvement in patient-reported outcomes.	PREMs/PROMs focused on safety, communication, diagnostic excellence, and care coordination.	Automated reporting, EHR integration, AI-supported analytics, and real-time dashboards.


PROJECT
PIVOT
Patients for Patient Safety US
1
PROJECT PIVOT EARN-BACK VALUE MODEL (PIVOT-EBV)
Incentivizing Safer, Patient-Defined Value Through
Continuous Improvement and Technology-Enabled Learning
A TWO-SIDED RISK, VALUE-BASED PAYMENT MODEL THAT REWARDS IMPROVEMENT AND PUTS THE PATIENT VOICE AT THE CENTER
PIVOT PATIENT-REPORTED QUESTIONS
Ability to report concerns about patient safety or escalate woresning symptoms
Unexpected physical harms, emotionally harmful interactions or complications during care
Whether patient and family member concerns were taken seriously and acted on
Delays in diagnosis, treatment, or response to clinical deterioration
Discharge readiness and confidence managing care at home
Overall perception of safety during hospitalization
COMPOSITE PERFORMANCE SCORE (CPS)
40% CLINICAL OUTCOMES
30% PATIENT-REPORTED OUTCOMES
30% COST EFFICIENCY
CPS integrates clinical outcomes, the patient experience, and cost efficiency to assess overall performance.

3 TECHNOLOGY-ENABLED LEARNING & BURDEN REDUCTION

AI-ASSISTED ANALYTICS	Automated survey delivery, NLP to analyze narratives, and identify emerging safety and diagnostic risks.
EHR INTEGRATION & INTEROPERABILITY	Automated linkage of patient-reported and clinical data. Reduces duplicate documentation and manual abstraction.
REAL-TIME LEARNING & FEEDBACK	Dynamic dashboards and predictive analytics identify care gaps and high-risk situations in real time.
ADMINISTRATIVE SIMPLIFICATION	Automated quality scoring, benchmarking, and streamlined CMS reporting workflows reduce manual reporting burden.
PATIENT ENGAGEMENT AT SCALE	Automated outreach and easy digital reporting improve response rates and amplify the patient voice.


THE EARN-BACK CYCLE
1
PERFORMANCE MISSED
Organization does not meet performance benchmarks. A portion of payment is withheld.
2
RESERVE ACCOUNT CREATED
CMS places 50–100% of penalties into a Performance Reserve Account (up to 3%).
3
IMPROVEMENT IMPLEMENTED
Organization implements measurable interventions focused on safety, communication, and care quality.
4
EARN-BACK ACHIEVED
Reserve funds are returned based on statistically significant improvement in PIVOT measures within 12–18 months.
PIVOT-EBV TRANSFORMS PENALTIES INTO INCENTIVES FOR SAFER, HIGHER QUALITY, PATIENT-CENTERED CARE.
BETTER FOR PATIENTS. BETTER FOR PROVIDERS. BETTER FOR CMS. BETTER FOR ALL.


THE ECONOMIC FLYWHEEL
Better Patient and Diagnostic Safety
Fewer Delays & Harm Events
Lower Total Cost of Care
Higher Earn-Back Recovery
More Resources for Safety Infrastructure
BETTER SAFETY
STRONGER RETURNS
Investing in patient and diagnostic safety reduces harm and cost, which increases earn-back returns. Those returns create capacity to invest even more—driving a continuous cycle of improvement and value.
PATIENTS WIN
Safer diagnoses, better experiences, better health.

5 WHY PIVOT-EBV MATTERS

Puts patients at the center of measurement and payment

Transforms penalties into incentives for learning

Drives measurable improvement in safety, communication, and outcomes

Reduces administrative burden through automation and interoperability

Builds trust, engagement, and better experiences

Improves outcomes while reducing total cost of care

“To err is human, to cover up is unforgivable and to fail to learn is inexcusable.”

Sir Liam Donaldson

Thank You