California Health Care Foundation

Making Quality Matter in Medi-Cal Managed Care:

How Other States Hold Health Plans Financially Accountable for Performance

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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Introduction

Across the country, many states are redoubling their efforts to encourage and accelerate improvements in their Medicaid managed care programs, driven by rising Medicaid expenditures, persistent and sometimes worsening health disparities, and overutilization of services that are ineffective, of low value, or potentially harmful. A growing number of state Medicaid programs are holding their contracted health plans financially accountable for assuring the provision of high-quality, cost-effective care that improves beneficiary outcomes.[1] Financial incentives[2] are one of many options available to states to focus health plan and provider investment and attention on quality improvement and cost management. There are also nonfinancial levers states can apply, including reporting and publicizing performance on quality, public recognition of health plans and providers that achieve high performance, auto-assignment of Medicaid members to higher-performing health plans, and a reduction of administrative requirements for top performers.

The California Department of Health Care Services (DHCS) has historically adopted a number of these nonfinancial strategies with its plans, or managed care plans (MCPs). Medi-Cal MCPs currently collect data and report on a robust set of access, quality, and patient experience measures, and competitively superior performance on select quality measures is rewarded through increased volume of auto-assignment of Medi-Cal beneficiaries to that plan. Performance is also reported on a public dashboard by DHCS. Notably, the June 2018 dashboard showed wide variation in quality across health plans. There is an opportunity to build on these DHCS incentive programs and further accelerate quality improvements in Medi-Cal through the use of financial incentives. One approach worth considering is to implement a performance-based incentive program that creates new financial accountability in the form of rewards or penalties.

This report examines different options for financing and designing an incentive program for MCPs that will either reward or penalize them for performance. It follows the California Health Care Foundation report *Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs*, which offers recommendations informed by a workgroup of Medi-Cal health plan leaders to mitigate the negative financial impact to Medi-Cal plans when they invest in initiatives that may result in Medicaid program cost savings. Under the state's current rate-setting method, plan-generated savings could lead to lower capitation payments for future years. This saves the state money, but creates a financial disincentive for Medi-Cal plans to focus on activities and improvements that could achieve savings. The workgroup proposed a method that would not reduce future capitation payments if a plan invested in health-related or flexible services that led to cost savings, so long as certain conditions are met, including strong quality performance. The workgroup's recommendation represents one approach to structuring a financial performance incentive program and was developed such that it would not result in additional state spending (MCPs benefit only when their actual costs are below the state's expected trends), and it would not require the plans to fund the financial incentives out of their capitation rates.

However, there are a variety of other options that California can draw from. This report describes other approaches that states across the country are taking to using financial incentives with Medicaid MCPs.

Using Financial Incentives to Drive Value in Medicaid Managed Care

Although there have been mixed results demonstrating the impact of financial rewards or penalties on provider performance,[3] there is some evidence of positive impact from state use of financial incentives with Medicaid MCPs. An evaluation of Oregon's Medicaid demonstration waiver, which permits the state to test new delivery system and payment models, found that "financial incentives were strongly associated with improvements in performance: Two-thirds of the incentive measures of Oregon MCPs, called Coordinated Care Organizations, improved in at least two of the three years from 2013 to 2015."[4] New York has been administering an MCP performance incentive program since 2001 and found that the "use of financial incentives has proven successful in engaging Medicaid managed care plans in developing infrastructure, programs, and resources to promote high quality care." New York also reported that the state's

"Medicaid plans have demonstrated a high level of care compared to national averages, and for many domains of care the gap in performance between commercial and Medicaid managed care has been decreasing since the QI Program was implemented."[5]

Characteristics[6] of a successful health plan financial incentive program include the following:

- Creates a significant incentive to motivate investment and improvement
- Draws the attention of health plans
- Targets clear and valid measures of performance
- Focuses on demonstrated opportunities for improvement
- Focuses on areas within the health plan's control
- Provides timely feedback and rewards/penalties related to performance
- Reinforces joint responsibility for the success of the performance incentive program

Two fundamental policy questions that Medicaid programs and policymakers need to consider when developing a performance-based incentive program are: "Where will the dollars come from to support the program?" and "How will the pool of funds be distributed among MCPs?" Of secondary importance, though critical, are "How should the measures for which performance will be financially rewarded or penalized be identified?" and "What should be the methodology for evaluating performance (e.g., reward absolute performance, improvement, etc.)?"[7] Establishing an effective and sustainable approach requires a multiyear financial commitment, and certainty around financial resources to maintain an incentive strategy over time and realize its potential improvement impact.

Options for Developing a Financial Incentive Program

States may consider multiple options to structuring their performance-based incentive programs. This section examines five approaches states have taken or are taking to financially support a performance-based incentive program. The approaches, which are not mutually exclusive, are organized in groups based on whether new or additional state dollars would be required for financial incentive payments (Table 1).

Table 1. Approaches to Financial Incentive Payments and Penalties

No new state funding[8]
▸ Bonus payment funded by withhold[9]
▸ Shared savings (i.e., profit sharing)
▸ Penalty
State funding required for incentive payments
▸ State-funded bonus payment
State funding may/may not be required, based on design
▸ Capitation rate adjustment

Additional details about each option are summarized below, with Table 4 identifying strengths and weaknesses of different approaches (see page 7). Examples of state programs are also included.

Bonus Payment Funded by Withhold

Withholding a percentage of an MCP's monthly capitation payment is the most common approach states have taken to implement a performance-based incentive program. Twenty-nine states reported having withhold arrangements in the 2017 National Association of Medicaid Directors' annual state budget survey, with withhold amounts ranging from 1% to 5%.[10] Under a withhold arrangement, MCPs can gain or lose the entire amount withheld based on performance. MCPs know in advance the maximum amount of their financial exposure. Additionally, the state has the option to retain the withhold or redistribute unearned dollars to top performers.

EXAMPLE

District of Columbia Pay-for-Performance[11]

In 2016, the district launched a Medicaid MCP pay-for-performance program to promote improved care coordination. The district withholds 2% of the MCP capitation payment. The withhold can be earned back for reduction in incidence in the following quality metrics:[12]

- Potentially preventable admissions (PPA)
- Low-acuity non-emergent (LANE) visits
- 30-day hospital readmissions for all causes

The district assigns equal weight to scoring the PPA and LANE metrics (33% each) and 34% for reducing all-cause readmissions. MCPs can earn back 50%, 75%, or 100% of the withhold attributed to the measure by demonstrating reductions of 2%, 3.5% or 5%, respectively. The district relies on claims data to evaluate performance, which results in a payment lag of four to six months after the end of the performance period to allow for claims runout.

Shared Savings (profit or gain sharing)

A state could permit MCPs to retain a greater percentage of profits it would otherwise share with health plans. This means a state forfeits amounts it would otherwise collect from MCPs when an MCP's performance results in a profit or its costs are less than a budget target or trend line established by the state. Some states, including Florida and Texas, have implemented profit-sharing requirements in their managed care contracts.

EXAMPLE

Texas Experience Rebate[13]

Texas integrated quality performance in its profit-sharing settlement requirement. MCPs refund to the state a share of profits the state deems excessive. Texas returns to the federal government the federal share.

The state calls these "experience rebates," and MCPs pay the rebate to the state when pretax income exceeds 3% of revenue for the contract period. Until September 2014 the state permitted an MCP to retain an additional 0.5% of profit, above the 3.0% cap, for demonstrating superior performance on select indicators. Texas implemented the adjustment as a onetime increase in the share of profits an MCP could retain.

Table 2. Texas Experience Rebates

PRETAX INCOME AS A PERCENTAGE OF REVENUES	MCP SHARE	HHSC SHARE
≤3%	100%	0%
>3% and ≤5%	80%	20%
>5% and ≤7%	60%	40%
>7% and ≤9%	40%	60%
>9% and ≤12%	20%	80%
>12%	0%	100%

Penalty

Under this approach, states impose a financial penalty for poor performance. This is a downside-only arrangement for MCPs, and the state does not have any financial exposure. Performance metrics for which states apply a penalty are typically operational indicators (e.g., timely submission of encounter data).[14] Penalties may be assessed for persistent low performance, noncompliance with contract terms, or serious violations.

EXAMPLE

Florida Performance Measure Sanctions[15]

Florida MCPs are subject to penalties, including monetary fines, for failing to achieve minimum performance scores on measures identified by the Medicaid agency. Sanctions apply to performance beginning in contract year two. Effective in 2019, MCPs performing below the National Committee for Quality Assurance's 25th percentile on the Healthcare Effectiveness Data and Information Set (HEDIS) Call Answer Timeliness are subject to an immediate monetary sanction and may be required to submit and complete a corrective action plan; performance below the 50th percentile may also require a corrective action plan.

MCPs are also subject to monetary fines (i.e., liquidated damages) for noncompliance with specific contractual terms. These are primarily operational performance issues, such as failure to adequately meet staffing requirements, failure to timely report marketing violations, or failure to comply with fraud and abuse requirements.

State-Funded Bonus Payments

A performance-based bonus payment provides an opportunity for MCPs to receive additional revenue on top of their base payment. This is an upside-only incentive arrangement for MCPs, but the amount of the incentive payment needs to be significant enough for an MCP to invest in changing its way of doing business. A Medicaid program's priorities may differ strategically from that of an MCP, and without an incentive that is large enough to motivate action, success in state-targeted areas could be limited.

EXAMPLE

New York Quality Incentive (QI) Program

New York state launched its Medicaid Managed Care QI program in 2001. Today, MCPs are eligible for bonus payments[16] for performance on select quality, patient satisfaction, and prevention measures. New York has combined financial and nonfinancial incentives to motivate performance achievement and improvement.[17] Medicaid MCPs are evaluated for performance on HEDIS and state-specific quality metrics, patient satisfaction, and prevention quality indicators.[18] The state assigns a different number of points for each domain, and the total number of points determines the final performance score. The scoring method for each domain differs. For example, quality performance is based on performance against Medicaid plans, and patient satisfaction is measured against the statewide average. A total score based on performance in those areas is calculated, but this is not the final score, as up to 20 points can be deducted for MCP noncompliance in six specified areas.[19] MCPs are also eligible to receive up to six additional "bonus" points for an approved telehealth plan.[20]

Table 3. New York Quality Incentive Program Domains and Points, 2017

DOMAIN/COMPONENT	NUMBER OF MEASURES	MAXIMUM POINTS
Quality: HEDIS and State-Specific (includes prevention measures)	27	100
Satisfaction: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey	3	30
Prevention Quality Indicators	2	20
Total Points		**150**
Compliance *(subtracted from total)*	6	Up to 20 points
Telehealth Innovation *(added to total)*	N/A	Up to 6 points
Final Score	Number of points ÷ 150	

Source: New York State Department of Health, "2017 Quality Incentive for Medicaid Managed Care Plans: A Report on Quality Incentive Program in New York State," *www.health.ny.gov* (PDF).

Capitation Rate Adjustment

States may adjust the base capitation rate for MCPs based on quality performance. This approach may be implemented so the adjustment is built into future year MCP rates and could be adjusted upward and downward based on performance, making it both an upside and downside arrangement for MCPs. (Rules governing actuarial soundness of rates limit downside risk.) This is also why additional or new state funding may or may not be required. Using a higher profit margin in the development of the base rate is different than the onetime profit-sharing adjustment described in the shared savings option. The former has a lasting impact on rates, as the adjusted capitation may then be used to determine future rates.

The methodology proposed in the California Health Care Foundation report *Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs* possesses characteristics of both a gain-sharing approach, in that MCPs are rewarded only if they generate savings, and a capitation rate adjustment approach given that the capitation rate impact extends beyond one year.

EXAMPLE

Oregon Margin Augmentation[21]

CMS approved Oregon's 1115 waiver renewal proposal to incorporate a higher profit margin into the rate of a high-performing coordinated care organization (CCO), resulting in a higher capitation payment. The state indicated that it would develop rates with a profit margin range, as opposed to a fixed percentage of premium. The percentage built into a CCO's rate would vary based on CCO performance on cost and quality indicators. An efficient and high-quality CCO would be eligible to earn a higher profit margin in its contracted rate than if it were not performing as well. The new rate would remain in effect for 12 months. CCOs that do not perform well on quality would not receive a profit margin adjustment in the calculation of its rates. Oregon will be reprocuring its CCO contracts in 2019 and for this reason has not yet implemented the new method.

Table 4. Strengths and Weaknesses of Incentive Structure Approaches

	STRENGTHS	WEAKNESSES
Bonus Payment Funded by Withhold	▶ Relatively easy to administer. ▶ MCPs know in advance the amount of potential gain/loss. ▶ Behavioral economics suggests that a potential loss in income is more effective to induce behavior change than a potential gain.[22]	▶ MCP (and possibly provider) opposition to a potential reduction, and minimally a disruption, in revenue given already low Medi-Cal payment. ▶ Lag time in receiving earned money back may create financial strains on MCPs, and potentially their contracted providers. ▶ The state's actuary must consider the withhold performance targets as "reasonably achievable" by the MCPs in order for the full portion of the withhold to be considered as part of actuarially sound MCP rates.[23] ▶ This approach would not be viable if the capitation rate pre-withhold is at a minimum level for actuarial soundness.
Shared Savings	▶ Relatively easy to administer.	▶ State reduces the amount it might otherwise collect from excessive MCP profits. ▶ Uncertainty for state and MCP on amount that can be retained/lost.
Penalty	▶ Behavioral economics suggests that a potential loss in income is more effective to induce behavior change than a potential gain. ▶ Can be structured to be applied immediately upon evidence of poor performance.	▶ May require more legal counsel involvement to develop policies for assessing penalties, which may be more complex to administer than a withhold.
State-Funded Bonus Payment	▶ Relatively easy to implement and administer. ▶ MCPs are not financially vulnerable if they don't achieve quality performance targets.	▶ Requires significant and sustained state financing to reward for excellence and improvement. ▶ Funding allocated for bonus or incentive payments may be targeted for cuts or redistribution by states during the budget process, creating uncertainty about sustainability.
Capitation Rate Adjustment	▶ May be easier to insulate from budget cuts as gains are built into rates (as opposed to a separate line-item budget, for example). ▶ Has potential to offset the "premium slide" and *may* accelerate cost savings and community / social determinants investments if MCPs are not financially penalized by future rate declines, particularly if the state requires reinvestment in those initiatives.	▶ May be more difficult to administer than other models ▶ Premiums will be higher than they otherwise might have been if performance results in increased capitation rates.

Table 4, on page 7, identifies select strengths and weaknesses of the incentive structure options described in Table 1 (see page 4). Many of these approaches would require MCP contract revisions.

Additional Design Considerations

In addition to the basic financial structure and the strengths and weaknesses of different approaches, states need to consider other important policy decisions that will influence the design of a performance-based MCP incentive program. Some of these considerations are relevant to certain incentive program designs.

- **Should all MCPs have the opportunity to earn a financial incentive, or are only top performers rewarded?** This is important for states that are implementing a bonus incentive. There could be winners and nonwinners, and states would distribute the full amount available for incentive payments to the top performers. Alternatively, a state could allocate a certain amount for each MCP to earn based on performance. This allows MCPs to know in advance the full amount of their potential financial reward. Unearned funds from this approach go unspent (or are redistributed to high performers.) Financially rewarding some MCPs could increase competition among plans, with potentially positive effects (e.g., greater investment to improve their performance) and negative effects (less collaboration among MCPs to improve the health of the communities they serve).

- **Should there be a shared quality incentive pool?** Shared incentive pools use combined dollars from a chosen financing approach (e.g., unearned withhold, bonus pool) to implement a performance-based incentive program. This is a secondary design decision for states, and for this reason it was not included in the summary of options. For example, unearned withheld dollars could be combined to create an incentive pool. This allows MCPs an opportunity through the withhold to earn back what they put in, plus an additional reward for superior performance. In at least three states (Maryland, Oregon, and Texas), the pool is used to distribute unearned (i.e., forfeited) incentive dollars. In some cases, different quality measures are used for the shared incentive pool than for the base incentive arrangement.

- **Should MCPs have to meet other requirements to be eligible for quality incentives?** Some states are imposing additional conditions on MCPs to earn back a withhold based on nonquality indicators. For example, states may require MCPs to have a certain percentage of payments to providers in value-based payment arrangements in order to access the withhold, even if quality performance is high. Some states may combine quality performance and cost management in a performance-based program. States that have included additional conditions in their quality incentive programs include Arizona and Washington.

- **What should be the frequency of incentive payments?** Greater than annual frequency of incentive payouts may motivate continuous improvement, though this may be more complex for a state to administer.

While states have taken different financing approaches, what *is* common is that states typically use HEDIS quality measures in whole or in part in their incentive models. States often rely on HEDIS measures because (1) they are endorsed by the National Committee for Quality Assurance (NCQA); (2) they have standardized, detailed specifications; (3) plans are required to report them to NCQA for health plan accreditation; and (4) NCQA offers national and regional benchmarks against which states can assess plan performance. The HEDIS measures adopted by states for performance-based programs are mostly process-of-care measures. Measures that assess clinical outcomes are harder to adopt because there are fewer available and they require more extensive and expensive data collection processes. The appendix includes a table of quality measures that select states are using in their MCP performance programs.

The authors have observed the number of performance measures that states include in their performance-based programs to vary from three in the District of Columbia to 31 in New York.[24] Each Medicaid incentive program is unique, and each state targets different priority areas and adopts different measures for performance improvement.

Conclusion

With the tools to monitor and measure MCP performance, Medicaid programs are increasingly developing and implementing strategies to assure they are getting the most value from their purchase of health care services. MCP financial incentive programs represent an approach not currently used by DHCS that could augment DHCS's existing nonfinancial incentive strategies. Other states have demonstrated that creative approaches are possible to produce such financial incentives.

Appendix. Quality Measures in MCP Performance-Based Incentive Programs

MEASURE NAME	MEASURE SOURCE	AZ	DC	MD	NY	OR	TX	WA	TOTAL
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA HEDIS				1				**1**
Adolescent Well-Child Visits (age 12–21)	NCQA HEDIS	1		1		1			**3**
Adult Prevention Quality Overall Composite	AHRQ				1				**1**
Ambulatory Care for SSI Adults	Maryland homegrown			1					**1**
Ambulatory Care for SSI Children	Maryland homegrown			1					**1**
Antidepressant Medication Management	NCQA HEDIS				1				**1**
Antidepressant Medication Management - Effective Acute Phase Treatment	NCQA HEDIS							1	**1**
Antidepressant Medication Management - Effective Continuation Phase Treatment (6 months)	NCQA HEDIS							1	**1**
Appropriate Treatment for Children with Upper Respiratory Infection	NCQA HEDIS						1		**1**
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	NCQA HEDIS				1				**1**
Assessments within 60 Days for Children in DHS Custody	Oregon homegrown					1			**1**
Asthma Medication Ratio	NCQA HEDIS			1					**1**
Breast Cancer Screening	NCQA HEDIS			1	1				**2**
CAHPS - Access to Care	CAHPS					1			**1**
CAHPS - Customer Service and Information	CAHPS				1				**1**
CAHPS - Getting Care Needed	CAHPS				1				**1**
CAHPS - Rating of Health Plan	CAHPS				1				**1**
CAHPS - Satisfaction with Care	CAHPS					1			**1**
Cervical Cancer Screening	NCQA HEDIS				1				**1**
Childhood Immunization Status - Combo 2	NCQA HEDIS					1			**1**
Childhood Immunization Status - Combo 3	NCQA HEDIS				1				**1**
Childhood Immunization Status - Combo 10	NCQA HEDIS							1	**1**
Children's Dental Visits (age 2–21)	NCQA HEDIS	1			1				**2**
Chlamydia Screening	NCQA HEDIS				1				**1**
Cigarette Smoking Prevalence Bundle	Oregon homegrown					1			**1**
Colorectal Cancer Screening	NCQA HEDIS				1	1			**2**
Comprehensive Diabetes Care	NCQA HEDIS				1				**1**

Appendix. Quality Measures in MCP Performance-Based Incentive Programs, *continued*

MEASURE NAME	MEASURE SOURCE	AZ	DC	MD	NY	OR	TX	WA	TOTAL
Comprehensive Diabetes Care - HbA1c Control (<8.0%)	NCQA HEDIS			1	1				**2**
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	NCQA HEDIS							1	**1**
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	NCQA HEDIS							1	**1**
Controlling High Blood Pressure	NCQA and CMS			1	1	1		1	**4**
Dental Sealants	EPSDT Form CMS-416					1			**1**
Developmental Screening in First Three Years	CMS Children's Core Set					1			**1**
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Meds	NCQA HEDIS				1				**1**
ED Utilization	NCQA HEDIS	1				1			**2**
ED Utilization Among Members Experiencing Mental Illness	NCQA HEDIS					1			**1**
Follow Up After Hospitalization for Mental Illness Within 7 Days	NCQA HEDIS				1				**1**
Follow Up for Children Newly Prescribed ADHD Medication	NCQA HEDIS				1				**1**
HbA1c Poor Control	CMS (eCQM)					1			**1**
Immunization for Adolescents	NCQA HEDIS				1				**1**
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA HEDIS				1				**1**
Lead Screening for Children (12–23 months)	Maryland homegrown			1					**1**
Low-Acuity Non-Emergent (LANE) Visits	Not identified		1						**1**
Medication Management for People with Asthma: Medication Compliance 75% (age 5–64)	NCQA HEDIS				1				**1**
Medication Management for People with Asthma: Medication Compliance 75% (age 5–11)	NCQA HEDIS							1	**1**
Medication Management for People with Asthma: Medication Compliance 75% (age 12–18)	NCQA HEDIS							1	**1**
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA HEDIS				1				**1**
Patient-Centered Primary Care Enrollment	Oregon homegrown					1			**1**
Pediatric Quality Overall Composite	AHRQ				1				**1**
Postpartum Care	NCQA HEDIS			1		1			**2**

Appendix. Quality Measures in MCP Performance-Based Incentive Programs, *continued*

MEASURE NAME	MEASURE SOURCE	AZ	DC	MD	NY	OR	TX	WA	TOTAL
Potentially Preventable Emergency Room Visits	3M						1		**1**
Potentially Preventable Hospitalizations	AHRQ		1						**1**
Prenatal and Postpartum Care	NCQA HEDIS				1	1	1		**3**
Readmissions Within 30 days	NCQA HEDIS	1	1						**2**
Use of Imaging Studies for Low Back Pain	NCQA HEDIS				1				**1**
Use of Spirometry Testing in Assessment and Diagnosis of COPD	NCQA HEDIS				1				**1**
Viral Load Suppression	CMS (MIPS #338)				1				**1**
Weight Assessment and Counseling for Children and Adolescents (BMI, Nutrition Counseling, Physical Activity Counseling)	NCQA HEDIS				1				**1**
Weight Assessment and Counseling in Children and Adolescents	CMS (eCQM)					1			**1**
Well-Child Visits (15 months)	NCQA HEDIS	1		1	1		1		**4**
Well-Child Visits (age 3–6)	NCQA HEDIS	1			1			1	**3**
	Total	**6**	**3**	**10**	**31**	**17**	**4**	**9**	**80**
BONUS MEASURES / CHALLENGE POOL MEASURES		AZ	DC	MD	NY	OR	TX	WA	TOTAL
Potentially Preventable Admissions	3M						1		**1**
Low Birth Weight	CMS						1		**1**
Children with Good Access to Urgent Care	CAHPS						1		**1**
Adults Rating Their MCP a 9 or 10	CAHPS						1		**1**
Depression Screening and Follow-up Plan	CMS (eCQM)					1			**1**
Developmental Screenings	CMS Children's Core Set					1			**1**
Effective Contraceptive Use	Oregon homegrown					1			**1**
	Total	N/A	N/A	N/A	N/A	3	4	N/A	**7**

Endnotes

1. Kathleen Gifford et al., *Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018*, Kaiser Family Foundation, October 2017, www.kff.org.
2. The term "incentive" here and elsewhere in the report is inclusive of negative incentives (i.e., disincentives) unless "disincentive" is specifically cited with "incentive."
3. Aaron Mendelson et al., "The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care: A Systematic Review" *Annals of Internal Medicine* 166, no. 5 (March 7, 2017): 341–53, doi:10.7326/M16-1881.
4. Jonah Kushner et al., *Evaluation of Oregon's 2012-2017 Medicaid Waiver: Final Report*, Oregon Health and Science University, December 29, 2017, www.oregon.gov (PDF).
5. *2017 Quality Incentive for Medicaid Managed Care Plans: A Report on Quality Incentive Program in New York State*, New York State Dept. of Health, n.d., www.health.ny.gov (PDF).
6. M. Bailit and M. B. Dyer, *Ensuring Quality Providers: A Purchaser's Toolkit for Using Incentives*, National Health Care Purchasing Institute, May 2002, www.bailit-health.com (PDF).
7. A recommended process for selecting performance measures for programs with financial incentives and evaluating MCP performance against the identified measures is outside the scope of this report, but will be covered in depth as part of a forthcoming report by Bailit Health.
8. The incentive dollars to support these approaches come from the base MCP payment structure, with the exception of penalties, which wouldn't require additional state dollars to fund.
9. A withhold could possibly require new state funding if expected provider forfeiture of the withheld funds would cause the rates to not be actuarially sound. See endnote 23 for related information.
10. Gifford et al., *Medicaid Moving Ahead*.
11. District of Columbia Managed Care Organization Request for Proposals, Solicitation Number DCHT-2017-R-0024, issued December 22, 2016.
12. *Medicaid Managed Care: 2017 Annual Technical Report*, District of Columbia Dept. of Health Care Finance, April 2018, dhcf.dc.gov (PDF).
13. Uniform Managed Care Terms and Conditions, version 2.25, Texas Health and Human Services Commission, effective March 2018.
14. As defined in 42 CFR § 438.6(a), arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement. The targets for a withhold arrangement must be distinct from general operational requirements under the Medicaid managed care contract.
15. *Core Contract Provisions — Effective February 1, 2018* (statewide Medicaid managed care model contract), Florida Dept. of Health Care, n.d., www.fdhc.state.fl.us (PDF).
16. The amount of the incentive award is determined by the Division of Finance and Rate Setting and subject to final approval from the Division of Budget and the Center for Medicare & Medicaid Services.
17. New York has also implemented performance-based auto-assignment.
18. The Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs) quantify hospital admissions that most likely could have been avoided through high-quality outpatient care.
19. Noncompliance in the following areas will result in a deduction of points: statements of deficiency for timely, complete, and/or accurate submissions of encounter data; the Medicaid Managed Care Operating Report; quality assurance reporting requirements; plan network; provider directory, and member services. For more information see: *2017 Quality Incentive for Medicaid Managed Care Plans: A Report on Quality Incentive Program in New York State*, New York State Dept. of Health, www.health.ny.gov (PDF).
20. Five of the six bonus points are earned when an MCP receives approval of a telehealth innovation plan and one additional point is earned if the MCP's telehealth plan "demonstrates enhanced access to services and seeks to improve outcomes for women with high risk pregnancies and/or children in their first 1,000 days of life."
21. The state sought and obtained approval from CMS of this approach in its 1115 Demonstration Waiver renewal, although approval was not required. This approach is believed to be in the design phase. See: *Application for Amendment and Renewal*, Oregon Health Plan 1115 Demonstration Project, May 2, 2016, www.oregon.gov (PDF).
22. Daniel Kahneman and Amos Tversky, "Prospect Theory: An Analysis of Decision Under Risk," *Econometrica* 47, no. 2 (March 1979): 263–91, doi:10.2307/1914185.
23. The 2016 Medicaid Managed Care Rule requires that MCP capitation payment less any portion of the withhold that the Centers for Medicare & Medicaid Services actuary deems unreasonable to earn back must be actuarially sound. Rate certification and documentation must describe any withhold amounts or incentives in the contract between the state and MCPs; the percentage of the certified capitation rate being withheld; an estimate of the percentage of the withheld amount that is expected to be returned and the rationale; and any effect that the incentive or withhold would have on the development of capitation rates.
24. This count does not include the compliance measures for which the state has attached financial incentives.