



Welcome

Briefing: Improving Quality in Medi-Cal Managed Care

Monday, April 29, 2019



Welcome, Overview, Introductions

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Monday, April 29, 2019



Quality of Care in Medi-Cal Managed Care: Lessons from the Past Decade

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Medi-Cal Managed Care

- California first state to implement Medicaid managed care
- Over past decade has grown from 3.5 million to more than 10 million beneficiaries
- Nationwide, one in five Medicaid beneficiaries who are in managed care reside in California
- More than 80% of Medi-Cal beneficiaries are in managed care
- Mandatory in all but one county for most enrollees

Insurers, Reporting Regions, and Plan Assessments: 2017

- 22 insurers
 - Four for-profit: three million enrollees
 - Three non-profit: 400,000 enrollees
 - 15 public: seven million enrollees
- 31 quality reporting regions covering 58 counties
 - 22 single counties
 - Nine clusters of counties
- 53 MCP assessments
 - 26 for-profit
 - 4 non-profit
 - 23 public

Quality Assessment of Medi-Cal Managed Care



Healthcare Effectiveness Data and Information Set (HEDIS)

- Standardized quality assessment tool
- Administrative and chart review data
- Reported annually on prior year
- Score is percentage on a measure
- Performance below national 25th percentile triggers “improvement plan”

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- Patient self-reported experience
- Collected and reported every three years
- Star ratings
 - 1 = < 25th percentile
 - 2 = 25th–50th percentile
 - 3 = 50th–75th percentile
 - 4 = 75th–90th percentile
 - 5 = ≥ 90th percentile

Evaluation of Medi-Cal Managed Care

Study Questions

- How has quality in Medi-Cal managed care changed over the past decade?
- Are there differences in quality of care, or in improvement over time, among:
 - MCP ownership type (public, non-profit, for-profit)?
 - Managed care models (Two-Plan, COHS, competing commercial)?
- Has the Department of Health Care Services (DHCS) auto-assignment incentive had an impact on quality improvement?

Methods

- Examined DHCS publicly reported HEDIS and CAHPS scores from 2008–2017
- Measures that phased out or phased in were included for shorter time
- Scores weighted by MCP enrollment to create statewide estimate of quality in Medi-Cal managed care
- When comparing managed care models and MCP types, controlled for county-level differences in:
 - Race/ethnicity, education level, and English proficiency of population at <138% of the federal poverty level (FPL)
 - Physician FTEs per population

Finding #1: Inconsistent Quality Over Time

- CAHPS
 - Five measures unchanged (2010 vs. 2016):
 - Rating of health plan: 1.1 to 1.1 stars
 - Rating of all health care: 1.2 to 1.5 stars
 - Rating of personal doctor: 1.6 to 2.0 stars
 - Getting needed care: 1.3 to 1.1 stars
 - Getting care quickly: 1.1 to 1.0 stars
 - One measure improved:
 - Doctor communication: 1.3 to 3.0 stars
- HEDIS
 - 19 measures improved
 - 11 measures declined
 - Five measures unchanged

Changes in Quality Over Time (Examples)

Quality Improvement

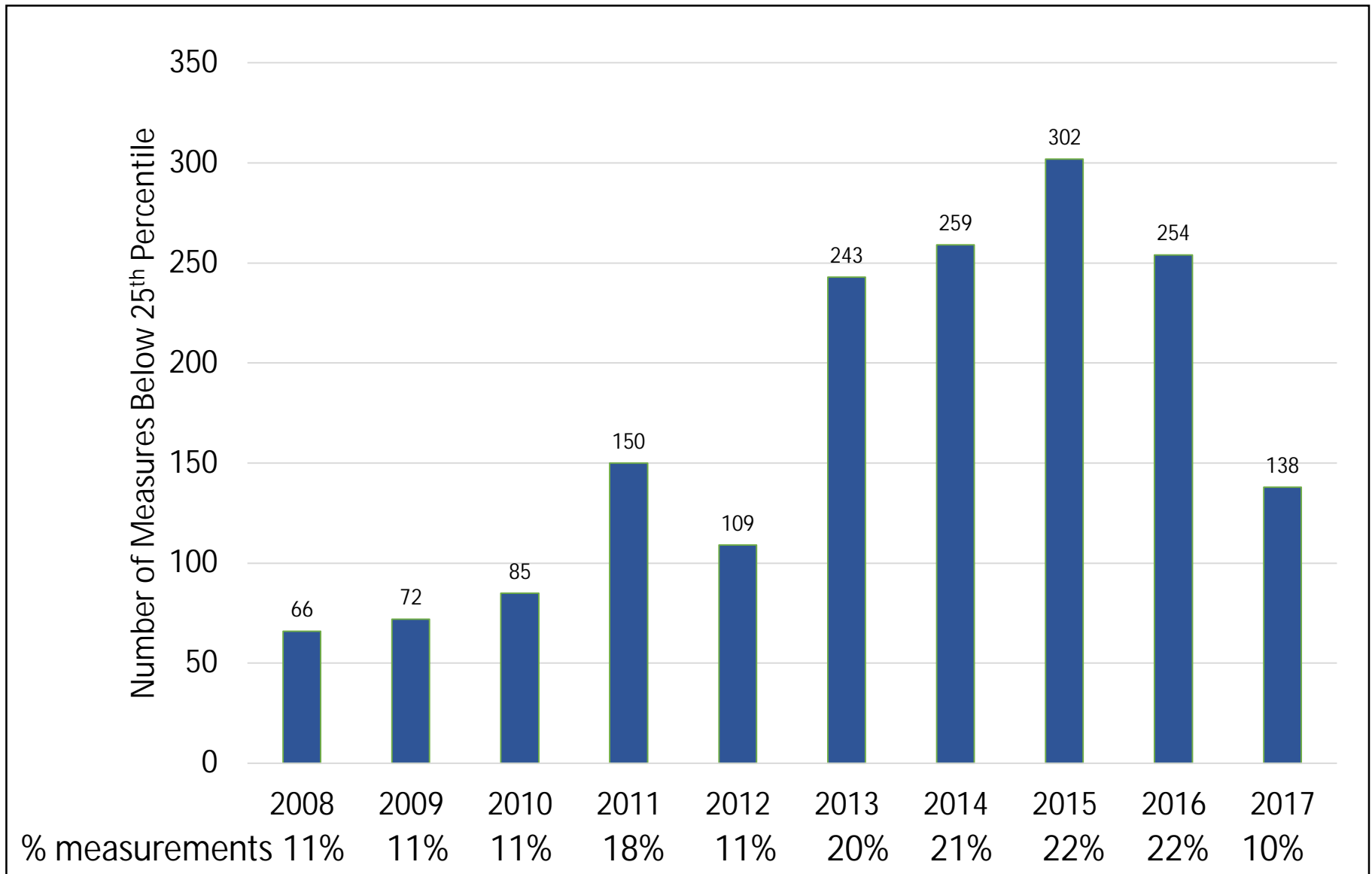
- Children's counseling
 - Weight: 56% to 77%
 - Nutrition: 64% to 76%
 - Activity: 48% to 69%
- Diabetes
 - Testing: 82% to 87%
 - Control: 48% to 51%
 - Poor control: 43% to 38%*
- Blood pressure control
 - 58% to 62%
- Breast cancer screening
 - 50% to 58%

* A lower rate is better for this measure.

Quality Declines

- Child access to primary care
 - 1–2 years: 96% to 93%
 - 2–6 years: 87% to 84%
 - 12–19 years: 86% to 83%
- Annual Well Child visit, 3–6 years
 - 76% to 74%
- Childhood immunization
 - 72% to 71%
- Timely prenatal care
 - 83% to 81%
- Cervical cancer screening
 - 69% to 56%

HEDIS Measurements Below 25th National Percentile by Year



Finding #2: Quality Varies Across MCPs

MCP Performance

- Large differences in quality across MCPs each year
- Little variability in relative ranking of MCPs across years (year-to-year correlation >0.8)
- MCP performance varies with ownership (public, non-profit, for-profit)

Example Measures: 2017

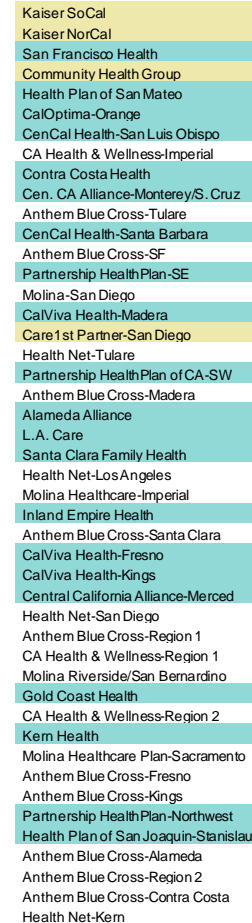
- Access to primary care (1–2 years)
 - 81–98%
- Cervical cancer screening
 - 38–86%
- Childhood immunization
 - 55–83%
- Diabetes HbA1c testing
 - 74–95%
- Blood pressure control
 - 45–89%

Ranking MCP Quality

Ranking MCPs

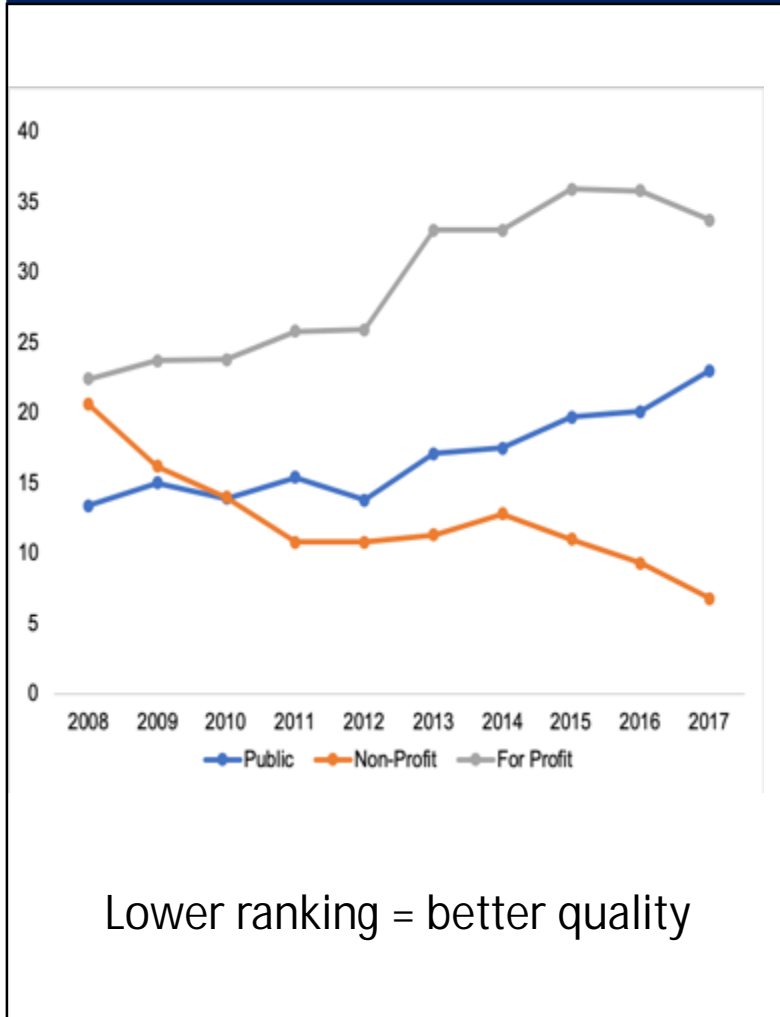
- MCPs ranked on how they score on each measure
- Ranks for each measure combined to create an overall MCP ranking
- On average, public MCPs and non-profit MCPs rank significantly better than for-profit MCPs

MCP Ranking: 2017

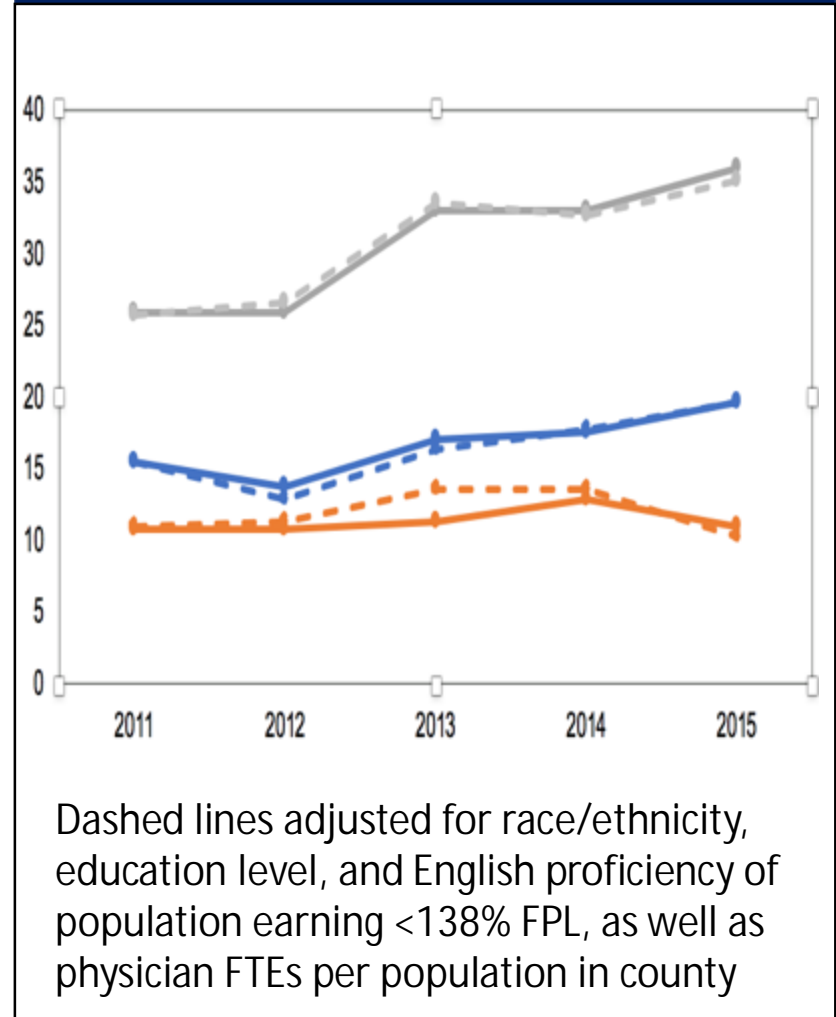


MCP Ranking by Ownership, Over Time

Unadjusted Ranking by Ownership



Adjusted for County Demographics and Physician Supply



HEDIS Measures Below National 25th Percentile by MCP Ownership: 2008–2017

MCP Ownership	Percentage of MCPs	Percentage of All Measures Below 25 th Percentile	Average Time to Resolve (Years)
For-Profit	47.5	66.8	2.3
Non-Profit	9.8	5.3	1.8
Public	42.6	27.9	2.0
Total	100	100	2.2

MCP Quality Ranking Within Two-Plan Counties

Year	Number of Counties in which MCP Ranked Higher	
	Public	For-Profit
2008	7	1
2009	7.5	0.5
2010	7	1
2011	5	3
2012	7	1
2013	11	0
2014	11	1
2015	9.5	2.5
2016	10.5	1.5
2017	12	0

Finding #3: MCP Choice Does Not Ensure Quality

- Competition among MCPs has the potential to drive quality improvement
- Choice of two or more MCPs in 34 of 58 counties
- Counties that furnish Medi-Cal managed care services through a single MCP (COHS) score better on average on quality measures than those relying on multiple MCPs even after adjusting for county demographics and MD supply
- Differences in model rankings have decreased over time with expansion of Medi-Cal managed care into rural areas

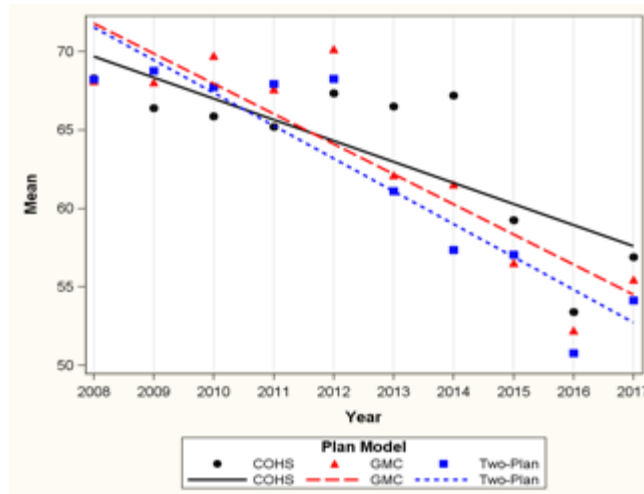
Managed Care Plan Competition

- MCPs don't compete on price but have auto-assignment incentive
- Beneficiaries who do not choose an MCP tend to be lower cost to manage
- Beneficiaries who do not choose an MCP assigned based in part on five HEDIS measures:
 - Cervical cancer screening
 - Diabetes HbA1c testing
 - Timely prenatal care
 - Well Child visits, ages 3–6 years
 - Childhood immunization

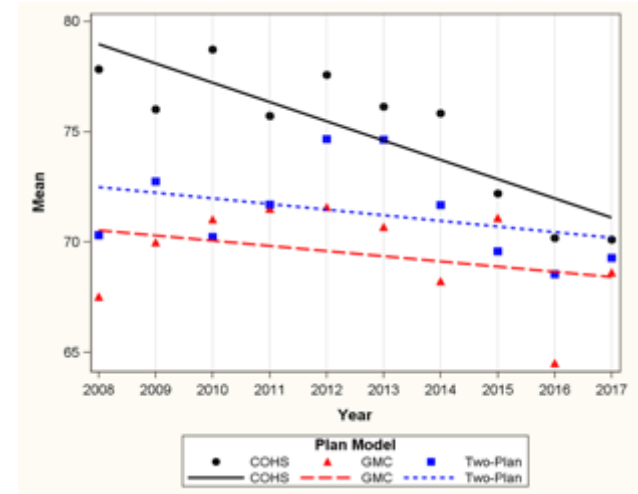
Auto-Assignment-Related HEDIS Measures

- COHS counties outperformed counties with competing MCPs on all five incentivized measures
- Counties with choice of MCPs had declines over time on four of five measures

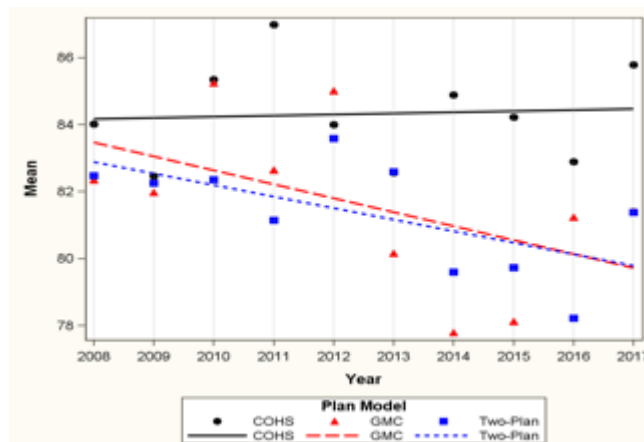
Cervical Cancer Screening



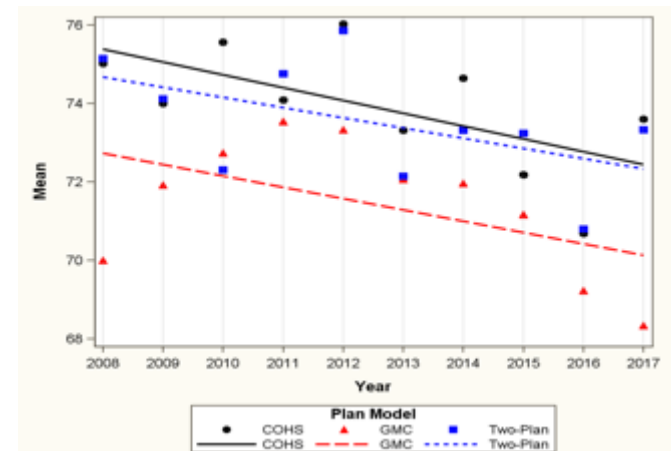
Child Immunization



Timely Prenatal Care



Well-Child Visits



Summary of Findings

What We Know

- Quality in Medi-Cal managed care has been inconsistent over time
- Quality scores in Medi-Cal managed are often below 25th percentile nationally
- There have been declines in children's access to care and women's health measures
- Quality varies across MCPs and by ownership of MCPs
- MCP choice is not enough to drive improvement

What We Don't Know

- Characteristics of MCP enrollees
 - Demographics
 - Eligibility categories
- Disparities by these characteristics
- Performance of delegated entities

What to Make of MCP Variation

Research Findings

- Not due to measured differences in county demographics
- Not due to physician supply
 - Total or primary care
- In some cases could reflect unique locations where MCPs operate
- Head-to-head competition between public and for-profit MCPs in Two-Plan counties suggest real differences in performance

Future Questions

- Difference in provider network capacity across MCPs?
- Difference in the penetration of the MCP in the provider's practice, which impacts level of cooperation between them?
- Difference due to type of providers in network (isolated or integrated)?
- Difference in the investment MCPs make in primary care, IT, and other strategies to support care management?

MCP Choice

- Less administratively efficient than relying on a single MCP
- On average producing lower quality than single public MCP, but there is variation in performance within county models, particularly with some of the newer MCPs and county expansion
- Auto-assignment as an incentive is not resulting in improvements in quality over time

Acknowledgments

- California Health Care Foundation
- Co-authors: Denis Hulett, Isabel Ostrer, Taewoon Kang
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- California Health Interview Survey (CHIS)
- California Medical Board



Raising the Bar: Strengthening Purchasing and Oversight of Medi-Cal Managed Care

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April 29, 2019



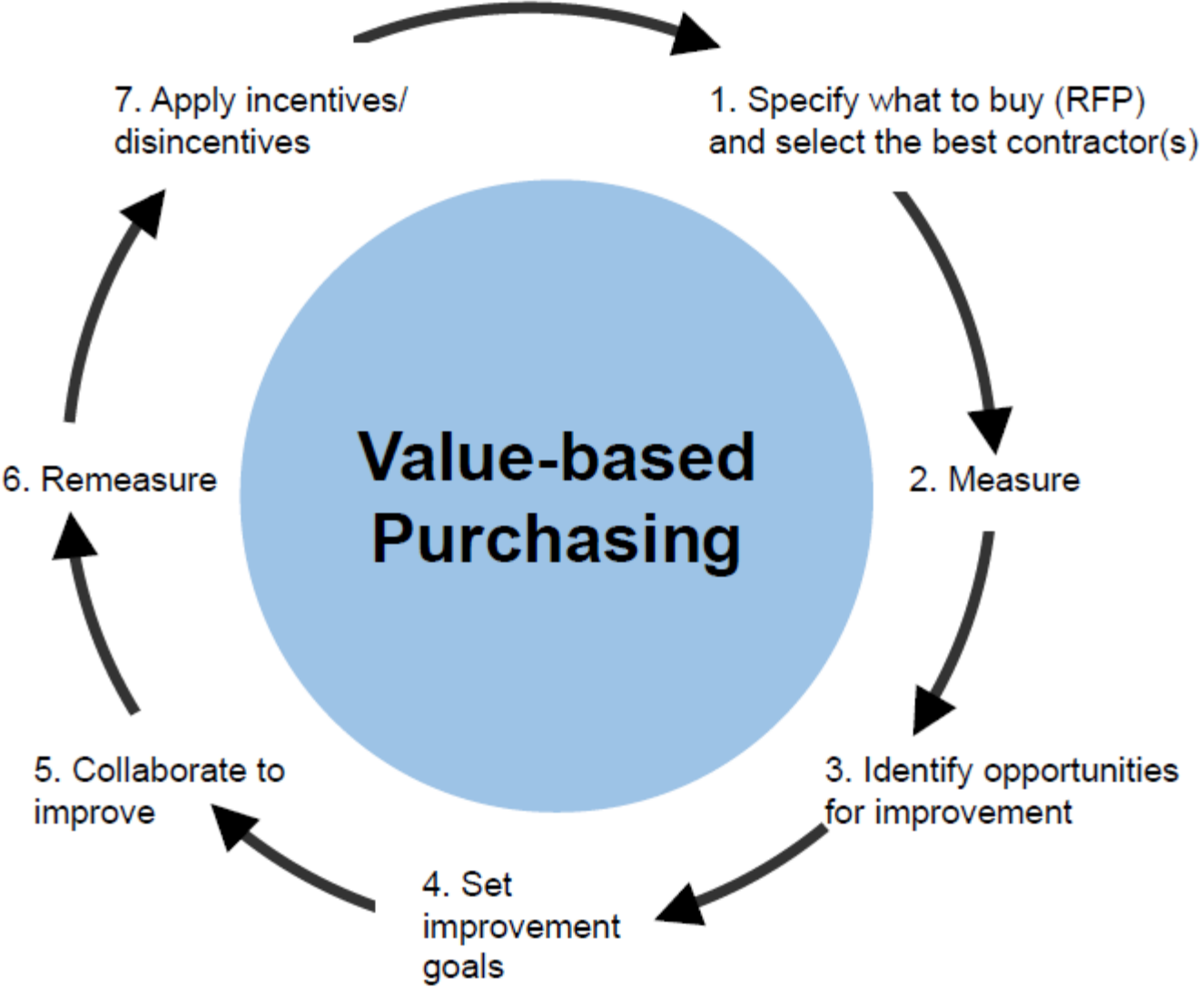
Background

- The California Department of Health Care Services (DHCS) has taken many steps in recent years to strengthen its oversight and monitoring of Medi-Cal managed care plans (MCPs).
- Some concerns persist, however, about Medi-Cal enrollee access, and there continues to be room for improvement in quality of care.
- Concern has also grown about transparency — for state officials and enrollees — of access, quality, and the financial health of medical groups to which Medi-Cal MCPs were delegating financial risk.
- Last year, with new administration and the start of Medi-Cal managed care procurement on horizon, CHCF contracted with Bailit Health to examine practices of other health care purchasers and recommend additional steps California should take.

Approach

- Identified strategies and tools used by active health care purchasers
- Reviewed MCP contracts:
 - In California: Medi-Cal, Covered CA, and CalPERS
 - Other Medicaid: Florida, Massachusetts, Tennessee, Texas, and Washington
- Interviewed experts:
 - In California: public purchasers, Medi-Cal MCP executives, consumer advocates, and others
 - Other Medicaid: senior Medicaid managed care staff

Purchasing for value is an ongoing cycle



Recommendations to state

Immediate

- Articulate a strategic vision for managed care and apply vision to MCP contracts
- Strengthen oversight of MCPs that delegate risk to another entity
- Enhance focus on quality measurement and reporting
- Apply both financial and non-financial incentives to improve performance
- Establish regular, plan-specific leadership meetings

Longer Term

- Improve operational simplification and coordination of MCP oversight
- Pursue greater alignment across DHCS initiatives and with other large purchasers
- Build upon efforts to improve access to care and measure network adequacy
- Implement a calendar of activities
- Continue to invest in training, particularly for MCP contract management staff

Articulate a strategic vision for managed care and apply vision to MCP contract

- Establish a 3–5 year vision for Medi-Cal managed care program, including clearly defined and measurable goals.
- Translate the vision into revised MCP contract requirements, including specific and measurable goals for MCPs.
- Shift focus from minimal compliance to one of excellence and continuous improvement.
- Establish a process for tracking progress and communicating with MCPs and key stakeholders to ensure they fully understand the new vision.

Articulate a strategic vision for managed care and apply vision to MCP contract

Current Approach

- DHCS publishes its quality strategy, MCP performance measures, and a Medi-Cal managed care performance dashboard
- However, MCPs and key stakeholders say they don't understand DHCS' vision for the program
- Governor Newsom has begun to articulate a new vision for oversight of Medi-Cal MCPs and a greater focus on child health

Best Practice: Massachusetts

- Medicaid managed care RFP included a vision statement and specific measurable goals and objectives linked to the managed care scope of work
- To ensure that stakeholders were aware of its strategy, Massachusetts conducted a widespread outreach campaign prior to the release of the Medicaid managed care procurement

Strengthen oversight of MCPs that delegate risk to another entity

- Add new MCP oversight approaches related to delegated entities':
 - Financial solvency
 - Impact on overall MCP network adequacy
 - Referral policies and beneficiaries' ability to access care
- Require MCPs to report on their use of risk-based alternative payment models with provider entities

Strengthen oversight of MCPs that delegate risk to another entity

Current Approach

- Contracts comply with minimum federal and state requirements for subcontracts
- DHCS provides less direct oversight of delegated entities and subcontractors, but has gotten involved in specific cases during the audit process
- DHCS is reviewing monitoring processes for “sub-delegates” and anticipates adding a component to the audit scope in the future

Best Practice: Florida

- Contract requires submission of subcontractors’ financial statements to the MCP for review
- Subcontractor must maintain an insolvency account equal to 2% of subcontract value
- If claims processing and payment is delegated, subcontractor must maintain a surplus account to meet its obligations
- If the MCP or subcontractor fails to comply with any delegation requirements, the MCP may be subject to sanctions or liquidated damages as specified in the contract

Enhance focus on quality measurement and reporting

- Make quality improvement an integral part of contract management and a focus of discussions between DHCS and MCP leaders.
- Set minimum MCP performance levels that are measure-specific.
- Focus on achieving excellence and continuous improvement over time.
- Create improvement targets for each measure based on current Medi-Cal MCP performance and national benchmarks.
- Regularly review and share plan-level and program-wide performance data to prioritize oversight activities.
- Pursue greater alignment on measure reporting and improvement expectations with Covered California, CalPERS, and Integrated Healthcare Association (IHA).

Enhance focus on quality measurement and reporting

Current Approach

- External quality review and audits
- Public reporting: Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) reports; Managed Care Performance Dashboard
- Recognizes performance through quality awards
- Auto-assignment based on performance outcomes
- Corrective action plans for performance below 25th percentile
- Proposed: Expand measure set; establish 50th percentile as minimum performance across all measures

Best Practice: Various

- Plan-specific public reports of MCP performance (TN and TX)
- MCPs are expected to improve their clinical quality performance year-over-year and meet performance measure-specific expectations tied to benchmarks (FL, MA, TN, TX, WA)
- Apply both sticks (penalties) and carrots (financial rewards) based on MCP-specific performance (FL, TN, TX, WA)

Apply both financial and non-financial incentives to improve performance

- Establish business case for MCPs to invest in quality and performance improvement on behalf of Medi-Cal beneficiaries.
- Share and discuss MCP-specific performance data with plans, consumer advocates, and other Medi-Cal stakeholders.
- Require MCPs to present their performance in person annually at regional meetings with DHCS and in the presence of stakeholders.
- Regularly publish data examining MCP performance over time, compared to other California MCPs and to national benchmarks where available.
- Assess financial penalties on MCPs whose performance on targeted measures falls below a minimum performance level.
- Create positive financial incentives for MCPs that are high-performing and/or that demonstrate significant improvement over time.

Apply both financial and non-financial incentives to improve performance

Current Approach

- Uses performance-based auto-assignment in regions where there is choice of MCPs
- Recognizes higher-performing plans as part of annual MCP quality awards
- Shares MCP performance dashboard and MCP-specific appendices in external quality review
- Requires corrective action plan for MCPs performing below 25th percentile
- Has general ability to impose sanctions

Best Practice: FL, MA, TN, TX, WA

- MCP performance incentives reflect state priorities and help establish a business case for quality
- Data on MCP performance actively used to:
 - Set performance improvement expectations
 - Compare MCP performance to benchmarks
 - Support public reporting
 - Prioritize MCP oversight activities
 - Apply specific financial incentives in the form of rewards and/or penalties

Improve operational simplification and coordination of MCP oversight

- Consider allowing DHCS to waive audits where Knox Keene-licensed Medi-Cal MCPs have had clean audits over a specified time period.
- Improve coordination with the Department of Managed Health Care (DMHC) to use resources more efficiently and reduce duplication. Potential areas for improved coordination include:
 - Network adequacy
 - Basic financial standards
 - Scheduling
 - Alignment of audit tools and scope
- Require MCPs to provide DHCS with a copy of any financial audit report and any public quality of care study or access study prepared by a federal or state regulatory agency, or by an accrediting body.

Improve operational simplification and coordination of MCP oversight

Current Approach:

- Comprehensive, legislatively-required audits on annual basis
- Coordination with DMHC where overlap
- Requires corrective action plans where plans don't meet contractual requirements or standards
- Conducts in-person meetings with individual MCPs as needed related to audits or corrective action plans

Best Practice: Tennessee

- Requires National Committee for Quality Assurance (NCQA) accreditation and MCP submission of NCQA reports
- Uses targeted, annual Medicaid audits, e.g., transportation and fraud
- Defers to state insurance department to conduct annual MCP financial and prompt pay/internal access audits
- Combines audit and other MCP oversight to ensure balance between focus on compliance and performance improvement
- Conducts scheduled, in-person meetings with Medicaid staff and individual MCPs on performance

Conclusion

- Operating a program as large and complex as Medi-Cal managed care requires significant resources and expertise.
- It is not uncommon for state Medicaid agencies to focus on compliance and lose track of the potential for improvement.
- DHCS should define and promote its vision, establish clear and measurable expectations for performance improvement, and provide meaningful financial and non-financial incentives.
- The upcoming Medi-Cal re-procurement offers a unique opportunity to reorient MCPs toward value-based performance improvement.
- DHCS should also consider how it can best leverage the enormous purchasing power of Medi-Cal to partner with other public purchasers.



Selecting Performance Measures for a Financial Incentive Program for Medi-Cal Managed Care Plans

Beth Waldman, JD, MPH
Bailit Health
April 29, 2019



Roadmap

- Introduction and purpose
- How other states hold health plans financially accountable for performance
- Advisory group process
- Measure selection process
- Performance measure set recommendations
- Performance evaluation methodology recommendations
- Next steps and key considerations for implementation

Background

- In April 2018, CHCF published *Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs*, which recommended a gain-sharing approach that would, if adopted, establish positive performance incentives for improving quality and reducing the cost of care.
- The report did not recommend which specific performance measures should be used and how they should be used.
- Picking up where that report ended, as one product of this engagement, CHCF published *Making Quality Matter in Medi-Cal Managed Care: How Other States Hold Health Plans Financially Accountable for Performance*.
- CHCF then worked with Bailit Health and an advisory group of Medi-Cal stakeholders to identify specific performance measures and assessment strategy for a financial incentive program for Medi-Cal managed care plans (MCPs).

How Other States Hold Health Plans Financially Accountable for Performance

No new state funding

- Bonus payment funded by withhold
- 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

Advisory Group Process

- CHCF convened the advisory group, and Bailit Health facilitated a series of four meetings between October 26, 2018, and February 1, 2019, to develop the measure set and performance evaluation methodology.
- The role of the advisory group was to advise on key elements of the performance measure set and performance evaluation methodology.
 - Each member was encouraged to offer ideas, provide feedback, and express preferences.
 - Advisory group members were not asked or expected to reach consensus.
 - The recommendations do not infer that full consensus was reached, or the support of individual members or their organizations.
- Advisory group members agreed on most recommendations.

Advisory Group Members

Member	Organization
Bill Barcellona, MD	America's Physician Groups
Greg Buchert, MD	Blue Shield of California Promise Health Plan
Joel Gray	Anthem Blue Cross
Sarah de Guia	California Pan-Ethnic Health Network
Brad Gilbert, MD	Inland Empire Health Plan
Giovanna Giuliani	California Health Care Safety Net Institute
Irina Harvey	Department of Managed Health Care
Susan Huang, MD	Health Plan of San Mateo
Kim Lewis	National Health Law Program
Bob Moore, MD	Partnership Health Plan
Linda Nguy	Western Center on Law and Poverty
Andie Patterson	California Primary Care Association
Jeff Rideout, MD	Integrated Healthcare Association
Anthony Wright	Health Access California

Measure Selection Process

- 1) Define the selection criteria
- 2) Identify domains and populations
- 3) Identify measure sources
- 4) Identify data sources and means to acquire data
- 5) Estimate the desired measure set size
- 6) Select the measures
- 7) Refine the measure set

Some Key Decisions

Measure Selection Criteria

- Be meaningful to patients
- Be meaningful to providers
- Be amenable to plan or provider influence
- Represent an opportunity for improvement
- Be nationally vetted or vetted by a California organization
- Have systemic impact on health if performance improves
- Be outcome-based, preferably
- Be feasible to collect with existing infrastructure
- Be pertinent to the Medi-Cal population
- Align with other measures currently in use in California, especially the Department of Health Care Services (DHCS) External Accountability Set (EAS)

Performance Domains

- Patient experience
- Preventive care/early detection
- Access
- Social determinants of health
- Care coordination
- Chronic illness care
- Maternity care
- Medication management

Also: Health disparities and equity should be threaded throughout performance measurement.

Measure Set Size

Size	Considerations
5–10 measures	<ul style="list-style-type: none">• Would focus MCP improvement efforts in highest priority areas, particularly if aligned with measures used in Medi-Cal auto-assignment• Would not allow for inclusion of measures in all domains of interest
12–15 measures	<ul style="list-style-type: none">• Would allow inclusion of 1–2 measures in each domain of interest• Would maintain some focus on priorities, but less focus than smaller measure set
20–25 measures	<ul style="list-style-type: none">• Would allow inclusion of 2–3 measures in each domain• Would signal an expectation that steps should be taken to increase performance• Would dilute incentives to improve any specific measure

Measure Selection

- Bailit Health analyzed more than 200 measures from nine measure sets.
- Winnowed down the list based on two considerations:
 - Measures appearing in two or more sets
 - High opportunity for improvement
- The advisory group was invited to submit “write-in” candidates
- Altogether, the advisory group discussed 43 measures, selecting 12.
- The strongest measures were those for which:
 - There was great variability in MCP performance and/or significant room for improvement
 - Improvement would have a significant impact on patient health
 - Improvement would affect a large Medi-Cal population
 - Data were already being reported to DHCS as part of the EAS

Recommended Measures

Domain	Measure
Preventive Care/ Early Detection	Breast cancer screening
	Cervical cancer screening
	Childhood immunization status — combo 3 or 10
	Chlamydia screening
	Immunizations for adolescents — combo 2
Care Coordination	Plan all-cause readmissions
Chronic Illness Care	Controlling high blood pressure
	Comprehensive diabetes care: HbA1c poor control (>9%)
Maternity Care	Cesarean rate for nulliparous, term, singleton, vertex (NTSV) births
	Prenatal and postpartum care
Medication Management	Asthma medication ratio
Patient Experience	Consumer Assessment of Healthcare Providers and Systems (CAHPS) — rating of health plan

Future Enhancements

- The advisory group recommended the following future enhancements to the measure set:
 - Include a depression measure when a valid and operationally feasible measure is available.
 - Include a statin measure once clinical guidelines have stabilized.
 - Continue efforts to stratify measurements by subpopulation.
 - Collect CAHPS survey data every year so that health plans can better understand their performance.
 - Use the DHCS timely access survey and Department of Managed Health Care (DMHC) access report as potential data sources in the future when there are mature methodologies and available benchmarks.

Using the Recommended Measures

- DHCS should use performance both as a gate to qualify a MCP for a financial reward and to tier rewards based on performance level, with higher levels of performance yielding higher rewards.
- DHCS should evaluate MCP performance both for high achievement and for improvement over time.
- DHCS should set the “gate” value at no lower than the 50th percentile. High achievement targets should vary by measure, and be informed by baseline performance and always be above baseline performance for nearly all MCPs.
- DHCS should set targets at an achievable level on an annual basis so that plans have a meaningful incentive to generate ongoing improvement.
- DHCS should give all measures equal weight for the purpose of allocating incentives.

Key Considerations and Lessons

- A stakeholder-involved process to inform the selection of a measure set and define an evaluation methodology might generally be expected to consume more than four meetings. Nonetheless, it:
 - Produced a thoughtful and well-reasoned set of recommendations
 - Demonstrated how a diverse mix of stakeholders can collaborate, exchanging perspectives and compromising, to reach agreement on substantive policy recommendations
- This effort was undertaken with understanding that the recommendations should be revisited when the governor and legislature are ready to move forward with a financial incentive program for Medi-Cal MCPs.
 - Clinical guidelines underlying the measures may have changed.
 - Some measures may have lost National Committee for Quality Assurance and/or National Quality Forum endorsement.
 - Measure specifications may have changed.
- State officials should articulate the goal of their incentive program and the financing method before finalizing the performance evaluation methodology in order to ensure alignment.



Panel Discussion

Panelists:

Bradley Gilbert, MD, MPH, CEO, Inland Empire Health Plan

Sarah de Guia, JD, Executive Director, California Pan-Ethnic Health Network

Jennifer Kent, MPA, Director, California Department of Health Care Services

Robert Moore, MD, MPH, MBA, Chief Medical Officer, Partnership Health Plan

Moderator:

Chris Perrone, MPP, California Health Care Foundation