California Health Care Foundation

Paying Medi-Cal Managed Care Plans for Value: Quality Goals for a Financial Incentive Program

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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.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Executive Summary

Across the country, many states are establishing clear performance expectations for their Medicaid managed care plans (MCPs) and adopting financial incentives tied to quality of care and other measures of performance.[1] California is not one of them, despite an abundance of poor MCP scores on many measures of quality and consumer experience.[2] Moreover, when Medi-Cal MCPs are able to reduce the cost of care, the state reduces their capitation rate — a phenomenon known as "premium slide" — even if they have improved quality of care and made health-related investments to address social determinants affecting individuals and communities.

A 2018 report from the California Health Care Foundation (CHCF) provided a recommendation for a performance incentive program that would address premium slide in Medi-Cal managed care.[3] This report picks up where that one left off. Specifically, this report provides recommendations for a measure set and performance evaluation methodology to encourage improvement in the quality of care provided to Medi-Cal beneficiaries by MCPs. These recommendations were developed over a series of four meetings with an Advisory Group representing a diverse array of Medi-Cal stakeholders, including Medi-Cal MCP leaders, consumer advocates, provider representatives, and other experts listed in Appendix A.

Recommended Performance Measures

Before selecting a set of performance measures for a financial incentive program, the Advisory Group established criteria after considering those adopted by national bodies and other states. They agreed that measures incorporated into a financial incentive program should:

- 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 charged with measure development for supporting evidence, validity, and reliability
- Have systemic impact on health if performance improves
- Be outcome-based, preferably
- Be pertinent to the Medi-Cal population
- Be feasible to collect with existing infrastructure
- Align with other measures currently in use in California, with special attention to measures in the Department of Health Care Services' External Accountability Set (EAS)[4]

After considering hundreds of measures and weighing options for the size of the measure set, 12 measures were selected. The 12 measures span six domains: preventive care / early detection, care coordination, chronic illness care, maternity care, medication management, and patient experience (Table 1).

Table 1. Recommended Measure Set, by 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
Maternity Care	▸ Cesarean Rate for Nulliparous Singleton Vertex Birth ▸ Prenatal and Postpartum Care
Medication Management	▸ Asthma Medication Ratio
Patient Experience	▸ Consumer Assessment of Healthcare Providers and Systems (CAHPS) – Rating of Health Plan

*Some Advisory Group members recommended Combination 3 because it includes the most important vaccinations, but others favored Combo 10, as it is the most complete and is used for NCQA accreditation and widely among other states. On March 7, 2019, after the Advisory Group's final meeting, DHCS announced its intention to move to Combination 10 for EAS Measurement Year 2019.

All of the recommended measures are found within the potential new Department of Health Care Services (DHCS) Measurement Year 2019 EAS measure set announced on March 7, 2019, at the Medi-Cal Managed Care Advisory Committee meeting.

The Advisory Group also determined that some important areas of Medi-Cal MCP performance that should be measured lack measures that meet the selection criteria. It recommended that California take the following steps to strengthen the incentive 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 to stratify measurement results by subpopulation to identify priorities for reducing disparities.
- Conduct the CAHPS survey annually.
- Incorporate access data from the DHCS timely access survey and/or the California Department of Managed Health Care (DMHC) access report when there are mature methodologies and available benchmarks.

Performance Evaluation Methodology Recommendations

There are many approaches states have taken when applying performance measures to a financial incentive program for Medicaid managed care. The Advisory Group considered and addressed four key design questions in constructing its recommended methodology. Table 2 presents four design questions considered by the Advisory Group and the resulting recommendation.

Key Considerations for Implementation

Adopting financial incentives tied to performance would focus the attention of Medi-Cal MCPs on key state priorities and could accelerate the MCPs' performance improvement efforts and improve health outcomes for over 10 million Californians enrolled in Medi-Cal managed care. The performance evaluation methodology discussed by the Advisory Group and recommended in this report does not benefit from knowing a specific state goal or a defined financing method (e.g., from state revenues or from MCP savings or capitation withholds). These are critical factors, however, and some modifications to the recommendations may be desirable once the specific program goal and financing method are established. Moreover, before the financial program is implemented, California would need to consider any changes in clinical guidelines, changes to measure specifications, and changes to measure endorsement from national organizations made between the time of this report and implementation.

Table 2. Performance Evaluation Methodology Design Questions

	RECOMMENDATION
Should performance scores be used as a "gate" that a Medi-Cal MCP must pass to qualify for financial incentives, or as a "ladder" in which the state tiers its financial rewards based on level of MCP performance?	Medi-Cal should use a combined "gate-and-ladder" model for assessing performance for the allocation of incentives.
Should California evaluate MCP performance for high achievement, improvement over time, or performance superior to the competition?	Medi-Cal should reward both high achievement and improvement over time.
How high must be performance to be evaluated positively?	When awarding achievement, Medi-Cal should set targets that are measure-specific. For improvement, Medi-Cal should set targets at an achievable level annually so that plans have a meaningful incentive to generate ongoing improvement.
Should DHCS weight some measures more than others?	Medi-Cal should give all measures equal weight for the purpose of allocating incentives.

Introduction and Purpose

California has the largest Medicaid managed care program in the country by far. With over 10 million enrollees, it is twice the size of the next largest Medicaid managed care program. Close to 90% of Medi-Cal enrollees with full-scope coverage, and one in four of all Californians, get their care from a Medi-Cal managed care plan. Yet despite the importance of Medi-Cal managed care to the people of California, quality of care is highly variable among Medi-Cal managed care plans (MCPs), and consumer satisfaction routinely ranks well below the national average. For example, in 2017, on average across all Medi-Cal MCPs, nearly half (46%) of women did not receive their recommended cervical cancer screening.

The Department of Health Care Services (DHCS) uses many tools available to manage MCPs, such as competitive procurement, contract management and oversight, public reporting, and penalties. However, one tool that many other states use that California does not is financial incentives tied to quality and other measures of Medi-Cal MCP performance.[5] Moreover, when Medi-Cal MCPs are able to reduce the cost of care, the state reduces their capitation rate — a phenomenon known as "premium slide" — even if they have improved quality of care and made health-related investments to address social determinants affecting individuals and communities.

In April 2018, the California Health Care Foundation (CHCF) published *Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs*,[6] which recommends 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, however, recommend which specific performance measures should be used and how they should be used. Picking up where that report left off, CHCF hired Bailit Health, formed an Advisory Group, and charged that body with developing a recommended performance measurement set and assessment strategy for a financial incentive program for Medi-Cal MCPs.

This report presents the approach and outcomes of that project. It provides a path forward for California and demonstrates that a diverse group of stakeholders — one that included MCP and provider representatives, consumer advocates, and other experts — could coalesce around a shared vision of the measurement set criteria, size, and measures.

Medi-Cal has many of the necessary building blocks for a financial incentive program tied to MCP performance, including collection of a robust set of access, quality, and patient experience measures, and a Medi-Cal managed care performance dashboard.[7] In all counties where beneficiaries have a choice of two or more plans, Medi-Cal uses six performance measures to assign beneficiaries to a plan if they do not choose one themselves. A financial incentive program would be a positive next step, one already taken by many other state Medicaid programs and by commercial and Medi-Cal MCPs in California that operate provider incentive (pay-for-performance) programs.

Approach and Methodology

CHCF convened an 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 Advisory Group included a mix of health plan, provider and consumer representatives, along with technical measurement experts (Appendix A).

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. The Advisory Group members were not expected to reach consensus and, as such, Advisory Group recommendations presented in this report do not imply that full consensus was reached. Nonetheless, the members of the Advisory Group found shared agreement on most points.

An incentive program design should reflect the goal of the incentive program and the financing method. For example, a performance incentive program designed to ensure that quality is acceptable before shared savings are distributed may have different design characteristics than one that allocates bonus dollars for high achievement. The evaluation methodology discussed by the Advisory Group and recommended in this report does not benefit from a specific goal or financing method. Once state officials finalize those decisions, some modification to the recommendations presented in this report may be desirable. Nonetheless, these recommendations

should generally prove themselves robust whatever goal and financing decisions are reached in the future. Also, because the goal was to develop recommendations that would undergo further review by state officials and other stakeholders, and not to design a methodology for date-certain implementation by DHCS, the Advisory Group did not develop recommendations at the level of detail that will be required for implementation.

Measure Selection Process

The measure selection process involved seven steps: (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, and (7) refine the measure set. Each step is described below with corresponding recommendations from the Advisory Group.

Selection Criteria

The Advisory Group established measure selection criteria that served as parameters for deciding which measures should be included and excluded from the measure set. They were selected following consideration of criteria adopted by national bodies and by other states. The Advisory Group recommended that measure selected for a financial incentive program for Medi-Cal MCPs should:

1. Be meaningful to patients
2. Be meaningful to providers
3. Be amenable to plan or provider influence
4. Represent an opportunity for improvement
5. Be nationally vetted or vetted by a California organization charged with measure development for supporting evidence, validity, and reliability
6. Have systemic impact on health if performance improves
7. Be outcome-based, preferably
8. Be pertinent to the Medi-Cal population
9. Be feasible to collect with existing infrastructure
10. Align with other measures currently in use in California, with special attention to measures in DHCS's External Accountability Set (EAS)

These criteria generally align with the National Quality Forum's criteria, with a few exceptions. Criteria eight and ten listed above are specific to Medi-Cal. Another reflects the Advisory Group's sentiment that it is important to increase use of outcome measures even though most measures in use today are process measures. These criteria also align with the newly released DHCS goals for its EAS. A full comparison of the EAS and Advisory Group measure selection criteria can be found in Appendix B.

Domains and Populations

The Advisory Group was asked to identify and prioritize performance domains and Medi-Cal populations it wanted represented in the measure set recommendations. It was given a comparative analysis of domains used in four other states (Massachusetts, Oregon, Rhode Island, Washington) in their measure set development processes and those employed by the Integrated Healthcare Association (IHA). The Advisory Group also considered the five program goals established by DHCS in its Medi-Cal Managed Care Quality Strategy Report: maternal and child health, chronic disease, tobacco cessation, reducing health disparities, and fostering healthy communities through reducing opioid misuse and overuse.[8] These priorities were mapped to the candidate measures for consideration.

The performance domains that received the most support were patient experience, preventive care / early detection, access, social determinants of health, care coordination, and chronic illness care. The Advisory Group subsequently elected to add maternity care as a domain given the large number of births for which Medi-Cal is responsible, and medication management, due to interest in inclusion of an asthma treatment–related measure.

The Advisory Group also recommended that DHCS continue its efforts to measure and reduce health disparities and that equity be considered throughout performance measurement. It recommended that DHCS conduct subpopulation analysis as an ongoing practice. This was recommended in lieu of a single statewide disparity measure because regional analysis was reported to have revealed that disparities differ in nature across California counties.

Measure Sources

The Advisory Group sought to align its recommended measure set with other measures currently in use in California. Measure set alignment helps focus plan and provider improvement efforts on high priorities and reduces some of the administrative burden associated with reporting and acting upon performance measures. Measure sets recommended by one or more Advisory Group members included the following:

- Core Measure Sets jointly developed by the Centers for Medicare and Medicaid Services (CMS) and America's Health Insurance Plans (AHIP)
- CMS Medicaid Adult Core Set
- CMS Medicaid and Children's Health Insurance Program Child Core Set
- Covered California Measure Set (plus its disparities measures)
- DHCS EAS for MCPs and Specialty Health Plans[9]
- DHCS Managed Care Performance Monitoring Dashboard Report
- IHA "Align. Measure. Perform." Measure Set — Medi-Cal Managed Care
- Medi-Cal Managed Care and Mental Health Office of the Ombudsman
  - California Department of Social Services (CDSS) Continuum of Care Reform Mental Health Care Measures[10]
  - CDSS Medi-Cal State Hearing Data Statistics
- National Quality Forum (NQF) disparities measures

Data Sources

There were four primary data sources for the measures found within the above-named measure sets: clinical data, claims or encounters, nonclaims administrative data, and survey data. Although data availability is often a significant constraint on measure options, the Advisory Group did not recommend eliminating from consideration any of the four data sources.

IHA Measure Set and Related Activity

The nonprofit Oakland-based Integrated Healthcare Association (IHA) has developed both a recommended Medi-Cal measure set and a performance incentive methodology for voluntary adoption by MCPs with their network providers. The "Align. Measure. Perform." (AMP) program's recommended Medi-Cal managed care measure set focuses on clinical quality, patient experience, utilization, and cost of care measures. IHA collects data from selected Medicaid providers and calculates their performance.[11] IHA also created a shared savings model for use by Medi-Cal managed care plans with their providers. This value-based incentive design recommends payment based on quality, cost, and resource use for physician organizations.[12]

Both the measure set and shared savings model for Medi-Cal are extensions of IHA's 15-year program for over 200 physician organizations and 10 health plans serving commercial HMO enrollees. The AMP Commercial HMO program is one of the nation's largest and longest-running alternative payment models and serves nearly 10 million enrollees. Provider organizations serving both Medi-Cal and commercial HMO members benefit from a common measure "superset" that is continuously evaluated and maintained by active and regular participation of health plans and provider organizations participating in the program with standing academic, regulator, and accreditation organizational support.

Although this project differs from IHA's work in important ways — namely, that this project is directed at incentives from a state purchaser (DHCS) to MCPs, whereas IHA's work focuses on incentives from MCPs to their network providers — there are, nevertheless, benefits to alignment and important lessons to be learned from IHA's experience. Materials and feedback provided by IHA informed the development of the recommended measure set and performance evaluation methodology for this project.

Measure Set Size

The Advisory Group was asked to consider three options for the size of the measure set (Table 3).

Table 3. Measure Set Size Options

	CONSIDERATIONS
5–10 measures	▶ 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	▶ 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	▶ Would allow inclusion of 2–3 measures in each domain ▶ Would signal an expectation that steps should be taken to increase performance across the board rather than focused on narrow set of measures

It is important to consider the purpose and use of the measure set when considering its size. Anticipating at the time that the measure set was to be used as a "gate" in which performance qualifies eligibility for shared savings, the Advisory Group recommended a more limited measure set of approximately 5 to 10 measures. The Advisory Group subsequently accepted that this same size measure set could be used in a manner other than as a "gate," such as a ladder system in which bonus payments are tiered according to level of performance or performance improvement.

Even among Advisory Group members who agreed on a smaller measure set, some expressed concern with limiting the size of the measure set. For example, one member noted that given the breadth and depth of the Medi-Cal population, he was unsure how to limit the size of the measure set while retaining the measures most appropriate for each given subpopulation. Overall, however, the Advisory Group recognized that financial incentives tied to performance were just one of several ways DHCS should manage MCP performance, and that additional performance measures would continue to be part of other improvement efforts, such as MCP-specific accreditation work, public reporting of EAS measures, statewide and plan-specific quality improvement projects, and penalties for very poor performance.

Analysis of Candidate Measures

Bailit Health analyzed over 200 measures from the ten measure sets identified by the Advisory Group, and then winnowed down the list of individual measures to be considered by the Advisory Group based on two considerations:

- **Measures appearing in two or more measure sets.** Bailit Health sorted all measures by domain and calculated the number of measure sets within which each measure appeared. For most domains, Bailit Health only selected measures appearing in two or more sets. For domains with measures found in only one set, Bailit Health included all measures.
- **High opportunity for improvement.** Bailit Health reviewed Medi-Cal MCP performance on EAS measures appearing in at least one other measure set of interest to the Advisory Group to determine which measures had the highest opportunities for improvement.[13] High-opportunity areas were those for which a measure has (1) a low statewide average score, defined as weighted performance below the Healthcare Effectiveness Data and Information Set (HEDIS)[14] HMO 50th percentile, and (2) significant variability among plans, defined as a greater than 15 percentage point difference between the plans with the third-lowest and third-highest scores. Additional data on high-opportunity EAS measures can be found in Appendix C.

Consideration of Candidate Measures

The Advisory Group considered candidate measures from the subset identified by Bailit Health. They were then invited to submit "write-in" measures — that is, measures of high interest that had not yet been considered by the group. Altogether, the Advisory Group discussed 43 measures. A summary of the outcome of this discussion is provided in Appendix D.

During its review, the Advisory Group applied the selection criteria described above and was particularly favorable toward measures for which:

- There was great performance variability 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

As the Advisory Group reviewed candidate measures, it identified a few measures that were not selected for the incentive measure set but which the group believed were of high importance and of value to include in measure sets used for other purposes, such as oversight, public reporting, and identifying statewide and plan-specific performance improvement projects. These measures are noted in Appendix D.

Refinement

After conducting its initial review of candidate measures, the Advisory Group assessed the draft recommended measure set. The Advisory Group considered:

- Gaps by measure domain or population age group
- The size of the draft recommended set
- Whether it wanted to reconsider any of the endorsed measures
- How well the measures met the measure selection criteria

The Advisory Group reviewed the 12 measures it initially recommended for further consideration and decided to endorse all measures for recommendation. These 12 measures represent a slightly larger set than the Advisory Group's earlier recommendation of 5 to 10 measures.

Performance Measure Set Recommendations

Table 4 lists the performance measures that the Advisory Group recommended DHCS consider using if California adopts a financial incentive program for Medi-Cal MCPs tied to performance.

The recommended measure set contains 2 measures addressing children, 5 addressing adolescents, and 10 addressing adults (Appendix E). The populations between these categories are not mutually exclusive: Asthma Medication Ratio, for example, reflects care provided to children, adolescents, and adults.

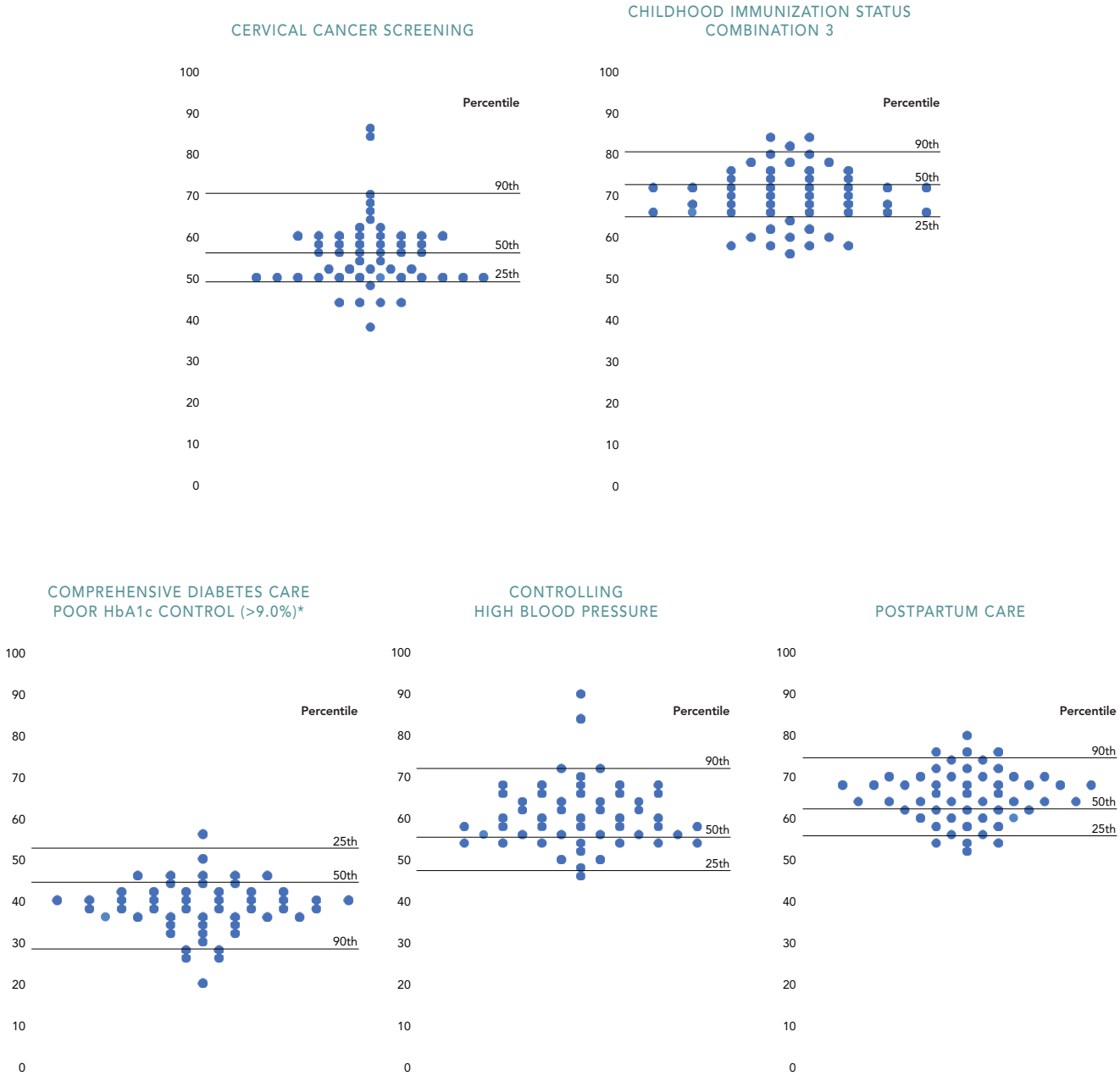
An analysis of Medi-Cal MCP scores for the recommended measures demonstrates the significant opportunity for improving health care quality and outcomes for California Medi-Cal beneficiaries (Figure 1, page 10).

Table 4. Performance Measures Recommended for Financial Incentive Measure Set, by Domain

	MEASURE (NQF NUMBER)	RATIONALE FOR SELECTION
Preventive Care / Early Detection	▶ Breast Cancer Screening (2372)	Screening impacts a large population, there is opportunity for improvement, and screening has a direct impact on mortality.
	▶ Cervical Cancer Screening (0032)	Performance is poor and there are disparities in performance.
	▶ Childhood Immunization Status – Combo 3 or 10* (0038)	Immunization is an important aspect of pediatric care.
	▶ Chlamydia Screening (0033)	The measure focuses on reproductive-age women potentially experiencing domestic violence.
	▶ Immunizations for Adolescents – Combo 2 (1407)	Concrete positive impact on outcome, with low median performance and high variation by plan.
Care Coordination	▶ Plan All-Cause Readmissions (1768)	A measure involving hospitals is important because they are a significant part of the care delivery system and readmissions are costly.
Chronic Illness Care	▶ Controlling High Blood Pressure (0018)	Performance has a high impact on morbidity and mortality, and there is room for improvement.
	▶ Comprehensive Diabetes Care: HbA1c Poor Control (>9%) (0059)	Clinically meaningful and high variability in performance. The Advisory Group selected this measure over the HbA1c Control (<8.0%) measure because diabetes complications increase dramatically around 9%.
Maternity Care	▶ Cesarean Rate for Nulliparous Singleton Vertex Birth (0471)	An important measure with opportunity for improvement.
	▶ Prenatal and Postpartum Care (1517)	Important measures of access, affecting a large Medi-Cal population, with room for improvement and disparities in performance.
Medication Management	▶ Asthma Medication Ratio (1800)	Asthma is an important issue for the Medi-Cal population, and this is the only chronic illness measure included for children and adolescents.
Patient Experience	▶ CAHPS – Rating of Health Plan (0006)	CAHPS is currently the only standardized measure for patient experience.

*Some Advisory Group members recommended Combination 3 because it includes the most important vaccinations, but others favored Combo 10, as it is the most complete and is used for NCQA accreditation and widely among other states. On March 7, 2019, after the Advisory Group's final meeting, DHCS announced its intention to move to Combination 10 for EAS Measurement Year 2019.

Figure 1. Medi-Cal Managed Care Plan HEDIS Scores for Selected Recommended Measures



*Indicates measures in which lower scores reflect better quality. In all other cases higher scores reflect better quality.

Notes: *HEDIS* is the Healthcare Effectiveness Data and Information Set. Each dot represents one plan. Percentile notations are national rankings.

Sources: The source for HEDIS® Medicaid benchmark data contained in this publication is Quality Compass® 2017 and is used with the permission of the National Committee for Quality Assurance (NCQA). Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. The HEDIS® Medicaid 25th, 50th and 90th percentiles reflect the measurement year from January 1, 2016 through December 31, 2016. Data are from Managed Care Quality and Monitoring Division California Dept. of Health Care Services, *Medi-Cal Managed Care External Quality Review Technical Report: July 1, 2016–June 30, 2017* (April 2018), www.dhcs.ca.gov (PDF).

Reflecting on key gaps in the list of 12 measures, including the absence of any measures from the access domain, the Advisory Group recommended that DHCS make 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 DMHC access report as potential data sources in the future when there are mature methodologies and available benchmarks.

The other domain of significant interest to the Advisory Group that is not represented in the recommended measure set is social determinants of health. While recognizing the important role that social determinants play in the health of individuals and communities, Advisory Group members noted that Medi-Cal does not cover services to address social determinants (although many MCPs are drawing from savings to address social determinants in targeted ways) and that there are currently no nationally recognized MCP measures for this domain.

Performance Evaluation Methodology

Integration of performance measurement with payment creates an economic motivation for managed care plans to make significant investments in targeted, high-priority areas. These investments hold the potential to improve the quality and outcomes of care for Medi-Cal beneficiaries.

The means by which performance on selected measures is translated into financial consequences requires careful consideration; poorly constructed evaluation methodologies will not motivate plan investment or influence measurable improvement. This section of the report reviews key design considerations for a performance evaluation methodology and examples from other states, and then summarizes Advisory Group recommendations for the Medi-Cal program.

Design Considerations and Recommendations

State Medicaid programs have taken many approaches to evaluating health plan performance as a means for applying financial rewards. Over time, states have studied the approaches of their peer states and often borrowed approaches for application in their own state. Each state has considered and addressed the following four key design questions when constructing its methodology.

Should DHCS Use Performance as a Gate to Qualify a MCP for a Financial Reward, Should It Tier Rewards Based on Performance Level, or Both?

The Advisory Group was asked to consider three approaches: a qualifying "gate" that ensures that only those MCPs that meet specific performance expectations qualify for financial incentives; a tiered "ladder" where the amount of the financial incentive increases as performance increases; or a combination of the two. Maryland uses a qualifying gate; Texas and the District of Columbia (see Table 5, page 13) both use a gate and a ladder.[15] In some cases, the ladder can extend "below ground," with poor or deteriorated performance generating a financial penalty or an offset to rewards earned on other measures. Texas's ladder methodology operates with increasing penalties for poor performance.

Table 5. District of Columbia "Gate-and-Ladder" Incentive Design

QUALITY MEASURE	WEIGHT (OUT OF 100%)	EARNED INCENTIVE (REDUCTION COMPARED TO BASELINE) <2%	2%	3.5%	5%
Potentially Preventable Admissions	33%	0%	50%	75%	100%
Low-Acuity Non-Emergent Emergency Department (ED) Visits	33%	0%	50%	75%	100%
30-Day All-Cause Readmissions	34%	0%	50%	75%	100%

Source: *Medicaid Managed Care: 2017 Annual Technical Report*, District of Columbia Dept. of Health Care Finance, April 2018, dhcf.dc.gov.

The Advisory Group recommended that DHCS use an incentive structure with both a gate and a ladder. It believed that DHCS should determine if performance is adequate to qualify a MCP for an incentive and also assess achievement at one or more tiers above the qualifying gate to provide heightened incentive and rewards for superior performance. The gate would ensure that MCPs with poor performance are not rewarded, and the tiers (ladder) would provide an incentive for MCPs whose performance exceeds the gate to achieve higher levels of performance.

Should DHCS Evaluate MCP Performance for High Achievement, Improvement, Performance Superior to the Competition, or Some Combination Thereof?

The first impulse for many states designing MCP performance incentive programs is to assess MCPs against high achievement[16] standards or benchmarks, reasoning that only those performing well should receive a reward. There are two significant limitations to such an approach: Among MCPs that were high performing prior to creation of the incentive, the financial incentives would have no impact on their motivation to improve their performance; and low performers won't invest resources to improve their performance if they find the high achievement standard or benchmark unattainable. Nevertheless, some states — including Maryland and New York — use this approach.[17]

Another option, employed by Tennessee, is to reward MCPs only for performance improvement[18] (Table 6). This entails comparing a MCP's own performance in a preceding year, or perhaps two preceding years, to the most recent performance period. Yet assessing improvement alone also has a limitation: MCPs with high baseline performance and limited or no opportunity for further improvement may find there is no opportunity to receive financial incentives despite their high performance.

Table 6. Tennessee "Improvement" Example

BASELINE RATE	MINIMUM EFFECT SIZE
0–59	At least a six percentage point change
60–74	At least a five percentage point change
75–84	At least a four percentage point change
85–92	At least a three percentage point change
93–96	At least a two percentage point change
97–99	At least a one percentage point change

Source: *Contractor Risk Agreement Between the State of Tennessee and Volunteer State Health Plan, Inc.*, Blue Cross Blue Shield of Tennessee, accessed February 13, 2019, www.bcbst.com (PDF).

A third option is a combination of the two: evaluate contracted MCPs for both high achievement and improvement. Oregon, Texas, and Washington have all adopted this option.[19]

A fourth approach, used by Arizona, is to assess MCP performance relative to that of plan competition in the state.[20] This approach creates winners and losers, even when multiple MCPs excel or improve, and can diminish motivation to improve. Consequently, it is used less often by states. It is, however, the approach DHCS employs for its performance-based auto-assignment algorithm in which Medi-Cal beneficiaries who don't choose a MCP themselves are assigned to a plan by DHCS.[21] In that context, it makes sense, as members needing to be assigned to a

plan is a "fixed pie" that needs to be divided up among participating MCPs that operate in the region where the members live. By contrast, financial incentives do not need to be allocated from a predefined pool of funds.

There are other important considerations when deciding whether and how to evaluate MCP performance for achievement, improvement over time, performance superior to the competition, or some combination thereof. These include the following:

- Should DHCS assess whether there has been deterioration in performance over time for any of the measures? States sometimes evaluate deterioration and adjust incentive rewards so that MCPs aren't financially rewarded when performance deteriorates — for example, preventing a plan that improves on one measure but declines on three others from being rewarded for the one improved measure, or preventing the allocation of an incentive to a plan that improved modestly after declining precipitously the preceding year.
- If DHCS rewards a combination of high achievement, improvement, and/or competitive superiority, should one be rewarded more highly than another?
- If DHCS assesses performance achievement, should it utilize national benchmarks (if available for a given measure), state benchmarks, or absolute values not pegged to a benchmark? States often use national benchmarks from the National Committee for Quality Assurance (NCQA) for their HEDIS measures and state benchmarks for non-HEDIS measures.
- If assessing performance improvement, should DHCS define improvement in absolute terms (e.g., four percentage points) or in statistical terms (e.g., statistically significant improvement at $p \leq .05$)? Use of absolute terms is simpler to administer, but is far less precise and fair than statistical testing.

If assessing performance improvement, at what level should additional improvement no longer be expected due to high achievement and/or diminution of opportunity?

The Advisory Group recommended that DHCS reward both high achievement and improvement over time. It thought that the goal of a value-based purchasing strategy is to improve value over time[22] and that DHCS should reward improvement as highly as it does high achievement. California needs its lowest performing Medi-Cal MCPs to improve in order to lift the performance of the entire Medi-Cal program and to close gaps in health equity. DHCS may need to take time to explain this concept to key stakeholders, including legislators, as it is not always intuitive why a state would want to financially reward what appear to be poorly performing MCPs. The Advisory Group also thought that DHCS should consider negative adjustments for MCPs with evidence of deteriorated performance, as is DHCS's current practice with its performance-based auto-assignment model.

How High Must a MCP's Performance Score to Be Evaluated Positively?

Determining what performance scores define high achievement or how large an improvement must be for incentive allocation is critical to a successful incentive design. If the bar is set too low, the performance incentive may have no impact on plan behavior or performance, except perhaps for the very poorest performers. The impact may be similar if the bar is set too high and MCPs gauge that they cannot achieve the necessary level of performance for the reward or that the effort required to attain the high achievement target level is too great relative to the available plan resources or the size of the potential reward.

Bailit Health recommended that states adopting financial incentives tied to MCP performance should consider the following:

- If adopting high achievement targets, set those targets on a measure-by-measure basis and at levels that are reasonably attainable for at least some MCPs, so that they are motivated to reach them.
- If adopting improvement targets, set the required improvement percentages at levels that seem reasonable and attainable, even if not statistically significant. Doing so should provide MCPs with sufficient motive to invest effort in improvement. It is exceedingly difficult to attain statistically significant improvement year after year, and steady progress in smaller increments will produce statistically significant improvement over time.

New York's high achievement target value of the national 90th percentile (Table 7) would be too high for California for some measures, as performance on quality measures in the nation's northeast is generally higher than in California. Medi-Cal MCP performance varies relative to national benchmarks when reviewed across a broad array of quality measures, so it may not be appropriate for DHCS to set a single value (if expressed as a percentage of the national average as New York does) across all measures.

Table 7. New York "High Achievement Level" Example, with Tiers

PLAN PERFORMANCE (HEDIS BENCHMARKS)	POINTS EARNED
<50th percentile	0
50th to <75th percentile	50% of possible points
75th to <90th percentile	75% of possible points
90th+ percentile	100% of possible points

Source: *2017 Quality Incentive for Medicaid Managed Care Plans*, New York State Dept. of Health, accessed February 13, 2019, www.health.ny.gov (PDF).

The Advisory Group recommended that DHCS set improvement targets at an achievable level on an annual basis so that plans have a meaningful incentive to generate ongoing improvement. Some managed care plans will make special staff and financial investments to improve and sustain performance only if they perceive linked financial rewards to be reasonably attainable.

Inspired in part by the approach used by the Oregon Health Authority with its contracted coordinated care organizations, the Advisory Group supported adoption of the following approach:

- Set the "gate" value for a given measure at no lower than the 50th percentile level, whether using NCQA national benchmarks for Medicaid managed care or state-level Medi-Cal benchmarks. (On March 7, 2019, DHCS announced that it intended to raise its Minimum Performance Level expectations for MCPs from the 25th percentile level to the 50th percentile level for Medicaid plans in the US where that information is available and the services are delivered by MCPs.)
- Set high achievement target values at either the 66th, 75th, or 90th percentile level depending upon baseline performance for a given measure. The high achievement benchmark should be above the performance of nearly all MCPs.
- If it is less than the 90th percentile, raise the high achievement target periodically if a considerable percentage of plans meet or exceed it.
- Set the improvement target value for each measure at two or three percentage points, depending upon the proximity of general MCP prior-year performance to the high achievement target. Two or three percentage points is unlikely to be significant improvement in a given year but will be cumulatively over time.

Should DHCS Weight Some Measures More Than Others?

States sometimes weight some performance measures in their MCP financial incentive program more than others. Weighting certain measures more highly is expected to increase motivation to focus MCP investment in the related clinical areas. This will, of course, also reduce MCP motivation to attend to other measures. The differences in weighting has to be significant to change behavior.

Weighting decisions may reflect several factors, such as when the state has:

- Explicitly established health priorities for the state population, the Medicaid program, or the Medicaid managed care program, and these priorities are associated with a subset of the full measure set
- Determined that the greatest opportunities for population health impact are associated with a subset of measures
- Identified where the gap between current and target performance is greatest
- Determined that more effort (or cost) is required by MCPs to improve performance on some measures more than others

Another reason to weight measures differently is when the balance of measures across domains or populations is uneven, but the state wants to weight each domain or population evenly. Arizona's approach, summarized in

Table 8. Arizona "Measure Weighting"

PERFORMANCE MEASURE	MINIMUM PERFORMANCE STANDARD	ASSIGNED WEIGHT FOR CALCULATING INCENTIVE PAYMENT
Adult Measures		
Emergency Department Utilization	≤55 visits/1,000 member months	25%
Readmissions Within 30 Days of Discharge	≤11%	25%
Child Measures		
Well-Child Visits: 15 Months	65%	12.5%
Well-Child Visits: 3–6 Years	66%	12.5%
Adolescent Well-Child Visits: 12–21 Years	41%	12.5%
Children's Dental Visits: 2–21 Years	60%	12.5%

Source: *Alternative Payment Model Initiative — Strategies and Performance-Based Payments Incentive*, Arizona Health Care Cost Containment System, accessed February 13, 2019, www.azahcccs.gov (PDF).

Table 8, provides an example. It weights each of the four child measures half as much as the two adult measures so that equal weight is given to MCP performance across child and adult populations.

The decision of which measures to weight higher relative to other measures is not easily reached, as state staff and external stakeholders typically have varied opinions on which conditions, populations, and aspects of performance warrant greatest attention. For these reasons, and also to simplify messaging to the MCPs, the Advisory Group recommended consistent weighting across all measures.

Next Steps and Key Considerations for Implementation

Integrating performance measurement with payment may create an economic motivation for Medi-Cal MCPs to make significant investments to improve performance in targeted, high-priority areas. Resulting delivery system changes hold the potential to improve the quality of care and outcomes for Medi-Cal beneficiaries.

The project undertaken by CHCF to select a set of performance measures to incorporate into a financial incentive program for MCPs shows that a diverse group of Medi-Cal stakeholders are able to make difficult choices together and reach general agreement on the ideal number of measures, measure selection, and methodology. This effort was undertaken, however, with the understanding that the recommendations should be revisited when the Newsom administration and California legislature are ready to move forward with a financial incentive program for Medi-Cal MCPs. Reasons for doing so include:

- Clinical guidelines underlying the measures may have changed.
- Some measures may have lost national NCQA and/or NQF endorsement.
- Measure specifications may have changed.

It is also imperative that state officials articulate the goals of their incentive program and the financing method before finalizing the performance evaluation methodology in order to ensure alignment.

Appendix A. Advisory Group Members

Organization names are included for identification only. Individuals were not required or expected to represent the views of their organizations or association members.

MEMBER	ORGANIZATION
Bill Barcellona, MD	America's Physician Groups
Greg Buchert, MD	Care 1st Health Plan
Sarah de Guia	California Pan-Ethnic Health Network
Joel Gray	Anthem Blue Cross
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 HealthPlan
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

Appendix B. Comparison of DHCS EAS and CHCF Advisory Group Measure Selection Criteria

DHCS: EAS FOR MY2020/RY2021	ADVISORY GROUP CRITERIA NUMBER
DHCS Goals	
Meaningful to the public, the beneficiaries, the state, and the MCPs	#1 – Be meaningful to patients #2 – Be meaningful to providers
Improves quality of care or services for the Medi-Cal population	#8 – Be pertinent to the Medi-Cal population
High population impact by affecting large numbers of beneficiaries or having substantial impact on smaller, special populations	#6 – Have systemic impact on health if performance improves
Known impact of poor quality linked with severe health outcomes (morbidity, mortality) or other consequences (high resource use)	#7 – Be outcome-based, preferably
Performance improvement needed based on available data demonstrating opportunity to improve, variation across performance, and disparities in care	#4 – Represent an opportunity for improvement
Evidence-based practices available to demonstrate that the problem is amenable to intervention and there are pathways to improvement	#3 – Be amenable to plan or provider influence
Availability of a standardized measure and data that can be collected	#5 – Be nationally vetted or vetted by a California organization charged with measure development for supporting evidence, validity, and reliability
Alignment with other national and state priority areas	#10 – Align with other measures currently in use in California, with special attention to measures in DHCS's External Accountability Set (EAS)
Healthcare System Value demonstrated through cost savings, cost-effectiveness, risk-benefit balance, or health economic benefit	
DHCS Other Considerations	
Avoid negative unintended consequences	
Limiting burden and intrusion on primary care provider offices	#9 – Be feasible to collect with existing infrastructure
The need to retain measures on the EAS for three years for baseline and trend analysis	
The impact of adding and deleting measures used in the auto-assignment and default algorithm	

Appendix C. High-Opportunity External Accountability Set Measures for Rate Year 2019

High-opportunity areas are those for which a measure has (1) a low statewide average score, defined as weighted performance below the HEDIS HMO 50th percentile, and (2) significant variability among plans, defined as a greater than 15 percentage point difference between the plans with the third-lowest and third-highest scores.

MEASURE	LOW STATEWIDE SCORE	SIGNIFICANT VARIABILITY
Ambulatory Care – Outpatient	Yes	*
Ambulatory Care – Emergency Department	Yes	*
Annual Monitoring for Patients on Persistent Medications – ACE or ARB	Yes	No
Annual Monitoring for Patients on Persistent Medications – Diuretics	Yes	No
Asthma Medication Ratio	Yes	Yes
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	No	Yes
Breast Cancer Screening	No	Yes
Cervical Cancer Screening	Yes	Yes
Childhood Immunization Status – Combo 3	Yes	Yes
Children and Adolescents' Access to Primary Care Practitioners – 12 to 19 Years	Yes	Yes
Children and Adolescents' Access to Primary Care Practitioners – 12 to 24 Months	Yes	No
Children and Adolescents' Access to Primary Care Practitioners – 7 to 11 Years	Yes	Yes
Children and Adolescents' Access to Primary Care Practitioners – 25 Months to 6 Years	Yes	Yes
Colorectal Cancer Screening	n.d.	n.d.
Comprehensive Diabetes Care: HbA1c Testing	Yes	No
Comprehensive Diabetes Care: Medical Attention for Nephropathy	No	No
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	No	Yes
Comprehensive Diabetes Care: Eye Exam	No	Yes
Comprehensive Diabetes Care: HbA1c Good Control	No	Yes
Comprehensive Diabetes Care: HbA1c Poor Control	No	Yes
Controlling High Blood Pressure	No	Yes
Immunizations for Adolescents (includes HPV)	No	Yes
Medication Reconciliation Post-Discharge	n.d.	n.d.
Plan All-Cause Readmission	n.d.	No
Prenatal & Postpartum Care – Postpartum Care Rate	Yes	Yes
Prenatal & Postpartum Care – Timeliness of Prenatal Care	Yes	Yes
Use of Imaging Studies for Low Back Pain	No	Yes
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Nutrition	No	Yes
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – PA	No	Yes
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	No	Yes

*Performance to benchmark or variability of these measures not considered, as higher or lower rates do not necessarily indicate better or worse performance.

Notes: *n.d.* indicates no data. Depression Screening and Follow-Up for Adolescents and Adults was not included since it did not appear in any sets of interest to the Advisory Group outside of the EAS.

Sources: Data used for these determinations were from *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*, DHCS, April 2018, www.dhcs.ca.gov (PDF). Statewide average scores were pulled from Table 5.7 for Rate Year 2017 (measurement year January 1, 2016 through December 31, 2016). Plan scores used to determine variability were pulled from Appendices B through Q. Data used to determine whether statewide average scores were above of below the HEDIS Medicaid HMO 50th percentile was pulled from NCQA's Quality Compass HEDIS 2017 (calendar year 2016) data.

Appendix D. Measures Considered by the Advisory Group and Summary of Discussions

MEASURE NAME (NQF NUMBER)	STEWARD	RECOMMENDATION	DISCUSSION
Ambulatory Care (AMB-OP and AMB-ED) (n/a)	National Committee for Quality Assurance	Excluded	Utilization measures are not good performance measures, as the appropriate utilization can vary greatly by population. This measure is also redundant with the goal of establishing performance gates, as savings can be achieved by avoiding ED visits.
Annual Monitoring for Patients on Persistent Medications (2371)	National Committee for Quality Assurance	Excluded	Measure is being retired.
Antidepressant Medication Management (0105)	National Committee for Quality Assurance	Excluded	Psychiatric care is carved out of Medi-Cal MCP contracts.
Appropriate Testing for Children with Pharyngitis (0002)	National Committee for Quality Assurance	Excluded	This measure is no longer NQF-endorsed and performance is high.
Asthma Medication Ratio (1800)	National Committee for Quality Assurance	**Endorsed**	Asthma is an important issue for the Medi-Cal population, and this is the only chronic illness measure included for adolescents. One Advisory Group member expressed concern about whether the measure was measuring what it intended, as people may have multiple inhalers and those with mild and intermittent asthma do not need a rescue inhaler.
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (0058)	National Committee for Quality Assurance	Excluded	This measure has coding issues that have led to the inclusion of patients with chronic obstructive pulmonary disease and is not a high priority for the Advisory Group.
Breast Cancer Screening (2372)	National Committee for Quality Assurance	**Endorsed**	This measure impacts a large population, there is significant opportunity for improvement, and it has a direct impact on patient mortality.
CAHPS Health Plan Survey v5.0 – Rating of Health Plan (0006)	Agency for Healthcare Research and Quality	**Endorsed**	Advisory Group members noted that CAHPS is collected by DHCS every three years. This fact, coupled with reporting delays, make it hard to use the CAHPS for incentive purposes. Some Advisory Group members did not like the CAHPS, as they thought results were unspecific, but noted that it is currently the only standardized measure for patient experience. The Advisory Group recommended that DHCS collect the CAHPS every year so that MCPs can better understand their performance and use rating of health plan as a measure of patient experience. Some Advisory Group members recommended including the measure Overall Rating of Health Plan.
Cervical Cancer Screening (0032)	National Committee for Quality Assurance	**Endorsed**	Performance is poor and there are disparities in performance.
Cesarean Rate for Nulliparous Singleton Vertex Birth (PC-02) (0471)	The Joint Commission	**Endorsed**	Advisory Group members thought that this was an important measure with significant opportunity for improvement. Some Advisory Group members noted that there were adverse financial incentives to deliver Cesarean sections.

MEASURE NAME (NQF NUMBER)	STEWARD	RECOMMENDATION	DISCUSSION
Child and Adolescents' Access to Primary Care Practitioners (n/a)	National Committee for Quality Assurance	Excluded	The types of encounters captured by this measure are too broad and the recommended measure set includes other measures, such as Childhood Immunization Status, that reflect access to care among children and adolescents.
Childhood Immunization Status – Combo 3 (0038)	National Committee for Quality Assurance	**Endorsed**	Advisory Group members thought that immunization status represents an important area of care. Some Advisory Group members recommended Combination 3, as it included the most important vaccinations, but others favored Combo 10 as it is the most complete, and it is used for NCQA accreditation and widely among other states.
Chlamydia Screening (0033)	National Committee for Quality Assurance	**Endorsed**	The measure focuses on reproductive-age women potentially experiencing domestic violence. Some Advisory Group members recommended against including this measure, as they saw it as a lower priority for them than other endorsed screening measures due to the lower severity of illness.
Colorectal Cancer Screening (0034)	National Committee for Quality Assurance	Excluded	This is not a Medicaid measure in HEDIS so no Medicaid benchmarks are available from NCQA.
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) (0061)	National Committee for Quality Assurance	Excluded	This population is captured in the Controlling High Blood Pressure measure.
Comprehensive Diabetes Care: Eye Exam (0055)	National Committee for Quality Assurance	Use in a larger set	This is an important measure for diabetes care, as eye disease needs to be caught early to prevent blindness. Advisory Group members are interested in tracking how the exam rates are impacted when Medi-Cal restores its vision benefit in 2020.
Comprehensive Diabetes Care: HbA1c Control (<8.0%) (0575)	National Committee for Quality Assurance	Excluded	Failure to meet this measure has less of a clinical impact for patients than Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%).
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (0059)	National Committee for Quality Assurance	**Endorsed**	Clinically meaningful and high variability in performance. The Advisory Group selected this measure over Comprehensive Diabetes Care: HbA1c Control (<8.0%) because the diabetes complication rate increases dramatically around 9%.
Comprehensive Diabetes Care: HbA1c Testing (0057)	National Committee for Quality Assurance	Excluded	Process measure captured in the Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%).
Comprehensive Diabetes Care: Medical Attention for Nephropathy (0062)	National Committee for Quality Assurance	Excluded	Performance is already high, and thresholds keep rising, making it harder for plans to meet targets even if they are already performing well.
Concurrent Use of Opioids and Benzodiazepines (n/a)	Pharmacy Quality Alliance	Excluded	There are data challenges to measurement because the measure requires pharmacy data.

MEASURE NAME (NQF NUMBER)	STEWARD	RECOMMENDATION	DISCUSSION
Contraceptive Care – Most & Moderately Effective Methods (2903)	US Office of Population Affairs	Excluded	Contraception is an important topic. Advisory Group members wanted to monitor performance as data become available. One Advisory Group member expressed concern that the measure did not account for physiological reactions to different types of contraception.
Contraceptive Care – Postpartum (2902)	US Office of Population Affairs	Excluded	Contraception is an important topic. Advisory Group members wanted to monitor performance as data become available. One Advisory Group member expressed concern that the measure did not account for physiological reactions to different types of contraception.
Controlling High Blood Pressure (0018)	National Committee for Quality Assurance	**Endorsed**	Performance has a high impact and there is room for improvement. One Advisory Group member noted that one could directly calculate how many lives would be saved by a reduction in blood pressure, and that if he could pick a single measure to include, it would be this one.
Developmental Screening in the First Three Years of Life (1448)	Oregon Health & Science University	Excluded	Providers do not regularly use the code in this measure.
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (2607)	National Committee for Quality Assurance	Excluded	No one spoke in favor of the measure.
Elective Delivery Prior to 39 Completed Weeks Gestation (PC-01) (0469)	The Joint Commission	Use in a larger set	Given the low number of elective deliveries, this did not rise as a high-priority measure. There is still an opportunity for improvement with regard to disparities in care.
Follow-Up After Hospitalization for Mental Illness (0576)	National Committee for Quality Assurance	Excluded	No one spoke in favor of the measure.
HIV Viral Load Suppression (2082)	Health Resources and Services Administration – HIV/AIDS Bureau	Excluded	No one spoke in favor of the measure.
Immunizations for Adolescents – Combo 2 (1407)	National Committee for Quality Assurance	**Endorsed**	Concrete positive impact on outcome, low median performance with high variation by plan.
Lead Screening in Children (n/a)	National Committee for Quality Assurance	Use in a larger set	There are low rates of abnormal tests in California, and it was not recommended as a key measure. This measure is already required for Medi-Cal and some Advisory Group members said it would be difficult to provide a rationale for singling out one Early and Periodic Screening, Diagnostic, and Treatment measure over others.
Plan All-Cause Readmission (1768)	National Committee for Quality Assurance	**Endorsed**	The Advisory Group thought it was good to include a measure involving hospitals, since hospitals are a large part of the care delivery system and readmissions are costly. One Advisory Group member noted that it would be important to evaluate Medi-Cal performance once DHCS adopts the standard methodology used by HEDIS.

MEASURE NAME (NQF NUMBER)	STEWARD	RECOMMENDATION	DISCUSSION
Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care) (1517)	National Committee for Quality Assurance	**Endorsed**	Important measures of access, large Medi-Cal population with room for improvement, and disparities in performance. It was noted that the measure lost National Quality Forum endorsement because there was no evidence tying frequency of visits to outcomes despite the consensus on the importance of the visits.
Prenatal Immunization Status (n/a)	National Committee for Quality Assurance	Revisit at a later time	This is a new measure that is still undergoing testing with HEDIS and the Integrated Healthcare Association.
Proportion of Days Covered by Medications: Statins (0541)	Pharmacy Quality Alliance	Revisit at a later time	Revisit when there is a clinical consensus (types of statins, dosage, age at which to start are in flux) on appropriate guidelines.
Screening for Clinical Depression and Follow-Up Plan (0418)	Centers for Medicare & Medicaid Services	Excluded	There are new and better measures available to address depression in HEDIS, but plans can't yet operationalize them.
State Fair Hearings (n/a)	California Department of Social Services	Excluded	This is not an actionable measure, since it only looks at count of hearings without an indication of the impact of a higher or lower count.
Statin Therapy for Patients with Cardiovascular Disease (n/a)	National Committee for Quality Assurance	Revisit at a later time	Revisit when there is a clinical consensus (types of statins, dosage, age at which to start are in flux) on appropriate guidelines.
Statin Therapy for Patients with Diabetes (n/a)	National Committee for Quality Assurance	Revisit at a later time	Revisit when there is a clinical consensus (types of statins, dosage, age at which to start are in flux) on appropriate guidelines.
Statin Use in Persons with Diabetes (n/a)	Pharmacy Quality Alliance	Revisit at a later time	Revisit when there is a clinical consensus (types of statins, dosage, age at which to start are in flux) on appropriate guidelines.
Use of Imaging Studies for Low Back Pain (0052)	National Committee for Quality Assurance	Excluded	The measure fails to capture clinically relevant information.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (0024)	National Committee for Quality Assurance	Excluded	This is a process measure with no evidence of impact on outcome.
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (1516)	National Committee for Quality Assurance	Use in a larger set	The measure is important, but of a lower priority. The measure timing is too late to catch developmental delays, and the measure imposes an artificial deadline for the visits.

Appendix E. Recommended Measure Set, by Domain and Population Age Group

Below is a breakdown of the recommended measure set by domain. Please note that measures can span multiple domains (e.g., the Prenatal and Postpartum Care measures — Timeliness of Prenatal Care and Postpartum Care — could be considered both preventive care / early detection and maternity care measures). The counts of measures by population age are not mutually exclusive (e.g., a measure can include both children and adolescents).

	MEASURE	NUMBER OF MEASURES	POPULATION AGE GROUP		
			CHILD	ADOLESCENT	ADULT
Preventive Care / Early Detection	▶ Breast Cancer Screening ▶ Cervical Cancer Screening ▶ Chlamydia Screening ▶ Childhood Immunization Status – Combo 3 ▶ Immunizations for Adolescents – Combo 2	5	1	2	3
Care Coordination	▶ Plan All-Cause Readmissions	1			1
Chronic Illness Care	▶ Controlling High Blood Pressure ▶ Comprehensive Diabetes Care: HbA1c Poor Control	2			2
Maternity Care	▶ Cesarean Rate for Nulliparous Singleton Vertex Birth ▶ Prenatal and Postpartum Care	2		2	2
Medication Management	▶ Asthma Medication Ratio	1	1	1	1
Patient Experience	▶ CAHPS – Rating of Health Plan	1			1
	Total	**12**	**2**	**5**	**10**

Endnotes

1. *Making Quality Matter in Medi-Cal Managed Care: How Other States Hold Health Plans Financially Accountable for Performance*, California Health Care Foundation (CHCF), February 2019, www.chcf.org.
2. Report forthcoming.
3. *Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs*, CHCF, April 2018, www.chcf.org.
4. The Advisory Group conducted its work based on the External Accountability Set (EAS) in use by DHCS as of February 2019. On March 7, 2019, DHCS announced to its Medi-Cal Managed Care Advisory Committee that it would significantly expand the EAS. Based on the manner in which DHCS has presented the current EAS and the new EAS measures, the measure set is expanding from 17 measures to potentially as many as the 59 unique measures comprising the 2019 CMS Adult and Child Core Sets (with seven measures found in both sets) for care delivered during Measurement Year 2019.
5. *Making Quality Matter*, CHCF.
6. *Intended Consequences*, CHCF.
7. "Medi-Cal Managed Care Quality Improvement Reports," California Dept. of Health Care Services (DHCS), accessed February 20, 2019, www.dhcs.ca.gov.
8. *Medi-Cal Managed Care Quality Strategy Report*, DHCS, March 28, 2018, www.dhcs.ca.gov (PDF).
9. See note 4.
10. "Continuum of Care Reform (CCR) Data Dashboard," California Dept. of Social Services, accessed April 6, 2019, www.cdss.ca.gov.
11. "AMP Medi-Cal Managed Care," Integrated Healthcare Association, accessed February 21, 2019, www.iha.org.
12. "Incentives," Integrated Healthcare Association, accessed February 20, 2019, www.iha.org.
13. The only EAS MCP measure excluded was NCQA's "Depression Screening and Follow-Up for Adolescents and Adults." This measure did not appear in any of the other measure sets of interest to the Advisory Group.
14. The Healthcare Effectiveness Data and Information Set (HEDIS) is the standard set of health plan performance measures in use in the US for Medicaid, Medicare Advantage, and commercially insured populations. It is maintained by the National Committee for Quality Assurance, which collects and reports performance by health plans, and which also uses performance data for health plan accreditation. For more information see www.ncqa.org.
15. *10.09.65.03: Quality Assessment and Improvement*, Maryland Div. of State Documents, accessed February 13, 2019, www.dsd.state.md.us; *Medicaid Managed Care: 2017 Annual Technical Report*, District of Columbia Dept. of Health Care Finance, April 2018, dhcf.dc.gov; and see hhs.texas.gov (PDF).
16. Some states use the term "attainment" or "excellence" instead of "achievement."
17. Maryland Div. of State Documents; and *2017 Quality Incentive for Medicaid Managed Care Plans*, New York State Dept. of Health, n.d., www.health.ny.gov (PDF).
18. Contractor Risk Agreement Between the State of Tennessee and Volunteer State Health Plan, Inc., Blue Cross Blue Shield of Tennessee, accessed February 13, 2019, www.bcbst.com (PDF).
19. "CCO Incentive Metrics," Oregon Health Authority Office of Health Analytics, accessed February 13, 2019, www.oregon.gov; *HHSC Uniform Managed Care Manual: Medical Pay-for-Quality (P4Q) Program*, Texas Health and Human Services, n.d., hhs.texas.gov (PDF); and *Moving Apple Health to Value: Changes to Contracts for 2018*, Washington State Health Care Authority, August 2017, www.hca.wa.gov (PDF).
20. "ACOM 306, Alternative Payment Model Initiative – Withhold and Quality Measure Performance Incentive," Arizona Health Care Cost Containment System, comments.azahcccs.gov.
21. "Auto Assignment Incentive Program," DHCS, last modified December 14, 2018, www.dhcs.ca.gov. While DHCS does not currently provide its MCPs with a financial incentive linked to quality performance, since 2005 it has rewarded MCPs with preferential auto-assignment enrollment volume for (1) superior performance relative to a competing plan(s) within a county, (2) improvement, and (3) excellence.
22. Mary Beth Dyer and Beth Waldman, *Value-Based Purchasing for Managed Care Procurements: A Toolkit for State Medicaid Agencies*, Robert Wood Johnson Foundation's State Health and Value Strategies Program, January 2018, www.shvs.org.