



# **Paying Medi-Cal Managed Care Plans for Value:** Design Recommendations for a Quality Incentive Program

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## About the Author

Bailit Health Purchasing, LLC (Bailit Health) is a health policy consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies. The firm primarily works with states to take actions that positively influence the performance of the health care system and support achievement of measurable improvements in health care quality and cost management.

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

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# Executive Summary

**M**edi-Cal, California's Medicaid program, is the state's health insurance program for Californians with low incomes, including over 40% of all children, half of those with disabilities, over a million seniors, and around one in six workers. In total, Medi-Cal covers more than 12 million people, or nearly one in three Californians. More than 80% of Medi-Cal enrollees get their care through a Medi-Cal managed care plan (MCP).<sup>1</sup> Every person enrolled in Medi-Cal managed care should have access to high-quality care.

Currently, the California Department of Health Services (DHCS), the state agency that runs Medi-Cal, contracts with 24 full-scope MCPs responsible for providing health care, including behavioral health services to those with mild to moderate mental illness. The quality of care provided to Medi-Cal managed care enrollees is, on average, below that received by Medicaid enrollees in many other states.<sup>2</sup> In addition, external evaluations have found that DHCS has not generated significant quality improvement gains in Medi-Cal over the past 10 years and that millions of children have not received the recommended preventive services to which they are entitled in the Medi-Cal managed care delivery system.<sup>3</sup>

Soon after these evaluation findings were shared, DHCS adopted new rules that require MCPs to perform at least as well as 50% of Medicaid plans nationally (up from 25%). In 2019, before the coronavirus pandemic, DHCS planned to require that MCPs performing below this national median be subject to a financial penalty and be required to complete a corrective action plan and quality improvement work beginning in 2020. Implementation of this policy change was delayed due to the pandemic.

Stakeholders expressed mixed reactions to this change. Some applauded the change and urged further steps to ensure that quality would improve for all Medi-Cal enrollees in managed care, while many MCP representatives expressed concern that the expectation that all MCPs perform "above average"

is unreasonable, and the financial consequences are too extreme.

In response to these reactions and with a desire to improve MCP quality performance, DHCS and the California Health Care Foundation (CHCF) partnered on a project to explore alternative approaches to improve the quality of care provided to Medi-Cal managed care enrollees. CHCF contracted with Bailit Health to research quality incentive methodologies used by California public purchasers and other states' Medicaid programs, interview DHCS staff and stakeholders about DHCS's approach to MCP quality and alternative approaches, and work with DHCS staff and an Advisory Committee to support the development of recommendations.

This report presents Bailit Health's recommendations, which call for DHCS to adopt a redesigned quality incentive strategy that aims to improve the provision of quality care for Medi-Cal enrollees by increasing Medi-Cal MCP motivation and accountability for quality performance. DHCS should use a combination of coordinated and aligned financial and nonfinancial incentives.

## Financial Incentive Structure

DHCS currently structures its MCP payments as capitation, which is a per member per month rate for the Medi-Cal enrollees assigned to the MCP. In structuring an MCP quality incentive program, DHCS should move from its current penalty structure to an approach that combines a capitation withhold (that is, DHCS would withhold part of its capitation payments to MCPs) with an incentive payment for MCPs whose performance meets or exceeds expectations. In other words, MCPs could earn back some or all of the amount withheld by DHCS depending on their performance.

Advantages of a withhold structure are numerous: It is relatively easy to administer, MCPs know in advance the amount of potential loss, a potential loss in income is more effective in inducing behavior change than a potential gain,<sup>4</sup> and it produces more timely payments

compared to some alternatives considered, such as adjustments to future capitation payments.

This approach should include the following:

- ▶ Move from a penalty to a withhold structure. Within a withhold structure, DHCS should continue to require that specific performance expectations must be met (a “gate”) to earn an incentive payment.
- ▶ DHCS should couple the gate with a “ladder,” in which the amount of the financial incentive increases as performance improves. This approach is preferable to a gate alone, as MCPs are incentivized to continue improving performance, regardless of their starting point, while still being held to a minimum standard.
- ▶ In addition, DHCS should reward both achievement, using the gate-and-ladder approach described above, and improvement, defined as a statistically significant gain over prior performance.
- ▶ The reward for improvement should be balanced with a negative adjustment for performance that has deteriorated by a statistically significant amount. The idea behind incorporating deterioration is to ensure MCPs are not rewarded when quality performance is deteriorating, as this runs contrary to the purpose of implementing a quality incentive program.
- ▶ To begin to address significant health disparities, DHCS should include one or more health-disparity reduction measures in the incentive measure set. In addition, DHCS could tie incentives to MCPs’ activities related to high-priority delivery system reforms, such as behavioral health integration, aligned interventions to reduce disparities, and long-term services and supports integration.
- ▶ Consideration of which specific performance measures are incentivized in the program was out of scope and had been addressed recently in other CHCF-funded work.<sup>5</sup> However, DHCS should consider reducing the number of financially incentivized MCP measures to allow MCPs and their networks to focus improvement efforts in high-priority areas for

the state and thereby be better positioned to generate improvement.

The Bailit Health team discussed other design features with DHCS staff and the Advisory Committee however, because they were beyond the scope and time frame of this project, these additional features were left unresolved. The following features should receive further consideration:

- ▶ **Geographic variation.** There is significant and persistent geographic variation in performance across the state. DHCS should give future consideration to geographic modifications to its methodology. Accounting for geographic variation in the quality incentive program model could help ensure that MCPs operating in communities with poor health care resources are not unfairly penalized compared to MCPs operating in communities with abundant health care resources. Additional analysis will be needed to better understand the extent of the impact of geographic variation across all MCP performance. An optimal approach would incentivize MCPs to invest in quality improvement in under-resourced regions as opposed to setting a lower bar for care provided to enrollees in these regions compared with others.
- ▶ **Social risk factors.** Social risk factors are adverse social conditions associated with poor health such as housing instability, food insecurity, and lack of transportation. Social risk factors are prevalent in Medicaid populations and have been shown to impact health behaviors, health care access, and outcomes.<sup>6</sup> DHCS should consider how social risk factors are accounted for in the quality incentive program model methodology. Additional analysis will be needed to better understand if social risk factors can be effectively captured, and how they might impact MCP performance and vary with geography and subpopulation. As DHCS identifies ways to systematically collect social-risk-factor data, it should focus on stratifying populations to identify and track disparities, not to adjust performance in a way that will mask key differences and potentially exacerbate underlying disparities. An

optimal approach would incentivize MCPs to invest in identifying and addressing social risk factors as opposed to adjusting performance and setting a lower bar for care provided to enrollees with social risk factors.

- **Reporting unit.** Currently, DHCS measures MCP performance at the level of the reporting unit, of which there are over 50 across the state. DHCS should further analyze the quality incentive program model at the reporting unit, county, and regional level to identify at which level accountability should be focused to have the most impact on improving MCP performance for Medi-Cal enrollees.

There are many ways in which DHCS could implement the design components described above. Table 1

provides a simplified demonstration of how the recommendations could work.

## Aligning and Enhancing Nonfinancial Incentives

To enhance and amplify these proposed changes to MCP financial incentives, DHCS should also enhance its nonfinancial incentives by:

- Enhancing performance-based auto-assignment through revised measures and adjustments to its methodology
- Creating interactive public reporting with detailed information at the domain and measure level

**Table 1. Summary of Financial and Nonfinancial Incentive Recommendations**

RECOMMENDATION	
<b>Financial</b>	
<b>Basic structure</b>	Change from a penalty structure to a capitation withhold with opportunity to earn back all or part of withhold through performance. <sup>7</sup> Add bonus and/or shared savings when financially and operationally feasible.
<b>Qualification for incentive</b>	Adopt both a gate and ladder so that MCPs are rewarded for both achievement and improvement in performance.
<b>Geographic modifications</b>	Consider additional points for improvement in selected regions if analysis determines such adjustment is warranted. Detailed regional analysis of performance is needed to inform this decision.
<b>Social risk modifications</b>	Consider incorporating in the future after further study.
<b>Reporting unit</b>	Conduct additional analysis to determine optimal level of MCP performance accountability (e.g., current DHCS reporting unit, county, or region).
<b>Nonfinancial</b>	
<b>Performance-based auto-assignment</b>	Enhance current approach by reducing the number of quality measures, changing the scoring of quality results, dropping measures of safety-net participation, capping percentage of total assignments, and adding encounter data quality adjustments.
<b>Corrective action plans</b>	No changes recommended.
<b>Public reporting</b>	Enhance current reporting with additional opportunities for recognition for achievement and improvement, and enhance with reporting at the domain and measure level, and new graphic and interactive formats.
<b>Quality improvement activities</b>	Pilot alternative Plan-Do-Study-Act quality improvement approaches.
<b>Contracting</b>	Prohibit service area expansion for MCPs with poor performance, and make past quality performance a variable when making future procurement contract award decisions.

- ▶ Expanding public performance reporting to provide additional opportunities for recognition for achievement and improvement
- ▶ Piloting alternative quality improvement approaches to the Plan-Do-Study-Act (PDSA) projects
- ▶ Exploring additional nonfinancial incentive opportunities, including prohibition of service area expansion for MCPs with poor performance and making past quality performance a strongly weighted variable when making future procurement contract award decisions.

## Conclusion

The recommendations in this report have been developed in the context of two current conditions. First, in California's economic climate in late 2020, DHCS does not have additional financial resources to add to the program in the form of bonus payment for exceptional performance; any proposed changes need to draw upon existing resources. Second, to implement an alternative penalty methodology, DHCS has stated that it would need to amend its MCP contract and obtain rate certification.

While DHCS may not be able to implement all of these recommendations until its reprocurement of Medi-Cal managed care plans scheduled for 2024, there are several design element recommendations DHCS could implement in the short-term. For example, within the current penalty structure DHCS could implement several of the recommended financial incentive design elements, including rewarding improvement, phasing in a parsimonious measure set, including delivery system reform and disparities gap reduction measures in the set that is tied to financial penalties, and enhancing its nonfinancial incentives.

While these recommendations were developed specifically for DHCS Medi-Cal managed care program, creating alignment in measures and incentives across DHCS's quality programs and with other California purchasers could result in accelerated quality improvement across the state.

Finally, quality incentive programs can provide focus and motivation for contracted MCPs. They must, however, be coupled with hands-on contract management activity by DHCS, as has been discussed in a prior report.<sup>8</sup> Even then, MCPs lacking sufficient leadership, staffing, and commitment may not rise to the challenge. In such cases DHCS will need to evaluate if partnership with these MCPs should be continued or are no longer in the best interest of Medi-Cal enrollees.

## Context

In 2019, an independent evaluation of quality in Medi-Cal managed care from 2009 to 2018 found that DHCS has not generated significant quality improvement gains over the past 10 years. That same year, the California State Auditor published a report finding that millions of children do not receive the preventive services to which they are entitled, citing as causes both limited access to Medi-Cal providers and deficient oversight by DHCS of managed care plans (MCPs).<sup>9</sup>

DHCS responded by requiring MCPs to perform at least as well as 50% of Medicaid plans nationally (up from 25%) on measures in its Managed Care Accountability Set. MCPs that do not meet the benchmark are subject to a financial penalty and will be required to complete a corrective action plan and quality improvement work. Implementation of this policy change was delayed from 2020 due to the pandemic.

Stakeholder reactions to these changes have been mixed. Some applauded the change and are urging further steps to ensure MCP accountability. MCP leaders have expressed concern that the expectations and financial consequences are too extreme.

In response to these reactions and with a desire to improve MCP performance and the health of Medi-Cal enrollees, DHCS and the California Health Care Foundation (CHCF) coled a project between March and October 2020 to explore alternative approaches to improving the quality of care provided to Medi-Cal managed care enrollees. CHCF contracted with Bailit Health to research quality incentive methodologies used by California public purchasers and other states' Medicaid programs, interview DHCS staff and stakeholders about DHCS's approach to MCP quality and alternative approaches, and work with DHCS staff and an Advisory Committee to support the development of recommendations. This brief presents Bailit Health's recommendations to DHCS for redesigning its quality incentive strategy.

This report builds upon prior Bailit Health work performed with support from CHCF. In 2019, CHCF engaged Bailit Health to research and make recommendations for how DHCS could strengthen its purchasing strategy and oversight of Medi-Cal MCPs,<sup>10</sup> use financial quality incentives with MCPs,<sup>11</sup> and apply a measure set and performance evaluation methodology with financial incentives to encourage improvement in the care provided to Medi-Cal enrollees.<sup>12</sup> The brief recommends a specific quality incentive approach that could be adopted by DHCS. It describes the process by which recommendations were developed, briefly summarizes the experience of other states and the Centers for Medicare & Medicaid Services (CMS) with financial incentives tied to MCP performance, and provides recommendations for incentive structure, performance evaluation, and performance measures.

## Process

To inform the authors' recommendations, Bailit Health conducted research on quality incentive methodologies used by California public purchasers and other state Medicaid programs, interviewed DHCS staff and MCP stakeholders on DHCS's approach to MCP quality and alternative approaches, and worked with an Advisory Committee to support the development of the recommendations. DHCS was an active partner in this process and provided feedback through regular meetings and a series of brainstorming sessions with Bailit Health regarding key elements of the recommended design. DHCS staff also participated in all Advisory Committee meetings.

## Review of Quality Incentive Methodologies

Bailit Health examined the approaches taken by California public purchasers and by six other state Medicaid programs to incentivize health plan quality performance. The research was conducted to inform development of an alternative quality incentive methodology. The list of reviewed programs is provided in Table 2.

**Table 2. Researched Quality Incentive Methodologies**

### California Public Purchasers

- ▶ CalPERS
- ▶ Covered California
- ▶ DHCS Medi-Cal Managed Care Plan Accountability Set Sanctions
- ▶ DHCS Public Hospital Quality Improvement Program
- ▶ DHCS Value Based Payment Program

### Other State Medicaid Programs

- ▶ Arizona
- ▶ Michigan
- ▶ New York
- ▶ Oregon
- ▶ Texas
- ▶ Washington

## Stakeholder Interviews

In May and June 2020 Bailit Health conducted stakeholder interviews with four Medi-Cal managed care plans (two public and two for-profit), several DHCS stakeholders, and DHCS's External Quality Review Organization, Health Services Advisory Group (HSAG). The purpose of the interviews was to elicit feedback on DHCS's approach to managed care plan quality performance to date, and to generate ideas about alternative approaches DHCS could consider. A full list of interviewees can be found in Appendix B.

## Advisory Committee

Bailit Health worked with CHCF and DHCS to create an Advisory Committee to support the development of the recommendations. The Advisory Committee consisted of representatives from the following categories: consumer advocates, MCPs, providers, and content experts. A full list of Advisory Committee members can be found in Appendix C. During its first meeting, the Advisory Committee provided feedback on principles for a DHCS Medi-Cal managed care plan quality incentive approach that informed the development of the recommendations. The design principles can be found in Appendix D.<sup>13</sup> The Advisory Committee also provided feedback on the approach and design of the proposed quality incentive program for Medi-Cal managed care plans.

### State Medicaid and CMS Experiences with Performance Incentives

For many years states have used a variety of strategies to promote managed care plan quality improvement, including financial and nonfinancial incentives and other tools to increase quality and accountability. A review of the literature did not reveal a robust set of effectiveness studies for these activities. Individual states, including New York and Oregon, however, have internally evaluated their Medicaid managed care quality financial incentive programs and concluded they have had positive impact on quality performance over time.<sup>14</sup>

There are limited and mixed-finding results from the application of quality scores ("star" ratings) to incentive payments to Medicare Advantage (MA) plans by CMS.<sup>15</sup> CMS continues to incorporate financial quality incentives for MA plans through its Medicare Advantage quality bonus program and the use of its transparency strategy of sharing star quality ratings with enrollees.<sup>16</sup>



# Recommendations

Recommendations to DHCS for strengthening its quality incentive program for Medi-Cal managed care are provided for both financial incentives and nonfinancial incentives. For financial incentives, recommendations are grouped by the following categories: incentive structure, performance evaluation, and performance measures.<sup>17</sup> Key topics within each of these areas are listed in Table 3 below.

**Table 3. Key Quality Incentive Considerations**

	SUBTOPICS
<b>Incentive Structure</b>	<ul style="list-style-type: none"> <li>▶ Financial incentive</li> <li>▶ Requirements to earn full incentive</li> <li>▶ Qualification for incentive</li> <li>▶ Geographic modifications</li> <li>▶ Social risk modifications</li> <li>▶ Unit of accountability</li> </ul>
<b>Performance Evaluation</b>	<ul style="list-style-type: none"> <li>▶ Reward</li> <li>▶ Achievement and improvement weights</li> <li>▶ Achievement benchmarks</li> <li>▶ Varying achievement benchmarks by measure</li> <li>▶ Improvement benchmarks</li> <li>▶ Adjustment for deterioration</li> </ul>
<b>Performance Measures</b>	<ul style="list-style-type: none"> <li>▶ Capturing health disparities</li> <li>▶ Number of measures</li> <li>▶ Measure weights</li> <li>▶ Incentives for delivery system reform</li> <li>▶ Which delivery system reforms</li> </ul>

## Financial Incentive Structure

In designing a quality incentive program, state Medicaid agencies must determine how the incentive will be structured. Incentive structure design decisions include:

- ▶ What form should the financial incentive take?
- ▶ What is the threshold required for MCPs to earn back the full incentive?
- ▶ How should managed care plans qualify for (earn) the incentive?

- ▶ Should the incentive structure account for performance variation by geography?
- ▶ Should the incentive structure account for variation in MCP member social risk?
- ▶ What should be the unit of accountability (e.g., by MCP, by each combination of MCP and county or region)?

These questions are addressed in the following sections of this report.

## Form of Financial Incentive

DHCS should move from a penalty structure to a capitation withhold structure in which DHCS would designate a portion of the base MCP capitation to be paid contingent upon achievement of quality performance targets. The value of the withhold should represent a significant portion of the MCP's anticipated margin in order to provide a meaningful incentive to ensure members are receiving high-quality care. In other states studied, the value of the withhold ranged from 1% to 3.5% of capitation payments, as detailed in Table 4 below.

**Table 4. Value of Withhold in Selected States**

	WITHHOLD
<b>Arizona</b>	1% of capitation payments
<b>Michigan</b>	1% of capitation payments
<b>Oregon</b>	3.5% of aggregate capitation and maternity case rate payments
<b>Texas</b>	3% of capitation payments
<b>Washington</b>	2% of capitation payments

**The value of the withhold should represent a significant portion of the MCP's anticipated margin in order to provide a meaningful incentive to ensure members are receiving high-quality care.**

A capitation withhold would work as follows. DHCS would withhold a fixed percentage (e.g., 2%) of each MCP's premium payment each month. To earn back that 2%, MCPs would need to receive a passing score for each measure within the quality incentive set. If an MCP earned half of the available quality points for the DHCS-selected measures, it would receive half of the withhold back after the end of the year, or 1% of the premium for the enrolled member months for the prior contract year.

Working within the confines of DHCS's existing resources, DHCS could choose to couple the capitation withhold with a "challenge pool," allowing MCPs to earn any forfeited withhold dollars based on meeting performance targets, as is done in Oregon and Texas. For example, MCPs could earn forfeited dollars for achieving the national 90th percentile performance, high performance on a small set of different quality measures, or a reduction in health disparities.

Regardless of the approach, it is important that DHCS publish the withhold methodology and the methodology for any challenge pool in advance of the performance year for MCPs to have the opportunity to thoroughly review and ask questions, to plan and budget for their improvement activities in advance, and to promote transparency.

The withhold structure holds several advantages: (1) it is relatively easy for DHCS to administer, (2) MCPs know in advance the amount of potential loss, (3) potential loss of income can more effectively induce behavior change than a potential gain,<sup>18</sup> and (4) DHCS can make more timely payments to MCPs compared to a capitation adjustment. All stakeholders interviewed thought that a withhold was a better way to pay for value than applying a penalty. The majority of Advisory Committee members expressed interest in eventually adding a bonus and/or shared savings, and all members highlighted the importance of timely MCP payment for withhold dollars that are earned back.

In addition to the capitation withhold, DHCS should incorporate a financial incentive for quality in the form

of upside bonus or shared savings opportunity as soon as it is practical and economically feasible to do so.

These recommendations have been developed in the context of two current conditions. First, during the economic downturn of 2020, DHCS does not have additional resources to add to the program; any proposed changes need to use existing resources. Second, in order to implement an alternative to the existing penalty methodology, DHCS believes it would need to amend its contract and obtain rate certification. If so, the timing of any change to the underlying structure might need to align with the DHCS's planned MCP reprocurement in 2024.

### Requirements to Earn Back the Full Incentive

Another key decision within the design of the methodology is how to earn back the full incentive. Two options include requiring that all possible points be earned as set forth in the specified methodology (i.e., the withhold), and requiring that fewer than all possible points be earned, and setting a target for the total number (or percentage) of points needed to earn back the full incentive. If selecting the latter approach, DHCS should balance creating a strong incentive to improve with recognition of the challenge in generating significant improvement simultaneously across a large number of measures.

In ultimately selecting a methodology to earn back the withhold, it is important that DHCS model measure-level performance for the measures that will be included in the program, as well as explore the impact of different thresholds to earn back the full withhold.

### Qualification for Incentive

In its current approach, DHCS uses the national 50th percentile as the performance gate for its penalty — the performance expectation that must be met to avoid a financial penalty. Moving forward, DHCS's approach should use both a gate and a "ladder" that credits continuous achievement. Use of a gate means that a minimum performance threshold is required to earn back any withhold. Use of a ladder means that as performance improves above the gate, the amount of withhold earned back increases, and as performance

decreases below the gate, the MCP forfeits more withhold dollars. Within its gate-and-ladder approach, DHCS should incentivize MCPs on a continuous scale, such that beyond the gate, increasingly strong performance results in increased achievement points, even within a single rung of the ladder. Similarly, increasingly poor performance results in increased negative points.

An advantage of this gate-and-ladder approach is that MCPs are incentivized to continue improving performance, regardless of their starting point, while still being held to a minimum standard with the gate. Most interviewees suggested combining a gate for minimum performance level with a ladder for higher achievement, as well as some credit for year-over-year improvement.

An example of the gate-and-ladder approach is presented in Table 5. In this example, the gate is set at the Medicaid NCQA (National Committee for Quality Assurance) 50th percentile, meaning the MCP must reach this performance gate to qualify to earn back the withhold. If the MCP performance falls below the 25th percentile, the MCP forfeits withhold dollars. Table 5 illustrates how this set of benchmarks can be translated into positive and negative points toward the withhold, such that as performance rises over the 50th percentile, points increase on a continuous scale, and as performance falls below the 25th percentile, points become negative and withhold dollars are not received. In this example, performance goes “below the ground,” with poor and deteriorating performance resulting in a negative point.

Example 1 below illustrates the number of points earned by a hypothetical MCP X based on its

performance for three measures where the national 50th percentile is worth one point.

**Table 5. Example Gate and Continuous Ladder Approach**

PERFORMANCE RANGE (percentile of Medicaid nationally)	POINTS EARNED*
≥90th	+3
>75th to <90th	+2 to +2.99
50th to <75th	+1 to +1.99
>25th to <50th	0
>5th to <25th	-1.99 to -1
<5th	-2

\*Points earned represent a range to incentivize continuous improvement. MCPs with scores closer to the higher ends of the ranges will earn more points (the formula for this calculation can be found in Appendix E).

### Geographic Modifications

Regional variation across California is significant, including distribution of health care resources, differences in population risk, and structural urbanism.<sup>19</sup> Advisory Committee members and stakeholder interviewees recommended that DHCS address regional variation in some way. If these conditions are not considered in an extremely geographically diverse state such as California, there is risk that the existing disparities in access and outcomes of rural residents could be further exacerbated by rewarding MCPs in regions with abundant health care resources (often associated with better access to and quality of care) and penalizing those in regions with inadequate resources. Conversely, Advisory Committee members were also concerned that adjusting for regional differences might cement regional disparities in place by setting lower expectations for MCPs operating in poorly

**Example 1. Application of Gate and Ladder for MCP X's Performance on Measures with Gate of the National 50th Percentile**

	MCP PERFORMANCE	POINTS EARNED
<b>Measure 1.</b> Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	>90th percentile	+3
<b>Measure 2.</b> Asthma Medication Ratio	25th percentile	-1
<b>Measure 3.</b> Cervical Cancer Screening	50th percentile	+1

resourced regions. Additional analysis is needed to determine if any adjustments to the methodology based on geography is warranted. If it is, DHCS could consider additional reward for quality improvement or delivery system infrastructure investments in selected regions.

### Social Risk Modifications

Another incentive structure consideration is whether to allow for modification due to variation in social risk among MCPs. Social risk has been shown to have significant impact on health status.<sup>20</sup> Certain plans may enroll member populations with different levels of social risk. This could be related to geography, or other factors, such as the providers within an MCP’s network. Advisory Committee members cautioned that social-risk-factor adjustment may be challenging to implement since this area is understudied. The authors are currently unaware of any state Medicaid agencies implementing social-risk-factor adjustment in evaluating MCP quality performance. As such, DHCS should study methods for making such adjustments in anticipation of possible future incorporation.

### Unit of Accountability

At present, MCPs are judged on performance at the reporting unit level, of which there are 50 across the state. In highly populated counties, a reporting unit

reflects one plan’s performance in a single county; in less populated counties, a reporting reflects a plan’s performance across a region. Because performance is so geographically variable, the smaller the unit of accountability, the more likely that an MCP will be subject to a penalty today, sometimes for a small percentage of its membership. Larger aggregations of geographies may reduce the number of penalties for small populations but may also mask performance improvement opportunities and reduce accountability. DHCS should analyze the impact of reporting at a managed care plan, county, and reporting unit level to understand the impact of these approaches and determine what the optimal reporting level and unit of accountability should be.

### Performance Evaluation

A major decision in developing any performance evaluation framework is to determine what should be rewarded. Programs can reward achievement, improvement, or both. With respect to achievement, this brief recommends how DHCS should set its benchmarks and whether they should vary by measure. With respect to improvement, this brief recommends how DHCS should measure improvement and whether it should account for performance deterioration. Table 6 compares the existing methodology

**Table 6. Performance Evaluation Recommendations**

	EXISTING STRUCTURE	RECOMMENDATION
<b>Reward</b>	Achievement	Achievement and improvement
<b>Achievement and improvement weights</b>	Achievement only	Equal weighting of achievement and improvement*
<b>Achievement benchmarks</b>	NCQA national Medicaid benchmarks	<b>HEDIS.</b> NCQA national Medicaid benchmarks <b>Non-HEDIS.</b> Best available benchmark from other states, or if not possible or desirable, percentile within CA
<b>Achievement benchmarks vary by measure</b>	No — 50th percentile for all measures	Yes
<b>Improvement benchmarks</b>	N/A	Yes — statistically significant improvement, with a floor of at least two to four percentage points, depending on the measure
<b>Adjustment for deterioration</b>	No	Yes

\*The exception to this principle is that where the gate is set at the national 50th percentile, DHCS should provide an additional point to MCPs performing at or above the national 90th percentile to recognize their performance excellence.

to the recommended approach for each of these categories. Of note, DHCS staff and Advisory Committee members discussed the goal of having a robust measure set, and the potential need to include non-HEDIS (Healthcare Effectiveness Data and Information Set) measures to accomplish this. Currently, DHCS has a financial penalty tied only to measures with NCOA national Medicaid benchmarks. This brief includes recommendations on how to benchmark non-HEDIS measures that may be included in an MCP quality incentive program to address critical populations, care pathways, or outcomes that current HEDIS measures do not capture.

### Reward

Current DHCS methodology rewards only achievement — that is, attainment of the national 50th percentile performance. Advisory Committee members and interviewees consistently recommended that both achievement and improvement be rewarded. Many suggested combining a gate for minimum performance with a ladder for higher achievement, as well as points for year-over-year improvement, which would motivate MCPs below the achievement benchmark. This approach would incentivize MCPs to improve poor performance or maintain higher performance.

Operationalizing this approach requires defining a series of conditions that must be met to determine whether an achievement or an improvement score is used for a measure. An example condition series is provided in Table 7.

Example 2 below illustrates the interplay between achievement and improvement scores for MCP X’s performance on three quality measures. For each of the measures below, the gate is the 50th percentile. Improvement is measured based on whether there was improvement, performance maintenance, or deterioration (additional information on deterioration can be found in the Improvement Benchmarks and Adjustment for Deterioration section below). For the three example measures, MCP X earned full points for Measure 1, as MCP X’s achievement score was 3. For Measure 2, while MCP X earned a negative achievement score based on its performance being below the 50th percentile, it earned an overall quality score of 2 based on it meeting the improvement target. For Measure 3, MCP X was awarded one achievement point based on meeting the 50th percentile gate despite the fact its performance on Measure 3 declined from its previous performance.

**Table 7. Example Conditions to Determine Use of Achievement or Improvement Score in Methodology**

	POINTS EARNED
If Achievement Score ≤0 and Improvement Score ≤0	Take the larger negative score
If Achievement Score ≤0 and Improvement Score >0	Use the Improvement Score
If Achievement Score >0	Take the larger positive score

**Example 2. Overall Quality Score Earned by MCP X Based on Achievement and Improvement Scores**

	ACHIEVEMENT			IMPROVEMENT		OVERALL QUALITY SCORE
	Target	MCP X Performance	Score	MCP X Performance	Score	
<b>Measure 1.</b> Well-Child Visits in the 3rd, 4th, 5h, and 6th Years of Life	50th percentile	>90th percentile	+3	Maintenance	0	+3
<b>Measure 2.</b> Asthma Medication Ratio	50th percentile	25th percentile	-1	Improvement	+2	+2
<b>Measure 3.</b> Cervical Cancer Screening	50th percentile	50th percentile	+1	Deterioration	-2	+1

### Achievement and Improvement Weights

Programs may elect to weight achievement and improvement equally or choose to weight one more than the other. DHCS should weight achievement and improvement equally to incentivize improvement within regions with lower quality scores. The main advantage of equal weighting is that MCPs with lower rates have a strong incentive to improve, including in geographic regions with historically poor performance that are far from the 50th national percentile benchmark. If Medi-Cal is to achieve overall high-quality care for all enrollees, MCPs with low performance must improve. Rewarding significant improvement is an important lever to utilize, and may have a stronger impact on performance compared to a penalty alone. In cases where DHCS uses the national 50th percentile as the achievement gate, DHCS should allow for an additional point for MCPs achieving the national 90th percentile, to recognize excellent performance.

### Achievement Benchmarks

DHCS should use NCQA national Medicaid benchmarks to determine the gate for HEDIS measures. For non-HEDIS measures, DHCS should use the best available benchmark from other states, or if not possible or desirable, a percentile score within the state.<sup>21</sup>

### Varying Achievement Benchmarks by Measure

Given DHCS's desire to move away from the 25th percentile, and consumer advocate representative recommendations that achievement benchmarks be set minimally at the 50th percentile, benchmarks should be set at least at the 50th percentile. However, instead of requiring all measures to have that same benchmark, DHCS should consider moving the achievement benchmark upward in cases where the majority of MCPs perform above the national 50th percentile.

Some Advisory Committee members agreed with the idea of using varying benchmarks to continue to incentivize improvement. Others thought that differing benchmarks would be complicated to administer, would be difficult to explain to providers, and would always be "raising the bar."

For example, DHCS could look at state mean performance and then select either the 50th percentile or 75th percentile as the achievement benchmark, considering the most achievable target above current state mean performance. This concept is illustrated in Table 8.

**Table 8. Example Selection of Achievement Benchmark Based on Current Performance**

	STATE MEAN PERFORMANCE	NATIONAL 50TH PERCENTILE	NATIONAL 75TH PERCENTILE	RECOMMENDED ACHIEVEMENT BENCHMARK
<b>Cervical Cancer Screening</b>	59%	61%	66%	National 50th Percentile
<b>Prenatal and Postpartum Care — Postpartum Care</b>	68%	66%	70%	National 75th Percentile

Notes: HEDIS percentile values were obtained using national Medicaid HEDIS 2019 (CY 2018) HMO performance. State mean performance was calculated using the data provided by DHCS.

## Improvement Benchmarks and Adjustment for Deterioration

DHCS should set its improvement benchmarks based on statistically significant improvement from the prior year’s performance to ensure that the improvement is not reflective of random variation. This approach should be coupled with an improvement floor of at least two percentage points. The purpose of the improvement floor is to ensure that calculated improvement targets represent meaningful change in the eyes of consumers, and not minimal change (e.g., amounting to a fraction of a percent).

There are two instances where MCP improvement should not be rewarded:

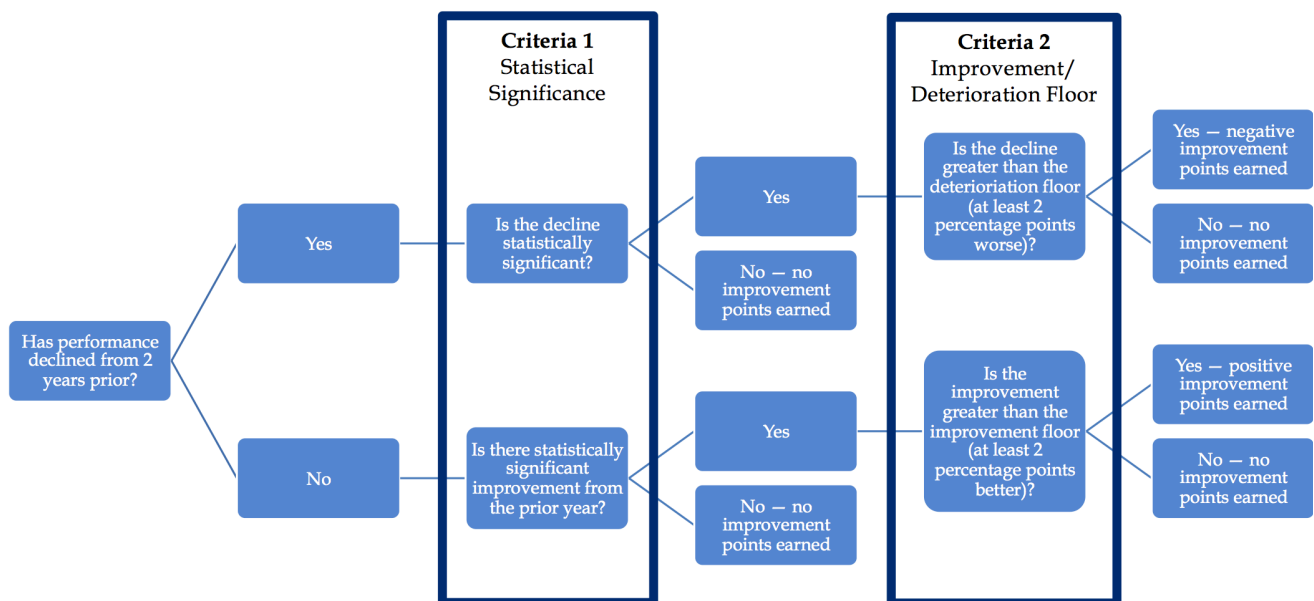
- 1. If improvement is statistically significant but is less than an improvement floor.**
- 2. If the rate is statistically significantly below the rate of two calendar years prior.** In this instance, an MCP is recovering from a deterioration in performance from the prior year.

DHCS should also ensure MCPs are held accountable for deteriorating performance below the gate performance threshold (e.g., achievement benchmark). DHCS staff and the Health Service Advisory Group (HSAG) interviewees thought this was an important design element, as did consumer advocates. MCP representatives thought this design element was overly punitive.

MCPs should receive negative points if performance declines from two years prior and the decline is below a deterioration floor equivalent in percentage point value to the improvement floor. In cases where there is both improvement *and* deterioration present for an MCP, the deterioration points will be used. Figure 1 provides a process chart of how to determine an MCP’s improvement score.

There are two situations in which measures would be ineligible to receive an improvement score. The first is when there are less than three years of performance data for a measure. The second is when there is a significant change in the measure specifications in the performance year or one of the two years prior.<sup>22</sup> In these situations, the achievement score alone would be used for the measure.

Figure 1. Process to Determine Improvement Score



Example 3 below illustrates MCP X's improvement scores on three measures. In this example, the improvement and deterioration floors are two percentage points, and improvement is worth two points. In the example below, MCP X maintained performance on Measure 1 without statistically significant improvement or decline, leading it to an improvement score of 0. For Measure 2, MCP X's performance improved statistically significantly between 2017 and 2018 and surpassed the improvement floor; coupled with the fact that 2018 performance did not represent a decline from 2017 performance leads MCP X to receive an improvement score of 2. For Measure 3, MCP X experienced a statistically significant decline of 10 percentage points between its 2016 and 2018 rates, surpassing the deterioration floor of two percentage points resulting in a negative two (-2) improvement score as a penalty for performance deterioration.

Finally, as with the performance-based auto-assignment recommendation, here too DHCS should move measures to "maintenance" status once performance is high enough that additional improvement focus is no longer warranted. MCPs would not be required to further improve performance on measures in maintenance status, but would be penalized in the algorithm if performance significantly dropped.

## Performance Measures

The key decision regarding performance measures is the selection of which measures should be incentivized in the program. While these considerations were out of scope (and were addressed in other recent CHCF-funded work),<sup>23</sup> the number, weighting, and type of measures will be addressed in this brief.

### Capturing Health Disparities in Performance Measurement

Since this project began, both racial and health equity have come to the forefront of public discourse. Both MCPs and DHCS have an important role to play in measuring and addressing significant health disparities experienced by populations they serve. Therefore, DHCS should include measurement of disparities reduction for one or more measures for which significant disparities exist in the measure set by race/ethnicity, language, or disability status. Specifically, DHCS should select a measure within its Managed Care Accountability Set for disparity-gap reduction based on the state's disparity priorities. DHCS should use its data to confirm which MCPs will have (1) adequate denominator sizes within the subpopulation of interest and (2) disparities in performance within that subpopulation. In the event that an MCP does not meet these criteria, DHCS could create a list of two or three alternative measures that reflect state priorities and/or ongoing disparity-reduction efforts for MCPs to select from. Consumer advocate representatives on the Advisory Committee strongly agreed with this recommendation and noted that areas such as

#### Example 3. Overall Quality Score Earned by MCP X Based on Improvement Scores

	2016 RATE	2017 RATE	2018 RATE	IMPROVEMENT SCORE	RATIONALE
<b>Measure 1.</b> Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	79%	79%	79%	0	Performance was maintained over the past three years without statistically significant change.
<b>Measure 2.</b> Asthma Medication Ratio	50%	55%	60%	+2	Performance improvement was statistically significant between 2017 and 2018, and its improvement rate surpassed the required improvement floor of two percentage points.
<b>Measure 3.</b> Cervical Cancer Screening	70%	65%	60%	-2	Performance decline from 2016 was statistically significant and surpassed the minimum deterioration floor of two percentage points.



postpartum care, chronic conditions, and behavioral health are areas with significant disparities and would be good candidates for consideration.

It is important to note that while there are many actions MCPs can take to help reduce disparities, there is also a limitation on the impact individual MCPs may have. DHCS also has a critical leadership role to play in monitoring and reducing health disparities, potentially in collaboration with other California agencies and purchasers, with the goal of achieving statewide impact at scale.

The remainder of this section considers three supplementary incentive design decisions:

- ▶ How many measures should be used in the incentive program?
- ▶ Should measures be weighted equally?
- ▶ Should incentives be tied to MCP activities or investments in delivery system reform?

Table 9 compares existing DHCS methodology to this brief’s recommendations.

### Number of Measures

DHCS should reduce the number of measures used in the quality incentive program to 15 to allow MCPs and their networks to focus improvement efforts on a set of high-priority areas for the state. Interviewees said there are too many measures in the Managed Care Accountability Set (MCAS), making it hard to get focus from providers. Advisory Committee members recommended including less than 21 measures, and the

majority agreed that the 2019 CHCF-convened advisory body recommendation of 12–15 measures would be optimal. Consumer advocates were wary of reducing measures, since a reduced set may not be able to address every area the agency may want to improve.

### Measure Weights

DHCS should continue to use equal weights in its incentive program. The concept of equal measure weights was supported consistently by Advisory Committee members and interviewees.

### Incentives for Delivery System Reform

DHCS should include assessment of delivery system reform efforts in its incentive measure set. The rationale for this approach is that targeted activities and investments to enhance the delivery system or to adopt value-based payment may have longer-term and sustained impacts on quality that reach beyond a specific set of clinical quality measures. Tying certain activities to incentive funding requires MCPs to develop infrastructure in priority areas for the program and its enrollees. This strategy can be used to incentivize activities for which there are no established quality measures or as a bridge to ready MCPs to adopt existing quality measures once infrastructure and performance reporting are in place. Most interviewees and Advisory Committee members thought adding these efforts would have a meaningful impact on quality over time for Medi-Cal. Most states researched included delivery system reform efforts in their quality programs — see Table 10, page 18.

**Table 9. Performance Measure Recommendations**

	EXISTING STRUCTURE	RECOMMENDATION
<b>Number of Measures</b>	21	15 measures
<b>Measure Weights</b>	Equal weights	Equal weights
<b>Incentives for Delivery System Reform</b>	No	Yes (1–3 measures)
<b>Which Delivery System Reforms</b>	N/A	<ul style="list-style-type: none"> <li>▶ Behavioral health integration</li> <li>▶ Health-disparity reduction</li> <li>▶ Long-term services and supports integration</li> </ul>

**Table 10. Delivery System Reform Efforts Used in Selected Other State Medicaid Quality Programs**

DELIVERY SYSTEM ACTIVITIES	
<b>Arizona</b>	▶ Alternative payment model adoption
<b>Michigan</b>	Incentivizes the following measures and activities in supplemental pay-for-performance and bonus programs for MCPs: ▶ Population health management ▶ Low birthweight ▶ ED utilization ▶ Cost-sharing and value-based services ▶ Integration of behavioral health and physical health services ▶ Alternative payment model strategic plan ▶ Encounter Quality Initiative
<b>New York</b>	▶ Telehealth adoption ▶ Access to maternal health
<b>Oregon</b>	▶ Access to dental services ▶ Access to care for children in Dept. of Homeland Security custody
<b>Washington</b>	▶ Value-based payment adoption ▶ Quality incentives paid to providers

**Table 11. Example Inclusion of Delivery Reform Activities in Incentive Structure**

	PERFORMANCE SCORE	SCORE
<b>Score on Quality Measures</b>	Achieved achievement or improvement on 10 of 15 measures	20
<b>Delivery Reform 1</b>	Pass	2
<b>Delivery Reform 2</b>	Fail	0
<b>Total Quality Incentive Score</b>		22*

\*Maximum points (34–49) are dependent on how many measures use the national 50th percentile as the achievement gate; this example assumes all measures use the 50th percentile as the gate.

One approach to incorporate delivery reform incentives included in the quality incentive methodology would be to reward MCPs on a pass/fail basis for accomplishing prescribed activities by DHCS and adding points to the calculation of the overall quality score. Table 11 illustrates this idea, with delivery reform efforts being worth two points each.

To implement this approach, DHCS needs to determine which delivery system reforms it wishes to incentivize. Interviewees and Advisory Committee members spoke in favor of including measures that address health disparities, behavioral health integration, and long-term services and supports (LTSS) integration. These are high-level concepts. DHCS should consider which activities it would like MCPs to focus on within these topical areas, prioritizing health disparities-focused interventions and behavioral health integration (behavioral health is also an area with significant disparities in access and outcomes). These domains were most frequently raised by stakeholders for consideration when developing delivery system reform activities. LTSS integration was also recommended by some as an important delivery system reform focus given the state has indicated its plan to integrate LTSS into Medi-Cal managed care, and it has also been a focus of recommendations by the governor’s Master Plan on Aging.<sup>24</sup> Given the details of LTSS integration are in development and forthcoming, this brief limits recommendations to delivery system reform measures that address health disparities and behavioral health integration.

As a first step, DHCS could look at delivery system reform activities that are incentivized by *Medicaid programs in other states*. For example, *State Health and Value Strategies published Medicaid Managed Care Contract Language: Health Disparities and Health Equity*, a compendium of contract language from five states. In Michigan, for example, contractors are required to perform data analytics to identify disparities and to implement and report on the effectiveness of evidence-based interventions designed to reduce health disparities and to promote health equity. Michigan Medicaid Managed Care also has a special statewide low-birthweight initiative related to

reducing racial disparities in birth outcomes.<sup>25</sup> DHCS could consider partnering with Covered California and other California purchasers to identify a focus disparity to address statewide, and require MCPs to collaborate on an initiative to reduce that disparity, similar to Michigan’s approach to birth outcomes.

A few states have incentivized MCPs for activities or metrics related to behavioral health integration. Stakeholders and DHCS staff agreed that this could be an important focus for delivery system reform activities. Because the carved-out specialty mental health and substance use disorder benefits in California involve multiple delivery systems, they too often result in siloed care and suboptimal outcomes for Medi-Cal enrollees.

DHCS could look to New York State for examples of how both behavioral health performance measures and behavioral health integration activities have been incorporated into incentive programs through DSRIIP.<sup>26</sup> New York includes incentives to implement behavioral health screening in primary care, as well as incentives to support the implementation of the collaborative care model in primary care practices that serve Medicaid patients. These incentives function primarily at the provider and delivery system level, and are paired with incentives tied to behavioral health performance measures at the MCP level.

DHCS could consider a delivery system reform measure that (1) requires MCPs to support behavioral health integration in their provider networks through targeted investments, incentives, and technical assistance or (2) requires MCPs to demonstrate achievement of a specific level of behavioral health integration in their network by region. Michigan also has a performance bonus program in its MCP contract for activities to promote integration of behavioral health and physical health.<sup>27</sup> The program includes implementing joint care-management processes between physical and behavioral health entities, requiring each mental health plan and prepaid inpatient health plan to document joint care plans for patients at a certain level of severity/risk that receive services from both entities. In addition, Michigan includes in its contract

performance metrics that reflect integrated services, such as follow-up after hospitalization for mental illness within 30 days, plan all-cause readmission, and follow-up after an emergency department visit for alcohol and other drug dependence.

DHCS could consider designing incentives that include a combination of behavioral health integration activities and metrics that reflect the needs and priorities of Medi-Cal enrollees. This could support DHCS goals of encouraging and aligning MCP behavioral health integration efforts and promoting MCP partnerships with specialty mental health plans and the organized delivery system of care.

## Example Calculation

There are many ways DHCS could implement the design components described above. Appendix A provides an example of high-level performance for fictitious MCP Y. In this example, MCPs are being evaluated based on their performance on 11 quality measures, with achievement targets that vary between the national Medicaid 50th and 75th percentiles. Percentiles selected represent the nearest national benchmark above state mean performance. The improvement and deterioration floor for all measures in the example is 2 percentage points.

“Full points” in the example is equivalent to two points, with a bonus point available for exceeding the 75th percentile value when the achievement target is set at the 50th percentile. The rationale for awarding the bonus point is that strong performance when compared to national benchmarks should be rewarded.

The example also includes delivery system reform measures (behavioral health integration and health disparities reduction) scored on a pass/fail basis and are ineligible for improvement scores. More detail on delivery system reform measures can be found in the section below.

The overall measure scores are added to produce a total score. These total scores are compared to the number of points required to earn full incentive. In

this example, 13 points are required, one point per measure, which translates to on average achieving the national Medicaid 50th percentile. The percentage of withhold earned is the total score divided by the points required to earn the full incentive, capped at 0% and 100%. In this example, MCP Y failed to meet the achievement target for seven quality measures and two delivery system reform measures, but had strong performance on four measures and earned back credit based on improvement for an additional measure, resulting in a total score 7.17 points, which results in MCP Y receiving 55% of the withhold in this example.

A detailed description of the methodology can be found in Appendix E. It is important to note that this methodology can serve multiple purposes, including withhold performance assessment, a portion of the auto-assignment performance assessment, and to inform public performance-reporting /publicity efforts.

## Nonfinancial Incentives

Currently, DHCS employs a mix of nonfinancial incentives for quality performance to further encourage MCPs to improve quality, including use of public performance-reporting mechanisms, Plan-Do-Study Act (PDSA) improvement projects, performance-based auto-assignment, and corrective action plans. Bailit Health offers recommendations for further enhancements in three of these four areas.

## Public Reporting of Performance

Public performance reporting is inclusive of two sub-strategies: *best practice profiling*, the provision of in-depth descriptions of the best practices used by MCPs to achieve high-performance rates, and *publicizing performance*, the disclosure of the performance rates for all MCPs to interested parties, including the public.

DHCS should enhance its best practice profiling with additional opportunities for recognition for achievement and improvement. This could include increasing the number of awards DHCS gives out to managed care plans to recognize both achievement

and improvement, creating a regular, widely distributed publication that highlights best practices of Medi-Cal MCPs in delivering quality care, creating workshops or collaboratives for best practice MCPs to share how they achieved high performance and/or improvement, and further enhancing the publicizing of awards, recognition, and best practices of managed care plans to the larger California stakeholder community.

DHCS could enhance its public reporting of individual MCP performance by adding MCP-level reporting at the domain and measure level and by creation of a dynamic dashboard<sup>28</sup> with search capabilities that could include selection of particular measures and domains and MCP comparisons for their region. Generally, Advisory Committee members and stakeholder interviewees found public performance reporting to be a motivating nonfinancial incentive for MCPs to improve quality.<sup>29</sup> DHCS should consider publishing data on the person-level impact of an MCP improving on quality measures by noting instances where an MCP's performance improvement to the achievement target would result in a specified number of additional people receiving a needed service, and when appropriate include the estimated impact on disease detection or health. For example, guideline-based cervical cancer screening to detect abnormalities before cancer develops has been shown to reduce cervical cancer by 67%.<sup>30</sup> California has an estimated 1,400 new cases of cervical cancer a year.<sup>31</sup> If Medi-Cal enrollees constitute one-third of these new cases, then if 90% of MCP members are screened per guidelines, approximately 279 cases of cervical cancer annually could be prevented through early detection.

## Quality Improvement Projects

DHCS should consider piloting alternative quality improvement approaches to the PDSA improvement projects. Advisory Committee members and stakeholder interviewees thought that PDSAs were of limited value to generate MCP quality improvement in the long term. Specifically, MCP interviewees explained they are typically implementing several complementary interventions to improve performance in a particular area of focus; therefore, it is difficult to

determine what impact is attributable to the PDSA project alone versus other interventions. Interviewees also noted that the PDSA project is focused on a small population and is often not scalable, so it cannot be used to inform sustained MCP work in the long term. One Advisory Committee member recommended an alternative approach — that MCPs submit an overall plan for improvement, of which an element could be the PDSA. DHCS and consumer advocates emphasized it is important for DHCS to ensure MCPs are engaged in quality improvement (QI) activities. DHCS should engage with MCPs to identify alternative approaches that meet the goals of focused QI, but explore other approaches that may be more aligned with an MCP's overall QI process and that could include multiple approaches the MCP may be taking to improve on a particular measure or domain.

### Performance-Based Auto-Assignment

In 2005, DHCS implemented a performance-based auto-assignment algorithm in counties with two or more MCP options. It replaced a system in which enrollees who didn't choose an MCP themselves (i.e., "non-choosers") were randomly assigned to an MCP unless they had a prior relationship with an MCP. The intent of the algorithm was threefold: (1) to assign a greater share of non-choosers to MCPs with higher quality scores and a larger share of traditional safety-net providers in their network, (2) to reward higher-performing MCPs with a greater share of these non-choosers, and (3) to incentive MCPs to improve their quality scores.

While the auto-assignment methodology seems to have achieved the first two goals, a recent study found no relationship between auto-assignment and MCP performance.<sup>32</sup> Furthermore, some stakeholders report that performance-based auto-assignment can result in significant rewards when there are wide swings in year-to-year performance but no actual trend of improvement under DHCS's current methodology. The authors believe performance-based auto-assignment can be a valuable component of the

broader DHCS quality incentive strategy, but should be strengthened by making the following changes:

- ▶ Move from the Aggregated Quality Factor Score to a smaller set of auto-assignment measures aligned with the measures used for the withhold (i.e., all of a subset of the withhold measures). Move measures to "maintenance" status once performance is high enough that additional improvement focus is no longer warranted. MCPs would not be required to further improve performance on measures in maintenance status, but would be penalized in the algorithm if performance significantly dropped.
- ▶ Change the scoring of quality results from a comparison with prior-year performance to a comparison with the average of the prior two years. This would protect against rewarding MCPs for performance that is the same or even worse than two years prior.
- ▶ Remove the two safety-net measures Percentage of Hospital Discharges from DSH Facilities, and Percentage of Members Assigned to PCPs Who Are Safety Net Providers. Neither measure rewards quality improvement. In addition, whereas safety-net provider inclusion in MCP networks was a reasonable safety-net provider concern in 2004, given the major role safety-net providers currently play in the networks of MCPs, it seems highly unlikely the measures continue to impact safety-net provider participation in MCP networks. Removal of these measures would strengthen the auto-assignment incentive for quality improvement.
- ▶ Remove the cap on percentage of total assignments. Doing so would provide MCPs demonstrating performance improvement with a greater immediate benefit, and thereby strengthen the incentive to improve.
- ▶ Remove the link between submission of encounter data and auto-assignment, and instead rely on the current process to address submission of encounter

data as a compliance issue and levy significant liquidated damage penalties for noncompliance.

### Corrective Action Plans

Corrective action plans (CAPs) require MCPs to submit a plan for how to address underperformance. DHCS currently requires CAPs to be submitted by MCPs that don't meet the national 50th percentile on quality measures. This brief does not recommend any changes to the CAP requirement, as stakeholders thought it was a productive process.

### Contracting

Finally, one of the strongest tools and clearest signals DHCS can use is to consider MCP performance when making contracting choices. DHCS should prohibit service area expansion for MCPs with poor performance and make past quality performance a significant factor when making future procurement contract award decisions.<sup>33</sup> Both of these strategies have been employed by other states and can complement other nonfinancial strategies. They would require that DHCS develop specific criteria on how to implement these strategies as part of reprocurement. The limitation of this approach is that this mechanism cannot be used for public MCPs and County Organized Health System (COHS) MCPs not required to reprocure. In these circumstances, DHCS could instead require a change in an MCP's executive team if a local initiative or COHS has continued poor performance. It is also limited by the frequency with which DHCS reprocures its managed care contracts or expands to new services areas.

Ultimately, should an MCP's performance remain poor over time despite application of financial and nonfinancial strategies and concerted MCP management work by DHCS, the MCP's contract with DHCS should be terminated. Furthermore, consistent with past recommendations, the authors recommend that DHCS have routine reprocurements every five years. Doing so provides an important opportunity for DHCS to

reiterate its vision and priorities and to secure commitments from bidding MCPs that help further those priorities.<sup>34</sup>

## Conclusions and Next Steps

When California adopted and later expanded Medi-Cal managed care, state officials set out to improve the quality of care for Medi-Cal enrollees and to contain health care costs. On the matter of quality, Medi-Cal managed care has not lived up to its potential. Over the past decade, there was improvement in fewer than half of the quality measures reported to DHCS by MCPs, and millions of children have not received the recommended preventive care services included in the Medi-Cal benefit.<sup>35</sup>

The recommendations in this report — informed by interviews with state officials and key stakeholders and the experience of other states — lay out a bolder vision for quality improvement in Medi-Cal managed care. By adopting the changes recommended in this report, DHCS can improve Medi-Cal and positively impact quality of care for millions of Medi-Cal enrollees.

Some elements of the recommended approach would be easier to implement using a withhold structure. Should DHCS conclude that it cannot implement the withhold structure until its planned 2024 reprocurement, DHCS should use a two-phase approach, summarized in Table 11, page 23. Before implementing any pre- or post-procurement changes, DHCS should model the impact of methodology changes on MCPs.

Finally, it should be noted that while quality incentive programs can provide focus and motivation for contracted MCPs, they must be coupled with hands-on contract management activity by DHCS, as discussed in a prior CHCF report.<sup>36</sup> Even then, MCPs lacking sufficient leadership, staffing, and commitment may not rise to the challenge. In such cases DHCS will need to consider changes in MCP partners.

**Table 11. Implementation Timing of Design Elements**

**Pre-Procurement (2021–23)**

- ▶ Expand public performance reporting, enhance auto-assignment, explore alternative quality improvement approaches to the PDSA, and explore other opportunities
  - ▶ Establish improvement benchmarks and reward both achievement and improvement
  - ▶ Reduce the number of quality measures used for financial and nonfinancial incentives
  - ▶ Consider incentivizing one to three structured MCP activities or investments to improve delivery system infrastructure
- 

**With New MCP Contracts (beginning in 2024)**

- ▶ Adopt a capitation withhold
  - ▶ Move to a gate-and-ladder methodology to reward higher levels of performance
  - ▶ Amplify the reward for improvement in specific geographic areas that have poor access and quality, or adjust the benchmark to account for geographic variation based on objective criteria
  - ▶ Vary the benchmark by measure
  - ▶ Implement statistically significant deterioration of at least two percentage points
-

## Appendix A. Example Calculation of Quality Incentive Earned for MCP Y

	ACHIEVEMENT/ IMPROVEMENT INPUTS			PLAN PERFORMANCE*			QUALITY INCENTIVE CALCULATION					
	Target* (percentile)	Target Value	Improvement/ Deterioration Floor	2016	2017	2018	Achievement Ladder Rung* (percentile)	Achievement Score <sup>†</sup>	Improvement <sup>‡</sup> from 2017?	Deterioration <sup>‡</sup> from 2016?	Improvement/ Deterioration Score <sup>§</sup>	Overall Measure Score
<b>Annual Monitoring for Patients on Persistent Medications – ACE Inhibitors or ARBs</b>	50th	88.9%	2%	93.0%	90.4%	90.9%	75th–90th	2.10	No	Yes	–2.00	2.10
<b>Asthma Medication Ratio</b>	50th	63.6%	2%	n.d.	62.6%	61.3%	25th–50th	0.00	No	N/A	N/A	0.00
<b>Breast Cancer Screening</b>	50th	58.7%	2%	n.d.	64.2%	65.0%	75th–90th	2.19	No	N/A	N/A	2.19
<b>Childhood Immunization Status – Combination 3</b>	50th	70.7%	2%	65.1%	73.7%	68.4%	25th–50th	0.00	No	No	0.00	0.00
<b>Children and Adolescents' Access to Primary Care Practitioners – 5 Months to 6 Years</b>	50th	87.9%	2%	85.8%	85.7%	85.8%	25th–50th	0.00	No	No	0.00	0.00
<b>Comprehensive Diabetes Care – Medical Attention for Nephropathy</b>	75th	91.9%	2%	91.8%	93.2%	91.2%	50th–75th	0.00	No	No	0.00	0.00
<b>Comprehensive Diabetes Care – HbA1c Control (&lt;8.0%)</b>	75th	56.0%	2%	48.6%	57.7%	57.4%	75th–90th	1.30	No	No	0.00	1.30
<b>Prenatal and Postpartum Care – Postpartum Care</b>	75th	69.8%	2%	56.4%	60.8%	68.9%	50th–75th	0.00	Yes	No	2.00	2.00
<b>Use of Imaging Studies for Low Back Pain</b>	75th	76.0%	2%	70.7%	70.5%	69.6%	25th–50th	–1.42	No	No	0.00	–1.42
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition – Total</b>	75th	79.8%	2%	80.3%	79.6%	75.7%	50th–75th	0.00	No	Yes	–2.00	–2.00
<b>Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life</b>	50th	78.5%	2%	74.4%	72.0%	83.9%	≥90th	3.00	Yes	No	2.00	3.00
<b>Behavioral Health Integration</b>	Pass/fail		N/A			Fail		0.00			N/A	0.00
<b>Health Disparity Reduction</b>	Pass/fail		N/A			Fail		0.00			N/A	0.00
<b>Total Score</b>											<b>7.17</b>	
<b>Points Required to Earn Full Withhold</b> (1 per measure) <sup>#</sup>											<b>13.00</b>	
<b>Percentage of Withhold Earned</b> (range: 0%–100%)											<b>55%</b>	

\*National Medicaid value or range.

<sup>†</sup> Points earned are on a continuous scale of improvement (the formula for this calculation can be found in Appendix E).

<sup>‡</sup> Statistically significant improvement/deterioration.

<sup>§</sup> Improvement is assessed based on performance compared to the calendar year prior, whereas deterioration is assessed based on performance from two calendar years prior.

<sup>#</sup> As a reminder, in ultimately selecting a methodology to earn back the withhold, it is important that DHCS model measure-level performance for the measures that will be included in the program, as well as explore the impact of different thresholds to earn back the full withhold. The threshold used in this example is for illustrative purposes only.



## Appendix B. Stakeholder Interviews

### DHCS

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## Appendix D. Principles for Quality Incentive Program Design for Medi-Cal Managed Care Plans

Below are principles for a DHCS Medi-Cal managed care plan quality incentive approach and principles for measure selection.

### Draft Principles for Quality Incentive Program Design

- ▶ Utilize a combination of financial incentives and disincentives to motivate improved performance. If additional financial incentives are not feasible initially, add them as soon as practical to ensure a balanced approach.
- ▶ Employ a mix of nonfinancial incentives.
- ▶ Require a minimum performance level for qualification for an incentive or avoidance of a disincentive.
- ▶ Reward increments in performance excellence.
- ▶ Incentivize both excellent performance and improved performance, with excellent performance most highly rewarded.\*
- ▶ Penalize deteriorating performance (i.e., the opposite of improvement).
- ▶ Hold all managed care plans to the same standards.
- ▶ Explore potential methods and feasibility of adjustments for geographic and social risk-factor variation across the state.
- ▶ Make benchmarks achievable and meaningful.
- ▶ Balance representation of key populations and conditions with measure set parsimony.
- ▶ Treat all measures and measured populations as equally important.
- ▶ Incentivize high-priority delivery system reform activities that do not currently have associated nationally endorsed quality metrics.
- ▶ Maintain reasonable measure set consistency over time, finalize the measure set in advance of the performance year, and distribute incentives in a timely manner afterward.

### Principles for Quality Measure Selection†

- ▶ Be meaningful to patients and 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 DHCS Medi-Cal Accountability Set.

\*The Advisory Committee veered from the original design principle and recommended equal weights to incentivize improvement within low-performing regions.

† Adopted in 2019 by a CHCF-convened advisory group representing a diverse array of Medi-Cal stakeholders, including Medi-Cal MCP leaders, consumer advocates, provider representatives, and other experts. For more detail on the advisory group and its recommendations for a Medi-Cal managed care measure set and performance evaluation methodology to encourage improvement in the quality of care provided to Medi-Cal enrollees by MCPs, see *Paying Medi-Cal Managed Care Plans*, CHCF.

Sources: Principles were drawn from the following sources: *Advancing Quality Through Collaboration: The California Pay for Performance Program* (PDF), Integrated Healthcare Assn., February 2006; *Putting Quality to Work: Rewarding Plan Performance in Medi-Cal Managed Care*, CHCF, May 2006; and *Pay-for-Performance in the Medi-Cal Managed Care and Health Families Programs: Findings and Recommendations*, CHCF, August 2009.

## Appendix E. Quality Incentive Methodology Scoring Details

### Overall Measure Scores and Total Score

The overall measure score is calculated using the following logic for quality measures with achievement and improvement scores:

- ▶ If achievement score  $\leq 0$  and improvement score  $\leq 0$ , use the largest negative points value.
- ▶ If achievement score  $\leq 0$  and improvement score  $> 0$ , use the higher of achievement and improvement.
- ▶ If achievement score  $> 0$ , use the higher of achievement and improvement.  
Measures with less than three years of available data are ineligible to receive an improvement score, and the achievement score will be used.
- ▶ For delivery reform measures, scores are calculated on a pass/fail basis, with either zero points for a failing score or full points for a passing score.

The total score is the sum of the individual overall measure scores. The total score should be compared to the total possible points, which takes the larger of the achievement weight multiplied by the number of measures and the improvement weight multiplied by the number of measures for which improvement is applicable, plus the number of delivery reform measures times their weights.

### Achievement Score

The achievement score is calculated by comparing MCP performance to the achievement targets (see table). The “gate” is the value an MCP needs to score above to earn positive points toward the achievement score; in this case, plans may select either the 50th or 75th percentile. As an MCP moves further above or below the gate, rewards increase or decrease, with set values for various national percentiles.

50TH PERCENTILE ACHIEVEMENT PERFORMANCE RANGE	POINTS EARNED	LOGIC
5th	-2	Full negative points
>5th and <25th	-2 to -1	Between half negative points and full negative points = full negative points + (performance score - 5th percentile target) / (25th percentile target - 5th percentile target)
25th	-1	Half negative points
>25th and <50th	0	Zero
50th	1	Half positive points
>50th and <75th	1 to 2	Between half and full positive points = half positive points + (performance score - 50th percentile target) / (75th percentile target - 50th percentile target)
75th	2	Full positive points
>75th and <90th	2 to 3	Between full points and full points and half points bonus = full positive points + (performance score - 75th percentile target) / (90th percentile target - 75th percentile target)
90th	3	Full points and half points bonus

75TH PERCENTILE ACHIEVEMENT PERFORMANCE RANGE	POINTS EARNED	LOGIC
25th	-2	Full negative points
>25th and <50th	-2 to -1	Between half negative points and full negative points = full negative points + (performance score - 25th percentile target) / (50th percentile target - 25th percentile target)
50th	-1	Half negative points
>50th and <75th	0	Zero
75th	1	Half positive points
>75th and <90th	1 to 2	Between half and full positive points = half positive points + (performance score - 75th percentile target) / (90th percentile target - 75th percentile target)
90th	2	Full positive points

### **Improvement Score**

The improvement score is calculated by comparing MCP performance to MCP prior performance. If improvement from the prior year's performance is statistically significant and is greater than or equal to the improvement floor, full points of +2 are earned. If deterioration from two years' prior performance is statistically significant and is greater than or equal to the deterioration floor, full negative points of -2 are earned. In cases where there is both statistically significant improvement and deterioration, the deterioration score will be used. Any nonsignificant changes or significant changes that do not meet the floor requirements will result in an improvement score of zero. Measures for which there are not three years of data are ineligible to earn an improvement score. Should there be a significant change in methodology between the performance year and either of the two years prior, improvement scores should not be used.

### **Delivery System Reform Measures**

For delivery system reform measures, scores are calculated on a pass/fail basis, with either zero points for a failing score or full points of +2 for a passing score.

### **Example Calculation of Withhold Earned**

DHCS could calculate the percentage of withhold earned. In our example, the denominator is based on one times the number of measures (inclusive of delivery system reform measures), with the numerator being total points earned. In this example, the full withhold can be earned back at NCQA Medicaid 50th percentile performance on average. This was selected as it maps most closely to the current penalty threshold of NCQA Medicaid 50th percentile; however, DHCS could alternatively set the threshold to earn back the full withhold at any performance level it chooses. The example caps the percentage of withhold earned, not allowing MCPs to earn less than 0% of the withhold, or more than 100% of the withhold. So if DHCS selected 12 quality measures and 2 delivery reform measures for its incentive, 14 points would be needed to earn the full withhold.

In ultimately selecting a methodology to earn back the withhold, it is important that DHCS model measure-level performance for the measures that will be included in the program, and explore the impact of different thresholds to earn back the full withhold.

## Endnotes

1. Len Finocchio, Matthew Newman, and Eunice Roh, *Medi-Cal Facts and Figures: Crucial Coverage for Low-Income Californians*, California Health Care Foundation (CHCF), February 2019.
2. *Volume 1 of 3 Medi-Cal Managed Care External Quality Review Technical Report: July 1, 2018–June 30, 2019* (PDF), California Dept. of Health Care Services (DHCS), June 2020.
3. Andrew B. Bindman, *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade*, CHCF, September 2019; and Elaine Howle, *Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services* (PDF), Auditor of the State of California, August 2019.
4. Daniel Kahneman and Amos Tversky, "Prospect Theory: An Analysis of Decision Under Risk," *Econometrica* 47, no. 2 (Mar. 1979): 263–92.
5. In 2019, CHCF engaged Bailit Health to research and make recommendations for a measure set and performance evaluation methodology to encourage improvement in the quality of care provided to Medi-Cal enrollees by MCPs: *Paying Medi-Cal Managed Care Plans for Value: Quality Goals for a Financial Incentive Program*, CHCF, April 2019.
6. Leela V. Thomas, Kenneth R. Wedel, and Jan E. Christopher, "Access to Transportation and Health Care Visits for Medicaid Enrollees with Diabetes," *Journal of Rural Health* 34, no. 2 (Mar. 17, 2017): 162–72; J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman, "The Case for More Active Policy Attention to Health Promotion," *Health Affairs* 21, no. 2 (Mar./Apr. 2002): 78–93; Tricia Brooks and Kelly Whitener, *Leveraging Medicaid to Address Social Determinants and Improve Child and Population Health*, Georgetown University Center for Children and Families, February 28, 2018; Sandro Galea et al., "Estimated Deaths Attributable to Social Factors in the United States," *American Journal of Public Health* 101, no. 8 (Aug. 1, 2011): 1456–65; Roberta Capp et al., "Coordination Program Reduced Acute Care Use and Increased Primary Care Visits Among Frequent Emergency Care Users," *Health Affairs* 36, no. 10 (Oct. 2017): 1705–11; and Sharon Hewner et al., "Integrating Social Determinants of Health into Primary Care Clinical and Informational Workflow During Care Transitions," *eGEMs (Generating Evidence & Methods to improve patient outcomes)* 5, no. 2 (2017): 2.
7. Bailit Health researched both performance-based capitation adjustment and shared-savings models for MCPs as alternative financial structures to the penalty. After review of public resources and discussions with two large actuarial firms that work with many states, the authors were not able to identify any states that had such approaches in place. Given the advantages identified above for the withhold structure, Advisory Committee support of this approach, and the fact that many other states utilize the withhold mechanism for plan quality incentives, the authors make this withhold recommendation.
8. *Raising the Bar: How California Can Use Purchasing Power and Oversight to Improve Quality in Medi-Cal Managed Care*, CHCF, April 2019.
9. Bindman, *A Close Look*; and Howle, *Millions of Children*.
10. *Raising the Bar*, CHCF.
11. *Making Quality Matter in Medi-Cal Managed Care: How Other States Hold Health Plans Financially Accountable for Performance*, CHCF, February 2019.
12. *Paying Medi-Cal Managed Care Plans*, CHCF.
13. Principles were drawn from the following sources: *Advancing Quality Through Collaboration: The California Pay for Performance Program* (PDF), Integrated Healthcare Assn., February 2006; *Putting Quality to Work: Rewarding Plan Performance in Medi-Cal Managed Care*, CHCF, May 2006; and *Pay-for-Performance in the Medi-Cal Managed Care and Health Families Programs: Findings and Recommendations*, CHCF, August 2009.
14. *2017 Quality Incentive for Medicaid Managed Care Plans: A Report on Quality Incentive Program in New York State* (PDF), New York State Dept. of Health, n.d.; and K. John McConnell, "Oregon's Medicaid Coordinated Care Organizations," *JAMA* 315, no. 9 (2016): 869–70.
15. *Evaluation of the Medicare Quality Bonus Payment Demonstration* (PDF), Centers for Medicare & Medicaid Services, February 2016; Timothy J. Layton and Andrew M. Ryan, "Higher Incentive Payments in Medicare Advantage's Pay-for-Performance Program Did Not Improve Quality but Did Increase Plan Offerings," *Health Services Research* 50, no. 6 (Dec. 2015): 1810–28; Rachel O. Reid et al., "The Roles of Cost and Quality Information in Medicare Advantage Plan Enrollment Decisions: An Observational Study," *Journal of General Internal Medicine* 31 (2016): 234–41; and Michael Darden and Ian Michael McCarthy, "The Star Treatment: Estimating the Impact of Star Ratings on Medicare Advantage Enrollments," *Journal of Human Resources* 50, no. 4 (Oct. 2015): 980–1008.
16. In June 2020, MedPAC recommended to Congress replacing the Medicare Advantage quality bonus program with a new value incentive program that (1) scores a small set of population-based measures, (2) evaluates quality at the local-market level, (3) uses a peer-grouping mechanism to account for differences in enrollees' social risk factors, (4) establishes a system for distributing rewards with no "cliff" effects, and (5) distributes plan-financed rewards and penalties at a local-market level.
17. The key decision regarding performance measures is the selection of which measures should be incentivized in the program. While this consideration was out of scope, the brief provides recommendations on some subtopics in this area.
18. Kahneman and Tversky, "Prospect Theory."

19. "Structural urbanism," a bias toward large population centers, has been posited to exacerbate many of these disparities. In the health care context, structural urbanism stems from (1) a focus on population-based outcomes resulting in preferential allocation of funding to large population centers, (2) innate inefficiencies of low populations and remote settings that result in higher per capita costs, and (3) health care driven by "market opportunities." Definition of structural urbanism is from Janice Probst, Jan Marie Eberth, and Elizabeth Crouch, "Structural Urbanism Contributes to Poorer Health Outcomes For Rural America," *Health Affairs* 38, no. 12 (Dec. 2019): 1976–84.
20. McGinnis, Williams-Russo, and Knickman, "The Case."
21. "The Buying Value Benchmark Repository" contains performance rates submitted by states and regional health improvement collaboratives for non-HEDIS measures.
22. For HEDIS measures, NCQA annually publishes Measure Trending Determinations outlining where measure changes are significant and should result in a break in trend.
23. In 2019, CHCF engaged Bailit Health to research and make recommendations for a measure set and performance evaluation methodology to encourage improvement in the quality of care provided to Medi-Cal enrollees by MCPs: *Paying Medi-Cal Managed Care Plans*, CHCF.
24. "Master Plan for Aging," California Health and Human Services Agency, n.d.
25. *Medicaid Managed Care Contract Language: Health Disparities and Health Equity* (PDF), State Health and Value Strategies, n.d.
26. "New York State Delivery System Reform Incentive Payment Program Project Toolkit," New York State Dept. of Health, February 2018.
27. *Comprehensive Health Care Program for the Michigan Department of Health and Human Services* (PDF), State of Michigan, retrieved September 8, 2020.
28. DHCS could look to New York's or Florida's reporting as an example. The NY State Department of Health website has an [online report of NY health plans](#) (includes Medicaid, commercial HMO/PPO, and specialty plans), which allows users to visualize plan performance by each measure and quality domain. [FloridaHealthFinder.gov](#) allows users to view Medicaid plan performance by geography and by measure category or by specific measures.
29. Public performance reporting will not have an impact on consumer choice in regions using County Organized Health Systems.
30. Susan Mayor, "Screening Reduced Cervical Cancer Deaths by More Than Two Thirds, UK Study Finds," *BMJ* 354 (2016): i5026, doi:10.1136/bmj.i5026.
31. Brenda M. Hofer et al., *Cervical Cancer in California, 2008* (PDF), California Dept. of Public Health, January 2008.
32. Bindman, *A Close Look*.
33. For MCPs with Medi-Cal experience, past performance would be specific to the Medi-Cal program. For new bidders without Medi-Cal experience, past performance would be drawn from experience in other states.
34. *Raising the Bar*, CHCF.
35. Bindman, *A Close Look*; and Howle, *Millions of Children*.
36. *Raising the Bar*, CHCF.