CHCF

Quality Incentive Program Design Decisions:
An Overview of Programs in California and Selected Other States

FEBRUARY 2021

AUTHORS
Justine Zayhowski, Jennifer N. Sayles, MD, MPH,
and Michael Bailit

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.

For more information, visit www.bailit-health.com.

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.

For more information, visit www.chcf.org.

Contents

Executive Summary

The California Department of Health Care Services (DHCS) is considering alternative quality performance incentives for use with Medi-Cal managed care plans to improve the provision of quality care for Medi-Cal enrollees and overall Medi-Cal managed care program performance. This white paper examines the approaches taken by California programs, including the new 2020 Medi-Cal managed care plan incentive strategy, and six state Medicaid programs across key incentive design considerations.

Incentive Structure

In designing a quality incentive program, health care agencies must determine how the incentive will be structured. Incentive structure considerations include these:

- What is the form of the financial incentive?
- Should nonfinancial incentives be applied?
- How do managed care plans qualify for the incentive?
- Should the incentive structure allow for modifications by geography within the state?
- Should the incentive structure allow for modifications based on variation in clinical risk among plans?

The most common forms of financial incentives used by researched programs include use of a capitation withhold or a quality bonus, with multiple programs coupling both approaches. Behavioral economics suggests that a potential loss in income, through use of a mechanism such as a withhold, is more effective to induce behavior change than a potential gain. An advantage of using a quality bonus, however, is that plans are not financially vulnerable if they do not achieve quality performance targets.

States have coupled their financial incentives with nonfinancial ones, with many programs using auto-assignment preference, requiring performance improvement or corrective action plans, and publicizing performance. The advantage of all these approaches is that they encourage quality improvement without the costs associated with financial incentives.

State health care agencies need to determine how plans qualify for quality incentives. Programs can decide to use a "gate," meaning that specific performance expectations must be met to qualify for the incentive; a "ladder," meaning the amount an incentive increases or a disincentive decreases as performance improves; or a combination of the two. All programs examined used either a "gate" or "gate-and-ladder" approach.

Gates establish minimum quality standards whereas ladders incentivize achieving incrementally higher levels of quality performance.

None of the programs examined by the authors modified their quality incentive methodologies to account for geographic variation or variation in clinical risk, but programs may elect to do so to try to avoid disadvantaging plans serving vulnerable regions or populations.

Performance Evaluation

A major decision in developing any performance evaluation framework is to determine what should be rewarded — achievement, improvement, or both. Based on this decision, there are further considerations for each of these approaches. Achievement alone rewards high-performing plans, whereas a combination approach incentivizes both low-performing plans to improve and high-performing plans to maintain and/or improve performance. In most cases, those using a combined approach weighted achievement more than improvement to recognize high performers and to provide incentive to maintain performance.

Within achievement and improvement, the next consideration is how to set the benchmarks. For achievement, a program could adopt national or regional percentile benchmarks, state percentile benchmarks, state ranking, or other non-percentile

benchmarks. Programs have tended to use national benchmarks for Healthcare Effectiveness Data and Information Set (HEDIS) measures since they provide a standardized comparison of performance across plans, and then employ a combination of state percentile benchmarks or non-percentile benchmarks where national benchmarks are not available. State benchmarks and non-percentile values can be used where no other benchmarks are available, but particularly in the case of non-percentile values, it is important to clearly communicate the rationale for benchmark selection. Programs may elect to vary the achievement benchmarks by measure or to use the same benchmark across all measures. Although maintaining the same benchmark sends a consistent message on performance expectations, allowing variable benchmarks accounts for performance variation by measure and allows for inclusion of measures with no national benchmarks. Examined programs were split on whether to use one benchmark (e.g., the same national percentile) or to vary benchmarks by measure.

For improvement, programs can use absolute percentage point improvement, gap reduction, or statistical significance to define improvement benchmarks. Each of these strategies were employed by the examined programs. Use of an absolute term for improvement is easy to explain and operationalize but may reward plans for improvement that results from chance and does not represent true improvement. When defining improvement either through a gap-reduction strategy or a test of statistical significance, states sometimes also apply a minimum improvement floor to ensure that these methods do not result in rewards for tiny, meaningless improvement.

A final consideration within performance evaluation is whether performance deterioration should be accounted for. The idea behind this design element is to ensure plans are not rewarded when quality performance is deteriorating, as this runs contrary to the purpose of implementing a quality incentive program. Only one state Medicaid program examined accounts for performance deterioration by financially penalizing plans.

Performance Measures

The key decision regarding performance measures is the selection of which measures should be incentivized in the program. While this consideration is outside of this report's scope,[1] there are three supplementary incentive design decisions considered: (1) How many measures should be used in the incentive program, (2) should measures be weighted equally, and (3) should incentives be tied to plan activities or investments in delivery system reform?

Size of the measure set is a key consideration of any quality incentive program. Smaller measure sets allow plans and their networks to focus improvement efforts on a set of high-priority areas for the state but may not be able to address every area the agency may want to improve. As the size of the measure set increases, it may signal the importance of broader improvement at the cost of jeopardizing improvement on any given measure. An important consideration, however, is the number of different types of providers impacted by the measures, since plan incentives will often flow down to providers. Programs ranged widely in the size of their measure sets.

Another way programs can signal priorities is through the weighting of individual measures within the incentive set. It can be difficult to reach a decision on which measures should be weighed higher relative to other measures, but programs doing so tend to consider factors including agency priority focus areas, greatest opportunity for population health impact, greatest variation between current and target performance, and differential effort or costs required to improve measure performance. Examined programs were split between using equal and unequal weights.

Finally, researchers found multiple states with incentive programs that reward delivery system reform activities. The rationale for this approach is that targeted activities and investments to enhance the delivery system or adopt value-based payment may have a longer-term and sustained impact on quality that reaches above and beyond a specific set of clinical quality measures. An advantage of this approach

is that tying certain activities to incentive funding requires plans to develop infrastructure in areas of priority 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 plans to adopt existing quality measures once infrastructure and performance reporting are in place.

Five states and two California programs used this approach with incentives for the following activities: advanced primary care model adoption, behavioral health integration, promoting integrated health care models, including essential community providers in the network, reducing disparities, value-based payment adoption, access to services for particular populations, emergency department utilization, population health management, telehealth innovation, and quality incentives paid to providers.

Conclusion

Many design decisions are required in the development of a quality incentive methodology. The programs examined revealed several possible paths to take in determining the incentive structure, evaluating performance, or considering performance measures. California has an opportunity to improve the quality care provided to Medi-Cal enrollees, as well as the overall Medi-Cal managed care program performance, through the adoption of practices employed in other states.

This white paper is a companion piece to *Paying Medi-Cal Managed Care Plans for Value: Design Recommendations for a Quality Incentive Program*.

Introduction

In 2020, the California Department of Health Care Services (DHCS) implemented a new set of quality performance incentives for Medi-Cal managed care plans (MCPs). Its approach is to implement a Managed Care Accountability Set (formerly the "External Accountability Set") and require MCPs to perform at least as well as 50% of Medicaid plans nationally (up from 25%). MCPs that do not meet the benchmark will be subject to a financial penalty and will be required to complete a corrective action plan and quality improvement work.

DHCS and the California Health Care Foundation (CHCF) jointly sponsored Bailit Health to examine alternative quality incentive methodologies that DHCS could consider for its use, as external evaluations suggest that DHCS has not been generating quality improvement through its purchasing activities.[2]

Many state Medicaid programs operate quality incentive programs for contracted managed care plans. These programs link some portion of plan revenue and/or nonrevenue consequences to quality performance. States have pursued this strategy based on a common belief that explicit incentives linked to performance will motivate plan behavior that will improve value for states and the beneficiaries they serve. This approach is sometimes referred to as "value-based purchasing." The application of financial incentives alone is referred to as "value-based payment."

The purpose of this white paper is to provide information on key quality incentive program design decisions and choices made by California purchasers and other states' Medicaid programs.

Methodology

The authors examined the approaches taken by California purchasers and by state Medicaid programs in six other states to incentivize health plan quality performance in order to help inform Medi-Cal's consideration of an alternative quality incentive methodology. Specifically, the following programs were considered:

- California programs
  - California Public Employees' Retirement System (CalPERS)
  - Covered California (Covered CA)

- DHCS Medi-Cal Managed Care Plan Accountability Set Sanctions (Medi-Cal MCP)
- DHCS Public Hospital Quality Improvement Program (DHCS QIP)
- DHCS Value-Based Payment Incentive (VBP Incentive)

- Other state Medicaid programs
  - Arizona (AZ)
  - Michigan (MI)
  - New York (NY)
  - Oregon (OR)
  - Texas (TX)
  - Washington (WA)

The body of this white paper contains an overview of key design decisions and choices made by these programs. Appendix A contains definitions of key terms. Appendix B contains high-level summaries of each program. Appendix C contains a crosswalk of measures used in each program.

Key Design Decisions

There are several key design decisions required to develop a structured quality incentive program. The broad categories of these decisions include:

1. **Incentive structure**
2. **Performance evaluation**
3. **Performance measures**[3]

The white paper reviews key questions within each of these categories and discusses advantages and disadvantages of each option.[4]

1. Incentive Structure

Incentive structure considerations include the following:

- What is the form of the financial incentive?
- Should nonfinancial incentives be applied?
- How do managed care plans qualify for the incentive?
- Should the incentive structure allow for modifications by geography within the state?
- Should the incentive structure allow for modifications based on variation in clinical risk among plans?

What Is the Form of the Financial Incentive?

To determine how the quality incentive will be funded, health care agencies must first determine whether they will use existing resources, or whether new dollars can be added to fund the incentive.

Bonus. New York structures its incentive program as a bonus program, with funding allocated by the NY Department of Finance each year. The bonus payments are structured as performance-based capitation payments.

An advantage of this strategy is that base rates are not at risk and therefore plans are less financially vulnerable if they fail to achieve the quality benchmarks. The disadvantage of this approach is that a successful program requires significant ongoing financing from the state.

Withhold. For many states, adding additional dollars to their program may be infeasible. They therefore utilize incentive structures that redistribute existing funds or use a penalty. For example, Washington State funds its incentive program by withholding 2% of plan premiums. Advantages of this approach are that it is administratively straightforward, plans know in advance how much of their finances are at stake, and behavioral economics suggest that negative financial consequences may result in more significant behavior change than a financial bonus.[5] Disadvantages of this approach include that the lag time for the plan to receive withhold dollars back could create financial strain, particularly in downcycle years; at-risk base payment may result in fewer overall dollars to the network due to uncertainty of what will ultimately be earned; a state's actuary needs to consider if the withhold performance targets are reasonably achievable; and this

approach is not viable for programs whose capitation rates are currently at the minimum level for actuarial soundness.

Penalty. Another option is to use a penalty as the Medi-Cal MCP program currently does. Advantages of this approach are that the potential loss in income could induce significant behavior change by gaining plan executive-level engagement, and the penalty can be structured to apply immediately upon evidence of low performance. Disadvantages include that plans have uncertainty of financial impacts until penalties are applied a year or more after the performance period due to measurement lag, and the structure may lend itself to plans passing on the penalties directly to provider payments, potentially impacting provider participation and the integrity of the network.

A full list of potential options as well as advantages and disadvantages to each approach can be found in Table 1 (see page 8). Options are categorized as disincentives or incentives, as a financial incentive could be coupled with a disincentive, such as use of a withhold and a quality bonus.

Should There Be Nonfinancial Incentives for Quality Performance?

In addition to financial incentives, programs may include nonfinancial incentives for quality performance to further encourage plans to improve quality. Common approaches include use of enrollment levers, intermediate sanctions, performance improvement plans and corrective action plans, best practice profiling, and publicizing performance. The advantage of all these approaches is that they encourage quality improvement without the costs associated with financial incentives. All the states studied included several forms of nonfinancial incentives for managed care plan quality performance. The most commonly used nonfinancial incentives were auto-assignment preference, requiring performance improvement or corrective action plans, and publicizing performance. The Medi-Cal MCP program utilizes all of the most commonly used forms of nonfinancial incentives to some degree. Table 2 provides information on nonfinancial incentives (see page 9).

Enrollment lever — auto-assignment. Medi-Cal uses this approach. DHCS uses a subset of its Managed Care Accountability Set measures, plus a cost index and a measure of use of essential community providers, to give plans preference in its auto-assignment algorithm. An advantage of this strategy is that it indirectly allows high-performance plans to earn more money since increasing attributed members increases the amount of money allocated to the plan. Attributed members tend to be low utilizers of services, so in addition to increasing allocated members, this strategy directs profitable members to high-performing plans. It also helps ensure that members are receiving care from high-quality providers. While DHCS staff and stakeholder interviews found the auto-assignment to be a useful incentive to focus plan attention, especially in times when Medi-Cal enrollment is increasing, one study examining California's auto-assignment algorithm found it did not significantly improve quality when compared to county-organized health system (COHS) performance, and it negatively impacted rates of improvement in other areas of care compared to COHS.[6]

New York also uses a quality-informed auto-assignment algorithm for new enrollees that do not have a prior link to a provider or health plan. Plans are divided into five tiers based on the percentage of points earned in the Quality Incentive Program, and only plans in tiers 1 to 4 are eligible for auto-assignment. There is no differentiation between tiers 1 to 4 in the auto-assignment algorithm, and tier 5 was defined as a score of less than 36.07% of possible points. As a frame of reference, in many years no plans were in tier 5, and in a few previous years only one plan has been in tier 5.

Publicizing performance. Washington publishes health plan aggregate quality scores by domain in the Apple Health (Washington Medicaid) new member enrollment packet.[7] Scores are displayed in a three-star rating format across domains of getting care, keeping kids healthy, keeping women and mothers healthy, preventing and managing illness, ensuring appropriate care, satisfaction of care provided to children, and satisfaction with plan for children.

Table 1. What Is the Form of the Financial Incentive?

	ADVANTAGES	DISADVANTAGES	PROGRAM USE
Incentive or Disincentive			
Performance-based capitation rate adjustment. Adjustments to the base rate received by plans based on performance	▶ May be easier to insulate from budget cuts, as any potential gains are built into rates (as opposed to a separate line item in the budget, for example) ▶ Has potential to offset "premium slide" and *may* accelerate cost savings and community / social determinants investments if plans are not financially penalized by future rate declines, particularly if the state requires reinvestment in those initiatives	▶ In the setting of an incentive, premiums will be higher than they otherwise might have been if performance results in increasing capitation rates	
Disincentive			
Capitation withhold. A portion of base health plan payment contingent upon achievement of performance targets	▶ Relatively easy to administer ▶ Plans know in advance the amount of potential loss ▶ Behavioral economics suggests that a potential loss in income is more effective to induce behavior change than a potential gain	▶ Plan (and possibly provider) opposition to a potential reduction, and minimally a disruption, in revenue given already low Medi-Cal payment ▶ Lag time in receiving earned money back may create financial strains on plans, and potentially their contracted providers ▶ The state's actuary must consider the withhold performance targets as "reasonably achievable" by the plans in order for the full portion of the withhold to be considered as part of actuarially sound plan rates ▶ This approach would not be viable if the capitation rate including the withhold is at the minimum for actuarial soundness	CA: CalPERS, Covered CA Other states: AZ, MI, OR, TX, and WA
Penalty. Downside-only arrangement in which poor performance results in a financial fine	▶ Behavioral economics suggests that a potential loss in income is more effective to induce behavior change than a potential gain ▶ Can be structured to be applied immediately upon evidence of poor performance	▶ May require more legal counsel involvement to develop policies for assessing penalties, which may be more complex to administer than a withhold	CA: Medi-Cal MCP
Incentive			
Quality bonus. Supplemental payments based on assessment of plan performance	▶ Relatively easy to administer ▶ Plans are not financially vulnerable if they do not achieve quality performance targets	▶ Requires significant and sustained state financing to reward for excellence and improvement ▶ Funding allocated for bonus or incentive payments may be targeted for cuts or redistribution by states during the budget process, creating uncertainty about sustainability	CA: DHCS VBP Incentive Other states: AZ[8], OR[9], and TX[10] (all partial); NY
Shared saving. A profit-sharing model in which plan performance influences the percentage of profits it retains	▶ Relatively easy to administer	▶ If the state requires repayment of excess plan profit at baseline, then the shared savings model may ultimately result in the state collecting less than it otherwise would if the plan performs well ▶ Uncertainty for state and plan on amount that can be retained/lost	

New York annually publishes *A Report on the Quality Incentive Program in New York State*,[11] which allows users to see the tiered ranking of plans based on their quality incentive program scores. Additionally, the NY State Department of Health website has an online report of NY health plans (including Medicaid, commercial HMO/PPO, and specialty plans) that includes a tool to visualize plan performance by each measure and quality domain.[12] Advantages of this strategy are that it creates positive publicity for high-performing plans, and it enables members to make plan selections informed by performance. A disadvantage of this strategy is that members may not be aware of or use available data on variation in plan quality.

Table 2. Should There Be Nonfinancial Incentives for Quality Performance?

	ADVANTAGES	DISADVANTAGES	PROGRAM USE
Enrollment levers. Quality performance influences enrollment, including new enrollment based on performance, auto-assignment preference, extending open enrollment based on performance, excluding new enrollment based on performance, or freezing enrollment based on performance	▸ Allows high-performing plans to obtain more members than low-performing plans ▸ Increases the number of members who will receive care through high-performing plans		CA: Medi-Cal MCP Other states: MI, NY, and TX
Intermediate sanctions. Civil money penalties, appointment of temporary management for a managed care organization (MCO), and/or suspension of payment for beneficiaries enrolled after the effective date of the sanction	▸ Ensures members are receiving care from high-quality providers	▸ Disruptive to members	CA: CalPERS NY
Performance improvement / corrective action plan. Requirement to submit a plan to address underperformance	▸ Helps plans think through a strategy to improve quality, and potentially leads to quality improvement	▸ Increases administrative burden on plans	CA: CalPERS, Covered CA, Medi-Cal MCP Other states: AZ, MI, NY, TX, and WA
Best practice profiling. The provision of in-depth descriptions of the best practices used by plans to achieve high-performance rates, possibly taking the form of descriptive text within a report or on a website	▸ Creates positive publicity for high-performing plans, and rewards them and their quality improvement staff	▸ Will likely be insufficient to motivate low-performing plans to improve	CA: Medi-Cal MCP Other states: NY, TX, and WA
Publicizing performance. The disclosure of the performance rates for all plans to interested parties or the public, possibly taking the form of annual report cards on quality or performance dashboards	▸ Creates positive publicity for high-performing plans and "public shaming" for poor-performing plans ▸ Allows members to make informed decisions when selecting plans	▸ Members may not be aware of or use these data	CA: Medi-Cal MCP Other states: AZ, MI, NY, OR, TX, and WA

How Do Managed Care Plans Qualify for the Incentive?

State health care agencies need to determine how plans qualify for quality incentives. Programs can decide to use a "gate," meaning that specific performance expectations must be met to qualify for the incentive; a "ladder," meaning the amount of an incentive increases or a disincentive decreases as performance improves; or a combination of the two (Table 3).

Medi-Cal MCP uses a gate, imposing financial penalties for each performance measure in the Medi-Cal Accountability Set when performance falls below the national Medicaid 50th percentile. A key advantage of this approach is that the program holds plans accountable for minimally acceptable standards. It does not, however, push higher-performing plans to improve and may discourage low performers, who may find the gate unattainable based on current performance.

Texas uses a gate-and-ladder approach, with tiered achievement and improvement targets. It uses a performance gate for which plans neither receive points nor lose points. Its ladder extends "below the ground," with poor and deteriorating performance resulting in a penalty. For example, in 2020, plans could earn +/–0.375% of their withhold based on achievement or improvement on the quality measure Well-Child Visits in the First 15 Months of Life – Six or More. Performance above the HEDIS 50th percentile or improvement of two or more percentage points results in positive points earned, increasing as plans meet the HEIDS 66.67th percentile or improve more than four percentage points. Performance below the state mean or deteriorating performance of at least two percentage points result in losses, with increasing penalties for performance below the HEDIS 33rd percentile or deteriorating performance of greater than four percentage points. The gate in this case is the state mean through HEDIS 50th percentile. This approach is detailed in Table 4 on page 11.

An advantage of this approach is that plans are incentivized to continue improving performance, regardless of their starting point. Texas has centered its ladder on state mean performance, to assure that positive earnings are only given to those plans meeting minimally acceptable performance.

Oregon uses a modified gate and a ladder. First, plans must meet minimum performance standards for "must-pass" measures, which are a subset of the total incentive pool measures. If all must-pass measures are not achieved, the incentive funding for which a plan would be eligible is reduced. This approach differs

Table 3. How Do Managed Care Plans Qualify for the Incentive?

	ADVANTAGES	DISADVANTAGES	PROGRAM USE
Gate. Specific performance expectations must be met to qualify for financial incentives.	➤ Establishes minimum quality standards	➤ Does not encourage improvement beyond the gate ➤ If the minimum standards are too high, may discourage poor performers	CA: Medi-Cal MCP
Ladder. The amount of the financial incentive increases/financial disincentive decreases as performance varies.[13]	➤ Incentivizes continued quality improvement	➤ May not require a minimum standard	
Gate and ladder. A combination of the above	➤ Requires minimum standards ➤ Incentivizes continued quality improvement	➤ More complex than use of either a gate or a ladder	CA: CalPERS, Covered CA Other states: AZ, MI, NY, OR, TX, and WA

from a true gate in that incentives are still available, but at reduced levels, even if the plan fails to meet the must-pass measures. The remainder of the funding is awarded based on the number of measures for which the plan meets achievement or improvement targets. The total potential earnings are outlined in Table 5, with achievement of must-pass measures in the columns and achievement/improvement of non-must-pass measures in the rows.

Table 4. Texas STAR Benchmarks: HEDIS Well-Child Visits in the First 15 Months of Life (W15) – Six or More, 2020

PERFORMANCE AGAINST BENCHMARKS			PERFORMANCE AGAINST SELF	
HEDIS RANGES	PERFORMANCE RANGES	PERCENTAGE EARNED/LOST	PERCENTAGE POINT CHANGE	PERCENTAGE EARNED/LOST
>66.67th percentile	>69.59%	0.375	>4	0.375
50th through 66.67th percentile	>66.24%–69.69%	0.1875	2 through 4	0.1875
State mean through 50th percentile	64.23%–66.23%	0	1.99 through –1.99	0
33.33rd percentile to state mean	61.31%–64.22%	–0.1875	–2 through –4	–0.1875
<33.33rd percentile	<61.31%	–0.375	<–4	–0.375

Source: "Medical Pay-for-Quality (P4Q) Program" (PDF), chap 6.2.14 in *HHSC Uniform Managed Care Manual*, Texas Health and Human Services, effective January 1, 2020.

Table 5. Oregon's Quality Pool Distribution

NUMBER OF TARGETS MET FOR 16 *NON-*"MUST-PASS" MEASURES (achieving benchmark/improvement target, and reporting requirements for EHR measures)	QUALITY POOL AMOUNT IF...	
	ALL THREE "MUST-PASS" MEASURES ARE MET (PCPCH, depression screening, and SBIRT)	*ONE OR MORE* "MUST-PASS" MEASURES ARE NOT MET (PCPCH, depression screening, and SBIRT)
at least 12	100%	90%
at least 11	80%	70%
at least 10	70%	60%
at least 8	60%	50%
at least 6	50%	40%
at least 4	40%	30%
at least 3	30%	20%
at least 2	20%	10%
at least 1	10%	5%
0	5%	0%

Source: *2019 Quality Pool Methodology (Reference Instructions)* (PDF), Oregon Health Authority, November 25, 2019.

Should the Incentive Structure Allow for Modifications by Geography Within the State?

Another incentive structure consideration is whether modifications should be made based on geography (Table 6). While none of the quality incentive programs studied vary the incentive structure by geography, a state health care agency may decide to do so to account for variation in local resources. The phenomenon of "structural urbanism," defined as a bias toward large population centers, has been posited to exacerbate many of these disparities.[14] 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) "market opportunity"–driven health care. 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. While adjusting actual performance benchmarks may not be a desired approach, earning additional points or qualifying for additional incentive payments based on rural versus urban could be explored. Disadvantages to this approach are that it adds administrative complexity to the program methodology, and it could be difficult to determine which regions should have an adjusted structure and how to fairly adjust their methodology.

Should the Incentive Structure Allow for Modifications Based on Variation in Clinical Risk Among Plans?

A final incentive structure consideration is whether to allow for modification due to variation in clinical risk among plans (Table 7). Different plans may attract patient populations with different levels of clinical risk. This could be related to geography or other factors, such as the providers within a plan's network. Similar to geographic modifications, plans could earn additional points or qualify for additional incentive payments based on clinical risk. The advantage

Table 6. Should the Incentive Structure Allow for Modifications by Geography Within the State?

	ADVANTAGES	DISADVANTAGE	PROGRAM USE
Geographic modifications made. Methodology adjustments are made based on geographic variation within the state.	➤ Accounts for variation in local resources ➤ Does not disadvantage plans serving vulnerable regions	➤ Adds administrative complexity ➤ Difficult to determine how to adjust the program by region	
No geographic modifications made. Methodology does not account for geographic variation within the state.	➤ Administratively simple	➤ Does not account for variation in local needs ➤ Could disadvantage plans serving vulnerable regions	CA: CalPERS, Covered CA, Medi-Cal MCP, DHCS QIP Other states: AZ, MI, NY, OR, TX, and WA

Table 7. Should the Incentive Structure Allow for Modifications Based on Variation in Clinical Risk Among Plans?

	ADVANTAGES	DISADVANTAGE	PROGRAM USE
Clinical risk adjustment. Methodology adjustments are made based on variation in clinical risk.	➤ Accounts for variation in clinical risk ➤ Does not disadvantage plans serving vulnerable regions	➤ Adds administrative complexity	
No clinical risk adjustment. Methodology does not account for variation in clinical risk.	➤ Administratively simple	➤ Does not account for variation in populations ➤ Could disadvantage plans serving vulnerable populations	CA: CalPERS, Covered CA, DHCS QIP, DHCS VBP, Medi-Cal MCP Other states: AZ, MI, NY, OR, TX, and WA

of this approach is plans serving sicker patients are not disadvantaged. A disadvantage of the approach is the additional administrative complexity to determine an appropriate and fair adjustment. None of the programs examined adjusted their quality incentive methodology based on clinical risk outside including some measures that involved risk adjustment within their specifications.

2. Performance Evaluation

A major decision in developing any performance evaluation framework is to determine what should be rewarded. Programs can reward achievement, improvement, or achievement and improvement. Based on this decision, there are further considerations within each of these categories. A second common consideration is if performance deterioration should be accounted for, and if so, how. These design decisions are outlined in detail below.

What Should Be Rewarded?

Of the programs reviewed, all rewarded either achievement or achievement and improvement (Table 8). Incentivizing improvement can motivate plans to invest in incremental improvement even when reaching an achievement benchmark for excellent performance is out of reach. However, when improvement reward is not coupled with achievement reward, high-performing plans are disincentivized to participate, since it is harder to improve when performance is already strong.

Achievement. New York rewards achievement only, using the national 50th percentile as a gate for its incentive program and then providing increasing points for plans meeting 75th- and 90th-percentile benchmarks. An advantage of this approach is it rewards high performance. Low-performing plans, however, may be discouraged from investing in performance improvement if the benchmarks seem out of reach.

Table 8. What Should Be Rewarded?

	ADVANTAGE	DISADVANTAGE	PROGRAM USE
Achievement. Assessment against standards or benchmarks	➤ Rewards high-performing plans	➤ Disincentive for low-performing plans to participate, since they may be unable to attain benchmarks	CA: Covered CA, Medi-Cal MCP Other states: AZ and NY
Improvement. Comparing a plan's own performance in a preceding year, or perhaps two preceding years, to the most recent performance period	➤ Incentivizes poor-performing plans to improve	➤ Disincentive for high-performing plans to participate, since it is harder to improve	
Achievement and improvement. A combination of the above	➤ Incentivizes low-performing plans to improve and high-performing plans to maintain performance		CA: CalPERS, DHCS QIP Other states: MI, OR, TX, and WA

Achievement and improvement. Michigan rewards achievement and improvement for many of its measure categories, with achievement having a higher weight. This incentivizes all plans to improve poor performance or maintain higher performance. Table 9 outlines the five categories of measures and the number of points associated with attainment of various percentile thresholds and/or statistically significant improvements in performance.

Should Performance Deterioration Be Accounted For?

A second key factor in developing an incentive design methodology is to consider whether deterioration in performance should be accounted for (Table 10, page 15). The idea behind this design element is to ensure plans are not rewarded when quality performance is deteriorating, as this runs contrary to the purpose of implementing a quality incentive program. Texas was the only state Medicaid program examined that accounts for performance deterioration. If performance declines, or is below a minimum standard — typically, the HEDIS 50th percentile or the state's mean performance — plans can earn increasing penalties for poor performance. An advantage of this approach is it incentivizes plans strongly to maintain or improve performance. It also protects against scenarios whereby a plan declines in performance on more measures than it improves, and yet receives a reward for performance.

Table 9. Michigan's Measure Categories and Potential Points Summary

	NO. OF MEASURES	TARGETS	POTENTIAL POINTS
Maintenance	5	Achievement ▶ 90th percentile — 2 pts. ▶ 75th percentile — 1 pt. ▶ 50th percentile — 0.5 pt.	10
Improvement	5	Achievement ▶ 90th percentile — 4 pts. ▶ 75th percentile — 3 pts. ▶ 50th percentile — 2 pts. Stat. significant improvement — 1 pt.	20
Plan-specific Measures	4	Achievement ▶ 90th percentile — 4 pts. ▶ 75th percentile — 3 pts. ▶ 50th percentile — 2 pts. Stat. significant improvement — 1 pt.	16
Health Equity*	2	Stat. significant improvement — 2 pts.	4
CAHPS	6	Achievement ▶ 90th percentile — 2 pts. ▶ 75th percentile — 1 pt.	12
Compliance Review	1	Achievement ▶ 96%–100% — 10 pts. ▶ 91%–95% — 9 pts. ▶ 86%–90% — 8 pts. ▶ 81%–85% — 7 pts. ▶ 76%–80% — 6 pts.	10

*Reduce performance variation

Source: *Comprehensive Health Care Program Contract*, Michigan Dept. of Health and Human Services, 2020, app. 5a.

Table 10. Should Performance Deterioration Be Accounted for?

	ADVANTAGE	DISADVANTAGE	PROGRAM USE
Yes. Evaluate deterioration and adjust incentive rewards if performance deteriorates (either declining performance or modest improvement after declining precipitously the preceding year)	➤ Prevents award allocation for performance that declines more than improves		TX
No. No mechanism in place for deterioration in quality performance to adjust financial incentives	➤ Administratively simpler	➤ Award allocation for performance that declines more than improves undercuts program intent and credibility	CA: Covered CA[15], DHCS QIP, DHCS VBP Incentive, Medi-Cal MCP Other states: AZ, MI, OR, and WA

For Programs Using Achievement

For programs that use achievement, there are two key considerations: (1) what is the source of the achievement benchmark and (2) does the benchmark vary by measure?

What is the source of the achievement benchmark?

When developing achievement benchmarks, programs want to consider benchmarks that are:

- Not below current performance of participating plans
- Achievable for at least some participating plans
- Are representative of a reasonable understanding of high performance (e.g., not lower than the national 50th percentile or requiring performance above the national 90th percentile where there is no further room for improvement)

See Table 11 on page 16 for a summary of sources of achievement benchmarks.

National and/or regional Medicaid percentile benchmarks. National and/or regional Medicaid performance benchmarks are available for some measures from NCQA (for HEDIS measures) and from CMS (for Medicaid Adult and Child Core Set measures). Advantages of using standard Medicaid benchmarks include that they are grounded in experience with Medicaid population across the country, they are in wide use by accredited health plans such as CMS and other purchasers, and they are generally translatable to enrollees and stakeholders. There are several challenges with using standard Medicaid benchmarks as well. These include that (1) there are not standard Medicaid benchmarks for all measures a state may want to include in a quality incentive program; (2) standard Medicaid benchmarks do not always translate into clinically meaningful achievement thresholds (e.g., the 90th percentile nationally on a metric may not translate into what providers consider "excellent clinical care"); and (3) the percentile benchmarks for some measures fall in a very narrow range, such that a very small change in performance can result in a significant increase in national percentile, and does not reflect meaningful change in performance overall. The programs examined used national benchmarks for HEDIS measures in their incentive measure sets, supplemented with state and peer benchmarks when national benchmarks were not available or appropriate for the intended use of the measure.

State percentile benchmarks or relative ranking of plan performance. Both of these options can be calculated for measures where national and regional Medicaid benchmarks are not available. State benchmarks also ensure that targets are relevant and account for local factors that may influence plan performance. Benchmarking performance relative to peers ensures predictable payout for the incentive pool. The disadvantage of both options is the creation of winners and losers among participating plans. Furthermore, assessing performance relative to peers may not end

up rewarding value when the payout is based on a rank order. If plan performance is all mediocre-to-poor, when graded on a curve, some plans will still be rewarded for substandard performance. To mitigate this weakness, Arizona requires attainment of a minimum performance standard be met before a plan is eligible to earn incentives based on relative peer performance.

Non-percentile-based value. Benchmarks can be established that are not relative in value and are not pegged to a specific plan percentile. Generally, such benchmarks are established based on acceptable clinical levels of care, state goals (e.g., Healthy People 2020), or through a stakeholder process. This approach to benchmarking is often used for measures that do not originate from NCQA's HEDIS measure set and do not have established national or regional benchmarks. This approach has the advantage of setting a benchmark that is clinically relevant and/or reflects a state, regional, or national goal for a measure that is not payer specific. This approach often resonates more clearly for providers delivering care and who can become frustrated with national percentile goals that do not represent desired performance. Several of the quality incentive programs researched used non-percentile values for specific measures. None used non-percentile values for benchmarking across the entire measure set.

Table 11. What Is the Source of the Achievement Benchmark?

	ADVANTAGES	DISADVANTAGES	PROGRAM USE
National. Reward based on attainment of a national benchmark (such as NCQA-reported Medicaid percentiles for HEDIS measures)	▶ Standardized comparison based on performance of other plans	▶ Not available for some measures ▶ Benchmarks may not represent desired performance for state	CA: CalPERS, Covered CA, DHCS QIP, Medi-Cal MCP Other states: AZ, MI, NY, OR, TX, and WA
Regional. Reward based on attainment of a regional benchmark		▶ Benchmarks may not represent acceptable level of care from a clinical standpoint ▶ Narrow range in scores can reward performance that is not well differentiated	
State percentile. Reward based on attainment of a state-based benchmark	▶ Can be calculated for measures where national and regional benchmarks are not available ▶ Benchmarks are relevant and account for local factors that impact performance	▶ Creates winners and losers among participating plans	CA: DHCS QIP Other states: OR, TX, and WA
State ranking. Performance assessed relative to plan competition in the state/program	▶ Can be calculated for measures where national and regional benchmarks are not available ▶ Predictable payout	▶ Creates winners and losers among participating plans ▶ Payment based on a rank order may not translate to high-performance standard	Other states: AZ and WA
Non-percentile-based value. Can be set based on an absolute value not pegged to a relative percentile target but rather on acceptable clinical levels of care or established by stakeholders using a consensus process	▶ Can be used where no known benchmarks are available ▶ Can be anchored in clinically meaningful achievement ▶ Clearer to communicate to providers and stakeholders	▶ Must have rationale for benchmark selection ▶ Appropriate absolute benchmark value may not be clear	CA: CalPERS, Covered CA OR

Both Covered California and CalPERS use a non-percentile benchmark for NTSV c-section rate that maps to the state / Healthy People 2020 goal of 23.9%. Oregon uses a consensus committee to determine a non-percentile target for its homegrown measure, Assessments for Children in DHS [Dept. of Homeland Security] Custody, based on the recommended benchmark from Oregon Health Authority staff.[16] States may also elect to look at other state health care agencies using the same measure to obtain information on non-percentile benchmarks used.[17] Non-percentile-based targets allow for use of program-specific or new measures; however, it is important that there is transparency about why a given benchmark was selected for it to gain support in the provider community.

Does the benchmark vary by measure?

Once the benchmark source is determined, states must decide whether to vary the benchmarks by measure (Table 12). Setting the same benchmark if it is national, state, or relative to peers sends a consistent message on performance expectations but does not account for the fact that performance may vary significantly by measure. Varying benchmarks by measure accounts for differing performance by measure but requires determination of when it is appropriate to vary performance expectations. If non-percentile-based values are selected, then benchmarks will most likely need to vary by measure to capture clinically meaningful performance.

New York State uses a standard approach across its measure set that includes benchmarks of the 50th, 75th, and 90th national Medicaid percentile performance. Washington uses a national Medicaid 90th percentile achievement benchmark across all of its HEDIS measures and uses state performance relative to peers to create benchmark for its two behavioral health metrics, which do not have applicable national benchmarks. Oregon's approach varies by measure using a combination of statewide averages through the 75th percentile, and national percentiles ranging from the Medicaid 75th to 90th percentile.

For Programs Using Improvement

How is improvement assessed?

The key question for programs rewarding improvement is how to define improvement benchmarks. There are three primary options: absolute terms using a set percentage point change, absolute terms using a gap-reduction strategy, and statistically significant improvement (see Table 13, page 18). The largest difference between the two absolute term options is that the gap-reduction approach sets greater improvement expectations for plans with low baseline performance. Use of absolute terms for improvement is easy to explain but may incentivize plans for improvement that is actually due to chance.

When defining improvement either through a gap-reduction strategy or test of statistical significance, one should also apply a "practical significance test" to ensure that calculated improvement targets represent meaningful change, and not minimal change such as an improvement target that is a fraction of

Table 12. Does the Benchmark Vary by Measure?

	ADVANTAGES	DISADVANTAGES	PROGRAM USE
Same. The benchmark level is the same across all measures (e.g., the national 50th percentile).	▸ Consistent message on performance expectations ▸ Straightforward to administer	▸ Does not account for performance variation by measure	CA: DHCS QIP, Medi-Cal MCP Other states: MI and NY
Varies. The benchmark level varies across all measures (e.g., the national 50th percentile for one measure, national 75th percentile for another, relative plan performance for another).	▸ Accounts for performance variation by measure ▸ Allows inclusion of measures with no national benchmark	▸ Requires determination of benchmark for each measure ▸ More complicated to administer	CA: CalPERS, Covered CA Other states: AZ, OR, TX, and WA

a percent. To account for small values resulting from gap reduction or statistical significance calculations, these approaches may be coupled with a minimum improvement floor. For example, rewards may be given for improvement if it is statistically significant and demonstrates a change of at minimum 2% in absolute value.

Set percentage point change. CalPERS uses an absolute methodology requiring improvement of three percentage points year over year until the achievement benchmark is attained for measures in the Medical Management category. All 13 clinical quality HEDIS measures have improvement benchmarks that require a year-over-year increase in the plan performance rate of three percentage points for each measure until the plan reaches or exceeds the National Committee for Quality Assurance's 50th percentile for the clinical quality measure.

Gap reduction. Oregon sets plan-specific improvement targets based on prior performance. This methodology was initially based on the Minnesota Department of Health's Quality Incentive Payment System, which at the time required at least a 10% reduction in the gap between baseline performance and the benchmark to qualify for incentive payments. Oregon sets an improvement floor of one to three percentage points of improvement, depending on the measure, to ensure the method does not produce tiny, meaningless improvements. Oregon's Improvement Target Methodology includes both the formula and a sample calculation, included in Figure 1 (CCOs are Medicaid managed care plans in Oregon).

Figure 1. Oregon's Improvement Target Methodology Sample Calculation

Value of *x*		Improvement Target
$\frac{\text{[State Benchmark]} - \text{[CCO Baseline]}}{10}$	$= x$	[CCO Baseline] + [x]

FOR EXAMPLE: A CCO's baseline for the timeliness of prenatal care measure may be 50%. Oregon has set the benchmark at 69.4%.

$$\frac{[69.4] - [50]}{10} = 194 \qquad 50 + 1.94 = 51.9$$

Source: *Oregon Health Authority Improvement Targets* (PDF), Oregon Health Authority, last updated September 30, 2013.

Statistical significance. Michigan uses statistical terms to measure improvement to ensure that change is meaningful. Statistical significance is determined by a year-over-year performance comparison based on a chi-squared test with a *p* value of <.05.[18] For its health equity measures, improvement is measured based on reduction in variation between subpopulations. This is computed using what Michigan refers to as an Index of

Table 13. How Is Improvement Assessed?

	ADVANTAGES	DISADVANTAGES	PROGRAM USE
Set percentage point change. Based on a fixed percentage point definition	➤ Easy to explain	➤ May not represent statistically significant improvement	CA: CalPERS TX
Gap reduction. The difference between the benchmark high-performance rate and the plan's rate, divided by a fixed integer (e.g., reduce gap between plan rate and high performance by 10%)	➤ Easy to explain ➤ Sets greater improvement expectations for low performers than for high performers	➤ May not represent statistically significant improvement	CA: DHCS QIP (improvement floor set through requiring given percentage point gap closure for each program year) OR (improvement floor of one to three percentage points) WA (no improvement floor but scores transformed into a curved distribution)
Statistical significance. Assessed statistically (e.g., statistically significant improvement at $p \leq .05$)	➤ Ensures that an increase or decrease in performance is not reflective of random variation	➤ Given large sample sizes with many measures, very small changes may be statistically significant but not clinically meaningful	MI (no improvement floor)

Disparity, calculated by finding the absolute difference (i.e., no negative numbers) between each subpopulation rate and the total population rate.

For Programs Using Achievement and Improvement

Programs that incentivize both achievement and improvement need to determine what weights should be assigned to achievement or improvement in the reward formula.

What weights should be assigned to achievement and improvement?

Programs may elect to weight achievement and improvement equally or choose to weight one more than another (Table 14). If a program emphasizes achievement more heavily, there is more incentive for high-performing plans to maintain performance but less incentive for low-performing plans to improve should they think the achievement targets are unattainable for them. If a program emphasizes improvement more, there is more incentive for low-performing plans to improve but less incentive for high-performing plans. Of the quality incentive programs reviewed that included reward for improvement, one state (Texas) weighted improvement and achievement equally, and three states (Michigan, Oregon, Washington) weighted achievement more than improvement. None of the quality incentive programs reviewed weigh improvement more than achievement.

Texas weighs achievement and improvement equally, ascribing equal opportunity to earn or lose points based on performance against achievement benchmarks and performance against the plan's previous performance.

There are many ways programs could weigh achievement more than improvement.

- Oregon uses a gate based on achievement of certain measures. Once the gate is passed, achievement and improvement are equally weighted for a different set of measures. It also uses a challenge pool based on achievement.
- Michigan varies its weighting approach based on the category of measures:
  - Maintenance measures reward only achievement
  - Improvement measures weight achievement more heavily
  - Plan-specific measures weight achievement more heavily
  - Health equity measures reward only improvement
  - CAHPS (member experience) performance rewards only achievement.

Table 14. What Weights Should Be Assigned to Achievement and Improvement?

	ADVANTAGES	DISADVANTAGES	PROGRAM USE[19]
Equal weight. Achievement and improvement have an equal impact on the ability to earn incentives.	▸ Incentives are equally applied for low- and high-performers	▸ High-performing plans could end up receiving the same incentive amount as low-performing plans	TX
Weigh achievement more. Achievement scores have a larger impact on the ability to earn incentives.	▸ More recognition of high performers and incentive to maintain performance	▸ Less incentive for low performers to improve	Other states: MI, OR, and WA
Weigh improvement more. Improvement scores have a larger impact on the ability to earn incentives.	▸ More incentives for low performers to improve	▸ Less incentive for high performers ▸ Incentive focused on raising the floor, not promoting excellent performance	CA: DHCS QIP[20]

Michigan also rates performance based on compliance review. Compliance scores are based on the quality of submitted compliance reports, graded between zero and 100%, with a minimum score of 76% needed to achieve any quality incentive points.

- Washington's methodology scales the improvement weight such that a higher level of gap closure increases the weight for the improvement score, which is then combined with the achievement portion of the score to calculate the overall measure composite score. The final Quality Improvement Score (QIS) is the weighted average of the individual measure composite scores, converted to a percentile. Overall, the combined score more heavily favors achievement.

3. Performance Measures

The key decision regarding performance measures is the selection of which measures should be incentivized in the program. This review is not focused on the selection of specific clinical quality measures; more information on that topic can be found in Bailit Health's 2019 CHCF-commissioned brief *Paying Medi-Cal Managed Care Plans for Value: Quality Goals for a Financial Incentive Program*.[21]

There are three incentive design decisions, however, that will be addressed that relate to quality measures. These are (1) how many measures should be used in the incentive program, (2) should measures be weighted equally, and (3) should incentives be tied to plan activities or investments in delivery system reform.

How Many Measures Should Be Used in the Incentive Program?

Size of the measure set is a key consideration of any quality incentive program (Table 15). Smaller measure sets allow plans and their networks to focus improvement efforts on a set of high-priority areas for the state but may not be able to address every area the agency may want to improve. As the size of the measure set increases, it may signal the importance of broader improvement at the cost of jeopardizing improvement on any given measure.

Of the programs examined, Arizona's Complete Care withhold is based on the fewest measures, with only seven measures determining the withhold distribution. These measures are all in the prevention / early detection and hospital domains. On the other end of the spectrum, Covered California's program incentivizes performance on 38 measures that span a broader range of domains. There is no empirical basis for deciding on appropriate measure set size. An important consideration, however, is the number of different types of providers impacted by the measures, since plan incentives will often flow down to providers. For example, some measure sets include hospital and medical specialty–focused measures, whereas others focus primarily if not exclusively on primary care measures.

Table 15. How Many Measures Should Be Used in the Incentive Program?

	ADVANTAGE	DISADVANTAGE	PROGRAM USE
<15 measures	▶ Incentivizes highly focused priorities	▶ Too small to address all high-priority areas	AZ, OR, and WA
16–30 measures	▶ Maintains some focus while allowing coverage for more high-priority areas	▶ Dilutes attention on individual measures	CA: CalPERS, DHCS QIP, DHCS VBP Initiative, Medi-Cal MCP Other states: MI and TX
>30 measures	▶ Signals the importance of improvement on performance across many measures and domains	▶ Significantly dilutes attention on individual measures	CA: Covered CA NY

Should Measures Be Weighted Equally?

Another way programs can signal priorities is through the weighting of individual measures within the incentive set (Table 16). It can be difficult to reach a decision on which measures should be weighed higher relative to other measures, but programs doing so tend to consider factors including priority focus areas, greatest opportunity for population health impact, greatest variation between current and target performance, and differential effort or costs required to improve measure performance. Those using larger measure sets may benefit from weighting individual measures to signal highest-priority areas to participating plans, although lower-weighted measures may then suffer from a complete lack of attention.

Michigan's program ascribes unequal weights to the measures in its set. The program includes measures in five categories: maintenance measures, improvement measures, plan-specific measures, health equity measures, CAHPS (member experience) measures, and an assessment of compliance review. Measures all have equal weights within a category, but the program has differentially weighted each category. For example, the five maintenance measures are worth a total of 10 points whereas the five improvement measures are worth a total of 20 points.

In this case, Michigan has ascribed a higher priority to improving measures with poor performance, while associating a lesser weight to measures for which it expects plans will maintain strong performance.

Should Incentives Be Tied to Plan Activities or Investments in Delivery System Reform?

Another consideration for states is whether to tie a portion of the quality incentive to actions other than performance on quality measures. The rationale for this approach is that targeted activities and investments to enhance the delivery system or to adopt value-based payment (VBP) may have a longer-term and sustained impact on quality that reaches beyond a specific set of clinical quality measures. An advantage of this approach is that tying certain activities to incentive funding requires plans to develop infrastructure in areas of priority 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 plans to adopt existing quality measures once infrastructure and performance reporting are in place.

The Washington Quality Incentive Program includes 25% of withhold dollars attributable to two focus areas: (1) prespecified level of managed care plan incentive payments to providers and (2) managed care plan provider payments that meet specific Health Care Payment Learning & Action Network (HCP-LAN) alternative payment model (APM) levels.[27] Provider incentive payments account for 12.5% of the withhold dollars, and Washington requires that at least 1.25% of overall assessment payments to the plan be distributed to the provider network in the form of provider incentive and provider disincentive payments according to specifications in the contract. Additionally, Washington requires that plans meet benchmarks for

Table 16. Should Measures Be Weighted Equally?

	ADVANTAGES	DISADVANTAGES	PROGRAM USE
Equal. All measures within the set contribute the same amount toward earning the financial incentive.	➤ Incentivizes performance change on all measures	➤ Does not focus on high-priority measures	CA: CalPERS[22], DHCS QIP, Medi-Cal MCP Other states: NY, TX, and WA
Unequal. Certain measures within the set contribute more toward the allocation of the financial incentive.	➤ Incentivizes focus on high-priority measures	➤ Reduces focus on measures with a lower weight	CA: Covered CA[23] Other states: AZ[24], MI[25], and OR[26]

APM arrangements each year, which are defined as a certain percentage of payments meeting HCP-LAN 3A or higher criteria. Each year the data submitted by plans are validated by a third-party contractor to ensure the payments meet the definition and levels required for earning back withhold dollars in the managed care plan contract.

New York includes additional points in its incentive calculations for plans to expand telehealth (up to 6 points out of 150) as well as penalty points for not meeting compliance standards (up to 20 points out of 150). Medicaid managed care plans that submit a Telehealth Innovation Plan and "in lieu of services" and receive approval of their Telehealth Innovation Plan earn 5 bonus points for their annual Quality Incentive award. An additional Quality Incentive bonus point will be earned if the submission demonstrates enhanced access to services and seeks to improve outcomes for women with high-risk pregnancies and/or children in their first thousand days of life.

Medicaid managed care plans are penalized up to 20 points if they do not meet compliance standards in the following six areas:

- Statements of deficiency for timely, complete, and/or accurate submissions of encounter data
- Medicaid Managed Care Operating Report
- Quality assurance reporting requirements
- Plan network
- Provider directory
- Member services

Many of the health care agencies that include compliance in their programs used penalties or point deductions or other disincentive approaches. This contrasts with adding points to the overall calculation for delivery system activities. Table 17 (page 23) shows all the incentives applied in the programs studied to key plan delivery system and compliance activities.

It is important to note that approaches to increase value-based payment adoption were in place in all six states researched. Some programs, such as Arizona and Covered California, take the approach of including APM activities in their quality incentive program, while others such as New York developed an entirely separate VBP Reform Roadmap and incentive structure program using Delivery System Reform Incentive Payments (DSRIP) funding.[28] Washington both includes VBP in its managed care plan quality incentive program and has a VBP Roadmap as part of its DSRIP funding similar to New York.[29]

Conclusion

There are many design decisions required in the development of a quality incentive methodology. The programs examined revealed several different paths that could be taken in determining the incentive structure, evaluating performance, or considering performance measures. There is an opportunity for California to improve the provision of quality care and overall Medi-Cal managed care program performance through the adoption of practices that have been employed in other states.

Table 17. Program Application of Incentives to Delivery System and Compliance Activities

	DELIVERY SYSTEM ACTIVITIES	COMPLIANCE ACTIVITIES
CalPERS	▶ Integrated health care models in network	▶ Account management ▶ Member services ▶ Pricing and payments ▶ Systems and data reporting management ▶ Provider network ▶ Medical management
Covered CA	▶ Promoting advanced primary care ▶ Promoting accountable care organizations (ACOs) in network ▶ Designing high-value network ▶ Reducing health disparities ▶ Increasing behavioral health integration models in network ▶ Including essential community providers in network	▶ 5 customer service metrics ▶ 5 operational and data-submission metrics
AZ	▶ Alternative payment model adoption	
MI	The following are incentivized through separate pay-for-performance and bonus programs: ▶ 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	▶ Compliance report submissions[30]
NY	▶ Telehealth adoption ▶ Maternal Health access	▶ Encounter data submission ▶ Medicaid Managed Care Operating Report ▶ Quality assurance reporting requirements ▶ Plan network ▶ Provider directory ▶ Member services
OR	▶ Access to dental services ▶ Access to care for children in DHS custody	
TX	The following are incentivized through separate programs: ▶ Alternative payment model adoption ▶ Nursing facility, hospital, and dental services	
WA	▶ Value-based payment adoption ▶ Quality incentives paid to providers	

Appendix A. Key Terms

INCENTIVE STRUCTURE

Financial Incentives

Quality bonus. Provisioning supplemental payments based on assessment of plan performance.

Shared savings. A profit-sharing model in which plan performance influences the percentage of profits it retains.

Performance-based capitation rate adjustment. Adjustments to the base rate received by plans based on performance.

Capitation withhold. A portion of the base health plan reimbursement contingent upon achievement of performance targets.

Liquidated damages. A variety of actual damages. Most often, the term "liquidated damages" appears in a contract, and often is the title for a whole clause or section. Parties to a contract use liquidated damages where actual damages, though real, are difficult or impossible to prove.

Penalty. Downside-only arrangement in which poor performance results in a financial fine.

Nonfinancial Incentives

Best practice profiling. The provision of in-depth descriptions of the best practices used by plans to achieve high-performance rates. This may take the form of descriptive text within a report or website.

Publicizing performance. The disclosure of the performance rates for all plans to interested parties or the public. This may take the form of annual report cards on quality or performance dashboards.

Intermediate sanctions. Civil money penalties, appointment of temporary management for an MCO, terminating enrollment without cause and notifying enrollees of their right to disenroll, suspension of new enrollment, and/or suspension of payment for beneficiaries enrolled after the effective date of the sanction.

Performance improvement plan / corrective action plan. Requirement to submit a plan to address underperformance.

Enrollment lever. Quality performance influences enrollment in the plan.

Enrollment Levers

New enrollment based on performance. High-quality performance influences whether a plan can capture new enrollment.

Auto-assignment preference. Assign a disproportionate percentage of members to high-performers.

Extending open enrollment based on performance. High-quality performance extends open enrollment for a plan.

Exclude from new enrollment based on performance. Low-quality performance excludes plans from capturing new enrollment.

Qualification for Incentive

Gate. Specific performance expectations must be met to qualify for financial incentives.

Ladder. The amount of the financial incentive increases or financial disincentive decreases as performance increases. 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.

Gate and ladder. A combination of the above.

Use of Geographic Modifications

Geographic modifications made. Methodology adjustments are made based on geographic variation within the state.

No geographic modifications made. Methodology does not account for geographic variation within the state.

Use of Clinical Risk Adjustment.

Clinical risk adjustment. Methodology adjustments are made based on variation in clinical risk.

No clinical risk adjustment. Methodology does not account for variation in clinical risk.

PERFORMANCE EVALUATION

Basis of Assessment

Achievement. Assessment against standards or benchmarks.

Improvement. Comparing a MCP's own performance in a preceding year, or perhaps two preceding years, to the most recent performance period.

Achievement and improvement. A combination of the above.

Accounts for Deterioration

Accounted for. Evaluate deterioration and adjust incentive rewards if performance deteriorates (this could be either declining performance or preventing allocation of an incentive to a plan that improved modestly after declining precipitously the preceding year).

Not accounted for. No mechanism in place for deterioration in quality performance to adjust financial incentives.

Benchmark Source (Use Achievement)

National. Reward based on attainment of a national benchmark (such as NCQA-reported percentiles for HEDIS measures).

Regional. Reward based on attainment of a regional benchmark. Unlike the incentive structure question above, this benchmark is compared to a geographic area larger than the state.

State percentile. Reward based on attainment of a state-based benchmark.

State ranking. Assessment of MCP performance relative to that of plan competition in the state.

Non-percentile-based value. Benchmarks can be set based on a value not pegged to a specific plan percentile target but based on acceptable clinical levels of care or established by state programs (often done by using best judgment or feedback from local stakeholders).

Benchmark by Measure (Use Achievement)

Same. The benchmark level is the same across all measures (e.g., the national 50th percentile).

Varies. The benchmark level varies across all measures (e.g., the national 50th percentile is used for one measure and the national 75th percentile for another).

Benchmark by Plan (Use Achievement)

Same. All plans are subject to the same performance benchmarks.

Varies. There is variation in performance benchmarks by plan.

Measurement of Improvement (Use Improvement)

Set percentage point change. Improvement is assessed in absolute terms based on a fixed percentage point definition.

Gap reduction. Improvement is assessed by taking the difference between the benchmark high-performance rate and the MCO's rate, and dividing by a fixed integer.

Statistical significance. Improvement is assessed in statistical terms (e.g., statistically significant improvement at $p \leq .05$).

Varying Requirements Based on Baseline Performance (Use Improvement)

Greater improvement expectations for low baseline performance. There are higher expectations for improvement among those with low baseline performance than high performance.

Same improvement expectations regardless of baseline performance. The methodology does not distinguish expectations for improvement based on level of baseline performance.

Not applicable. Methodology does not use achievement.

Use Improvement and Absolute Terms

Set performance floor. The improvement assessment sets a performance floor. If performance is below this value, improvement is not incentivized.

Do not set performance floor. The improvement assessment does not set a performance floor. All performance meeting absolute terms is eligible for incentivization.

PERFORMANCE MEASURES

Measure Weights

Equal. All measures within a slate are weighted equally.

Unequal. Measures within a slate have variable weights.

Application of Incentives for Delivery System Reform and Compliance Activities

Application of incentives and penalties. Is tied to related but non-measure performance (e.g., submission and approval of a quality improvement plan due to poor measure performance).

Not applicable. Application of incentives and penalties is only tied to measure performance.

Appendix B. Program Summaries

Summaries of the DHCS QIP or DHCS VBP Incentive programs are not included, as they are provider-focused.

CALPERS

Incentive Structure

Financial incentives. CalPERS uses a capitation withhold by putting a percentage of plan Administrative Service Fee (ASF) at risk, which must be paid back to CalPERS when a metric standard is not achieved.

Nonfinancial incentives. CalPERS uses intermediate sanctions and corrective action plans for poor performers as nonfinancial disincentives.

Qualification for incentives. A gate is in place for all performance measures, supplemented by a ladder for clinical effectiveness metrics and certain other metrics.

Geographic or clinical risk adjustment modifications? No.

Performance Evaluation

Achievement and improvement. The performance metrics at risk span a broad range of categories, including clinical quality measures, account management, member services, pricing and payments (includes total cost of health care), systems and data reporting management, provider network, medical management, and integrated health care models. Some metrics have only achievement benchmarks, others reward both achievement and improvement, and a few metrics reward only year-over-year improvement.

Achievement benchmark source. Plans must meet or exceed NCQA's national 50th percentile for clinical quality measures.

Improvement measurement source. Generally, improvement is measured in absolute terms with a three percentage point increase required.

Variations in benchmark by measure? No.

Deterioration accounted for? No.

Performance Measures

Number of measures. Twenty quality measures are at risk. Metrics for "medical management" include 13 clinical effectiveness HEDIS metrics, NTSV c-section rate, readmission rate, PQI 90 Composite, concurrent review, pre-service review, HIT connectivity for participating providers and hospitals, and opioid use at high dose PQA (Pharmacy Quality Alliance) measure.

Weights. Measures are weighted unequally.

Application of incentives for delivery system reform and compliance activities. Performance standards are applied at the individual measure level across multiple health plan function categories as listed in the Performance Evaluation section. Plans must pay CalPERS the ASF amount at risk, which is set each contract year.

Source

"Attachment D: Performance Measures," in *CalPERS 2019–2023 issuer contract* (unpublished), CalPERS, provided January 2020.

COVERED CALIFORNIA

Incentive Structure

Financial incentives. Covered California withholds 10% of qualified health plan (QHP) participation fees (which represent 3.6% of premium) for performance guarantees (PGs). Group 2, operational metrics, uses penalties.

Nonfinancial incentives. A plan may be required to submit a corrective action plan for any standard not met.

Qualification for incentive. A gate-and-ladder approach is used for Groups 1, 3, 4, and 5. A gate approach is used for Group 2.

Geographic or clinical risk adjustment modifications? No.

Performance Evaluation

Achievement. The PG program is structured to include five groups of metrics that in 2020 represented 98% of at-risk fees, and four of the five groups are structured as a ladder such that performance below a threshold results in a penalty, performance at another threshold results in no penalty, and performance at the highest threshold results in a credit. Credits can offset penalties across all measures and all groups/domains. In the current system of penalties and credits, QHPs may have poor quality scores but not have penalties overall due to performance in other areas (e.g., customer service, operations, Covered California customer service performance). Improvement is not incorporated into the PG design. The five groups of PGs are as follows.

- **Group 1: QHP customer service metrics.** 15% of fees at risk; a ladder of three tiers for penalty, no penalty, and credit for meeting metrics.
- **Group 2: QHP operational metrics.** 15% of fees at risk; one threshold and penalty if a metric is not met.
- **Group 3: Quality (12 metrics).** 48% of fees at risk; the Quality Rating System (QRS) clinical effectiveness and enrollee survey components use the CMS benchmarks for QRS percentiles/stars such that one to two stars results in a 3.5% penalty, three stars results in no penalty, and four to five stars results in a 3.5% credit. One composite star score is created for the clinical effectiveness metrics (3% at-risk fees), and another composite star score is created for the enrollee survey (3% at-risk fees). For the other Group 3 metrics (essential community providers, reducing health disparities, network design based on quality, primary care, ACOs, appropriate use of c-sections, and hospital safety) the percentage of participation fee at risk varies.
- **Group 4: Covered California customer service.** Metrics have the same ladder and metrics as Group 1, and if Covered California performs poorly, then up to 15% performance credit goes to the QHPs.
- **Group 5: Dental DQA pediatrics metrics.** No participation fee at risk, just reporting.

Achievement benchmark source. National benchmarks.

Improvement. Covered California does not incorporate improvement into its methodology.

Improvement measurement source. Not applicable.

Variations in benchmark by measure? Benchmarks vary by measure but not plan.

Deterioration accounted for? No.

Performance Measures

Number of measures. The program includes 38 measures.

Weights. Measures are unequally weighted, reflective of Covered California prioritization.

Application of Incentives for Delivery System Reform and Compliance Activities. Covered California's Group 3 (Quality) incentivizes key activities in the following areas. access to essential community providers, reducing health disparities, network design based on quality, primary care, ACOs, appropriate use of c-sections, and hospital safety.

Source

"Attachment 14: Performance Standards" (PDF), in *Qualified Health Plan Issuer Contract for 2017-2020 for the Individual Market – 2020 Plan Year Amendment*, Covered California, effective 2020.

MEDI-CAL MCP

Incentive Structure

Financial incentives. The program is structured as a penalty, with plans required to pay fines should performance not be met on any of the Medi-Cal Accountability Set measures.

Nonfinancial incentives. A subset of the Medi-Cal Accountability Set measures plus a cost index and use of essential community providers are used for an auto-assignment algorithm. Plan performance is publicly reported, best practices are profiled at the plan level, and corrective action plans are nonfinancial components of the incentive structure. Information is shared with members at the time of enrollment/re-enrollment on aggregate quality performance of the available plans in the county/geography.

Qualification for incentive. The program uses a gate, with all performance falling below a minimum performance level subject to penalty.

Geographic or clinical risk adjustment modifications? No.

Performance Evaluation

Achievement. Achievement of NCQA 50th percentile nationally for Medicaid is required to avoid a financial penalty for each measure.

Achievement benchmark source. National benchmarks.

Improvement. The program does not use improvement.

Improvement measurement source. Not applicable.

Variations in benchmark by measure? No.

Deterioration accounted for? No.

Performance Measures

Number of measures. There are 21 quality measures subject to financial penalty.

Weights. All measures have equal weights.

Application of incentives for delivery system reform and compliance activities. There are no other activities included in the program.

Sources

Medi-Cal Managed Care Accountability Set (PDF), DHCS, last updated December 31, 2019.

Nathan Nau (chief, Managed Care Quality and Monitoring Division, DHCS) to all Medi-Cal managed care plans, all-plan letter 19-017 (PDF), December 26, 2019.

ARIZONA (AZ)

Incentive Structure

Financial incentives. The program is funded using a 1% withhold of prospective gross capitation. Plans can also earn additional incentive payments based on performance. If plan performance is above that required to earn its withhold, the difference between the earned withhold and performance is due to the plan as incentive payments.

Nonfinancial incentives. Arizona publicizes plan performance using annual health plan report cards. If the state identifies performance deficiencies, plans must submit a corrective action plan.

Qualification for incentive. Arizona uses a gate-and-ladder approach. First, plans must demonstrate attainment of a minimum standard, and then both performance and rank compared to peers influence the amount of withhold earned.

Geographic or clinical risk adjustment modifications? No.

Performance Evaluation

Achievement. Arizona uses a combined performance score to determine earned withhold and incentive payments. This score is determined by the plan's attainment of minimum performance standards (based on national benchmarks) and the plan's performance ranking when compared to peers. If minimum standards are met, the performance measure score is standardized and added to the performance rank score. If the minimum standard is not met, then the measure score is zero. Calculation of the combined performance score can be found in Arizona Health Care Cost Containment System (AHCCCS) Policy 306 on page 5.

Achievement benchmark source. National benchmarks and performance relative to peers.

Improvement. Arizona's methodology does not use improvement.

Improvement measurement source. Not applicable.

Variations in benchmark by measure? Arizona varies its benchmarks by measures.

Deterioration accounted for? No.

Performance Measures

Number of measures. For 2019, Arizona Complete Care used seven withhold measures and the Arizona Long Term Care System used five.

Weights. All measures have equal weighting.

Application of incentives for delivery system reform and compliance activities. To qualify for the earned withhold or incentive payments, the plan must meet requirements set forth by Arizona for adoption of alternative payment models, as described in AHCCCS Policy 307.

Sources

AHCCCS Contract Amendment #7 to Contract YH19-0001, AHCCCS, effective October 1, 2019.

CYE 2020 Performance Measure Crosswalk (PDF), AHCCCS, last updated August 20, 2019.

"Health Plan Report Card," AHCCCS, n.d.

306 — Alternative Payment Model Initiative — Withhold and Quality Measure Performance Incentive (PDF), AHCCCS, as approved on September 5, 2019.

307 — Alternative Payment Model Initiative — Strategies and Performance-Based Payments Incentive (PDF), AHCCCS, as approved on September 5, 2019.

Quality Strategy, Assessment and Performance Improvement Report (PDF), AHCCCS, July 1, 2018.

MICHIGAN (MI)

Incentive Structure

Financial incentives. Michigan's incentive program is funded using a 1% withhold on health plan capitated payments.

Nonfinancial incentives. High-performing plans are given preference in auto-assignment. Failure to meet minimum standards results in required submission of a performance improvement plan. Michigan also publishes plan performance on quality measures.

Qualification for incentive. The program uses a gate-and-ladder approach, with increasing financial incentives given based on increased performance after certain minimum performance standards are met.

Geographic or clinical risk adjustment modifications? No.

Performance Evaluation

Achievement and improvement. The program rewards achievement and/or improvement for performance. Achievement is rewarded for the categories of maintenance, improvement, plan-specific measures, CAHPS, and compliance review. Michigan rewards improvement on plan-specific and health equity measures.

Achievement benchmark source. Maintenance, improvement, plan-specific measures, and CAHPS measures are compared to national Medicaid benchmarks. Compliance review is based on attainment of a passing score based on assessment of the quality of routine compliance reports.

Improvement measurement source. Michigan uses statistical improvement for its measures to ensure that change is meaningful. Statistical significance is determined based on a year-over-year performance comparison based on a chi-squared test with a *p* value of <.05. For its health equity measures, improvement is measured based on reduction in variation between subpopulations, using the following formula. Index of Disparity (ID) = (∑ | r(n)−R | /n) / R*100; *r* = subpopulation rate, *R* = total population rate, *n* = number of subpopulations. The ID is calculated by finding the absolute difference (i.e., no negative numbers) between each subpopulation rate and the total population rate.

Variations in benchmark by measure? No.

Deterioration accounted for? No.

Table B1. Michigan's Measure Categories and Potential Points Summary

	NO. OF MEASURES	TARGETS	POTENTIAL POINTS
Maintenance	5	Achievement ▶ 90th percentile — 2 pts. ▶ 75th percentile — 1 pt. ▶ 50th percentile — 0.5 pt.	10
Improvement	5	Achievement ▶ 90th percentile — 4 pts. ▶ 75th percentile — 3 pts. ▶ 50th percentile — 2 pts. Stat. significant improvement — 1 pt.	20
Plan-specific Measures	4	Achievement ▶ 90th percentile — 4 pts. ▶ 75th percentile — 3 pts. ▶ 50th percentile — 2 pts. Stat. significant improvement — 1 pt.	16
Health Equity*	2	Stat. significant improvement — 2 pts.	4
CAHPS	6	Achievement ▶ 90th percentile — 2 pts. ▶ 75th percentile — 1 pt.	12
Compliance Review	1	Achievement ▶ 96%–100% — 10 pts. ▶ 91%–95% — 9 pts. ▶ 86%–90% — 8 pts. ▶ 81%–85% — 7 pts. ▶ 76%–80% — 6 pts.	10

*Reduce performance variation

Source: *Comprehensive Health Care Program Contract*, Michigan Dept. of Health and Human Services, 2020, app. 5a.

Performance Measures

Number of measures. The program uses 20 quality measures as well as a compliance review score.

Weights. Measures within categories are equally weighted, but Michigan has ascribed different weights to each category as detailed in the performance evaluation section above. The four plan-specific and two health equity measures are HEDIS measures selected by individual plans. These can be found in the Appendix 5a Attachment in Michigan's contract.

Application of incentives for delivery system reform and compliance activities. Health plan performance on compliance review accounts for 13.89% of total points in Michigan's incentive methodology. Michigan also has separate pay-for-performance or bonus initiatives in the following areas. 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, and an Encounter Quality Initiative.

Sources

Comprehensive Health Care Program for the Michigan Department of Health and Human Services (PDF), State of Michigan, expires December 31, 2020.

2019 HEDIS Aggregate Report for Michigan Medicaid (PDF), MDHHS, September 2019.

NEW YORK (NY)

Incentive Structure

Financial incentives. The overall Quality Incentive Program (QIP) is structured as a bonus program, with dollars allocated by the New York Department of Finance each year. The bonus payments are structured as performance-based capitation payments, above the base capitation rates MCOs receive regardless of performance.

Nonfinancial incentives. Performance also influences auto-assignment, with the worst performance tier ineligible to receive auto-assignment.

Qualification for incentive. The QIP uses at a gate-and-ladder approach.

Geographic or clinical risk adjustment modifications? No.

Performance Evaluation

Achievement. The QIP uses the NCQA 50th percentile nationally as the gate, with points increasing when the 75th and 90th percentile benchmarks are met as the incentive ladder. The QIP measures performance across multiple domains. Quality (100 pts. / 30 QARR measures), CAHPS (member experience) (30 pts. / 3 measures), and PQI (20 pts. / 2 measures) for a total of 150 points. Points can be subtracted from the 150 total for Compliance (–20 pts. / 6 measures) and bonus points can be added to 150 for Telehealth Innovation (up to 6). MCO scores are then normalized on a scale of 0–100, and MCOs are assigned a performance tier of 1–5.

Achievement benchmark source. National benchmarks.

Improvement. New York's program does not use improvement.

Improvement measurement source. Not applicable.

Variations in benchmark by measure? No.

Deterioration accounted for? No.

Performance Measures

Number of measures. 35, as of 2018.

Weights. All measures are weighted equally.

Application of incentives for delivery system reform and compliance activities. New York includes additional points in its incentive calculations for plans to expand telehealth (up to 6 points out of 150) as well as penalty points for not meeting compliance standards (up to 20 points out of 150). Medicaid managed care plans that submit a Telehealth Innovation Plan (TIP) and "in lieu of services" and receive approval of their TIP earn 5 bonus points for their annual Quality Incentive award. An additional Quality Incentive bonus point will be earned if the submission demonstrates enhanced access to services and seeks to improve outcomes for women with high-risk pregnancies and/or children in their first thousand days of life.

Source

New York State 2018 Quality Incentive Report (PDF), New York State Dept. of Health, n.d.

OREGON (OR)

Incentive Structure

Financial Incentives. In 2019, Oregon plans were eligible for Quality Pool payments, worth at least 3.5% of aggregate capitation payments made in CY 2019. The Quality Pool is created based on a withhold of the capitated rate payments made to plans.

Nonfinancial Incentives. Oregon publicizes health plan performance in an annual report on quality measures.

Qualification for Incentive. Oregon uses both a modified gate and a ladder. First, plans must meet minimum performance standards for "must-pass" measures, which are a subset of the total incentive pool measures. If not all must-pass measures are achieved, the incentive funding for which a plan would be eligible is reduced. This approach differs from a true "gate" in that incentives are still available, but at reduced levels, even if the plan fails to meet the must-pass measures. The program then distributes additional funds based on performance for additional measures. To earn full Quality Pool dollars, a plan must meet all must-pass measures and achievement or improvement targets for 75% of the remaining measures. Oregon also has a Challenge Pool, which allows for distribution of remaining funds based on performance for a subset of the total measures.

Geographic or clinical risk adjustment modifications? No.

Performance Evaluation

Achievement and improvement. Oregon rewards both achievement and improvement. Achievement is weighted more heavily, as must-pass measures rely solely on achievement. Once plans have met must-pass measures, achievement and improvement are weighted equally.

Achievement benchmark source. Achievement targets are based on national percentiles or state averages and vary by measure. Oregon also uses non-percentile-based values based on a consensus stakeholder committee decision to determine a target for its multiple homegrown measures (this was the process used for the 2020 measure, Assessments for Children in DHS Custody).

Table B2. Oregon's Quality Pool Distribution

NUMBER OF TARGETS MET FOR 16 *NON*-"MUST-PASS" MEASURES (achieving benchmark/improvement target, and reporting requirements for EHR measures)	QUALITY POOL AMOUNT IF...	
	ALL THREE "MUST-PASS" MEASURES ARE MET (PCPCH, depression screening, and SBIRT)	*ONE OR MORE* "MUST-PASS" MEASURES ARE NOT MET (PCPCH, depression screening, and SBIRT)
at least 12	100%	90%
at least 11	80%	70%
at least 10	70%	60%
at least 8	60%	50%
at least 6	50%	40%
at least 4	40%	30%
at least 3	30%	20%
at least 2	20%	10%
at least 1	10%	5%
0	5%	0%

Source: *2019 Quality Pool Methodology (Reference Instructions)* (PDF), Oregon Health Authority, November 25, 2019.

Figure B1. Oregon's Improvement Target Methodology Sample Calculation

Value of *x*		Improvement Target
$\frac{\text{[State Benchmark]} - \text{[CCO Baseline]}}{10}$	= x	[CCO Baseline] + [x]

FOR EXAMPLE: A CCO's baseline for the timeliness of prenatal care measure may be 50%. Oregon has set the benchmark at 69.4%.

$\frac{[69.4] - [50]}{10}$	= 194	50 + 1.94 = 51.9

Source: *Oregon Health Authority Improvement Targets* (PDF), Oregon Health Authority, last updated September 30, 2013.

Improvement measurement source. Oregon sets plan-specific improvement targets based on prior performance. This methodology is based on the Minnesota Department of Health's Quality Incentive Payment System, which requires at least a 10% reduction in the gap between baseline performance and the benchmark to qualify for incentive payments. Oregon sets an improvement floor of one to three percentage points of improvement, depending on the measure, to ensure the method does not result in awards for tiny, clinically meaningless improvement. Oregon's Improvement Target Methodology includes both the formula and a sample calculation, included below (managed care plans are called CCOs in Oregon):

Variations in benchmark by measure? Benchmarks vary by measure.

Deterioration accounted for? No.

Performance Measures

Number of measures. Oregon has 13 measures in its 2020 incentive program (this number was 19 for 2019). As of the date of writing, 2020 must-pass measures were not available publicly (in 2019, these measures were Patient-Centered Primary Care Home Enrollment; Depression Screening and Follow-Up Plan; and Screening, Brief Intervention, and Referral to Treatment). Measures used in the Challenge Pool include Child Immunization Status (Combo 2); Disparity Measure: Emergency Department Utilization Among Members with Mental Illness; Oral Evaluation for Adults with Diabetes; and Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life.

Weights. Must-pass measures carry the highest weight, as failure to meet these measure targets renders a plan ineligible for incentive payments.

Application of incentives for delivery system reform and compliance activities. Oregon's performance measures include homegrown measures around access to dental services and access to physical and mental health services for those in DHS custody. Separate from its quality incentive program, it also has standards and evaluation mechanisms related to value-based payment adoption.

Sources

2019 CCO Incentive Measure Benchmarks (PDF), Oregon Health Authority, September 13, 2019.

2019 Quality Pool Methodology (Reference Instructions) (PDF), Oregon Health Authority, November 25, 2019.

2020 CCO Incentive Measure Benchmarks (PDF), Oregon Health Authority, last updated July 20, 2020.

Improvement Targets (PDF), Oregon Health Authority, last updated September 30, 2013.

Minnesota Statewide Quality Reporting and Measurement System: Quality Incentive Payment System (PDF), Minnesota Dept. of Health, June 2015.

TEXAS (TX)

Incentive Structure

Financial incentives. Texas's quality incentive program is funded by putting 3% of capitated payments at risk. These payments are paid out to plans and then recouped through a penalty should a plan fail to meet benchmarks. On top of the capitation adjustment, there is also the opportunity to earn additional funding through the bonus pool, which incentivizes a separate set of measures.

Nonfinancial incentives. Nonfinancial incentives for performance include best practice profiling and auto-assignment preference. Texas also publicizes performance through use of a performance dashboard and by providing members with managed care plan report cards.

Qualification for incentive. The program uses a gate-and-ladder approach for its at-risk pool, with increasing incentives for strong performance and increasing penalties as performance deteriorates. Plans receive neither an incentive nor a penalty if performance is within a certain range, which varies my measure.

Geographic or clinical risk adjustment modifications? No.

Performance Evaluation

Achievement and improvement. Texas uses a ladder approach with tiered achievement and improvement targets for its at-risk pool. For example, in 2020 plans can earn +/–0.375% of their withhold based on achievement or improvement on Well Child Visits in the First 15 Months of Life – Six or More Visits. Performance above the HEDIS 50th percentile or improvement of two or more percentage points results in positive points earned, increasing as plans meet the HEDIS 66.67th percentile or improve more than four percentage points. Performance below the state mean or deteriorating performance of at least two percentage points result in losses, with increasing penalties for performance below the HEDIS 33rd percentile or deteriorating performance of greater than four percentage points. The gate in this case is the state mean through HEDIS 50th percentile. This approach is detailed below.

The bonus pool awards points for meeting achievement targets.

Achievement benchmark source. The achievement threshold is based on attainment of national benchmarks. The state uses a combination of state means and national benchmarks to determine a plan's "safety band," within which point performance is neither rewarded nor penalized.

Improvement measurement source. Improvement targets use percentage point improvement from the plan's prior rate with a "safety band" around maintenance of performance, for which a plan is neither rewarded nor penalized.

Variations in benchmark by measure? Achievement and improvement benchmarks vary by measure.

Deterioration accounted for? Low achievement or plan performance deterioration can result in lost points.

Performance Measures

Number of measures. 12 at-risk measures and 16 bonus pool measures.

Weights. Measures are equally weighted.

Application of incentives for delivery system reform and compliance activities. No. Separate from its quality incentive program, the state incentivizes: value-based payment adoption, dental, nursing facility, and hospital services.

Sources

"Medical Pay-for-Quality (P4Q) Program" (PDF), chap. 6.2.14 in *HHSC Uniform Managed Care Manual*, Texas Health and Human Services Commission, effective January 1, 2020.

"Texas Healthcare Learning Collaborative Portal," Texas Health and Human Services, retrieved February 9, 2021.

"Managed Care Report Cards," Texas Health and Human Services, retrieved February 9, 2021.

Annual Report on Quality Measures and Value-Based Payments (PDF), Texas Health and Human Services, December 2020.

Table B3. Texas STAR Benchmarks: HEDIS Well-Child Visits in the First 15 Months of Life (W15) – Six or More, 2020

PERFORMANCE AGAINST BENCHMARKS			PERFORMANCE AGAINST SELF	
HEDIS RANGES	PERFORMANCE RANGES	PERCENTAGE EARNED/LOST	PERCENTAGE POINT CHANGE	PERCENTAGE EARNED/LOST
>66.67th percentile	>69.59%	0.375	>4	0.375
50th through 66.67th percentile	>66.24%–69.69%	0.1875	2 through 4	0.1875
State mean through 50th percentile	64.23%–66.23%	0	1.99 through –1.99	0
33.33rd percentile to state mean	61.31%–64.22%	–0.1875	–2 through –4	–0.1875
<33.33rd percentile	<61.31%	–0.375	<–4	–0.375

Source: "Medical Pay-for-Quality (P4Q) Program" (PDF), chap 6.2.14 in *HHSC Uniform Managed Care Manual*, Texas Health and Human Services, effective January 1, 2020.

WASHINGTON (WA)

Incentive Structure

Financial incentives. Washington currently withholds 2% of MCO premium for its Integrated Managed Care Value Based Purchasing program.

Nonfinancial incentives. In addition to its financial incentives, Washington profiles high performers, publicizes performance, and requires use of performance improvement plans.

Qualification for incentive. Washington uses a gate-and-ladder approach requiring a minimum performance level be attained before performance achievement or improvement is rewarded.

Geographic or clinical risk adjustment modifications? No.

Performance Evaluation

Achievement and improvement. Washington's methodology scales the improvement weight such that a higher level of gap closure increases the weight for the improvement score, which is then combined with the achievement portion of the score to calculate the overall measure composite score. The final Quality Improvement Score (QIS) is the weighted average of the individual measure composite scores, converted to a percentile. Overall, the combined score more heavily favors achievement. If the Provider Incentive Payment and Value Based Payment (VBP) thresholds are met, the full withhold is earned; however, a partial earn-back percentage can be achieved based on the portion of the threshold dollar amount the MCO paid in Provider Incentives and VBPs.

The overall structure of the program has a total of 100 points, and includes 75 points for the Quality Improvement Score (QIS) (nine HEDIS measures and two non-HEDIS behavioral health measures in 2020), 12.5 points for reaching the threshold for Provider Incentive Payment (1.25% of MCO payments to providers), and 12.5 points for meeting the VBP threshold (85% in 2020).

Achievement benchmark source. The Withhold measure targets for the nine Quality Improvement Score HEDIS measures are set at the NCQA 90th percentile nationally for Medicaid. The Withhold measure targets for the two behavioral health measures (regarding mental health and substance use disorder treatment penetration) are set at 1% above the statewide mean performance.

Improvement measurement source. Quality improvement is measured as progress toward closing the gap between last year's score and this year's Withhold measure target. For each measure, the improvement weight is scaled such that higher levels of gap closure increase the weight for the improvement score when combined with the achievement portion of the score for the overall measure composite score.

Variations in benchmark by measure? No.

Deterioration accounted for? No.

Performance Measures

Number of measures. The program uses nine measures.

Weights. The measures all have equal weight.

Application of incentives for delivery system reform and compliance activities. Incentives are tied to both meeting value-based payment and provider incentive benchmarks.

Sources

Washington Apple Health — Integrated Managed Care Contract (DOWNLOADS .DOC FILE), Washington State Health Care Authority, effective January 1, 2020.

Appendix C. Quality Measures Used in Each Program

MEASURE (STEWARD)	CALPERS 2019	COVERED CA 2020	MEDI-CAL MCP* Reporting Year 2021	DHCS QIP July 1, 2019–June 30, 2020	AZ† 2020	MI‡ FY2020	NY 2018	OR 2020	TX§ 2020	WA 2020
Acute Inpatient Care Timeliness: Concurrent Reviews (CALPERS)	✔									
Acute Inpatient Care Timeliness: Pre-Service Reviews (CALPERS)	✔									
Adherence to Antipsychotics for Individuals with Schizophrenia (NCQA)							✔			
Adolescent Well-Care Visits (NCQA)			✔		✔ ACC	✔			✔ STAR Kids	
Adult BMI Assessment (NCQA)		✔	✔							
Adults' Access to Preventive/Ambulatory Health Services (NCQA)						✔ ages 20–44; ages 45–64				
Alcohol and Drug Misuse Screening, Brief Intervention and Referral to Treatment (SBIRT) (OREGON HEALTH AUTHORITY)								✔		
Alcohol and Drug Treatment (Service) Penetration Total (ages 18–64, all eligible enrollees, including IMC, BHSO, AHMC, AHIFC) (WASHINGTON DSHS)										✔
Ambulatory Care (AMB-OP & AMB-ED) (NCQA)					✔ ED ACC and LTC					
Ambulatory Sensitive Condition Acute Composite (PQI-91) (AHRQ)									✔ STAR+PLUS	
Annual Dental Visit (NCQA)		✔			✔ ACC		✔ ages 2–18			
Annual Monitoring for Patients on Persistent Medications (NCQA)					✔ LTC					
Antibiotic Utilization (NCQA)										
Antidepressant Medication Management (NCQA)		✔	✔				✔			✔
Appropriate Testing for Children with Pharyngitis (NCQA)		✔								
Appropriate Treatment for Children with Upper Respiratory Infection (NCQA)		✔							✔ STAR	
Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia (INFECTIOUS DISEASES SOCIETY OF AMERICA)				✔						

MEASURE (STEWARD)	CALPERS 2019	COVERED CA 2020	MEDI-CAL MCP* Reporting Year 2021	DHCS QIP July 1, 2019–June 30, 2020	AZ† 2020	MI‡ FY2020	NY 2018	OR 2020	TX§ 2020	WA 2020
Assessments for Children in DHS Custody (OREGON HEALTH AUTHORITY)								✔		
Asthma Medication Ratio (NCQA)	✔		✔	✔						
Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy (AMA-PCPI)				✔						
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (NCQA)		✔								
Board Certification (NCQA)										
Breast Cancer Screening (NCQA)	✔	✔	✔			✔	✔			
Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients (AMERICAN COLLEGE OF CARDIOLOGY)				✔						
Cervical Cancer Screening (NCQA)	✔	✔	✔				✔		✔ STAR+PLUS	
Cesarean Rate for Nulliparous Singleton Vertex (PC-02) (TJC)	✔									
Childhood Immunization Status (NCQA)	✔ Combo 3	✔ Combo 3	✔ Combo 10	✔ Combo 10			✔ Combo 3	✔ Combo 3	✔ STAR, STAR Kids, CHIP - Combo 10	✔ Combo 10
Children and Adolescents' Access to Primary Care Practitioners (NCQA)				✔		✔				
Chlamydia Screening (NCQA)	✔	✔	✔	✔			✔			
Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%) (AMERICAN COLLEGE OF CARDIOLOGY)				✔						
Chronic Stable Coronary Artery Disease: Antiplatelet Therapy (AMERICAN COLLEGE OF CARDIOLOGY)				✔						
Cigarette Smoking Prevalence (OREGON HEALTH AUTHORITY)								✔		
Colorectal Cancer Screening (NCQA)	✔	✔					✔			
Compliance Review (MICHIGAN)						✔				
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) (NCQA)						✔				✔

MEASURE (STEWARD)	CALPERS 2019	COVERED CA 2020	MEDI-CAL MCP* Reporting Year 2021	DHCS QIP July 1, 2019–June 30, 2020	AZ† 2020	MI‡ FY2020	NY 2018	OR 2020	TX§ 2020	WA 2020
Comprehensive Diabetes Care: Eye Exam (NCQA)		✔		✔			✔			
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (NCQA)		✔		✔			✔		✔ STAR+PLUS	
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (NCQA)			✔	✔				✔		✔
Comprehensive Diabetes Care: HbA1c Testing (NCQA)	✔						✔			
Comprehensive Diabetes Care: LDL-C Control (<100 mg/dL) (NCQA)		✔								
Comprehensive Diabetes Care: Medical Attention for Nephropathy (NCQA)	✔	✔					✔			
Concurrent Use of Opioids and Benzodiazepines (PQA)				✔						
Congestive Heart Failure Admission Rate (PQI-08) (AHRQ)					✔ LTC					
Contraceptive Care: Most & Moderately Effective Methods (US OFFICE OF POPULATION AFFAIRS)				✔						
Contraceptive Care: Postpartum (US OFFICE OF POPULATION AFFAIRS)										
Controlling High Blood Pressure (not stratified) (NCQA)										
Controlling High Blood Pressure (stratified) (NCQA)	✔	✔	✔			✔	✔		✔ STAR+PLUS	✔
Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) (AMA-PCPI)				✔						
Dental Fluoride Varnish (CALIFORNIA DHCS)										
Diabetes Monitoring for People with Diabetes and Schizophrenia (NCQA)							✔			
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (NCQA)			✔						✔ STAR+PLUS	
Diabetes Short-Term Complications (PQI-01) (AHRQ)					✔ LTC					
Discharged on Antithrombotic Therapy (STK-2) (TJC)				✔						

MEASURE (STEWARD)	CALPERS 2019	COVERED CA 2020	MEDI-CAL MCP* Reporting Year 2021	DHCS QIP July 1, 2019–June 30, 2020	AZ† 2020	MI‡ FY2020	NY 2018	OR 2020	TX§ 2020	WA 2020
Disparity Measure: Emergency Department Utilization Among Members with Mental Illness (OREGON HEALTH AUTHORITY)								✔		
Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older (AMERICAN COLLEGE OF EMERGENCY PHYSICIANS)				✔						
Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years (AMERICAN COLLEGE OF EMERGENCY PHYSICIANS)				✔						
Flu Vaccinations for Adults Ages 18–64 (NCQA)		✔					✔			
Follow-Up After Emergency Department Visit for Mental Illness (NCQA)							✔			
Follow-Up After Hospitalization for Mental Illness (NCQA)		✔ 7-day			✔ ACC		✔		✔ STAR Kids	
Follow-Up Care for Children Prescribed ADHD Medication (NCQA)							✔		✔ STAR and CHIP - Initiation	
Health Information Technology Connectivity	✔									
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)				✔						
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) (AMA-PCPI)				✔						
Help with Care Coordination (NATIONAL SURVEY OF CHILDREN'S HEALTH)									✔ STAR Kids	
HIV Viral Load Suppression (HRSA - HIV/AIDS BUREAU)				✔			✔			
Identification of Alcohol and Other Drug Services (NCQA)										
Immunizations for Adolescents (NCQA)		✔ Combo 2	✔ Combo 2	✔ Combo 2			✔ Combo 2	✔ Combo 2	✔ STAR, STAR Kids, CHIP - Combo 2	
Influenza Immunization (AMA-PCPI)										
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (NCQA)		✔					✔	✔ ages 18+		

MEASURE (STEWARD)	CALPERS 2019	COVERED CA 2020	MEDI-CAL MCP* Reporting Year 2021	DHCS QIP July 1, 2019–June 30, 2020	AZ† 2020	MI‡ FY2020	NY 2018	OR 2020	TX§ 2020	WA 2020
Inpatient Utilization - General Hospital/Acute Care (NCQA)										
International Normalized Ratio Monitoring for Individuals on Warfarin (PQA)		✔								
Lead Screening in Children (NCQA)										
Low Birth Weight (CMS)									✔ STAR	
Medical Assistance with Smoking and Tobacco Use Cessation (NCQA)		✔					✔			
Medication Management for People with Asthma (NCQA)		✔ 75% of treatment period								
Medication Management for People with Asthma (NCQA)							✔			✔ medication compliance 75% (ages 12–18)
Medication Reconciliation Post-Discharge (NCQA)				✔						
Members Receiving Dental Services: Diagnostic, Preventive, Treatment and Any Services (OREGON HEALTH AUTHORITY)								✔		
Mental Health Treatment (Service) Penetration Total (ages 18-64, all eligible enrollees, including IMC, BHSO, AHMC, AHIFC) (WASHINGTON DSHS)										✔
Metabolic Monitoring for Children and Adolescents on Antipsychotics (NCQA)			✔				✔			
Oral Evaluation for Adults with Diabetes (DENTAL QUALITY ALLIANCE)								✔		
Perioperative Care: Selection of Prophylactic Antibiotic: First OR Second Generation Cephalosporin (AMERICAN SOCIETY OF PLASTIC SURGEONS)				✔						
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (when indicated in ALL patients) (AMA-PCPI)				✔						
Plan All-Cause Readmission (NCQA)	✔	✔			✔ ACC and LTC					
Potentially Preventable Admissions (PPA) (3M)									✔ STAR	

MEASURE (STEWARD)	CALPERS 2019	COVERED CA 2020	MEDI-CAL MCP* Reporting Year 2021	DHCS QIP July 1, 2019–June 30, 2020	AZ† 2020	MI‡ FY2020	NY 2018	OR 2020	TX§ 2020	WA 2020
Potentially Preventable Complications (PPC) (3M)									✔ STAR+PLUS	
Potentially Preventable Emergency Room Visits (PPV) (3M)									✔ STAR+PLUS, STAR, STAR Kids, CHIP	
Potentially Preventable Readmissions (PPR) (3M)									✔ STAR+PLUS	
PQI 90 Prevention Quality Overall Composite (AHRQ)	✔						✔ adult and child			
Prenatal & Postpartum Care (NCQA)		✔	✔			✔ timeliness of prenatal care	✔	✔ timeliness of prenatal care	✔ STAR	
Prenatal Immunization Status (NCQA)										
Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections (AMERICAN SOCIETY OF ANESTHESIOLOGISTS)				✔						
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (AMA-PCPI)										
Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category (PQA)		✔								
Screening for Clinical Depression and Follow-Up Plan (CMS)								✔		
Stable Housing Status (NEW YORK STATE)							✔			
Statin Therapy for Patients with Cardiovascular Disease (NCQA)							✔ Statin adherence 80%			
Statin Therapy for Patients with Diabetes (NCQA)							✔			
Substance Use Disorder Treatment Initiation (WASHINGTON DSHS)										✔
Substance Used Disorder Engagement (WASHINGTON DSHS)										✔
Surgical Site Infection (SSI) (AMERICAN COLLEGE OF SURGEONS)				✔						

MEASURE (STEWARD)	CALPERS 2019	COVERED CA 2020	MEDI-CAL MCP* Reporting Year 2021	DHCS QIP July 1, 2019–June 30, 2020	AZ† 2020	MI‡ FY2020	NY 2018	OR 2020	TX§ 2020	WA 2020
Tobacco Use: Screening and Cessation Intervention (AMA-PCPI)										
Transition to Care as an Adult (NATIONAL SURVEY OF CHILDREN'S HEALTH)									✔ STAR Kids	
Use of Imaging Studies for Low Back Pain (NCQA)	✔	✔								
Use of Opioids at High Dosage (NCQA)	✔									
Use of Opioids at High Dosage in Persons without Cancer (PQA)				✔						
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (NCQA)							✔			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (NCQA)	✔	✔	✔				✔		✔ STAR Kids and CHIP	
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (NCQA)		✔	✔		✔ ACC		✔	✔		✔ Combo 10
Well-Child Visits in the First 15 Months of Life (NCQA)		✔	✔	✔	✔ ACC		✔		✔ STAR	

Note: DHCS Value Based Payment Incentive was not included in this table, as the program pays an enhanced rate for specific services based on provider coding. There is no denominator nor are rates calculated.

*Only measures required for the minimum performance level are included.

† Reported are measures used in the withhold. Measures are reported for the Arizona Complete Care (ACC) and Arizona Long Term Care System (LTC).

‡ Plan-specific and health equity measures are not included.

§ Values are reported for the STAR+PLUS, STAR, STAR KIDS, and CHIP programs.

Appendix D. Consumer Experience Survey Use

PROGRAM	TOPICS
Covered CA	QHP Enrollee Survey ➤ Access to Care ➤ Access to Information ➤ Care Coordination ➤ Plan Administration ➤ Rating of All Health Care ➤ Rating of Health Plan ➤ Rating of Personal Doctor ➤ Rating of Specialist
MI	CAHPS (3 surveys fielded) ➤ Customer Service Composite ➤ Getting Care Quickly ➤ Health Plan Rating ➤ Tobacco Cessation Strategies
NY	CAHPS Adult ➤ Customer Service and Information ➤ Getting Care Needed ➤ Rating of Health Plan
TX	CAHPS Adult ➤ Good Access to Urgent Care CAHPS Child ➤ Getting Care Quickly ➤ Getting Specialized Services ➤ Rating Their Child's Personal Doctor a 9 or 10

Endnotes

1. CHCF convened an Advisory Group to examine this question. Its recommended Medi-Cal measure set can be found in *Paying Medi-Cal Managed Care Plans for Value: Quality Goals for a Financial Incentive Program*, CHCF, April 2019.
2. Andrew B. Bindman, *A Prescription for Performance Assessment and Accountability in Medi-Cal*, CHCF, May 2018; and Andrew B. Bindman, Denis Hulett, and Taewoon Kang, *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade*, CHCF, September 2019.
3. Inclusive of quality measures and the application of incentives for delivery system reform and compliance activities.
4. This section includes incentive structure for six other state Medicaid programs, Covered California, and CalPERS. Because DHCS's VBP Incentive Program and QIP are provider/public hospital performance programs, they were excluded.
5. Daniel Kahneman and Amos Tversky, "Prospect Theory: An Analysis of Decision Under Risk," *Econometrica* 47, no. 2 (Mar. 1979): 263–92, doi:10.2307/1914185.
6. Bruce Guthrie, Glenna Auerback, and Andrew B. Bindman, "Health Plan Competition for Medicaid Enrollees Based on Performance Does Not Improve Quality of Care," *Health Affairs* 29, no. 8 (Aug. 2010): 1507–16, doi:10.1377/hlthaff.2009.0468.
7. *Welcome to Washington Apple Health Integrated Managed Care* (PDF), Washington State Health Care Authority, n.d.
8. If plan performance is above the performance required to earn its withhold, the difference between the earned withhold and performance is due to the plan.
9. Plans have an opportunity to earn unearned withhold funds based on performance on an additional pool of measures.
10. Plans have an opportunity to earn unearned withhold funds based on performance on an additional pool of measures.
11. *2018 Quality Incentive Report: A Report on the Quality Incentive Program in New York State* (PDF), New York State Dept. of Health, n.d.
12. "eQARR - An Online Report on Quality Performance Results for Health Plans in New York State," New York State Dept. of Health, last updated October 2018.
13. 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.
14. 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, doi:10.1377/hlthaff.2019.00914.
15. In Covered California, if a plan's performance declines, it could result in moving from a reward to a penalty. However, if performance is already low, a further decline does not result in additional penalty owed.
16. Meeting minutes, Metrics and Scoring Committee: August 16, 2019 (PDF), Oregon Health Authority.
17. The Buying Value Benchmark Repository contains benchmark information on homegrown and non-HEDIS measures used by state agencies.
18. Based on calculations in *2018 HEDIS Aggregate Report for Michigan Medicaid* (PDF), Michigan Dept. of Health and Human Services, October 2018.
19. CalPERS is not included in this table, as it was unclear whether achievement or improvement was more heavily weighted. Some of the measures have only achievement targets, and others have only improvement targets.
20. DHCS QIP includes both achievement and improvement benchmarks, but improvement is more heavily emphasized. Targets are set based on gap closure between prior performance and a high-performance benchmark, the HEDIS 90th percentile.
21. CHCF convened an Advisory Group to recommend measures for the Medi-Cal measure set. A summary of its recommendations can be found in *Paying Medi-Cal Managed Care Plans for Value: Quality Goals for a Financial Incentive Program*, CHCF, April 2019.
22. CalPERS has a different percentage of premium at risk for each measure, but clinical quality measures are all within one category and are treated equally.
23. Covered California uses unequal weights based on the program's prioritization / value / domains of interest.
24. Arizona has different weights for its withhold measures.
25. Michigan has equal weights within a category by not between categories.
26. Oregon has equal weights within each measure stage; weights are unequal in that Oregon selects a subset of measures to serve as a gate.
27. *Alternative payment model* and *value-based payment* are synonyms.
28. "DSRIP - Value Based Payment Reform (VBP)," New York State Dept. of Health, last updated September 2019.
29. *Paying for Health and Value: Health Care Authority's Long-Term Value-Based Purchasing Roadmap 2022–2025* (PDF), Washington State Health Care Authority, August 2020.
30. Compliance scores are based on the quality of submitted compliance reports, graded between 0%–100%, with a minimum score of 76% needed to achieve any quality incentive points.