



CALIFORNIA
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Pay-for-Performance in the Medi-Cal Managed Care and Healthy Families Programs: Findings and Recommendations

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by

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About the Foundation

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I. Executive Summary

THERE EXISTS SIGNIFICANT INTEREST WITHIN California regarding the potential benefits of applying pay-for-performance (P4P) to state managed care contracting. The California Legislative Analyst's Office recommended in its 2008–2009 Health and Human Services Analysis that the California Department of Health Care Services (DHCS) pursue a pay-for-performance strategy with providers and managed care plans. In addition, the implementation plan component of the DHCS Strategic Plan, published in October 2008, includes a task to develop a P4P program for managed care plans.

Financial pay-for-performance is a value-based purchasing strategy that has the potential to promote greater emphasis on improving quality of care for low-income beneficiaries enrolled in Medi-Cal and Healthy Families programs. Pay-for-performance strategies are typically devised as a means for aligning provider or managed care plan incentives so that it is in the economic interest of the provider or plan to improve access to care or quality of care. In other words, the incentives create a “business case” for pursuit of access and quality objectives.

The California HealthCare Foundation (CHCF) contracted with Bailit Health Purchasing, LLC (Bailit), to explore how pay-for-performance might promote improved quality of care in the Medi-Cal and Healthy Families programs.

The objectives of the project were to identify and examine Medicaid and SCHIP managed care pay-for-performance programs in use in other states; assess the desirability and feasibility of a P4P program in California; and identify and analyze several design options for pay-for-performance programs within Medi-Cal Managed Care and Healthy Families.

Information was gathered from a variety of sources, including published reports and evaluations of pay-for-performance as a strategy for supporting quality improvement in general and in Medicaid in particular; interviews with state officials and managed care plans in six states currently operating Medicaid P4P programs with managed care plans; and interviews with California policy and program officials and a variety of stakeholders.

The California interviews included representatives from managed care plans that contract with Healthy Families and Medi-Cal; consumer advocates; provider and health plan associations; management staff at the California Health and Human Services Agency, DHCS, and the state's Managed Risk Medical Insurance Board (MRMIB); and legislative staff.

This report summarizes the findings from these research activities, and presents recommendations for the DHCS, MRMIB, and administrators of Medi-Cal and Healthy Families.

Key Findings

While some state Medicaid programs have been employing pay-for-performance strategies with managed care plans and providers for many years, P4P has been commonly pursued by states only in the last several years. Interviews were conducted with representatives from six sample states that have P4P programs in place: Indiana, Michigan, New York, Oregon, Pennsylvania, and Rhode Island. In addition, a growing body of research regarding pay-for-performance as a strategy for improving health care quality was also analyzed for this report.

The research about and interviews with other states reveal several important findings:

- State Medicaid agencies commonly use pay-for-performance programs with contracted managed care plans to motivate improvements in health care access and quality.
- These programs have not been subject to significant external evaluation.
- The states that operate P4P programs with contracted managed care plans firmly believe in the value and effectiveness of their programs.

The information gathered from California state policy and program officials and external stakeholders about the desirability and feasibility of a P4P program in California revealed the following findings:

- The DHCS performance-based auto-assignment algorithm has caused many affected managed care plans to dedicate significant plan resources and attention to generating improvement in the targeted areas.
- State agency senior executives and all other stakeholder groups are positive in their assessment of the potential use of P4P to generate improvements in managed care plan performance. Provider associations and consumer advocates have some reservations.
- Stakeholders are more optimistic about the potential use of financial incentives to generate performance change than they are about non-financial incentives.
- The current state fiscal crisis and its impact on capitation rates—particularly those of Medi-Cal—will make it impossible to implement a financial P4P program until state finances improve and Medi-Cal provider and plan rates are increased.

From information gathered, it is clear that P4P presents a real opportunity to generate improvement in plan performance. This notion is also generally endorsed by leading stakeholders. However, state financial pressures are a significant deterrent to implementation in the near future.

Recommendations for Pay-for-Performance in California

In consideration of the research findings regarding pay-for-performance, the assessed experience of six other states, and interviews with state agency and legislative staff and stakeholders, this report provides recommendations regarding the use of P4P programs within Medi-Cal and Healthy Families programs, relative to central design considerations. The recommendations follow.

Objectives of a P4P Program

- **Clarify motivations of and desired results for P4P.** Before DHCS or MRMIB initiates a P4P program design effort, they need to be clear about why they are pursuing the strategy, and what ends they intend to achieve.
- **Focus the program on motivating improvements in key areas.** The P4P program should be focused on motivating improvements in contractor performance in areas of high priority and clear opportunity.
- **Evaluate the impact of the program periodically.** The impact of DHS and MRMIB P4P programs should be evaluated periodically to ensure these programs are having their desired impact and that any unintended consequences are identified.

Measures That Should Be Employed

- **Align measures with existing priorities.** Like the objectives for the program, the adopted measures should reflect a consideration of existing priorities and opportunities, as well as consideration of current and past performance.
- **Consider a regional or plan-specific approach.** DHCS should consider a regional or even plan-specific approach, if operationally feasible.
- **Align child/adolescent care measures with Medi-Cal and Healthy Families.** The measures employed for child and adolescent care should be aligned wherever possible with Medi-Cal and Healthy Families.
- **Use measures different from current auto-assignment algorithm measures.** Vary the measures used for any new financial P4P program from those used for the current performance-based auto-assignment algorithm.
- **Limit the number of measures introduced.** The set of new P4P performance measures should be limited to approximately six to eight, depending on the measures selected.
- **Use measures from national data sets.** Measures should be taken from national data sets. HEDIS and CAHPS are obvious sources since MRMIB and DHCS currently require reporting of both.

How Plans Qualify for Rewards

- **Allocate rewards based on current performance.** Agencies should allocate rewards based on a consideration of performance during the most recent calendar year relative to a benchmark (a “point-in-time” assessment), as well as a consideration of plan performance over time (a “change-over-time” assessment).

Structuring Financial Incentives and Rewards

- **Implement financial incentives when the timing is right and then use thoughtful financing strategies.** Implement a financial P4P initiative only when additional funds can be provided above and beyond what is necessary to obtain actuarially appropriate rates.
- **Structure the incentive as a discrete percentage.** The financial performance incentive could be structured as a discrete percentage of the rate (e.g., \$x per-member per-month), or a discrete percentage of an annual rate increase (e.g., 1 percent) that is placed at risk.

About Non-Financial Incentives and Rewards

- **Consider modifying existing incentives.** Modify the Healthy Families auto-assignment process so that it uses the same child health HEDIS indicators that are used by DHCS in its auto-assignment algorithm.
- **Consider making data more accessible for consumers.** Utilize a Medi-Cal Managed Care consumer report card that simplifies the existing, extensively detailed HEDIS and CAHPS data presented on the DHCS Web site, and make the document easier to find for consumers.
- **Utilize performance as a plan procurement criterion.** Consider past performance scores on existing measures when competitively procuring managed care contractors in the future.
- **Revisit the use of safety net provider support measures in the Medi-Cal management care auto-assignment algorithm.** Reconsider the use of the two safety net provider support measures in the performance-based auto-assignment

algorithm to determine to what degree managed care plans have the ability to impact their scores on these measures, and whether the measures have resulted in changes in plan performance.

- **Evaluate opportunities to waive plan administrative requirements for high-performing plans.** Convene a workgroup of DHCS and managed care plan staff to review opportunities to waive existing administrative requirements for high-performing plans, and to deem compliance oversight for any plan functions to NCQA, URAC, or DMHC.

Design Process and Timing

- **Coordinate the process.** The design of a new financial P4P program, and of any refinements or new non-financial P4P activities, should be undertaken in coordinated fashion by DHCS and MRMIB.
- **Manage the process using an advisory group.** The development process should be managed using a representative stakeholder advisory group, comprising plan representatives for both programs and all three Medi-Cal managed care models, provider organization representatives, consumer advocates, and state agency program staff.
- **Provide legislative staff with briefings and solicit input.** DHS and MRMIB should provide periodic briefings and solicit input from legislative staff so that legislative staff members are apprised of the effort's progress and afforded the opportunity to influence the outcome.
- **Begin as soon as possible.** If a pay-for-performance program is indeed a policy direction in which both DHCS and MRMIB want to

move, the design process should begin as soon as possible.

- **Consider a pilot prior to implementation.** DHS and MRMIB could consider piloting the P4P program prior to statewide implementation, to limit risks and afford the agencies and the participating plans a learning opportunity.

Addressing Stakeholders' Concerns

- **Be proactive about addressing legislative staff feedback.** DHCS should consider how to address the broader concerns voiced by legislative staff.
- **Consider modifying measures to address disparity.** DHCS should consider whether it could modify performance measures to report along racial and ethnic groups, as MRMIB does currently.

Sustaining a P4P Program

- **Conduct periodic assessments of purchasing strategy elements.** DHCS and MRMIB should develop and implement plans for periodic assessment of all elements of their purchasing strategies.
- **Collaborate via scheduled communication.** DHCS and MRMIB should coordinate their efforts through regularly planned communication prior to convening their respective advisory groups each year, and consult with each other prior to making any methodology changes that would have relevance for the other.

II. Background

STATES HAVE AN ENORMOUS OPPORTUNITY and a responsibility to leverage the purchasing power of their Medicaid program and the federal State Children’s Health Insurance Program (SCHIP) to improve the health of the population and maximize the contributions that taxpayers have made to these programs.

To this end, many state Medicaid and SCHIP programs have adopted the principles of “value-based purchasing.” Value-based purchasing is a data-driven approach to specifying what an agency wants to buy (both processes and outcomes), identifying the gaps between current and desired performance, and using disciplined contract management activities and aligned incentives to achieve continuous improvements in performance. California has had some success applying these principles in its governance of Medi-Cal, the state’s Medicaid Managed Care program, and Healthy Families, California’s version of the SCHIP program.

For example, the Medi-Cal Managed Care Division, which contracts with managed care plans to provide care to one-half of Medi-Cal’s 6.6 million beneficiaries, implemented in late 2005 a performance-based “auto-assignment” program. Auto-assignment occurs when a Medi-Cal beneficiary who is required to participate in managed care does not select a plan within 30 days of notification, and so is assigned to a health plan in order to receive coverage. This newer performance-based program differentially assigns default enrollments to various contracted managed care plans based on a set of performance indicators. The program has created strong economic incentives for contracted health plans to dedicate themselves to achieving quality

improvement and excellence in areas of priority to the state.

Financial pay-for-performance (P4P) is another value-based purchasing strategy that has the potential to promote greater emphasis on improving quality of care for low-income beneficiaries enrolled in Medi-Cal and Healthy Families programs. Financial P4P strategies, as used with managed care plans, employ payment methods and other monetary incentives to encourage quality improvement and patient-focused, high-value care.

There exists significant interest within California regarding the potential benefits of applying pay-for-performance to state managed care contracting. The California Legislative Analyst’s Office, which provides fiscal and policy analysis for the California Legislature, recommended in its 2008–2009 Health and Human Services Analysis that the California Department of Health Care Services (DHCS) pursue a pay-for-performance strategy with providers and managed care plans.¹

In addition, the Implementation Plan component of the DHCS Strategic Plan, published in October 2008, includes a task to develop a P4P program for managed care plans.²

Exploring Pay-for-Performance with Medi-Cal and Healthy Families

The California HealthCare Foundation (CHCF) contracted with Bailit Health Purchasing, LLC (Bailit) to explore how pay-for-performance might promote improved quality of care in the Medi-Cal and Healthy Families programs.

The objectives of the project were threefold:

1. Identify and examine Medicaid and SCHIP managed care pay-for-performance programs in use in other states;
2. Assess the desirability and feasibility of a P4P program in California by gathering input and perspectives from state policy and program officials and a variety of stakeholders; and
3. Identify and analyze several design options for pay-for-performance programs within Medi-Cal Managed Care and Healthy Families.

To address these objectives, information was gathered from a variety of sources:

- Published reports and evaluations of pay-for-performance as a strategy for supporting quality improvement in general and in Medicaid in particular;
- Interviews with state officials and managed care plans in six states currently operating Medicaid P4P programs with managed care plans; and
- Interviews with California stakeholders and state government personnel, including managed care plans that contract with Healthy Families and Medi-Cal; consumer advocates; provider and health plan associations; management staff at the California Health and Human Services Agency, DHCS, and the state's Managed Risk Medical Insurance Board (MRMIB); and legislative staff.

The California interviewees were identified by CHCF, DHCS, and MRMIB, and recruited for participation by Bailit. Their names and affiliations are provided in Appendix C.

The review of published reports/evaluations and interviews with other states did not focus on

SCHIP for the following reasons: Many states utilize common P4P approaches for both Medicaid and SCHIP as P4P is applied to care for children, and little has been written on the topic of P4P for SCHIP. The literature review instead focused on general research and experience with P4P for Medicaid.

Information from published reports and interviews was synthesized to assess the feasibility of and recommended approach to implementing a pay-for-performance strategy to improve the quality of care for participants in the Medi-Cal and Healthy Families programs.

Overview of Pay-for-Performance

Pay-for-performance strategies are typically devised as a means for aligning provider or managed care plan incentives so that it is in the economic interest of the provider or plan to improve access to care or quality of care. In other words, the incentives create a “business case” for pursuit of access and quality objectives. States and large employer purchasers and purchasing coalitions use P4P strategies with contracted insurers, while states and insurers employ the strategies with providers.

Despite the use of the word “pay” in “pay-for-performance,” this purchasing strategy is not always payment-related. Many state programs use other incentives and rewards, such as public report cards and enrollment assignments, to encourage high-quality care. For this reason, at least one national purchaser organization utilizes the term “incentives and rewards” instead of P4P.³ Others penalize health care providers and health plans if their performance doesn't meet a defined performance threshold by levying fines, and by imposing restrictions on enrollment and on expansion of service areas.

Some observers question why incentives need to be employed for providers and managed care plans “to do what they should already be doing.” The

answer lies in the fact that existing incentives, which are very complex, generally do not reward quality. For example, managed care plans are financially rewarded largely by enrolling more members and ensuring that their health care costs fall below the capitated premium rate. Providers are financially rewarded for delivering more services, regardless of their impact on patients. P4P strategies are intended to mitigate some of the unintended consequences of the current payment system and encourage the delivery of accessible, high-quality, and efficient care.

Measures of Quality

Pay-for-performance strategies that encourage managed care plans to improve performance can encompass a range of quality measures, depending on the priorities of the sponsor. Some of these measures are discussed here.

Access. Many Medicaid programs have traditionally defined the quality of managed care plans by how well they afford members easy access to services. While the understanding of quality at the state level has grown substantially over the years to recognize that mere access to services doesn't ensure quality health care and improved health, access to care remains a key focus for some state P4P programs.

Process. P4P strategies are most often linked to "process" measures of quality, such as whether an individual received recommended tests or treatments such as vaccinations and mammograms. These types of measures are often employed because they are relatively easy to measure and because standardized national measures that relate to process are part of the Healthcare Effectiveness Data and Information Set (HEDIS), maintained by the National Committee for Quality Assurance (NCQA).

Outcome. To a lesser degree, outcome measures, such as cholesterol levels that are under control,

or bedsores in nursing home residents, are also employed. These measures are more challenging to use than process measures for several reasons: Many outcomes take years to manifest; it is difficult to attribute an outcome to the actions of a health plan; and outcomes are frequently influenced by comorbidities or other patient characteristics.

For this reason, when outcome measures are employed, they typically are used as "interim" outcome measures. For example, controlled cholesterol is used as an interim outcome measure because it decreases the likelihood of other possible future outcomes, such as heart disease and premature death.

Structure. Health plans are sometimes rewarded for having networks with a specific administrative capacity or capability, or for taking steps to develop such capacity. For example, a plan might be rewarded for its network's adoption of e-prescribing or its use of incentives so that providers will adopt e-prescribing.

Satisfaction. Scores from standardized member satisfaction surveys such as CAHPS are frequently used to measure quality.

Efficiency. The Institute of Medicine has identified efficiency as one of the six aims of quality improvement, defining it as avoiding waste.⁴ States generally approach efficiency through the use of capitated payment, often including risk adjustment. Some states make limited use of other efficiency and cost-reduction incentives, focusing on topics such as generic drug use and third-party liability notification.

Participation in a quality improvement activity. Instead of paying for performance per se, a few P4P programs provide incentives for plans to participate in a collaborative quality improvement initiative, or to initiate one. For example, Massachusetts provides incentives to its statewide managed behavioral health contractor to develop

new service capacity and to undertake quality improvement initiatives.⁵

Other. Other quality measures that are sometimes recognized by P4P programs include the following:

- NCQA accreditation of the managed care plan;
- Administrative services that are handled in a timely manner, such as the distribution of member identification cards and handbooks, new member outreach, and resolution of grievances and appeals; and
- The support of safety net hospitals and clinics by increasing patient volume.⁶

Reward Strategies

P4P strategies, as they are used with managed care plans, are intended to confer some type of economic benefit as a result of undertaking a desired action or achieving desired results. Some economic benefits are financial, in that they result in the purchaser or payer allocating fewer or more dollars to the plan. Others are non-financial, in that the plan is rewarded indirectly, with no money involved. Examples of different types of financial and non-financial incentive strategies follow.⁷

Quality bonuses. The most common type of P4P program, this financial incentive involves provisioning supplemental payments based on a retrospective assessment of plan performance. The available dollars typically range between 0.5 percent and 3.0 percent of premium.

Premium withholding. Another financial incentive, premium withholding is used by some states to designate that a portion of the base health plan reimbursement is contingent upon achievement of a set of performance targets. The state withholds a fixed percentage of capitation payments, and returns

the withheld funds to the degree that the managed care plan meets state-defined criteria.

Profiling performance. State purchasers frequently profile the performance of their managed care plans. The profile reports are typically fed back to the managed care plan and include peer and/or benchmark comparisons, functioning as a non-financial incentive for motivating quality improvement activity.

Publicizing performance. Most profiling initiatives of managed care plans eventually, if not immediately, lead to the disclosure of performance to interested parties (e.g., Medicaid recipients with a choice of health plans), and/or to the general public. Both DHCS and MRMIB publicize HEDIS and CAHPS data, as well as other managed care plan assessment information, on their Web sites, providing yet another non-financial incentive for quality improvement.

Technical assistance for quality improvement. Some organizations provide consultative assistance to their contracted health plans and/or providers. For example, a coalition of Medicaid and commercial health plans in Pennsylvania is providing training and coaching to primary care practices to help transform themselves into “medical homes.”⁸

Sanctions. State purchasers sometimes apply non-financial sanctions to contractors who fall below performance expectations. Sanctions can include prohibition from serving additional patients or members, and increased administrative requirements.

Reducing administrative requirements. Purchasers will sometimes exempt contractors from certain requirements should they demonstrate superior performance. For example, a state might waive certain reporting requirements for managed care plans that have attained NCQA or URAC accreditation.

Preference in auto-assignment. Several states, including California, assign a disproportionate percentage of members to managed care plans that perform better than their competitors on a defined set of performance measures.⁹

Eligibility Criteria for Incentive Rewards

States usually assess whether a managed care plan is eligible for P4P incentive rewards by comparing its performance at a given point in time (e.g., CY 2009) to one of the following:

- National Medicaid managed care plan performance (NCQA reports percentile scores annually);
- Intra-state managed care performance (relative to state or regional averages, or to directly competing managed care plans); or
- State-defined targets (established by the state for all plans in the state or in a region).

States also sometimes assess a managed care plan's eligibility for P4P incentives based on changes in that plan's performance over time. This strategy is used to motivate improvement by all plans, but especially those plans with performance that falls far below best practices in the state or region. It can be implemented in a few different ways, including assessment of the following:

- Statistically significant improvement (i.e., current year rates are compared to prior year rates, and changes are tested for statistical significance); and
- Performance relative to state-defined targets (i.e., targets established by the state for each individual managed care plan).

III. Published Research and Reports on Other States

TO INFORM AN ASSESSMENT OF OPTIONS for Medi-Cal and Healthy Families, prior experience with P4P was studied. Analysis began with a review of published surveys and analyses of state P4P programs. This information was then supplemented with information collected directly from states and their contracted health plans during structured interviews.

The research and interview that were performed for the purposes of this project reveal several important findings:

- State Medicaid agencies commonly use pay-for-performance programs with contracted managed care plans to motivate improvements in health care access and quality.
- These programs have not been subject to significant external evaluation.
- The states that operate P4P programs with contracted managed care plans firmly believe in the value and effectiveness of their programs.

Details of these findings follow.

Published Research on Pay-for-Performance with Managed Care Plans

There is a growing body of research regarding pay-for-performance as a strategy for improving health care quality. Some of the research seeks to identify which aspects of pay-for-performance practitioners are associated with success in improving quality. Other research seeks to determine the overall impact of P4P on health care quality. Most of the latter, however, has focused on the use of P4P with service providers, and not with managed care plans.

One of the largest surveys to date of P4P programs is a 2006 survey of state Medicaid directors regarding pay-for-performance.¹⁰ Of the 38 responders, 20 states indicated they used some form of a financial or non-financial incentive strategy with their contracted health plans. Approximately 30 percent of the states with existing incentive programs of any type reported that they had conducted or planned to conduct formal evaluations of their programs.

The study found that many pay-for-performance programs included both non-financial and financial incentives. The most common non-financial incentive was public reporting of performance. In addition, more than 40 percent of new programs were planning to include assessment methodologies that combined attainment and improvement goals for the same measures.

Two other 2006 surveys, one performed with 15 state Medicaid programs and the other a survey of SCHIP and Medicaid programs, both noted that evaluation studies were limited in number and scope.¹¹

An observational analysis in 2002 examined some of the first state Medicaid managed care P4P programs—those operated by Iowa, Massachusetts, Rhode Island, Utah, and Wisconsin.¹² In Iowa and Massachusetts, the case studies focused on performance incentives with managed behavioral health plans. In the other three states, the case studies focused on incentives in health maintenance organization (HMO) contracts. The study concluded that because of the variety of incentives, the limited number of programs examined, and the lack of a controlled study methodology, it was not possible

to make conclusive statements about the extent to which contractual incentives were effective in producing a higher level of performance from contractors.

However, the study did note situations in which financial incentives, financial penalties, and non-financial incentives appeared to be effective in motivating contractors. In addition, interviewed states and contracted plans largely agreed that incentive programs in general are effective in getting plans and the state to review performance data in detail and to improve the quality and timeliness of reporting on performance indicators. Participants noted that performance incentives are effective in focusing both the purchasers' and the contractors' attention on targeted performance areas.

A more recent study evaluated the effectiveness of the P4P program that New York employs with its contracted Medicaid managed care plans.¹³ New York has a long-standing financial incentive program that it supplements with a public report card and performance-based auto-assignment. The 2007 study concluded that quantitative findings suggest that the program improved plan performance for Medicaid enrollees in some but not all instances. The positive effects were more widespread for enrollees in plans with a higher share of Medicaid enrollees.

A significant amount of research literature has also been published on the characteristics of successful P4P programs.¹⁴ While much of this literature focuses on P4P as it relates to service providers, most of the tenets are applicable to managed care plans as well. The literature suggests the following:

- A P4P strategy should focus on demonstrated opportunities for performance improvement that are within the control of the targeted plans.
- Performance measures should be scientifically sound and drawn from national standards.
- Performance measures should be feasible to collect without imposing added burdens on providers.
- Performance measures should not be highly sensitive to patient case mix considerations that would require the use of a risk adjustment mechanism.
- The P4P methodology should be developed in close collaboration with the affected plans, and made transparent to all.
- Significant education should be provided to managed care plan representatives so that they understand the specifics of the P4P methodology, and what actions are expected of them to attain the potential P4P rewards.
- The methodology should provide incentives for excellence and for performance improvement over time so that the P4P program doesn't simply reward those who are already performing well, without motivating those who need most to improve.
- When possible, it is best to align incentives across payers within a geographic area so that providers do not face multiple unaligned P4P incentives that make it difficult, if not impossible, for them to focus and achieve the desired improvements.
- Plans must have sufficient economic reasons to engage in quality improvement activities. States should make sure that financial incentives are sufficiently large, and utilize complementary non-financial strategies.
- States should dedicate adequate resources to program administration to avoid errors in

measurement or algorithm calculations, payment delays, or inaccurate payments, all of which could irreparably harm the credibility of the program.

States need to monitor, revise, and improve P4P programs, including the selected measures, on an ongoing basis after initial implementation.

Reports about Pay-for-Performance in Use in Other States

While some state Medicaid programs have been employing pay-for-performance strategies with managed care plans and providers for many years, P4P has been commonly pursued by states only in the last several years, and the growth of state use of P4P in recent years has been considerable. The previously cited 2006 state survey found that more than half of states were operating one or more pay-for-performance programs and nearly 85 percent expected to do so within the next five years.¹⁵

To learn first hand about state’s experiences with Medicaid and SCHIP pay-for-performance programs, interviews were conducted with six sample states: Indiana, Michigan, New York, Oregon, Pennsylvania, and Rhode Island. These states were chosen because they represent a breadth of experience with pay-for-performance: those that were some of the first to apply P4P programs to managed care plans, those that have recently implemented P4P programs, and those that operate P4P programs with financial reward strategies that are complemented by a performance-based auto-assignment program like that operated by DHCS. The year that each state began its P4P program is listed in Table 1.

Table 1. Inception Dates for Six State Financial P4P Programs

STATE	YEAR OF INCEPTION
Rhode Island	1998
Michigan	1999
New York	2001
Pennsylvania	2005
Indiana	2007
Oregon	2008

For each of the six states, state personnel with responsibility for the P4P program’s operation were interviewed, as were managed care plan stakeholders. The stakeholders were contracted managed care plans in the state or the state health insurer trade association. Some of the distinguishing characteristics of the state programs follow. More detail about the measures utilized in each state’s P4P program can be found in Appendix A. Information about states requiring their managed care organizations (MCOs) to implement P4P with network providers can be found in Appendix B.

Rhode Island

Rhode Island has one of the longest-standing P4P programs in the country, having used P4P with Medicaid managed care since 1998.¹⁶ The state was ranked the highest in the nation on health care quality in a recent Commonwealth Fund report.¹⁷

Rhode Island initially had a contractor design its P4P program, but it has been convening contracted plans regularly since 2005 to obtain their input on the program’s methodology and possible changes to the program.

The state uses a mix of HEDIS and CAHPS measures, as well as a smaller set of state-defined measures that address member services administrative functions, cost management, and, on occasion, special quality topics of interest to the state. Rhode

Island uses a separate set of core measures for SCHIP, but there is no separate SCHIP P4P program. (A detailed list of HEDIS and CAHPS measures employed by the state in 2007 can be found in Appendix A.)

Rhode Island provides tiered bonuses for achievement of HEDIS and CAHPS measures. Amounts are typically based on the managed care plan's performance compared to NCQA's annual performance percentile scores for Medicaid managed care. The state originally set the potential available bonus at one percent of the capitation rate. For the past six years, however, it has instead set the bonus at a maximum dollar amount per-member per-month (currently \$1.75), which causes the bonus to drop as a percentage of premium as capitation rates increase. The bonus algorithm allocates 80 percent of the available points to performance on HEDIS measures and similar quality indicators. The remaining 20 percent is allocated to the state-defined member services and cost management measures. Rhode Island distributes most of its P4P bonus funds. For instance, 84 percent were distributed in 2008.

The state reports that contracted plans have urged the state to apply as many HEDIS quality measures as possible, since doing so helps the plans also meet a state contractual requirement that they be accredited by NCQA.

Rhode Island believes the P4P program has been successful, and cites the following evidence:

- All three Medicaid-participating managed care plans have consistently been among the top ten Medicaid managed care plans in the country, according to NCQA and *U.S. News & World Report*.¹⁸ Similar high levels of performance have not been demonstrated by the very same managed care plans for their commercial or Medicare populations.

- The state has obtained positive External Quality Review Organization (EQRO) evaluations.
- There have been observable improvements on HEDIS scores, reaching up to the 90th percentile.

The state identified the following as key success factors when developing a P4P program for managed care plans:

- It is very valuable to use HEDIS and CAHPS data, which represent a series of well-honed measures that support national comparison.
- Collaboration with health plans is essential, as is a focus on driving quality improvement.

Rhode Island does not incorporate performance considerations into its auto-assignment algorithm.

Personnel from one of the state's three contracted managed care plans were interviewed for this report to learn about their experiences with the state's P4P program.¹⁹ They assessed the program favorably, noting that the plan has a close relationship with the state. They also added that because so many of the P4P measures are drawn from HEDIS and CAHPS measures, the program does not require the plan to make investments in quality improvement efforts not otherwise being addressed, since the program aligns improvement efforts with other work, such as accreditation.

The managed care plan representatives also reported that much of what the program does operationally is derived from the priorities established by the P4P measures, including non-HEDIS and non-CAHPS measures. Like the state, they attribute at least part of the high scoring of the Rhode Island health plans by NCQA and *U.S. News & World Report* to the P4P program.

The managed care representatives identified the following as key success strategies:

- Align P4P measures to national measures.
- Collaborate with the state on operational details, particularly around timelines and specifications. Recognize that such collaboration requires a continuing conversation: Once decisions are made, the work isn't over.
- Conduct in-person meetings on a regular basis to further develop and solidify the partnership.

Michigan

Michigan's P4P program for managed care plans was initiated by the Department of Community Health, but legislative language generally supports the state's ability to administer such a program.²⁰ The program has been in place since the state's 1999–2000 managed care plan procurement. The legislature did not specify how the P4P program should be designed, although it has specified certain measures and performance goals over time (e.g., the legislature set a lead screening target for Medicaid managed care plans).

Michigan's P4P program employs a withholding model. To the state's surprise, there was not much resistance to this design; it reports that the managed care plans generally agree with the decision to award money to the highest performers.

Michigan withholds .0019 percent of premium every month, which yields an annual bonus pool of approximately \$5 million. The state distributes the aggregated withheld money by assessing managed care plans on their performance around 22 HEDIS and CAHPS measures, their plan accreditation status, and an annual state-defined focused incentive. For example, the focused incentive for 2008 involved an

assessment of each plan's case management/disease management program.

Michigan assesses performance by comparing it to NCQA's national percentile scores for Medicaid managed care plans. The 50th, 75th, and 90th percentiles are used for scoring purposes. (A list of measures utilized by Michigan can be found in Appendix A.)

Michigan's P4P algorithm is dynamic. The state makes changes from year to year based on changes in the HEDIS data set, legislative action, and changing state priorities. Plans have expressed a preference for the state to inform them a year or two in advance of measure changes. Generally speaking, all plans get some money from the bonus pool, but not necessarily as much as they contribute via the withholding of a percentage of the premium.

Like California, Michigan operates a performance-based auto-assignment algorithm. The state has generally aligned the algorithm's clinical measures with those used in its financial P4P program. For instance, while it excludes consideration of accreditation and of the periodically legislated improvement targets referenced earlier, it does include consideration of performance relative to timely claims processing, encounter data submission, and primary-care-physician capacity by region.

The state rotates the auto-assignment HEDIS and CAHPS measures so that the algorithm assesses performance against a different set of measures for each calendar quarter (e.g., eight measures in Q1 and Q4, and then seven measures in Q2 and Q3). While the financial P4P program assesses plans relative to NCQA percentile scores, the auto-assignment algorithm rule is to assess whether a plan exceeds one or both the NCQA 50th percentile and the Michigan Medicaid health plan average, with more points awarded for exceeding both. The algorithm allocates assignments to the highest-achieving plans

within each state-defined geographic region, with an adjustment to account for differences in plan enrollment.

Michigan has not formally evaluated its program, but the representative who was interviewed for this report believes that positive trends in HEDIS and CAHPS rates can be attributed at least in part to its P4P program. The state notes that *US News & World Report* ranks 10 of its health plans in the top 20 nationally.

The state identified the following as key success strategies when developing a P4P program for managed care plans:

- Clearly specify measurement criteria to evaluate whether performance meets the state's target.
- Utilize transparency of managed plan performance data to promote competition among managed care plans.

To gauge plan response to Michigan's P4P program, an executive from the Michigan Association of Health Plans was interviewed for this report.²¹ The representative stated that plan management views the withholding as fair, for various reasons:

- It was the only way the state could implement the P4P financial incentive.
- The plans are able to account for the withholding in their rate proposals.
- The state's payments must meet the actuarial soundness test in the Balanced Budget Act.

The association representative also reported that the financial incentive of the P4P program is significant enough to grab plans' attention and change behavior. However, the incentive is not as important to the plans as the performance-based

auto-assignment algorithm, which accounts for 25 percent to 33 percent of all plan enrollment. Another reason the auto-assignment algorithm is important is because the state adjusts the distribution of assignments quarterly using submitted encounter data, thus giving higher performers an immediate benefit.

While the state spoke of an alignment of measures between the financial P4P program and the auto-assignment algorithm, the association representative emphasized the differences between the financial P4P withholding model using HEDIS and CAHPS measures, and the auto-assignment algorithm using different measures based on administrative data.

The association representative offered the following advice for California:

- Maintain some consistency in measures over time. Continually switching priorities and measures creates frustration among the plans.
- Use objective data in the P4P algorithm.
- Continually "raise the bar."

New York

New York instituted its managed care plan P4P program in 2001.²² Unlike Michigan, New York does not use a withholding incentive. It instead pays managed care plans a bonus of up to 3 percent of the premium (initially it equaled up to 1 percent of the premium). The state uses HEDIS and CAHPS measures to evaluate performance, and rotates the measures that it uses from year to year. Occasionally, it supplements these measures with one or more state-defined quality measures. New York adds to these quality measures a group of what it refers to as "compliance measures."

For example, the state collected data from contracted plans for 40 distinct HEDIS measures in

2007, using a quarter of them for its P4P program. That same year it added three CAHPS measures and three compliance measures. The measures are collectively part of what New York refers to as its Quality Assurance Reporting Requirements (QARR). (A list of HEDIS, CAHPS, and compliance measures can be found in Appendix A.)

In contrast to some other states that evaluate plan performance on HEDIS and CAHPS measures using national benchmark data from NCQA, New York evaluates performance by comparing each plan to the recent historical statewide average. And unlike Michigan, which considers plans separately based on the regions they serve, New York makes no geographic distinctions.²³

Plans are awarded bonus payments based on an algorithm that weights HEDIS measures at 67 percent, CAHPS measures at 20 percent, and compliance measures at 13 percent. Historically, approximately two-thirds of the contracted managed care plans have received a bonus payment each year. In any given year, four of the approximately 23 plans have earned the full 3 percent incentive, while a half dozen have not earned any bonus payment.

The state reported the following challenges facing the program:

- Health plans don't know how to act on their CAHPS data. CAHPS measures capture patient perception, and plan management finds it difficult to determine what should be changed.
- The state typically announces the measures that will be used for the coming calendar year in September. Plan managers find this timing too late for them to design effective strategies for the next year.
- The state establishes the benchmark by looking at the 75th percentile of the statewide average of all participating plans from two years earlier, but

the managed care plans question the subjectivity of the look-back period used to define the benchmark.

Like California and Michigan, New York operates a performance-based auto-assignment algorithm, and has done so since 2000. The state has leveraged its use of both a financial P4P incentive and the auto-assignment algorithm by weighting 75 percent of the auto-assignment algorithm to those plans eligible for the P4P bonus payments following a three-year phase-in process.

When surveyed by the Urban Institute about the auto-assignment algorithm, 54 percent of plans responding thought more auto-assignment was positive, 38 percent had mixed feelings about it, and 8 percent thought more auto-assignment was negative.²⁴ Overall, plans felt more positively about the use of QARR data for public reporting (New York publicizes a report card) and for bonus payments.²⁵

State officials believe the program has been a success. In addition to the previously cited Urban Institute evaluation findings, the state has found that performance has further improved since the evaluation period, when the state increased the potential bonus from 1 percent to 3 percent of the premium.

To gauge plan response to New York's P4P program, two representatives, one from a contracting health plan and one from the New York State Coalition of Prepaid Health Services Plans (PHSP), were interviewed for this report.²⁶ The interviewees spoke well of the program, commenting that the state had been thoughtful in its design and implementation, and that the existence of a sizable "carrot" provided enough incentive for plans to make an effort to improve quality. This finding is consistent with the Urban Institute's conclusion that 89 percent of 82 managed care plan executives

believe the use of financial incentives with health plans is a good strategy for improving quality.

Nonetheless, these representatives identified the following challenges and opportunities for improvement:

- Some plans have focused on collecting more complete data rather than by actually improving quality.
- Plans that have focused on quality improvement have had to work closely with their providers, since provider P4P incentives often don't address physicians and office staff. The plans need to earn the trust of the practices on a clinical level so that they have opportunities to impart process improvement techniques.
- Plans have been frustrated by changes in measures and their components. The changes have caused the plans to reorient internal quality improvement activities. This frustration is amplified when the state does not communicate the rationale for the changes.
- The competition created by the P4P strategy serves as a disincentive to collaboration with providers across plans, since plans are only rewarded when they perform better than their competitors.

The managed care representatives identified the following as key success strategies for P4P programs:

- Use a “carrot” rather than a “stick,” and provide adequate funding.
- Use nationally accepted measures and methodologies.
- Involve physicians and plans in the program design and ensure transparency about the methodology design and the choice of measures.

- Ensure accurate measurement: “Once bad data goes out, your efforts are poisoned for at least a year.”

Pennsylvania

Pennsylvania has maintained a P4P program with its contracted managed care plans since 2005.²⁷ The state initially designed the program with its technical assistance contractor. After the second year of implementation, the state recognized several opportunities to improve its methodology, so it began working closely with the managed care plans to make refinements.

The state has rewarded plans for achieving improvements over plan-specific historical performance, with differential point allocation for improvements of greater than 1 percent, 2 percent, 3 percent, 4 percent, and 5 percent, and for demonstrating performance at or above the 50th, 75th, and 90th national percentile scores.

Pennsylvania currently makes available bonuses worth up to 2.5 percent of the capitation rate. However, managed care plans have earned only 27 percent to 42 percent of the bonus money available annually. The state now believes the initial model was too complex, and has since worked to simplify it and make it transparent.

The state uses the following performance measures in its P4P algorithm:

- NCQA accreditation status;
- State Medicaid agency certification status (the successful implementation of two internal performance improvement projects in priority topic areas that have been chosen by the state); and

- HEDIS measures addressing preventive care, chronic illness care and ER utilization (for a complete list, see Appendix A).

Beginning in 2008, the state implemented a penalty for poor performance, sanctioning any plan with performance that falls below NCQA's 50th percentile for a given clinical indicator. The state views this penalty as a way of effectively communicating its expectations—it will not pay for sub-par performance. Pennsylvania penalizes plans 5 percent of the maximum incentive amount allocated for a given measure. It weights strong performance relative to national benchmarks higher than it does incremental improvement.

Pennsylvania recently finished an analysis of the first three years of the P4P program. It concludes that the overall results have been positive and anticipates further improvement using the simplified model. Of the 11 HEDIS measures in use during the time period, 5 of them showed statistically significant improvement between 2005 and 2007.

Pennsylvania identified the following key success strategies for developing a P4P program with managed care plans:

- Keep the algorithm simple enough that it can be easily explained and discussed.
- Develop a methodology that enables plans to receive a payout in more than one manner (e.g., change-over-time performance and point-in-time performance relative to a benchmark).
- Avoid routinely changing the quality measures so that plans have time to realize the results of multi-year efforts in improvement.
- Be mindful that differences in demographics could result in some clinical quality indicators being more important in some regions of the state

and less important in others. Involve advocacy groups to help select measures. However, be aware that adjusting for demographic differences may ultimately mean that plans operating in several regions could have to manage different P4P initiatives throughout the state.

In January 2009, Pennsylvania implemented a performance-based auto-assignment pilot in its Southwest region employing a quality-based algorithm. It is Pennsylvania's intention to eventually roll out the model across the state.

Personnel from three Pennsylvania managed care plans were interviewed to learn about their experience with the state's P4P program.²⁸ While these representatives believe the initial design set standards that were too high, they feel positive about the role they have played in helping to shape the program design moving forward, and are positive in their overall assessment of the program.

The plans identified the following ongoing challenges in dealing with the P4P program:

- Providers do not appropriately document evidence that the state's standards are being met or always submit encounter data when they are reimbursed using capitation payments.
- Members move around a great deal both between physicians and plans, making it difficult to generate statistically meaningful measures of physician performance.
- Physicians participating in Medicaid are not well paid; as a result, they do not easily engage in collaboration.
- As plans become more focused on rallying providers and members around evidence-based medicine, it can take several years for clinical behavior changes to take effect. This time lag

means that it will probably not be possible to know how much quality improvement is attributable to a P4P program.

- It is difficult to obtain laboratory value data on an ongoing basis. This data is needed for several important clinical quality measures and must be obtained from multiple independent laboratories.
- It is hard to influence treatment-regimen compliance among plan members when the plan can't use benefit design to motivate people to change their behavior.
- One plan representative questions the state's selection of performance metrics, believing that the state may obtain improvement in measurement, but not in outcomes or costs.

Indiana

Most state P4P programs designed for Medicaid managed care plans either provide a bonus that provides added reimbursement or use a premium withholding strategy.²⁹ However, Indiana's P4P program uses both. It allows additional budgeted bonus funds equal to 0.5 percent of the premium and a 1.5 percent premium withholding.

The bonus fund payments are triggered when a plan's performance extends above NCQA's 50th percentile of national scores for Medicaid managed care plans, with payments increasing for performance above the 75th and 90th percentile levels.³⁰ Because the state has set qualifying performance thresholds at a high level relative to current plan performance, Indiana awarded only about half of the available funds for 2007 performance.

The premium withholding approach is being implemented in 2009. Withheld funds will not be returned if performance falls below NCQA's 50th percentile (with a cervical cancer screening exception)

and performance has not been maintained (a 2009 requirement) or improved (a 2010 requirement) over time. MCOs may request a waiver of this requirement; the state reviews requests on a case-by-case basis. Indiana developed this withholding policy based on its position that it does not "want to pay for mediocrity." (See Appendix A for the list of HEDIS measures utilized by the state.)

Indiana identified the following as key success strategies when developing a P4P program with managed care plans:

- Ensure state priorities are clearly identified and communicated.
- Avoid setting too many priorities—managed care plans need to be able to focus their attention to be effective.
- Encourage external stakeholders to contribute to the design process.

Personnel from three Indiana Medicaid managed care plans were interviewed for this report.³¹ These representatives were generally quite favorable in their assessment of the P4P program and the state's management of it.

Because all three plans already had their own provider P4P programs in place, implementation of state P4P requirements generally required only some realignment of measures. Two plan interviewees said the state should decrease the number of measures it employs because they believe the current measures are too diffuse, which impedes their plans' efforts to garner adequate attention from their contracted providers. One plan representative expressed a desire for more attainable performance targets (Indiana rewards only excellence, and not improvement over time). This interviewee also felt that the state's measures did not align with the NCQA core measures used for accreditation (Indiana requires

accreditation of its contracted plans) and that this was problematic.

Because of the state's 2007 pass-through requirement, which mandates that contracted managed care plans distribute 50 percent of earned P4P funds to contracted providers and/or to members, all plans consider the P4P program in terms of their relationships with their contracted providers. This consideration was not encountered in interviews with representatives in other states.

Plan representatives expressed other observations about and suggestions for Indiana's P4P program:

- Plans need to support practices with data to help them achieve improvement targets.
- P4P is difficult to apply at the practice level because of the “problem of small numbers” — i.e., insufficient patient volume to identify statistically significant differences in performance.
- Physician practices may engage in “cherry picking” — i.e., restrict their practices to only those patients who are likely to adhere to clinical guidelines and thus help the practice generate higher performance measurements.
- The state needs to foster a collaborative approach with contracted plans to achieve quality improvement: “A lot of improvement can come through more collaboration on the community level. Aligning goals is critical. A lot of these issues are bigger than the health plan, and there is a limited amount that the health plan can do alone.”
- Data needs to be reconciled faster so that practices receive their money sooner. (One managed care plan representative reported the plan's 2007 practice payments were not made until the end of 2008.)

Plan representatives offered the following advice for other states considering P4P programs:

- The state has to be really transparent as to why it is assigning an incentive to each measure. This includes investing heavily in communicating to advocates what its priorities are and why.
- Plans need to be involved early, but they should not be allowed to dictate terms. Indiana's willingness to partner, its openness to the concerns of plan managers, and its flexibility about making adjustments during the negotiation period were keys to the success of the program.
- Couple the P4P financial incentive with public reporting. Transparency is a big motivator — possibly more powerful than the financial incentive.
- Design the methodology so that plans are continuously motivated to improve. The link between increased payments and the attainment of higher NCQA percentile scores is a great motivator.
- Plans will respond to the idea of a bonus much more receptively than they will to a penalty.

Oregon

Relative to the other state pay-for-performance programs described in this report, Oregon's program is quite new and of a distinctly narrower scope.³² Initiated in April 2008, Oregon's P4P program resulted from state legislative action that allocated Medicaid funds to be used for enhancing access to preventive services. The Medicaid agency crafted the P4P program as a means to achieve the increased access.

The design of this two-year pilot was expedited to comport with legislative timeframes. The compressed

timeline for the design and a limitation on the initiative's duration led to limited plan involvement in the design—plans typically provide feedback to state draft proposals.

Oregon's P4P program is voluntary. Plans that are interested in participating are required to submit a proposal addressing how they will achieve improved access. If the proposal is accepted, the state and plan execute a contract amendment. Most of the state's 17 HMOs have opted to participate. Plans have been given flexibility in terms of how they will achieve the improved access.

Oregon's model is unusual in that it pays plans up front before they have demonstrated improved performance, but plans must return the funds to the state if they don't achieve their target (i.e., a 4 percent increase in preventive care visits).

The state reported confronting the following challenges:

- Funding for continuing the program in future years is problematic, given the state's tight financial environment.
- New creative initiatives such as the P4P project are difficult to administer due to the lack of additional state staff.

The state identified open and transparent communication with managed care plans as a key success factor.

Oregon does not incorporate performance considerations into its auto-assignment algorithm.

To gauge plan response to Oregon's P4P program, two managed care plan representatives were interviewed for this report.³³ Both interviewees felt positively about the degree to which the state involved plans in program design. They viewed the initiative as a way to help support a declining primary care infrastructure. In addition, they liked

the latitude provided by the state in approaching the target in a manner that would allow them to honor what was important for their own plans.

The managed care plan representatives identified the following challenges and opportunities for improvement:

- It is problematic to compensate primary care physicians (PCPs) the same regardless of the composition of their practice. Patients with complex medical conditions usually call the office frequently and place much greater demands on the practice than patients who have less complex conditions.
- The state needs to be very clear about measurement metrics. Both plans initially had difficulty replicating the state's calculations.

The interviewees identified the following as key success strategies for states considering P4P programs:

- Communicate a clear goal—the P4P target will be beneficial to plan members and is reasonably achievable for the provider—to get provider buy-in.
- Ensure that the measures have a well-defined and accepted evidence base.
- Collaborate with managed care plans on program design.
- Provide plans with the flexibility to operate in a manner that works well with the communities they serve.

IV. Input from California Policy and Program Officials and Stakeholders

TO ASSESS THE DESIRABILITY AND FEASIBILITY of a P4P program among California state policy and program officials and external stakeholders, an extensive interview process was conducted with representatives from managed care plans and trade associations, state executive branch agency managers, consumer advocates, provider associations, and legislative staff.

The information gathered from the participants revealed the following findings:

- The DHCS performance-based auto-assignment algorithm has caused many affected managed care plans to dedicate significant plan resources and attention to generating improvement in the targeted areas.
- State agency senior executives and all other stakeholder groups are positive in their assessment of the potential use of P4P to generate improvements in managed care plan performance. Provider associations and consumer advocates have some reservations.
- Stakeholders are more optimistic about the potential use of financial incentives to generate performance change than they are about non-financial incentives.
- The current state fiscal crisis and its impact on capitation rates, particularly those of Medi-Cal, will make it impossible to implement a financial P4P program until state finances improve and Medi-Cal provider and plan rates are increased.

This rest of this section summarizes the findings from the interviews.

Interviews with Managed Care Plans and Trade Associations

Representatives of nine managed care plans in California were interviewed. These plans represent a broad mix, including those operating in all three Medi-Cal managed care models through the DHCS (i.e., County Organized Health Systems, Two-Plan, and Geographic Managed Care), those participating in both Medi-Cal and Healthy Families, and one participating only in Healthy Families. In addition, representatives of the California Association of Health Plans and Local Health Plans of California were also interviewed. (See Appendix C for participants' names and affiliations.)

Some key distinctions between the Medi-Cal and the Healthy Families programs were identified by those who were interviewed:

- The Healthy Families population is much more akin to the commercially insured population, and some plans manage the program with the same provider contract that is used for commercial businesses.
- Medi-Cal dwarfs Healthy Families in size, so interviewees focused more on Medi-Cal initially when responding to questions.
- Healthy Families is considered a friendlier program to the plans because of its superior payment rates and comparatively fewer administrative demands on the plans.
- Plans see DHCS as having comparatively greater administrative capabilities because of its larger staff.

The text that follows provides a summary of responses to questions that were asked of the managed care plans and their association representatives.

Initial Reaction to a P4P Program in California

The interviewees voiced a strong positive response to this potential opportunity, although some expressed some restraint out of concern about how the program would be structured.

Initial Concerns about Implementing a P4P Program

The interviewees had some common responses regarding concerns about a P4P program.

New money. Almost every person interviewed said that a P4P program could only work if the state funded the P4P program with “new money.” The idea of putting existing payments at risk was a non-starter.

Stifling collaboration. A few plan representatives worried that the P4P program would create competition between plans, thereby stifling opportunities to collaborate across plans. Some added they thought stifled collaboration had been one of the unfortunate byproducts of the DHCS performance-based auto-assignment algorithm.

State staff capacity. Some individuals voiced concern about the capacity of state agency staff to implement the program given staffing limitations and their perception that state staff lack the necessary technical expertise.³⁴

Base rates. Most interviewees felt that a P4P program was not likely while the state was in a financial crisis. Two individuals expressed the opinion that the state should not even consider a P4P program until base capitation rates are improved.

Who Should Be Involved in Developing the Initiative?

Everyone recommended that plans be significantly involved in any development process. Those who were involved in the Medi-Cal Managed Care Division’s performance-based auto-assignment design process recommended that it be replicated, while someone else recommended a scaled-down version of the 2005 health reform process. A few people recommended that the Integrated Healthcare Association (IHA) either participate in or lead the process. In general, plans with commercial business experience tended to periodically reference IHA during their interviews, while those with a public program focus did not.

Financial Incentives

Representatives were asked what types of financial incentives DHCS or MRMIB should employ in a P4P program. Most voiced a preference for a distinct pool of funds that would be available to plans based on their performance. Some found the current rate process opaque and said they would feel more comfortable if the P4P funds were not included in a process that one plan representative described as “muddy.”

A smaller set of plan interviewees presented the option of putting a portion of a rate increase at risk. For example, plans would get a 4 percent rate increase, with an additional 1 percent available based on performance.

When pressed to consider the increased risk of the legislature recouping a sizable pool of dollars that were identified as performance incentives, some of the interviewees acknowledged that it might be necessary to tie the P4P incentive into the rate in some fashion to decrease the risk of losing the funds altogether.³⁵

Non-Financial Incentives

Most managed care plan representatives were intrigued by the notion that DHCS or MRMIB might design non-financial incentives. The following ideas were suggested in response, most having to do with waiving DHCS administrative requirements for high-performing plans:

- Remove the state requirement that new members need to receive a health assessment within 180 days of enrollment;
- Remove the 85 percent medical loss ratio requirement;
- Allow the administrative costs required to run the P4P program to be included in the calculation of the medical loss ratio;
- Accept NCQA deeming in lieu of the site audits, or portions of the site audits;
- Allow deeming of credentialing across plans;
- Integrate audit activity with that of the California Department of Managed Health Care (DMHC);
- Provide a plan with favorable consideration when it competes for new counties;
- Mirror DMHC practice, and conduct site audits at the same time that NCQA is onsite;
- Publish data on the state Web site³⁶ and identify and publicize the highest-performing plan in the state; and
- For Healthy Families, create differential copayments for the highest-performing plan.

Only one health plan executive felt that non-financial incentives did not appear to be a fruitful avenue.

Measures

When asked what recommendations they might give about the type of measures or specific measures the state should employ, about half of the plan and industry association participants recommended working from HEDIS and CAHPS measures. They tended not to be specific about desirable measures. The same proportion also recommended using a limited set of measures (eight or fewer).

A few managed care plan executives would encourage the state to think beyond the HEDIS and CAHPS datasets, and suggested considering the following:

- Care beyond that delivered by PCPs;
- Measures for which there is evidence of cost benefit from improved performance;
- Diabetes outcome measures;
- Ambulatory-sensitive, condition-related emergency room visit and hospital admission rates;
- Hospital-acquired infection rates;
- Measures of the treatment of heart disease;
- Measures of specialty access (e.g., time to get an appointment with a specialist); and
- Efficiency measures.³⁷

All of the interviewees felt that Healthy Families and Medi-Cal should use common pediatric measures, and one plan would urge MRMIB and DHCS to utilize the same P4P algorithm.

Finally, a few interviewees counseled that the state should carefully consider two things before selecting measures to be utilized in the design of a P4P program: its purchasing and quality improvement

priorities, and the areas where the greatest opportunities for improvement lie.

Determining Whether a Provider Qualifies for Incentive Payment

There was strong agreement across the plans that the state should consider both performance at a point in time relative to some benchmark, and an individual plan's change in performance over time on the same measures.

Not all participants in the interview process had an opinion regarding what should be the basis for comparison when making the assessment of plan performance at a point in time (e.g., CY 2009). Of those that did, a majority wanted something other than an internal county comparison, and in most cases advocated for a comparison to statewide performance. Some of the plans felt that an intra-county comparison would harm efforts among plans to collaborate.

The option of using a statewide average was not without some controversy. Some plans referenced the regional variation in the state, and specifically the tendency for plans in the north to perform better than those in the south on quality measures. DHCS HEDIS and CAHPS data confirm this pattern, at least for Medi-Cal (see Appendix D). There are plans that serve as exceptions in each region, however. Some interviewees felt that this should be a consideration in the methodology, while others dismissed it.

Size of Financial Incentives

When plan and industry association participants were asked how large a financial incentive would be necessary to motivate health plans to make additional investments in time and resources to improve performance, only six of the eleven organizations provided a response. Four of those responses were

provided in terms of a percentage of the capitation rate—generally between 0.5 percent and 1.0 percent, with one individual extending the range up to 3.0 percent.

Relationship Between P4P and Performance-Based Auto-Assignment

Only a few of those interviewed were familiar with the measures used in the DHCS' performance-based auto-assignment process, thereby limiting the responses. While there appeared to be an impulse to use a common set of measures, those who were concerned about impeding cross-plan collaboration recommended the use of a separate set of measures. One plan executive recommended that DHCS ultimately select its P4P measures and broader algorithm alongside the performance-based auto-assignment algorithm, since the state really should not look at either in isolation.

Another individual suggested that DHCS evaluate whether the performance-based auto-assignment incentive is working. If it is not, then the state should use common measures so that it can strengthen the incentive. If the auto-assignment incentive is working, then the state should use a different set of measures.

Current Provider Performance Incentives

Eight of the nine managed care plans operate a P4P program with their contracted providers, with one having suspended the program as a result of state rate issues. These programs vary in design and scope, with some much more expansive than others. In general, the programs provide incentives to PCPs, groups, and/or to independent practice associations. All include quality-related incentives; the more comprehensive programs are more multi-dimensional in terms of the performance metrics. A subset of

plans makes P4P opportunities available to hospitals and specialists.

Requiring MCOs to Implement P4P with Their Networks

Seven interviewees responded when asked whether DHCS and/or MRMIB should contractually require MCOs to implement pay-for-performance with their networks. Four voiced strong opposition, saying it would be inappropriate for the state to have such a requirement. The remaining three liked the idea, with the assumption that the state would provide new funding for the provider P4P incentive.

Interviews with State Executive Branch Agency Managers

Executive branch agency managers from the California Health and Human Services Agency, DHCS, and MRMIB were interviewed for this report (see Appendix C for their names and affiliations).

The participants were first asked to explain what they believe are the general motivations for implementing P4P programs. They provided a range of responses:

- Leverage purchasing power to drive certain outcomes;
- Use incentives and rewards to motivate managed care plans to demonstrate measurable improvement in quality and cost savings; and
- Use incentives and rewards with providers to get them to demonstrate measurable improvement in performance.

All of the state agency staff who were interviewed believe P4P offers promise as a tool to improve health care for those served by the Medi-Cal and Healthy Families programs. Senior executives were particularly optimistic in this regard.

The text that follows provides a summary of responses to specific questions that were asked of the agency managers.

Concerns about Implementing a P4P Program

State agency personnel reported a number of consistent concerns.

Current reimbursement. The state's current provider reimbursement schedule is "parsimonious," which inclines providers and plans to seek higher rates. As a result, a P4P program for managed care plans likely will be feasible only when provider fee increases return to the state policy agenda.

Technical design. Deciding which measures should be used and why is a very complicated and difficult process, as is developing confidence in data quality, and building support from plans and providers.

Unintended consequences. A program like pay-for-performance always brings with it the danger of unintended consequences, such as driving behavior in one direction at the expense of efforts to improve performance in other areas.

Quality of encounter data. The state has ongoing concerns regarding the quality and timeliness of the encounter data that managed care plans submit to DHCS.³⁸ The state also believes that DHCS can and should improve the processing of this data. These concerns limit what the state believes it could do with encounter data for P4P purposes.

Agency staffing. Because the state has a limited infrastructure for measure calculation, analysis, and ongoing monitoring and adjustment, a P4P program would be difficult to maintain.

Financial Incentives

When asked what types of financial incentives DHCS or MRMIB should employ in a P4P program, agency managers cited three financial incentive models:

- A bonus pool;
- Placing a portion of a rate increase at risk; and
- Paying high-performing plans at the higher end of the actuarial rate range.

Participants said the latter two strategies could be employed either by withholding the enhanced portion of the rate until a performance review, or by paying it out, and then deducting some or all of it if performance fell short. MRMIB staff indicated that MRMIB has in the past discussed placing rate increases at risk.

Many of the interviewees in this category agree with the perspective that a stand-alone pool is more vulnerable to legislative seizure than a methodology that integrates the enhanced payment into the capitation payment in some fashion. While they realize that plans prefer a bonus pool, they believe such a model is less viable.

Non-Financial Incentives

With respect to non-financial incentive models, agency managers noted that DHCS already publicly recognizes its best-performing plans at an annual conference, as well as producing a consumer report card. Some believe that additional public recognition strategies could be worthwhile, perhaps through other means.

With regard to the option of eliminating certain administrative requirements for high-performing plans, DHCS interviewees acknowledged previous internal discussions on the topic. The main challenge appears to be in identifying which requirements

to waive. One individual could not think of any administrative requirement of the plans that was discretionary on the state's part. MRMIB staff noted that they already ask little of the plans administratively, so there is not much that could be eliminated.

Measures

Agency managers had many suggestions regarding measures that should be utilized as part of the P4P algorithm. The following were most common:

- Measures that can be identified through data analysis, such as those that provide the greatest opportunities for improvement, and those that represent the greatest contributors to morbidity and mortality.
- Preventive care measures, including prenatal care and healthy birth outcomes; cancer screening; and well-child and adolescent care, including immunizations.
- Chronic disease measures, including those for diabetes, heart disease, and asthma.
- Measures that address unnecessary ER visits.

Multiple agency managers suggested adopting measures that relate to physicians' and hospitals' adoption of health information technology, but were of mixed opinion as to the feasibility of including such measures in the P4P algorithm.

Other ideas that were mentioned with less frequency included measures that address the quality of MCO reporting, patient safety in hospitals, persons with disabilities, the transformation of physician practices into medical homes, reducing disparities, and services provided as part of California Children's Services.³⁹

Determining Whether a Provider Qualifies for Incentive Payment

State agency managers agreed that managed care plans should be assessed on their relative performance at a point in time, as well as whether they have improved over time.

Size of Financial Incentives

Most of those interviewed did not have a sense of how large an incentive would be necessary to motivate managed care plans to make additional investments in time and resources to improve their performance. Some DHCS staff who have researched what other states are doing and have discussed the topic internally cited a figure of approximately 1 percent.

Relationship Between P4P and Performance-Based Auto-Assignment

Most of those interviewed believe a set of measures separate from those used by DHCS for the current performance-based auto-assignment process should be employed for the new P4P program. They voiced concern that the auto-assignment algorithm may have caused plans to drop pre-existing improvement efforts in other areas, and they would like to expand plans' attention to additional priority topics that are not a part of the limited auto-assignment algorithm measurement set.

Requiring MCOs to Implement P4P with Their Networks

Most of those interviewed were open to the idea of DHCS and/or MRMIB contractually requiring managed care organizations to implement P4P, but they said it would only make sense if the state provided new funds that plans could use for provider incentives. They believe that given the current rate environment, any other type of mandate would

understandably be ill received. DHCS staff also noted that many plans already operate P4P programs with their network providers.

Interviews with Consumer Advocates

Four consumer advocacy organizations—the California Pan-Ethnic Health Network, Children's Partnership and 100% Campaign, Community Health Councils, and Western Center on Law and Poverty—were interviewed for this report (see Appendix C). An additional consumer advocacy organization declined to be interviewed.

The consumer advocates in most cases did not know much about P4P and its potential impact on quality. While one advocate was a strong supporter of the concept, others voiced more cautious reactions.

Concerns about Implementing a P4P Program

When asked to identify potential concerns, the advocates responded with the following:

- It will be incredibly challenging to obtain the necessary funding given the current state environment.
- Underlying problems with capitation rates and their impact on managed care plan compensation of providers may dwarf the potential benefit of a P4P program. The low rates may drive the providers out of the program, creating a problem that P4P will not be able to address.
- Current political perception will be negative, given the current economic situation and the status of Medi-Cal fee-for-service rates.
- Small providers have fewer resources and less capacity to set up the necessary structures for reporting to the plans and for effecting improvements in care.

- The Medi-Cal Local Initiative health plans may object, arguing that these plans serve a different population.
- It will be challenging to reach agreement regarding how to quantify and measure in a reliable manner.

Who to Involve in Developing the Initiative

The advocates recommended the program be developed with heavy stakeholder input, including that of consumer advocates. They suggested making use of existing advisory committees (e.g., the Medi-Cal Advisory Committee or one of its subcommittees and the Healthy Families Advisory Committee), or creating a group like that used by DHCS for performance-based auto-assignment.

One advocate noted that the success of the process would depend entirely on how much freedom state participants are given in determining the direction of the program.

The remainder of the interview was focused on getting consumer advocates to describe their preferred characteristics of a P4P program in California.

Incentives

The interviewees were uncomfortable with the notion of the state relaxing administrative requirements as a reward for high performance. They were also uncomfortable about the idea of taking current funds to create P4P financial incentives.

Measures

The consumer advocates believe that any measures that are selected should address racial, ethnic, and geographic disparities and be used to promote improvement in these areas. Addressing health disparities was their highest priority.

Other suggestions about the types of measures that should be adopted include those that would accomplish the following:

- Address cultural and linguistic competency standards;
- Address care for children; and
- Place more focus on outcome than on process.

Two advocates voiced concern that plans may not currently be addressing basic contractual quality and access requirements, and stated that P4P should not be used for enforcing these core obligations. Two other advocates argued that the state should first identify its priorities before selecting measures.

Determining Whether a Provider Qualifies for Incentive Payment

Consumer advocates support the idea of combining incentives for point-in-time excellence against a benchmark and improvement over time.

In summary, the consumer advocates that were interviewed as part of this study were cautiously supportive of the P4P concept. They voiced concern about the ability to fund and the appropriateness of funding a P4P initiative given other pressing state priorities, including existing plan and provider rates. And they were clear that their support for the concept would be heightened if the P4P program addressed disparities, but worried about the technical ability of the state and plans to do so.

Interviews with Provider Associations

Representatives of four statewide provider associations were interviewed. The associations included the California Association of Public Hospitals, the California Hospital Association, the California Medical Association, and the California Primary Care Association (see Appendix C).

Initial Reaction and Concerns about Implementing a P4P Program

The association representatives were supportive of the notion of a P4P program for Medi-Cal and Healthy Families, but in some cases were quick to note the concerns that would need to be addressed for their unqualified support.

Those concerns were as follows:

- New money would be necessary to fund the P4P program.
- Because Medi-Cal is underfunded and providers that do care for Medi-Cal beneficiaries do so “out of the goodness of their hearts,” a P4P program might prompt a negative rather than a positive provider reaction.
- Savings and incentive payments should go back to the provider, and not just to the health plan.
- The initiative should not create new administrative requirements for providers.
- The methodology should adhere to the American Medical Association’s P4P principles,⁴⁰ which were cited by the interviewee as follows: physician participation in design, a scientifically sound methodology, promotion of the doctor/patient relationship, design recognition of administrative cost, and positioning the program as a voluntary option.

Who to Involve in Developing the Initiative

Like other stakeholder groups, the provider associations urged an open process for designing the program. They advocated for the inclusion of a diverse set of perspectives, including those of safety net providers who have significant expertise in treating the sickest patients, and argued that providers should be the leaders in developing the

measures. They stated that if providers did not assume this role, the initiative would not be well received and its feasibility would be inadequately assessed.

The remainder of the interview was focused on getting the provider association representatives to describe their preferred characteristics of a P4P program in California.

Incentives

Provider association respondents were particularly interested in financial incentives that would be transferred to providers.

Measures

When participants were asked what recommendations they might give about the specific measures or type of measures the state should employ, they stated that a P4P program should include an even mix of measures for inpatient, outpatient, and other settings. They believed some of the measures adopted should address the following:

- Chronic diseases and medical homes (e.g., use of patient registries by primary care practices), particularly given the relevance of the medical home concept for the Medi-Cal population; and
- Areas where patient care and public health are most advanced, such as pediatric immunizations, care of patients with diabetes, cervical cancer screening, and breast cancer screening.

The participants also stated that any measures that are adopted should be those endorsed by national bodies, and their methodology must utilize a risk-adjustment mechanism. They added that focusing solely on measures of cost savings or reduced spending is not sufficient.

Determining Whether a Provider Qualifies for Incentive Payment

When participants were asked what basis they would use in determining whether a provider qualifies for an incentive payment, they responded that they support the idea of combining incentives for point-in-time excellence against a benchmark with those for improvement over time.

One provider association interviewee advocated use of a statewide benchmark for the point-in-time assessment.

In summary, the provider association representatives were supportive of the P4P concept, but they were concerned about the potential positive and negative implications for the providers.

Interviews with Legislative Staff

Five legislative staff members were interviewed, with a sixth individual declining to be interviewed. The names of the staff members and their affiliations are listed in Appendix C.

Legislative staff displayed a good general understanding of P4P, and in some cases provided detailed thoughts on the purchasing activity of MRMIB and DHCS Medi-Cal managed care. In general, they displayed a concern that DHCS was reticent to make changes, particularly changes that would require managed care plans to be more accountable. They also sought more information from the agencies on current performance.⁴¹

Concerns about Implementing a P4P Program

Legislative staff were supportive of the introduction of P4P for MRMIB and DHCS managed care contracting. Their primary concerns were as follows:

- The P4P program should pay for true performance (i.e., real improvements in outcomes) rather than reward process.

- The program should not penalize plans or physicians that take responsibility for caring for more seriously ill patients.
- The program should not be perceived as a rate cut. However, if the agencies don't want withholding employed, it will be several years before funding for such a program can be considered.

One legislative staff member suggested that DHCS should prioritize doing more to improve transparency by improving its regular reporting activities. This individual cited the specific need for some information on beneficiary experience for aged, blind, and disabled patients in the County Organized Health Systems and in voluntary managed care.

The remainder of the interview was focused on getting legislative staff to describe their preferred characteristics of a P4P program.

Incentives

Legislative staff did not have any strong ideas regarding the nature and design of incentives.

Measures

Respondents suggested that the state initially begin by using the same measures employed by DHCS for performance-based auto-assignment.⁴² Other recommendations included the following:

- Utilize a set of performance measures that are as broad as the characteristics and needs of the beneficiary population, including measures for those who are mentally ill and/or substance abusers, for example;
- Consider measures that encourage the adoption of information technology and of medical home practice (although the primary care shortage may limit options for the latter);

- Focus on well-child care, care for women, heart disease, diabetes, and creative ways to reduce ER utilization;
- Focus on areas in which the programs are not performing well (e.g., opportunities identified in the EQRO report);
- Employ risk-adjust measurement data so as not to heighten the problem of disparities; and
- Select measures with a perceived cost benefit, and then retrospectively determine whether the investment amounts to an intelligent use of state tax dollars.

individual suggested that agencies start planning the design process in advance. This way, the individual posited, the plans could be notified a priori of what measures will be used, and then they could begin working toward improving quality in those areas.

Determining Whether a Provider Qualifies for Incentive Payment

When asked what the basis should be for determining whether a provider qualifies for an incentive payment, legislative staff were not of one mind. Some favor a focus on improvement, and others favor a focus on excellence (and not paying plans more “for what they should already be doing”), with the remaining respondents favoring a mix of point-in-time and change-over-time assessments.

One individual spoke emphatically about DHCS’ failure to set performance improvement targets for its contracted managed care plans, and its failure to help plans improve by transferring best practices across plans.

In summary, legislative staff were open to the P4P concept, but only if state funding becomes available. Compared to other stakeholders that were interviewed for this report, these respondents were more concerned that a P4P initiative be accompanied by additional agency efforts to improve accountability for managed care plan performance.

While there was an acknowledgement that a P4P incentive could not be funded at present, one

V. Recommendations for Pay-for-Performance in California

THE INFORMATION GATHERED FROM published research, from interviews with those involved in P4P programs in other states, and from interviews with California policy and program officials makes it clear that P4P presents a real opportunity to generate improvement in plan performance. This notion is also generally endorsed by leading stakeholders. While state financial pressures are a significant deterrent to implementation in the near future, initiating a planning process that involves state and external stakeholders will position DHCS and MRMIB to implement P4P programs more quickly and more effectively when state finances become more favorable.

This section of the report identifies different P4P models that California might pursue and makes recommendations for how to pursue them. These options are presented relative to the following central design considerations:

- Objectives of the program;
- Measures that should be employed;
- How plans should qualify for the reward;
- How financial incentives and rewards should be structured;
- Whether non-financial incentives and rewards should be employed, and if so, how;
- The process that should be followed in developing the P4P design and the timing for its initiation;

- Which stakeholders' concerns should be an area of focus; and
- How the program can be sustained over time.

Because these considerations are common for both MRMIB and DHCS, these agencies' programs are addressed together.

It must be stressed that DHCS already employs a non-financial P4P program with Medi-Cal managed care plans, using performance-based auto-assignment, an awards ceremony at an annual conference, and publication of HEDIS, CAHPS, and other performance information on its Web site.⁴³ In addition, MRMIB publishes HEDIS and CAHPS performance information on its Web site.⁴⁴ Therefore, the recommendations that follow primarily address the use of financial P4P strategies, as well as potential additional non-financial P4P strategies.

Objectives of the P4P Program

Effective P4P programs need to begin with clear and thoughtful purpose and focus.

1. Clarify the motivations of and desired results for P4P. Before DHCS or MRMIB initiates a P4P program design effort, they need to be clear about why they are pursuing the strategy, and what ends they intend to achieve. The purpose of a P4P program should be to complement a broader set of value-based purchasing strategies, designed to accomplish the following:

- Ensure compliance with state contractual and regulatory requirements;

- Motivate and facilitate improvements in the areas of service access, quality of care, consumer experience, cost containment, and administrative service; and
- Assess performance and value.

P4P should not be viewed as a stand-alone program, but as part of a larger purchasing strategy. As such, it should be designed with a sense of how it will interconnect with, complement, and reinforce other state purchasing efforts, including contracting, auditing, public reporting, auto-assignment, and so on.

- 2. Focus the program on motivating improvements in key areas.** The P4P program should be focused on motivating improvements in contractor performance in areas of high priority and clear opportunity.

“High priority” means areas that the state has selected because improvement will make a discernible impact on many people, or a dramatic impact on a smaller group of people. These areas of priority should be informed by existing state data and conversations with stakeholders, and should be aligned with each agency’s strategic plan.

“Clear opportunity” means that performance is far below desired or best practice, and plans and providers have the ability to positively influence performance. It is notable that several stakeholders reported that they were unclear as to the state’s priorities for improvement in its managed care programs.

- 3. Evaluate the impact of the program periodically.** The impact of DHCS and MRMIB P4P programs should be evaluated periodically

to ensure these programs are having their desired impact and any unintended consequences are identified.

A successful P4P program is one in which the performance of contracting managed care plans improved to a greater degree and at a faster pace than it would have otherwise. Evaluations of provider-oriented P4P programs have concluded that these efforts have sometimes not succeeded because they rewarded those who were already performing well, without providing sufficient incentive to those with the greatest need for improvement.⁴⁵ An expenditure of new state tax dollars for P4P that does not achieve this aim will be subject to reconsideration.

Measures That Should Be Employed

There is no definitive answer to which measures should be employed. There are, however, a series of general considerations that should be part of any process to select P4P program measures.

- 1. Align measures with existing priorities.** Like the objectives for the program, the adopted measures should reflect a consideration of existing priorities and opportunities, reflecting a consideration of current and past performance. The measures should also align with the agency’s strategic plan, and with the focus of its broader value-based purchasing strategy. Finally, measure selection should start with internal agency analysis, and then continue through an inclusive stakeholder process.

Table 2 shows potential areas for statewide focus within a DHCS financial P4P program, based on a comparison of 2007 Medi-Cal HEDIS rates to national Medicaid managed care norms, as reported by NCQA.⁴⁶

Table 2. Measures Warranting Consideration for a DHCS P4P Program

MEASURE	RATIONALE
Adolescent Well-Care	Statewide weighted plan average is low in absolute terms (36.9%) and may not be favorable relative to the national average (43.6%).
Well-Child 15 Months: six or more visits	Statewide weighted plan average is low in absolute terms (57.5%) and may approximate the national average (55.6%).
Comprehensive Diabetes Care: Eye Exam	Statewide weighted plan average is low in absolute terms (57.5%).
Chlamydia Screening	Statewide weighted plan average is low in absolute terms (52.8%) and approximates the national average (54.2%).
Breast Cancer Screening	Statewide weighted plan average is low in absolute terms (48.6%) and approximates the national average (49.9%).
Postpartum Care	Statewide weighted plan average is low in absolute terms (58.7%) and approximates the national average (58.5%).

2. Consider a regional or plan-specific approach.

DHCS should consider a regional or even plan-specific approach, if operationally feasible. Analysis of Medi-Cal managed care plan data by region (Northern vs. Southern)⁴⁷ reveals significant variation. The examples in Table 3 depict the extent of the variation.

An analysis of Medi-Cal Managed Care HEDIS data can be found in Appendix D.

Table 4 shows potential areas for statewide focus within a MRMIB P4P program, based on a comparison of 2007 Healthy Families HEDIS rates to national commercial managed care norms, as reported by NCQA.⁴⁸

Table 3. Regional Variation in Medi-Cal HEDIS Rates

MEASURE	PERCENT OF PLANS ABOVE THE STATE WEIGHTED AVERAGE...	
	FROM THE NORTH	FROM THE SOUTH
Adolescent Well-Care	67%	33%
Well-Child 15 Months: six or more visits	69%	31%
Comprehensive Diabetes Care: Eye Exam	42%	58%
Postpartum Care	36%	64%

Table 4. Measures Warranting Consideration for a MRMIB P4P Program

MEASURE	RATIONALE
Adolescent Well-Care	Statewide plan average is low in absolute terms (44%).
Well-Child 15 Months: six or more visits	Statewide plan average is low in absolute terms (57%) and approximates the 10th percentile nationally (55.6%).
Appropriate Testing for Children with Pharyngitis	Statewide plan average (31%) is half the 10th percentile nationally (60.2%).
Chlamydia Screening	Statewide weighted plan average is low in absolute terms (41%).

An analysis of Healthy Families HEDIS data can be found in Appendix E.

3. Align child/adolescent care measures with Medi-Cal and Healthy Families. The measures employed for child and adolescent care should be aligned wherever possible for Medi-Cal and Healthy Families. This helps to better leverage state purchasing power, particularly given the fact that most of the Healthy Families managed care plan contractors are also Medi-Cal contractors.

4. Use measures different from current auto-assignment algorithm measures. Vary the measures used for any new financial P4P program from those used for the current performance-based auto-assignment algorithm.

There are two good reasons for doing so. First, the scope of measures currently used for performance-based auto-assignment is limited,⁴⁹ leaving many important performance areas unaddressed. Second, it is worth exploring whether the use of a separate set of measures for which there would not be direct intra-county plan competition, and hence opportunity for cross-plan collaboration, yields actual collaboration and improved performance.

5. Limit the number of measures introduced. The set of new P4P performance measures should be limited to approximately six to eight, depending on the measures selected. Managed care plans may not be able to meaningfully address more than that number, especially when one considers that some of the plans will already be focusing resources on the performance-based auto-assignment algorithm measures.

6. Use measures from national data sets. Measures should be taken from national data sets. HEDIS and CAHPS are obvious sources since MRMIB and DHCS currently require reporting of both. Additional measures should not be ruled out if they align with high priorities and if the agencies are able to develop valid and reliable means of measurement.

How Plans Qualify for Rewards

The selection of criteria for reward allocation is critical to P4P program success. Many P4P programs have failed to generate improvement as a result of designs that reward those that are currently best performers, and fail to sufficiently motivate broad-based improvement over time.

- **Allocate rewards based on current performance.** Agencies should allocate rewards based on a consideration of performance during the most recent calendar year relative to a benchmark (a “point-in-time” assessment), as well as a consideration of plan performance over time (a “change-over-time” assessment). For managed care plans that have achieved such high levels of performance that additional improvement is likely not possible, the state should recognize the plans as if they had achieved improvement.

Additional related recommendations include:

- Weight point-in-time performance 30 percent and change-over-time performance 70 percent to create a compelling business case for plans to continually improve. This also helps to ensure that the state’s investment in P4P truly produces added value.
- For the point-in-time assessment, compare Medi-Cal managed care plans to national NCQA Medicaid managed care benchmarks

and award points for performance that exceeds the 75th and 90th percentile levels. This will ensure that the state is only rewarding superior performance on a point-in-time basis. For the same reason, compare Healthy Families managed care plans to national NCQA commercial managed care benchmarks and award points for performance that exceeds the 75th and 90th percentile levels.

The change-over-time assessment will mean that every plan has an opportunity to be rewarded every year.

Structuring Financial Incentives and Rewards

A financial P4P strategy lacking sufficient funding is unlikely to succeed. Even if funding is adequate, the public nature of the Medi-Cal and Healthy Families requires careful construction of financing strategies to ensure ongoing funding availability.

1. Implement financial incentives when timing is right and then use thoughtful financing strategies. Implement a financial P4P initiative only when additional funds can be provided above and beyond what is necessary to obtain actuarially appropriate rates. Whenever such funds do become available (reported estimates ranged from two years to “at least” five years), the financial incentive should be structured in a way that it lies atop the capitation rate as a per-member per-month (PMPM) rate add-on.

Additional related recommendations include:

- DHCS and MRMIB should avoid the creation of a distinct bonus pool, since this type of approach invites easy tapping by a legislature that is seeking funds to redirect for other uses; and

- The financial incentive should equate to between .5 percent and 1.0 percent of the capitation rate paid to the managed care plans.

2. Structure the incentive as a discrete percentage.

The financial performance incentive could be structured as a discrete percentage of the rate (e.g., \$x PMPM), or a discrete percentage of an annual rate increase (e.g., 1 percent) that is placed at risk. It could be made payable in one of two possible scenarios:

- Once performance has been assessed; or
- After the first of the year, but then recouped by the state should some or all of the funds not be earned.

While the first approach is the more common one, one stakeholder observed that research shows that people are generally more motivated by fear of losing than by the benefit of gaining,⁵⁰ leading her to suggest that the latter approach might generate more improvement than the former.

One downside of the approach, however, is that the funds earn interest for the plan rather than for the state, unless the state requires a return of interest as well. On the other hand, the funds may be better protected if they are initially paid out.

About Non-Financial Incentives and Rewards

While many of those interviewed expressed interest in the possible use of additional non-financial incentives, and in particular the removal of administrative requirements for high-performing plans, it is uncertain if there are many effective non-financial incentives and rewards available beyond those already in use. It is clear, however, that some of the existing non-financial performance incentives might be used to better effect.

1. Consider modifying existing incentives.

Modify the Healthy Families auto-assignment process so that it uses the same child health HEDIS indicators that are used by DHCS in its auto-assignment algorithm (i.e., childhood immunizations—combination 2, well-child visits—third through sixth years of life, and adolescent well-care visits).

While MRMIB is governed by the Healthy Families statute and its requirement to give preference to plans that contract with traditional and safety net providers (Insurance Code Section 12693.37, and specifically subsections (b)(1) and (c)(1)), there appears to be an opportunity to modify the existing algorithm to incorporate some of the same HEDIS child health quality measures that are employed by DHCS, while still adhering to the statutory requirement.⁵¹

- ### 2. Consider making data more accessible for consumers.
- Use a Medi-Cal managed care consumer report card that simplifies the existing, extensively detailed HEDIS and CAHPS data presented on the DHCS Web site, and make the document easier to find for consumers. For example, Wisconsin has a two-page report card, and Maryland has a one-page report card,⁵² both for Medicaid beneficiaries.

In addition, reformat the comparative data so that it facilitates consumer comparisons across plans, ideally by county. This more consumer-friendly format has been used with Medi-Cal managed care data on the Office of the Patient Advocate Web site,⁵³ and should appear on the DHCS Web site as well.

While the Healthy Families performance data on the MRMIB Web site is much more limited and simpler in presentation than that for Medi-Cal, constructing a one-page document that presents and compares all of the information would be very helpful. MRMIB could address this recommendation by working with the Office of the Patient Advocate.

- ### 3. Utilize performance as a plan procurement criterion.
- Consider past performance scores on existing measures when competitively procuring managed care contractors in the future.
- ### 4. Revisit the use of safety net provider support measures in the Medi-Cal management care auto-assignment algorithm.
- Reconsider the use of the two safety net provider support measures in the performance-based auto-assignment algorithm to determine to what degree managed care plans have the ability to impact their scores on these measures, and whether the measures have resulted in changes in plan performance.
- ### 5. Evaluate opportunities to waive plan administrative requirements for high-performing plans.
- Convene a workgroup of DHCS and managed care plan staff to review opportunities to waive existing administrative requirements for high-performing plans, and to deem compliance oversight for any plan functions to NCQA, URAC, or DMHC.

Design Process and Implementation Timing

All stakeholders voiced a desire for an open process to design any new P4P program. Interviews with managed care plan and association representatives revealed that among those who were not involved in the development of the DHCS performance-based auto-assignment algorithm, there was low confidence in DHCS capacity to implement and operate a new P4P initiative. Conversely, those plan representatives who did participate in that earlier process recommended a similar approach, and voiced no concerns about the ability of DHCS to manage the process. Stakeholders worried about MRMIB's administrative capacity as well, largely based on their perception of the limited staffing available to manage the Healthy Families program.

- 1. Coordinate the process.** The design of a new financial P4P program and of any refinements or new non-financial P4P activities should be undertaken in coordinated fashion by DHCS and MRMIB. By proceeding in this fashion, DHCS and MRMIB should attempt to align their child-specific measures.
- 2. Manage it using an advisory group.** The development process should be managed using a representative stakeholder advisory group, comprising plan representatives for both programs and all three Medi-Cal managed care models, provider organization representatives, consumer advocates, and state agency program staff. The advisory committee process should be facilitated, and draw upon experience in other states, including the information contained within this report.
- 3. Provide legislative staff with briefings and solicit input.** DHCS and MRMIB should provide periodic briefings and solicit input from

legislative staff so that legislative staff members are apprised of the effort's progress and afforded the opportunity to influence the outcome.

- 4. Begin as soon as possible.** If a pay-for-performance program is indeed a policy direction that both DHCS and MRMIB want to move in, the design process should begin as soon as possible for several reasons. The process is likely to take from six months to one year, depending on the measures selected and the degree to which they extend beyond the HEDIS and CAHPS data sets. And once the program design is set, more time may be needed to prepare agency budgets, capitation rates, and administrative processes for implementation. In addition, when the areas that will be targeted by the new P4P program are identified as much as a year in advance of the start date, managed care plans have more time to improve their rates in the targeted areas.

For all of these reasons, starting work on the design of a P4P program as much as 24 months prior to the likely start date makes the most sense. Unfortunately, the recent volatility of state finances may make it impossible to project when adequate funding might exist for such an initiative with that much advance time. Nevertheless, DHCS and MRMIB could commence work now in a manner that would allow each organization to focus initially on non-financial P4P strategies, in terms of refinements to existing efforts and consideration of new ones.

- 5. Consider a pilot prior to implementation.** DHCS and MRMIB could consider piloting the P4P program prior to statewide implementation, if feasible. Doing so would limit risks and afford the agencies and the participating plans a learning opportunity. However, the agencies may find it difficult to limit participation among plans.

Addressing Stakeholders' Concerns

In the course of meetings with stakeholders, the stakeholders provided unsolicited feedback at times with regard to how DHCS and MRMIB administer their respective managed care programs. To garner support for a potential future P4P program, the agencies may want to address these recommendations:

- 1. Be proactive about addressing legislative staff feedback.** DHCS should consider how to address the broader concerns voiced by legislative staff. Legislative staff conveyed significant skepticism about the intensity of the efforts of DHCS to hold contracted managed care plans accountable, and to demonstrate the value that they are generating to the state and taxpayers. Because legislative support will be important should MRMIB and DHCS wish to pursue a financial P4P strategy, the agencies should consider how they might be able to address some of the concerns voiced in the interviews.
- 2. Consider modifying measures to address disparity.** DHCS should consider whether it could modify performance measures to report along racial and ethnic groups, as MRMIB does currently. There appears to be significant interest in addressing health care disparities, especially among consumer advocates, but also to a lesser degree among others.

Sustaining a P4P Program

As noted earlier, P4P is but one component of a value-based purchasing strategy. Like the other components, it requires an ongoing assessment of effectiveness and modifications where needed.

- 1. Conduct periodic assessments of purchasing strategy elements.** DHCS and MRMIB should develop and implement plans for periodic assessment of all elements of their purchasing strategies, including any new P4P initiatives they may pursue in the future. For example, the agencies should assess whether performance audits, report cards, and the auto-assignment process are yielding desired results.

In addition, there should be regular review and consideration of the component elements of each purchasing strategy. For example, DHCS currently convenes a multi-stakeholder advisory committee annually for one to three meetings to consider modifications to the auto-assignment algorithm. This appears to be a good process, and one that could be expanded in scope to consider other elements of a broader P4P strategy, particularly given the need to coordinate the efforts for maximum effectiveness.

MRMIB should consider a similar process for its multi-stakeholder Advisory Committee on Quality, which was initially convened in September 2008 to help guide quality improvement efforts in the Healthy Families program.

- 2. Collaborate via scheduled communication.** DHCS and MRMIB should coordinate their efforts through regularly planned communication prior to convening their respective advisory groups each year, and consult with each other prior to making any methodology changes that would have relevance for the other (e.g., changing child immunization measures).

Appendix A: Performance Measures Employed by P4P Programs in Other States

Rhode Island

Rhode Island used the following HEDIS and CAHPS measures in 2007:⁵⁴

Medical Home Preventive Care

- Members Were Satisfied with Access to Urgent Care;
- Adults' Access to Preventive/Ambulatory Health Services (20 to 44 years);
- Adults' Access to Preventive/Ambulatory Health Services (45 to 64 years);
- Well-Child Visits in first 15 months of life;
- Well-Child Visits in the third through sixth years of life;
- Childhood Immunization Status;
- Children and Adolescents' Access to Primary Care Practitioners (12 to 24 months);
- Children and Adolescents' Access to Primary Care Practitioners (25 months to 6 years);
- Children and Adolescents' Access to Primary Care Practitioners (7 to 11 years);
- Children and Adolescents' Access to Primary Care Practitioners (12 to 19 years);
- Medical Assistance with Smoking Cessation;
- Prenatal Care;
- Postpartum Care;
- Adolescent Well-Care Visit; and
- Frequency of Ongoing Prenatal Care.

Women's Health

- Cervical Cancer Screening (21 to 64 years);
- Chlamydia Screening in Women (16 to 20 years); and
- Chlamydia Screening in Women (21 to 25 years).

Chronic Care

- Use of Appropriate Medications for People with Asthma (5 to 9 years);
- Use of Appropriate Medications for People with Asthma (10 to 17 years);
- Comprehensive Diabetes Care: Hemoglobin A1c Testing;

- Antidepressant Medication Management (acute phase); and
- Follow-up Care for Children Prescribed ADHD Medication (initiation phase).

Behavioral Health

- Follow-up After Hospitalization for Mental Illness.

Michigan

Michigan utilizes the following measures:

1. Clinical measures:

- Breast Cancer Screening;
- Cervical Cancer Screening;
- Chlamydia Screening in Women (combined rate);
- Prenatal Care;
- Postpartum Care;
- Comprehensive Diabetes Care: Hemoglobin A1c Testing;
- Controlling High Blood Pressure;
- Use of Appropriate Medications for People with Asthma (combined rate);
- Medical Assistance with Smoking Cessation, including Smoking Cessation Strategies and Advising Smokers to Quit (rolling two-year average);
- Well-Child Visits for the first 15 months of life (six or more visits), in the third through sixth years of life, and Adolescent Well-Care Visits;
- Childhood Immunization Status—Combination 2;
- Lead Screening in Children; and
- Appropriate Treatment for Children with Upper Respiratory Infection.

2. Access:

- Children and Adolescents' Access to Primary Care Practitioners; and
- Adults' Access to Preventive/Ambulatory Health Services.

3. Member satisfaction (CAHPS child and adult surveys):

- Getting Needed Care;
- Getting Care Quickly; and
- Health Plan Rating.

4. Plan accreditation (NCQA or URAC)

5. Legislative incentive:

The bonus is distributed based on a point system, with a total of 164 possible earned points for each plan. The distribution of points by measure category is as follows:

- Clinical measures: 42 percent;
- Access measures: 15 percent;
- Satisfaction measures: 13 percent;
- Accreditation status: 6 percent; and
- Legislative mandate: 24 percent.

New York

New York’s HEDIS, CAHPS, and compliance measures include:

- Adolescent Well-Care Visits;
- Well-Child Visits in the third through sixth years of life;
- Cervical Cancer Screening;
- Appropriate Testing for Children with Pharyngitis;
- Controlling High Blood Pressure;
- Follow-up after Hospitalization for Mental Illness (30-day measure);
- Prenatal Care;
- Postpartum Care;
- Use of Imaging Studies for Low Back Pain;
- Comprehensive Diabetes Care: Poor HbA1c Control;
- Overall Satisfaction with the Health Plan;
- Satisfaction with Getting Care;
- Satisfaction with Customer Service;
- Timeliness of quarterly financial statement submissions; and
- Timeliness and accuracy of network directories and availability, which is determined by EQRO “secret shopper” calls.

Pennsylvania

Pennsylvania utilizes the following HEDIS measures:

- Controlling High Blood Pressure;
- Comprehensive Diabetes Care: HbA1c Poor Control;
- Comprehensive Diabetes Care: LDL Control;
- Cholesterol Management for Patients with Cardiovascular Conditions;
- Frequency of Ongoing Prenatal Care;
- Breast Cancer Screening;
- Cervical Cancer Screening;
- Prenatal Care;
- Use of Appropriate Medications for People with Asthma;
- Adolescent Well-Care Visits;
- Lead Screening in Children; and
- Emergency Room Utilization.

Indiana

Indiana utilized the following HEDIS measures in its bonus and withholding P4P algorithm in 2008:

- Well-Child Visits in the first 15 months of life;
- Follow-up after Hospitalization for Mental Illness; and
- Frequency of Ongoing Prenatal Care.

Appendix B: States' Requirements for Managed Care Organizations to Implement P4P with Network Providers

Rhode Island

Rhode Island neither requires nor encourages managed care organizations to make P4P opportunities available to their contracted providers.

Michigan

Michigan does not have a requirement that Medicaid HMOs provide P4P opportunities to network providers. The state encourages the plans to do so, however, and 13 out of 14 plans have made provider P4P an integral part of their quality improvement strategy. In addition, because of legislative mandates, most plans have implemented member incentives.

New York

New York does not have a requirement that Medicaid HMOs provide P4P opportunities to network providers. However, the state reports being impressed by the number of plans that have developed their own incentive and reward programs for contracted physicians. For example, some plans are rewarding providers \$50 for each fully immunized two-year-old, and/or applying monetary incentives, such as those pertaining to adolescent measures, to members and physicians.

The state is directing a legislatively initiated demonstration—a collaboration between multiple insurers and physicians to develop aligned physician incentive programs that promote patient safety and quality of care—in five regions. The model, similar to one used by IHA in California with commercial insurers, has been quite difficult to implement, according to one health plan representative.⁵⁵

Pennsylvania

Pennsylvania implemented in 2008 a separate pay-for-performance initiative for contracted HMO network providers. The state designed the initiative to provide incentives for improved quality. It provides a separate funding stream for provider incentives, and requires MCOs to award all provider P4P dollars to providers. Any allocated P4P dollars not awarded to providers are recouped by the state.

The state also adds \$1 PMPM to each plan's payment if the state approves the plan's proposed provider P4P program. It provides no specific parameters for how the provider P4P program should be structured, aside from informally encouraging plans to focus on one or more of the 12 HEDIS measures of interest to the state.

Because of this latitude, the state reports that all seven contracted health plans have designed highly divergent programs, which makes it more difficult to ensure appropriate oversight. The provider P4P programs have largely targeted primary care providers and OB/GYNs. Some plans have focused on diabetes care provided by both PCPs and endocrinologists.

Pennsylvania requires that the effectiveness of the approved provider P4P initiative(s) be evaluated by the managed care plan. The results of the analysis must be submitted to the state no later than one year after the initiative has been implemented.

The state also requires that all funding received from the additional \$1 PMPM must be paid in incentives to network practitioners. The state uses a plan-specific, individualized reconciliation and monitoring process, which is based on the practitioner initiative proposed by the plan to improve quality. A clinical reconciliation informs the state whether the plan utilized the incentive methodology as proposed, and the financial reconciliation should demonstrate whether all the money was invested in the network.

The plans report that, for the most part, they have aligned the state's P4P incentives with those they have created for physicians.

Indiana

Indiana implemented in 2007 a requirement that its contracted managed care plans distribute 50 percent of any earned P4P funds to contracted providers and/or to members. Those funds were distributed in the fall of 2008. The state will be utilizing an accounting firm to confirm that the managed care plans actually distributed the bonus funds as required by the contract.

Indiana has not specified how the bonus payments should be distributed to providers or members. Plans have full discretion to select the performance they want to reward, and the measures need not include those used by the state in its P4P methodology with the plan.⁵⁶ Managed care plans must, however, submit a proposed methodology for state review and approval.

Oregon

Oregon neither requires nor encourages plans to make P4P opportunities available to their contracted providers.

Appendix C: California Interviewees

NAME	ORGANIZATIONAL AFFILIATION
California Managed Care Plans and Associations	
Chris Ohman	California Association of Health Plans
Elaine Batchlor	L.A. Care Health Plan
Verne Brizendine	Blue Shield of California
Elissa Estrella	Community Health Plan
Jeff Flick	Anthem Blue Cross
Joseph Garcia	Community Health Group
Brad Gilbert	Inland Empire Health Plan
Brianna Lierman Hintze	California Association of Health Plans
Sunil Joshi	Anthem Blue Cross
Ingrid Lamirault	Alameda Alliance for Health
Alan McKay	Central Coast Alliance for Health
Dave Meadows	Health Net
Jennifer Nuovo	Health Net
John Ramey	Local Health Plans of California
Bill Rice	Community Health Group
Wendy Surfes-Lekavich	Community Health Plan (on behalf of)
Ann Warren	Community Health Group

NAME	ORGANIZATIONAL AFFILIATION*
California State Agency Staff	
Vanessa Baird	Department of Health Care Services
Kim Belshé	Health and Human Services Agency
Lesley Cummings	Managed Risk Medical Insurance Board
Don Fields	Department of Health Care Services
Cathy Halvorson	Department of Health Care Services
Bob Martinez	Department of Health Care Services
Vicki Orlich	Department of Health Care Services
Stan Rosenstein	Department of Health Care Services
Shelley Rouillard	Managed Risk Medical Insurance Board
Bob Sands	Health and Human Services Agency
Sandra Shewry	Department of Health Care Services
Steve Soto	Department of Health Care Services
California Consumer Advocates	
Lark Galloway Gilliam	Community Health Councils
Angela Gilliard	Western Center on Law & Poverty
Terri Shaw	Children’s Partnership and 100% Campaign
Ellen Wu	California Pan-Ethnic Health Network
California Provider Associations	
Larry DeGhetaldi	California Medical Association and Sutter Health
Lisa Folberg	California Medical Association
Allison Homewood	California Primary Care Association
Anne McLeod	California Hospital Association
Erica Murray	California Association of Public Hospitals
California Legislative Staff	
Scott Bain	Assembly Health Committee
Elizabeth Chung	Legislative Analyst’s Office
Roger Dunstan	Senate Health Committee
Kim Flores	Senate Office of Research
Deborah Kelch	Assembly Health Committee
Anissa Nachman	Republican Fiscal Office
California – Other	
Jean Fraser	California Medicaid Research Institute

*Organizational affiliation at time interview was conducted

Appendix D: Comparison of Medi-Cal Managed Care HEDIS Data by Region, 2007

HEDIS MEASURES	STATEWIDE SIMPLE AVERAGE	NCQA MEDICAID*	STATEWIDE WEIGHTED PLAN AVERAGE	PLANS BELOW AVERAGE (TOP) AND ABOVE AVERAGE	
				NORTHERN CA	SOUTHERN CA
Well-Child 15 Months: six or more visits (W15)	56.8%	55.6% [†]	57.5%	6/18 (33%) 9/13 (69%)	12/18 (67%) 4/13 (31%)
Well-Child 3 to 6 Years (W34)	71.6%	66.8% [†]	74.3%	14/23 (61%) 6/13 (38%)	9/23 (39%) 8/13 (62%)
Childhood Immunization Status–Combo 2	76.8%	72.2%	77.9%	13/21 (62%) 5/14 (36%)	8/21 (38%) 9/14 (64%)
Adolescent Well-Care (AWC)	37.0%	43.6% [†]	36.9%	11/23 (48%) 10/15 (67%)	12/23 (52%) 5/15 (33%)
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	84.3%	84.0%	78.9%	2/10 (20%) 19/28 (68%)	8/10 (80%) 9/28 (32%)
Breast Cancer Screening (BCS)	50.7%	49.9%	48.6%	9/18 (50%) 10/17 (59%)	9/18 (50%) 7/17 (41%)
Cervical Cancer Screening (CCS [†])	65.9%	64.7%	67.9%	14/23 (61%) 7/15 (47%)	9/23 (39%) 8/15 (53%)
Chlamydia Screening (CHL)	55.9%	54.2%	52.8%	4/13 (31%) 17/25 (68%)	9/13 (69%) 8/25 (32%)
Timeliness of Prenatal Care (PPC-Time)	79.6%	81.9%	79.4%	10/15 (67%) 9/21 (43%)	5/15 (33%) 12/21 (57%)
Postpartum Care (PPC-Post)	58.0%	58.5%	58.7%	15/23 (65%) 5/14 (36%)	8/23 (35%) 9/14 (64%)
Comprehensive Diabetes Care: Eye Exam [†]	56.1%	49.9%	54.1%	12/18 (67%) 8/19 (42%)	6/18 (33%) 11/19 (58%)
Comprehensive Diabetes Care: HbA1c Test	80.6%	77.3%	79.5%	9/16 (56%) 11/21 (52%)	7/16 (44%) 10/21 (48%)
Comprehensive Diabetes Care: LDL-C Screening	75.7%	70.8%	75.9%	12/22 (55%) 9/15 (60%)	10/22 (45%) 6/15 (40%)
Comprehensive Diabetes Care: Medical Attention for Nephropathy	78.9%	74.4%	81.0%	16/28 (57%) 5/8 (63%)	12/28 (43%) 3/8 (38%)
Use of Appropriate Medications for People with Asthma (ASM)	87.0%	86.9%	86.8%	7/14 (50%) 12/21 (57%)	7/14 (50%) 9/21 (43%)
Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis (AAB) (above average is worse)	69.3%	25.9%	71.0%	4/10 (40%) 11/21 (52%)	6/10 (60%) 10/21 (47%)

*Rate is from NCQA's "The State of Health Care Quality 2008" report for Medicaid HEDIS 2007.

†Rate is from NCQA's Medicaid HEDIS 2007 Audit Means, Percentiles and Ratios spreadsheet (April 2008) (Note: These data are not benchmarks; they are to be used only for checking reasonableness in the audit process.)

Note: For the purposes of the above analysis, "Northern CA" includes Alameda, Contra Costa, Monterey, Napa, Sacramento, San Francisco, San Mateo, San Joaquin, Santa Clara, Santa Cruz, Solano, Stanislaus, and Yolo counties; "Southern CA" includes Fresno, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Tulare counties.

Appendix E: Comparison of Healthy Families HEDIS Data with National Commercial Benchmarks, 2007

HEDIS MEASURES	STATEWIDE AVERAGE	NCOA COMMERCIAL		
		AVERAGE	10TH PERCENTILE	90TH PERCENTILE
Well-Child:				
• Aged 15 months: 6 visits or more (W15)	57%	73%	56%	89%
• Ages 3 to 6 years (W34)	73%	67%	55%	83%
Childhood Immunization Status:				
• Combination 2	79%	81%	73%	89%
• Combination 3	73%	76%	66%	82%
Adolescent Well-Care (AWC)	44%	40%	25%	58%
Child and Adolescent Access to PCP:				
• Ages 12 to 24 months	97%	97%	94%	99%
• Ages 25 months to 6 years	89%	89%	84%	95%
• Ages 7 to 11 years	89%	90%	83%	96%
• Ages 12 to 18 years	86%	87%	81%	94%
Use of Appropriate Medications for People with Asthma (ASM), ages 5 to 18 years	94%	95%	89%	95%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	83%	84%	75%	93%
Appropriate Testing for Children with Pharyngitis	31%	75%	60%	88%
Chlamydia Screening (CHL), ages 16 to 18 years	41%	36%	26%	49%
Mental Health Utilization	2%	6%	4%	9%
Identification of Alcohol and Other Drug Services	0.2%	1%	0.4%	N/A

Endnotes

1. See www.scribd.com/doc/2440528/Legislative-Analysts-Office-LAO (accessed August 4, 2009).
2. See www.dhcs.ca.gov/Pages/DHCSStrategicPlanandImplementationPlan.aspx (accessed August 4, 2009).
3. Bailit, M.H., M.B. Dyer, M.S. Joseph. *Incentives and Rewards Best Practices Primer: Lessons Learned From Early Pilots*. The Leapfrog Group. Washington, D.C.: July 2006.
4. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C.: March 2001.
5. The PCC Plan's Behavioral Health Program Contract between The Executive Office of Health and Human Services and The Massachusetts Behavioral Health Partnership. Appendix H-1: FY2008 Performance Incentive Projects.
6. Bailit, M. and M.B. Dyer. *Putting Quality to Work: Rewarding Plan Performance in Medi-Cal Managed Care*. California HealthCare Foundation. Oakland, CA: May 2006.
7. Dyer, M.B., M.H. Bailit, L.L. Burgess. *Provider Incentive Models for Improving Quality of Care*. National Health Care Purchasing Institute. Washington, D.C.: March 2002.
8. Pennsylvania Chronic Care Commission. *Transforming Primary Care Practice: The Southeast Pennsylvania Rollout*. June 17, 2008.
9. See note 6.
10. Kuhmerker, K. and T. Hartman. *Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs*. The Commonwealth Fund, New York, NY: April 2007.
11. Duchon, L. *Recent State Experiences with Pay-for-Performance in Medicaid Management Care*. The Second National Pay-for-Performance Summit, Los Angeles, CA: February 16, 2007. The presenter cited two studies: a George Washington University/Health Management Associates study of 15 states, and a National Association of Children's Hospitals/Health Management Associates study of SCHIP and Medicaid programs.
12. Dyer, M.B. and M.H. Bailit. *Are Incentives Effective in Improving the Performance of Managed Care Plans?* Bailit Health Purchasing, LLC, for the Center for Health Care Strategies, Lawrenceville, NJ: March 2002.
13. Berenson, R., and others. *Evaluating the New York State Medicaid Managed Care Quality Improvement Incentive Program*. The Urban Institute for the Commonwealth Fund, New York, NY: February 2007.
14. Bailit. *Incentives and Rewards*; Kuhmerker. *Pay-for-Performance in State Medicaid Programs*; Dudley, R.A. and M.B. Rosenthal. *Pay for Performance: A Decision Guide for Purchasers*. Agency for Healthcare Research and Quality, Rockville, MD: April 2006 www.ahrq.gov/qual/p4pguide.htm (accessed August 4, 2009); Robert Wood Johnson Foundation. *Rewarding Results Pay-for-Performance Initiative Ten Lessons Learned*. Princeton, NJ: November 15, 2005 www.rwjf.org/files/newsroom/RewardingResultsLessons_110705.pdf (accessed August 4, 2009); Christianson, J.B., S. Leatherman, K. Sutherland, and C.H. Williams. "Paying for Quality: Understanding and Assessing Physician Pay-for-Performance Initiatives." The Synthesis Project, Issue 13, The Robert Wood Johnson Foundation. Princeton, NJ: December 19, 2007. www.rwjf.org/pr/product.jsp?id=24373 (accessed August 4, 2009); Damberg, C., K. Raube, S. Teleki, and E. dela Cruz. *Rewarding Performance: Three-Year Results from California's Statewide Pay-for-Performance Experiment*. June 5, 2007.
15. See note 10.
16. Rhode Island Department of Human Services Center for Child Health. Interview with Robyn Hoffmann, QI Consulting Manager, Affiliated Computer Services, Inc. October 10, 2008.
17. Cantor J.C., C. Schoen, D. Belloff, S.K.H. How, and D. McCarthy. *Aiming Higher: Results from a State Scorecard on Health System Performance*. The Commonwealth Fund Commission on a High Performance Health System, New York, NY: June 2007.

18. See www.usnews.com/directories/health-plans/index_html/plan_cat+Medicaid (accessed on August 4, 2009).
19. Neighborhood Health Plan of Rhode Island. Interview with Mac Johnston, M.D., Nancy Coburn, and Tom Boucher, December 16, 2008.
20. Michigan Department of Community Health, Medical Services Administration, Managed Care Plan Division. Interview with Cheryl Bupp and Shelia Embry, September 29, 2008.
21. Michigan Association of Health Plans. Interview with Rick Murdock, November 9, 2008.
22. New York State Department of Health, Office of Managed Care, Bureau of Quality Management. Interview with Joe Anarella, September 29, 2008; Foels, T. Independent Health: The Health Plan Perspective. Third Annual Pay for Performance Summit, Los Angeles, CA: February 28, 2008; Anarella, J. New York Perspective: Pay for Performance in Medicaid Managed Care. Third Annual Pay for Performance Summit, Los Angeles, CA: February 28, 2008.
23. A recent Urban Institute evaluation of the program described the algorithm for HEDIS and CAHPS measures as follows: “To determine whether a plan is eligible for rewards under the QI program, QARR scores from each plan are compared to the 75th percentile of the statewide average (SWA) of all participating plans from two years prior (or three years if a measure was not used in that year). For each QARR measure that a plan scores the same as or greater than the 75th percentile of the SWA they receive 10 points. For each CAHPS measure, a plan receives ten points if they exceed the SWA and five points if their score is equal to the SWA. The most recent CAHPS survey data collected are used to make this determination. In the QI program, a plan may receive up to 150 points (normalized to 100 points). Plans that meet or exceed a specific point threshold, which is set by the Department of Health each year, are eligible to receive rewards under the program.”
24. The Urban Institute reported that respondents with mixed or negative feelings about auto-assignment “said that this population was hard to find and to engage in routine care. This difficulty might bring down a plan’s quality scores. Some thought that the auto-assigned population represented adverse selection, because they have more health care needs, tend to use health care episodically through avoidable emergency room visits and hospitalizations, and, generally, are less compliant with preventive health practices. Interestingly, only three plans had rigorously studied their own data to determine whether auto-assigned enrollees had different utilization experiences after joining the plan. Two of the three plans concluded there were no significant utilization or cost differences. The other plan found that the first group of auto-assignees (during implementation of mandatory managed care) had somewhat lower utilization experience but that the most recent group was sicker and needed more health care.”
25. The Urban Institute reported that the impact of public reporting is powerful—plans often work first on those measures for which they are performing the worst relative to the competition, even if they have no reasonable prospects for earning pay-for-performance bonuses, at least in the short term, for those measures. See www.health.state.ny.us/health_care/managed_care/reports (accessed August 4, 2009).
26. PHSPs are managed care entities specifically authorized by New York state law; PHSP Coalition. Interview with Andy Cohen and Patricia Boozang of Manatt, Phelps and Phillips, LLP, November 5, 2008; Independent Health. Interview with Tom Foels, M.D., November 21, 2008.
27. Pennsylvania Department of Public Welfare, Bureau of Managed Care Operations, Division of Quality and Special Needs Coordination. Interview with Barbara Molnar, October 16, 2008.
28. UPMC Health Plan. Interview with Michael Culyba, M.D., Jen Nolty, and Deb Smyers, November 11, 2008; AmeriChoice. Interview with Humberto Guerra-Garcia, M.D., November 12, 2008; Gateway Health Plan. Interview with Robert Mirsky, M.D., November 12, 2008.
29. Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning. Interview with Stephanie Baume, October 16, 2008.

30. With the exception of cervical cancer screening in 2009, for which the MCOs are eligible for 25 percent of the withhold if they attain the 25th percentile level. Managed care plans are not eligible for bonus fund payment if certain corrective actions have been imposed or audited HEDIS data has not been submitted by the required date. However, the state may reinstate eligibility for participation in the P4P program once the managed care plan has corrected all prior instances of noncompliance.
31. Anthem. Interview with Jim Swinford, October 2, 2008; MDwise. Interview with Barbara Wilder, November 14, 2008; Managed Health Services (Centene). Interview with Jim Barth, December 4, 2008.
32. Oregon Department of Human Services, Division of Medical Assistance Programs. Interview with Tom Van der Veen, October 10, 2008.
33. Doctors of the Oregon Coast South. Interview with Bill Murray, November 12, 2008; Lane Individual Practice Association. Interview with Rhonda Musik, November 21, 2008.
34. Individuals who had worked directly with DHCS on the design and implementation of the performance-based auto-assignment project tended not to have the same concerns about the technical capabilities of state agency staff.
35. Maryland Medicaid had this same experience.
36. Not all plan representatives seemed aware that both DHCS and MRMIB currently publish plan performance data on their agency Web sites.
37. The individual who made this suggestion noted that IHA has struggled with implementing such a measurement into its provider P4P methodology.
38. MRMIB does not collect encounter data because of the California Confidentiality of Medical Information Act, which prohibits plans from sharing data on outpatient visits with a psychotherapist.
39. California Children's Service, or CCS, is a state program that helps children with certain diseases, physical limitations, or chronic health problems. For more information, see www.dhcs.ca.gov/services/ccs/pages/default.aspx (accessed August 4, 2009).
40. See the AMA's Principles for Pay-for-Performance Programs at www.ama-assn.org/ama1/pub/upload/mm/368/principles4pay62705.pdf (accessed August 4, 2009).
41. Legislative staff sought information such as clear performance benchmarks, financial performance data, complaint data, outcomes, more measures with greater clinical scope, and an assessment of how access and ED use compare between Medi-Cal managed care and fee-for-service programs.
42. A couple of legislative staffers were quite knowledgeable about the Medi-Cal performance-based auto-assignment algorithm, and raised questions about the following: the current mix of measures; whether some of the measures are too "easy"; and DHCS' prolonged retention of the 10 percent cap on annual changes in apportionment. (This cap was increased by DHCS to 20 percent in November 2008.)
43. See www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx (accessed August 4, 2009).
44. See www.mrmib.ca.gov/MRMIB/HFP/HEDIS07.pdf (accessed August 4, 2009).
45. Rosenthal, M.B., R.G. Frank, Z. Li, A.M. Epstein. "Early Experience With Pay-for-Performance," *JAMA*, 294:1788–1793, 2005.
46. NCQA, 2008. "The State of Health Care Quality 2008," and NCQA, April 2008. "NCQA Medicaid HEDIS 2007 Audit Means, Percentiles, and Ratios Spreadsheet". See www.ncqa.org/tabid/334/default.aspx (accessed August 4, 2009). NCQA notes that the data points are not intended for use as benchmarks, but for checking reasonableness in the audit process.
47. The Northern counties were defined as Alameda, Contra Costa, Monterey/Santa Cruz, Napa/Yolo, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, and Stanislaus. The Southern counties were defined as Fresno, Kern, Los Angeles, Orange, Riverside/San Bernardino, San Diego, Santa Barbara, and Tulare.
48. See note 46.

49. For 2008–09, the algorithm utilizes six HEDIS measures (childhood immunizations–combination 2; well-child visits [third through sixth years of life]; adolescent well-visits; timeliness of prenatal care; appropriate medications for people with asthma; and cervical cancer screening) and two state-defined measures (the percentage of members assigned to safety net provider PCPs; and the percentage of hospital discharges at “disproportionate share” hospitals).
50. Caldini, R. *Influence: The Psychology of Persuasion*. HarperCollins, 2007.
51. This statutory requirement has been the driver behind MRMIB’s Community Provider Plan (CPP) designation process. CPP is the plan in each county that has the highest percentage of traditional and safety net providers in its network. The advantage to a plan of receiving CPP designation is that the premium cost to the subscriber is reduced by \$4 per month per child for CPP plans. Healthy Families subscribers who do not choose a plan when they enroll in the program are enrolled through a default enrollment process into the CPP.
52. See www.dhmh.state.md.us/mma/healthchoice/pdf/2009/CY2009_MD_Cons_Rpt_Card%20032309.pdf (accessed August 4, 2009).
53. See www.opa.ca.gov/report_card/medi-calmeasure.aspx?County=ALAMEDA (accessed August 4, 2009).
54. Rhode Island Department of Human Services, Center for Child and Family Health. *Monitoring Quality and Access in RITE Care*. Cranston, RI: October 2008. Available at www.ritecare.ri.gov/documents/reports_publications/PGP%20report%202008%2010-08.pdf (accessed on August 4, 2008). The state would not disclose the specific member service and cost management measures it has employed.
55. The following white paper describes and assesses California’s P4P program: IHA. February 2006. “Advancing Quality Through Collaboration: The California Pay for Performance Program”. See www.iha.org/wp020606.pdf (accessed June 26, 2009).
56. The state reported that proposals it had received for distribution of the 2007 bonus funds utilize the state’s measures for the managed care plan P4P program, with one plan adding the use of electronic health records and physician extenders to its proposal.

23. A recent Urban Institute evaluation of the program described the algorithm for HEDIS and CAHPS measures as follows: “To determine whether a plan is eligible for rewards under the QI program, QARR scores from each plan are compared to the 75th percentile of the statewide average (SWA) of all participating plans from two years prior (or three years if a measure was not used in that year). For each QARR measure that a plan scores the same as or greater than the 75th percentile of the SWA they receive 10 points. For each CAHPS measure, a plan receives ten points if they exceed the SWA and five points if their score is equal to the SWA. The most recent CAHPS survey data collected are used to make this determination. In the QI program, a plan may receive up to 150 points (normalized to 100 points). Plans that meet or exceed a specific point threshold, which is set by the Department of Health each year, are eligible to receive rewards under the program.”
24. The Urban Institute reported that respondents with mixed or negative feelings about auto-assignment “said that this population was hard to find and to engage in routine care. This difficulty might bring down a plan’s quality scores. Some thought that the auto-assigned population represented adverse selection, because they have more health care needs, tend to use health care episodically through avoidable emergency room visits and hospitalizations, and, generally, are less compliant with preventive health practices. Interestingly, only three plans had rigorously studied their own data to determine whether auto-assigned enrollees had different utilization experiences after joining the plan. Two of the three plans concluded there were no significant utilization or cost differences. The other plan found that the first group of auto-assignees (during implementation of mandatory managed care) had somewhat lower utilization experience but that the most recent group was sicker and needed more health care.”
25. The Urban Institute reported that the impact of public reporting is powerful—plans often work first on those measures for which they are performing the worst relative to the competition, even if they have no reasonable prospects for earning pay-for-performance bonuses, at least in the short term, for those measures. See www.health.state.ny.us/health_care/managed_care/reports (accessed August 4, 2009).
26. PHSPs are managed care entities specifically authorized by New York state law.
27. Pennsylvania Department of Public Welfare, Bureau of Managed Care Operations, Division of Quality and Special Needs Coordination. Interview with Barbara Molnar, October 16, 2008.
28. UPMC Health Plan. Interview with Michael Culyba, M.D., Jen Nolty, and Deb Smyers, November 11, 2008; AmeriChoice. Interview with Humberto Guerra-Garcia, M.D., November 12, 2008; Gateway Health Plan. Interview with Robert Mirsky, M.D., November 12, 2008.
29. Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning. Interview with Stephanie Baume, October 16, 2008.
30. With the exception of cervical cancer screening in 2009, for which the MCOs are eligible for 25 percent of the withhold if they attain the 25th percentile level.
31. Anthem. Interview with Jim Swinford, October 2, 2008; MDwise. Interview with Barbara Wilder, November 14, 2008; Managed Health Services (Centene). Interview with Jim Barth, December 4, 2008.
32. Oregon Department of Human Services, Division of Medical Assistance Programs. Interview with Tom Van der Veen, October 10, 2008.
33. Doctors of the Oregon Coast South. Interview with Bill Murray, November 12, 2008; Lane Individual Practice Association. Interview with Rhonda Musik, November 21, 2008.