California's Medi-Cal Managed Care Pay for Performance Landscape

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With rapid growth in California's Medi-Cal population and the increasing role of managed care, an imperative is emerging for consistent and comparative performance measurement across P4P programs.

Medi-Cal, California's Medicaid program, is the nation's largest—with an enrollment of more than 12 million members and a proposed budget of more than $97 billion state and federal dollars for 2015-16.[1] The recent surge that nearly doubled Medi-Cal enrollment[2] is largely related to the Affordable Care Act (ACA), which expanded coverage to individuals who were previously ineligible. With this vast budget of public funds earmarked to serve so many low-income Californians, it is a state imperative to establish systems which ensure Medi-Cal members receive high value health care.

California's Department of Health Care Services (DHCS) is responsible for overseeing all Medi-Cal managed care plans by monitoring access to program services, quality of care delivered to enrollees and timeliness of appropriate levels of care.

To assess the quality of care delivered to Medi-Cal members[3], DHCS requires the plans to annually report performance measurement results on selected measures, administer a consumer satisfaction survey, conduct ongoing Quality Improvement Projects (QIPs) and create improvement plans if their performance is poor.

While monitoring and performance incentives are essential at the plan level, incentives will be most effective if they flow down to the providers. Many plans have implemented innovative payment programs for their providers to improve both the quality and efficiency of care delivered to their members—most commonly, pay for performance (P4P) programs.

P4P strategies offer financial incentives to health care providers that improve their performance on predetermined measures or meet targets that focus on quality and efficiency of care. While Medi-Cal plans have embraced P4P strategies, no statewide program exists. In the fall of 2014, the Integrated Healthcare Association (IHA) conducted a survey of Medi-Cal managed care health plans to assess their current P4P activities and to discern what additional support they might need to be more effective. Of the 20 Medi-Cal plans surveyed, 16 had a P4P program—a program offering financial incentives or bonuses tied to provider performance.

ABOUT THIS ISSUE BRIEF

This Issue Brief examines the Pay for Performance (P4P) programs developed by California's Medi-Cal managed care plans. Based on a survey of Medi-Cal plans, it covers a range of topics—including performance measurement, incentive design, provider engagement and specific strategies for strengthening P4P programs.

Of the 20 Medi-Cal plans surveyed, 16 had a P4P component—a program offering financial incentives or bonuses tied to provider performance. The length of time Medi-Cal plans have had such programs varied. While some plans were just starting a P4P program, others had been in place for more than a decade.

See Appendix A for a description of the survey and the specific plans included.

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OVERSIGHT OF MEDI-CAL MANAGED CARE PLANS

California's DHCS uses several methods to track plans' performance and reward quality care.

- **External Accountability Set.** Each year, DHCS selects a set of performance measures, called the External Accountability Set (EAS), to assess the quality of care Medi-Cal managed care plans provide. Most measures are taken from the Healthcare Effectiveness Data and Information Set (HEDIS), a nationally recognized and standardized set of performance measures. Every year, plans are required to collect, calculate and report their rates for all EAS measures. Rates are audited by an External Quality Review Organization and must be reported at the county level unless DHCS approves an alternative. DHCS publishes a report of the quality performance results for each plan.
- **Medi-Cal Managed Care Performance Dashboard.** The dashboard is a monitoring tool produced quarterly by the Managed Care Quality and Monitoring Division (MCQMD) of DHCS. DHCS collects Medi-Cal managed care plans' quality performance data and reports aggregated HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores for plans through the dashboard. In addition to reporting data on quality of care, the dashboard reports cover enrollment, health care utilization and network adequacy. The tool assists DHCS in assessing Medi-Cal managed care plan performance—individually, statewide and by plan model.
- **Auto-Assignment.** In counties using the Two-Plan and Geographic Managed Care models, DHCS uses its Auto Assignment Incentive Program to motivate plans to improve their quality scores. The algorithm will be used in all non-COHS counties in the future, excluding San Benito. (See Appendix C for a comprehensive look at the county models.) The incentive program uses HEDIS measures and two measures related to plan use of safety net providers to develop quality scores that determine which plans will receive a greater percentage of default enrollment.

PERFORMANCE MEASUREMENT AND DATA COLLECTION

Selecting appropriate performance measures and implementing data collection strategies are key components in designing any P4P program. Most of the Medi-Cal managed care plans included in this survey developed their own programs and measure sets. See Appendix B for a crosswalk of all measures included.

Domains for measurement

Some plans were more comprehensive and included many domains; all but one contained more than one measurement domain in their P4P programs.

Five domains for measurement were most prevalent among the programs.

- **Clinical quality:** All plans incorporated clinical quality measures into their P4P programs, largely using the standardized national measures in Healthcare Effectiveness Data and Information Set (HEDIS) or similar measures. The primary focus was on the most common Medi-Cal priority areas—including diabetes care, cervical cancer screening and pediatric wellness.
- **Utilization:** The two most common measures included were all-cause readmissions following acute inpatient stays and avoidable emergency department visits.
- **Encounter submission:** Encounter data are records of the health care services for which plans pay in capitated arrangements. Encounter data are essential for measuring clinical quality and utilization, as well as predicting future utilization and as a basis for risk-based payments. Health plans used metrics to track whether encounter data submitted by providers were complete and timely.
- **Access to care:** Monitoring access to care for Medi-Cal members was a priority for plans. Measures included extended office hours and access to primary care physicians for children and adolescents.
- **Patient experience:** These measures captured the overall experience of patients and their families with the care they received.

Additional measures used by some plans included:

- Operational measures, such as provider continuity
- Meaningful Use of Health Information Technology (MUHIT)
- Patient Centered Medical Home (PCMH) recognition, and
- Completion of a Physician Orders for Life-Sustaining Treatment (POLST) or other advanced care planning form.

Performance measures

The number of performance measures used by plans varied from 3 to 34 distinct measures, while the majority of plans included at least 15 measures in their P4P programs.

Data collection sources

A variety of data sources were used to measure performance. All P4P programs used claims or administrative data—including encounter, pharmacy and lab data. Several plans also used other data sources—including registry data and data supplied by their contracted providers, such as EMR data or PM 160 Forms for well child visits and immunizations.

Overlap of measures

In all, 86 distinct measures were included in all the plans' Medi-Cal P4P programs. There was some overlap in measurement areas such as diabetes care, but only one specific metric—blood sugar testing for people with diabetes—was used in all programs. This lack of alignment has been attributed to diversity across the state and the county-based structure of the Medi-Cal managed care market in which plans design programs to meet the needs of their member populations.

There was some overlap in measurement areas such as diabetes care, but only one specific metric—blood sugar testing for people with diabetes—was used in all programs.

While there was little alignment of measures across P4P programs, where measures did align, they also aligned with other existing measure sets. The 10 most common measures P4P programs used across all managed care plans are shown in Table 1 below, along with an indication of whether each is included in other measure sets: DHCS' External Accountability Set (EAS) and Auto-Assignment, HRSA's Uniform Data System (UDS) and IHA's commercial P4P HMO program. While these 10 measures are the most common, the plans may calculate the metrics differently. For example, while eight plans include a measure of childhood immunizations, this measure varies based on what vaccines are included; therefore, results are not comparable.

Table 1: Alignment of Most Common Measures Used in Medi-Cal P4P Programs, Measurement Year 2014

MEASURES	DHCS EAS	Auto-Assignment Measure	IHA's Commercial P4P Program	Uniform Data System	Number of Health Plans Measuring in P4P Programs
Blood Sugar Testing for People with Diabetes	X	X	X		13
Well Child Visit with Primary Care Provider (3-6 years)	X	X		X	12
Diabetes Eye Exam	X				11
Cervical Cancer Screening	X	X	X	X	10
Kidney Disease Monitoring for People with Diabetes	X		X		9
Blood Sugar Control for People with Diabetes	X		X	X	8
Childhood Immunizations	X	X	X	X	8
Cholesterol Testing for People with Diabetes*					6
Postpartum Care	X				
Timeliness of Prenatal Care	X	X		X	6

* This measure was removed from the HEDIS Comprehensive Diabetes Care measure due to the release of the American College of Cardiology (ACC)/American Heart Association (AHA) 2013 guidelines that do not specify LDL targets for treatment.

Alignment with DHCS's EAS: All Medi-Cal managed care plans are required to collect and report their rates for all EAS measures; DHCS reports the results annually. Nine of the measures most commonly included in Medi-Cal plans' P4P programs are EAS measures and likely align with each plan's quality improvement projects. Plans placed considerable emphasis on EAS measures and designed P4P incentives to improve performance on the measures for which DHCS held them accountable.

Alignment with DHCS's Auto-Assignment Program: In counties adopting the Two-Plan and Geographic Managed Care models, DHCS uses its Auto-Assignment Incentive Program (see sidebar) to motivate plans to improve quality scores. Five of the ten most common measures used by managed care plans were the HEDIS measures DHCS uses in its auto-assignment measure set. When compared to their COHS counterparts, plans operating in Two-Plan and GMC counties included more auto-assignment measures in their P4P programs (see Table 2). By focusing on improving DHCS's auto-assignment measures, plans in Two-Plan and GMC counties also enhanced their abilities to increase plan enrollment. See Appendix C for a comprehensive look at the county models offered.

Alignment with the Uniform Data System (UDS): Medi-Cal is the largest payer for patient services in California's Federally Qualified Health Centers (FQHCs). The Health Resources and Services Administration (HRSA) collects UDS reports from FQHCs and FQHC Look-Alikes; UDS is another measure set many Medi-Cal providers must report. Five of the most common measures included in Medi-Cal plans' P4P programs are also UDS measures.

Alignment with IHA's P4P Program: With Medi-Cal now providing health care services for approximately one-third of California's population, many plans and providers are assessing the opportunity to enter or expand their presence in the Medi-Cal managed care market. A few Medi-Cal plans mentioned their efforts to align some measures in their P4P programs with those in IHA's P4P program to reduce the administrative burden for their contracted providers that participate in both. Half of the most common measures used by Medi-Cal plans were included in IHA's commercial P4P program measure set, suggesting there is already some alignment across Medi-Cal and commercial markets.

Table 2: Inclusion of Auto-Assignment Measures in Medi-Cal P4P Programs

	Plans Eligible to Receive Auto-Assignment Incentives								Plans Not Eligible to Receive Auto-Assignment Incentives				
AUTO-ASSIGNMENT MEASURES	Anthem	CA Health & Wellness	Health Net	Health Plan of San Joaquin	Inland Empire Health Plan	Kern Health Systems	L.A. Care Health Plan	San Francisco Health Plan	CalOptima	CenCal	Central California Alliance for Health	Health Plan of San Mateo	Partnership Health Plan
Blood Sugar Testing for People with Diabetes	X	X	X	X	X	X	X	X	X		X	X	X
Timeliness of Prenatal Care	X	X			X	X	X					X	
Cervical Cancer Screening		X	X	X	X	X	X	X	X		X		X
Childhood Immunizations	X	X			X	X	X	X	X				X
Well Child Visit with Primary Care Provider (3-6 years)	X	X		X	X	X	X	X	X	X	X	X	X
TOTAL NUMBER OF MEASURES	4	5	2	3	5	5	5	4	4	1	3	3	4

INCENTIVE DESIGN AND PAYMENT METHODOLOGIES

While the incentive designs and payment methodologies varied among the P4P programs surveyed, there were some common elements.

All Medi-Cal managed care plans targeted primary care physicians for incentives. Five plans indicated they had other incentive programs for specialists and other providers such as hospitals and pharmacy services.

All programs were financed with funds from general operating revenues. Most plans budgeted a specific amount of funds for their P4P programs each year, although two were funded by withholding an amount from monthly capitation payments to providers.

One plan emphasized that including an improvement component alongside attainment was key to motivating all providers.

Most plans contracted with physician organizations—identified as medical groups, Independent Physician Associations (IPAs) and FQHCs—and paid a large percentage of their bonuses at the group level, with five plans paying more than 90 percent of their bonuses that way. Some plan administrators mentioned that one limitation of paying at the group level was uncertainty about whether incentive payments trickled down to individual physicians; only three plans reported paying a significant percentage of their bonuses to individual providers.

Plans also tailored their incentive programs in a variety of ways, with several using a combination of approaches.

Three incentive methodologies were identified.

1. **Improvement:** The most common incentive methodology was to reward providers for improving over the previous year. One plan reported that including an improvement component was key to motivating all providers. It originally structured its P4P program to reward only top performers, but later learned that lower performing providers were not motivated to engage in the program because they felt they could not reach the established targets.
2. **Attainment:** The second most common methodology was to pay incentives to providers that achieved a specific benchmark.
3. **Per-event:** Several plans also used per-event incentives to directly reward providers for specific activities, such as completing a PM 160 Form used to document well child visits and immunizations.

Auto-assignment based on provider performance

The strategy of assigning enrollees to providers based on their performance (auto-assignment) could benefit both plans and providers, raising plans' HEDIS scores by assigning members to the highest performing providers and increasing the number of patients assigned to them. A few plans indicated they had considered doing so, but none had implemented the strategy. Several plans identified access to care concerns as a deterrent, given the higher levels of enrollment due to the recent expansion of Medi-Cal.

PROVIDER ENGAGEMENT AND IMPACT

All plans developed strategies to engage providers in their P4P programs. The most common practice was to issue progress reports or report cards on performance. Some reports included only individual provider or site-specific performance results, while others included peer-to-peer performance comparisons. The timeliness of feedback is an important issue for providers. For example, one provider in southern California reported that the Medi-Cal plan with which it contracted had a significant lag in reporting results, making it very challenging to be actionable. The frequency of the reports varied from monthly to annually. A few plans also created portals where providers could view performance results throughout the year and access additional information the plans provided. In addition to progress reports, most plans had training programs aimed at sharing quality improvement strategies with their providers. Some focused on improving HEDIS scores and offered in-person workshops or webinars on how to improve measures such as childhood immunization rates, while others dealt with specific quality improvement topics such as effective ways to communicate with patients. The most common strategies used are summarized in Table 3.

While plans identified several strategies to engage providers, many expressed concerns that providers needed additional support to build or expand their capacities with performance measurement and quality improvement. One plan suggested that while it provided data to providers, it was unclear how effectively they used it to change their care management workflow—mostly due to complications caused by limited resources.

Table 3: Provider Engagement Strategies

STRATEGY	Number of Plans Using Strategy
Progress Reports on Provider Results	14
Meetings and Trainings	13
Site Visits	7
Physician Advisory Groups	5
Orientation for New Providers	3
Provider Surveys to Solicit Feedback	2

Program impact

Only one Medi-Cal managed care plan reported conducting an assessment of its P4P program, and confirmed it was not a robust evaluation. Plans with new programs indicated that it was too early to determine whether they were successful. Plans with more established programs noted that while they did not conduct formal evaluations, they had received positive feedback from providers on their P4P programs. Several plans noted an improvement in their HEDIS scores; however, with several quality improvement interventions overlapping, it was difficult to attribute these improvements solely to their P4P programs. One survey respondent explained that he viewed his plan's P4P program not as a definitive solution for improving care, but as a tool for achieving collaboration, meaningful reporting and quality improvement.

THE EVOLUTION OF P4P PROGRAMS

IHA conducted a similar inventory of Medi-Cal managed care plans in 2007. Given the substantial changes in P4P, a different survey was used in 2014. There were, however, some areas of overlap in the surveys, providing opportunities for comparison.

Increased inclusion of non-clinical measures. The number of plans using measures in domains other than clinical quality, such as encounter submission, access to care, and utilization, increased in 2014.

Shift from per-event incentives towards population-based incentives. Comparing results from the inventories over time indicates that plans are moving away from per-encounter incentives toward more population-based incentives focused on improvement and attainment.

EXAMPLES OF MANAGED MEDI-CAL P4P PROGRAMS

Three examples illustrate how Medi-Cal managed care plans have designed their P4P programs. The plans were chosen based on their geographic variation, sophistication and length of time the P4P programs have been in place as well as their willingness to share their P4P designs.

Inland Empire Health Plan

Inland Empire Health Plan (IEHP) serves more than one million residents of Riverside and San Bernardino counties. IEHP has developed two P4P programs: one for primary care providers that has been in place since 2001, and another for pharmacists that was started in 2013.

Performance Measurement: Physicians are reimbursed directly by IEHP through their P4P program under eight distinct program components:

1. Immunizations
2. Well Child Visits
3. Pap Tests
4. Perinatal Visits
5. Postpartum Services
6. Asthma
7. DualChoice Annual Visits,* and
8. Diabetes

Incentive Design & Payment: The Physician P4P program is financed from general operating funds. In 2015, the total payout is estimated to be $30-35 million.

The Physician P4P program includes three components:

1. Event based payments that include payments for completion of well child exams, immunizations, diabetic testing, timely prenatal/postpartum visits, pap testing and the DualChoice annual visit
2. Outcome based payments for asthma (prescribing of a long term controller) and diabetes blood sugar control, and
3. Fixed performance payments based on meeting thresholds on HEDIS measures (new in 2015).

* IEHP Medicare DualChoice is designed for people with full-scope Medi-Cal and Medicare Part A and B. The goal is to ensure all DualChoice members receive timely annual visits, with an emphasis on evaluating chronic illness.

Partnership Health Plan

Partnership Health Plan of California (PHC) serves more than 540,000 residents of 14 Northern California counties. PHC has developed four distinct quality improvement programs (QIPs): one for primary care sites (medical groups, clinics, and individually contracted physicians) that has been in place since 1995, and three others for hospitals, pharmacies, and specialty care.

Performance Measurement: Primary care sites are rewarded based on their performance in four categories: clinical quality, appropriate use of resources, operations and access, and patient experience.

Incentive Design & Payment: The PCP QIP program is financed from general operating funds. The program uses two types of incentives:

1. PHC budgets a $5 per member, per month (PMPM) amount for their fixed-pool incentives. This amount represents 20 to 40 percent of the average capitation rate paid to their PCP sites in the program. For each measure there is a specific goal and primary care sites receive points if targets are met. Actual performance targets and improvement targets are used. Incentive payments are based on point totals. PHC distributes 100 percent of the fixed-pool budget, estimated at $18 million in 2014.
2. Unit of Service payments are based on completion of specific tasks or provision of services. For example, PHC pays physicians for each eligible advance care planning attestation form submitted.

San Francisco Health Plan

San Francisco Health Plan (SFHP) serves 121,586 members in San Francisco County. SFHP has developed two programs: one for primary care physicians called Practice Improvement Program (PIP) launched in 2011 and a specialty care P4P program.

Performance Measurement: Within PIP, clinics and medical groups are rewarded based on their performance in four measure domains:

1. Clinical Quality – focused on HEDIS measures of priority to DHCS and self-reportable by the program's participants
2. Patient Experience – focused on lowest performing Consumer Assessment 0f Healthcare Providers & Systems (CAHPS) composite, which currently is Access
3. Systems Improvement – focused on improved coordination between care providers, and
4. Data Quality – focused on DHCS electronic data requirements, including timeliness, comprehensiveness, and accuracy, and to support comprehensiveness of coding

Incentive Design & Payment: PIP is financed from a capitation withhold with a total estimated budget of $22.9 million in 2015. The withhold represents 18.5 percent of professional capitation. Program participants are able to earn back 100 percent of their withheld funds, depending on performance. The program is not competitive and participants are only able to earn back their withheld funds. Any unearned funds are put back into the program for more technical assistance and training.

SFHP rewards providers on both attainment against a specific threshold and relative improvement over a baseline. Providers are rewarded at either the clinic level or medical group level.

LOOKING AHEAD

This study reveals that Medi-Cal managed care plans have largely embraced P4P as a strategy to align incentives with performance, and that they strongly support such programs. The inventory also highlights the high degree of variability across Medi-Cal managed care P4P programs in both design and scope; some programs were quite sophisticated and comprehensive, while others were less developed.

This study also reveals some possibilities for greater collaboration and standardization to help make P4P programs more effective. As the state continues to transform the Medi-Cal payment and delivery system to expand access, improve health outcomes and control costs, several specific opportunities to strengthen the existing P4P infrastructure in Medi-Cal managed care have emerged.

Form a learning collaborative to share best practices

Stakeholders—including Medi-Cal managed care plans, providers serving Medi-Cal members, DHCS and other state leaders—should explore specific ways for Medi-Cal plans to collaborate in sharing experiences and lessons learned from existing P4P programs. Sharing information about strategies and best practices could help foster a community of learning to help drive improvements across programs statewide.

While this survey helps underscore that P4P is a common value-based payment strategy among Medi-Cal

managed care plans, there is currently little collaboration among the programs in place. A majority of plans expressed interest in participating in a forum in which they could share information and best practices with other plans. Some suggested convening experts and other stakeholders to share their expertise regarding existing quality improvement and incentive models.

Some plans were concerned that sharing their successful P4P strategies could jeopardize their enrollment standings in the very competitive Medi-Cal managed care market. Specifically, the auto-assignment program used in Two-Plan and GMC counties creates county-based competition where plans are in direct competition for new membership. Despite this concern, there is common ground among Medi-Cal plans to improve their P4P programs.

Develop a core set of measures for Medi-Cal P4P

Every Medi-Cal plan participating in this survey used a distinct measure set for its P4P program, and there is currently little overlap of measures across plans. Greater standardization is needed and could enhance provider effectiveness, decrease the burden associated with multiple programs and ensure validity and comparability of performance results statewide. DHCS, working collaboratively with plans, providers and other stakeholders, should develop a core measure set for all plans to adopt as a part of their P4P incentive programs.

The proliferation of measure sets and lack of alignment across incentive programs create unnecessary burdens on providers and confusion among consumers. For example, one large FQHC serving the Los Angeles area reported that its providers contracted with three separate Medi-Cal plans, and that each plan operated its own independent P4P program with its own distinct measure set, creating numerous challenges. To simplify dealing with the array of measures across programs, FQHC staff created a single set of tracking metrics for physicians, choosing a subset from a broader set of measures used by any of the incentive programs.

Providing all participating Medi-Cal physicians with one set of measures using the same specifications would create greater efficiency by eliminating redundant work—and decrease the administrative workload of providers that contract with multiple Medi-Cal plans, especially in Two-Plan or GMC counties. Reducing the frustrations and difficulties associated with multiple measure sets could also free providers to participate more fully in P4P programs, help focus their improvement efforts and also help target their resources more effectively.

Several plans in the survey expressed interest in greater standardization of measures and the development of common benchmarks and targets. They noted that consistency and transparency would benefit Medi-Cal providers in counties with more than one plan. A few plans supported the collaborative model IHA developed in the commercial market as a standard to emulate in the Medi-Cal space.

Other plans were concerned that adopting a standardized measure set would prevent them from tailoring their P4P approaches to best meet their local needs. Because Medi-Cal managed care plans operate on a county-by-county basis, their providers generally contract with only one plan in COHS counties and only a few plans in other counties. As a result, some providers and plans are only minimally affected by the lack of standardization.

Although the benefits of a core measure set are less significant for some plans and providers in Medi-Cal managed care settings, all would benefit from the statewide benchmarking standardized measures can generate.

The optimal measure set would include both mandatory core measures and optional measures for plans interested in supplementing the core measure set at the local level to tailor programs based on provider capacity and member needs. It could use quality metrics already in place in the state, such as those in DHCS' EAS. A core measure set using state authorized and nationally recognized metrics could not only increase standardization across Medi-Cal managed care, but could also create opportunities for measures that are consistent across many product lines—including Covered California, Medicare and commercial offerings.

Offer providers technical assistance

P4P can be an effective quality improvement tool to engage providers to improve their care delivery—but only if they have the capacity to meet performance targets. Providers often need to build and expand their capabilities in performance measurement and quality improvement to take advantage of the incentive payments their plans offer.

DHCS should work with plans and other interested stakeholders to explore innovative ways to support providers through increased technical assistance, quality improvement trainings and infrastructure development. For example, many plans in this survey reported they would

like assistance in developing physician training opportunities and outreach support activities for their providers—particularly those designed to improve their performance on clinical measures.

Specific assistance opportunities that plans requested focused on:

- Using data to drive quality improvements
- Sharing data to motivate changes in providers' behaviors
- Delivering technical assistance to their providers and their staffs to help them use data effectively, and
- Engaging providers to participate in improvement activities.

With rapid growth in California's Medi-Cal population and the increasing role of managed care, an imperative is emerging for consistent and comparative performance measurement across P4P programs. It is critical that stakeholders reach consensus on a unified direction, but also allow plans the flexibility to tailor programs to geographic location and provider sophistication.

Notes

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APPENDIX A

Background and Methodology

ABOUT THE SURVEY

In the fall of 2014 the Integrated Healthcare Association (IHA) conducted a survey of Medi-Cal managed care health plans to assess their current pay for performance (P4P) activities and to discern what additional support they might need to be more effective. The results are summarized in this Issue Brief.

METHODOLOGY

Between October and November of 2014, IHA conducted telephone interviews with representatives from the plans, using a standardized list of survey questions emailed to participants in advance. The interviews, ranging from 30 to 60 minutes in length, were conducted with plan representatives—including incentive program managers, network management officers, chief medical officers and quality directors.

IHA focused on several key content areas:

- Performance Measurement
- Incentive Design
- Provider Participation & Engagement
- Data Collection, and
- Program Impact.

PLANS INCLUDED IN THE STUDY

Of the 20 Medi-Cal plans surveyed, 16 had a P4P program—a program offering financial incentives or bonuses tied to provider performance. Of those 16 plans, 15 developed their own programs; one subcontracted with another Medi-Cal plan to administer its program. Two of the four remaining plans were considering implementing a program. One plan that previously had a P4P program in place was discontinuing it.

PLAN	Type	Managed Care Model	Counties	Total Enrollment*	P4P Program	Program Started
Alameda Alliance for Health	Local Initiative	Two-Plan	1	237,517	No, in development	N/A
Anthem Blue Cross	Commercial	Two-Plan, Regional, GMC	28	703,595	Yes	2014
California Health & Wellness	Commercial	Regional, Imperial	19	177,352	Yes	2013
CalOptima	COHS	COHS	1	746,767	Yes	1998
CalViva Health	Local Initiative	Two-Plan	3	310,934	Yes, subcontracts to Health Net to administer program	2011
CenCal	COHS	COHS	2	163,264	Yes	1997
Central California Alliance	COHS	COHS	3	331,148	Yes	2010
Community Health Group	Commercial	GMC	1	243,563	Phasing Out	Unknown
Contra Costa Health Plan	Local Initiative	Two-Plan	1	158,844	Yes	2002
Gold Coast Health Plan	COHS	COHS	1	190,750	No, under consideration	N/A
Health Net	Commercial	Two-Plan, GMC	7	1,384,879	Yes	2009
Health Plan of San Joaquin	Local Initiative	Two-Plan	2	306,141	Yes	2005
Health Plan of San Mateo	COHS	COHS	1	106,080	Yes	2008

PLAN	Type	Managed Care Model	Counties	Total Enrollment*	P4P Program	Program Started
Inland Empire Health Plan	Local Initiative	Two-Plan	2	1,066,493	Yes	1998
Kaiser Foundation	Commercial	GMC, Regional	5	119,679	No, plan does not have a program	N/A
Kern Family Health Care	Local Initiative	Two-Plan	1	205,209	Yes	2012
L.A. Care	Local Initiative	Two-Plan	1	1,714,038	Yes	2010
Molina Healthcare	Commercial	Two-Plan, GMC	5	421,346	Yes	Unknown
Partnership Health Plan	COHS	COHS	14	542,890	Yes	2000
San Francisco Health Plan	Local Initiative	Two-Plan	1	121,586	Yes	2009

*Two plans did not participate in the inventory: Care1st and Santa Clara Family Health Plan

**Enrollment based on the DHCS Medi-Cal Managed Care Enrollment Report for May 2015

APPENDIX B

A Comparison of Medi-Cal Managed Care P4P Measure Sets

All plans that participated in the inventory were asked to share their P4P measure sets. The matrix below provides a comparison of all measures included in Medi-Cal P4P programs and the measures includes in DHCS's External Accountability Set and Auto-Assignment program. It is arranged in alphabetical order by the name of the managed care plan and includes all measures included in the plans' primary care P4P programs. The measures are broken down by domain—including access, clinical quality, encounter submission, patient experience, utilization and all other measures.

Measure	DHCS EAS	DHCS Auto Assignment Measure Set	Anthem	California Health & Wellness	CalOptima	CenCal	Central California Alliance for Health	Health Net	Health Plan of San Joaquin	Health Plan of San Mateo	Inland Empire Health Plan	Kern Health Systems	L.A. Care Health Plan	Partnership Health Plan	San Francisco Health Plan	Measure Overlap Across P4P Programs
ACCESS																
Children and Adolescents' Access to PCPs	X						X					X				2
Cycle time															X	1
Extended hours						X				X				X	X	4
Improvement in access as measured by CG-CAHPS															X	1
Member reassignments							X									1
Patient auto assignment										X						1
PCP office visits per member per year														X		1
Practice open to new members						X								X		2
Third next available appointment														X	X	2
CLINICAL																
Depression screen										X						1
Annual monitoring for patients on persistent medications: ACE or ARB, Digoxin, Diuretics, Anticonvulsants	X								X				X	X	X	4
Controlling high blood pressure	X			X										X	X	3
Comprehensive chronic pain management															X	1
Diabetes blood pressure control	X			X										X		2
Diabetes eye exam	X		X	X	X	X	X		X	X		X	X	X	X	11
Diabetes HbA1c control	X			X		X			X	X	X		X	X	X	8
Diabetes HbA1c testing	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	13
Diabetes LDL control						X			X	X						3
Diabetes LDL testing						X	X		X	X		X		X		6
Diabetes nephropathy	X			X		X	X		X	X	X	X	X	X		9
Postpartum care	X		X				X			X	X	X	X			6
Same day pregnancy testing and referrals															X	1
Timeliness of prenatal care	X	X	X	X						X	X	X	X			6
Overuse of imaging studies for low back pain	X								X			X				2
Adolescent comprehensive well-care visits 12-21 years					X	X				X	X		X			5
Adolescent immunizations	X										X	X	X	X	X	5
Adult preventive medicine evaluation						X										1
BMI percentile-adult										X						1
BMI percentile-pediatric	X						X		X	X				X		4
Breast cancer screening					X						X		X			3
Cervical cancer screening	X	X		X	X		X	X	X		X	X	X	X	X	10
Childhood immunizations	X	X	X	X	X						X	X	X	X	X	8
Chlamydia screening													X			1
Colorectal cancer screen															X	1

Measure	DHCS EAS	DHCS Auto Assignment Measure Set	Anthem	California Health & Wellness	CalOptima	CenCal	Central California Alliance for Health	Health Net	Health Plan of San Joaquin	Health Plan of San Mateo	Inland Empire Health Plan	Kern Health Systems	L.A. Care Health Plan	Partnership Health Plan	San Francisco Health Plan	Measure Overlap Across P4P Programs
CLINICAL																
Counseling for nutrition 3-17 years	X								X		X	X		X		4
Counseling for physical activity 3-17 years	X								X		X	X		X		4
Healthy weight for life form							X									1
Smoking status & intervention															X	1
Well child visit with PCP 3-6 years	X	X	X	X	X	X	X		X	X	X	X	X	X	X	12
Well infant care 0-15 months						X					X					2
Women's Health Exam (Pap, pelvic, breast)										X	X					2
Appropriate testing for children with pharyngitis					X		X						X			3
Appropriate treatment for children with URI					X											1
Asthma health assessment/action plan						X										1
Avoidance of antibiotic treatment for adults with acute bronchitis	X						X					X	X			3
Use of appropriate medications for people with asthma	X					X					X	X	X			4
PATIENT EXPERIENCE																
Appointment with specialist					X											1
Implement survey (such as CAHPS)													X	X		2
Implement training														X		1
Meet PCMH criteria														X		1
Rating of all healthcare					X											1
Rating of PCP					X											1
Staff satisfaction improvement strategies															X	1
Team based care															X	1
Timely patient visits					X											1
Overall rating of health network					X											1
Overall satisfaction with UM process					X											1
RESOURCE USE																
All-cause readmissions following acute inpatient stays	X					X	X		X				X	X		5
Ambulatory care sensitive admissions							X									1
Avoidable emergency department visits							X		X				X	X	X	5
Emergency department visits per 1,000 member years	X					X										1
Generic prescription and formulary compliance rates						X			X					X		3
Inpatient bed days per 1,000 member years						X	X						X	X		4
Physician and outpatient expenses not covered by capitation						X										1
Potentially preventable admissions						X			X							2
ENCOUNTER AREA																
Timeliness, completeness, acceptance rate of data submitted															X	1
Data accuracy between encounter and medical record data															X	1
Encounter data submission			X			X		X			X		X			5

Measure	DHCS EAS	DHCS Auto Assignment Measure Set	Anthem	California Health & Wellness	CalOptima	CenCal	Central California Alliance for Health	Health Net	Health Plan of San Joaquin	Health Plan of San Mateo	Inland Empire Health Plan	Kern Health Systems	L.A. Care Health Plan	Partnership Health Plan	San Francisco Health Plan	Measure Overlap Across P4P Programs
OTHER																
Call abandonment														X		1
Provider continuity														X		1
Show rate/no show rate														X	X	2
Initial health assessment										X	X	X				3
Meaningful use of health IT					X								X			2
Medicare DualChoice Annual Visit											X					1
Outreach to patients recently discharged from hospital										X				X	X	3
PCMH recognition														X		1
Peer led self management support groups														X		1
POLST/advanced care planning form														X		1
Utilization of CAIR										X				X		2
TOTAL NUMBER OF MEASURES	22	5	7	10	16	21	17	3	17	19	19	17	23	34	24	

APPENDIX C

A Closer Look at the County–Based Models

Medi-Cal managed care operates on a county-by-county basis in all of California's 58 counties, with each falling under one of six contracting models. The model largely dictates the number of managed care health plans directly contracted with Medi-Cal in that county. The six models are summarized in the table below.

Name	Overview	Number of Counties	Number of Plans	Percent of Medi-Cal Enrollment*
County Organized Health Systems (COHS)	▪ DHCS contracts with one health plan created by the County Board of Supervisors ▪ COHS plans serve all managed Medi-Cal members in their counties	22	6	2,080,899 (≈22%)
Two-Plan	▪ DHCS contracts with a "Local Initiative" plan (county owned) and a "commercial" plan	14	11	6,108,785 (≈64%)
Geographic Managed Care (GMC)	▪ DHCS contracts with several commercial plans	2	6	1,007,350 (≈11%)
Regional	▪ DHCS contracts with two commercial plans	18	3	278,749 (≈3%)
Imperial	▪ DHCS contracts with two commercial plans	2	2	68,847
San Benito	▪ DHCS contracts with one commercial plan	1	1	7,231

*Enrollment based on the DHCS Medi-Cal Managed Care Enrollment Report for May 2015