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Aligning Performance Measures Across Medi-Cal Initiatives

Sarah Lally, M.S., Project Manager

Both the largest Medicaid program in the nation and the leading source of health insurance in California, Medi-Cal covers nearly one in three Californians, or about 13.5 million low-income children, adults, and people with disabilities.[1] In tandem with Medi-Cal coverage expansions under the 2010 Affordable Care Act (ACA), California has expanded use of managed care plans to cover more enrollees, including people with serious mental illnesses and those dually eligible for Medicaid and Medicare. As of October 2016, more than 10.5 million people [2] were enrolled in Medi-Cal managed care plans across California's 58 counties.[3]

Through a federal Medicaid Section 1115 waiver, California is launching multiple innovative delivery system and payment reform pilots over the next five years to support efforts to deliver high-quality, cost-effective care. Several initiatives move beyond the scope of traditional health care delivery systems to provide housing and other assistance to counter social determinants, such as homelessness, that can affect physical and mental health outcomes. At this point, it is unclear how efforts to repeal or modify the ACA will affect Medi-Cal coverage expansions and pilot initiatives.

Across Medi-Cal initiatives, a key component is measuring health plan and provider performance to assess the effectiveness of the various interventions. Given the range of Medi-Cal efforts to advance high-quality, affordable, patient-centered care, a new Integrated Healthcare Association (IHA) analysis indicates that a standardized performance measurement system across initiatives could help ease reporting burdens for health plans and providers and generate more meaningful comparative performance information for policymakers and other stakeholders.

Medi-Cal Initiative Landscape

Under the ACA, states can expand Medicaid coverage to all eligible people with incomes below 138 percent of the federal poverty level, or $33,534 a year for a family of four in 2016. Following the law's passage, California quickly moved to expand health coverage to low-income people through the 2010 Bridge to Reform Medicaid Section 1115 waiver, which allowed the state to make major changes to Medi-Cal, including greater use of managed care[4] for vulnerable populations, and to expand county-based coverage programs for low-income, uninsured residents. In December 2015, the state's Section 1115 waiver renewal, also known as Medi-Cal 2020, was approved.

Through the waiver, the California Department of Health Care Services (DHCS) has launched multiple Medi-Cal initiatives designed to improve the quality of care and control costs. A key component across Medi-Cal initiatives is measuring health plan and provider performance to assess the effectiveness of the various interventions. To better understand the evolving landscape of Medi-Cal care delivery reforms and identify opportunities for greater measure alignment, IHA, with input from key stakeholders, identified eight existing and developing initiatives impacting the health care safety net (see Exhibit 1 for a summary of key components of the initiatives):

- Federally Qualified Health Centers (FQHCs) Alternative Payment Methodology Pilot;
- Global Payment Program;

- Public Hospital Redesign and Incentives in Medi-Cal (PRIME);
- Whole Person Care Program;
- Health Homes for Patients with Complex Needs;
- Drug Medi-Cal Organized Delivery System waiver;
- California Children's Services Whole Child Model; and
- Coordinated Care Initiative.

The eight initiatives focus on two main areas of intervention: 1) high-need Medi-Cal populations, including children with certain diseases or health problems, dual-eligibles, individuals with substance use disorders and other high utilizers, along with people ineligible for Medi-Cal who remain uninsured; and 2) specific sites, including FQHCs, designated public hospitals, and district public hospitals.

Exhibit 1: Overview of Key Medi-Cal Initiatives

Initiative	Summary	Timeline	Funding	Implementing Entities	Target Population
Federally Qualified Health Centers (FQHCs) Alternative Payment Pilot Project	Converts FQHC current prospective payment system (PPS) reimbursement rate into a PPS-equivalent per member, per month capitation payment	Expected to begin October 2017	No additional funding outside regular Medi-Cal	DHCS, health plans, and participating FQHCs	Medi-Cal enrollees whose assigned primary care provider is a participating FQHC
Global Payment Program	Payment reform pilot for the remaining uninsured focused on primary and preventive care; allows for new services that were previously unreimbursable	5-year pilot project	No new funding stream; funding is a combination of a portion of the state's existing disproportionate share hospital allotment and renewed uncompensated care funding under the waiver; estimated $1.1 billion in federal funding	County-owned or affiliated designated public hospitals (DPHs)	People receiving uninsured services—no Medi-Cal-covered services
Public Hospital Redesign and Incentives in Medi-Cal (PRIME)	Demonstration builds on Delivery System Reform Incentive Program and continues P4P for DPHs and District/Municipal Public Hospitals (DMPHs); incentive payments based on achievement of national or state benchmark targets across various metrics; also requires DPHs to move toward alternative payment methods (APMs)	Jan. 1, 2016-June 30, 2020	$3.7 billion in federal funding for incentive components; APM component will include a shift in funding	Designated DPHs/ DMPHs	DPHs' assigned Medi-Cal enrollees or any individual with 2 or more primary care encounters; DMPHs with any 2 encounters with Medi-Cal enrollees
Whole Person Care Program	Designed to provide integrated, patient-centered care to complex Medi-Cal patients by supporting county and other efforts to coordinate delivery of physical health, behavioral health, housing, and social services	Jan. 1, 2016-Dec. 31, 2020	$300 million annually in federal funding for 5 years. ($1.5 billion total)	Pilots will vary; collaboration among public and private entities (county mental health agencies, managed care plans, providers, housing, criminal justice, etc.); 18 counties were approved for the first implementation round	High-risk, high-intensity Medi-Cal enrollees using multiple health care systems (not just focused on patients with chronic conditions)
Health Homes for Patients with Complex Needs	An optional health home Medicaid benefit for intensive care coordination for people with chronic conditions	Phased; first round to begin no earlier than July 2017	Enhanced federal Medicaid match (90% vs. 50%) available for first 2 years	Only in select counties; managed care plans certify and contract with community-based care management entities	High-complexity (top 3-5% risk) Medi-Cal patients; first focus on those with eligible chronic physical conditions and substance use disorders (SUDs); second focus on serious mental illness (SMI) population
Drug Medi-Cal Organized Delivery System (Drug Medi-Cal Waiver)	Test new health care delivery system for Medicaid-eligible individuals with a SUD	5 year pilot; planning for Phase I started May-August 2015	Cost of waiver services shared among federal government, state government, and counties	Counties can opt-in; DHCS has approved implementation plans for 10 counties, 5 others have submitted draft plans for approval	Medi-Cal enrollees living in participating counties who meet medical necessity criteria

Exhibit 1 continued on next page

Initiative	Summary	Timeline	Funding	Implementing Entities	Target Population
California Children's Services (CCS) Whole Child Model	Redesign of CCS program using a "whole child model" to transition CCS from a Medi-Cal carve-out to an integrated program that covers the full range of a child's health needs in a single managed care plan	Begin no earlier than July 2017; subject to successful DHCS readiness review	No additional funding outside regular Medi-Cal	Proposed implementation in following health plans/counties: CalOptima (Orange); Central California Alliance for Health (Merced, Monterey, Santa Cruz); CenCal (San Luis Obispo, Santa Barbara); Health Plan of San Mateo (San Mateo); and Partnership (Del Norte, Humboldt, Lake, Lassen, Mendocino, Marin, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo)	Medi-Cal enrollee with CCS-eligible conditions in participating counties
Coordinated Care Initiative	Intended to integrate and coordinate delivery of Medicare and Medi-Cal health benefits into a single system of care	2014-2017; potential extension through 2019	Federal funding through "Bridge to Reform" 1115 Medicaid waiver;	Participating plans and contracted providers	Dual-eligibles (eligible for both Medi-Cal and Medicare)

Source: Author's analysis.

Additionally, both individually and collectively, the eight initiatives focus on two key issues: 1) increased care coordination and integration of health and community-based services; and 2) payment reforms aimed at improving both the quality and efficiency of care delivery. Many of the initiatives focus on practice transformation through greater care coordination and integration for Medi-Cal enrollees with complex health and social needs spanning multiple care delivery systems and community social services. Many also focus on payment reforms designed to align incentives for providers to deliver high-quality, affordable, patient-centered care. The hope is that greater flexibility to target funding on needed services will allow Medi-Cal to advance new models of care that reward health plans and providers for delivering high-value care instead of high-volume care.

Finally, every initiative, except the Coordinated Care Initiative, is either in its first year of implementation or is still in development. With so many initiatives launching simultaneously, there is a significant opportunity for alignment and learning across initiatives.

Performance Measurement

Performance measurement is a key way to evaluate whether specific interventions are achieving their goals. However, reliable and actionable information can be difficult to obtain when measurement requirements are not aligned.

Only three initiatives—the Coordinated Care Initiative, the Whole Person Care Program, and the PRIME project—have finalized measure sets. Draft measure sets are publicly available for two of the other initiatives, while the remaining three initiatives have not published draft measure sets. The four measurement domains most prevalent among the final and draft measure sets are: clinical quality, utilization, patient experience, and operational. There is some overlap in measurement areas such as behavioral health, but no one measure is used in all programs (see Exhibit 2 for a summary of each initiative's measure set development status).

A Closer Look at Complex Populations

To better understand the challenges and opportunities for greater measure set alignment across emerging Medi-Cal initiatives focused on high-need enrollees, IHA took a closer look at two similar but distinct initiatives: Health Homes for Patients with Complex Needs and the Whole Person Care Program. Although both initiatives target similar high-risk populations, there appears to be little coordination and measure set alignment between the two initiatives.

The Health Homes for Patients with Complex Needs initiative (HHP), authorized under Section 2703 of the ACA and California Assembly Bill 361, allows California to create a new optional Medicaid health home benefit to provide increased, intensive care coordination for the highest risk Medi-Cal members with chronic conditions. The HHP is focused on the 3 percent to 5 percent of the Medi-Cal population that is the highest risk—roughly 400,000 to 700,000 of the total Medi-Cal population. The HHP will enable health plans to focus on integrating services for physical health, mental health, substance use disorders, community-based long-term services and supports, palliative care, social supports, and, as appropriate, housing[5] (see page 5 for an example of a similar pilot already underway.)

Exhibit 2: Medi-Cal Initiatives and Performance Measure Set Development Status

Initiative	Brief Overview
FQHC Alternative Payment Methodology Pilot	The California Primary Care Association, the California Association of Public Hospitals and Health Systems (CAPH), and health centers recently proposed measures that could be tracked and quantified as part of the pilot. The draft measure set has been submitted to DHCS for approval. More information: California Primary Care Association, August 2016 Payment Reform Quarterly Update (slide 43).
Global Payment Program (GPP)	Measure set is to be determined as part of the GPP evaluation (currently under review by the Centers for Medicare & Medicaid Services (CMS)).
Public Hospital Redesign and Incentives in Medi-Cal (PRIME)	DHCS, CAPH, the California Health Care Safety Net Institute, and Medi-Cal clinical and quality experts identified metrics for all PRIME projects. Each project has a required set of core measures for all participating entities. More information: California Section 115 Waiver, Attachment Q - PRIME Projects and Metrics Protocol (pgs. 12-17).
Whole Person Care Program	All pilot sites are required to report on a standardized set of performance metrics (universal measures). Each pilot also has the opportunity to choose additional metrics designed to meet the needs of its target population (variant measures). More information: Whole Person Care Pilot Requirement and Metrics.
Health Homes for Patients with Complex Needs	CMS has established a recommended core set of 8 quality measures based on priority areas of behavioral health and preventive care and aligned with existing core measure sets for adults and children. DHCS has also proposed additional measures for the pilot, but these measures have not yet been finalized. More information: Health Homes for Patients with Complex Needs California Concept Paper (pgs. 30-31).
Drug Medi-Cal Organized Delivery System (Drug Medi-Cal Waiver)	No measure set is publicly available to review.
California Children's Services (CCS) Whole Child Model Redesign	No measure set is publicly available to review.
Coordinated Care Initiative	CMS developed a set of core measures that all states participating in Cal MediConnect will report. It includes measures focused on medical services, pharmacy, long-term services and supports, and behavioral health, as well as care coordination and consumer satisfaction. In consultation with CMS, DHCS also developed state-specific metrics focused on clinical quality and utilization. More information: Coordinated Care Initiative Health Plan Quality and Compliance Report.

Source: Author's analysis.

The Whole Person Care (WPC) initiative is designed to provide high-quality, integrated, patient-centered care to complex Medi-Cal enrollees—high-risk, high-intensity users of multiple health care systems—by supporting counties and other entities in coordinating delivery of physical health services, behavioral health services, and housing and social services that meet the full spectrum of enrollees' needs. Each WPC pilot can tailor resources to create a program targeted at specific populations, such as frequent utilizers of emergency departments, people with serious mental illnesses, the homeless, or people transitioning to the community after being incarcerated. The

Creating a Footprint for Health Homes in the Inland Empire

Inland Empire Health Plan and 32 clinical sites are working to create integrated, population-based health homes and care management systems for complex patients through a two-year pilot known as the Behavioral Health Integration Complex Care Initiative (BHICCI). The BHICCI's main strategy is integrating behavioral health with physical health care delivery to develop health homes and lay the groundwork for Medi-Cal's Health Homes for People with Complex Needs demonstration. The BHICCI target population is people with two or more chronic conditions—one chronic medical condition and one mental health disorder and/or substance abuse disorder—who could benefit from greater care coordination and management. Through the pilot, provider teams and community-based partners, such as county hospitals, county departments of behavioral health, FQHCs, and private substance abuse and mental health treatment organizations, are collaborating to test and implement fundamental practice changes. This includes introducing integrated complex care teams that utilize a registry for management of physical health conditions, such as diabetes and hypertension, as well as depression, anxiety, and substance use, to target treatment based on clinical practice guidelines. The initiative aims to improve individual patient health outcomes; use data to improve population health management; improve care coordination and integration of primary, specialty, addiction, and mental health services; improve both patient and health care team experiences; and reduce overall health care costs in the Inland Empire safety net.

goal is to provide centralized access to services and prevent enrollees from having to navigate multiple programs and systems on their own.[6] The pilots will enable counties and their partners to share data and coordinate care in real time and evaluate progress in improving both individual enrollees' health and overall population health.[7] Eighteen counties will participate in the first round of implementation. Overall pilot sizes range from between 250-800 Medi-Cal enrollees in smaller counties to more than 100,000 people in Los Angeles County[8] (see page 6 for an example of a similar pilot already underway.)

The initiatives have many similarities, including:

- **Targeting Vulnerable Populations.** Both initiatives focus on high-need or high-utilizing Medi-Cal enrollees, including those with serious and persistent mental illness.
- **Enhancing Care Coordination Across Delivery Systems.** Both initiatives focus on improving enrollees' health by coordinating delivery of services across all sectors—physical health services, mental health services, substance use disorder services, and social support services.
- **Supporting Integration of Physical and Behavioral Health Services.** Both initiatives focus on implementing strategies to integrate behavioral health care with medical care to improve health outcomes (see page 9 for an example of an innovative approach taken in San Mateo County with relevance to both initiatives).
- **Increasing Financial Flexibility to Address Nonclinical Needs.** Both initiatives focus on a whole-person approach to care that does not just address a medical condition but also addresses the socioeconomic factors that can contribute to or aggravate medical conditions.

Overall, while the initiatives have similar goals and strategies, they are distinct programs with strategic differences. Specifically, while HHP pays for care coordination services directly, WPC pays for non-Medi-Cal covered services, including housing supports. Therefore, while enrollees may be eligible for both programs depending on which county they live in, each initiative is designed to address specified—different yet complementary—issues affecting the health of enrollees.

Health Home and Whole Person Care Performance Measures

The measure set for the Whole Person Care initiative is final, and while the measure set for the Health Home initiative is not yet final, a draft performance measure set is available. Both measure sets include clinical quality, utilization, and operational measures. A short overview of each measure set follows:

Whole Person Care: All pilot sites are required to report on a standardized set of performance measures (universal measures). Each pilot also can choose additional measures designed to meet the needs of its target population (variant measures). Pilots will utilize the quality improvement approach known as Plan Do Study Act, or PDSA, to continually monitor and improve performance on their universal and variant measures throughout the pilot period.[9]

Health Homes Initiative: The Centers for Medicare & Medicaid Services (CMS) has established a recommended core set of eight health care quality

measures focused on the priority areas of behavioral health and preventive care and aligned with existing core measure sets for adults and children. CMS also identified three utilization measures to assist with HHP evaluation, which will become a reporting requirement. DHCS also proposes adding measures in addition to the required CMS core measures. These measures are not yet finalized.[10]

Both measure sets include several clinical quality measures. The initiatives focus on a wide array of measurement areas, including behavioral health, cardiovascular, and prevention. Overall, there is very little alignment across the clinical quality measures with two exceptions. Two of the four behavioral health measures and the Blood Pressure Control measure were used in both initiatives (see Exhibit 3 for a crosswalk of clinical quality measures in the two programs).

The Home Health and Whole Person measure sets also have utilization measures, including hospital, nursing facility, and potentially avoidable event measures. Both of the utilization measures included in the Whole Person Care initiative—emergency department visits and inpatient utilization—are included in the Health Homes initiative (see Exhibit 4 for a crosswalk of utilization measures between the initiatives).

Both measures sets include several operational measures related to the delivery of services. Currently there is no alignment across the measure sets (see Exhibit 5 for a crosswalk of operational measures). In all, 31 measures are included across both initiatives. There is some overlap in measurement areas; however, only four measures are used in both programs. Overall, the lack of alignment is noteworthy since both initiatives focus on similar populations.

Alameda County's Approach: Focusing on the Whole Person & Including Nonclinical Services

The Alameda County Care Connect (AC3) pilot, developed by the Alameda County Health Care Services Agency, aims to improve health outcomes for the homeless, for high utilizers of multiple crisis systems, and for people with complex conditions needing extra care coordination across systems. Key aims of the pilot include: strengthening care coordination by linking service providers—primary care, specialty care, mental health, housing, substance abuse, probation, and others—to collaboratively help patients access needed services across systems; using technology to create a "community health record" that all service providers on the patient's team can access; and training providers and others to promote process improvements.

A key component of the AC3 pilot is housing. Alameda County is one of 14 counties that are focusing on individuals who are homeless or at risk for homelessness as a key target population. To address this issue, the program will provide funds to help people find housing and supportive services to help them stay in the housing. It will also work with landlords and community living facilities to increase quality, affordable housing options for those in need of it, including those that could move from costly skilled nursing facilities to more appropriate and less expensive housing arrangements.

IHA also looked at one of the projects included in the PRIME program that focused on similar high-risk or high-cost populations. Specifically, IHA reviewed the measures included in project 2.3 focused on Complex Care Management for High Risk Medical Populations; this project does not focus on the substance use disorder or serious mental health populations. The measures included in this project are as follows:

- Care Coordinator Assignment (Measure Steward: University of Washington/Coordinated Care Initiative).
- Medication Reconciliation—30 days (Measure Steward: National Committee for Quality Assurance).
- Prevention Quality Overall Composite #90 (Measure Steward: Agency for Healthcare Research and Quality).
- Timely Transmission of Transition Record (Measure Steward: American Medical Association-PCPI).

Again, while focused on similar high-risk medical populations, none of the measures included in the PRIME project overlap with the measures included in the Health Home or Whole Person Care initiatives. While some differences in the target populations exist, there are still opportunities for greater standardization.

Looking Ahead

At the forefront of increasing coverage through the ACA's Medicaid expansion provisions, California is now focused on transforming care delivery and payment methods in Medi-Cal to improve quality and access to care while slowing cost growth through more efficient care delivery. Many new initiatives and pilot projects are under development or already underway. Since many of the initiatives are complementary, there are significant opportunities for greater standardization in performance

Exhibit 3: Little Alignment Across Clinical Quality Measures for Health Homes and Whole Person Care Initiatives

Measure Area	Measure	Health Homes	Whole Person Care	Measure Overlap
Behavioral Health/ Substance Abuse	Adult Major Depression Disorder: Suicide Risk Assessment		V	No
Behavioral Health/ Substance Abuse	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	C	U	Yes
Behavioral Health/ Substance Abuse	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	C	U	Yes
Behavioral Health/ Substance Abuse	Screening For Clinical Depression and Follow-up	C		No
Behavioral Health/ Substance Abuse	Depression Remission at 12 Months		V	No
Cardiovascular	Controlling Blood Pressure for People with Hypertension	C	V	No
Prevention	Adult Body-Mass Index (BMI) Assessment	C		No

Key: For Health Homes: C=CMS Core Measure. For Whole Person Care: U=Universal Measure; V=Variant Measure.
Source: Author's analysis.

Exhibit 4: Little Alignment Across Utilization Measures for Health Homes and Whole Person Care Initiatives

Measure Area	Health Homes	Whole Person Care	Measure Overlap
All-Cause Readmissions	C		No
Avoidable Hospital Readmissions Following Inpatient Stay	D		No
Emergency Department Visits	C	U	Yes
Inpatient Utilization	C	U	Yes
Nursing Facility Utilization	C		No
Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite	C		No

Key: For Health Homes: C=CMS Core Measure. For Whole Person Care: U=Universal Measure.
Source: Author's analysis.

measurement across initiatives. As the state continues to transform the Medi-Cal program, several distinct but related opportunities to create greater alignment have emerged, and the following recommendations could help reduce reporting burdens on health plans and providers and generate more meaningful comparative performance information for policymakers and other stakeholders.

Adopt a Core Measure Set Across Medi-Cal Initiatives

While serving similar high-risk populations, the Whole Person and Health Homes initiatives rely on distinct measure sets with little overlap of measures. Greater measure set alignment is needed to enhance provider effectiveness, decrease the burden associated with the many program requirements, and minimize data collection efforts across programs. DHCS, working collaboratively with stakeholders, should

Exhibit 5: Little Alignment Across Operational Measures for Health Homes and Whole Person Care Initiatives

Measure Area	Health Homes	Whole Person Care	Measure Overlap
Aggregate Care Manager to Member Ratio	D		No
Annual Reassessment Completed	D		No
Community-Based Care Management Entity Network Information	D		No
Care Coordination, Case Management, and Referral Infrastructure		U	No
Data and Information Sharing Infrastructure		U	No
Documented Discussions of Care Goals	D		No
Health Action Plan (HAP) Completed Within 90 Days	D		No
Member Consent Date	D		No
Number of Health Home Program Members (HHP)	D		No
Number of Members Experiencing Homelessness and Their Current Housing Status by the End of the Reporting Period (Stable, Wait List, Temporary Shelter)	D		No
Number of Members No Longer Participating (HHP)	D		No
Number of New HHP Members Who Previously Participated in HHP and Had a Break in Membership	D		No
Number of the HHP Service Units Provided in the Reporting Period	D		No
Process in Place with Hospitals for Referral of Potential HHP-eligible Members	D		No
Proportion of Participating enrollees with a Comprehensive Care Plan, Accessible by the Entire Team, Within 30 Days of Enrollment into the Whole Person Care pilot		U	No
Proportion of Participating Enrollees with a Comprehensive Care Plan, Accessible by the Entire Team, Within 30 Days of the Enrollee's Anniversary of Participation in the Pilot (to be conducted annually)		U	No
Status of Engagement (contacted, engaged, chose not to participate, not appropriate for HHP), HAP Completed, Method of Contact (by mail, by phone, in person)	D		No

Key: For Health Homes: D=DHCS Draft Measure. For Whole Person Care: U=Universal Measure.
Source: Author's analysis.

consider developing a core measure set for all Medi-Cal initiatives as a starting point.

The optimal core measure set would include three key measurement domains: clinical quality, patient experience, and utilization. A common performance measurement system using the same specifications across all three measurement domains would increase efficiency by eliminating redundant work and decrease the administrative burden on providers that are participating in multiple programs. An overview of alignment opportunities across each measurement domain follows:

- **Clinical Quality.** For the core set of clinical quality measures, DHCS could consider starting with the Medi-Cal Pay-for-Performance (P4P) Core Measure Set developed by IHA with input from Medi-Cal health plans and providers in hopes of gaining broad adoption across all P4P

programs. The Medi-Cal P4P core measure set was developed through a voluntary, collaborative process and includes 10 clinical quality measures that address Medi-Cal priority areas, including chronic diseases, such as diabetes care; maternity care; and prevention (see the appendix for additional information about the core measure set). Since the emerging initiatives may deal with distinct populations, clinical quality measures may vary, but the core measure set is a good starting place to create more standardization.

- **Patient Experience.** Capturing patients' perspectives on the care they receive is critical to assessing the degree of patient-centered care, which is an important aspect of engaging and empowering patients to be involved in their care. Therefore, a core measure set should include patient experience measures. While several challenges exist in measuring patient experience, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which is currently used across multiple programs, is a logical starting place until other measurement tools are developed. Furthermore, since CAHPS is used in several existing programs, there are opportunities for comparing patient experience across various initiatives.
- **Utilization.** Finally, it is important that any core measure set include a standard set of utilization measures. Utilization measures are a reasonable proxy for cost and represent the frontier of value-based measurement. While utilization metrics are tracked and monitored by both health plans and providers, their use in existing Medi-Cal measure sets is not widespread. Further, little effort has been invested in refining and standardizing performance measures based on utilization as compared to quality. Utilization measures, however, offer significant opportunity for alignment across emerging initiatives. Identifying a small subset of aligned utilization measures to monitor performance across all Medi-Cal initiatives could help policymakers better understand what changes in care delivery are most effective in advancing high-quality, affordable, patient-centered care.

Innovative Approach to Treat Patients with Alcohol Use Disorders in San Mateo

In 2012, San Mateo County Behavioral Health and Recovery Services (BHRS) conducted a small pilot to study the effectiveness of medication assisted treatment (MAT) and case management support for people with alcohol use disorders. In the initial pilot phase, there was a substantial reduction of alcohol use among clients and a significant decrease in clients' use of emergency department (ED) services, from an initial average of 5.8 ED visits per client in six months to 0.2 visits. Impressed by the findings, BHRS, working with Health Plan of San Mateo, began implementation of the Integrated Medication Assisted Treatment (IMAT) program across the county. As part of the program, case managers, stationed in EDs and primary care clinics and working in the field with probation services, screen, assess, and refer clients to the IMAT program and other behavioral health programs. Clients receive treatment, including both injectable and oral medications and peer-to-peer counseling, in clinics across the county and, when necessary, are provided with an extended stay in a detoxification facility. The program is also one of the initiatives included in San Mateo's Whole Person Care pilot.

One opportunity for alignment of utilization measures is around the small subset used in IHA's *California Regional Health Care Cost & Quality Atlas*. The Atlas tracks three utilization measures, as well as clinical quality and total cost of care measures, across 19 California geographic regions and various types of coverage, including commercial insurance products—health maintenance organizations and preferred provider organizations —Medicare Advantage, traditional Medicare fee for service (FFS), Medi-Cal managed care, and Medi-Cal FFS. IHA recruited a Technical Advisory Group, made up of health plan leadership and technical staff, to develop the Atlas measure set. Three HEDIS utilization measures were selected: Emergency Department Visits, All-Cause Readmissions, and Inpatient Bed Days. DHCS could use the three utilization measures as a starting point for the core utilization measures.

Form a Core Measure Clearinghouse

In addition to a core measure set, DHCS could work with plans, providers, and performance measurement experts to develop a clearinghouse of additional measures that health plans and providers participating in Medi-Cal initiatives can use to supplement the core set to meet the needs of their specific patient populations. Selecting additional measures from a limited menu of vetted and endorsed measures provides an opportunity to increase standardization outside of the core set. Using a library

of additional measures will also decrease the resource burden on providers and ensure there are opportunities to compare results across initiatives.

A measure clearinghouse also could house the measure sets being used by existing initiatives. Creating a single platform for existing measure sets would be valuable for plans and providers participating in multiple programs to highlight opportunities for alignment and could be a useful resource for future initiatives to develop measure sets.

Convene a Collaborative Performance Measurement Forum

Recently, CMS and America's Health Insurance Plans, or AHIP, realizing the need for greater measure set standardization and alignment, addressed the problem by establishing a collaborative of interested stakeholders called the Core Quality Measures Collaborative. The collaborative includes health plans, purchasers, providers, consumers, and others working together to develop core measure sets that public and private payers broadly agree on and commit to using. A comparable approach, with leadership from DHCS and key stakeholders, could explore opportunities for establishing a collaborative to develop a core measure set to evaluate performance across Medi-Cal initiatives. Creating a collaborative structure to share ideas and lessons learned could create a common purpose among participants to drive improvement across Medi-Cal initiatives.

With the rapid growth in California's Medi-Cal population and the significant number of initiatives emerging focused on improving the care of Medi-Cal enrollees, the imperative is growing for consistent and comparative performance measurement across the initiative landscape. It is important for DHCS and all stakeholders to reach consensus on a standardized approach to performance measurement to reduce measurement burden for providers and create a foundation for payment incentives that could help advance high-quality, affordable, patient-centered care.

Notes

1. Department of Health Care Services (DHCS), *Certified Eligible Statistics-Medi-Cal Population* (May 2016), accessed at: http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_May_2016_ADA.pdf; and DHCS, Medi-Cal Expansion: Covering More Californians, accessed at: http://www.dhcs.ca.gov/Pages/Medi-CalExpansionInformation.aspx.
2. DHCS (May 2016).
3. Tater, M., J. Paradise, and R. Garfield, *Medi-Cal Managed Care: An Overview and Key Issues*, The Henry J. Kaiser Family Foundation (March 2016), accessed at: http://files.kff.org/attachment/issue-brief-medi-cal-managed-care-an-overview-and-key-issues.
4. Unlike most other states, which typically operate statewide Medicaid managed care programs with private health plans, California's Medi-Cal managed care programs operate on a county-by-county basis, following one of six models. Most Medi-Cal managed care enrollees are served under the Two-Plan Model, where a county-organized plan and a private health plan compete. More than 6.8 million people—two-thirds of those enrolled in Medi-Cal managed care—receive care under the Two-Plan Model in 14 counties. The second most common model is the County Organized Health System, which serves nearly 21 percent of Medi-Cal managed care enrollees in 22 counties through six regional health plans governed at the local level. The remaining contracting models are the Geographic Managed Care (GMC), Regional, Imperial, and San Benito. Collectively, these models serve nearly 15 percent of Medi-Cal enrollees in 22 counties.
5. DHCS, *Health Homes for Patients with Complex Needs California Concept Paper-Final* (March 2016), accessed at: http://www.dhcs.ca.gov/services/Documents/HealthHomesForPatients_Final.pdf.
6. California Association of Public Hospitals and Health Systems, *Whole Person Care, Going Beyond Medical Services to Help Vulnerable Californians Lead Healthy Lives*, Issue Brief (September 2016), accessed at: http://caph.org/wp-content/uploads/2016/09/caph-sni-issue-brief-wpc.pdf.
7. Harbage Consulting, *Medi-Cal 2020: Continuing Transformation and New Initiatives to Improve Health Outcomes*, (January 2016), accessed at: http://harbageconsulting.com/wp-content/uploads/2016/08/Medi-Cal-2020-Continuing-Transformation-and-New-Initiatives-to-Improve-Health-Outcomes.pdf.
8. DHCS, *Whole Person Care Program-Medi-Cal 2020 Waiver Initiative*, Webinar (November 2016), accessed at: http://www.dhcs.ca.gov/provgovpart/Documents/WPCProgramOverview.pdf.
9. California Association of Public Hospitals and Health Systems (September 2016).
10. DHCS (March 2016).

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Aligning Performance Measures Across Medi-Cal Initiatives
Appendix

Starting in 2015, IHA has led an effort among Medi-Cal plans and provider organizations to create a standardized performance measure set for all Medi-Cal P4P programs. IHA recruited an Advisory Committee of representatives from Medi-Cal managed care plans, providers serving Medi-Cal patients, DHCS, and other stakeholders to support this work. Through a voluntary, collaborative process, the Advisory Committee reached consensus on a core measure set that all Medi-Cal managed care plans could incorporate into their existing P4P programs.

The core measure set includes three features. First, no more than 10 measures are included in the measure set. Second, only measures from DHCS' External Accountability Set, the measures that plans are currently held accountable for, are included in the measure set. Finally, only those measures that a wide range of provider entities can report using administrative data are included in the measure set.

The Medi-Cal P4P core measure set includes clinical quality measures across a variety of priority areas for Medi-Cal, including chronic disease (e.g. diabetes care), maternity care, and prevention. The 10 core measures represent areas where there is room for improvement statewide and areas of focus for DHCS' quality strategy. The measures are also included in several other existing quality measurement requirements for Medi-Cal plans and providers, including: DHCS External Accountability Set (EAS) and Auto-Assignment (AA) program, Covered California Quality Rating System (QRS), CMS Medicaid Core Measures for Adults and Children (CMS), NQCA Medicaid Managed Care Health Plan Accreditation Standards (NCQA), and the Health Resources and Services Administration (HRSA) Uniform Data System (UDS) (see Appendix Exhibit 1 for the complete list of measures).

The Medi-Cal P4P Core Measure Set was developed with the goal of attaining broad adoption across all P4P programs and could provide a starting place to create more consistent performance measurement for current and future primary care initiatives. One emerging initiative has already used the Medi-Cal P4P Core Measure Set during its own measure set development process. The FQHCs Alternative Payment Methodology Pilot is a payment reform initiative that converts a FQHC's current prospective payment system (PPS) reimbursement rate to a PPS-equivalent per member, per month (PMPM) capitation payment. Under the pilot, DHCS sets rates for health plans and calculates clinic-specific PMPM capitation payments. Medi-Cal health plans report the number of Medi-Cal members assigned to pilot sites, and

Appendix Exhibit 1: Core Measure Set for Medi-Cal P4P programs

Domain	Measures	National Quality Forum #	Alignment*
Cardiovascular	Annual Monitoring for Patients on Persistent Medications: ACE or ARB	0021	EAS, QRS, CMS
	Annual Monitoring for Patients on Persistent Medications: Diuretics	0021	EAS, QRS, CMS
Diabetes Care	HbA1c Testing	0057	EAS, AA, QRS, CMS, NCQA
	HbA1c Control	0575	EAS & QRS
	Eye Exam	0055	EAS, QRS, NCQA
Maternity	Timeliness of Prenatal Care	1517	EAS, AA, QRS, CMS, NCQA
Prevention	Childhood Immunizations, Combo 3	0038	EAS, AA, QRS, CMS, NCQA, UDS
	Well-Child Visits in 3rd, 4th, 5th, and 6th Years of Life	1516	EAS, AA, QRS, CMS
	Cervical Cancer Screening	0032	EAS, AA, QRS, CMS, NCQA, UDS
Respiratory	Medication Management for People with Asthma	1799	EAS, QRS, CMS

Source: Integrated Healthcare Association

the state pays a supplemental "wrap cap," the difference between the health plan payment and the FQHC's per visit rate, on all pilot-assigned members.[1]

The California Primary Care Association, California Association of Public Hospitals and Health Systems, and health centers recently completed identifying measures that could be tracked and quantified as part of the pilot. The draft set of measures has been submitted to DHCS for approval. To create greater alignment, stakeholders used the Medi-Cal P4P Core Measure Set created by IHA and its Advisory Committee during their development process. Four of the nine core measures were included in the FQHC draft measure set.

For the FQHC pilot measure set development process, the Medi-Cal P4P Core Measure Set was valuable in setting a unified direction for primary care performance measurement. However, many of the emerging initiatives focus on high-need Medi-Cal enrollees and need to tailor performance measurement to specific target populations. Additional metrics outside the core set are needed to meet the needs of these complex populations.

Note

1. Department of Health Care Services, Federally Qualified Health Center Alternative Payment Methodology Pilot, Webinar (August 2016), accessed at: http://www.dhcs.ca.gov/services/Documents/FQHC_APM_SAC081116.pdf.