



State of Texas Medicaid Payment Reform – Market Assessment and Recommendation Analysis

**Deloitte Consulting LLP
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I. Executive Summary

As market pressures continue to mount, states are not only looking to derive more value from their managed care programs but also seeking to use these programs to address CMS' Triple Aim: better health, better quality, and lower cost. In doing so, more states are seeking alternative methods to reduce costs while maintaining and/or improving quality. To gain an understanding of current payment reform programs around the country, the State of Texas asked Deloitte to conduct interviews with Medicaid managed care personnel from eight states to understand the nuances of their experiences rolling out payment reform programs. This report focuses on analyzing payment reform and value based purchasing initiatives in Texas and other targeted states, as well as performance measures needed to design and test alternative payment models.

There are a number of approaches the surveyed states have implemented or are considering:

- Pay-for-performance Models,
- Capitation Withholds,
- Competitive Bidding,
- Enrollment Processes,
- Publishing Performance Data, and
- Supplemental Programming.

Pay-For-Performance

One of the primary means of driving payment reform at the state level has been through Pay-for-Performance ("P4P") programs. Of the eight surveyed states, Florida, Kansas, Minnesota, Oregon, Pennsylvania, Tennessee, and Wisconsin utilized quality measures in their P4P programs. These seven states employed a total of 73 unique quality measures, described in the body of this report. Texas's P4P program utilizes eight quality measures.

Surveyed states presented similar challenges regarding the use of quality measures in their programs, especially around risk adjustments and adjusting for insufficient data for particular measures in specific markets. There does not appear to be a prevailing approach for addressing the concept of adjusting quality measures for risk or insufficient data; however, there is strong interest in pursuing appropriate means of doing so.

One of the most common P4P program features is the capitation withhold discussed in the subsequent section. Beyond standard capitation withhold programs a number of states are implementing slight variations that, while preliminary, appear to be driving success. For example, Oregon uses a purely incentive driven approach by offering a quality bonus in addition to the flat capitation payment if a health plan achieves its quality metrics. On the other hand, Pennsylvania incorporates an offset to discourage poor performance by withholding a portion of funds from an MCO whose quality measure falls below the 50th percentile of the national HEDIS benchmark.

Capitation Withholds / At-Risk

Kansas, Minnesota, Tennessee, and Wisconsin use capitation withhold programs to drive performance and quality improvements. The most common approach was to set a portion of the Managed Care Organization's ("MCO's") capitation payment at-risk, dependent upon meeting predetermined quality

measures. The capitation withhold administered by the surveyed states varies from 2.5% of capitation payments to 10% of capitation payments. Texas currently administers a 4% capitation “at-risk” program.

Competitive Bidding

Competitive bidding is an alternative means states use to drive quality improvements outside of formal quality improvement programs such as pay for performance. It has effectively been utilized to reduce the administrative burden associated with a large number of MCOs in the market. Florida, Kansas, Minnesota, Pennsylvania, and Tennessee have adopted a competitive bidding process that has enabled them to reduce the number of MCOs operating in the state, thereby increasing the state’s bargaining power. Texas does not currently employ a competitive bidding model.

Enrollment Processes

As another means of driving quality improvement, many of the interviewed states have considered incorporating quality measures in the Medicaid auto-enrollment process, which is the approach states use for assigning new Medicaid members to an MCO if the participant has not already specified one. Minnesota was the only state currently trying this approach. Texas does not currently employ a differentiated enrollment process; however, this effort is currently under consideration.

Publishing Performance Data

Florida, Minnesota, Oregon, Pennsylvania, Tennessee, and Wisconsin have either started or plan to start making quality information publicly available as a means of driving quality improvements without the need for major contractual negotiations or legislation. By arming the consumers with a direct basis for comparison, these states have been able to tap into the competitive nature of the market to inform consumers and drive cost and quality improvement. Texas currently has some public reporting, but it isn’t easily accessible nor is it timely. An effort to broaden public reporting is currently underway as Texas is deploying MCO report cards in 2014. These report cards, based on select quality and consumer satisfaction metrics, will be published on the web. The MCO report cards are intended to help individuals make informed plan choices.

Supplemental Programs

Some states are trying supplemental programs in order to provide incentives for improvements in quality. In addition to the extensive public reporting Oregon produces, Oregon has multiple initiatives in place to track “super-utilizers”, or those individuals with a significantly greater than average use of the healthcare system. Tennessee has recently shifted its focus to a more unique quality payment model: episode-based payments. Tennessee found that approximately 60-70% of their spending is tied up in acute care. As such, the State developed an episode-based program that identifies the Principal Accountable Provider (PAP), or what Tennessee refers to as the “Quarterback.” The Quarterback is provided with actionable information including, but not limited to, the lab work that was done, number of office visits, and the total cost.

The following table summarizes the Medicaid programs in place at each of the surveyed states.

Program Features									
	California	Florida	Kansas	Minnesota	Oregon	Pennsylvania	Tennessee	Texas	Wisconsin
Pay-for-performance Models		✓	✓	✓	✓	✓	✓	✓	✓
Capitation Withholds			✓	✓			✓	✓	✓
Competitive Bidding		✓	✓	✓		✓	✓		
Enrollment Processes				✓					
Publishing Performance Data		✓		✓	✓	✓	✓	✓	✓
Supplemental Programming				✓	✓		✓		

Figure 1. Summary of Surveyed State Medicaid Quality Enhancement Programs

Medicaid payment reform is an evolving process, one which no state has perfected. With the challenges states continue to face regarding expanding enrollment and budget constraints, the importance of effective Medicaid payment reform only continues to grow. There is no single solution for bending the Medicaid cost curve and improving the quality of care provided to Medicaid beneficiaries. As each state continues to refine its attempt at doing so, it remains difficult to isolate the impact of any given incremental reform. Pair this with the unique characteristics found within each state’s population and Medicaid structure and it is easy to understand why a prevailing market solution has not yet evolved.

II. Background¹

Medicaid Expansion and Reform

Even without formal Medicaid expansion, the population covered by Medicaid in Texas could potentially grow as the Affordable Care Act (ACA) takes effect and individuals learn of their existing Medicaid eligibility. Indeed, as of June 2013, Medicaid enrollment in Texas has increased by 285,000, or roughly 8.5%, since passage of the ACA in 2010. Texas has recently expanded its Medicaid managed care program to provide needed health care services more efficiently to both existing and newly eligible Medicaid beneficiaries. As of November 1, 2013, the number of Medicaid beneficiaries covered by the STAR managed care program in Texas was up 44% compared to just two years earlier². With ever greater numbers of Medicaid beneficiaries to cover, Texas is considering managed care payment options that encourage quality of care and cost efficiency in its Medicaid managed care program.

Texas Medicaid Payment Reform

Texas has received both an 1115 Waiver and a State Innovation Model (SIM) grant to initiate payment shifts within the state's Medicaid program. In December 2011, Texas received federal approval of a Medicaid 1115(a) waiver that would preserve Upper Payment Limit (UPL) funding under a new methodology, while allowing for managed care expansion in additional areas of the state. This waiver allowed Texas to design, implement, and measure quality-based payment programs for enrolled managed Medicaid members (services for uninsured will continue to be reimbursed via fee-for-service). The payments under this new model flow from the Delivery System Reform Incentive Payment (DSRIP) pool, which was created by the State to fund these new payment initiatives.

The 20 Regional Healthcare Partnerships (RHPs) that formed as a result of the waiver have sought DSRIP funding for more than 1,300 quality improvement projects. Although the degree of coordination between RHPs and MCOs is unclear, many of these projects align with overall goals of the Managed Care Organization (MCO) quality strategy. The impacts of the RHP projects as manifested through the Medicaid Managed Care Organization strategy will be evaluated as data become available.³

Texas has also been granted a Model Design SIM grant to develop a State Health Care Innovation Plan. The state recently submitted the innovation plan to CMS for review. Texas is expecting to apply for a SIM Testing Grant when the next cycle of grants takes place this spring.⁴

Texas seeks to develop a common understanding and consensus among participants (payers, providers, and other stakeholders) around the design of innovative models, as well as the elements needed to successfully implement such models. Specific issues to be addressed are gaps in health information technology and information exchanges (HIT/HIEs), administrative, clinical and financial data sources and requirements, and performance measures needed to design and test alternative payment systems that incorporate quality-based outcomes. Texas also will work towards aligning various initiatives taking place across the state to transform the delivery and payment of health care. Texas plans to leverage the resources and activities of additional quality-improvement initiatives underway, including: the Texas Institute of Health Care Quality and Efficiency, the formation of federally recognized accountable care

¹ <https://www.hhsc.state.tx.us/research/MedicaidEnrollment/ME-Monthly.asp>

² <http://www.hhsc.state.tx.us/medicaid/mc/confirmed-eligible-reports.shtml>

³ SB7-quality-based-initiatives.pdf

⁴ <http://innovation.cms.gov/initiatives/State-Innovations/index.html>

organizations (ACOs) and other advanced quality-based entities around the state, and HIT infrastructure.⁵ The Texas Institute of Health Care Quality and Efficiency was established through recent legislation to support implementation and evaluation of innovative payment and delivery systems across payers.

⁵ <http://innovation.cms.gov/initiatives/state-innovations-model-design/>

III. Project Scope and Methodology

Methodology and Activities

The following summarizes the project steps completed for the Medicaid Payment Reform Assessment:

- 1. Gain an understanding of current Texas payment reform programs and future program objectives**
 - a. Conduct interviews with HHSC personnel to understand the State's current status and future vision for Medicaid payment reform.
 - b. Review publicly available information to better understand how Texas programs have evolved over time.

- 2. Gather innovative programs and leading practices across selected target states**
 - a. Review publicly available information to understand the current programs in each of the following states: Arizona, California, Florida, Kansas, New Hampshire, New Jersey, New York, Minnesota, Tennessee, Pennsylvania, Oregon, and Wisconsin.
 - b. Conduct extensive interviews with Medicaid managed care personnel from eight of the targeted states to understand the nuances of their experiences rolling out payment reform programs. These eight states include: California, Florida, Kansas, Minnesota, Tennessee, Pennsylvania, Oregon, and Wisconsin. Information for each program was collected across four general dimensions:
 - i. Currently in use or conceptual / work in progress
 - ii. Provider and MCO reaction to proposals
 - iii. Pain points during implementation
 - iv. Lessons learned

- 3. Provide a high level overview of potential payment alternatives that could be a good fit for the current Texas Medicaid programs**
 - a. Summarize the implementation successes and challenges other states faced with potential payment alternatives.
 - b. Prioritize potential payment alternative considerations as Texas moves to the next phase.

Reliance and Data Considerations

This report has been solely prepared for use by HHSC and should not be reproduced in any form without the prior consent of Deloitte Consulting and should not be relied upon by any entity other than HHSC.

This analysis was based on information provided by HHSC and similar agencies in other states, including some information collected through interviews with personnel. We assumed without audit or verification that all data and information provided was done so in good faith and is reliable. If the underlying data or information provided is inaccurate or incomplete, the results of our review may likewise be inaccurate or incomplete.

This report focuses on analyzing the payment reform and value based purchasing initiatives in Texas and other selected states, the performance measures needed to design and test alternative payment models, and the administrative capabilities needed to support the performance measures.

IV. Findings

A number of interviews were conducted with officials from Texas and from other states selected for their long-term use of managed care within the Medicaid program or their efforts to establish quality and cost efficiency programs. The results of these interviews are presented below.

A. State of Texas – Current payment program designs for Texas Medicaid

Program Background

The primary Medicaid managed care programs in Texas are the “Star Programs.”

- Texas Star Program – Primary Medicaid managed care program.
- Texas Star Plus Program – Medicaid managed care program with increased long term care (LTC) access for disabled and elderly.
- Texas Star Health Program – Medicaid managed care program for foster children.
- NorthSTAR –Behavioral health managed care “carve-out” program in Dallas service area.

The size of the Texas Medicaid enrollment and spending is summarized in the table below.

State of Texas Medicaid Overview	
Total Medicaid Beneficiaries⁶	4,201,519
Percentage of Beneficiaries in Managed Care⁷	85%
Yearly Spending (State and Federal FY 2011)⁸	\$28.6B

Figure 2. Enrollment and Funding for the State of Texas Medicaid Program

Current Quality Care Payment Models

The State of Texas is in the middle of a gradual shift from fee-for-service to managed care for Medicaid populations. More specifically, the shift is occurring through two mechanisms:

- 2014 adjustment of the capitation at-risk contracting between HHSC and MCOs⁹.
 - 4% of capitation payments will be at-risk based on performance quality measures.
- 2014 implementation of annual fee-for-service and capitation reimbursement adjustments (reductions) to hospitals based on Potentially Preventable Re-admissions (PPR) and Potentially Preventable Complication (PPC) rates exceeding established thresholds.
 - 1% to 2% reduction of inpatient claims for PPRs.
 - 2% to 2.5% reduction of inpatient claims for PPCs.

⁶ “2013 Market Overview: Houston.” HealthLeaders Study, Decision Resource Group.

⁷ “2013 Market Overview: Houston.” HealthLeaders Study, Decision Resource Group.

⁸ “Federal and State Share of Medicaid Spending.” Kaiser Family Foundation. <http://kff.org/medicaid/state-indicator/federalstate-share-of-spending/>

⁹ http://www.hhsc.state.tx.us/medicaid/reports/PB9/8_PB_9th_ed_Chapter7.pdf

Current Quality Care Indicators and Link to Payment Models¹⁰

A key component of any quality care payment model is the ability to accurately measure quality. Historically, the Medicaid fee-for-service model in Texas did not have well developed processes to track outcome and process quality measures. With the advent of the MCO model, HHSC is able to better leverage numerous outcome and process quality measures for acute care Medicaid and CHIP programs. The analysis and tracking of these measures are done by HHSC's contracted Medicaid/CHIP External Quality Review Organizations (EQROs). Measures used by HHSC have included the following national and state level process and outcome measures of healthcare quality:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Agency for Healthcare Research and Quality (AHRQ) measures
- Other measures endorsed by National Quality Forum (NQF)
- Hybrid measures that utilize data from provider claims coupled with medical records reviews
- HEDIS Relative Resource Use (RRU) measures (future measures)
- Potentially Preventable Events
- Enrollee Perception of Care
- Provider Network Adequacy
- Enrollee Complaints/appeals
- Emerging Data from Electronic Health Records (future)
- Relative Resource Use Measures (cost-quality)
- Quality Assessment and Performance Improvement Tool (QAPI)
- MCO Administrator Interviews and Surveys
- Assessment of Member Experiences with their Medical Home

As part of the 2014 Pay for MCO Quality program revisions, HHSC is now focusing the at-risk portion of capitation payments on eight quality measures, including:

- Adolescents Well-Care Visits (STAR, CHIP)
- Antidepressant Medication Management (STAR+PLUS)
- HbA1c Control (Diabetes) (STAR+PLUS)
- Potentially Preventable Admissions (STAR, CHIP, STAR+PLUS)
- Potentially Preventable ED Visits (STAR, CHIP, STAR+PLUS)
- Potentially Preventable Readmissions (STAR, CHIP, STAR+PLUS)
- Prenatal and Postpartum care (STAR)
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (STAR, CHIP)

As part of the 2014 Pay for DMO (Dental Management Organization) Quality program revisions, HHSC is now focusing the at-risk portion of capitation payments on four quality measures, including:

- Preventive dental services
- Preventative (Texas Health Steps) checkups
- Preventative (Texas Health Steps) checkups after enrollment
- Sealant measure

¹⁰ SB7-quality-based-initiatives.pdf

In addition, Texas is developing projects to improve quality-measurement capabilities over the next several years, including the following:

- ***Adult Quality Measures Grant***
 - A program designed to support state Medicaid agencies in developing staff capacity to collect, report, and analyze data on the initial core set of health care quality measures for adults enrolled in Medicaid (Initial Core Set).
 - Texas completed Year One of the grant project and declined to pursue Year Two due to a narrow time frame. However, Texas is continuing to work independently on two projects identified within Year One. One project is an initiative with MCO to increase the use of 17-Hydroxyprogesterone in women at risk for pre-term labor. The other is an effort to create closer coordination between MCOs in the Dallas service area and the local contracted Behavioral Health Organization (BHO). Dallas still operates with a carved-out Medicaid behavioral health population where services are provided by a capitated BHO under a separate contract.
- ***Contractual Requirements in MCO-Provider Payment Structure***
 - This recent provision in the MCO contract now requires MCOs to submit to HHSC a plan for alternative payment structures with providers, such as value based purchasing, thereby allowing HHSC to better assess MCOs progress in the field of value based purchasing. This requirement was established recognizing that FFS payment models innately reward volume and not necessarily quality.
- ***First Dental Home Initiative***
 - First Dental Home is an initiative designed to establish a Dental Home, provide preventive care, identify oral health problems, and provide treatment and parental/guardian oral health instructions as early as possible.

B. Summary of State Interview Findings¹¹

Overview of State Programs

Each of the states interviewed is at a different stage in the process to implement payment reforms. Prior to discussing specific payment reform methodologies, it is important to understand some of the key features of the eight states we interviewed. The following table shows the Medicaid enrollees and Managed Care Penetration reported through Health Leaders as of January 1, 2013:

¹¹Medicaid Managed Care - Key Data, Trends, Issues.pdf

Enrollment and Managed Care Penetration				
	California^{12,13}	Florida^{14,15}	Kansas^{16,17}	Minnesota^{18,19}
Total Medicaid Beneficiaries	8,534,628	3,449,179	390,954	862,827
Percentage of Beneficiaries in Managed Care	67%	50%	61%	71%
Number of MCOs	22	20	3	9
Yearly Spending (FY 2011)²⁰	\$54.9B	\$18.3B	\$2.7B	\$8.4B
	Oregon^{21,22}	Pennsylvania^{23,24}	Tennessee^{25,26,27}	Wisconsin^{28,29}
Total Medicaid Beneficiaries	622,053	2,348,843	1,272,339	1,155,754
Percentage of Beneficiaries in Managed Care	88%	63%	100%	49%
Number of MCOs	15	10	3	17
Yearly Spending (FY 2011)	\$4.4B	\$20.5B	\$8.0B	\$7.0B

Figure 3. Enrollment and Managed Care Penetration by Surveyed States.

MCO Program Trends

The shift to managed care Medicaid programs began in the 1980s and is still strong today. Two thirds of all Medicaid enrollees (26 million MCO members and 9 million primary care case management program members³⁰) now receive most or all of their benefits in managed care, with that number expected to rise in the future. Despite this high penetration rate, payments to MCOs account for only 20% of total Medicaid spending because disabled and elderly beneficiaries typically remain in fee-for-service (FFS) programs and expensive services such as long-term-care lag in the implementation of managed care. The high membership, low cost Medicaid managed care paradigm (relative to Medicaid FFS) is shifting – as the majority of states now report that MCO enrollment is or will be required for high risk members in at least

¹² “2013 Market Overview: Los Angeles” HealthLeaders InterStudy, Decision Resource Group. Pg. 51
¹³ <http://www.chcf.org/~media/MEDIA%20LIBRARY%20FILES/PDF/M/PDF%20MonitoringPerformanceDashboardMediCal.pdf>
¹⁴ “2013 Market Overview: Jacksonville.” HealthLeaders InterStudy, Decision Resource Group. Pg. 37
¹⁵ http://www.fdhc.state.fl.us/mchq/managed_health_care/MHMO/med_data.shtml
¹⁶ 2013 Market Overview: Kansas” HealthLeaders InterStudy, Decision Resource Group. Pg. 15
¹⁷ “KanCare RFP” <http://da.ks.gov/purch/EVT0001028.zip>
¹⁸ 2013 Market Overview: Minneapolis.” HealthLeaders InterStudy, Decision Resource Group. Pg. 46
¹⁹ http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_159905#
²⁰ “Federal and State Share of Medicaid Spending.” Kaiser Family Foundation. <http://kff.org/medicaid/state-indicator/federalstate-share-of-spending/>
²¹ 2013 Market Overview: Portland.” HealthLeaders InterStudy, Decision Resource Group. Pg. 36.
²² <https://cco.health.oregon.gov/Pages/Home.aspx>
²³ 2013 Market Overview: Philadelphia.” HealthLeaders InterStudy, Decision Resource Group. Pg. 50.
²⁴ http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/p_040151.pdf
²⁵ 2013 Market Overview: Knoxville.” HealthLeaders InterStudy, Decision Resource Group. Pg.45
²⁶ <http://www.tn.gov/tenncare/>
²⁷ State of Tennessee. Email interview. 16 April 2014.
²⁸ 2013 Market Overview: Milwaukee.” HealthLeaders InterStudy, Decision Resource Group. Pg. 42.
²⁹ https://www.forwardhealth.wi.gov/WIPortal/Tab/42/jcscontent/managed%20care%20organization/reports_data/monthlyreports/index.htm.spagae
³⁰ <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8046-02.pdf>

one of their MCO programs or geographic areas. An example of this is an ambitious program in California, built around a “Bridge to Reform” waiver, which expects to enroll up to 400,000 seniors and individuals with disabilities into MMC programs.³¹

The majority of states carve-out some services from the core MCO and reimburse for those services on a FFS basis. Typical carve-outs include dental (as is done in California, Oregon, and Tennessee), pharmacy (as is done in Wisconsin and Tennessee) and portions of behavioral health (as is done in California and Wisconsin). As states move towards patient centered medical homes, and as the ACA extends the Medicaid drug rebate program to MCOs, states have re-considered the value of carving out these types of services.

More recently, and as discussed in detail throughout this report, states have begun developing managed care models that differ from traditional MCO and PCCM models. These new models concentrate on the coordination and integration of care, with an emphasis on improving care for those with chronic and complex health care needs. The models incorporate accountability and align payment incentives with performance. Examples include effective care management models, such as Accountable Care Organizations (ACOs), Health Homes, and Patient Centered Medical Homes (PCMHs). Establishing regional collaboratives is another method used in some states to improve the coordination of care. By redesigning systems at the regional or community levels, states also have the ability to test new delivery/payment models.³²

Trends in Quality Care Payment Models³³

Focusing more on quality and value, states are moving away from the traditional FFS payment models and seeking alternative methods to reduce costs while maintaining and/or improving quality. Some examples include:

- Pay-for-performance Models,
- Capitation Withholds,
- Competitive Bidding,
- Enrollment Processes,
- Publishing Performance Data, and
- Supplemental Programming.

Pay for Performance

The concept of “Pay for Performance” (P4P) has been increasing in popularity over the past decade. While there is no universal description or solution for incorporating P4P, programs typically include incentives for meeting quality and efficiency performance measures and disincentives for medical errors or increased costs. The following table describes the P4P models currently utilized by the interviewed states.

³¹ <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8046-02.pdf> , pg 2

³² <http://www.nachc.com/client/Medicaid%20reform%20efforts.pdf>

³³ <http://www.nachc.com/client/Medicaid%20reform%20efforts.pdf>

Pay for Performance Programs			
Florida ³⁴	Kansas ³⁵	Minnesota ³⁶	Oregon ³⁷
<p>Achieved Savings Rebate This program, which began in 2013, is a retained profit opportunity for the MCOs. The past structure allowed plans to retain:</p> <ul style="list-style-type: none"> • 100% of the profit up to 5% of revenue, • 50% of profits between 5-10%, and • 0% of profits over 10%. <p>This structure allows plans to earn a maximum of 7.5% profit. Plans now have the opportunity to earn an additional 1% by meeting select HEDIS quality measures.</p>	<p>Pay-for-Performance Withhold Year 1: 3% capitation withhold that will be returned based on the MCO's performance in 6 metrics, which were primarily operation, with 50 basis points assigned for each metric. Years 2-5: 5% capitation withhold that will be returned based on the MCO's performance on 15 quality health outcome metrics, with 30 basis points each.</p>	<p>Bridges to Excellence Purchaser-led pay-for-performance encouraging the improvement of quality care, raising awareness of the variations in quality of care, and encourage provider competition based on quality outcomes. In 2011, the program distributed more than \$473,000 in rewards to 295 clinics.</p>	<p>Quality Pool Funding This pool funds 2% of payments made to CCOs outside of the capitation rate and may increase up to 5%. Distributions are made based on the CCO's performance in 17 incentive measures. In the second stage, the remainder of the funds not paid out in stage one are distributed based on the CCO's performance in a subset of 4 measures.</p>
Pennsylvania ³⁸	Tennessee ³⁹		Wisconsin ⁴⁰
<p>Pay-for-Performance MCOs can earn up to 1% of their PMPM revenue based on how they compare to national HEDIS quality benchmarks, and up to .5% of their PMPM revenue based on their improvement over the previous year.</p>	<p>Pay-for-Performance Quality Incentive Payments The withhold rate begins at 10% of the monthly capitation payment and for each consecutive 6 month period without deficiencies, the monthly withhold is cut in half (to a minimum of 2.5%). Capitation payment is returned if each of the 8 or 9 metrics are met (number of metrics varies by program). Capitation withhold is evaluated for compliance monthly.</p> <p>Money Follows the Person (MFP) Rebalancing Demonstration There are 5 benchmarks that can be achieved in a calendar year, and the result is a one-time payment of up to \$100,000 per MCO.</p>		<p>Pay for Performance Premium Withhold 2.5% capitation withhold to be paid out annually, for all populations, based on 6 quality measures.</p> <p>Wisconsin currently purchases NCQA's "Quality Compass," which breaks into percentiles how plans are doing across the country. Although it varies by measure, most are based on the 50th percentile of this report.</p>

Figure 4. Summary of Surveyed States Pay for Performance Programs

³⁴ State of Florida. Phone interview. 19 December 2013.

³⁵ State of Kansas. Phone interview. 3 December 2013.

³⁶ State of Minnesota. Phone interview. 8 January 2014.

<http://mnhealthactiongroup.org/newsletter/improving-care-through-collaboration-minnesota-bridges-to-excellence/>

³⁷ State of Oregon. Phone interviews. 11 December 2013, 19 December 2013.

³⁸ State of Pennsylvania. Phone interview. 6 December 2013.

³⁹ State of Tennessee. Phone interview. 13 December 2013.

⁴⁰ State of Wisconsin. Phone interview. 17 December 2013.

The Minnesota P4P program creates a structure for provider organizations to voluntarily contract with the State to better enable appropriate care for patients in both FFS and managed care. This contract provides a payment model that holds these organizations accountable for the total cost and quality of care provided to the populations. Through the demonstration project across different regions and the integration of models, the project will include clear incentives for quality of care and targeted savings. The idea behind this implementation is that it will result in increased competition because of the direct contracting with providers^{41,42}.

Wisconsin also implements hospital-specific P4P. Specifically, 1.5% of hospital FFS claim payments are withheld until six quality measures are met. In addition to earning back the 1.5% withhold amount, hospitals are able to earn a bonus payment of up to 1.5% of hospital FFS claim payments, which is funded by performance withholds by other hospitals⁴³. An additional P4P incentive, which totals \$5 million annually, is available for acute care hospitals, children's hospitals, and rehabilitation hospitals pending satisfactory scores on performance measures⁴⁴. This pool is funded from the Act 2 hospital assessment.

In Pennsylvania, the P4P program goes beyond pure incentives and incorporates an offset to discourage poor performance. For any measure in which the MCO falls below the 50th percentile of the national HEDIS benchmark, there is an offset equal to 25% of the measure's incentive amount. This offset does not take into account whether an MCO shows improvement or even declines, but instead looks only at how they compare to the 50th percentile.

Oregon also focuses its P4P program efforts on working with MCOs (also known as Coordinated Care Organizations (CCOs) in Oregon). Instead of withholding a portion of the capitation payment as is done in a number of other states, Oregon sets aside funds specifically to be distributed based on a CCO's performance in 17 incentive measures. This is currently 2% of all payments and is fully outside of the capitation rate arrangement. Under Oregon's current waiver, this funding pool can increase to be 5% of total CCO payments.

Capitation Withhold/At-Risk

A key component of many P4P programs used by states with their MCOs is the concept of withholding capitation payments to provide incentives for specific behaviors. The following table provides additional details regarding the capitation withhold programs implemented by four of the surveyed states. The capitation withhold in these programs varies from 2.5% of capitation payments to 10% of capitation payments and is dependent upon a variety of quality and operational measures. Performance against targeted measures is evaluated anywhere from monthly to annually, depending upon a given state's program.

⁴¹ Minnesota Interview, 1/8/14

⁴² http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_17710
3 January 2013.

⁴³ "Medical Assistance and Related Programs (BadgerCare Plus, Family Care and SeniorCare)." Wisconsin Legislative Fiscal Bureau. January 2013. pg. 48
http://legis.wisconsin.gov/lfb/publications/informational-papers/documents/2013/43_medical%20assistance%20and%20related%20programs.pdf

⁴⁴ Ibid., pg. 48

Capitation Withhold Programs			
Kansas ⁴⁵	Minnesota ⁴⁶	Tennessee ⁴⁷	Wisconsin ⁴⁸
<p>Year 1: 3% capitation withhold that will be returned based on the MCO's performance in 6 metrics, which were primarily operation, with 50 basis points assigned for each metric.</p> <p>Years 2-5: 5% capitation withhold that will be returned based on the MCO's performance on 15 quality health outcome metrics, with 30 basis points each.</p>	<p>5% of each plan's capitation rate is withheld annually and returned pending the plan's completion of performance targets in various process and quality measures.</p>	<p>The capitation withhold rate begins at 10% of the monthly capitation payment and for each consecutive 6 month period without deficiencies, the monthly withhold is cut in half (to a minimum of 2.5%). Capitation payment is returned if each of the 8 or 9 metrics (which vary between TennCare and TennCareSelect) are met.</p> <p>Capitation payment withhold is evaluated for compliance monthly.</p>	<p>2.5% capitation withhold to be paid out annually, for all populations, based on 6 quality measures.</p>

Figure 5. Summary of Surveyed States Capitation Withhold/At-Risk Programs

Similar to the capitation programs described above, Florida recently implemented the Achieved Savings Rebate (ASR)⁴⁹ program. The program is not a withhold of a portion of the capitation rate, but is instead a retained profit opportunity. ASR is structured to measure the revenue received from plans, service expenditures and certain allowable non-medical expenses. The current structure for retaining profits allows MCOs to retain 100% of profits up to 5%, retain 50% of the profits between 5% and 10%, and must return all profits over 10%. This allows the plans a maximum of 7.5% profit. Under the ASR, plans that attain the 7.5% profit limit are then eligible for an additional 1% incentive payment, based on their performance in a pre-determined set of measures. The plan is compared to national HEDIS benchmarks for six performance measure groups. For the first year, plans must achieve the 60th percentile or above, as compared to national averages. In subsequent years, plans must perform at the 75th percentile, as compared to national averages. This program has allowed Florida to move away from heavy reliance on the Minimum Loss Ratio (MLR) while building on some of the strengths of MLR.

Performance Measures

Each of the surveyed states' P4P and capitation withhold programs are reliant upon achieving a series of specific operational and/or quality measures. Many of these measures are driven by HEDIS or the NCQA, but some measures are customized by the state. The following table provides a full comparison of the targeted quality measures and their variations by state. Measures highlighted in green indicated

⁴⁵ State of Kansas. Phone interview, 3 December 2013.
http://www.kancare.ks.gov/download/Attachment_J_State_Quality_Strategy.pdf
⁴⁶ State of Minnesota. Phone interview, 8 January 2014.
<http://www.house.leg.state.mn.us/hrd/pubs/medastib.pdf>
⁴⁷ State of Tennessee. Phone interview, 13 December 2013.
http://tn.gov/generalserv/cpo/sourcing_sub/documents/31865-00368.pdf
⁴⁸ State of Wisconsin. Phone interview, 17 December 2013.
⁴⁹ State of Florida. Phone interview, 19 December 2013.

measures used for the purpose of evaluating payment incentive programs. Measures highlighted in red indicated those measures used for a state’s capitation withhold program. Finally, the bolded measures are those whose results are publicly reported.

Performance Measure Comparison ⁵⁰						
	FL	KS	MN	OR*	PA	TN
Effectiveness of Care	Diabetes Short-Term Complication Admission Rate (NQF)					
	Eye Exam (HEDIS)					
	HbA1c Control (HEDIS)					
	HbA1c Testing (HEDIS)					
	LDL-C Control (HEDIS)					
	LDL-C Screening (HEDIS)					
	Adherence to Antipsychotic Medications for Individuals with Schizophrenia					
	Annual Dental Visits (HEDIS)					
	Annual Monitoring for Patients on Persistent Medications (HEDIS)					
	Antidepressant Medication Management (HEDIS)					
	Appropriate Testing for Children with Pharyngitis (HEDIS)					
	Appropriate Treatment for Children with Upper Respiratory Infection (HEDIS)					
	Asthma Medication Ratio (HEDIS)					
	Avoidance of Antibiotics in the Treatment of Adult Bronchitis (HEDIS)					
	Beta-Blocker Treatment After a Heart Attack (HEDIS)					
	BMI Assessment (HEDIS)					
	Breast Cancer Screening (HEDIS)					
	Cardiovascular Monitoring for People with Cardiovascular and Schizophrenia					
	Cervical Cancer Screening (HEDIS)					
	Childhood Immunization Status (HEDIS)					
	Chlamydia Screening for Women (HEDIS)					
	Cholesterol Management for Patients with Cardiovascular Conditions (HEDIS)					
	Colorectal Cancer Screening (HEDIS)					
	Controlling High Blood Pressure (HEDIS)					
	Developmental Screening in the First 36 Months of Life (NCQA)					
	Diabetes Monitoring for People with Diabetes and Schizophrenia					
	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis					
	Follow-up after Hospitalization for Mental Illness (HEDIS)					
	Follow-up Care for Children Prescribed ADHD Medication (HEDIS)					

⁵⁰

Florida: http://ahca.myflorida.com/medicaid/quality_mc/pdfs/2013_Draft_Comprehensive_Quality_Strategy_Update_08-29-2013.pdf
 Kansas: http://www.kancare.ks.gov/download/Attachment_J_State_Quality_Strategy.pdf
 Minnesota: <http://mncm.org/wp-content/uploads/2014/02/2013-HCOR-Final-2.4.2014.pdf>
 Oregon: <http://www.oregon.gov/oha/Metrics/Pages/measures.aspx>
 Pennsylvania: http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/s_002207.pdf;
http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/s_002206.pdf
 Tennessee: <http://www.tn.gov/tenncare/forms/hedis13.pdf>

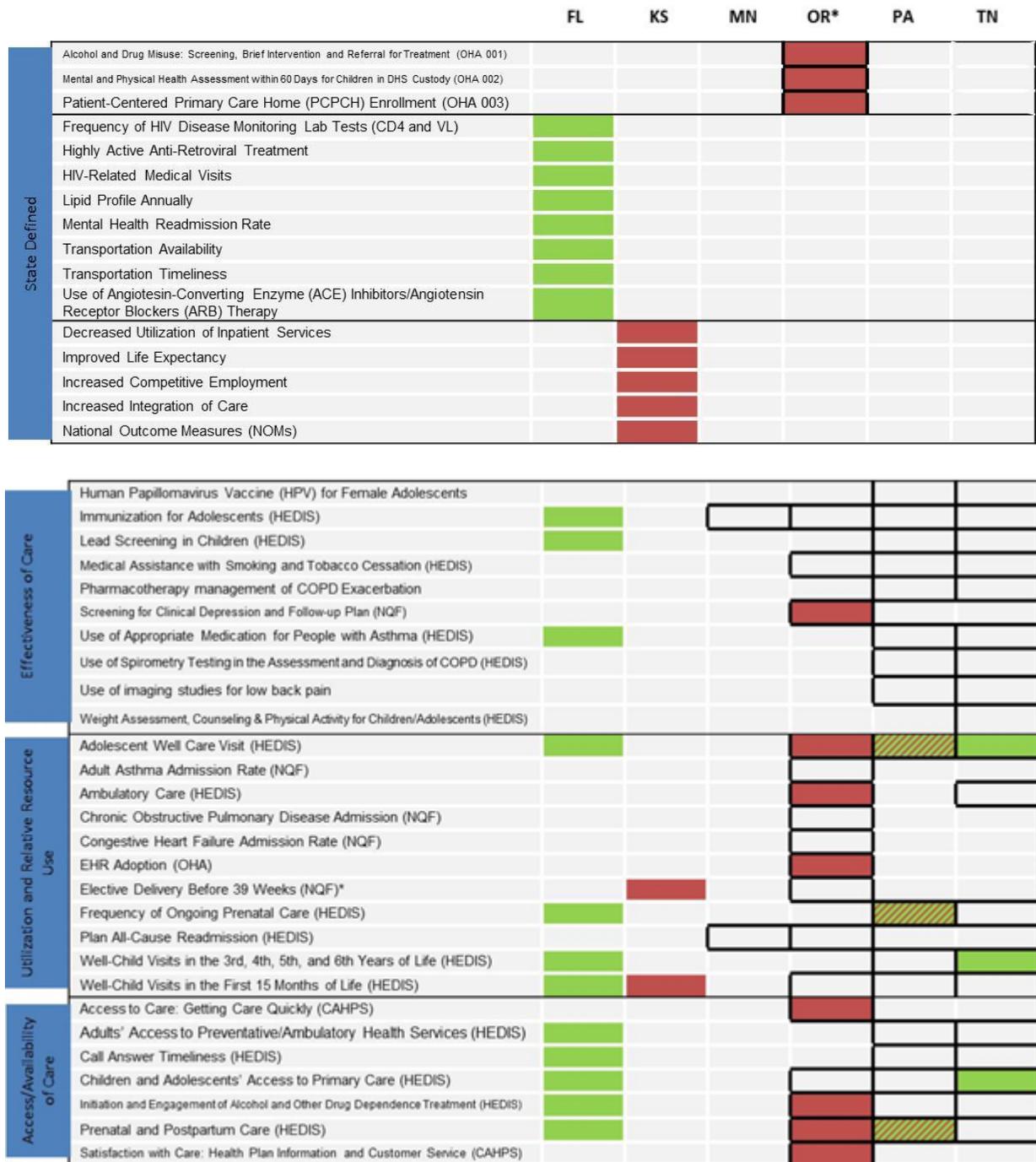
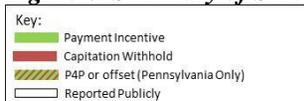


Figure 6. Summary of Surveyed States Quality Measures



There were two common issues that many of the interviewed states considered when incorporating quality measures into their P4P programs: risk adjustment and adjusting for sufficient data.

Risk Adjustment

The concept of risk adjustment as it applies to quality measures remains an elusive topic. Some of the surveyed states have utilized risk adjustment techniques to account for varying patient characteristics when evaluating quality metrics. The risk adjustment approach varies from identifying basic demographic differences to utilizing customized predictive models developed specifically for each measure.

Texas currently employs various techniques for risk adjustment of quality measures. Texas’ Potentially Preventable Events (“PPE”) measures (potentially preventable ED visits, potentially preventable hospital admissions, and potentially preventable readmissions) are risk adjusted based on health status, service area, and census tract poverty rate. Texas’ HEDIS measures are risk adjusted based on service area and census tract poverty.

The following table summarizes the risk adjustment methodologies associated with each state’s quality measures.

Quality Measure Risk Adjustment			
Oregon⁵¹	Minnesota⁵²	Florida⁵³	Tennessee⁵⁴
The quality measures are not currently risk adjusted; however, Oregon has utilized quality measure risk adjustment in the past.	For "Minnesota Community Measurements" the measures were adjusted across the Minnesota statewide average distribution of patients by three major insurance product types. Depression measures were based on the severity using initial PHQ-9 scores. Quality rates for each category are re-weighted to arrive at a final risk-adjusted score.	The health plans provide basic risk adjustment consistent with NCQA standards. Florida is considering moving to a performance based risk adjustment (diagnosis and Rx based) for the TANF population of MMA.	The measurements for episode-based payments will be risk adjusted, but TN has not specified a model yet. P4P measures are not risk adjusted.
Pennsylvania⁵⁵	Wisconsin⁵⁶	Kansas⁵⁷	California⁵⁸
P4P revenue is not risk adjusted, but does take into account instances when certain users should be excluded from the calculations, such as super utilizers.	Risk adjustment is not currently being utilized.	Risk adjustment is not currently being utilized.	Not applicable as California does not currently rely on quality measures.

Figure 7. Summary of Surveyed States Quality Measure Risk Adjustment Approach

While there doesn’t appear to be a clear consensus on the best way to account for varying patient characteristics when evaluating quality metrics, there is significant interest in this topic. This particularly

⁵¹ State of Oregon. Phone interviews. 11 December 2013, 19 December 2013.
⁵² http://mncm.org/wp-content/uploads/2013/04/2012_Final_HealthCareQualityReport_2.18.13.pdf, pg. 222
⁵³ State of Florida. Phone Interview. 19 December 2013.
⁵⁴ State of Tennessee. Phone interview. 13 December 2013.
⁵⁵ State of Pennsylvania. Phone interview. 6 December 2013.
⁵⁶ State of Wisconsin. Phone interview. 17 December 2013.
⁵⁷ State of Kansas. Phone interview. 3 December 2013.
⁵⁸ State of California. Phone interview. 22 January 2014.

holds true for Tennessee as the Tennessee Medicaid program will be implementing risk adjustment for episode-based payments, which are subject to more substantial risk variation than the experience monitored within most states' quality measures.

Insufficient Data Adjustment

Several of the surveyed states have encountered issues with an insufficient number of observations being present to allow the state to sufficiently evaluate these metrics in a statistically sound way. Because some quality and performance measures target very specific criteria, a given MCO, especially an MCO in a less densely populated region, may not have a sufficient number of participants fitting the criteria of a measure to make the evaluation of said measure statistically significant. The following table describes the differing approaches four of the surveyed states followed to address this issue:

Insufficient Data Adjustment	
Oregon⁵⁹	Florida⁶⁰
<p>When Oregon first evaluated this challenge, most recommendations from experts were to exclude small plans from the calculations where they were showing small denominators. However, a member of the evaluating committee who happened to be part of a small CCO suggested small plans need to still be held accountable. Oregon now recognizes there will be some noise in the measure, but still wants to encourage small plans to drive towards improvement. There have not been any instances where a denominator zeroes out, or no members participated in a particular quality metric, but Oregon typically uses broad measures that generally use close to the entire population.</p>	<p>Florida previously faced challenges with insufficient denominators; however, the recent competitive RFP process reduced the number of MCOs in the state so Florida is hopeful this will mitigate the issue. If having fewer plans still does not result in large enough denominators for the measures, Florida plans to only include the measures that meet minimum thresholds.</p>
Minnesota⁶¹	Wisconsin⁶²
<p>For the Minnesota hospital pay-for-performance measure risk-adjustment methodology, the rates are adjusted based on insurance type (Commercial, Medicare and MN Healthcare programs). If a clinic does not have at least 10 patients in each insurance category, adjustments are made before reweighting the scores. If a clinic had no patients in a certain category, they were assigned the statewide average score for the same category. If a clinic had between 1 and 9 patients in each category, the clinic was assigned the average of its score among those patients in that category, and the remainder of the patients were assigned the statewide average for that population for that category.</p>	<p>For two of the measures in the Wisconsin pay for performance program, thirty-day hospital readmission and mental health visit follow-up, the measures are only used if the hospital has at least 23 observations, otherwise they are not applicable to that hospital.</p>

Figure 8. Summary of Surveyed States Insufficient Denominator Approach

⁵⁹ State of Oregon. Phone Interview. 11 December 2013, 19 December 2013.
⁶⁰ State of Florida. Phone Interview. 19 December 2013.
⁶¹ http://mcm.org/wp-content/uploads/2013/04/2012_Final_HealthCareQualityReport_2.18.13.pdf
⁶² https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/medicaid/hospital/P4P_FY2013.pdf.spage

Competitive Bidding

Outside of formal quality improvement programs such as P4P, a number of states identified alternative means of achieving quality improvements. For example, five of the states interviewed have recently adopted a competitive bidding process that has enabled them to reduce the number of MCOs operating in the state, thereby increasing the state’s bargaining power. The following table describes the process underwent by the surveyed states:

Competitive Bidding				
Florida ⁶³	Kansas ⁶⁴	Minnesota ⁶⁵	Pennsylvania ⁶⁶	Tennessee ⁶⁷
Florida recently completed their first successful procurement for Long-Term Care and Managed Medical Assistance Program. They attributed the success to publishing rate ranges so the plans had parameters to guide them. This competitive procurement required MCOs to demonstrate a 5% savings over the prior year’s total spend.	Kansas used a competitive bidding process for KanCare and CHIP Capitated Managed Care Services starting in 2013. 3 MCOs were selected through this process for a 5-year contract.	Minnesota used a competitive bid for Medical Assistance and MinnesotaCare in 27 counties throughout the state, which reduced costs and the number of health plans. However, this resulted in transition and continuity of care concerns as some providers were no longer covered.	Pennsylvania issued an RFP for HealthChoices Physical Health Program in 35 counties of the Commonwealth. 8 Physical Health MCOs were selected during the 2011 RFP process.	Tennessee released an RFP in October 2013 with the intention of selecting 3 contractors to provide services for TennCare enrollees.

Figure 9. Summary of Surveyed States Competitive Bidding Approach

Oregon established several programs to better enable the State to maintain frequent contact with CCOs, thereby enabling appropriate accountability. For example, Oregon created the *Metrics and Scoring Committee* in 2012, which is legislatively structured and includes no state employees. This group is responsible for determining the quality measures used in the Quality Pool Funding program. This allowed stakeholders to be included in the process, and had recommendations come from CCO representatives, measurement experts, and community-at-large representatives. Furthermore, the state is very open with CCOs about performance in these metric areas. Although not originally the intention of the reporting process, the state gives reports on performance to the CCOs on a monthly basis. By doing so, the state believes this has allowed much more agreement with the plans about the measures and allows the plans to feel comfortable with how the measures are reported. A downfall of providing these reports is that it uses a substantial amount of resources. Oregon considered contracting this out, but chose not to because they wanted to be responsive to the data they were observing. In addition to the Metrics and Scoring Committee, there is a Quality and Health Outcomes Committee developed, which holds monthly “office hours.” During this time, anyone is able to call in and ask questions regarding metrics and data. Even if a plan does not have a specific question, they are able to call in and listen to the questions from

⁶³ State of Florida. Phone Interview. 19 December 2013.

⁶⁴ <http://da.ks.gov/purch/EVT0001028.zip>

⁶⁵ State of Minnesota. Phone interview. 8 January 2014.

http://www.dhs.mn.gov/main/idcplg/RFP%20Health%20Care%20MA%20MinnesotaCare%20Recipients%20Counties%20%20imbedded%20version%205%20May%2028%202013.doc?IdcService=GET_FILE&dID=157357&dDocName=dhs16_175755&allowInterrupt=1

⁶⁶ http://communityplans.net/Portals/0/ACAP%20Docs/PA-HealthChoices_Solicitation_4.pdf

⁶⁷ http://tn.gov/generalserv/cpo/sourcing_sub/documents/31865-00368.pdf

other plans. Through this initiative, Oregon believes they provide openness and availability for the plans.⁶⁸

MCO Contractual Requirements

Incorporated within this competitive bidding process in other states is an effort to more fully hold MCOs accountable for the promises made during the RFP process. For example, beginning July 1, 2014, New Hampshire will withhold 1% of the total capitation amount for MCOs to implement payment reform strategies. Each MCO will have to submit payment reform strategies annually and the MCO will only recoup the withhold once implementation milestones have been achieved. In Wisconsin, the State can impose sanctions or reduce enrollment levels if an MCO has failed to provide any contracted services. Wisconsin also holds regular one-on-one meetings directly with the quality and medical departments at each of its MCOs. Wisconsin believes that actively incorporating the quality directors has better equipped the State to drive quality success and hold MCOs accountable for any promises. Many of the other surveyed states discussed a desire to contractually hold MCOs more accountable for enabling payment reform; however, suitable means of doing so have not yet been identified.

Enrollment Processes

As another means of driving quality improvement, many of the interviewed states have considered incorporating quality measures in their Medicaid auto-enrollment process, which is the approach the state uses for assigning new Medicaid members to an MCO if they have not already specified one. For example, Minnesota implemented a quality-driven enrollment process for the portions of the Medicaid program under their competitive RFP agreement in which those MCOs that were determined to have the highest value will receive a larger portion of enrollees. Wisconsin, on the other hand, previously assigned new members to MCOs based on the past quality performance of the MCO; however, Wisconsin is currently reverting back to the more traditional means of assigning new members to MCOs as a result of time and budgetary constraints. Pennsylvania had previously tried to find a way to assign higher enrollment weights to top performing MCOs, but faced resistance and has since focused their attention elsewhere.

Publishing Performance Data

Making quality information publicly available has been an effective means of achieving quality improvements without the need for major contractual negotiations or legislation. This approach is so highly regarded that Tennessee, for example, believes that its consumer-friendly website, which allows for the easy comparison of one MCO's performance against another, has more successfully impacted cost savings and quality improvements than its historic P4P program. By arming the consumers with a direct basis of comparison, Tennessee was able to tap into the competitive nature of the market to make this methodology successful. Five of the surveyed states are currently publishing, or soon plan to publish, quality information for public consumption, as described in the following table.

⁶⁸ Oregon Interviews, 12/11/13, 12/19/13

Publish Performance Data		
Florida⁶⁹	Minnesota⁷⁰	Oregon⁷¹
Although not currently available, Florida plans to publish data as a result of the latest round of competitive bidding as a means of encouraging competition.	Minnesota publishes data through the Minnesota Community Measurement program using a tiered system to encourage public knowledge and better enable competition.	Quarterly progress reports are published, with each CCO required to submit 33 performance measures. The majority of these measures (23) for 2013 are based on National Quality Forum (NQF) measures. The remainder of the measures are a variety of Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), as well as measures determined by Oregon Health Authority (OHA).
Pennsylvania⁷²	Tennessee⁷³	Wisconsin⁷⁴
Plans submit applicable HEDIS, CAHPS, and PA performance measures, not just the measures included in pay-for-performance program.	MCOs annually complete and submit all applicable HEDIS measures designated by NCQA as relevant to Medicaid, not just the measures included in pay-for-performance incentive.	Currently the Wisconsin Statewide Value Committee is working to determine how to publicly report the measures in a way that is valuable. The Statewide Value Committee is also developing report cards for all plans that are linked to the pay-for-performance measures.

Figure 10. Summary of Surveyed States Approach to Publishing Performance Data

Supplemental Programs

Throughout our interviews, a number of states discussed the unique approaches they utilize to address some of the common challenges faced by Medicaid programs today. For example, Minnesota is implementing an accountable care model through its State Innovation Model (SIM) grant and Tennessee is starting to embark on episode-based payments. New York, Arizona, and Pennsylvania have introduced reinsurance and risk-corridor protections.

⁶⁹ State of Florida. Phone Interview. 19 December 2013.

⁷⁰ State of Minnesota. Phone interview. 8 January 2014. Available at: <http://mncm.org/wp-content/uploads/2014/02/2013-HCQR-Final-2.4.2014.pdf>

⁷¹ <http://www.oregon.gov/oha/Metrics/Pages/ccos.aspx>

⁷² http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/s_002207.pdf, pg. 9

⁷³ State of Tennessee. Phone interview. 13 December 2013.

⁷⁴ State of Wisconsin. Phone interview. 17 December 2013.

Tennessee has recently shifted its focus to a more unique quality payment model: episode-based payments. Tennessee found that approximately 60-70% of their spending is tied up in acute care. As such, the State developed a program focused around an “episode”, defined as a healthcare event that has a distinct start and end date, and identifies the Principal Accountable Provider (PAP), or what Tennessee refers to as the “Quarterback.” The quarterback is identified as the person with the largest influence over the outcome of a given episode. The quarterback is provided with actionable information including, but not limited to, the lab work that was done, the number of office visits, and the total cost. Tennessee has selected three episodes (out of the 270 recognized episodes), to start with and plans to roll out a new episode every six months after the initial trial period is complete. The three episodes to be included in the roll out are Total Joint Replacement (with the Orthopedic Surgeon as the Quarterback), Deliveries (with the Obstetrician as the Quarterback), and Acute Asthma Exacerbation (with the hospital where the ED visit took place as the Quarterback).

Through this program, quarterbacks are benchmarked against other quarterbacks, on a risk adjusted basis. Ultimately, if the cost of a quarterback’s care falls above the acceptable line, the quarterback is eligible for risk-sharing as long as he/she also meets established quality metrics. Similarly, if the cost of the quarterback’s care falls above the commendable line, he/she is eligible for gain sharing, assuming he/she has met the established quality metrics. The methodology behind determining the acceptable and commendable lines is still being determined. The model will calculate performance after a service has been performed and will reconcile gains and losses on a periodic basis, such as quarterly or yearly, rather than pay for each episode. If a quarterback consistently falls outside of the acceptable range, he/she will be expected to bear some financial risk for that performance.⁷⁵

Oregon has multiple initiatives in place to track “super-utilizers”, or those individuals with a significantly greater than average use of the healthcare system. Through these initiatives, Oregon works individually with plans to share detailed information to help the CCOs identify super-utilizers and highest-costing participants earlier.⁷⁶

In conjunction with the rise in aggressive quality care payment models, some states are introducing reinsurance and risk corridor type protections for MCOs taking on substantial risk. Examples include the following⁷⁷:

- Arizona has a multi-tiered reinsurance program for high inpatient costs that operates similar to a specific stop loss policy. The state also operates a “catastrophic reinsurance” plan, which covers 85 percent of the cost of care provided to enrollees with specific high-cost diagnoses, including Gaucher’s disease, von Willebrand disease, and hemophilia.
- Arizona also uses a risk-corridor type process for adult enrollees without dependents—a population experiencing significant recession-related enrollment growth. Since new enrollees in this group were expected to have different health care use patterns than existing (non-recession related) enrollees, the state sought to limit the amount health plans could profit from covering the population. Under the reconciliation process, health plans must remit (in the case of profits) or are reimbursed (in the case of losses) the amount that exceeds the cap.

⁷⁵ Tennessee Interview, 12/13/13

⁷⁶ State of Oregon Interviews, 12/11/13, 12/19/13

⁷⁷ <http://www.urban.org/UploadedPDF/412925-Medicaid-and-CHIP-Managed-Care-Payment-Methods-and-Spending-in-20-States.pdf>

- New York has a true specific stop-loss program for inpatient care, and caps plan risk at \$100,000 of inpatient spending for any single enrollee in a year. Costs exceeding this amount are the responsibility of New York.
- Pennsylvania runs a reinsurance program that caps health plan claim costs at \$80,000 for any single enrollee in a year. The program is funded by plan premiums.

Capitation Rate Development

While not the primary focus of our interviews, several states discussed their capitated rate development process. Because much of the capitated rate setting process is prescribed by CMS, and all rates must be actuarially sound, relatively little variation exists among approaches. That said, noteworthy variations emerged in the areas of risk adjustment, administrative expenses, and carved out services.

Risk Adjustment

In most of the surveyed states, base capitation rates were adjusted to reflect the health status, or acuity, of the population enrolled in each health plan. The purpose of acuity risk adjustment is to recognize the anticipated cost differential between multiple health plans in a service area by analyzing the health status of their respective memberships. Of the eight surveyed states, two states (Oregon, and Kansas) are not currently risk adjusting their capitated rates. California, Florida, and Pennsylvania are using the Medicaid Rx Model, while Pennsylvania and Wisconsin are using the Chronic Illness and Disability Payment System (CDPS) for risk adjustment. Texas also relies upon CDPS to incorporate risk adjustment.

Surveyed states applied risk adjustment techniques anywhere from monthly (Pennsylvania) to annually (California, Minnesota, Tennessee, Wisconsin). Currently, Pennsylvania updates the MCO's plan risk score monthly by tracking individuals who move from plan-to-plan and recalculating based on a given plan's new enrollment. Risk scores for individuals are updated every six months while the underlying risk weights are done periodically, usually every two to three years. Pennsylvania mentioned during the interview that they are considering a less frequent method of risk adjustment going forward as the monthly approach is comparatively labor intensive.

Capitation Rate Risk Adjustment				
	California⁷⁸	Florida⁷⁹	Kansas⁸⁰	Minnesota⁸¹
Risk-Adjustment Tool	Medicaid Rx Model	Medicaid Rx Model	No risk-adjustment currently	Diagnosis Codes and the John Hopkins ACG
Risk Adjustment Interval	Annual	Quarterly	N/A	Previously had done quarterly, now do an interim risk-adjustment and then look back over entire year
	Oregon⁸²	Pennsylvania⁸³	Tennessee⁸⁴	Wisconsin⁸⁵
Risk-Adjustment Tool	No risk-adjustment since the CCOs submit costs on actual experience	Chronic Illness and Disability Payment System and Medicaid Rx	John Hopkins ACG	Chronic Illness and Disability Payment System
Risk Adjustment Interval	N/A	Monthly	Annually	Annually

Figure 11. Summary of Surveyed States Approach to Capitated Rate Risk Adjustment

Administrative Expenses

Capitated rates typically include an explicit provision for administrative examples. The administrative expenses used by the surveyed states ranges from 6.6% to 14%. For administrative expenses, Texas currently allocates the following:

- \$8PMPM plus 5.75% of gross premium for the STAR program,
- \$12.50 PMPM plus 5.75% of gross premium for the STAR +PLUS program,
- \$23.50 PMPM plus 5.75% of gross premium for the STARHealth program,
- \$1.03 PMPM plus 5.75% of gross premium for the NorthSTAR program, and
- \$1.75 PMPM for the Medicaid Dental program.

⁷⁸ State of California. Phone interview. 22 January 2014.

⁷⁹ State of Florida. Phone Interview. 19 December 2013.

⁸⁰ State of Kansas. Phone interview. 3 December 2013.

⁸¹ State of Minnesota. Phone interview. 8 January 2014

⁸² State of Oregon Interviews, 12/11/13, 12/19/13

⁸³ http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/p_034747.pdf

⁸⁴ State of Tennessee. Phone interview. 13 December 2013.

⁸⁵ State of Wisconsin. Phone interview. 17 December 2013.

Capitated Rate Administrative Expenses			
California ⁸⁶	Florida ⁸⁷	Kansas ⁸⁸	Minnesota ⁸⁹
8.90%	12%	Risk-corridor is incorporated	PMAP: 6.6-10% MNCare: 7.0%
Oregon ⁹⁰	Pennsylvania ⁹¹	Tennessee ⁹²	Wisconsin ⁹³
Based on cost proposal - average of 8.01%	Average: 8-9%	9% (combined administrative allowance and operating margin)	14%

Figure 12. Summary of Surveyed States Medicaid Capitation Rate Administrative Expense

Carved-Out Services

Traditionally, states will carve-out services from their capitated rate arrangements. These are often service categories for services that are more challenging to operate in a managed care setting. Texas has historically carved out prescription drug services; however, beginning in fiscal year 2013, pharmacy is now carved-in to the capitated rate. Early Childhood Intervention services, which were also historically carved out, are now incorporated in the capitated rate. Behavioral Health, and other Long Term Services and Support Services, will be incorporated in the capitated rate on September 1, 2014.

Surveyed states had a wide range of carve-out services. For example, Kansas and Minnesota are rapidly moving toward not carving out any services and instead utilizing statewide Medicaid managed care across all populations. Some more common carve-outs include mental health (California and Wisconsin), dental (California and Oregon), and long term care services (California).

⁸⁶http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/TwoPlanRateCerts/CY1011/TwoPlanCYE11RateRangeCert.pdf
⁸⁷ State of Florida. Phone Interview. 19 December 2013.
⁸⁸ State of Kansas. Phone interview. 3 December 2013.
⁸⁹ http://www.publicrecordmedia.com/wp-content/uploads/2012/05/MNGDPAMNDHS2012B_pd_029.pdf
⁹⁰ [http://www.oregon.gov/oha/healthplan/DataReportsDocs/November%202012%20to%20December%202013%20\(CCOs%20only\).pdf](http://www.oregon.gov/oha/healthplan/DataReportsDocs/November%202012%20to%20December%202013%20(CCOs%20only).pdf)
⁹¹ State of Pennsylvania. Phone interview. 6 December 2013.
⁹² State of Tennessee. Phone interview. 13 December 2013.
⁹³ State of Wisconsin. Phone interview. 17 December 2013.

V. Considerations for Texas Medicaid Payment Reform Programs

Recognizing that each state's Medicaid program is customized in many respects as it serves the unique population characteristics of its state, some of the payment reform elements previously discussed will be more applicable than others. At approximately \$29B in annual State Medicaid spending (including Long-Term Care)⁹⁴, and more than 4 million Medicaid beneficiaries⁹⁵, the Texas Medicaid program is larger than nearly every one of the Medicaid programs interviewed. This section describes some considerations for the payment reform initiatives and their challenges, including:

- Pay-for-performance Models,
- Capitation Withholds,
- Performance Measures,
- Risk Adjustment,
- Adjusting for Insufficient Data,
- Competitive Bidding, and
- Publishing Performance Data.

Pay for Performance

The current Texas "Pay for Quality" (P4Q) program has evolved over time, as have many other states' P4P programs. The 2014 P4Q program now focuses on one consolidated set of measures that emphasizes an MCO's incremental improvement rather than separate at-risk measures and quality challenge measures. Because the Texas P4P program underwent substantial revisions as of 2014, it is too early to evaluate the effectiveness of these changes; however, some other states' programs have facets of their P4P programs that could reasonably supplement the current Texas P4Q efforts.

For example, the Minnesota P4P program focuses on contracting directly with provider organizations to better enable appropriate care for patients in both fee-for-service and managed care. Contracting directly with providers has also enabled Minnesota to hold provider organizations directly accountable for the total cost and quality of care. Wisconsin also implements hospital-specific pay for performance in which 1.5% of hospital fee-for-service claim payments are withheld until six quality measures are met. However, directly contracting with providers within a Medicaid managed care program may reduce the management control of the MCOs the state hired to manage recipient's care.

Alternatively, many states have P4P programs similar to Texas in which the focus is on MCO negotiations. Pennsylvania has a unique feature of its P4P program in which it administers a penalty to discourage poor performance. For any measure in which the MCO falls below the 50th percentile benchmark, there is an offset equal to 25% of the measure's incentive amount. This offset does not take into account whether an MCO shows improvement or declines, but instead looks at how it compares to the 50th percentile.

Depending upon the evolving nature of HHSC-MCO relationships in Texas, a purely incentive driven P4P program, such as that utilized in Oregon, could be an effective means of driving quality improvement while emphasizing a strong working relationship with local MCOs. Oregon's current waiver allows the

⁹⁴ State of Texas, phone interview with Oregon. 11 December 2013.

⁹⁵ "2013 Market Overview: Houston" HealthLeaders InterStudy, Decision Resource Group. Pg. 47

Medicaid program to set aside funds to be distributed fully outside of the capitation rate arrangement. Under this approach, regardless of quality outcomes, the MCOs capitation payment would never fall below the lower limit of the approved rate range. Instead, an MCO earns additional payment by meeting required incentive measures. As Texas looks to expand current quality measures, even a short-term version of an incentive driven approach could be an effective means of establishing a new culture amongst the Texas Medicaid stakeholders.

Capitation Withhold/At-Risk

The current Texas P4Q program sets 4% of an MCO's capitation payment at-risk, pending favorable performance in eight quality measures (described below). A strict capitation withhold is being implemented in four of the surveyed states, with an additional two states utilizing a variation of the more common capitation withhold program. The capitation withhold administered by the surveyed states varies from 2.5% of capitation payments to 10% of capitation payments. While administration techniques vary, some states, such as Kansas, have implemented a phased-in approach when revising P4P programs. For example, in its first year of operation, Kansas administered a 3% capitation withhold that was based on six operational metrics. In subsequent years, Kansas will move to a 5% withhold that will be driven by quality health outcome metrics.

The Florida variation to a capitation withhold program, the Achieved Savings Rebate program previously discussed, is still too new to evaluate whether the program has been successful. The complexity of this program compared to a more simplistic capitation withhold program does add additional administrative burden worth considering.

While increasing the amount of capitation withheld pending achievement of certain performance measures certainly increases the incentive of a given MCO to meet this mark, excessively high withhold amounts could have consequences in other areas such as reducing the ability of smaller, non-profit health plans to participate which could, in turn, lead to potential access issues in certain underserved areas.

Performance Measures

Each of the surveyed states' pay for performance and capitation withhold programs is reliant upon achieving a series of specific operational and/or quality measures. The following table provides a comparison of the eight targeted Texas quality measures and how those measures are utilized by the other surveyed states. The percentage contained within a highlighted cell denotes the HEDIS threshold the MCO must achieve in order to satisfy a given metric. In Tennessee, these measures are not compared against a HEDIS benchmark. Rather, MCOs must show significant improvement over the prior year, as defined by NCQA's minimum effect size change methodology. At the time of this report, Texas had not yet established the minimum target an MCO must achieve in order to satisfy one of these eight given quality measures.

Texas MCO Quality Measures ⁹⁶						
	FL	KS	MN	OR	PA	TN
Adolescents Well-Care Visits	75%			75%	50%	
Antidepressant Medication Management	75%					
HbA1c Control	75%	50%		TBD	50%	
Potentially Preventable Admissions						
Potentially Preventable ED Visits						
Potentially Preventable Readmissions					Improvement	
Prenatal and Postpartum Care	75%			75%	50%	
Well-Child Visits in the 3 rd , 4 th , 5 th , and 6 th Years of Life	75%					

Figure 13. Comparison of Current Texas Quality Measures as Utilized by Surveyed States

Note that Texas intends to add Potentially Preventable Complications as an additional quality measure in 2015.

Of the eight surveyed states, six of them utilized quality measures in their P4P programs. These six states employed a total of 73 unique quality measures, which were listed in detail in *Figure 6*. As described below in *Figure 14*, 17 of these quality measures are currently being utilized in more than half of the surveyed states. Three of these 17 most commonly utilized measures are currently in effect in Texas (adolescent well care visits, HbA1c Control, and Prenatal/Postpartum care), leaving the remaining 14 mostly commonly used measures as potential candidates for future quality metric expansion in Texas.

⁹⁶Florida: http://ahca.myflorida.com/medicaid/quality_mc/pdfs/2013_Draft_Comprehensive_Quality_Strategy_Update_08-29-2013.pdf, pg. 12
 Kansas: http://www.kancare.ks.gov/download/Attachment_J_State_Quality_Strategy.pdf, pg. 35.
 Minnesota: <http://mncm.org/wp-content/uploads/2014/02/2013-HCQR-Final-2.4.2014.pdf>
 Oregon: <http://www.oregon.gov/oha/CCODData/2014%20Benchmarks.pdf>
<http://www.oregon.gov/oha/CCODData/Diabetes%20-%20HbA1c%20Poor%20Control%20-%202014.pdf>
 Pennsylvania: http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/s_002207.pdf, pg. 9
 Tennessee: <http://www.tn.gov/tencare/forms/hedis13.pdf>
 Texas: <https://www.hhsc.state.tx.us/medicaid/UMCM/Chp6/6-2-11.pdf>

Most Commonly Utilized Quality Measures ⁹⁷						
	FL	KS	MN	OR	PA	TN
Controlling High Blood Pressure						
Appropriate Testing for Children with Pharyngitis						
Cervical Cancer Screening						
Childhood Immunization Status						
Chlamydia Screening for Women						
Immunization for Adolescents						
Annual Monitoring for Patients on Persistent Medications						
Breast Cancer Screening						
Children and Adolescents' Access to Primary Care						
Eye Exams for People with Diabetes						
Follow-up after Hospitalization for Mental Illness						
HbA1c Testing						
LDL-C Screening						
Well-Child Visits in the First 15 Months of Life						

Figure 14. Summary of the Quality Measures Most Commonly Utilized by Surveyed States

Risk Adjustment

Based on the surveyed states, there does not appear to be a prevailing approach for addressing this topic. In fact, none of the surveyed states are currently implementing quality measure risk adjustment. Several of the surveyed states mentioned in conversation that they would like to begin to incorporate risk adjustment techniques into their quality metrics, but time and budget constraints have not yet permitted them to do so.

Adjusting for Insufficient Data

Several of the surveyed states reported challenges around an insufficient denominator being present to allow the state to sufficiently evaluate these metrics in a statistically sound way. Because some quality and performance measures target very specific criteria, a given MCO, especially an MCO in a less densely populated region, may not have a sufficient number of participants fitting the criteria of a measure to make the evaluation of said measure statistically significant.

Regardless of the explicit means of addressing this issue, it is important to recognize the effects insufficient data may have on a given quality metric. Oregon, for example, does not exclude small denominators from the quality metric calculations in an effort to ensure all MCOs are held accountable; instead, Oregon recognizes there may be noise in the data while still encouraging smaller plans to drive toward improvement. Other states, such as Minnesota and Wisconsin, have placed limits for consideration by which they will not consider a quality metric valid unless a minimum number of observations occurred during the evaluation period.

The simplest approach surveyed states used to address this issue is to restrict the number of MCOs currently participating, thereby increasing the exposure a given MCO has to each metric. One of the

⁹⁷ Florida: http://ahca.myflorida.com/medicaid/quality_mc/pdfs/2013_Draft_Comprehensive_Quality_Strategy_Update_08-29-2013.pdf
 Kansas: http://www.kancare.ks.gov/download/Attachment_J_State_Quality_Strategy.pdf
 Minnesota: <http://mncm.org/wp-content/uploads/2014/02/2013-HCOR-Final-2.4.2014.pdf>
 Oregon: <http://www.oregon.gov/oha/Metrics/Pages/measures.aspx>
 Pennsylvania: http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/s_002207.pdf;
http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/s_002206.pdf
 Tennessee: <http://www.tn.gov/tenncare/forms/hedis13.pdf>

means utilized to reduce the administrative burden associated with a large number of MCOs in the market is through competitive bidding.

Competitive Bidding

A number of surveyed states identified alternative means of driving quality improvements outside of formal quality improvement programs such as pay for performance. For example, five of the eight states interviewed have recently adopted a competitive bidding process that has enabled them to reduce the number of MCOs operating in the state, thereby increasing the state's bargaining power. It is important to strike the right balance when considering the desired number of MCOs participating in a Medicaid program. Too few MCOs may result in concerns regarding access to care and/or shift the balance of bargaining power away from the state. While there is potential for concerns regarding access to care that may result from reducing the number of MCOs, none of the interviewed states voiced this as a challenge they faced.

While many of the interviewed states found competitive bidding to be highly productive, Wisconsin faced challenges with its competitive bidding process. For example, one plan bid too low as a means of getting in the door and subsequently had to pull out of the contract for lack of financial viability. Due to the challenges faced in the competitive bidding process, the State made the business decision to move away from the procurement model for the time being. Wisconsin did mention they may go back to competitive bidding in the future, but for the time being they will move to a prescribed statewide rate setting process.

Texas has a rich history of strong MCO relationships and has historically been committed to the sustainability of smaller MCOs in the state. As such, full competitive bidding would represent a substantial shift from the status quo in Texas today.

Publishing Performance Data

Making quality information publicly available has been an effective means of driving quality improvements without the need for major contractual negotiations or legislation. This approach is so highly regarded that Tennessee, for example, believes that its consumer-friendly website, which allows for easy comparison of one MCO's performance against another, has more successfully impacted cost savings and quality improvements than its historic pay for performance program. By arming the consumers with a direct basis for comparison, Tennessee was able to tap into the competitive nature of the market to make this methodology successful. The effectiveness of public data production hinges on the lag and frequency of the updates, as well as the ease of access to this information.

Half of the surveyed states currently publish performance data. Texas currently has some public reporting, but it isn't easily accessible nor is it timely. An effort to broaden public reporting is currently underway as Texas is deploying MCO report cards in 2014. These report cards, based on select quality and consumer satisfaction metrics, will be published on the web. The MCO report cards are intended to help individuals make informed plan choices. The following table lists all quality measure for which surveyed states are currently reporting publicly.

Published Performance Data⁹⁸

	MN	OR	PA	TN
Effectiveness of Care	Diabetes Short-Term Complication Admission Rate (NQF)			
	Eye Exam (HEDIS)			
	HbA1c Control (HEDIS)			
	HbA1c Testing (HEDIS)			
	LDL-C Control (HEDIS)			
	LDL-C Screening (HEDIS)			
	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (HEDIS)			
	Annual Monitoring for Patients on Persistent Medications (HEDIS)			
	Antidepressant Medication Management (HEDIS)			
	Appropriate Testing for Children with Pharyngitis (HEDIS)			
	Appropriate Treatment for Children with Upper Respiratory Infection (HEDIS)			
	Asthma Medication Ratio (HEDIS)			
	Avoidance of Antibiotics in the Treatment of Adult Bronchitis (HEDIS)			
	Beta-Blocker Treatment After a Heart Attack (HEDIS)			
	BMI Assessment (HEDIS)			
	Breast Cancer Screening (HEDIS)			
	Cardiovascular Monitoring for People with Cardiovascular and Schizophrenia (HEDIS)			
	Cervical Cancer Screening (HEDIS)			
	Childhood Immunization Status (HEDIS)			
	Chlamydia Screening for Women (HEDIS)			
Cholesterol Management for Patients with Cardiovascular Conditions (HEDIS)				
Colorectal Cancer Screening (HEDIS)				
Controlling High Blood Pressure (HEDIS)				
Diabetes Monitoring for People with Diabetes and Schizophrenia (HEDIS)				
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (HEDIS)				
Access/Availability of Care	Access to Care: Getting Care Quickly (CAHPS)			
	Adults' Access to Preventative/Ambulatory Health Services (HEDIS)			
	Call Answer Timeliness (HEDIS)			
	Children and Adolescents' Access to Primary Care (HEDIS)			
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS)			
	Prenatal and Postpartum Care (HEDIS)			
	Satisfaction with Care: Health Plan Information and Customer Service (CAHPS)			
	State Defined	Alcohol and Drug Misuse: Screening, Brief Intervention and Referral for Treatment (OHA 001)		
Mental and Physical Health Assessment within 60 Days for Children in DHS Custody (OHA 002)				
Patient-Centered Primary Care Home (PCPCH) Enrollment (OHA 003)				

⁹⁸Minnesota: <http://mncm.org/wp-content/uploads/2014/02/2013-HCOR-Final-2.4.2014.pdf>
 Oregon: <http://www.oregon.gov/oha/Metrics/Pages/measures.aspx>
 Pennsylvania: http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/s_002207.pdf;
http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/s_002206.pdf
 Tennessee: <http://www.tn.gov/tenncare/forms/hedis13.pdf>

	MN	OR	PA	TN
Effectiveness of Care	Developmental Screening in the First 36 Months of Life (NCQA)			
	Follow-up after Hospitalization for Mental Illness (HEDIS)			
	Follow-up Care for Children Prescribed ADHD Medication (HEDIS)			
	Human Papillomavirus Vaccine (HPV) for Female Adolescents (HEDIS)			
	Immunization for Adolescents (HEDIS)			
	Lead Screening in Children (HEDIS)			
	Medical Assistance with Smoking and Tobacco Cessation (HEDIS)			
	Pharmacotherapy management of COPD Exacerbation (HEDIS)			
	Screening for Clinical Depression and Follow-up Plan (NQF)			
	Use of Appropriate Medication for People with Asthma (HEDIS)			
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (HEDIS)			
	Use of imaging studies for low back pain (HEDIS)			
	Weight Assessment, Counseling & Physical Activity for Children/Adolescents (HEDIS)			
	Utilization and Relative Resource Use	Adolescent Well Care Visit (HEDIS)		
Adult Asthma Admission Rate (NQF)				
Ambulatory Care (HEDIS)				
Chronic Obstructive Pulmonary Disease Admission (NQF)				
Congestive Heart Failure Admission Rate (NQF)				
EHR Adoption (OHA)				
Elective Delivery Before 39 Weeks (NQF)				
Frequency of Ongoing Prenatal Care (HEDIS)				
Plan All-Cause Readmission (HEDIS)				
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (HEDIS)				
Well-Child Visits in the First 15 Months of Life (HEDIS)				

Figure 15. Summary of Published Quality Metrics by Surveyed State

Other Opportunities

Texas has implemented a contractual requirement by which MCOs must submit an annual plan describing how they will encourage value base contracting/reimbursement practices with their providers. Many of the surveyed States expressed interest in incorporating a contractual requirement to further payment reform. For example, beginning July 1, 2014, New Hampshire will withhold 1% of the total capitation amount for MCOs to implement payment reform strategies. Each MCO will have to submit payment reform strategies annually and the MCO will only recoup the withhold once implementation milestones have been achieved.

Fee-for-service provider payments remain highly prevalent within current MCO payment structures and because MCO capitation is largely built on their provider payment experience, capitation payments alone do not fully facilitate value based payment reform. Transformation of these payment structures from volume based (fee-for-service) to value based (payment more directly tied to outcomes or quality) is an essential component to achieving the CMS Triple Aim of better health, better quality, and lower cost.

Medicaid payment reform is an evolving process, one which no state has perfected. With the challenges states continue to face regarding expanding enrollment and budget constraints, the importance of effective Medicaid payment reform only continues to grow. There is no silver bullet for bending the Medicaid cost curve and improving the quality of care afforded to Medicaid beneficiaries. As each state continues to

refine its attempt at doing so, it remains difficult to isolate the impact of any given incremental reform. Pair this with the unique characteristics found within each state's population and Medicaid structure, and it is easy to understand why a prevailing market solution has not yet evolved.

Again, we appreciate the opportunity to perform this analysis for you. If you have questions or concerns regarding this analysis, feel free to reach out to Jeff Smith or Amanda Lothrop.

Sincerely,

Handwritten signature of Jeff Smith in cursive script.

Jeff Smith
Specialist Leader
Deloitte Consulting LLP

Handwritten signature of Amanda M.B. Lothrop in cursive script.

Amanda M.B. Lothrop
Manager
Deloitte Consulting LLP

Appendix A: Summary of State Programs

State of California – Current Medicaid Payment Programs⁹⁹

California’s Medical Assistance Program, known as “Medi-Cal”, is California’s primary Medicaid program. Medi-Cal focuses on low-income families, seniors, persons with disabilities, children in foster care, pregnant women, and certain low-income adults. As of October 2013, enrollment in Medi-Cal was over 8.5 million, with approximately 67% of all beneficiaries in managed care. Every county in California currently offers managed care Medicaid options.

Current Quality Care Payment Models

Medi-Cal’s capitation rate is an experience based methodology, primarily relying on data submitted by plans monthly. According to the interview, California does not currently incorporate quality measures in its capitated rate arrangements.

California uses two supplemental payments as a mechanism to adjust its capitated payments for adverse selection: maternity payments and hospital quality assurance fees. The hospital quality assurance fee (“QAF”) was established to enable the State to make supplemental payments to certain general acute care hospitals to maximize their funding (allow payments up to the upper limit). Since its inception in 2010, this program has passed \$3.4 billion to the MCOs, which is ultimately passed to the hospitals.

California relies upon two cost-efficiency measures as a means of controlling costs in the managed care Medicaid population: potentially preventable admissions (“PPAs”) and pharmacy cost management. The State identifies PPAs through encounter data using criteria from the Agency for Healthcare Research and Quality (AHRQ) Guide to Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI), while applying exclusions for enrollment duration and risk¹⁰⁰. The pharmacy cost management program has instituted a maximum allowable cost pricing adjustment for purchasing drugs. California benchmarks a list of prescription drugs annually and applies an adjustment to the base period, trended forward.

Medi-Cal capitation rates rely upon the Medicaid Rx model for risk adjustment and focuses on two categories: Adult/Family and Seniors and Persons with Disabilities (SPDs). Beneficiaries that are enrolled in either managed care or fee-for-service are included in the risk adjustment. Risk scores are based on approximately 45 conditions and 11 age-gender bands. Risk scores are risk neutral and averaged at the county level. Only a portion of the State’s capitation rates are risk adjusted: currently 40% of the rate is composed of risk adjusted figures, and the remainder 60% is the standard, plan-specific rates. California’s risk adjustment was phased in to the capitation rates over time: at the beginning, only 10% of the capitation rate was driven by risk adjustment and the State gradually increased that to its current state of 40% of the capitation rate being driven by risk adjustment. California has considered implementing rates that are 55% plan specific, 40% risk adjusted, and 5% quality adjusted; however, they struggled to identify a way to adjust the 5% quality portion in an actuarially sound capacity.

Finally, California builds a MCO tax into its capitation rates. The tax is specific to Medicaid Managed Care and is treated as sales tax. This tax raise up to \$350 million per year to supplement the general funds and address the health care needs of the Medicaid population.

⁹⁹ State of California. Phone Interview. 22 January 2014.

¹⁰⁰ http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/Webinar_022712.pdf

Current Quality Care Indicators and Link to Payment Models

During the interview with the California Department of Health Care Services, we were informed there are currently no capitation withholds or incentive payments in place to incorporate quality measures into the capitation rate development. The interviewees noted quality payment options are under consideration, but would not be implemented for at least another two to three years.

While not discussed during the phone interview with California, there is an association in place, the Integrated Health Association (“IHA”) that aligns key stakeholders to improve healthcare services. This association was not discussed during the phone interview with California, but was identified via publicly available research. IHA was established through the California Managed Care Division. Texas has requested contact information for the managed care department, but response was still pending at the time this report was written. The IHA first initiated a P4P program in 2002, which appears to have the foundation to transition to a value based incentive programming going forward¹⁰¹.

State of Florida – Current Medicaid Payment Programs¹⁰²

Florida Medicaid is currently in the process of transitioning to a statewide Medicaid managed care program composed of two components: Long-Term Care (LTC) and Managed Medical Assistance (MMA) programs. The LTC program will consolidate five home and community-based service waivers into a single managed LTC and Home and Community-Based Service (HCBS) waiver. Seven managed care plans were selected to provide these services, with the first operations beginning in one region of the state in August 2013. All 11 regions of the state will be rolled out by March 1, 2014. The MMA program will be phased-in by region between Spring 2014 and October 2014. This program will provide primary and acute medical assistance and related services.

Current Quality Care Payment Models

Florida recently completed their first successful competitive procurement for the LTC and MMA programs. Per instruction from the Florida State Legislature, this competitive procurement required MCOs to demonstrate a 5% savings over the prior year’s total spend. During the procurement process, Florida negotiated with the plans that scored the highest on the technical proposal, as long as they met the minimum 5% savings over the prior year costs. Rate ranges were published for LTC so plans knew what range their rates needed to fall within; however, rates were not published for MMA since the plans had experience. Prior to procurement, State actuaries set guidelines regarding what rates would be certifiable during the procurement process.

Current Quality Care Indicators and Link to Payment Models

In Florida, MCOs are eligible for a unique payment incentive, known as “*Achieved Savings Rebate*” (ASR). This is a new program that Florida considers to be a retained profit opportunity focused on ensuring plans are able to retain significant savings while achieving fair profits. ASR is structured to measure the revenue received from plans, service expenditures and certain allowable non-medical expenses. The current structure for retaining profits allows MCOs to retain 100% of profits up to 5%, retain 50% of the profits between 5% and 10%, and must return all profits over 10%. This allows the plans a maximum of 7.5% profit. Under the ASR, plans that attain the 7.5% profit limit are then eligible

¹⁰¹ “Health Care Payment in Transition: A California Perspective.” Prepared for California Healthcare Foundation. Pg. 20 <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PaymentReformInTransition.pdf>

¹⁰² State of Florida. Phone Interview. 19 December 2013

for an additional 1% incentive payment, based on their performance in a pre-determined set of measures. The plan is compared to national HEDIS benchmarks for six performance measure groups. For the first year, plans must achieve the 60th percentile or above, as compared to national averages. In subsequent years, plans must perform at the 75th percentile, as compared to national averages. This program has allowed Florida to move away from heavy reliance on the Minimum Loss Ratio (MLR) while building on some of the strengths of MLR.¹⁰³

Additional Results and Commentary

This was Florida's first ever successful competitive procurement, and the largest competitive procurement in Florida history. Florida attributes this procurement's success to two primary components: publishing the rate ranges for LTC so the plans had parameter in place; and negotiating with technically eligible MCOs based on the cost proposal. One of the challenges for Florida going forward will be how to maintain the savings demonstrated in the initial MCO cost proposals.

Florida previously faced challenges with insufficient denominators; however, the recent competitive RFP process reduced the number of MCOs in the state so Florida is hopeful this will mitigate the issue. If having fewer plans still does not result in large enough denominators for the measures, Florida plans to only include the measures that meet minimum thresholds.

State of Kansas – Current Medicaid Payment Programs¹⁰⁴

In 2013, Kansas moved most of its Medicaid beneficiaries to a managed care model known as KanCare. Kansas used a competitive RFP bidding process and ultimately awarded five-year contracts to three statewide MCOs. Kansas essentially turned off the FFS switch on December 31, 2012 and turned the managed care switch on January 1, 2013.

Current Quality Care Payment Models

Given the major structural change Kansas went through in 2013, the rate development process also evolved.

Kansas strives to establish capitated rates that are as population-specific as is feasible given resource constraints. During the competitive bidding process, each MCO was able to offer a discount to the base data provided in the databook with the RFP. MCOs had to commit to this discount rate for the duration of the contract and certify they would be financially sound using the subsequent rates.

To ensure the recent Medicaid changes are being fairly and accurately reflected in the capitated rates, Kansas performed a mid-year review to compare scheduled capitated rates against actual 2013 experience. A mid-year rate increase was implemented in 2013. Going forward, Kansas' capitation rates are scheduled to be adjusted on an annual basis; however, Kansas will continue to perform a mid-year rate review and will apply mid-year adjustments if needed. Given the recent drastic shift the state's Medicaid program recently underwent, this has proved to be a valuable tool that has increased buy-in from participating MCOs.

¹⁰³ http://ahca.myflorida.com/medicaid/quality_mc/pdfs/2013_Draft_Comprehensive_Quality_Strategy_Update_08-29-2013.pdf

¹⁰⁴ State of Kansas. Phone Interview. 3 December 2013

Current Quality Care Indicators and Link to Payment Models

In the first year of the contracts, three percent of the MCO's payments will be withheld. In the following two years, five percent will be withheld. The percentage withhold is tied to six performance measures in the first year, with each measure worth 50 basis points of the withhold. The focus in the first year is on operational metrics as those metrics are more universally measured, and theoretically easier to reach agreement on. Fifteen performance measures will be tied to the five percent withhold in later years, with each measure being worth one third of a percent. These measures are on the medical level, and are equally divided between behavioral health, physical health, and long-term care services. The measures were determined during the process of developing the RFP, and established as a result of a combination of stakeholder input, as well as MCO and provider feedback. The measures that go into effect in year two will be compared to the actual results found in year one. Some measures will be evaluated monthly, some quarterly, and some annually, but all measures are reconciled annually and determined if they are met or unmet. KanCare health plans who meet the State target on some, but not all, of the required measures can receive a portion of the withhold back.

Kansas MCOs may consider the premium withhold to be a discount on the LCE; however, CMS requires the MCOs certify they will remain financially sound at the discounted level.

Additional Results and Commentary

In the first year of KanCare, providers have expressed concerns, but overall has been a positive experience. KanCare is a significant change to how healthcare is delivered to the Medicaid population in Kansas, and with this change comes differences in how claims are filed, paid and processed. Some providers were not initially paid as timely as they wanted, but all payments fell within contract terms. There have also been some challenges with encounter data so they have struggled to validate self-reported information from MCOs.

State of Minnesota – Current Medicaid Payment Programs¹⁰⁵

Medical Assistance (MA) is Minnesota's Medicaid program which includes four distinct programs: Prepaid Medical Assistance Program (PMAP), Minnesota Senior Care Plus (MSC+), Minnesota Senior Health Options (MSHO), and Special Needs Basic Care (SNBC). In 2013, Minnesota did an RFP for the managed care contracts in 27 of the 87 counties in Minnesota.

Minnesota has a SIM grant for approximately \$45 million. The primary focus of the SIM grant is to better enable the provider community to take on risk contracts via direct contracting with public programs and private sector carriers. In 2011, Minnesota issued an RFP for providers to establish ACO-style contracts, known as the Health Care Delivery System (HCDS) model. The HCDS demonstration is intended to deliver higher quality and lower costs through innovative approaches to care and payment. Similar to the CMS Medicare Shared Savings Program (MSSP), delivery systems can share in savings during their first year of participation. After the first year, they also share the risk for losses. Delivery systems' total costs for caring for enrollees in Medical Assistance are measured against targets for cost and quality.

¹⁰⁵ State of Minnesota. Phone Interview. 08 January 2014

Current Quality Care Payment Models

Capitation rate ranges are developed for the counties not included in the competitive bidding process. Rates for the metro counties that participated in the competitive RFP vary by each participating MCO based on the bid process and negotiations between Minnesota and each plan¹⁰⁶. Five percent of each plan's capitation rate is withheld annually and returned pending the plan's completion of performance targets related to various process and quality measures.

Current Quality Care Indicators and Link to Payment Models

Because the competitive managed care RFP was new to Minnesota, there was some confusion and potential concerns from the MCO community. Minnesota held individual meetings with many of the MCOs to address potential concerns and scheduled conferences to enable detailed group discussions regarding the RFP with the State's MCOs.

The 2012 quality measures for the five percent withhold were a mix of administrative and clinical measures. The administrative measures have generally been achievable for plans, but the clinical measures are more challenging for MCOs to meet; consequently, some of the withhold funds were actually retained by the State in 2012. The State will continue to move towards having more clinical measures than administrative measures to ensure health plans continue to strive to achieve the 5%. As Minnesota tightens down the rates, it is hard to have significant dollars at risk while still having the rates satisfy other requirements.

In the Health Care Delivery System model, two different types of contracts were offered: gain sharing or gain/risk sharing. The solely shared savings model is most commonly utilized by smaller organizations. Participants in both the managed care and FFS programs are attributed to organizations participating in the HCDS model. To ensure the cost savings generated under this model do not come at the expense of quality, all HCDS participants must meet established quality metrics in order to achieve savings.

Additional Results and Commentary

Minnesota attributes its recent Medicaid program savings to the use of the competitive bidding process for the managed care population. In prior procurements, if an entity met the federal definition of MCO, they could submit a proposal. Under this competitive procurement process, Minnesota only considers plans that meet a minimum technical threshold and base the ultimate decision on plans who demonstrate the most efficiencies from a cost perspective. This has reduced the number of MCOs functioning in the State. With the reduction in MCOs, there have been some challenges during the transition. Continuity of care was one the biggest challenges they faced as a result of the competitive procurement process.

State of Oregon – Current Medicaid Payment Programs¹⁰⁷

Launched in August 2012, the Coordinated Care Organization (CCO) initiative calls for the formation of a cross-functional network of all health care providers working together to provide medical services to persons covered under the Oregon Health Plan (Medicaid). As of September 2013, 16 CCOs are in operation.

¹⁰⁶ http://www.publicrecordmedia.com/wp-content/uploads/2012/05/MNGDPAMNDHS2012B_pd_029.pdf, pg. 27.

¹⁰⁷ State of Oregon. Phone Interview. 11 December 2013 and 19 December 2013

Current Quality Care Payment Models

Oregon currently has one budget that grows at a fixed rate for mental health, physical health, and ultimately dental care. The rate development process in Oregon recently changed. Historically, rates were set statewide, risk adjusted to the plan level, and altered according to what rate was needed to keep the managed care plans in business. Oregon no longer sets rates according to the MCO's fiscal requirements. Oregon now sets boundaries on what services the State requires and all contractors must pledge to fulfill these requirements. Oregon gives CCOs guidelines and the plans have the option to either conform their business model to be able to meet the rates provided or withdrawal their bid for consideration. The Oregon Health Authority's Actuarial Service Unit develops a cost and rate template for CCOs to submit their cost and rate estimates for each individual eligibility category. The Actuarial Service Unit looks at each bid produced by the CCO to determine if it is actuarially sound and consistent with the State internal expectations. If the State cannot accept the proposed rate, the bid will send it back to the CCO for revision. Currently, rates are being set on a quarterly basis due to roll-in plans. However, Oregon's goal is to set rates annually.

Current Quality Care Indicators and Link to Payment Models

All Oregon CCOs participate in "Quality Pool Funding," which is a pool totaling 2% of the aggregate CCO payments. The payments are made completely outside of the capitation rates, and are considered an expenditure from a budget perspective. Oregon plans to increase the incentive percentage on an annual basis, and has a waiver in place that allows the supplemental pool to grow to 5%. The entire pool is paid out annually, and the distribution is paid out in two stages.

In stage 1 the distribution is made based on a CCOs performance against the 17 measures identified by the Metrics and Scoring Committee. The portion of the fund that a CCO receives is based on their performance compared to benchmarks, which is also determined by the Metrics and Scoring Committee. For 13 of the 17 incentive measures, the payments are based on the number of measures for which they reach an absolute benchmark or improvement target. For the 3 clinical measures (diabetes blood sugar control, hypertension control, and depression screening), funds are distributed in advance based on the CCO's submission of a technology plan for collection of the necessary data and initial submission of proof of concept data. The last of the 17 measures is associated with Patient Centered Primary Care Homes (PCPCH) and is measured according to a tiered formula.

Stage 2, known as the Challenge Pool Distribution, is a pool consisting of all the funds that were not allocated during Stage 1. For CCOs that qualify, the fund is distributed based on a subset of 4 measures: diabetes blood sugar control, depression screening, PCPCH enrollment, and the SBIRT measure (Screening, Brief Intervention, Referral to Treatment. SBIRT represents an innovative, evidence-based approach to addressing unhealthy alcohol use in a primary care setting. Using these measures, the Oregon Health Authority will calculate the base payment to be distributed. The base payment is calculated by taking the total number of measures met by CCOs and dividing by the total challenge pool. For example, if the challenge pool is \$1 million, and 10 CCOs meet the PCPCH target, 5 meet the SBIRT target, 3 meet the depression target, and 2 meet the diabetes target, the \$1 million challenge pool would be divided by 20 ($20 = 10+5+3+2$), and the base payment would be \$50,000. The base payment is then adjusted based on average monthly enrollment.

Additional Results and Commentary

Oregon believes one of the most successful aspects of their program is their strong relationship with the CCOs. One of the reasons for these strong relationships is that Oregon designates a single point of contact who is made available to the CCOs to address all questions regarding quality measures and the reporting and analyzing of their results. Oregon also provides CCOs with reports on a monthly basis, which Oregon believes has led to an improved mutual understanding of how the measures are reported. Not only do the plans benefit from receiving these reports on a monthly basis, but it also enables the State to be responsive to the data and results. Finally, there is also a Quality and Health Outcomes Committee which holds “office hours” on a monthly basis. These office hours allow plans to call in and ask questions around metrics and data. All plans are allowed to call in and listen to the questions and answers, which has improved the openness and availability for plans.

Oregon publishes Quarterly Progress Reports, showing the performance of the CCOs on 33 designated measures. Of these measures, 17 are linked to incentive payments, and the remaining measures are data the CCOs are required to submit to the State to be reported publicly. Some of the noted improvements based on the Quarterly Progress Report published in November 2013 are included in the table below:

Utilization and Spending Compared to 2011 Reported in November 2013 Using January – June 2013 Data¹⁰⁸		
Measure	Utilization	Spending
Emergency Room Visits	down 9%	down 18%
<i>Hospitalization for Chronic Conditions</i>		
Congestive Heart Failure	down 29%	
Chronic Obstructive Pulmonary Disease	down 28%	
Adult Asthma	down 14%	
Primary Care Outpatient Visits	up 18%	up 7%
Adoption of Electronic Health Records	up 29%	

Figure 16. Summary of Changes in Oregon’s Utilization and Spending

State of Pennsylvania – Current Medicaid Payment Programs¹⁰⁹

Pennsylvania’s mandatory Medicaid managed care program, HealthChoices, began in 1997 and offers physical and behavioral health as the two primary services. The Department of Public Welfare (DPW) implemented P4P in the HealthChoices programs in July 2005 as a means of shifting from paying for care to paying for quality of care.

Current Quality Care Payment Models

Pennsylvania has a 1915 (b) waiver to meet CMS requirements for actuarial soundness. Pennsylvania’s P4P program focuses on financial incentives to the MCOs based on performance relative to HEDIS benchmarks and year-over-year improvements. As P4P has evolved, was implemented, Pennsylvania has

¹⁰⁸ <http://www.oregon.gov/oha/Metrics/Documents/report-november-2013.pdf>.

¹⁰⁹ State of Pennsylvania. Phone Interview. 6 December 2013

begun paying lower in the rate ranges and offering MCOs more opportunity to earn additional revenue via the P4P. Given the way the State's P4P progressed, Pennsylvania does not implement a capitation withhold. That said, Pennsylvania does incorporate an offset to discourage poor performance by withholding a portion of funds from an MCO whose quality measure falls below the 50th percentile of the national HEDIS benchmark.

Current Quality Care Indicators and Link to Payment Models

Pennsylvania's P4P program included 11 HEDIS measures in 2013, as well as one customized Pennsylvania performance measure. These measures were determined by the Medical Director who works closely with the State's MCOs. MCOs in Pennsylvania have played an active role in shaping the evolution of the program. Pennsylvania has found there is less opportunity for improvement as the program ages because the MCOs are consistently improving their performance. The P4P measures are generally based on the HEDIS 50th percentile and prescribed year-over-year improvements. The capitation rate offset relies on these same measures and is intended to discourage poor performance. For each measure that falls below the 50th percentile nationally, the MCO pays an offset equal to 25% of the incentive payment. The offset does not take into account whether the MCO shows no improvement, or even if they decline, but is solely applied to plans that fall below the 50th percentile nationally for a given measure. Pennsylvania rarely has to apply the offset as most of the State's plans consistently operate above the national average. Whenever the offset is applied, it typically affects new plans who have not had as much experience being evaluated on the HEDIS measures. Plans rarely have the offset applied multiple years in a row.

Additional Results and Commentary

From the program's inception to 2011, there has been statistically significant improvement in 11 of the 12 measures used over that time¹¹⁰. While there has not been significant improvement in recent years, Pennsylvania believes this is because there is little room available for improvement on these measures.

State of Tennessee – Current Medicaid Payment Programs¹¹¹

Tennessee has been employing Medicaid managed care programs since 1994 through TennCare, including physical health, behavioral health, and long-term living services. Tennessee recently shifted to a competitive bidding process during which the State selected three contractors in late 2013 to provide managed care services in all three regions of the state. In addition, Tennessee also has a State health plan, *TennCareSelect*, which was originally established to be a backup if other plans failed or if there was inadequate MCO coverage in a given area. Tennessee has not needed to use this as a backup plan in recent years and now uses this as a program to enroll specific populations, such as Intellectually Disabled wavier populations, and manage benefits for undocumented populations.

Current Quality Care Payment Models

During the most recent competitive procurement, Tennessee provided appropriate capitated rate ranges prior to the MCO bids. Consequently, there was little variation in the cost component of the procurement process. Instead, about 70% of the decision was based on the technical components.

¹¹⁰ http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/s_002207.pdf

¹¹¹ State of Tennessee. Phone Interview. 13 December 2013

Over the next 3-5 years, Tennessee will be shifting the majority of healthcare spending across Tennessee's public and private sector into outcome-based payment and service delivery models. The shift is occurring because plans and providers in Tennessee (and much of the country) are still heavily reliant upon a fee-for-service model, which consequently means that providers who are striving to provide more integrated care coordination are failing to be appropriately rewarded for their efforts. This initiative, while still in the implementation stage, focuses on two core components: episode-based payments and Patient Centered Medical Homes.

Current Quality Care Indicators and Link to Payment Models

For 2011, HEDIS measures were selected as the basis for the P4P quality incentives payments. Payments are made if the contractor shows significant improvement, as defined by NCQA's minimum effect size change methodology, over the preceding calendar year. Tennessee previously used national benchmarks to determine if a plan had met them, but found it to be less meaningful than they anticipated. As such, Tennessee moved to measuring improvement via NCQA standards. While results were not formally captured, Tennessee believes they've seen more plans able to achieve improvement since this evaluation switched occurred in 2006-2007. Formal MCO evaluations take place annually, but Tennessee still monitors each plan's performance on monthly and quarterly basis using an internal dashboard.

Stakeholders are very involved in the design and implementation of the programs. Tennessee formed three committees to better enable dialogue around programmatic changes. The payer committee, composed of managed care organizations, meets every other week. The provider committee, composed of representatives of organized benefits, meets monthly. Finally, there is the technical advisory group, composed of a cross-functional sampling of clinicians, meets four to five times per year. The technical advisory group provides expertise and guidance around program specifics associated with each new episode of care to be incorporated in the payment reform process. In addition, there are four public Open Tables per year, as well as one-on-one meetings with large employers.

Tennessee has noted that approximately 60-70% of their spending is associated with acute care. As a means of addressing this challenge Tennessee has recently shifted its focus to a more unique quality payment model: episode-based payments. The episode-based payment program identifies the Principal Accountable Provider (PAP), or what Tennessee refers to as the "Quarterback." The quarterback is provided with actionable information including, but not limited to, the lab work that was done, number of office visits, and the total cost of care associated with each payment. Currently, there are 3 episodes being used and the State intends to roll out a new episode every six months after the program is up and running. During the first wave of implementation, there will be a reporting-only period where there participants will not face financial risks. After this reporting period, each PAP will be eligible for gain sharing or bear financial risks based on his/her performance.

Additional Results and Commentary

Although Tennessee offers financial incentives based on HEDIS measures, the interviewees believe the single greatest driver of success in the State's Medicaid program thus far results from publicly publishing performance data. Tennessee publishes the results of all Medicaid applicable HEDIS measures, not just those used in the pay-for-performance program. Tennessee believes that by making this information publicly available they not only better inform the Medicaid beneficiaries, but they also ignite the competitive nature of the plans in the state.

State of Wisconsin – Current Medicaid Payment Programs¹¹²

Wisconsin primary Medicaid program is BadgerCare, which covers any child under the age of 19. Wisconsin plans to expand to 100% federal poverty level coverage for childless adults and the SSI population. The managed care SSI program will be implemented in 2014. Wisconsin also offers coverage through the State's Division of Long-Term-Care: Family Care (FC), Program of All-Inclusive Care for the Elderly (PACE), and Family Care Partnership (FCP).

Current Quality Care Payment Models

For the past two years, Wisconsin has used encounter data (priced at a FFS level) to establish its capitated rates. To evaluate the encounter data, the State runs data through CMS Medicaid Management Information Systems (MMIS) to price encounter data at the FFS level, and it is a huge undertaking. In an effort to evaluate how that compares to what is actually being paid, the State recently began collecting paid data (with consideration for any financial adjustments). Wisconsin recently converted to the "8375010" model, which is in the very early stages, and hopes to use both encounter and paid data in its capitated rate determinations going forward.

Wisconsin relies upon a capitation withhold program to incorporate MCO performance in the payment process. The Wisconsin Medicaid program had previously split the state into six regions, with the MCOs in regions 5 and 6 selected through a competitive RFP. Previously, the capitation rate in regions 5 and 6 were at risk for 3.25% of the capitation rate, and regions 1-4 had 1.5% of the capitation rate. Wisconsin is currently finalizing contracting a 2.5% capitation rate withhold for all regions, as they are looking to consolidate the program.

The existing competitive procurement process led to challenges, such as one plan bidding too low as a means of getting in the door and subsequently having to pull out of the contract for lack of financial viability. Due to the challenges faced in the competitive bidding process, the State made the business decision to move away from the procurement model for the time being. Wisconsin did mention they may go back to competitive bidding in the future, but for the time being they will move to a prescribed statewide rate setting process.

Current Quality Care Indicators and Link to Payment Models

The Wisconsin Department of Health Services introduced a multi-year P4P program in 2009, as incentive-based payment approach that paid MCOs for meeting or exceeding prescribed benchmarks. The program has since been altered to be a capitation withhold program where 2.5% of capitated payments will be withheld starting in 2014. The P4P measures are HEDIS-based and are primarily geared towards improving quality. Meaningful measures for Wisconsin are driven by the Statewide Value Committee, the CMS "Core Set of Adult Health Care Quality Measures" and the "Core Set of Children's Health Care Quality Measures".

During the measurement development period, the Medicaid program wanted to align with the State's public health agenda, as well as target the areas where improvement was most needed. The measures change on a contract basis, which is currently two years, but the State tries not to alter the methodology or number of measures. The measures are calculated annually to determine if the benchmarks have been met. The baseline for these measures has changed as the program has evolved. Currently, Wisconsin

¹¹² State of Wisconsin. Phone Interview. 17 December 2013

purchases the NCQA Quality Compass, which breaks into percentiles how plans are performing across the country. Most of the measures are based on the 75th percentile of this report, but there are a few measures based on past performance and utilization to achieve the improvement measure.

Additional Results and Commentary

Public reporting is a statewide goal and Wisconsin is currently looking to develop report cards they can provide to members during enrollment so members are able to better understand the options they have available. The Statewide Value Committee is working on how they can report core measures across all state programs.

One of the successful practices Wisconsin learned during the early years of its P4P program was to hold separate one-on-one meetings with each of the State's MCOs. In particular, Wisconsin now makes sure that quality and medical directors are involved in these one-on-one meetings and not just the business unit.

State of Arizona – Current Medicaid Payment Programs

Arizona's managed Medicaid program, generally referred to as the Arizona Health Care Cost Containment System (AHCCCS), began in 1982 as the first statewide Medicaid managed care system in the nation. AHCCCS oversees three programs: AHCCCS Acute Care, Arizona Long Term Care System, and KidsCare¹¹³. During Fiscal Year 2014, AHCCCS is expected to spend approximately \$9.5 billion to provide health care coverage to over 1.3 million Arizonans. This coverage will be provided through contracts with 11 MCOs that depend on over 55,000 providers¹¹⁴.

Current Quality Care Payment Models

Arizona continues to explore payment reform models. One example of this is a shared savings arrangement equal to 5% or more of their contracted medical spend to compete for capitation withhold incentives. This began on October 1, 2013 and all health plans are required to enter into this arrangement¹¹⁵.

Arizona will be transitioning from a per diem model to an All Patient Refined Diagnostic Related Grouper (APR-DRG) methodology for hospital reimbursement beginning in October 1, 2014¹¹⁶.

Current Quality Care Indicators and Link to Payment Models

Since July 2011, AHCCCS has been administering Medicaid EHR Incentive payments to eligible professionals and hospitals, with payments totaling over \$132 million¹¹⁷.

State of New Hampshire – Current Medicaid Payment Programs

New Hampshire established the Medicaid Care Management program in response to the 2011 State Legislature's direction to develop a statewide managed care program for all Medicaid program enrollees.

¹¹³ http://www.azahcccs.gov/reporting/Downloads/StrategicPlans/StrategicPlan_14-18.pdf
¹¹⁴ http://www.azahcccs.gov/reporting/Downloads/PaymentModernizationPlan_SFY2014.pdf
¹¹⁵ http://www.azahcccs.gov/reporting/Downloads/StrategicPlans/StrategicPlan_14-18.pdf
¹¹⁶ http://www.azahcccs.gov/reporting/Downloads/StrategicPlans/StrategicPlan_14-18.pdf
¹¹⁷ http://www.azahcccs.gov/reporting/Downloads/StrategicPlans/StrategicPlan_14-18.pdf

The Care Management program will be rolled out in three stages. The first stage will include all State Amendment services, with the exception of dental and long term care services for all New Hampshire beneficiaries. The second stage will begin mandatory enrollment for all populations, upon CMS approval. The third step will allow for enrollment of any New Hampshire Medicaid expansion populations that may result from the State's implementation of the ACA¹¹⁸.

Current Quality Care Payment Models¹¹⁹

In an effort to adhere to the State's Quality Strategy, all MCOs are required to develop, maintain and operate a Quality Assessment and Performance Improvement (QAPI). The QAPI will outline the MCOs four selected Performance Improvement Projects (PIP), one of which must have a behavioral health focus. The State will begin having quarterly meetings with the three MCO Medical and Quality Improvement Directors, which will routinely bring all of the MCOs together, and as much as possible, harmonize quality initiatives across the three MCOs and the New Hampshire Medicaid program.

In addition to the PIPs, the New Hampshire DHHS will also select four quality measures to evaluate MCO performance for its Quality Incentive Program (QIP). For each measure, the MCO will be eligible for .25% of the premium withhold. The MCO must meet or exceed improvement targets to be eligible for the incentive payment.

A relatively new initiative for New Hampshire is the Medicaid Quality Indicators, which will make data publicly available on the New Hampshire Indicator website, aimed to enhance the identification of program strengths and opportunities. Currently the data collected and reported includes all of the CMS Core Set of Adult and Child Quality Indicators. The State will be contracting with an External Quality Review Organization (EQRO) to audit and validate the encounter data submitted by the MCOs.

Current Quality Care Indicators and Link to Payment Models

The four measures selected by the State for QIPs in Calendar Year 2013 are the following:¹²⁰

- Timeliness of Prenatal and Post-partum Care (PPC) (HEDIS)
- Follow Up After Hospitalization for a Mental Illness Within 7 Days of Discharge (HEDIS)
- Parental Satisfaction with Children Getting Appointments for Care (CHAPS)
- Satisfaction (Adults) with Getting Appointments for Care (CHAPS)

State of New Jersey – Current Medicaid Payment Programs

New Jersey began moving Medicaid beneficiaries from fee-for-service to managed care in 1995. Currently, there are approximately 1.3 million residents are covered through the Medicaid programs¹²¹. A bill was signed into law in August 2011 that established a three-year Medicaid Accountable Care Organization (ACO) Demonstration Project. This project is intended to test and demonstrate the effectiveness of ACOs for Medicaid recipients. New Jersey submitted an 1115 Medicaid demonstration waiver to seek authorization to design the ACO pilot program. Some of the requirements include, but are

¹¹⁸ <http://www.dhhs.nh.gov/ombp/caremtg/documents/qualitystrategydraft9-4-2013.pdf>

¹¹⁹ <http://www.dhhs.nh.gov/ombp/caremtg/documents/qualitystrategydraft9-4-2013.pdf>

¹²⁰ <http://www.dhhs.nh.gov/ombp/caremtg/documents/qualitystrategydraft9-4-2013.pdf>

¹²¹ <http://www.state.nj.us/humanservices/dmahs/home/index.html>

not limited to, defining a gain-sharing arrangement, defining a quality plan, and defining a community engagement process¹²².

Current Quality Care Payment Models

The ACO's start-up revenue will come of total cost of care for the designated area. In future years of the program, the ACO's revenue will come from a combination of gain sharing and outside capital investment¹²³.

Current Quality Care Indicators and Link to Payment Models

Twenty-one quality metrics must be measured and reported as part of the ACO demonstration. The mandatory measures consist of 6 different categories: Prevention and Effectiveness of Care, Acute Care, Behavioral Health, Chronic Conditions, Resource and Utilization, and Patient Experience. There are also six voluntary measures required to be submitted by the plans. Although these measures are required, they are considered voluntary because the ACOs can choose one of the fourteen Prevention and Effectiveness of Care, and select five of the twenty-five Chronic Conditions. Furthermore, the ACOs report six additional quality measures however these measures are not included in the gain-sharing.

State of New York – Current Medicaid Payment Programs

The New York State Department of Health was awarded a SIM grant by the CMS Innovation Center in April 2013, to develop a State Healthcare Innovation Plan (SHIP) with the goal of achieving improved health, lower cost, and better quality/experience¹²⁴. SHIP is composed of five pillars: improve access to care for all New Yorkers, without disparity; integrate care to address patient needs seamlessly; make the cost and quality of care transparent to empower decision making; pay for healthcare value, not volume; and promote population health¹²⁵. The long-term goal for New York is to have all Medicaid members enrolled in high-quality, fully-integrated care management plans in five years¹²⁶.

Current Quality Care Payment Models

New York created the Medicaid Redesign Team (MRT), which changed the Medicaid budget discussion, creating a new global Medicaid spending cap and giving the Commissioner of Health the power to enforce that cap. The cap provides savings for both the state taxpayers and the federal government. All new expenditures are analyzed to assess their impact on both cost and quality.

New York has a large set of performance measures for Medicaid Managed Care that has been in place for over 15 years. The MRT is expanding to create a more comprehensive set of measures that will measure performance across the entire state's health plans, not just managed care. There are two sets of performance measures that have been developed, with the first being Medicaid core measures which build off existing measures such as HEDIS and CAHPS. The other set of measures are the population core measures, which will align New York's public health goals and monitor quality across all payers¹²⁷.

¹²² http://www.chcs.org/usr_doc/New_Jersey_Medicaid_ACO_Business_Planning_Toolkit_Final4.pdf

¹²³ http://www.chcs.org/usr_doc/New_Jersey_Medicaid_ACO_Business_Planning_Toolkit_Final4.pdf

¹²⁴ https://www.health.ny.gov/technology/innovation_plan_initiative/

¹²⁵ https://www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_state_health_innovation_plan.pdf

¹²⁶ http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf

¹²⁷ http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf

Current Quality Care Indicators and Link to Payment Models

The New York Department of Health began a pay-for-performance program known as “Quality Incentive” in 2002. The program uses a standardized algorithm to award health plans for high quality in Effectiveness of Care, Access and Availability, and Use of Services. The plans can also have points deducted for lack of compliance with managed care requirements. Plans are able to earn up to an additional 3% per member per month premiums¹²⁸. The following table shows the number of plans earning the maximum incentive, partial incentive and no incentive for 2007 – 2012. The last row also shows the expenditures in each year.

New York Quality Incentive Program Statistics¹²⁹						
Number of Plans	2007	2008	2009	2010	2011	2012
Full Award (3% PMPM)	2	3	1	1	1	2
Partial Award (any tier between full and none)	12	17	13	13	11	10
No Award (0% PMPM)	11	3	6	4	6	6
Dollars (millions)	\$62.3	\$76.7	\$49.5*	**	\$159.5	\$181

Figure 17. Summary of Key New York Quality Incentive Program Statistics

* Reflects 85% reduction to the QI from 12/1/09 - 2/28/10.

**QI 2010 in effect until April 2012. October 2010 - March 2012 QI was reduced by .5% resulting in revised tiers of .5%, 1.5% and 2.5%. April 2012 Phase 2 - QI was reduced by .3% resulting in revised tiers of .7%, 1.7% and 2.7%.

¹²⁸ https://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf
¹²⁹ https://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf

Appendix B: Commercial Payment Reform in Texas¹³⁰

In July 2011 the governor of Texas signed SB-7, an omnibus bill containing numerous provisions relating to the administration, quality, and efficiency of health care, health and human services, and health benefits programs in Texas. The legislation allows the Texas Department of Insurance to certify Health Care Collaboratives (HCCs), new entities composed of physicians and health care providers that can contract with payers to assume responsibility for a range of health care services. HCC's must demonstrate the ability and processes to promote and measure quality-based care for certification.

HCCs can contract for, accept, and distribute payments from public or private payers based on fee-for-service or alternate payment methodologies, including:

- Episode-based or condition-based bundled payments,
- Capitation or global payments, and
- Pay-for-performance or quality-based payments.

Health Care Collaboratives are required to have processes in place to report on measures of quality and cost of health care services, utilization patterns, and availability of services. The statute requires that HCCs establish standards and procedures relating to the development, implementation, monitoring, and evaluation of:

- Evidence-based practices and other processes to improve the quality and control the cost of health care services provided by participating physicians and health care providers, including practices or processes to reduce the occurrence of potentially preventable events, and
- Processes to improve patient engagement and coordination of health services provided by participating physicians and providers.

Regulations proposed by the Texas Department of Insurance in September 2012 would require that HCC continuous quality assurance and quality improvement programs include practice evaluation tools including:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys developed by the Agency for Healthcare Research and Quality,
- Agency for Healthcare Research and Quality standards, and
- National Quality Forum standards.

Further quality measurement and evaluation requirements can be specified in contracts between individual HCCs and payers.

¹³⁰ <http://www.nashp.org/aco/texas>