Executive Insights

Volume XIX, Issue 35

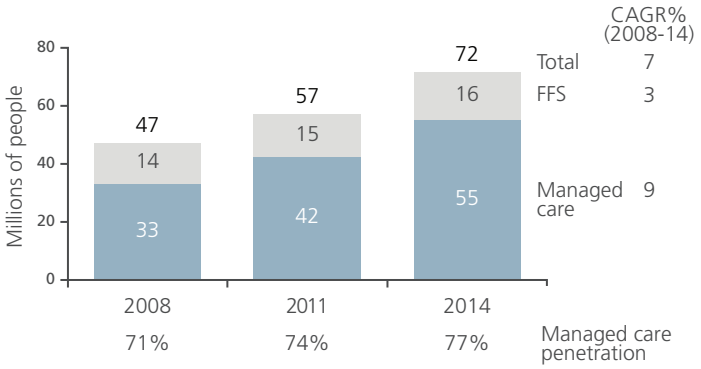
# Toward the Stick (From the Carrot): The Evolution in Medicaid MCO Pay-for-Performance Programs

In the midst of the continuing uncertainty related to the "repeal and replace" of the Affordable Care Act (ACA), those with an eye on Medicaid programs are bracing for reduced funding in some form, whether or not they manifest in block (per capita) payments. The likely outcome is that managed Medicaid will continue to grow, and states will continue to pressure managed care organizations (MCOs) through more-stringent Medicaid contract requirements to demonstrate value for payments — including downside risk for failure to perform.

Even before the enactment of the ACA and throughout the past eight years, states have adopted managed Medicaid contracts that fall along a spectrum of risk models, including comprehensive risk-based managed care and primary care case management programs (PCCMs). Managed care offers governments a number of benefits relative to traditional fee-for-service (FFS) models, including improvements to access and quality of care, more predictability over costs, and the ability to better incentivize private payers to exert cost control. Between 2008 and 2014, the number of Medicaid recipients living under some form of managed care has grown at 9% annually, reaching 55 million, or 77% of the eligible population (see Figure 1). Further growth is expected, as states enroll newly eligible Medicaid beneficiaries into managed care programs and shift long-term services and supports into managed care.

The rise in managed care has enabled states to hold MCOs accountable for performance metrics through increasing emphasis on pay-for-performance (P4P) programs. The state regulators define metrics that measure the quality, efficiency and value

Figure 1
Managed care and FFS Medicaid enrollment (2008-2014)




Source: Kaiser Family Foundation

*Toward the Stick (From the Carrot): The Evolution in Medicaid MCO Pay-for-Performance Programs* was written by **Todd Clark** and **Joan Kim**, Managing Directors, and **Neil Menzies**, Manager in L.E.K. Consulting's Healthcare Services practice. **Catrina Pheeney**, Consultant, also contributed to this article.

For more information, please contact **healthcare@lek.com**.

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Table 1
State pay-for-performance incentive types

| Incentive type | Description | |
|---|---|---|
| Upside | Bonus payments | States offer bonuses to MCOs achieving certain quality benchmarks<br>Bonuses typically range from 0% to 5% of revenue |
| Downside | Withhold | States withhold a portion of capitation payment on an annual or monthly basis and allow MCOs to recover payment only upon achievement of quality benchmarks<br>States typically withhold between 1% and 10% of capitation payment |
| Downside | Penalties | States charge fines or place sanctions on plans that fail to meet certain quality standards |
| Upside and downside | Auto-assignment preference | States preferentially place members who do not actively select a plan into plans with high quality scores |
| | Shared incentive pools | States withhold a portion of payment and pool the withheld funds from all MCOs to create an incentive pool<br>MCOs can earn money from the incentive pool based on performance<br>States typically withhold from 0% to 5% of revenue per plan |
| | Differential reimbursement | States increase or decrease capitation payments based on plan performance |

of healthcare provided to a population as incentives for care providers to optimally care for patients.

States utilize a range of mechanisms to incentivize MCO performance. These include upside programs ("carrots") such as bonus payments to MCOs that have achieved certain quality benchmarks. Alternatively, states can use downside programs ("sticks") such as withholds and penalties. Under a withhold program, portions of capitation payments are withheld on an annual or monthly basis, allowing MCOs to recover payment only upon achievement of quality benchmarks. Penalties come in the form of fines or sanctions on plans that fail to meet certain standards. Additionally, there are incentives that contain a combination of carrots and sticks, in which preferential auto-assignment of newly eligible members, allocation of shared incentive pools or differential capitation rates are implemented based on plan performance (see Table 1).

States with P4P in place have shown a tendency to evolve their programs, forcing MCOs to adapt their performance focus. First-generation models largely involved incentives or bonuses paid on top of standard capitation payments in return for meeting or exceeding certain pre-established performance metrics. In the recent past, however, states have increasingly adopted downside-oriented elements into their incentive programs. Our analysis of P4P plans in 35 states suggests a trend toward withholds and penalties — usage of incentives that transfer substantial downside risk to the MCO based on performance on specified metrics (see Figure 2). This points to a new reality for MCOs — fulfilling quality measures is part and parcel of obtaining full capitation payments.

In October 2015, the Kaiser Family Foundation noted that introducing a withhold structure into P4P was the most common change for states in 2015 and 2016: "In FY 2015, a total of 21 states implemented new or expanded quality initiatives and 19 states planned to do so in FY 2016. The most common initiative that was new or expanded in FY 2015 and 2016 was managed care payment withholds tied to quality performance" (see Figure 3).

## Case study: District of Columbia Department of Health Care Finance

In order to incentivize performance on care coordination, the DC Department of Health Care Finance implemented a P4P program beginning in October 2016. Since then, DC Medicaid MCOs have been required to meet performance goals in order to receive their full capitated payment rate, requiring reductions in the incidence of the following three patient outcomes:

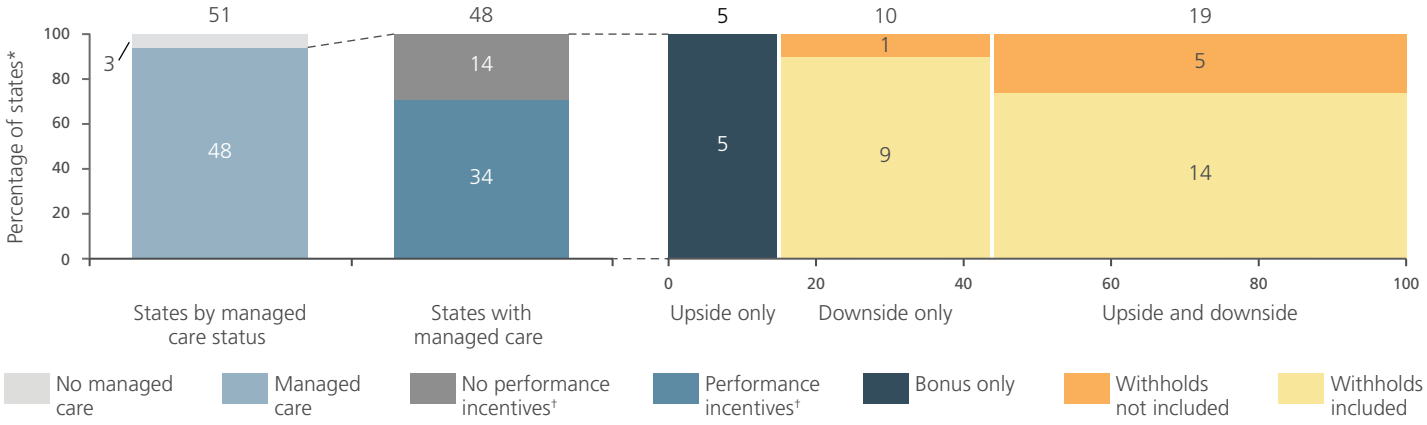
- Potentially preventable admissions (PPA)
- Low-acuity non-emergent (LANE) visits
- 30-day hospital readmissions for all causes

The program is funded through a 2% withhold of each MCO's capitation payments for the corresponding period (see Figure 4). The reference period used for the program is April 1, 2015, through March 31, 2016.

## Case study: Ohio Department of Medicaid

In 2012, Ohio began a P4P program to incentivize performance improvement in its Medicaid MCOs. The state calculates a maximum bonus amount for each participating plan, and it pays this bonus to plans based on percentile scores (relative to

Figure 2
States by nature of Medicaid managed care plan pay-for-performance (2016)

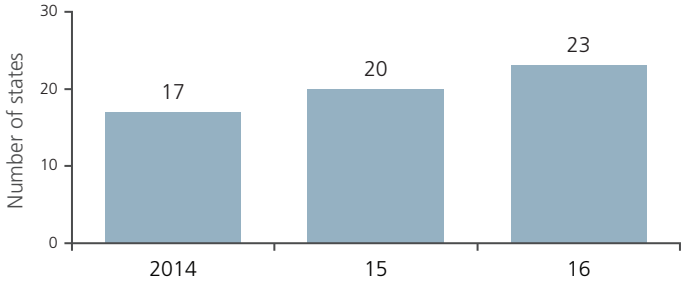



Note: *50 states and DC; † Performance incentives used by the state for full-risk managed care entities
Source: Medicaid.gov; state Medicaid websites; KFF; L.E.K. analysis

national benchmarks) across seven Health Effectiveness Data and Information Set (HEDIS) measures:

- Timeliness of prenatal care
- Postpartum care
- Controlling high blood pressure for patients with hypertension
- Seven-day follow-up after mental illness admission
- Adolescent well-care visits
- Appropriate treatment for children with upper respiratory infections
- Comprehensive diabetes care

Figure 3
States implementing managed care payment withhold (FY 2014-2016)




Source: Kaiser Family Foundation; L.E.K. analysis

Bonuses started at 1% of each plan's total annual premiums but increased to 1.5% in 2016. The majority of the bonus (1.25% of premiums) is divided evenly among the seven measures. For each measure, payout starts above the 25th percentile and the full amount is awarded if the measure is at or above the 75th percentile (see Figure 5).

Additionally, starting in 2015, MCOs were required to implement one Quality Improvement Project (QIP) for each P4P measure that does not meet specified standards.

Figure 4
DC DHCF scoring system to determine distribution of payment incentives

| | Weighting factor | % of capitation at risk | % of capitation withheld assuming reduction in utilization (compared to reference period) of: | | | |
|---|---|---|---|---|---|---|
| | | | <2% | 2% | 3.5% | 5% |
| PPAs | 33% | 0.66 | 0.66 | 0.33 | 0.165 | 0 |
| LANEs | 33% | 0.66 | 0.66 | 0.33 | 0.165 | 0 |
| Hospital readmissions | 34% | 0.68 | 0.68 | 0.34 | 0.17 | 0 |
| Total | 100% | 2.00 | 2.00 | 1.00 | 0.50 | 0 |

MCOs can earn back 50%, 75% or 100% of the withhold attributed to the metric by demonstrating reductions of 2%, 3.5% and 5%, respectively.

Source: DC Department of Health Care Finance

Figure 5
Ohio Department of Medicaid scoring system to determine distribution of payment incentives

| | % of capitation at risk | % of payout earned assuming performance (percentile relative to national benchmarks) of: | |
|---|---|---|---|
| | | 25% | 75% |
| Timeliness of prenatal care | 0.18 | 0 | 0.18 |
| Postpartum care | 0.18 | 0 | 0.18 |
| Controlling high blood pressure for patients with hypertension | 0.18 | 0 | 0.18 |
| 7-day follow-up after mental illness admission | 0.18 | 0 | 0.18 |
| Adolescent well-care visits | 0.18 | 0 | 0.18 |
| Appropriate treatment for children with upper respiratory infections | 0.18 | 0 | 0.18 |
| Comprehensive diabetes care | 0.18 | 0 | 0.18 |
| Total | 1.25 | 0.00 | 1.25 |

MCOs meeting standards of care management operational readiness for members that fall into the "high risk" stratification level can earn another 0.25% of premium awarded.

Source: Ohio Department of Medicaid

In 2016, the state introduced a new care management performance measure, requiring MCOs to show operational readiness for care management of the 2% of members that fall into the "High Risk" stratification level. If the MCO meets the standard, 0.25% of premium is awarded.

## Case study: South Carolina Department of Health and Human Services

For a number of years, the South Carolina Department of Health and Human Services (SCDHHS) has used both withhold and incentive payments to measure and support quality outcomes. In 2016 and 2017, the SCDHHS has been withholding capitation rates equal to 1.5% of the overall sum of rates, based on three (HEDIS-derived) indices (see Figure 6).

Each quality index will be evaluated independently and will represent one-third of the MCO's overall withhold. To determine a plan's performance against these measures, SCDHHS will assign a point value to each of the HEDIS measures within the quality index, apply weights to each measure and aggregate the weighted scores. Withholds will be returned based on a plan's weighted score, on a sliding scale ranging from 0% to 100% of the withhold returned. Additionally, the top-performing plans (averaging >90th percentile across all measures) will be eligible for a bonus payout. According to the SCDHHS MCO Policy and Procedure Guide, "Information related to payout of the bonus pool will be made available to MCOs annually."

Figure 6
SC Medicaid MCO quality indices, measurement years 2016 and 2017

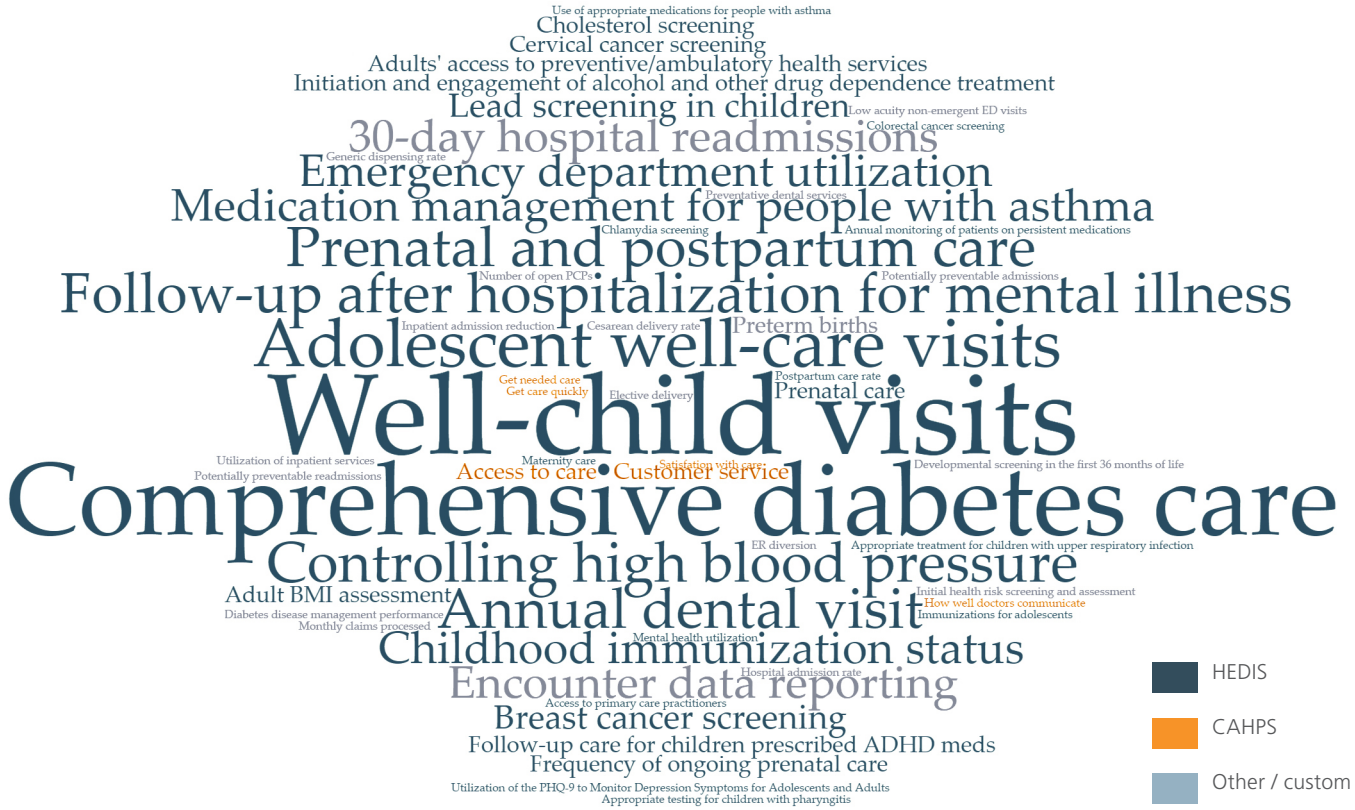
| HEDIS measure / abbreviation | | Weight |
|---|---|---|
| Index 1: Diabetes | | |
| CDC | Hemoglobin A1c (HbA1c) testing | 45% |
| CDC | HbA1c poor control (>9.0%) | 15% |
| CDC | Eye exam (retinal) performed | 20% |
| CDC | Medical attention for nephropathy | 20% |
| Index 2: Women's Health | | |
| PPC | Prenatal care, *Timeliness of prenatal care* | 40% |
| BCS | Breast cancer screening | 20% |
| CCS | Cervical cancer screening | 20% |
| CHL | Chlamydia screening in women, Total | 20% |
| Index 3: Pediatric Preventive Care | | |
| W15 | Well-child visits in the first 15 months of life (w15), 6+ visits | 30% |
| W34 | Well-child visits in the third, fourth, fifth and sixth years of life (w34) | 30% |
| AWC | Adolescent well-care visits (AWC) | 30% |
| WCC | Weight assessment and counseling for nutrition & physical activity for children/adolescents: BMI percentile, Total | 10% |

Source: South Carolina Department of Health and Human Services

## Metrics used to measure MCO performance

The specific metrics on which P4P incentives are based are determined by individual states. Common metrics include a subset of those contained within the Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS), the Joint Commission National Quality Measures, and the Prevention Quality Indicators (PQIs) specified by the Agency for Healthcare Research and Quality (AHRQ).

Figure 7
Common metrics used to evaluate MCO performance in P4P programs




HEDIS measures, most commonly used to measure performance in P4P programs, consist of a set of standard performance measures, developed and maintained by the National Committee for Quality Assurance (NCQA), that are aimed at allowing plan performance to be evaluated on an "apples-to-apples" basis. HEDIS includes 83 measures, divided into five dimensions, including Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Relative Resource Use, and Health Plan Descriptive Information.

Additionally, a number of states use custom sets of quality indicators that include hospital admissions and readmissions (overall or preventable), as well as metrics associated with emergency-room usage. There is significant variance in the metrics used from state to state (see Figure 7).

## Implications for MCOs

While opinions are divided about which performance incentives metrics work best, it is clear that we are entering an era that favors more sticks versus pure carrots, and increasing financial pressure will be placed on Medicaid plans by state governments. Success in this performance-based environment requires careful prioritization of investments. As quality performance is increasingly tied to revenue, health plans are required to deal with increased risks, but such programs enable plans to differentiate themselves in the marketplace.

At L.E.K. Consulting, our experience in supporting Medicaid plans — in assessing drivers of quality performance, designing and implementing quality improvement programs, and developing strategies to impact HEDIS gap closures — has given us the context around the challenges of the performance-based environment, and our work with payers and providers to optimize quality outcomes has given us experience in understanding the continuously rising bar for quality care.

## About the Authors

Todd Clark is a Managing Director and Partner in L.E.K. Consulting's San Francisco office. He joined L.E.K.'s Healthcare Services practice in 2015, bringing more than 20 years of experience in strategy consulting, analytics, corporate finance and Big Data. Todd spent 14 years in management consulting with both The Parthenon Group and Mars & Co., leading client engagements in corporate growth strategy, shareholder value creation, financial strategy, and mergers and acquisitions.

Joan Kim, a Managing Director and Partner in the L.E.K. Consulting San Francisco office, has been an integral part of building the firm's Healthcare Services practice. She has more than 17 years of experience advising managed care organizations, health insurance companies, providers and other clients in the industry on strategy development, diversification options assessment, mergers and acquisitions due diligence, post-merger integration and medical cost trend diagnostics.

Neil Menzies is a Manager in L.E.K. Consulting's San Francisco office. He joined the firm in 2007 and has significant experience in L.E.K.'s healthcare and technology practices. He received an MBA in Operations and Strategic Management from the Wharton School of the University of Pennsylvania, and a bachelor's degree in Computer Systems Engineering from the University of Auckland, New Zealand.

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