Piloting Performance Measurement of Physician Organizations in Medi-Cal Managed Care: Findings and Implications

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The pilot highlights the interest and engagement of managed Medi-Cal plans in collaboration on a set of standard quality and resource use performance indicators that can be measured at the physician organization level, and demonstrates the feasibility of standard physician organization-level measurement in the Medi-Cal managed care market.

ABSTRACT

In July 2013, in response to interest from health plans and supported by a grant from the Blue Shield of California Foundation, the Integrated Healthcare Association (IHA) launched a pilot project to collect standardized Medi-Cal quality of care results in four southern California counties at the physician organization (PO) level. Five Medi-Cal managed care health plans in Los Angeles, Orange, San Bernardino, and Riverside counties worked collaboratively with IHA to establish a common measure set and submit Medi-Cal results stratified by PO. Measurement focused on clinical quality, resource use, and meaningful use of health information technology. This pilot shows that performance measurement of POs in Medi-Cal managed care is feasible and that plans are interested in moving in this direction—measuring and reporting closer to where care is delivered.

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INTRODUCTION

Medi-Cal enrollment has been growing quickly. California's Department of Health Care Services (DHCS) funds health care services for nearly 10.6 million Medi-Cal members—more than a quarter of California's population of 38 million—and predicts that total enrollment will near 11.5 million members in 2015.[1] This figure represents a significant increase from Medi-Cal's 2011 population of 7.6 million,[2] due largely to expanded coverage under the Affordable Care Act (ACA), including coverage for low-income adults without dependent children.

The Physician Organization: Medical Groups and IPAs

In this brief, the term "Physician Organization" (PO) refers to medical groups and Independent Practice Associations (IPAs) that contract with health plans to provide professional health care services to enrollees in Medi-Cal managed care. Sometimes, community health centers (CHCs), which can be Federally Qualified Health Centers (FQHCs) and FQHC look-alikes, or county-run clinics can form an additional layer between individual physicians and POs. Community health center organizations may contract with IPAs or form their own IPA (see Appendix A: Physician Contracting Arrangements.) Many, but not all, POs take financial risk from contracted plans to care for managed Medi-Cal enrollees. Examples of POs for which results were reported in the pilot include:

- Monarch HealthCare, an association of physicians in private practice
- AltaMed Health Services, which includes a multi-site FQHC and an IPA that contracts with community-based primary care physicians
- Health Care LA, IPA, which contracts with CHCs, primary care physicians, and specialty providers
- Los Angeles County Department of Health Services, a public health care system of providers, clinics, and hospitals.

As Medi-Cal enrollment increases, the role of managed care in the program is increasing. Seniors and persons with disabilities (the "SPD" population) began transitioning into managed care in 2011, and managed care expanded into rural communities across the state in 2013. As of November 2014, more than 8.7 million Medi-Cal beneficiaries were enrolled in managed care plans across all 58 California counties,[3] each county falling under one of six contracting models with Medi-Cal. (See Appendix A: Medi-Cal Contracting Arrangements and Models.) These developments highlight an important opportunity: The time is right to create an infrastructure for consistent, comparative performance measurement among the POs serving Medi-Cal managed care beneficiaries.

At present, there is no statewide, standardized quality measurement at the PO level—even though Medi-Cal plans have a number of reasons to care about the quality of care delivered to their members by the POs with which they contract. While some health plan quality measures, such as customer service, are the sole responsibility of the plan, POs typically have much greater impact on clinical quality and resource use than do plans. Those are critical areas: Auto-assignment means that plans with lower quality ratings receive fewer enrollees, while plans that contract with high-quality POs with better performance results will enroll a greater percentage of assigned Medi-Cal beneficiaries. Moreover, for plans interested in pursuing a pay for performance (P4P) program, establishing a data collection and reporting framework can provide the tools to enable payments to POs based on clinical quality and resource use.

PERFORMANCE MEASUREMENT AND REPORTING AT THE PO LEVEL

IHA coordinates annual standardized performance measurement and public reporting at the PO level in California's commercial HMO and Medicare Advantage markets. In these product lines, risk-bearing POs contract with multiple health plans, most of which operate statewide. Almost three-quarters of POs participating in IHA's statewide Value Based Pay For Performance program (Value Based P4P) contract with five or more commercial plans. A common measure set with standardized definitions of indicated populations and interventions allows for:

- POs to be efficient in their data-gathering.
- PO-level results to be combined across multiple plans,

Performance Measurement at the Health Plan Level

DHCS requires Medi-Cal managed care plans to report annual quality and resource use results based on a set of core measures called the External Accountability Set (EAS). The 15 EAS performance measures, containing 32 distinct indicators, are selected from the national HEDIS measure set.[1] HEDIS, the Healthcare Effectiveness Data and Information Set, is a national performance measure set administered by the National Committee for Quality Assurance (NCQA). HEDIS measures:

- Effectiveness and access/availability of care
- Utilization and relative resource use
- Patient experience of care.

Full-scope Medi-Cal managed care plans (those that provide the entire range of Medi-Cal services) are required to report on all 15 EAS measures annually, at the county level or in some cases at a combined county level.[2] In addition to monitoring plan performance and public reporting, DHCS uses these results in auto-assignment, which rewards better-performing plans in the two-plan and geographic managed care delivery models with a greater percentage of assigned mandatory enrollees (those who do not choose a plan). Moreover, DHCS oversees collection of patient experience survey results on behalf of plans.[3]

1. California Department of Health Care Services. 2013 HEDIS Aggregate Report for the Medi-Cal Managed Care Program. November 2013. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/CA2013_HEDIS_Aggregate_Report.pdf
2. California Department of Health Care Services. All Plan Letter 14-003. January 14, 2014. Available at: http://www.dhcs.ca.gov/formsandpubs/documents/mmcdaplsandpolicyletters/apl2014/apl14-003.pdf
3. California Department of Health Care Services. Medi-Cal Managed Care Program Quality Strategy Report. June 2013. Available at: http://www.dhcs.ca.gov/dataandstats/reports/documents/mmcd_qual_rpts/studies_Quality_Strategy/qualityStrategyRpt_2013.pdf

so that small denominators often aggregate into larger, more statistically meaningful populations.

- Plans to benchmark their calculated rates for any PO against that PO's cross-plan average and see discrepancies in the rates, potentially pointing to data exchange issues between the PO and the particular plan (although variability in sample size or case mix can also play a role).

Information at the level of the Medi-Cal managed care health plan is valuable in identifying quality deficiencies and opportunities for improvement, but performance measurement and reporting are more actionable at the PO level, closer to where care is delivered. In fact, while avoiding the political resistance and technical challenges (e.g., small numbers) associated with measurement at the physician level, PO-level data provides key advantages over plan-level data:

- POs see information on their own performance showing how they perform relative to peers, helping prioritize metrics for improvement.
- Resource use results allow POs to focus on decreasing unnecessary costs and utilization, and to negotiate with plans for ACO models and shared savings arrangements.
- Health plans can see the full picture of the distribution of performance among contracting partners, since plan-level reporting tends to wash out variation among the POs that comprise the network.
- Plans can use that data in negotiations and contracting, as well as in efforts to support quality improvement activities at low-performing POs and reward high-performing POs.

THE PROJECT
IHA received a grant from the Blue Shield of California Foundation beginning July 2013 to develop performance metrics for POs and to pilot reporting of these metrics with several Medi-Cal managed care plans. IHA collaborated with health plan leadership and technical staff from five health plans in Southern California to create a measure set and collect results from those plans, stratified at the PO level. Health plan staff con-tributed expertise and data through a strategy group of high-level staff, and a technical workgroup of plan staff who worked in quality improvement, in Healthcare Effectiveness Data and Information Set (HEDIS) data collection, and in data reporting and analytics business areas. **Figure 1** shows the participating plans and the counties where they provide Medi-Cal managed care services.

The target population for the pilot was Medi-Cal members continuously enrolled with participating plans throughout the measurement year (except for resource use measures, where members did not have to be continuously enrolled). Healthy Families members were not included in the pilot.

Figure 1. Pilot Participating Plans and Counties Served

PLAN	COUNTY
Anthem Blue Cross	Los Angeles
CalOptima	Orange
Health Net	Los Angeles
Inland Empire Health Plan	Riverside, San Bernardino
L.A. Care	Los Angeles

Of the above plans, all but Anthem directly submitted data to IHA. As a subcontracted health plan of L.A. Care in Los Angeles County, Anthem's results were submitted via L.A. Care.

Determining Measures
In the spirit of alignment, the technical workgroup started with a list of measures that Medi-Cal managed care plans are already required to report and/or are part of Value Based P4P. Next, the workgroup used an iterative and collaborative process to evaluate the feasibility, importance, and usefulness of each measure. The decision was made to collect administrative data only—that is, no chart abstraction was conducted to supplement claims and other electronic data sources. Administration of patient experience surveys was outside the scope of this pilot. While all Medi-Cal managed care plans are required to collect a similar measure set at the plan level for reporting to DHCS, and many plans measure POs as part of internal P4P programs, this was the first time that a number of plans in the same region collected PO-level results using a common measure set with common specifications for data collection.

- **Clinical**

Figure 2 shows the clinical measures selected for the pilot, and whether each measure is included in other quality reporting programs for Measurement Year (MY) 2013. Measures were stratified by age band where appropriate. The resulting clinical measure set encompasses 22 measures within six clinical priority areas; stratification of clinical measures by enrollee age and other variables resulted in 45 distinct clinical indicators.

- **Appropriate Resource Use**

The workgroups selected four HEDIS-based resource use

measures already reported by Medi-Cal managed care plans to NCQA and/or the State of California. Measures were stratified by Medi-Cal–specific population types: seniors and persons with disablties (SPD) and non-SPD.

HEDIS data collection has shown differences in quality and resource use scores between those two populations, which were reflected in the pilot results.[4] **Figure 3** shows the resource use measures selected.

Figure 2: 22 Clinical Measures Selected

CLINICAL PRIORITY AREA	MEASURE	HEDIS MY2013	VALUE BASED P4P MY2013	DHCS EAS
CARDIOVASCULAR	Annual Monitoring for Patients on Persistent Medications: ACE or ARB, Digoxin, Diuretics, Anticonvulsants	X	X	X
DIABETES CARE	Eye Exam (Retinal) Performed	X		X
	Cholesterol Control	X	X	X
	Cholesterol Screening	X	X	X
	HbA1c (Blood Sugar) Control	X	X	X
	HbA1c (Blood Sugar) Poor Control	X	X	X
	HbA1c (Blood Sugar) Testing	X	X	Auto Assignment
	Medical Attention for Nephropathy	X	X	X
MATERNITY	Postpartum Care	X		X
	Timeliness of Prenatal Care	X		Auto Assignment
MUSCULOSKELETAL	Overuse of Imaging Studies for Low Back Pain	X	X	X
PREVENTION	Adolescent Comprehensive Well–Care Visits	X		
	Breast Cancer Screening (Mammography)	X	X	X
	Children and Adolescents' Access to Primary Care Practitioners	X		
	Cervical Cancer Screening	X	X	Auto Assignment
	Chlamydia Screening in Women	X	X	
	Childhood Immunization Status	X	X	Auto Assignment
	Immunizations for Adolescents	X	X	X
	Well–Child Visits with a Primary Care Practitioner in the Third to Sixth Years of Life	X		Auto Assignment
RESPIRATORY	Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	X	X	X
	Use of Appropriate Medications for People with Asthma	X	Replaced with Asthma Medication Ratio	
	Appropriate Testing (Strep Test) for Children with Pharyngitis	X	X	

Figure 3: Resource Use Measures Selected

MEASURE	HEDIS MY2013	VALUE BASED P4P MY2013	DHCS EAS
All-Cause Readmissions Following Acute Inpatient Stays	X	X	X*
Emergency Department Visits per 1,000 Member Years	X	X	X
Inpatient Bed Days per 1,000 Member Years	X	X	
Inpatient Stays (Discharges) per 1,000 Member Years	X	X	

* Modeled on HEDIS Plan All-Cause Readmission measure, but doesn't include risk adjustment

▪ **Health Information Technology**

IHA used public lists from CMS and DHCS of Medicare and Medi-Cal physicians who have received government incentives for achieving Stage 1 Meaningful Use, in conjunction with crosswalks of physicians to POs from health plans, to determine the percentage of physicians who had already achieved meaningful use of health information technology (MUHIT). Stage 1 Meaningful Use is defined by 18 measures that show that providers are using electronic health records to improve quality, safety, and efficiency, and to reduce health disparities; to engage patients and family; to improve care coordination, and population and public health; and to maintain privacy and security of patient health information.[5]

▪ **Encounter Rates**

Under a capitated payment structure, POs and hospital delivery systems have fewer incentives to submit comprehensive and specific claims (although plan contracts with POs and hospital delivery systems generally require complete and thorough encounter submission). Encounter rates provide a method of evaluating the completeness of data submission by comparing the number of encounters submitted by physician organizations against an expected benchmark. For this pilot, we collected encounter rate by service type metrics and analyzed them to determine an appropriate minimum threshold rate. We calculated separate rates for SPD and non-SPD populations. Two participating plans submitted encounter rates; because of this small sample, they were not used.

Determining Reporting Level

Participating plans agreed to submit results for all POs with which they contracted in the pilot counties. Plans supplied lists of POs, which IHA then compared to each other, to Value Based P4P information, and to publicly available data, in order to define standard identifiers for those POs contracting with multiple pilot plans. **Figure 4** shows the plans that submitted results, and the number of POs for which each plan submitted results (L.A. Care and Health Net contract with a large number of overlapping POs for Medi-Cal in Los Angeles County).

Many Medi-Cal managed care enrollees (in 2011, researchers estimated nearly 24 percent) received care from small physician practices—with five or fewer physicians—that directly contract with Medi-Cal managed care plans.[6] Indeed, among the pilot plans, there is significant enrollment with physicians who contract directly with the plans, bypassing POs. As a result, IHA worked with the plans to combine the directly contracted physicians into "virtual POs" for measurement and reporting purposes. **Figure 5** shows blinded pilot plans with the percent of their enrollees assigned to direct-contract physicians.

Figure 4: Pilot Plans that Submitted Data, with Number of POs

PLAN	NUMBER OF POs REPORTED*
L.A. Care	60
Health Net	50
Inland Empire Health Plan	12
CalOptima (MY 2012 only)	10
TOTAL reported by all plans	132
TOTAL UNDUPLICATED across all pilot counties	80

* Excludes direct-contract physicians

PILOT PLAN	ENROLLMENT UNDER DIRECT–CONTRACT PHYSICIANS AS PERCENT OF TOTAL ENROLLMENT*
Plan A	34%
Plan B	5%
Plan C	1%
Plan D	0%

* Enrollment as of 12/31/2013 except CalOptima as of 12/31/2012

Data Acquisition and Preparation

By February 2014, all participating health plans had submitted MY 2012 results that passed IHA's edit checks. For the MUHIT measure, the data was generated differently, using a combination of lists provided by the plans, publicly available registries from CMS and DHCS, and IHA's knowledge of plan operations.

IHA created a web site with secure logins where POs could see the results specific to their contracts: health plans could view results for all contracted POs, while POs could see only their own results, including their cross-plan aggregate scores. (**Figure 6** shows a screen shot from the web portal.) All users could export results, and POs could view measure-specific graphs showing where their scores fall in blinded distributions of all POs. IHA rolled out the web portal, loaded with MY 2012 results, to participating plans in February 2014.

Participating plans expressed concern about displaying aggregate results, especially aggregate numerators and denominators. In a two-plan county such as Los Angeles, one plan can easily back into the second plan's numbers using their own numbers and the aggregate numbers. In the end, all plans were comfortable with displaying aggregate numerators and denominators for clinical measures, but not for resource use measures.

In September 2014, three participating plans submitted updated results for MY 2013, for sharing with POs. CalOptima chose not to submit refreshed results until such time as the results could be presented in a format more actionable to their providers, including possible drilldown to the CHC level, and combined results across product lines. In October 2014, IHA rolled out results to POs contracting with L.A.

Figure 6: Web Portal Health Plan View, Showing Scores for Each Contracted PO, Including Cross-plan Aggregate Scores, and Color–coded Comparison to Pilot Benchmarks
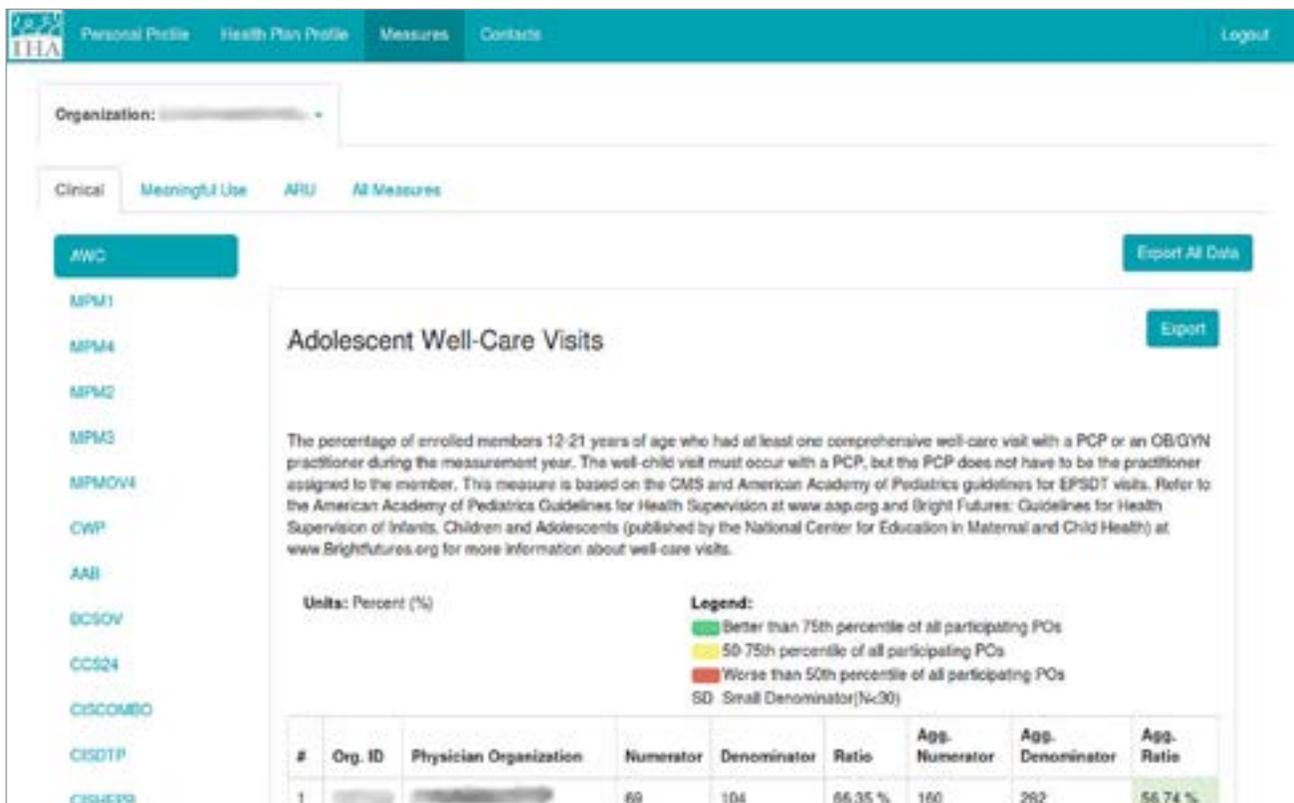
Care and Inland Empire Health Plan. Health Net declined to participate in the rollout, due to conflicting internal quality improvement activities. Unfortunately, this meant that IHA was not able to display cross-plan aggregated results to POs in Los Angeles County.

IHA performed edit checks and validity tests on results data, using many of the rules we have developed for Value Based P4P. We found that results passed the validity test, and that combining scores across health plans increased the number of reliable results. We also analyzed the scores for any insights they could yield regarding the factors that might influence results in the Medi-Cal market. See Appendix B for details.

THE FINDINGS

To better interpret the results, we created a clinical composite score by combining results for clinical measures for each PO, across all contracted plans. Each composite was a simple (nonweighted) average of scores with denominators >= 30. As a result, we could compare different types of POs. Although composite scores are negatively affected by measures such as Childhood Immunizations that rely heavily on chart data, this should wash out across POs, making the composite score sufficient for internal comparison. Using this clinical composite score, we see the following results.

▪ **PO Results Varied Widely**

Composite clinical scores ranged from 28.7 to 75.8, with a median score of 53.0 (**Figure 7**). Twenty-one percent of POs had a clinical composite score of 45 or less.

▪ **Higher Scores for the Largest POs**

Although correlation testing between PO enrollment and clinical score did not reach statistical significance (correlation = 0.1910; p<0.0961), we did see better clinical results in the largest POs. On average, very large groups (25k+ members) have a clinical score that is 5.5 points higher than large (10k–25k members), significant at the 5 percent level. Naturally, very large POs have resources and economies of scale by which to create their own population management, disease management, and utilization management programs, as well as to implement more sophisticated data capture. To keep results confidential, we grouped POs into quartiles by enrollment and compared clinical results (**Figure 8**).
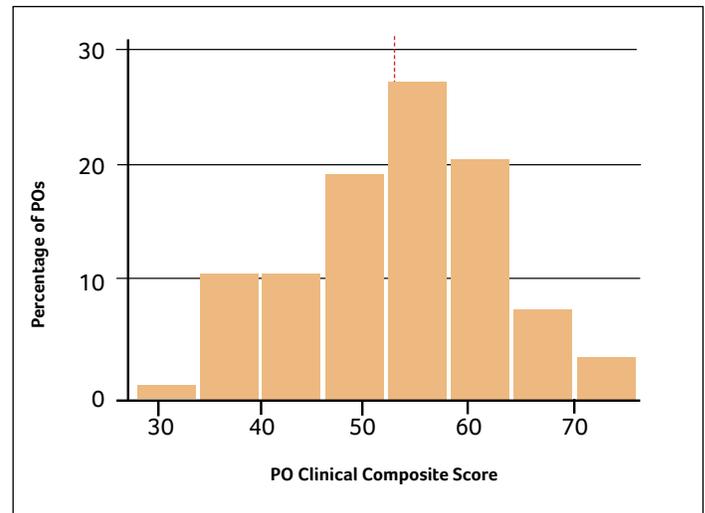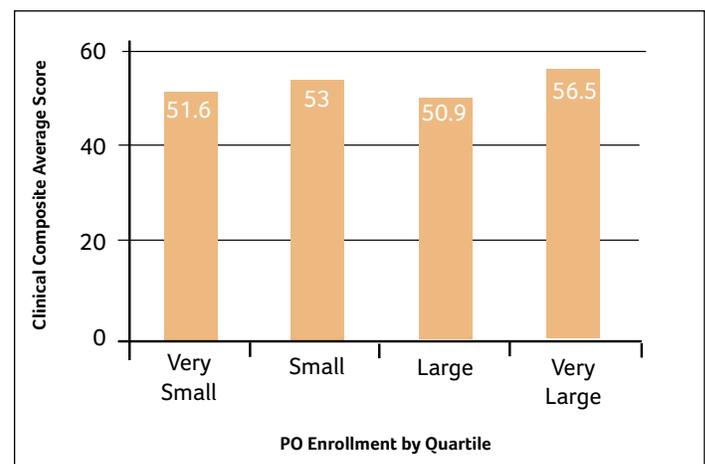
Figure 7: Distribution of PO Clinical Scores

Figure 8: Average Clinical Scores by Physician Organization Size

Quartile cutoffs: Q1 <=4,233 members; Q2 4,234–11,083 members; Q3 11,084–27,154 members; Q4 >27,154 members

▪ **Higher Scores for POs Participating in Value Based P4P**

Of 80 POs in the pilot, 43 participate in Value Based P4P, and they are fairly evenly distributed across pilot counties and across the enrollment quartiles mentioned above. We saw better clinical scores for POs participating in Value Based P4P (significant at the 5 percent level) (**Figure 9**). Note that scores can be driven by both quality of care and data accuracy; it is possible that POs participating in Value Based P4P have improved their quality of care through long-term participation in quality measurement, public reporting, and incentives, and that they have developed more complete data submission to contracted health plans.

Figure 9: Average Clinical Scores by Participation in Value Based P4P

PO PARTICIPATES IN VALUE BASED P₄P	CLINICAL COMPOSITE AVERAGE SCORE
Yes (43 POs)	55.5
No (37 POs)	49.9

▪ **Mixed Results for Direct-Contract Physicians**

We also compared PO scores to direct-contract physician scores. Since direct-contract physicians are by definition not represented by a PO for the population in question, we did not compare simple PO averages, but instead compared the population averages of all enrollees assigned to physicians in POs versus enrollees assigned to direct-contract physicians. That is, the unit of analysis was the member, not the PO. The results were mixed, but show an overall result of POs yielding better, or about the same, scores compared to direct-contract physicians (**Figure 10**).

Figure 10: Average Scores for PO Physicians vs. Direct-Contract Physicians, by Health Plan

| HEALTH PLAN	CLINICAL COMPOSITE AVERAGE SCORE	
	PO Contracts	Direct Contract
Plan 1	62.9	58.4
Plan 2	59.4	60.1
Plan 3	54.4	27.8
Plan 4	53.2	None

▪ **No Correlation Between Meaningful Use and Clinical Scores**

Finally, we examined the correlation between MUHIT scores and clinical composite scores (**Figure 11**). We have found a positive correlation in Value Based P4P, but did not see a correlation in the pilot results.

Health I.T. would seem to lend itself to more complete and accurate data submission, but there may be other factors at play in the Medi-Cal market. We know that a significant portion of care is provided by CHCs, and health center billing is largely driven by the Prospective Payment System (PPS) model. Because that model is encounter-based it may not require the comprehensive and specific medical coding that is necessary to document HEDIS results.

Figure 11. Meaningful Use vs. Clinical Quality
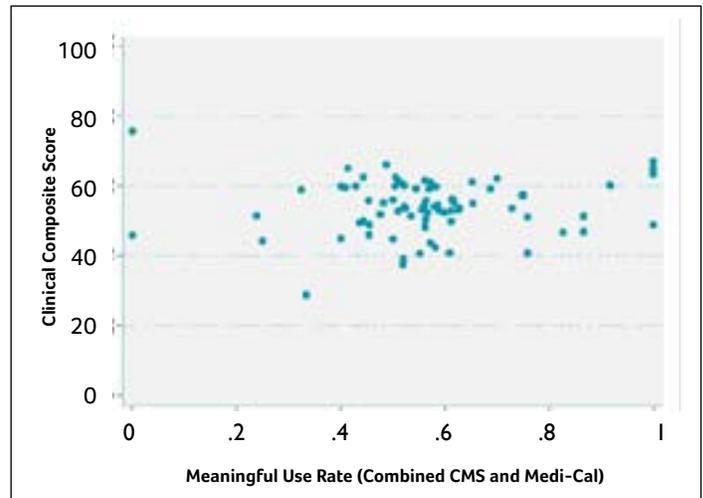
Each observation represents a single PO. Correlation = +0.0754 (p<.5230)

IMPLICATIONS

The pilot highlights the interest and engagement of managed Medi-Cal plans in collaboration on a set of standard quality and resource use performance indicators that can be measured at the PO level, and demonstrates the feasibility of standard PO-level measurement in the Medi-Cal managed care market. At the same time, the pilot reveals the many significant benefits of standardized measurement for POs, including the ability to combine results across multiple plans, thus increasing the reliability of results. It also underscores the opportunity for more focused and efficient data-gathering and quality improvement activities, as is the case for the POs participating in the statewide commercial Value Based P4P program. Finally—and not surprisingly, given that results are driven by data accuracy as well as quality of care—the findings of this study point toward higher performance scores for the largest POs and for those POs already participating in standardized performance measurement and incentive programs.

These results, along with broader discussions about performance measurement in Medi-Cal managed care with payers, providers, and policy experts, suggest three

directions to consider for the future: (1) standardization of performance measurement and reporting at the PO level; (2) testing performance measurement and reporting at the clinic or practice level; and (3) increased investment in the data and analytic capacity of POs and community health centers to enable more robust quality improvement efforts.

We discuss these implications in the sections below.

▪ **Develop Standardized Performance Measurement and Reporting at the PO Level**

A core measure set that aligns with other lines of business—Commercial, Medicare, Covered California— would allow POs to track and improve their performance for their entire enrollee membership, regardless of coverage type. This will be even more useful if, as expected, opportunities increase for members to shift between different types of insurance. Standardized PO-level measurement would provide the means for statewide public reporting of PO results, driving competition among POs to provide high-quality, affordable care—and giving consumers a broader basis of comparison for selecting top-performing providers.

The value proposition of a standard measure set in Medi-Cal managed care depends on the unique geo-graphic and contracting structures in this sector (see Appendix A). In the managed Medi-Cal model, POs generally contract with far fewer health plans than in the commercial market, in which most plans operate statewide and many POs contract with multiple plans. This geographic concentration reduces the advantages of both standardized performance measurement and cross-plan aggregation of PO performance scores. However, POs in Geographic Managed Care counties contract with multiple health plans; there are POs in California that serve multiple counties; and the practice of managed Medi-Cal plans contracting with sub-delegated plans increases the number of PO-plan contracts. Moreover, increased standardization would benefit even POs that contract with two or three managed Medi-Cal plans by providing a single set of metrics and using the same specifications; it would also benefit plans by increasing the reliability of results, thanks to cross-plan aggregation.

Local initiative plans, which have a county-specific focus, enjoy more flexibility than statewide plans to customize performance measurement sets to the characteristics of the patient population, such as disease prevalence. One option here would be a core statewide measure set with a "wrap-around" menu of other validated measures from which plans could select to meet their own needs, while still benefiting from the statewide benchmarking that standardized measures could generate.

▪ **Test Performance Measurement and Reporting at the Clinic or Practice Level**

Based on the market and contracting arrangements in Medi-Cal managed care, where many community health center organizations provide an additional layer of administration between plans and physicians (see Appendix A), it may be the case that the CHC or practice level is the more relevant and actionable unit of data collection and reporting than the PO. While it is not uncommon for plans to contract directly with community health center organzations in managed Medi-Cal, looking at performance results below the PO level will likely pose data collection challenges that would best be explored in a small pilot project.

To minimize resource demands on providers, measure sets would need to align with existing performance measurement requirements of POs and CHCs. For example, FQHCs are required by the federal government to report specific metrics as part of the Uniform Data Set (UDS). Also, many managed Medi-Cal plans have existing P4P programs in place that incentivize performance of their providers on specific measures, and many plans are also presumably focused on improving those metrics that fall under DHCS's auto-assignment program.

▪ **Build Data and Analytic Capabilities at Provider Organizations and Clinic Organizations**

Given the apparent advantage of POs that were among the largest in the pilot and/or that participate in Value Based P4P, the State and other funders should explore ways to support data capture and reporting capabilities, standardized performance measurement, and quality improvement programs in POs and community health center organizations. Funders could facilitate better data exchange between plans and providers, and support providers in developing the analytic capacity necessary to use available data to improve care delivery. They could also help develop learning collaboratives to document and share information about existing quality improvement models and best practices. And although most managed Medi-Cal plans operate at the county level and many already have well-developed P4P programs,

there is room for greater consistency across programs and an opportunity to share best practices in incentivizing quality improvement.

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Given the recent rapid growth in California's Medi-Cal population and the increasing role of managed care in Medi-Cal, it is critical to ensure the availability of actionable performance measurement results for providers serving Medi-Cal beneficiaries. This data supports population management and quality improvement at multiple levels—plan, PO, and CHC/practice—and offers California health care consumers in the safety net the same transparency around provider quality that is currently found in the commercial market.

Notes

1. California Department of Health Care Services. Fact Sheet. 2014. Available at: http://www.dhcs.ca.gov/formsandpubs/publications/opa/Documents/Fact%20Sheets/DHCSFactSheet6-2014.pdf
2. California Department of Health Care Services. Medi-Cal Population By County. July 2011. Available at: http://www.dhcs.ca.gov/dataandstats/statistics/Documents/18_Medi_Cal_population_by_County_2011.pdf
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http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCDEnrollRptNov2014.pdf

4. California Department of Health Care Services. 2013 HEDIS Aggregate Report for the Medi-Cal Managed Care Program. November 2013. Available at:
http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/CA2013_HEDIS_Aggregate_Report.pdf
5. Office of the National Coordinator for Health Information Technology (ONC). Meaningful Use Definition & Objectives. 2014. Available at:
http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives
6. Memorandum to IHA from Diane Rittenhouse and Robert H. Miller of UC San Francisco, Medi-Cal Managed Care Provider

Figure A-1: Managed Medi-Cal Physician Contracting Arrangements
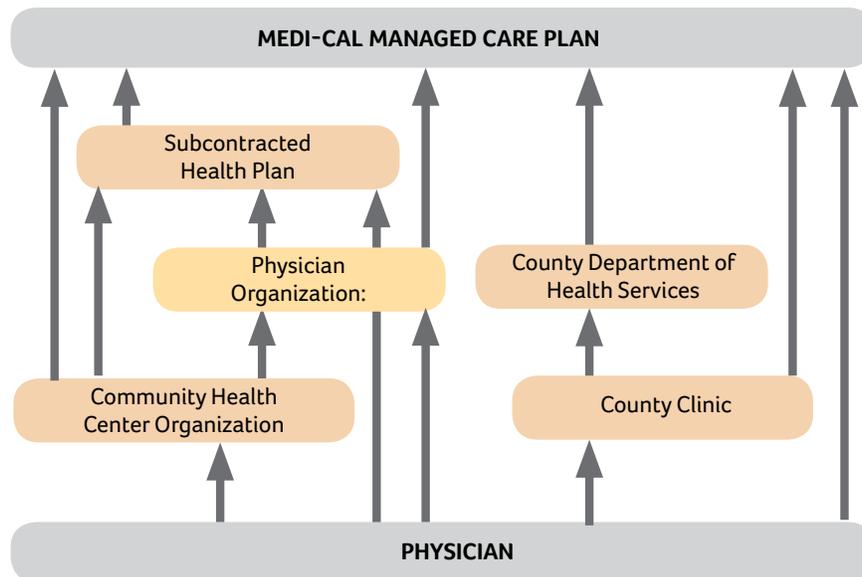
Physician Contracting Arrangements

Figure A-1 illustrates the varieties of physician contracting arrangements in Medi-Cal managed care. Physicians may contract with, or be employed by, one or more community health centers; they may contract with, or be employed by, one or more POs; they may contract directly with one or more Medi-Cal managed care health plans.

Medi-Cal Managed Care County-Based Model

Medi-Cal managed care operates on a county-by-county basis, with each county falling under one of six contracting models. For the most part, the model drives the number of managed care health plans directly contracted with Medi-Cal in that county. Of California's 58 counties, 53 have either one or two contracted plans. Of these counties, 14 are under the "Two-Plan" model, in which there is a "Local Initiative" (county organized) plan and one "Commercial" plan; together these Two-Plan counties serve more than 5.6 million enrollees, or 65 percent of total Medi-Cal managed care enrollment. Some Local Initiative plans serve multiple counties; there are a total of nine Local Initiative plans.

Twenty-two other counties are served by a County Organized Health System (COHS) model, representing 22 percent of managed Medi-Cal enrollees. COHS plans serve all managed Medi-Cal beneficiaries in their counties; with some COHS plans serving multiple counties, there are a total of six unique COHS plans.[1]

The remaining contracting models are Geographic Managed Care (GMC); Regional; Imperial; and San Benito.[2]

Notes

1. California Department of Health Care Services. Medi-Cal Managed Care Enrollment Report. November 2014. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCDEnrollRptNov2014.pdf

2. California Department of Health Care Services. Medical Managed Care Program Fact Sheet—Managed Care Models. July 2014. Available at: http://www.dhcs.ca.gov/provgovpart/documents/mmcdmodelfactsheet.pdf

Validity and Reliability

Validity Testing

To test the validity of the results, we rolled the PO-level results up to the health plan level and compared them to publicly reported HEDIS Medicaid results for each plan (for Health Net, which holds Medi-Cal contracts for multiple counties, we used results specific to Los Angeles County). Health plan aggregate results were comparable to plans' HEDIS results for measures that only use administrative (electronic) data in HEDIS, confirming the validity of the PO-level results. **Figure B-1** displays select administrative measure results for a sample pilot health plan, compared to that plan's local HEDIS Medicaid scores for MY 2012, the most recent HEDIS benchmarks available.

Not surprisingly, we also found that plan-level results display the impact of chart review: health plan pilot averages for administrative-only data are lower than results for the same measures when data sources include both electronic data and chart abstraction. The Childhood Immunizations measure is particularly influenced by chart data in Medi-Cal, as providers receive free vaccines through the California Vaccines For Children (VFC) program; any claims generated would only be for the nonspecific administration codes.[1] **Figure B-2** illustrates these findings, displaying select hybrid measure results for a sample pilot health plan, compared to that plan's local HEDIS Medicaid scores.

Figure B-1: Select Administrative Measures Scores for a Sample Pilot Plan (MY 2012)

MEASURE	PLAN PILOT AVERAGE (WEIGHTED): Administrative-Only Data	PLAN HEDIS MEDICAID: Administrative-Only Data
Overuse of Imaging Studies for Low Back Pain	78.30	78.34
Breast Cancer Screening: Ages 42-69	63.93	62.66
Chlamydia Screening: All Ages (16-24)	67.23	66.55
Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	21.88	21.81
Use of Appropriate Medications for People with Asthma: All Ages (5-64)	85.72	85.70
Appropriate Testing for Children with Pharyngitis	40.25	39.99

(Plan pilot averages are weighted by PO denominators)

Figure B-2: Select Hybrid Measures Scores for a Sample Pilot Plan (MY 2012)

MEASURE	PLAN PILOT AVERAGE (WEIGHTED): Administrative-Only Data	PLAN HEDIS MEDICAID: Administrative Data and Chart Abstraction
Diabetes Care: HbA1c Control < 8.0%	35.65	56.98
Diabetes Care: Medical Attention for Nephropathy	80.34	83.02
Prenatal Care	68.41	78.42
Cervical Cancer Screening: Ages 24-64	70.35	75.07
Childhood Immunization Status: Combination 3	35.28	84.25
Immunizations for Adolescents: All Antigens	72.83	80.86
Well-Child Visits in the Third to Sixth Years of Life	81.45	86.69

(Plan pilot averages are weighted by PO denominators)

Reliability Testing

We then examined clinical denominators, comparing PO denominators for each PO–plan pairing to each PO's denominators when aggregated across plans. Clinical results are calculated by selecting the continuously enrolled population indicated for the intervention (denominator) and determining which of those enrollees received the intervention (numerator).

In Value Based P4P, a decade-long statewide program, a denominator of 30 has long been considered a sufficient sample size to produce reliable results. In the Medi-Cal pilot, combining POs' denominators across plans reduced the number of small clinical denominators from

1,561 to 667, largely among POs contracting with both plans in L.A. County (Figure B-3).

Figure B-3: Clinical Results and Small Denominators

	All Counties
Total number of results (health plan-PO-measure)	5,324
Number of results with denominator < 30 at the health plan-PO level	1,561
Number of results with denominator <	667

Note

1. California VFC Program. Available at: http://eziz.org/vfc/