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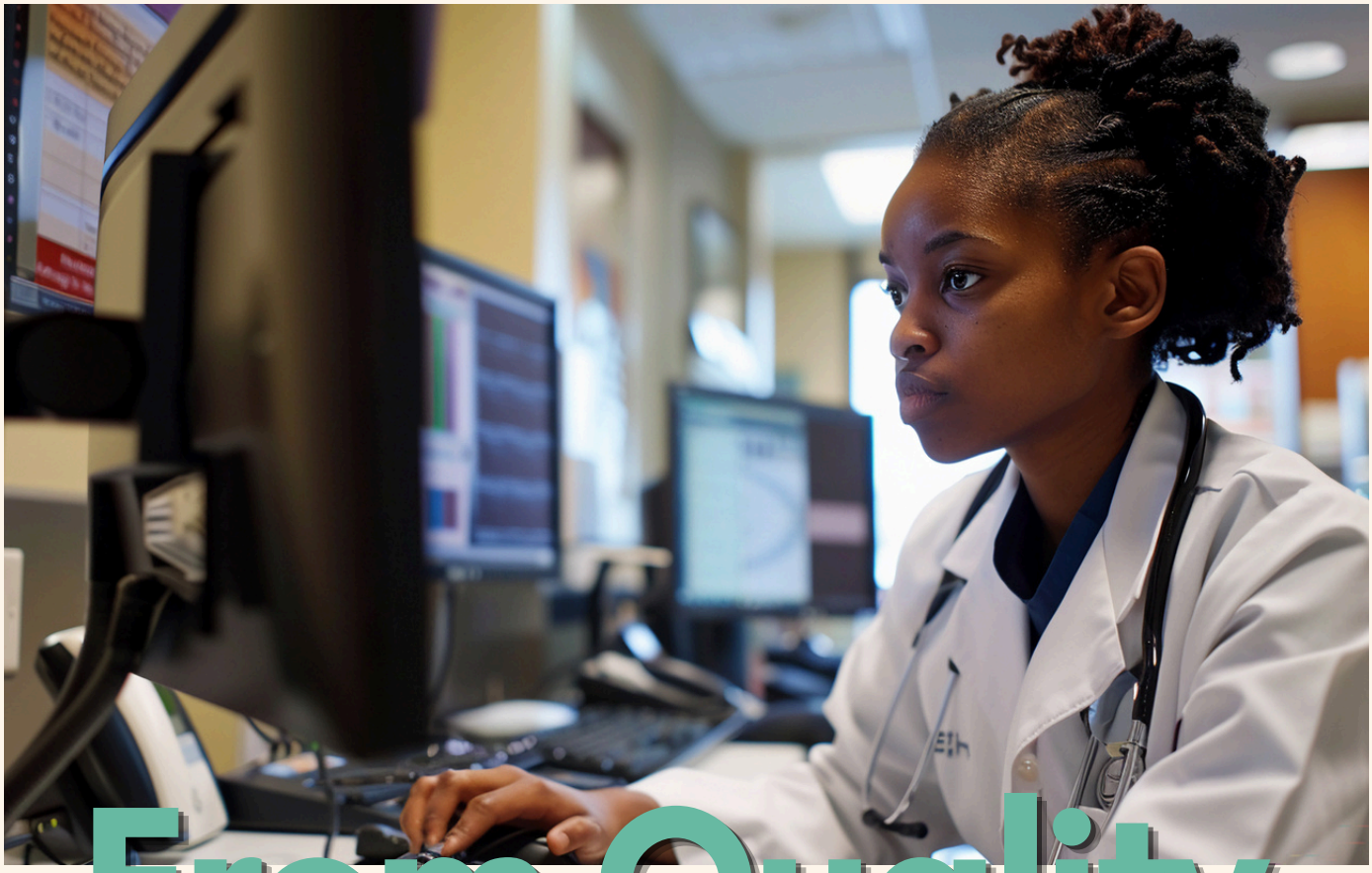
Primer Guide

Part 2



From Quality Measures to Money

Building a Better Understanding of How Money Flows Through the Youth Mental Health Quality Measures System

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Moving Measures and Getting Paid

In Part 1 of our series, we explained which quality measures matter in youth behavioral health and the 4 most common measures sets that exist. If you haven't read that yet, catch up here with our Quality Measures Decoded Primer Guide.

If you are an innovator who is impacting these measures, this next part will help you understand how a quality measure can become a dollar, whose hands it passes through along the way, what that looks like contractually, and what it ultimately means for you.

The core idea here is that a quality measure only has financial power once it is written into a contract, has dollars attached to it, and those dollars are put at risk. Every layer of the system takes this premise and applies it to the layer below it and understanding the stakeholders before you is essential.

This guide will talk through the relationship between system stakeholders. Check out our primer on the Systems Flow from Federal to State to MCO to Provider to learn how these stakeholders interact.

The Money Chain

This primer will take you through how the layers in the chain will flow, highlighting what you need to know as an innovator.

CMS / Core Set → State Medicaid → Managed care plan (MCO) → Innovator

CMS sets the universe and mandates reporting

The federal government defines the measure landscape and requires states to report on it. For youth Medicaid, you can find those measures in our previous guide here.

It is important to note that CMS does not pay innovators directly. The lever CMS has is obligation. It makes measures mandatory and standardized which guarantees that every state is now accountable for the same numbers. Mandatory measures are what make the rest of the chain possible.

The state converts measures into contract terms and puts money at risk

Contract Terms

The state level is where measures first acquire real financial weight. Each state pays an MCO a per-member-per-month (PMPM) capitation rate. Around that base payment, below are **contract terms** that tie the MCO's money to quality measures.

- **Withholds:** The state holds back a slice of the PMPM payment (commonly 1–2%) that the MCO earns back only by meeting quality and value-based metrics goals
- **Incentive payments:** Additional money paid for strong performance. These cannot exceed 105% of the approved PMPM capitation (known as the 5% cap).
- **Value based payment (VBP) targets:** More and more states require that MCOs use value based models to pay providers and gate payments around hitting certain measures, including but not limited to quality measures.
- **State-directed payments (SDPs):** A mechanism that lets a state direct how plans pay providers, including VBP arrangements and quality measure payments (you can learn more here: (42 CFR 438.6(c))

Health Care Payment Learning & Action Network (LAN): Payment Ladder

The LAN is the Payment Ladder. Essentially, it's the industry standard way of categorizing types of payment arrangements and how much risk an innovator takes on in those arrangements. This is used by both states and MCOs to talk about "how value-based" a contract truly is (Check our VBC intro guide here).

- **1: Fee for service (FFS), no quality link:** This is good ol' FFS. Quality is not relevant to the payment and measures are not related to any revenue billed.
- **2: FFS linked to quality (2A–2C):** FFS plus payments for reporting (2B) or performance on measures (2C). In this scenario, payments are modest but it is the first time bonus or "add-on" payments are seen for quality measures
- **3: VBC on a FFS chassis (3A–3B):** Shared savings with only upside (3A) or also downside risk (3B). In this scenario, you have to meet the goals around quality measures first and can then either share in the savings or be penalized for not meeting them (3B downside arrangements).
- **4: Population Based Payment (4A-4C):** Risk based models that can be diagnosis specific, have caveats, or be completely integrated. In this scenario, innovators hold all the risk. Quality measures here show who is not being served, where cost is unnecessarily high, or can trigger a bonus pool.

State Specific Examples

Ohio

Money is withheld for quality measures via a single youth BH plan called OhioRise. If the goal is met, 100% of payment is received; 5% below the goal and 50% is received; greater than 5% below the goal and 0% is received. This can be seen in the LAN framework from scenarios 2-4.

Arizona

AZ wrote escalating LAN-category target requirements into their contracts. MCOs are required to have a minimum dollar amount that is spent through quality measures, value based arrangements, and risk-bearing agreements. This is called an escalating "LAN" category target (more on that below). The result? Between 2017 and 2024, that spend rose from 16-36.6% depending on the contract to 64.3-76.6%.

For innovators that means the more you can measure and prove your impact, the more likely you are to get these dollars.

The MCO carries the quality risk and pushes it down to innovators

Once the state has put the plan's money at risk, the MCO is now financially accountable for numbers it cannot move by itself. For example, follow-up after a mental health hospitalization, ADHD medication continuation, and depression screening are all quality measures that depend on what providers actually do while delivering care. As a result, MCOs push the risk and reward down to providers and vendors through the LAN payment ladders.

There are three variables that impact how heavily weighted a quality measure is for a MCO and how innovators are likely to experience that weight: how heavily the MCO is judged for the measure, how hard it is for them to move the measure without help, and whether the measure is operational or requires a clinical breakthrough.

For example, over the years follow-up after ER and Hospitalization (FUH 7 and 30) have become more and more important to innovators from MCOs because of the difficulty MCOs had in conducting these follow-ups themselves.

The combination of the three and what leverage you have as an innovator is where measures turn into money and is the main focus of the remainder of the primer.

Innovators: Move the Measures, Get Paid

Use Quality Measures to Earn Revenue

If you are a digital tool, point solution, provider group, state funded organization, or any other type of innovator that works with the state or MCOs, this is the part that is written for you. To do so, you need to answer the following questions: Which measures can you actually move?, What does moving them get you in a contract?, and How do you structure the deal so that moving the number pays you?

It is critical to remember that you are not getting paid for having a product or solution in this scenario. You are getting paid for changing a number that the State or MCO is already accountable for so show up with data demonstrating how you are already moving these measures and you will be well ahead of the game.

How an Innovator Moves Measures

- **Close the follow-up gap (FUH-CH, FUM-CH, FUA-CH):** These are the most contract-relevant levers in youth BH. If your solution reliably connects a youth to an outpatient visit within 7 and 30 days of a hospitalization or ED crisis then this applies to you. This could be: warm hand-offs, navigation, scheduling, follow-up outreach and more. The key difficulty is knowing when it is required and acting within the 7 and 30 day period.
- **Drive documented screening and a follow-up plan (e.g., CDF-CH):** CDF-CH credits screening for depression (ages 12–17) and rewards the documentation of it. If your solution captures PHQ-9 screening and a follow-up plan inside the clinical workflow, then you are already proving you meet the measure. Note that your role here may not be to own the entire clinical workflow but rather the technology portion of it. How do you then work with providers to bring the quality measurement all together to increase revenue?
- **Improve engagement and experience (e.g., ADD-CH; child/family CAHPS):** Keeping youth engaged and retained in care for certain medication or lifting child and family experience-of-care scores (the CAHPS survey carried in the Core Set) are typically outside of the state and MCOs locus of influence or control.
- **Supply the data the plan can't easily get.** This one is a bit atypical, but I have seen it before. Most quality measurement data is received by the state or MCO on a significant delay (2-6 months). Data demonstrating quality that can be received close to real-time is a game changer for these stakeholders.

The Contract Ladder

Once you can credibly move a measure, you have something state, MCO, or provider group will pay for. There are several contract types outlined below, ordered from lowest risk and modest dollars to highest risk and highest upside and along the way require more maturity, scale, leverage, impact, and outcomes.

Contract Type	Details and Payment Mechanisms
Performance guarantee (at-risk vendor contract)	• Share of fees are at risk against a measure goal so no payment is made unless that goal is hit • Can be lower base + performance on top or higher performance on top with no guaranteed base
Pay-for-performance bonus	• A base rate + bonuses specific to measures. • Bonuses can be for hitting certain percentage of population goals or on a per individual basis.
Shared savings (upside and/or downside risk)	• You share in savings versus a specific care target target or can incur losses • These contracts typically exist well beyond quality measures but they are included within the terms
Population-based / case rate	• Risk-adjusted PMPM or case rate for a defined population that is reconciled against expected cost. • Similarly, these contracts exist well beyond quality measures but measures are included

That said, many innovators fall into the trap that the ladder can always be climbed to the top, but the reality is quite different. In youth mental health, very few contracts move past pay for performance bonuses. Therefore, remember the 5% cap rule referenced earlier. The state and MCOs have limited dollars to designate towards quality measures and so having a clear story, data, and relevance to the youth demographic they are trying to serve is essential.

Contract Calculus

So far it's been frameworks and tips, but seeing the math truly brings it to life. Under each of the LAN types, there is a specific set of calculations. We are going to lay out the two main ones for quality measures here only. These formula structures are drawn from CMS, Medicaid ACO, and State payment methodology. For these purposes, the dollar values are illustrative and rounded so the arithmetic is easy to follow and we'll dig in to where problems can arise.

Performance Guarantee (At-Risk Vendor Fee)

These are contracts most non-care delivery vendors or innovators are signing. Again, there is a base fee + money that is tied to a measure target.

Total Fee = Base Fee + At-Risk Fee
At-Risk Fee Paid = At-Risk Fee x Measure Target Achievement

Seems simple right? But the detail lies in the "Measure Target Achievement" variable. Achievement usually comes in 1 of 3 forms:

- **Binary:** hit the target, you get paid; you don't, you get $0 for anything at-risk
- **Tiered:** hit the goal, 100%; hit a number below the goal, 50%; anything below that is $0 payment for anything at risk
- **Per-Unit:** this is the per-patient model and not the population model; you get a set fee per successful outcome

Example

Contract is $4 PMPM fee for 1,000,000 attributed youth = $4.8M/year, with 25% ($1.2M) at risk and 75% ($3.6M) base. Your goal is moving FUH-30 from 55% to 65%.

- **Binary:** Hit 65%, keep the full $4.8M; don't and get only the $3.6M base
- **Tiered:**
  - Hit 65% → you keep the full $4.8M
  - Land at 60% on a prorated tier (halfway) → you keep the $3.6M base plus $600,000 of the at-risk portion = $420,000.
  - Miss entirely → you keep $3.6M but do not get $1.2M at all
- **Per-Unit**: Scenario where your $1.2M at risk is measured via a per-youth Achievement Target of $25 per FUH-30 completed. You could earn $50 or $1.2M.

Quality Withhold / Pay-For-Performance Payout

This is the most straightforward version of how quality measures can earn money. As a reminder, the state or MCO sets aside (withholds) a slice of payment and releases a contracted proportion of it to innovators who meet targets. It is calculated by the formula below (don't worry, it will come to life in the example):

Withhold Pool = Withhold % x Capitation Amount
Payout = (Withhold Pool x Measure Weight) x Allocated % to Innovator x Measure Target Achievement

Now in this scenario, there are a few key things to keep in mind:

- **Each measure gets a weight:** Not all measures are created equally. Remember how important it is to the plan depends on the factors mentioned before.
- **Allocated % to Innovator:** an MCO is not going to only give you the opportunity to meet this measure because they have too much relying on. You are allocated a portion of the pool they are allocated.
- Target Achievement Measure: like before, this can be set up as binary, tiered, or per-unit.

Example

An MCO's youth capitation totals $60M/year and the state withholds 2% for quality measures, totaling a $1.2M quality measures pool. That pool is split across 15 equally weighted youth measures, making each measure worth ~$80,000 (in real life, the measures are not weighted equally).

For the MCO: the state usually pays the MCO in a tiered format. They could get the full $80K or less than that depending on the MCO's achievement targets with the state.

For the innovators: If $80K is the entire pool per measure for an MCO, 20% may be then allocated to you as an innovator, which is a max of $16K. The rest of the calculations then follow as described prior: binary of $16K or no; tiered of $16K, a lesser amount for hitting a smaller goal, or nothing at all; per-unit fixed amount per instance of meeting the goal.

Design the Contract Terms

Before ever getting to the point of seeing a contract, you must think about the type of arrangement you want to enter into and with detail. Many of these contracts go from being incredible opportunities to not being delivered upon because of the details around terms, variables, and how success is measured. The most successful innovators do the following:

- **Pick a measure that is movable and already gating the plan's money:** The intersection of "you can move it operationally" and "the plan already loses money if it doesn't move" is where your leverage lives.
- **Confirm the outcome is verifiable by claims or the plan's own data:** The plan must verify the number on their side; they won't pay you based off your data.
- **Define exactly how the benchmark is calculated:** Align on what outcome benchmark you are being held against and how it is being calculated (e.g., raw number, benchmark vs. yourself, benchmark vs. others, impact on ROI, etc.).
- **Pin down how the benchmark changes over time:** Pin down how the benchmark changes over time. A target set against a percentile, a national average, or "your own prior year" is not fixed year over year. You can meet that target this year or in this contract but the year after or renewal contract may not be attainable. Be clear in your contracts about how the benchmark changes, re-sets, and more.
- **Decide whether you're measured at the patient or population level:** Cohort level goals typically keep the contract clean but can also be harder to achieve depending on what the benchmarks are. Patient level can get messy when verifying if the measure was indeed met for every single patient.
- **Define exactly who qualifies in your numerator and denominator:** Are certain diagnoses excluded? Are there engagement expectations? What would disqualify a measure being met based on patient-level circumstances? Do you want to exclude a population based on their severity or acuity or if they are outside of your usual population? Be clear and honest with yourself on where and with whom you can achieve meeting these measures.
- **Check the denominator is large enough to be stable:** Understand the minimum population size where the number is meaningful but not so small, that a small number of patients can change meeting the target significantly.
- **Be honest about where and with whom you can actually win:** Exclude a population by severity, acuity, or fit with your usual population if you need to. Be clear-eyed about the patients where your solution genuinely moves the number and the ones where it won't. This is not the time to be purely aspirational.

- **Nail down attribution:** Be very explicit about which members count as "yours." They may meet the criteria but perhaps another provider saw them more than you did or they engaged with another tool more than yours. Typically, multiple solutions cannot claim a patient across multiple contracts. Ambiguous attribution is where these contracts most often break down.
- **Settle whether payment is prospective or retrospective:** Quality measure money is typically retrospective (i.e., prove that you did it, we verify you did it and you get paid). Sometimes though, depending on the contract it can be prospective (i.e., we will give you $X, after a year or quarter if you don't meet the goal, you owe us that money back). In the prospective scenario, don't assume you will always hit the target and in both directions, ensure your financials can absorb the downside.

Survive the Contract Terms

As you can tell, quality measure contracts can seem simple but get complicated quick. Keeping these lessons below in mind is what separates the smart negotiators from the ones who learn a little too late.

- **Expect an actuary or data analyst to check and contest your numbers:** MCOs are skeptical of vendor-reported, vendor-measured outcomes. Be prepared for an actuary or data analyst at the plan to check your data or come forward with their own that does not match yours.
- **Track leading indicators, because the official data lags:** State and MCO data lags, sometimes by a year or more. Track upstream process metrics so you know real time if you need to adjust, improve, and where you are in hitting your goals.
- **Plan for maintenance so the effect doesn't decay:** For certain measures, the effect has to hold over a period of time. You may have done your part but when the patient is no longer using your service or product, that effect may not continue to hold. You can still be penalized for that or miss hitting a quality measure as a result. Maintenance solutions or partners are critical.
- **Protect the solution from the measure:** The moment a number is tied to your revenue, innovators tend to overfocus on the number rather than the patient's outcomes. When the quality measure incentive differs significantly from your clinical or operating model, measure targets are missed and patients suffer.
- **Know where you rank in the MCO's budget priorities:** Your measure is a small part of the MCO's total quality strategy. Understand where your measures rank in their list, and don't assume today's priority is permanent.

Key Resources

CMS Direct Documents

- CMS Managed care rate setting & withholds, 42 CFR 438.6
- CMS Medicare Shared Savings Program methodology: the real shared-savings/quality-scoring math; it's for Medicare but you can apply it to Medicaid
- CMS: Behavioral Health Strategy: federal direction tying together youth BH, quality measures, and value-based models

Helpful Value Based Resources

- HCP LAN APM Framework (categories 1–4)
- CHCS Value-Based Payment hub:CHCS helps states use alternative payment models and managed care contracting mechanisms across Medicaid providers; strong, practical material on how these contracts are actually designed.
- CHCS "Moving Toward Value-Based Payment for Medicaid Behavioral Health Services": how states and MCOs are building on physical-health models and incorporating VBP arrangements into behavioral health.
- MACPAC: the authoritative independent analysis of Medicaid managed care, VBP, and quality

State Specific Examples

- Ohio: ODM Managed Care Quality Withhold Payout Methodology
- North Carolina Standard Plan Withhold Program Guidance 2026
- Arizona AHCCCS Value Based Purchasing Strategies (spend %s)

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