1115 Waiver Renewal
Plan-Provider Incentives
Expert Stakeholder Workgroup

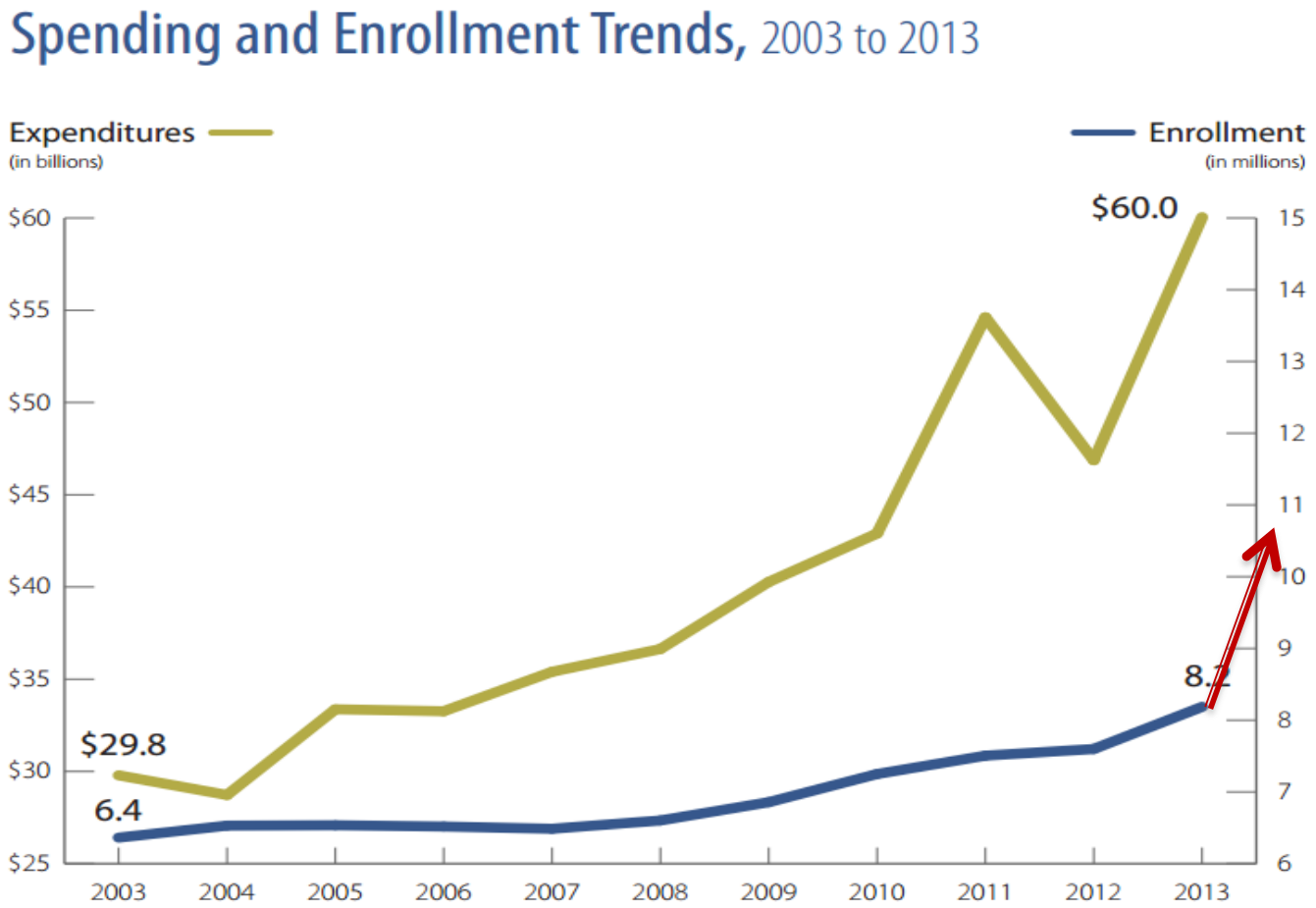
November 12, 2014
Sacramento, California

Integrated Healthcare Association

- Statewide multi-stakeholder leadership group that promotes quality improvement, accountability, and affordability of health care in California.
- Actively convenes all healthcare parties for cross-sector collaboration on health care topics; manages regional and statewide programs; and serves as an "incubator" for pilot programs and projects.
- Mission: to create breakthrough improvements in health care services for Californians through collaboration among key stakeholders.

Overview of California Medi-Cal Landscape

Medi-Cal Spending & Enrollment Trends



Notes: Expenditures include total Medi-Cal spending. For FY2002–03 to FY2011–12, enrollment estimates are for the month of January for the corresponding fiscal year. The enrollment estimate for FY2012–13 is a projection based on the November 2012 Local Assistance Estimate from the California Department of Health Care Services (DHCS).

Sources: California HealthCare Foundation, Medi-Cal Facts and Figures: A Program Transforms, http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalFactsAndFigures2013.pdf

Growing Role for Managed Care

- **Transition to managed care in rural areas**
  - 410,000 beneficiaries in 28 rural counties
- **Transition of Seniors and Persons with Disabilities (SPDs) from FFS to Medi-Cal Managed Care**
  - 240,000 Medi-Cal-only SPD beneficiaries transitioned in 2011 in 16 counties
  - December 2014: transitioning SPDs in rural counties (~25,000 beneficiaries)
- **Cal MediConnect**
  - Beneficiaries eligible for both Medicare and Medi-Cal (dual eligible beneficiaries)
  - 3 year initiative starting April 2014 in 8 counties
- **Low Income Health Program (LIHP)**
  - Expanded Medi-Cal to individuals up to 200% FPL
  - Over 85% of LIHP enrollees were in counties with Medi-Cal managed care

5

Plan-Provider Incentives Overview

Key Assumptions

California's Medi-Cal program will continue to rely on managed care plans to provide services to beneficiaries

- DHCS already delegates risk to plans
- New incentives should build on that core model as well as existing incentive structure (e.g. auto-assignment & Medi-Cal P4P)

Prospective Payment System (PPS) will remain in place

- FQHCs will continue to receive cost-based reimbursement through reconciliation with DHCS
- Separate workgroup focused on FQHC payment and delivery system reform

1115 waiver activities should coordinate with (not duplicate) related efforts underway or under development

- Patient Centered Health Homes for Complex Patients & CalSIM

Plan-Provider Incentives: Outline

Value Based Payment in California's Commercial Market

- Pay-for-Performance
- Bundled Payment
- Accountable Care Organizations

Medi-Cal Initiatives

- Medi-Cal Pay-for-Performance
- Mental Health Benefit
- Coordinated Care Initiative/Dual-Eligible Demonstration
- California's State Innovation Model (CalSIM)
    - Patient Centered Health Homes for Complex Patients

Value Based P4P Program

$500m
paid out

200
Medical Groups and IPAs
35,000 physicians

10
Plans

Blue Shield of California
An Independent Member of the Blue Shield Association
Anthem BlueCross
SHARP
Health Net
aetna
Cigna
KAISER PERMANENTE
Western Health Advantage
Chinese Community Health Plan CCHP
UnitedHealthcare

9 Million Californians

Value Based P4P: Core Program Elements

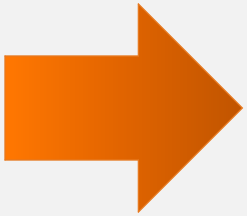
The California P4P program aims to create a compelling set of incentives that will drive improvements in clinical quality, resource use, and patient experience through:

- A Common Set of Measures
- Health Plan Incentive Payments
- A Public Report Card
- Public Recognition Awards

Transition to Value Based P4P

P4P Classic

- Emphasis on quality improvement
- Separate incentives for quality and resource use
- Standardizes health plan quality measures and payment methodology
- Set budget for incentive payments



Value Based P4P

- Emphasis on affordability and value
- Combined incentive for quality, resource use and total cost of care
- Standardizes health plan resource use measures, as well as quality measures and payment methodology
- Shared savings incentive

Value Based P4P: Lessons Learned

- Initial improvements in performance measurement results due to better data collection/reporting vs. actual improvement
- External audit process important to build trust in process & results
- Active participation by physician organizations in measure selection, specification and testing important to continued engagement; considerable administrative support required
- Amount, method and flow of financial incentives important
- Non-financial incentives important (e.g. awards, public reporting)
- Uniform measure set allows comparable public reports and program performance

Questions?

Bundled Payment

What?

- A fixed, single price for an episode of care (acute or chronic)
- Bundle covers all medical care (physician, inpatient, tests, devices) for defined episode
- Includes treatment of complications /readmissions for "warranty"
- Entity receiving bundle responsible for distribution payment to participating providers

Why?

- Improve quality, care coordination
- Reduce costs through incentive alignment
- Administrative adjustments ahead of payer mandates

Bundled Payment: California Initiatives

Bundled Episode Payment & Gainsharing Demonstration:

- IHA's 3-year grant from Agency for Healthcare Research & Quality (AHRQ): September 2010 – September 2013
- Key Objectives:
  - Test feasibility/scalability of bundled episodes in multi-payer environment
  - Develop 10 bundled episode definitions
  - Recruit 20 physician/facilities teams for health plan contracting in multiple payer settings
  - Evaluate implementation of hip and knee episodes (RAND)
  - Disseminate key lessons and best practices

Bundled Payments for Care Improvement (BPCI) Initiative:

- 3-year pilot launched by Centers for Medicare & Medicaid Innovation (CMMI) to test 4 different bundled payment models for fee-for-service Medicare beneficiaries
- Several California organizations participating

Bundled Payment: Lessons Learned

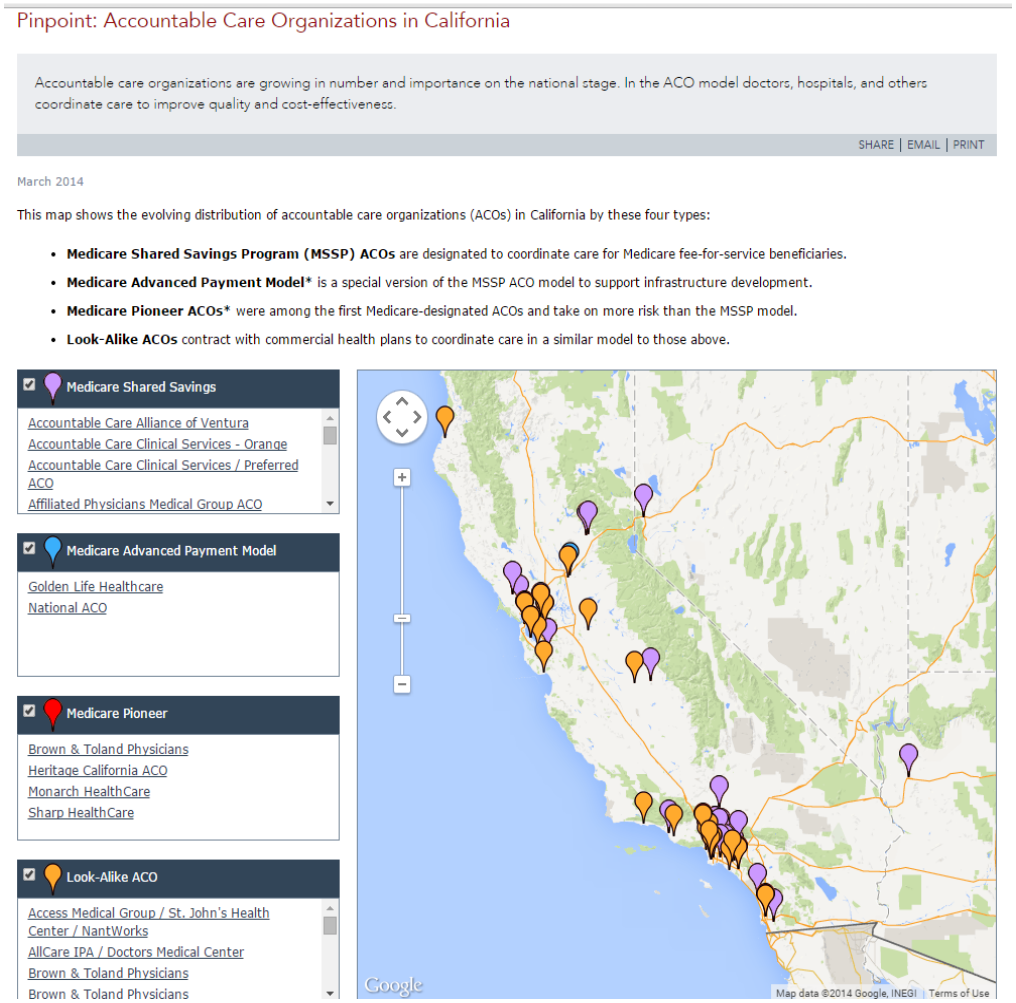
- Target markets in which bundled payment represents significant step forward
  - California highly capitated; bundled payment unwinds existing capitation arrangements
- Best suited to procedures, not primary care or care for complex patients
  - Clear start and end date, along with clinical criteria for exclusions
- Requires care redesign, not just payment changes
  - Standardization, transformation of clinical process of care
- Start retrospective, then transition to prospective
  - Issues with regulatory approvals, adjudication much more significant with prospective model

Questions?

Accountable Care Organizations (ACOs)

What?

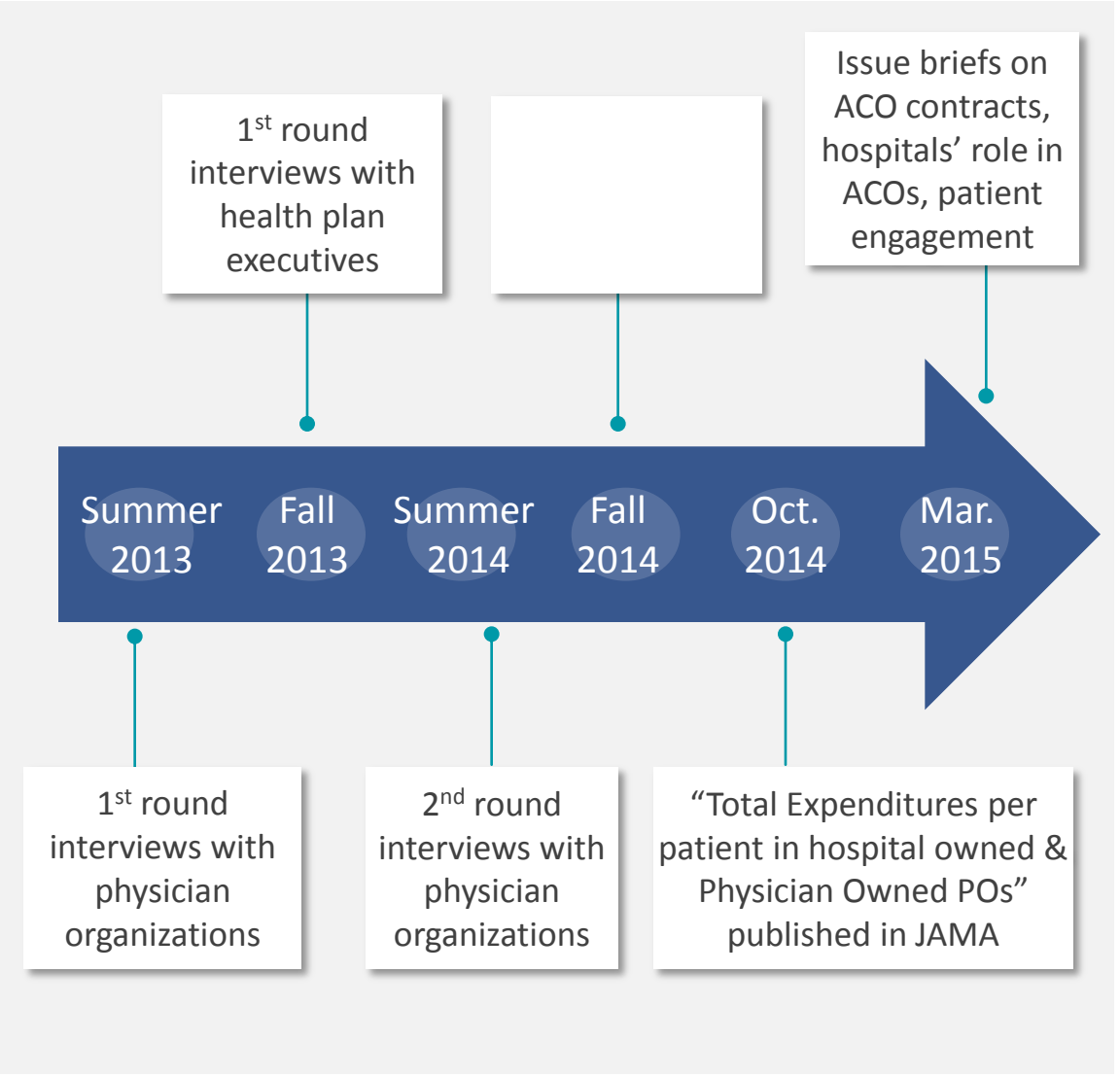
- Groups of providers that are jointly held accountable for quality and total cost of care for a defined patient population
- Key Principles: aligned incentives, shared savings, and performance measurement
- Models:
  - Medicare Shared Savings Program (MSSP) ACOs
  - Medicare Pioneer ACOs
  - Commercial ACOs – both PPO and HMO



A map of ACOs in California, last updated March 2014, is available at www.chcf.org

Evolution of ACOs in California: Case Study

- Partnership between IHA and University of California, Berkeley
- Funding from Robert Wood Johnson Foundation
- Participating Physician Organizations:
  - AltaMed, Los Angeles
  - Brown and Toland, San Francisco
  - HealthCare Partners, Los Angeles
  - St. Joseph Heritage, Orange
  - Monarch, Orange
- Plan interviews:
  - Aetna
  - Anthem
  - CIGNA
  - Blue Shield of CA



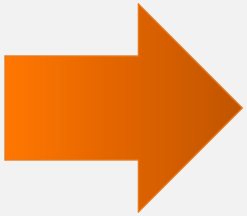
ACOs: Takeaways from the Commercial Market

- **Many different variants**
  - HMO – shifting back toward full risk
  - PPO – supplementing with care management fee (for all, or just chronic)
- **Both HMO and PPO have shared savings**
  - No savings = no bonus, regardless of quality
  - Targets vary – set against market vs. own trend
  - Healthy population – harder to find savings (relative to Medicare)
- **Referral management critical to managing cost**
  - Lower cost AND higher patient satisfaction due to lower OOP costs (in-network utilization)
  - Maternity: can't avoid admission, rely on steerage
- **Mixed financial results**

HMO ACO Model

Capitated HMO Model

- Plans pays professional capitation to physician organizations (POs)
- Plan pays hospital, pharmacy costs separately
- Physicians have some incentives to manage hospital, pharmacy costs
- Often, hospital has no incentive to manage costs – squeezed by physicians and plans



HMO ACO Model

- Global budget with up/downside risk for all partners – physician, hospital, and plan
- Plans pay POs professional cap plus shared savings based on Total Cost of Care (TCC)
- Hospital shares in savings – incentives aligned

Questions?

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    - Patient Centered Health Homes for Complex Patients

Medi-Cal Pay-for-Performance

Current Structure

- **DHCS to Plans:** auto-assignment rewards high-performing plans
- **Plans to Providers:** Medi-Cal Managed Care plans' P4P programs vary in existence and approach

IHA's Medi-Cal Activities

1. Medi-Cal Physician Organization Performance Measurement Pilot: July 2013 – October 2014
2. Medi-Cal Managed Care P4P Inventory: September 2014 – February 2015

Managed Medi-Cal Pilot: Overview

- **Goal**
  - Build a statewide framework for standardized performance measurement and public reporting at the physician organization level across Medi-Cal managed care health plans
- **Participating Plans**
  - LA Care
  - Anthem Blue Cross
  - CalOptima
  - Inland Empire Health Plan
  - Health Net
- Funding from Blue Shield of CA Foundation July 1, 2013 – October 31, 2014

Managed Medi-Cal Pilot: Activities

- **Finalized measure set**
  - Collaboration with leadership and technical staff from participating plans
  - Chosen from measures that Medi-Cal managed care plans are already required to report to NCQA and/or the State
  - 22 clinical measures, 1 health IT measure, 3 resource use measures
- **Collected measure results from participating health plans**
  - Reported at the physician organization level
- **Built Web reporting portal**
  - Displays aggregated and benchmarked results to plans and physician organizations

Medi-Cal Pay for Performance

Medi-Cal P4P Inventory

- Survey of P4P activities across all Medi-Cal managed care plans
- Areas of focus: measurement, incentives, provider participation, program impact
- September - November 2014: Telephone interviews with plan representatives
- Inventory underway; 20 plans have participated (22 total)

Follow-up Analysis

- Drilldown on specific areas of focus

Issue Brief

- February 2015 - Key findings published in IHA Issue Brief & comparative matrix

Medi-Cal P4P: Preliminary Results

Of the 20 Medi-Cal managed care plans interviewed, 16 have pay-for-performance programs in place.

Overview of Current P4P Activities	Number of Plans
P4P Programs in Place	16
Just Starting	1
Started 2009 - 2013	5
Started 2004 - 2008	3
Started 2003 and before	7
No P4P Program in Place	4
Total	20

Medi-Cal P4P: Preliminary Themes

- **Measurement Domains**: clinical, utilization, encounter submission, access, and patient experience
- **Incentive Targets:** most plans pay on both attainment and improvement; several include both population-based incentives and per-activity payments
- **Provider Engagement Strategies**: most plans provide regular feedback reports; many plans conduct trainings and orientations
- **Data Sources:** encounter/claims data most common source; effort to minimize burden for providers
- **Support Needed**: best practices, expert/peer information sharing; standardization of measures and shared benchmarks; data use

Medi-Cal P4P: Overview of L.A. Care's Program

	Physician P4P Program	LAP4P
Target	High-volume solo and small group physicians and community clinics	IPAs and medical groups with at least 2,500 Medi-Cal members
Domains	Clinical quality, encounter data submission	Clinical quality, appropriate resource use, patient experience, meaningful use of HIT, encounter data submission
Budget	$12.5 million annually	$12.5 million annually

Source: L.A. Care Health Plan P4P Programs, presentation by Nico Potterat at IHA Stakeholders Meeting on September 23, 2014, http://www.iha.org/pdfs_documents/news_events/2B-Medi-Cal-P4P-Potterat.pdf

Medi-Cal P4P: Overview of Partnership HP's Program

- Primary Care Quality Improvement Program (QIP), Hospital QIP, Pharmacy QIP, Specialty Quality and Access Improvement Plan
  - PC QIP: $4-5 PMPM (started 1995)
  - Hospital QIP: 4.5% average hospital income (started 2012)
  - Pharmacy QIP: $1 per prescription filled (started 2013)
  - Specialty QAIP: 10% average yearly income (started 2014)
- Primary Care QIP
  - Domains: Clinical, Resource Use, Operations and Access, Patient experience
  - Two types of incentives: fixed pool (PMPM) and unit of service
- P4P Program budgeted globally, and allocated across all participating providers

Source: Pay for Performance Programs at Partnership Health Plan of California, presentation by Bob Moore, M.D. at IHA Stakeholders Meeting on 9/23/14, http://www.iha.org/pdfs_documents/news_events/2B-Medi-Cal-P4P-Moore.pdf

Medi-Cal P4P: Non-Financial Incentive Models

Non-Financial Reward	Example
1. Performance profiling	The percent of a PCP's age-appropriate female adult patients who received a mammogram in the past two years is compared to statewide averages and shared with the PCP.
2. Public recognition	The percent of a PCP's age-appropriate female adult patients who received a mammogram in the past two years is published on a web site in conjunction with other measures and compared to statewide averages. The high-performing PCP is recognized with a distinguished provider rating.
3. Technical assistance	The state or its vendor offers the PCP free practice consultation on how to increase the percent of the PCP's age-appropriate adult female patients receiving prescribed mammograms.
4. Practice sanctions	The PCP is not assigned new patients until the PCP demonstrates improved and acceptable performance on specific performance metrics or completion of approved quality improvement initiatives.
5. Auto-assignment	The PCP is eligible to obtain member-panel assignments for female clients in mandatory programs who do not select a provider if the PCP performs above a specific threshold on women's health measures.
6. Reduced administrative requirements	If the PCP demonstrates excellent performance on mammography and other defined preventive measures, the PCP can undergo a quality audit every other year instead of annually.[8]

Sources: Center for Health Care Strategies, Physician Pay-for-Performance in Medicaid: A Guide for States 2007, http://www.chcs.org/media/Physician_P4P_Guide.pdf

Questions?

Medi-Cal Mental Health Benefit

What?

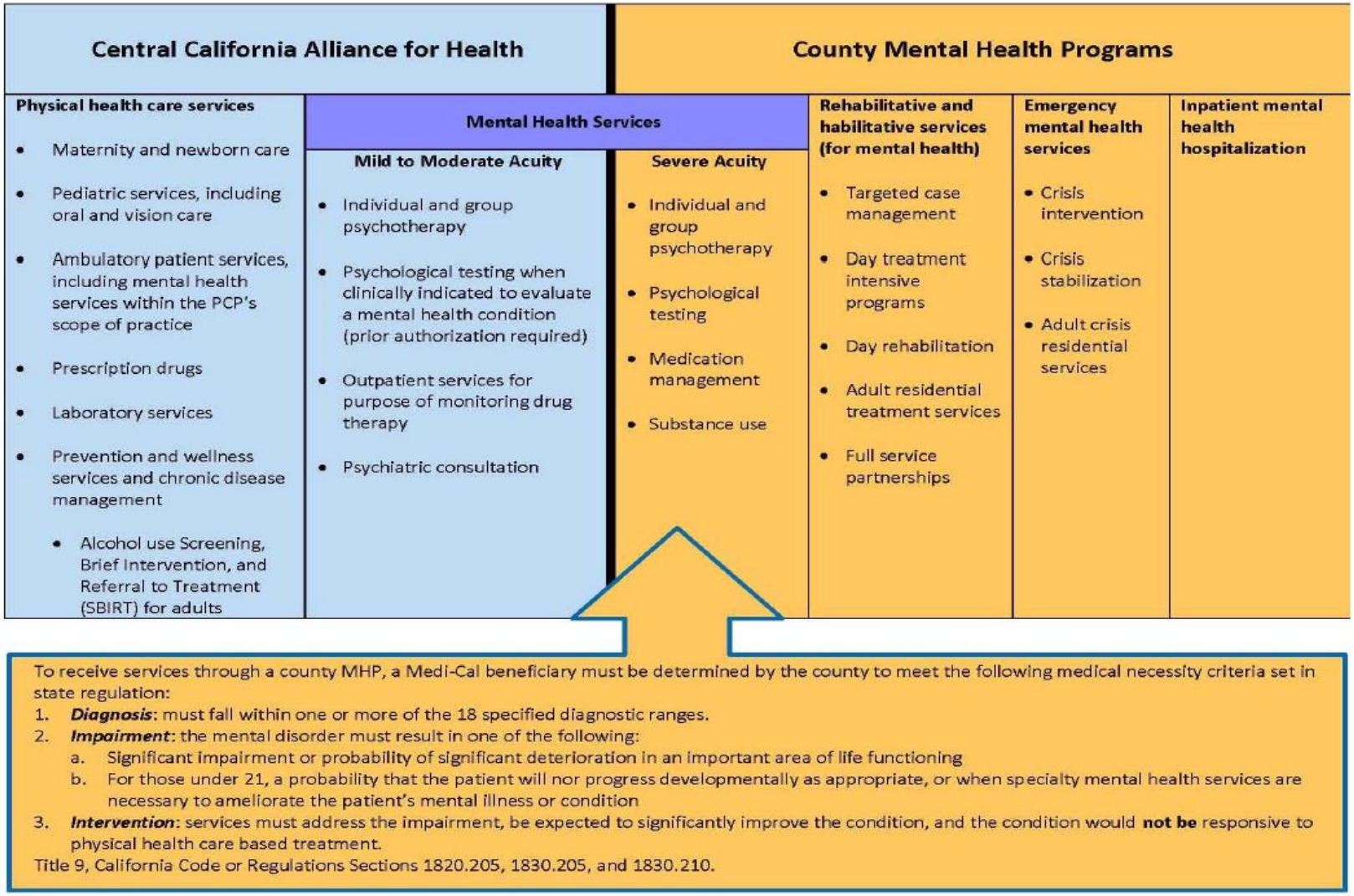
- Between 2012–2014, two fundamental changes to Medi-Cal mental health delivery system:
    1. Mental health incorporated into Department of Health Care Services from California Departments of Mental Health and Alcohol and Drug Programs
    2. Mental health and substance use disorder services is one of 10 essential health benefits mandated by ACA
- Starting in January 2014, Medi-Cal beneficiaries with mild to moderate mental health conditions will receive mental health benefits through Medi-Cal managed care plans.

Why?

- Improved integration of physical & mental health – shared goal of duals and health homes for complex patients initiatives
- Closer coordination between County Mental Health Plans and Managed Care Plans

Source: Department of Health Care Services, California Mental Health and Substance Use System Needs Assessment and Service Plan, http://www.dhcs.ca.gov/provgovpart/Documents/CABridgetoReformWaiverServicesPlanFINAL9013.pdf & Overview of the Affordable Care Act Implementation within the DHCS Behavioral Health Services Delivery System, www.acjrca.org/ppxsp2014/9-grealish.pptx

Medi-Cal Mental Health Services: Plan-County



Source: Central California Alliance for Health, New Medi-Cal Mental Health Benefits, https://www.ccah-alliance.org/providerspdfs/CCAH_Mental_Health_PowerPoint_for_remote_attendees.pdf

California Behavioral Health Integration Initiatives

- **County Medical Services Plan (CMSP) Behavioral Health Pilot Project**
  - Three-year project (2008 to 2011) in 15 of 34 rural CMSP counties
  - Enhanced covered behavioral health services; decreased hospitalizations and emergency department use
- **Frequent Users of Health Services Initiative**
  - $10 million project (2003 to 2008) funded by The California Endowment and the California HealthCare Foundation
  - Focused on frequent users of health services; avoiding unnecessary use of emergency departments
- **Integrated Behavioral Health Project**
  - Statewide initiative started in 2006 funded by The California Endowment and the Tides Center
  - Focus on integrating mental health, substance use, and physical health services
- **SAMHSA Primary and Behavioral Health Care Integration Grants**
  - Funds ongoing projects to support integration of primary care prevention and services into behavioral health settings

Source: California HealthCare Foundation, A Complex Case: Public Mental Health Delivery and Financing in California, 2013, http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20ComplexCaseMentalHealth.pdf

Dual-Eligible Demonstrations

What?

- Dual-eligible beneficiaries (eligible for both Medicare and Medicaid) include seniors and non-elderly people with significant disabilities; among poorest/sickest covered by either program
- CMS launching demonstrations to improve care/control costs for people dually eligible for Medicare & Medicaid

Why?

- Currently little coordination between Medicare & Medi-Cal
- Dual-eligible beneficiaries account for disproportionate share of spending in both programs

Dual Demonstration – Coordinated Care Initiative

- Intended to integrate and coordinate the delivery of Medicare and Medi-Cal health benefits into a single system of care
  - Benefits include physican health, behavioral health and long-term supports and services.
- 8 counties participating: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara
- Implementation began in April 2014; implementation staggered by county
- Two parts of CCI:
  1. Cal MediConnect – voluntary enrollment into Medi-Cal managed care plan that combines Medicare and Medi-Cal benefits; up to 456,000 beneficiaries eligible
  2. Mandatory enrollment of Medi-Cal beneficiaries (including duals not participating in Cal MediConnect) into managed care for all Medi-Cal benefits

Source: CalDuals.org, http://www.calduals.org/ and Department of Health Care Services, Dual Eligibles Coordinated Care Demonstration – Cal MediConnect, http://www.dhcs.ca.gov/pages/dualsdemonstration.aspx

CalSIM: California's State Innovation Plan

- April 2013: California Health and Human Services Agency (CHHS) received a SIM model design grant
- Let's Get Healthy California Framework: Foundation for California's State Innovation Model (CalSIM) plan
- CalSIM plan focuses on 4 key initiatives:
    1. Maternity Care
    2. Health Homes for Complex Patients
    3. Palliative Care
    4. Accountable Care Communities
- July 2014: CHHS submitted SIM testing grant proposal to implement the plan; response expected in November
- Estimated period: January 2015 – January 2019

Key Takeaways for Discussion

- **Bundled Payment** – existing administrative process and benefit designs make implementation difficult and are further complicated by the existence of capitation arrangements which often must be reconfigured to support bundled payment.
- **Accountable Care Organizations (ACO)** – existing capitation arrangements with organized physician organizations offer a starting point for pilots that test new risk arrangements for physicians and hospitals based on total cost of care, global budgeting and shared savings.
- **Pay for Performance** – existing pay-for-performance programs offered by Managed Medi-Cal plans offer opportunity to drive DHCS priorities through the implementation of a limited core set of performance goals/measures, while allowing customization and flexibility to adapt to local market dynamics and needs of the specific patient population.
- **Non-Financial Incentives** – public reporting, awards and other non-financial incentives can be powerful motivators for providers, leveraging performance measurement infrastructure.
- **Patient Centered Health Homes** – synergy between Section 2703 opportunity and Managed Medi-Cal plan infrastructure offers a significant opportunity to implement a high degree of care integration (including mental health) for patients with the most complex needs.