



December 17, 2014

Mari Cantwell
Chief Deputy Director
Health Care Programs
Department of Health Care Services

Re: MCO/Provider Incentive Workgroup, 1115 Waiver

Dear Ms.Cantwell,

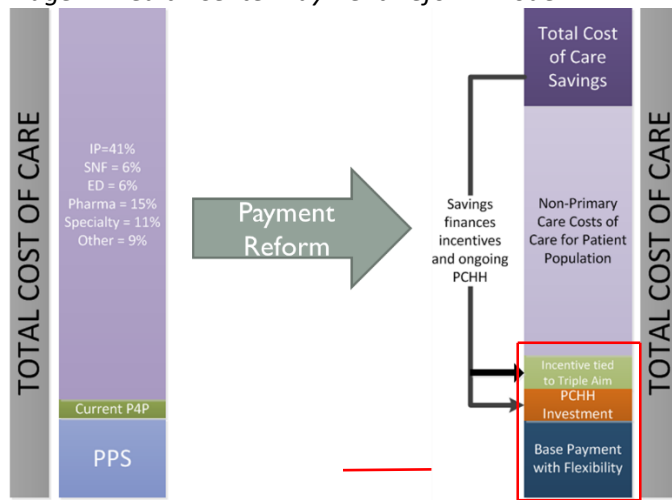
We would like to thank the Department again for selecting the California Primary Care Association (CPCA) to participate on the MCO/Provider Incentives Workgroup as part of the State's effort to develop the next 1115 Waiver. We have appreciated the rigorous and thoughtful approach of the last two meetings and look forward to the last one in January. The proposals and framing of the conversations are forward thinking and in CPCA's estimation absolutely moving the health delivery system in the right direction. We were particularly heartened at the last meeting when reviewing the strawman proposals to see the same ideas we are committed to advancing in a statewide dialogue.

There was one key theme at the last meeting that bears re-asking- where is the money for these incentives going to come from? The shared savings / budget neutrality proposition is innovative and we are supportive of the state's effort to explore this idea with CMS as long as the savings are reinvested in patients and affording primary care providers the necessary resources to positively impact outcomes. However there remains a great deal of skepticism that CMS will approve this approach, especially if there are no additional state resources put forward. And while we appreciate the Administration's desire to lower the costs of health care, we implore you to reconsider how to achieve that goal. Like our other colleagues around the table, we do not believe it can happen solely by cutting rates. There must be an infusion of resources upfront in primary care to drive the longer term savings. By way of example, in New Jersey Hurricane Sandy wrought massive damage to the state, particularly to the City of Hoboken. The city has chosen to rebuild, at a greater initial expense, in an innovative way that merges environmental planning and design so that when the next storm hits they will not be as impacted. California's aging population will be our next big storm, and if we infuse the system with more resources from the state for the next five plus years, the outcome will blunt the ever rising costs of health care. The health centers want to help the state achieve the triple aim and with the right strategies we can make it happen.

As the Department knows well, CPCA along with our colleagues at the California Association of Public Hospitals, have been working on a payment reform strategy for about three years (see Image A). The model we are using has three layers. The first is an alternative payment methodology, restructuring the PPS rate into a flexible capitation payment. The second is a payment for patient centered health home in order to provide the health centers the necessary resources to case manage patients with complex conditions, and the third is a robust Pay for Performance Program tied to Triple Aim incentives funded

through shared savings. In order to work as partners with the managed care plans and the state to bend the cost curve and improve patient experience and quality to ensure healthier Californians, all three layers are essential.

Image A. Health Center Payment Reform Model



As such, when CPCA reviews the strawman proposals put forward to the MCO/Provider Incentive WG we look at them as layers rather than as isolated ideas. All of the payment reform strategies CPCA and CAPH are exploring for health centers are in the six strawman proposals and we would argue that none in isolation is sufficient to dramatically change the trajectory of care and cost. They must be layered together and built slowly as change in institutions like health centers does not happen quickly and outcomes from changes are not seen immediately.

We assume the FQHC payment reform demonstration would be foundational, at least for the health centers in those counties. Layering on top a standardized statewide P4P program for primary care providers, as **strawman proposal 3** suggests, is an important and necessary element. We are supportive of this proposal and would expect that all MCOs would be expected to execute the P4P program with their contracted providers, including FQHCs and community clinics, in order to ensure that Medi-Cal enrollees assigned to all providers are able to experience the benefits of a payment system designed to optimize care quality.

We are also supportive of **strawman proposal 2**, which offers an incentive opportunity for care coordination that directly supports one of our preferred payment reform strategies – patient centered health home. We urge DHCS to work with counties and MCOs to build upon rather than duplicate existing care coordination infrastructure for behavioral health services. Incentives to the plan for care coordination should be used to fund hands-on coordination that takes place in the patient’s health home, rather than at the MCO plan and county level. FQHCs are in a particularly advantageous position as we have been delivering mental health on site for years and in the most recent years have been

working hard to build integrated primary and mental health delivery. In a recent CPCA conducted mental health services survey of clinics and health centers, 75% of the 80 corporation respondents indicated they had integrated behavioral health care. With the proper incentives health centers have the ability to appropriately manage the individuals who cycle through mild/moderate/severe mental health episodes, and eventually help stabilize the primary and mental health needs of the individual thereby ensuring a better, healthier life for that patient, but also saving the larger system money.

We are also particularly compelled by **strawman proposal 5**- shared savings for Medi-Cal providers. Shared savings is a desirable strategy to move the entire delivery system – including clinics and health centers – toward the triple aim. Shared savings does require some sophistication however, and is further along the spectrum of value based payment reform than many Medi-Cal providers, MCOs, and delegated risk bearing organizations are currently able to support. Shared savings assumes the ability to capture total cost of care, which at this point is challenging to all parts of the Medi-Cal delivery system. Health information exchange, electronic medical records, bi-directional data flow, and data analytics are all required elements before strawman proposal 5 can become widespread. From the health center perspective, some health centers are ready for this step, but the whole system of clinics needs staged support and incentives to achieve this vision for the state. We believe that making **strawman proposal 3** statewide is a perfect first step to an eventual move toward **strawman proposal 5**.

In sum we are supportive of the direction the department wants to move the State of California. We encourage the state, and the plans who will effectuate many of them, to layer these models and offer providers a package of strategies to achieve the end goal.

Regards,

Andie Patterson
Director of Government Affairs
California Primary Care Association