CHCS Center for Health Care Strategies, Inc.

IHA INTEGRATED HEALTHCARE ASSOCIATION

Straw Proposal 1: Payment Reform Contractual Accountability for Medi-Cal Plans

Proposed Approach – Contractual accountability for health plans to implement alternative payment arrangements from a menu of options

Target Population – All Medi-Cal managed care health plan members

Target Providers – Negotiated percentage of the health plan's provider network

Incentive Approach

- Health plans would receive an incentive payment if they establish alternative payment arrangements with providers and make a specified percentage of provider payments through approved alternative payment arrangements.
- The proportion of each plan's revenue that is tied to alternative payment arrangements could increase over time. For example, Year 1 could be 5%, Year 2 could be 10%, etc.
- Alternative payment arrangements could include shared savings based on quality and cost targets, bundled payments, or shared risk programs.
- Health plans would be able to submit other proposed arrangements for approval by DHCS.
- Health plans would attest to meeting the percentage benchmark and provide supporting data as requested by DHCS.

Desired Outcome

- Reduction in growth of per capita expenditures
- Improved quality

Alignment with other DHCS Initiatives – N/A

Role of DHCS

- Approve alternative payment arrangements and monitor compliance with initiative
- Foster alignment across plans
- Provide support to MCOs (e.g. data analytics, collaboration on provider initiatives)
- Create opportunities for stakeholders to discuss innovative payment strategies
- Distribute incentives to health plans

Examples

- South Carolina: Value Oriented Contracting https://msp.scdhhs.gov/managedcare/sites/default/files/Master%20Copy.pdf
- Arizona: Acute Care Program Payment Reform Initiative http://www.azahcccs.gov/commercial/Downloads/Solicitations/BiddersLibrary/Procurement/YH14-0001RFP_attachments_included.pdf

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Straw Proposal 2: Shared Savings for Medi-Cal Managed Care & County Behavioral Health Plans

Proposed Approach – A shared savings program for MMC plans and county behavioral health entities to jointly promote care integration and better outcomes for adults who meet medical necessity criteria for Medi-Cal Specialty Mental Health Services or Drug Medi-Cal Substance Abuse services.

Target Population – Adults who meet medical necessity criteria for Medi-Cal Specialty Mental Health Services or Drug Medi-Cal Substance Abuse

Target Providers – N/A

Incentive Approach – Dollars from the incentive pool would be allocated to MCPs and county entities based on performance on measures that MCPs and county entities can jointly influence by improving care coordination and collaboration and eventually patient outcomes across both programs. The key components of the program would include:

1. Incentive pool: DHCS fully funds initial pool, to be distributed to MCPs and county partners for jointly achieving shared outcome measures. Incentive pool funding could shift to an advance payment model after one or more years whereby MCPs would receive advance payments as part of their incentive payment that would be repaid to the state from the future shared savings they earn.
2. Incentive distribution: DHCS would distribute incentive payments to MCPs based on health plan performance across jointly-influenced metrics. MCPs would provide an incentive payment to county plans or agencies, similar to how funds flow from plans to counties under Cal MediConnect. Incentives could be structured to focus initially on process measures; percentage of payment tied to outcomes would increase annually until all incentive payments reflect outcomes.

Quality Approach – State would define performance measures and methodology for distributing earned incentives. Example process measures could focus on measurable activities that demonstrate evidence of collaborative processes and requirements as laid out in MOUs. Joint outcome targets could include reductions in ED use and admissions, medication management protocols and community supports and social outcomes. Metrics could include (but not be limited to) shared accountability measures required under Cal MediConnect.

Desired Outcome – Integrated care plans and other evidence of improved collaboration, improved medication adherence, reduced emergency department visits.

Alignment with other DHCS Initiatives – Cal MediConnect

Role of DHCS – DHCS would fund the initial incentive pool; develop performance measures, specifications, and benchmarks; outline methodology for MCP payments to counties; and determine the methodology for transition from a fully-funded incentive pool to a partial shared-savings arrangement with advance payments to entities.

Examples:

- Pennsylvania Serious Mental Illness Innovation pilot project – Expanded requirements for coordination across health plans and local county agencies to provide seamless access to specialty behavioral health services. Final evaluation report: http://www.chcs.org/media/Mathematica-RCP-FinalReport-2012.pdf
- Medicare Advance Payment Accountable Care Organization (ACO) Model – an initiative designed for organizations participating as ACOs in in the Shared Savings Program by which selected participants will receive advance payments that will be recouped from the shared savings they earn. http://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model/index.html

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Straw Proposal 3: Pay-for-Performance for Medi-Cal Providers

Proposed Approach – Each Medi-Cal Managed Care plan would adopt a P4P program that meets certain requirements (core design elements), with flexibility for tailoring to local area and provider sophistication.

In Fall 2014, IHA conducted a survey of Medi-Cal managed care health plans to assess their current P4P activities, with funding from the Blue Shield of California Foundation. Of the 22 Medi-Cal managed care plans, 18 have participated in interviews to date and 16 of those plans have P4P programs. Plans' P4P programs currently vary in existence and approach.

Target Population – All Medi-Cal managed care members

Target Providers – Primary care physicians who have a Medi-Cal contract with plans would be eligible for incentives. Plans could also provide incentives for specialists and other providers, e.g. hospitals

Incentive Approach – Core design elements of program would include:

1. A core set of standard measures that all plans could adopt, with allowance for plan flexibility based on local needs. The core measure set should align measures with existing programs (e.g., auto-assignment measures and/or current measures included in P4P programs).
2. Flexibility to allow plans to tailor the incentive approach to the level of sophistication of their contracted providers (e.g., solo physicians, FQHCs, Medical Groups/IPAs); match incentives to abilities (e.g., per-event incentive for less sophisticated providers).
3. A funding requirement for plans to develop programs that meet a minimum payout. Options for funding an incentive pool could include: new money from DHCS, a withhold percent from capitation, and placing a portion of rate increases at risk.

Quality Approach – Provider incentive based upon performance against and/or improvement on a set of core quality measures developed by DHCS. To reduce disparities, plan could offer higher payments to providers for achieving goals with vulnerable patients.

Desired Outcome

- Maximize the effectiveness of P4P programs by increasing standardization and reducing burden/duplications.
- Improve the quality of care and moderate cost trend by aligning provider incentives with performance on quality and cost.

Alignment with other DHCS Initiative – Auto-Assignment and DHCS "Strategy for Quality Improvement in Health Care"

Role of DHCS –

- DHCS would contractually require each plan to adopt a P4P program that meets core elements.
- With the support of a stakeholder advisory group, DHCS would:

- Set stable core measure set (identify performance measures, specifications, benchmarks)
- Set funding requirement for plans to develop programs that meet a minimum payout
- Develop a set of tools and resources to support plans with implementation and maintenance
- Monitor, revise and improve P4P programs on an ongoing basis to ensure programs have desired impact and unintended consequences are identified.

Examples: Most managed care plans have a P4P program. Examples include:

Partnership Health Plan P4P Program:

- Includes several P4P programs for different providers: 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: http://www.iha.org/pdfs_documents/news_events/2B-Medi-Cal-P4P-Moore.pdf

Inland Empire Health Plan P4P Program:

- IEHP's P4P program includes seven program components: (1) Immunization; (2) Well Child Visits; (3) Pap Tests; (4) Perinatal Services; (5) Postpartum Services; (6) Asthma; (7) Medicare DualChoice Annual Visit
- Participants: Primary Care Providers (participate in all components); OB Specialists (limited to select components)
- Incentive type: primarily per-event incentives paid directly to physicians; developing additional target-based programs (one for providers and one for IPAs) with total population focus
- P4P program financed from general operating funds; payments to providers significant (estimated $33-34 million payout in 2015)
- In 2013, IEHP also added a P4P program for Pharmacists

Source: https://ww3.iehp.org/en/providers/p4p-program/

Modification Option - The program could also be structured so that the incentives operate at the level of the Medi-Cal managed care plans, rather than the providers. Incentives could be funded a number of different ways, including

using downstream savings from reduced utilization, earmarking future capitation rate increases, or allocating a performance-based percentage of capitation payment for the pool. Depending on priorities, incentives could be structured to focus on quality (attainment, improvement, or some combination), total cost of care, and resource use. Incentives would be distributed based on health plan performance. Medicaid programs with similar features are in operation in Kansas, New York, and Pennsylvania.

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Straw Proposal 4: Behavioral Health Pay-for-Performance for Medi-Cal Providers

Proposed Approach – Each Medi-Cal managed care plan would adopt a care management/P4P program focused on care for patients with depression.

Target Population - Adults with diagnosis of major depression or dysthymia (chronic depression) and score of > 10 on PHQ-9

Target Providers - Provider Organizations/primary care practices with PCMH capabilities and care teams

Incentive Approach – Practices receive a per member per month (PMPM) payment to implement the IMPACT collaborative care model for patients with depression. The PMPM would cover the cost of a depression care manager (RN, MSW) and a consulting psychiatrist. The care manager works with the PCP and psychiatrist to develop an individualized care plan for each patient, provides weekly follow-up and outcomes monitoring, with evidence-based protocols for stepped care and anti-depressant medication management. Costs average $580 per patient annually.

Quality Approach – Care managers measure the patient's depressive symptoms using the Patient health questionnaire (PHQ) 9. 50% of the payment is based on whether the patient's symptoms are reduced over a 6 month period.

Desired Outcome –

- Remission/reduced depressive symptoms
- Lower total cost of care (~$1,000 per patient annually)
- Higher patient satisfaction with care
- Lower absenteeism

Alignment with other DHCS Initiatives – Complements the Health Homes for Complex Patients/2703 and PCMH

Role of DHCS

- DHCS would contractually require each plan to adopt a P4P program focused on care for patients with depression
- Funding for practice training in the care model

Examples – This proposal is based on the IMPACT Collaborative Care model developed by the AIMs Center at the University of Washington. http://impact-uw.org/. The model has been implemented in MN, NY, and WA.

In California, the AIMS Center has worked with Santa Clara County Mental Health Department and the Alameda Health Consortium on the IMPACT model.

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Straw Proposal 5: Shared Savings for Medi-Cal Providers

Proposed Approach – Each Medi-Cal managed care plan would implement a total cost of care target with shared savings between plans and providers for the difference between actual and targeted costs. Approach can be tailored to level of provider sophistication, e.g. plans can support small practices in rural areas by supplying data and analytics.

Target Population - All Medi-Cal managed care members (especially high cost patients and patients with 2+ chronic conditions)

Target Providers – A range of providers, from large groups that take risk to smaller providers whose results can be pooled for reliability

Incentive Approach

- The program features a Total Cost of Care (TCC) target with shared savings between plans and providers for the difference between actual and targeted costs. The program is an upside only model, i.e. providers share in any savings but are not at risk if targets are not reached. The incentive design is flexible – the decision about what providers/services are included in the total cost of care determines the scope of the program. For example, if the TCC measure includes behavioral health payments, the plan/providers will have a stronger incentive to manage BH care. The method for shared savings can be modified depending on the size and sophistication of the contracted providers and local market dynamics. Two options are outlined below:

    A. *Option 1* (*for larger providers*): A three-way agreement between provider organizations, hospitals and the health plan
        a. Institutional risk shared between hospital and provider group through a risk pool
        b. Hospitals get 50% of inpatient savings, group gets 50% of outpatient savings, some of savings to plan goes back to State

    B. *Option 2 (for smaller providers or large providers where no hospital is willing to participate)*: A two-way agreement between provider organizations and the health plan
        a. This option may require the health plan to change hospital contracts from per diem to DRG so that hospitals incentives are aligned
        b. For smaller providers, the plans could provide data and analytic services. With this option, plans could pool results across groups of smaller providers for more reliable results.

- Common elements that could be included in either model include:
    a. Upfront investment in technology, data
    b. Higher PMPM for patients with 2+ chronic conditions
    c. Employing FTEs in high cost hospitals to repatriate patients to lower cost hospitals

Quality Approach - Quality targets must be hit in order for hospital and physician group to be eligible for share of savings. To reduce disparities, plans could offer higher payments to providers for achieving goals with vulnerable patients.

Desired Outcome

- Increased care coordination to keep patients out of the hospital
- More collaboration between provider groups and hospitals (and less resistance from hospitals since they are either sharing in the savings or receiving DRG payments)
- Lower overall TCC per patient; maintenance of current quality scores, or quality improvement

Alignment with other DHCS Initiatives – Work within framework of Medi-Cal managed care

Role of DHCS

- DHCS would contractually require each plan to implement a total cost of care target with shared savings between plans and providers for the difference between actual and targeted costs.
- Authorization/issuance of clear guidance that gain sharing is legal
    - In the late 1990s and early 20002, DMHC became worried that medical groups without HMO/limited liability licenses were assuming financial risk. DMHC began to limit the amount of risk medical groups could assume, and determined that provider groups could not be capitated for services or take downside risk unless they obtain a "limited license" approval from DMHC.

Examples: Plans (e.g. Blue Shield of California, Anthem Blue Cross) and provider organizations (e.g. AltaMed) are negotiating contracts with some or all of these features across the state.

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Straw Proposal 6: Shared Savings for Physical & Behavioral Health Providers for Team-Based Care

Proposed Approach – Each Medi-Cal managed care plan would offer a package of payment reforms based on tiers of increasing physical health-behavioral health coordination and co-location to ensure that team-based care is provided to beneficiaries with mild/moderate mental health needs as well as highest-cost/need beneficiaries

Target Population

- *Model A:* Individuals with mild to moderate behavioral health needs
- *Model B:* Individuals with specialty treatment behavioral health needs

Target Providers

- *Model A*: Primary care practices acting as the "provider of choice" for patients with behavioral health needs
- *Model B*: Behavioral health providers/clinics acting as the "provider of choice" for patients with severe mental illness that coordinate with primary care practices and/or employ nurses and/or nurse practitioners.

Incentive Approach

- Providers receive supplemental capitation payment based on their "tier"; i.e., level of care coordination and integration. Payment increases by tier. Multiple tiers allow for providers with different infrastructure capabilities and other resource levels to engage in some form of care coordination/integration.

Tier	Model A: Primary care practice, FQHC	Model B: Behavioral health provider, CMHC
1	Care coordination of BH services with primary care, either as a designated health home (and receive health home payment) or in line with PCMH care coordination principles	Care coordination of BH services with primary care, either as a designated health home (and receive health home payment) or in line with PCMH care coordination principles
2	Brief interventions, screening/ assessment/triage, consultations, outpatient BH services by master's/ bachelor's level professional (e.g. social worker, clinical psychologist) onsite	Basic primary care screening and assessments (e.g., BMI, blood pressure, diabetes, etc.), medication reviews, referrals for lab and diagnostic tests. Nurse professional on-site
3	Psychiatric assessments, medication management, psychotherapy by prescribing clinicians and psychotherapists onsite	Comprehensive primary care by nurse practitioner or PCP onsite, medication management by prescribing provider

- Add-on quality incentive payment for meeting performance benchmarks related to desired outcomes below
- Shared savings for primary provider organization in Models A or B
    - Calculations would be based on savings from non-capitated spend, including hospital, pharmacy, and specialist services

— Can be structured to include upside risk only, upside transitioning to downside, or upside and downside risk depending upon the capabilities of the provider organization. Shared savings model would align with straw proposal #6

Quality Approach – Higher payments to groups with coordinated or co-located models and that achieve quality outcomes targets. Shared savings create incentives to ensure high-quality behavioral health or physical health care in respective settings.

Desired Outcomes

- Lower overall total cost of care per patient
- Improved overall metrics, focused on Health Home quality indicators, reduction in emergency department visits and readmission among individuals with behavioral health needs
- Increase care team collaboration and shared electronic records across systems
- *Model A*: Improvements in physical health indicators among individuals with serious mental illness
- *Model B*: Lower PHQ-9 scores and other BH metrics

Alignment with other DHCS Initiatives – Complements State's HH for Complex Patients/2703 and PCMH; can also dovetail with shared savings models developed for providers under Model #6

Role of DHCS

- DHCS would contractually require each plan to offer a package of reforms based on tiers of physical and behavioral health coordination and co-location
- Funding for learning collaborative of participating practices
- Oversight of State's HH for Complex Patients/2703

Examples

- Massachusetts Primary Care Payment Reform (1115 waiver available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf)

- Arizona Mercy Maricopa Integrated Care (http://mercymaricopa.org/; provider resources at: http://mercymaricopa.org/providers/resources/)