

**CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
1115 WAIVER RENEWAL
PLAN/PROVIDER INCENTIVE PROGRAMS EXPERT STAKEHOLDER WORKGROUP
MEETING SUMMARY**

**Wednesday, November 12, 2014
10:00am – 3:00pm
Sacramento Convention Center**

Members present:

Molly Brassil, County Behavioral Health Directors Association of California; Michelle Cabrera, SEIU; Richard Chambers, Molina HealthCare of California; Lishaun Francis, California Medical Association; Brad Gilbert, Inland Empire Health Plan; Jennifer Kent, Local Health Plans of California; Ann-Louise Kuhns, California Children's Hospital Association; Elizabeth Landsberg, Western Center on Law and Poverty; Anne McLeod, California Hospital Association; Erica Murray, California Association of Public Hospitals and Health Systems; Paul Pakuckas, Anthem Blue Cross; Michael Schrader, CalOptima; Rusty Selix, Mental Health Association of California; Peter Shih, San Diego County; Abbie Totten, California Association of Health Plans; Anthony Wright, Health Access

Members on the phone: None

Members Not Attending: Don Crane, California Association of Physician Groups; Dean Germano, Shasta Community Health Center; Sandra Naylor Goodwin, California Institute for Behavioral Health Solutions; Andie Patterson, California Primary Care Association.

Others Attending: Jill Yegian, Integrated Healthcare Association (IHA); Tom Williams, IHA; Sarah Lally, IHA; Tricia McGinnis, Center for Health Care Strategies (CHCS); Greg Howe, CHCS; Michelle Soper, CHCS; Mari Cantwell, DHCS Wendy Soe, DHCS; Sarah Brooks, DHCS; Pilar Williams, DHCS; Dana Moore, CDPH Bobbie Wunsch, Pacific Health Consulting Group.

18 Members of the public attended the meeting.

Meeting Summary

Presentation Slides are available at: <http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-MCO-Provider-Incentives.aspx>

Following introductions of Workgroup Members, DHCS staff Wendy Soe and Sarah Brooks provided an overview of 1115 Medicaid Waivers, including budget neutrality. They reviewed the 2015 1115 Waiver Renewal goals and objectives, timeline and the eight renewal concepts. The current waiver expires October 2015. Current incentive structures were reviewed (e.g. auto assignment incentive program) and a potential construct for incentives under the waiver renewal was presented for discussion.

Questions/Comments from Members:

Michelle Cabrera, SEIU: Can you clarify the methodology for the county average rate setting process? Is the risk adjustment based on clinical factors or are social demographic factors included?

Cantwell, DHCS: We use a method called Medicaid RX that includes clinical, age and gender to risk adjust. The risk adjustment is budget neutral.

Anthony Wright, Health Access: Do we have initial data on plans that have reached the threshold for payments on Cal MediConnect incentives?

Brooks, DHCS: It is too early to tell.

Michael Schrader, CalOptima: Can you talk more about Managed Care Plan incentives to county behavioral health proposed?

Brooks, DHCS: This could include an incentive based on a measure such as reduced ED visits.

Jennifer Kent, Local Health Plans of California: What is being waived on slide 14 [options for incentive payment arrangements between entities]; why is an 1115 Waiver needed?

Soe, DHCS: It will depend on how we structure the waiver. We are arguing efficiencies gained under managed care, which is under the waiver, would demonstrate savings.

Cantwell, DHCS: We don't know how this will be structured or specific waivers. Perhaps for passing through incentives to providers contracted with managed care plans or waiver of limits on incentive payments as a percent of capitation.

Paul Pakuckas, Anthem Blue Cross: Cal MediConnect incentive program is too early to measure. Is there any data on whether auto assignment or the 50% risk adjustment program have moved the needle on quality?

Brooks, DHCS: There have been studies on the auto assignment program and we are looking at effectiveness and how we might modify the algorithm but we do see it creates an incentive for the health plans.

Williams, DHCS: In relation to the 50-50 risk adjustment program, we do not have data analysis. States are moving more to county average methodology for rates.

Paul Pakuckas, Anthem Blue Cross: If the waiver renewal will include previous incentives, will they expand?

Brooks, DHCS: Auto-assignment and current health plan incentive structures are not built into the waiver.

Cantwell, DHCS: Yes, all are outside the waiver with the exception of Cal MediConnect withholds – which is in the waiver. We will continue what we are doing in managed care and we are looking to add, not take away.

Rusty Selix, Mental Health Association of California: Is the health home option included? Would it make incentives work better? Also, the 1915i category, such as paying for respite, transportation for severe mental illness. Are they part of this to improve incentives?

Soe, DHCS: Yes, health homes could be leveraged to support the delivery system transformation under the waiver. The health homes program is being developed under CalSIM and happening on a different timeline.

Rusty Selix, Mental Health Association of California: How do we bring issues together? New York used the 1115 process to implement 1915i concepts.

Cantwell, DHCS: This work group is the place for that discussion.

Anthony Wright, Health Access: What is the philosophy behind current incentives – is the expectation that entities would be able to earn all incentive dollars or are targets aspirational?

Cantwell, DHCS: In general, we are seeking more standardized measures, and will expect plans and providers would be able to attain them.

Current California Experience with Incentive-Based Payment

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Jill Yegian and Tom Williams, Integrated Healthcare Association provided information about incentive programs from both commercial and Medi-Cal experience to create a shared base of knowledge for the discussion going forward. Some assumptions for the workgroup to consider:

- Continued reliance on managed care for Medi-Cal;
- Prospective Payment System will remain in place; and,
- Waiver renewal will coordinate, not duplicate, Health Home and Cal-SIM efforts.

California's commercial and Medi-Cal incentive payment options were outlined and the experience with each option was presented, including:

Value Based Payment in California's Commercial Market

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

Medi-Cal Initiatives

- Medi-Cal Pay-for-Performance (memo is posted)
- Mental Health Benefit (too early for experience)
- Coordinated Care Initiative/Dual-Eligible Demonstration (too early for experience)

Questions/Comments from Members:

Michael Schrader, CalOptima: Has Value-Based Pay for Performance been used for Medi-Cal?

Yegian, IHA: It has not been used in Medi-Cal and we are not proposing it here. It is presented because lessons learned could inform this discussion.

Brad Gilbert, Inland Empire Health Plan: The medical group and provider structure is different in Medi-Cal. With IEHP, 40% of beneficiaries are direct contracted – not through a medical group; also, many groups and IPA's in Medi-Cal were created specifically for Medi-Cal. While the pay

for performance can be compared across many plans on the commercial side, it would be different in Medi-Cal.

Lishaun Francis, California Medical Association: What were upfront costs when program began?
Williams, IHA: There are two upfront costs: 1) administrative costs were modest; 2) there were bigger costs to providers. Organized groups built registries, hired staff to manage program and had other infrastructure costs that were not insignificant.

Ann-Louise Kuhns, California Children's Hospital Association: Can you elaborate on why bundled payment is less useful for complex populations?

Yegian, IHA: It is difficult to define the episode of care for complex patients.

Ann-Louise Kuhns, California Children's Hospital Association: it has been suggested that NICU might be appropriate for bundled payment, yet this is not really an episode.

Williams, IHP: Yes, that has come up and we have discussed maternity generally.

Brad Gilbert, Inland Empire Health Plan: An ACO is licensed. Some examples used in the presentation were partnerships. The two are different.

Williams, IHP: Yes, I agree. There is a lot of action in the less-formal ACO examples.

Brad Gilbert, Inland Empire Health Plan: Yes, I think it is very relevant for Medi-Cal to look at the examples that vary from the formal ACO. There are special challenges in Medi-Cal to find hospital partners as well as other issues.

Rusty Selix, Mental Health Association of California: Do the different payment models change the way the state and federal payment occurs? Does it change the way the state and county would be paid in the mental health context? Mental health has specific federal care documentation requirements that are very detailed and different.

Yegian, IHA: The presentation focused primarily on commercial examples.

Michael Schrader, CalOptima: How do Medi-Cal pay for performance measures align with NCQA?

Yegian, IHA: The memo posted lists the metrics used for the pilot IHA recently completed of physician organization-level measurement in Medi-Cal managed care. They were drawn from measures already collected by plans.

Brooks, DHCS: We work with NCQA and NQF to align our efforts. We are looking to create a structure that works within these structures. It is an option to go beyond these measures.

Peter Shih, San Diego County: CA has the lowest reimbursement for Medicaid, much lower than some of the examples such as NY. We have issues with specialists and other challenges. Without the right level of funding, it is difficult to get the outcomes we seek. If consults are six months delayed, it makes it difficult to reach incentives.

Incentive Ideas in Other States' 1115 Waivers and Initiatives

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Tricia McGinnis and Greg Howe, Center for Health Care Strategies presented an overview of national trends to inform development of concepts for in-depth follow up discussion. The presentation included descriptions of provider-facing incentives and state-managed care plan incentives. Emerging trends in state-led payment reform include:

- Moving beyond P4P;
- Increasing provider accountability;
- Incentivizing coordination;
- Investing in data infrastructure; and,
- Pursuing multi-payer alignment.

State-led provider-facing incentives were described from Massachusetts and Minnesota as well as provider-level incentives for Behavioral Health Integration. Plan-facing incentives and lessons learned were described from Arizona, New Jersey and Oregon. Themes from Behavioral Health Integration plan-level incentives were described from a number of states including Kansas, New York, Connecticut, Pennsylvania and New Mexico. Policy questions and considerations were posed for discussion.

Additional Input from Members:

Erica Murray, California Association of Public Hospitals and Health Systems: These are the right questions. One issue for assuming full risk is timing – how do we shift to a new structure while operating in the current structure? Another issue to keep in the forefront is the low reimbursement rate. The resources needed at baseline in the Medi-Cal networks is significant.

Anne McLeod, California Hospital Association: We are tagged as the most efficient Medi-Cal program in the country. What is the minimal level of investment needed to make this a high quality program?

Peter Shih, San Diego County: In San Diego, the medical plans have about 50% FQHCs in the network. They love Medi-Cal and private providers don't. We need a broad provider network and we need to strengthen infrastructure for providers. In the San Diego Low Income Health Program, we supported provider infrastructure to succeed with pay for performance.

Brad Gilbert, Inland Empire Health Plan: Small groups and individual providers don't have the administrative structures to integrate the technical assistance we provide on how to improve outcomes. We can't afford to lose these providers and they need EHR, registries, etc.

Anthony Wright, Health Access: What are the specific challenges and opportunities that come with the Medi-Cal population? How does pay for performance address the diverse needs of Medi-Cal population? There may be an opportunity that follows from the high density of Medi-Cal in certain geographies that could lead to a population health approach.

Michelle Cabrera, SEIU: I want to emphasize the need to identify what the state wants to get out of incentives. Significant disparities exist within Medi-Cal populations. Where have incentives helped identify disparities and improve outcomes? What we measure matters and sends a message about our priorities.

Rusty Selix, Mental Health Association of California: Related to disparities, there is an external review organization for mental health that presented stark findings. We need to ensure that everyone in primary care receives a behavioral health assessment and action. We know this pays for itself in physical health improvements. We should build on what we know works.

Molly Brassil, County Behavioral Health Directors Association of California: Thank you for the focus on BH. In PA, they started with infrastructure and tied this to outcomes in the later years. How is this accomplished?

Lishaun Francis, California Medical Association: What are the differences between states that implemented mandatory vs voluntary programs?

McGinnis, CHCS: This is difficult to say as each market is so different. The range of flexibility is a good consideration for discussion within the consideration of each goal and the specific market.

Michael Schrader, CalOptima: Have you found a staged approach to accommodate the needs in different geography (urban, rural) and provider types (IPA, FQHC)? Can we match the approach to the needs?

Richard Chambers, Molina HealthCare of California: Is there evaluation of what is working in the various approaches? How do the ACO incentives intersect with managed care operation geographically?

McGinnis, CHCS: CMMI will be a key evaluator. State data is published but little evaluation other than CMMI as the funder. There is a range of ACO approaches in states and a key question is, what are the right parameters to standardize?

Anthony Wright, Health Access: What are the policy options to continue consumer protections and regulatory oversight in these programs? How are other states providing this?

McGinnis, CHCS: They are focusing on quality measures to ensure there is no skimping on care. New Jersey is evaluating the cost in markets with ACOs. This remains an area that is evolving.

Williams, IHA: California is a state with lots in place to build on for consumer protections.

Erica Murray, California Association of Public Hospitals and Health Systems: What patterns or trends have you noted regarding what is in waivers vs Cal SIM grants? It seems there are many initiatives but we don't have a clear picture for what is working or not.

Peter Shih, San Diego County: In addition, what is the opportunity to bring the various waivers and conversations together?

McGinnis, CHCS: Waivers are used to get approval for part of SIM grants, for example Massachusetts wrapped shared savings in waiver. However, SIM is not a green light, waiver approval is needed. SIM funding cannot pay for services.

Howe, CHCS: For the first time, an evaluation of waivers across the country will be conducted by CMS. One reason is to identify standard terms and conditions across states.

Williams, IHA: Managed care plans in California are as large as some state's Medicaid programs. We have to cull information from our experience here. Also, we need to hear from provider groups that what we discuss will work for them.

Brooks, DHCS: Within state staff, we are discussing how to coordinate across and tie initiatives together. Pilar Williams is attending every work group and we will all make sure the discussions are shared as they touch on each other.

Williams, DHCS: Yes, DHCS still has siloes but is trying to integrate more, continue to move to managed care.

What Has Been Learned from Current Incentive Programs: Plan and Provider Perspectives and Potential Opportunities Identified by Workgroup Members

Michael Schrader, CalOptima: A success from Cal-Optima is a Medicare example. We are getting assessments, individual plans and PCP identified; we developed report cards and we are sharing what works. I think a key consideration is the balance of standardization/statewideness vs specific community needs. Another issue is layers: providers say they hear about incentives but it doesn't make to the pocket of the provider. We need to consider how to ensure the incentive gets to the provider.

Brad Gilbert, Inland Empire Health Plan: We have a \$40M incentives program with three levels. 1) Process: if provider does a service, we pay extra for events (well child, postpartum, early prenatal care); 2) outcome: we pay for hemoglobin level at a patient population level; 3) threshold payments: for example, 70% compliance with HEDIS measure across an IPA or a practice. The world is moving away from event-based payments but they have been successful with doctors. Counties are great place to work on whole person care. If working with solo doctors, we have to stay simple.

Jennifer Kent, Local Health Plans of California: We have success with some of the measurable things done under DSRIP (e.g. 30 day admissions). We need to set the larger goals we want to incentivize and then talk about how we want to pay for it. There are many things individual plans are doing and we should let those continue while we add overarching goals for the state.

Paul Pakuckas, Anthem Blue Cross: We customize incentive to the network in a specific market. The flow of incentive dollars is as important as the structure. For example, the doctors don't engage if incentive payment is 18 months from now or too complex. Success means: regular flow of money; ensure the money flows all the way to provider who drives the score; ensure the provider actually has control of that driver; ensure encounter data and reporting are incentivized. We have success in Medi-Cal ranking providers in quartiles against each other to create competition.

Richard Chambers, Molina HealthCare of California: A few comments. On multi-payer alignment – each plan creating a different incentive program is a problem. On infrastructure – is the reward big enough to invest in infrastructure? Unless you would terminate them, they might bypass if reward not big enough. On funding – is it big enough to finance the bonus? On

engagement – MD engagement easier than facility (hospital/SNF). On variation – each county has a different network (e.g. many FQHCs vs not).

Brad Gilbert, Inland Empire Health Plan: Withhold incentives do not work with providers. It is a negative incentive and positive incentives work better. It's not clear why we have this at the plan level.

Abbie Totten, California Association of Health Plans: My biggest concern is that we have already assumed such a low cost, how can we move forward from this level. The reason this is moving on the commercial side is because there is more money to work with. There is great variability among plans so we need flexibility in the implementation.

Dana Moore, CDPH: How have other state's incentive programs incorporated public health?
McGinnis, CHCS: Oregon required community advisory boards with public health involvement to develop community assessment and action plans. Minnesota is piloting an accountable communities approach with public health + ACO involved.

Anthony Wright, Health Access: How do we reconcile the tension between: simplicity matters and the incentive must be tied to direct control, in contrast to more inclusive programs with broad parameters like SDOH with multiple staff involved?

Brad Gilbert, Inland Empire Health Plan: A county has the ability to organize a coordinated approach where a global incentive would work. A small group or solo doc has no control over many of the variables and an event based incentive works. Reconciling it requires that we have the right incentive for the right model. They can co-exist.

Jennifer Kent, Local Health Plans of California: I agree. It varies by where the behavior can be incentivized. In large groups, the PCP may be paid by encounter but this is part of a global approach.

Michelle Cabrera, SEIU: Since 30% of Californians are in Medi-Cal and 70% of Medi-Cal is in managed care, it seems we can figure this out based on the specific interests we have and not look to commercial plan experience. We want to incentivize and pay for broad issues like care coordination and individual doctor incentives.

Michael Schrader, CalOptima: Lots can happen outside incentive program on SDOH that is aligned with mission and not part of incentives e.g. school base vision services, ED discharge coordination.

Brad Gilbert, Inland Empire Health Plan: We will have 25% of the local population in the plan and this volume brings leverage. We can drive patients to high performing, high quality MDs and groups.

Jennifer Kent, Local Health Plans of California: There is a plan that looks at solo MDs and will terminate contracts if the MD is not meeting a certain volume of enrollments.

Rusty Selix, Mental Health Association of California: Within mental health, the original realignment is the best example of successful incentives. It gave flexible funding to counties and this was used to decrease hospitalizations of mentally ill and move them to community settings. We need to get at another issue as well. Mentally ill patients have poor physical health. Most initiatives to work on this have been grant funded to support embedding staff in each other's systems. When we screen and coordinate, we get better outcomes. How do we create incentives, using the potential savings for plans, state and feds, to put these models in place that we know work?

Brad Gilbert, Inland Empire Health Plan: We have electronic integration of care plans between PCP and MH provider. I am more convinced about having integration on the PCP side. We need funding to get it started. How can we prime the pump?

Ann-Louise Kuhns, California Children's Hospital Association: We have kids sitting in the ED because the service they need does not exist.

Peter Shih, San Diego County: San Diego did behavioral health integration as part of the LIHP. Did good job incentivizing this and data is at the state. We should look at LIHP data.

Molly Brassil, County Behavioral Health Directors Association of California: Individuals with serious mental illness die 25 years sooner, often because of a lack of care coordination. How do we identify additional resources to seed the care coordination? How do we identify resources that do not come from shared savings or withholds?

Lishaun Francis, California Medical Association Generally, MDs have love-hate relationship with incentives. Keeping track can be harder than actually meeting the incentive. The MD's first question will be; how much money is state going to invest? We need to talk about upfront resources. If we are not careful, we will lose the small and solo providers. They all want to participate but the devil is in details. To hire staff, create data infrastructure, etc. takes upfront resources. It is also important to be transparent with measures and increase MD understanding of the measures.

Erica Murray, California Association of Public Hospitals and Health Systems: Although we have distinct workgroups, there is overlap. Our strong county structure lends itself to Hennepin Health models with fully integrated behavioral health, public health, etc. We need to recognize the need for systemwide advances and the opportunity costs when we focus in on a set of changes. We need consistent metrics. There is a tension in need for variability and a statewide approach. We need synergies between SIM and the Waiver. We also need to figure out what to do about maintaining high performance – when we get to 90%, it cost just as much to maintain.

Ann-Louise Kuhns, California Children's Hospital Association: A dilemma is that there are few quality indicators for sick kids and the numbers are low in general provider groups. How do we fit? How do we measure quality for this population? The impetus to improve efficiency in Medi-Cal cannot have the unintended consequence of moving kids out of the special hospital designed to care for all sick kids?

Elizabeth Landsberg, Western Center on Law and Poverty: We need to start with goals of what we want to achieve. SDOH are important to customize into incentives. As we go forward, we do need to get into the specifics of what we need a waiver for.

Bobbie Wunsch, Pacific Health Consulting Group: Future meetings will include discussion of what incentive arrangements hold the most promise. DHCS and consultants can put options forward for discussion.

Public Comment

Catherine Douglas, Private Essential Access Community Hospitals (PEACH), President and CEO: Thank you for the wonderful comments today. My comments are relevant for DSRIP and the work group and I am not sure how these two intersect. California's DSRIP is amazing and other states have emulated it. As you think about design of incentives, it is important to include private DSH hospitals. In 2012-13, private DSH hospitals provided 31% of acute care for Medi-Cal population and 67% of mental health days and not included in DSRIP. We agree we need overall goals for incentives and we need to align incentives. We would like to consider partnership with the private DSH hospitals as you do this work.

Plan Provider Incentive Expert Stakeholder Workgroup Meeting Dates:

- Meeting #2 – December 15, 2014 at USC State Capitol Center; 1800 I St
- Meeting #3 – January 23, 2015 at DHCS Training Rooms