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

Monday, December 15, 2014
10:00am – 3:00pm
USC Capitol Center, Room E, 1800 I Street, Sacramento
Meeting Summary

Members present:
Molly Brassil, County Behavioral Health Directors Association of California; Michelle Cabrera, SEIU; Don Crane, California Association of Physician Groups; Lishaun Francis, California Medical Association; Dean Germano, Shasta Community Health Center; Jennifer Kent, Local Health Plans of California; Ann Kuhns, California Children's Hospital Association; Paul Pakuckas, Anthem Blue Cross; Andie Patterson, California Primary Care Association; Chris Perrone, California HealthCare Foundation; Rusty Selix, Mental Health Association of California; Peter Shih, San Diego County; Richard Thomason, Blue Shield of California Foundation; Abbie Totten, California Association of Health Plans; Rachel Wick, Blue Shield of California Foundation; Anthony Wright, Health Access.

Members on the phone: Brad Gilbert, Inland Empire Health Plan; Elizabeth Landsberg, Western Center on Law and Poverty; Michael Schrader, CalOptima.

Members Not Attending: Sandra Naylor Goodwin, California Institute for Behavioral Health Solutions; Anne McLeod, California Hospital Association; Erica Murray, California Association of Public Hospitals and Health Systems.

Others Attending: Mari Cantwell, DHCS Wendy Soe, DHCS; Sarah Brooks, DHCS; Pilar Williams, DHCS; Efrat Eilat, DHCS; Dana Moore, CDPH; 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; Bobbie Wunsch, Pacific Health Consulting Group.

22 Members of the public attended the meeting.

DHCS Goals for Plan/Provider Incentives Programs;
Potential Approaches to Incentive Programs and Waiver Authority
Wendy Soe/Sarah Brooks, Department of Health Care Services

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

Sarah Brooks, DHCS presented three goals aligned to the triple aim. She spoke to three target areas for incentives: technology, utilization and integration. Under each area, potential ideas

for focus were highlighted for discussion by the group. For example, under technology an idea for discussion is to improve encounter data. She reviewed additional ideas and encouraged input and feedback from the group.

Member Questions and Comments:
Molly Brassil, County Behavioral Health Directors Association of California: I appreciate behavioral health (BH) being included under integration. The bi-directional aspect is very important because if we only have mental health in primary care, we may not reach everyone. We need to have primary care in mental health settings. Under technology, it is important to emphasize the need to share information – between mental health plans and managed care health plans.
Brooks, DHCS: Great addition.

Rusty Selix, Mental Health Association of California: Building on Molly's comment about integration, there are additional measures that could be added, such as the percentage of people being screened for all BH conditions. It is important that the co-located person be able to provide all of the needs. There are three categories of need that right now are in three different provider networks: 1) mild to moderate that health plans are responsible for; 2) specialty mental health that counties are responsible for; and, 3) Alcohol and Drug that really no one is responsible for. If you can't serve them all, just having colocation won't solve the problems. In some cases, FQHC will have all services in one location. Another item for integration is postpartum care because postpartum depression is a leading condition and least diagnosed.
Brooks, DHCS: I agree.

Dean Germano, Shasta Community Health Center: With serious mental illness, being able to connect to a medical home is critical. On health information exchange, there are policy issues that make sharing information difficult on the mental health side. Also, counties lack the technology to be part of a system.

Michael Schrader, CalOptima: As we try to balance standardization vs flexibility to meet local system and member needs. Maybe one way is to define the waiver at this level but allow plans to choose some number of items to implement based on local needs of members and communities. Perhaps the waiver lists all 12 proposals and lay out the requirements under each one, but require 9 or so to be implemented based on local needs.
Brooks, DHCS: Excellent comments. We know that CMS will not approve plans to do just anything, but some flexibility based on a menu justified through local diversity and plan experience.

Don Crane, California Association of Physician Groups: Seeing the reference of shared risk models, should it include an explicit mention that this is a move from volume to risk based contracting?
Williams, *DHCS*: I don't know that we have been explicit about this. We will discuss more this afternoon.

Peter Shih, San Diego County: Treating the whole person means coordinating with social services and sharing information across different systems is needed. In San Diego, we are trying to create a community information exchange vs a health information exchange. Being a Cal MediConnect county, we see the progress with Dual Eligibles. We should include intensive case management and coordination such as the Housing First model as needed, not just a focus on medical homes and care management.

Chris Perrone, California HealthCare Foundation: I want to clarify what feedback you are seeking. Are the nine examples illustrative or are these choices you have made? Are you proposing to select a finite number of domains and asking for input from us about what should be included?
Brooks, *DHCS*: Yes, we will discuss this further at the next meeting as well. This is not a set list. These are items as a starting point for discussion. We don't want to create too many buckets so I pulled from examples we are working on at the state level for feedback and input.

Anthony Wright, Health Access: Can you talk about the goals? Do you want them to be process vs outcomes or patient satisfaction vs cost? These seem good for process objectives. We could add consumer experience and health outcomes such as: Could they get an appointment; communicate clearly with their provider; is their health improved?
Brooks, *DHCS*: They could be outcome based. That is part of the discussion.

Paul Pakuckas, Anthem Blue Cross: Perhaps another column could be added to show the clarity on cost and budget neutrality. So we can tell whether each item is funded vs unfunded?

Abbie Totten, California Association of Health Plans: To what extent will these measures replace measures that already exist vs adding to the administrative requirements we have at the plans? If there are quality measures that are already in place, we should rely on those.

Richard Thomason, Blue Shield of California Foundation: I want to emphasize the importance of BH/primary care integration in a bi-directional way and highlight this as an opportunity for state leadership. We work with stakeholders around the state and still see confusion and difficulty with the hand-off.

Michelle Cabrera, SEIU: One of three linked goals is to improve health of ALL Californians and I wonder if this goal should be focused on Medi-Cal beneficiaries. Do we need to target cost reductions in some way? I want to understand the business case for doing this in Medi-Cal. Is there a trend we can follow? I want to focus on items where the spending is high and we want to manage that vs trying to manage across the whole program – given our low PMPM. I am concerned we getting to global caps on rates. Also, how are we collecting better data on race/ethnicity so that we don't miss the story on specific populations and disparities?

Eilat, DHCS: On the topic of process vs outcome measures, I want to give examples from other states that are far along in integration. They recommend starting with process measures as well as including outcome measures.

Andie Patterson, California Primary Care Association: I want to discuss reducing the total cost of care. We need lots of data to understand this. HIE is the tough part and incentives for data analytics, data repositories would be good. Medi-Cal encounter data is just one piece of the bigger picture. We need to add some additional items to get to reducing total cost of care.

Brooks, DHCS: Thank you for the information. We will be updating this for additional discussion at the next meeting. There are some ideas from New York where beneficiaries are signing off on data sharing when they enroll. We do run into policy issues in California on sharing information.

Summary of Possible Ideas, Investments and Straw Proposals
Jill Yegian, Tom Williams and Sarah Lally, IHA
Tricia McGinnis, Greg Howe and Michelle Soper, CHCS
Presentation Slides are available at: http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-MCO-Provider-Incentives.aspx

Jill Yegian, IHA offered an overview of straw proposals. Proposals are overlapping and can operate at multiple levels: DHCS to Plan; Plan to Provider; DHCS to Provider. The straw proposals try to coordinate with the many other efforts such as Cal SIM. Consultants from IHA and CHCS presented individual straw proposals for discussion.

Greg Howe, CHCS presented Straw Proposal 1 between DHCS and Plans: Payment Reform Contractual Accountability for Medi-Cal Plans - Contractual accountability for plans to implement payment reforms from a menu of options a payment model proposal for DHCS to health plans.

Comments on Payment Model Proposal 1:
Brad Gilbert, Inland Empire Health Plan: Are you saying that a portion of the plan's revenue is tied to the arrangement? Can we discuss whether this is DHCS to plan incentive payments or plan to provider? Second, are you thinking about this at the primary care provider level vs the group level? The examples of bundled payments or shared risk wouldn't work that well with individual PCPs. Can you clarify? In general, I am not sure that mandated payment arrangements is the way to go. I think it is more of what South Carolina did, they set quality metrics and then let the plan determine how to get to the quality metric.
Howe, CHCS: South Carolina requires both quality threshold and a proportion of payments are value based. On your first question, it would be the total of all payments. It wouldn't distinguish between the two groups.

Michael Schrader, CalOptima: if the goal is to put a percent of provider payments at risk, I think we already do that with P4P. If we want to get more specific on the payment methodology, we would need a menu. Shared risk might work for big medical groups; but other payment

methodology would be needed with small PCPs. Plans need the ability to tailor to the local delivery system. We need to be careful of unintended consequences that we leave the smaller PCP behind. They could get dropped from the network because they can't meet the quality threshold. We will create access issues if we lop off the bottom tier. We need to lift them up to help everyone succeed.

Jennifer Kent, Local Health Plans of California: The underlying premise seems to be to move away from FFS but we already have moved away from that in California. That would be different than a place like South Carolina where they may want to incentivize moving away from FFS. There are very few plans in CA paying FFS and if so, it is probably to solve an access issue. Second, on the percentage of revenue – 5% is well beyond what a plan could pay for incentive payments. Third, this doesn't say how we shift cap arrangements solely by paying incentive. There could be unintended consequences. Recently, I worked with a provider who wanted 5,000 enrollees to raise overall cap revenue. This is less appealing to me.

Abbie Totten, California Association of Health Plans: I agree with Jennifer. There are plans that are almost exclusively delegated. Plans have a reason when they pay FFS to drive quality, such as in rural areas, FFS is needed. I don't think solely moving to cap rates will not improve quality.

Paul Pakuckas, Anthem Blue Cross: I agree. Plans will figure a payment method to incentivize providers. It would be useful to set goals rather than set payment methods. In other states that use withholds, it would be important to look at overall rates. They are able to successfully use withholds because the overall rates are much higher.

Don Crane, California Association of Physician Groups: Over 50% of CA is already capitated, so are you seeking to move the residual into capitation and if so, it would have to be more specific to accomplish that.

Howe, CHCS: Good comments. One point is that I wasn't pushing withhold since that was clear from the discussion last time but included it as an example of some other states' efforts.

Lishaun Francis, California Medical Association: I agree with the plans on their comments. I want to reiterate the point that FFS rates are needed in rural areas to improve access. Also, I am concerned that small plans would not be able to give up incentives at these levels.

Dean Germano, Shasta Community Health Center: Most providers in my rural area are FQHCs or RHCs and the ideas you are thinking about don't play out under the PPS payment methodology. Also, the comments about FFS for rural areas is real. This is an urban approach.

Chris Perrone, California HealthCare Foundation: Can you go deeper on information from other states? What was the rationale to layer this incentive on top of quality measures? It seems far reaching to set quality measures and also set the payment methods.
Howe, CHCS: In South Carolina, they feel it needs to go beyond cap rates to shared savings. Rather than a P4P, they looked at total cost of care and factoring in these measures to push it

farther. For the bonus payment, there are quality measures and the contracting measures to be eligible for the incentive. They are not prescriptive to the plans but offer it as an option.

Michelle Soper, CHCS presented Straw Proposal 2: Shared Savings for Medi-Cal Managed Care & County Behavioral Health Plans - 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

Comments on Payment Model Proposal 2:
Molly Brassil, County Behavioral Health Directors Association of California: I appreciate the focus on BH and the emphasis on process measures first, leading to outcomes in future years. In BH, need time to build infrastructure to exchange information before you can get to outcomes. In Pennsylvania, the seed dollars for the process incentives came from a foundation. In CCI, the incentives come from a quality withhold. In this proposal, you mention state dollars as funding - are there new dollars coming in for this? Would the incentive be paid back? How does this proposal differ from the financing under Cal MediConnect? We have been thinking about the opportunity for a BH DSRIP to bring new dollars into the system because this would lessen reliance on a withhold in the out years. How might this look under a DSRIP type program? Finally, we need to look at how drug Medi-Cal and mental health are proposed. In this proposal they are melded together, but in California, these are very distinct programs.

Williams, DHCS: Your mention of DSRIP is important because of the back and forth between the different parts of the waiver. This could be part of a DSRIP. The housing and workforce could also be part of this discussion. The funding here would come from the room in budget neutrality. The funding is dependent on budget neutrality and what room we have for new ideas.
Soper, CHCS: The initial pool would not be paid back under this proposal. If this is transitioned to a shared savings approach, then perhaps an advance payment method could be used and that would be paid back.

Rusty Selix, Mental Health Association of California: This proposal is aligned closely to the paper we submitted. The greatest benefit of seamless access is in the physical health access for those with serious mental illness. Better physical health is the impact because most of the ER visits are not for psychiatric care, but for physical health problems. On the issue of mental health and substance abuse, the financing is different but we should assume people have both issues and design for this.

Andie Patterson, California Primary Care Association: What are the opportunities from Pennsylvania for plans to providers to implement the work and hit the quality measures?
Soper, CHCS: The plans worked with large mental health provider entities. Staffing included a care navigator to do in person coordination or a care managed/coordinator to do telephonic consultation. There was an investment in health information exchange. There were challenges with privacy laws when they tried to fully integrate information, however, one pilot was able to

get consent for a partially integrated model where providers could view information. One pilot met the 90% goal for hospital admission notification and one did not due to technology.

Brad Gilbert, Inland Empire Health Plan: This is really good idea. This creates the motivation to solve those challenges like data sharing, common care planning. The savings will be on physical health side. The key is shared data, shared care management. We are doing an investigation of the barriers on data sharing to publish for others because we think they may be less difficult.

Chris Perrone, California HealthCare Foundation: This is an exciting proposal. My question is whether we could have this kind of proposal (shared shavings P4P) options beyond BH for the other issues like diabetes. On the document we reviewed earlier, there are many goals listed.
Brooks, *DHCS*: Great comments. Integrated BH is important but you make a good point and this is meant as an example of a possible construct so yes, we could look at other conditions.

Ann-Louise Kuhns, California Children's Hospital Association: It might have be modified for other conditions because this is plan to plan. It would have to be different if it was plan to provider.
Chris Perrone, California HealthCare Foundation: It said "DHCS would fund" and we could say "P4P for diabetes care measures/complete a POST form" rather than BH. You would pick things where shared savings exist.

Jennifer Kent, Local Health Plans of California: This is the only area where the integration is two bifurcated systems, where the financing is drawn differently. In the case of diabetes or other conditions, it is within a single system. I like this one because it drives integration of two very different systems. Given the poor physical health outcomes for those with serious mental illness, you have to include basic process measures to force the physical health. I don't understand the shift to a partial shared savings later on as working toward the integration.

Michelle Cabrera, SEIU: It seems in line with targeted goals. The population in Medi-Cal managed care needs this coordination and it could accelerate where we are headed. This seems a good use of waiver dollars. Do the incentive payments from the health plan to the mental health plan? What level of relationship building are we incentivizing? What does success look like?
Soper, CHCS: That would have to be worked out. In Pennsylvania, the state gave equal amounts of earned incentive to each – the mental health plan and health plan. The state could give funding to the health plan with the expectation that 50% of the earnings would go to the mental health plan – that would be a state choice.
Williams, *DHCS*: This is not determined yet. We have county responsibility for the mental health benefit and state for funding of physical health.

Rusty Selix, Mental Health Association of California: Is this adults only or children as well? There are two groups of youth (mental health plus asthma/diabetes) with significantly poorer outcomes.
Brooks, DHCS: We have not decided to limit the population. We need to think that through.

Anthony Wright, Health Access: This seems specific and targeted. I am supportive of the direction. With regard to the intersection of health care and county services, there is also a connection with corrections and police that has potential for savings and integration. I don't want to overly complicate this proposal but there is a lot we could do with those systems.

Dean Germano, Shasta Community Health Center: Looking at specialty mental health system in the north state, there are many holes. Many primary care systems try to compensate for that by having psychiatrists on staff. We need to incorporate efforts beyond the plan level to the PCP level.

Sarah Lally, IHA presented Straw Proposal 3: P4P for Medi-Cal Providers - Each plan would adopt a P4P program that meets requirements (e.g. a core set of standard measures, minimum payout), with flexibility for tailoring to local area. The program would include support for plans in design and implementation and support for providers in participating.

Comments on Straw Proposal 3:
Jennifer Kent, Local Health Plans of California: Most plans do already have P4P programs. This is similar to proposal #1 in that it tells the plan how to operate. I think we should tell the plans what the state wants to accomplish rather than how to do it. For example, drop asthma rates. Every plan has a different network and the incentives would be different to get to the outcome.
Brooks, DHCS: That is how we see the initial document tying into the proposals but I understand you are looking for a focus area.

Lishaun Francis, California Medical Association: Is the idea that if the plans don't meet core measures, they would be financially penalized?
Yegian, IHA: No, the idea isn't to change what is already going on with individual P4P programs. It is to create a core set of P4P and have more consistency and standardization across the plans.

Abbie Totten, California Association of Health Plans: There is a penalty if there is a withhold so it depends on the financing.

Jennifer Kent, Local Health Plans of California: I don't see the problem with a lack of standardization. Plans have adopted P4P based on what they see as the issues they have.

Lishaun Francis, California Medical Association: I was confused by core set of measures plus ability to tailor. Can you clarify how the flexibility would work?

Yegian, IHA: in talking to plans, we heard an interest in standardization, so this was in response to what we perceived as a need not an attempt to impose. If you think of auto assignment as an example, what plans have done is to flow that down through their own P4P programs. In the case of diabetes, that might be the standard measure set plus other supplemental things.

Brooks, DHCS: We envision standardization with flexibility – set areas to focus on with the ability to modify for a certain population. We recognize each plan has a different network and they will need to modify. At the overarching level, there would be standardization.

Brad Gilbert, Inland Empire Health Plan: I was confused because there would have to be standard metrics overall. There might be some variation for a provider or a population, as you say. It is correct that we pick P4P based on what we are being held accountable for, such as auto assignment or HEDIS. I don't think it is a bad idea to have a standard process with a menu. I think this is the right place; statewide metrics, plan delivery.

Michael Schrader, CalOptima: I have a different perspective. I wonder if the standardization comes from laying out a common set of goals and let the plans create metrics, pick from a menu. Also, we need flexibility around the rate of deployment – we all have different PCPs. We are asking the PCP to do more so I think it has to be new money.

Williams, IHA: The intent of this proposal is to coordinate the existing programs. What is lacking is an ability to compare provider performance. ACA requires that and we can't get it done. Patient experience is expensive to collect so if you work together on a system, there are administrative savings as well. This would make things more coherent and effective.

Don Crane, California Association of Physician Groups: I second Brad's motion. We are talking here about replicating what we are doing in commercial arenas, which is working well. We are reducing the dueling of different P4Ps for physician groups. I am in favor of standardization.

Dean Germano, Shasta Community Health Center: I agree. There is only so much infrastructure to drive to P4P.

Andie Patterson, California Primary Care Association: I echo that CPCA supports standardization statewide. Not all clinics have had the opportunity to participate in P4P and they want to.

Abbie Totten, California Association of Health Plans: One overarching caution: if a plan has not been focusing on an area that is chosen here, they will be at a disadvantage. The plans are not all starting at the same place.

Chris Perrone, California HealthCare Foundation: Some are saying they like this for its standardization; some are saying they like it for its flexibility. We can't have it both ways. Similar to Anthony's observation earlier, this seems to be an incentive to an incentive. If we want to model after auto assignment, just implement P4P for the plans and the plans pay that.

Tricia McGinnis, presented Straw Proposal 4: Behavioral Health P4P for Medi-Cal Providers - Each plan would adopt a P4P program focused on care for patients with depression. The program would support plans in design and implementation and support providers in participating.

Comments on Straw Proposal 4:
Jennifer Kent, Local Health Plans of California: I like the BH integration themes. I am not sure why depression is picked vs the whole spectrum of issues. On the target providers, the program is likely very small because there are not many providers with capability to do this. How could a PMPM support a care manager + consultant? Last issue, is it the role of DHCS to do the practice training? I questioning how that would work.
McGinnis, CHCS: Depression was chosen because it impacts 20-25% of the population and is under-diagnosed and treated and there is an evidence base for clinical success. It has been applied with both FFS and PMPM in other states. It requires PCMH as a precursor for success.

Paul Pakuckas, Anthem Blue Cross: I also question why depression although it sounds like there is an option to build in other topics. Given that it is small, will this move the needle?

Rusty Selix, Mental Health Association of California: Depression is an even bigger number because typically depression is not the reason patient presents in the provider office. It is a significant missed opportunity and is easy to treat. It stands alone in this regard.

Don Crane, California Association of Physician Groups: Who is making the payment to provider - the state vs plan?

Michelle Cabrera, SEIU: It seems it could work in primary care. This layers with the mild to moderate work moving forward. From a strategy perspective, this might help with investments to incentivize care coordination and we support that.

Dean Germano, Shasta Community Health Center: This does need critical mass to support a position and that kicks a number of folks out. There is no added revenue for FQHC with a PMPM model – so there must be an added mechanism to do that.

Abbie Totten, California Association of Health Plans: This seems out of place because it is not about larger system change. What is the state's goal? If driving to system change, we can't offer something that doesn't work across the state, for example this wouldn't work in the rural areas.

Michael Schrader, CalOptima: BH should be a priority but this proposal doesn't address the greatest needs I hear. I hear about people with SMI in ER; difficult to discharge homeless people; there is no recuperative care; there is no shelter to send folks to. I am not sure this matches the greatest BH needs I hear.

J**ill Yegian, IHA presented Straw Proposal 5: Shared Savings for Medi-Cal Providers - Each 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.**

Comments on Straw Proposal 5:

Abbie Totten, California Association of Health Plans: The idea here seems to be that there is fat in the system. To assume that the total cost of care can be reduced with shared savings to providers is not the way to move the ball forward in Medi-Cal because we are the lowest payer. We need to pay incentives to move the ball on quality – not take money out of the system.

Don Crane, California Association of Physician Groups: I echo the funding question. We have a monstrous funding issue. This is an excellent idea, similar to the Blue Shield and Dignity program that produced significant savings. Any shared saving plan has a short shelf life of a few years and is predicated on the fact of waste. There is a point where you reduce to where you can't save more. For this to work, we need to consider hospital issues – encourage them through greater volume or other incentive. This does cause hospitals, plans, providers to share data like they haven't before and reduces fragmentation.

Ann-Louise Kuhns, California Children's Hospital Association: I echo Abbie's comments. For the Children's Hospitals, if we receive 50% but we generate 100%, it is not a win for you. Unless we start with a new pot of money, it won't work in Medi-Cal because the money is so low. This is similar to the proposal we put forward for CCS so we are thinking on similar lines. Our thinking was for direct contracting not through the health plan. Fee For Service already pays hospitals on a DRG basis. It is difficult for hospitals to get plans to do that in managed care.

Don Crane, California Association of Physician Groups: I don't see direct contracting in any straw proposals. If we are talking about pilots, new ideas, we should talk about direct contracting. With fewer middle men, there are efficiencies. This gives the state a much bigger insight into the care delivered. It seems one proposal should include direct contracts to bigger, more sophisticated groups.

Michelle Cabrera, SEIU: This seems more focused on the cost rather than quality. Within Medi-Cal, our costs can be brought down but some are driven because people are neglected. We have to use serious incentives for large groups/providers to move away from hands-off approach to a more coordinated approach appropriate for the Medi-Cal managed care program we are building. Overall, need to be more serious and directed about what we expect from plans and providers on disparities and ethnicities. Can we create incentives to move the dial on disparities and track it. Can create incentives not to cherry-pick within Medi-Cal.

Jennifer Kent, Local Health Plans of California: This is a very sophisticated proposal and is better suited to a commercial population. There is a greater amount of money, it's a more stable population, and they don't move providers or come in and out every month. This concept is based on a very different population and set of providers. Some other specific comments about why this might not be practical in a Medi-Cal universe:
1: the savings don't quite make sense; it doesn't seem the plans are incentivized to do anything.
2: hospitals are difficult to contract with so changing to DRGs is not likely.
3: having repatriation from high cost hospital to lower cost can drive complaints and bring in regulators.

Anthony Wright, Health Access: I want to ask, how is this different from capitation or resolve problems with capitation (underutilization)? I agree with Michelle that this needs more on the quality side so that we don't incentivize the "problem" side. I still don't know how you can resolve the fact that the hospital budget will overwhelm whatever happens outside the hospital because the cost inside hospital is so large.

Paul Pakuckas, Anthem Blue Cross: This is the commercial ACO program and it works there. It may or may not work in Med-Cal. Hospitals are willing to lower revenue for more volume in commercial but that is not likely to work in Medi-Cal. We do use elements of this in Medi-Cal IPA agreements.

Brad Gilbert, Inland Empire Health Plan: This is a means to an end but is not focused on the goals.

Michelle Soper presented Straw Proposal 6: Shared Savings for Physical & Behavioral Health Providers for Team-Based Care - Each plans would offer a package of payment reforms based on tiers of increasing physical behavioral health coordination and colocation to ensure that team-based care is provided to highest-cost/need beneficiaries (including those with SMI; lower-intensity version for M&M MI). Could be led by plan or provider depending on provider sophistication. Savings shared between plan and physical / behavioral health providers.

Comments on Proposal #6:
Bobbie Wunsch, Pacific Health Consulting Group: Is Substance Use included in this model?
Soper, CHCS: it is not included. It does not lend itself to this type of coordination at this point.

Ann-Louise Kuhns, California Children's Hospital Association: Why is the focus on adults? There is also serious shortage of treatment options for children with serious mental health disorders. Also, we have gravitated toward quality indicators, primarily for behavioral health, and the mechanisms to improve it. Should we have a conversation about all the quality measures and what are the outcomes we want to focus on?

Rusty Selix, Mental Health Association of California: We have a long way to go to catch up BH to where other issues are already. Our providers are interested in these proposals. One comment is that likely all three tiers are needed inside organizations. Some partnerships are well developed; others are not. Also, I want to add that at least the co-occurring A&D problems could work here.

Molly Brassil, County Behavioral Health Directors Association of California: I want to better understand how this aligns to 2703 Health Homes and Cal SIM. With the exception of tier 3 here, we would be challenged to achieve any measures or savings without being linked to incentive for infrastructure at the plan level we saw in the earlier proposal.
Soe, DHCS: 2703 focuses on team based care and one of the focus areas is BH so this aligns there. Also, 2703 focuses on certain populations and counties.

Don Crane, California Association of Physician Groups: In the category of wishful thinking, what does the financial modeling reveal? How much supplemental capitation might be provided? If it is enough to incentivize commercial markets to take Medi-Cal, that would create a new landscape for Medi-Cal and would be a worthwhile goal.

Jennifer Kent, Local Health Plans of California: Our mental health rate that ramps up over time, it is $2 PMPM, then up to $4, to $8 then it will smooth back down based on experience. That funding level is a fundamental issue. Also, there is a Cal MediConnect overlap and this overlaps with those measures.

Brad Gilbert, Inland Empire Health Plan: We would need new dollars to get this going to get to savings. To Ann's comment, I think the goal is the integration of BH and Physical health.

Peter Shih, San Diego County: Looking at HEDIS measures, not many Medi-Cal plans are ranked in the top 100 plans. The state needs to take a leadership role to say what they want from plans. If state said, plans have to hit 90% of HEDIS, the plans will do that but there has to be money to do it. From my perspective, we can mix the proposals and meet the outcomes if we have a bar set by the state.

Richard Thomason, Blue Shield of California Foundation: BSCF has worked over last few years to integrate specialty, BH and primary care. Some combination of proposals 2, 6 and a BH DSRIP is a place to advance this integration. The focus on coordinating the elements of the waiver with that focus is to be commended and needed based on what we hear from the field. The waiver is a real place to save people's lives.

Eilat, DHCS: There is a summary from the MH/SUDS task force meeting and many of the issues mentioned here are included in that summary and might be useful for the group.

Overview of Medi-Cal Rate Setting and Opportunities for Aligning Incentives
Pilar Williams, DHCS and Workgroup Members
Facilitated by Bobbie Wunsch

Pilar Williams, DHCS offered introductory comments about the rate setting process. The state develops rates in two ways: 1) use FFS to pay for counties (e.g. LIHP, rural expansion) or populations or services that are new; and, 2) use experience-based methods to set rates. Use data from plans, validate it with actuaries and then consider only Medi-Cal information. The state separates the information into category of aid and service. Rates are adjusted for risk and any new requirements of service to develop a rate range.

Anthony Wright, Health Access: You mentioned the rate cut legislation as one factor and others have mentioned that proposals to restore the rates are irrelevant to beneficiaries in health plans. Does AB 97 impact health plans?
Williams, DHCS: AB 97 did impact Medi-Cal managed care rates.

Jennifer Kent, Local Health Plans of California: On the FFS side, it was a 10% cut across the board. On the health plans, it was an actuarial rate cut and they decided whether to pass that on to the provider.

Michelle Cabrera, SEIU: Does DHCS try to quantify avoidable ER/hospital into the rates?

Abbie Totten, California Association of Health Plans: There are efficiency rates implemented that are based on utilization so there are ways the performance is measured and rates reflect that. The data that is used in most cases is two years old so it is based on past performance, not current.

Williams, DHCS: To the extent the plan is saving cost and spending less, we are setting rates based on this. It may not mean there is quality, only that the plan is decreasing cost. How do we tie together the proposals discussed to incentivize quality?

Abbie Totten, California Association of Health Plans: The flip side is that if a plan is spending money efficiently and providing quality care, your rates are still cut.

Chris Perrone, California HealthCare Foundation: If a plan takes on seniors and persons with disabilities, and reduce inpatient utilization by 50%, then for 2 years I reap the benefit. Following that time period, my rates are cut. It doesn't matter what my competitor is doing?
Williams, DHCS: Yes, although there are some county averaging.

McGinnis, CHCS: New territory that CMS wants to explore with innovative states is how to set rates to include value based rate setting.

Jennifer Kent, Local Health Plans of California: The Rate Development Template from Mercer is collected from the plans, then financial staff discuss what is beneath the rates such as population category, services carved in or out, AB 97, hospital assessment and other overlays. It is not simple. We haven't talked about the pipeline. CMS only approves one rate package at a time. We are submitting several new packages and CMS will approve only one at a time. We have become concerned about how complicated it has become and no matter what we add, there is not much room for more complexity in the rates.

Elizabeth Landsberg, Western Center on Law and Poverty: We talk about our FFS rates being low. Most of our beneficiaries are in managed care paid by cap rates, so it is unclear how the low rates impact this. Can you talk about how quality is included?

Williams, DHCS: A quality payment is only included in Cal MediConnect. On rates, there is the lag we discussed. Sometimes we use a "kick" payment e.g. maternity and Hepatitis C to ensure the plans are paying attention to an issue. There are also carve outs for some conditions. As we put new benefits into the rates, we look at the data sooner than two years to see how the experience is aligning with rates.

Jennifer Kent, Local Health Plans of California: Most of the rates we pay to providers are not tied to FFS schedule anymore. We use the cap rates to pay providers.

Dean Germano, Shasta Community Health Center: What happened to the ACA primary care bump in rates?

Chris Perrone, California HealthCare Foundation: If a plan increases its payments to providers by 20% that never gets built into the rates? It is only utilization?

Jennifer Kent, Local Health Plans of California: The costs and utilization are built into the rates. If you gave rate increases to providers, the state may not include enough in the rates to cover it.

Michelle Cabrera, SEIU: You mentioned only factoring allowable expenditures for Medi-Cal, what about case management or something that is only relevant for some patients?

Abbie Totten, California Association of Health Plans: Care coordination is considered an administrative expense. The only care management that is factored in is utilization management, not anything like coordinating with county mental health, getting housing or other care coordination. In some larger, capitated groups, the overall capitation can include an administrative cost factored in. Otherwise no.

Thoughts from the health plans about how rate methods could work with incentives:

Brad Gilbert, Inland Empire Health Plan: I will speak to three potential areas:
1) If we have savings by reducing inpatient and ED utilization, then it floats through our rates in a negative way and we really need to look at shared savings.
2) Right now, for value based incentive measures, we only have auto assignments. We need value based incentives in the rates. Aligned incentives from the state to the plan. If you meet the metrics, you receive additional payments not based on withhold.
3) Finally, there are two groups of things not well represented because they are not claimable in our rates, like housing or food. If I make an investment in care navigators in the provider office, it goes in my administrative cost which is a set percentage. It doesn't get reflected on the medical side. If we can reflect those costs, especially for BH, in the medical side then we need to figure out how to be reimbursed for that.

Michael Schrader, CalOptima:

1) Shared risk: 75% of Cal Optima is delegated to medical groups and we share risk. So, putting more shared risk at the state level won't advance it more.
2) Efficiency factors: For each incentive measure, assume a saving and budget it to the plan. We need to let the incentive prove itself.
3) The way benefits are rolled out without rates: Now, we negotiate with providers without knowing the rates. New funding should be identified and provided upfront.
4) Providers: the closer the payment is to the time of action, the more focused they are. If we wait 6 months following fiscal year is too late.

5) PCPs asked to do more so we need to address that with additional funding not just different payment mechanisms.

Paul Pakuckas, Anthem Blue Cross: There is increased shortage of providers based on ACA. For any incentive that takes money out through a withhold or makes it harder to earn, there is no appetite from providers to do anything new, anything more for the plans without getting something up front. There needs to be a carrot – not a stick. We need to focus on quality. Now, sometimes we don't even get encounter data unless we pay more. We need to figure out another funding layer to focus on quality.

Jennifer Kent, Local Health Plans of California: The people most difficult to care for are the most expensive, we pay the worst for this. We need to have a set goal for what we are incentivizing. The rate process could incentivize providers by building funding into rates to trickle down to provider. Better screening and integration of BH will increase utilization on the mental health side. The upfront expectation needs to be considered in the rate process. We need a pot of money to deliver the services.

Ann-Louise Kuhns, California Children's Hospital Association: There are also non-medical care costs that are not considered part of the rates, medical homes and support services.

Jennifer Kent, Local Health Plans of California: Yes, we need to look at what we can waive? What will CMS let us include in the rates? The more we take in the plan area, the less there is for other areas of the waiver. There is a trade-off in the overall waiver.

Abbie Totten, California Association of Health Plans: One issue we keep touching on is that it needs to be an incentive, not a withhold or reduction and it has to be timely. We still don't have the money for the Medicare bump. We need prospective rates.

Lishaun Francis, California Medical Association: On the Medicare bump, it is really important to talk about the process, the administrative process about how the flow of money is going to work. If provider feels it isn't worth it due to long delays, it won't work.

Williams, DHCS: It is really important to educate CMS how the capitation and sub capitation flows before a provider sees the payment. We have to do a better job to get prospective rates.

Jennifer Kent, Local Health Plans of California: Didn't CMS disapprove an add-on that was built into the expansion rate previously?

Williams, DHCS: There was an add-on that was taken out by CMS.

Don Crane, California Association of Physician Groups: I echo these comments. 1) If providers have to work harder and add infrastructure to earn the same, they won't do it. 2) You don't get the behavior you want if there are delays.

Dean Germano, Shasta Community Health Center: If there are savings in the system and risk reduction, it happens at primary care. Primary care is pushed to the limit. If we are talking

about incentives, it needs to be about building the team around the physician or provider to help them; it is too hard otherwise.

Peter Shih, San Diego County: It is important to increase rates to have patients seen by specialists. The administrative hassle for specialists to get paid is a problem.

Bobbie Wunsch, Pacific Health Consulting Group: One issue we struggled with is the distinction of incentives for DHCS to plan and Plan to provider. What is the workgroup's input on this?

Peter Shih, San Diego County: It has to start with DHCS to plans. In San Diego, we have four different P4P incentive programs. We would love to see the state put out a standardized approach and say what it needs to be. Providers are trying to keep track of different programs.

Jennifer Kent, Local Health Plans of California: The funding flows from the state to the plans. Ultimately, what we discussed today happens in provider office and can be solved by time and money. We need to pay providers to spend more time with patients and be less focused on volume.

Lishaun Francis, California Medical Association: it also needs to be less complicated – whatever it looks like. Providers want to take care of patients and get paid.

Don Crane, California Association of Physician Groups: I reiterate my interest in direct contracting. Also, if I were DHCS, I would look for a dotted line relationship for payments to providers, hospitals. DHCS should create a visible, high traction incentive design. Med PAC is looking at this for Medicare in targeted programs.

Paul Pakuckas, Anthem Blue Cross: One issue to help providers is to establish the best practices for measuring a certain HEDIS measure so there are standard calculations.

Chris Perrone, California HealthCare Foundation: If DHCS focuses on its incentive to plans, the rest will follow. The question I pose is, what problem are you trying to fix – most issues can be addressed from the state to the plans with clear outcomes. For some issues, perhaps in the area of BH, maybe there is something more than what a P4P objective can accomplish and there you go a step farther to say to plans, you need to do this specifically. One of the concerns I will mention is that on the auto assignment algorithm, it is dividing up a fixed pie. Every plan wants to raise its score in relation to other plans and this discourages cooperation. Let's make sure in this new approach, it is not a fixed pie but each plan competing on its own merit.

Soe, DHCS: Should we explore viable approaches for state to provider incentives?

Ann-Louise Kuhns, California Children's Hospital Association: We want to suggest that, instead of putting CCS into managed care plans, we could carve the whole child out and pay a contracted rate directly to the CCS network caring for the population. It is a small population relative to Medi-Cal so we believe CCS would be better served with the providers historically caring for them. CCHA has offered to set this up centered around children's hospitals and create a network for primary care. This is a way to keep the resources in the pediatric system.

Jennifer Kent, Local Health Plans of California: If you set a goal, then either carve out a service and have the state pay directly or leave it in and put cash in to make it achievable.

Volunteers for a call with the state to discuss direct to provider incentive concepts: Ann Kuhns, California Children's Hospital Association**,** Michael Schrader, CalOptima**,** Don Crane, California Association of Physician Groups, Jennifer Kent, Local Health Plans of California, Brad Gilbert, Inland Empire Health Plan, Dana Moore, CDPH.

Public Comment

Jack Iams, 3M: We make population based performance metrics and consult with MedPac. We believe in an expanded population approach to effective incentives for quality and efficiency. We use claims data and a few key measures for quality and efficiency such as reduced re-admissions and improved preventative and coordinated care as measured by lower admissions and ED visits for chronic illness. Then, benchmark the relative risk adjusted performance of plans and reward plans that meet the benchmark. The advantages: direct correlation to needed outcomes of shifting care to primary, preventive, coordinated care; and, the indirect measures such as less administrative burden, plan flexibility to incentivize providers as they see fit; standardized metrics that the state needs and, better data over time.

Next Steps and Next Meeting #3 (January 23, 2015)

DHCS and Bobbie Wunsch

Send feedback on the overview diagram of goals and measures or ideas on any of the straw proposals to inform the next meeting.

Thanks to CHCF and BSCF for supporting the stakeholder process. USC offered the facility at no cost. CHCS and IHA have added value. DHCS working very hard on this. Great conversation today.

Next meeting: **January 23, 2015 – DHCS Training Rooms A, B, C, 1500 Capitol Avenue, Sacramento.**