

### 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.ihha.org/pdfs\\_documents/news\\_events/2B-Medi-Cal-P4P-Moore.pdf](http://www.ihha.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 Medical 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.

## 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 2000s, 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.