CHCS Center for Health Care Strategies, Inc.

IHA INTEGRATED HEALTHCARE ASSOCIATION

1115 Waiver Renewal
Plan-Provider Incentives
Expert Stakeholder Workgroup

January 23, 2015

Sacramento, California

New Framework:
3 Potential Directions

IHA
INTEGRATED HEALTHCARE ASSOCIATION

Overview

- **GOAL #1:** Improve patient care, improve health outcomes and reduce the total cost of care trend through delivery system integration supported by value-based payment
- **GOAL #2**: Integrate behavioral and physical health care across the spectrum of severity

Proposed Approach	Status
Straw Proposal 1: Payment Reform Contractual Accountability for Medi-Cal Plans	NO
Straw Proposal 2: Shared Savings for Medi-Cal Managed Care & Behavioral Health Entities	Under consideration
Straw Proposal 3: P4P for Medi-Cal Providers	Under consideration
Straw Proposal 4: Behavioral Health P4P for Medi-Cal Providers	NO
Straw Proposal 5: Shared Savings for Medi-Cal Providers	Under consideration
Straw Proposal 6: Shared Savings for Physical & Behavioral Health Providers for Team-Based Care	Under consideration
Straw Proposal 7: Shared Savings for Medi-Cal Managed Care Plans	**NEW**
Straw Proposal 8: Value based payment for Maternity Services in Fee-for-Service Medi-Cal	**NEW**

Potential Directions

INTEGRATE BEHAVIORAL & PHYSICAL HEALTH

GOAL

Integrate behavioral and physical health care across the spectrum of severity and reduce total cost of care through value-based payment

STRATEGY

Incentivize all parties involved in provision of Medi-Cal behavioral health services to share accountability for improved health outcomes, cost of care and service coordination

LEVELS

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

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

PROMOTE ACCOUNTABILITY & INNOVATION IN MMC

GOAL

Improve patient care, improve health outcomes and reduce the total cost of care (TCOC) trend through delivery system integration supported by value-based payment

STRATEGY

To hold the MMC plans accountable for quality and cost while enabling flexibility in care management

LEVELS

DHCS → PLANS
Straw Proposal 7: Shared Savings for Medi-Cal Managed Care Plans

PLANS → PROVIDERS

- **Straw Proposal 3:** P4P for Medi-Cal Providers
- **Straw Proposal 5:** Shared Savings for Medi-Cal Providers

IMPROVE MATERNITY CARE IN FFS MEDI-CAL

GOAL

Improve quality and reduce costs in maternity care in FFS Medi-Cal through value-based payment

STRATEGY

Incentivize Medi-Cal providers to improve maternity care in FFS Medi-Cal

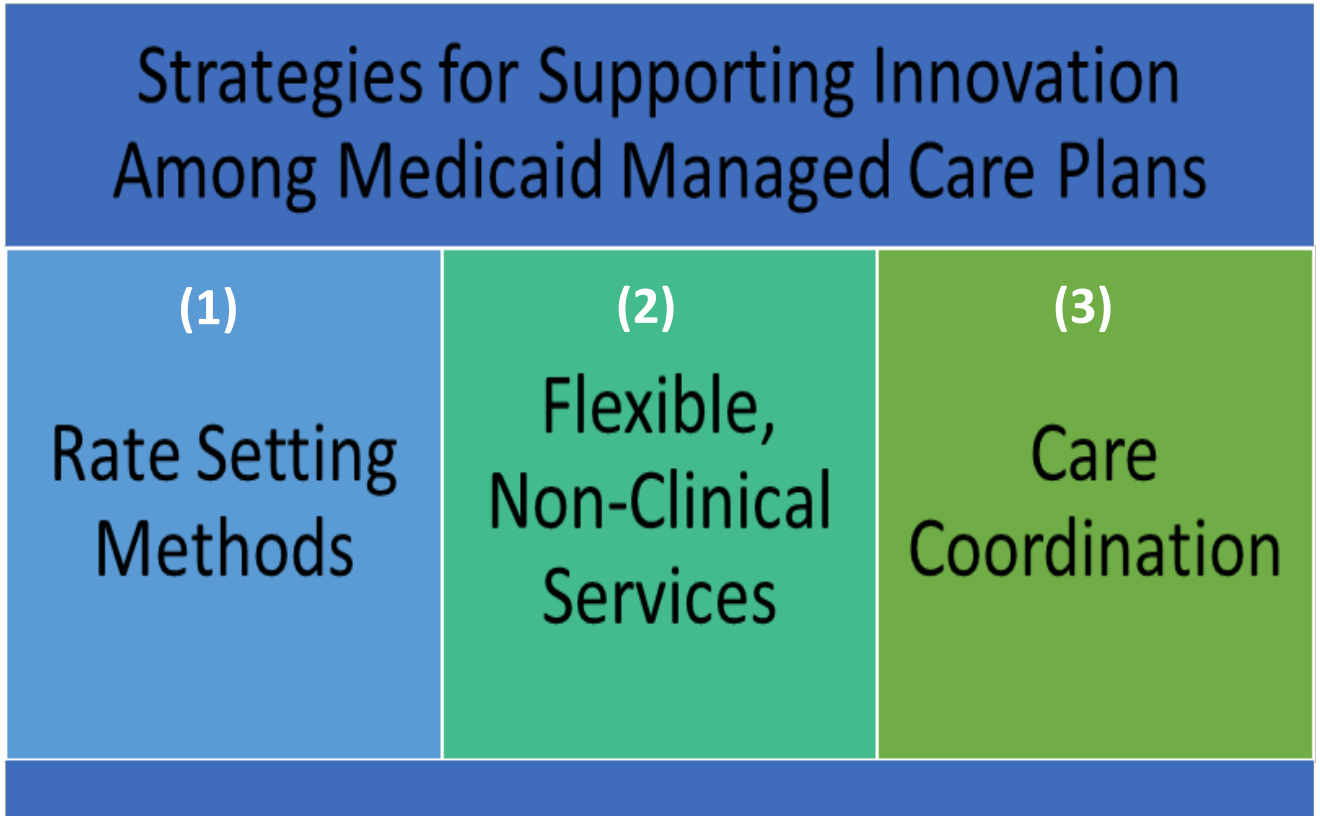
LEVEL

DHCS→ FFS PROVIDERS
Straw Proposal 8: Value based payment for Maternity Services in Fee-for-Service Medi-Cal

Rate Setting Overview

New Rate Setting Strategy to Sustaining Payment Reform in Managed Care

DHCS is considering three potential components of a new rate setting strategy that would create flexibility for MMC plans to invest in new payment reforms beyond capitation:



(1) Rate Rebasing

- **Problem:** Current rate setting methods do not provide the plans with long term incentives for efficiency improvements.

- **Goal of new rate rebasing strategy:** To create financial incentive for plans to invest in better care management/coordination.

Potential Rate Rebasing Options

Partial Cap Rebasing

- Focus on rate components where utilization will fall (e.g. inpatient/ED, imaging)
- Set rates for each component at an intermediate point between predicted trend and actual trend for each MCP

Full Cap Rebasing

- Revise the entire rate rebasing method so that MCPs have flexibility across all categories
- Set entire rate at an intermediate point between predicted trend and actual trend

Hypothetical Rebasing Examples

Partial Rebasing

	Inpatient Trend	Primary Care Trend
Predicted	5%	4%
Actual	1%	6%
Final	3%	5%

Full Rebasing

	Full Cap Trend
Predicted	7%
Actual	4%
Final	**6%**

Questions for the Work Group

- Which options is most appealing and why?
- For approach #1, which categories of services would fall under the proposed modifications?
- What considerations or challenges do you anticipate with either approach?

(2) Inclusion of Flexible Services

- Given the social determinants of health, certain non-clinical services can have a positive health impact
- Greater flexibility to fund these services using capitation can help MCPs meet the DHCS Waiver goals
- Capitation rates could cover a set of non-State Plan services
  - Plans would need to submit an encounter for each service
  - Could potentially count as a medical expense "in lieu of" State-plan covered medical services

Flexible Service Examples from Oregon

- Training and education (e.g., classes on healthy meal preparation, diabetes self-management curriculum);
- Self-help or support group activities (e.g., post-partum depression programs, Weight Watchers groups);
- Home and living environment items (non-DME items to improve to address a particular health condition, e.g., air conditioner, athletic shoes, or other special clothing);
- Transportation not covered under State Plan benefits (e.g., other than transportation to a medical appointment);
- Programs to improve the general community health (e.g., farmers' market in the "food desert");
- Housing supports related to social determinants of health (e.g., shelter, utilities, or critical repairs); and/or
- Assistance with food or social resources (e.g., supplemental food, referral to job training or social services).

Questions for the Work Group

- What types of services are plans most interested in covering via capitation?
- What services would have the largest overall cost savings impact?
- What infrastructure would MCPs need to implement this provision?
- What considerations or challenges do you anticipate?
- How would the cost effectiveness of this process be measured and evaluated?
- Would this apply to certain populations (i.e. SPDs) or to all managed care beneficiaries?

(3) Care Coordination

- Some care coordination may currently be considered an administrative expense
- Care coordination could be re-categorized or expanded as a medical expense for quality improvement purposes:
  - On the ground provider-level care coordination for certain populations (e.g. health home patients, PCMH, and BH/PH integration, super utilizers)

Questions for the Work Group

- What are the consequences of considering care coordination a medical expense versus an administrative expense?
- What considerations or challenges should DHCS consider when implementing this approach?
- What are the plans' responsibilities today and how could those be enhanced?

Discussion of Packages

Integration of Physical & Behavioral Health

Goal: Integrate behavioral and physical health care across the spectrum of severity and reduce total cost of care through value-based payment

Strategy: To incentivize all parties involved in provision of Medi-Cal behavioral health services to share accountability for improved health outcomes, cost of care and service coordination

DHCS → PLANS
Straw Proposal 2: Shared Savings for Medi-Cal Managed Care & County Behavioral Health Entities

↓

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

Straw Proposal #2: Shared Savings between MCPs and Counties

Structural Elements	Description
Target Population	*Adults who meet medical necessity criteria for Medi-Cal Specialty Mental Health or Drug Medi-Cal Substance Abuse Services*
Target Providers	*N/A; plan – based*
Incentive Approach	*State-funded joint incentive pool for counties for shared outcome measures; potential to transition to shared savings model over time*
Quality Approach	*Jointly developed, integrated data collection and reporting process, integrated care plans; outcomes tied to different incentive amounts*
Expected outcomes	*Integrated care plans, improved medication adherence, reduced ED visits, readmissions and mental health admissions*
DHCS Role	*Fund initial incentive pool; oversight of calculations, distribution of funds, transition to shared savings as appropriate*
Alignment with Other DHCS Initiatives	*Cal Medi-Connect*
Example(s)	*Pennsylvania Serious Mental Illness Innovation pilot project, Medicare Advanced Payment ACO model*

Feedback on Straw Proposal #2: Behavioral Health Integration at the Systems Level

Shared savings for Medi-Cal Managed Care and County Behavioral Health Entities

- Explore data collection/ measurement approaches that encourage coordination with social services
- Link to/align with Cal MediConnect efforts
- Phased approach: Structure ⇨ Process ⇨ Outcome
- Likely greatest impact on improved physical health for individuals with SMI
- Embed integration activities at the plan/county level within practice/delivery level

Joint Approach to Quality Measurement

- Key proposed principles for quality approach
  - KISS
  - Set clear parameters upfront: target population, number of metrics, expectations around data collection
- Suggestions for meaningful metrics
  - Structural: e.g., ensure MOU requirements between MCPs and county MHPs are followed in practice
  - Process: e.g., concurrently improve care experience and facilitate collaborative activities
  - Outcome measures: e.g., areas can systems jointly impact
  - Non-medical determinants of health: e.g., employment, housing, quality of life

Work Group Discussion Questions for Straw Proposal #2

1. What other principles or related activities should drive measurement selection?
2. How would incentive payments actually flow from DHCS to MCPs and MHPs?
3. What must happen operationally within MCPs/county MHPs and at DHCS to improve alignment? What are opportunities to catalyze these activities?
4. How should substance use disorder services be incorporated into this construct?

Straw Proposal #6A: Shared Savings for Team-Based Care—Mild/Moderate Behavioral Health

Structural Elements	Description
Target Population	*Adults with mild to moderate behavioral health needs that can be addressed in primary care settings*
Target Providers	*Primary care teams: PCPs, care managers,*
Incentive Approach	*Optional tiered capitation enhancement + shared savings + P4P*
Quality Approach	*Reward increasing tiers of coordination/co-location; shared savings for high-quality physical and behavioral health care*
Expected outcomes	*Lower TCOC/patient, Lower emergency room admissions and inpatient hospitalizations; lower PHQ-9 scores and other BH metrics*
DHCS Role	*Contract requirements for package of reforms based on tiers; Funding for learning collaborative of participating practices*
Alignment with Other DHCS Initiatives	*Health homes for patients with complex needs, patient-centered medical homes*
Example(s)	*Massachusetts Primary Care Payment Reform*

Straw Proposal #6B: Shared Savings for Team-Based Care--Serious Mental Illness

Structural Elements	Description
Target Population	*Adults who meet medical necessity criteria for Medi-Cal Specialty Mental Health services*
Target Providers	*Behavioral health providers, care managers, nurse/nurse practitioner*
Incentive Approach	*Optional tiered capitation enhancement + shared savings + P4P*
Quality Approach	*Reward increasing tiers of coordination/co-location; shared savings for high-quality physical and behavioral health care*
Expected outcomes	*Lower TCOC/patient, lower ED/ inpatient hospitalizations; physical health improvements; care team collaboration*
DHCS Role	*Contract requirements for package of reforms based on tiers; Funding for learning collaborative of participating practices*
Alignment with Other DHCS Initiatives	*Health homes for patients with complex needs, patient-centered medical homes*
Example(s)	*Arizona Mercy Maricopa Integrated Care*

Feedback on Straw Proposal #6: Bi-Directional, Team-Based Care

Shared savings for Physical & Behavioral Health Providers for Team-Based Care

- Bi-Directional approach
- Co-location  integration
- Leverage current quality measurement activities to greatest extent possible
- Address key issues: plan level infrastructure needed to incentivize care coordination, low rates for mental health services in primary care settings
- Align with Health Homes
- Incorporate IMPACT model for depression care

Approach to Quality Measurement

- Align with similar activities in other programs, e.g.
  - Health home measures for tier 1 (TBD)
  - HEDIS measures collected; what is the before and after impact of team-based care?
- Emphasis on screening and follow-up
- Seize opportunity to collect individual experiences with team-based care: member satisfaction, quality of life, care experience

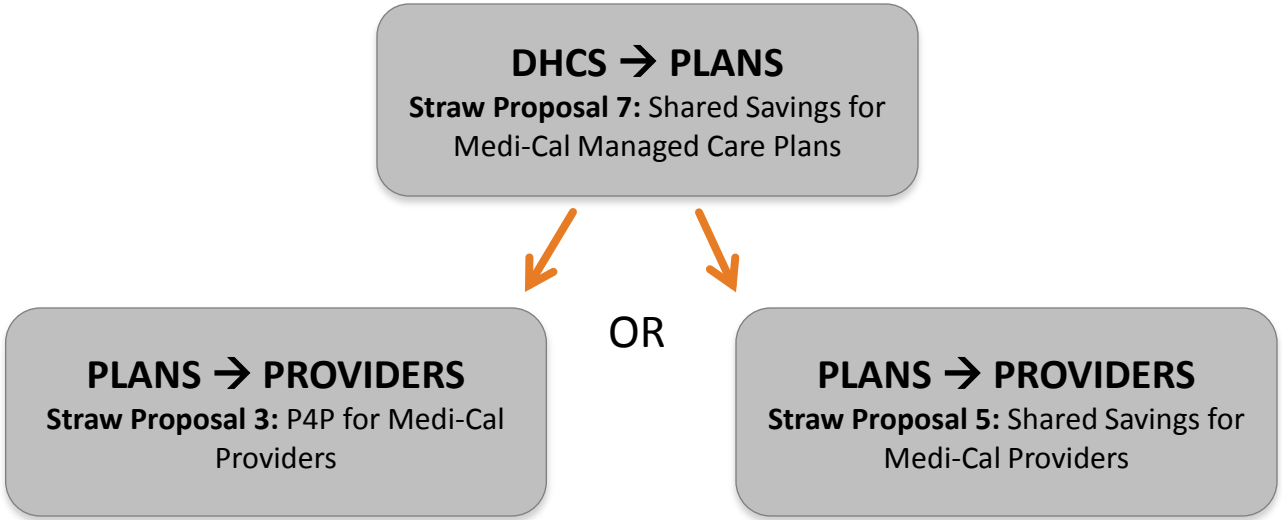
Key Discussions Questions for Straw Proposal #6

1. What are necessary investments that plans would make?
2. What are the biggest gaps on the ground at the delivery level to fill to make this work?
3. How can plans work with county behavioral providers to encourage physical health co-location at their clinics?
4. Does this proposal sufficiently incentivize providers?

Accountability & Innovation in MMC

Goal: Improve patient care, improve health outcomes and reduce the total cost of care (TCOC) trend through delivery system integration supported by value-based payment

Strategy: For DHCS to hold MMC plans accountable for both quality and cost of care while enabling flexibility to determine the appropriate care management strategy for their contracted providers



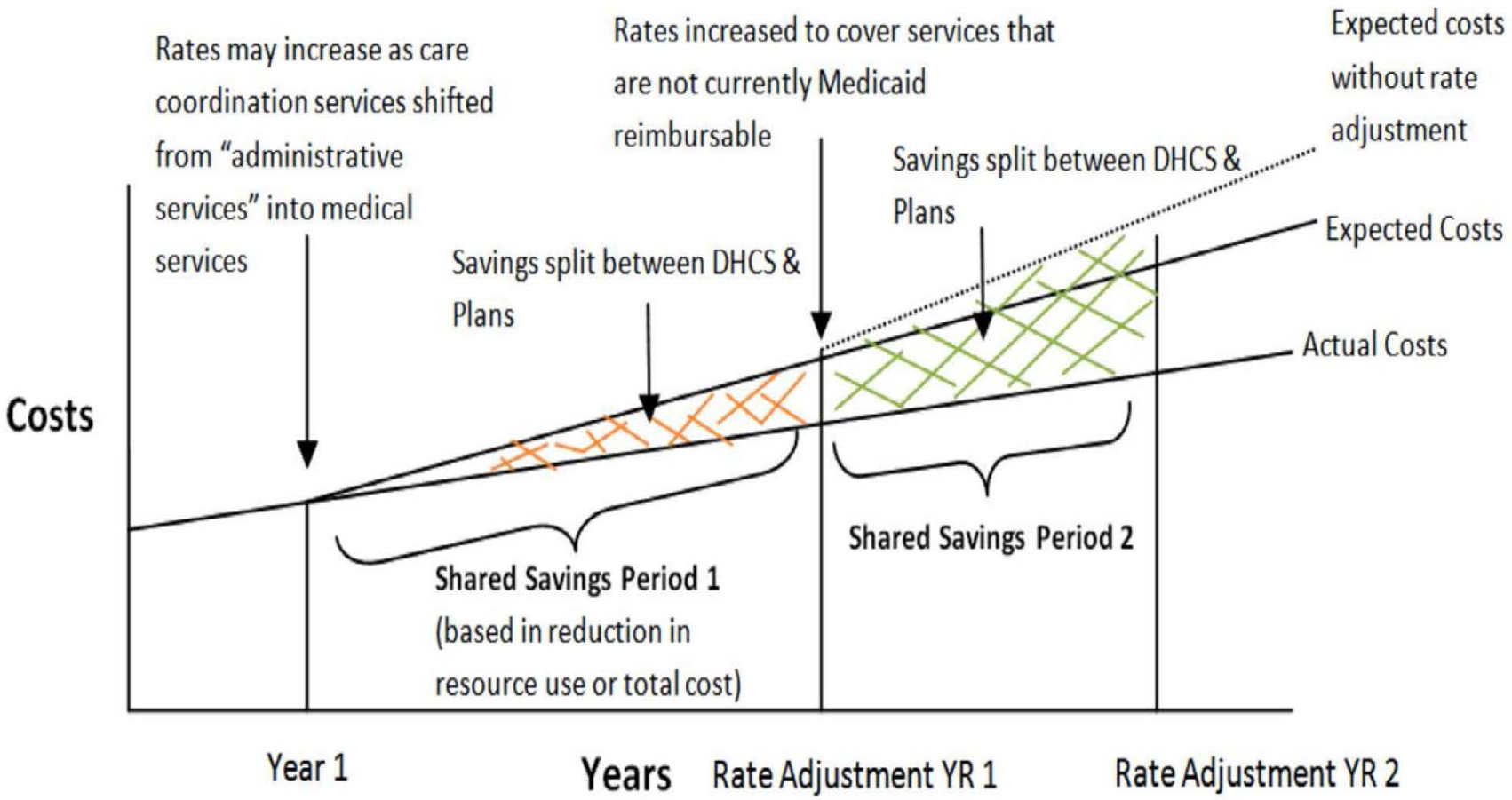
Straw Proposal 7: Shared Savings for MMC Plans

Structural Elements	Description
Target Population	All Medi-Cal managed care members
Target Providers	N/A
Incentive Approach	- Resource use or TCC target with shared savings for difference between actual and targeted cost - New rate setting strategy
Quality Approach	Quality targets must be reached in order for plans to be eligible shared savings
Expected Outcomes	Increased care management/coordination to reduce avoidable utilization; lower TCC alongside quality improvement
Alignment with other DHCS Initiatives	N/A
Role of DHCS	- Develop performance measures, specifications, benchmarks - Determine expected costs for shared savings - Collect, validate, report results - Provide support to MMC plans - Distribute savings to plans
Example(s)	- IHA's Value Based P4P - Utah 1915(b) waiver modification

Incentive Approach

1. **Shared Savings Calculation & Distribution:** If the plan meets quality targets, it becomes eligible for shared savings based on performance on resource use or total cost of care – the difference between expected and actual costs
2. **Rate Setting:** Rebase rates according to expected spending rather than actual spending – creates financial incentive for plans to invest in better care management without penalizing them with lower rates based on reduced utilization.

Timeline & Structure for Shared Savings



Proposed Measure Set

Alignment with DHCS External Accountability Set – Administrative measures only

Measure	Value Based P4P MY2013	DHCS EAS
Clinical Measures		
Annual Monitoring for Patients on Persistent Medications: ACE or ARB, Digoxin, Diuretics	X	X
Overuse of Imaging Studies for Low Back Pain	X	X
Children and Adolescents' Access to Primary Care Practitioners		X
Medication for Management of Asthma		X
Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	X	X
Resource Use Measures		
All-Cause Readmissions Following Acute Inpatient Stays	X	X*
Emergency Department Visits per 1,000 Member Years	X	X
Inpatient Bed Days per 1,000 Member Years	X	
Inpatient Stays (Discharges) per 1,000 Member Years	X	
Cesarean rate for low-risk births	X	

** Modeled on HEDIS Plan All-Cause Readmission measure, but doesn't include risk adjustment*

Approach to Quality/RU/TCC

- Align core measure set with DHCS External Accountability (EAS) Set
- Expand measurement on resource use and total cost of care
- Consider standardizing patient experience measurement
- Address social determinants of health
- Develop and vet performance benchmarks

Work Group Discussion Questions for Straw Proposal #7

1. Health plans: what are the key strengths and concerns regarding this approach? Would it work better for some plans than others?
2. What are the tradeoffs among basing the shared savings on total cost of care vs. resource use?
3. What investments would DHCS and the MMC plans need to make to support this direction?
4. Does the new rate setting strategy provide enough incentive for plans?
5. How feasible is it to develop TCC and risk-adjusted resource use measures?

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

Structural Elements	Description
Target Population	All Medi-Cal managed care members
Target Providers	Primary Care Physicians; Specialists and other providers optional
Incentive Approach	- Core set of measures for all plans (ability to tailor to local needs) - Incentive approach tailored to provider sophistication - Funding requirement for plans that meets minimum payout
Quality Approach	Provider incentive based on performance against core quality measures
Expected Outcomes	Maximize P4P programs' effectiveness and moderate cost trend
Alignment with other DHCS Initiatives	Auto-Assignment
Role of DHCS	- Require each plan to adopt P4P program that meets core elements - Development of tools/resources to support plans - Monitor, revise and improve programs
Example(s)	Most MMC plans have a P4P program. Examples include: Partnership and Inland Empire Health Plan P4P Programs

Feedback on Straw Proposal #3

Opinions varied on standardization vs. flexibility and no real consensus emerged. Snapshot of feedback below:

- DHCS needs to develop goals for MMC plans to focus on and allow plans the flexibility to tailor approach based on local needs; lack of standardization not a problem
- Current system lacks the ability to compare provider performance statewide – statewide metrics would accomplish this goal
- Plans pick P4P measures based on what they are being held accountable for; opportunity for statewide metrics and delivery tailored to local needs
- Overarching caution: plans are not starting at the same place and some plans may be at a disadvantage.

Medi-Cal Pay for Performance Inventory

Medi-Cal P4P Inventory

- Survey of P4P activities across all Medi-Cal managed care plans
- Areas of focus: measurement, incentives, provider participation, program impact
- September - November 2014: Telephone interviews with plan representatives
- 20 plans have participated (22 total)

Issue Brief

- Spring 2015 - Key findings published in IHA Issue Brief & comparative matrix

Funding -- from Blue Shield of CA Foundation

Medi-Cal P4P Inventory: Program Prevalence

P4P Program

Of the 20 Medi-Cal managed care plans interviewed, 16 have pay-for-performance programs in place.

Overview of Current P4P Activities	Number of Plans
P4P Programs in Place	16
Just Starting	1
Started 2009 - 2013	5
Started 2004 - 2008	3
Started 2003 and before	7
No P4P Program in Place	4
Total	20

Medi-Cal P4P Inventory: Measurement Results

- Domains in P4P programs include: clinical, utilization, encounter submission, access, and patient experience
- Two most frequently cited domains were clinical and utilization
  - 14 P4P programs include clinical quality measures
  - 7 P4P programs include utilization measures
- 5 plans also measure and reward specific activities (e.g. completion of PM 160 form to document well-child visits and immunizations)
- There is overlap of clinical measurement areas across P4P programs but there is not any specific metric used by all plans

Medi-Cal P4P Inventory: Incentive Design Results

- Primary care physicians are eligible for incentives in all P4P programs
  - 5 plans also provide incentives for specialists and other providers, e.g. hospitals
- Plans tailor their incentives to their contracted providers in various ways
  - 3 plans paid incentives based on attainment (meeting some specific target or benchmark set in advance of measurement year)
  - 5 plans paid incentives based on improvement in performance over time (e.g. year-to-year decreases in the rate of avoidable hospital readmissions)
  - 3 plans paid providers a per-activity bonus (e.g. completion of PM 160 forms)
  - 5 plans paid incentives on a combination of approaches
- The level at which providers are rewarded in P4P programs varies. Levels include: the individual physician level, the practice/clinic level, FQHC level and the medical group/IPA level.

Medi-Cal P4P Inventory: Additional Supports

Plans were asked to indicate what additional supports they would find most helpful to strengthen their P4P program. Most frequently cited responses were:

1. Learning collaborative to document and share information about existing P4P programs, best practices
2. Standardization of measures and shared benchmarks
3. Better (and better use of) data, including real time data, training for providers on how to use data for improvement, increased understanding of measures.

Approach to Quality/RU/TCC

- Align core measure set with DHCS requirements of the plans
  - Each measure included in core measure set would include specifications and benchmarks based on existing data
- Develop a menu of additional measures for plans interested in supplementing the core measure set at the local level
- Create opportunity for core measure set that is consistent across payers (Commercial, Medicare, Covered California)

Work Group Discussion Questions for Straw Proposal #3

1. Should standardization be restricted to a core measure set, or apply to incentive design as well?
2. Will a core measure set with a menu of additional measures provide sufficient flexibility to plans with diverse patient and provider populations?
3. Would a smaller subset of measures from the DCHS EAS make implementation more focused and actionable? What measures should be included?
4. What key factors need to be resolved related to incentive design?
5. What tools or resources would plans need to support implementation and maintenance?
6. How would DCHS monitor programs?

Straw Proposal 5: Shared Savings for Medi-Cal Providers

Structural Elements	Description
Target Population	Managed care members - emphasis on high cost patients and patients with 2+ chronic conditions
Target Providers	Range of providers (both large groups and small providers)
Incentive Approach	Total cost of care target with shared savings for difference between actual and target costs; can be modified based on provider sophistication and local market
Quality Approach	Quality targets must be reached to share in savings
Expected Outcomes	Increased care coordination and collaboration; lower TCC per patient
Alignment with DHCS	Work within framework of Medi-Cal managed care
Role of DHCS	Require each plan to adopt TCC target with shared savings between plans and providers
Example(s)	Plans and provider organizations

Feedback on Straw Proposal #5

- Funding problem: Medi-Cal lowest payer and proposal assumes savings to be shared; would need to be new money
- Medi-Cal has very different population and set of providers; better suited for the commercial sector
- Contracting with hospitals is different in Medi-Cal compared to the commercial space where hospitals are willing to lower revenue for more volume; the same is not true in Medi-Cal
- The focus is on cost rather than quality

Approach to Quality/RU/TCC

- Align core measure set with DHCS requirements of the plans
- Requires further development of TCC and resource use measures

Work Group Discussion Questions for Straw Proposal #5

1. Providers: what are the key strengths and concerns regarding this approach? Would it work better for some providers than others?
2. Are Medi-Cal providers caring for a sufficient number of patients to ensure that shared savings approaches are workable/actuarially sound?

Discussion of FFS Medi-Cal

Maternity Services in Fee-for-Service Medi-Cal

Problem

- Statewide growing number of cesareans and early elective deliveries when not medically indicated; practices result in complications for mothers and babies
- Recent data suggests progress but large variation across geographical areas, hospitals, and clinicians persists

Maternity Care Services in FFS Medi-Cal

- Medi-Cal finances 50% of births in California; ≈62% of births financed by Medi-Cal paid on FFS basis

<table>
<tr><th></th><th>Physicians</th><th colspan="2">Hospitals</th></tr>
<tr><td rowspan="2">Fee-for-service
(62.2% of Medi-Cal births)</td><td rowspan="2">FFS from DHCS
(Equalized OB Rate: Blended rate for delivery)</td><td>PER DIEM
(based on hospital allowed costs)
(24.4% of payments or (17.4% of deliveries)</td><td>Designated Public Hospitals
(21)</td></tr>
<tr><td>DRG
(via hospital specific rate)
(75.6% of payments or 82.6% of deliveries)</td><td>▪ Non-Designated Public Hospitals
- District Hospitals (25)
▪ Private Hospitals (202)</td></tr>
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Improve Maternity Care in Fee-for-Service Medi-Cal

Goal: Improve quality and reduce costs in maternity care in FFS Medi-Cal through value-based payment

Strategy: Incentivize Medi-Cal providers to improve maternity care in FFS Medi-Cal

DHCS→ FFS PROVIDERS

Straw Proposal 8: Value based payment for Maternity Services in Fee-for-Service Medi-Cal

- Opportunity to align with CalSIM Maternity Care initiative

CalSIM: Maternity Care Initiative

GOAL: To promote safe, evidence-based deliveries to improve birth outcomes, promote maternal and infant health, and reduce unnecessary costs.

Main Components:

1. Data Collection/Quality Improvement
2. Public Reporting
3. Payment Innovation
4. Patient Engagement

CalSIM: Maternity Care Initiative

There was significant stakeholder input around which performance measures to include in the initiative.

The four measures selected are:

- Early Elective Delivery Measure (EED)
- Cesarean Section Rate for Low-Risk Births (CSX)
- Vaginal Birth After Cesarean Delivery Rate (VBC)
- Unexpected Newborn Complications in Full-Term Babies (UNC)

Straw Proposal 8: Value Based Payment for Maternity Services in Fee-for-Service Medi-Cal

Structural Elements	Description
Target Population	Pregnant women in FFS Medi-Cal
Target Providers	Obstetricians and private hospitals with obstetrical programs
Incentive/Quality Approach	Two options for value based payment (can be implemented as one package or separately): 1. Quality Hospital Incentive Program (Q-HIP) – "DSRIP-like" P4P program for private hospitals that ties bonus payments to performance against and/or improvements on core maternity measures (CalSIM measures) 2. Prior Authorization ("hard stop" policy) – Requires physicians to receive prior authorization for deliveries before 39 weeks without medical indication
Expected Outcomes	- Promote healthy, evidence based obstetrical care and improve quality - Reduce unnecessary costs related to medically unnecessary cesareans - Create statewide reductions in early elective deliveries (before 39 weeks)
Alignment with other DHCS Initiatives	CalSIM Maternity Care initiative

Work Group Discussion Questions for Straw Proposal #8

- What opportunities or challenges do you anticipate with either option? Should they be implemented together or separately?
- Should all hospitals (not just private hospitals) participate in the hospital incentive program?
- What level of savings are expected from this incentive program? Could the savings fund an incentive pool?