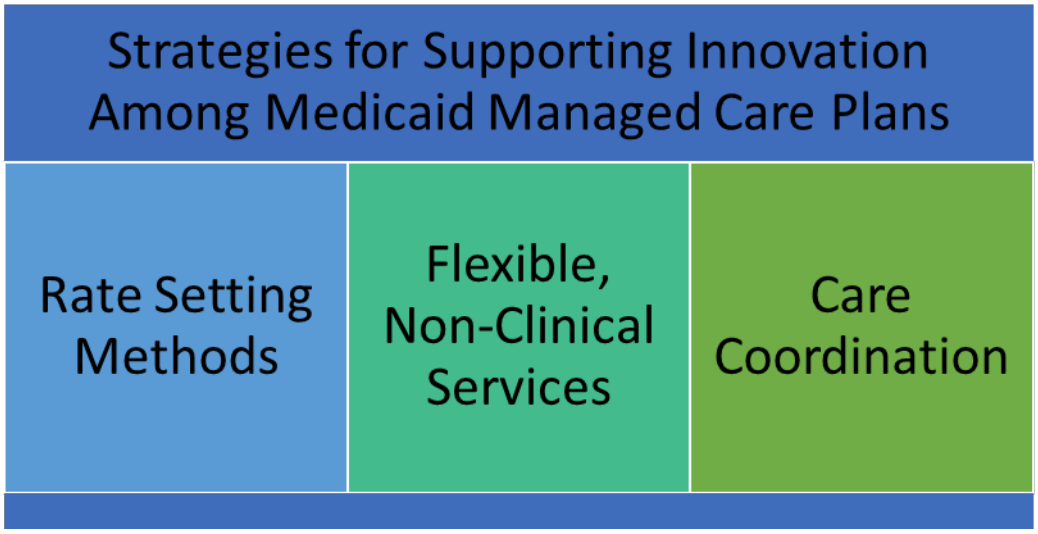
CHCS Center for Health Care Strategies, Inc.

IHA INTEGRATED HEALTHCARE ASSOCIATION

Making a Better Business Case for Sustainable Payment Reform in Medicaid Managed Care

Changes to the Medicaid managed care business model may be necessary to create the right incentives for managed care plans (MCPs) to invest in and support widespread and sustainable provider-level payment reforms that go beyond the well-established delegated and sub-capitated models already in place. This document presents three potential strategies that DHCS is considering which would support the eight specific incentive straw proposals:



1. **Rate setting methods.** Current rate setting methods do not provide the plans with long-term incentives for efficiency improvements. When rates are rebased using lower utilization achieved under such reforms, MCPs receive a lower rate than they otherwise would have received if past trends in utilization held true. DHCS would like to explore how the rate setting methodology could be modified so that both DHCS and plans are able to share in the savings produced by payment reforms. The goal is to create financial incentives for plans to invest in better care management/coordination.
2. This could be achieved under one of two potential approaches:
    a. DHCS could modify the rate setting methodology for certain categories of services most likely to decrease (e.g. inpatient services, imaging, outpatient procedures, delivery services) under payment reform activities. Under this approach, rates for these services are rebased not using actual utilization trends, but using a trend rate that falls between the predicted trend and the lower, actual trend. This approach retains the adjustments for other service

categories, and therefore would not penalize MCPs for a rise in services such as primary care utilization, which one would expect under the proposed reforms.

b. DHCS could establish a fixed rate increase over the next five years. This is similar to the approach that Utah took in its 1915b waiver and Oregon in its 1115. The fixed increase (appropriately risk-adjusted and reflective of changes in enrollment) would provide MCPs with a predictable budget and would be structured so that plans are not penalized for achieving improvements relative to the fixed trend rate. The rate would need to be set such that DHCS also accrue some savings relative to current trend. This approach would provide plans with wider flexibility.

Questions for the Work Group:

- Which approach is most appealing and why?
- Which categories of services would fall under the proposed modifications?
- What considerations or challenges do you anticipate for these approaches?

3. **Flexible services –** DHCS would give MCPs the option to cover a set of non-State plan "flexible" services within the capitation rate, which would directly support patients in improving their health. Related expenditures would be counted as medical expenses. By giving MCPs the option to include a set of non-clinical services in the capitation rate, they would have the incentive to provide beneficiaries a broader range of services that would improve health outcomes and patient experience. The inclusion of such services would help plans and providers address the social determinants of health that otherwise present barriers for patients, thereby making the straw proposals more effective. This would also complement Health Homes, DSRIP 2.0, and the Coordinated Care Initiative.

   Potential services could include:

   - Non-emergency transportation (e.g. wheelchair van, taxi, bus passes and other secured transport)
   - Nurse home-visiting case management programs (e.g. maternity, post-natal, post-discharge, etc.)
   - Other items directly related to improving specific patient's health that are non-state plan services, such as housing supports related to care (e.g. air-conditioners), classes/training, support programs, supports that address social determinants of health

   An encounter would need to be submitted to reflect the provision of such services.

   Current Medicaid Examples:

   Oregon's 1115 waiver provided its Coordinated Care Organizations the ability to cover "flexible services." Although flexible services were not categorized as medical expenses, utilization assumptions

are applied to rate development. CCOs are required to submit an encounter for each flexible service provided. Oregon defined flexible services as:

- Training and education for health improvement or management (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);
- Care coordination, navigation, or case management activities (not covered under state plan benefits, e.g., high utilizer intervention program);
- Home and living environment items or improvements (non-DME items to improve mobility, access, hygiene, or other improvements 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?
- What considerations or challenges do you anticipate for implementing this approach?

4. **Care Coordination.** Under current program requirements, care coordination reimbursement is considered an administrative expense, not a medical expense. Given current MLR requirements, this penalizes plans that otherwise would want to reimburse providers for delivering care coordination services that are critical for new delivery models to be effective. DHCS could under the waiver request that these services be recategorized as medical expenses, thus creating a better business case for MCPs to reimburse provider organizations for such services.

Questions for the Work Group:

- What considerations or challenges should DHCS consider when implementing this approach?