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

Friday, January 23, 2015
10:00am – 3:00pm
DHCS Training Room A/B/C, 1500 Capitol Mall, Sacramento
Meeting Summary

Members present:
Molly Brassil, County Behavioral Health Directors Association of California; Michelle Cabrera, SEIU; Richard Chambers, Molina HealthCare of California; Athena Chapman, California Association of Health Plans; Nathan Davis, California Children's Hospital Association; Lishaun Francis, California Medical Association; Dean Germano, Shasta Community Health Center; Jennifer Kent, Local Health Plans of California; Paul Pakuckas, Anthem Blue Cross; Andie Patterson, California Primary Care Association; Erica Murray, California Association of Public Hospitals and Health Systems; Sandra Naylor Goodwin, California Institute for Behavioral Health Solutions; 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, Health Net; Rachel Wick, Blue Shield of California Foundation; Brad Gilbert, Inland Empire Health Plan; Elizabeth Landsberg, Western Center on Law and Poverty; Michael Schrader, CalOptima.

Members on the phone: No members attending on the phone.

Members Not Attending: Don Crane, California Association of Physician Groups; Anthony Wright, Health Access; Anne McLeod, California Hospital Association.

Others Attending: Sarah Brooks, DHCS; Efrat Eilat, DHCS; Hannah Katch, DHCS; Dana Moore, CDPH; Jill Yegian, Integrated Healthcare Association (IHA); Sarah Lally, IHA; Tricia McGinnis, Center for Health Care Strategies (CHCS); Greg Howe, CHCS; Michelle Soper, CHCS; Laura Hogan, Pacific Health Consulting Group; Bobbie Wunsch, Pacific Health Consulting Group.

13 Members of the Public Attending

Welcome, Purpose of Today's Meeting and Introductions of Workgroup Members
Bobbie Wunsch, Pacific Health Consulting Group
Following introductions, Bobbie Wunsch thanked the foundations for their support of the stakeholder process. She announced that an evaluation survey of the stakeholder process will be sent to members next week and asked that members offer their candid feedback and comment.

DHCS Linked Goals Framework Revised

Sarah Brooks, Department of Health Care Services

Sarah Brooks, DHCS, presented a revised version of the three goals document incorporating workgroup member input. The document may continue to evolve as the waiver proposal develops. In integration, this is about treating the whole person, including linking to community services and housing.

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

Member Questions and Comments:
Elizabeth Landsberg, Western Center on Law and Poverty: Looking at the three goals, since the waiver is directed to Medi-Cal, should it be "low-income" instead of "all Californians"?

Brooks, DHCS: I wanted to stay in line with the DHCS mission to improve the health of all Californians, but I think you're correct that this waiver is specifically targeting low-income populations.

Jennifer Kent, Local Health Plans of California: On utilization, do we agree that the specific diseases at the top are the right ones to work on from an overutilization, cost perspective?

Brad Gilbert, Inland Empire Health Plan: I think chronic disease care in general is the right focus because it generates the largest cost. The nexus of chronic disease care and behavioral health are the big drivers; diabetes and hypertension are the leading diagnoses among adults; asthma is the biggest in kids. Some others – congestive heart failure, etc – are less prevalent. So generally, I think that these are the correct areas of focus.

Richard Chambers, Molina HealthCare of California: Brad said it well. Hospitalizations are the big drivers of cost and are listed here.

Michael Schrader, CalOptima: The only one to add is dental – glad to see this there. Behavioral health is an access issue – in a lot of counties there are just not the right facilities available. Temporary housing is a big issue when we go to discharge and there is nowhere for patients to go.

Paul Pakuckas, Anthem Blue Cross: Does this assume that pharmacy costs are included in all the boxes?

*Brook*s: That will be built in but we may not have already discussed it. We need to think about this in the bigger picture – medication adherence, behavioral health/primary care physician medication reconciliation is included but not so much the pharmacy costs.

Jennifer Kent, Local Health Plans of California: Diagnosis testing and sharing of information might be import to add.

Abbie Totten, HealthNet: Palliative care is a major initiative within DHCS and the plans, but this is very new and very small overall percentage of the population. I have a question on this one - Is this the right target? This is not as well established as diabetes and other chronic disease. Also palliative care has a strong cultural aspect – death is viewed so differently in different communities.

Peter Shih, San Diego County: In San Diego, there are many HIV and behavioral health high pharmaceutical costs so this is important to include. Managing the meds for these lowers hospital costs.

Lishaun Francis, California Medical Association: Is the reduction in administrative costs included here? The system is set to go up this summer (PAVE) to enroll providers.

Brooks: It is embedded throughout but not detailed yet. There are opportunities to implement technology solutions and reduce administrative expenses.

Erica Murray, California Association of Public Hospitals and Health Systems: Very impressive. My only comment is that metrics may need to be at the overarching level. What will we need to achieve to meet these goals? The waiver is very outcome oriented and we need to commit to waiver-wide goals. We have been thinking about ambitious outcomes we can commit to by 2020.

Brooks: There will be target metrics above and some detailed metrics below.

Nathan Davis, California Children's Hospital Association: I think it's important to maintain a focus on maternity.

Dean Germano, Shasta Community Health Center: Brad is spot on. I am glad to see the emphasis on behavioral health. Half of our clinic population is dealing with serious mental illness and the difficult part is care coordination and navigation.

Andie Patterson, California Primary Care Association: Echo the comments on comprehensiveness. I like the call-out on social services. We will be more successful when we incorporate holistic health needs. On behavioral health, it appears everywhere but want to be sure we include real solutions on the substance use disorder side. Do all of these steps operate simultaneously? Does updated technology come at the same time as coordination, does one come first – What is the process and what steps need to be in place first as we think about reaching these goals?

Brooks: Excellent question that will play out as we discuss with CMS. We need to be strategic with goals that are reachable. Your comments on substance use are important. This needs to be tied together with the Drug Medi-Cal waiver.

Rusty Selix, Mental Health Association of California: On substance use disorders, in other states the comprehensive mental health providers have capacity to bill for co-occurring disorders. We have trifurcated system: SUDS only, SMI, mild/mod MH only – with co-occurring as well. We need to use the Drug Medi-Cal waiver to eliminate the silos.

Molly Brassil, County Behavioral Health Directors Association of California: When thinking about behavioral health and physical health integration, we need to think of this as bi-directional. It is helpful to provide behavioral health in physical health and we need physical health in behavioral health as well. I would encourage you to make this to be explicit here.

Brooks: We do intend it to be bi-directional.

Sandra Naylor Goodwin, California Institute for Behavioral Health Solutions: People with serious mental illness die 25 years sooner, with substance use it is 30 years sooner. Most of that is from untreated physical health conditions. Without the bi-directional care, we will continue to have high costs and young deaths. Because we have learning collaboratives around integration, we have successful models to make integration and team-based care work.

Michelle Cabrera, SEIU: I want to raise an issue – making the identification and reduction of disparities a fourth linked goal. We assume this can be accomplished if embedded but I am not confident that will happen. What is measured matters. We need this to be explicitly outlined – I find this dimension lacking. I think it can be an overall theme in the waiver because it is coming up in DSRIP and other workgroups.

Chris Perrone, California HealthCare Foundation: Great job on all the materials and incorporating the feedback. This is very comprehensive at this stage. Each of these is specific, should there be broad based measures that cut across primary care such as consumer experience, reducing disparities, etc.?

Brooks: This ties to Erica's comment and Michelle. We will have bigger measures that cross all the goals.

Katch: It may be that we need to better define the goals. Equity could be a measure of quality, for example.

Chris Perrone, California HealthCare Foundation: It is an exciting development to think about benchmarks being set for the 5 years. On palliative care, I actually appreciate that it's on here, and I recognize that these are not all equal goals. Perhaps put palliative care in to announce an intention to work on it, but with considerations of what can be accomplished.

Brooks: Yes.

Dana Moore, CDPH: From CDPH, we applaud the integration of prevention and disparities. There is opportunity to collaborate on upstream approaches and on metrics.

Brooks: Thank you. We met this week with CDPH to begin this collaboration.

Andie Patterson, California Primary Care Association: Maternity care and prevention – have we considered pregnancy prevention here? Long Acting Contraception could be an opportunity to help women control decisions about when to have children.

Bobbie Wunsch, Pacific Health Consulting Group: We will hear from Planned Parenthood about ideas for women's health incentives in fee for service and managed care incentives.

Brooks: Much of this feedback aligns with our internal conversation and we appreciate hearing that perspective here. We may reach out to members going forward to test changes.

Katch: We look forward to working with you. We are starting to think about the overarching goals of the waiver and would appreciate input from members. For example, New York's overarching goal is 25% reduction in unnecessary ED utilization and this is an example of what we need to develop.

Peter Shih, San Diego County: My request is for DHCS to link the 1115 renewal waiver, drug Medi-Cal waiver and health home together. If we are to create incentives, we need to work across all of these initiatives. This is our last meeting and I want to underscore how critical this is. We need to be very coordinated as we approach CMS. Housing, case management, social services are critical.

Katch: That is how we are thinking about it. The five workgroups represent specific expertise but the work now is to integrate and link every one of the workgroup priorities. Incentives also need to be aligned.

Brooks: Hannah, Efrat and I are working closely to link health homes and MH/SUDS drug Medi-Cal waiver.

Bobbie Wunsch, Pacific Health Consulting Group: This is the beginning of the waiver development and the ideas here may change; new ones could be added. There are six months ahead with continued development and the work of integrating across the workgroups. On January 30, there will be a meeting on budget neutrality held here in the auditorium. On February 11, at the stakeholder advisory committee, we will hear from DHCS about how they're thinking of integrating input from all workgroups. A webinar will follow for workgroup members to receive feedback.

Review New and Updated Plan/Provider Incentive Proposals
Integrated Healthcare Association
Center for Health Care Strategies
Presentation slides available: http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-MCO-Provider-Incentives.aspx

Introduction
Jill Yegian, IHA, provided introductory comments to bring members up to date on the progress since the last meeting. She reminded members of the two goals for incentives – improving patient care and integrating behavioral and physical health – and the six straw proposals brought to the last meeting. Proposals 2, 3, 5, and 6 continue for discussion from the previous meeting. Proposal 1 and 4 are dropped. Two new proposals – number 7 and 8 – are on the agenda for today.

Member Questions and Comments:
Michelle Cabrera, SEIU: The rate setting seems like a totally new concept. I need more clarity about this. Are we proposing to do both of these at the same time?

Jill Yegian, IHA: My understanding is that in order for some of the straw proposals (e.g. #7) to be effective, we need to mitigate the effect that, if a plan is successful in accomplishing the goal of an incentive, it would have the impact of lowering the plan's rates. Rate setting is the DHCS perspective to address this impact.

Brad Gilbert, Inland Empire Health Plan: If I as a plan do innovative things, it has a negative financial impact. We have discussed underfunding in so many ways, we need to address this element. It is critical.

Chris Perrone, California HealthCare Foundation: You mentioned maternity is an example? In what other areas is Medi-Cal still paying significant fee for service? The data on maternity is from 2011. Do we have a sense of whether the trends are continuing?

Brooks: It is likely somewhat lower, but we get more requests for medical exemption in maternity.

Elizabeth Landsberg, Western Center on Law and Poverty: We want to see increased quality, but we are moving many more women into managed care.

Rate Setting Overview: Business Case Proposal
Tricia McGinnis, Center for Healthcare Strategies (CHCS), provided an overview of rate setting strategy to sustain payment reform and address underlying disincentives. This is an umbrella strategy to make all eight incentives successful and would also incentivize and align to DSRIP and housing proposals. This umbrella will make the incentives throughout work.

Questions for workgroup members:
- Which option 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?

Member Questions and Comments:
Abbie Totten, Health Net: When you present actual vs trend, what year of data are you using? Right now the data is two years old in rate setting. Would this change the data submission process? This will impact the accuracy.

Brooks: HEDIS is delayed but recent work on the encounter data positions us to do this.

Brad Gilbert, Inland Empire Health Plan: I like the concept generally. I would choose partial re-basing. On partial re-basing, I don't understand is why you include a factor that means we are penalized on primary care. I would like to be very focused on the areas we can change and are high cost – like ER use. We need a model that manages new drugs/pharmacy costs. This does keep dollars in the system. Remember we are starting with a very low base because we have been doing some of this work for a long time. Inpatient utilization is already very low through past initiatives. And, the trend lines will make or break this.

Michael Schrader, CalOptima: I also like partial re-basing. It gives plans visibility into the assumptions that might be lost in full re-basing. The areas should only be those where we are pursuing changes. Areas like behavioral health and primary care should be excluded because we are expanding these.

Richard Chambers, Molina HealthCare of California: There is merit to the partial re-basing. Full rebasing may be useful as well. There may be different perspectives from public vs private plans. It would be essential for all plans that the original trend lines are set realistically. If set well, this is a good option.

Paul Pakuckas, Anthem Blue Cross: If we use partial rebase, does this leave out incentives for savings that are outside of these focus areas?

Abbie Totten, Health Net: I need input from financial folks on the specific options. It is difficult to set rates with providers when we don't have consistency and predictability so establishing the timing is a plus. A concern on partial re-basing is that reduced ER could include increased specialty costs as well as primary care.

Richard Chambers, Molina HealthCare of California: The full rebase is in Oregon's waiver. The state has historically said that long-term concepts are off the table because of the budget cycle but predictability over a longer term will help.

Michael Schrader, CalOptima: One of the risks of full rebasing is that a plan might focus on one or two areas where the goal is easier to reach and ignore other areas that require work.

Strategy 2: Flexible Services
Greg Howe, CHCS, presented information on Strategy 2. The services include housing and other services that require approval by CMS to become medical services rather than administrative. If

approved, they would be included in the rate setting for medical services. This is included in the Oregon waiver.
Questions for workgroup members:

- 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?

Member Questions and Comments:
Michelle Cabrera, SEIU: With the variation among plans, my question would be how the state can link this to our end goals. Plans' input is vital but the motivation should be the vision.

Katch: We should ask this question at every step. This goes back to the linked goals. I look to the group for input.

Dana Moore, CDPH: Oregon had a great public health list. What did this look like? Do you know if the health plans in Oregon work with local public health? Did public health agencies have to become certified to get reimbursed? We should leverage resources in the community and support using local health departments.

Tricia McGinnis, CHCS: I don't have the operational level details. Oregon did bake in close relationships with public health departments. There were requirements about partnerships. Public health could be certified providers for reimbursement as long as we account for potential duplication.

Lishaun Francis, California Medical Association: Physicians would like to see the education and training – are agnostic about who provides this. Campaigns on certain issues like meal preparation for elderly so that providers are not handling both clinical care and consumer education.

Elizabeth Landsberg, Western Center on Law and Poverty: Transportation, housing supports and community linkages are key. We agree we don't want to reinvent the wheel – health plans are not the best place to do some of these things and should link to existing services.

Peter Shih, San Diego County: In San Diego, we are convening local stakeholder group for input to the waiver. Clearly the objective for DHCS should be improve health. We are focusing in on highest user and this narrows us to high-risk population. The flexibility of this list of services would be for that population, not necessarily for all Medicaid populations. We have Home & Community Based Services that plans can leveraged. We have a HUD collaborative, a CalFresh linkage. It seems we need the intensive case management as well as services. If high users have

intensive case managers (1:6; 1:10, 1:20) depending on severity, we can improve the utilization and improve health. Can there be a case rate to pay for more intensive case management?

Brad Gilbert, Inland Empire Health Plan: Peter, we need to do both (services and intensive case management). Elizabeth, we don't want to run a farmers market. The list is missing navigators – such as moms and babies are in the ER because they are not in primary care. Health plans do lots of this through admin side of rates. There is a difficulty with encounters, how to count things and understand the costs. This will be hard with CMS. Concept is great.

Katch: Do you have thoughts on how to narrow, where to narrow? Admin considerations are in statute and we have little discretion. To Peter's comment, linking to health homes and the housing workgroup are being discussed. We want to utilize existing resources with the varied picture of this in different places.

Andie Patterson, California Primary Care Association: I want to emphasize the case management. If you are narrowing the list, keep case management at the top.

Michael Schrader, CalOptima: One size fits all must be a consideration. The local needs, populations, resources vary. It is important to have flexibility to choose which of these topics will achieve the goals.

Richard Thomason, Blue Shield of California Foundation: Echo the comments on case management. We hear this from grantees. The navigation role is a need. As populations come in who are new to coverage, they need navigation help to avoid the ER.

Sandra Naylor Goodwin, California Institute for Behavioral Health Solutions: In mental health most of this is being done because we have Targeted Case Management and Rehab Option. There is a whole series of things that can be done under targeted case management, so I think it's a good model to focus on.

Richard Chambers, Molina HealthCare of California: To the admin rate methods, could it be set up with core plan admin requirements, including targeted goals for administrative funds?

Strategy 3: Care Coordination
Greg Howe, CHCS, briefly introduced the third strategy.

Questions for workgroup members:

- What are the consequences of considering care coordination a medical expense versus an administrative expense?
- Does it matter to plans if care coordination is considered a medical or an administrative expense?
- What considerations or challenges should DHCS consider when implementing this approach?
- Which populations are included and how does it affect other programs?

Member Questions and Comments:
Paul Pakuckas, Anthem Blue Cross: I like the concept overall. We need more details about how this impacts risk.

Lishaun Francis, California Medical Association: If we are going to expand care coordination as a medical expense, we need to be very specific. Everything could be lumped there so more specificity not less.

Michelle Cabrera, SEIU: I agree with the need for specificity. If we think about how we want care to change over the course of the waiver, it is about having a care plan for an individual that details each role, such as providers coordinating clinical aspects. We could also include other roles to help with disparities that can tailor the care plan to special populations, including formerly incarcerated individuals, LGBTQ population, etc. How will we build in the training and support for those individuals into the rates over the long term? I am excited about the integration here of the goals.

Brad Gilbert, Inland Empire Health Plan: I would be very specific, very focused here. Right now, I pay a cap and say it includes care coordination. I support this being funneled to the point of care and be very specific if this is a medical expense.

Abbie Totten, Health Net: We delegate much of this to medical groups so having a way to include their cap rates with expectation is important. To what extent have there been discussions with CMS about the fact that our state and federal definitions of MLR differs?

Katch: We have not but that is important.

Dean Germano, Shasta Community Health Center: I have seen care coordination play out in our environment. There is a great difference between someone on the phone remotely vs someone inside the clinic working to coordinate. If FQHC's are two-thirds of the primary care physician network, this is adjusted out on the back end. It would have to be a grant or some other policy attention to that piece.

Rusty Selix, Mental Health Association of California: For mental health, this needs to be on the ground with the mental health provider. How do you do that from the health plan?

Brad Gilbert, Inland Empire Health Plan: Dean makes a good point. It might be a grant or different methods we need to consider but it is important to be at the point of care.

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

Straw Proposal 2: Behavioral Health Integration at the System Level

Michelle Soper, CHCS, presented behavioral health straw proposals on integration of physical health and behavioral health. The population, approach, outcomes and suggested parameters for meaningful metrics were detailed. She offered examples from other states.

Questions for workgroup members:

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

Member Questions and Comments:

Michael Schrader, CalOptima: What if the provider or service a consumer wants is not the one co-located at the primary care provider office? Shouldn't there be as much priority on a good referral system for behavioral and physical health as on co-location?

Brooks: Excellent point. Member preference is a top priority. Co-location is an effective practice so both need to work together.

Abbie Totten, Health Net: There are places where co-location works and sometimes there is no space or other reasons it won't work. Looking at this from a wide perspective, it seems how this works will vary by county. Each county does not have the same capacity, the same relationships. Our expectations need to be tailored and the benchmarks should be flexible. Both sides need to equally accountable to make this work.

Molly Brassil, County Behavioral Health Directors Association of California: From our perspective, this is an exciting opportunity to focus on specialty mental health population to serve them better. There is less evidence about how to improve life expectancy and health for severe mental illness. We can think of this in the context of a demonstration. By targeting this population, how can we improve care and cost over the course of the waiver? Also, on substance use disorders – we don't have answers about how to do this. We need to call this out explicitly and we need to be aware that the SUDS system is not at the same capacity. We don't want to disadvantage the work we can do on the mental health side with the need for significant influx of capacity on substance use disorder side.

Peter Shih, San Diego County: We have 58 different counties and different capacity. The state should customize this. San Diego is GMC. Another level of complexity has to do with the coordination of severe mental illness populations. About 10,000 severe mental illness patients are cared for by FQHC's. The County is paying for this and the plan pays for mild to moderate. We don't want this disrupted so there is a need for coordination. Drug Medi-CAL has a request for counties to opt in. It will depend on the finances. So, how does that factor into this? If counties opt in, is there funding? Is this linked?

Brad Gilbert, Inland Empire Health Plan: I see this differently. These are our members – it is a shared responsibility and this brings us together. Agree we need to get the financing right but this is new money to help us integrate.

Dean Germano, Shasta Community Health Center: Co-location doesn't guarantee integration. On referral methods, we must take specific steps are necessary to ensure the feedback loop. There are barriers, real or perceived, that co-location negatively impacts the care.

Rusty Selix, Mental Health Association of California: We need county by county and provider by provider. Some have provider next door, others have no relationship. One way to do this is to frame the goals: in primary care, everyone gets screening and a warm hand off; if it can't be through co-location, it must be better than traditional referral which doesn't work (only 20% use the referral). On AOD, there must be a new system under Drug Medi-Cal. Community mental health providers have capacity (90% provide AOD services), but none are billing.

Sandra Naylor Goodwin, California Institute for Behavioral Health Solutions: Given the uncertainty of substance use disorder benefit limitations and the need for counties to build capacity, I think it makes sense for a phase in that starts with mental health. One issue is that IT systems don't talk to each other – we need new systems, especially where no co-location exists.

Rachel Wick, Blue Shield of California Foundation: Echo from our foundation grantees many of the points being made here. ER and mental health is where people are coming together to solve problems with case management, peers, information pathways, and transportation. Access to substance use is a huge challenge.

Proposal #6: Shared savings for team-based care

Michelle Soper CHCS offered a brief overview of bi-directional integration of mental health and primary care. Three tiers are proposed based on different levels of integration. She reviewed feedback previously discussed by the workgroup such as quality measures already being reported, rates and aligning with health homes.

Questions for workgroup members:

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

Member Questions and Comments:

Molly Brassil, County Behavioral Health Directors Association of California: Very supportive of 6B. On 6A, we need to use different terminology for "mild to moderate" because this does not represent the continuum of care and recovery concept that is the more accurate way to think about their care. Patients in recovery from a serious mental health illness may be able to

receive care through an FQHC. So, how can we make sure that patients are able to receive treatment from the most appropriate setting at different times throughout their lives?

Brooks: Agree about terminology. This is not about diagnosis, it is about functionality. This terminology is in state plan amendment but we need to revisit it.

Abbie Totten, Health Net: For both 2 and 6, there need to be clear and legally binding agreements on information sharing. County counsels differ in their interpretation of privacy requirements.

Brooks: I agree. California has additional laws on privacy but agree this is a key component.

Michelle Cabrera, SEIU: In the evaluation, we are not looking at mental health side – it is on the physical health side. We need to build in the mental health side.

Michelle Soper, CHCS: I agree. It was lost on the slide but that is incorporated.

Dean Germano, Shasta Community Health Center: The person embedded in a county system has to be linked to a comprehensive primary care system with the support from that system.

Proposal 7: Shared savings for MMC Plans.
Jill Yegian, IHA, presented information about Proposal 7. This proposal incentivizes the plan to meet quality targets in order to become eligible for shared savings based on performance on resource use or total cost of care – the difference between expected and actual costs This is predicated on the previous rate setting discussion to rebase rates according to expected spending rather than actual spending. This creates financial incentive for plans to invest in better care management without penalizing them with lower rates based on reduced utilization.

Questions for workgroup members:

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

Member Questions and Comments:
Paul Pakuckas, Anthem Blue Cross: This appears to include new money. What is the expected cost based on?

Jill Yegian, IHA: There are different ways to project the expected costs and that can be detailed if this proposal moves forward.

Abbie Totten, Health Net: I thought we agreed that the total cost of care in Medi-Cal is so low that there is little ability to discuss reducing costs. We can work on reducing utilization but the rates are so low that it is difficult to incentivize behavior change. How does this address the fundamental underfunding of the program?

Brooks: I understand the point and we would have to consider the issue of new money in order to move forward.

Paul Pakuckas, Anthem Blue Cross: If the premiums are rebased between expected and actual, the intent is to create a double incentive – sharing savings + new rates that don't penalize the plan.

Jill Yegian, IHA: That is correct.

Jennifer Kent, Local Health Plans of California: This aligns with discussions we are having with counties on whole person care. This incentivizes plans to do the right thing and keep individuals out of high cost settings. With "diversionary costs" there is a strong disincentive to reduce costs and be efficient with current rate setting. This is worth continuing to discuss because removing these disincentives is important.

Brad Gilbert, Inland Empire Health Plan: Adding the quality threshold to project savings seems too early. I don't care for the particular quality measures as being high priority. We would want to look at those, look at quality measures as an absolute and look at regional variety (northern California vs southern California). These things are feasible with regional adjustments, look at quality measures and think about whether quality measures are an absolute threshold. Diabetes is our number one disease, so you could use some of the outcome measures on the diabetes side. I think asthma measure could be utilized on long-term meds. More clinical outcome measures would be better.

Richard Chambers, Molina HealthCare of California: Devil is in the details here but very much support the concept. The history has been a disincentive so this will spur innovation. What we saw in the enrollment incentive was, when we were most efficient, rates go down but we are given more members to serve.

Michael Schrader, CalOptima: The timing could be an issue here. We need to pay providers as close to the behavior change as possible and this looks to include a long lag.

Paul Pakuckas, Anthem Blue Cross: I don't think this needs to take away from auto assignment. I agree on the comments about specific quality measures.

Andie Patterson, California Primary Care Association: How does this relate to the shared savings to providers? We want the plans to be incentivized but providers complain that the plans have money and providers do the heavy lifting.

Jill Yegian, IHA: This could stand-alone or could flow down through a pay for performance approach. This is a response to what we heard at the last meeting in order to do population management.

Brooks: We understand Andie's comments and we need to be sure providers are paid and there is some standardization. For example, in San Diego if we don't standardize, we could have seven different frameworks.

Lishaun Francis, California Medical Association: I am concerned about this if there is no pass through to providers. We would have to ensure that there is a trickle down.

Jennifer Kent, Local Health Plans of California: To the extent there are savings on both sides, the general reaction of plans is to pay providers because otherwise the network can collapse. I understand the provider concerns but the way managed care works, they can't really sit on the money. Plans have boards and community input.

Paul Pakuckas, Anthem Blue Cross: Eighty percent of our membership is delegated so if we don't pass this through, we can't accomplish any change.

Michelle Cabrera, SEIU: I remember some discussion of P4P on commercial side that has not moved over to the safety net. If we don't adjust for disparities, what will happen for a provider in the community with higher low income and disparity? What incentive does the plan have to contract? If we experiment and don't take into account information about sub populations, with everything reported at the plan level, I am very uncomfortable with this from that aspect.

Katch: I agree with that. If we were to just do this, then it would be a concern. However, this is in addition to the other pieces and metrics.

Chris Perrone, California HealthCare Foundation: With regard to plan to providers, why would DHCS want to do the plan's business and manage how they contract with providers? With respect to P4 differences among plans, I am not sure this is an issue. It may be less a problem on the Medi-Cal side than commercial. On quality measures, there is a line for administrative measures – did you include all of the administrative measures? Should DHCS choose and focus or should we go with broad route? Commercial P4P goes the broader route, auto assignment goes narrower yet has some unintended consequences. You might go the broad route creates incentivizes to fix the system, not reporting on process.

Jill Yegian, IHA: The issues raised are the right ones and are critical to the final design. From our perspective, it has to incorporate the perspective of those who will implement them. The

hybrid measures are expensive and we want to focus on the improvement not the measurement.

Erica Murray, California Association of Public Hospitals and Health Systems: Specific to provider incentives, I love what I see as parts of the waiver coming together. We have P4P in DSRIP as well and it is critical as to how these align. We are hearing from CMS we need to standardize. We are mindful of the trajectory of improvement and how much we can accomplish by when. It is enticing to project this timeline too quickly. Some providers are just implementing EHR so collecting data is a big question.

Peter Shih, San Diego County: I keep referring back to LIHP. We had the experience of having 72,000 in care for 2 years that the plans inherited. We sat with our FQHC partners to identify which measures would accomplish certain improvements. We must pay in timely fashion – we paid within a quarter of hitting a target. Otherwise, they wouldn't be able to sustain the effort. Now, it is really about saving hospital expense. We need to get upstream to prevent the condition. We ensured mental health co-location, had secret shoppers to verify access, required PCMH certification and the results were there. In this effort, bed days down, even primary care down. We didn't do anything that innovative – we sat down and talked to gain agreement. There will be challenges if it is too complicated.

Brad Gilbert, Inland Empire Health Plan: We have to do hybrid measure reports now. Shared savings at plan-DHCS level is good. I would not do shared savings at plan-provider level. We are doing that on our own. I am comfortable with P4P with flexibility for implementation and standard measures but I would not go down the road of mandating the total cost of care because it really depends on the structure of the plan.

Dean Germano, Shasta Community Health Center: In thinking of my own environment, we have a grant for targeted case management. Staff indicate the program could really expand with shared savings. So, I think not prohibiting plans from working with targeted populations where savings can be shared, is perfectly reasonable.

Michael Schrader, CalOptima: Lots of shared savings between plans and providers are happening. On the ethnic community concerns, we have providers specific to the needs of individual communities, Vietnamese, Korean and others.

Andie Patterson, California Primary Care Association: I appreciate the need for flexibility. I feel for providers who may be in an area where the plan is not a leader in P4P. Not everyone does this or does it well. We may need triple incentives to create a level playing field across the state.

Chris Perrone, California HealthCare Foundation: If we hold the plans accountable, it will play out on the ground. We don't have P4P for plans so we don't know it won't work.

Paul Pakuckas, Anthem Blue Cross: If we build this in a way that means we will need to share rather than a mandate to share.

Discussion of FFS Medi-Cal Straw Proposal
Slide presentation is available:
http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MCO3_IHACHCS.pdf

Sarah Brooks, DHCS, presented information about the populations and services remaining in fee for service. There is a lot of variability about what is in and out of managed care in different locations. Ms Brooks offered information on populations and special exclusions and programs excluded from managed care.

Member Questions and Comments:
Nathan Davis, California Children's Hospital Association: On slide two, it would be helpful to know the number of beneficiaries and total spend on these areas as we try to create a set of standards around it.

Jennifer Kent, Local Health Plans of California: Is the department's goal to eventually move these populations to managed care? How do we have 62% of maternity in fee for service?

Brooks: More recent data can be obtained on births in fee for service vs managed care although there will be a lag.

Proposal #8: Maternity Services in FFS
Sarah Lally, IHA, offered context for why maternity care was chosen for this proposal. She reviewed information and potential measures compiled for the CalSIM proposal, such as reducing c-sections. She also presented options from other states that use incentives to improve maternity care.

Questions for workgroup members:

- 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 is expected from this incentive program? Could the savings fund an incentive pool?

Member Questions and Comments:
Elizabeth Landsberg, Western Center on Law and Poverty: A short review of who is in FFS Medi-Cal for maternity care. Women 0 – 59% FPL are in full scope Medi-Cal and Medi-Cal Managed Care; those at 60% FPL and above who don't have other children but are pregnant are in Fee for Service with limited scope coverage. As part of the budget last year, the Governor agreed to full scope for women up to 138% FPL and federal approval is pending. Many women will move into

full scope Medi-Cal once it is approved. In California, we have pregnant women 138-213% FPL (213% is 200% FPL with MAGI conversion) in Covered CA, Medi-Cal or both. If they are in both, they pay for the Covered CA plan and Medi-Cal is the payer of last resort. There are questions about how pregnancy-only Medi-Cal really works. The budget compromise created a wrap – Medi-Cal would pay cost sharing and the benefit package would be integrated together but this is in flux pending decisions by CMS on minimum essential coverage.

Lishaun Francis, California Medical Association: My colleagues at ACOG support these proposals. NY tried to implement prior authorization and abandoned it. Did you research that? Would it be a logistical problem to get prior authorization?

Sarah Lally, IHA: Various states have approached hard stop procedures differently. Some have reduced rates to vaginal delivery rates, as opposed to the higher cesarean rate, so it would really depend on the type of policy the state is interested in pursuing. I don't have an answer for the second question.

Nathan Davis, California Children's Hospital Association: Some comments from our perspective. We provide lots of maternity and NICU services. Since we moved to electronic TAR, it is taking 45 days to get approval and this proposal may exacerbate that. On the rate reduction to vaginal births, how many elective c-sections are we talking about? Private hospitals loose money even with DSH and the quality fee.

Erica Murray, California Association of Public Hospitals and Health Systems: Should all hospitals participate? I think it would be duplicative to DSRIP although we have pulled data and have very low c-section rates.

Jennifer Kent, Local Health Plans of California: I want to look at the data. It looks like two-thirds vaginal and one-third c-section in both settings even with the price differential. What is the real nexus of the problem in this data – is it that the c-sections that are taking place are happening too early, or is one-third still too high?

Sarah Lally, IHA: Across the state, c-sections are higher than they need to be so the rate is a concern.

Jill Yegian, IHA: The starting place for this proposal is that c-section rates are too high. Cal SIM set targets to reduce CA rate significantly and draws from best practice across the country. It was intended to be across all payers.

Michael Schrader, CalOptima: If we want a direct provider incentive, this is a good place to focus. This might not work for other populations, like CCS, it would be much more complicated.

Elizabeth Landsberg, Western Center on Law and Poverty: Even though many women will move to managed care, not all will. There are racial disparities. I am not sure why this is focused on

delivery and would want us to add prenatal care to the initiative. In California, 2 million are still in fee for service and they are some of the most vulnerable individuals.

Michelle Cabrera, SEIU: Very important topic and want to include this but add a disparity lens. Pre and postpartum care both have huge disparities. It is appalling and there are incentives we could use to address this.

Bobbie Wunsch, Pacific Health Consulting Group: Are there other places in the FFS where direct incentives might improve outcomes?

Rachel Wick, Blue Shield of California Foundation: Mental health in foster care.

Brad Gilbert, Inland Empire Health Plan: That is difficult to track in fee for service because they move so often. We need to follow the child.

Elizabeth Landsberg, Western Center on Law and Poverty: It is more challenging to create incentives but vitally important.

Nathan Davis, California Children's Hospital Association: Something could be accomplished with incentives in fee for service on Telehealth.

Erica Murray, California Association of Public Hospitals and Health Systems: In a separate workgroup we are having a robust conversation about becoming more value based for remaining uninsured.

Peter Shih, San Diego County: In LIHP, we worked on a referral system. We contracted with specialists and reduced visits by 51% because the specialist consulted with PCP.

Elizabeth Landsberg, Western Center on Law and Poverty: Can we get data on FFS so we can comment with knowledge of the scope?

Public Comment
Amber Kent, California Hospital Association: We will submit written comment on the proposals.

Paul Knepprath, *Planned Parenthood Affiliates:* We serve 1.5M patient visits in 115 health centers. We would like to see incentives for comprehensive reproductive health care. We know that half of the people in plans are women and access to reproductive care is a win-win. A written proposal will be submitted on this and other aspects of the incentive proposals.

Next Steps in 1115 Waiver Renewal Development
DHCS and Bobbie Wunsch

Sarah Brooks expressed her thanks to the workgroup. The comments and input has been so helpful, especially hearing all the different points of view and perspectives. I want to thank the consultants and the foundations.

On January 30th, a presentation of the shared federal-state savings will be offered. Bobbie encouraged stakeholders to complete an evaluation survey about the process. Many thanks to foundations for their support of the workgroup process.