Care Coordination Advisory Committee
October 5, 2018
Meeting Summary

The Department of Health Care Services (DHCS) held the fifth of six Care Coordination Advisory Committee meetings on October 5, 2018. The meeting was attended by invited committee members, staff from other state agencies and the Legislature, and members of the public. Mari Cantwell, Chief Deputy Director of Health Care Programs and Medicaid Director, DHCS and Jacey Cooper, Assistant Deputy Director of Health Care Delivery Systems facilitated the meeting, with support from other DHCS leadership and staff.

This meeting focused on the following topics:

- Shared savings models
- Value-based payment
- In lieu of services and IMDs
- Regional model approach
- FQHC payment in managed care

Meeting materials.

Discussion Summary

Mari Cantwell opened the meeting by asking members to think creatively about how to solve the challenges being discussed.

Shared Savings

Lindy Harrington, Deputy Director of Health Care Financing at DHCS discussed the multiple levels of shared savings arrangements (from state to plan and plan to provider) as well as DHCS' current rate setting process. DHCS asked several questions of the committee, including whether shared savings is best done from the state to the plan, the plan to the provider, or both. A summary of the discussion is below:

- Committee members were concerned that the current rate setting process penalizes plans for improving care.
- One health plan spoke to the value of their current shared savings models with their various providers as a way of incentivizing creativity and reduced costs. However, they noted the importance of making accurate assumptions of cost trends and making them regionally rather than statewide, as well as tailored to the sophistication of the provider organization.
- Many noted that rates need to be reviewed to make sure there is room for shared savings.
- Other members noted the importance of maintaining a focus on quality and beneficiary access.
- While most members agreed that a shared savings model should be both from the state to the plan and from the plan to providers, they noted that some providers are less sophisticated than others and that local flexibility would be important to setting up shared savings models with rural or less sophisticated providers.

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- Members wanted to ensure there was a clear plan for how shared savings should be invested back into the Medi-Cal population and how plans and providers would be held accountable.
- Carve-outs were raised as a concern in regard to shifting costs to other systems or sharing savings among different systems.
- Focusing on whether there should be one standardized savings model across the state, committee members were concerned about regional differences between southern and northern California. One committee member recommended focusing on standardizing the process rather than all of the measures. Another recommending doing community assessments and encouraged the state to encourage and engage hospital groups (especially in Northern California) to participate. Ultimately most members agreed that some standardization with the ability to tailor locally would be best.

DHCS then asked the committee to consider the possibility of incorporating county behavioral health in shared savings relationships. A summary of the committee's reactions is below:

- While much of the committee agreed in concept to the idea of sharing savings across the systems, they were concerned about coordinating and aligning the systems and overcoming bifurcation. Many noted that incentives will need to be aligned.
- Committee members felt that in order to share savings between systems, there would need to be a clearly defined population in the shared savings pool, determined based on historical utilization.
- Members participating in WPC noted that there is a lot to learn from the pilots in regard to bringing health plans and counties to the table. Continuing to incentivize these relationships could lead to shared savings and saved lives.

Value-Based Payments (VBP)

Mari Cantwell presented on VBP and Karen Mark, Medical Director at DHCS presented on VBP in the context of the PRIME program. A summary of the committee's discussion is below:

- Members familiar with the PRIME program noted the value of the program in improving outcomes through payments tied to meeting benchmarks and noted the importance of continuing to dedicate resources to this work.
- It was noted that quality metrics tied to dental and children are just now being developed and are not appropriate to tie to VBP at this time.
- Members noted that FQHCs are very risk adverse and traditionally wary of VBP, as they already feel they don't have enough funding to meet the needs of the safety net. While conceptually they are open to VBP, the state should consider an extra incentive to get them there. They are also more interested in social determinants of health, so DHCS will need to consider how to measure that in relation to shared savings. Oregon ACOs may be a good place to start.

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In Lieu of Services (ILOS)
Mari Cantwell explained and provided examples of ILOS and Dana Durham, Chief of the Policy and Medical Monitoring branch at DHCS, presented on the Whole Person Care (WPC) Pilot Program. Mari asked the committee what services from WPC the committee would want to be added to Medi-Cal, noting that many WPC services wouldn't be eligible for inclusion in a SPA. The committee responses are summarized below:

- Many committee members agreed that the state shouldn't create a menu of ILOS but should allow for flexibility at the local level. This is due to the variation in local infrastructure to provide these services. Several members discussed ways that plans or counties have had to build up the infrastructure to provide these services.
- The State and a few committee members noted that too much local flexibility may be a concern when it comes to beneficiaries' access to similar services throughout the state. One member noted that flexibility as to where a service is provided might be helpful, but not flexibility in regard to services.
- Plans noted that they currently provide many services that are not covered by Medi-Cal at their own cost and that they need a structure in place to tie provision of these services back to savings.
- Members suggested doing a survey of ILOS that are best practices, like CHWs.

Institutions of Mental Disease (IMD)
Mari Cantwell provided an overview of the IMD exclusion prohibiting federal funding for care provided to individuals aged 21 to 64 years in an IMD and the flexibilities to the exclusion. A summary of the committee discussion is below:

- While members were wary of going back to institutionalized care, they see the importance of being able to fund services in IMDs, which has proved beneficial in counties participating in the Drug Medi-Cal Organized Delivery System.
- Other members were against removing the exclusion entirely due to regulation concerns and worry that IMDs will not be reactive to trends and innovations in care for the mental health population.
- Members discussed potentially piloting lifting the exclusion with heavy regulation at the plan level and addressing issues with length of stay concerns by placing that decision to the plans rather than the IMDs.

Regional Model
Mari Cantwell overviewed two potential changes to the current county-based managed care model: regional rate setting and regional plans. Committee members spoke to the pros and cons of the regional model, as summarized below:

- Members acknowledge the challenge of county boundaries but in regard to rate setting noted that wide averaging does not work, and there needs to be a strong process for determining regions, rate setting, and accounting for network issues.
- One member suggested that the state look at utilization and the patterns of care to determine rates.

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- Some members advocated for the COHS model because it can carve services in more easily and can be a model for a single payer system.
- There was a suggestion that if the state moves to a regional model, the plan offerings should be standard across the region.

FQHC Payment in Managed Care

Lindy Harrington overviewed the delegation of FQHC PPS payments and responsibility and provided an update on current litigation. Mari Cantwell noted that the department is committed to building relationships with the FQHCs but understands that wraps and reconciliation are difficult and FQHCs are risk adverse. Committee comments are summarized below:

- It was noted that FQHCs are dedicated to their mission of serving the safety net and willing to work with plans but very concerned about losing out on payments if plan is responsible for PPS rate and not the state. Encouraged the state to consider a plan similar to Oregon's ACOs, and begin the APM process without risk.
- There may be an opportunity to increase incentives or move toward pay for performance.
- Health plans wanted the state to be aware of the extra administrative burden they would take on in managing PPS payments, though they are willing to think through this challenge.

The last of the Care Coordination Advisory Committee meetings will be Monday, October 29th and will focus on benefits, including carve-outs.