CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

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California Department of Health Care Services
Director's Office
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Subject: 1115 Waiver Plan-Provider Incentive Strategies and Options

Dear Ms. Soe:

The California Academy of Family Physicians (CAFP), representing nearly 9,000 family physicians and medical students in the state, thanks you for your commitment to renewing the Section 1115 Medicaid Waiver and for making Plan-Provider Incentives a priority in this renewal effort. We appreciate the opportunity to work with the California Department of Health Care Services (DHCS) and offer the following comments.

At the outset, CAFP urges the state to consider the effect of depressed payment rates in the expanded Medi-Cal program. We understand DHCS's goals for health plan and provider incentives in the Waiver: improving the health of Californians, enhancing quality, improving the patient care experience and reducing costs. For the state to realize these goals, Medi-Cal beneficiaries must have adequate, timely access to health care providers; access that is jeopardized by the recent end of the Medicare-Medicaid Primary Care Payment Parity and the cuts enacted by Assembly Bill 97 of 2011.

CAFP joins the California Medical Association (CMA) in advocating for an independent assessment of Medi-Cal payment rates. An analysis of baseline rates is a necessary antecedent to the development of an effective incentive payment program. In the approval of the extension of the State of Florida's 1115 Medicaid Waiver, the Center for Medicare and Medicaid Services (CMS) required the commissioning of an independent report to "review the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the state's funding mechanisms for these payments." We encourage California to do the same.

CAFP supports two proposals described in the "1115 Waiver Workgroup on Plan-Provider Incentives: Straw Proposal Matrix" developed by the Center for Health Care Strategies and the Integrated Healthcare Association: Pay-for-Performance for Medi-Cal Providers (Straw Proposal 3) and Shared Savings for Physical and Behavioral Health Providers for Team-Based Care (Straw Proposal 6). We believe these proposals hold the most promise to achieve quality and patient satisfaction metrics and costs savings in the short- and long-term.

Pay-for-Performance for Medi-Cal Providers

CAFP supports DHCS in its goal of building on the approaches and successes of the existing 2010 Waiver as California moves forward with expanding and improving the Medi-Cal program through delivery system and payment transformation. A major focus of the 2010 Waiver was expanding Medi-Cal eligibility. California must now make a concerted effort to ensure the millions of new Medi-Cal

beneficiaries have access to care. With that in mind, CAFP urges the state to design a pay-for-performance program that encourages provider participation. Specifically, we ask the state to (1) work with providers in the design and implementation of the program; (2) reduce administrative burdens associated with such a program; (3) avoid penalizing providers who participate in the program; and (4) manage Medi-Cal providers' performance data with care.

The state, health plans and providers need to collaborate in the design of a pay-for-performance program. Initiatives that do not include providers in their design encounter more hurdles and are less successful than those that have providers' buy-in and support. CAFP urges substantial physician involvement in determining appropriate values to be assigned to payment for various physician services. Collaboration with physicians should occur at every stage of decision-making, implementation and evaluation, including the development and ongoing utilization of measures, determining data sources used for evaluation and attribution of patients with multiple care providers.

The administrative burden of pay-for-performance programs can be significant, particularly as providers are now regularly juggling requirements for multiple pay-for-performance and reporting programs. To reduce this burden, the state should develop a core set of measures for all plans and use this opportunity to encourage consistency in pay-for-performance measures across commercial and public payers.

Performance payments should be financed with new or supplemental funds, with no reduction in existing payments to physicians. Those providers who choose to participate in an incentive program but do not meet stated metrics should be offered technical support to help them reach their goals, not penalized financially. Payments should be sufficient to cover administrative costs as well as encourage participation.

Pay-for-performance programs should improve the physician-patient relationship and the quality of patient care. The data must be accurate, fair and reliable and analyzed using a consistent and scientifically valid methodology. Data should track specific performance measures, chosen to reflect real-world patient care and should have physician involvement in their selection. Suitable mechanisms for physicians to update and correct inaccurate data should be available. In assessing attainment of quality measures, physicians should be compared to their own progress as well as across specialty.

CAFP also encourages DHCS to require plans participating in pay-for-performance programs to notify the patients affected, provide related self-care information and reinforce patient responsibilities in achieving the desired health outcomes.

Shared Savings for Physical and Behavioral Health Providers for Team-Based Care

CAFP is a long-standing advocate for the Patient Centered Medical Home (PCMH) model of care. We support the increased integration of behavioral health into primary care PCMH practices, as we think this is an evidence-based approach to improving patients' overall health and quality of care while reducing costs. We recognize and appreciate variation in the PCMH model related to the significant diversity in the delivery of and payment for health care. One fundamental principle of the PCMH, however, born out in a significant body of research, is that the model is based in primary care practices and clinics. Research shows primary care practices and clinics have some inherent strengths when it comes to care management, coordination and, not surprisingly, delivering primary care. With this research as background, we support the proposed model that is based in primary care practices or clinics.

CAFP strongly supports the incentive approach of a supplemental capitation payment and quality incentive or shared savings payment. We have seen tremendous success, measured in terms of quality metrics, patient satisfaction metrics and cost savings, in a PCMH Pilot in Fresno, California. The Fresno PCMH Pilot used a blended payment model that looks very similar to the incentive approach outlined in this straw proposal, with a monthly capitated payment to support care coordination and a bonus payment for achieving quality metrics and cost savings. In an 18-month pilot period in which the payer invested $450,000, we saw more than $2 million in savings from reduced hospitalizations and prescription costs. A report on the Pilot can be accessed here: http://www.familydocs.org/f/FresnoPCMHPilotReport2014.pdf

While CAFP fully supports the incentive approach to further support Medi-Cal beneficiaries with behavioral health needs, we would encourage the state to consider the same incentive approach for patients with multiple chronic illnesses. We think great strides could be made in patient health, quality improvement and cost savings for patients with multiple chronic illnesses by offering providers a supplemental capitation payment based on their level of care coordination and integration and a quality incentive or shared savings payment. The state should consider CMS's new care coordination program beginning in January 2015. CMS is paying physicians a monthly fee of $42 to coordinate the care of beneficiaries with two or more chronic diseases. CAFP encourages the state to consider testing a similar model in the Medi-Cal program through the Waiver.

CAFP agrees with the "tiered" approach outlined in the straw proposal, as it allows providers with different capabilities and resources to participate and develop some level of care coordination and integration. In our experience, primary care practices and clinics are coming at this from different places. With this in mind, we would also encourage the state to use the Waiver to create technical assistance for primary care practices and clinics that want to better integrate behavioral health services and increase care coordination, use of interventions and assessments.

Conclusion

Quality care, access to care and positive health outcomes must be the primary goals of any incentive payment program. Both public and private payers recognize the importance of experimentation with physician payment methodologies that incentivize medical practices to expand the provision of preventive services, improve clinical outcomes and enhance patient safety and satisfaction. These pay-for-performance programs have the potential to improve use of evidence-based clinical guidelines, access to care and administrative and clinical best practices. A multitude of organizational, technical, legal and ethical challenges arise, however, in the design and implementation of these programs. The unique partnership embodied in the doctor-patient relationship must be preserved. The value of prevention, health maintenance, early diagnosis and early treatment, with appropriate incentives to the patient and to the physician must be recognized.

Sincerely,

Del Morris, MD
President, California Academy of Family Physicians