CHCS Center for Health Care Strategies, Inc.

IHA INTEGRATED HEALTHCARE ASSOCIATION

1115 WAIVER WORKGROUP ON PLAN-PROVIDER INCENTIVES: STRAW PROPOSAL MATRIX

GOAL #1: Improve patient care, improve health outcomes and reduce the total cost of care (TCOC) 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	Target Population	Target Providers	Incentive Approach	Quality Approach	Desired Outcome(s)	DHCS Role	Examples
Straw Proposal 1: Payment Reform Contractual Accountability for Medi-Cal Plans - Contractual accountability for plans to implement payment reforms from a menu of options	All Medi-Cal managed care members	Negotiated percentage of the health plan's provider network	Plans receive incentive payment if they make a specified % of provider payments through an approved alternative payment methodology	Must meet minimum threshold on specified quality and cost measures (e.g. E.D. utilization, readmissions)	Improved quality and reduction in slower growth of per capita expenditures	• Monitor compliance with initiative • Provide support to MCOs (data analytics, collaboration on provider incentives) • Create stakeholder process to discuss innovative payment strategies	▪ South Carolina: Value Oriented Contracting ▪ Arizona: Acute Care Program Payment Reform Incentive
Straw Proposal 2: Shared Savings for Medi-Cal Managed Care & Behavioral Health Entities - A shared savings program for MMC plans and county behavioral health entities to jointly promote care integration and better outcomes for adults who meet medical necessity criteria for Medi-Cal Specialty Mental Health Services or Drug Medi-Cal Substance Abuse services.	Adults who meet medical necessity criteria for Medi-Cal Specialty Mental Health Services and/or Drug Medi-Cal Services	N/A	▪ State-funded joint incentive pool for MCPs and counties for shared outcome measures; potential to transition to shared savings model over time ▪ New rate setting strategy	Jointly developed and integrated data collection and reporting process, integrated care plans; outcome measures tied to different incentive amounts	Integrated care plans, improved medication data sharing and adherence, reduced emergency department visits	▪ Fund the initial incentive pool ▪ Develop performance measures, specifications, and benchmarks ▪ Outline methodology for MCP payments to counties ▪ Determine the methodology for transition to shared savings	▪ Pennsylvania Serious Mental Illness Innovation pilot project ▪ Medicare Advance Payment Accountable Care Organization (ACO) Model
Straw Proposal 3: P4P for Medi-Cal Providers - Each plan would adopt a P4P program that meets requirements (e.g. a core set of standard measures, minimum payout), with flexibility for tailoring to local area. The program would include support for plans in design and implementation and support for providers in participating.	All Medi-Cal managed care members	Primary Care Physicians; Specialists and other providers optional	A core set of measures for all plans to adopt with flexibility to tailor to local needs; ability to tailor incentive approach to sophistication of contracted providers that meets minimum payout requirement	Provider incentive based on performance against and/or improvement on a set of core quality measures	▪ Maximize P4P programs' effectiveness with increased standardization and reduced burden/duplication ▪ Improve quality and moderate cost trend	▪ Contractually require each plan to adopt P4P program that meets core elements ▪ Development of tools/resources to support plans ▪ Monitor, revise and improve programs	Most MMC plans have a P4P program. Examples include: ▪ Partnership Health Plan Primary Care Quality Improvement Program ▪ Inland Empire Health Plan P4P Program

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Straw Proposal 4: Behavioral Health P4P for Medi-Cal Providers - Each plan would adopt a P4P program focused on care for patients with depression. The program would support plans in design and implementation and support providers in participating.	Medi-Cal Managed Care members with depression	Primary care practices, care managers, consulting psychiatrist	PMPM payment for depression management	50% of payment tied to meeting quality metrics	Improved Patient Health Questionnaire 9; lower total cost of care	▪ Contractually require each plan to adopt P4P program focused on care for patients with depression ▪ Funding for practice training in the care model	▪ IMPACT model of depression management ▪ Minnesota DIAMOND initiative
Straw Proposal 5: Shared Savings for Medi-Cal Providers - Each plan would implement a total cost of care target with shared savings between plans and providers for the difference between actual and targeted costs. Approach can be tailored to level of provider sophistication, e.g. plans can support small practices in rural areas by supplying data and analytics.	Managed care members (emphasis on high cost patients and patients with 2+ chronic conditions)	Range of providers, including both large groups that take risk, and small providers whose results can be pooled for reliability	Total cost of care target with shared savings for difference between actual and target costs; methods for shared savings can be modified depending on the size and sophistication of provider and local market	Quality targets must be reached in order for providers to be eligible for share for savings	▪ Increased care coordination ▪ More collaboration between provider groups and hospitals ▪ Lower overall cost per patient alongside quality improvement	▪ Contractually require each plan to adopt TTC target with shared savings between plans and providers ▪ Authorization/ issuance of clear guidance that gain sharing is legal	Plans (e.g. Blue Shield of California, Anthem Blue Cross) and provider organizations (e.g. AltaMed) are negotiating contracts with some or all of these features across the state
Straw Proposal 6: Shared Savings for Physical & Behavioral Health Providers for Team-Based Care - Each plans would offer a package of payment reforms based on tiers of increasing physical-behavioral health coordination and co-location to ensure that team-based care is provided to highest-cost/need beneficiaries (including those with SMI; lower-intensity version for M&M MI). Could be led by plan or provider depending on provider sophistication. Savings shared between plan and physical / behavioral health providers.	**Model B:** Patients with mild/moderate BH needs	Primary care practices + social worker or therapist. Plan or provider-led.	Supplemental capitation payment + shared savings between MCOs/BH providers (model A) and MCOs/PCPs (model B) + P4P.	Three tiered levels tied to integration, beginning with payment for health home coordination services through comprehensive BH care co-located in primary care practice	Lower total cost of care; improved BH metrics; care team collaboration across systems	▪ Contractually require each plan to offer a package of reforms based on tiers of physical-behavioral health coordination and co-location ▪ Funding for learning collaborative of participating practices ▪ Oversight of State's Health Homes for Complex Patients/2703	Massachusetts Primary Care Payment Reform
	Model A: Adults who meet medical necessity criteria for Medi-Cal Specialty Mental Health	Behavioral health providers/clinics; nurses and/or nurse practitioners. Plan or provider-led.		Three tiered levels tied to integration, beginning with payment for health home coordination services through comprehensive PC co-located in BH clinic			Arizona Mercy Maricopa Integrated Care

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Straw Proposal 7: Shared Savings for Medi-Cal Managed Care Plans - A shared savings program between DHCS and MMC plans based on quality and resource use or total cost of care.	All Medi-Cal managed care members	N/A	▪ Resource use or total cost of care target with shared savings for difference between actual and target cost ▪ New rate setting strategy	Quality targets must be reached in order for plans to be eligible for share for savings	▪ Increased care management/ coordination to reduce avoidable utilization ▪ Lower overall TCC alongside quality improvement	▪ Develop performance measures, specifications, and benchmarks ▪ Determine expected costs for shared savings benchmark ▪ Collect, validate, report results ▪ Provide support to MMC plans ▪ Distribute savings to plans	▪ IHA Value Based P4P ▪ Utah 1915(b) waiver modification
Straw Proposal 8: Value based payment for Maternity Services in Fee-for-Service Medi-Cal – A financial incentive program for maternity care services in FFS Medi-Cal.	Pregnant women in FFS Medi-Cal	Obstetricians and private safety net hospitals	The following two value based payment options for maternity care in FFS Medi-Cal could be implemented as one package or separately. 1. Hospital quality incentive program (QHIP) – A DSRIP-like program for private hospitals that ties bonus payments to improvement in maternity care 2. Prior Authorization ("hard stop") – Requires physicians to receive authorization from the chief of obstetrics for a scheduled delivery before 39 weeks.	Provider incentive based on performance against and/or improvement on a set of core measures in CalSIM Maternity Care initiative	▪ Promote healthy, evidence based obstetrical care and improve quality ▪ Reduce unnecessary costs related to medically unnecessary cesareans ▪ Create statewide reductions in EEDs	QHIP: ▪ Develop QHIP incentive design and program structure ▪ Contractually require FFS providers to participate in quality incentive program Hard Stop: ▪ Review approval of Treatment Authorization Requests (TARs) to determine implementation feasibility ▪ State legislation to require prior authorization ▪ Contractually require FFS providers to receive prior authorization for elective deliveries	QHIP Example: Washington State: Medicaid Quality Incentive Program with EED focus Hard Stop Policy Examples: South Carolina, Texas, Oklahoma, Tennessee