

Straw Proposal 2: Shared Savings for Medi-Cal Managed Care & County Behavioral Health Entities

Proposed Approach – 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.

Target Population – Adults who meet medical necessity criteria for Medi-Cal Specialty Mental Health Services or Drug Medi-Cal Substance Abuse

Target Providers – N/A

Incentive Approach – Dollars from the incentive pool would be allocated to MCPs and county entities based on performance on measures that MCPs and county entities can jointly influence by improving care coordination and collaboration and eventually patient outcomes across both programs. The key components of the program would include:

1. Incentive pool: DHCS fully funds initial pool, to be distributed to MCPs and county partners for jointly achieving shared outcome measures. Incentive pool funding could shift to an advance payment model after one or more years whereby MCPs would receive advance payments as part of their incentive payment that would be repaid to the state from the future shared savings they earn.
2. Incentive distribution: DHCS would distribute incentive payments to MCPs based on health plan performance across jointly-influenced metrics. MCPs would provide an incentive payment to county plans or agencies, similar to how funds flow from plans to counties under Cal MediConnect. Incentives could be structured to focus initially on process measures; percentage of payment tied to outcomes would increase annually until all incentive payments reflect outcomes.

Quality Approach – State would define performance measures and methodology for distributing earned incentives. Example process measures could focus on measurable activities that demonstrate evidence of collaborative processes and requirements as laid out in MOUs. Joint outcome targets could include reductions in ED use and admissions, medication management protocols and community supports and social outcomes. Metrics could include (but not be limited to) shared accountability measures required under Cal MediConnect.

Desired Outcome – Integrated care plans and other evidence of improved collaboration, improved medication adherence, reduced emergency department visits.

Alignment with other DHCS Initiatives – Cal MediConnect

Role of DHCS – DHCS would fund the initial incentive pool; develop performance measures, specifications, and benchmarks; outline methodology for MCP payments to counties; and determine the methodology for transition from a fully-funded incentive pool to a partial shared-savings arrangement with advance payments to entities.

Examples:

- Pennsylvania Serious Mental Illness Innovation pilot project – Expanded requirements for coordination across health plans and local county agencies to provide seamless access to specialty behavioral health services. Final evaluation report: <http://www.chcs.org/media/Mathematica-RCP-FinalReport-2012.pdf>
- Medicare Advance Payment Accountable Care Organization (ACO) Model – an initiative designed for organizations participating as ACOs in in the Shared Savings Program by which selected participants will receive advance payments that will be recouped from the shared savings they earn. <http://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model/index.html>

Straw Proposal 6: Shared Savings for Physical & Behavioral Health Providers for Team-Based Care

Proposed Approach – Each Medi-Cal managed care plan would offer a package of payment reforms based on tiers of increasing physical health-behavioral health coordination and co-location to ensure that team-based care is provided to beneficiaries with mild/moderate mental health needs as well as highest-cost/need beneficiaries

Target Population

- *Model A:* Individuals with mild to moderate behavioral health needs
- *Model B:* Individuals with specialty treatment behavioral health needs

Target Providers

- *Model A:* Primary care practices acting as the “provider of choice” for patients with behavioral health needs
- *Model B:* Behavioral health providers/clinics acting as the “provider of choice” for patients with severe mental illness that coordinate with primary care practices and/or employ nurses and/or nurse practitioners.

Incentive Approach

- Providers receive supplemental capitation payment based on their “tier”; i.e., level of care coordination and integration. Payment increases by tier. Multiple tiers allow for providers with different infrastructure capabilities and other resource levels to engage in some form of care coordination/integration.

Tier	Model A: Primary care practice, FQHC	Model B: Behavioral health provider, CMHC
1	Care coordination of BH services with primary care, either as a designated health home (and receive health home payment) or in line with PCMH care coordination principles	Care coordination of BH services with primary care, either as a designated health home (and receive health home payment) or in line with PCMH care coordination principles
2	Brief interventions, screening/ assessment/triage, consultations, outpatient BH services by master’s/ bachelor’s level professional (e.g. social worker, clinical psychologist) onsite	Basic primary care screening and assessments (e.g., BMI, blood pressure, diabetes, etc.), medication reviews, referrals for lab and diagnostic tests. Nurse professional on-site
3	Psychiatric assessments, medication management, psychotherapy by prescribing clinicians and psychotherapists onsite	Comprehensive primary care by nurse practitioner or PCP onsite, medication management by prescribing provider

- Add-on quality incentive payment for meeting performance benchmarks related to desired outcomes below
- Shared savings for primary provider organization in Models A or B
 - Calculations would be based on savings from non-capitated spend, including hospital, pharmacy, and specialist services

- Can be structured to include upside risk only, upside transitioning to downside, or upside and downside risk depending upon the capabilities of the provider organization. Shared savings model would align with straw proposal #6

Quality Approach – Higher payments to groups with coordinated or co-located models and that achieve quality outcomes targets. Shared savings create incentives to ensure high-quality behavioral health or physical health care in respective settings.

Desired Outcomes

- Lower overall total cost of care per patient
- Improved overall metrics, focused on Health Home quality indicators, reduction in emergency department visits and readmission among individuals with behavioral health needs
- Increase care team collaboration and shared electronic records across systems
- *Model A:* Improvements in physical health indicators among individuals with serious mental illness
- *Model B:* Lower PHQ-9 scores and other BH metrics

Alignment with other DHCS Initiatives – Complements State’s HH for Complex Patients/2703 and PCMH; can also dovetail with shared savings models developed for providers under Model #6

Role of DHCS

- DHCS would contractually require each plan to offer a package of reforms based on tiers of physical and behavioral health coordination and co-location
- Funding for learning collaborative of participating practices
- Oversight of State’s HH for Complex Patients/2703

Examples

- Massachusetts Primary Care Payment Reform (1115 waiver available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf>)
- Arizona Mercy Maricopa Integrated Care (<http://mercymaricopa.org/>; provider resources at: <http://mercymaricopa.org/providers/resources/>)