

CAPG's Proposal to Pilot an "Accountable Community for Health"

California's goals for its new waiver are to:

- (1) Strengthen primary care delivery and access;
- (2) Avoid unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency;
- (3) Address social determinants of health; and
- (4) Use California's sophisticated Medicaid program as an incubator to test innovative approaches to whole person care.

California's backbone for organized delivery systems in MediCal Managed Care (MMC) is the "Delegated Model" of clinically integrated care. Pursuant to the Delegated Model, physician groups:

- Assume responsibility for clinically integrated, comprehensive, and coordinated healthcare; and
- Comprise the largest component of the MMC delivery system, serving over 6 million Medi-Cal beneficiaries and almost one million dually eligible Medi-Cal - Medicare beneficiaries across this state.

Many states have followed California's 2010 DSRIP Program with broader delivery system model demonstrations to integrate safety net providers to build a more comprehensive delivery system, while transitioning these critical providers into accountable, risk-based payment systems. CAPG is one of the country's leading organizations providing support and advocacy for accountable physician organizations to improve the quality and value of health care provided to patients. CAPG physician groups can help California meet all its goals for integrated care by providing the chassis for such demonstration delivery systems in DSRIP. Specifically, CAPG members can provide three decades of experience in clinically integrated care and significant infrastructure at the financial and care coordination level to broaden the types of providers within an accountable care entity to form a true "accountable community of care."

The following are demonstrable ways in which CAPG physician groups can support California's goals:

- CAPG physician groups can accept full-risk capitation for both professional and institutional risk, creating an entity that can provide maximum accountability and cost containment. Further, many such groups already have limited and restricted Knox Keene licenses. These entities can provide an infrastructure of proven cost accountability.
- CAPG physician groups have subcontracted with HMOs for several decades and have existing contracts within the -MMC plans throughout California.
- CAPG physician groups have been monitored for financial solvency compliance by the DMHC for over a decade.
- CAPG physician groups participating in the Integrated Healthcare Association Pay-for-Performance and the Medicare Advantage 5-STAR program have the administrative capacity to collect and report performance data to provide accountability for quality.
- The "Delegated Model" has for decades incorporated the capacity to pay downstream provider claims, which is unique among delivery systems in the 50 states. Delegated model entities can organize and pay downstream providers in several methodologies, from fee-for-service, to bundled payment, to shared-risk arrangements like sub-capitation, and also have experience in federal shared-savings ACO payment models.

Many “provider” silos interfere with a more efficient and cost-accountable delivery system for MediCal beneficiaries. CAPG proposes to use its members’ infrastructure to organize multiple demonstration projects in provider-underserved regions across California that would utilize the demonstrable experience, success, and organizational capacity of its member groups to create a broader “accountable community for health” demonstration that incorporated local safety net providers, including physicians, clinics, hospitals and skilled nursing facilities. Many of these other entities do not know how to function in a risk-bearing payment environment.

By creating a fully-capitated entity that functions like an ACO, CAPG physician groups could provide the claims and care coordination management infrastructure to organize a community of safety net providers and teach the providers over time to function under a risk-bearing, accountable payment model. For example, a demonstration project could include the creation of an “Accountable Community for Health” that sets milestones and includes the formation of the entity across a broad spectrum of medical and social services safety net providers; this entity could be contracted to an existing MCO in a county or across counties. In the first year, the “Accountable Community for Health” could be paid full-risk capitation, but downstream participants in the entity could be paid under a variety of other payment models and then transitioned during the life of the DSRIP demonstration to risk-based payment.

The goal would be to start with a fragmented, siloed delivery system and then build an “Accountable Community for Health” operating under a risk-based payment model, collecting and reporting performance data in an organized and efficient manner, meeting milestones for increase care coordination across the entire spectrum of medical and social services care delivery, while delivering this care under a set budget and meeting pre-determined quality and performance standards.

Current System	Proposed
<ul style="list-style-type: none"> • DHCS contracts with MMC Plan • DHCS sets criteria for subcontracting • MMC Plan contracts with providers 	<ul style="list-style-type: none"> • DHCS contracts with MMC Plan • DHCS sets expectations for accountable payment model and range of payment models for the accountable payment model • MMC plan contracts with “Accountable Community for Health” using variety payment models