CHCS Center for Health Care Strategies, Inc.

IHA INTEGRATED HEALTHCARE ASSOCIATION

Straw Proposal 7: Shared Savings for Medi-Cal Managed Care Plans

Proposed Approach –A shared savings model between DHCS and MMC plans based on improving quality and reducing the total cost of care. To reward investments in better care management and create a financial incentive for continuous improvement, rates are not rebased for plans that appropriately reduce utilization over the 5-year period.

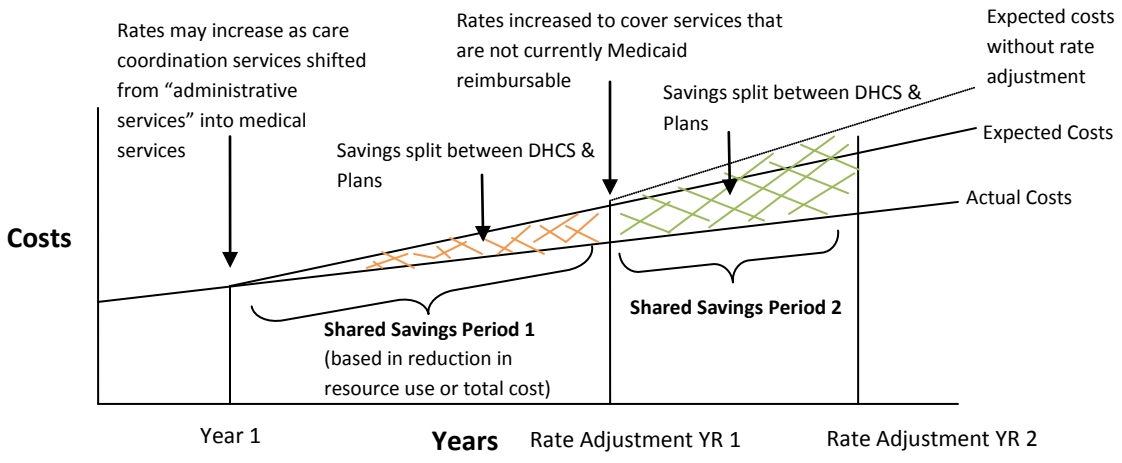
Target Population – All Medi-Cal managed care members

Target Providers – N/A

Incentive Approach – Any savings generated would be shared between MMC plans and DHCS (savings split with CMS).

Shared savings calculation and distribution: If the plan meets quality targets, shared savings would be based on performance on resource use or total cost of care – the difference between expected and actual costs, determined prior to the measurement period. Resource use measures could include: inpatient utilization (acute care discharges, bed days), inpatient readmissions (HEDIS-based all cause), emergency department visits, outpatient utilization (% of preferred facilities), generic prescribing and cesarean section rate for low-risk births. Savings would be distributed to the plans annually.

Rates: The new rate-setting process would create a financial incentive for plans to invest in better care management/coordination without being penalized with lower rates based on reduced utilization. Under the new process, when rates are re-determined, they would not be rebased according to the lower level of utilization. Instead, the rates would be based on the expected costs that would have resulted if the plans had not reduced resource use. Plans will be required to demonstrate that utilization reduction is not due to inappropriate denial of services to the Medi-Cal beneficiaries. In addition, and if applicable and necessary, care coordination services would shift from the administrative category into the medical services category for rate-setting purposes. DHCS would also identify a menu of non-Medicaid reimbursable goods and services (e.g. housing) to be counted in each plan's Medicaid utilization rate development process. CMS would have to approve such services as reimbursable for the purposes of rate setting. The timeline and structure of the new shared savings proposal is detailed below:



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Quality Approach – Quality targets must be met in order for plans to be eligible for shared savings. Plan performance can be scored on attainment, improvement between years, or a combination.

Desired Outcome –

- Increased care management/coordination to reduce avoidable healthcare utilization
- Lower overall TCC per patient while improving quality.

Alignment with other DHCS Initiatives – N/A

Role of DHCS –

- Develop performance measures, specifications, and benchmarks
- Determine expected costs for shared savings benchmark.
- Collect, validate, report results
- Provide support to MMC plans (e.g. data analytics and collaboration on provider initiatives)
- Distribute shared savings payments to health plans

Examples:

IHA Value Based P4P

- IHA's Value Based P4P program features shared savings based on resource use, with "gates" for quality and total cost of care trend. The key design elements are:
    - In order to be eligible to receive an incentive, physician organizations must first meet a minimum level of quality and not exceed a total cost of care trend.
    - Each physician organization's quality performance is scored for attainment and improvement, and an overall score out of 100 is determined
    - The shared savings calculation is then determined and based on year-over-year improvement on the resource use measures
    - In order ensure quality remains a key focus area, the shared savings amount is adjusted based on the Quality composite score

Other States:

- Utah amended an existing state Section 1915(b) waiver to modify three MCO contracts with ACO contracts. The state pays the plans a monthly risk-adjusted capitated payment to the plans, which are allowed flexibility to implement alternative payment arrangements among their providers. The state committed to keeping baseline reimbursement levels intact so that plans would not be adversely affected by implementing reforms, and factored this consideration into its rate setting process.