

California succeeded in enrolling 1.4 million in Covered California plans and 2.2 million in Medi-Cal during the first year of the ACA coverage expansions. As we redouble our efforts to enroll all eligible individuals, California must be sure to deliver on the promise of accessible, high-quality health care. This challenge will be particularly pressing for Medi-Cal managed care (MMC) plans with their robust enrollment in the last year. Ultimately, now that we have covered so many who were previously unable to get insurance, health plans should increasingly strive toward a more difficult and important goal: better health outcomes.

To realize better health outcomes, Medi-Cal managed care plans have many challenges to confront. Plans must tackle the tasks of ensuring that provider networks are of sufficient size, coordinated, high performing in service quality, and engaging patients to be critical partners in improving their health. These achievements require a great deal of investment and the right incentives to maintain systems in the longer term.

Health plans, providers, and the California Department of Health Care Services (DHCS) are implementing new policies and systems in service of these aims. These innovations and advancements are particularly important for many newly eligible beneficiaries who have a different health profile and care needs than previously eligible beneficiaries. Health plans are addressing these challenges in a variety of different ways, which depend on their local managed care environment, provider networks, and service delivery models. This paper highlights some of these efforts across the state, with a focus on successes that different organizations have seen and what promise they might hold in the future.

For this project, we interviewed a range of stakeholders from health plans, providers, independent practice associations (IPAs), community clinics, and county health departments. Their opinions and expertise were compiled in the following paper and considered in our recommendations.

ITUP recommends that:

1. DHCS take on a more active oversight role
2. DHCS and MMC plans standardize data collection and increase transparency in performance reporting to the public and to providers
3. DHCS serve as an assertive facilitator and promoter of innovative best practices in value-based payment and delivery system reform
4. MMCs expand member engagement programs to reach new managed care populations
5. DHCS develop mental health and substance use disorder services quality performance metrics
6. All safety net delivery systems use the §1115 waiver to coordinate managed care with carved out services, with the aim of integrating delivery systems as soon as possible
7. MMCs include carved out providers in risk and shared savings programs

Background

There are six models of Medi-Cal managed care, which vary by county, although the vast majority of counties utilize two-plan, regional, or County Organized Health System (COHS) structures.¹ The primary distinctions between models are the number and type (public or

¹ For a breakdown of Medi-Cal managed care models by county, see DHCS' map at http://www.dhcs.ca.gov/services/Documents/MMCD_County_Map.pdf

commercial) of plans available. Under the COHS model, nearly all Medi-Cal members are enrolled in the same health plan, which is operated by a public, county-appointed agency. Examples include CalOptima in Orange, Central California Alliance for Health in the central coastal counties, and Partnership Health Plan in the rural north. In the two-plan model, members can choose between a public county-appointed Local Initiative or a commercial plan (e.g., Inland Empire Health Plan and Molina Healthcare in Riverside and San Bernardino). Under the regional, geographic, Imperial, and San Benito models, members may select from a ranging number of commercial health plans (just one in San Benito and five in San Diego). Members in some counties have additional plan choices through subcontracted plan partners (e.g., Kaiser Permanente, Care1st, and Anthem Blue Cross are subcontractors of L.A. Care Health Plan).

Medi-Cal Managed Care Models			
Model	Plans Available	# of Members (8/2014)	Counties
<i>County Organized Health System</i>	One public plan created by the County	1.78 million	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Mateo, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, Yolo
<i>Two-Plan</i>	One public plan and one commercial plan	5.13 million	Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare
<i>Regional</i>	Two commercial plans	215,000	Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba
<i>Geographic Managed Care</i>	Multiple commercial plans	818,000	Sacramento, San Diego
<i>Imperial</i>	Two commercial plans	52,000	Imperial
<i>San Benito</i>	One commercial plan	6,000	San Benito

Sources: Department of Health Care Services (2014). *Medi-Cal Managed Care Program Fact Sheet – Managed Care Models*. Retrieved from <http://www.dhcs.ca.gov/provgovpart/Documents/MMCDModelFactSheet.pdf>

Department of Health Care Services (2014). *Medi-Cal Managed Care Enrollment Report – August 2014*. Retrieved from http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCDEnrollRptAug2014.pdf

Member Population

As of July 2014, 77% of Medi-Cal members were enrolled in managed care plans.² The number and proportion of Medi-Cal members enrolled in managed care has increased significantly in

² Department of Health Care Services. 2014. *Medi-Cal Managed Care Program Fact Sheet – Managed Care Models*. Available at: <http://www.dhcs.ca.gov/provgovpart/Documents/MMCDModelFactSheet.pdf>

recent years, given the transitions of Healthy Families children, seniors and persons with disabilities, and rural counties into Medi-Cal managed care, along with the Medi-Cal expansion and creation of Cal MediConnect. This has created challenges for plans, as the member population has shifted from relatively healthy children and parents to a diverse group with varied health needs. Plans are continuing to alter strategies to serve these new groups, and some outcomes have improved as both the plans and the new members adjust to the transition.³

Delegation

Plan administration varies by county and plan. In some regions, including many COHS counties, plans take on all administrative responsibilities, including contracting with providers, engaging members, referring members to specialists, and processing and paying claims. Other plans use

Independent Practice Association (IPA) – an organization of providers that collectively negotiate with health plans. In managed care, they are usually responsible for referrals and may take on financial risk.

variations of “delegated” models, in which the primary plan contracts with outside entities, including other plans and independent practice associations (IPAs), to conduct much of the plan’s core duties. Plans utilizing subcontractors must oversee their efforts, ensuring that regulations around provider networks and other obligations are met, and subcontractors are subject to audits from the parent plan, although there is some debate about the adequacy of oversight.

In addition to delegating administrative responsibilities, IPAs and plan subcontractors typically take on some of the financial risk of each assigned member, generally for medically necessary primary and specialty care. IPAs receive a monthly capitated rate for each member (PMPM), which varies by aid code, and sometimes

demographic factors like age, sex, and ethnicity) from the plan, which is then paid to primary care providers based on contracts with the IPAs, with a portion withheld for administrative costs and specialty care. Plans and IPAs compensate specialists in different ways, with some paying fee-for-service and others capitation, along with a few intricate cost-sharing models (detailed later).

Challenges to delegation include the difficulty of getting encounter data from providers, IPAs, and subcontractors, increased administrative costs, and efficiency limitations. Opinions of the delegated model greatly vary. Some stakeholders claim IPAs are focused on generating profit and, as a result, hinder patient access to care. Opponents say IPAs are not adequately monitored by plans or the State and that additional regulation and oversight of functions like timely referrals and on-time and correct provider payments is needed.

However, others stress that IPAs are better able to meet quality measures than health plans because they operate as a small provider network capable of targeted improvement efforts. All agreed that the key to successful delegation is appropriate oversight and organization of delegated activities. In larger, urban regions, the task of delivering care may be best achieved through delegation, due to massive administrative workloads.

“Delegation can encourage providers to work together.” – Plan executive

Contracting

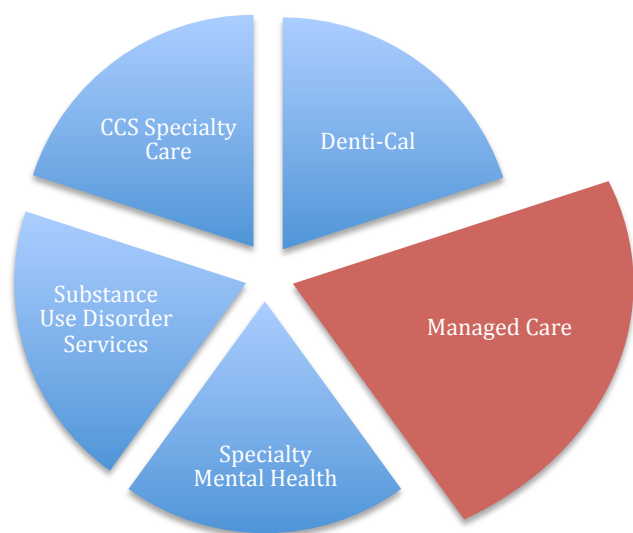
Medi-Cal managed care plans use a variety of strategies in contracting with providers. Some plans utilize “any willing provider” contracts that allow all licensed providers to participate in

³ In a CHCF survey, 83% of SPDs transitioned from fee-for-service to managed care reported that getting an appointment was more challenging through managed care. See Graham C. 2014. *In Transition: Seniors and Persons with Disabilities Reflect on Their Move to Medi-Cal Managed Care*. California HealthCare Foundation. Available at: <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/T/PDF%20TransitionSPDsMoveMMC.pdf>

the networks, while other plans strategically contract with providers and provider groups that achieve quality and/or cost standards. Some plans delegate all contracting to the IPAs, while others contract directly with providers, although this is resource-intensive; many practice both forms of contracting. Some have expressed concerns about adverse selection, claiming IPAs aim to capture the healthiest, lowest cost members, shifting risk for members with health problems to the plans. Some plans have increasingly moved toward direct contracting for a greater share of their networks because they felt that IPAs were not helpful in improving performance, despite the administrative savings of delegating these functions to IPAs. Some plans may favor larger practices and community clinics because they have more resources to prioritize and improve quality compared to solo or small group practices.

Carve Outs

While Medi-Cal managed care plans are responsible for covering and coordinating health care, some services are “carved out” or exempt from managed care but provided to members through other programs. All services provided through California Children’s Services (CCS) therapy to children with specific chronic medical conditions, including cardiovascular diseases, blood



disorders, and various genetic conditions, are carved out from managed care and billed on a fee-for-service basis. Because CCS only covers care related to the qualifying condition, primary care and any conditions not related to the CCS-condition are provided through the MMC plan.

Behavioral health care, including specialty mental health and substance use disorder services, is fragmented between managed care plans and county behavioral health departments, creating challenges for integrated holistic health treatments. Psychological services for less severe disorders (i.e. mild to moderate depression, anxiety, etc.) are provided through Medi-Cal

managed plans and their (often contracted) provider networks, while mental health services for consumers with severe and chronic mental illness are carved out of managed care.⁴ Those with severe mental health issues receive care from the county mental health plans, the capacities of which vary across the state.

In 2014, Medi-Cal managed care plans became responsible for administering the psychological services benefit for mild to moderate mental health disorders. Plans must work with county agencies to establish the difference between mild/moderate and severe (there is no state definition) and provide consumers with a “warm handoff” when transitioning clients between the delivery systems. Additionally, all treatment for substance use disorders, with the exception of SBIRT for alcohol,⁵ is carved out from managed care. The range of drug and alcohol treatment services are divided between the county-administered Drug Medi-Cal program and through fee-

⁴ With the exception of San Mateo, where all behavioral health services are provided by the county.

⁵ SBIRT refers to “Screening, Brief Intervention, and Referral to Treatment.”

for-service Medi-Cal.⁶

Dental services are carved out of managed care and administered by DHCS through the Denti-Cal program, billed on a fee-for-service basis. In Sacramento and Los Angeles counties, dental services are delivered through dental managed care plans that operate independently of medical managed care.

The various carve outs have posed difficulties in managing care for members. Generally, there is little to no care coordination, communication between differing provider networks, or data sharing between administrators of carved out services and managed care plans. This has somewhat improved with the specialty mental health carve out, as plans were required to establish memorandums of understanding (MOUs) with county mental health agencies to navigate the grey area between mild/moderate and severe mental health conditions; however, it is too early to evaluate the success of the coordination. Some plans are working broadly to expand coordination between various providers, as detailed in the Quality section below, but financial incentives to do so are needed.

While some have called for carved out services to be integrated into managed care, these services have remained carved out in part because managed care plans may not have the competency to deliver the specialized services. Specialized agencies were created to focus on the complex or traditionally siloed health conditions (such as mental health and dental) under the assumption that they would be better suited to develop the specialized provider networks and assess medical necessity. Based on the challenging experience of managed care plans taking on the seniors and persons with disabilities population in 2011, if the State were to integrate carved out services into managed care, the plans would need extensive data on patient needs and time to establish adequate networks before the benefits could be integrated.⁷

Quality and Payment

How Does California Currently Measure Quality?

DHCS tracks and reports Medi-Cal managed care plans' quality performance through a quarterly "dashboard." The dashboard includes aggregated Healthcare Effectiveness Data and Information Set (HEDIS) scores, which were developed by the National Committee for Quality Assurance (NCQA). To gauge enrollees' satisfaction with their plans, DHCS uses Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores.^{8, 9} Both of these measures are important nationally recognized benchmarks of delivery of clinically appropriate and patient-centered services.

Plans' HEDIS scores vary considerably, with the most high-performing plans scoring above 90%, while a few plans scored around or below 40%. Similar variation existed on the CAHPS scores, with the highest scoring plans (Kaiser Permanente) receiving a 9 or 10 (out of 10) rating

⁶ For details on Drug Medi-Cal and substance use disorder treatment services, see Connolly J, Pegany V. (2014). *Toward a Better Medi-Cal Substance Use Disorder benefit in California: Smart Investments for Improving Lives*. Insure the Uninsured Project.

⁷ Graham CL. 2013. *Transitioning Beneficiaries with Complex Care Needs to Medicaid Managed Care: Lessons from California*. Kaiser Commission on Medicaid and the Uninsured. Kaiser Family Foundation.

⁸ California Department of Health Care Services. 2014. Quarterly Medi-Cal Managed Care Performance Dashboard, August 2014. Available at:

http://www.dhcs.ca.gov/services/Documents/MMCD/MMCD_Dashboard_August2014.pdf

⁹ For a more detailed explanation of the DHCS quality measures:

http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/CA2013_HEDIS_Aggregate_Report.pdf

from about 70% and 80% of members for care for adults and children, respectively. By contrast, the lowest-rated plans received a 9 or 10 rating from around 45% and 60% for adults and children, respectively.

MMC plans in two-plan and geographic managed care counties have an added incentive from DHCS to improve their quality scores (and overall costs). These performance scores affect the share of beneficiaries that each plan receives through auto assignment of new enrollees who do not actively select a plan.¹⁰ This system aims to motivate the plans' efforts to improve performance on selected metrics among their provider networks.

The task of including the most appropriate indicators of care quality may become increasingly challenging with the more complex health profiles of many new managed care enrollees. Many health plan leaders felt that DHCS ought to explore the inclusion of other measures of service quality to provide a better assessment of how well plans are meeting the needs of groups new to managed care (e.g., seniors and people with disabilities). Some health plan representatives felt that being at risk for providing care to people who have behavioral health conditions or are homeless should also motivate the inclusion of specific metrics of care for these individuals. For example, new measures might assess coordination of managed care services and data sharing with carved-out services. Some providers also recommended that primary care providers should be rewarded for patient retention rates, as well as prescription medication adherence for children under 13. In general, many stakeholders felt that the number and scope of the metrics reported and incorporated into the dashboard's aggregate performance scores should be much more expansive.

The aggregate HEDIS and CAHPS scores that DHCS uses to rank the plans also lack transparency for Medi-Cal consumers. The scores communicate relatively little to enrollees about the dimensions of care quality that might be important to them, depending on their needs and priorities. Increasing the transparency of plans' performance by reporting the data with greater detail, *and* in a consumer-friendly format should be a priority. It may be difficult to achieve the aims of both providing greater detail and of communicating data in an understandable format. However, consumers who have a choice of plans in GMC and two-plan model counties should have access to this kind of information. And consumers in counties with COHS models should be able to assess how their plans are performing in different areas of quality measurement, relative to other plans across the state.

One area that needs increased measurement and development, both nationally and in the Medi-Cal program, is the improvement, management, coordination, and ultimately, integration of mental health and substance use disorder services.¹¹ The inclusion of quality metrics for mental health services is particularly important now that managed care plans have responsibility for psychological services. Several such metrics related to behavioral health screenings, depression remission, follow-up after hospitalization for mental illness, and timely transmission of health records are already named in DHCS' DSRIP 2.0 §1115 waiver renewal concepts.¹² Both the State and managed care plans should, when appropriate, proactively include measures like these in performance reporting and incentive programs.

¹⁰ California Department of Health Care Services. 2014. *Auto Assignment Incentive Program Overview*. Available at: <http://www.dhcs.ca.gov/provgovpart/Documents/MMCDAutoAssignOrvw.pdf>

¹¹ Institute of Medicine. 2006. *Improving the Quality of Health Care for Mental Health and Substance-Use Conditions*. Available at: <http://www.ncbi.nlm.nih.gov/books/NBK19830/>

¹² California Department of Health Care Services. 2014. *DSRIP 2.0 Concept Paper for Designated Public Hospitals*. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver_Renewal/DSRIP2_DHCS_Concept.pdf

Plans should be particularly motivated to assess the performance of behavioral health services because they are now at financial risk for psychological services. Improving mental health and substance use disorder services for many beneficiaries could measurably reduce their overall health care costs. Some data suggest that 12.5% of all ED visits nationally are attributable to behavioral health conditions.¹³ Studies have also demonstrated that high-quality, evidence-based mental health and SUD services have a considerable impact on inpatient and ED utilization.^{14, 15} For this reason, DHCS should begin to phase in metrics for quality performance in behavioral health care as a part of its measurement of managed care plans.

Additionally, while many plans and IPAs already use provider incentives to reduce avoidable ED visits, hospitalizations, and readmissions (more information about these arrangements below), these programs often do not include mental health and substance use disorder service providers. Creating performance metrics for behavioral health services and outcomes would allow for the inclusion of behavioral health providers in risk sharing or shared savings programs.

Oversight

Oversight has become an increasingly important focus for DHCS, and it needs to become even more important in the coming years. DHCS' administrative role should respond to the expansion of managed care by shifting more staff and resources toward plan oversight. DHCS must ensure that care not only meets federal and state standards, but also is of high quality and cost-effective. In pursuit of this goal, the State should actively facilitate the development of new, innovative delivery system and payment reforms, and act as a clearinghouse for disseminating best practices across plans, local delivery systems, and providers.

To ensure that plans' performance meets federal and state standards and that incentives reflect the actual quality of services provided, rigorous data collection and analysis are necessary. DHCS reports and certain stakeholders indicated that data reporting should be improved in MMC. DHCS' most recent MMC technical report cites this issue as an oversight and quality improvement priority.¹⁶ Some contracted IPAs and providers also identified data reporting as an area for improvement.

While plans may be motivated to improve quality, the lack of adequate data means that some still have a less than complete picture of the care that their providers deliver. The DHCS technical report recommends that plans include more information about specific providers that render services. This step would reduce the workload of medical record reviews.¹⁷ The report also recommends that plans be more vigilant about tracking and documenting the adequacy and timeliness of their providers' reporting activity, and apply penalties for those that do not meet benchmarks.¹⁸

¹³ Owens L et al. 2007. *Mental Health and Substance Abuse-Related Emergency Department Visits among Adults*. Agency for Healthcare Research and Quality.

¹⁴ Zuvekas SH, Rupp A, Norquist G. 2007. *Cost Shifting under Managed Behavioral Health Care*. *Psychiatric Services* 58(1): 100-108.

¹⁵ Mann C. 2014. *CMCS Informational Bulletin: Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings*. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-16-14.pdf>

¹⁶ California Department of Health Care Services. 2014. *Medi-Cal Managed Care Technical Report, July 1, 2012—June 30, 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/TechRpt/CA2012-13_Technical_Report_F1.pdf

¹⁷ Ibid.

¹⁸ Ibid.

An additional policy that complicates quality performance data collection is the ability of health plan beneficiaries (in most counties) to switch their plan each month. Gathering data about a sizeable cohort of beneficiaries who remain in one plan for an entire year can be very challenging with the volume of churn that occurs between the plans. Creating open enrollment periods and special enrollment periods, or reducing the frequency with which enrollees can switch plans could increase the plans' administrative abilities to monitor quality performance over time. Such a policy could also meaningfully increase beneficiaries' continuity of care and boost the effectiveness of plan's patient engagement initiatives to change enrollees' behavior over time. Notably, the Governor's FY2015-6 Budget Proposal includes this policy change.¹⁹ (For a more in-depth discussion of the issues, see the Patient Engagement section below.)

Role of Subcontractors and IPAs in Quality Improvement

Plans with more delegated arrangements rely on subcontracted plans and IPAs to perform many essential managed care functions—with plan oversight. The layers of delegation that exist within some plans can complicate the tasks of provider monitoring and data collection. In capitated models, plans and IPAs often have difficulty collecting encounter data from their providers. Plans' ability to create effective contracts that include specific encounter data reporting requirements for delegated entities, and to conduct audits is very important to reaching quality improvement objectives. For these reasons, Health Net has started an incentive program in Los Angeles for providers to report encounter data to increase the plan's data collection capabilities.

The Managed Care Delegation Process



Health Care LA IPA, an IPA comprised of community clinics in Los Angeles County, has many procedures to improve quality and reduce costs. When beneficiaries are leaving hospitals, the IPA engages a “transition-of-care unit.” After a hospital discharge, care managers contact primary care providers within 10 days to ensure follow up and prevent avoidable readmissions. The Los Angeles Jewish Home is another program that has a very successful model for care transitions from hospital to home for Medicare beneficiaries; one health plan executive cited it as an important model for the duals pilots (known as the Coordinated Care Initiative). A transition coach meets with patients before they leave the hospital and explains the transition program. The coach also makes a home visit within 48 hours of the patient's arrival at home. Coaches additionally schedule all follow-up care appointments, create a list of all medications for review by a pharmacist or physician, and identify any concerning symptoms that may require intervention.²⁰

Some plans contact beneficiaries after inappropriate ED visits to ask them about why they chose to go to the ED, and to inform them about their primary care provider. Health Care LA sends a list of patients who were discharged from EDs to its member clinics each month. This activity allows each clinic to communicate with its patients and to educate them about appropriate ways to seek care. Roughly half of the IPA's patients do not see their PCP in the 90 days prior to their ED visit, and half do not see their PCPs in the 90 days following the visit. The IPA's performance incentives, which are partly based on ED utilization, motivate this kind of communication to

¹⁹ Governor's 2015-2016 Budget Summary. Available at: <http://www.ebudget.ca.gov/FullBudgetSummary.pdf>

²⁰ Los Angeles Jewish Home. 2014. Available at: <http://www.jha.org/about/care-transitions.asp>

drive more appropriate and cost-effective utilization and to prevent complications. Still, the performance and value of IPAs were highly variable according to many of our interviewees, with some reporting that IPAs provide very active care management and quality improvement activities, and others claiming that IPAs do not help providers meet these objectives (see *Background*).

Data Collection Challenges:
Providers often need assistance with data entry and collection. Some IPAs withhold a portion of providers' capitated payment if they do not adequately report data, and plans penalize IPAs if they do not adequately report association-wide data.

Payment and Delivery System Reform Activities

Pay for Performance (P4P)

The most common quality and cost-saving payment models among the plans are capitated provider payments and pay-for-performance (P4P) programs. An ongoing Integrated Healthcare Association (IHA) Survey of MMC plans (with 18 of 22 responding) indicated that the vast majority (16) have P4P programs.²¹ Capitated payments were very common for primary care providers, while considerably less so for specialty care. Certain plans also reported that they had begun paying hospitals under capitated arrangements.

Central California Alliance for Health has a “care-based incentives” program for primary care providers. After two years of evaluation, the plan rewards providers for both attainment (overall score) and improvement to motivate all providers to boost performance. The plan tracks both process and outcomes measures, which include ED visits, ambulatory care outcomes, and HEDIS measures. The plan paid out \$10 million annually in care-based incentives, and the plan's leadership reports that the program's evaluation demonstrates that that the size and orientation of the incentives have had a meaningful effect on the quality of care for its members.

Partnership Health Plan has Quality Improvement Programs (QIPs) for primary care, specialty, hospital, and pharmacy services.^{22, 23} The programs vary in their structure (PMPM vs. payment per unit) across the provider types; however, the incentives can be sizeable, reaching 10% of average annual income for specialists.²⁴ Further, the metrics range across several dimensions of care, including clinical measures, resource use, operations and access, and patient experience.

Inland Empire Health Plan (IEHP) also has a P4P incentive program for both primary care and obstetricians, as well as newer program for pharmacists that was first implemented in 2013. IEHP targets seven areas: immunizations, well-child visits, Pap tests, perinatal services, postpartum services, asthma, and Medicare DualChoice annual visits.²⁵ The incentives are primarily payments per event, and the plan estimates that total P4P incentive payments will total \$33-34 million in 2015. IEHP leadership also noted that the plan is piloting a hybrid payment model with a modest capitated rate for care coordination, along with a FFS payment for encounters and additional incentive payments for quality performance.

²¹ Integrated Healthcare Association. 2014. *Medi-Cal Managed Care Pay for Performance Health Plan Preliminary Results*. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver_Renewal/MCO1_IHA_MCP4P.pdf

²² IHA and CHCS. 2014. *Summary of Possible Ideas, Investments, and Straw Proposals for §1115 Waiver MCO/Provider Incentives*. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver_Renewal/MCO2_IHACHCS_SPs.pdf

²³ Moore R. 2014. *Partnership Health Plan Pay for Performance Programs*. Available at: http://www.ihc.org/pdfs_documents/news_events/2B-Medi-Cal-P4P-Moore.pdf

²⁴ Ibid.

²⁵ Inland Empire Health Plan. 2013. *P4P Overview*. Available at: <https://ww3.iehp.org/en/providers/p4p-program/overview/>

San Francisco Health Plan (SFHP) has a “Practice Improvement Program” that includes clinics, medical groups, Northeast Medical Services, Chinese Community Health Care Association, UCSF Medical Group, and UCSF Clinical Practice Group.²⁶ While the incentives are all based on HEDIS measure performance, SFHP allows the different providers to choose which specific measures upon which they would like to focus. The Practice Improvement Program has seen around 90% of the participating providers receive all of their incentive payments. The incentives are equivalent to 18.5% of their payment in Medi-Cal.

L.A. Care additionally has P4P program for primary care providers that empanel a certain number of members (250 or more members). Despite L.A. Care’s very delegated structure, the health plan directly operates the incentive program with its networks of providers. It has two separate programs: L.A. P4P for IPAs and medical groups with at least 2,500 members, and Physician P4P for solo and small group practices and community clinics. The incentives are based on an average of all constituent HEDIS scores, and L.A. Care allocates incentive payments by dividing an incentive pool (\$25 million annually, with \$12.5 million for each of the two programs) and disseminating the payments among the providers at year-end, based according to their performance scores in that year.²⁷ The allocation has both overall attainment and improvement components for both high performing and improving providers.

Capitation, Risk Sharing, Shared Savings, and Delivery System Integration

In Los Angeles County, Health Net has a shared savings arrangement between hospitals and primary care providers. Primary care and specialist providers are grouped into pods with nearby hospitals, and hospitals receive a capitated rate. If hospitals achieve savings at the end of the year, they share 50% of the savings with the primary care providers in their pods. A local IPA representative reported that primary care providers had not received any shared savings in recent years, and asserted that capitated payments to hospitals would need to increase for primary care providers to share in savings from reduced hospital utilization.

Stakeholders reported that another key difficulty of the Los Angeles model is the negotiation required to assemble the pods, and to design contractual arrangements for care delivered by hospitals outside of the pod. The mobility of many of the patients empanelled with primary care providers causes them to seek care from hospitals outside of the pods. This level of care seeking outside of the pods makes performance and cost measurement and management much more difficult because patients receive services that are outside of their control.

San Francisco Health Plan also pays both hospitals and outpatient providers under capitation. San Francisco is somewhat unique because many of the hospitals and the outpatient providers grouped themselves and split responsibilities among themselves, requiring relatively modest effort from the plan. The Chinese Community Health Care Association and the Chinese Community Hospital demonstrated this kind of collaboration; San Francisco General Hospital, San Francisco’s public health clinics, and the specialty practice groups at UCSF are another example. Overall, the arrangements depended on the agreements between the entities.

IEHP similarly has ongoing initiatives to coordinate and eventually integrate care across inpatient and outpatient providers, as well as across specialties. The plan has created an ACO look-alike program to serve beneficiaries dually eligible for Medicare and Medi-Cal. The program offers up-front financial incentives for providers to establish ACO infrastructure and

²⁶ San Francisco Health Plan. 2014. *Practice Improvement Program Guides*. Available at: <http://www.sfhp.org/providers/improving-quality/practice-improvement-program-pip/>

²⁷ Potterat N. 2014. *L.A. Care Health Plan P4P Programs*. L.A. Care Health Plan and IHA. Available at: http://www.ih.org/pdfs_documents/news_events/2B-Medi-Cal-P4P-Potterat.pdf

care delivery procedures. It additionally connects its primary care network with county and other hospitals' specialists, and these providers share both data and financial incentives. Overall, IEHP aims to create a more integrated delivery system, in the model of Kaiser Permanente, and has directly invested health plan funds into the project.

Community Clinics, PPS, and APM

The Prospective Payment System (known as PPS) for Federally Qualified Health Centers (FQHCs) and FQHC look-alikes raises an issue for health plans' quality performance incentive programs for community clinics. PPS involves a wrap-around payment from DHCS, and provides critical financial support for the special care obligations of FQHCs, including services for the uninsured. At the same time, some stakeholders argued that it has the effect of diluting the incentives that clinics receive from health plans. The addition of a wrap-around payment reduces the overall share of a clinic's revenue from the performance-based payment, and reduces the financial motivation to meet quality benchmarks. Moreover, PPS is a visit-based payment, which requires patients to come into clinics for a visit with a billable provider for clinics to receive payment for their services. This payment model directly reduces the incentive to be more efficient in service delivery by using less expensive non-billable practitioners, and e-medicine or telemedicine.

DHCS and the California Primary Care Association (CPCA) are currently developing models for an Alternative Payment Methodology (APM) that would divorce payment from a clinic visit, and potentially be important to improving quality and efficiency in MMC. APM would ensure that clinics would receive payments equivalent to what they are currently receiving under PPS, but it would come in the form of DHCS adding a capitated wrap payment to the capitated PMPM payment that clinics presently receive from MMC health plans.²⁸ This payment structure would allow clinics the flexibility to use their resources in the most cost-effective way, while still incentivizing and supporting high-quality, coordinated care.

APM may ease some access and workforce issues, but fundamental difficulties with salary and caseload may still present sizable challenges for community clinics.

Further, CPCA would like the State to provide an additional PMPM to clinics for care coordination through the ACA Section 2703 Medicaid Health Homes funds. California has elected to take advantage of 90% federal matching funds for two years to create health homes for Medicaid beneficiaries with chronic conditions.²⁹ This added PMPM would allow clinics to provide additional care coordination services above and beyond what they can currently offer through their payment in the Medi-Cal program.

Community clinic representatives voiced guarded optimism about APM easing some difficulties offering access to care for many beneficiaries, particularly newly eligible adults. By separating payment from a visit, clinic representatives hoped to use many mid-level practitioners who may not have previously been able to bill for services as a result of Medi-Cal rules. Clinics also reported that they planned to use more tele-health approaches and group visits to manage a larger panel size, and to use in-person visits for more complex patients.

²⁸ Douglas T. 2014. *APM Demonstration Framework*. California Department of Health Care Services. Available at: <http://www.cPCA.org/cPCA2013/assets/File/Policy-and-Advocacy/Active-Policy-Issues/Payment-Reform/2014-08-25-TobyDouglas-DHCS-CHI-Presentation.pdf>

²⁹ California Primary Care Association. 2014. *Leveraging Opportunities in the Affordable Care Act: A Community Clinic & Health Center Patient Centered Health Home Proposal*. Available at: <http://www.cPCA.org/cPCA2013/assets/File/Health-Center-Information/PCHH/CPCA CalSIM 2703 Proposal 2014.pdf>

Nevertheless, concerns about access to care and workforce adequacy remain. Many beneficiaries frustrated by appointment delays because of increasing panel volume may simply go to the ED. The ED's 24-hour availability and geographic proximity to people who need care may make it a convenient choice, particularly because there is no copay in Medi-Cal, which removes the financial disincentive to go to the ED.

Community clinic leaders also relayed continuing concerns about recruiting and retaining primary care physicians. The market for primary care physicians is very competitive, making it difficult to hire a sufficient number. Clinics have had more success hiring mid-level practitioners, which could relieve some of the access problems with the implementation of APM. However, this new care delivery model may place a greater burden on primary care physicians because they will only see the most complex patients, and the profile Medi-Cal patients has only become increasingly complex with the Medi-Cal expansion. One IPA leader anticipated challenges with physician retention and burnout if the expected daily volume of visits remained constant while the complexity of their caseloads increased substantially.

Provider Network Support and Technical Assistance

Performance incentives and P4P programs often motivate providers to improve quality performance, yet smaller practices still may not have the resources or the capability to improve their performance. Many MMC plans have responded by offering technical support and guidance to improve overall provider and plan quality performance. In fact, Several plan executives reported provider engagement and education as a performance improvement priority.

While incentives are necessary to provide concrete, financial motivation, very practical technical assistance can be an important piece of communicating *how* providers can reach quality objectives.

While incentives are necessary to provide concrete, financial motivation, very practical technical assistance can be an important piece of communicating *how* providers can reach quality objectives. Central California Alliance for Health has convened its provider networks to share best practices and to educate providers about how to successfully meet benchmarks for incentive payments. Both San Francisco Health Plan and Central California Alliance for Health have hired the Coleman Group to assist clinics with their care delivery and business processes to improve the patient experience, staff collaboration, and increase cost and quality performance.

IEHP gives each of its solo and small practices a report card to allow them to see their performance relative to other providers. Many of these practices have limited capability to manage or coordinate care, and they often do not have electronic medical records (EMRs). As a result, IEHP additionally offers intense training to staff in physicians' offices to improve their quality performance. A new model that IEHP has considered is physician pods of around 25 practitioners who share both resources and risk to provide access across different specialties. The idea would be to increase access, coordination, integration, and quality by pooling resources where they are scarcest.

Many community clinics expressed a desire to improve their performance and partner with plans in quality improvement, but they cited difficulty in obtaining data from health plans. Clinics reported receiving information about ED visits and admissions as late as several weeks or months after the event. The clinics expressed concern that the lack of timely performance data reduces their ability to monitor care transitions, and to reach out to patients to educate them about how to use their coverage more appropriately. From a financial perspective, the lack

of real time information also reduces their ability to meet performance benchmarks in P4P programs.

Under a model with care and quality management delegated to an IPA, Health Care LA organizes many of these activities among its member clinics. The IPA convenes an operations improvement committee to review ED utilization, hospitalization, and readmissions rates and creates correction plans for low-performing clinics.

One project that may inform and assist these provider improvement activities is an IHA performance measurement pilot funded by the Blue Shield of California Foundation. L.A. Care, Anthem Blue Cross, CalOptima, IEHP, and Health Net participated in the initiative by collecting quality measures that the plans must already submit to DCHS or NCQA. The aim of the project was to build a standardized performance measurement and data reporting model for physician organizations in Medi-Cal managed care. This project enables plans and providers to view quality metrics at the physician-organization level, which could inform and motivate providers in terms of their performance relative to other providers.³⁰

Further, DHCS and plans should make these data available to Medi-Cal consumers as soon as possible. As discussed in the *Quality* section above, consumers should have enough information about plans' performance on different measures of quality to make a good plan choice for themselves. The same should be true for their selection of providers, and disseminating standardized, comparable performance data about provider organizations is a necessary first step toward this goal.

Health Information Exchange Development

Two medical societies and IEHP collaborated to establish a Health Information Exchange (HIE) in the Inland Empire (San Bernardino and Riverside Counties). It is the largest HIE in Southern California and is roughly two years old. Hospitals and IEHP have begun entering data into the HIE, and local community clinics have received a grant to build the technological capability to participate. The major challenge with this project remains incorporating mental health and substance use disorder data. While the specialty behavioral health systems in Riverside County has EHRs, that system is not interoperable with IEHP's. Confidentiality requirements for sharing behavioral health data also present a hurdle for the participation of these delivery systems, though not insurmountable with the appropriate client consent protocols.

Improving Quality Across Carved-Out Delivery Systems

In 2014, the Medi-Cal program added a psychological services benefit that MMC plans deliver; yet specialty behavioral health services (specialty mental health and Drug Medi-Cal) remain carved out of managed care—and separate from each other. Stakeholders had mixed reactions to the implementation of the newly available mental health benefits and the overall coordination of managed care services with those that are carved out. Some felt that the rollout and subsequent coordination activities have been inadequate and problematic, while others felt that the delivery systems had handled the process fairly smoothly. Still other stakeholders also felt that it was still too early in the implementation to offer a strong statement about how well the new arrangement was working.

³⁰ Integrated Healthcare Association. 2014. *Managed Medi-Cal Pilot: Performance Measurement at the Physician Organization Level*. Available at:

http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MCO1_IHA_ADA.pdf and at:
http://www.iha.org/pdfs_documents/resource_library/Medi-Cal-Pilot-Results-20141010.pdf

The added behavioral health benefit in managed care and the alignment of the various delivery systems remains young, yet many stakeholders felt that the requirement that county departments of mental health (specialty mental health delivery systems) develop MOUs with MMC plans was an important advancement. The process allowed both entities to articulate responsibilities and improve care coordination among their service providers. At the same time, others felt that the division of responsibilities was not clear. Community clinics with practitioners who are able to bill both systems expressed concern about a lack of clear guidance about which entity to bill in certain scenarios.

Although stakeholders had different views about whether or not the financial separation of the carve out should be maintained, all believed that more coordination (e.g., referral networks, data sharing, quality improvement activities, and uniform consent documents) among delivery systems and providers was necessary. Many primary care providers signaled frustration with the lack of communication and data transfer between the delivery systems. These separations often leave them totally unaware of what happens to patients whom they refer to specialty behavioral health treatment.

Nevertheless, primary care providers also felt optimistic that the new psychological services benefit would motivate plans to leverage the newly billable services to improve health outcomes, and to more effectively connect primary care and specialty behavioral health networks in service of that goal. Many providers shared their hope that both MMC plans and county behavioral health departments would invest in the ability to transfer data, coordinate, and eventually integrate treatments. For example, IEHP has very strong and regular communication with its county behavioral health delivery systems. In fact, IEHP physically embeds staff in the county behavioral health departments to facilitate delivery system alignment.

Community clinics could also play a very important role in integrating carved-out and managed care benefits at the provider level. As a central part of most MMC plans' networks, clinics could potentially develop the capability to provide carved out specialty behavioral health services. However, clinics expressed the need for clearer state regulations outlining the scope of FQHCs' participation in county specialty mental health plans. Without clearer guidance from the state, clinics felt that the planning and development of new specialty behavioral health service capabilities would be far less feasible.

The continued separation of physical and behavioral health delivery systems creates limitations for many of the risk-sharing and shared savings arrangements described above. These groupings typically involve only outpatient physical health service providers and hospitals. As research has repeatedly demonstrated, behavioral health affects physical health, and many individuals with behavioral health conditions have co-occurring physical health conditions.^{31, 32} Many of the events that DHCS and the health plans track most closely are ED visits, admissions, and readmissions. However, the providers that may, in many cases, have the strongest impact on these outcomes lie in the sphere of behavioral health, and they are frequently not included these arrangements. While a carve-out remains, behavioral health service providers should still be included in care coordination, integration, and shared savings/risk models (an option DHCS has presented for the §1115 waiver renewal—see discussion below). Omitting this portion of the safety net from payment reform and quality improvement programs only serves to reduce their positive impacts.

³¹ Zuvekas SH, Rupp A, Norquist G. Op. cit.

³² Kronick R, Bella M, Gilmer T. 2009. *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions*. Center for Health Care Strategies. Available at: http://www.chcs.org/media/Executive_Summary_-_Faces_III.pdf

Future of Payment and Delivery System Reform

Medi-Cal managed care plans, IPAs, and providers have begun to move away from FFS and siloed provider networks, and toward more value-based payments and integrated delivery systems. Still, while some approaches have become common among the plans (P4P, for example), their reach sometimes remains narrow within plans' networks. Also, many of the payment and delivery system reforms described above have only begun in a few plans across the state, and many areas of the state have seen fairly limited movement.

DHCS should use the available financing through the §1115 waiver renewal to continue to motivate payment and delivery system reform activities that improve service quality and health outcomes. (See *Waiver* discussion below.) Further, continuous refinement of data collection and improvements in transparency of data reporting at both the plan and provider levels will provide new motivation for improvement.

Another important obstacle to payment reform in the Medi-Cal delivery system remains the large share of revenue that many providers, particularly hospitals, receive from other payer sources, including FFS Medi-Cal. According to 2013 OSHPD data, just 9.1% of hospital patient revenue was from MMC, and that share was 16.1% for county and city hospitals. For community clinics statewide, the proportion was 28.6%.³³ The percentage of revenue from MMC has very likely increased for many providers with the Medi-Cal expansion in 2014, and it may continue to increase somewhat. In any case, continued change in provider behavior will require sufficient financial incentives, which demonstrates the importance of assembling multi-payer coalitions to align payment reform approaches. DHCS' and health plans' collaboration with IHA to bring commercial market payment reform models to MMC is an example of this kind of activity to coordinate multiple payers' incentives to emphasize quality and outcomes.

Member Engagement

Medi-Cal managed care plans have an obligation to inform members of how to access care, obtain referrals, file grievances, and other important plan details; however, many plans go beyond the basic communication with members.³⁴ Plans engage members in a variety of ways, but with the common goals of improving health and lowering costs.³⁵ Educational efforts and incentive programs are thought to lead to increased adherence to treatments, positive lifestyle changes, and more appropriate use of care. Plans may also be interested in establishing and enhancing members' relationships with the plan, as Medi-Cal beneficiaries in many counties have multiple plan choices.

Many plans operate incentive programs for members, in which they are rewarded for specific actions, such as lowering blood sugar levels, losing weight, or simply receiving an annual physical. Incentives are often tied to HEDIS measures, and are part of an effort to improve health outcomes and quality scores. The programs offer modest financial incentives for meeting goals, including gift cards, movie tickets, and raffles, along with public recognition in a newsletter or on a bulletin

“Are you communicating in a way that clients can understand? Are you giving people achievable goals? Are you celebrating their success?” – Community Clinic Executive

³³ Yoo K. 2014. 2013 OSHPD Clinic and Hospital Data Summaries. Insure the Uninsured Project. Available at:

<http://itup.org/health-financing/2015/01/07/2013-oshpd-clinic-and-hospital-data-summaries/>

³⁴ Department of Health Care Services. 2014. *Geographic Managed Care Boilerplate Contract*. Exhibit A, Attachment 13: Member Services. Available at: <http://www.dhcs.ca.gov/provgovpart/Documents/GMCBoilerplate032014.pdf>

³⁵ James J. 2013. *Patient Engagement*. Health Affairs.

board.

Some argue that incentives are not enough to achieve significant lifestyle changes. Financial incentives paired with educational efforts to inform members about how to make the changes are generally regarded as more successful. Most plans have health education departments that communicate with members and some have resource centers that offer classes and counseling focused on topics like healthy eating, exercise, and disease management. Plans often mail information to members on topics like appropriate use of care for children. Cultural competence, awareness of individualized needs, emphasis on goals, and positive messaging were key areas of importance to those interviewed.

While most member programs have focused on the traditional Medicaid population of children and parents, plans are now faced with the challenge of engaging a diverse member population consisting of individuals with varied health statuses and care needs, as well as education levels and cultural backgrounds. Most experts we spoke to called upon plans to expand member programs to include and appeal to new groups in managed care, such as seniors and persons with disabilities and adults without dependent children living at home. Expansion of the programs to the entire Medi-Cal population is an important step in improving outcomes and reducing costs, particularly since many new members may be unfamiliar with the health care system. It is necessary to utilize different approaches for different member populations; for example, some members may be interested in mobile applications that manage appointments, test results, and track symptoms. Yet, others will lack access to smart devices, the skills to use the apps, or simply the interest in utilizing health technology. Customized programs for specific populations like homeless individuals or patients with mental illness could potentially improve the health of these members with unique circumstances that result in high costs.

“Primary care providers can save the system money, but they’re going to be saving someone else the money. PCPs need to be rewarded for performance improvement that is very dependent on them.” – Community Clinic Executive

On a personal level, plans find it challenging to engage members. It is extremely difficult to have a significant impact on members’ lifestyle choices and to encourage self-care, as habits are often deeply ingrained and tied to socioeconomic status and cultural norms. Not all members are interested in interacting with their health plan or have the time to dedicate to improving their health. However, while plans attempt to engage members by encouraging them to make personal changes, plans do not provide sufficient information to consumers to allow them to make informed decisions. In particular, quality ratings on the provider level (just aggregated, general ratings

for the overall plan with no data on how particular providers perform) are absent from consumer materials. If plans were to offer quality information to current and prospective members, consumers would be better able to make choices of where to seek care. This could drive patients to hospitals and other providers that achieve the best outcomes.

Additionally, the frequent movement in the member population interferes with engagement, as it does with data collection. Medi-Cal members can change plans and providers on a monthly basis, which disrupts continuity of care and halts plan-member communication. Churn between Medi-Cal and Covered California eligibility causes similar issues. Churn and plan switching has a negative impact on HEDIS scores and minimizes the sample size. For this reason, COHS plans have an advantage in engaging members, as all Medi-Cal managed care members are enrolled in a single plan.

Some stakeholders hope that plans will create incentives for providers to engage members. Many providers currently provide education services, but large-scale incentive-based programs have yet to be implemented. Providers may be the best source of education for their patients due to the trusted provider-patient relationship, however they need incentives to offer the services. Such a program could be possible through a shared savings arrangement between the plan, IPA, and the providers.

There also may be an opportunity for plans to collaborate with other social services programs. For example, plans could develop a cookbook with WIC programs that contains recipes using food that's available through WIC.

Opportunities in §1115 Waiver Renewal in 2015

DHCS promotes the 2015 renewal of the §1115 Waiver as an opportunity for California to “focus our efforts on...critical components to the success of health care reform such as expanding access, improving quality and outcomes, and controlling the cost of care.”³⁶ DHCS has pledged to use the Waiver to improve payment and delivery systems in Medi-Cal, potentially creating financial incentives for quality achievements, expanding provider capacity, and integrating silos. The §1115 Waiver is expected to be submitted to the Centers for Medicare & Medicaid Services (CMS) in early 2015 and will hopefully be approved in the fall.

Of all of DHCS' recently proposed concepts for the §1115 waiver renewal, the MCO/Provider Incentives concepts may have the most direct impact on how plans operate, interact with providers, and improve performance. The possible approaches include incentives for quality improvement and many involve coordination and integration of physical and behavioral health. DHCS has created them as a set of options from which different plans can choose in accordance with their local capacity and needs.³⁷

The proposed MCO and provider-incentive concepts have the potential to substantially contribute to what we believe are two of the most important tasks for MMC: improving overall service quality and health outcomes, and more effective coordination of physical and behavioral health services. Of the six concepts, three involve alternative payment models designed to improve quality and control costs:

- Plans would receive incentive payments to incorporate alternative payment models, including shared savings, shared risk, and bundled payments that would be equivalent to a specified percentage of provider payments
- Pay-for-Performance for Medi-Cal providers—standardize and support plans' programs
- Shared savings for Medi-Cal providers with a total-cost-of-care target

The other three concepts explicitly involve quality improvement and care coordination/integration for behavioral and physical health services:

- Shared savings arrangements for MMC plans and county specialty behavioral health programs

³⁶ Department of Health Care Services. 2014. *Concepts for California's Next Medicaid Waiver Renewal*. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Initial_Concepts_for_2015_Waiver-July_2014.pdf

³⁷ Center for Health Care Strategies and Integrate Healthcare Association. 2014. *1115 Waiver Workgroup on Plan-Provider Incentives: Straw Proposal Matrix*. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver_Renewal/MCO2_IHA_SPM.pdf

- Behavioral health P4P for Medi-Cal providers (for depression treatment)
- Shared savings for physical and behavioral health providers for team-based care; the model offers quality incentives and shared savings to providers that coordinate or co-locate primary care and behavioral health services

With the continuation of the carve out of behavioral health services, the strong emphasis on behavioral health coordination and integration in the provider and MCO incentive concepts could be particularly valuable for improving Medi-Cal outcomes.

Moreover, formalizing some of the agreements between MMC plans and county mental health and substance use disorder programs could serve to strengthen and increase the longevity of the connections between them. One national study of behavioral and physical health integration in Medicaid found that informal arrangements “require the least administrative upheaval,” but “that they are the most tenuous since they depend on relationships among agency leadership and staff.”³⁸ Creating lasting operational alignments (e.g., referral and data-sharing procedures) and financial agreements (e.g., shared savings) between delivery systems should serve to improve the quality of services in the long run.

The interoperability of EHRs in the physical health and behavioral health systems should be a priority within the incentive models. Up-front investments available through some of the shared savings and total-cost-of-care concepts ought to include provisions for information technology for behavioral health providers. Since many behavioral health providers either lack EHRs, or do not have systems that are compatible with physical health EHR systems, the waiver should direct resources toward the necessary connectivity for broader coordination between delivery systems.

In fact, the waiver concepts should advance coordination of services among Medi-Cal providers more generally to create a more integrated safety net. Shared savings programs with a total cost of care target could incorporate primary, specialty (physical health, mental health, and substance use disorder providers), and hospital care. Greater service alignment and data sharing among all plans, IPAs, and providers could improve accessibility and quality of services. Additionally, reducing utilization of expensive services through clinically appropriate outpatient care must involve mental health and substance use disorder service providers. These networks are important to the goal of preventing avoidable ED visits, admissions, readmissions, errors, and adverse events.

DHCS also proposed a Delivery System Reform Incentive Pool 2.0 (or DSRIP 2.0) to improve and coordinate the services of designated public hospitals. While this waiver concept is more facility-specific, many elements of this project align with the MCO and provider incentives proposals. The DSRIP 2.0 delivery system transformation goals include developing patient-centered medical homes, improving access to specialty care, improving transitions from acute care, and integrating physical and behavioral health.³⁹ These areas of focus could allow designated public hospitals to be key partners in many of the MCO waiver projects in the next five years.

³⁸ Bachrach D, Anthony S, Detty A. 2014. *State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment*. The Commonwealth Fund. Available at:

<http://www.commonwealthfund.org/publications/fund-reports/2014/aug/state-strategies-behavioral-health>

³⁹ Kohatsu N. 2014. DSRIP 2.0 Concept for Designated Public Hospitals. California Department of Health Care Services. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/DSRIP2_DHCS.pdf

In sum, many of the waiver options that seek to coordinate and integrate managed care providers with each other, and with carved out delivery systems, reflect many of the trends in Medicaid programs across the states. As DHCS and stakeholders move forward with California's Waiver renewal proposal, we should design the infrastructure and financial incentives to move Medi-Cal managed care and the safety net toward a high-performing delivery system. This waiver has great potential to leverage expanded health coverage to yield improved health outcomes, which will serve the state's residents for years to come.

Recommendations

Based on our discussions with a range of Medi-Cal Managed Care stakeholders, ITUP recommends the following:

1. DHCS must increasingly focus on plan oversight as it shifts from a benefits administrator to a managed care oversight entity. This shift requires an appropriate investment of resources and staff into these activities.
2. Both DHCS and the Medi-Cal managed plans should invest in improving and standardizing performance data collection capabilities, particularly at the provider organization level, and DHCS should improve timely data reporting to providers and to the public.
3. DHCS should serve as a clearinghouse and facilitator in spreading best practices for value-based payment and delivery system reform (e.g., P4P, shared savings, ACOs, PCMHs etc.), and patient engagement programs across MMC plans. These activities should include regular data collection and dissemination to inform plans, providers, and stakeholders about successful activities in these areas.
4. Plans must prioritize member engagement as they continue to enroll an increasing number and more diverse groups of beneficiaries. Recently enrolled and newly eligible groups have different and often more complex health care profiles, which will require member outreach and engagement activities that accommodate these needs.
5. DHCS, in consultation with health plans and other stakeholders, should develop behavioral health quality performance metrics for psychological services delivered through managed care plans.
6. DHCS (including Denti-Cal), Medi-Cal managed care plans, and county mental health plans, Drug Medi-Cal programs, and CCS offices should take full advantage of the §1115 waiver renewal to coordinate managed care and carved out services as closely as possible, with the broader aim of creating an integrated, high-performing safety net.
7. To the extent that Medi-Cal managed care plans have developed risk sharing and shared savings programs among outpatient and inpatient providers, carved out (particularly behavioral health) providers and delivery systems ought to be included in these arrangements. MMC plans should ultimately strive to build more integrated safety net delivery systems based on financial incentives that reward quality and cost performance that all providers jointly influence. These efforts should include primary and specialty outpatient care and inpatient care.