# Medi-Cal Managed Care Issue Workgroup Executive Summary

## *Quality: Data Collection, Reporting, and Performance Incentives*

Workgroup participants discussed the need for accessible and meaningful metrics. MCO disagreements on the appropriate metrics to measure suggests that metric choices need to be reviewed. Overall, stakeholders expressed a desire to see a greater variety of disaggregated data, and for selected metrics to better reflect healthcare quality, as opposed to providing details about less relevant aspects of healthcare. Although there was also interest in getting provider-level information, DHCS currently does not collect data from delegated entities.

Stakeholders also discussed the possible creation of a statewide standard for P4P. Currently, P4P initiatives are implemented on an MCO by MCO basis. Standardization could help providers, who are frequently caught between differing P4P criteria between MCOs and varying incentives offered by the different plans that they contract with. Ultimately, the goal is for patients to receive the same care regardless of provider or plan. Some participants cautioned against the creation of a single rigid standard, as P4P frequently needs to be targeted to specific regional needs. Some regions have also already pioneered P4P programs that are very well liked – eliminating these programs to create a Statewide P4P program would be unpopular and upend a lot of the investment and work made by those stakeholders. An issue that needs to be addressed is how P4P will impact solo and small group practitioners, who do not always have the infrastructure needed to provide the level of data reporting P4P needs to succeed.

## *Payment and Delivery System Reform*

The shift to global capitation necessitates increased reliance on data management. Stakeholders noted that shifting to capitation is not just a shift in payment scheme, but also a shift in practice to emphasize managed care, timely primary care and preventative services. However, smaller practices do not have the resources to succeed when expected to manage risk. Stakeholders also noted that as long as capitation is focused solely on primary care, incentives will not be aligned between primary care providers and hospitals/specialists. Some stakeholders suggested that incentive alignments could still occur with some providers on FFS reimbursement.

Stakeholders also agreed that hospitals need a network of outpatient providers to help reduce ER utilization with whom they can share savings achieved from reduced ER utilization. This requires capitation rates to be set high enough to ensure there are savings to share. However, patients who do not stay in-network complicate these efforts. Because patients do not always care about staying in network, hospitals struggle to direct patients to in-network specialists. Plans need to do more to educate and redirect their members to stay in network, or in the case of ACOs, within ACO providers.

Payment and delivery system reform efforts need to be extended to carved-out services, which are handled separately. Cal-Mediconnect is already pioneering a shared savings arrangement between the MCO's administration of the mild-to-moderate benefits and the County's administration of care for the severely mentally ill. Information sharing barriers make setting up integrated arrangements challenging, even if the information sharing is necessary to provide care. Counties also frequently do not provide the real-time information needed to drive careful coordination efforts.

Stakeholders also discussed FQHC movement towards an alternative payment methodology, moving away from a PPS FFS payment rate towards a PPS-equivalent capitation rate that would emphasize value over volume of visits. This change would grant FQHCs more flexibility in how they treat patients, eliminating FFS restrictions on how many services can be provided during a single visit. Some stakeholders pointed out that it is still hard to deliver specialty care in FQHCs, and that strict rules about bringing in providers make it difficult to mitigate this without Federal support.

## *Patient Engagement*

Participants discussed ways to improve patient engagement with the managed care system. Although many patients now have insurance cards, they are still used to seeking care through the emergency room and don't understand the value offered by primary and preventative care. Stakeholders emphasized that patients need to understand that primary care provides additional value over simply seeking care when sick at the emergency room.

In some cases, Covered California beneficiaries are being surprised by the costs of care because they don't understand how cost-sharing, deductibles, and premiums work. As a result, they are frequently choosing low-premium plans with high cost-sharing. Additionally, for some patients, free preventative care visits turn into treatment visits with cost sharing after underlying health issues are discovered. These experiences can confuse and discourage patients about the value of their healthcare. Addressing these issues will require meaningful engagement past just giving new plan enrollees a booklet on their insurance. Over the next few years, engagement will hopefully help consumers understand the real value of having insurance. Stakeholders also noted that patient engagement will only be meaningful if networks are sufficient to provide care to these patients. This will require adequate reimbursement rates.

## *§1115 Waiver*

The §1115 waiver will increase focus on improving managed care by incentivizing providers to take on more beneficiaries while developing the workforce and integrating siloed systems to provide a simpler system for beneficiaries. The pace of reform will likely be quick, with the State consulting and checking in with stakeholders periodically but individual counties having the flexibility to decide implementation details on top of a basic infrastructure.

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