Senate Health Committee Testimony

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Written Testimony

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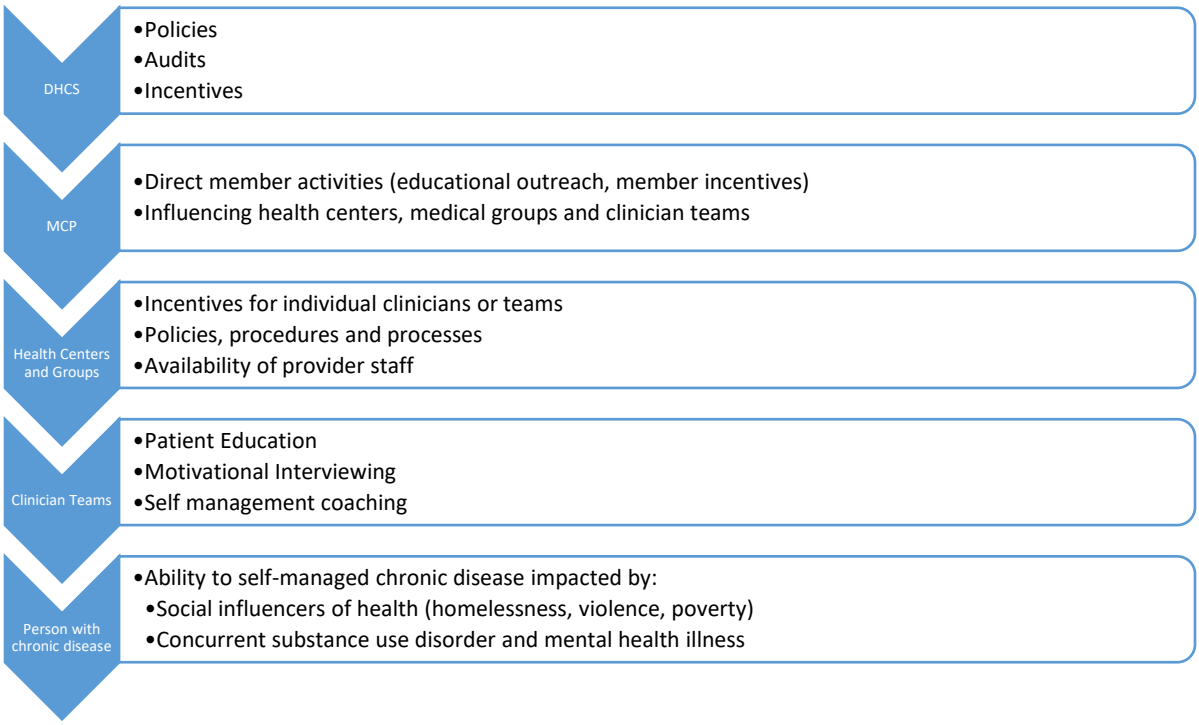
Executive Summary

1. Quality of chronic disease care is most influenced by the doctor, clinical team and primary care provider organization caring for patients living with chronic diseases like type 2 diabetes and asthma. Those of us working in higher levels of the health care system, like managed care plans, state Medicaid agencies or the legislature, must understand how our efforts and activities affect front-line clinicians.
2. Pay for performance programs are not the Holy Grail to improving quality. They are but one way health plans can support primary care clinicians. Others include
    a. Transparency of Data/Tools for managing data (e.g. Health plan data portal for providers).
    b. Training and technical assistance to providers and QI staff of health centers.
    c. Comparative Data, to foster social pressure to improve and learn best practices from each other.
    d. Direct to member outreach activities to support primary care clinician activities
3. Pay for performance programs, if not designed carefully by those experienced in managing such programs, can have unintended negative consequences. For that reason, I recommend legislation set the general parameters, but a stakeholder process managed by the MMCD Quality Monitoring Division or an external organization like the California Health Care Foundation define the measures and the structure of the program, and allow it to be modified over time.
4. DHCS has implemented public reporting of Health Plan quality performance with corrective action plans and quality improvement projects where performance is lacking. Performance improved across the board between 2016 and 2017 with these activities. It worth asking how much additional focus on quality the state would get from health plans by adding pay for performance incentives to this mix.

<u>Overarching question</u>: How can DHCS incentivize better quality and better management of chronic diseases?

<u>Part I: Understanding the Cascade:</u> What *layers* of influence does DHCS have to achieve excellent control of chronic disease?

To answer this question, it is important to remember the cascade of organizations that exists between DHCS and individual Medi-Cal beneficiaries, and how they can influence each other at each stage of the cascade.



The overwhelming majority of chronic disease care for the Medi-Cal population is largely provided by doctors and their clinician teams working at health centers and large group practices.

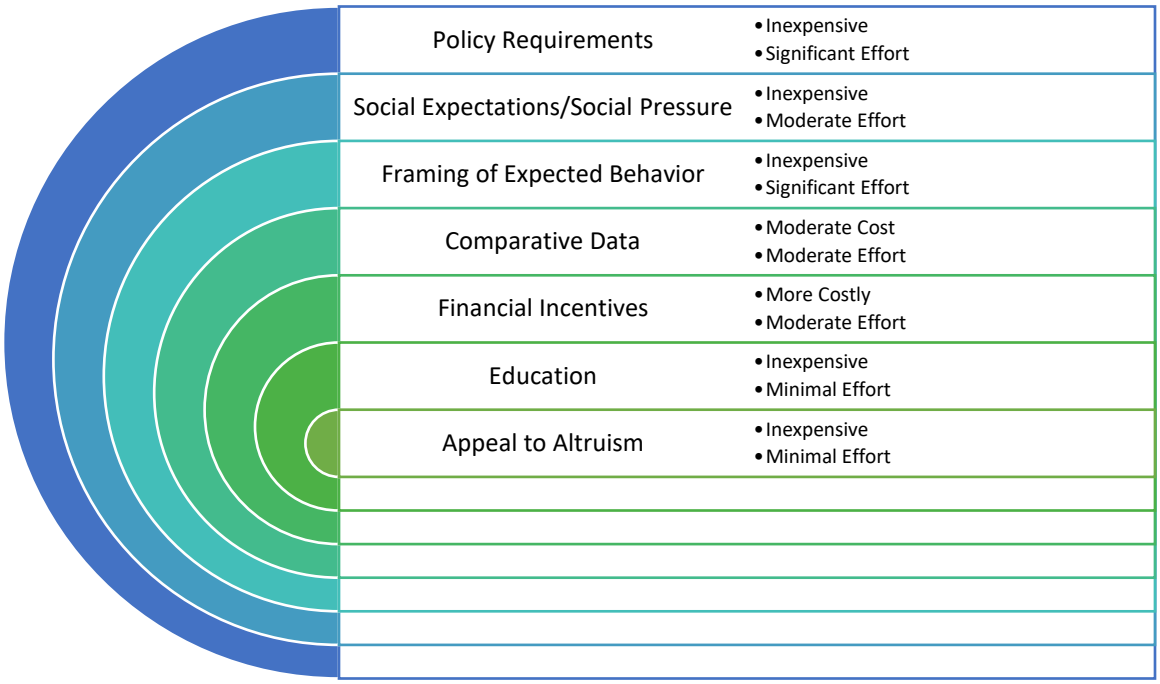
Medi-Cal Managed Care Plans can influence quality of chronic disease care either through direct member outreach and incentives, or through activities (such as pay for performance incentives or trainings) that support the clinicians and their teams that are caring for their patients.

DHCS, in turn, can influence quality of chronic disease care through policies, audits and incentives on the processes and outcomes that their contracted Medi-Cal Managed Care Plans achieve in influencing quality of chronic disease care.

Even if all these organizations have the most efficient cascading support mechanisms possible for supporting the quality of chronic disease care, important patient-level factors such as the social influencers of health, substance use disorder and mental illness may lead the individual patient to choose to not focus on chronic disease self-management.

<u>Part II: Understanding the Cascade:</u> What *levers* of influence does DHCS have to influence Health Plans?

Behavioral economists have defined seven basic levers for influencing behavior that can be used by any of the cascading organizations above, including DHCS. While these seven levers work synergistically, they vary in effectiveness, cost and effort. They are listed here in approximate order of most effective to least effective.



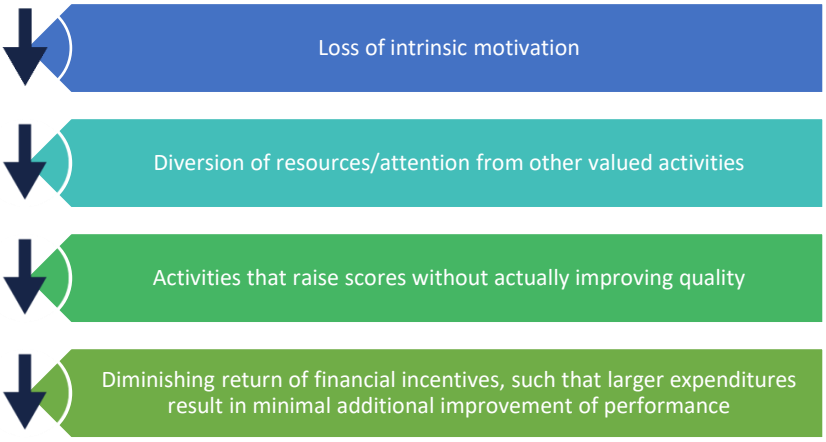
Policy Requirements	• Inexpensive • Significant Effort
Social Expectations/Social Pressure	• Inexpensive • Moderate Effort
Framing of Expected Behavior	• Inexpensive • Significant Effort
Comparative Data	• Moderate Cost • Moderate Effort
Financial Incentives	• More Costly • Moderate Effort
Education	• Inexpensive • Minimal Effort
Appeal to Altruism	• Inexpensive • Minimal Effort

Beginning about 3 years ago, DHCS has used all 7 of these strategies to some degree. It has policies around measure performance, presents quality measure data unblinded at the Health Plan level, and coordinates educational interventions that include the argument that improving quality metrics is the right thing to do. Medical Directors and CEOs compare each other's performance on clinical measures, exerting social pressure to improve. DHCS has defined financial penalties (experimentally shown to be twice as powerful financial incentives than rewards) for lack of progress on improving quality measures. Quality scores improved significantly across health plans from 2016 to 2017 (most recent data available).

As DHCS already attempts to influence Health Plans through all 7 levers, it is not clear how much adding financial rewards will result in more rapid or dramatic improvement of quality outcome scores.

Part III: Financial incentives: Potential unintended consequences

While financial rewards can result in behavior change, social scientists have identified a number of potential negative consequences.



In addition to these 4 potentially negative consequences to a financial incentive, there are 22 other variables that can impact the effectiveness of an incentive program. Given this complexity, the structural elements of a large financial incentive program need to be carefully thought through before being implemented with input from those experienced in designing financial incentives in health care settings. The outcomes of any particular financial incentive program must be monitored carefully, and the program needs the flexibility to change aspects of the program over time, based on new lessons learned.

These dual needs (a thoughtful initial design and flexibility to change over time) have an important implication for potential legislation to create financial incentives. Such legislation should set the general parameters, but an expert stakeholder process managed by the MMCD Quality Monitoring Division or an external group such as the California Healthcare Foundation should define the measures and the structure of the program, monitor the effectiveness of the program, and modify it over time.

Part IV: Understanding the Big Picture: What actions can the California Legislature take to cost-effectively improve the quality of care provided to California's Medi-Cal enrollees?

Optimal health status for Medi-Cal enrollees depends on many factors. Each is under the influence of different components of the health and human services system. Many of us who talk of quality of care in the Medi-Cal population are referring to section C below, which deals with more *measurable* quality and access outcomes within the *medical* delivery system.

When deciding where to intervene, however, *all* these many interacting factors must be kept in mind, to understand that interventions in many ways are needed to synergistically make major improvements.

A. Cross sectoral purview (Government, community groups, DHCS, CDPH, local health department, Health Plans, health care delivery system)
    1. Avoidance or mitigation of social influencers of health, such as homelessness, food insecurity, transportation barriers, economic instability, substandard housing, and other

sources of chronic stress such as adverse childhood events (ACEs), racism and community violence.

B. DHCS purview (treatment) and CDPH/local health department purview (prevention)
    2. Prevention and (if needed) treatment of substance use disorders.
    3. Prevention and (if needed) treatment of mental health disorders.
    4. Preventive dental care and (if needed) treatment of dental disease and abnormalities.

C. Purview: *Monitored* closely by DHCS; *organized* by MediCal Managed Care plan purview, *provided* by clinicians and organizations in the medical care delivery system
    5. Timely access to primary care and specialty care
    6. Timely access to medications, durable medical equipment, and supportive services such as physical therapy, occupational therapy, audiology etc.
    7. Excellent preventive care, partly measurable by HEDIS prevention measures
    8. If the beneficiary has a chronic disease, optimal care of this chronic disease, as partly measured by HEDIS chronic care measures.
    9. Communication capability of the clinician/team (sometimes known as bedside manner), available in a language and cultural context that the beneficiary can understand, partly measured by patient experience surveys, such as CAHPS.

D. Health care provider/individual clinician purview (many elements audited or monitored by Health Plans, the joint commission, OSHPD, and state licensing boards)
    10. Diagnostic accuracy by clinicians
    11. Treatment appropriately selected, according to best available evidence at the time of treatment
    12. Optimization of the Clinical microsystem (office practices, medical team structure and training) for the process of providing care at the clinician office
    13. Optimization of record keeping and communication: electronic medical records, health information exchange, and cross sector communication system
    14. Adherence to safety standards designed to prevent errors and preventable complications.

Cost effectiveness of interventions in any of these 14 areas has statutory and regulatory constraints, such that little cost effectiveness criteria is applied in some areas (such as many medical treatments) but the structural lack of money dedicated to other sectors, such as small amounts of funding for addressing the social influencers of health or the low reimbursement rates for dental care and substance use disorder treatment, lead these areas to be significantly underfunded leading to major unaddressed gaps that contribute to poor health status, in spite of better cost effectiveness than many treatments covered as medical benefits. The legislature should weigh cost effectiveness in deciding how to expend new resources and incentivize improvements in quality, or it risks making policy decisions that will make health care significantly more expensive with minimal improvement in quality.

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