



California Health Care Foundation



**Intended Consequences:**  
Modernizing Medi-Cal Rate-Setting to  
Improve Health and Manage Costs

MARCH 2018

# Contents

## About the Authors

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is a fully integrated, multidisciplinary legal, regulatory, advocacy, and strategic business advisory health care practice. Manatt Health's extensive experience spans the major issues re-inventing health care, including payment and delivery system transformation; health IT strategy; health reform implementation; Medicaid re-design and innovation; health care mergers and acquisitions; regulatory compliance; privacy and security; corporate governance and restructuring; pharmaceutical market access, coverage and reimbursement; and game-changing litigation shaping emerging law.

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The Optumas Healthcare consulting team works with clients to design appropriate, efficient, and effective health care reform initiatives to achieve clients' policy goals of improving health care access, health care quality, and health care coverage. Through strategic actuarial analysis, Optumas develops coverage, cost, and affordability estimates and strategies to meet client's program needs and health reform goals. The Optumas team's goal is to ensure all people have equal access to the timely, cost-effective quality health care they need to be productive members of our society.

## About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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## 3 Executive Summary

## 6 Introduction and Background

Overview of Current Medi-Cal MCO Rate-Setting Process  
Work Group Process and Principles for Evolving California's Rate-Setting Methodology

## 9 Recommended Approach

### COMPONENT 1

Implementing a Rate Adjustment

### COMPONENT 2

Enhancing Financing for Health-Related Investments

### COMPONENT 3

Adding a Social Determinants of Health Risk Adjustment to the Rate-Setting Methodology

## 21 Conclusion

## 22 Appendices

A. Status Quo Model, Year by Year

B. Rate-Adjustment Scenarios, Year by Year

C. Other Options Considered

D. California Health-Related Investments and HCBS Crosswalk

## 30 Endnotes

# Executive Summary

## Overview and Purpose

The Medi-Cal program plays a critical role in California, providing health coverage for a third of all residents, including those with complex health care needs and significant economic and social challenges. Like other states facing federal and other budgetary pressures on their Medicaid spending, California is eager to identify and support innovative models of care that have the potential to both improve member health outcomes and reduce cost trends over the long term.

With 81% of Medi-Cal beneficiaries enrolled in managed care, Medi-Cal managed care organizations (MCOs) are central to achieving these objectives. Several plans are already investing in innovative models that go above and beyond the required benefits; examples include enhancing case management, providing housing supports to give older disabled members an alternative to living in a nursing home, and integrating physical and behavioral health. However, these plans have been hampered in their efforts to bring such initiatives to scale and maintain them over time by disincentives built into the Medi-Cal MCO rate structures. What is needed is an approach that aligns health plan incentives with the state's goal to reduce the long-term cost trend.

An unintended consequence of the current rate-setting methodology is that plans are negatively impacted when they invest in initiatives that result in lower costs. This can occur when an MCO seeks to improve care by investing in services or other initiatives that are not traditional Medicaid benefits, such as improved care coordination or housing supports; such efforts can result in a decline in inpatient hospital use, emergency department use, or other high-cost utilization. In such cases, the cost basis for the plan's future rates declines and the plan receives a lower rate than it would have received without the intervention. The state recognized this dilemma in its 1115 waiver renewal and proposed a program where plans could receive some of the savings generated through improvements in care. (This initiative was ultimately not part of the approved waiver, although a waiver is not necessary to implement such a program.)

To seek possible solutions to the unintended consequences of rate-setting methods, the California Health Care Foundation, with support from Manatt and Optumas, convened a work group to explore options for addressing this issue and encouraging joint state and plan investments in innovative health-related initiatives. The work group comprises leaders of several Medi-Cal MCOs, and the Medi-Cal director served as an advisor to the group.

This report presents the output of that work group process. Specifically, it:

- ▶ Provides an overview of the current rate-setting process, highlighting challenges and unintended consequences
- ▶ Describes the work group process and principles that guided the evaluation of new options
- ▶ Offers a recommended approach for updating the current rate-setting methodology to advance Medi-Cal's goals of improving member health outcomes and promoting efficient resource use.

One of the parameters of the work group was to work within current Medi-Cal funding constraints — designing approaches that would not require any net investments by the state. Additional state investments, however, to improve Medi-Cal access and quality would augment the impact of these recommendations and yield health improvements for members.

### Medi-Cal 2020 KEY CONCEPTS FOR RENEWAL

*“The current managed care capitation rate-setting process has limited long-term ability to incentivize widespread adoption of payment reforms that promote investments in strategies that incent efficiencies such as appropriate reduction in costs and utilization.”*

— California Department of Health Care Services (DHCS), March 2015

## Recommended Approach for Moving Forward

While the work group considered a variety of options and complementary strategies, the primary component of the recommended approach is to devise a rate adjustment that would encourage plans to consistently invest significant dollars in care improvements and health-related services that can generate program savings. The rate adjustment is discussed below, followed by a brief review of two complementary strategies recommended by the work group.

**Implementing a rate adjustment.** The recommended approach is to update the rate-setting process so that it supports the state's desire to improve health outcomes and reduce the growth of health care spending. This concept was first proposed in Oregon and is currently being refined for implementation there. As envisioned for California, a plan-specific rate adjustment would be triggered if a plan meets three criteria: (1) it generates savings above a certain threshold, (2) it meets specified quality targets, and (3) it makes an investment in approved health-related initiatives at a level set by the state.

These three criteria are described in detail below. The size of the adjustment for any plan meeting the criteria depends on how much savings are generated (i.e., the return on investment for health-related initiatives) as well as certain design decisions — or state policy levers — relating to the overall approach, including:

- ▶ **The shared-savings split.** The state and a qualified plan would share the savings and, as such, the size of the rate adjustment would depend not only on the level of savings but on how the savings are split between the state and plans (e.g., on a 50/50 basis).
- ▶ **The minimum-savings rate.** The rate adjustment is triggered if a plan achieves savings above a minimum level; the level selected will influence whether a plan qualifies for an adjustment (e.g., if the minimum-savings rate is set at 0.5%, a plan has to achieve savings above that level to qualify for any adjustment).
- ▶ **The threshold for the health-related investment.** The adjustment is only made if a plan makes an investment in approved initiatives. The state would need to set the level of investment that

would qualify and to establish the types of investment that would be recognized.

The work group, with the support of Optumas, reviewed a variety of scenarios modeled for a hypothetical Medi-Cal population. The modeling provided insight into the size of potential savings and the impacts of varying these policy levers. Those observations are detailed in the report.

The second criterion of the rate-adjustment approach is that for a plan to receive the rate adjustment, it must not only bend the cost curve but must also attain quality metrics. The quality criterion helps ensure that the recommended approach actively advances the state's quality objectives, and that cost savings do not come at the expense of quality and access. The work group recommended the development of a balanced scorecard that includes social determinants of health metrics, and indicators of data-reporting completeness and quality, in addition to more traditional quality measures, such as the Healthcare Effectiveness Data and Information Set (HEDIS). The objective is to encourage innovative and promising interventions as well as to strengthen the reporting capabilities of plans and their delegated entities.

The third criterion is a requirement that plans make health-related investments as a condition of qualifying for the rate adjustment. Like the quality component, the investment component is aimed at ensuring that this approach is anchored in achieving health improvements, not just savings. Investments may be targeted to help address social and economic conditions that affect health, improve or maintain member health, and/or support delivery system reform efforts. Specific plan investments can take many forms, such as helping members obtain and remain in stable housing, providing home equipment or modifications, funding a local opioid coalition, building telehealth capacity, and implementing or expanding provider quality-improvement initiatives. The state currently provides coverage for some of these types of investments to certain populations under home and community-based services waivers and other programs. However, these populations are carved out of managed care and therefore MCOs are generally not required to provide these benefits. Some investments in these types of initiatives are part of the "whole-person" pilots authorized by the current Medi-Cal waiver.

The state, in consultation with the plans, will need to set the level of investment required and identify the types of investments that would qualify. Once in place, the state and the plans would need to develop a way to account for the plans' level of investment, while minimizing the administrative burden to both. Plans would not be required to show causation between savings and investments, but would be expected to evaluate the impact of their investments, get smarter, and refine their investment strategies over time. They would have an incentive to do so under this approach, as the return on investment has a large impact on the size of the rate adjustment.

#### **Enhancing financing for health-related investments.**

The work group also recommended a complementary strategy that would support and enhance the investments that plans would make under the rate-adjustment approach. Specifically, plans expressed a strong interest in both clarifying what types of investments can count within the current plan expense base and exploring additional avenues for financing these investments. The state has a variety of ways to recognize some of the investments that plans would be making when it calculates the MCO rates. Certain investments may be counted in the medical load when setting rates. For example, enhanced care management can be incorporated as a Medi-Cal benefit through a state plan option, and other types of investments can be financed through the capitated payments made to the plans at the discretion of the plan and as approved by the state, with the cost built into the medical load when managed care rates are developed (these are called "in-lieu-of services"). Other investments may be deemed quality-improvement activities by the state and can be counted in the nonmedical load when setting capitation rates. Investments that do not qualify for inclusion in the medical or nonmedical loads can be paid for through other plan resources.

**Establishing a social determinants of health risk adjustment.** An additional complementary strategy that the work group recommended is to further explore adding a social determinants of health risk adjustment to the Medi-Cal rate-setting methodology. California's current risk-adjustment model is driven by medical diagnoses; a risk adjustment that reflects member socioeconomic status could help identify subpopulations that would benefit from targeted interventions. Additionally, layering in social determinants into the risk-adjustment methodology could enhance the equity of resource

distribution across plans to ensure that resources are being directed to plans serving the most vulnerable populations. Incorporating social determinants of health in risk adjustment is a fairly new concept now being tested in Massachusetts. While there may be challenges with execution — such as robustness of data and avoiding duplication with the existing risk-adjustment methodology — the work group found merit to further considering this refinement of Medi-Cal's rate-setting methodology.

## **Key Takeaways**

The analyses undertaken by the work group led to the following key takeaways:

- ▶ **Relative to the status quo, the rate-adjustment approach would better align plans' incentives with state goals.** The approach is aimed at improving health and health outcomes and doing so in a way that reduces costs. The modeling shows that the approach can generate savings for the state and avoid the disincentives in the current rate-setting methodology that discourage plans from making ongoing, substantial cost-effective investments.
- ▶ **The design can be dynamic to encourage continued investments and to balance risks and benefits for state and plans.** How the policy levers are set plays a critical role in ensuring impact for all stakeholders. If all of the savings accrue to the state — as is the current situation — plans would not invest as aggressively or in a sustained manner, and state savings would not materialize. And if the plans reap all the savings, the state has no reason to revise its rate-setting methodology. Further, the levers could be adjusted over time to reflect experience and to ensure that ongoing investments and cost savings are sustainable.
- ▶ **Downside risks for all parties are limited.** If the investments fail to generate meaningful savings, the state may have incurred some expense (by recognizing some of the investment in the medical and nonmedical loads of plan rates), as will have the plans. However, other than those early investment losses, not much would change if the approach does not generate meaningful savings, because behaviors would regress to being very similar to the status quo. The state could mitigate its exposure by requiring

plans to bear more of, or even the entirety of, their investments, perhaps until the efficacy of the interventions becomes apparent.

► **Beneficiaries would see improvements in care.**

While the state and plans both benefit through better alignment of Medi-Cal's rate-setting methodology with quality and cost goals, beneficiaries potentially stand to gain the most from the recommended approach. The investments in health-related initiatives are aimed at making the care delivery system more responsive to beneficiary needs, more preventive and outpatient-oriented, and more attuned to the whole person's situation — not simply their medical ailments.

While states are facing increased economic and federal government pressure to slow the growth of Medicaid spending, there is broad agreement that cost containment should not come at the expense of quality, access, and innovation. California has an opportunity to be on the leading edge of advancing models of care and interventions with the potential to improve member health and reduce costs. This report provides ideas that can help the state evolve the Medi-Cal rate setting methodology and advance those goals. These ideas have been discussed with and carefully examined by a work group of Medi-Cal MCO executives, with the Medi-Cal director serving in an advisory role. With little downside risk, the recommended approach could be expected to generate savings while promoting plan investments to address the complex and interrelated medical and socioeconomic needs of Medi-Cal beneficiaries. The recommended approach also could help the state evolve and continue successful 1115 waiver pilot initiatives after the waiver ends. Finally, although one of the parameters for this project was that the initiative would not result in any new investment by the state, additional state investment to improve Medi-Cal access and quality could augment the impact of these recommendations and yield health improvements for members.

## Introduction and Background

The Medi-Cal program plays a critical role in California, providing health coverage for a third of all residents, including those with complex health care needs and significant economic and social challenges. Like other states facing federal and other budgetary pressures on their Medicaid spending, California is eager to identify and support innovative models of care that have the potential to both improve member health outcomes and reduce cost trends over the long term.

Medi-Cal managed care organizations (MCOs) are central to achieving these objectives, and some are investing in innovative models that go above and beyond the required benefits. However, these plans have been hampered in their efforts to bring such initiatives to scale and maintain them over time by disincentives built into the Medi-Cal MCO rate structures. What is needed is an approach that aligns health plan incentives with the state's goals and to reduce the long-term cost trend.

The California Health Care Foundation, with support from Manatt, convened a work group to consider how the state's rate-setting methodology might be revised to address these unintended consequences, within the constraints of the current Medi-Cal budget. Work group members included high-level representatives from six Medi-Cal MCOs representing over 50% of covered lives; the Medi-Cal director served as an advisor (see sidebar).

### Work Group Participants

#### Members

Maya Altman, CEO, Health Plan of San Mateo

Patricia Clarey, Chief State Health Programs and Regulatory Relations Officer, Health Net, Inc.

Brad Gilbert, CEO, Inland Empire Health Plan

Patti McFarland, CFO, Partnership HealthPlan of CA

Marie Montgomery, CFO, L.A. Care Health Plan

Matthew Schueren, CFO, Molina Healthcare of CA

#### Advisor

Mari Cantwell, Chief Deputy Director, Health Care Programs, DHCS

This report reflects their analyses and recommendations for improving the state's rate-setting methodology.

## Overview of Current Medi-Cal MCO Rate-Setting Process

Of Medi-Cal's 13.3 million enrollees, four of five (81%) are served through managed care, the majority through one of three models: the two-plan model, County Organized Health Systems (COHS), and Geographic Managed Care (GMC). In the two-plan model — the most common in terms of number of lives covered — DHCS contracts with one county-developed plan called a local initiative and one commercial plan. In COHS counties, the county operates a single managed care plan with which DHCS contracts directly. In GMC counties, DHCS contracts with several commercial plans. A variety of other managed care contract models are in use in California as well.

Medi-Cal's managed care system typically involves additional layers of delegation and subdelegation of risk and responsibilities for the coordination and provision of patient care. In some areas, the plan or county subcontracts to other plans; in many areas, the plans (the primary plan and/or the subcontracted plan) delegate risk to independent practice associations, medical groups, and sometimes hospitals. California is somewhat unique in its use of delegation of risk from plans to providers, not just in Medi-Cal but across business lines, including Medicare Advantage and commercial products.

Regardless of the model, the state's Medi-Cal program establishes the methodology used to develop the rates paid to Medi-Cal managed care organizations. In general, for any given rate-setting year, DHCS and its actuary employ a combination of plan-specific utilization and risk-adjusted county average utilization to inform each plan's rates (see Figure 1). There is a significant lag involved in the process; the rates are based on data from about 33 months prior to the beginning of the rate year.

Information used in rate setting includes plan-specific encounter data and supplemental utilization and cost data. Various adjustments are made — for example, to account for program changes that took place during or after the base data period. Efficiency adjustments are then applied at the health plan level, including two related to pharmacy cost management and one related to potentially preventable admissions. The last step in the rate-setting methodology is applying an administrative

and profit load. The administrative load is model-specific, not MCO-specific.

Figure 1. Rate Development Process Flowchart



Source: Mercer (Medi-Cal actuary).

## Current Challenges and Unintended Consequences

While California's current rate-setting methodology is actuarially sound and similar to the methodologies in other states, it does not encourage plans to improve health care access and quality or to address socioeconomic issues that impact member health. In fact, the rate-setting methodology discourages plans from investing in a significant and sustained way in initiatives that can reduce costs while helping members gain or maintain better health. Because rates are based on prior utilization, if a plan invests in initiatives that result in lower use of expensive inpatient, emergency, or other services, the cost basis for its rates in future years will decline. This phenomenon is sometimes referred to as "premium slide." Similarly, the efficiency adjustments are one-sided, meaning that they are used to lower rates rather than reward or encourage successes in providing efficient care.

Another challenge is a lack of clarity regarding what non-medical investments and activities plans can get credit for in the rate-setting process. As part of rate setting and medical loss ratio (MLR) calculations, plans can get credit for quality-improvement initiatives. However, the current definition of what counts as quality improvement is vague; plans may be hesitant to make certain health-related investments out of concern that they may not count and would therefore be viewed as administrative expenses.

Currently, the rate-setting methodology also limits the state's ability to recognize an MCO's specific business model when applying policy change adjustments and nonmedical load assumptions. For instance, if an MCO invests in an intervention that increases its administration expenses but lowers use of services, the current methodology would recognize the lower utilization (resulting in lower base data as discussed above) but would not adjust the administration expenses for that MCO. Lastly, the 33-month rate-setting lag means capitation rates may not be well matched to current expense levels.

These features of the Medi-Cal rate-setting process are not unique to California; other states have similarly considered how their rate-setting methodology might be modernized to achieve greater efficiency and improved health outcomes.

Optumas developed a model to illustrate the current rate-setting methodology and to help explain the associated challenges (see box). This model was also used as a basis to compare how the recommended rate adjustment would work. It demonstrates the current disincentives

### Medi-Cal Rate-Setting Status Quo

Using data for a hypothetical Medi-Cal population with 155,000 member months, Optumas developed a "status quo" model with a time horizon of 10 years to illustrate the current rate-setting methodology and how a health plan investment that achieves a reduction in use of health care services affects state savings. The model assumes that:

- ▶ The hypothetical plan invests minimally (\$100,000 total, or \$0.65 per member per month) every other year in interventions that improve care and lower costs.
- ▶ These interventions do not receive credit in rate setting — either in the medical or nonmedical load.
- ▶ The cost-savings rate from the intervention is low (0.5% to 1%).
- ▶ The nonmedical load of the total per member per month (PMPM) rate (i.e., administrative expenses and profit margin) is 7%.
- ▶ The total starting PMPM rate in year one (including medical and nonmedical load) is \$497.90.
- ▶ There is no change to how the state currently sets its cost trend, and the model uses a 5% cost trend as a placeholder assumption.

The table below summarizes the outcomes of the model over the 10-year projection period for the following statistics:

- ▶ **10th-year premium PMPM.** The capitation rate for the 10th year.
- ▶ **Total health-related investment (HRI).** Sum of plan expenditures on health-related investments for years 1 to 10.
- ▶ **State portion of HRI.** The 10-year aggregate amount the state contributes to plan investments via capitation rates, by giving plans credit for investments in medical and/or nonmedical load of rates.
- ▶ **Plan portion of HRI.** The 10-year aggregate amount of plan intervention costs that do not receive state financing support.
- ▶ **State savings.** Savings associated with reductions in utilization for years 1 to 10. Savings represent cost avoidance and are realized by lowering the base rate in future rate-setting cycles. The savings are net of state funding for HRI.
- ▶ **Plan rate adjustment.** The amount of savings shared with a plan in the form of an addition to their nonmedical load for future rates; the amount is dependent on savings generated by the plan's investment.

#### Status Quo Model

10TH-YEAR PREMIUM PMPM	TOTAL HRI	STATE PORTION OF HRI	PLAN PORTION OF HRI	STATE SAVINGS	PLAN RATE ADJUSTMENT
\$768.55	\$1.0 million	\$0	\$1.0 million	\$1.6 million	\$0*

\*Because there is no incentive for investments in the current rate-setting methodology.

Notes: Please see Appendix A for a year-by-year view of the status quo model. For ease of modeling, the rate-setting lag is assumed to be 36 months instead of 33 months.

for plans to make substantial, ongoing investments in health-related initiatives. The model shows that when plans do make investments, they bear the cost. When those investments are successful, they negatively impact future rates, with the state reaping all the savings, except in the first three years, due to the rate-setting lag. As such, it is unlikely that plans will make these investments, or sustain them over the long term, or that the state will realize these savings.

## Work Group Process and Principles for Evolving California’s Rate-Setting Methodology

The work group met five times between May and December 2017, starting with an articulation of principles for the rate-setting method (see sidebar). Optumas provided actuarial expertise and modeling to examine the options considered by the work group.

### Work Group Principles for Evolving the Medi-Cal Rate-Setting Methodology

- ▶ Encourages health plans to work with providers to promote care “with the right provider, in the right place, at the right time”
- ▶ Encourages health-related investments that yield better health outcomes and lower costs
- ▶ Encourages innovation for care transformation activities
- ▶ Allows health plans to reinvest cost-savings into the care delivery system, in alignment with Medi-Cal’s objectives
- ▶ Aligns with the state’s vision for the future of Medi-Cal

## Recommended Approach

The work group recommended an approach with three components:

1. **Implementing a rate adjustment**
2. **Enhancing financing for health-related investments**
3. **Adding a social determinants of health risk adjustment to the rate-setting methodology**

Only component 1 — implementing a rate adjustment — directly reduces the current disincentive for plans to invest in health-related initiatives. Components 2 and 3 enhance the impact of the first component, but would not on their own address the disincentive; as such, they are not essential to the integrity of the approach but are proposed as complementary strategies. The work group also considered other options, including one in which there would be shared savings between the state and the plans and another for state direction to plans regarding adoption of value-based purchasing strategies with their providers. The work group also considered other options, including one in which there would be shared savings between the state and the plans and another for state direction to plans regarding adoption of value-based purchasing strategies with their providers. For various reasons, the work group chose not to incorporate these options into the recommended approach (see Appendix C). Additionally, a critical assumption of the work group was that it would not consider carving in additional populations or services or increasing the level at which rates are set. For this reason, a pay-for-performance initiative was not considered.

After identifying the basic approach, the work group focused on identifying key design elements, ways in which those elements might be structured, how they may impact plans’ decision to make investments, and their impact on overall savings. These issues are discussed below following a basic description of each of the components of the recommended approach.

COMPONENT 1

## Implementing a Rate Adjustment

The primary component of the recommended approach is to devise a rate adjustment that would address the disincentives for plans to invest in initiatives that improve care and generate savings. In this approach, the state and plans each benefit if the plans' investments achieve savings. The concept, which is similar to shared savings, was first generated in Oregon and a version is currently under design and implementation in that state.

### Overview

As envisioned for California, a plan-specific rate adjustment is triggered if a plan meets each of the following three criteria: (1) generates savings above a threshold, (2) meets quality targets, and (3) demonstrates that it is investing at least a specified amount into health-related initiatives as defined by the state (see Figure 2). The rate adjustment would be incorporated into the nonmedical load of a plan's rate — the size of which primarily depends on how much savings are generated, and how those savings are split between the state and plans. A major objective is to encourage different kinds of investments — ones that plans typically have not made — that have high potential to benefit member health and cost.

The cost-savings criterion ensures that no rate adjustment is made unless the plan is successful in achieving savings above a minimum level. This makes certain that there is not a net increase in Medi-Cal rates. The cost-savings criterion is described in detail in the following section

(Mechanics and Critical Design Elements on page 12), and the quality and threshold level of investment criteria are described in the following paragraphs.

The quality criterion helps ensure that the recommended approach actively advances the state's quality objectives, and that cost savings do not come at the expense of quality or access. The work group was supportive of developing a balanced scorecard approach that includes metrics focused on data quality and social determinants of health in addition to more traditional quality measures, such as the Healthcare Effectiveness Data and Information Set (HEDIS). The group recommended that plans be expected to both meet an absolute threshold level of performance on important indicators and to achieve improvement over prior performance. Given the high variation in performance across rural and urban counties, the quality targets should take into consideration California's geographic realities. The work group also considered ways to further encourage improvements in quality performance by linking the size of the rate adjustment to quality scores. For example, the rate adjustment for plans that achieve high quality scores could reflect a plan-state savings split that directs a higher portion of the savings to the plan.

The third criterion, the threshold level of health-related investments, is aimed at ensuring that plans are not benefiting from the rate adjustment unless they are investing in health-related initiatives at a minimum level, which could be proportional to the number of lives and defined as a per member per month amount. Allowable initiatives

Figure 2. Rate-Adjustment Criteria



would be determined by the state in consultation with plans and other stakeholders and could evolve over time with experience on efficacy. Investments may be targeted to help address social and economic conditions that affect health, improve or maintain member health, and/or support delivery system reform efforts. Plans have identified several areas of interest (see box), which can serve as a starting point for further discussion. The state and plans would need to determine a way to account for the plans' level of investment while minimizing administrative burden to both. Plans would not be required to

show causation between savings and investments but would be expected to evaluate the impact of their investments, get smarter, and refine their investment strategies over time.

The sidebar on page 12 provides examples of how two plans are currently making some health-related investments; implementing the proposed rate adjustment could help plans to bring these types of initiatives to scale and sustain them over time.

### Work Group-Generated List of Health-Related Services and Interventions for Coverage Consideration

Work group members reported interest in securing coverage or at least credit in the rate-setting process for the following health-related services and interventions:

- ▶ Residential care facilities for the elderly and adult residential facilities in lieu of long-term care (LTC) or psychiatric inpatient stays
- ▶ Personal care service (PCS) in lieu of LTC for those who live alone and cannot self-direct
- ▶ Recuperative care / medical respite care in lieu of inpatient or skilled nursing facility (SNF) stay
- ▶ SNF in lieu of inpatient stay
- ▶ Medical care in the home in lieu of office visit
- ▶ Housing in lieu of post-acute care facilities
- ▶ As part of a cost-effective community living arrangement, a care plan with the following services in lieu of custodial LTC or psychiatric inpatient stay:
  - ▶ Medically tailored meals
  - ▶ Onsite residential support
  - ▶ Fiduciary services
- ▶ Transitional medically tailored meals
- ▶ Behavioral health services — sobering stations, crisis stabilization/centers
- ▶ Drug Medi-Cal flexibility
  - ▶ Medication education and delivery
  - ▶ Medication-assisted treatment drugs added to managed care toolbox (e.g., Suboxone)
  - ▶ Long-term injectable medications
  - ▶ Financial aid on high-cost meds that the state mandates coverage for
- ▶ Home modifications
- ▶ Technology (e.g., iPads or other for use in rural areas)
- ▶ Housing supports — security deposits, short-term motel stays, bridge housing, vouchers for short- and long-term) room/board, board and care, and recuperative care centers
- ▶ Socialization/peer supports
- ▶ Support with the opioid crisis
- ▶ Additional PCS
- ▶ Scope-of-practice issues (i.e., ability for nurse practitioners and others to deliver services)

## Two Examples of Plans Testing Novel Health-Related Investments

### Health Plan of San Mateo (HPSM)

#### *Community Care Settings Pilot*

In 2004, HPSM started the Community Care Settings Pilot, which gives older and disabled members living in nursing homes options to live in the community with extensive but less costly services. The program includes two components: (1) intensive transitional case management designed to aid nursing home residents to return to the community or helping those at risk of long-term care maintain community living and (2) housing services including housing search, unit repairs and modifications, lease arrangements, owner-resident liaising, and ongoing service supports. To date, HPSM has transitioned more than 200 people. Program evaluations show greater member satisfaction and 50% lower health care costs in the six months after the move than in the previous six months.

### Inland Empire Health Plan (IEHP)

#### *Integrating Physical and Behavioral Health*

IEHP has created an in-house behavioral health program to address the mild-to-moderate mental health needs of its members, integrated behavioral health into every department, trained staff, and expanded its behavioral health provider network to ensure timely access. Additionally, IEHP created a web-based coordination-of-care system to facilitate communication and collaboration among behavioral health providers, the member's primary care physician, and IEHP behavioral health care managers. IEHP reports that, as a result of these and other changes, the number of outpatient behavioral visits has increased while inpatient behavioral health bed days have dropped significantly.

IEHP is investing in a \$20 million initiative to revamp how care is delivered by integrating behavioral health care at the point of care with 13 entities across 34 sites (including county-operated primary care clinics, FQHCs, a community-based adult services center, an assisted living facility, and behavioral health clinics). The initiative is aimed at improving care and addressing the high cost of caring for people with comorbidities in siloed settings.

See component 2 on page 18 for further discussion on health-related investments and for options on incorporating them into the rate-setting methodology.

## Mechanics and Critical Design Elements

The outcomes of the rate adjustment — state savings and the size of the rate adjustment for any plan that qualifies — are highly dependent on certain design decisions or policy levers relating to the overall approach, including the following:

**Shared-savings split.** The size of the rate adjustment depends not only on the level of savings generated but on how the savings are split between the state and plans (e.g., on a 50/50 basis). The goal is to achieve state savings, but also to use a portion of savings to provide the rate adjustment to plans, which is integral to achieving the savings. The higher the percentage of savings directed to MCOs, the greater their incentive to make investments.

**Minimum-savings rate (MSR).** The MSR is the level of savings necessary to trigger an incentive payment; it is designed to ensure that plan savings are not due to chance. For example, if the state had projected a plan's PMPM expenditures to increase by 3% but they rose by only 2%, then the plan's savings rate is 1%. If the state set the MSR at 0.5%, then that plan would meet the MSR requirement. The higher the MSR, the more savings that plans will have to generate before being eligible for the rate adjustment. Also, as modeled, if the MSR is met, total savings — not just those above the MSR — are split between the state and plans; however, the model could be constructed such that only savings above the MSR will be shared with plans.

**Credit for health-related investments in plans' rate.** It is possible to recognize some portion of the plan's investments in the rate-setting process through inclusion as part of the medical or nonmedical load. (See component 2 on page 18 for a discussion of how such investments might be included in the computations of the plan's rates.)

The outcomes of the rate adjustment are also highly dependent on assumptions about intervention return on investment (ROI) — which typically is not fully known at the launch of a program and is dependent on intervention effectiveness.

Optumas developed a model using hypothetical plan data to examine the extent to which updating the rate-setting methodology to include a rate adjustment could promote plan and state investments in health-related initiatives and illustrate the range of performance outcomes under different policies (i.e., the design levers) and assumptions relating to ROI. The goal of the modeling was not to determine the optimal setting for each

lever but rather to demonstrate the sensitivity of the approach to different design features and assumptions. The box below indicates the features modeled for the various scenarios.

Similar to the status quo model, each scenario was modeled to determine the expected impact on the 10th-year premium, total health-related investment, state portion

## Features Modeled

**Scenario 1, or the “rate-adjustment baseline model,”** incorporates the following features:

- ▶ MSR at 0.5%, meaning no savings are split unless at least this level of savings is achieved
- ▶ Shared-savings split (plan/state): 50%/50% for years 1 to 10
- ▶ Credit that plans receive for their investments in rate setting (medical load/nonmedical load/not credited): 25%/25%/50% for years 1 to 10
- ▶ Intervention expense: \$600,000 annually for years 1 to 10
- ▶ Cumulative savings rate: tops out at 4% for years 6 to 10\*

**Scenario 2, or “increased shared-savings rate,”** maintains all the features of Scenario 1/Baseline, except for the shared-savings rate, which is modified as follows:

- ▶ Years 1 to 6: 50%/50%
- ▶ Years 7 to 10: 75%/25%

The rationale for this change is that over time, it may be challenging for plans to generate incremental savings: as plans generate savings, they need to not only maintain the savings from prior years but also exceed it in order to generate incremental savings and a rate adjustment. Implementing this change at year 7 was selected based on the rate-setting lag: year 7 represents two cycles of experience with rate adjustments and savings being built into capitation rates. Therefore, year 7 is a reasonable time to change savings to encourage continued incremental savings. Optumas chose 75% as a method of limit-testing the impact of this modification.

**Scenario 3, or “increased credit for plan investment in medical and nonmedical load,”** maintains all the assumptions of Scenario 1/Baseline except for the level of credit that plans receive as part of the rate-setting methodology for their investments. The modification boosts level of credit to 33.3% in both the medical load

and the nonmedical load (which leaves 33.3% uncredited). This tests the impact of when the state partners with plans in bearing more of the up-front cost of the intervention investment. At the same time, it recognizes that some plan investments — for instance, direct payment for housing — will never qualify as a coverable expense.

**Scenario 4, or “combined,”** represents a blend of scenarios 1, 2, and 3 to consider the interaction of the modified design elements.

- ▶ **Shared-savings split (plan/state):** 50%/50% in years 1 to 6, 75%/25% years 7 to 10 (same as Scenario 2)
- ▶ **Credit that plans receive for their investments in rate setting (medical load/nonmedical load/uncredited):**
  - ▶ Years 1 to 5: 25%/25%/50% (same as Scenario 1)
  - ▶ Year 6 to 10: 33.3%/33.3%/33.3% (same as Scenario 3)

All scenarios assume the same level of plan investment and the same cumulative savings rate\* and maintain the MSR at 0.5%. The following simplifying assumptions were made for the purposes of the modeling exercise: the model assumes investments result in savings within the same year, but in reality, there will likely be a lag in when the impact of an investment manifests in a change in plan members’ use of services and in the utilization data reported to DHCS. Similarly, an average ongoing investment of \$4 PMPM has been modeled out, but in reality, the experience may be less even year over year, depending on whether investments are capital-intensive or programmatic.

\*Cumulative savings rate refers to the total savings associated with health-related investments from the beginning of the intervention. For example, based on the rate-setting lag, beginning in rate-setting year 4, the savings generated from health-related investments in year 1 are factored into the base rate. To generate incremental savings, the plan must maintain original savings and generate more.

of health-related investments, plan portion of health-related investments, state savings, and the plan rate adjustment. The box below summarizes the quantitative outcomes from the model and shows that:

- ▶ When compared to the status quo, implementing a rate adjustment would result in lower PMPM premium for plans at the end of 10 years — 2.8% lower. It would also result in savings for the state (\$4.3 million) and rate adjustments for plans (\$4.4 million)

as a result of increased and high-value health-related investments by the plans (Scenario 1).

- ▶ Increasing the shared-savings rate in favor of plans in the out years could help to sustain investments as savings become harder to achieve over time. It would result in a modest shift of savings from the state to the plans of about \$0.5 million (Scenario 2).

### Results of Rate-Adjustment Scenario Modeling

The table below summarizes the outcomes of all scenarios over a 10-year projection.

	10TH-YEAR PREMIUM PMPM (% CHANGE RELATIVE TO STATUS QUO)	TOTAL HRI (MILLIONS)	STATE PORTION OF HRI (MILLIONS)	PLAN PORTION OF HRI (MILLIONS)	STATE SAVINGS (MILLIONS)	PLAN RATE ADJUSTMENT* (MILLIONS)
<b>Status Quo</b>	\$768.55	\$1.0	\$0	\$1.0	\$1.6	\$0
<b>Scenario 1.</b> Baseline	\$747.02 (-2.8%)	\$6.0	\$2.1	\$3.9	\$4.3	\$4.4
<b>Scenario 2.</b> Increased shared-savings rate	\$748.18 (-2.7%)	\$6.0	\$2.1	\$3.9	\$3.8	\$4.8
<b>Scenario 3.</b> Increased credit for plan investment in medical and nonmedical load of base	\$746.47 (-2.9%)	\$6.0	\$2.8	\$3.2	\$4.3	\$3.3
<b>Scenario 4.</b> Combined increase in shared savings and in credit for plan investment	\$745.45 (-3.0%)	\$6.0	\$2.3	\$3.7	\$4.6	\$3.8

### DEFINITIONS

**10th-year premium PMPM.** The capitation rate for the 10th year.

**Total health-related investment (HRI).** Sum of plan expenditures on health-related investments for years 1 to 10.

**State portion of HRI.** The 10-year aggregate amount the state contributes to plan investments via capitation rates, by giving plans credit for investments in medical and/or nonmedical load of rates.

**Plan portion of HRI.** The 10-year aggregate amount of plan intervention costs that do not receive state financing support.

**State savings.** Savings associated with reductions in utilization for years 1 to 10. Savings represent cost avoidance and are realized by lowering the base rate in future rate-setting cycles. The savings are net of state funding for HRI.

**Plan rate adjustment.** The savings shared with a plan in the form of an addition to its nonmedical load for future rates; the amount is dependent on savings generated by the plan's investment.

\*Plans also retain any savings generated by investments in the first three years, before utilization reductions get factored into their rates. Note that the model employs a simplifying assumption that savings are generated in the first year of implementation. In reality, it is likely that there will be a delay in when interventions demonstrate impact.

Note: See Appendix B for year-by-year results for each scenario.

- ▶ Increasing credit for plan investments would reduce the risk for plans. Of the total \$6 million health-related investment, the plan would contribute \$3.2 million (down from \$3.9 million in Scenario 1). The portion covered by the state would increase from \$2.1 million in Scenario 1 to \$2.8 million. However, it would also reduce the plan rate adjustment by over \$1 million, from \$4.4 million in Scenario 1 to \$3.3 million. In this scenario, the plan takes on less risk by having more intervention funding included in capitation rates, and sees lower rewards (Scenario 3).
- ▶ Combining the increased shared-savings rate in favor of plans and the increased credit for plan investments would achieve the greatest drop in the PMPM (3% relative to status quo) and the largest amount of state savings (\$4.6 million). It would decrease the plan's rate adjustment by \$0.6 million relative to Scenario 1 — although it's still sizable at \$3.8 million (Scenario 4).

In all of the scenarios modeled above, the same level of ROI is assumed, but of course, the efficacy of the investments may vary from year to year or plan to plan. This is not a policy lever per se, since neither the state nor the plan can set an ROI. However, as plans test new types of interventions and as the plans and the state gain more insight into the efficacy of investments, it is reasonable to assume the rate of return will vary. Optumas conducted a sensitivity analysis to provide insight into the range of possible outcomes if return is higher or lower than assumed in the scenarios modeled above. The sensitivity analysis demonstrates that savings for the state and plans is highly dependent on ROI but that even a less-effective intervention, with a lower ROI (Sensitivity A in box below), still generates savings and reduces the 10th-year PMPM relative to the status quo.

### Sensitivity Analysis

	10TH-YEAR PREMIUM PMPM	TOTAL HRI (MILLIONS)	STATE PORTION OF HRI (MILLIONS)	PLAN PORTION OF HRI (MILLIONS)	STATE SAVINGS (MILLIONS)	PLAN RATE ADJUSTMENT (MILLIONS)
<b>Status Quo</b>	\$768.55	\$1.0	\$0	\$1.0	\$1.6	\$0
<b>Scenario 4.</b> Combined increase in shared savings and in credit for plan investment	\$745.45	\$6.0	\$2.3	\$3.7	\$4.6	\$3.8
<b>Sensitivity A.</b> Scenario 4 with a decreased investment ROI	\$753.57	\$6.0	\$2.3	\$3.7	\$2.1	\$3.5
<b>Sensitivity B.</b> Scenario 4 with an increased investment ROI	\$748.15	\$5.0	\$2.0	\$3.0	\$3.8	\$4.9

### DEFINITIONS

**Sensitivity A.** Assumes a lower ROI by decreasing the cumulative savings for interventions over time to max out at 3% instead of 4%. The rationale for this test is that 4% savings may be hard for plans to achieve, and a more probable outcome is 3%.

**Sensitivity B.** Assumes a higher ROI by decreasing the cost of the intervention (from \$600,000 annually to \$400,000 in years 6 to 10) while maintaining the same savings percentage. The rationale for this change is that as plans develop greater expertise implementing and evaluating certain interventions, they become more effective and can achieve the same results with lower investment.

## Implications

The analyses undertaken by the work group, including the modeling, pointed to the following key takeaways:

### 1. Relative to the status quo, implementing a rate adjustment into the current rate-setting methodology better aligns plans' incentives with state goals.

As modeled, the rate adjustment can generate savings for the state and reward plans for bending the cost curve; in this way, the recommended approach aligns incentives for plans to support the state's cost, quality, and investment objectives.

### 2. The model can be dynamic to encourage continued investments and balance risks and benefits for the state and plans.

Overall, the risks and rewards are tilted toward the plans. If there are fewer savings than anticipated, it predominantly impacts plan experience, and if there are additional savings the plan benefits. This is partly due to the model parameter settings, including the shared-savings split and MSR, but it is also caused by the rate-setting lag, which allows plans to bear the risk and benefit of early investments before they get incorporated into the base data for rate updates. Over time, however, it can become increasingly challenging for plans to maintain savings and generate new savings — creating the risk of reverting to the status quo. To mitigate this challenge, the design can be dynamic; for instance, the state can increase plan incentives in the out years (e.g., with a greater share of savings going to the plans) to encourage continued investments.

Policy levers, such as the shared-savings split, and credit for health-related investments in rate setting, as well as the MSR level, can be adjusted to balance risk and reward for the state and plans. The key is to ensure not just a “fair” balance but that the mix is such that the approach is successful in generating savings in the first place (with no negative impact on quality). That requires mitigating premium slide for plans and promoting effective investments. If all of the savings accrue to the state — as is the current situation — the plans will likely not invest and the state savings likely will not materialize or continue. And of course, if the plans reap all the savings, the state has no reason to revise its rate-setting methodology in these ways.

Another important finding from the modeling exercise is that increasing the percentage of health-related investment expenses accounted for in rate setting — either in the medical or nonmedical load — provides a plan with more financial support for interventions but less potential for the rate adjustment. The converse is also true.

### 3. The downside risks for all parties are limited.

If the investments fail to generate meaningful savings, the state may have incurred some expense (by recognizing some of the investment in the medical and nonmedical loads of plan rates), as will have the plans. However, other than those early investment losses, not much would change if the approach does not generate meaningful savings; this is because behaviors would regress to being very similar to the status quo — with plans scaling back on investments, generating limited savings, and therefore not being eligible for a rate adjustment. The state could mitigate its exposure by requiring plans to bear more of, or even the entirety of, their investments, perhaps until the efficacy of the interventions becomes apparent.

In the event of an extremely successful outcome, it may become necessary to monitor whether the rate adjustment trips the 5% incentive cap set by the Centers for Medicare & Medicaid Services (see sidebar) or the 85% MLR threshold. The scenarios modeled by Optumas suggested this was a low risk.

## Federal Considerations for Implementing a Rate Adjustment

There are different ways a state can structure some sort of rate-adjustment approach consistent with federal managed care regulations. One way is to consider the portion of the savings shared with plans as an incentive payment. The Medicaid Managed Care Final Rule (42 CFR 438.6 [b] [2]) explains that MCOs may receive an incentive arrangement payment of up to 5% of capitation rates. Incentive arrangements are defined as any payment mechanism under which a contractor may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract. Assuming the state builds an actuarially sound rate and the incentive payments do not exceed 5% of that rate, the state will be able to claim federal matching dollars for rates developed using this new methodology.

#### 4. Beneficiaries stand to gain the most.

While the state and plans both benefit through better alignment of Medi-Cal's rate-setting methodology with quality and cost goals, beneficiaries potentially stand to gain the most from the recommended approach. The investments in health-related initiatives are aimed at making the care delivery system more responsive to beneficiary needs, more preventive and outpatient-oriented, and more attuned to the whole person's situation — not simply their medical ailments.

### Design and Implementation Considerations

Should the state choose to update the current rate-setting methodology with the recommended rate-adjustment approach, the following are important implementation considerations:

#### ► Complementarity with current rate-setting process

The rate adjustment could be layered on top of the current rate-setting process, described earlier. In the event of significant program changes, such as the addition of a relatively costly new benefit or population, the state could apply the rate-adjustment calculations to the preexisting populations and benefits and essentially carve out the program change for the first year(s) of its implementation. This could allow MCOs time to adjust, and give the state sufficient experience with the program changes to develop trend projections. Alternatively, the program change could be included in the rate-adjustment calculations as long as the state is able to accurately model the projected costs associated with the program change.

Implementing the quality targets and establishing a threshold level of health-related investment will not require updates to the rate-setting methodology, but will require processes for target setting and evaluating whether a plan has met the criteria to receive a rate adjustment when it generates cost savings.

The work group briefly explored whether shifting to regional rate setting could complement and enhance the impact of a rate adjustment. Regional rate setting would essentially enlarge the (currently county-based) pools that get used for averaging of participating plans, which could provide more incentive for plans to achieve lower utilization than the regional trend. On its own, however, regional rate setting would not necessarily encourage or support the types of non-traditional, innovative health-related investments intended through the rate-adjustment approach.

The group did not fully explore the implications of regional rate setting but did conclude that shifting to regional rate setting would neither obviate the need for, nor materially affect, the rate adjustment. It would also likely require a fundamental restructuring of the Medi-Cal program. The group recommended it be considered separately.

#### ► Pilot versus full launch

The work group recommended that the rate adjustment be implemented as an update to the rate-setting process applicable to all plans. While conducting a pilot could provide insightful information, at least four years would need to elapse to see results due to the rate-setting lag. The group thought that a broad launch that includes all plans would accelerate the pace of reform and maximize the potential for savings. Note that plan participation in the broad launch could in theory be voluntary, but plans in multiplan counties that opt not to participate may feel downward pressure on their rates if other plans participate and are successful at bending the cost curve. This is because the majority of their rate is determined through county averaging.

A broad launch would not preclude the state from making refinements to the model — including the quality and investment criteria — over time.

The recommended rate-adjustment approach requires a medium- to long-term view (3 to 5 years) of performance for health plans as a result of both the time it takes for investments to demonstrate impact, and the almost-three-year rate-setting schedule. This could require a shift in strategy for those plans focused primarily on annual or quarterly performance results.

#### ► Refinements to model parameters

To move the recommended approach into implementation, the following steps would need to be taken:

- *Determining the settings for policy levers.* This includes determining the MSR, shared-savings split, and level of credit for health-related investments in rate setting. The values used in the modeling provide a starting point for refining the policy levers.

- ▶ *Defining the quality requirement.* The work group recommended that the quality component include a balanced scorecard of metrics focused on data quality, social determinants of health, as well as traditional health care quality metrics. It also recommended that plans be offered incentives for both absolute performance as well as improvement. More work will need to be done to develop a preliminary dashboard, and the state could integrate it into existing quality initiatives.
- ▶ *Establishing the threshold and process for reporting health-related investments.* A process would need to be developed for defining allowable investments and determining how to set and report the health-related investment spending threshold. It also recommended that plans be encouraged to meet an absolute threshold level of performance on important indicators and to achieve improvement over prior performance. Plans and the state may also need to develop accounting systems to track health-related investments, both for calculating whether the investment threshold is met and for credit in rate setting. This information is not currently captured in encounter data. Arizona might serve as an example in that respect.

## COMPONENT 2

### Enhancing Financing for Health-Related Investments

As a complementary strategy to the rate adjustment, the work group expressed a strong interest in both clarifying what types of investments can count within the current plan expense base and exploring additional avenues for financing these investments. Doing so would encourage the state to share in some of the investment risk with plans, since the investments are expected to be non-traditional, innovative approaches for addressing members with complex medical and social needs that could yield savings down the road. The state is eager to encourage such savings (see sidebar). The savings associated with the rate-adjustment approach is expected to offset state funding for investments, thus ensuring the Medi-Cal program does not increase its aggregate PMPM expenditures. Additional state funding for such investments or tied to health plan performance would augment improvements in access, quality, and outcomes.

#### The Role of Social Determinants of Health in Health Outcomes

A growing body of evidence indicates that social factors, such as income, education, access to food and housing, and employment status play an equal, if not more important role, than medical care in influencing health outcomes, particularly in lower-income populations.<sup>9</sup> According to Booske and colleagues, up to 40% of health outcomes are driven by non-medical factors such as income, education, and occupation, compared to only 20% driven by clinical care.<sup>10</sup> State Medicaid agencies and MCOs are uniquely positioned to work together and with other key partners — including local government and community-based organizations — to address the social determinants of health as a means to improve member health status and to drive down use of high-cost emergency and acute care services.

The state has a variety of ways to recognize some of a plan's health-related investments when it calculates the MCO rates. Some investments can be counted in the medical load when setting capitation rates. For example, making effective linkages to social service programs and services that help people secure housing can be classified by a state as Medicaid benefits under existing federal legal authorities.<sup>11</sup> In some cases, the state may be able to rely on its existing authority to cover these services, and in other cases, it may need to modify its state plan, as permitted by federal law. Other types of investments can be financed through the capitated payments made to the plans at the discretion of the plan and as approved by the state, with the cost built into the managed care rates. These are called "in-lieu-of services." Examples of in-lieu-of services include care in a SNF rather than acute inpatient facility for recovery, and recuperative care / medical respite care in lieu of an inpatient or SNF stay. Some investments, such as those deemed quality-improvement activities by the state, can be counted in the nonmedical load when setting rates. Investments that cannot be included in the calculation of an MCO's rate can be paid for through other plan resources. As noted above, credit for investments in rate setting, either under the medical or nonmedical load, has implications under the rate-adjustment approach; it increases plans' certainty of state financial support for some investments but reduces the size of the potential rate adjustment. It also has implications for the MLR; investments that qualify as benefits, in-lieu-of services, and even quality-improvement activities in the nonmedical load will count in the numerator of the MLR.

Below is a list of ways that states can finance these investments with Medicaid funds:

**State plan amendment (SPA).** While some services are required to be provided under federal Medicaid rules, states have discretion to shape the scope of their benefits for adults. For example, under the case management and targeted case management benefit, states may cover costs associated with helping beneficiaries access needed medical and social services (for example, linking people with Supplemental Nutrition Assistance Program or other nutritional services). States define the scope of the benefits they cover through their state plan and can modify the scope through an SPA; as long as the

modification is consistent with federal law, no waiver is required. While the state may choose to make such benefits broadly available to beneficiaries who need them, states have authority under Section 1937 of the Social Security Act to design benefits under its state plan (no waiver required) for a targeted group of adults through what is referred to as an Alternative Benefit Plan. To limit financial exposure and align benefit enhancement with the rate-adjustment approach, California could target enhanced services to beneficiaries enrolled in managed care.

**In-lieu-of services.** Medicaid managed care plans can also cover certain services or investments with the Medicaid payments they receive from the state if they are considered "in-lieu-of services" under federal rules. These are services covered under the state plan but are delivered by a different provider or in a different setting than is described in the state plan; for example, providing a service in an ambulatory surgical center rather than an inpatient hospital setting. The costs of in-lieu-of services can generally be built into the medical load when setting capitation rates.<sup>12</sup> An in-lieu-of service or setting can only be covered if (1) the state determines it is a medically appropriate and cost-effective substitute or setting for the state plan service, (2) beneficiaries are not required to use the in-lieu-of service, and (3) the in-lieu-of service is authorized and identified in the contract with plans.

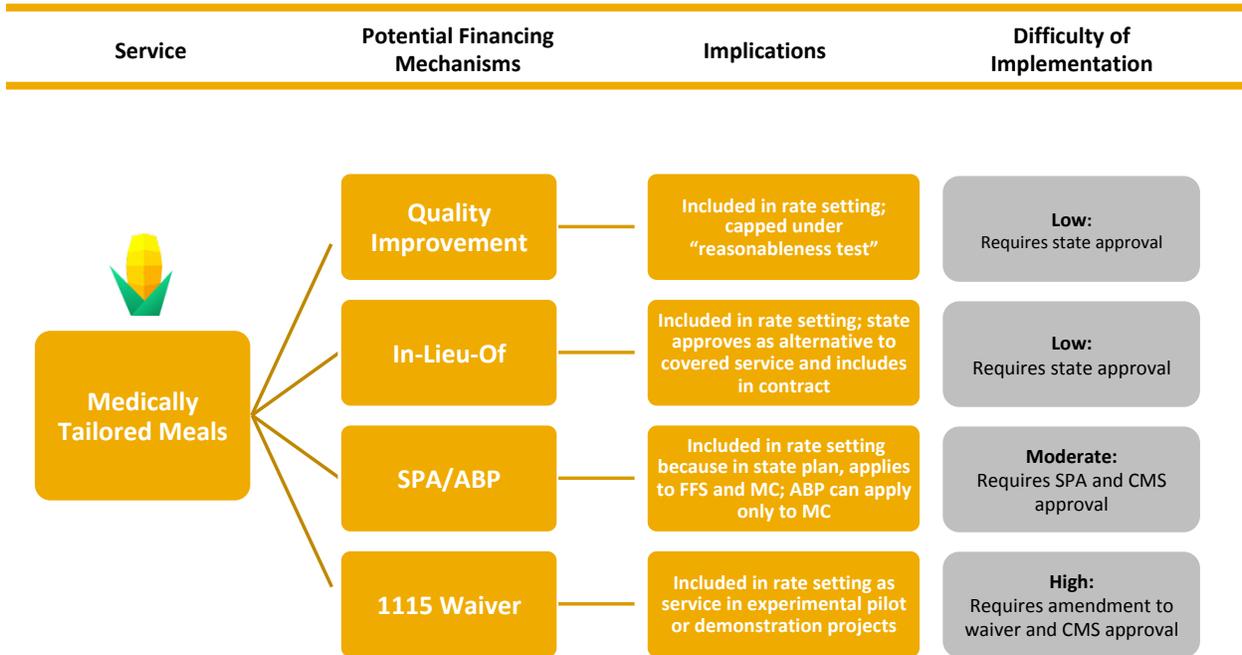
**Quality improvement.** Investment expenses deemed quality-improvement activities by the state can also be counted in the nonmedical load when setting capitation rates. Federal regulations set out broad parameters for what counts as quality improvement.<sup>13</sup>

**Waivers.** The state may also pursue different waiver options: 1115 demonstration waiver, 1915(b) managed care delivery system waiver, or 1915(c) Home and Community-Based Services (HCBS). Of particular relevance to the rate-adjustment approach is the 1115 waiver authority, as California no longer relies on a 1915(b) waiver, and its HCBS services are generally carved out of managed care (see Appendix D).

Figure 3 demonstrates how medically tailored meals — currently being piloted — could potentially be financed with Medicaid funds (see page 20).

**Figure 3. Medically Tailored Meals Example**

Medically tailored meals are not a traditional benefit covered by Medi-Cal. However, Medi-Cal — in partnership with local community organizations — is currently conducting a pilot program that provides medically tailored meals to low-income Medi-Cal beneficiaries with chronic diseases. If the pilot is successful, the state and/or plans can pursue various avenues to finance medically tailored meals and other health-related investments.



### Design and Implementation Considerations

As referenced earlier, plans expressed a strong interest for the state to develop a menu of investments that qualify for some level of coverage in the rate-setting process and count toward the health-related investment threshold.

The state-derived menu could contain three categories of investments (with overlap across the categories): (1) investments that meet the health-related investment threshold requirement, (2) existing or new Medi-Cal state plan benefits and approved in-lieu-of services that count as part of the medical load in rate setting, and (3) investments that count as quality improvement and can be included as part of the nonmedical load in rate setting.<sup>14</sup>

Specific investments will depend on state and plan priorities for different member populations and geographies. Some investments may be a one-time cost (e.g., equipment), while others may be ongoing (e.g., housing

supports). The state can work with plans to identify areas or populations where interventions are likely to improve health outcomes and generate savings, and revise the list as the state and plans gain more experience.

To provide some financial support for these investments, the state could identify opportunities to incorporate priority health-related services in future SPAs and waivers — meaning that these services would become part of the medical load in rate setting. Notably, the state could explore the feasibility of creating an Alternative Benefit Plan — for all or certain managed care enrollees — that includes certain health-related services.<sup>15</sup>

California’s current 1115 waiver ends on December 31, 2020, and includes initiatives such as the Whole Person Care pilots that encourage investments similar to those described in this report. The recommended rate adjustment could help sustain promising waiver activities after the waiver ends.

## Adding a Social Determinants of Health Risk Adjustment to the Rate-Setting Methodology

The work group was interested in further exploring adding a risk adjustment reflecting member socioeconomic status to the current rate-setting process — an approach currently being tested in Massachusetts (see sidebar).

### Massachusetts Social Determinants of Health Risk Adjustment

Massachusetts implemented a risk-adjustment methodology that leverages existing state data sets to identify proxies for social determinants of health (e.g., frequent address changes as a proxy for instable housing, and linking zip codes with census neighborhood stress scores). Massachusetts implemented this methodology in fall 2016 and is currently evaluating it.<sup>16</sup>

California's current risk-adjustment model only accounts for medical conditions; an SDOH risk adjustment could help identify subpopulations for which targeted interventions should be prioritized and could guide health-related investments under the rate-adjustment approach. Existing member data could be used to identify proxies for social determinants. For example, frequent address changes could be used as a proxy for unstable housing. Additionally, the adjustment could help allocate premium dollars more equitably across plans in multiplan counties.

### Design and Implementation Considerations

The work group noted concerns about execution, including ensuring robustness of data to identify valid proxy indicators for members' social determinants of health, and ensuring any new risk-adjustment methodology is not duplicative of existing risk adjustment — since social issues tend to co-occur with certain high-risk medical diagnoses (e.g., behavioral health, substance abuse).

Since SDOH risk adjustment is a fairly new concept and there is limited evidence of its success and implementation, the state may consider conducting a review of methodologies, including Massachusetts's model, and simulating different measurement strategies to evaluate their effectiveness in predicting high-cost and high-need members.

## Conclusion

As states and plans face increasing economic and federal pressure to slow the growth of Medicaid spending, they need to work together to bend the cost curve while ensuring that quality, access, and innovation are not jeopardized. California has an opportunity to be on the leading edge of developing models of care and interventions that improve the health of members with complex social, economic, and medical situations while also driving down Medi-Cal's spending. Implementing the recommended rate adjustment can help achieve these objectives and better align plan incentives with the state's objectives for cost containment, quality, and innovation. The recommended approach could, in addition, serve as a roadmap for supporting and financing successful 1115 waiver initiatives after the waiver ends in 2020.

As a complementary strategy, California has the opportunity to clarify which types of investments can count within the current plan expense base and explore additional avenues for financing health-related services. Doing so would demonstrate the state's commitment to supporting nontraditional investments intended to improve care and outcomes for members with complex medical and social needs. Lastly, the state also has an opportunity to refine its risk-adjustment methodology to better reflect the underlying socioeconomic conditions of members to ensure that resources are appropriately directed to the most vulnerable populations.

As a next step, this proposed approach should be shared, further assessed, and refined with a wider group of stakeholders, including the administration and legislature.

Finally, one of the parameters for this project was that the initiative would not result in any new investment by the state. Additional state investment to improve Medi-Cal access and quality, however, could augment the impact of these recommendations and yield health improvements for members.

## Appendix A. Status Quo Model, Year by Year

### Key Assumptions

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Intervention Cost	\$ 100,000	\$ 100,000	\$ 100,000	\$ 100,000	\$ 100,000	\$ 100,000	\$ 100,000	\$ 100,000	\$ 100,000	\$ 100,000
Portion to Incl. as Medical	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Portion to Incl. as Nonmedical	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Plan Shared Savings Rate	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
MSR	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Projected Savings	0.0%	0.5%	0.0%	0.5%	0.0%	0.5%	0.0%	0.5%	0.0%	0.5%
Cumulative Savings	0.0%	0.5%	0.0%	0.5%	0.5%	0.5%	0.5%	1.0%	0.5%	1.0%
Member Months	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000

### Scenario Modeling

#### Status Quo

Ref	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	10-Year Total
<b>Base Data</b>												
	Base Year (Year n - 2)	(Year -2)	(Year -1)	(Year 0)	(Year 1)	(Year 2)	(Year 3)	(Year 4)	(Year 5)	(Year 6)	(Year 7)	
(a)	Base PMPM	\$ 400.00	\$ 420.00	\$ 441.00	\$ 463.05	\$ 483.77	\$ 510.51	\$ 533.36	\$ 560.03	\$ 588.03	\$ 617.43	\$ 501.72
(b)	Intervention PMPM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Trend</b>												
	Annual Historical Trend (a / 3 Year Prev. a) ^ (1/3) - 1				5.0%	4.8%	5.0%	4.8%	5.0%	4.8%	5.0%	
(c)	Base w/ Intervention Cost (a + b)	\$ 400.00	\$ 420.00	\$ 441.00	\$ 463.05	\$ 483.77	\$ 510.51	\$ 533.36	\$ 560.03	\$ 588.03	\$ 617.43	\$ 501.72
(d)	Annual Projection Trend	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
(e)	Trended PMPM (c) * (1 + d) ^ 3	\$ 463.05	\$ 486.20	\$ 510.51	\$ 536.04	\$ 560.03	\$ 590.98	\$ 617.43	\$ 648.30	\$ 680.72	\$ 714.75	\$ 580.80
<b>Non Medical Load</b>												
(f)	NML %	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%
(g)	Intervention Expense %	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(h)	Rate Adjustment %	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	MLR	93.0%	92.5%	93.0%	92.5%	93.0%	92.5%	93.0%	92.5%	93.0%	92.5%	
(i)	Gross Rate (e / (1 - (f + g + h)))	\$ 497.90	\$ 522.80	\$ 548.94	\$ 576.39	\$ 602.18	\$ 635.46	\$ 663.90	\$ 697.10	\$ 731.95	\$ 768.55	\$ 624.52
<b>Savings</b>												
	Intervention Savings PMPM	\$ -	\$ 2.61	\$ -	\$ 2.88	\$ -	\$ 3.18	\$ -	\$ 3.49	\$ -	\$ 3.84	\$ 1.60
	Intervention Savings Total Dollars	\$ (100,000)	\$ 305,169	\$ (100,000)	\$ 346,699	\$ (100,000)	\$ 392,485	\$ (100,000)	\$ 440,250	\$ (100,000)	\$ 495,626	\$ 1,480,228
	Rate Adjustment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	<b>Total State Savings</b>			\$ -	\$ 469,033	\$ -	\$ 517,109	\$ -	\$ 570,113	\$ -	\$ 1,556,256	

## Appendix B. Rate-Adjustment Scenarios, Year by Year

### Scenario 1. Baseline

#### Key Assumptions

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Intervention Cost	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000
Portion to Incl. as Medical	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%
Portion to Incl. as Nonmedical	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%
Plan Shared Savings Rate	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
MSR	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
Projected Savings	2.0%	3.0%	3.0%	1.0%	0.5%	1.0%	1.0%	0.5%	0.0%	0.0%
Cumulative Savings	2.0%	3.0%	3.0%	3.0%	3.5%	4.0%	4.0%	4.0%	4.0%	4.0%
Member Months	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000

#### Scenario Modeling

##### Baseline

Ref	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	10-Year Total
<b>Base Data</b>												
	Base Year (Year n - 2)	(Year -2)	(Year -1)	(Year 0)	(Year 1)	(Year 2)	(Year 3)	(Year 4)	(Year 5)	(Year 6)	(Year 7)	
(a)	Base PMPM	\$ 400.00	\$ 420.00	\$ 441.00	\$ 453.09	\$ 470.52	\$ 494.04	\$ 519.92	\$ 542.82	\$ 566.77	\$ 596.48	\$ 490.46
(b)	Intervention PMPM	\$ -	\$ -	\$ -	\$ 0.97	\$ 0.97	\$ 0.97	\$ 0.97	\$ 0.97	\$ 0.97	\$ 0.97	\$ 0.68
<b>Trend</b>												
	Annual Historical Trend (a / 3 Year Prev. a) ^ (1/3) - 1				4.2%	3.9%	3.9%	4.7%	4.9%	4.7%	4.7%	
(c)	Base w/ Intervention Cost (a + b)	\$ 400.00	\$ 420.00	\$ 441.00	\$ 454.06	\$ 471.49	\$ 495.01	\$ 520.88	\$ 543.79	\$ 567.74	\$ 597.44	\$ 491.14
(d)	Annual Trend	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
(e)	Trended PMPM (c) * (1+d) ^ 3	\$ 463.05	\$ 486.20	\$ 510.51	\$ 525.63	\$ 545.80	\$ 573.04	\$ 602.99	\$ 629.50	\$ 657.23	\$ 691.61	\$ 568.56
<b>Non Medical Load</b>												
(f)	NML %	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	
(g)	Intervention Expense %	0.0%	0.0%	0.0%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%	
(h)	Rate Adjustment %	0.0%	0.0%	0.0%	0.9%	1.4%	1.4%	0.3%	0.0%	0.3%	0.3%	
	MLR	91.3%	90.3%	90.2%	91.2%	91.1%	90.6%	91.8%	92.6%	92.8%	92.8%	
(i)	Gross Rate (e / (1 - (f + g + h)))	\$ 497.90	\$ 522.80	\$ 548.94	\$ 571.57	\$ 597.02	\$ 626.82	\$ 651.19	\$ 677.93	\$ 709.89	\$ 747.02	\$ 615.11
<b>Savings</b>												
	Intervention Savings PMPM	\$ 9.96	\$ 15.68	\$ 16.47	\$ 5.72	\$ 2.99	\$ 6.27	\$ 6.51	\$ 3.39	\$ -	\$ -	\$ 6.70
	Intervention Savings Total Dollars	\$ 943,500	\$ 1,831,013	\$ 1,952,563	\$ 285,935	\$ (137,308)	\$ 371,575	\$ 409,350	\$ (74,608)	\$ (600,000)	\$ (600,000)	\$ 4,382,019
	Rate Adjustment	\$ -	\$ -	\$ -	\$ 767,464	\$ 1,308,364	\$ 1,382,882	\$ 255,935	\$ -	\$ 309,025	\$ 332,453	\$ 4,356,123
	<b>Total Plan Savings</b>	<b>\$ 943,500</b>	<b>\$ 1,831,013</b>	<b>\$ 1,952,563</b>	<b>\$ 1,053,399</b>	<b>\$ 1,171,056</b>	<b>\$ 1,754,456</b>	<b>\$ 665,285</b>	<b>\$ (74,608)</b>	<b>\$ (290,975)</b>	<b>\$ (267,547)</b>	<b>\$ 8,738,142</b>
	<b>Total State Savings</b>				<b>\$ 746,230</b>	<b>\$ 1,268,390</b>	<b>\$ 1,339,562</b>	<b>\$ 262,725</b>	<b>\$ 11,542</b>	<b>\$ 312,214</b>	<b>\$ 334,045</b>	<b>\$ 4,274,708</b>
	State Share of HRI Costs	\$ -	\$ -	\$ -	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 2,100,000
	Plan Share of HRI Costs	\$ 600,000	\$ 600,000	\$ 600,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 3,900,000

## Scenario 2. Increased Shared-Savings Rate

### Key Assumptions

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Intervention Cost	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000
Portion to Incl. as Medical	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%
Portion to Incl. as Nonmedical	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%
Plan Shared Savings Rate	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	75.0%	75.0%	75.0%	75.0%
MSR	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
Projected Savings	2.0%	3.0%	3.0%	1.0%	0.5%	1.0%	1.0%	0.5%	0.0%	0.0%
Cumulative Savings	2.0%	3.0%	3.0%	3.0%	3.5%	4.0%	4.0%	4.0%	4.0%	4.0%
Member Months	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000

### Scenario Modeling

Increased Shared Savings Rate

Ref	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	10-Year Total
<b>Base Data</b>												
	Base Year (Year n - 2)	(Year -2)	(Year -1)	(Year 0)	(Year 1)	(Year 2)	(Year 3)	(Year 4)	(Year 5)	(Year 6)	(Year 7)	
(a)	Base PMPM	\$ 400.00	\$ 420.00	\$ 441.00	\$ 453.09	\$ 470.52	\$ 494.04	\$ 519.92	\$ 542.82	\$ 566.77	\$ 596.47	\$ 490.46
(b)	Intervention PMPM	\$ -	\$ -	\$ -	\$ 0.97	\$ 0.97	\$ 0.97	\$ 0.97	\$ 0.97	\$ 0.97	\$ 0.97	\$ 0.68
<b>Trend</b>												
<b>Annual Historical Trend</b> (a / 3 Year Prev. a) ^ (1/3) - 1												
(c)	Base w/ Intervention Cost (a + b)	\$ 400.00	\$ 420.00	\$ 441.00	\$ 454.06	\$ 471.49	\$ 495.01	\$ 520.88	\$ 543.79	\$ 567.74	\$ 597.43	\$ 491.14
(d)	Annual Trend	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
(e)	Trended PMPM (c) * (1 + d) ^ 3	\$ 463.05	\$ 486.20	\$ 510.51	\$ 525.63	\$ 545.80	\$ 573.04	\$ 602.99	\$ 629.50	\$ 657.23	\$ 691.60	\$ 568.56
<b>Non Medical Load</b>												
(f)	NML %	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%
(g)	Intervention Expense %	0.0%	0.0%	0.0%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%
(h)	Rate Adjustment %	0.0%	0.0%	0.0%	0.9%	1.4%	1.4%	0.4%	0.0%	0.4%	0.4%	0.4%
	MLR	91.3%	90.3%	90.2%	91.2%	91.1%	90.6%	91.7%	92.6%	92.6%	92.6%	92.6%
(i)	Gross Rate (e / (1 - (f + g + h)))	\$ 497.90	\$ 522.80	\$ 548.94	\$ 571.57	\$ 597.02	\$ 626.82	\$ 652.09	\$ 677.93	\$ 710.96	\$ 748.18	\$ 615.42
<b>Savings</b>												
	Intervention Savings PMPM	\$ 9.96	\$ 15.68	\$ 16.47	\$ 5.72	\$ 2.99	\$ 6.27	\$ 6.52	\$ 3.39	\$ -	\$ -	\$ 6.70
	Intervention Savings Total Dollars	\$ 943,500	\$ 1,831,013	\$ 1,952,563	\$ 285,935	\$ (137,308)	\$ 371,575	\$ 410,734	\$ (74,608)	\$ (600,000)	\$ (600,000)	\$ 4,383,403
	Rate Adjustment	\$ -	\$ -	\$ -	\$ 767,464	\$ 1,308,364	\$ 1,382,882	\$ 384,429	\$ -	\$ 464,242	\$ 500,743	\$ 4,808,124
	<b>Total Plan Savings</b>	<b>\$ 943,500</b>	<b>\$ 1,831,013</b>	<b>\$ 1,952,563</b>	<b>\$ 1,053,399</b>	<b>\$ 1,171,056</b>	<b>\$ 1,754,456</b>	<b>\$ 795,163</b>	<b>\$ (74,608)</b>	<b>\$ (135,758)</b>	<b>\$ (99,257)</b>	<b>\$ 9,191,527</b>
	<b>Total State Savings</b>				<b>\$ 746,230</b>	<b>\$ 1,268,390</b>	<b>\$ 1,339,562</b>	<b>\$ 124,338</b>	<b>\$ 11,542</b>	<b>\$ 145,069</b>	<b>\$ 154,557</b>	<b>\$ 3,789,687</b>
	State Share of HRI Costs	\$ -	\$ -	\$ -	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 2,100,000
	CMS Compliance Check											
	Rate Adjustment as % of Unadjusted Rate	0.0%	0.0%	0.0%	0.9%	1.4%	1.4%	0.4%	0.0%	0.4%	0.4%	0.4%
	Plan Share of HRI Costs	\$ 600,000	\$ 600,000	\$ 600,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 3,900,000

### Scenario 3. Increased Credit for Plan Investment in Medical and Nonmedical Load of Base

#### Key Assumptions

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Intervention Cost	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000
Portion to Incl. as Medical	33.3%	33.3%	33.3%	33.3%	33.3%	33.3%	33.3%	33.3%	33.3%	33.3%
Portion to Incl. as Nonmedical	33.3%	33.3%	33.3%	33.3%	33.3%	33.3%	33.3%	33.3%	33.3%	33.3%
Plan Shared Savings Rate	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
MSR	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
Projected Savings	2.0%	3.0%	3.0%	1.0%	0.5%	1.0%	1.0%	0.5%	0.0%	0.0%
Cumulative Savings	2.0%	3.0%	3.0%	3.0%	3.5%	4.0%	4.0%	4.0%	4.0%	4.0%
Member Months	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000

#### Scenario Modeling

Increased Credit for Plan Investment in Medical and Nonmedical Load

Ref	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	10-Year Total
<b>Base Data</b>												
	Base Year (Year n - 2)	(Year -2)	(Year -1)	(Year 0)	(Year 1)	(Year 2)	(Year 3)	(Year 4)	(Year 5)	(Year 6)	(Year 7)	
(a)	Base PMPM	\$ 400.00	\$ 420.00	\$ 441.00	\$ 453.09	\$ 470.52	\$ 494.04	\$ 520.29	\$ 543.19	\$ 567.14	\$ 597.28	\$ 490.66
(b)	Intervention PMPM	\$ -	\$ -	\$ -	\$ 1.29	\$ 1.29	\$ 1.29	\$ 1.29	\$ 1.29	\$ 1.29	\$ 1.29	\$ 0.90
<b>Trend</b>												
	Annual Historical Trend (a / 3 Year Prev. a) ^ (1/3) - 1				4.2%	3.9%	3.9%	4.7%	4.9%	4.7%	4.7%	
(c)	Base w/ Intervention Cost (a + b)	\$ 400.00	\$ 420.00	\$ 441.00	\$ 454.38	\$ 471.81	\$ 495.33	\$ 521.58	\$ 544.48	\$ 568.43	\$ 598.57	\$ 491.56
(d)	Annual Trend	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
(e)	Trended PMPM (c) * (1+d) ^ 3	\$ 463.05	\$ 486.20	\$ 510.51	\$ 526.00	\$ 546.18	\$ 573.41	\$ 603.79	\$ 630.31	\$ 658.03	\$ 692.92	\$ 569.04
<b>Non Medical Load</b>												
(f)	NML %	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	
(g)	Intervention Expense %	0.0%	0.0%	0.0%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	
(h)	Rate Adjustment %	0.0%	0.0%	0.0%	0.8%	1.3%	1.4%	0.0%	0.0%	0.0%	0.0%	
	MLR	91.3%	90.3%	90.3%	91.2%	91.2%	90.7%	92.0%	92.5%	93.0%	93.0%	
(i)	Gross Rate (e / (1 - (f + g + h)))	\$ 497.90	\$ 522.80	\$ 548.94	\$ 571.90	\$ 597.35	\$ 627.16	\$ 650.63	\$ 679.14	\$ 708.95	\$ 746.47	\$ 615.12
<b>Savings</b>												
	Intervention Savings PMPM	\$ 9.96	\$ 15.68	\$ 16.47	\$ 5.72	\$ 2.99	\$ 6.27	\$ 6.51	\$ 3.40	\$ -	\$ -	\$ 6.70
	Intervention Savings Total Dollars	\$ 943,500	\$ 1,831,013	\$ 1,952,563	\$ 286,441	\$ (137,050)	\$ 372,091	\$ 408,470	\$ (73,668)	\$ (600,000)	\$ (600,000)	\$ 4,383,360
	Rate Adjustment	\$ -	\$ -	\$ -	\$ 706,149	\$ 1,247,664	\$ 1,322,193	\$ -	\$ -	\$ -	\$ -	\$ 3,276,005
	<b>Total Plan Savings</b>	<b>\$ 943,500</b>	<b>\$ 1,831,013</b>	<b>\$ 1,952,563</b>	<b>\$ 992,591</b>	<b>\$ 1,110,613</b>	<b>\$ 1,694,284</b>	<b>\$ 408,470</b>	<b>\$ (73,668)</b>	<b>\$ (600,000)</b>	<b>\$ (600,000)</b>	<b>\$ 7,659,365</b>
	<b>Total State Savings</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 695,582</b>	<b>\$ 1,216,757</b>	<b>\$ 1,287,914</b>	<b>\$ 350,746</b>	<b>\$ (176,379)</b>	<b>\$ 457,398</b>	<b>\$ 502,702</b>	<b>\$ 4,334,721</b>
	State Share of HRI Costs	\$ -	\$ -	\$ -	\$ 400,000	\$ 400,000	\$ 400,000	\$ 400,000	\$ 400,000	\$ 400,000	\$ 400,000	\$ 2,800,000
	CMS Compliance Check											
	Rate Adjustment as % of Unadjusted Rate	0.0%	0.0%	0.0%	0.8%	1.4%	1.4%	0.0%	0.0%	0.0%	0.0%	
	Plan Share of HRI Costs	\$ 600,000	\$ 600,000	\$ 600,000	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000	\$ 3,200,000

## Scenario 4. Combined Increase in Shared Savings and in Credit for Plan Investment

### Key Assumptions

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Intervention Cost	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000
Portion to Incl. as Medical	25.0%	25.0%	25.0%	25.0%	25.0%	33.3%	33.3%	33.3%	33.3%	33.3%
Portion to Incl. as Nonmedical	25.0%	25.0%	25.0%	25.0%	25.0%	33.3%	33.3%	33.3%	33.3%	33.3%
Plan Shared Savings Rate	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	75.0%	75.0%	75.0%	75.0%
MSR	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
Projected Savings	2.0%	3.0%	3.0%	1.0%	0.5%	1.0%	1.0%	0.5%	0.0%	0.0%
Cumulative Savings	2.0%	3.0%	3.0%	3.0%	3.5%	4.0%	4.0%	4.0%	4.0%	4.0%
Member Months	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000	155,000

### Scenario Modeling

Combined Increase in Shared Savings and in Credit for Plan Investment

Ref	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	10-Year Total
<b>Base Data</b>												
	Base Year <i>(Year n - 2)</i>	(Year -2)	(Year -1)	(Year 0)	(Year 1)	(Year 2)	(Year 3)	(Year 4)	(Year 5)	(Year 6)	(Year 7)	
(a)	Base PMPM	\$ 400.00	\$ 420.00	\$ 441.00	\$ 453.09	\$ 470.52	\$ 494.04	\$ 519.92	\$ 542.82	\$ 566.77	\$ 596.47	\$ 490.46
(b)	Intervention PMPM	\$ -	\$ -	\$ -	\$ 0.97	\$ 0.97	\$ 0.97	\$ 0.97	\$ 0.97	\$ 1.29	\$ 1.29	\$ 0.74
<b>Trend</b>												
	Annual Historical Trend <i>( a / 3 Year Prev. a ) ^ (1/3) - 1</i>				4.2%	3.9%	3.9%	4.7%	4.9%	4.7%	4.7%	
(c)	Base w/ Intervention Cost <i>( a + b )</i>	\$ 400.00	\$ 420.00	\$ 441.00	\$ 454.06	\$ 471.49	\$ 495.01	\$ 520.88	\$ 543.79	\$ 568.06	\$ 597.76	\$ 491.20
(d)	Annual Trend	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
(e)	Trended PMPM <i>( c ) * ( 1 + d ) ^ 3</i>	\$ 463.05	\$ 486.20	\$ 510.51	\$ 525.63	\$ 545.80	\$ 573.04	\$ 602.99	\$ 629.50	\$ 657.60	\$ 691.98	\$ 568.63
<b>Non Medical Load</b>												
(f)	NML %	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%
(g)	Intervention Expense %	0.0%	0.0%	0.0%	0.2%	0.2%	0.2%	0.1%	0.1%	0.2%	0.2%	0.2%
(h)	Rate Adjustment %	0.0%	0.0%	0.0%	0.9%	1.4%	1.4%	0.4%	0.0%	0.0%	0.0%	0.0%
	MLR	91.3%	90.3%	90.2%	91.2%	91.1%	90.7%	91.7%	92.6%	93.0%	93.0%	93.0%
(i)	Gross Rate <i>( e / ( 1 - ( f + g + h ) ) )</i>	\$ 497.90	\$ 522.80	\$ 548.94	\$ 571.57	\$ 597.02	\$ 626.82	\$ 652.09	\$ 677.93	\$ 708.49	\$ 745.45	\$ 614.90
<b>Savings</b>												
	Intervention Savings PMPM	\$ 9.96	\$ 15.68	\$ 16.47	\$ 5.72	\$ 2.99	\$ 6.27	\$ 6.52	\$ 3.39	\$ -	\$ -	\$ 6.70
	Intervention Savings Total Dollars	\$ 943,500	\$ 1,831,013	\$ 1,952,563	\$ 285,935	\$ (137,308)	\$ 371,575	\$ 410,734	\$ (74,608)	\$ (600,000)	\$ (600,000)	\$ 4,383,403
	Rate Adjustment	\$ -	\$ -	\$ -	\$ 767,464	\$ 1,308,364	\$ 1,382,882	\$ 384,429	\$ -	\$ -	\$ -	\$ 3,843,139
	<b>Total Plan Savings</b>	\$ <b>943,500</b>	\$ <b>1,831,013</b>	\$ <b>1,952,563</b>	\$ <b>1,053,399</b>	\$ <b>1,171,056</b>	\$ <b>1,754,456</b>	\$ <b>795,163</b>	\$ <b>(74,608)</b>	\$ <b>(600,000)</b>	\$ <b>(600,000)</b>	\$ <b>8,226,542</b>
	<b>Total State Savings</b>	\$ <b>746,230</b>	\$ <b>1,339,562</b>	\$ <b>1,339,562</b>	\$ <b>1,268,390</b>	\$ <b>1,339,562</b>	\$ <b>1,339,562</b>	\$ <b>124,338</b>	\$ <b>11,542</b>	\$ <b>528,803</b>	\$ <b>577,568</b>	\$ <b>4,596,433</b>
	State Share of HRI Costs	\$ -	\$ -	\$ -	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 400,000	\$ 400,000	\$ 2,300,000
	CMS Compliance Check											
	Rate Adjustment as % of Unadjusted Rate	0.0%	0.0%	0.0%	0.9%	1.4%	1.4%	0.4%	0.0%	0.0%	0.0%	0.0%
	Plan Share of HRI Costs	\$ 600,000	\$ 600,000	\$ 600,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 300,000	\$ 200,000	\$ 200,000	\$ 3,700,000

## Appendix C. Other Options Considered

The work group also considered the following options but chose not to incorporate them in the recommended approach for the following reasons:

### Shared Savings

Shared savings and the rate-adjustment approach are similar in concept in that they allow plans to benefit from savings they generate relative to their projected expense trendline; however, they differ in their mechanics. Shared savings are distributed as a lump-sum payment to plans, while in the rate-adjustment approach the savings are added into the non-medical load of the plans' future rates. The work group thought that a rate adjustment would be a more viable approach over the longer term.

### Plan-Provider Value-Based Purchasing (VBP) Arrangements

Many states are establishing VBP goals and requirements to promote quality and value of health care service in managed care. Some states have created requirements on the types of risk arrangements (e.g., upside/downside risk and capitation) that plans should include in contracts with providers. Additionally, states sometimes tie incentive payments or rate percentage withholds with meeting certain performance measure or VBP requirements.

Medi-Cal MCOs already engage in a high degree of delegated risk through subcapitation agreements with providers. Plans have noted mixed success with providers in managing risk and with subcapitation agreements promoting quality objectives. The work group's preference is for the state to articulate cost and quality objectives and to allow plans flexibility to work with providers on achieving those goals — which may be through VBP arrangements in certain circumstance.

## Appendix D. California Health-Related Investments and HCBS Crosswalk

California currently provides the following health-related services to subsets of the Medi-Cal population through the following programs and authorities. However, most of these services are for a targeted group of individuals, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses. Managed care is typically carved out of these programs and therefore is generally not required to provide these benefits.

	PROGRAM/AUTHORITY
<b>Meals, Medically Tailored Meals, Other Nutritional Services</b>	<ul style="list-style-type: none"> <li>▶ Community-Based Adult Services (1115): meals, nutritional counseling</li> <li>▶ Assisted Living Waiver (1915[c]): Meals</li> <li>▶ HCBS Waiver for Individuals with Developmental Disabilities (1915[c]): nutritional consultation</li> <li>▶ HCBS for Individuals with Developmental Disabilities (DD) (1915[i]): nutritional consultation</li> <li>▶ HIV/AIDS Waiver (1915[c]): home-delivered meals / nutrition supplements, nutritional counseling</li> <li>▶ In-Home Supportive Services (1915[k]): meal preparation, grocery shopping</li> <li>▶ Multipurpose Senior Services Program (1915[c]): nutritional services (congregate meals, home-delivered meals, food)</li> <li>▶ Food Is Medicine Pilot</li> </ul>
<b>Home Modifications</b>	<ul style="list-style-type: none"> <li>▶ California Community Transitions (Deficit Reduction ACT, MFP): home setup, home modifications</li> <li>▶ HCBS Waiver for Individuals with Developmental Disabilities (DD) (1915[c]): environmental accessibility adaptations</li> <li>▶ HCBS for Individuals with Developmental Disabilities (1915[i]): environmental accessibility adaptations</li> <li>▶ HIV/AIDS Waiver (1915[c]): minor physical adaptations to the home</li> <li>▶ In-Home Operations Waiver (1915[c]): environmental accessibility adaptations</li> <li>▶ Home and Community-Based Alternatives Waiver (1915[c]): environmental adaptations</li> <li>▶ Multipurpose Senior Services Program (1915[c]): minor home repairs and maintenance</li> </ul>
<b>Personal Care Services</b>	<ul style="list-style-type: none"> <li>▶ Assisted Living Waiver (1915[c]): personal care services</li> <li>▶ Community-Based Adult Services (1115): meals, nutritional counseling</li> <li>▶ Home and Community-Based Alternatives Waiver (1915[c]): waiver personal care services</li> <li>▶ In-Home Operations Waiver (1915[c]): waiver personal care services</li> <li>▶ In-Home Supportive Services (1915[k]): personal care services</li> <li>▶ Multipurpose Senior Services Program (1915[c]): supplemental personal care</li> <li>▶ Pediatric Palliative Care Waiver (1915c): personal care</li> </ul>
<b>Behavioral Health Services</b> (mental health, substance use disorder, crisis centers, long-term placement)	<ul style="list-style-type: none"> <li>▶ Community-Based Adult Services (1115): mental health services, social services, behavioral health treatment and stabilization</li> <li>▶ HCBS Waiver for Individuals with Developmental Disabilities (1915[c]): crisis intervention, behavior intervention services</li> <li>▶ State plan 1905(a)(13) — rehabilitative services</li> <li>▶ Health Home Program (1945): comprehensive care management, including behavioral health</li> <li>▶ Whole Person Care Program (1115): mental health coordination and other services, sobering centers, post-incarceration services</li> </ul>

PROGRAM/AUTHORITY

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**Housing Supports and Services**

- ▶ Assisted Living Waiver (1915[c]): nursing facility transition care coordination
- ▶ California Community Transitions: transition coordination, home setup
- ▶ HCBS Waiver for Individuals with Developmental Disabilities (1915[c]): transition and setup expenses
- ▶ HCBS for Individuals with Developmental Disabilities (1915[i]): transition and setup expenses
- ▶ Home and Community-Based Alternatives Waiver: community transition services
- ▶ In-Home Operations Waiver: community transition, transitional case management
- ▶ Multipurpose Senior Services Program (1915[c]): nonmedical home equipment, emergency move, emergency utility services, temporary lodging
- ▶ Health Home Program (1945): comprehensive care management, including housing navigator
- ▶ Whole Person Care Program (1115): tenancy-based care management, county housing pools

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**Health Promotion**

- ▶ Health Home Program (1945): health promotion, medication administration and management
- ▶ Whole Person Care Program (1115): wellness and education services, sobering centers, post-incarceration services

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**Employment Assistance**

- ▶ HCBS Waiver for Individuals with Developmental Disabilities (1915[c]): supported employment, prevocational services
- ▶ HCBS for Individuals with Developmental Disabilities (1915[i]): supported employment, prevocational services

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**Transportation**

- ▶ Community-Based Adult Services (1115): transportation to and from CBAS center and residence
- ▶ HCBS Waiver for Individuals with Developmental Disabilities (1915[c]): nonmedical transportation
- ▶ HCBS for Individuals with Developmental Disabilities (1915[i]): nonmedical transportation
- ▶ HIV/AIDS Waiver (1915[c]): nonemergency transportation
- ▶ Multipurpose Senior Services Program (1915[c]): transportation

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**Chores/  
Homemaker**

- ▶ HCBS Waiver for Individuals with Developmental Disabilities (1915[c]): homemaker services, chore services
  - ▶ HCBS for Individuals with Developmental Disabilities (1915[i]): homemaker services, chore services
  - ▶ HIV/AIDS Waiver (1915[c]): homemaker
  - ▶ Multipurpose Senior Services Program (1915[c]): supplemental chores
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## Endnotes

1. Manatt retained Optumas to provide actuarial support, which included research, analysis, and modeling to evaluate the potential impact of the revisions to the rate setting methodology.
2. As an advisor to the work group, Medi-Cal Director Mari Cantwell did not join the recommendations of the work group.
3. "In-lieu-of services" are services or settings that a state determines are medically appropriate, cost-effective alternatives to state plan services or settings covered in the MMC contract. For example, an MCO could choose to move an enrollee to a skilled nursing facility for recovery after an inpatient stay instead of keeping the enrollee in the hospital during recovery.
4. *Medi-Cal Monthly Enrollment Fast Facts*, California Department of Health Care Services (DHCS), July 2017, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
5. *Medi-Cal Managed Care Enrollment Report - June 2017*, DHCS, June 2017, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
6. "Moving Medi-Cal Forward on the Path to Delivery System Transformation," California Health Care Foundation, July 21, 2016, [www.chcf.org](http://www.chcf.org).
7. *Medi-Cal Managed Care Rate Development Overview*, DHCS, June 2015, [www.dmhc.ca.gov](http://www.dmhc.ca.gov) (PDF).
8. 45 CFR 158.150.
9. Deborah Bachrach et al., "Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment," The Commonwealth Fund, May 2014, [www.commonwealthfund.org](http://www.commonwealthfund.org).
10. Bridget Booske et al., *Different Perspectives for Assigning Weights to Determinants of Health*, University of Wisconsin Population Health Institute, February 2010, [www.researchgate.net](http://www.researchgate.net).
11. Deborah Bachrach, Jocelyn Guyer, and Ariel Levin, "Medicaid Coverage of Social Interventions: A Road Map for States," Milbank Memorial Fund, July 25, 2016, [www.milbank.org](http://www.milbank.org).
12. An exception is when federal financial participation is prohibited by law, as in the case of an Institution for Mental Disease (IMD).
13. See 45 CFR 158.150. In general, activities to improve health quality must increase the likelihood of better outcomes in ways that can be "objectively measured" and produce verifiable results; be directed toward individual enrollees (or, if directed more broadly, result in no additional costs); and be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations. States also must ensure that the activity is primarily designed to improve health outcomes; improve hospital readmissions through a comprehensive discharge program; improve patient safety, reduce medical errors, and lower infection and mortality rates; implement, promote, and increase wellness and health activities; enhance the use of health care data to improve quality, transparency, and outcomes; and support meaningful use of health information technology.
14. In addition to being captured in rate setting, in-lieu-of services and quality-improvement initiatives are included in the numerator for purposes of medical loss ratio (MLR) calculations. On October 13, 2017, California enacted a minimum 85% MLR requirement. Health-related investments that are deemed in-lieu-of services or quality-improvement activities are included in the numerator of the MLR.
15. In addition to providing the 10 essential health benefits, the plan would have to be voluntary for certain populations and meet other federal requirements. For more details, see [www.medicaid.gov](http://www.medicaid.gov).
16. Arlene Ash and Eric Mick, *UMass Risk Adjustment Project for MassHealth Payment and Care Delivery Reform: Describing the 2017 Payment Model*, UMass Center for Health Policy and Research, October 11, 2016, [www.mass.gov](http://www.mass.gov) (PDF). The UMass researchers' model and findings were featured in *JAMA Internal Medicine*: Arlene Ash et al., "Social Determinants of Health in Managed Care Payment Formulas," *JAMA Internal Medicine* 177, no. 10 (October 2017): 1424-30, [jamanetwork.com](http://jamanetwork.com).