CALIFORNIA MEDICAL ASSOCIATION

March 22, 2019

Jennifer Kent, Director
Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Submitted via email to DHCS_PMMB@dhcs.ca.gov

Re: Comments of California Medical Association on proposals in Governor's budget relating to the Value Based Payment Program, developmental screenings, and trauma screenings.

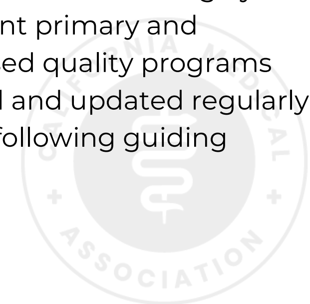
Dear Director Kent:

On behalf of more than 44,000 physician members and medical students of the California Medical Association (CMA), we would like to thank you for considering stakeholder input on the Department of Health Care Services' (DHCS) Value-Based Payment (VBP) Program Measures, as proposed in the Governor's Budget for FY 19-20. CMA appreciates the work of DHCS in developing these measures, and has a few suggestions to ensure the success of this incentive program.

CMA supports efforts to expand adoption of payment models that promote better health outcomes, reduce costs, and increase access to care for both the Medi-Cal population and more broadly in the health care system. CMA supports promoting alignment with other purchasers as much as possible on these efforts, because this will allow for reforms in the health care system to be more impactful and will allow for simplification and standardization in the system.

We support the overall intent and direction of the proposed VBP program. However, successful implementation of the program depends on the development of clear and reasonable policies and processes. We encourage the Department to evaluate and learn from previous efforts related to quality data reporting and supplemental payments to ensure its effectiveness and a smooth implementation that is informed by stakeholder input.

Selection of Incentive Measures. Overall, CMA is pleased with the clinical measures selected by DHCS as eligible for increased incentive payments. The proposed measures are largely clinically appropriate and will help ensure increased access to important primary and preventive services for Medi-Cal beneficiaries. CMA supports value-based quality programs that use evidence-based clinical practice guidelines that are evaluated and updated regularly for continued clinical relevance. We encourage DHCS to consider the following guiding principles for selecting incentive measures:



- The quality performance standards tied to value-based payment models must be physician specialty-validated clinical measures.
- Quality reporting measures should be consistent and aligned with other programs and payers. Developing mechanisms for sharing standardized quality measure data among different programs will reduce time and resources spent reporting duplicative or redundant measures.
- The development and revision of these measures should be an ongoing process that reflects new clinical evidence and quality data.
- When new quality measures are adopted, others should be sunset.

We are pleased with the recent changes to its quality metrics that DHCS announced at the Managed Care Advisory Group on March 7, 2019. We support DHCS's plan to expand its managed care plan (MCP) quality measures from the current External Accountability Set to include a wider array of measures from the 2019 CMS Child and Adult Core Sets. Additionally, we support DHCS's plan to raise the minimum performance levels of MCPs from 25% to 50% of Medicaid plans in the US. As DHCS works with MCPs and their network physicians to increase the quality of care, we would caution DHCS to ensure that these efforts do not result in reduced network adequacy for beneficiaries.

Specific suggestions for how to improve specific measures are detailed in the attached comment chart.

Reporting of Incentive Measures. Minimizing additional administrative burdens on physicians should be a priority. Currently, physicians are required to report multiple quality measures in different ways to different entities. This imposes significant burdens on physician practices and impedes comprehensive improvement in overall quality of care. A recent study[1] indicates physicians and their staff can spend upwards of 15 hours per week dealing with various quality measures with different payors. The physician time alone spent dealing with quality programs is estimated to be enough time to care for approximately nine additional patients and the staff time spent is incredibly costly to practices.

CMA is pleased that DHCS is including only those quality measures that can be assessed based on available data, and that it has announced its intention to use existing encounter data rather than requiring physicians to complete additional reporting. Ensuring these measures can be automatically extracted from encounter data would reduce the need for physicians and their staff to manually extract and manipulate data measures according to the individual specifications of each entity requiring quality data reporting.

CMA strongly supports using existing sources of data when evaluating physician participation in this program and that any assessment of the proposed measures be done

[1] Lawrence P. Casalino, et al., *US Physician Practices Spend More Than $15.4 Billion Annually to Report Quality Measures,* HEALTH AFFAIRS (March 2016), *available at* https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1258.

through existing encounter data. CMA also strongly opposes any measures that require increased manual review of medical records by physicians, their staff, or external auditors.

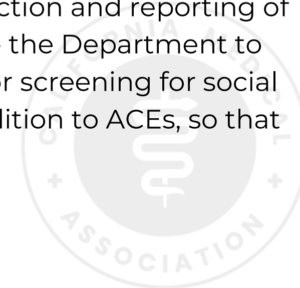
Distribution of Incentive Payments. To have a meaningful impact on physician behavior with regard to meeting the quality measures, value-based payments must be distributed in a timely and transparent manner. Payment to physicians should occur as soon as goals are met to increase affiliation between incentives and behavior. Additionally, physicians must have the right and ability to appeal inaccurate quality reports and have them corrected.

MCPs and their delegated entities should be required to disburse accurate payments in a timely fashion to physicians, and to attest that they have done so. An MCP should be responsible for ensuring that any payments disbursed by its delegated entities. If the MCP is passing the directed payments through its delegated entities, it must do so in a manner that ensures that the payment will be made to the physician by the same deadline. MCPs should attest in their quarterly reports that all payments for the prior quarter have been disbursed, either by the MCP itself or its delegated entities.

While we understand some of the payments will be retroactive due to delays in receiving federal approvals, once federal approval is received, we recommend that MCPs be required to make all feasible efforts to ensure physicians receive retroactive payments within 90 calendar days of receipt of funds from DHCS. Additionally, in future fiscal years, we recommend that MCPs be required to ensure physicians receive the incentive payments within 90 calendar days of performing qualified services. DHCS should enforce this requirement with sanctions on non-compliant MCPs, including imposing a Corrective Action Plan and financial penalties.

Trauma Screening Incentive Payments. We applaud the Administration's interest in improving service referral and delivery to children experiencing adverse childhood experiences (ACEs). California's population of children and families experience high rates of adversity and trauma, including those related to current immigration policies. The Department, potentially working with the Surgeon General's office, could transform care delivery in communities by working with state and local agencies and early childhood experts to develop, align, and issue trainings, tools, guidance and expectations about trauma-informed care best practices. To strengthen the system and services that care for children who have experienced trauma, we recommend that the Department provide guidance and resources to help providers become trauma-informed.

The Department should consider and seek to improve the system of referrals and care coordination for children who have experienced trauma, and the collection and reporting of data to inform and improve the system of care. Further, we encourage the Department to recognize the evolving nature of such screening tools, and the need for screening for social determinants of health and related home and community risks, in addition to ACEs, so that providers can act preventatively and mitigate adversity and trauma.



However, we strongly recommend that trauma screening not be used as an eligibility threshold for additional services. Unlike developmental screening, which has an eligibility and diagnostic purpose, trauma screenings require the adoption of trauma-informed training, performance guidance, as well as practice and systems transformation.

Conclusion

Thank you in advance for your consideration of our comments on DHCS's Value-Based Payment Programs. California's physicians look forward to working with you to develop strategies and recommendation that improve quality care for Medi-Cal beneficiaries. We hope this letter will serve as guidance as this program is finalized and implemented.

Sincerely,

David H. Aizuss, M.D.

President

California Medical Association