CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

ISSUE BRIEF

THE MEDI-CAL 2020 WAIVER AND THE WORK AHEAD FOR PUBLIC HEALTH CARE SYSTEMS

The Opportunity

On December 30, 2015, the federal Centers for Medicaid and Medicare Services (CMS) approved *Medi-Cal 2020* – a five year renewal of California's Section 1115 Medicaid Waiver, which could provide California with more than $6.2 billion in new federal funding through programs that will shift the focus away from hospital-based and inpatient care, towards outpatient, primary and preventative care – in other words, from volume to value.

With 1 in 3 residents now enrolled in the Medi-Cal program, and another 3 million who remain uninsured, California has an opportunity through the waiver to maintain its successful implementation of the Affordable Care Act and improve health care delivery for low-income patients.

The Critical Role of Public Health Care Systems

California's 21 public health care systems (PHS) are central to the success of *Medi-Cal 2020*. Serving more than 40% of the state's remaining uninsured and 25% of its Medi-Cal population, these county-owned and operated health care systems and University of California medical centers operate in 15 counties where more than three quarters of the state's population lives.

Though just 6% of all health care systems in the state, they serve more than 2.85 million patients a year, provide 10.5 million outpatients visits annually, operate more than half of the state's top-level trauma and burn centers, and train more than half of all new doctors in the state.

Public health care systems' essential safety net mission and mandate – to provide access to care to everyone, regardless of insurance status, ability to pay, or other circumstance – can only be maintained if these systems can also attract, retain and compete for newly covered patients.

Medi-Cal 2020 is designed to give public systems the incentive and opportunity to achieve these long term strategic goals of supporting their safety net role and their ability to compete. PHS intend to do so by becoming models of integrated care that are high value, high quality, patient-centered, efficient and equitable, with great patient experience and a demonstrated ability to improve health care and the health status of populations.

The vision is ambitious and clear, and California's public health care systems have embraced the challenge.

1. For more on California's 2010 Bridge to Reform waiver, visit caph.org/bridge

This Brief

This brief will provide an overview of the new waiver programs detailed in the Special Terms and Conditions (STCs) of the waiver, viewable at the California Department of Healthcare Services website, or at caph.org/stc.

Waiver Structure

The waiver features four new programs that aim to improve care for the state's Medi-Cal and remaining uninsured patients. Most programs will help California's public health care systems (PHS) better succeed in their dual missions of fulfilling their safety net roles while competing in the marketplace.

- **Public hospital Redesign and Incentives in Medi-Cal (PRIME)**, a pay-for-performance delivery system transformation and alignment program (pages 4 & 5)
- **Global Payment Program**, an innovative payment reform program for services to the uninsured in California's PHS (page 5)
- **Whole Person Care**, a pilot program to provide more integrated care to the highest-risk and most vulnerable patients (page 6)
- **Dental Transformation Initiative**, an incentive program to increase the frequency and quality of dental care provided to children (page 6)

The waiver agreement also requires independent assessments of access to care in Medi-Cal managed care, uncompensated care for patients who remain uninsured, and hospital financing, as detailed in the STCs.

In addition to these programs, the waiver continues several programs from California's 2010 Bridge to Reform waiver.[1] See page 3 for more details on these programs.

"Transforming care delivery is a journey, and we know that this work doesn't happen overnight. This waiver will support our efforts over the next five years to innovate and improve the way we deliver care to our most vulnerable patients, so that we can focus on keeping them healthy, rather than just treating them when they're not."

– Bill Walker, MD, Director of Contra Costa Health Services, 2016 Chair of the CAPH Board of Directors

What is a Section 1115 Medicaid Waiver?

Section 1115 of the Social Security Act allows states to waive certain federal statutory Medicaid program requirements or obtain federal matching funds for costs or investments that would not otherwise be allowed under the Medicaid program. This flexibility allows states to test innovative approaches to care, in an effort to improve quality, access, and efficiency. Waivers can cover all, or part, of a state's Medicaid program.

All Section 1115 Medicaid waivers include three key elements: budget neutrality, sources of non-federal share, and programmatic components.

Key Elements of a Waiver

Budget neutrality stipulates that federal Medicaid expenditures over the course of the waiver cannot exceed what they would have been absent the waiver. The state and CMS agree on projected cost trends without the waiver, and project the costs that will occur under the waiver. The gap between these two determines the potential savings that is available for spending for waiver programs. For *Medi-Cal 2020*, this gap was determined to be of sufficient size to allow $6.2 billion[1] in federal spending.

As Medicaid is a state-federal partnership, the State and CMS must also agree on sources of matching funds in order to receive federal funding. The source of **non-federal share** can include state general fund revenue or other public funds, such as local funds from counties, public health care systems (PHS) or district and municipal public hospitals (DPMH). California's Medicaid matching rate is 50%, which means that ever dollar of federal funding must be matched with a corresponding dollar of non-federal share. If all targets are met, at least 87% of the roughly $6.2 billion in non-federal share for *Medi-Cal 2020*'s new programs will come from counties, public health care systems, or district and municipal hospitals.

The **programmatic elements** of the waiver are the efforts that will be undertaken over the course of the waiver demonstration. Through its programs and structure, *Medi-Cal 2020* recognizes the vital role that California's public health systems play in delivering care to low-income patients and puts a strong emphasis on improving patient outcomes and health while moving toward value-based payments that link quality of care with increased risk at the provider level.

1. For the purposes of this brief, the size of the waiver is being calculated using only federal contributions, and limited to new programmatic elements. Potential federal funding totals $6.2 billion over five years, which includes the four programs described in this brief, as well as matching federal funding for Designated State Health Programs (DSHP). See next page for details.

This total does not include federal funding provided under the Disproportionate Share Hospital (DSH) program, which was established by federal statute. While this waiver does not govern the amount of DSH funding the state receives, it *can* reclassify it, as described in the section on the Global Payment Program pilot. DSH funding will add an estimated $5.4 billion in federal funds over the five years of the waiver.

David Lin, PhD with Christina Stevenson
San Mateo Medical Center

How Can a Waiver Affect Patients?

Section 1115 Medicaid Waivers support the efforts of providers to transform their care and care delivery. For example, through *Medi-Cal 2020's* PRIME program, all of the state's public health care systems will be required to strengthen their integration of behavioral health and primary care. Through their PRIME projects, PHS will work on increasing the use of consistent screening, improving communication between primary care and behavioral health providers, and improving patient adherence with their treatment regimen.

For some patients, like Christina Stevenson at San Mateo Medical Center (SMMC), a successful treatment regimen *requires* this high quality of care, including tools to manage depression and other behavioral health issues.

"The tools help me keep control of my thoughts. That helps with my blood sugar levels. When I get angry, my blood sugars tend to go very high, and I wind up in the emergency room," says Stevenson.

"When a patient is positive for depression and is okay speaking about it, we'll page one of our mental health providers, who will see that patient within the hour. That connection makes a huge difference for the patient in so many ways," says David Lin, PhD, Chief of Outpatient Medical Psychiatry Services at SMMC.

ABOUT CAPH / SNI

The California Association of Public Hospitals and Health Systems (CAPH) and the California Health Care Safety Net Institute (SNI) represent California's 21 public health care systems and academic medical centers.

As a trade association, CAPH works to advance policy and advocacy efforts that strengthen the capacity of its members to ensure access to comprehensive, high-quality, culturally sensitive health care services for all Californians, and educate the next generation of health care professionals.

SNI, a 501(c)3 affiliate of CAPH, designs and directs programs that accelerate the spread of innovative practices among public health care systems, public clinics, and beyond. SNI's work helps these providers deliver more effective, efficient and patient-centered health care to the communities they serve.

Medi-Cal 2020 Waiver Expenditures

Total Computable (TCE = Federal + Non-Federal Share)

		FY15-16	FY16-17	FY17-18	FY18-19	FY19-20		
	Waiver Expenditures	DY11	DY12	DY13	DY14	DY15	5-Year Total (TCE)	5-Year Total (FFP)
A	**Global Payment Program**	**$ 2,895,161,227**	**$ 2,471,624,452**	**$ 2,125,503,107**	**$ 1,977,980,939**	**$ 1,831,576,406**	**$11,301,846,131**	**$5,650,923,066**
B	DSH Component (estimate - will be based on actual)*	$ 2,423,161,227	$ 2,471,624,452	$ 2,125,503,107	$ 1,977,980,939	$ 1,831,576,406	$10,829,846,131	$5,414,923,066
C	SNCP Component (only DY11 is actual)**	472,000,000					$472,000,000	$236,000,000
D	**Dental Incentives**	**$150,000,000**	**$150,000,000**	**$150,000,000**	**$150,000,000**	**$150,000,000**	**$750,000,000**	**$375,000,000**
E	**Public Hospital Redesign and Incentives in Medi-Cal (PRIME)**	**$1,600,000,000**	**$1,600,000,000**	**$1,600,000,000**	**$1,440,000,000**	**$1,224,000,000**	**$7,464,000,000**	**$3,732,000,000**
F	PHS	$1,400,000,000	$1,400,000,000	$1,400,000,000	$1,260,000,000	$1,071,000,000	$6,531,000,000	$3,265,500,000
G	NDPH	$200,000,000	$200,000,000	$200,000,000	$180,000,000	$153,000,000	$933,000,000	$466,500,000
H	**Whole Person Care Pilots**	**$600,000,000**	**$600,000,000**	**$600,000,000**	**$600,000,000**	**$600,000,000**	**$3,000,000,000**	**$1,500,000,000**
I	**Designated State Health Programs**	**$150,000,000**	**$150,000,000**	**$150,000,000**	**$150,000,000**	**$150,000,000**	**$750,000,000**	**$375,000,000**
J	**IHS Uncompensated Care*** **	**$1,550,000**	**$1,550,000**	**$1,550,000**	**$1,550,000**	**$1,550,000**	**$7,750,000**	**$3,875,000**
K = A+D+E+H+I+J	TOTAL EXPENDITURES (TCE)	$ 5,396,711,227	$ 4,973,174,452	$ 4,627,053,107	$ 4,319,530,939	$ 3,957,126,406	$ 23,273,596,131	$ 11,636,798,066
L = K-B	**TOTAL WAIVER EXPENDITURES (without DSH)**	$ 2,973,550,000	$ 2,501,550,000	$ 2,501,550,000	$ 2,341,550,000	$ 2,125,550,000	$ 12,443,750,000	**$ 6,221,875,000**
M = L/2	**TOTAL WAIVER EXPENDITURES (without DSH, FFP only)**	$ 1,486,775,000	$ 1,250,775,000	$ 1,250,775,000	$ 1,170,775,000	$ 1,062,775,000	**$ 6,221,875,000**	

In addition to the new projects detailed above, *Medi-Cal 2020* continues several programs from the 2010 *Bridge to Reform* waiver. This includes the Coordinated Care Initiative (CCI), Seniors and Persons with Disabilities Program (SPD), California Children's Services Program (CCS), Community-Based Adult Services Centers (CBAS), and Drug Medi-Cal Organized Delivery System. See the STCs for more information on these programs.

* The national DSH allotment will decline as required by the ACA, beginning in FY17-18. These are estimates of how those declines will impact California's allotment. See adjacent tab for more on the national DSH cuts.

** Estimates for DY12-DY15 are included in the state's calculations for the purpose of ensuring adequate budget neturality room if future years of SNCP funding are approved.

*** Indian Health Service

Source: http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_FINAL_STC_12-30-15.pdf

PUBLIC HOSPITAL INCENTIVES AND REDESIGN IN MEDI-CAL (PRIME)

FUNDING: An opportunity for PHS to earn up to $3.27 billion in federal incentive payments over the course of the waiver, with an additional $466 million available for District and Municipal Public Hospitals. These totals include scheduled decreases in annual funding of 10% in year four, and an additional decline of 15% in year five. For more detail, including a year-by-year breakdown, see page 3.

SOURCE OF NON-FEDERAL SHARE: Intergovernmental transfers (IGTs) from PHS and District and Municipal Public Hospitals.

DESCRIPTION: PRIME directs PHS and District and Municipal Hospitals to use evidence-based quality improvement methods to achieve ambitious, year-over-year performance targets. All federal funding for this program is contingent on meeting these targets.

The PRIME program is considered the successor to the 2010 Bridge to Reform waiver's Delivery System Reform Incentive Program (DSRIP)[1], a pay-for-performance program that improved care delivery to prepare California's PHS for an influx of newly covered patients through the implementation of the Affordable Care Act.

Efforts within DSRIP included expanding primary care capacity, enrolling individuals into medical homes, and reducing hospital infections. PRIME builds on the success of DSRIP, with a greater focus on clinical outcomes and improved health for patients.

CAPH / SNI, in support of the state's efforts, led an extensive research and development process to design the proposed PRIME projects and their associated metrics, working with multiple advisory boards made up of clinical and data leaders from across California's public health systems, and the broader health care landscape.

STRUCTURE: Organized in three domains, PRIME includes projects that focus on improvements in ambulatory care, high-risk populations, and efforts to improve patient care and efficiency.

Each PHS must take on **no less than nine projects,** consisting of six required projects, and at least one additional project from each domain. District and Municipal Hospitals are required to select at least one project from a single domain. (See chart on right)

Each PHS will submit a plan for approval at the outset of the PRIME program, and will have its work regularly monitored and evaluated. Through CAPH / SNI, they will share best practices and lessons learned with each other.

1. For more on the success of California and the state's PHS under DSRIP, visit caph.org/dsripsuccess

2. The Million Hearts® Initiative is a project led by the U.S. Department of Health and Human Services aimed at preventing 1 million heart attacks and strokes over a five year period.

PRIME Domains and Projects

Domain 1: Outpatient Delivery System Transformation and Prevention

These projects emphasize preventive services and the early diagnosis and treatment of illnesses. Domain 1 projects also encourage empowering patients and equipping them with additional tools through access to behavioral health care, social supports, and other well-being needs.

Required for PHS:

- **Integration of Physical and Behavioral Health**
- **Ambulatory Care Redesign: Primary Care**
- **Ambulatory Care Redesign: Specialty Care**

PHS must also select **at least one** other Domain 1 project from the list below:

- Patient Safety in the Ambulatory Setting
- Million Hearts® Initiative[2]
- Cancer Screening and Follow-up
- Obesity Prevention and Healthier Foods Initiative

Domain 2: Targeted High-Risk or High-Cost Populations

The second domain is focused on patients who would benefit most significantly from improved care integration and alignment, especially during the transition from inpatient to outpatient care, and in post-acute settings.

Required for PHS:

- **Improved Perinatal Care**
- **Care Transitions: Integration of Post-Acute Care**
- **Complex Care Management for High Risk Medical Populations**

PHS must also select **at least one** other Domain 2 project from the list below:

- Integrated Health Homes for Foster Children
- Transition to Integrated Care: Post Incarceration.
- Chronic Non-Malignant Pain Management
- Comprehensive Advanced Illness Planning and Care

Domain 3: Resource Utilization Efficiency

The third domain seeks to reduce the ineffective and potentially harmful overuse, misuse, and inappropriate underuse of various diagnostics and treatments.

PHS must choose **at least one** of the following projects:

- Antibiotic Stewardship
- Resource Stewardship: High Cost Imaging
- Resource Stewardship: Therapies Involving High Cost Pharmaceuticals
- Resource Stewardship: Blood Products

ALTERNATIVE PAYMENT MODELS (APMs): PRIME is specifically aimed at preparing California's PHS to move towards sustainable delivery system reform through the increasing use of alternative payment models which place PHS at risk for the quantity and quality of services provided to Medi-Cal managed care enrollees that are assigned to PHS for their care. In an effort to demonstrate that PRIME improvements can be sustained beyond *Medi-Cal 2020*, the waiver requires that, by January 2018, 50 percent of the state's Medi-Cal managed care beneficiaries who are assigned to a PHS will receive all or a portion of their care under a contracted APM. By January 2019 the goal will increase to 55%, and by the end of the waiver renewal period in 2020, it will increase to 60%. In both years four and five of the waiver, 5% of the statewide yearly allocated pool amount for all PHS will depend on meeting these goals.

"The PRIME projects are designed in a way that will maximize impact on a health system, and to better ensure that our patients can experience timely access to high-quality, efficient, and patient-centered care. Investing in this work now will have an enormous impact on our patients' outcomes, and on the sustainability of our improvement efforts."

– Angela Scioscia, Chief Medical Officer, UC San Diego Health

GLOBAL PAYMENT PROGRAM (GPP)

FUNDING: The GPP combines most[1] of California's annual federal Disproportionate Share Hospital (DSH) allotment, which equaled about $1.2 billion in federal funds in FY2014-2015, with federal funds previously designated as the Safety Net Care Pool (SNCP).

In year one of the waiver, the federal SNCP portion will be $236 million. Funding for years 2-5 will depend on the results of a study, due in spring 2016, aimed at determining the ongoing need for federal funds for uncompensated care for the remaining uninsured.Overall funding levels for the GPP will also be impacted over the course of the waiver by reductions in Medicaid DSH funding starting in federal FY2017-2018, as required by federal law.

SOURCE OF NON-FEDERAL SHARE: IGTs from public health care systems

DESCRIPTION: The Global Payment Program (GPP) is a first-in-the-nation payment reform program that aims to change the way county-owned and operated PHS in California are compensated for providing care to the remaining uninsured, an estimated 3 million people. The program encourages a shift away from cost-based, hospital-centric models of care, through financial incentives to provide cost-effective primary and specialty care.

DSH is a federal program to support safety-net hospitals caring for a disproportionate share of low-income patients, restricted to services provided in a hospital setting. Under GPP, this funding is being pooled with the SNCP, which was established under California's 2005 waiver to support services provided to uninsured patients. The GPP lifts restrictions that have historically impeded providing services for the remaining uninsured in the most appropriate setting for each patient, and will also now include non-traditional methods of care delivery that had not been covered under either program.

This shift from volume to value is done through an innovative value-based point methodology, which takes into account both the value of care to the patient, and the recognition of costs to the health care system.

Each participating PHS will have the opportunity to earn a global budget for care to the remaining uninsured, and must meet service thresholds to receive full funding. Points will be assigned to services in the following categories:

- Traditional Outpatient (ex. primary or specialty care visit, dental, ER/urgent care, mental health visit)
- Non-Traditional Outpatient (ex. health coaching, care navigation, community wellness encounters)
- Technology-Based Outpatient (ex. nurse advice line, email consultation, provider-to-provider eConsult for specialty care)
- Inpatient and Facility Stays (ex. trauma care, ICU stays, recuperative care, respite care, sober center stays, skilled nursing facility stays)

Services that promote the right care, in the right place, at the right time for a particular illness are valued relatively higher than services that would be considered less appropriate under the same conditions.

Physician consulting with Pharmacist
Kern Medical

"The GPP will give us the flexibility we need to care for our uninsured patients in ways we never have before. The encouragement of care delivery outside the traditional office setting will also allow patients who can benefit from telephone consults or group visits to get the care they need, while leaving more room in the office for patients who do need to see a physician."

- Russell Judd, President and CEO, Kern Medical

1. A portion of California's DSH allotment will retain its traditional structure for those PHS and Districts not participating in the GPP.

WHOLE PERSON CARE

FUNDING: $1.5 billion in federal funding over five years, for selected counties

SOURCE OF NON-FEDERAL SHARE: Local IGTs

DESCRIPTION: The Whole Person Care (WPC) pilot offers an innovative approach to caring for our communities' highest-risk and most vulnerable people. Under the WPC pilot, participating counties will better coordinate physical health, behavioral health, and social services and other supports to help meet needs like housing or food in a patient-centered manner. This coordination aims to improve patient health and well-being, and will result in a more efficient and effective use of a county's resources, by reducing emergency department usage and inpatient readmission. *Medi-Cal 2020* offers California an opportunity to test the WPC approach in multiple counties, in order to identify effective strategies that can be replicated elsewhere.

WPC Pilots will be chosen based on a competitive application process. Each participating pilot must be organized by a lead entity that could be a county, a city and county, a health or hospital authority, or a consortium of counties serving a region. The lead entity will work with a number of other key partners, like county behavioral health and health plans, social services, housing authority, probation, and other health care providers in their community who are serving the targeted pilot population.

Chosen pilot sites will receive federal funding to integrate care in their communities for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems, and who continue to have poor health outcomes.

These groups will include, but not be limited to, individuals:

- with repeated incidents of avoidable hospital utilization;
- with two or more chronic conditions;
- with mental health and/or substance use disorders;
- who are currently experiencing homelessness, and/or
- who are at risk of homelessness, especially upon release from institutions, including health care institutions, rehabilitation facilities, county jails, or state prisons.

Whole Person Care pilots will identify these individuals, share data, coordinate care in real-time through an individualized care plan, and evaluate individual and population progress – all with the goal of providing comprehensive coordinated care for the patient, resulting in better health.

A successful pilot will require relationship building and increased integration among county agencies, health plans, providers, and other entities that serve high-risk, high-utilizing Medi-Cal beneficiaries. Successful pilots will not only improve health outcomes for some of the most vulnerable in their communities, they will create a more collaborative infrastructure that can endure into the future.

"We know that what's bringing our most vulnerable patients back into the E.R. week after week is rarely just whatever acute health condition they present with. If we're sincere about caring for these patients, we need to address these underlying issues, whether it's housing, nutrition, mental health or substance use disorder issues, or the likely combination of these and other factors. We need to equip these patients with the tools and support they need to get healthy, stay healthy and improve their overall life opportunities."

Mark Ghaly M.D., Director, Community Health & Integrated Programs, Los Angeles County Health Services

Patient at Crossroads Respite Home
Alameda Health System

DENTAL TRANSFORMATION INITIATIVE

FUNDING: $375 million over five years

SOURCE OF NON-FEDERAL SHARE: State savings from Designated State Health Programs (DSHP)

DESCRIPTION: The goal of the Dental Transformation Initiative is to ensure that patients can consistently and easily access high quality dental services supportive of achieving and maintaining good oral health. The program is focused on increasing preventative dental care for children age 20 and under, and includes the creation of an incentive program for participating providers to perform specific pre-identified treatment plans for children, determined by a risk assessment.

The Dental Transformation Initiative also includes a pilot program to provide incentive payments for providers who maintain continuity of care (providing regular examinations, with no gap in service, at the same office location) for patients age 20 and under.

CONCLUSION

Medi-Cal 2020 includes payment reform efforts for California's public health systems that will help them focus on value over volume, and are geared towards supporting providers in seeing and treating each patient as a whole person, rather than focusing solely on immediate instances of acute ailments. These reforms will incentivize PHS to provide better care, not just more care.

Just as the Bridge to Reform waiver supported California's efforts to lead the nation in implementing the Affordable Care Act, *Medi-Cal 2020* will support the efforts of California and its public health care systems to lead the nation towards care for low-income and vulnerable patients that emphasizes preventative and patient-centered care in the right place at the right time.

If they succeed in meeting the performance-based metrics and outcomes in *Medi-Cal 2020* programs, California's public health care systems will have changed the focus of their care delivery to emphasize more effective and efficient care in primary and specialty outpatient settings.

As a result, patients served by PHS will be regularly engaged with their provider teams to manage their health conditions, with the goal of staying healthy and out of the emergency room and hospital. California's public health care systems are deeply committed to improving care for their patients, and are eager to succeed under this ambitious waiver.

California's 21 Public Health Care Systems include county-owned and operated facilities and University of California medical centers:

Alameda County
- Alameda Health System

Contra Costa County

Contra Costa Health Services:
- Contra Costa Regional Medical Center

Kern County
- Kern Medical

Los Angeles County

Los Angeles County Department of Health Services:
- Harbor/UCLA Medical Center
- LAC+USC Medical Center
- Olive View / UCLA medical Center
- Rancho Los Amigos National Rehabilitation Center

Monterey County
- Natividad Medical Center

Riverside County
- Riverside University Health System - Medical Center

San Bernardino County
- Arrowhead Regional Medical Center

San Francisco County

San Francisco Department of Public Health:
- Zuckerberg San Francisco General
- Laguna Honda Hospital and Rehabilitation Center

San Joaquin County

San Joaquin County Health Care Services:
- San Joaquin General Hospital

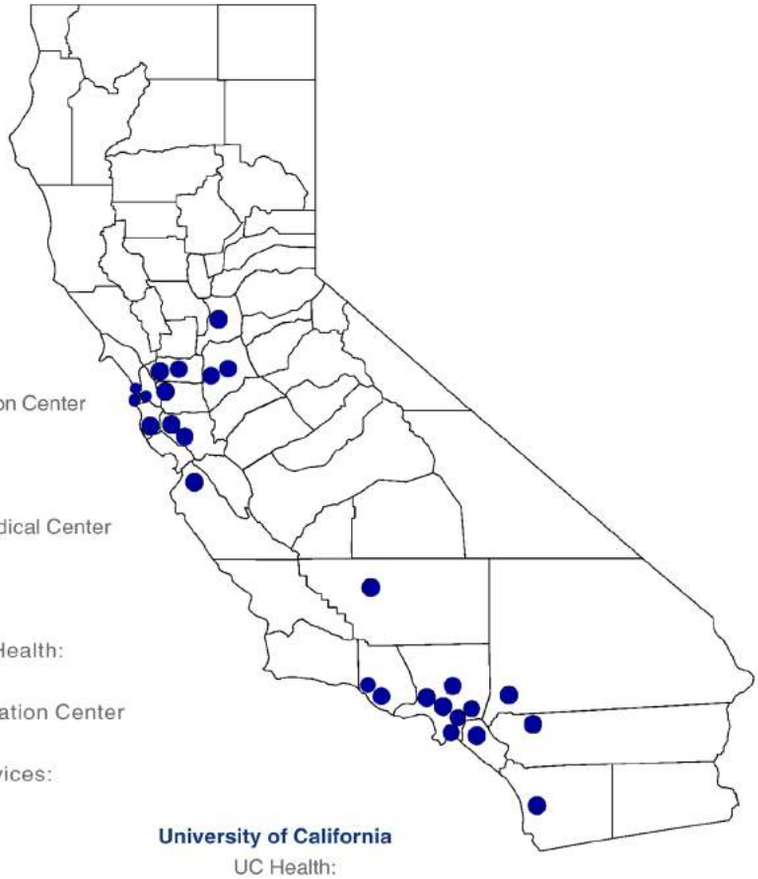
San Mateo County
- San Mateo Medical Center

Santa Clara County

Santa Clara Valley Health & Hospital System:
- Santa Clara Valley Medical Center

Ventura County

Ventura County Health Care Agency:
- Ventura County Medical Center



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