

# California's Public Health Care Systems' Journey to Value-Based Care

March 2019

## Executive Summary

For more than a decade, California's 21 public health care systems have been leading efforts to evolve safety net payments from volume to value. Beginning with coverage expansion and an emphasis on process and infrastructure, the value-based approach has intensified over the years to improve health outcomes and increase financial risk.

Throughout this process, Section 1115 Medicaid (called Medi-Cal in California) waivers have served as the primary policy vehicle for public health care systems' payment and delivery system transformation. The waivers have provided opportunities for public health care systems to earn billions of dollars in federal funding in order to develop the infrastructure and care delivery systems needed to improve the quality and efficiency of care. Matched dollar for dollar by the public health care systems themselves, incentive payments have constituted a massive investment by local and federal entities to care for millions of patients across the state.

These programs have presented both challenges and opportunities for public health care systems to improve quality and patient experience, and to develop new collaborations with organizations and managed care plans to help improve care coordination and data reporting. As a result, health care processes and outcomes have improved dramatically.

For example, nearly all public health care systems are now at or above the national 90th percentile in managing blood sugar control for patients with diabetes, and 88% are meeting yearly depression screening targets, with an additional 185,000 patients screened. Public health care systems have also expanded access

for the uninsured and are providing a range of innovative non-traditional services for patients with complex health and social needs.

Although truly meaningful outcomes have been achieved, much more work remains. As we contemplate the unknown future of performance-based programs through 1115 waivers, public health care systems are committed to seeking opportunities to continue their value-based journey, particularly efforts that leverage their expertise in caring for complex and vulnerable patients and their innovative work to address homelessness, behavioral health, and other social determinants of health.

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## California's Public Health Care Systems

California's public health care systems are the cornerstone of the state's health care safety net. Primarily county owned and operated or affiliated, they also encompass the five University of California medical centers. You can find them in 15 counties across California where more than 80% of Californians live.

Though public health care systems constitute just 6% of all hospitals in the state, they provide 35% of all hospital care to Medi-Cal beneficiaries and 40% of hospital care to the remaining uninsured in the communities they serve. In addition, they operate half of the state's top-level trauma and burn centers, and conduct half of all physician hospital training in the state.

California's public health care systems are integrated systems of care, providing top-quality primary and specialty care on their main campuses and over 200 outpatient clinics located throughout their communities, in addition to life-saving hospital-based emergency and inpatient services. They provide 10 million outpatient visits annually and are the primary care provider to more than 500,000 patients who have become eligible for Medi-Cal since California's coverage expansion efforts began. This system-based structure has enabled public health care systems to more readily embrace the challenges of value-based care, which seeks to reduce emergency and inpatient services.

## Value-Based Components of the 1115 Medicaid Waivers

Section 1115 Medicaid waivers, generally five year agreements between states and federal administrations, waive certain federal requirements in exchange for advancing shared policy goals. Waivers provide a pathway for states to test new approaches in Medicaid that differ from federal program rules.

In 2009,  
zero dollars tied to  
performance.  
Now more than  
\$2.8B annually.

Since 2005, California has implemented three 1115 Medicaid waivers, each challenging public health care systems to tie a greater amount of funding to value-based care. In 2009, public health care systems in California had zero dollars tied to performance; today that figure is approximately \$2.8 billion annually.<sup>1</sup>

The magnitude of these payments reflects public health care systems' willingness to test new and innovative care delivery models to improve care and patient experience.

Since Medicaid is a state-federal partnership, the State must provide matching funds in order to receive federal funding (the matching rate for California is 50% for traditional patient populations). In California, almost all matching funds, or non-federal share, for 1115 waivers have been provided by public health care systems themselves. Thus, the significant funding tied to value also reflects a local investment by public health care systems to the important work of value-based care.

1. This analysis includes Whole Person Care, PRIME, Quality Incentive Program, Global Payment Program, Medicare (HRRP, VBP, HAC), and Medi-Cal Managed Care P4P (voluntary plan-by-plan).

2. Kaiser Family Foundation: State Health Facts (2018). Delivery System Reform and Payment Program (DSRIP) Waivers and Uncompensated Care Pools in Place. Retrieved from: <https://www.kff.org/medicaid/state-indicator/delivery-system-reform-incentive-payment-program-dsrrip-waivers-and-uncompensated-care-pools-in-place/> (Accessed February 15, 2019).

## WHAT IS VALUE-BASED CARE?

In value-based care, health systems take on greater financial risk for the provision and quality of services. Public health care systems in-particular have been demonstrating this approach in Medi-Cal managed care, which has led to increased collaboration with health plans to better align managed care payments with quality and efficiency.

The section below describes how the 1115 waiver programs have facilitated this transition, with an emphasis on performance-based risk as a key stepping stone towards value-based care arrangements.

### 2005 Waiver: Early Coverage Expansion

Though mostly a hospital financing mechanism, the 2005 waiver featured a three year Health Care Coverage Initiative (HCCI) to expand coverage to childless adults. From 2007-2010, the HCCI provided \$540 million (\$180m per year over a three year period) in federal funding to expand health care coverage and services to childless adults. Ten counties participated in the HCCI, covering over 236,000 Californians.

### 2010 Waiver: Unprecedented Delivery System Reform

In 2010, California recognized the need to prepare the delivery system for increased demand as a result of Medicaid expansion under the Affordable Care Act (ACA). Accordingly, the waiver renewal known as *The Bridge to Reform* featured the first Delivery System Reform Incentive Program (DSRIP) in the nation, since replicated in nine other states.<sup>2</sup> The Low Income Health Program (LIHP), another 2010 waiver program, built on the prior waiver's HCCI to expand coverage to an additional 500,000 adults, essentially pre-enrolling them in Medi-Cal when ACA coverage became effective on January 1, 2014. With these programs, California's public health care systems emerged as leaders in ACA implementation and delivery system transformation.

The DSRIP provided public health care systems with the chance to earn \$3.4 billion in federal incentives to develop infrastructure and system improvements to improve care coordination, quality, access, and efficiency. Public health care systems selected local projects in primary care, specialty care, inpatient, and other settings that expanded capacity and improved patient care. Each project fell within one of five key categories: infrastructure development, innovation and

redesign, population-focused improvement, urgent improvement in care, and HIV transitions. For each milestone achieved, health care systems were able to draw down a predetermined incentive payment. Each public health care system carried out an average of 15 simultaneous projects, averaging a total of 217 milestones per year, spanning every part of their system. By year five (2015), public health care systems had achieved 97% of 3,764 milestones across all projects.

As a result of coverage expansion and delivery system reform, public health care systems dramatically accelerated improvements in the way they delivered care:

- Over 680,000 patients enrolled in medical homes – a patient-centered, comprehensive, team-based care model focused on quality and safety.
- More than 1 million patients were tracked via chronic disease registries, which allowed for more effective, proactive, and timely disease management. For patients with short-term diabetes complications, a 20% decrease in hospitalizations was reported.
- Thirty six clinics, across seven systems, offered integrated physical and behavioral health services. Among systems reporting screening for behavioral health, more than 70% of patients seeking care for a physical health issue also received depression screening.
- Some public health care systems focused on expanding access to primary and specialty care, leading to an 18.5% increase in patients seen annually in primary care and an average increase of 14% for specialty services like optometry, dermatology, orthopedics, and others.



Dr. Amy Sitapati,  
Chief Medical  
Information Officer,  
Population Health,  
University of  
California San Diego

“ We have a four prong approach to population health that includes: 1) novel electronic methods to activate patients in their care; 2) registries to inform data-driven decision making and target interventions; 3) standard reliable workflows for ambulatory settings; and 4) collaboration and teamwork. This framework has allowed us to substantially improve the quality of care we deliver and is the driving force behind our value-based care strategy. ”

## DSRIP PERFORMANCE HIGHLIGHTS

- Over 680,000 patients enrolled in medical homes
- More than 1 million patients tracked via chronic disease registries
- 36 clinics offered integrated physical and behavioral health - among those that reported screening, 70% of patients received depression screening while seeking care for a physical health issue
- Participating systems reported an 18.5% increase in patients seen annually in primary care and an average increase of 14% in specialty services

### 2015 Waiver: More Ambitious Value-Based Reforms

The Centers for Medicare & Medicaid Services (CMS) recognized California’s tremendous success of performance-based payments and Medi-Cal expansion, renewing its waiver in 2015 with even more challenging and aggressive delivery system milestones. *Medi-Cal 2020* features four performance-based programs:

1. Public Hospital Redesign and Incentives in Medi-Cal (PRIME);
2. The Global Payment Program (GPP);
3. Whole Person Care (WPC); and
4. The Dental Transformation Initiative (DTI).

Together, these programs have continued to strengthen the delivery system by challenging public health care systems to provide preventive and patient-centered care in the right place at the right time to Medi-Cal and uninsured patients.

### Public Hospital Redesign and Incentives in Medi-Cal (PRIME)

Built upon DSRIP’s infrastructure, PRIME features more standardized and challenging performance metrics. PRIME metrics are more outcome, rather than process-based, and the metrics are standardized across all systems, with year-



Dr. Reena Gupta,  
Chief of Value-  
Based Care, San  
Francisco Health  
Network

“Using LEAN methodology, which engages all staff on quality improvement strategies and aims to continuously reduce waste and inefficiencies in our system, has been an important component of our value-based care strategy. With LEAN, we have been able to focus on optimizing data analytics, strengthening our performance improvement infrastructure, and expanding population health management.”

over-year improvement requirements. The number of pay-for-performance metrics (as opposed to pay-for-reporting) increases over the course of the program, with 88 in year five, representing 95% of total measures. If all California’s public health care systems meet the performance requirements over the course of the five year program, they could earn a total of \$3.27 billion in federal funds.

PRIME also requires public health care systems to adopt Alternative Payment Models (APMs), in which systems assume greater financial risk for care delivery within Medi-Cal managed care. By January 2018, each public health care system was required to contract with at least one Medi-Cal managed care plan in the service area they operate in using an APM. These APM arrangements can include capitated or shared savings arrangements between plans and public health care systems, and must demonstrate greater alignment between financing and the cost, quality, and care associated with serving Medi-Cal managed care enrollees.

In addition, public health care systems were required to collectively meet a January 2018 requirement that at least half of the Medi-Cal managed care beneficiaries who are assigned to a public health care system receive some or all of their care under a contracted APM. The requirement increased to 55% for January 2019 and will increase to 60% by the end of the waiver renewal period in 2020. Failure to meet these requirements would jeopardize 5% of all PRIME funding.

Fortunately, public health care systems are meeting the APM requirements. As of January 2019, three systems receive fully capitated payments from their local Medi-Cal managed care plan, and all other public health care systems participating in PRIME have established partial capitation arrangements.<sup>3</sup> APM’s have given public health care systems more experience tying payments to value and opportunities to strengthen and expand their partnership with Medi-Cal managed care plans.

### **The Global Payment Program (GPP)**

Public health care systems set a new national precedent through the 1115 Medicaid waiver in developing the Global Payment

Program, this time targeting the roughly 3 million remaining uninsured who access care in public health care systems. The GPP creates approximately \$1.1 billion in federal financial incentives for California’s public health care systems to provide care to uninsured and underinsured individuals in more appropriate outpatient settings.<sup>4</sup>

The GPP rewards primary and preventive care through a point system that assigns a relatively higher value for those services than would traditionally be done under a purely cost-based or fee-for-service model. Every time a public health care system provides an eligible service to an uninsured patient, it earns points based on that service’s point value. In order to receive its full allotment for that year, the system must accumulate enough points to meet or exceed its service threshold, which is based on historical provision of services to uninsured individuals. Over the course of the GPP, relative point values for inpatient and emergency care decrease vis-à-vis all other services, which recognizes the desired shift in care delivery.

The GPP’s incentives also encourage public health care systems to provide “non-traditional” services, which are services previously unreimbursed but have been shown to improve health outcomes. These services may include technology-based consultations, health coaching, and group education visits, among others.

Year two GPP program data shows that inpatient and emergency room visits decreased for patients with physical health issues, while outpatient visits increased. Treating uninsured patients with behavioral health issues has proven more of a challenge, in part due to a lack of accurate quality data, which can contribute to gaps in care. Data improvement and continued efforts to improve access remain a major focus area of the program moving forward.

## **GLOBAL PAYMENT PROGRAM SPOTLIGHT**

Public health care systems are implementing a range of innovative programs to better serve the needs of their diverse patient populations.

For example, **Riverside University Health System** partners with local churches to offer events focused on behavioral health, providing education, screening, and referrals to county programs. **Kern Medical Center** offers mobile wellness events for rural community members and **San Mateo Medical Center** created an after-hours clinic for farm workers.

3. Los Angeles County Department of Health Services, which oversees 4 hospitals and 19 health centers, participates in PRIME as a single entity.

4. The GPP funding pool changes each year based on the amount of available Disproportionate Share Hospital (DSH) funding, a federal payment to qualifying hospitals that serve a large number of low-income and underserved populations. Over the past two years of GPP, combining funds from DSH and the additional Safety Net Care Pool under the 1115 waiver, approximately \$1.1 billion was available annually.

## Whole Person Care (WPC)

The concept of Whole Person Care is premised on the recognition that the best way to care for people with complex needs is to address their full spectrum of needs – medical, behavioral, socioeconomic and beyond. For people in low-income communities, medical problems can be caused and exacerbated by factors related to poverty that include poor nutrition, lack of safe and stable housing, incarceration, unemployment, and the chronic anxiety of income insecurity.

While services may be available to help alleviate some of these stresses and inequities, they are often delivered in a siloed fashion. Different types of service providers do not regularly communicate or coordinate care, even though they may be serving the same individuals and families. By receiving tailored “whole person” support and coordinated services, patients can ultimately enjoy healthier lives. Greater care coordination also enables safety net providers to more efficiently and effectively use their resources, maximizing their ability to improve patient health outcomes and making limited resources go further to help more people in the community.

The 2015-2020 Medi-Cal waiver includes a WPC pilot program that ties \$1.5 billion in federal funds to improve care for Medi-Cal beneficiaries through a collaborative approach that addresses physical, behavioral, and social needs. Through a competitive process, California’s Department of Health Care Services selected 25 WPC pilots across the state to participate in the program. Each pilot is tailored to the local context and needs of the population it serves. Health care and behavioral health providers, social services, and community partners, such as housing support organizations, are working together to identify their highest-need clients and provide them with comprehensive, coordinated care.

In many instances, public health care systems are leading local WPC efforts and have played a major role in designing appropriate interventions, strengthening local partnerships, and identifying successful strategies for outreach and to engage hard-to-reach patients. This work -- linking the provision of medical services to more holistic health approaches -- is critical as public health care systems consider ways to expand their value-based care efforts with a greater emphasis on population health.



William Gilbert,  
CEO, Arrowhead  
Regional Medical  
Center

“Our partnership with Inland Empire Health Plan has been absolutely critical to our success in value-based care. They partnered with us to build the infrastructure and workforce necessary to deliver high-quality integrated care to our patients, including adding social workers, care coordinators, and community health workers to enhance existing care teams.”



Tangerine Brigham,  
Chief Administrative  
Officer, Population  
Health, Alameda  
Health System

“We are taking a clinic-by-clinic approach and focusing on several key elements: training and education for frontline staff on population health, partnering with our local Medi-Cal health plan, including aligning quality metrics, and developing robust reporting mechanisms and data governance structures. It’s a culture change to take on value-based care and we have embraced this across the organization at every level.”

## The Impact of the Medicaid Managed Care Rule in Driving Value-Based Care

In addition to 1115 waivers, recent federal regulations regarding Medi-Cal managed care have offered public health care systems the opportunity to again tie significant federal dollars to delivery system performance. A final regulation went into effect July 1, 2017, placing new restrictions on how health care providers receive supplemental payments in Medicaid managed care.

For years, California’s public health care systems had been financing and receiving supplemental payments for services provided to patients enrolled in Medi-Cal managed care plans. These supplemental payments helped to partially bridge the gap between Medi-Cal base rates and the actual cost of providing care. The new regulation required a restructuring of the supplemental funds, and with it, a voluntary opportunity to convert a portion of those dollars to performance.

As a result, public health care systems now finance and participate in two new supplemental payment programs -- the Quality Incentive Program (QIP) and the Enhanced Payment Program (EPP). The QIP, a performance-based program, is described below. The EPP creates a funding pool to supplement base rates that public health care systems receive through Medi-Cal managed care rates.

### Quality Incentive Program (QIP)

QIP payments are tied to performance on a set of established quality measures for Medi-Cal managed care enrollees. Prior to QIP, supplemental payments did not have a pay-for-performance structure, so this marked a significant change in how funds are distributed. Each public health care system is now responsible for at least 20 performance targets across primary care, specialty care, inpatient care, and resource utilization.

QIP is structured similar to PRIME and the measures complement existing efforts; however, the QIP directly links measures to Medi-Cal managed care enrollees, creating an

opportunity to better align and expand risk and performance-based improvement efforts with Medi-Cal health plans. If all public health care systems achieved their QIP performance milestones, they would be eligible to receive between \$320 and \$450 million in federal funds annually.

## Impact to Date of Performance-Based Structures

Public health care systems' performance- and value-based structures have resulted in significant improvements in care delivery, and consequently, health, for the millions of patients they serve each year. For example, as of year three performance in PRIME:

- Almost all public health care systems are performing better than 90% of the country's Medicaid providers in managing blood sugar for patients with diabetes.
- Roughly 65% of public health care systems are performing better than 90% of all Medicaid providers across the country in managing patients' high blood pressure – representing an additional 12,300 patients in better blood pressure control.
- Seventy percent of public health care systems are performing better than 90% of the country's safety net providers in tobacco screening – equating to an additional 83,600 screened and counseled if appropriate.
- Eighty-eight percent of public health care systems are meeting their yearly PRIME target for depression screening, representing an additional 185,000 patients screened.

In the first year of WPC implementation:<sup>5</sup>

- Seventy five percent of pilots opened or expanded post-acute facilities and/or temporary housing, including medical and psychiatric respite, low-threshold homeless shelters with on-site intensive case management, and transitional housing units.
- Across 12 WPC pilots, over 190 partner organizations, including housing providers, homeless advocates, social service agencies, behavioral health departments, food banks, and corrections departments, among others, are collaborating to coordinate care for enrollees.

## Looking Ahead: More Work to Do

Through the 1115 waiver programs and the Quality Incentive Program, public health care systems have made significant advancements in value-based care. Aligning performance metrics with financial incentives and quality improvement, pay-for-performance, and other value-based programs have

5. Based on available data from CAPH member pilots.

## BEHAVIORAL HEALTH SPOTLIGHT

LAC+USC Medical Center's efforts to address behavioral health in primary care have resulted in promising outcomes.

For example, six months after patients with social or behavioral health needs received psychiatric or social work services, 20% of patients, on average, were less likely to return to the emergency department or urgent care and 40% were less likely to have inpatient stays.

Among the 1,100 patients seen for social or behavioral needs, this resulted in 101 fewer hospital inpatient visits in the six months following initiation of care and 163 fewer emergency department and urgent care visits - leading to a potential cost savings of over \$400,000.

increased public health care systems' accountability to improve the quality of care. The PRIME APM requirement also allowed public health care systems to experiment with risk-based capitation arrangements, which is a logical next step in experimenting with greater risk in full capitation, global budgets, or other shared savings arrangements.

Public health care systems are proud of these successes, and are eager to continue to achieve even greater results. Yet, the looming expiration of the 2015-2020 waiver, in addition to Medicaid Disproportionate Share Hospital (DSH) payment cuts, threatens to jeopardize public health care systems' important work.

As we look ahead and contemplate an unknown future of performance-based programs through 1115 waivers, public health care systems are considering and analyzing policies and programs that: 1) leverage their expertise in caring for complex and vulnerable patients; 2) maintain the resources needed for their essential safety net mission; and 3) continue to tie payments to performance that yields even greater values.

### About CAPH:

The California Association of Public Hospitals and Health Systems (CAPH) represents California's 21 public health care systems, which include county-affiliated systems and the five University of California academic medical centers. Together, these systems form the core of the state's health care safety net.

### About SNI:

The California Health Care Safety Net Institute (SNI) is the 501c3 affiliate of the California Association of Public Hospitals and Health Systems (CAPH), and supports California's public health care systems in their efforts to improve the way they deliver care.