CA
P
H
CALIFORNIA ASSOCIATION of
PUBLIC HOSPITALS
AND HEALTH SYSTEMS

SNI
CALIFORNIA HEALTH CARE
SAFETY NET INSTITUTE

ISSUE BRIEF: THE GLOBAL PAYMENT PROGRAM

PROGRAM UPDATE — POSITIVE TRENDS IN IMPROVING CARE FOR THE REMAINING UNINSURED

October 2017 - Revised Edition[1]

INTRODUCTION

Despite California's robust implementation of the Affordable Care Act, nearly 3 million residents remain uninsured[2] – individuals who, like all others, require regular primary and preventive care in order to stay healthy and out of the emergency room and hospital. In response, California's public health care systems[3] are once again leading the nation in piloting value-based Medicaid innovations[4], this time through the Global Payment Program (GPP).

The GPP is structured to create strong financial incentives for county-based public health care systems to shift the focus of their care for uninsured patients towards primary and preventive services.

The GPP is a core program of California's current five year Section 1115 Medicaid waiver[5], known as Medi-Cal 2020, along with Public Hospital Redesign and Incentives in Medi-Cal (PRIME), a pay-for-performance delivery system transformation program; Whole Person Care, which aims to improve the health and well-being of high-risk, high-utilizing patients by coordinating services beyond just health care; and the Dental Transformation Initiative (DTI), which aims to improve dental health for Medi-Cal children.

Launched in 2015, the GPP is a first-of-its-kind restructuring of existing federal funding, giving providers more flexibility to work with patients to deliver the right care, in the right place, at the right time, and reducing the financial incentive to care for uninsured patients primarily in a hospital setting. It is a powerful vehicle that helps California's public health care systems achieve their mission of providing high quality health care to all – regardless of ability to pay – in the most cost-effective manner.

The flexibility provided by the program's structure encourages public health care systems to improve uninsured patients' access to appropriate care. This structure allows health care systems to invest in much-needed services for the GPP's population. Data infrastructure and workflow improvements are keys to the program's implementation, and will continue to push the work forward in a data-driven way.

Across the board, the data shows positive trends when compared to data collected prior to the start of the GPP.

This report will summarize California's public health care systems' progress in implementing the GPP, based on the most recent year-end reports and information gathered from state and local program officials. In addition, we will offer our initial thoughts on the future prospects for the program.

California's Public Health Care Systems

California's public health care systems are a core part of the state's health care safety net. Though they operate just 6% of all hospitals in the state, California's 21 public health care systems serve 15 counties where more than 80% of Californians live and serve more than 2.85 million patients a year. They provide 35% of all hospital care to Medi-Cal beneficiaries and 34% of hospital care to the remaining uninsured in the communities they serve, operate half of the state's top-level trauma and burn centers, and train more than half of all new doctors 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 in dozens of community-based clinics, in addition to life-saving hospital-based emergency and inpatient services. They provide 10.5 million outpatients visits annually, and are the primary care provider to more than 560,000 patients who have become eligible for Medi-Cal since California's coverage expansion efforts began.

1. This version contains a revision regarding how certain services are categorized and calculated in the Early Data and Reporting section.

2. The GPP supports health care services provided to patients who lack health insurance, as well as medically-necessary health care services provided to those who have some type of health insurance, but whose health insurance does not cover that particular service. For the purposes of this brief, the term "uninsured" includes both of these groups.

3. For the purposes of this brief, the term "public health care systems" refers only to county-owned and operated public health care systems, which are the systems participating in the GPP. Outside of the GPP, public health care systems also include the five University of California medical centers, which do not participate in the GPP but do participate in other programs under the Medi-Cal 2020 waiver, including PRIME. A portion of California's Medicaid DSH allotment has retained its traditional structure for public and district hospitals not participating in the GPP.

4. In 2010, California's public health care systems piloted the first Delivery System Reform Incentive Program (DSRIP), which has since been adapted by thirteen other states.

5. For more on the Medi-Cal 2020 waiver and its programs, visit caph.org/waiver.

GPP STRUCTURE

The Global Payment Program combines two federal funding sources that are matched with county funds: Medicaid Disproportionate Share Hospital (DSH) funding and California's Safety Net Care Pool (SNCP). These two funding sources are merged into a single pool, thereby removing restrictions that had been historically placed on both sources, in order to drive more out-patient and preventive care.

The size of the combined pool changes each year based on the amount of available DSH funding, which was approximately $1.1 billion annually in Program Year 1 (PY1) and Program Year 2 (PY2) of the GPP.

Each public health care system is eligible to receive a certain amount of funding for care to the uninsured in any given year under the GPP. This amount is referred to as a system's **global budget**.

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 global budget 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, point values for inpatient and emergency care decrease, and the relative values of all other services increase, in recognition of the shift in care delivery. The GPP's point system thus rewards primary and preventive care. However, point values for critical services like trauma and burn care recognize the high cost and acuity of emergency room (ER) visits and inpatient days, and the program places a commensurate value on these lifesaving services.

The GPP also encourages "non-traditional" patient-centered services, which are services that were previously unreimbursed but are high value, innovative services that have been shown to improve health outcomes. These include technology-enabled services such as telephone visits, and low-tech services such as patient support groups. These services are described in greater detail in a later section.

For a more detailed description of the GPP's structure and mechanics, including a complete list of services and their point values, read our introductory issue brief at caph.org/gppbrief.
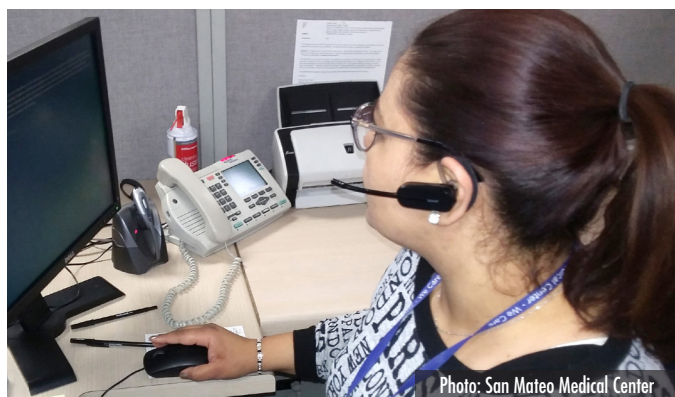

Photo: San Mateo Medical Center

Program Profile: Natividad Medical Center

Photo: Natividad Medical Center

In 2016, during Program Year 1 of the GPP, Monterey County launched a pilot program to provide outpatient services to patients who remain uninsured, paid for by Natividad Medical Center (NMC).

"These individuals are part of the backbone of our nation's agriculture economy," says Dr. Craig Walls, Natividad Medical Center's Chief Medical Officer. "They're out there every day in our community, producing food that will be on dinner tables in Cleveland a few days later."

"As (our county's) public health care system, it's our responsibility to the entire community to give those without insurance the care they need to stay healthy," says Dr. Walls. "The GPP helps us do that."

NMC earns many of its GPP points through services provided to the pilot program's enrollees. When the pilot program launched, it provided primary care and some ancillary services, such as x-rays and labs. As the program progressed, it became clear that many of its enrollees were also in need of specialty care, and the pilot program expanded to include specialty services in September of 2017.

NMC also leverages the GPP to provide integrated physical and behavioral health care to uninsured patients who are not enrolled in the program; offer robust patient support services and community health education; and provide critical acute and inpatient care.
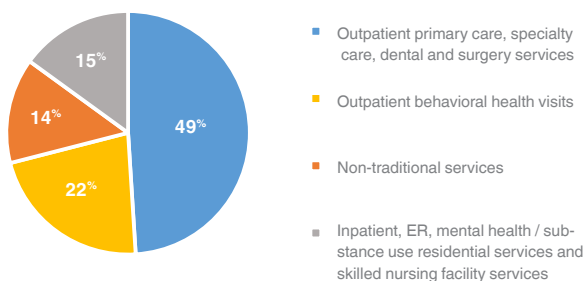
"We'll always be there to provide emergency care to anyone in our community who needs it," says Dr. Walls. "Our goal in caring for all our patients, including the uninsured, is to have fewer who do."

EARLY DATA AND REPORTING

Early data reveals positive initial trends overall.

In terms of the total quantity of services provided, in PY1 public health care systems tracked and reported around 2.8 million services provided to uninsured patients. Of these, nearly 1.4 million (49%) were outpatient primary care, specialty care, dental and surgery services. An additional 600,000 (22%) were outpatient behavioral health visits and almost 400,000 (14%) were non-traditional services.

GPP services provided, PY1

- Outpatient primary care, specialty care, dental and surgery services
- Outpatient behavioral health visits
- Non-traditional services
- Inpatient, ER, mental health / substance use residential services and skilled nursing facility services

In Program Year 1 (PY1), seven of the twelve GPP participants met or exceeded their service threshold to receive their full funding, with two others at 99%. Overall, performance ranged between 80% and 108%.

The GPP's point system divides services into four categories:

Category 1: Outpatient in traditional settings
Category 2: Complementary patient support and care services
Category 3: Technology-based outpatient
Category 4: Inpatient

Each category is then broken out into lettered tiers based on service types. These categories and tiers will be referenced in the charts below; see the full list in our introductory brief at caph.org/gppbrief.
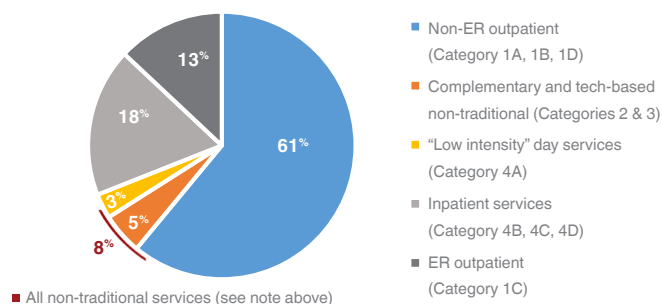
In PY1, 61% of points earned came from non-ER outpatient services in Category 1, such as primary and specialty care visits. Around 3% came from "low intensity" services in Category 4 (mental health / substance use residential services, skilled nursing facility services, respite care, and sobering center services).

Overall, 8% of points came from non-traditional services. About 5% came from Categories 2 and 3 (complementary and tech-based services). An additional 3% came from non-traditional services that are listed in Categories 1 or 4.

These are all services that further the goals of the GPP program.

Public health systems also earned 18% of their points from inpatient services and 13% from outpatient ER services.

Percentage of GPP points claimed, by service type

- Non-ER outpatient (Category 1A, 1B, 1D)
- Complementary and tech-based non-traditional (Categories 2 & 3)
- "Low intensity" day services (Category 4A)
- Inpatient services (Category 4B, 4C, 4D)
- ER outpatient (Category 1C)
- All non-traditional services (see note above)

The graph below indicates positive trends in the way care was delivered to uninsured patients in PY1 when compared to data collected from FY14-15, prior to the start of the GPP.

If GPP points had been allocated using FY14-15 reporting, 54% would have come from non-ER outpatient services, 28% would have come from inpatient services, 14% would have come from ER outpatient services, and 3% would have come from "low intensity" services in Category 4. No points would have been earned for complementary and technology-based non-traditional services, which were as-of-yet not reimbursable, and not reported.

Percentage of GPP points claimed, PY1 vs. FY14-15

FY14-15   PY1
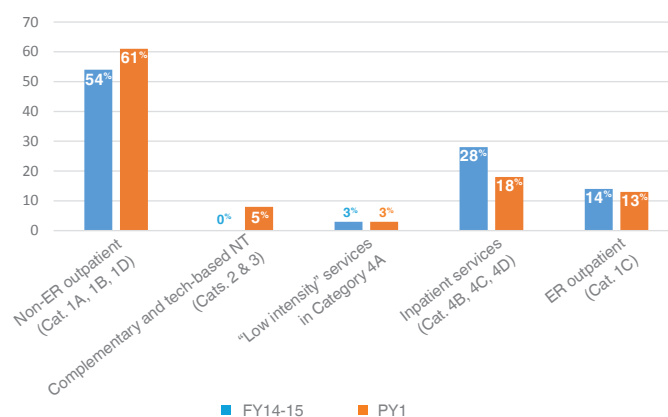
Improving Care Through Strengthened Data Infrastructure

The GPP's reporting requirements are spurring public health care systems to improve their data infrastructure in several key ways. Systems were required to submit **aggregate** data in the first year, but in later years the GPP requires that systems submit **encounter-level** data for each service.

Data collected for encounter-level entries includes the service provided, a unique patient identifier, the number of GPP visits for that patient, principal and other diagnoses and any procedures conducted, as well as the patient's age, gender, race, ethnicity, and zip code.

For the most part, public health care systems had not been collecting and aggregating data at this granular level for uninsured patients, especially for services provided by contracted providers. In some cases, such as services provided by a partner clinic, data may have been captured at the time of service, but was not shared with the public health care system. In other cases, encounters now being measured may have never been recorded before. This is the case for a large portion of the non-traditional services supported by the GPP.

Encounter level data collection and reporting will improve the ability of public health care systems and their partner providers to make data-driven decisions about continued efforts to improve care delivery, and to better identify disparities among specific populations or in particular locations. For example, they will be able to more easily identify patients who could benefit from available primary and preventive services, and optimize the right care in the most cost-effective setting.

In total, improved tracking of all services provided to the uninsured will create a more robust picture of the health care delivery to this population.

Program Profile: Riverside University Health System

Photo: Riverside University Health System

"We had people from our behavioral health team speak to them one weekend, we had some of our physicians speak the following weekend, we showed videos, and we conducted a survey," says RUHS Assistant Hospital Administrator Luis Orozco. "We needed to let them know they would be safe, comfortable, and welcome."
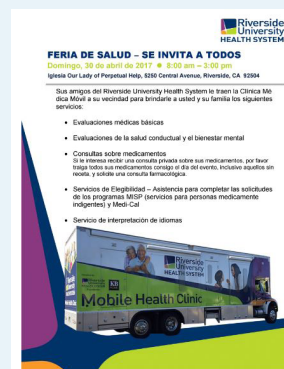

In early 2017, Riverside University Health System (RUHS) and its local Catholic Archdiocese launched a partnership to hold a series of health events at some of the county's large Catholic churches (1500-2000 congregants).

"The priest at one of the churches had expressed serious concerns about the mental health of his parishioners, with regard to heightened fear, anxiety, and depression," says Dr. Arnold Tabuenca, Chief Medical Officer at RUHS.

"We also knew we had to overcome tremendous stigma around seeking help for behavioral health, so we saw an opportunity to bring our services to the people so that they wouldn't have to come to us. Then we could connect them to our FQHCs, so that it wouldn't be a one-time visit."

The events are preceded by several weeks of pre-event talks at the churches to help build trust, allay fears, and address some of the stigma.

Mobile health workers then conducted basic health exams, checked vital signs and HbA1c levels, provided enrollment assistance into either Medi-Cal or Riverside County's Medically Indigent Services Program, gave patients clinic information, and administered a PHQ9 mental health assessment. Those who scored high on the PHQ9 were seen on-site by a psychiatrist, who determined appropriate next steps and connected patients to county services and programs.

RUHS treated approximately 200 people over the first two events, in April and June of 2017, about half of whom were uninsured. There are now plans for these events to continue quarterly.

"Ultimately, we're responsible for the health of our community," says Dr. Tabuenca. "That means investing in our community's health now, or facing a greater cost later if we don't."

Challenges in Capturing and Reporting Services

Although systems, providers, and patients will reap benefits from GPP-related data improvements, the initial undertaking to establish the needed infrastructure, train appropriate staff and collect required GPP information has been challenging.

Systems have trained staff, implemented new workflows, solved (or created temporary workarounds for) coding challenges and EHR compatibility issues, and have improved their methods of obtaining data from partner clinics. Even still, thousands of services continue to be provided but not reported.

In many public health care systems, solutions to data capture challenges are still being developed and implemented. Contra Costa Health Services, for example, is in the process of rolling its behavioral health services into its EHR system, but to date has had to rely on manual data extraction and clean-up for its GPP reporting.

Similarly, San Joaquin General Hospital actively communicates with patients through an online patient portal, and it can claim GPP points for certain patients, but the portal doesn't identify patients' insurance status, so connections have to be made manually.

Improvements in data collection and analysis, even including the implementation of temporary workarounds, have revealed flaws and inconsistencies in prior collection and reporting methods for many public health care systems, resulting in ongoing efforts to ensure the accuracy of the data – both current and previously reported.

However, in some cases, the inability to report on all services is actually by design. Clinical leaders at California's public health care systems have raised concerns that critical services provided in locations such as mobile clinics and shelters, and highly impactful non-traditional services such as support groups, would likely experience a sharp drop off in participation if personal data was being captured – especially around issues of behavioral health.

These services help advance the GPP's goal of providing the right care, in the right place, at the right time, and are a key part of public health care systems' strategies for improving care to all patients, including the uninsured, even if they are not captured in the GPP's quantitative data.

IMPROVEMENTS IN CARE DELIVERY

Since the start of the GPP, California's public health care systems have reported improvements to their systems in an effort to strengthen care delivery. Most notably, systems have reported new investments in expanding primary and preventive physical and behavioral health care, as well as specific outreach efforts to uninsured patients.

Systems are now offering more non-traditional services, and their improved data collection and analytics capacity is allowing them to more effectively coordinate services for patients and identify areas for additional investment.

Expanding Access to Primary and Specialty Care

All public health care systems are making progress in their efforts to expand access to primary and specialty care services to all patients.

Individual systems reported this progress in a number of ways, including conducting specific outreach to communities with high numbers of uninsured individuals, expanding initiatives such as mobile clinics and nurse visits, expanding certain services lines, and leveraging existing local programs to better coordinate services and connect patients with care teams.

Some systems are increasing staff in response to greater demand. For example, Ventura County Health Care Agency doubled the number of full time employees providing behavioral health services, after increased behavioral health screenings revealed the need. Kern Medical hired a Director of Community Health and Wellness to organize wellness fairs and classes for patients and community members.

Increasing the Provision of Non-Traditional Services

Non-traditional services are services that were previously unreimbursed as Medicaid services, but which add value by improving care delivery and ultimately health outcomes.

In a few cases, these are services that still take place in traditional settings – such as outpatient care provided by RNs, PharmDs, or complex care managers rather than traditional providers like physicians and physician assistants. Non-traditional services can also include technology-assisted services such as real-time patient-to-provider telehealth or provider-to-provider eConsults, as well as low-tech but often high-impact services such as wellness visits, patient support groups, and health coaching. For a full list of non-traditional services, see the chart in our introductory GPP brief at caph.org/gppbrief.

Of the 51 services health care systems can earn GPP points for, the majority (35) are considered non-traditional, though their point values are generally lower than more traditional services. For example, telephone consultations have a lower point value than face-to-face primary care visits.

In PY1, almost all public health care systems included non-traditional services in their GPP reports. Eight of the twelve public health care systems claimed points from at least six such services, and half of those systems included more than eleven.
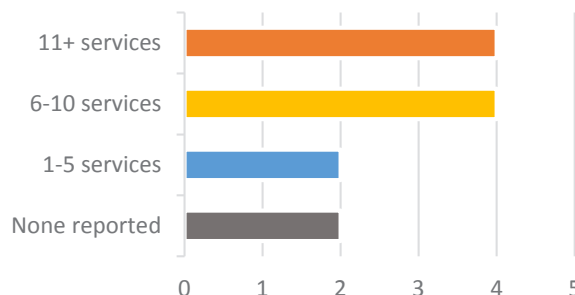
Systems claiming points for non-traditional services

Many of these services were already being provided to some extent within public health care systems, but trends show that the GPP has helped drive considerable expansion and much more robust data tracking across the board.

Photo: Santa Clara Valley Health & Hospital System
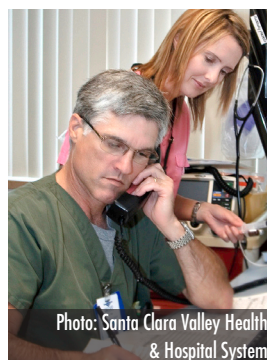
Santa Clara Valley Health & Hospital System, for example, has made significant investments in expanding access to its telehealth program, enabling more patients to do things like review test results, discuss medications, or manage certain chronic or acute conditions, in a much more convenient and comfortable way, while also freeing up clinic space for other patients to be seen in-person.

In other cases, non-traditional services are being newly added, such as Arrowhead Regional Medical Center rolling out an eConsult platform for primary care physicians to communicate with specialty care physicians, and both Ventura County Health Care Agency and San Francisco Health Network adding outpatient palliative care programs.

Though these services are only supported by federal funding for uninsured patients, they are being made available to all patients. Their increased availability and utilization will improve the entire delivery system.

Program Profile: Alameda Health System

Photo: Alameda Health System

Alameda Health System (AHS) earns GPP points for a wide variety of services, including those provided to individuals seeking asylum in the United States, through its Human Rights Clinic.

This specialized clinic sees patients who are referred for evaluations by doctors or a variety of community partners working with displaced people. The clinic provides trauma-informed primary care, psychological evaluations, and physical examinations for medically complex survivors of torture and trauma.

"Our patients almost all suffer from post-traumatic stress disorder and other mental health conditions as a result of the conditions they are escaping from," says Dr. Nicholas Nelson, attending physician at the Human Rights Clinic.

"Patients from cultures where mental health issues aren't generally talked about often have a hard time discussing them, and the conditions end up manifesting physically. The fact that we have co-located behavioral health services has led to some amazing successes."

"We had a patient who came to one of our emergency rooms as a result of extreme weight loss and severe rectal pain," says Dr. Nelson. "Doctors there immediately suspected colorectal cancer, but the tests all came back negative, and he was released."

"He was referred to us, and after several visits we uncovered that he was fleeing his home country because his local government had imprisoned and tortured him for protesting the government's seizure of his family's property," says Dr. Nelson. "All of the symptoms he was experiencing were specifically related to the emotional trauma of that horrific experience, and we were able to treat his conditions appropriately."

Dr. Nelson says this story illustrates the critical need to integrate both mental and behavioral health in care provided to populations with high levels of stress and conflict.

"You not only provide better care to the patient, in many cases you find you can use your resources much more efficiently."

Building and Strengthening Local Programs

Many counties operate indigent care programs for uninsured patients so that they can receive regular, coordinated primary and specialty care from public health care systems and often other services from local partners.

Two such programs have launched since the start of the GPP - Kern County's Kern Medical Wellness program, with care provided by Kern Medical, and Monterey County's pilot program for the uninsured, with care provided by Natividad Medical Center. Similar programs in Alameda, Contra Costa, Los Angeles, San Francisco, San Mateo and Santa Clara counties were in place prior to the start of the GPP.

A very clear trend has emerged: all public health care systems in counties with such programs report that the GPP has enabled them to strengthen the care they provide to these programs' enrollees, and in many cases, expand program enrollment. For example, since the start of the GPP, Los Angeles County's My Health LA program has enrolled an additional 8,000 people, increasing from 137,000 to 145,000 – growth the Los Angeles County Department of Health Services credits in part to the incentives of the GPP.

Focusing on Behavioral Health

Another trend that has emerged has been an increased awareness of the need to proactively provide and expand behavioral health services. Public health care systems are addressing this need through physical/behavioral health co-location efforts (including warm hand-offs), workforce development, and investment in data and capital infrastructure. The expansion of non-traditional services like telehealth also helps address this need, as treating patients effectively without an office provider visit creates space for patients who do require face-to-face provider encounters.

Alignment with PRIME

PRIME, the Medi-Cal 2020 waiver's 3.26 billion-dollar pay-for-performance delivery system transformation program, measures performance and health outcomes for two overlapping populations. PRIME includes all Medi-Cal managed care patients who are assigned to a public health care system whether they have been seen in primary care or not; and it also includes all patients who have had an encounter with the primary care team at least twice in a measurement year, whether or not they are assigned.

This second population can include uninsured patients. PRIME does not pay for the provision of services – rather, it provides incentives for systems to hit ambitious performance targets for clinical and operational metrics based on state and national benchmarks, including diabetes and blood pressure control, depression screenings and tobacco cessation.

For uninsured patients whose primary and preventive care services are supported by the GPP, PRIME provides an extra incentive for public health care systems to improve the care they provide.

LOOKING AHEAD

The Global Payment Program – a first-in-the-nation pilot – has the potential to demonstrate effective ways to utilize payment reforms to drive clear improvements in care for the uninsured, both in California and perhaps nationwide. California's public health care systems' early success in implementing and leveraging the GPP will inform national efforts to more closely align financial incentives with the right care, in the right place, at the right time, and to capture and utilize accurate data.

Initial data and reports all trend towards the achievement of the goals of the GPP, and indicate the likelihood of continued progress.

PHS are learning from each other as the program rolls out, as CAPH/SNI regularly convenes GPP leaders at California's public health care systems in order to share experiences, hear from experts in the field, and get critical questions answered.

Processes and programs that are successful in one county are being modified and tested in others.

Workflow improvements developed and piloted in single clinics are being standardized and spread throughout entire systems and shared with leaders from other systems.

Innovative approaches to provide and track non-traditional services to communities, both hi-tech and low-tech, are being considered for adoption by other communities.

Although the program is still early in its implementation, California's public health care systems are already demonstrating shifts in care to more appropriate settings, and a greater use of cost-effective services to reach patients and keep them healthy. We anticipate further success in a program being closely watched for important lessons about care for the uninsured.

ABOUT CALIFORNIA'S PUBLIC HEALTH CARE SYSTEMS

California's public health care systems are true systems of care, providing a comprehensive range of health care services, including primary care, outpatient specialty care, emergency and inpatient services, rehabilitative services, and in some instances, long-term care. They offer life-saving trauma, burn and disaster-response services, provided by expert medical staff.

These health care systems serve more than 2.85 million patients each year. They are the primary care provider for more than 560,000 Californians who gained Medi-Cal coverage through the expansion, and provide 10.5 million outpatients visits annually. They operate half of the state's top-level trauma and burn centers, and train more than half of all new doctors in the state.

California's PHS operate in 15 counties where more than 80% of Californians live. Despite accounting for just 6% of the state's hospitals, they provide 35% of hospital care to Medi-Cal beneficiaries and 34% of hospital care to the remaining uninsured in the communities they serve.

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 501c3 affiliate of CAPH, informs CAPH's policy and advocacy efforts, and helps California's public health care systems deliver more effective, efficient and patient-centered health care to the communities they serve by providing performance measurement expertise and by supporting and accelerating decision-making.