HURST+BROOKS+ESPINOSA

March 20, 2015

TO: Matt Cate, Executive Director, CSAC

FROM: Kelly Brooks-Lindsey, Partner, Hurst Brooks Espinosa, LLC

Re: Medicaid Section 1115 Waiver Renewal: Medi-Cal 2020 Draft Paper

The Department of Health Care Services (DHCS) unveiled its draft Medicaid Section 1115 Waiver concept paper on March 16, 2015, followed by a webinar on March 18. The concept paper includes a number of proposals previously discussed with stakeholders. DHCS intends to submit a final proposal to the Centers for Medicare and Medicaid Services (CMS) on March 27, 2015. They are currently soliciting feedback from stakeholders on the draft concept paper. Counties can submit comments to WaiverRenewal@dhcs.ca.gov. Additionally, DHCS is encouraging stakeholders to submit letters of support to CMS.

This memorandum provides an overview of DHCS's concept paper and additional detail provided on the webinar.

BACKGROUND

California's "Bridge to Reform" Medicaid Section 1115 Waiver expires on October 31, 2015. The current waiver provides approximately $10 billion to California over its five-year life, with $2 billion directly benefiting the state General Fund. The Brown Administration, under the leadership of DHCS, is moving forward to renew the waiver.

California's waiver renewal, which is dubbed Medi-Cal 2020, represents the state's vision for continued transformation of the Medi-Cal program's delivery and payment systems. California is focused on critical aspects of health reform, including expanding access, improving quality and outcomes, and controlling the cost of care. DHCS believes the waiver proposal is also a framework for ensuring ongoing support for California's safety net and ensuring the long-term viability of Medi-Cal and the Medicaid expansion.

Medi-Cal 2020 makes the case for a waiver renewal worth $15 to $20 billion in federal funds for the next five years.

The paper emphasizes California's trailblazing in managed care enrollment – 80 percent, or over 9 million individuals, are currently enrolled into Medi-Cal managed care plans. The paper also heavily

1127 Eleventh St., Ste. 805
Sacramento, CA 95814
916.245.3445

hbeadvocacy.com

emphasizes continued integration of primary and behavioral health care as an important component of the next phase of the waiver demonstration.

The paper details three key strategies for achieving the vision of Medi-Cal 2020:

- **Delivery System Transformation and Alignment Programs.** DHCS is proposing to "reinvent thinking on how to promote quality, improve health outcomes, expand access and promote cost efficiency" by creating six cross-cutting programs that DHCS believes will advance delivery system transformation:

  1) Managed Care Systems Transformation & Improvement Program
  2) Fee-for-Service Transformation & Improvement Program
  3) Public Safety Net System Transformation & Improvement Program
  4) Workforce Development Program
  5) Increased Access to Housing and Supportive Services
  6) Whole Person Care Pilots

- **Public Safety Net Global Payment for the Remaining Uninsured.** Transforming California's public safety net for the remaining uninsured by unifying the Disproportionate Share Hospital (DSH) and Safety Net Care Pool (SNCP) funding streams into a global payment system.

- **Shared Savings.** California is proposing to test a new investment strategy with the federal government by initiating a Federal-state shared savings model.

Each of these waiver elements are discussed in greater detail on the following pages.

CSAC PRIORITIES

There are a number of major priorities for counties heading into the waiver renewal discussions, including ensuring that the next waiver includes the same level of funding for public hospitals and counties. Additionally, it is important that another Medicaid waiver include a Delivery System Reform Incentive Program (DSRIP) successor that will allow public hospitals and health systems to continue the important transformation work, continue to improve outcomes, and increase efficiencies. There are also important opportunities for improving care coordination – through a county-based whole person care pilot and in better integrating primary care and behavioral health services.

DHCS's draft concept paper, as presented on March 16, addresses the counties' priorities. Additionally, the paper introduces a new concept transforming California's public safety net for the remaining uninsured by created a global payment system. Individual payments would allow each hospital system more certainty about its budget and how much federal funds would be available. The global payments offer a unique opportunity for California to serve as an incubator in testing new payment methods for delivering care to the uninsured and in transforming care away from high cost settings – like emergency rooms – toward primary care.

Additionally, counties should note that the waiver document is very cross-cutting and impacts a number of county services – including county health and hospital systems, public health, mental health, substance use disorder treatment, social services, housing, homeless services, veterans'

services, probation and public safety. DHCS's vision for Medi-Cal 2020 includes breaking down silos across public systems, providers and health plans to improve care for Medi-Cal members. It is clear that to achieve the Triple Aim, health plans, providers and public systems – health, behavioral health, social services, and public safety – will need to forge new and lasting relationships focused on outcomes.

FINANCING

The current waiver has provided approximately $10 billion in federal funds over the five-year life of the waiver. The Medi-Cal 2020 concept paper includes details to support $17 billion in federal funds for a five-year waiver renewal. DHCS is proposing to continue a number of elements from the current budget neutrality calculation into the 2015 waiver renewal, which assists in California's case for approximately $7 billion in additional federal funds.

Budget Neutrality Background. Part of the budget neutrality calculation requires states to calculate their costs without the waiver and then to update those costs with the waiver. The difference between the "without" waiver and "with" waiver costs is the basis for budget neutrality. States use the budget neutrality calculation to inform how they approach CMS in asking for additional federal funds. See page 35 of the concept paper and Appendix D for additional detail on budget neutrality.

The Medi-Cal 2020 concept paper details that the existing Medicaid Section 1115 waiver authorities and programs that would continue through 2020 include the Coordinated Care Initiative, the Community Based Adult Services (CBAS) waiver, the managed care program, Indian Health Services uncompensated care, Designated State Health Programs, the pending Drug Medi-Cal Organized Delivery System waiver, and the provision of full scope benefits for pregnant women with incomes between 109-138% of the federal poverty level.

California's current waiver uses fee-for-service (FFS) costs in its budget neutrality calculation. The movement of seniors and persons with disabilities into Medi-Cal Managed Care occurred in the existing waiver and the geographic managed care expansion. In the 2010 waiver, DHCS's budget neutrality calculation included a comparison of per member per month costs of Medi-Cal beneficiaries in FFS and in Medi-Cal managed care.

DHCS is proposing to continue to calculate budget neutrality by using a comparison of FFS costs with managed care costs. DHCS has acknowledged that CMS will likely raise questions with the continued assumption of FFS for the "without" waiver calculation. Counties should anticipate that this will likely be a negotiation point between the state and federal governments.

DHCS released some funding detail on the March 18 webinar not included in the Medi-Cal 2020 concept paper. Additional funding details include:

- **Global Payments for the Uninsured:** $6.2 billion in federal funds for five years to transform existing DSH and SNCP payments into public safety net global payments ($12.4 billion total funds) for the

remaining uninsured. The current waiver includes $236 million in SNCP funds in the final 16-months of the waiver.

Please recall that the Administration is proposing to combine SNCP and Disproportionate Share Hospital (DSH) funds into global payments for the remaining uninsured. Currently DSH and SNCP are only available for designated public hospitals; the global payments proposal funding source would only be available for designated public hospitals in the 2015 waiver.

The current waiver does not include DSH payments in the budget neutrality calculation. The Administration is assuming that the federal DSH allotment that California would otherwise receive will be part of the global payments. It is anticipated DSH payments will be approximately $1.1 billion in 2016. DSH payments will decline over the life of the waiver due to cuts slated to occur at the federal level. DSH payments are included in the 2015 waiver budget neutrality calculation on both the "without" and "with" waiver.

- **State designated health programs:** $400 million in federal funds each year for five years ($2 billion total) for state designated health programs. The current waiver contains $2 billion for state designated health programs. As part of California's 2010 waiver, CMS approved the following designated state health programs as eligible for federal match:

  - ✓ California Children's Services (CCS)
  - ✓ Genetically Handicapped Persons Program (GHPP)
  - ✓ Medically Indigent Adult Long Term Care (MIALTC)
  - ✓ Breast and Cervical Cancer Treatment Program
  - ✓ AIDS Drug Assistance Program
  - ✓ Expanded Access to Primary Care (EAPC)
  - ✓ County Mental Health Services Program
  - ✓ Department of Developmental Services
  - ✓ Prostate Cancer Treatment Program
  - ✓ Cancer Detection Programs; Every Woman Counts
  - ✓ County Medical Services Program (for the period November 1, 2010 through December 31, 2011)
  - ✓ Office of Statewide Health Planning and Development:
    - o Song Brown HealthCare Workforce Training Program
    - o Steven M. Thompson Physician Corp Loan Payment Program
    - o Mental Health Loan Assumption Program

- **Public Safety Net System Transformation & Improvement Program:** $800 million in federal funds each year for five years ($4 billion total federal funds) for a Delivery System Reform Incentive Program (DSRIP) successor that DHCS is calling Public Safety Net System Transformation and Improvement Program. The current waiver contains approximately $3.3 billion for DSRIP. DHCS is proposing to include non-designated hospitals, or district hospitals, in the Public Safety Net System Transformation and Improvement Program in the 2015 waiver. Currently DSRIP is available only to designated public hospitals.

- **Delivery system transformation and alignment payments:** $2 billion each year for five years in federal funds ($10 billion total) for the delivery system changes for five cross-cutting programs that DHCS

believes will advance delivery system transformation: 1) Managed Care Systems Transformation & Improvement Program; 2) Fee-for-Service Transformation & Improvement Program; 3) Workforce Development Program; 4) Increased Access to Housing and Supportive Services; and 5) Whole Person Care Pilots. DHCS has not provided detail regarding how the $2 billion would be allocated among the five cross-cutting programs.

The following chart details the elements of the waiver proposal and the proposed federal funding and total funding levels over the five years. The figures in the chart assume that the federal government agrees to California's shared savings proposal.

MEDI-CAL 2020 PROGRAM FUNDING – FEDERAL FUNDS & TOTAL FUNDS

	5-Year Total Federal Funds	**5-Year Total All Funds**
Global Payments for the Uninsured (merging of DSH and SNCP)	$6.2 billion Funds decline over the 5 years – starting at $1.4 billion in FY 16-17 and declining to $1.25 billion in FY 19-20.	$12.4 billion Funds decline over the 5 years – starting at $2.8 billion in FY 16-17 and declining to $2.5 billion in FY 19-20.
Designated Health Programs	$2 billion federal funds	$4 billion total funds
DELIVERY SYSTEM TRANSFORMATION & ALIGNMENT		
Public Safety Net System Transformation and Improvement Program	$4 billion ($800 million/year)	$8 billion ($1.6 billion/year)
Other transformation & alignment programs ▪ Managed care ▪ Fee for service ▪ Workforce ▪ Housing ▪ Whole Person Care	$5 billion ($1 billion/year)	$10 billion ($2 billion/year)
Indian Health Services Uncompensated Care	$3.875 million ($.775 million)	$7.75 million ($1.55 million/year)
TOTAL	**$17.2 billion**	**$34.4 billion**

SHARED SAVINGS

The Federal-State Shared Savings initiative included in the concept paper seeks recognition of the Federal savings that California's waiver renewal generates and would allow the state to keep and reinvest portion of those savings in the Medi-Cal program for continued delivery system transformation. [See p. 34 of the concept paper.] DHCS argues that this concept has been used in commercial and public insurance markets (for example, Medicare, Duals) and should be explored in Medicaid.

California would receive a portion of Federal savings in the form of ongoing performance payments as long as net savings to the Federal government are demonstrated as calculated under the Waiver Budget Neutrality agreement. If California does not attain the agreed-upon level of savings to be shared, expenditures on the reinvestment Waiver strategies would need to be reduced in order to maintain budget neutrality. This is also a new concept and will likely be an area of negotiation between California and the federal government.

MANAGED CARE SYSTEMS TRANSFORMATION & IMPROVEMENT PROGRAM

DHCS is looking to transform disparate financial incentives by creating shared accountability across providers and plans. The proposals in this area are focused heavily on behavioral health care. Reforms include pay-for-performance based on quality and resource utilization, as well as shared savings between providers, managed care plans and the state that will lower the cost of care relative to expected cost trends. The state is also interested in rethinking the managed care capitation rate process to incentivize payments reform that promote investments to enable shared savings. For additional detail, see pages 14-17 of the concept paper.

The paper includes three specific strategies:

1. **Shared Savings Incentives with Managed Care Organizations.** The state would identify targeted populations and/or services for which they would like to see change in outcomes and cost, and increased shared accountability among plans, county services and providers. If the plan, in partnership with providers and the behavioral health system (joined in what would be similar to accountable care groups) is able to demonstrate costs below total costs of care and meet mutually determined outcome and quality targets, the plan would be eligible to receive shared savings incentive payments.

   Additionally, the state is interested in addressing social determinants of health through this proposal. The state would identify non-traditional services that a plan could provide and, depending on a demonstration of the impact on improved outcomes, would permit a plan to receive an incentive payment. Tenancy supports would be an example of non-traditional services and are discussed further in the "Increased Access to Housing and Supportive Services" section.

2. **Pay-for-Performance Strategies for Managed Care Plans to Implement with their Providers.** DHCS is proposing to standardize metrics for pay-for-performance (P4P) programs. The paper outlines a number of required and optional measures.

3. **Integrate Behavioral Health and Physical Health at the Plan/county and Provider Levels.** The paper includes two integration approaches that do not need to be implemented simultaneously:

   - Plan/County Coordination Model. Participating Medi-Cal managed care plans would be required to work with county mental health plans to support Medi-Cal members with identified mental health issues. The managed care plans and county mental health plans would be jointly responsible for improving health outcomes and reducing avoidable emergency room visits and hospital stays by promoting care coordination and information sharing for members. An incentive pool would be allocated to both the

managed care and county mental health plans under two incentive payment streams: 1) for developing a process and procedures to affect change and 2) for meeting joint performance goals for a set of quality and outcome measures. The quality incentive payments would be allocated after plans have met the measures and would be the majority of payments. Over time, this model would evolve to a risk based shared savings model.

- Provider Integration Model. This model would encourage physical health and mental health plans to implement an integrated care model for patients with serious mental health and other chronic health conditions at the provider level. Medi-Cal managed care plans would offer incentives to increase physical health and behavioral health integration, using either a coordination or co-location approach, and could include the use of telehealth.

FEE-FOR-SERVICE TRANSFORMATION & IMPROVEMENT PROGRAM

California is proposing to improve care delivery in the fee-for-service program in two key areas – dental services and maternity care. Details can be found on pages 17-18 of the concept paper.

Medi-Cal Dental. California is proposing to implement a statewide provider incentive payments for the provision of dental preventative services. Dental providers would be eligible to receive incentive payments for providing increased access to dental services. Incentive payments would available for dental providers who are new Medi-Cal providers and provide specified levels of access to Medi-Cal beneficiaries (e.g. dedicate X percent of their practice for Medi-Cal members). In addition, for existing Medi-Cal dental providers, incentives would be available to increase the number of Medi-Cal members they treat. Please note that this mirrors some of the workforce proposals.

Maternity Care. California proposes to pilot a hospital incentive program for maternity care. The program would provide bonus payments to hospitals that meet or exceed quality threshold baselines on four performance measures: 1) early elective delivery, 2) cesarean section rate for low-risk births, 3) vaginal births after cesarean delivery rate, and 4) unexpected newborn complications in full term babies.

PUBLIC SAFETY NET SYSTEM TRANSFORMATION & IMPROVEMENT PROGRAM

The Delivery System Reform Incentive Program (DSRIP) is a five-year, federal pay-for-performance quality improvement initiative for California's 21 public hospitals in the existing waiver, which provides $3.3 billion over five years. DSRIP funding has been used to expand access to primary care, improve quality of care and health outcomes and increase efficiency at public hospitals.

Under Medi-Cal 2020, California is proposing to build upon DSRIP by creating a “public safety net system transformation and improvement program.” In addition to California’s 21 public hospitals, the 42 healthcare districts, known as non-designated public hospitals, would participate in the Public Safety Net System Transformation and Improvement Program. Due to the diversity of district hospitals, DHCS is proposing to implement a “tiered” approach for these hospitals’ participation in the successor DSRIP. Additionally, California is requesting a funded planning period of up to 12 months to give interested district hospitals time to get the tools and technical assistance in place to participate.

For additional details on the public safety net system transformation and improvement program, please see pages 18-21 of the concept paper.

DHCS's goal is to drive even further change in public safety net systems, while also providing a more standardized approach and outcomes focused metrics. California is proposing five core domains to drive quality improvement and population health advancement:

1. **System Redesign.** Projects in this domain are focused on redesigning ambulatory care for primary and specialty care, integration of post-acute care, and integration of behavioral health and primary care services.

2. **Care Coordination for High Risk, High Utilizing Populations.** Examples of such populations includes foster children, individuals who have recently been incarcerated and patients with advanced illness. Objectives for this domain are focused on care management, reducing avoidable acute care utilization, palliative care, and patient experience and improving health indicators for chronically ill patients, including those with mental health and substance use disorders.

3. **Prevention.** Areas of emphasis in this domain are focused on areas such as cardiac health, cancer, and perinatal care.

4. **Resource Utilization Efficiency.** This domain is focused on eliminating the use of ineffective or harmful clinical services and curbing the overuse and misuse of clinical services. Projects in this domain will focus on appropriate use of antibiotics, high cost imaging and pharmaceuticals.

5. **Patient Safety.** This domain is focused on improving performance on metrics related to potentially preventable events and reducing inappropriate surgical procedures.

WORKFORCE DEVELOPMENT PROGRAM

The concept paper acknowledges a number of California's workforce challenges for Medi-Cal providers – including enrollment growth in Medi-Cal and increased competition for providers as a result of the Affordable Care Act, an aging workforce, an aging Medi-Cal population, geographic and cultural differences between provider and member distribution, and a long educational "pipeline" for some professions. Additional specifics on workforce development can be found on pages 22-24 of the concept paper.

To address these challenges, California proposes:

Incentives to Increase Provider Participation. DHCS wants to provide financial incentives to encourage new providers to accept Medi-Cal members and to encourage existing Medi-Cal providers to increase the number of Medi-Cal members they are serving. The incentives would target geographic areas with the greatest need and professions and specialties that are the most challenging to recruit providers. Additional emphasis would be on racially/ethnically diverse health professionals.

Financial Incentives for Non-Physician Community Providers. California would provide incentives to managed care plans to support non-physician community providers, including Community Health Workers and Peer Support Specialists. The paper highlights that expanded use of peer support in mental health and substance use disorder treatment, in particular, can further improve care coordination between primary health and behavioral health needs of patients.

Screening Brief Intervention, and Referral to Treatment (SBIRT) Training and Certification. California would expand SBIRT to make it available in additional settings and to make the trainings and certification available to a broader spectrum of providers. Currently, SBIRT is only required for Medi-Cal enrollees in primary care settings.

Training:

- Targeted Training for Non-Physician Health Care Providers. Voluntary training for non-physician health care providers such as In-Home Supportive Services (IHSS) workers, Community Health Workers, patient navigators, Peer Support Specialists, and others
- Palliative Care Training. Increased voluntary training programs on palliative care for physicians, nurses and other appropriate licensed providers.
- Expanded Residency Training Slots. California would provide targeted funding for existing and new residency programs at teaching health centers or primary care sites, particularly those for which federal Health Resources and Services Administration (HRSA) grant funding ends in 2015. In addition, under the waiver renewal, California would provide incentives for additional training slots in geographic areas of the state where there are shortages in the number of physicians that participate in Medi-Cal, and for the specialties that are in the greatest need. The programs would further target medical school graduates to take positions in racially and economically diverse areas in order to improve access to culturally appropriate care for Medi-Cal members.

Incentives to Expand the Use of Telehealth. Under the waiver, California will provide incentives for telehealth. First priority is for geographic areas or certain specialists where access is more limited. The state will pilot-test incentive payments to encourage the use of telehealth and require corresponding reporting of outcome data.

INCREASED ACCESS TO HOUSING AND SUPPORTIVE SERVICES

As part of DHCS's vision for improving care coordination for California's most vulnerable populations, the concept paper proposes a new approach to providing care to individuals experiencing homelessness, including tenancy supports and intensive medical case management. These concepts are detailed on pages 24-26 of the state's paper. The state will partner with Medi-Cal managed care plans, counties, community organizations, and Federal partners to develop county-specific pilot programs in counties where there is a commitment from the full spectrum of stakeholders that will provide homeless individuals with the support to find and maintain housing and gain consistent access to needed community supports. DHCS anticipates that Medi-Cal managed care plans will see cost savings in serving homeless individuals and will designate a portion of those savings to reinvest in the

supportive services that will assist homeless individuals in maintaining their health, including housing supports. Details include:

Target population. 60,000 at risk Medi-Cal members, including: individuals who are currently homeless or will be homeless upon discharge from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, Institutions for Mental Disease (IMD), or county jail) AND a) have repeated incidents of emergency room use, hospitals admissions, or nursing facility placements; OR b) have two or more chronic conditions; OR c) mental health or substance use disorders. DHCS notes that this population may include veterans.

Intervention Strategies:

- Managed Care Plans. Through the waiver, DHCS would provide access to intensive housing-based care management services and intensive care management to tenants who meet target population criteria. Managed care plans will have the option of paying for non-traditional services such as nutritional services, continuous nursing, personal care, habilitation services, and tenancy supports (like outreach and engagement, housing search assistance, stabilization, paying rent and bills on time, not disruptive to other tenants, maintaining SSI and other benefits).
- Regional Housing Partnerships. Local partnerships may be eligible for incentive funding through the waiver to establish and support regional integrated care partnerships specifically focused on housing. These partnerships would be required to include managed care plans, county health agencies (including county behavioral health), cities, hospitals, and housing and social services providers. A region could include a single county, a portion of a large county, or counties working together. The lead entity could be a county, managed care plan, local non-profit coordinating organization or foundation. Regional partnerships would include a number of elements:
    - DHCS would request proposals from counties and plans to partner. These partnerships would build on the section 2703 health homes programs (also known as 90/10 health homes) where appropriate.
    - Programs would support housing as a health care intervention approach.
    - Counties/plan would receive incentive payments under the pilot to create and maintain the partnership, including support to develop MOUs/MOAs/contracts, create shared data systems and develop processes for assisting eligible Medi-Cal members in moving to permanent housing.
    - Counties and plans would receive performance payments to the extent that a pilot achieves specific performance metrics (e.g. members of the target population accessing subsidized housing units, certain HEDIS or other quality measures, reduction is use of ED and other institutional services).
    - Each pilot must include a shared savings funding pool made up of contributions from plans and counties based on savings generated.

  DHCS envisions the savings pool will provide support for services like respite care; fund support for long-term housing, including housing subsidies; finance further expansion of housing-based case management; and leverage local resources to increase access to subsidized housing units. The savings pool can also provide long-term rental subsidies and assistance.

WHOLE PERSON CARE PILOTS

The concept paper also provides additional detail about Whole Person Care Pilots. Regional partnerships – a county or group of counties, jointly working with Medi-Cal managed care plans in the region – would be eligible to pursue Whole Person Care pilots. The Whole Person Care Pilot section is on pages 27-28 of the concept paper. Details include:

Pilot Partnerships. Pilots would be required to include all of the following participants, as appropriate to the targeted population:

- Medi-Cal managed care plans (in counties with more than one plane, the pilot must include at least two plans participating)
- County behavioral health systems
- Hospitals
- Clinics and doctors
- Other medical providers
- Social services agencies and providers
- Public health agencies and providers
- Non-medical workforce
- Housing providers/local housing authorities
- Criminal justice/probation
- Other community-based organizations with experience serving high need populations.

Critical Elements. Proposals must have a clear governance structure that describes the role of the various partner entities and proposed financing arrangements. Pilots must include a detailed plan for achieving care coordination and integration, including behavioral health integration.

Target Population. Pilots must describe how they will identify the target population who frequently use multiple systems, what data will be used, local partnerships, and minimum enrollment target. At a minimum, the target population must be at least 50 Medi-Cal members or the top 1 percent of emergency/inpatient users.

Patient Centered Care. Pilots must specify how they plan to structure care teams; how they will create individualized care plans for each patient that addresses the medical, behavioral, and social needs of the patient; and how they will select a single accountable individual on the care team to ensure the care plan is carried out in a culturally and linguistically competent manner. Pilot will need to integrate with the section 2703 health home programs (or 90/10 health home) to the extent that the county is participating in the health home project.

Social Supports. Pilots must assess the needs of the target population and provide additional supports such as social services (CalFresh, child care, homeless services, foster care supports, job training); benefit advocacy; outreach and engagement strategies; housing and enhanced care coordination and tenancy supports; criminal justice; and public health.

Shared Data and Evaluation. Pilots will need to describe how data will be shared across agencies and how shared data will be used for care coordination and patient-centered care. Specific evaluation criteria includes:

- Improvements in health outcomes, health status and disparities
- Success at enrolling individuals for eligible social supports
- Housing
- Impacts on total cost of care, scalability and sustainability beyond the waiver term

Financial Flexibility. Pilot sites must identify additional services and supports that they expect to offer in addition to non-traditional Medicaid services and work with DHCS to establish appropriate reimbursement mechanisms. Pilot partners must agree to reinvest any savings into areas that further support whole person care.

PUBLIC SAFETY NET GLOBAL PAYMENT FOR THE REMAINING UNINSURED

The concept paper includes a proposal to create Public Safety Net Global Payments for the remaining uninsured. The Global Payments are detailed on pages 29-33 of the concept paper. DHCS is interested moving away from volume-based and cost-based care and, instead, towards risk-based care for the remaining uninsured. DHCS intends to incentivize coordination of care for the remaining uninsured, including rewarding the provision of primary care. Specifically, DHCS is proposing to combine two funding sources – DSH and SNCP funds – into a Public Safety Net Global Payment for the remaining uninsured.

Disproportionate Share Hospital (DSH) Funding Background

Currently, DSH payments are not part of the existing waiver. However, DHCS is proposing to include those payments in Medi-Cal 2020. DSH funds currently provide reimbursement for hospital-based services.

DSH payments are federal payments that provide additional reimbursement to those hospitals that serve a significantly disproportionate number of low-income patients (both Medicaid and uninsured). States receive an annual federal DSH allotment to pay for a portion of the uncompensated care costs. California's allotment is approximately $1.188 billion, with designated public hospitals receiving approximately $1.176 billion (federal funds).

Federal health care reform included provisions to reduce DSH; those reductions are slated to begin in 2016-17. The DSH reductions increase each year until 2022 when they stabilize. Nationally, the DSH cut is approximately 50 percent of the current DSH total. It is not yet clear how the DSH reduction formula will work in the context of state Medicaid expansions (i.e. how the DSH cuts will be implemented in states that chose not do a Medicaid expansion v. those states, like California, that opted to expand Medicaid).

Safety Net Care Pool Background

The Safety Net Care Pool was an element of the 2005-2010 waiver, as well as the current waiver. The state and designated public hospitals are eligible to claim uncompensated costs of services to the uninsured using certified public expenditures (CPEs). Private hospitals and non-designated public hospitals cannot access the SNCP.

At the height of the SNCP, over $900 million was available for the state and designated public hospitals to claim. In 2015, less than $636 million in federal funding is available. The state is able to claim $400 million per year out of the SNCP. Public hospitals are eligible to claim approximately $236 million in the final 16 months of the waiver.

Global Payments Overview

The following chart provides an overview of how DSH and SNCP are used today and how they compare to the global payments as outlined by DHCS:

	DSH today	SNCP today	Global Payments
Uncompensated costs related to Medi-Cal	✓		
Uncompensated costs related to the uninsured	✓	✓	✓
Uncompensated costs related to undocumented persons	✓		✓
Hospital costs	✓	✓	✓
Non-hospital costs		✓	✓
Intergovernmental transfers (IGTs)	✓		✓
Certified Public Expenditures (CPEs)	✓	✓	

Elements of this new global payment include:

- Each individual public hospital system would have its own “global payment” from within the pool of overall federal funding. Individual payments would allow each hospital system more certainty about its budget and how much federal funds would be available.

- Funding would be claimed quarterly with the public hospital providing the necessary IGT, which moves away from today’s cost-based methodology.

- A public hospital system would achieve “points” for threshold service targets, with a base level of points required for each system to earn their full global budget.

- Partial funding would be available for partial achievement of points.

- Points would allow for the continuation of traditional services but encourage more appropriate and innovative care. Additionally, point values would be developed for innovative or alternative services where there is currently little to no reimbursement.

Services. The state will establish baseline threshold point targets for services currently provided today. DHCS has grouped services into four categories.

- **Category 1. Traditional Outpatient:** Face-to-face outpatient visits an individual could have at a public hospital facility. Specifics include: a) non-physician practitioner (RN, PharmD, Complex Care Management); b) traditional, provider-based primary care or specialty care visit; c) mental health visit; d) dental; e) public health visits (TB clinic, STC screening); f) post-hospital discharge/post-ED primary care; g) emergency room/urgent care; h) outpatient providers/surgery (wound check), provider performed diagnostic procedures, other high-end ancillary services (e.g. chemo, dialysis)

- **Category 2. Non-Traditional Outpatient:** Outpatient encounters where care is provided by nontraditional providers or in nontraditional or virtual settings. Specifics include: a) community health worker encounters; b) health coach encounters; c) care navigation; d) health education and community wellness encounters; e) patient support and disease management groups; f) immunization outreach; g) substance use disorder counseling groups; h) group medical visits; i) wound check; j) pain management; k) case management; l) mobile clinic visits; m) palliative care; n) home nursing visits post-discharge; o) paramedic treat and release encounters.

- **Category 3. Technology-Based Outpatient:** Technology-based outpatient encounters that rely mainly on technology to provide care. Examples include: a) call line encounters (nurse advice line); b) texting; c) telephone and email consultations between provider and patient; d) provider-to-provider eConsults for specialty care; e) telemedicine; f) video-observed therapy.

- **Category 4. Inpatient and Facility Stays.** Specifics include: a) recuperative/respite care days; b) sober center days; c) sub-acute care days; d) skilled nursing facility days; d) general acute care and acute psychiatric days; e) higher acuity inpatient days in ICU and CCU; f) highest acuity days and services such as trauma, transplant and burn

Threshold. To determine threshold amounts, each system would estimate the volume and mix of uninsured services likely to occur based on historical data and projected estimates of uninsured care needed. The intent is to determine the level of services that would have been provided absent this proposal. The thresholds would need to be adjusted over time to account for the federal DSH reductions.

Evaluation and Accountability. The proposal would also include an evaluation component. California would be seeking to demonstrate that shifting payment away from cost and toward value can encourage care in more appropriate settings, to ensure that patients are seen in the right place and given the right care at the right time. DHCS would establish clear metrics to measure whether the pooled funding is successful. The evaluation would focus on the resource allocation and workforce investments and the extent to which investments shift the balance of primary and specialty care toward longitudinal care in primary care settings. Potential metrics:

- Ratio of new to follow-up appointments within specialty care
- Average time to discharge from specialty care
- Ratio of primary care to emergency room/urgent care visits
- Mental health/substance use disorder visits

- Inpatient stays related to ambulatory sensitive conditions
- Non-emergency use of the emergency room
- Use of non-traditional workforce classifications (such as community health workers)
- Expansion of the roles/responsibilities (within the scope of practice) for traditional workforce classifications

GOALS AND METRICS

Medi-Cal 2020 is a demonstration waiver, and as such the federal government requires an evaluation of the waiver. DHCS is developing performance metrics – including statewide measures, regional measures, plan measures and provider measures. The state is committed to measuring improvement through the initiatives outlined above. The paper does not provide detail on the measures, but DHCS indicates they are looking at reducing preventable events (i.e. readmissions and inappropriate emergency room use) and improved access to timely care.

NEXT STEPS

DHCS's March 16 concept paper is a draft document. They are soliciting feedback from stakeholders and intend to formally submit the Medi-Cal 2020 waiver proposal to CMS on March 27, 2015. Once the proposal is submitted to CMS, California will begin its federal negotiations in earnest. In April, DHCS will be doing a webinar for CMS similar to the stakeholder webinar on March 18 to formally walk through the proposal. It is not unusual for waiver negotiations to take several months. DHCS anticipates communicating with stakeholders – formally and informally over the next several months – as they get a better understanding of how CMS views various components of the waiver proposal.

When negotiations between the state and federal governments conclude on the major concepts, CMS will create the Special Terms and Conditions (STCs), the legal document governing the waiver. Finally, once the STCs are complete, state implementation of the waiver can begin. The goal is to begin implementation in November 2015.

Additionally, the California Legislature will be involved in the waiver development and implementation. Currently there are two bills – AB 72 by Assembly Member Rob Bonta and SB 36 by Senator Ed Hernandez – that make changes to state law in order to implement Medi-Cal 2020. Each author chairs the Health Committee in his respective house. Both bills are currently in spot bill form; details will be added as details emerge on the discussions between California and CMS.

Hurst Brooks Espinosa, LLC will continue to provide updates to counties and CSAC on details related to California's Medi-Cal 2020 Waiver renewal – the final waiver submission, the political and policy negotiations that unfold over the next several months, and the legislative process.

For additional questions, please contact Kelly Brooks-Lindsey at kbl@hbeadvocacy.com or 916.272.0011.