DHCS Stakeholder Webinar

Medi-Cal 2020: Global Payment Program Valuation Protocol Review

May 26, 2016

Agenda

GPP Overview

Valuation Protocol Overview

- Categories & Tiers of Service
- Valuation of Traditional Services
- Valuation of Non-Traditional Services
- Point re-evaluation over time
- PHCS Specific Point Thresholds

GPP: Key Goals

Improve health of the remaining uninsured through coordination of care

Integrate and reform Medicaid DSH and Safety Net Care Pool funding

Move away from a cost-based payment methodology restricted to mostly hospital settings to a more “risk-based” and/or “bundled” payment structure

Encourage public hospital systems to provide greater primary and preventive services, as well as alternative modalities such as phone visits, group visits, telemedicine, and other electronic consultations

Emphasize the value of coordinated care and alternative modalities by recognizing the higher value of primary care, ambulatory care, and care management as compared to the higher cost, avoidable emergency room visits and acute care hospital stays

GPP: Methodology

Establish statewide pool of funding for the remaining uninsured by combining federal Disproportionate Share Hospital (DSH) funding for Public Health Care Systems (PHCS – county DPHs) and former federal SNCP Uncompensated Care funding

Establish individual PHCS “global budgets” for remaining uninsured for each PHCS from the overall pool based on annual threshold amount determined through a baseline analysis of historical/projected volume/cost/mix of services to the uninsured

GPP: Methodology

Funding claimed on a quarterly basis with the PHCS providing the necessary IGTs for the non-federal share

Achievement of threshold service targets is done on a “points” system with a base level of points required for each system to earn their full global budget

Partial funding is available based on partial achievement of the “points” target

Service Valuation

Valuation Overview

Each eligible uninsured service a PHCS provides will earn the PHCS a number of points

Each service has an identical point value for every PHCS

Assigned point values per service will vary by GPP Program Year for selected services

Valuation Overview

Services are grouped into major categories for purposes of reporting

Service values are based off a relative value initially, compared to the cost of a traditional outpatient primary/specialty care visit

Intent is to provide flexibility in provision of services while encouraging a broad shift to more cost-effective care that is person-centered

Categories & Tiers of Service

Services associated with points in the GPP are grouped into both categories (1-4) and tiers within categories (A-D)

Groupings can contain both traditional and non-traditional services.

Categories are organized according to their similar characteristics

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

Categories & Tiers of Service

Tiers are based on factors including training/certification of the individual providing the service, time or other resources spent providing the service, and modality of service (in person, electronic, etc.)

Generally, within each category:

- Tier D has the highest point value (most intensive / costly / req. advanced training)
- Tier A has the lowest point value (least intensive, inexpensive)

However, there can still be significant point value variation within tiers, based on cost, resource utilization, or other relevant factors.

Categories & Tiers of Service

Category 1: Outpatient in Traditional Settings

Tier A: Care by Other Licensed or Certified Practitioners

- RN-Only visit
- PharmD visit
- Complex care manager

Tier B: Primary, Specialty, and Other Non-Emergent Care

- Primary/specialty care
- Contracted primary/specialty care
- Mental health outpatient
- Substance use outpatient
- Substance use: methadone
- Dental

Tier C: Emergent Care

- Outpatient ER
- Contracted ER
- Mental health ER/crisis stabilization

Tier D: High-Intensity Outpatient Services

- Outpatient surgery

Categories & Tiers of Service

Category 2: Complementary patient support and care services

Tier A: Preventive Health, Education and Patient Support Services

- Wellness
- Patient support group
- Community health worker
- Health coach
- Panel management
- Health education; Nutrition education
- Case management
- Oral hygiene

Tier B: Chronic and Integrative Care Services

- Group medical visit
- Integrative therapy
- Palliative care
- Pain management

Tier C: Community-Based Face-to-Face Encounters

- Home nursing visit
- Paramedic treat and release
- Mobile clinic visit
- Physician home visit

Categories & Tiers of Service

Category 3: Technology-Based Outpatient

Tier A: Non-Provider Care Team Telehealth

- Texting
- Video-observed therapy
- Nurse advice line
- RN eVisit

Tier B: eVisits

- Email consultation with PCP

Tier C: Store and Forward Telehealth

- Telehealth (patient-provider): store & forward
- Telehealth (provider-provider): eConsult/eReferral
- Telehealth: Other store & forward

Tier D: Real-Time Telehealth

- Telephone consultation with PCP
- Telehealth (patient-provider): real time
- Telehealth (provider-provider): real time

Categories & Tiers of Service

Category 4: Inpatient

Tier A: Residential, SNF, Other Recuperative Services – Low Intensity

- Mental health/substance use residential
- Sobering center
- Recuperative/respite care
- SNF

Tier B: Acute Inpatient – Moderate Intensity

- Medical/surgical
- Mental health

Tier C: Acute Inpatient – High Intensity

- Intensive Care Unit/Coronary Care Unit

Tier D: Acute Inpatient – Critical Community Services

- Trauma
- Transplant/burn

Valuation of Traditional Services

- "Traditional" services are services for which payment typically is made available upon provision of the service

- Initially valued on their historical (SFY 13-14) cost per unit of service

- Grouped into categories that reflect generally where care is being provided and intensity

- Total costs incurred for services provided to the uninsured by PHCS in SFY 13-14 are summed across all PHCS by service type to obtain an average cost per unit for each traditional service

- **Outpatient primary and specialty visit serves as the benchmark traditional service**
  - All other traditional services are assigned point values based on their relative cost compared to the benchmark service

Valuation of Traditional Services

Find average cost of benchmark service, then value that cost at 100 points.

Find average cost of other traditional services and assign point values relative to the point value / cost of the benchmark service.

	Total PHCS Costs	Total PHCS Uninsured Service Units	Average Cost Per Unit of Service	Relative Cost to OP Primary/ Specialty	Point Value, Benchmarked to OP Primary/ Specialty @ 100
OP Primary/ Specialty	$600,185,095	1,022,130	$587	1.0	100
Mental Health Outpatient	$154,852,925	688,564	$225	.38	38
Outpatient ER	$211,699,939	224,797	$942	1.6	160
IP Med/Surg	$287,655,541	77,300	$3,721	6.34	634

Categories of Service and Point Values, Traditional

Category	Tier	Service Name	Cost/unit	Initial point value
1: Outpatient	B	OP Primary / Specialty **(benchmark)**	$587	**100**
	B	Dental	$365	**62**
	B	MH Outpatient	$225	**38**
	B	SU Outpatient	$62	**11**
	B	SU Methadone	$11	**2**
	B	Contracted Prim/Spec	$110	**19**
	C	OP ER	$942	**160**
	C	Contracted ER	$411	**70**
	C	MH ER/Crisis Stabilization	$1,470	**250**
	D	OP Surgery	$4,554	**776**
4: Inpatient	A	SNF	$829	**141**
	A	MH/SU Residential	$138	**23**
	B	Med/surg	$3,721	**634**
	B	MH Inpatient	$2,000	**341**
	C	ICU/CCU	$5,663	**964**
	D	Trauma	$5,069	**863**
	D	Transplant/Burn	$6,644	**1,131**

Valuation of Non-Traditional Services

"Non-traditional" services are services typically not directly or separately reimbursed by Medicaid or other payors

Often provided as substitutes for or complementary to traditional services

Assigned initial point values based on:

- Their estimated relative cost compared to the benchmark traditional service
- Their value in enhancing the efficiency and effectiveness of traditional services.

Non-traditional services provide value to the delivery of health care to the uninsured population by:

- Enhancing the efficiency and effectiveness of traditional services
- Improving uninsured individuals' access to the right care, at the right time, in the right place

Valuation of Non-Traditional Services

Category	Tier	Service Name	Point Value
1: Outpatient	A	RN-only visit	50
		PharmD visit	75
		Complex care manager	75
2: Complementary patient support/care	A	Wellness	15
		Patient support group	15
		Community health worker	15
		Health coach	15
		Panel management	15
		Health education	25
		Nutrition education	25
		Case management	25
		Oral hygiene	30
	B	Group medical visit	50
		Integrative therapy	50
		Palliative care	50
		Pain management	50
	C	Home nursing visit	75
		Paramedic treat and release	75
		Mobile clinic visit	90
		Physician home visit	125

Valuation of Non-Traditional Services

Category	Tier	Service Name	Point Value
3: Tech Outpatient	A	Texting	1
		Video-observed therapy	10
		Nurse advice line	10
		RN e-Visit	10
	B	Email consultation with PCP	30
	C	Telehealth (patient - provider): store & forward	50
		Telehealth (provider - provider): eConsult/eReferral	50
		Telehealth – Other Store & Forward	65
	D	Telephone consultation with PCP	90
		Telehealth (patient - provider): real time	90
		Telehealth (provider - provider): real time	90
4: Inpatient	A	Sobering center	50
		Recuperative / respite care	85

Point Revaluation Over Time

Point values for certain services will be modified over the course of the GPP, from being linked primarily to cost to being linked to both cost and value

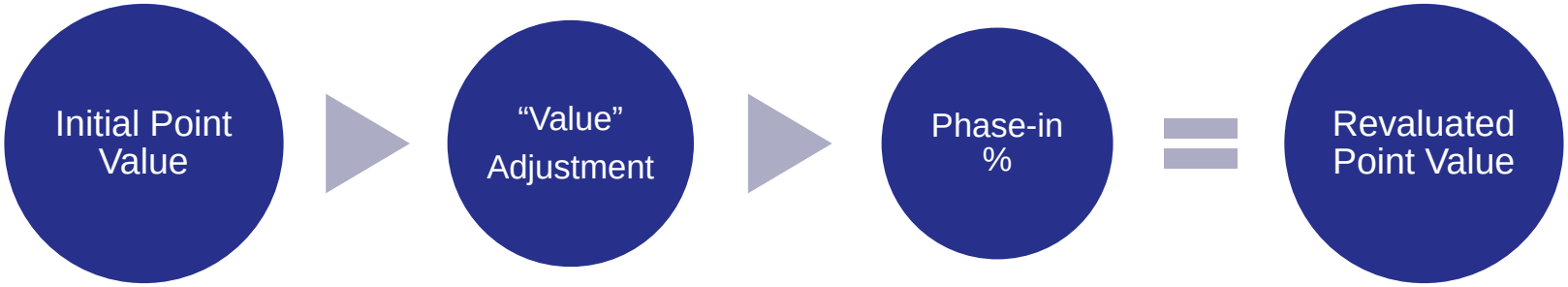
In order to maintain the core goal of ensuring that over time PHCS could not just do the exact same services they had before GPP and still meet their threshold, the final structure was based on reducing the point value of certain services, while all others would remain constant

The selected services for decreases were those that could be potentially avoidable, namely acute inpatient services and emergency services

Designed to incentivize PHCS to provide care in the most appropriate and cost-effective setting feasible

The revaluation will occur over the course of the 5 years. DHCS set end goals of reducing ER values by 5% and IP values by 3%. These are phased in starting in GPP PY2 with full phase-in occurring in GPP PY4

Point Revaluation Over Time



Category of service	Initial point value	GPP PY 1	GPP PY 2	GPP PY 3	GPP PY 4	GPP PY 5
		Point value (% change)	*Point value (% change)*	*Point value (% change)*	*Point value (% change)*	*Point value (% change)*
OP ER	160	160	158	156	152	152
		0%	*(-1%)*	*(-2.5%)*	*(-5%)*	*(-5%)*
MH ER/crisis stabilization	250	250	248	244	238	238
		0%	*(-1%)*	*(-2.5%)*	*(-5%)*	*(-5%)*
IP med/surg	634	634	630	624	615	615
		0%	*(-0.6%)*	*(-1.5%)*	*(-3%)*	*(-3%)*
IP mental health	341	341	339	336	331	331
		0%	*(-0.6%)*	*(-1.5%)*	*(-3%)*	*(-3%)*

Note: Values for categories not listed are unchanged. Contracted IP and ER values are changed identically with other IP/ER.

Global Budget and Thresholds

Point Thresholds by Public Health Care System

DHCS established GPP PY 1 point thresholds for each PHCS by collecting utilization data for all traditional uninsured services provided in SFY 2014-15, and then multiplying those service counts by corresponding initial point values.

For GPP PY 2 and onward, each threshold shall be adjusted proportionally to the total GPP funds available for that PY compared to the total GPP funds available in GPP PY 1

Example: If total GPP funding in PY 2 is 5% less than PY 1 each PHCS threshold will be reduced by 5%

Budgets and Thresholds

If a PHCS does not reach its point threshold, it will be paid a proportion of its global budget equal to the % of the point threshold achieved

- PHCS A reaches 95% of point threshold receives 95% of its global budget

Any GPP global budget amounts that PHCS were individually unable to claim can potentially be redistributed to PHCS that exceeded their point thresholds for the applicable GPP PY

Amounts unclaimed by an individual PHCS will be made available to PHCS exceeding their thresholds on a pro-rata basis up to a maximum based on the dollar value per point by which they have exceeded their individual thresholds.

Attachment EE: Global Payment Program Funding and Mechanics Protocol
http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MC2020AttEE.pdf

GPP PY 1 Thresholds

Public Health Care System	System Threshold, GPP PY1
Alameda Health System	19,151,753
Arrowhead Regional Medical Center	7,525,819
Contra Costa Regional Medical Center	5,674,651
Kern Medical Center	3,633,669
Los Angeles County Health System	101,573,445
Natividad Medical Center	2,959,964
Riverside University Health System Medical Center	8,066,127
San Francisco General Hospital	12,902,913
San Joaquin General Hospital	3,021,562
San Mateo County General Hospital	8,733,292
Santa Clara Valley Medical Center	19,465,293
Ventura County Medical Center	9,213,731

Comments/Questions

Please email WaiverRenewalMailbox@dhcs.ca.gov for questions or comments.

For more information on the GPP, please visit the Medi-Cal 2020 and GPP webpages.

Attachment EE: Global Payment Program Funding and Mechanics Protocol
http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MC2020AttEE.pdf

Attachment FF: Global Payment Program Valuation Protocol:
http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MC2020AttFF.pdf