Medi-Cal 2020: Key Concepts for Renewal

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California's Medicaid Section 1115 Waiver embodies the shared commitment between the state and the Federal government to support the successful realization of some of the most critical objectives for improving our health care delivery system. As California continues to be a leader in implementing the Affordable Care Act, while at the same time operating the nation's largest Medicaid program, our state seeks to partner with the Centers for Medicare & Medicaid Services to ensure that strides made toward delivery of high quality, cost effective care can be further expanded and sustained over time. A renewal of our Medicaid Waiver is a fundamental component to California's ability to continue to successfully implement the Affordable Care Act beyond the primary step of coverage expansion.

Toward that end, California is seeking a Waiver Renewal that will build on the approaches, lessons learned and successes of the existing 2010 Bridge to Reform Waiver and move our Medi-Cal program forward through delivery system and payment transformation. Current Waiver initiatives such as the managed care delivery system for Seniors and Persons with Disabilities (SPDs) and the state's Coordinated Care Initiative (CCI) would continue through the waiver renewal, which will be known as Medi-Cal 2020.

Because of the successes of the Bridge to Reform Waiver, California is in a position to focus its efforts on other critical components of health care reform such as expanding access, improving quality and outcomes, and controlling the cost of care. An ongoing commitment to the partnership between the Federal government and the state and CMS' ongoing support of California's efforts to realize the full potential of the Affordable Care Act through a successor 1115 Waiver will allow the state to continue its pursuit of better care and improved health equity and outcomes for the 12 million individuals served by our state's Medicaid program.

The focus of the Waiver Renewal will be on continuing to drive the transformation of our Medi-Cal program, ensuring ongoing support for the safety net in California, and ensuring the long-term viability of the program and the Medicaid expansion. The Waiver Renewal will continue to facilitate financing innovation in developing sources of the non-federal share of Medicaid matching funds as California has done in prior years through partnerships with the federal government and with our other public entity partners throughout the state.

Concepts included in Medi-Cal 2020 will complement other delivery system and payment transformation efforts California is undertaking, such as initiatives and building blocks under the State Health Care Innovation Plan, including a planned implementation of ACA Section 2703 Health Home Option, leveraging frontline workers, and advancing Accountable Communities for Health.

Existing 1115 Waiver authorities and programs that would continue under the next Waiver include California's Coordinated Care Initiative, the Community Based Adult Services (CBAS) waiver, managed care program, Indian Health Services (IHS) uncompensated care, Designated State Health Programs (DSHPs), and the pending amendments to implement a county-based Drug Medi-Cal Organized Delivery System program and to provide full scope benefits for pregnant women with incomes between 109% to 138% of the federal poverty level.

2.1 Medi-Cal 2020

As a result of the "Bridge to Reform" Waiver's successful health coverage expansion and foundational managed care infrastructure development, California will transform and align the Medi-Cal delivery system around improving health outcomes for the member. In order to achieve a healthier California, Medi-Cal 2020 would invest $15 to $20 billion in Federal funds to facilitate the system transformation, including whole-person health care integration across the physical health, behavioral health, and long-term care spectrum in order to improve health outcomes and quality of life overall and support long-term sustainability of the program, and ensuring the ongoing viability of the safety net, particularly for the remaining uninsured. At the center of this effort is the Medi-Cal member, who will benefit from the creation of shared accountability among all providers to achieve high-value, high-quality, and whole-person care. By 2020, Medi-Cal will be a more accountable and sustainable program for Medi-Cal members and for California's safety net population which in turn strengthens California's health care system more broadly.

The rapid increase in Medi-Cal enrollment – nearly 50% (or about 3.8 million people) in the last 24 months – and the advancement of Medi-Cal managed care throughout the state and across populations are important achievements and also provide new opportunities for California. Enrollment in our managed care delivery system is now at 80%, up from 55% when the 2010 *Bridge to Reform* demonstration began. This growth has resulted in stronger partnerships between local and state entities in the delivery of health care services. In addition, the expansion of Medi-Cal benefits to augment the availability of mental health and substance use disorder services for members provides an important stepping stone for the next phase of the demonstration.

The lessons learned over the past five years highlight the need to continue to build Medi-Cal capacity in ways that better coordinate care and align incentives around Medi-Cal members to improve health outcomes while also containing health care costs. California also needs to ensure sufficient access and capacity in the broader delivery system, and maintain the health care safety net that is critical in serving all Californians, but particularly for in supporting those with unmet health care needs.

2.2 Key Strategies

Demonstrating California's commitment to improving quality and better integrating care, Medi-Cal 2020 will combine a set of strategies to collectively build a stronger and healthier system for all Medi-Cal members. Medi-Cal 2020 is built around specific, interconnected strategies that will improve health of members by strengthening the health care system as a whole, while also assisting in targeting populations in need of specific focus or services to improve coordination, utilization, equity, and at the same time control health care costs.

Within each of these strategies, specific population focus areas may be included, as appropriate, to ensure health equity and elevate support for the Californians with the most complex and acute needs.

- **Delivery System Transformation and Alignment Programs –** The Department of Health Care Services (DHCS) conceptualized and developed the nation's first Delivery System Reform Incentive Payments (DSRIP). California is ready to reinvent thinking on how to promote quality,

improve health outcomes, expand access and promote cost efficiency through a series of programs aimed at delivery system transformation and alignment. Under the renewed Waiver, we will pursue a set of six, cross-cutting approaches that together will advance delivery system transformation in California:

- Managed Care Systems Transformation & Improvement Program
- Fee-for-Service Transformation & Improvement Program
- Public Safety Net System Transformation & Improvement Program
- Workforce Development Program
- Increased Access to Housing and Supportive Services Program
- Whole Person Care Pilots

- **Public Safety Net System Global Payment for the Remaining Uninsured –**This Waiver renewal will transform California's public safety net for the remaining uninsured by unifying the disproportionate share hospital and safety net care pool funding streams into a global payment system. Medi-Cal 2020 will align incentives to deliver quality, coordinated care to California's remaining uninsured by moving away from a cost-based uncompensated care payment structure toward a value-based methodology.

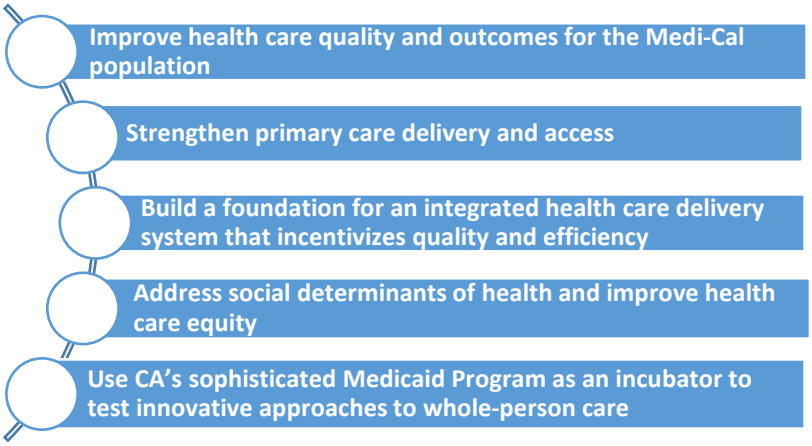
  The funding pool would support public safety net systems in their efforts to deliver comprehensive care for the remaining uninsured that includes primary care in lower cost outpatient and clinic settings. Under the proposed global payment structure, the public safety net systems would be paid a global budget amount for all services provided to the remaining uninsured, the systems would be required to meet service thresholds in order to receive their global budget amounts. The thresholds would be designed to incentivize high-value, low-cost care through recognizing the importance of primary care as well as alternative methods of providing care in ways that best meet the needs of the population. The range of services to be provided would span traditional inpatient facility stays, face-to-face and technology based outpatient encounters, as well as non-office based outpatient encounters and preventative, case management, and health education services.

- **Shared Savings –** In support of California's efforts to achieve the goals outlined above, the state seeks to test a new investment strategy in partnership with the Federal government by initiating a Federal-state shared savings model. California's shared savings initiative would involve a reinvestment of Federal funding in recognition of the savings that California's section 1115 demonstration initiatives generate to the benefit of both the state and the Federal government. This reinvestment would provide the state with a portion of the Federal savings that are generated through the demonstration to facilitate and augment continued Medi-Cal delivery system transformation. Under this initiative, California would be required to demonstrate that the Federal savings generated under the Waiver are substantial enough to permit California to retain a portion or percentage of that savings. The state would need to demonstrate that, even after reinvestment in the Waiver strategies, the Federal government will continue to realize savings. If the Waiver strategies implemented through Medi-Cal 2020 do not result in the level of Federal savings that is projected, California would be required to limit the spending on Waiver reinvestment initiatives to ensure overall savings and budget neutrality.

2.3 Goals and Metrics

Medi-Cal 2020 is designed to improve the quality of care and ultimately the health of Medi-Cal members by driving quality and health outcomes improvement across settings of care, promote system integration, and align incentives. This effort will bring together the Department of Health Care Services, CMS, other state and local agencies, plans, providers, and safety net programs to share accountability for Medi-Cal members' health outcomes, which will result in high-quality, integrated care and increase the value of California's health care dollar, promoting the long-term viability of the program.

The core goals of Medi-Cal 2020 are to:



The success of these interlocking strategies will be demonstrated by a clear set of performance metrics – including statewide measures as well as measures focused at the regional, plan, and provider system level. In particular, DHCS is committed to achieving measurable improvement through the initiatives pursued in this Waiver.

While the details of these measures are still under development, we are looking at the key arena of reducing preventable events (such as readmissions and inappropriate emergency room use) and improved access to timely care in alignment with the overarching goals described above.

Metrics will be selected based on their ability to reflect the underlying opportunities for an improved Medi-Cal health system. These demonstration goals seek to balance quality, efficiency, and patient experience, all key components of a high performing health system. Taken together, the result will be a health system where care shifts away from high cost settings that are most often the last resort for individuals whose care has not been sufficiently coordinated and managed, into settings where patients can easily access coordinated care, when they need it and from a care team that is attuned to the specific needs of the individual. Patient health and care outcomes will improve, fewer Medi-Cal patients will report having poor health, and overall costs will reduce. The goals established for this purpose will complement the broader evaluation of the Medi-Cal 2020 Waiver, as discussed in Section 11.

Section 3: Medi-Cal 2010 Success: Crossing the Bridge to Reform

In November 2010, the Federal government approved California's five-year Medicaid section 1115 *Bridge to Reform* waiver, through which the state received the necessary authority and corresponding Federal support to invest in its health care delivery system and prepare for the full implementation of the Affordable Care Act. The goals for the demonstration were centered on simultaneously implementing an historic coverage expansion, beginning the process of transforming the health care delivery system and reinforcing California's safety net to meet the needs of the uninsured.

The *Bridge to Reform* Waiver was initially designed to support the following primary initiatives:

- Phased-in coverage in individual counties for adults aged 19-64 with incomes up to 200% of the federal poverty level (FPL) through the **Low Income Health Program (LIHP)**

- Improved care coordination for vulnerable populations by mandatorily enrolling **Seniors and Persons with Disabilities (SPDs)** into Medi-Cal Managed Care

- Supported California's public hospitals in their effort to enhance quality of care by providing payment incentives through the **Delivery System Reform Incentive Pool (DSRIP**) Program for projects that support infrastructure development, innovation and redesign of the delivery system, population-focused improvements, and urgent improvements in care.

- Supported the ongoing provision of services to otherwise uninsured individuals through the **Safety Net Care Pool (SNCP) Uncompensated Care** Component and federal funding of **Designated State Health Programs (DSHP)**.

In addition, several amendments were made to augment the original framework of the demonstration over the years, including:

- **Effective April 1, 2012**: The Department of Health Care Services (DHCS) began operating an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to Medi-Cal members enrolled in a managed care organization at Community-Based Adult Services Centers (CBAS).

- **Effective January 1, 2013**: Children enrolled in California's Healthy Families Program were transitioned into Medi-Cal's Optional Targeted Low-Income Children's (OTLIC) Program, where they will continue to receive comprehensive health, dental, and vision benefits. The OTLIC Program covers children with family incomes up to 250 percent of the FPL.

- **Effective April 2013:** The state received CMS approval for the DHCS to make uncompensated care payments to Indian Health Service (IHS) and tribal facilities to assist them with their uncompensated care costs. Qualifying uncompensated encounters include primary care encounters furnished to uninsured individuals with incomes up to 133 percent of the FPL who

are not enrolled in a California County LIHP. In December 2014, DHCS received approval to extend the Indian Health Services uncompensated care payments for tribal providers through October 31, 2015.

- **August 29, 2013:** DHCS received approval to expand Medi-Cal Managed Care into 28 additional counties, with phased-in enrollment beginning in September 2013, with additional approval in 2014 to enroll SPDs into managed care in all but one of California's counties.

- **Effective January 1, 2014**: Individuals newly eligible for Medi-Cal with incomes up to 133% of the FPL were added to the Medi-Cal managed care delivery system. The waiver amendment allowed for a seamless transition of the Medi-Cal Expansion Low-Income Health Program into Medi-Cal managed care. The state also received approval for an expansion of Medi-Cal managed care benefits to include outpatient mental health services.

- **In March 2014**: DHCS received approval of an amendment to begin coverage under the Coordinated Care Initiative (CCI) on April 1, 2014. The CCI is providing integrated care across delivery systems and working to rebalance service delivery away from institutional care and into the home and community. The CCI was authorized in eight counties across California: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.[1] This amendment also allows for the operation of a Program of All-Inclusive Care for the Elderly (PACE) in Humboldt County alongside the Humboldt County-Organized Health System (COHS) plan.

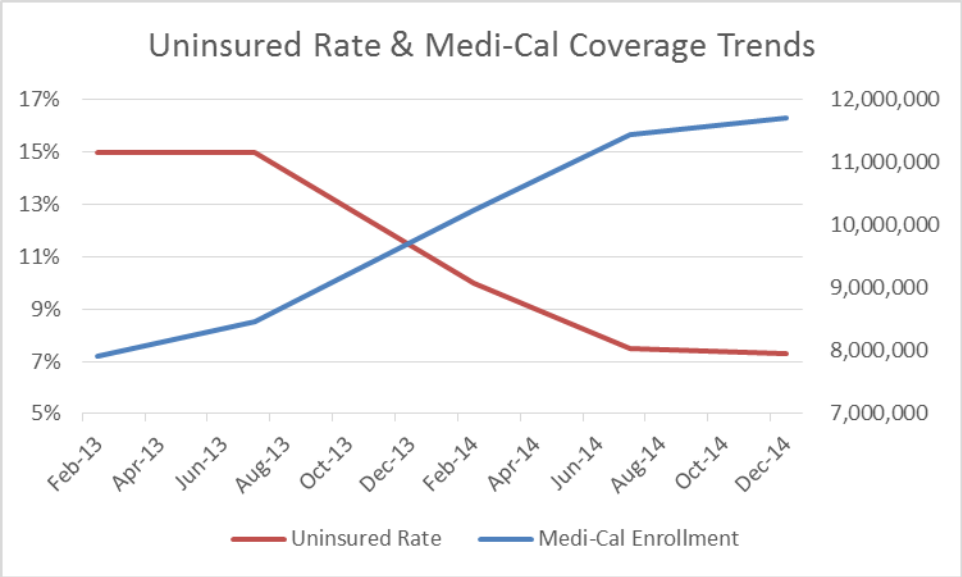
DHCS also has two amendments pending approval with CMS. The Drug Medi-Cal Organized Delivery System waiver seeks to provide better coordination of care and a full continuum of care for substance use disorder treatment services, including residential treatment services which would be unavailable for most beneficiaries absent a waiver. The second amendment seeks to expand full scope Medi-Cal eligibility to pregnant women with incomes between 109% and 138% of the FPL.

Results

California has successfully achieved all of the established goals in the Bridge to Reform demonstration and has used the resources available through the demonstration to begin the process of transforming the Medi-Cal delivery system and putting the program on a path to long-term viability. While there is more refinement to be done, this Waiver has successfully advanced access to comprehensive, affordable health coverage while also putting the tools in place for achieving long-term quality improvement and financial sustainability.

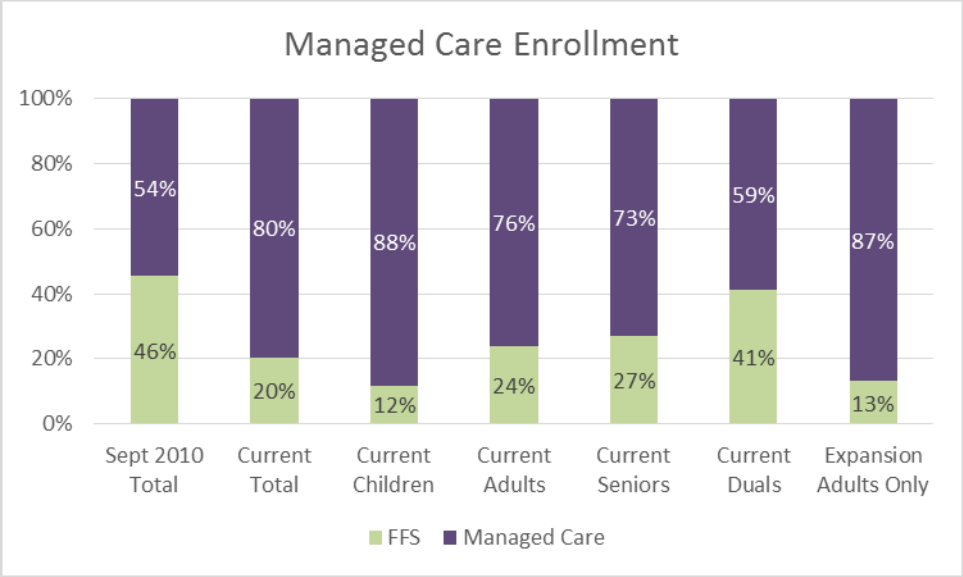
[1] Alameda is no longer implementing a CCI program. The state has implemented the CCI program in 6 of the 7 remaining counties to date.

Coverage Expansion. As a result of the state's commitment to fully expanding Medi-Cal coverage to its low-income residents and providing an affordable coverage option through the state's health insurance Marketplace -- Covered California – the uninsured rate in the state has declined from 15% in late 2013 to just over 7% today. Medi-Cal enrollment has increased by nearly 50% in 24 months, and Covered California is serving 1.12 million residents. (See Figure 1)



Transition to Managed Care. As one of the leading states in testing the value of managed care delivery systems in providing cost-effective coverage for its Medicaid population, California has proven that managed care can be an important option for people of all ages and health conditions. Under the *Bridge to Reform* demonstration, we expanded managed care to 28 new counties and to provide coordinated care for some of our most vulnerable populations such as Seniors and People with Disabilities (SPDs) and in certain counties, members who are dually eligible for Medicare and Medicaid. Presently, 80% of Medi-Cal members, or 9 million plus individuals, are enrolled into the managed care delivery system across all 58 California counties, up from around 54% at the start of the Waiver in 2010. This continuing effort to provide high quality care while containing costs has proven to be a critical element of the sustainability of the program.

Figure 2 -- Medi-Cal Managed Care Enrollment – By Population



Delivery System Reform. The *Bridge to Reform* demonstration was the first in the nation to include a Delivery System Reform Incentive Payment (DSRIP) program. One of 7 states with approved DSRIP programs in their demonstrations today, California has many lessons to share from its experience, including[2]:

- **Primary Care.** The public hospital systems in California used the DSRIP program to expand primary care medical homes. Eleven of the systems expanded primary care capacity and seven focused on primary care redesign. These activities included offering more weekend and evening appointments, increasing the number of patients assigned to primary care providers, improving panel management, and instituting navigation programs to connect patients from the emergency department to primary care providers.

DSRIP Success: Kern Medical Center

In 2011, Kern Medical Center launched its Emergency Department (ED) Navigator Program to help ED patients, particularly those seen for non-urgent conditions, better navigate the health care system. The ED Coordinator educates patients about the importance of primary care and coordinates with community and county-run clinics to schedule primary care appointments upon the patient's discharge from the ED. The program also connects patients to care management services, resulting in a 61% reduction in ED visits and 66% reduction in avoidable inpatient admissions in 2012.

[2] The following examples are an excerpt from an issue brief released by the California Association of Public Hospitals entitled "Leading the Way: The Delivery System Reform Incentive Payment Program (DSRIP)", September 2014. Available at http://caph.org/wp-content/uploads/2014/09/Leading-the-Way-CA-DSRIP-Brief-September-2014-FINAL.pdf

- **Improved Use of Data**. A number of the hospital systems used the DSRIP to develop disease registries, standardize quality data reports and capture race, ethnicity, and language data. Once data systems were accessible, care teams were able to utilize more sophisticated data for population health management, including personal health records for complex care management and self-management. Teams were also able to run reports that identified patients based on condition or assigned provider for panel management efforts.

DSRIP Success: San Joaquin General Hospital

San Joaquin General Hospital's (SJGH) primary care clinics implemented the i2i Tracks disease management registry. Between July 2012 and June 2013, more than 20,000 patients were assigned to medical homes using i2i Tracks, enabling medical home teams to more systematically monitor and manage the health of their patient population. For example, the registry helps providers identify diabetic patients with unsafe blood sugar levels for targeted outreach and support.

- **Care Coordination.** The public hospital systems have improved care coordination for patients by enhancing linkages between primary care, specialty care and inpatient settings. Efforts have included expanding chronic disease management programs, and piloting targeted care management approaches for patients who were frequent utilizers of the emergency department. These programs aim to ensure that patients receive the right care, at the right place, at the right time to produce better health outcomes and more efficient use of health care resources.

DSRIP Success: UC Irvine Medical Center

UC Irvine Medical Center's "Care Connect" patient navigation system assigns patients with complex treatment regimens to chronic disease coaches to ensure a high level of coordination between their providers and services across the care continuum. Coaches work closely with primary care doctors to improve outcomes for high-risk patients identified using risk-stratification algorithms. After just six months of enrollment, the system achieved a 52% reduction in inpatient visits and 60% reduction in emergency department visits.

- **Patient Safety.** Making hospital care safer has been a critical component of the DSRIP. All of the 21 participating hospitals are working on reducing sepsis and central line associated blood stream infections (CLABSI) and working to prevent hospital acquired conditions.

Collectively, these accomplishments have ensured that California is well on its way to achieving full delivery system transformation, but there is more work to be done. Medi-Cal 2020 is a critical component in enabling the state to continue on its path toward meeting the Triple Aim and ensuring long-term financial stability for the Medi-Cal program and the California health care system as a whole.

Section 4: Delivery System Transformation and Alignment Programs

The California Department of Health Care Services developed the first DSRIP program in the country. California is again ready to step up as a pioneering partner to reinvent thinking on how to promote quality, improve health outcomes, reduce disparities, expand access and promote cost efficiency through a series of programs aimed at transformation and alignment across the full spectrum of the delivery system. Additional descriptions of each Delivery System Transformation and Alignment Programs proposal are detailed in Sections 4.1 – 4.6.

Managed Care Systems Transformation & Improvement Programs: Regional Incentives among Managed Care Organizations, County Behavioral Health Systems, and Service Providers

The Waiver will transform Medi-Cal's historically disparate financial incentives through a culture of shared accountability across providers and plans. Historically, managed care plans have served as incubators for innovation; one of the goals of the waiver renewal will be to extend payment reforms across the entire managed care plan network, as well as bridging care across delivery systems to include behavioral health care, serving Medi-Cal members in ways that can flexibly meet the specific needs of each region.

Innovative value-based purchasing strategies, such as joint incentive pools with Medi-Cal's plans, behavioral health systems, and providers, will align incentives at each layer of the delivery system, ensuring that members receive the right care in the most appropriate setting, which will improve health outcomes while reducing the overall cost. Incentive arrangements would require Medi-Cal managed care plans, county behavioral health systems, and providers to work together to achieve specific metrics.

California would use Waiver authority and funding to test alternative flexibilities to traditional Medicaid services that address social determinants of health, enhance plan/provider capacity, and foster enhanced care coordination. As a long-term goal, these incentives would enable the delivery system to transition away from eligibility group-specific cost-based rate setting to blended value-based models.

A series of incentive programs are envisioned to strengthen partnerships and collaboration between Medi-Cal managed health care plans, county specialty mental health plans, substance use disorder treatment services, and contracted providers.

Fee-for-Service System Transformation & Improvement Program

Through the Waiver, DHCS would also target FFS incentives in two key areas where FFS continues to play a critical role in care delivery – dental and maternity care.

DHCS is looking to address local needs to expand access to dental services through Waiver incentives. Strategies include targeted incentives to increase provider participation, and incenting delivery of preventative services in lieu of more invasive and costly procedures.

Pregnant women are one of the largest remaining Medi-Cal populations in fee-for-service. Medi-Cal currently pays for nearly 60 percent of all deliveries in California, giving the program tremendous ability to promote value in maternal and child health. Under the Waiver, we will look at cost and quality drivers in prenatal, delivery, and postpartum care and help improve health outcomes and promote a standard for efficient care that will benefit all Californians.

Public Safety Net Transformation & Improvement Program

Building on lessons learned over the past five years and from the experiences in other states, California will continue its drive toward quality, improved outcomes and accountability in public safety net systems. In the Waiver renewal, California will continue to advance quality improvement through the 21 large public safety net systems (Designated Public Hospitals). In addition, California will provide an opportunity for the state's 42 safety net systems run by health care districts (Non-Designated Public Hospitals) to participate in this program, provided that the hospitals are able to meet specified criteria.

The District hospital systems are often located in more rural areas of the state and as such are frequently the only hospital system for the community. We anticipate that many of these health systems will both be interested and equipped to participate in this program. This Program will contain fairly standardized and rigorous evaluation metrics, new improvement categories, and an expanded focus on advancing the Department's three linked goals: Improve population health and overall health outcomes; Improve quality and access, and therefore the experience of care; and reduce the per capita cost of care.

The projects will be organized in five core domains that will each include required core components and standard quality and outcome metrics:

- *Systems Redesign* – focused on redesigning ambulatory care, improving care transitions, and the integration of behavioral health (both mental health and substance use disorders) and primary care services.
- *Care Coordination for High Risk/High Utilizing Populations* – focused on complex care management, health homes, and advanced illness planning and care.
- *Resource Utilization Efficiency* – focused on appropriate use of antibiotics, high cost imaging and pharmaceuticals.
- *Prevention* – focused on core areas such as cardiovascular health, obesity, cancer, perinatal care.
- *Patient Safety* – focused on improving safety in ambulatory care (e.g., medication reconciliation) and creating a culture of safety.

Workforce Development Program

California is facing several workforce challenges for Medi-Cal providers, such as enrollment growth and increased competition for providers under the ACA, an aging workforce and Medi-Cal population, geographic and cultural differences between provider and member distribution, and a long educational "pipeline" with limited capacity for some professions. To achieve better outcomes through whole-person care, the Medi-Cal provider workforce must become more integrated and coordinated across the full array of services: physical health, mental health, substance use disorder services, and long-term services and supports.

Medi-Cal 2020 will increase beneficiary access to the full spectrum of Medi-Cal providers and augment the Medi-Cal workforce by developing a system that rewards providers' commitment to serving the

Medi-Cal and safety net populations. The Waiver will invest in evidence-based opportunities and align financial incentives to enhance workforce capacity.

- The Waiver will provide financial incentives to health professionals who have not previously cared for Medi-Cal members, and to existing Medi-Cal providers who treat additional Medi-Cal beneficiaries. Financial incentives would be targeted to health professionals in geographic areas with the greatest need for Medi-Cal participating providers and to professions and specialties where recruiting is most challenging.

- Medi-Cal 2020 will develop a culturally-competent workforce that leverages non-physician and frontline workers to ensure that Medi-Cal members are receiving appropriate and timely care. Under the Waiver, the health system will utilize non-clinical members of the care team to help those new to coverage navigate the health system through health education and other outreach efforts. As needed to improve care quality, the Waiver would provide for voluntary training opportunities for these workers.

- The Workforce Development Program strategy ties into the overall focus of the Waiver on improving whole-person care through creating incentives and programs to expand cross-training of providers in primary care, mental health, substance use disorder services, and long-term services and supports, to support integration of multi-disciplinary teams across care settings.

Increased Access to Housing and Supportive Services Program

The Waiver will provide tools to better coordinate care for the most vulnerable Medi-Cal members through policies, data analysis and measurement that facilitate access to supportive services that are also proven to reduce costs, including improved access to affordable housing. Medi-Cal 2020 will elevate community resources and align incentives to provide the supportive services for Medi-Cal's most vulnerable population on the premise that the availability of stable housing arrangements ultimately serves the goal of improving health outcomes.

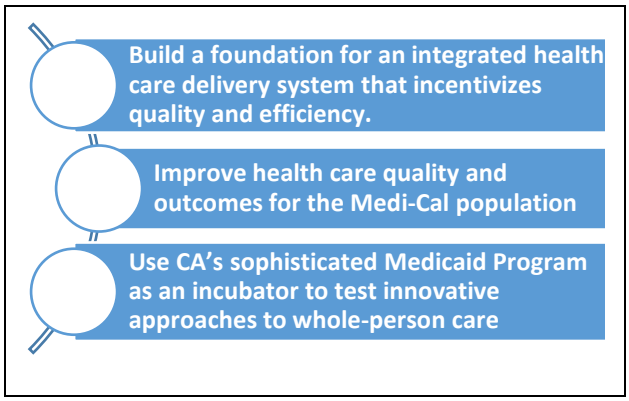
Research suggests that individuals experiencing homelessness, particularly those individuals with multiple chronic conditions, often struggle to receive appropriate health care services and are disproportionately likely to be high utilizers of the health care safety net. For this population, targeted case management services can play an instrumental role in obtaining and maintaining housing and reducing health care utilization while improving health outcomes.

Regional Integrated Whole-Person Care Pilots

Through this Waiver, DHCS seeks to offer an option for enhanced model of regional partnerships requiring proposals for a geographic region-- a county or group of counties, jointly pursued by the county and applicable Medi-Cal plans-- for that region. Managed care plans, counties, and local partners would provide Whole-Person Care for target high need patients through collaborative leadership and systematic coordination with other public and private entities identified by the county. Pilots would be subject to state and federal approval. The pilot design would encourage innovation in delivery and financing strategies to improve health outcomes of target populations. The pilots would include approaches outlined in the delivery system transformation and alignment incentives section of this concept paper across the spectrum of whole-person care delivery (MCO/provider, MCO/county, and access to housing and supportive services, workforce development).

4.1 Managed Care Systems Transformation & Improvement Programs: Regional Change through Incentives among Managed Care Organizations, County Services, and Service Providers

Medi-Cal has been at the forefront of Medicaid payment reform, with widespread adoption of a delegated, sub-capitation model, wherein provider organizations receive a per-member-per-month capitated payment to provide both primary care and specialty services. In addition to this model, several Medi-Cal managed health care plans have implemented other innovative payment reforms to eliminate the perverse incentives for volume-based care that underlie fee-for-service systems, improve the quality of care, and make the delivery of health services more efficient. Under Medi-Cal 2020, reforms will 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 total cost of care, relative to expected trends.



The current managed care capitation rate setting process has limited long-term ability to incentivize widespread adoption of payment reforms that promote investments in strategies that incent efficiencies such as appropriate reduction in costs and utilization. . When capitation rates are set, actuaries consider the managed care plans' data as one factor in determining actuarially sound rates. For plans that achieve lower utilization through payment reforms, the current methodology allows those plans to benefit from those utilization gains until the rates are revised using data from this time period. This approach creates a negative tension between the state and the plan because the financial incentives are misaligned. New contracting and capitation models could be structured to recognize potential benefits to purchasers (state and federal government), plans, and providers thus creating rewards and incentives throughout the system that are sustainable over the long run.

During the course of the Waiver, the state would move toward restructuring the capitation rate setting methodology to enable shared savings between managed health care plans and providers, the state, and CMS. The goal of the Waiver programs outlined below is to demonstrate that this type of shift in managed care rate-setting will result in better outcomes and reduced total cost of care. A shift to this approach would better align incentives for pursuing payment reforms across the continuum of the state, the managed health care plans, and providers, including behavioral health providers.

As part of Medi-Cal 2020, DHCS would take lessons learned from California and other Medicaid programs and spread these and other payment reform models more widely across the Medi-Cal managed health care plan network.

Proposed Payment Reform Strategies:

- *Strategy 1: Shared Savings Incentives with MCOs*
  Under this strategy, the state would identify targeted populations and/or services for which we would like to see change in outcomes and cost, and increased shared accountability among plans, county services and providers.

  The core of the proposal is to provide a shared savings calculation between the state and the MCO, based on the projected total cost of care. If the plan, in partnership with the providers and behavioral health systems (joined in what would be similar to accountable care groups) is able to demonstrate costs below total cost of care and meet mutually determined outcome and quality targets, the plan would be eligible to receive shared savings incentive payments. Improvements in access to and provision of preventive dental care would also be an opportunity to drive down overall costs and improve health. The value of the shared savings incentive would be calculated as the difference between projected expected costs, determined prior to the measurement period, and actual costs. This approach requires development of total cost of care measurement for Medi-Cal managed health care, including adjustment for geography and risk which is currently performed today. Quality performance would be based on a combination of attainment and improvement; plans that did not pass the quality threshold would be ineligible to share in any savings. Formal agreements such as contracts, MOUs, or MOAs would be required as appropriate to codify arrangements between impacted entities.

  A second complementary component of this proposal would address some of the social determinants of health that drive poorer health outcomes and higher costs for Medi-Cal members. The state would identify non-traditional services (e.g., tenancy supports, as detailed under the Section 4.5, Increased Access to Housing and Supportive 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.

- *Strategy 2: Pay-for-Performance Strategies for Managed Care Plans to Implement with their Providers*. The majority of managed care plans have a pay-for-performance (P4P) program in place; however, these programs often vary across plans. Providers may find these differences burdensome, thus, standardization of metrics, whenever possible, will decrease administrative burden while at the same time driving improvement in quality.

  Managed care plans would adopt a P4P program that meets certain core design elements, with flexibility for tailoring to local area and provider sophistication. The core design elements would include standard quality, patient satisfaction, data completeness, and resource-use measures that all plans should adopt, as well as an optional set of measures from which plans could chose that reflect their member population and provider readiness. The core set of metrics would align with the core waiver goals. The optional measures would align with one or more of the following: the DHCS Strategy for Quality Improvement in Health Care, Medi-Cal Managed Care Quality Strategy, Let's Get Healthy California, other areas of focus under the waiver (DSRIP, housing, workforce), health plan quality improvement projects and improvement plans, and the overall DHCS mission and vision. Coordination would occur with other focus areas of the waiver; however, no duplicate payments would be made. Areas for targeted P4P programs are outlined on the DHCS website:
  http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MCO3_DHCS2.pdf

Strategy 3: Integrate behavioral health and physical health at the plan/county and provider levels. Under California's current structure, managed health care plans are responsible for physical health care and mental health services for individuals with "mild to moderate" mental health impairments, while county behavioral health systems (county mental health plans and substance use disorder systems) are responsible for specialty mental health services and substance abuse services. The goal of the following two proposed reform strategies is to better coordinate and promote integration of behavioral and physical health for a more seamless care experience and reduce the total cost of care through aligned financial incentives and value-based payments. The proposals would address the opportunity for better coordination at both the plan/county and provider levels. While highly complementary, these two models need not be implemented simultaneously.

- Plan/County Coordination Model*:* Under the first component of this reform strategy, 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. This approach, as facilitated by the state, would build on the coordination and shared accountability approaches implemented in the Cal MediConnect program, and the current MOUs that Medi-Cal managed care plans (MCPs) are currently required to sign with county entities. MCPs and county specialty mental health plans (MHPs) 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 who meet medical necessity criteria for Medi-Cal Specialty Mental Health Services. Progress would be measured using a set of metrics that MCPs and MHPs can jointly influence by improving care coordination and collaboration and demonstrate improved patient outcomes across both programs.

  An incentive pool would be allocated to MCPs and MHPs under two incentive payment streams. The first incentive payment would be allocated before performance measures or outcomes measures are met, when both plans commit to collaborate and sign an agreement that outlines specifics on health information exchange, data collection, shared accountability processes, and targeted improvement metrics and financial alignment incentives that are subject to DHCS review and approval. This first incentive payment would provide the MCPs and MHPs the necessary financial incentive to develop processes and procedures to truly affect change in the outcomes for these members. A second set of quality incentive payments would be available in subsequent periods of the demonstration for plans that meet joint performance goals for a set of quality and outcome measures. The state would define performance measures and methodology for distributing earned incentives. The quality incentive payments would be allocated after plans have met the measures, and would be the majority of the payments under this proposal. Over time, this incentive structure would ultimately evolve to a risk based shared savings model taking both quality and financial performance into account.

- Provider Integration Model: The state proposes a second reform strategy that 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. Under this proposal, each MCP would offer incentives based on tiers of increasing physical health and behavioral health integration to ensure that team-based care is provided

to Medi-Cal members with mental health and physical health needs, using either a coordination or co-location approach. This could include incenting cross-training of providers, as well as the use of telehealth. Both primary care practices and mental health providers would be eligible to adopt this model, so there is "no wrong door" for a member who needs integrated care for both mental and physical health care who chooses to receive their care in each respective setting. This work would be integrated with the State's proposal under Workforce Development; no duplicate payments would be made.

4.2 Fee-for-Service System Transformation & Improvement Program

While the vast majority of services are provided through Medi-Cal managed care plans, there are still critical services provided through Medi-Cal's fee-for-service program, in particular dental services and deliveries. In order to improve care delivery and institute transformation in these areas, California proposes the following programs aimed at our FFS system.

Incentives in Medi-Cal Dental: Oral health is fundamental to improving overall health status and quality of life. California has actively participated in the CMS Oral Health Initiative for several years. In order to more rapidly meet these goals, California will implement statewide provider incentive payments for the provision of preventive services.

The provision of dental services in Medi-Cal is almost entirely done through our FFS system, although we do offer dental managed care in two counties, and with the recent restoration of adult dental service in California, the state proposes to test the efficacy of incentive payment strategies for dental providers to assess the impacts on access to care and utilization of services. California has two proposals for value based incentives in Medi-Cal dental services aimed at expanding access to oral health services and improving utilization of preventive services.

Under this proposal, dental providers would be eligible to receive incentive payments for providing increased access to dental services for Medi-Cal beneficiaries. Incentive payments would be available for dental providers who are new providers to the Medi-Cal system and provide specified levels of access to Medi-Cal beneficiaries (e.g. provide space for X percent of their practice for Medi-Cal members). In addition, for existing Medi-Cal dental providers, incentives would be available to them for increasing the number of Medi-Cal members they treat.

Incentives in Medi-Cal Maternity Care*:* Over 500,000 babies are born every year in California. We have not, however, achieved optimal benchmark target rates across the state for procedures such as first-born, low-risk C-sections; vaginal birth after C-section and early elective deliveries. Although elective deliveries and C-sections are declining in California, there is more to be done to reduce avoidable complications and lower attendant costs.

Currently Medi-Cal finances approximately 60% of California births, which presents a tremendous opportunity to promote value in maternity care. While the State has successfully expanded their

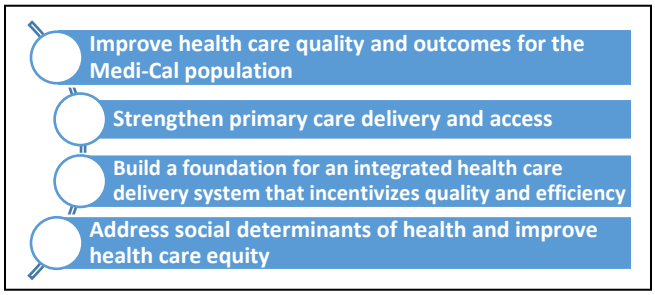
managed care infrastructure and now delegates the responsibility for most Medi-Cal members to managed care plans, pregnant women remain one of the largest Medi-Cal populations in fee-for-service. Over half of all hospital births financed by Medi-Cal are still paid on a fee-for-service basis.

To promote evidence-based obstetrical care and to reduce the quality shortfalls and high costs in Medi-Cal FFS, California proposes to pilot a hospital incentive program for hospitals. The Hospital Incentive Program will provide bonus payments to hospitals that meet quality thresholds. Hospitals will collect and report data on the four performance measures: (1) Early Elective Delivery, (2) Cesarean Section Rate for Low-Risk Births, (3) Vaginal Birth after Cesarean Delivery Rate[3], and (4) Unexpected Newborn Complications in Full-Term Babies. Hospitals will earn incentive payments if their performance meets or exceeds established benchmarks set for these four core measures.

This incentive program presents an opportunity to align with managed care plans' pay-for-performance and quality improvement initiatives to maximize the impact of delivery system transformation.

4.3 Public Safety Net System Transformation & Improvement Program

Over the past five years, the California Delivery System Reform Incentive Program (DSRIP) has supported the initial steps of transforming and stabilizing the public safety net health system, built important foundations for health care transformation (e.g., chronic disease registries, expansion of health homes, chronic care management programs), advanced patient safety and clinical quality, and developed data systems to support population health. While the DSRIP has helped public health care systems achieve impressive results, much work remains in order to fully transform these into high performing health systems that provide everyone with timely access to safe, high-quality, and effective care.



Under Medi-Cal 2020, California proposes to build upon DSRIP and the transformative changes started in the BTR Waiver, by creating a public safety net system transformation and improvement program. Concepts for this program are informed by several sources including: (1) CMS guidance; (2) experience with the current 1115 waiver; (3) health care recommendations in the report of the Governor's Let's Get Healthy California Task Force Report (4) consideration of the leading causes of preventable mortality and morbidity; and (5) alignment with state (e.g., DHCS Strategy for Quality Improvement in Health Care) and national health targets (e.g., as identified in the National Quality Strategy and the National Prevention Strategy). The goals of this program are to drive even further change in the public safety net systems, while also providing a more standardized approach and outcomes focused metrics to demonstrate statewide changes occurring in the public safety net systems.

[3] If applicable to a particular hospital

Domains
Under this program, California is proposing five core domains representing important themes that drive quality improvement and population health advancement. Within each domain, public safety net systems will embark on multiple projects, each with a required set of core components and standardized quality and outcomes metrics.

Domain 1 - System Redesign. Major health system transformation has been called for to make significant progress toward advancing the Triple Aim, in part through improved system integration including physical and behavioral health services.

Projects in the System Redesign domain seek to advance the transformation and integration of the delivery system by emphasizing high-quality and efficient primary care in coordination with specialty care services. All projects in this domain are required and their areas of focus include: (1) ambulatory care redesign for primary care, to improve the effectiveness of care delivery; (2) ambulatory care redesign for specialty care, to improve access to specialty expertise and the coordination and collaboration with primary care; (3) integration of post-acute care to prevent avoidable readmissions; and (4) integration of behavioral health and primary care services to ensure coordinated and comprehensive care for our members.

Domain 2 - Care Coordination for High Risk, High Utilizing Populations. Researchers, policymakers, and clinicians have all emphasized the need to better coordinate care within and across the sectors of physical health, behavioral health, and social aspects of health (e.g., access to food, housing, transportation, jobs, and education). This need for care coordination through more team-based approaches to care and better use of front-line workers in care navigation, and in offering culturally and linguistically competent care, is particularly critical for high-utilizers of health resources. The state's health care system has not generally addressed care across sectors. This coordination is a fundamental element of delivery system transformation.

Transformation and improvement in care coordination for high-risk, high-utilizing populations including foster children, individuals who have recently been incarcerated, and patients with advanced illness, will focus on identifying target populations, conducting qualitative assessments of high-risk, high-utilizing patients, developing evidenced-based complex care management programs, and implementing data driven systems for rapid cycle improvement and performance feedback to address quality and safety of patient care in order to achieve specific objectives and metrics. These objectives include: (1) increasing patients' capacity to self-manage their condition; (2) reducing avoidable acute care utilization; (3) improving health indicators for chronically ill patients including those with mental health and substance use disorders; and (4) improving the patient experience.

Domain 3 - Prevention. McGinnis and Foege and Mokdad and colleagues[4] have demonstrated the importance of prevention in reducing preventable morbidity and mortality. The leading underlying causes of death (smoking, poor nutrition, physical inactivity, alcohol abuse) account for 35-50% of preventable mortality depending on the specific population. The U.S. Preventive Services Task Force and other sources have specified the evidence-based preventive services that can reduce morbidity and mortality while also reducing the financial burden of care.

[4] McGinnis JM, Foege WH. *Actual causes of death in the United States*. JAMA. 1993; 270:2207-2212; AH Mokdad, JS Marks et al*. Actual causes of death in the United States*, 2000. JAMA. 2004; 291:1238-1245.

Delivery system improvements in prevention will focus on identifying and implementing standardized, evidence-based and population resource stewardship approaches that address, in large part, the leading causes of preventable morbidity and mortality, reduce disparities, and reduce variation and improve performance. Areas of emphasis in this domain include: (1) meeting the Million Hearts® initiative clinical targets, starting with tobacco cessation, hypertension control, and aspirin use for secondary prevention; (2) increasing rates of screening and completion of follow-up for breast, cervical, and colorectal cancer; (3) improving performance on obesity screening and referral to treatment for children, adolescents, and adults, as well as supporting the provision of healthful food in clinical facilities by implementing the Partnership for a Healthier America's Hospital Healthier Food Initiative; and (4) improving timely prenatal and postpartum care, decreasing cesarean section rates, and improving breastfeeding initiation, continuation, and baby-friendly practices.

Domain 4 - Resource Utilization Efficiency. Eliminating the use of ineffective or harmful clinical services and curbing the overuse and misuse of clinical services have been championed by the Choosing Wisely Campaign (CWC). CWC was launched by the American Board of Internal Medicine and supported by the Robert Wood Johnson Foundation and the Consumers Union. Thus, improved resource stewardship is an important goal for a transformed health care delivery system.

Projects in this domain will use evidence-based guidelines and comparative data and benchmarking to drive improvement in the following areas: (1) antibiotic stewardship to reduce overuse and misuse from a system perspective; (2) employing proven intervention methods to drive reduction in high cost imaging; (3) apply value-based principles and drive shared decision-making to move pharmaceutical use to higher levels of cost-effectiveness; and (4) implement evidence based approaches to the use of blood products to improve the safety and appropriateness of use.

Domain 5 - Patient Safety. Using updated methods, a recent patient safety paper projected that 200,000 to 400,000 preventable deaths occur each year in the U.S. due to medical error.[5] There is widespread agreement that more can be done systematically to improve patient safety. However, there is also broad acknowledgement in the research and practice community that the challenges to achieving such improvement are real. One of the most serious challenges is developing data systems that can efficiently identify patient safety issues and track progress tied to corrective policies and programs. Additionally, despite the fact that the vast majority of health care takes place in the ambulatory care setting, efforts to improve safety have mostly focused on the inpatient setting. The ambulatory environment is prone to problems and errors that include missed/delayed diagnoses, delay of proper treatment or preventive services, medication errors/adverse drug events, and ineffective communication and information flow. However, a body of research dedicated to patient safety in ambulatory care has emerged over the past few years. These efforts have identified and characterized distinct factors that influence safety in office practice, the types of errors commonly encountered in ambulatory care, and potential strategies for improving ambulatory safety.

Transformation and improvement in patient safety will focus on substantially reducing adverse events through safety protocols and medication reconciliation in the ambulatory setting. Areas of emphasis in this domain include: (1) medication reconciliation and proper documentation of current medications in

[5] JT James. *A New, evidence-based estimate of patient harms associated with hospital care*. J Patient Saf. 2013; 9:122-128.

the medical record; (2) increasing levels of patient activation; and (3) creating a culture of safety in the ambulatory setting.

Eligible Public Safety Net Systems
The hospitals eligible to participate in this program include the spectrum of public safety net systems (county systems, University of California systems, and systems operated by healthcare districts or municipalities)

The 21 county and UC systems, known as the designated public hospitals (DPHs), participated in the 2010 DSRIP and their participation in this program will continue to drive transformation in the public safety net resulting in improved care delivery and outcomes for the Medi-Cal and other populations served by these systems.

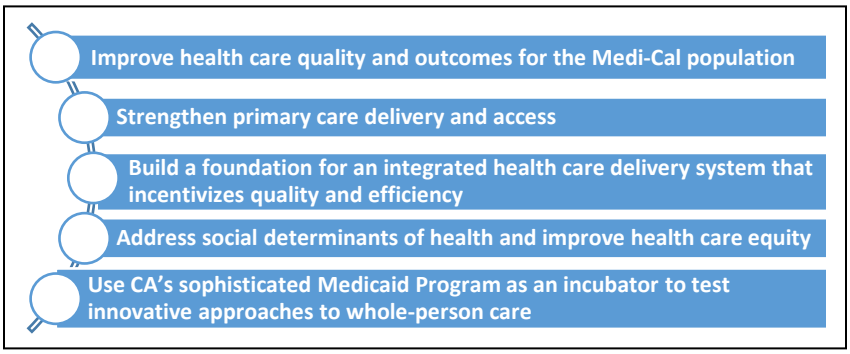
The 42 healthcare district/municipality systems, known as non-designated public hospitals (NDPHs), are also critical public safety net systems. Two-thirds of these systems are rural, and nearly half are designated as critical access hospitals. In addition, many of these facilities operate rural health clinics. These systems are located in 28 counties across the state. Due to the diversity among NDPHs, we propose to implement a "tiered" approach for these hospitals' participation in the DSRIP.
Large facilities would select/create multiple projects which would be scaled according to facility size and resources, while small facilities might only take on one project with a smaller scaled and may only focus on an area of improvement rather than multiple areas. Given that these 42 NDPH systems did not participate in the 2010 DSRIP effort, California is requesting a funded planning period of up to 12 months to give interested NDPHs time to get the tools and technical assistance in place to enable them to successfully operate these program, as has been done in New York and other states implementing DSRIPs.

This planning period will be critical to allow these facilities' limited time and resources to be focused on the extensive work required to finalize plans, milestones, metrics, etc. The NDPH systems likely will need to make investments beyond current staffing levels and a planning period would allow for both funding and time to ensure the appropriate innovative and non-traditional projects are thoughtfully considered before implementation has officially begun.

Evaluation and Accountability
Similar to all of the other Delivery System Transformation & Alignment Incentive Programs, the Public Safety Net Transformation and Improvement program will include a robust and rigorous evaluation to assess how these efforts contributed toward the state's 2020 goals, as well as how this work resulted in improvements in health for many of California's most vulnerable populations. These efforts, combined with the other elements of the California's proposal, will support our Medi-Cal 2020 vision to help our public safety net providers become models of integrated systems of care that are high value, high quality, patient-centered, efficient, equitable, with great patient experience and demonstrated ability to improve health care and health status of populations.

4.4 Workforce Development Program

California faces several workforce challenges for health care providers, including Medi-Cal, such as enrollment growth and increased competition for providers as a result of the Affordable Care Act, an aging workforce and Medi-Cal population, geographic and cultural differences between provider and member distribution, and a long educational "pipeline" for some professions. To achieve better outcomes through whole-person care, the Medi-Cal provider workforce must become more integrated and coordinated across the full spectrum of services: physical health, mental health, substance use disorder services, and long-term services and supports.



To address these challenges, California proposes to implement a combination of short- and long-term strategies under Medi-Cal 2020, targeted for the specific needs of Medi-Cal members and providers, and consistent with the overall goals of the Waiver. A particular focus will be paid to strategies that address the needs of members with mental health and substance use disorders. Other initiatives outlined in this application also incentivize the delivery system to focus on workforce strategies such as integration, team-based care, and enhanced provider participation. These strategies will also help managed care plans in their efforts to ensure network adequacy standards.

The proposed strategies outlined below have been selected based on existing evidence of the effectiveness of each approach in California, and specifically for Medi-Cal:

Incentives to Increase Provider Participation*:* California would provide financial incentives to health professionals who are not currently serving Medi-Cal members, and to existing Medi-Cal providers to encourage them to accept additional Medi-Cal members into their patient panels. Financial incentives will be targeted to attracting health professionals in geographic areas with the greatest need for Medi-Cal providers and to professions and specialties in which it is most challenging to recruit providers. Emphasis would also be placed on recruiting racially/ethnically diverse health professionals to enhance Medi-Cal's ability to provide culturally competent care.

Financial Incentives for Non-Physician Community Providers: The state will provide incentives to managed care plans to support non-physician community providers including Community Health Workers and Peer Support Specialists. These providers would participate as part of the member's care coordinating team as appropriate.

- Front-line Workers/Community Health Workers***:*** Introduction of the Community Health Worker (CHW) as an addition to the current health care workforce will contribute to the goals of the Triple Aim. Numerous studies attest to the value of CHW's as liaisons to help navigate a member's medical needs through the challenges faced by communities of traditionally underserved populations. The use of CHWs as part of a primary care team has a positive impact on health care costs by way of reduced inpatient and emergency utilization as well as improved

health behavior and outcomes in health areas such as diabetes management, cancer screenings, and maternal/perinatal health. Serving in the capacity of a community extender as part of the traditional provision of health care, CHWs can help reduce barriers of access to health services and improve the quality and cultural competence of services delivered.

- Peer Support Specialists***:*** A substantial number of studies demonstrate that peer support specialists improve patient functioning, increase patient satisfaction, reduce family burden, alleviate depression and other symptoms, reduce hospitalizations and hospital days, increase patient activation, and enhance patient self-advocacy. Peer support specialists are used in at least 36 states and throughout the Veterans Health Administration. Peer support specialists participating in substance abuse treatment activities are currently a recognized Medicaid service provider in California for SUD services; however these providers are often limited in the services they are able to provide in traditional health care settings. The Waiver presents an opportunity to build upon existing infrastructure and statewide efforts. Expanded use of peer providers in MH and SUD as part of a care-team can further improve care coordination between behavioral health needs and physical health care needs of patients. Improved patient care management will lead to a reduction of high-cost care such as poor management of chronic conditions, hospitalizations, and emergency department visits

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training and Certification:
California would expand SBIRT services to be available in additional settings and make training and certification available to a broader spectrum of providers. SBIRT is an evidence-based practice used to identify, reduce, and prevent substance use and abuse problems. SBIRT training is used as a tool to promote better health outcomes and reduces overall health care spending. SBIRT is currently required for Medi-Cal enrollees in primary care settings.

Training:

- Targeted Training for Non-Physician Health Care Providers***:*** Non-physician workers who provide care and supportive services in the home and community are an important component of whole person care, and ensure Medi-Cal members are able to live healthy and independent lives. Under this strategy, the state will provide additional voluntary training, and in some cases certification, for non-physician health care providers such as IHSS workers, Community Health Workers, Patient navigators, Peer Support Specialists, and others to obtain training in mental health, substance use, and LTSS, to help improve their skills or gain new skills as appropriate. The state would work with stakeholders, including consumers, workers, managed care plans, local government and community partners and other key stakeholders to develop models based on lessons learned of existing programs and determine the options that would work best for targeted segments of the Medi-Cal population and delivery system.

  Palliative Care Training***:*** The state will work to increase participation in voluntary training programs on palliative care, for physicians, nurses and other appropriate licensed providers, and will emphasize cultural competency in training programs. Palliative care has an extensive evidence base for improved quality of life for patients, increased patient satisfaction, reduced hospital stays and lower overall health care costs. However California has insufficient numbers of physicians and nurse practitioners with adequate training in palliative care to meet the needs of

consumers with complex conditions who could potentially benefit from palliative care. As of 2012, it is estimated that less than 1% of physicians and nurses, 1% of certified nursing assistants, and 2% of social workers in California are trained in palliative care. Training would address the shortage of health professionals trained in administering palliative care. Additionally, DHCS is interested in palliative care education for families and consumers, consistent with the patient-centered approaches that are described throughout this document.

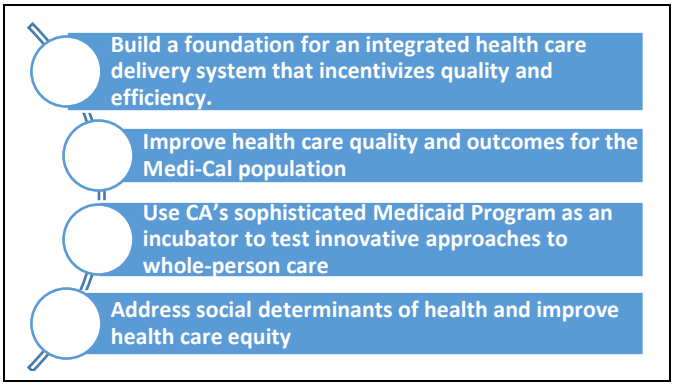
- Expand Physician Residency Training Slots***:*** The state would provide targeted funding for existing and new residency programs at teaching health centers or primary care sites, particularly those for which HRSA grant funding ends in 2015. This effort would help address the important need to maintain and expand health care access for Medi-Cal beneficiaries and to build program sustainability by investing in residency programs. Residents provide care to Medi-Cal members by serving in facilities that see high volume of Medi-Cal patients. Support for expansion of residency programs can improve recruitment and retention of physicians in the facilities that sponsor them. It is has been well documented that physicians tend to remain in the same geographic area as their training, therefore expanding residency programs will help build future capacity.

  In addition, under the waiver renewal, the state 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 state would further target residency programs with incentives for 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. We note that the Medicare Graduate Medical Education program (GME) does not precludes a state from contributing funds from Medicaid for new resident positions at hospitals, FQHCs, and RHCs who are sponsoring Residency Training institutions.

Incentives to Expand the Use of Telehealth*:* Under the Waiver, the state will expand access to specialty services by providing incentives for telehealth. Priority would first be given to geographic areas or certain specialists where access is more limited. Under the Waiver, the state will pilot-test incentive payments to encourage use of telehealth and require corresponding reporting of outcome data.

4.5 Increased Access to Housing and Supportive Services Program

As part of the overall vision for Medi-Cal 2020 and specifically in an attempt to improve care coordination for the state's most vulnerable populations, we propose a new approach to providing care to individuals experiencing homelessness, including enhanced tenancy support and intensive medical case management. Research suggests that individuals experiencing homelessness, particularly those with multiple chronic conditions, often struggle to receive appropriate health care services and are disproportionately likely to be high utilizers of the health care safety net who experience poor health outcomes.



Under this approach, the state will reimburse for a new set of tenancy-based care management services for plans statewide. These evidence-based services will support at-risk beneficiaries to allow them to stay in their homes, and will assist Medi-Cal

beneficiaries who are experiencing homelessness in securing stable housing. The state will also 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 the population with the support they need to find and maintain housing and gain consistent access to needed community supports. As a result, these individuals will be better equipped to effectively manage their health care utilization, seek appropriate medical services in appropriate settings, and ultimately improve their overall health outcomes.

It is our expectation that Medi-Cal managed care plans will see cost savings in this population and as part of their participation in the pilot program, the plans will designate a portion of those savings to be reinvested in the supportive services that will assist this population in maintaining their health, including housing supports. The reduced costs that will result from these efforts will, in turn, reduce costs for Medi-Cal overall and improve the sustainability of the program.

Target population. This program would target a portion of the estimated 60,000 at risk Medi-Cal members. Specifically, the target population includes:

- Individuals who are currently homeless, such as veterans, or will be homeless upon discharge from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, IMD, county jail, or state prisons); and
- Have repeated incidents of ED use, hospital admissions, or nursing facility placement; or
- Have two or more chronic conditions; or
- Mental health or substance use disorders.

Intervention Strategies.

- Managed Care Plans: Under the waiver, DHCS would provide access to intensive housing-based care management services and intensive care management to tenants who meet target population criteria. The level of care provided would be tiered based on the level of acuity and need of the individuals. Managed care plans will have the option of paying for non-traditional services (e.g. Nutritional services, continuous nursing, personal care, habilitation services) to the extent that such services improve health outcomes and reduce reliance on institutional-based care.

  Non-traditional Medi-Cal services would include 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. The managed care plan would also provide intensive medical case management and care coordination, discharge planning, creating a care plan, and coordination with primary, behavioral health and social services to improve health outcomes and reduce inpatient services among this high-utilizer, complex population.

- Regional housing partnerships: In counties that have strong partnerships or have a demonstrated interest in developing strong partnerships between the county, the managed care plans, and the housing authority, these partnerships may be eligible for incentive funding 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 plans), cities, hospitals, and housing and social service providers. A region could incorporate a single county, a portion of a large county, or counties

working collectively together to form a partnership. Counties, managed care plans, local non-profit coordinating organizations, or foundations could act as a lead in creating a partnership,

Managed care plans, counties, and other partners could be eligible to receive incentive or shared savings payments for their participation in these strategies. Incentive or shared savings payments could be available for entities that demonstrated the use of housing-based care management and/or partnership activities to improve access to subsidized housing units.

For managed care plans and counties to form regional housing partnerships:

- DHCS would request proposals from counties and plans that partner with providers and community-based organizations to pilot test approaches to house and coordinate care for the targeted populations. These pilots would intersect with and build on the section 2703 health homes program, where appropriate.

- The programs would support housing as a health care intervention approach, which would address the need for housing and supportive services, and could include various health care providers, payers, or other partners attempting to move eligible Medi-Cal members out of homelessness, hospitals, and nursing facilities into independent, and permanent supportive housing.

- Counties/plans would receive incentive payments under the pilot to create and maintain these partnerships, including support to develop MOUs/MOAs/contracts, create shared data systems, and develop processes for assisting eligible Medi-Cal members in moving into permanent housing.

- Counties and plans could also receive performance payments to the extent that such a pilot could achieve specific performance metrics which may include the number or percentage of plan members of the target population accessing subsidized housing units, certain HEDIS or other quality measures relevant to the characteristics of the population, and reductions in the use of ED and other institutional services.

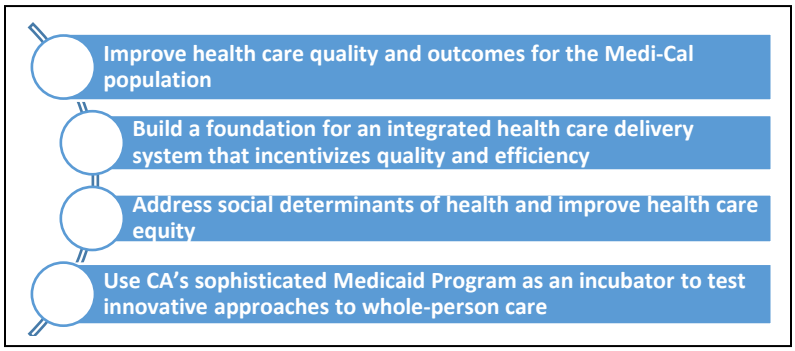
- Each Pilot must include a shared savings funding pool made up of contributions from plans and counties and based on savings generated from the reduction of institutional utilization that are expected to result from the introduction of housing-based case management for Medi-Cal members and spending flexibility for the plans.

The savings pool will provide needed support for services like respite care (or interim housing with services) to enable timely discharge from inpatient stays or nursing facilities while permanent housing is being arranged; fund support for long-term housing, including housing subsidies; finance further expansion of housing-based case management in addition to existing Medi-Cal medical, LTSS, county mental health, substance abuse services; and leverage local resources to increase access to subsidized housing units. The savings pool can also provide long-term rental subsidies and assistance.[6]

[6] It is important to note that although this strategy is focused on a particular high-need population, the approach is aligned with the Accountable Communities for Health Model proposed in the State HealthCare Innovation Plan.

4.6 Regional Integrated Whole-Person Care Pilots

Through this Waiver, DHCS seeks to offer an option for enhanced model of regional partnerships requiring proposals for a geographic region — a county or group of counties, jointly pursued by the county and applicable Medi-Cal plans — for that region. Managed care plans, counties, and local partners would provide Whole-Person Care for target high-need patients through collaborative leadership and systematic coordination with other public and private entities identified by the county. Pilots would be subject to state and federal approval. The pilot design would encourage innovation in delivery and financing strategies to improve health outcomes of target populations. The pilots would include approaches outlined in the delivery system transformation and alignment incentives section of this concept paper across the spectrum of whole-person care delivery (MCO/provider, MCO/county, access to housing and supportive services, and workforce development).



Pilot partnerships would be required to include all of the following, as appropriate to the targeted population:

1. Medi-Cal managed care plans (in counties with more than one plan, the pilot must include at least two plans participating)
2. County behavioral health systems
3. Hospitals
4. Clinics and doctors
5. Other medical providers, including dental providers
6. Social services agencies and providers
7. Public health agencies and providers
8. Non-medical workforce
9. Housing providers/Local housing authorities
10. Criminal justice/probation
11. Other community-based organizations with experience serving high need populations

DHCS would request proposals from counties and plans that partner with providers and community-based organizations to pilot approaches to fully coordinate care for the targeted populations. These pilots would intersect with and build on the section 2703 health homes program, where appropriate.

Participating entities in the pilots would receive incentive payments under the pilot to create and maintain these partnerships, including support to develop necessary MOU/MOAs and contracts, create shared data systems, and develop processes for care coordination across the spectrum of physical health, behavioral health, long-term care and other social service supports, including housing supports,

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The infrastructure, including community partnerships and the development of a shared saving financing strategy, could provide a foundation upon which an ACH could be built that would serve an entire community.

nutrition assistance and post-incarceration supports designed to improve the overall health of their members.

Participating entities could also receive performance payments, to the extent that such a pilot could achieve specific performance metrics, which may include the number or percentage of plan members from the target population that meet the specified outcomes metrics, certain HEDIS or other relevant quality metrics tied to the characteristics of the population and reductions in ED utilization and institutional services.

Participating entities will be responsible for identifying the cross cutting needs of the Medi-Cal members, provide coordination services and share data across all of the involved entities in order to achieve the whole-person care model. Members will have an individualized care plan and a single accountable, trusted care manager that ensures access to all needed services across the spectrum of care and support. Financial flexibility will permit providers across partnering sectors to do what is right for the client and will align incentives for providers to collaborate.

Critical Elements
In order to receive approval for a pilot program under Medi-Cal 2020, proposals must feature a clear governance structure that describes the role of the various partner entities and the proposed financing arrangements. Proposals must include a detailed plan for achieving care coordination and integration across all of the participating entities and must include behavioral health integration as a component.

- Target Population: Pilot partnerships must describe how they will identify a target Medi-Cal population who frequently use multiple systems, what data will be used, local partners they will work with, and the minimum enrollment target. At a minimum, the target population must be at least 50 Medi-Cal patients or the top 1% of emergency/inpatient users. Once a target population is identified, pilot partnerships must make a concerted effort to outreach to all eligible individuals to participate in the pilot.

- Patient Centered Care: The partnership 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 that will be the patient's main contact and be accountable for ensuring the patient's care plan is carried out, in a culturally and linguistically competent manner. Pilots located in counties that are also expanding use of Medical Homes for Complex Patients (the 90/10 Health Home) will integrate their work with Health Homes and use those care coordination funds to advance patient support in the pilot.

- Social Supports: To identify the needed social supports, pilots must assess the needs of the target population. The additional social supports could include: Social services- i.e. CalFresh, child care, homeless services, foster care supports, job training, etc.; Benefit advocacy; Outreach and engagement strategies; Housing and enhanced care coordination and tenancy supports; Criminal justice/probation; Public health.

- Shared data and Evaluation: As part of pilot design, partner entities must describe how data will be shared across agencies, incompliance with all privacy laws, for identifying the target population; describe how shared data will be used for care coordination and patient-centered care. (If data restrictions prohibit certain agencies (e.g. substance use) from sharing data,

counties must describe how they will address these barriers when the pilot is implemented.); describe how they will use electronic medical records to support care coordination.

Specific evaluation criteria will include:

1. Improvements in health outcomes, health status, and disparities
2. Success at enrolling individuals for eligible social supports (i.e. enrollment in CalFresh, child care subsides, job training programs, etc.)
3. Housing- TBD
4. Evaluation component will also measure impact on total cost of care, scalability, and sustainability of pilot beyond Waiver term

- Financial Flexibility: Pilots must identify additional services and supports they expect to offer in addition to non-traditional Medicaid services and work with DHCS to establish appropriate reimbursement mechanisms. Partner entitles must agree to reinvest any savings from the pilot into areas that further support whole-person care. Partner entities must agree to report on an annual basis encounter and cost data on all non-medical services provided for which Medicaid financing is made available. The pilot application must describe how the partner entities plan to collect and report data on non-traditional services. In addition, the pilot application would need to identify the how the shared savings incentives and other incentive payments would be allocated and paid to all participating entities.

Section 5: Public Safety Net System Global Payment for the Remaining Uninsured

California's 21 public hospital and clinic systems are a critical element of the state's safety net for all Californians, and particularly for those who remain uninsured even after implementation of the Affordable Care Act. The public hospital systems serve more than 2.85 million patients annually with preventive, primary, and specialty, pharmacy, and emergency and inpatient services and provide 10 million outpatient visits per year.

Although the uninsured rate in California has declined remarkably from 15% at the end of 2013 to only 7.2% in November 2014, there will always be a significant population of residents who will remain uninsured indefinitely. Research shows that this group can be difficult to reach with limited ties to health insurance. According to a Kaiser Family Foundation survey, nearly 4 in 10 (37 percent) say they have never had health insurance (compared to 20 percent who became insured) and an additional 45 percent say they have been uninsured for two or more years. Overall, an estimated three million Californians will remain uninsured after full implementation of health reform.

In California, two important funding sources have historically helped core public safety net providers provide care to the uninsured – the Safety Net Care Pool Uncompensated Care Pool (SNCP), funded through the 1115 waiver, and the Medicaid Disproportionate Share Hospital Program (DSH) funded outside of the waiver. Since 2005, these funds have supported the 21 public hospital and clinic systems, which are a critical element of the state's safety net for all Californians, and particularly for those who remain uninsured even after implementation of the Affordable Care Act.[7] These systems are the primary source of care for the uninsured in the counties that are home to over 80% of the state's total population. While these funds have provided critical resources to support the safety net, they have also operated through a cost-based system that has not necessarily provided the best levers for coordinated or cost-effective care.

In an effort to transform funding from cost-based to value-based, and in light of the fact that there will be millions of remaining uninsured for which public hospital systems will continue to provide care, Medi-Cal 2020 proposes moving DSH and SNCP into a global budget structure where care for the remaining uninsured would be provided within a global budget for all uninsured services. By unifying DSH and SNCP funding streams into a county-specific global payment system, public hospital systems would have the incentive to provide more coordinated, upstream care for the uninsured and the opportunity to

[7] The levels of SNCP uncompensated care funding authorized under Bridge to Reform declined commensurate with the expansion of coverage through the LIHP and Medi-Cal, but recognizes that this level of reduced funding is still necessary to provide continued support post-2014 and beyond. DSH funds are also scheduled to decline to account for the impact of health reform, but about half will still remain, also acknowledging the continued need for support for uninsured services.

reduce inappropriate utilization. The new structure would recognize the higher value of primary care, ambulatory care, and other core components of care management as compared to the higher cost, avoidable emergency room visits and acute care hospital stays. This proposal would encourage care delivery in more appropriate settings, including primary and preventive care as well as alternate modalities not currently explicitly recognized, such as phone and e-mail consults.

Methodology Overview. The proposed approach under the renewed demonstration would provide public hospital systems the opportunity to receive quarterly payments to provide services to the uninsured. The service value would reflect value for the patient, not simply cost to the health care system. Services like primary care visits or phone call consults would be recognized as high-value services, and their ability to draw payment would be weighted in a way that incentivizes their use and encourages more appropriate utilization of traditionally costly services such as emergency room visits. To operationalize such a system, the value of each service would be identified with commensurate points assigned. Health care systems would be required to reach a threshold amount of uninsured services (measured in points) provided in order to earn their entire global payment. The methodology would allow for the continuation of traditional services as they exist today, but encourage more appropriate and innovative care to ensure that patients are seen in the right place, given the right care, at the right time by assigning point values to those types of appropriate services where there is currently little to no reimbursement.

Specifically, points for services would be assigned in a manner that recognizes value, where higher values would be assigned to services that meet criteria such as:

- Timeliness and convenience of service to the patient
- Increased access to care
- Earlier intervention
- Appropriate resource use for a given outcome
- Health and wellness services that result in improved patient decisions and overall health status
- Potential to avoid future costs

Partial funding would be available based on partial achievement of the "points" target.

Services. A comprehensive, but not exhaustive, list of the services that would qualify for the global payment is shown below. Acknowledging that health care is delivered differently in different geographies, the public health care systems would not be required to provide every service on this list, but through the point system, would be required to provide a base level of services that address local needs. This flexibility in provision of services allows systems to tailor to their own needs while also encouraging a broad shift to more cost effective, person-centered care. The categories below represent groupings based on activities and settings, but credit for these services in the demonstration would be assigned based on the value of a given service, which may vary within any given category.

Items within each of the four categories would be grouped into tiers of similar service intensity for purposes of reporting and for developing tiers of point values. The development of point values will recognize the high-value of services designed to improve health, prevent unnecessary emergency room/inpatient stays, and prevent longer term health complications. Services that are currently afforded minimal to no reimbursement will be valued at levels recognizing the downstream impact they can have in generating positive health outcomes. Service groups that have the similar ability to impact

overall care delivery and quality will have relatively equal values. Service groups that may today have over-utilization and are not the most cost-effective or ideal delivery sites will have lower relative value than current reimbursement structures. Certain traditional services such as emergency room visits and inpatient stays will continue to be recognized for their value and importance, although at a slightly diminished valuation to incentivize increased use of outpatient and primary care services. The state will establish baseline threshold point targets for services currently provided today.

Category 1: Traditional Outpatient: Face-to-face outpatient visits an individual could have at a public hospital system facility

- Non-physician practitioner (RN, PharmD, Complex Care Management)
- Traditional, provider-based primary care or specialty care visit
- Mental health visit
- Dental
- Public health visit (TB Clinic, STC screening)
- Post-hospital discharge/post-ED primary care
- Emergency room/Urgent Care
- Outpatient procedures/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

- Community health worker encounters
- Health coach encounters
- Care navigation
- Health education & community wellness encounters
- Patient support & disease management groups
- Immunization outreach
- Substance use disorder counseling groups
- Group medical visits
- Wound check
- Pain management
- Case management
- Mobile clinic visits
- Palliative care
- Home nursing visits post-discharge
- Paramedic treat & release encounters

Category 3: Technology-Based Outpatient: Technology-based outpatient encounters that rely mainly on technology to provide care

- Call line encounters (nurse advice line)
- Texting
- Telephone and email consultations between provider and patient
- Provider-to-Provider eConsults for specialty care
- Telemedicine
- Video-observed therapy

Category 4: Inpatient and Facility Stays

- Recuperative/respite care days
- Sober center days
- Subacute care days
- Skilled nursing facility days
- General acute care & acute psychiatric days
- Higher acuity inpatient days in ICU & CCU
- Highest acuity days & services such as trauma, transplant, and burn

Threshold. To determine an appropriate threshold amount, 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. These estimates would use the most recent complete data available trended, taking into account changes in utilization of uninsured services due to the implementation of the Affordable Care Act. Although thresholds would vary for each respective public health system, point values would be consistent across all systems. Threshold point values per unit of service would be established based on current, cost based reimbursement structures for DSH and SNCP. The intent of the threshold is to determine the level of services that would have been provided absent this proposal. The thresholds would need to be adjusted overtime to account for the federal DSH reductions.

Payment and Allocation. Under this new approach, the public hospital systems, in order to earn a global payment, would be required to reach a threshold amount of uninsured services provided, measured in points. The threshold amount would decline over time, tracking with the cuts to the DSH program in recognition of the likely decline in uninsured services that will be provided as health insurance coverage continues to increase. A public hospital system could achieve partial payment if it does not meet its threshold, with excess funds made available to other systems that exceed their threshold.

Evaluation and Accountability. The waiver renewal would seek to demonstrate that, while the need for sustained funding to support California's safety net continues, shifting payment away from cost and toward value can help ensure that patients are seen in the right place, and given the right care at the right time. The evaluation for this component of the demonstration would focus on relative resource allocation and the extent to which services and workforce investments shift the balance of primary and specialty care toward longitudinal care in primary care settings. Clear, concise metrics would be established to ensure accurate gauging of success. Public hospital systems participating in the demonstration would report data on the following:

Resource allocation**:** Measure the shift in balance of primary and specialty care toward longitudinal care in a primary care setting

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

***Workforce involvement*:** Invest in alternative uses of workforce able to provide higher quality care and service for lower long-term costs on a per-patient basis

Potential Metrics:

- Use of non-traditional workforce classifications (e.g. CHWs)
- Expansion of roles/responsibilities (within scope of practice) for traditional workforce classifications

Section 6: State-Federal Shared Savings & Reinvestment

California's Federal-State Shared Savings initiative seeks recognition of the Federal savings that California's section 1115 demonstration generates and would provide the state with a portion of those Federal savings to be reinvested in the Medi-Cal program and facilitate continued delivery system transformation. This strategy is in alignment with the Waiver goals and initiatives to foster shared accountability and fiscal stewardship across providers, managed care plans, and payers to achieve high-value, high-quality and whole-person care. This concept has been incorporated into payment models in both commercial and public insurance markets (Medicare, Duals) over the last several years and should be explored in Medicaid as the Federal government becomes more vested in effective and efficient state delivery systems driving expenditures that are nearly fully funded by the Federal government.

The Shared Savings initiative will test the impact of establishing a prospective state performance payment based on Federal Medicaid savings achieved for Medi-Cal 2020 enrollees over the life of the waiver. California would receive a portion of Federal savings in the form of ongoing performance payments as long net savings to the Federal government are demonstrated as calculated under the Waiver Budget Neutrality agreement. Absent this shared savings approach, California would be extremely limited in the ability to enact the proposed delivery system transformation and alignment programs that are so necessary to ensure the ongoing successful implementation of the ACA and the long-term sustainability of the Medi-Cal program.

Budget Neutrality and Shared Savings

In order to share in Federal savings, California would need to demonstrate that Federal savings generated under the Waiver are sufficient to permit California to retain a share of the Federal funding saved in the form of a performance payment. ***Even after the reinvestment of funding to support the Waiver strategies, there must still be overall savings to the Federal government, thereby ensuring that the Waiver is budget neutral.*** The methodology for calculating the shared savings payments would leverage the budget neutrality agreement for the Waiver but would include additional cost trend factors intended to further incentivize the state to slow the cost trend in California's Medicaid program relative to the cost trend the state would face absent the Waiver initiatives. All shared savings payments would be retrospectively reconciled as part of the ongoing reconciliation of actual expenditures to projected expenditures that occur under the budget neutrality agreement. California would be limited to utilizing the funds to support approved reinvestment strategies that are considered integral to meeting cost and program metrics. The concept does not cap Medicaid spending; rather, should California 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.

Section 7: Demonstration Financing & Budget Neutrality

The limit on expenditures in the current *Bridge to Reform* Waiver is based on a combination of per-capita and aggregate spending amounts and California will propose to continue this model for the Waiver renewal. For Medi-Cal State Plan populations, California proposes to continue to utilize historical fee-for-service expenditure information to develop annual, per capita cost projections for each demonstration year.

The Medi-Cal 2020 budget neutrality model will also propose to retain the existing "Bridge to Reform" (BTR) Waiver diversion of hospital Upper Payment Limit (UPL), "Limit B" that currently funds a portion of the Safety Net Care Pool.

New for Medi-Cal 2020

Budget Neutrality for the Waiver Renewal will include a new proposal to support California's key strategy for Alignment for Public Safety Net Systems. California will propose to include expenditures currently authorized as DSH expenditures in the Medi-Cal 2020 waiver spending limit. As described in Section 7, these DSH expenditures would be a component of the funding for the new county-specific global payment system.

Budget Neutrality for the Medi-Cal 2020 Waiver will also reflect California's Federal-State Shared Savings Initiative as described in Section 7. The Federal/State shared savings concept does not cap Medicaid spending in the methodology; rather, any excess spending on the reinvestment Waiver strategies over the anticipated amounts will be required to be counted against the Waiver Budget Neutrality margin.

Cost projections for the per-capita expenditures, historical hospital UPL funding and DSH expenditures will establish the "without waiver" budget ceiling. Actual waiver expenditures for covered populations and Medi-Cal 2020 initiatives will be applied against the without waiver budget limit. California has included the full budget neutrality calculations as an attachment to this document as well as the most current version of the BTR budget neutrality file. Table 1 below provides the proposed "without waiver" (WOW) per-member-per-month by the Waiver Medi-Cal eligibility groups (MEGs). Table 2 provides estimated WOW expenditures for the MEGs and the UPL limit. Table 3 provides projected "with waiver" (WW) expenditures and member months. Table 4 provides current estimates of BTR WW expenditures and member months.

Table 1: Proposed MEGs, PMPMs and Trend Factors (based on existing BTR)

			FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20
WOW PMPM	**MEGS**	**Trend Rate**	**DY11**	**DY12**	**DY13**	**DY14**	**DY15**
TPM/GMC							
	Family	5.30%	$195.78	$206.15	$217.08	$228.59	$240.70
	SPDs	7.40%	$928.95	$997.69	$1,071.52	$1,150.81	$1,235.97
	Duals	3.28%	$121.84	$125.84	$129.97	$134.23	$138.63
	New Adult	4.10%	$527.95	$549.60	$572.13	$595.59	$620.01
COHS							
	Family	5.30%	$221.57	$233.32	$245.68	$258.70	$272.42
	SPDs	7.40%	$1,737.97	$1,866.58	$2,004.71	$2,153.05	$2,312.38
	Duals	2.47%	$450.10	$461.22	$472.61	$484.29	$496.25
	New Adult	4.10%	$715.68	$745.02	$775.57	$807.37	$840.47
CCI TPM/GMC							
	Family	5.30%	$197.76	$208.24	$219.28	$230.90	$243.14
	SPDs	7.40%	$1,128.79	$1,212.32	$1,302.03	$1,398.38	$1,501.87
	Duals	3.40%	$774.83	$801.17	$828.41	$856.58	$885.70
	Cal MediConnect	3.40%	$774.83	$801.17	$828.41	$856.58	$885.70
CCI COHS							
	Family	5.30%	$225.08	$237.01	$249.57	$262.80	$276.72
	SPDs	7.40%	$2,183.24	$2,344.80	$2,518.32	$2,704.67	$2,904.82
	Duals	1.61%	$663.28	$673.95	$684.80	$695.83	$707.03
	Cal MediConnect	1.61%	$663.28	$673.95	$684.80	$695.83	$707.03
CBAS		3.16%	$1,166.69	$1,203.56	$1,241.59	$1,280.82	$1,321.30

Table 2: Estimated WOW Expenditures

	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	
	DY11	**DY12**	**DY13**	**DY14**	**DY15**	**5 Year Total**
Total Population Expenditures	**$ 41,991,973,636**	**$ 44,627,527,507**	**$ 47,439,270,963**	**$ 50,439,658,680**	**$ 53,642,068,892**	**$238,140,499,678**
DSH	$ 2,352,648,102	$ 2,002,648,102	$ 1,852,648,102	$ 1,792,648,102	$ 2,052,648,102	**$10,053,240,510**
IP UPL PH	$ 3,730,300,150	$ 3,970,158,450	$ 4,225,439,638	$ 4,497,135,407	$ 4,786,301,214	**$21,209,334,860**
Total Without Waiver Ceiling (Tot	***$ 48,074,921,888***	***$ 50,600,334,059***	***$ 53,517,358,703***	***$ 56,729,442,190***	***$ 60,481,018,208***	***$269,403,075,049***

Table 3: Projected Member Months and WW Expenditures

	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	
	DY11	**DY12**	**DY13**	**DY14**	**DY15**	**5 Year Total**
Total Member Months	*102,305,153*	*103,328,205*	*104,361,487*	*105,405,102*	*106,459,153*	
Total Population Expenditures	$36,032,479,886	$38,133,908,104	$40,352,295,847	$42,694,203,383	$45,166,569,554	$202,379,456,774
Total Hospital Expenditures	$2,811,751,705	$2,992,547,340	$3,184,968,134	$3,389,761,585	$3,607,723,255	$15,986,752,019
Total Waiver Expenditures	$7,226,198,102	$6,876,198,102	$6,726,198,102	$6,666,198,102	$6,926,198,102	$34,420,990,510
Total With Waiver Expenditures	**46,070,429,693**	**48,002,653,546**	**50,263,462,083**	**52,750,163,070**	**55,700,490,910**	**252,787,199,303**

Table 4: Historical BTR Enrollment and Expenditures

	FY 10-11	FY 11-12	FY 12-13	FY 13-14	FY 14-15
	DY6	**DY7**	**DY8**	**DY9**	**DY10**
Historical Enrollment	51,576,881	58,420,445	63,769,315	66,558,574	83,233,890
Historical Expenditures	$15,397,202,160	$19,471,360,377	$21,129,317,683	$23,494,057,783	$30,867,521,032

Section 8: Waiver Authorities and Changes to the Demonstration

NOTE: The below is subject to change as substantive details for the eventual waiver components are refined in the application and approval processes.

BRIDGE TO REFORM AUTHORTIES EXPECTED TO CONTINUE

Managed Care Waiver Authorities:

1. **Freedom of Choice Section 1902(a)(23)(A)** (authorizing Medi-Cal managed care delivery models)

2. Statewideness Section 1902(a)(1) (authorizing county-by-county variance.)

3. Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B) (specific to SPDs in the current waiver authority)

Safety Net Care Pool (SNCP) Expenditure Authorities:

The following expenditures are authorized under the existing Bridge to Reform Demonstration, subject to an overall cap.

1. **Uncompensated Care** (*only to the extent necessary to carry out SNCP uncompensated care activities authorized under the Bridge to Reform Demonstration*)

(Expenditures for uncompensated care meeting the section 1905(a) medical assistance definition incurred by hospitals, providers and clinics for Medicaid eligible or uninsured individuals, and to the extent that those costs exceed the amounts paid to the hospital pursuant to Section 1923)

2. **Designated State Health Care Programs (DSHP)**

(authorizing reimbursement of expenditures for certain state-funded programs: (1) Breast and Cervical Cancer Treatment Program (BCCTP); (2) Medically Indigent Adults/Long Term Care Program; (3) California Children's Services Program; (4) Genetically Handicapped Persons Program; (5) Expanded Access to Primary Care Program; (6) AIDS Drug Assistance Program; (7) Department of Developmental Services; (8) County Mental Health Services.)

3. **Workforce Development**

(Expenditures for workforce development programs in medically disadvantaged service areas: (1) Song Brown HealthCare Workforce Training; (2) Health Professionals Education Foundation Loan Repayment; (3) Mental Health Loan Assumption; (4) Training program for medical professionals at CA Community Colleges, CA State Universities, and the University of CA)

4. **Delivery System Reform Incentive Pool** (*only to the extent necessary to carry out DSRIP activities authorized under the Bridge to Reform Demonstration*)

(Expenditures for incentive payments from a Delivery System Reform Incentive Pool)

5. Uncompensated care for Indian Health Service (IHS) and tribal facilities
(Authorizing payments for certain uncompensated care expenditures)

Community Based Adult Services (CBAS) Expenditure Authority:

1. Authorizing expenditures for CBAS services to qualifying individuals

Drug Medi-Cal Organized Delivery System Proposed Authorities:
(The following expenditure authority has been requested in the DMC-ODS waiver amendment, and if approved for the current demonstration, would be expected to continue)

1. DMC-ODS residential-based services
(Expenditures not otherwise eligible for FFP for covered services furnished to Medi-Cal members who are residents in facilities that meet the definition of an Institution for Mental Disease under Section 1905(a))

AUTHORITIES EXPECTED TO CHANGE OR NEW AUTHORITIES REQUESTED

1. Federal-State Shared Savings and Reinvestment

To authorize the reinvestment of state-designated shared savings towards applicable demonstration expenditures. The amount of state-designated shared savings available for use under this authority will be based on the difference between the State's actual expenditures under the demonstration and pre-established per beneficiary per month amounts.

2. Public Safety Net Systems Global Payment for Remaining Uninsured
To authorize disproportionate share hospital (DSH) and uncompensated care payments under a global payment budget structure to public hospital systems (including affiliated hospitals, providers, and clinics) for services provided to the uninsured. This may include payment for services not recognized as medical assistance under Section 1905(a), and may extend to a broader set of modalities, provider types, and provider settings. Global payment expenditures under this authority would not be subject to title XIX requirements.

This may also include specific waiver authority for the following provisions:
(1) **Statewideness, Section 1902(a)(1)** (to limit this demonstration component to certain counties or geographic areas that include designated public hospitals);

e(2) **Disproportionate Share Hospital payments, Section 1902(a)(13)(A)** (insofar as it incorporates Section 1923) (to exempt the State from making DSH payments to hospitals which qualify as a disproportionate share hospital in any year for which the public hospital system with which it is affiliated is receiving payments under the global payment budget structure).

3. Public Safety Net System Transformation & Improvement Program

To authorize expenditures for incentive payments pursuant to the Public Safety Net System Transformation & Improvement Program.

4. Increased Access to Housing and Supportive Services Program

To authorize reimbursement for housing-based case management and supportive services, to the extent not encompassed under the Section 1905(a) definition of medical assistance, for qualifying beneficiaries accessing Medi-Cal benefits. This includes, but is not limited to, housing-based expenditures made with respect to Medi-Cal beneficiaries in facilities that meet the definition of an Institution for Mental Disease under Section 1905(a).

Depending on the details of the proposal and the proposed mechanism(s) for payment, expenditure authority relating to the following provisions may be requested: (1) Section 1903(m) and 42 CFR §438.60 (to allow for direct payments to managed care providers).

This may also include specific waiver authority for the following provisions:
(1) **Statewideness, Section 1902(a)(1)** (to the extent housing-based case management is limited to only certain counties or geographic areas);

(2) **Amount, duration and scope of services and comparability, Section 1902(a)(10)(B)** (to limit housing-based case management to certain targeted groups of Medi-Cal beneficiaries);

5. Workforce Development Program

To allow for reimbursement for select workforce development subsidies, incentive payments, and related expenditures to or on behalf of targeted health care providers, including providers who have not previously participated in the Medi-Cal program, existing Medi-Cal providers who commit to treat additional Medi-Cal beneficiaries, or nontraditional provider types, to the extent not otherwise allowable as medical assistance or administrative costs under Section 1903.

Expenditure authority relating to the following provisions may also be requested, depending on the applicable payment mechanism envisioned: (1) Section 1903(m) and 42 CFR §438.60 (to allow for direct payments to managed care providers); (2) Section 1903(m) and 42 CFR §438.6(c)(5)(iii) and (iv) (to the extent subsidies and incentives included in capitation rate and as necessary to exceed the 105% limit for approved capitation payments)

This may also include specific waiver authority for the following provisions:
(1) **Statewideness, Section 1902(a)(1)** (to the extent workforce development programs are limited to only certain counties or geographic areas).

6. Plan/Provider/System Incentives and Whole Person Care Pilots

To allow for reimbursement for select provider, managed care plan, and/or system payments, geared toward performance, quality, system alignment and whole person care coordination principles, to the extent not otherwise considered allowable medical assistance or administrative costs under Section 1903. This may include both fee-for-service and managed care based incentive payments, reimbursement for services not recognized as medical assistance under Section 1905(a), and expenditures in support of value-based transformation strategies under contracts with managed care plans and providers that may not meet the requirements in section 1903(m)(2)(A).

This may also include specific waiver authority for the following provisions:
(1) **Statewideness, Section 1902(a)(1)** (to the extent plan or provider incentives, or regional whole person care pilots, are limited to only certain counties or geographic areas).

(2) **Freedom of choice, Section 1902(a)(23)(A)** (to allow the state to require certain beneficiaries to receive services from specified providers);

(3) **Amount, duration and scope of services and comparability, Section 1902(a)(10)(B)** (to allow the state to provide a different benefit package to those eligible to participate in regional whole person care pilots);

Section 9: Public Notice and Comment Process

Over the past several months, DHCS has engaged the stakeholder and provider communities and solicited public comment to gain input and insight into how the Medi-Cal program can continue to evolve and mature over the next five years.

DHCS began public input and stakeholder engagement on Waiver Renewal with the release of the initial concept paper in July 2014 which identified the central proposals for the renewal of the state's section 1115 Medicaid Waiver. The key proposals included: 1) Housing and Supportive services for vulnerable populations; 2) Managed Care Plan/Provider Incentives; 3) Delivery System Reform Incentive Payments (DSRIP) 2.0; 4) Workforce Development strategies; and 5) Safety Net Payment and Delivery System Transformation.

To facilitate public involvement and to solicit meaningful input with regard to the proposals, DHCS convened five distinct expert stakeholder workgroups composed of subject matter experts in Medicaid delivery system and payment reform, social determinants of health, care coordination and integration, and clinical practice improvement. The experts who participated represent a broad sample of stakeholders, including representatives from managed health care plans, hospitals, advocacy/special interest groups, counties and other members of the interested public. Between November 2014 and March 2015, DHCS convened approximately twenty stakeholder meetings on Waiver Renewal (date, times, materials detailed on DHCS website). Comprehensive descriptions of concepts considered for inclusion in the Waiver Renewal, including the goals and objectives and potential impact of the proposals are made available to the public on the DHCS Waiver Renewal website at: http://www.dhcs.ca.gov/provgovpart/Pages/1115-Waiver-Renewal.aspx.

Finally, DHCS hosted a broad stakeholder engagement session on January 30, 2015 to specifically solicit input and public comment on a financing strategy for achieving federal-state shared savings under Medi-Cal 2020.

Before each expert stakeholder workgroup meeting, the meeting agenda and meeting presentation materials have been posted on the DHCS Waiver Renewal website. The expert workgroup meetings have been open to the public with a conference call option for those who wish to participate, but cannot attend in person. Each meeting concludes with dedicated time for public comments and discussion.

The input provided by the stakeholder representatives has been documented in meeting summaries and made available on the DHCS website, along with the meeting presentation materials and in-depth background information on each topic.

Additionally, DHCS invites comment on the Waiver Renewal proposal from the public and interested stakeholders through a dedicated inbox: WaiverRenewal@dhcs.ca.gov as well as a physical address, made available on the website. All comments received via the inbox and by mail are made available to the public on the DHCS Waiver Renewal website.

DHCS published an abbreviated notice informing the public of Waiver Renewal efforts and concepts in the February 13, 2015 state register. The notice outlined upcoming opportunities for public engagement and input. DHCS also issued tribal notice on February 17, 2015 to provide opportunity for input from tribal entities and Indian Health Programs.

The Waiver stakeholder meetings have provided opportunity for stakeholders and other interested parties to provide feedback on the renewal proposal and to ask questions about the technical aspects of the State's plans for Medi-Cal 2020.

The stakeholder engagement process has been extremely robust and has substantially informed the content of the proposals included in this concept paper. We expect that the anticipatory approach that has been underway over the past several months has ensured that the stakeholder and provider communities are in full support of the Waiver Renewal.

Section 10: Medi-Cal 2020 Evaluation Design

As the Medi-Cal program evolves, evaluation of the Waiver gains more complexity as an analytic process and involves applying quantitative and qualitative research methods to test a set of questions or hypotheses that focus on the demonstration's goals and objectives. The intent of the Med-Cal evaluation is to produce valid and reliable information that fully and robustly assesses the impacts of the Waiver on the critical aspects of the program areas, and in the case of the DSRIP program, it also focuses on impacts relative to the three-part aim.

In the renewal, the state will work to develop an evaluation design for the Medi-Cal 2020 demonstration that builds upon and incorporates the lessons learned in the Bridge to Reform 2010. The demonstration design and evaluation plan will support generalized findings, and the evaluation reports should carefully explore and explain the limitations of the demonstration design, as well as the integrity and appropriateness of the data and the analytic methods used to support the study. In addition consideration will be given to the intervening and future expected effects of the Affordable Care Act in California. The evaluation plan will include use of comparison groups wherever possible, establish or identify baseline data, measure the programs and pilots, as well as the explore of the meaning of the findings in a lessons-learned format. The evaluation will aim to ensure sufficient causal factors and population effects.

Appendix A: "Bridge to Reform" Interim Evaluation

In accordance with the Special Term and Condition of the BTR Waiver paragraph 8(vi), the California Department of Human Services submits the following narrative summary of the evaluation designs, the status and findings to date.

Program and Design

The California Bridge to Reform Section 1115 Demonstration Program (Waiver) was approved on November 1, 2010. The renewed demonstration created multiple initiatives to ensure that adequate support was provided by the state in their efforts to prepare safety net providers for expansion to the new adult group in conjunction with the state based Exchange operations as provided for by the Affordable Care Act. The majority of existing Medi-Cal managed care programs participate through the Waiver including multiple California specific seniors initiatives such as the program dual Medicare and Medicaid beneficiaries known as the Coordinated Care Initiative (CCI). The demonstration also expanded the state's Safety Net Care Pool (SNCP) to continue support for uncompensated care payments to safety net providers and to incentivize safety net hospitals via the Delivery System Reform Incentive Programs (DSRIP).

Due to the diversity of the Bridge to Reform (BTR) programs and the varied timing of the roll out of each of the unique programs, it was determined that it was most effective and appropriate to focus specific demonstration evaluations on specific initiatives and their impact on target populations and DSRIP initiatives.

Given the nature of the BTR evaluation design, this interim evaluation report provides for an individual evaluation and program specific hypotheses and measures as appropriate for each of the targeted programs:

- Delivery System Reform Incentive Program (DSRIP)
- Low Income Health Program (LIHP)
- Indian Health Services (IHS) Uncompensated Care Pool
- Healthy Families Program Transition to Medi-Cal

Evaluations on some of the more recent Waiver initiatives which became active in during or after 2013 and for the implementation of health care reform were not included in this interim report. Because evaluation for the following programs are still under development or are in process, for the interim period we have included operational reports for each of the following:

- Seniors and Persons with Disabilities (SPD)
- California Children's Services (CCS) pilots
- Coordinated Care Initiative (CCI) initiative

Transition of SPDs into Managed Care

In compliance with State Senate Bill (SB) 208 (Steinberg, Chapter 714, Statutes of 2010), DHCS took its first steps toward implementing the Waiver by transitioning Medi Cal-only SPDs from FFS Medi-Cal into Managed Care Plans (MCPs) in 16 of the 30 counties that participated in Medi-Cal Managed Care at that time. (The other 14 counties operated under the County-Organized Health System model, which already enrolled all SPDs into their MCPs.) During 2013 and 2014 DHCS expanded managed care into an additional 27 counties in California and as part of the expansion, also transitioned the SPD population into MCPs in these counties.

DHCS will work with CMS towards an approval of an evaluation design to that addresses policy questions in five areas of the transition of SPD beneficiaries into MCPs: eligibility and enrollment processes, network adequacy and coverage, access to care and continuity of care, quality of care, and value-based care (costs associated with the transition).

CCS Pilots

Health Plan of San Mateo pilot:

The Health Plan of San Mateo (HPSM) California Children Services Demonstration Project (CCS DP) pilot was implemented on April 1, 2013. HSPM's pilot includes ~1,500 Medi-Cal CCS members in San Mateo County and covers most healthcare conditions with a few exclusions.

As part of the CCS DP operational review, DHCS developed and administered a "Family Satisfaction Phone Survey" (Phone Survey) to HPSM CCS DP families between the months of July through September 2014. The survey objective was to assess the families' knowledge and satisfaction of the CCS DP, their knowledge and satisfaction with their care coordinator, their access and satisfaction with providers, and their satisfaction with the medical services provided.

DHCS also developed a Provider Satisfaction e-Mail Survey (Provider Survey) for the HPSM CCS DP. It is anticipated the Provider Survey will be e-Mailed spring 2015. The survey objective is to assess the providers' CCS DP knowledge and satisfaction.

On October 17, 2014, DHCS conducted site visits with both HPSM and San Mateo County CCS office. These first annual site reviews discussed the main goals of the CCS DP (focused on care coordination, medical home, and family centered-care), successful components of the CCS DP, and unexpected challenges of the CCS DP.

Rady Children's Hospital San Diego Pilot

Rady Children's Hospital San Diego (RCHSD) CCS DP pilot is anticipated to be operational by summer 2015. RCHSD's pilot will include ~450 Medi-Cal CCS members with Sickle Cell, Cystic Fibrosis, Hemophilia, Acute Lymphoblastic Leukemia or Diabetes Type I and II (for ages 1-10 yrs.)

As part of the CCS DP operational review, SCD intends to conduct Phone Surveys, Provider Surveys and annual site reviews. In addition, SCD and RCHSD are working on an evaluation metric, consisting of two clinical measures per health condition covered in the CCS DP that RCHSD will report to SCD. The first year's clinical data will be utilized as a baseline to measure future outcomes.

CCI

Several CCI evaluation efforts are currently in various stages of the implementation. The SCAN Foundation has funded two evaluation projects that will be conducted by third party organizations that are working collaboratively with The SCAN Foundation and DHCS in the evaluation design. The more near term evaluation is the Rapid-Cycle Polling Project that will be conducted by Field Research Corporation to evaluate the Cal MediConnect enrollment process and beneficiary satisfaction. Field Research Corporation will be selecting a random sample of beneficiaries that have enrolled in and/or opted out of Cal MediConnect to conduct two telephone surveys, one in the spring of 2015 and another in the fall of 2015.

The second evaluation is a three year longitudinal evaluation that will be conducted by UC Berkeley. The results of the Rapid-Cycle Polling Project will be used to help design the more detailed evaluation that will be comprised of telephone surveys as well as advisory and focus groups. This evaluation is in the beginning phase, with the survey design currently in the development process.
All plans participating in Cal MediConnect are required to routinely submit quality reporting data to CMS which includes quality measures for Medicare and Medi-Cal benefits and services. CMS and DHCS currently review these reports and are working with the plans to ensure data is reported consistently for evaluation purposes. DHCS recently published the first quarterly Health Risk Assessment Dashboard (http://www.calduals.org/enrollment-information/hra-data). The report compares how each participating plan is complying with the completion of Health Risk Assessments for participating members.

CMS' evaluation vendor, Research Triangle Institute, has been contracted to conduct a national and state-wide evaluation of the Demonstration. RTI is currently collecting data from California and will be submitting evaluation reports to CMS at various points throughout the three year demonstration.

DSRIP – The First in the Nation

Many lessons were learned during this partnership and pioneering project period.
Designated Public Hospitals (DPH) varied in characteristics and choice of Categories 1 and 2projects, the challenges they faced in implementing their projects and the solutions they devised to address such challenges. Despite their unique situations, the great majority of the project milestones were achieved. Specifically:

- Participating DPHs include five University of California and 12 County-owned and operated systems and include six multihospital systems. DPHs varied in size from 76,000 to 4,128 discharges and from 1.2 million to 130,000 outpatient visits in 2010.
- Many DPHs selected specific and related projects in Categories 1 and 2, including expanding primary care capacity and implementing and utilizing disease management registries for their Category 1 infrastructure development, and expanding medical homes for their Category 2 innovation and redesign initiatives.
- Nearly 50% of the implemented projects were envisioned prior to DPHs participation in DSRIP, though most were not implemented extensively or system-wide.
- DPHs cited consistency with organizational goals, availability of project champions among existing staff, and synergy with existing projects as principal reasons for selecting DSRIP projects.
- DPHs achieved nearly all (99%) of their proposed milestones in DY 7-8, covered in this interim report. This success was achieved with high levels of planning, resource investments, and many DPHs reported high level of overall difficulty in implementing projects.
- DPHs perceived a high level of impact on improving quality of care and health outcomes, two of the three components of the Triple Aim. The third component, cost containment/efficiency, had a lower perceived impact in part because not enough time had elapsed to assess the full effect of implemented projects.
- Category 1 infrastructure development and Category 2 innovation and redesign were perceived as having the greatest impact on the Categories 3, 4, and 5.

For this evaluation, the DHPs were asked to provide summary level information of this DSRIP impact to their organization, the feedback included:

- DSRIP led to systematic and major change and was considered as an investment in the future of DPHs. The focus of DSRIP on population-based measures and outpatient care was particularly valuable.
- DSRIP significantly transformed the operations and information technology in DPHs.
- DSRIP provided the resources and financial incentives to effectively implement the selected projects and obtain buy-in from executives and staff.
  DSRIP led to new collaborations between DPHs and sharing of innovations.

In addition, DPHs were asked to provide their recommendations for renewal of DSRIP under the next Medicaid §1115 Waiver. These recommendations included:

- Align DSRIP projects with other initiatives and organizational goals.
- Consider projects that prepare DPHs for the future.
- Reduce the number of projects and narrow the focus of the program.
- Provide DPHs with clear metrics, instructions, and direction.
- Reevaluate the relevance of some measures to ensure consistency with current evidence.
- Allow for flexibility so that projects can be aligned with organization goals and characteristics. But increase standardization of some measures to reduce confusion and shifting goals.
- Improve measurement methods so that high performing DPHs are not penalized for small marginal improvements.
- Better measure time and effort required to complete projects.
- Provide CMS timely feedback and establish direct communication lines between CMS and DPHs.

Appendix B: Data Infrastructure and Use of Health Information Technology

Each of the initiatives described in the previous sections outlining activities to address delivery system transformation and alignment for Medi-Cal 2020 will need to be built on a robust data infrastructure that supports data use and sharing within the delivery system and with the state Medi-Cal program. In meeting opportunities to provide quality health care and services, the Medi-Cal program is changing from a quantity based reimbursement system to an integrated whole patient management system using value driven patient clinical data to demonstrate that California is reimbursing for clinical outcomes in a value driven system. Data infrastructure developments as part of the 1115 waiver will include the following:

Adoption of Health Information Technology (HIT) to Support Service Delivery

Over $2.5 billion federal funds have come to California professionals and hospitals through the Medicare and Medi-Cal Electronic Health Record (EHR) Incentive Programs. Additionally, DHCS is beginning a $38 million technical assistance program to assist providers in achieving meaningful use of the EHR technology in a CMS/DHCS program under the Medi-Cal EHR Incentive Program. The ongoing investment in EHR adoption and meaningful use provides the basis to further advance the use of HIT to support services for members. The 1115 Waiver Initiatives will provide programmatic incentives for use of HIT by incentivizing care coordination, targeting of specific populations, focusing on quality metrics. California has also supported adoption of EHRs for behavioral health services as has been funded in significant part through the California Mental Health Services Act. Work under the Waiver will specifically focus on inter-operability to support timely data transfer between data systems (e.g., primary care clinic EHRs and behavioral health EHRs, between hospital data systems and primary care, or between managed care plan Clinical Information Systems (CIS) and behavioral health EHRs) so that all primary care, mental health, substance use disorder treatment entities and managed care plans can assimilate and analyze the data sets from a variety of sources.

Although significant investment and transformation has occurred around adoption and use of EHRs, there are still significant gaps in the use of HIT to facilitate data sharing within the delivery system. The state has multiple organizations (over two dozen) supporting health information exchange (HIE) and yet a number of parts of the state do not have organizations or tools to support HIE. Challenges include linking of individual members between different and often disparate systems, the cost (effort, expertise, and system) of developing system interfaces, and the difficulty in maintaining up-to-date provider information to facilitate exchange. As part of the 1115 Waiver, DHCS will work with stakeholder internally and externally to address these issues for the Medi-Cal population with a focus on those individuals directly served by initiatives in the Waiver.

Incorporation of Clinical Data to Support Monitoring and Reporting

Currently the DHCS has invested significant funds to receive, standardize and analyze administrative data representing paid claims and capitated encounters to the health delivery system. While DHCS expects this investment to continue to be used, DHCS recognizes that the focus on value based purchasing, outcomes and care coordination cannot be supported by administrative data alone. Therefore, DHCS will evaluate methods for using clinical data and develop solutions that will make that data available to the department to monitor, manage and evaluate various Waiver Initiatives. The expanded data collection to include clinical data that is not included with a billing claim may include but is not limited to pharmacy data providing medication dosage, medication strength, and medication schedule, laboratory data documenting the diagnosis and the response to therapy, clinical findings such as blood pressure and physical findings documenting responses to treatment.

As is highlighted in the Medicaid Information Technology Architecture (MITA) Framework, clinical data is required to drive improved maturity in Medi-Cal activities. Clinical data originating from EHRs may be used in the clinical care environment to improve and document patient safety and direct resources to specific conditions. As the state Medicaid agency, DHCS will also use clinical data to evaluate the number of hospitalizations, emergency room visits, length of hospitalization, readmissions; assess cost of services and opportunities for reduction of services not contributing to improved health outcomes; and, evaluate the quality and cost for selected disease conditions and the effect of treatment on outcomes.

Medi-Cal employs HEDIS measures for its Managed Care Plans which include both administrative and hybrid measures. Hybrid measures cannot be calculated without clinical data and thus the DHCS is dependent on Managed Care Plans to use a sampling methodology to assess performance. Incorporation of clinical data to DHCS systems would allow DHCS to assess performance, perform more complex analysis around various member and provider demographics as well as outcome comparisons that can be adjusted for the various population mixes in each Manage Care Plan. This would allow the Department to use clinical data to provide outcome measures documenting the success and cost effectiveness of various treatments and interventions.

Appendix C: "Bridge to Reform" Evaluation Reports

Interim Evaluations attached in a separate file:

- DSRIP Interim Evaluation
- LIHP Interim Evaluation
- IHS Uncompensated Care Interim Evaluation
- Healthy Families Program Transition

Most Recent Operational Reports for Bridge to Reform demonstration:

- DY9 Annual Report
- DY 10 Quarter 2 Report

Appendix D: Proposed Medi-Cal 2020 Budget Neutrality

Attached in a separate file.

Appendix E: Updated "Bridge to Reform" Budget Neutrality

Attached in a separate file.