



DHCS Stakeholder Webinar – Medi-Cal 2020 Waiver

January 25, 2016



Presentation Outline

Medi-Cal 2020 Overview

Key Programmatic Elements

- Public Hospital Redesign and Incentives in Medi-Cal (PRIME)
- Global Payment Program
- Dental Transformation Initiative
- Whole Person Care

Designated State Health Programs

Budget Neutrality

Reporting and Evaluation Requirements



Medi-Cal 2020 Overview

CMS approval for renewal on December 30, 2015

Effective January 1, 2016 through December 31, 2020

\$6.2 billion total initial federal funding over 5 years



Funding Overview

Waiver Programs

PRIME

GPP*

DTI

DSHP

WPC

TOTAL

Initial Federal Funding

\$3.732b

\$236m**

\$375m

\$375m

\$1.5b

\$6.218b

**GPP funding on this chart does not include the DSH component of the funding. Projecting DSH cuts, DSH funding over the 5 years is estimated to be \$10.830b TF / \$5.915B FF.*

***For GPP, initial federal funding only accounts for DY 11 GPP funding as later years may be affected by uncompensated care assessments.*



Public Hospital Redesign & Incentives in Medi-Cal (PRIME)



PRIME: Overview

Builds on the success of the Delivery System Reform Incentive Program (DSRIP) that significantly improved care delivery in the Designated Public Hospital (DPH) systems

PRIME participating entities will consist of DPHs and District and Municipal Public Hospitals (DMPHs)

Incentive payments are earned based on the achievement of specified benchmarks across various metrics

In addition, requires the achievement of set targets for moving toward alternative payment methodologies (APM) for DPHs over the course of the Waiver



PRIME: Drivers and Purpose

Program Purpose:

- Improve the health of Californians, by advancing improvements in the quality, experience and value of care that DPHs/DMPHs provide
- Align projects and goals of the PRIME with the other elements of Medi-Cal 2020, avoiding duplication of resources and double payment for program work
- Develop health care systems that offer increased value for payers and patients
- Emphasize advances in primary care, cross-system integration, and data analytics



PRIME:

Public Safety Net Hospital Demographics

Designated Public Hospitals

- More than 50% of patients served are Medi-Cal or uninsured
- Provide 30% of all hospital-based care to the Medi-Cal population in the State
- 17 integrated delivery systems (full spectrum ambulatory/hospital care)
- 21 hospitals
- Located in urban and suburban areas
- Academic teaching hospitals
- Operate more than 1/2 of the State's trauma centers and more than 2/3 of its burn centers
- Licensed acute beds range approximately from 160 - 600

District/Municipal Public Hospitals

(formerly Non-Designated Public Hospitals)

- More than 21% of patients served are Medi-Cal or uninsured and at some locations over 50%
- Provide 4% of the hospital-based care to the Medi-Cal and uninsured and 20% of care for these populations in rural California
- 39 district hospitals
- 1 municipal hospital
- 28 rural hospitals
- 20 designated critical access hospitals
- Licensed acute beds range approximately from 3 - 500



PRIME: Funding

Annual federal funding available as shown below

Non-federal share will be provided by DPHs/DMPHs through IGTs

Semi-annual reporting and payment

Potential for partial payment for partial achievement

	DPHs	DMPHs
DY 11 (Jan 2016 – June 2016)	\$700M	\$100M
DY 12 (July 2016 – June 2017)	\$700M	\$100M
DY 13 (July 2017 – June 2018)	\$700M	\$100M
DY 14 (July 2018 – June 2019)	\$630M	\$90M
DY 15 (July 2019 – June 2020)	\$535.5M	\$76.5M
5 Year Total	\$3,265.5M	\$466.6M



PRIME: Domain Areas

Domain 1: Outpatient Delivery System Transformation

Domain 2: Targeted High-Risk or High Cost Populations

Domain 3: Resource Utilization Efficiency



PRIME: Domain Areas

Domain 1: Outpatient Delivery System Transformation

Domain Goals

- Achieve high-quality and efficient, patient-centered care
- Integrate primary, behavioral health and specialty care
- Provide appropriate preventive services, early diagnosis and treatment
- Deliver support for improved self-care
- Reduce disparities and variation in performance



PRIME: Domain Areas

Domain 1: Outpatient Delivery System Transformation

Projects

- Integration of Physical and Behavioral Health (required for DPHs)
- Ambulatory Care Redesign: Primary Care (required for DPHs)
- Ambulatory Care Redesign: Specialty Care (required for DPHs)
- Patient Safety in the Ambulatory Setting
- Million Hearts Initiative
- Cancer Screening and Follow-up
- Obesity Prevention and Healthier Foods Initiative



PRIME: Domain Areas

Domain 2: Targeted High-Risk or High-Cost Populations

Domain Goals

- Enhance quality of life and health outcomes for focus populations that would benefit most significantly from care integration and alignment
- Reduce avoidable acute care and interventions
- Improve care transitions



PRIME: Domain Areas

Domain 2: Targeted High-Risk or High-Cost Populations

Projects

- Improved Perinatal Care (required for DPHs)
- Care Transitions: Integration of Post-Acute Care (required for DPHs)
- Complex Care Management for High Risk Medical Populations (Required for DPHs)
- Integrated Health Home for Foster Children
- Transition to Integrated Care: Post Incarceration
- Chronic Non-Malignant Pain Management
- Comprehensive Advanced Illness Planning and Care



PRIME: Domain Areas

Domain 3: Resource Utilization Efficiency

Domain Goals

- Decrease unwarranted variation in the use of evidence-based, diagnostics and treatments
- Avoid overuse and misuse
- Eliminate the use of ineffective or harmful targeted clinical services



PRIME: Domain Areas

Domain 3: Resource Utilization Efficiency

Projects

- Antibiotic Stewardship
- Resource Stewardship: High Cost Imaging
- Resource Stewardship: Therapies Involving High Cost Pharmaceuticals
- Resource Stewardship: Blood Products



PRIME: APM Requirements

A goal of the waiver is to move participating DPH PRIME providers toward a value-based payment structure when receiving payments for managed care beneficiaries.

The waiver establishes DPH APM targets in the aggregate that, if not met, result in financial penalties.

These target percentages are based on the number of Medi-Cal managed care beneficiaries assigned to DPHs where all of, or a portion of, their care is paid for under a contracted APM:

- 50% by January 2018 (DY 13)
- 55% by January 2019 (DY 14)
- 60% by end of waiver (DY 15)

5% of DPH PRIME funding at risk in DY14 and DY15 is tied to the achievement of the APM targets.



APM Payment Types

Four ways for payments to be counted towards APM threshold

- 1) Partial Capitation: Primary care only
- 2) Partial-plus Capitation: Primary care and some specialty care (varies)
- 3) Global Capitation: Primary, specialty, ancillary and/or hospital care
- 4) Additional payment methodologies approved by the State and CMS (set forth in Attachment R)



APM Methodology

of unique MCP beneficiaries who choose/are assigned to all PRIME DPHs where MCP-DPH contract requires portion of payment from the MCP to the DPH system is in one of the four accepted APM forms



of unique MCP beneficiaries who choose/are assigned to all PRIME DPH systems in aggregate for the applicable demonstration year



APM % for the DY



Global Payment Program



GPP: Key Goals

Improve health of the remaining uninsured through coordination of care

Integrate and reform Medicaid DSH and Safety Net Care Pool funding

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

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

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



GPP: Methodology

Establish statewide pool of funding for the remaining uninsured by combining federal DSH funding for Designated Public Hospitals (DPHs) and some level of federal SNCP funding based on final years of current Waiver

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



GPP: Methodology

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

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

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



GPP: Service Valuation

Services would be grouped into major categories for purposes of reporting

- Traditional provider-based, face-to-face outpatient encounters (Traditional OP)
- Other non-traditional provider, groups, prevention/wellness, face-to-face (Other OP)
- Technology-based outpatient (Tech OP)
- Inpatient facility (IP)

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

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



GPP: Service Valuation

Point valuation would allow for the continuation of traditional services as they exist today, but encourage more appropriate and innovative care

Point values would also be developed for those innovative or alternative 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 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 mitigate future costs;
- Preventive services;
- Likelihood of bringing a patient into an organized system of care;
- Additional criteria, to be designed by the State



GPP: Service Thresholds

The threshold amounts for each PHCS will initially be constructed using the volume and cost of services occurring in participating providers and will use the most recent complete state fiscal year data.

Point values for each service will be consistent across all providers.

The threshold amounts will be determined in accordance with the methodology in a forthcoming attachment, which takes into account the following requirements and factors:

- Historic point values for each service category on a per unit of service basis across all Public Health Care Systems;
- Base SFY utilization for each Public Health Care System; and
- Adjustments to account for changes in uninsured service needs since Base SFY, including the coverage expansions resulting from ACA implementation.
- Thresholds for GPP PY2-PY5 will decline in proportion to reductions in annual limits.



Dental Transformation Initiative

Dental Transformation Initiative: Purpose and Goals



Program Purpose

- Improve the dental health of children to achieve overall better health outcomes
- Focus on high-quality care and improving access to dental care for Medi-Cal children
- Utilize performance measures to drive dental delivery system reform
- Develop dental health homes
- Prevent and mitigate oral disease through the delivery of preventive services in lieu of more invasive and costly procedures

Program Goals

- Increase the utilization of preventive dental and oral health services among children
- Expand prevention and risk assessment model to prevent and treat early childhood caries
- Increase dental continuity of care for children



Dental Transformation Initiative: Structure and Requirements

Program Structure

- **Core Components**
 - Promotes overall utilization of preventive services and oral health disease management
 - Providers may qualify for each provider incentive program (3 domains) simultaneously
- **Required Project Metrics**
 - Baseline data and active data tracking of preventive and restorative services provided
 - Tracking effectiveness of caries management based on positive changes relative to the beneficiary “risk” level
 - Baseline data and active monitoring of participating dental providers
 - 90 days continuous eligibility as parameters for beneficiaries ages 20 and under
- **Incentive Payments**
 - Total of \$750 million in total funds over 5-year period with \$10 million in total funds contingent on achieving statewide metrics



Dental Transformation Initiative: Domain Areas

Domain 1: Increase Preventive Services Utilization for Children

Domain 2: Caries Risk Assessment and Disease Management

Domain 3: Increase Continuity of Care

Domain 4: Local Dental Pilot Programs (LDPPs)



Dental Transformation Initiative: Domain Areas, Benchmarking, and Criteria

Domain 1: Increase Preventive Service Utilization for Children

Domain Goal

- Increase statewide proportion of children ages 20 and under enrolled in Medi-Cal who receive a preventive dental service by 10 percentage points over a five-year period.

Metric Benchmarking

- Performance targets will be set based on the most recent completed year preceding implementation of the waiver.
- Incentive payments will be made annually to providers for utilization and provider participation and will be used to determine the subsequent year's threshold.



Dental Transformation Initiative: Domain Areas, Benchmarking, and Criteria

Domain 1: Increase Preventive Service Utilization for Children

Criteria

- Semi-annual incentive payments will be made to dental provider service locations that provide preventative services to an increased number of Medi-Cal children, as compared to the department determined baseline.
- Incentive payments will be made to the service office locations for rendered preventive services once they have met the Department established goal.



Dental Transformation Initiative: Domain Areas, Benchmarking, and Criteria

Domain 2: Caries Risk Assessment and Disease Management

Domain Goal

- Diagnose early childhood caries by utilizing Caries Risk Assessments (CRA) to treat it as a chronic disease.
- Introduce a model that proactively prevents and mitigates oral disease through the delivery of preventative services in lieu of more invasive and costly procedures (restorative services).
- Identify the effectiveness of CRA and treatment plans for children ages 6 and under.
 - Treatment plans are prescribed based on caries risk level and include: CRA (globally includes motivational interviewing, nutritional counseling, and use of antimicrobials), topical fluoride varnish application, toothbrush prophylaxis, and exams.



Dental Transformation Initiative: Domain Areas, Benchmarking, and Criteria

Metric Benchmarking

- Baseline year will consist of statewide data for the most recent state fiscal year preceding implementation of the domain.
- DHCS will track and report the following measures:
 1. Number of, and percentage change in, restorative services;
 2. Number of, and percentage change in, preventive dental services;
 3. Utilization of CRA CDT codes and reduction of caries risk levels (not available in the baseline year prior to the Waiver implementation);
 4. Change in use of emergency rooms for dental related reasons among the targeted children for this domain; and
 5. Change in number and proportion of children receiving dental surgery under general anesthesia.



Dental Transformation Initiative: Domain Areas, Benchmarking, and Criteria

Criteria

- Dentists must opt-in by completing a Department recognized training program.
- Treatment plans and associated procedures will be carried out as follows, over a 12 month period:
 - “high risk” children will be authorized to visit 4 times
 - “moderate risk” children will be authorized to visit 3 times
 - “low risk” children will be authorized to visit 2 times
- Incentive payments will be made to providers for successful completion of caries treatment plan and improvement in “elevated risk” levels.



Dental Transformation Initiative: Domain Areas, Benchmarking, and Criteria

Domain 3: Increase Continuity of Care

Domain Goal

- Increase continuity of care for beneficiaries ages 20 and under for 2, 3, 4, 5, and 6 continuous periods.

Metric Benchmarking

- Baseline year will be based on data from the most recent complete state fiscal year.
- Claims data will determine number of beneficiaries who received an examination each year from the same service office location for 2, 3, 4, 5, and 6 year continuous periods.



Dental Transformation Initiative: Domain Areas, Benchmarking, and Criteria

Criteria

- Incentive payments will be available to service office locations that provide examinations to an enrolled Medi-Cal child for 2, 3, 4, 5, and 6 continuous periods.
- The incentive payment will be an annual flat payment for providing continuity of care to the beneficiary.

Dental Transformation Initiative

Optional Project



Domain 4: Local Dental Pilot Programs (LDPPs)

Project Goal

- LDPPS will address 1 or more of the 3 domains through alternative programs, potentially using strategies focused on rural areas including local case management initiatives and education partnerships
 - DHCS will solicit proposals once at the beginning of the demonstration and shall review, approve, and make payments for LDPPs in accordance with the requirements stipulated in the Medi-Cal 2020 Waiver
 - A maximum of 15 LDPPs shall be approved

Metric Benchmarking

- LDPPs will be evaluated consistent with the performance metric of the aforementioned dental domains and the goals outlined in the individual proposals

Dental Transformation Initiative Optional Project



Criteria

- The specific strategies, target populations, payment methodologies, and participating entities shall be proposed by the entity submitting the application for participation and included in the submission to the Department.
 - DHCS shall approve only those applications that meet the requirements to further the goals of 1 or more of the 3 dental domains.
- Each pilot application shall designate a responsible county, Tribe, Indian Health Program, UC or CSU campus as the entity that will coordinate the pilot.



Whole Person Care



Whole Person Care Pilots

Program Goal

- The overarching goal of the Whole Person Care (WPC) Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources.

Program Overview

- WPC pilots will provide an option to participating entities to receive support to integrate care for beneficiaries who are high-risk and high-utilizers of multiple systems and continue to have poor health outcomes.
- Allows a county, a city and county, a health or hospital authority, or a consortium of any of the above entities serving a county or region consisting of more than one county, or a health authority, to receive support to integrate care for a high-risk population.
- Pilots will include collaboration between two or more public entities (e.g. county mental health plans and local housing authorities), at least one managed care health plan (MCP), and other community entities. Pilots must provide a source of non-federal share to support the project.
- Through collaborative leadership and systematic coordination among public and private entities, Pilot sites will identify target populations, share data between systems, coordinate their care in real time, and evaluate individual and population progress.



Whole Person Care Pilots

Program Strategies

- Increase integration among county agencies, health plans, providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries and develop an infrastructure that will ensure local collaboration among the entities participating in the WPC Pilots over the long term;
- Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries;
- Reduce inappropriate emergency and inpatient utilization;
- Improve data collection and sharing amongst local entities to support ongoing case management, monitoring, and strategic program improvements in a sustainable fashion;
- Achieve targeted quality and administrative improvement benchmarks;
- Increase access to housing and supportive services (optional); and
- Improve health outcomes for the WPC population.



Whole Person Care Pilots

Program Target Populations, include but are not limited to individuals:

- with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement;
- with two or more chronic conditions;
- with mental health and/or substance use disorders;
- who are currently experiencing homelessness; and/or
- individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (e.g. hospital, skilled nursing facility, rehabilitation facility, jail/prison, etc.)



Whole Person Care: Housing & Supportive Services

Housing & Supportive Service Interventions

- To test interventions that achieve these improved health outcomes and cost savings, WPC Pilots may focus on Medical beneficiaries with a demonstrated medical need for housing and supportive services. These Pilots would ensure that the entities collaborating and participating in the Pilot would include local housing authorities, community based organizations, and others serving the homeless population.
- WPC Pilots with a focus on housing may include interventions such as tenancy-based care management services and county housing pools.



Whole Person Care: Housing & Supportive Services

Tenancy-based care management services

- Tenancy-based care management services may include:
 - individual housing transition services, such as individual outreach and assessments;
 - individual housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching; and
 - housing-related collaborative activities, such as services that support collaborative efforts across public agencies and the private sector that assist WPC entities in identifying and securing housing for the pilot population.



Whole Person Care: Housing & Supportive Services

County Housing Pools

- In order to improve access to housing and reduce churn in the Medicaid population, MCPs and other WPC Pilot entities may include contributions to a county-wide housing pool that will directly provide needed support for medically necessary services.
- These services may include services such as 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; and leverage local resources to increase access to subsidized housing units.
- The Pool may also incorporate a sustainable financing component to reinvest a portion of the savings from the reduced utilization of health care services into the Pool.



Whole Person Care Pilots

Application Process

- By April 1, 2016, or within 90 days following CMS approval of WPC Pilot attachments, whichever is later, DHCS will publish an WPC Pilot application process, detailed timelines, and selection criteria.
- Lead Entities shall submit WPC Pilot applications to DHCS by May 15, 2016, or 45 days after DHCS issues the WPC Pilot application process, whichever is later.
 - Additional funds for existing WPC Pilots or applications for new WPC Pilots may be accepted by the state after the initial application period if additional funds are available.
- DHCS shall review each application to verify that it conforms to the relevant requirements.
 - Within 60 days after submission of the application, DHCS will complete its review of the application, and will respond to the WPC Pilot Lead Entity in writing with any questions, concerns or problems identified.
 - Within 30 days after submission of final responses to questions about the application, DHCS will take action on the application and promptly notify the applicant and CMS of that decision.



Whole Person Care Pilots

Financing

- Up to \$300M in federal funding available annually
- No single WPC pilot will be awarded more than 30% of total available funding unless additional funds are available after all initial awards are made
- Applications will specify requested funding amount and activities/interventions to be performed to receive the funding
- Semi-annual reporting of activities/interventions
- Non-federal share provided by WPC pilots via IGT
- WPC program years (PY) are based on calendar year (e.g. PY 1 is January 1, 2016 – December 31, 2016)



Designated State Health Programs



Designated State Health Programs

DSHP funds will be used to fund Dental Transformation Initiative

FFP claiming not to exceed \$375 million over 5 years

- California Children Services (CCS)
- Genetically Handicapped Persons Program (GHPP)
- Medically Indigent Adult Long Term Care (MIALTC)
- Breast & Cervical Cancer Treatment Program (BCCTP)
- AIDS Drug Assistance Program (ADAP)
- Department of Developmental Services (DDS)
- Prostate Cancer Treatment Program (PCTP)
- Song Brown Health Care Workforce Training Program
- Steven M. Thompson Physician Corp Loan Repayment Program
- Mental Health Loan Assumption Program



Budget Neutrality



Budget Neutrality

- Federal expenditures with Medi-Cal 2020 must be at or below what they would be without the waiver
- State must measure hypothetical “without waiver” (WOW) expenditures against “with waiver” (WW) expenditures
- Difference between WOW and WW expenditures is “savings” or budget neutrality “room”



Bridge to Reform Budget Neutrality

WOW Expenditures

- Limit A
 - Population Expenditures, grouped by Medicaid Eligibility Group (MEG)
 - MEGs included: Families, SPDs, Duals, Duals Demonstration (CMC)
 - Hypothetical fee-for-service population expenditures
 - Trended using historical data
- Limit B
 - DPH UPL
- Limit C
 - DSH

WW Expenditures

- Actual Population Expenditures
- Predetermined amount of DPH hospital payments
- Waiver program expenditures
- Non-Waiver DSH expenditures



Medi-Cal 2020 Budget Neutrality

Same basis as BTR budget neutrality, with a few key changes noted below

Reduce savings for MEGs that have been in managed care for a significant amount of time

- Historically managed care MEGs (Family excluding rural expansion, Duals) – Reduce savings derived by 77%
- All other MEGs: After a population has been moved into managed care for 5 years, reduce savings derived by 10% each year until reaching the 77% reduction

All MEGs: Use President's Budget trend rates instead of state historical trend rates

Static Limit B for designated public hospitals UPL at DY 10 level (No trend)

Add "Limit C" to budget neutrality

Medi-Cal 2020 Budget Neutrality



BUDGET NEUTRALITY	MEDI-CAL 2020 WAIVER					
	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	
	DY11	DY12	DY13	DY14	DY15	5 Year Total
WITHOUT WAIVER						
Projected WOW Population Expenditures (Limit A)	28,462,532,805	29,865,687,048	31,340,432,455	32,890,041,021	34,518,587,055	157,077,280,384
DPH Hospital UPL (Limit B)	3,504,932,961	3,504,932,961	3,504,932,961	3,504,932,961	3,504,932,961	17,524,664,805
DSH (Limit C)	2,423,161,227	2,471,624,452	2,125,503,107	1,977,980,939	1,831,576,406	10,829,846,131
WITH WAIVER						
Projected WW Population Expenditures	23,620,210,801	24,893,145,933	26,235,791,129	27,652,075,573	29,146,160,972	131,547,384,408
DPH Hospital Payments	2,641,878,893	2,641,878,893	2,641,878,893	2,641,878,893	2,641,878,893	13,209,394,463
INITIAL BUDGET NEUTRALITY ROOM						
Population Expenditures Savings Available (after savings %)	2,258,173,465	2,251,732,493	2,240,437,883	2,089,771,698	1,922,781,679	10,762,897,218
DPH UPL Savings	863,054,068	863,054,068	863,054,068	863,054,068	863,054,068	4,315,270,342
DSH	2,423,161,227	2,471,624,452	2,125,503,107	1,977,980,939	1,831,576,406	10,829,846,131
Total	5,544,388,761	5,586,411,013	5,228,995,058	4,930,806,706	4,617,412,154	25,908,013,691
WAIVER EXPENDITURES						
PRIME	1,600,000,000	1,600,000,000	1,600,000,000	1,440,000,000	1,224,000,000	7,464,000,000
GPP	2,895,161,227	2,943,624,452	2,515,503,107	2,337,980,939	2,151,576,406	12,843,846,131
<i>DSH Component</i>	2,423,161,227	2,471,624,452	2,125,503,107	1,977,980,939	1,831,576,406	10,829,846,131
<i>SNCP Component (placeholder for DY12-15)</i>	472,000,000	472,000,000	390,000,000	360,000,000	320,000,000	2,014,000,000
DTI	150,000,000	150,000,000	150,000,000	150,000,000	150,000,000	750,000,000
WPC	600,000,000	600,000,000	600,000,000	600,000,000	600,000,000	3,000,000,000
DSHP	150,000,000	150,000,000	150,000,000	150,000,000	150,000,000	750,000,000
IHS Uncompensated Care	1,550,000	1,550,000	1,550,000	1,550,000	1,550,000	7,750,000
Total Waiver Expenditures	5,396,711,227	5,445,174,452	5,017,053,107	4,679,530,939	4,277,126,406	24,815,596,131
BUDGET NEUTRALITY MARGIN						
Annual Budget Neutrality Margin	147,677,533	141,236,561	211,941,951	251,275,767	340,285,748	1,092,417,560
Cumulative Budget Neutrality Margin	147,677,533	288,914,094	500,856,045	752,131,812	1,092,417,560	1,092,417,560



Assessments & Evaluations



Assessments and Evaluations

The Waiver also contains several independent analyses of the Medi-Cal program and evaluations of the Waiver programs:

- Medi-Cal Managed Care Access Assessment
- Uncompensated Care Assessments for California hospitals
 - 2016 Assessment
 - 2017 Assessment
- GPP Evaluations
- PRIME Evaluation

Managed Care Access Assessment



EQRO will produce and publish an Access assessment report that includes a comparison of health plan network adequacy compliance across different lines of business

One-time assessment will evaluate primary, core specialty, and facility access to care for managed care beneficiaries based on Knox-Keene and MMC contracts

Report will provide recommendations in response to any systemic network adequacy issues

Report will describe the State's current compliance with the Medicaid Managed Care proposed rules (42 CFR 438)

CMS will approve the Access assessment design

Advisory Committee will be established to provide input on the structure of the Access assessment

- To include consumer advocacy organizations, providers/provider associations, health plans/health plan associations, and legislative staff



Access Assessment Components

Measure health plan compliance in network adequacy requirements

- Will consider State Fair Hearing and IMR decisions, grievances and appeals/complaints data
- Across entire health plan network
- Including applicable network adequacy requirements of the proposed or final NPRM
- Within DHCS/MCP contract service areas, accounting for
 - Geographic differences, previously approved alternate network access standards, access to in-network providers and out-of-network providers, network of providers available to beneficiaries at the State contractor plan level, and other modalities used for assessing care

Measure health plan compliance in timely access requirements

Review encounter data including a review of data from sub-capitated plans



Uncompensated Care Assessments

Both reports to include:

- Total hospital revenue for all payors
- Total Medicaid revenue (including patient care revenue and all other Medicaid revenue such as demonstration revenue and incentive payments)
- Total Medicaid patient care revenue
- Total safety net care pool revenue

First Independent Report (due May 15, 2016)

- Focus on Designated Public Hospitals
- To determine the appropriate level of Uncompensated Care Pool funding at those providers in years two through five of the demonstration.
- Will review the impact of the uncompensated care pool on those providers who participate in the UC pool with respect to:
 - Uncompensated care provided
 - Medicaid provider payment rates
 - Medicaid beneficiary access
 - Role of managed care plans in managing care .
- CMS will provide a formal determination of the funding levels for demonstration years two through five within 60 days of receipt of the complete report



Uncompensated Care Assessments

Second Independent Report (due June 1, 2017)

- Includes main elements of first report, but focus on uncompensated care, provider payments and financing across all hospital providers that serve Medicaid beneficiaries
- Will examine:
 - The role of the PRIME program for designated public hospital systems
 - The current Medicaid hospital payment and financing system, with a major focus on services currently supported with pool funds, financing of providers that play a significant role in serving the Medicaid population and the low income uninsured, and pool funds that are needed to cover uncompensated care
 - How uncompensated care has changed since implementation of the ACA expansion



GPP Evaluations

Two evaluations of provider expenditures and activities under GPP methodology

Not intended to be the basis of funding changes to Uncompensated Care Pool

Both evaluations will:

- Monitor the implementation and impact of the demonstration to inform how improvements to the GPP can be made following the expiration of the Demonstration
- Examine the purpose and aggregate impact of the GPP, care provided by PHCS and patients' experience, with a focus on understanding the benefits and challenges of this innovative payment approach.
- Include narrative hospital self-assessments of the successes and challenges of the GPP
- Assess each individual PHCS':
 - Number of uninsured individuals served
 - Number and types of services provided
 - Expenditures associated with the services provided
 - Expenditures that were avoided or reduced due to the Global Payment Program
 - Effects of the GPP on care delivery and costs



GPP Evaluations

First evaluation

- At the midpoint of the demonstration

Second evaluation

- As part of the interim evaluation report due at the end of GPP PY 4
- Evaluation will also examine factors to evaluate the objectives of the GPP program:
 - Care in more appropriate settings, to ensure that patients are seen in the right place and given the right care at the right time
 - Changes in resource allocation
 - Improvements in workforce involvement and care team transformation under the demonstration



PRIME Evaluation

CMS-approved evaluation design with public engagement

Evaluation Design - Core Components

- Specific aims and hypotheses
 - Specific research questions and testable hypotheses that address the goals of the demonstration
- Safety net system transformation at the system and state level
- Accountability for, and improvements in, health outcomes and other health measures at the system and state level
- Efforts to ensure sustainability of transformation of/in the managed care environment
- Performance Measures
 - Identifying quantitative/qualitative process and outcome measures to adequately assess effectiveness of program
- Description of data collection and sources
- Assurances needed to obtain data
- Method of data analysis
- Timeline for evaluation related metrics



PRIME Evaluation Reports

Interim Evaluation Report (due after DY 14)

Summative Evaluation Report (due after DY 15)

- Study design
- Findings and conclusions
- Policy implications
- Interactions with other State initiatives



Continuing Authorities

Medi-Cal Managed
Care

Community-Based
Adult Services
(CBAS) program

Coordinated Care
Initiative (CCI),
including
CalMediConnect

Drug Medi-Cal
Organized Delivery
System

Uncompensated
Care for Indian
Health Service (IHS)
and tribal facilities

Low Income
Pregnant Women,
109%-138% FPL

Medi-Cal 2020 Waiver Authorities: http://www.dhcs.ca.gov/provgovpart/Documents/CA_waiver_list_FINAL_12.30.15.pdf

Medi-Cal 2020 Expenditure Authorities: http://www.dhcs.ca.gov/provgovpart/Documents/CA_FinalExp_Auth_123015.pdf



Comments/Questions

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

