



# **1115 Waiver Renewal Update DHCS Stakeholder Advisory Committee**

February 11, 2015



# Agenda

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California 1115 Waiver Renewal – Overall Context & Framework

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Vision and Goals for Medi-Cal 2020

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**Core Strategy** 1: Shared Savings Proposal

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**Core Strategy** 2: Delivery System Transformation & Alignment Incentive Programs

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**Core Strategy** 3: Payment and Delivery System Alignment for Public Safety Net Systems

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Budget Neutrality

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Stakeholder Workgroup Process

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Process with CMS & Next Steps

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# Overall Context & Framework

California's 2010 Waiver was critical to successful implementation of ACA

This Waiver renewal is critical to ongoing success, viability, and long-term sustainable change of the Medi-Cal Program

## *CRITICAL COMPONENTS FOR CALIFORNIA*

### Strategies

- Delivery System Transformation & Alignment Incentive Programs
- Payment and Delivery System Alignment for Public Safety Net Systems for the Remaining Uninsured

### Financing

- Federal/State Partnership on Shared Savings
- Budget Neutrality
- Continued Federal Funding Support



# “Bridge to Reform” Waiver 2010 – 2015 Achievements

The Bridge to Reform Demonstration has been successful.

## Key Achievements

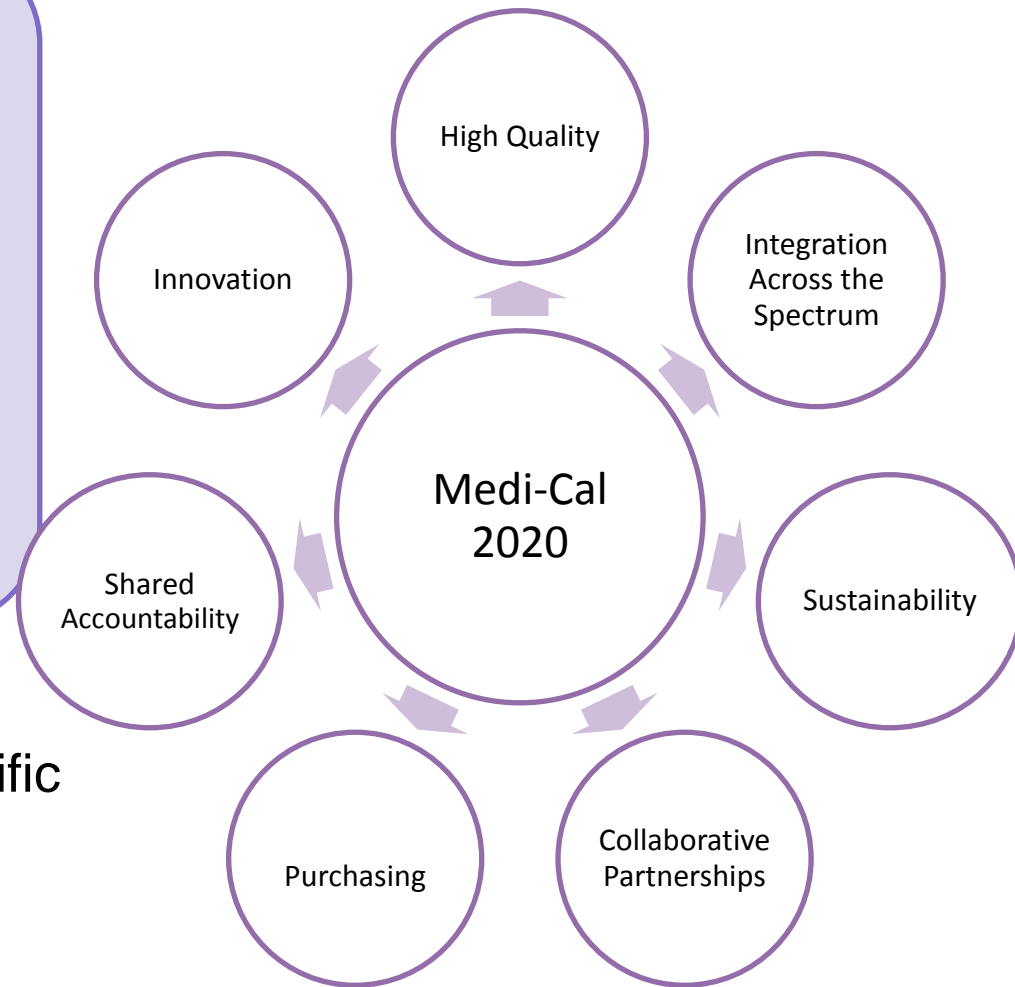
- Cut the uninsured rate in California by **50%** (*29% increase in Medi-Cal enrollment due to expansion – More than 12 million Californians enrolled in Medi-Cal today, about 1/3 of the entire state*).
- Led the nation in implementation of DSRIP; 21 public safety net systems participating
- Completed full implementation of managed care delivery system
- Promoted long-term, efficient, and effective use of state, local and federal funds
- Advanced utilization of home and community-based care
- Sustained the critical role of the safety net



# Medi-Cal 2020: Vision and Goals

## Vision for 2020

- Continue to build capacity in ways that better coordinate care and align incentives around Medi-Cal beneficiaries to improve health outcomes, while also containing health care costs.
- Bring together state and federal partners, plans and providers, and safety net programs to share accountability for beneficiaries' health outcomes.



Committed to demonstration of specific achievable metrics:

- Statewide
- Regional
- Plans
- Provider Systems



# Core Strategies

**Core Strategy 1:** \$15 - \$20 billion Federal investment in the Waiver's comprehensive approach to delivery system alignment and innovation

**Core Strategy 2:** Advance quality improvement and improved outcomes through expanded Delivery System Transformation & Alignment Incentive Programs

- DSRIP 2.0 targeted at public safety net systems
- Regional Incentives among MCOs, County Behavioral Health Systems, Providers
- Fee-for-service quality improvement incentives
- Workforce development initiatives
- Access to housing & supportive services
- Whole-Person Care Pilots

**Core Strategy 3:** Transform California's public safety net for the remaining uninsured by unifying DSH and Safety Net Care Pool funding streams into a county-specific global payment system



# Core Strategy 1: Federal-State Shared Savings

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Under the Waiver, a per-beneficiary-per-month cost amount would be established based on predicted costs for those beneficiaries absent the waiver (total funds)

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The state would retain a portion of federal funds for the difference between actual expenditures and pre-established per beneficiary amounts

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The savings serve as key reinvestment funding that will allow CA to implement many of the other waiver initiatives that will drive this savings as well as quality improvement

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Concept is not a per-capita cap that limits entitlement spending; any excess spending over the anticipated per-beneficiary cost would count against budget neutrality margin and reduce Waiver expenditures



# Core Strategy 2: Delivery System Transformation & Alignment Incentive Programs

Building upon successes under Bridge to Reform and broad innovation in healthcare, reinvent approaches to care delivery and purchasing that will improve health of Medi-Cal beneficiaries

Ability to target populations in need of specific focus or services

Establish statewide, regional, or provider level metrics working towards improvements in health equity, integration, and reducing total cost of care

1. Public Hospital Safety Net Systems Improvement through DSRIP 2.0
2. Regional Incentives among MCOs, County Behavioral Health Systems, Providers
3. Fee for service quality improvement incentives
4. Workforce Development initiatives
5. Access to Housing and Supportive Services
6. Whole Person Care Pilots



# DSRIP 2.0



Expand and build on lessons learned from 2010 DSRIP and other states' DSRIPs

Focused on public safety net systems (both existing participants in DSRIP and the addition of over 40 generally smaller, often rural, public safety net systems)

Focused more on outcomes and standardized projects and metrics

## Five core domains:

- **Delivery System Transformation** – focused on redesigning ambulatory care, improving care transitions, and the integration of behavioral health and primary care
- **Care Coordination for High Risk/High Utilizing Populations** – focused on care management, health homes, and palliative care
- **Resource Utilization Efficiency** – focused on appropriate use of antibiotics, high cost imaging and pharmaceuticals
- **Prevention** – focused on core areas such as cardiac health, cancer, and perinatal care
- **Patient Safety** – focused on improving performance on metrics related to potentially preventable events and reducing inappropriate surgical procedures

# Regional Incentives among MCOs, County Behavioral Health Systems, Providers



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Focus on coordinated care across physical health, mental health, substance abuse disorder services, and long term care; improve quality and value within the delivery system

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Incentive arrangements would require Medi-Cal managed care plans, county behavioral health systems, and providers to work together to achieve specific metrics

# Regional Incentives among MCOs, County Behavioral Health Systems, Providers (cont'd)



## Strategy 1: Shared Savings & Flexibilities:

- 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, transition away from eligibility group-specific cost-based ratesetting to a blended value-based model
- Identify specific expenditure categories of plan rate (e.g.: inpatient expenditures) that would be available for shared savings within and beyond the standard rate development process.
- Rebased on these categories would not be based on actual utilization trend rates but rather, one that falls between the predicted trend and a lower trend that is indicative of health plan efficiencies and resource stewardship
- Shared savings and distribution linked to meeting quality targets for performance and reduction in total cost of care (adjusted for geography and risk)

# Regional Incentives among MCOs, County Behavioral Health Systems, Providers (cont'd)



## Strategy 2: Pay-for-Performance for Provider organizations:

- P4P programs for Managed Care Plans with standardized core design elements, with flexibility for tailoring to local area or provider sophistication
- Standardized core elements include: quality measures, health equity, patient satisfaction and resource use measures that all plans must adopt as well as an optional set of measures from which plans can choose
- Alignment with State and Managed Care Quality Strategy, the Triple Aim and broad Waiver metrics for Delivery System Transformation and Alignment Incentive Programs
- DHCS chart on potential target areas for health plans (“Three Linked Goals”):  
[http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MCO3\\_DHCS2.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MCO3_DHCS2.pdf)

# Regional Incentives among MCOs, County Behavioral Health Systems, Providers (cont'd)



## Strategy 3a: Integrated Physical Health and Behavioral Health:

- ***Plan/County Coordination Model:*** Enhance behavioral health integration achievements under Bridge to Reform to coordinate full spectrum of care for beneficiaries with behavioral health conditions
- Reduce total cost of care across physical health and behavioral health systems through value-based purchasing strategies at the health plan, county behavioral health systems and provider level
  - Incentive program design starts as incentive payments under which a formal agreement between entities would exist to share in incentive payments for achievement of joint performance/total cost of care targets
  - Over time, the structure could transition into a shared savings arrangement
- Build upon strategies in Cal Medi Connect

# Regional Incentives among MCOs, County Behavioral Health Systems, Providers (cont'd)



## Strategy 3b: Integrated Physical Health and Behavioral Health:

- ***Provider Integration Model:*** Team-based integrated care model with tiered care coordination services for mild/moderate/severe mental health needs
- Care coordination or co-location approach
- Incentive design could include:
  - 1. Supplemental payments for care coordination tiered based on acuity
  - 2. P4P payments for achievement of quality, integration, and health equity goals
  - 3. Shared savings structure that incentivizes use of an integrated care model
- Could be complemented by a health home program



# FFS Quality Improvement Incentives

## Hospital Incentives for Maternity Care Improvement

- Medi-Cal pays for approximately 50% of all deliveries in CA. Over 60% of those deliveries occur through the Medi-Cal fee-for-service system
- Opportunity to influence quality and cost drivers
- Fee-for-service incentives to reduce non-medically necessary early elective Caesarians and promote efficient maternal and child health
- Bonus payments to hospitals that meet quality and reporting goals

## FFS Dental Incentives

- Address local needs to expand access to dental services
- Strategies include: teledentistry, incentives to increase provider participation, training, encourage delivery of preventative services



# Workforce Development

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Address need to transform and expand primary care and specialty care access to serve the Medi-Cal population, given increased competition for providers post-ACA

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Expand existing providers' ability to deliver quality care to additional Medi-Cal members and users of CA's safety net

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Attract additional workforce to participate in the Medi-Cal program including new categories of health workers with expertise in physical-behavioral health integration and that have cultural and linguistic skill sets for broad community reach

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Drive value by leveraging non-physician workforce





## Workforce Development (continued)

### Incentive arrangements include:

- **Financial Incentives to Increase Provider Participation:** Incentive payments for newly participating providers or providers expanding the number of Medi-Cal beneficiaries served
- **Pilots for voluntary workforce training programs:** Likely administered through managed care plans for targeted high-need populations (potentially peer providers, IHSS workers, CHWs)
- **Expand use of telehealth:** Incent plans and providers to leverage telehealth strategies to address geographic needs for specialty access
- **Expand residency slots/programs:** Funding for programs at teaching health centers or for new programs in geographic areas and/or specialties of need
- **Cross-training and use of multi-disciplinary care teams:**
  - Incent integrated model for better coordinated physical health, behavioral health, and long term care for high need populations
  - Potential for targeted care options in palliative care
  - Include non-licensed, frontline workforce

# Access to Housing and Supportive Services



Potential target populations: high-utilizers, nursing facility discharges; those experiencing or at risk for homelessness

Provide funding for housing-based care management/tenancy supports (outreach and engagement, housing search assistance, crisis intervention, application assistance for housing and benefits, etc.)

Allow health plans flexibility to provide non-traditional Medicaid services (discharge planning, creating care plan, coordination with primary, behavioral health and social services, etc. )

Allow plan contribution of funding to shared savings pool with county partners that could be used to fund respite care, housing subsidies, additional housing-based case management

Allow for health plans and counties to form regional integrated care partnership pilot programs leveraging the range of existing local, state and federal resources in a targeted approach

# Regional Integrated Whole-Person Care Pilots



An enhanced model of Regional Partnerships requiring proposals for a geographic region, likely a county or group of counties, jointly pursued by the county and applicable Medi-Cal plans for that region

Subject to State and federal approval with potential to test additional flexibilities not currently allowed under Medicaid

Would include: Medi-Cal managed care plans, county entities (e.g. physical health, behavioral health, social services, etc), spectrum of providers (e.g. hospitals, clinics, doctors, other medical/behavioral health providers), non-traditional supportive providers/services, etc.

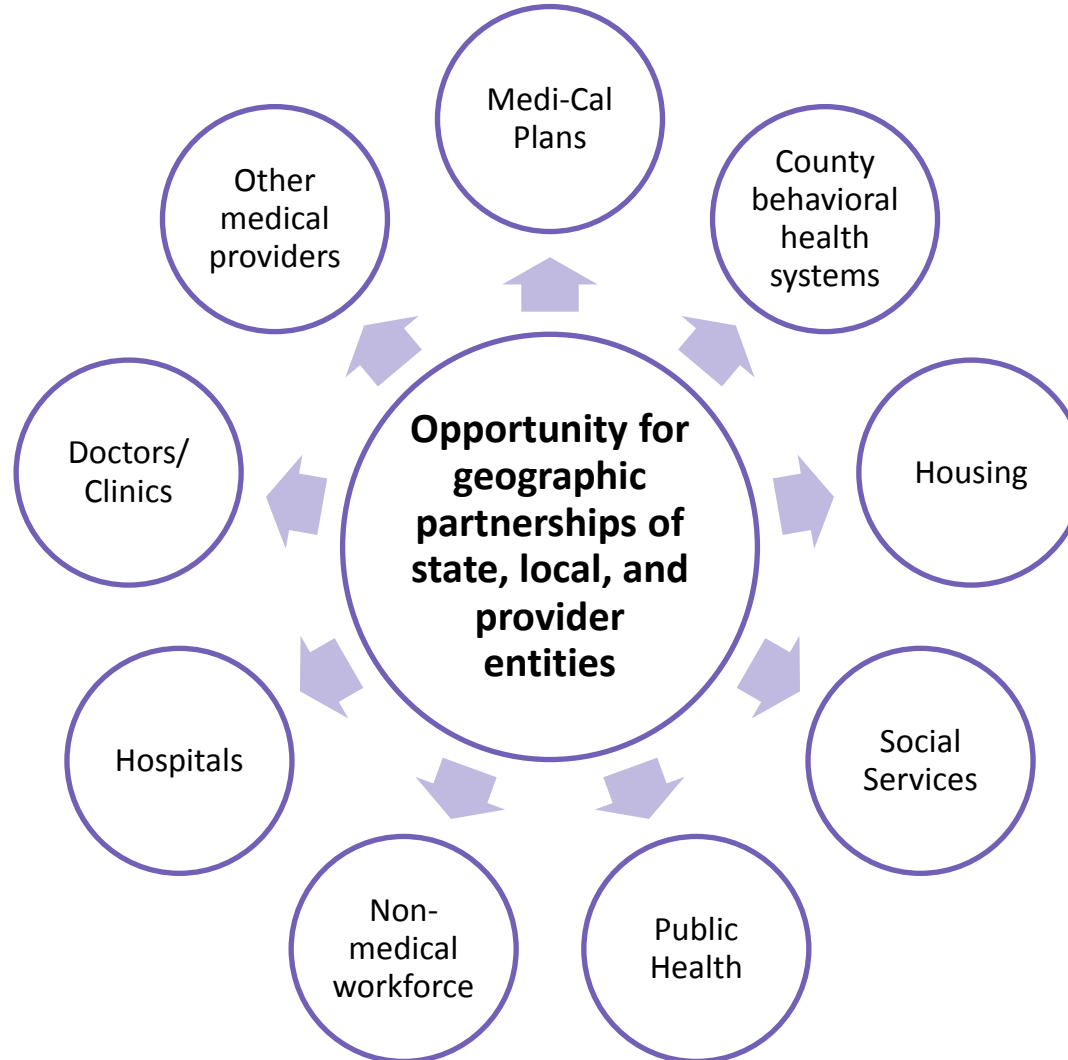
Encourage innovation in delivery and financing strategies to improve health outcomes of target populations

Include approaches across the spectrum of delivery system alignment and transformation (MCO/provider, MCO/county, access to housing and supportive services, workforce development)

Evaluation component will measure health outcomes, impact on total cost of care, scalability, and sustainability beyond Waiver term



# Regional Integrated Whole-Person Care Pilots



# Core Strategy 3: Public Safety Net Payment Reform



Transform the traditional Disproportionate Share Hospital (DSH) and Safety Net Care Pool (SNCP) reimbursement structures away from cost-based systems

Establish county-specific global payments that integrate DSH and SNCP funding and serve as lever for whole-person coordinated care

Public safety net systems would be paid a global budget amount for services provided to the uninsured; systems would be required to meet established service thresholds in order to receive full payment

Includes inpatient facility stays, face-to-face and technology-based outpatient visits, and preventative, case management, and health education services

Service targets would recognize the high-value of activities designed to reduce unnecessary emergency room visits/hospital stays, including non-traditional services

# Public Safety Net Payment Reform (continued)



**Service Categories/Point Valuation:** Items within each of the five categories would be grouped into tiers of similar activity/effort

Point values will be established for each tier within each category

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

Traditional services will also continue to be recognized for their value and importance, including that emergency room visits and inpatient stays are sometimes necessary and appropriate.

Current services will need to be assigned point values in order to establish the baseline threshold point targets



# Public Safety Net Payment Reform (continued)

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**Evaluation/Accountability:** Under this global payment/coordinated care for the uninsured proposal, California is seeking to demonstrate that shifting payment away from cost and toward value can encourage care in more appropriate settings, to ensure that patients are seen in the right place and given the right care at the right time.

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It will be critical to establish clear metrics by which to gauge whether this effort is successful.

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A key component of the program will be an evaluation, which would focus on the relative resource allocation and workforce investments and the extent to which services shift the balance of care.

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In support of this evaluation, in addition to the reporting necessary for claiming the funding, the public hospital systems would report data in two core areas: resource allocation and workforce involvement

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# 1115 Budget Neutrality





# 2010 Budget Neutrality

***As a principle of Budget Neutrality: Spending under the waiver must not exceed what spending would be without a waiver***

## Without Waiver

- Projects Medi-Cal expenditures absent the Waiver.
- In California, the managed care program exists under Waiver authority. Therefore, Budget Neutrality “without waiver” assumes that absent the Waiver, Medi-Cal would operate as a fee-for-service program and assumes continuation of trends from historical (typically 5 years) fee-for-service experience

## With Waiver

- Anticipated expenditures with waiver in effect
- Reconciled during the life of the Waiver to ensure meeting requirements of budget neutrality

## Costs Not Otherwise Matchable (CNOM)

- The difference between “Without Waiver” expenditures and “With Waiver” expenditures generate the budget neutrality “room”, or savings, in total funds (federal funds and state funds)
- Upon CMS approval, these savings can be spent on state programs that would otherwise not be matchable with federal financial participation
- Examples include DSRIP, DSHPs, etc.



# 2015 Budget Neutrality

Generally retain structure and calculations as under the 2010 Waiver, with modifications as noted:

- Trend existing FFS PMPMs based on existing trend factors for MEGs, split by model type (two-plan/GMC, COHS, CCI, non-CCI):
  - Family
  - Seniors & Persons with Disabilities, including partial duals
  - Full scope dual eligibles
- Given experience attained for new adult group, add new MEG for new adults
- Maintain separate limit B for designated public hospitals UPL as in 2010 Waiver
- Add designated public hospital DSH funding into budget neutrality on both sides
- Consider incorporating CBAS into overall PMPMs



# 2015 Budget Neutrality (continued)

- With waiver expenditures funded through budget neutrality margin (CNOM) would include:
  - Funding of global budget amounts related to former SNCP funding
  - Continuation of designated state health programs
  - Delivery system transformation & alignment incentive program funding (DSRIP 2.0; regional incentives; FFS incentives; workforce development incentives; housing/supports)
  - Federal shared savings amounts
  - IHS uncompensated care funding (as today)
- Actual MCO PMPMs used for With Waiver as today
- Estimated CPE FFS payments for designated public hospitals as today



# Stakeholder Workgroup Process Summary



# Stakeholder Engagement & Public Input

Began Public Input/Stakeholder Engagement process in July 2014

- **Waiver concept paper (July 2014):** Web posting and distribution through DHCS list serv
- **Webinar on Waiver Renewal concepts (July 25, 2014):** web posting and distribution through DHCS list serv and tribal list serv. Opportunity for public comment
- Presentation at quarterly **DHCS Stakeholder Advisory Committee meetings (Sept. 11, 2014, December 3, 2014):** web posting of materials. Opportunity for public comment
- **2015-16 Governor's Budget Proposal** (January 9, 2015): web posting
- Ongoing opportunity for public input to dedicated e-mail inbox or by mail
- Continuous posting of public input on DHCS website
- Upcoming public forums on Waiver Renewal:
  - March 2015: webinar on updated Waiver Renewal proposal to be submitted to CMS
  - Budget/legislative hearings



# ***Stakeholder Engagement & Public Input (continued)***

## **Application Development:**

- From November 2014 – February 2015, DHCS convened expert workgroups designed to maximize the discussion and input into the key elements for Waiver Renewal:
  - Housing/Shelter and Supportive services (4 sessions);
  - Managed Care/Provider Incentives (3 sessions)
  - Delivery System Reform Incentive Payments (DSRIP) 2.0 (4 sessions);
  - Workforce Development (3 sessions); and
  - Safety Net Financing (3 sessions)
  - Federal-State shared savings proposal/ Budget Neutrality design (1 session)
- Meetings have been open to the public and include a conference call-in line. Each meeting concludes with dedicated time for public comments and discussion.
- All materials were made available on the DHCS website in advance of each meeting and minutes for each meeting are also posted-  
<http://www.dhcs.ca.gov/provgovpart/Pages/1115-Waiver-Renewal.aspx>
- Stakeholders and public input will inform demonstration evaluation design for each program strategy and impact to beneficiaries



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Consultants: Harbage Consulting, Centers for Health Care Strategies, Corporation for Supportive Housing, Integrated Healthcare Association, University of California, San Francisco

Stakeholder Workgroup participants



# Upcoming CMS Engagement



# CMS Engagement (Feb. – Oct. 2015)



Early agreement on conceptual framework and funding level

Weekly/Bi-weekly staff level workgroups on concepts

Leadership touch points

Collaborative program development and negotiation on Special Terms and Conditions (STCs)

- Program Detail – reporting requirements, protocols, metrics
- Evaluation Design

Start of new Waiver



Questions / Comments:

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[http://www.dhcs.ca.gov/provgovpart/  
Pages/WaiverRenewal.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx)