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The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program: Continuing California's Delivery System Transformation

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The California Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program is a five-year initiative under the Medi-Cal 2020 section 1115 waiver that builds upon the Delivery System Reform Incentive Payment (DSRIP) program established under the Bridge to Reform waiver. The goal of PRIME is to continue significant improvement in the way care is delivered through California's safety net hospital system to maximize health care value and to move toward alternative payment models (APMs), such as capitation and other risk-sharing arrangements.

To implement PRIME, the Department of Health Care Services (DHCS) approved plans submitted by 17 Designated Public Hospitals (DPHs) and 37 District/Municipal Public Hospitals (DMPHs) to become PRIME entities. These PRIME entities may receive up to $3.7 billion in federal Medicaid funding over five years for achieving metrics in implementing clinical projects designed to change the way care is delivered. Like all Medicaid financing arrangements, these funds must be matched with a "state share," in this case, provided by other governmental health entity funds that are transferred to DHCS.

PRIME Facts	
Participating Entities	54 Hospitals/Hospital Systems • 17 Designated Public Hospitals • 37 District/Municipal Public Hospitals
Total Federal Funding Available, (2016-2020)	$3.7 billion
Top 3 Clinical Projects	1. Care Transitions: Integration of Post-Acute Care (30) 2. Complex Case Management for High-Risk Medical Populations (26) 3. Ambulatory Care Redesign: Primary Care (24)

PRIME Goals

The four primary goals of PRIME are to:

1. Increase the PRIME entities' ability to provide patient-centered, data-driven, team-based care to high utilizers and those at risk of becoming high utilizers;

2. Improve the PRIME entities' capacity to provide point-of-care services, complex care management, and population health management by strengthening their data analytic capacity;

3. Improve population health and health outcomes for Medi-Cal beneficiaries, as demonstrated by the achievement of performance goals related to clinical improvements, preventive interventions, and patient experience metrics; and

4. Improve participating PRIME entities' ability to provide high quality care that integrates physical and behavioral health and coordinates care across different settings.

PRIME Funding

The state's share of Medi-Cal funding is furnished by intergovernmental transfers (IGTs) from the DPHs and DMPHs. IGTs are transfers of public funds between government entities for purposes of accessing federal Medicaid matching funds. In this case, PRIME entities – which are funded through sources like county governments, the University of California, or local health care districts – transfer funds to the state to cover the state's share of the PRIME program. The federal government matches these funds and returns them to the state. Figure 1 below shows the total maximum annual state and federal PRIME funding allotment for DPHs and DMPHs.

For the first reporting period of the waiver (Demonstration Year 11, July 1, 2015 – June 30, 2016), DHCS paid out nearly all of the $1.4 billion in PRIME funding that was available to the DPHs, $350 million of which was based on submission of their PRIME five-year implementation plans. The rest of these funds were paid to the DPHs for submitting baseline data. Additionally, DHCS paid out approximately $200 million in PRIME funding to the DMPHs for submitting both their PRIME five-year plans and baseline data and/or for completing process measures related to developing the necessary infrastructure to successfully implement PRIME clinical projects.

For the second and third years of the waiver (Demonstration Years 12 – 13), DPHs may collectively qualify for up to $700 million in federal funds per year and DMPHs are collectively eligible for up to $100 million in federal funds per year if they meet all required quality improvement targets within specified timeframes. In order to receive funding, each PRIME entity must report on progress toward and achievement of the metrics to DHCS. The annual PRIME allotments will decrease in the 4th and 5th years of the waiver (Figure 1).

Figure 1: Total Federal and State PRIME Funding

Demonstration Year**	Annual Funding for DPHs***	Annual Funding for DMPHs***
DY 11 (July 1, 2015 - June 30, 2016)	Up to $1.4 billion	Up to $200 million
DY 12 (July 1, 2016 - June 30, 2017)	Up to $1.4 billion	Up to $200 million
DY 13 (July 1, 2017 - June 30, 2018)	Up to $1.4 billion	Up to $200 million
DY 14 (July 1, 2018 - June 30, 2019)	Up to $1.26 billion	Up to $200 million
DY 15 (July 1, 2019 - June 30, 2020)	Up to $1.071 billion	Up to $200 million

* Note: The following annual allotments represent the maximum amount that will be provided to the hospitals assuming all of the required project metrics are achieved within the specified timeframes.

** Note: The DYs for the PRIME program do not align with the DYs for the overall waiver, which includes a DY 16 that begins on July 1, 2020 and ends on December 31, 2020.

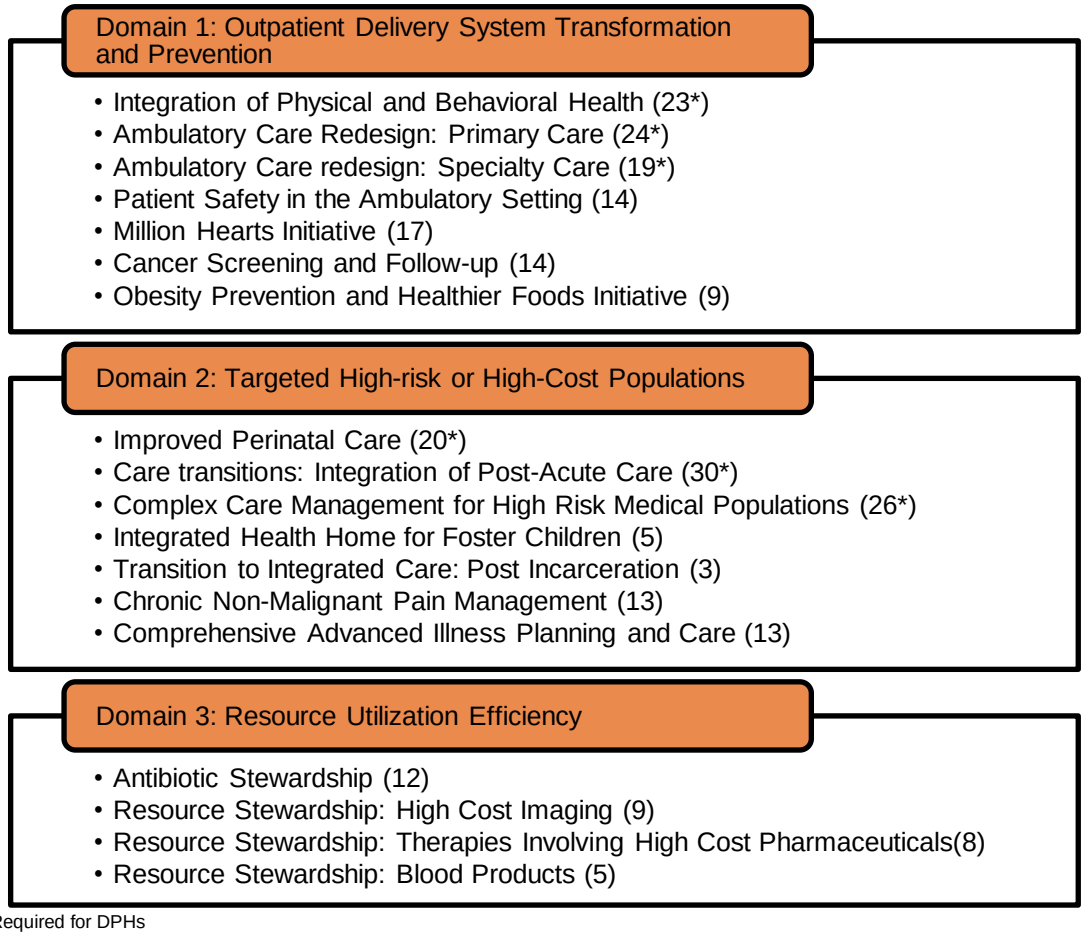
*** 50% of these funds will be provided by the federal government and the remaining 50% will come from the public hospitals themselves via intergovernmental transfers.

PRIME Domains and Clinical Projects

PRIME includes three Domains that consist of 18 clinical project areas that are tied to a required set of reporting and performance metrics. The hospitals' ability to meet the performance metrics will ultimately determine the amount of PRIME funding they will receive.

The DPHs are required to implement a minimum of nine projects including at least four projects from Domain 1, at least four projects from Domain 2, and at least one project from Domain 3. Most DPHs are implementing nine or ten clinical projects, with one doing 13. The DMPHs are only required to implement one project from any of the three Domains. The number of clinical projects the DMPHs are implementing ranges from one to ten, averaging three projects per PRIME entity. Most of the hospitals selected projects that are tied to system-wide issues like improving care transitions, care management for high risk, high needs populations, redesigning ambulatory care approaches, and integration of physical and behavioral health. (Additional details about the projects, required metrics, and funding are available in Attachment Q –"PRIME Projects and Metrics Protocol" and Attachment II – "PRIME Program Funding and Mechanics" of the waiver Special Terms and Conditions.)

Figure 2: PRIME Domains and Projects



* Required for DPHs

( ) Indicates the number of hospitals that selected each project

Below are summaries of the three most commonly selected PRIME clinical projects:

Care Transitions: Integration of Post-Acute Care

All 17 DPHs and 13 DMPHs are implementing this project, which focuses on addressing transitions from inpatient to outpatient care. Integrating post-acute care into the care transition process can help improve patient outcomes and reduce hospital readmissions, which are costly and often preventable. The project objectives are to:

- Improve communication and coordination between inpatient and outpatient care teams;
- Increase patient capacity for self-management;
- Improve patient experience;
- Reduce avoidable acute care utilization; and
- Reduce disparities in health and health care.

Complex Care Management for High-Risk Medical Populations

All 17 DPHs and 9 DMPHs are implementing this project, which aims to improve care for high-risk patients through care management. The project objectives are to:

- Improve patient functional status;
- Increase patient capacity to self-manage their condition;
- Improve medication management and reconciliation;
- Improve health indicators for chronically ill patients including those with mental health and substance use disorders;
- Reduce available acute care utilization; and
- Improve patient experience.

Ambulatory Care Redesign: Primary Care

All 17 DPHs and 7 DMPHs are implementing this project, which aims to address the shortage of primary care providers by creating efficiencies in the system. The project objectives are to:

- Increase the number of primary care practices undergoing Patient Centered Medical Home transformation, most notably implementing team-based care and better utilization of front line workers;
- Increase the provision of recommended preventive health services;
- Improve health indicators for patients with chronic condition(s) (including mental health and substance use disorder conditions);
- Increase patient access to care;
- Decrease preventable acute care utilization;
- Improve patient experience of care;
- Increase staff engagement;
- Improve the completeness, accuracy, and specificity of race, ethnicity, and language, and sexual orientation and gender identity data; and
- Reduce disparities in health and health care.

Moving Toward Value-Based Purchasing

In addition to achieving the milestones for the PRIME project work, the DPHs that are participating in PRIME will be held accountable for their progress in shifting to APM arrangements (including capitation, risk-pool payments, or other risk-sharing arrangements) with Medi-Cal managed care plans (MCPs) in order to ensure sustainability beyond the waiver. Beginning in January 2018, 50 percent of all Medi-Cal managed care beneficiaries assigned by their MCPs to receive care through DPHs will receive all, or a portion of, their care under a contracted APM. Under the waiver, this number must increase by at least five percent each year, with the goal of reaching 60 percent by the end of 2020. The adoption of APMs is intended ensure that public hospitals shift their focus from volume to value-based payments by providing incentives to clinicians and promoting accountability across the health system.

Looking Ahead

The next reporting deadline is March 31, 2017, when PRIME entities will report on data from July 1, 2016 - December 31, 2016 (Figure 3). In DY 12 and beyond, DPHs will only receive the PRIME incentive payments if they achieve project-based metrics. DMPHs, which were not previously included in DSRIP, may use the second year to continue to develop their infrastructures and report baseline data. In DY 12, DMPHs are eligible to receive up to 40 percent of their funding for achieving infrastructure building measures; the remaining 60 percent can only be obtained from by reporting baseline data for project metrics. In DYs 13-15, DMPHs will only receive funding in the form of incentive payments for achieving targets within project metrics.

Figure 3: Reporting Measurement Periods

Demonstration Year	Mid-Year Report Measurement Period	Mid-Year Report	Year-End Report Measurement Period	Year-End Report Due
DY 11	N/A	N/A	July 1, 2015 - June 30, 2016	September 30, 2016
DY 12	January 1, 2016 - December 31, 2016	March 31, 2017	July 1, 2016 - June 30, 2017	September 30, 2017
DY 13	January 1, 2017- December 31, 2017	March 31, 2018	July 1, 2017- June 30, 2018	September 30, 2018
DY 14	January 1 2018 - December 31, 2018	March 31, 2019	July 1, 2018 - June 30, 2019	September 30, 2019
DY 15	January 1, 2019 - December 31, 2019	March 31, 2020	July 1, 2019 - June 30 2020	September 30, 2020

Finally, in 2017, DHCS will formally launch the PRIME Learning Collaborative, designed to be a vehicle for promoting the engagement of all of the PRIME hospital systems. The Learning Collaboratives will feature peer-to-peer learning opportunities and technical assistance from national and state quality improvement experts on a wide range of topics.