Summary of DHCS Waiver Renewal Concepts[1] (March 16, 2015)

The concept paper includes the following: Delivery System Transformation and Global Safety Net Payments for the Remaining Uninsured. Within the Delivery System Transformation are the following six sub-elements: managed care transformation, fee for service transformation, public safety net transformation, workforce development, housing and supportive services, and regional whole person care pilots.

DHCS is seeking $15 to $20 billion over the next 5 years or $3-4 billion a year. It projects that without the waiver it would spend $269 billion over the five years and with the waiver it would reduce spending to $253 billion, thereby saving $16 billion with the waiver. The tables on page 36 of the concept paper show spending per member per month and the growth rates, California's spending rates and amounts with the waiver and spending without the waiver.

Since 80% of the Medi-Cal population (up from 54%) is now in managed care[2] and over 3 million Californians (including all the LIHP {Low Income Health Program} enrollees) are newly enrolled in Medi-Cal (12 million enrollees) and the state's uninsured rate has been cut in half (from 15% to 7%), the starting point for the 2015-2020 waiver renewal is entirely different from the 2010 waiver. The concept paper points out that under the last waiver, public systems expanded primary care, improved care coordination, developed data systems and increased patient safety. The goals in the waiver renewal are: better outcomes and quality, stronger primary care systems, integrated health delivery systems that incent quality improvements and greater cost effectiveness, address social determinants of health and health equity and test innovative approaches.

The proposed new waiver is therefore about improving health outcomes and reducing health costs for Medi-Cal enrollees and aligning the funding for the remaining uninsured in county hospitals so that the delivery system for the remaining uninsured can parallel the structure of the Medi-Cal managed care delivery systems. It proposes a shared savings plan with the federal government such that if California does not generate the savings, the federal government is not on the hook for any increased costs.

Managed care transformation (Section 4.1) includes: extending payment reforms across all the managed care plan networks, aligning incentives between behavioral and physical health, building partnerships between the local MCOs and county behavioral health plans and providers, moving MCO payment rates from cost-based rate setting that are linked to specific eligibility groups towards blended and value-based rates. Reforms include P4P, shared savings, moving from volume to value and

[1] http://www.dhcs.ca.gov/provgovpart/Pages/1115-Waiver-Renewal.aspx
[2] Including SPDs, Healthy Families children, rural Californians, MIAs and portions of the Medi-Medis.

aligning incentives for providers, plans and government. The State would identify those populations or services where it wants the MCOs to show improved outcomes and greater cost effectiveness. Plans that do not meet the minimum quality thresholds would receive no share of the shared savings pool. Plans and the State would share savings if and to the extent the plans meet outcome and quality targets and reduce the total cost of care. All plans would adopt a common set of P4P incentives and measurements; there would be local options for those plans seeking to achieve even better results. For example, the plan could identify a set of non-traditional services that could address one or more of the social determinants of health and if the plan shows improved outcomes and cost savings, it would receive an incentive payment.

The waiver seeks to improve coordination/integration of physical and behavioral health at both the plan and also the provider levels. The local MCO and the local county managed care plan would agree with the State on a plan to improve outcomes and reduce the total costs of care and share in the savings. The two local plans would be jointly responsible to reduce avoidable ED use and hospitalizations for members who meet the medical necessity criteria for specialty mental health (i.e. chronically and severely mentally ill). The state would set up an incentive pool with two components: the smaller one is to first finance the initial collaboration, and the larger second one would be allotted for the plans after they meet their performance and outcomes targets. The collaboration would evolve into shared risk and savings between the two local plans. Provider level integration includes the primary care clinics expanding behavioral health and/or the behavioral health providers offering primary care. The goal is to give the patient the ability to transcend the current two and three-way silos so there is no wrong door to getting the care needed. Telemedicine and close local coordination between the community clinic and its adjacent mental health clinic are other approaches to offering fully integrated care to the patients.

Fee-for-service (Section 4.2) transformation includes better outcomes for dental care and maternity care. Denti-Cal has had three interlinked problems: insufficient provider participation, patients not seeking/receiving what they need, low rates of use of preventive care, and high rates of treatment for preventable acute conditions. The waiver proposes incentive payments so that more dentists will participate and those participating will open their practices to more patients, and the providers will offer and patients will receive more of the preventive services (such as sealants or cleanings) that will prevent caries, tooth loss and costly gum disease. Medi-Cal pays for 60% of the births in the state, and half are in the fee-for-service system. This initiative is targeted at reducing inappropriately high rates of caesarean sections, and elective deliveries by offering bonuses to hospitals that reduce their institution's high rates of early elective induced deliveries, C-section rates for low risk births, unexpected new born complications and increase rates of vaginal births after previous deliveries via c-section. It is not clear whether these bonuses should

be better targeted to the physicians as opposed to the hospitals or whether the economic incentives could be rebalanced through a blended rate for deliveries.

Public safety net transformation (Section 4.3) would be built on the achievements of the 2010 DSRIP. Each public safety net would build on a common set of expectations for each system: 1) system redesign, 2) care coordination, 3) prevention, 4) resource efficiency and 5) patient safety. 1) System redesign includes ambulatory care that is of higher quality and more efficient in achieving improved patient outcomes; better access to specialty consults for the primary care practitioners, better follow-up care after discharge to prevent readmissions and integration of primary care and behavioral health services. 2) Care coordination is targeted to high risk, high utilizing populations, including foster children, re-entry populations and patients with advanced illness. The goals include: increased self-management of conditions, reduced use of hospital care and improving heath indicators for the chronically ill. 3) Prevention includes the Million Hearts Initiative, improved cancer screening and follow-up, obesity screening and referrals to healthy foods, and improved perinatal care, reduced C-sections and improved breastfeeding practices. 4) Resource efficiency includes over-use of antibiotics, over-use of high cost imaging, value-based use of pharmaceuticals and evidence-based use of blood products. 5) Patient safety is focused on ambulatory care in this waiver: including medication reconciliation, patient activation and promoting a culture of safety in ambulatory care. It is proposed that the County, UC and District Hospitals are eligible to participate in DSRIP while the community clinics, private hospitals and private doctors are not.[3] The goal is to become model, integrated systems offering great patient experience and demonstrated ability to improve patient outcomes. Standardized metrics will be developed at a later date.

Workforce development (Section 4.4) is targeted to the need for effective behavioral health treatments, better provider participation and integrated team based care. Medi-Cal would provide financial incentives for providers to increase the numbers of Medi-Cal patients they treat and/or to join the Medi-Cal managed care panels; these incentives would be particularly targeted to those geographic areas with the greatest unmet needs for participating providers. Financial incentives would also be available through Medi-Cal managed care plans to add community health workers to the primary care teams and peer support specialists to the behavioral health teams. SBIRT (Screening, Brief Intervention, and Referral to Treatment) training and certification would be expanded. Palliative care training would be increased; currently only 1-2% of physicians, nurses and social workers are so trained. Physician residency training slots in teaching health centers would be increased. Residency slots would be particularly targeted to those geographic regions where the shortages are most acute. This would include additional Medi-Cal funding for

[3] We assume that the rationale for this is that county hospitals, UC and District hospitals have independent matching capacities that are missing in the facilities that are left out.

GME (Graduate Medical Education) residencies where hospitals treating large percentages of Medi-Cal patients are at their Medicare GME caps.

The new housing and supportive services (Section 4.5) component of the waiver would be targeted to the homeless, high-cost users of Medi-Cal services. The goal is to reduce inappropriate use; the means are by assuring stable housing. This would include pilot partnerships between Medi-Cal managed care plans, counties, CBOs and federal partners to find and sustain supportive housing for the target populations of homeless, high users of health services, with 2 or more chronic conditions or mental health or SUD disorders. The managed care plans would have the options to pay for non-traditional services such as rent, nutritional services, intensive care management and care coordination. Medi-Cal managed care plans would also have the option to form regional housing partnerships with housing, social services and county health and behavioral health agencies. The regional partnerships could involve multiple counties or a single county. The plan could receive shared savings incentive payments based on their successes in reducing Medi-Cal's institutional care costs for the homeless. The plans could pay for respite care, interim housing with services, housing based case management and other services to enable patients to be timely discharged from the hospital or nursing home. The savings pool can also pay for long-term rental subsidies. This would be tied to specific performance metrics to assure that reductions in the use of the ED and other institutional services for the high cost, target populations being served.

Regional integrated whole-person care pilots (Section 4.6) would be a joint project of the plan(s) and the count(ies) to improve health outcomes for targeted high need patients by delivering "whole person" care. The partnerships may include the MCOs, county behavioral health, hospitals, doctors, social services, public health, housing authorities, criminal justice and CBO's. Members will have an accountable and trusted care manager, an individualized care plan, and assured access to the spectrum of services. The "high need" target must be at least 50 Medi-Cal patients or the top 1% of emergency and inpatient users. Partnering agencies must have shared governance and a financing agreement. They must agree to reinvest the pilot program savings in expanding whole person care.

Global payments for public safety nets for the remaining uninsured (Section 5) would combine DSH and SNCP to fund fully integrated systems of care for the remaining uninsured. This would eliminate the hospital silos of current funding, and recognize the higher value of primary care and ambulatory care. Payments would be based on "value" and "points" of their care to the remaining uninsured and enhance the ability, flexibility and incentives of the public system to evolve from an emergency and hospital-based system towards a better balanced and more fully integrated delivery system. *Value* reflects the following factors: timeliness, earlier intervention, increased access, appropriate for the outcomes, improved overall health status and potential to avoid future costs. So getting a diabetic patient into

effective clinic care early has a higher value than treating that patient later when they need emergency care and hospitalization. The values would be consistent across the 21 public systems. *Points* appear to be units of service. The metrics would be clear, consistent and concise for both resource allocation and workforce evolution, but they are not yet established. The combination of value and points for the full range of services only applies to safety net care for the remaining uninsured; the global payments are not available for the safety net's care to patients with Medi-Cal or Covered California. This innovative approach is only available for California's 21 public hospital systems. However it is not clear why the same approach and logic could/should not apply to the private hospitals Medi-Cal DSH-like allocations and rate supplements.

Missing from the waiver are any changes in the ways FQHC clinics are reimbursed and any incentives to collaborate between community clinics and either public or private hospital partners.[4] Also missing are New York's DSRIP waiver approaches that seek to improve patient outcomes through integrated efforts among the public and private sectors (other than for behavioral health).[5] CCS pilot programs are deferred to the ongoing discussions in that working group. Missing also is a concerted effort to improve the effectiveness and availability of primary care and the varied performance of IPAs (although there are scattered references throughout the waiver concepts).[6] Finally California's counties have huge variations in health outcomes and health risk factors, and there is no explicit effort to upgrade the plans and safety nets in the Central Valley and rural North regions where these problems appear to be at their worst.[7]

ITUP Reference Materials on California's 2010 §1115 Medicaid Waiver and 2015 Waiver Renewal: posted at www.itup.org

Wulsin, Upcoming Waiver – Thoughts from Southern California (February 2015)
Wulsin, Open Letter on the Next §1115 Waiver (January 2015)
Wulsin, California's Implementation of the 2010 DSRIP Waiver (November 2014)
Wulsin, New York's New DSRIP Waiver and What it Could Mean in California (July 2014)
Wulsin, Updated Summary of California's Implementation of the 2010 Waiver (January 2012)
Wulsin, The Search for CPEs (Certified Public Expenditures) (March 2011)
Wulsin and Yoo, Summary of California's 2010 Section 1115 Waiver (January 2011)

[4] This could be built into Sections 4.1, 4.2 4.3 and Section 5.
[5] This could be achieved through managed care initiatives in Section 4.1 of the waiver.
[6] The concept paper may need a Section 4.7 devoted to primary care transformation.
[7] See http://www.countyhealthrankings.org/app/california/2015/overview. This could become incorporated into Section 4.1 of the waiver as well. However many of the counties with the highest needs lack the county hospital infrastructures whose much needed evolution is the focal point of much of the details in the waiver concept paper.