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Medi-Cal 2020: Continuing Transformation and New Initiatives to Improve Health Outcomes

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Introduction

On December 30, 2015, the California Department of Health Care Services (DHCS) received federal approval from the Centers for Medicare & Medicaid Services (CMS) for a renewal of its Medicaid section 1115 waiver. The new demonstration (waiver), entitled "Medi-Cal 2020," builds upon the Bridge to Reform (BTR) waiver that was approved in 2010. In addition to preserving many of the existing elements of BTR, Medi-Cal 2020 includes several new and ambitious initiatives aimed at continuing the delivery system improvements that began five years ago. The waiver provides opportunities for innovation through "Whole Person Care" pilots, expanded care opportunities for California's remaining uninsured, and a Dental Transformation initiative. The waiver represents a shared commitment between California and CMS to provide 13 million Medi-Cal beneficiaries with efficient, high quality care that will ultimately improve health outcomes and reduce costs.

Medi-Cal 2020 will provide the state with at least $6.2 billion[i] in ongoing federal funding over the next five years. The waiver renewal took effect on January 1, 2016 and will continue through December 31, 2020. Medi-Cal 2020 includes four key elements that are designed to improve the health care experience for beneficiaries:

- The Public Hospital Redesign and Incentives in Medi-Cal Program (PRIME) to provide ongoing and new incentives for Designated Public Hospitals and District/Municipal Hospitals to change the way care is delivered;
- A Global Payment Program (GPP) to fund care for the remaining uninsured in California;
- A Whole Person Care (WPC) pilot program to test new approaches to coordinating medical, behavioral health and social services for beneficiaries; and
- A Dental Transformation Initiative (DTI) designed to promote access to preventive dental care and treatment for children enrolled in Medi-Cal.

This document provides a summary of the key components of the Medi-Cal 2020 waiver as outlined in the approved Special Terms and Conditions (STCs)[ii]. The waiver also continues many other programs that were approved under BTR, including the Coordinated Care Initiative (CCI) for dual eligibles, the Community-Based Adult Services (CBAS) eligibility and delivery system, the California Children's Services (CCS) pilots, care coordination for Seniors and Persons with Disabilities (SPDs), and the Drug Medi-Cal Organized Delivery System. The Appendix details how Medi-Cal 2020 builds on the Bridge to Reform waiver with both new and ongoing initiatives.

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

Total Federal Funding: $3.7 billion

The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) initiative continues the Delivery System Reform Incentive Payment (DSRIP) program that was established under the BTR waiver. It provides new incentives for California's 21 Designated Public Hospitals (DPHs) and gives 39 District/Municipal Public Hospitals (DMPHs) the opportunity to participate in the program for the first time. The goal of PRIME is to continue and enhance efforts to change the way care is delivered in California's safety net in order to maximize health care value. PRIME will also serve as a vehicle for moving the DPHs toward alternative payment models (APMs), such as capitation and other risk sharing arrangements. Starting in January 2018, 50% 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 5% each year, reaching 60% 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 requiring accountability across the health system.

For the first three years of the waiver (technically referred to as Demonstration Years (DYs) 11 – 13), DPHs may collectively qualify for up to $700 million in federal funds per year in PRIME funding and DMPHs are collectively eligible for up to $100 million in federal funds per year if they meet all required milestones and metrics within specified timeframes. In order to receive funding, each PRIME entity must report on progress toward and achievement of the metrics to DHCS. As part of the state's commitment to long-term sustainability of the Medi-Cal program, the annual PRIME allotments will decrease in the 4th and 5th years of the waiver, as illustrated in Table 1. The state's share of Medi-Cal funding will be 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 will be funded through sources like county governments, the University of California, or local health care districts – will transfer funds to the state to cover the state's share of the PRIME program. The federal government will then match these funds and return them to the state.

Table 1: PRIME Funding Under Medi-Cal 2020*

Demonstration Year**	Annual Funding for DPHs***	Annual Funding for DMPHs***
DY 11 January 1, 2016 - 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 $180 million
DY 15 July 1, 2019- June 30, 2020	Up to $1.071 billion	Up to $153 million

* Note: The following annual allotments represent the maximum amount that will be provided to the hospitals assuming all of the required milestones and 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.

The four main goals of PRIME are to:

1. Increase the ability of PRIME entities to provide patient-centered, data-driven, team-based care to Medi-Cal beneficiaries, especially those who are high utilizers or at risk of becoming high utilizers.
2. Improve the capacity of PRIME entities to provide point-of-care services, complex care management, and population health management by strengthening their data analytic capacity to drive system-level improvement and culturally competent care.
3. Improve population health and health outcomes for Medi-Cal beneficiaries served through PRIME, as evidenced by the achievement of performance goals related to clinical improvements, effective preventive interventions, and improved patient experience metrics.
4. Improve participating PRIME entities' ability to provide high quality care that integrates physical and behavioral health and coordinates care in different settings for the most vulnerable Medi-Cal beneficiaries.

PRIME Domains

Similar to DSRIP, PRIME is structured under several "Domains," or clinical project categories. PRIME includes three Domains that consist of several clinical project areas that are tied to a required set of performance metrics. The hospitals' ability to meet the performance metrics will ultimately determine the amount of PRIME funding they will receive.

The DPHs must implement a minimum of nine projects across the three Domains. The DPHs must implement at least four projects from Domain 1, at least four projects from Domain 2, and at least one project from Domain 3 (See Figure 1). The DMPHS, which will have the opportunity to participate in the state's delivery system reform initiatives for the first time under the new waiver, are only required to implement one project from any of the three Domains. Additional details about the projects, required metrics, and funding will be provided in a set of PRIME "protocols" that will become part of the STCs once they are agreed upon by the state and CMS.

Figure 1: PRIME Domains and Projects

Domain 1: Outpatient Delivery System Transformation and Prevention	**Domain 2:** Targeted High-risk or High-Cost Populations	**Domain 3:** Resource Utilization Efficiency
• Integration of Physical and Behavioral health* • Ambulatory Care Redesign: Primary Care* • Ambulatory Care redesign: Specialty Care* • Patient Safety in the Ambulatory Setting • Million Hearts Initiative • Cancer screening and follow-up • Obesity Prevention and Healthier Foods Initiative	• Improved Perinatal Care* • Care transitions: Integration of Post-Acute Care* • Complex Care Management for High Risk Medical Populations* • Integrated Health Home for Foster Children • Transition to Integrated Care: Post Incarceration • Chronic Non-Malignant Pain Management • Comprehensive Advanced Illness Planning and Care	• Antibiotic Stewardship • Resource Stewardship: High Cost Imaging • Resource Stewardship: Therapies Involving High Cost Pharmaceuticals • Resource Stewardship: Blood Products

***Required project for DPHs**

In order to ensure that the selected projects impact a significant portion of the target population under the waiver, the hospitals that become PRIME entities must conduct an assessment of beneficiary needs. This assessment will help determine the number of beneficiaries that will be impacted by each selected project, as well as the magnitude of the impact with respect to achieving improved health outcomes for the target population.

PRIME Entities and Project Payments

In order to become a participating PRIME entity, DPHs and DMPHs must submit and receive approval for a five-year PRIME Project Plan from the state. The hospitals also have the option of submit joint plans for consideration. The project Plans will be due to the state 30 days after the date that the PRIME project protocols are approved. The state will complete its review of the Project Plans and issue any questions to the entity within 45 days of plan submission. The state will approve or disapprove the PRIME Project Plans within 60 days of submission. During the 60-day approval process, the state will hold at least two public meetings regarding the review and approval process for the PRIME Project Plans. During these meetings, the public will have an opportunity to ask questions and provide feedback to the state.

Once a PRIME entity's Project Plan is approved, the hospital will be eligible to receive payments from the PRIME funding pool, contingent on making progress toward achieving the predetermined metrics for each project. Initial PRIME payments will be made based on the achievement of process metrics, but the majority of the metrics will be performance-based. In addition to achieving the milestones for the PRIME project work, DPH PRIME entities will also be held accountable for their progress in shifting to APM arrangements (including capitation, risk-pool payments, or other risk-sharing arrangements) with managed care plans in order to ensure sustainability beyond the waiver.

Learning Collaboratives

The Department of Health Care Services will work in collaboration with PRIME entities to support regular Learning Collaboratives in order to encourage and facilitate learning among the PRIME entities. PRIME entities will be required to participate in the Learning Collaborative forums to share best practices and get assistance with implementing their PRIME projects. The Learning Collaboratives will take place through at least one annual in-person meeting, coordinated by the state and PRIME entities, regular webinars and conference calls, and will be supported by a website that will enable PRIME entities to share ideas and data over time.

Global Payment Program for Public Health Care Systems

Total Federal Funding: $236 million for DY 11; DYs 12 – 15 to be determined[iii]

Although the Medi-Cal program now serves 13 million beneficiaries and the uninsured rate in California has declined significantly since 2014, 13.6% of the population remains uninsured[iv]. In recognition of this reality, the state and CMS reached agreement to provide ongoing funding to support the remaining uninsured through a Global Payment Program (GPP) for Public Health Care Systems (PHCSs). A PHCS is comprised of a DPH and its affiliated contracted providers. For the GPP, multiple DPHs and their contracted providers may comprise a single PHCS.[v] The goal of the GPP is to assist PHCSs in providing value-based care to the uninsured through a payment structure that rewards PHCSs for providing care in

appropriate settings rather than through emergency rooms or inpatient hospital stays. This means that, unlike previous Disproportionate Share Hospital (DSH) and Safety Net Uncompensated Care Pool (UC) funding, GPP funding can be used without restrictions on where the care is provided.

Annual GPP funding will be allocated through a combination of the state's existing DSH allotment and the additional UC funding. The amount of new UC funding will be $236 million for the first program year. UC funding for the remaining four years will be determined based on the information provided through an Independent Report on Uncompensated Care. The state share of GPP funding will be furnished by voluntary intergovernmental transfers (IGTs) by the PHCSs or governmental agencies affiliated with the PHCSs.

Uncompensated Care Reporting

While funding for the first year of the GPP is set, funding for the remaining four years under the waiver depend on the results of an independent report on uncompensated care in DPHs that must be submitted to CMS by May 15, 2016. Information from the report will be used to determine the appropriate level of UC funding for the remaining years of the waiver. A second report is due by June 1, 2017 and will focus on uncompensated care, provider payments, and financing across all Medi-Cal hospital providers. The reports are intended to inform discussions on how to improve payment systems and the quality of health care services for Medi-Cal beneficiaries and the uninsured.

Whole Person Care Pilots

Total Federal Funding: $1.5 billion

One of the most innovative aspects of Medi-Cal 2020 is a new opportunity for counties to leverage resources more effectively by coordinating physical health, behavioral health, and social services in a patient-centered manner with the goal of improving the health and well-being of beneficiaries. The new Whole Person Care (WPC) pilots will enable counties and their partners to target these high users, share data between systems, coordinate care in real time, and evaluate progress in improving individual and population health.

The WPC pilots provide extensive local flexibility, enabling a county, city and county, a health or hospital authority, or a consortium of entities, to design approaches that address the specific needs of their most vulnerable Medi-Cal beneficiaries. While there must be one "Lead Entity," the WPC pilot applications will identify the comprehensive set of participating entities that will work together to provide beneficiaries with more integrated, person-centered care. The WPC pilots also permit applicants to choose target populations, identify strategies for meeting the needs of the populations, and develop payment methodologies.

The formal allocation of WPC funding is under development, but in order to participate, WPCs will need to meet the following conditions:

- The WPC must have an established infrastructure to integrate services among local entities that serve the target population;
- Services provided must not be otherwise covered or directly reimbursed by Medi-Cal; and
- The WPC must employ strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

Housing and Supportive Services

One of the likely target populations for the WPC pilots is individuals at risk of or experiencing homelessness who have a demonstrated medical need for housing or supportive services. Permissible housing interventions included in the WPC pilot are:

- **Tenancy-based care management services**: Services such as individual housing transition services, individual tenancy sustaining services, and housing-related collaborative activities designed to assist the target population in locating and maintaining medically necessary housing.

- **County housing pools:** These pools, which may include contributions from county entities, will directly support medically necessary housing services with the goal of improving access to housing and reducing churn in Medi-Cal. Services can include respite care or interim housing arrangements and services to enable timely discharge from inpatient stays or nursing facilities while permanent housing is being arranged. While federal funds cannot be used to support long-term housing arrangements, state or local contributions can be used for rental subsidies.

Dental Transformation Initiative

Total Federal Funding: $375 million[vi]

The addition of a Dental Transformation Initiative (DTI) in the Medi-Cal 2020 waiver renewal reflects a shared commitment between the state and the federal government to improve access to consistent, high quality dental care for children in California. The DTI leverages an unprecedented amount of new federal support to establish a funding pool that will be used for incentive payments to both fee-for-service and dental Managed Care providers that meet the goals outlined in three DTI Domains and through a Local Dental Pilot program.

DTI Domains

Domain 1: Preventative Services Utilization for Children

Activities under this domain are designed to increase the statewide proportion of children ages 1-20 enrolled in Medi-Cal who receive a preventive dental service in a given year. The goal is to increase the rate of preventive visits by at least 10% over the five-year waiver.

- Incentive Payments: Eligible providers will receive incentive payments if they provide dental services to a greater number of Medi-Cal children as compared to a pre-determined baseline

level. This incentive is also available to providers who have not previously participated in Medi-Cal.

- Implementation: The state will use a public messaging campaign to explain the program to the 5,370 eligible provider locations in the state and to generate interest among beneficiaries.

Domain 2: Caries Risk Assessment and Disease Management

This domain aims to formally assess and manage the risk of dental caries among children and to emphasize the efficacy of preventive services over more invasive and costly treatment, particularly for Medi-Cal beneficiaries six years old and younger.

- Incentive Payments*:* Payments will be made to providers in participating pilot counties who first complete a Carries Risk Assessment (CRA) and follow through with a treatment plan generated by the state. The treatment plan will reflect the child's determined caries risk level (low, moderate, or high) and include directions for frequency of visits and recommendations for provision of exams, prophylaxis, and topical fluoride varnish. Table 2 outlines the formula for the frequency of provider visits based on the results of the CRA.

Table 2: Provider Visit Frequency Based on CRA

Caries Risk Level	Provider Visit Frequency
Low	2 visits/year
Moderate	3 visits/year
High	4 visits/year

- Implementation: This domain, available for four years of the waiver, will be offered as a pilot for counties that submit a plan for state approval. Pilots that are determined to be successful will be considered for statewide adoption.

Domain 3: Continuity of Care

Activities under this domain are designed to encourage continuity of care for children enrolled in Medi-Cal who are 20 years old and younger by providing incentive payments to service office locations. Locations that maintain continuity of care by providing examinations to this population over the course of the waiver are eligible for these payments.

- Incentive Payments: Incentive payments will be made annually to service office locations that provide examinations to Medi-Cal enrolled children continuously for two to six years.
- Implementation: This will begin as a pilot in select counties and will be expanded if deemed successful by the state.

Local Dental Pilot Program
The Local Dental Pilot Program will give counties the opportunity to address one or more of the three domains through alternative programs targeting an identified population of Medi-Cal child beneficiaries ages 20 and younger. The pilots may include strategies focused on rural areas including local case management initiatives and education partnerships.

- Incentive payment: Payments will be related to goals and metrics that contribute to the overall goals of the state in any of the three domains, including in the DTI.
- Implementation: The program will initially begin in pilot counties and may expand subject to DTI funding availability.

Access Assessment and Report

In an effort to address reported access issues for Medi-Cal beneficiaries in managed care plans, the Medi-Cal 2020 waiver requires the state to use an independent contractor to complete an "access assessment" and accompanying report. The access assessment will evaluate primary, core specialty, and facility access to care for managed care beneficiaries in California based on current health plan network adequacy requirements. The assessment must account for State Fair Hearing and Independent Medical Review decisions as well as grievances and appeals complaints data.

The final report must include:

- A description of the state's current compliance with access and network adequacy standards;
- Data on the number of Medi-Cal providers accepting new beneficiaries;
- A comparison of health plan network adequacy compliance across different lines of business; and
- Recommendations that respond to any systemic network adequacy issues that are identified.

Provided that the enabling legislation authorizes the state to do so, DHCS will amend its contract with the state's External Quality Review Organization (EQRO) to include authorization and funding for completion of the access assessment and report.

Conclusion

The Medi-Cal 2020 waiver will continue the state's vision for transforming the way hospital care is delivered and continue the shift toward paying for value over volume. The four initiatives included in the waiver renewal solidify the state's focus on the triple aim goals of improving the patient experience and improving health outcomes, while managing costs. The ongoing federal support provided through the waiver enables California to move the Medi-Cal program forward in a sustainable manner that ultimately improves the health of its beneficiaries.

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Appendix – Side-By-Side Comparison of Medi-Cal 2020 and Bridge to Reform

Program	Medi-Cal 2020	Bridge To Reform (BTR)[vii]
Public Hospital Redesign and Incentives in Medi-Cal (PRIME)	PRIME builds off of DRSIP and supports the State's efforts towards adoption of alternative payment methodologies and supports better integration, improved health outcomes and increased access to health care services, particularly for those with complex needs. Medi-Cal 2020 includes an opportunity for the state's 39 District/Municipal Public Hospitals to join the 21 public hospitals in receiving incentive payments for implementing a series of clinical projects.	PRIME was formerly California's Delivery System Incentive Payment (DSRIP) program, which supported the ability of the state's 21 Designated Public Hospitals to enhance quality of care through payment incentives for projects that support infrastructure development, delivery system innovation, population-focused improvements, and urgent improvement in care.
Global Payment Program (GPP)	The GPP streamlines funding sources for care for California's remaining uninsured population and creates a value-based mechanism to increase incentives to provide primary and preventive care services and other high-value services.	Formerly the state's Disproportionate Share Hospital state plan funding and the Safety Net Care Pool/Uncompensated Care Pool.
Whole Person Care Pilot (WPC)	WPC aims to support local and regional efforts to integrate the systems and improve the care provided to Medi-Cal's most high-risk beneficiaries	N/A
Dental Transformation Initiative	DTI aims to improve access to dental care and reduce preventable dental conditions for Medi-Cal beneficiaries.	N/A
Low Income Health Program (LIHP)	Superseded by the January 1, 2014 implementation of the Affordable Care Act	Coverage for adults 19-64 with incomes up to 200% FPL prior to ACA implementation in 2014.
Coordinated Care Initiative (CCI)	Carried over from BTR	CCI offers integrated care across delivery systems and rebalances service delivery away from institutional care and into the home and community
Seniors and Persons with Disabilities (SPDs)	Carried over from BTR	Care coordination for vulnerable populations by mandatorily enrolling SPDs into Medi-Cal Managed Care

California Children's Services (CCS)	Carried over from BTR	Pilot Coordinated systems of care through CCS demonstrations
Community-Based Adult Services Centers (CBAS)	Carried over from BTR	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 beneficiaries enrolled in a managed care organization at CBAS Centers.
Drug Medi-Cal Organized Delivery System	Carried over from BTR	Continuity of care for substance use disorder treatment services through enabling local control and accountability, greater administrative oversight, utilization controls, and implementation of evidence-based practices through coordination with other systems of care.

ENDNOTES

[i] The initial amount of $6.2 billion in new federal waiver funding includes $3.732 billion in PRIME funding, $236 million (for the first year only) of Global Payment Program funding, $375 million for the Dental Transformation Initiative (DTI), $1.5 billion for the new Whole Person Care Pilots, and $375 million in Designated State Health Program (DSHP) savings that will help fund the DTI. It is assumed that the state will qualify for additional federal funding to support the GPP in the subsequent years of the waiver once the required reports are complete.

[ii] The STCs are available at http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_FINAL_STC_12-30-15.pdf

[iii] The GPP pool is a combination of the state's existing DSH allotment and new Uncompensated Care funding. The DSH funds are not considered new federal funds and are therefore not included in the waiver funding amount.

[iv] UCLA Center for Health Policy Research. *Adult Medi-Cal Enrollment Surges, Uninsured Rate Plummets in 2014.* August 2015. http://healthpolicy.ucla.edu/publications/Documents/PDF/2015/Medi-Cal-factsheet-aug2015.pdf

[v] UC hospitals will not be participating in the GPP.

[vi] The total amount of funding for the Dental Transformation Initiative is $750 million in combined federal/state funds, however $10 million in federal funding is contingent on the state achieving a set of metrics. The state share of DTI funding ($375 million) will be generated through Designated State Health Program (DSHP) savings.

[vii] California Department of Health Care Services, *Section 1115 "Bridge to Reform" Waiver Summary.* July 2014. http://www.dhcs.ca.gov/provgovpart/Documents/BTR-1115-Waiver-Summary.pdf