



City and County of San Francisco
Edwin M. Lee
Mayor

San Francisco Department of Public Health

Barbara A. Garcia, MPA
Director of Health

Office of Policy and Planning

MEMORANDUM

DATE: January 28, 2016

TO: Dr. Edward Chow, Health Commission President, and Members of the Health Commission

THROUGH: Barbara A. Garcia, MPA, Director of Health

FROM: Colleen Chawla, Deputy Director of Health and Director of Policy & Planning

RE: Medi-Cal 2020: California's 1115 Medicaid Waiver Renewal

California's recently renewed 1115 Medicaid Waiver, called Medi-Cal 2020, is a significant and critical funding source for California's public hospitals. This memo provides a summary of and notes the impact of key components relevant to the San Francisco Department of Public Health (SFDPH).

BACKGROUND

The Medicaid program is jointly financed by state and federal funds; California has a 50:50 state to federal financing ratio, meaning that each dollar the state spends on its Medicaid program, called Medi-Cal, is matched by a federal dollar. Medi-Cal serves over 13 million individuals statewide, including more than 173,000 San Franciscans. The program is administered by the California Department of Health Care Services (DHCS), with the Centers for Medicare and Medicaid Services (CMS) providing federal oversight.

1115 Medicaid Waivers allow states flexibility in the delivery of their Medicaid programs. The most significant condition for granting 1115 Waivers is that the waiver be budget neutral; that is, the proposed services and financing included in the waiver may not cost more than they would in the absence of the waiver. Many states, including California, have used 1115 Waivers to expand program eligibility to populations beyond those identified in federal Medicaid statute, as well as to transition their programs from fee-for-service to managed care.

The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans.

We shall ~ Assess and research the health of the community ~ Develop and enforce health policy ~ Prevent disease and injury ~
~ Educate the public and train health care providers ~ Provide quality, comprehensive, culturally-proficient health services ~ Ensure equal access to all ~

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California's first public hospital 1115 Medicaid Waiver was approved for in 2005. At the expiration of the initial Waiver's five-year term in 2010, it was renewed and named "Bridge to Reform." The Waiver was renewed once again in 2015 as "Medi-Cal 2020" and is to be its last five-year term. The Waiver plays an integral role in supporting California's safety net hospitals and health systems.

MEDI-CAL 2020

The Special Terms and Conditions governing Medi-Cal 2020 were released on December 30, 2015, largely reflecting the October agreement reached by DHCS and CMS. Several attachments, which contain financing and programming detail, are expected to be completed by April 1, 2016. **The total size of this Waiver is smaller than the one it replaced, totaling \$6.2 billion in initial federal funding over the next five years, compared to approximately \$10 billion in federal funds received during the previous five years.**

Medi-Cal 2020 seeks to achieve the Triple Aim¹, support the safety net, ensure long-term viability of Medi-Cal, and continue the integration of primary and behavioral health care. Medi-Cal 2020 includes the following new elements. These new elements form the core of the Waiver's support for California's safety net health systems, which serve more than 50 percent of the state's Medi-Cal beneficiaries.

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

PRIME is the successor program to the Delivery System Reform Incentive Program (DSRIP), and will provide \$3.27 billion in federal support for designated public hospitals and district municipal hospitals over the next five years.² The matching \$3.27 billion will be provided by public hospital counties through intergovernmental transfers.

Like DSRIP, PRIME offers incentives to drive the Medi-Cal program toward a value-based payment model. However, PRIME emphasizes outcomes rather than processes and standardizes projects and metrics. Table 1 shows the required and optional projects under the three PRIME domains; each public hospital will complete a total of nine projects.

ZSFGH earned approximately \$200 million over five years through DSRIP. PRIME not only does not make any new funds available, but also reduces funding by 10 and 15 percent in years four and five of the waiver, respectively. Additionally, while there is the potential to earn partial incentives for partial achievement of metrics, each designated public hospital must meet all benchmarks across its nine projects to earn all available incentives. Table 2 depicts the total federal funding available to the 21 designated public hospital systems through PRIME.

¹ The Triple Aim of health reform is to increase care quality, reduce per-capita costs, and improve population health.

² ZSFGH is among the state's 21 designated public hospitals and health systems.

Table 1: PRIME Domains and Projects

Domain	Required projects	Optional projects (must choose one for each domain)
1: Outpatient Delivery System Transformation	<ul style="list-style-type: none"> Integration of Physical & Behavioral Health Ambulatory Care Redesign: Primary Care Ambulatory Care Redesign: Specialty Care 	<ul style="list-style-type: none"> Patient Safety in the Ambulatory Setting Million Hearts Initiative Cancer Screening and Follow-up Obesity Prevention and Healthier Foods Initiative
2: Targeted High Risk or High Cost Populations	<ul style="list-style-type: none"> Improved Perinatal Care Care Transitions: Integration of Post-Acute Care Complex Care Management for High Risk Medical Populations 	<ul style="list-style-type: none"> Integrated Health Home for Foster Children Transition to Integrated Care: Post Incarceration Chronic Non-Malignant Pain Management Comprehensive Advanced Illness Planning and Care
3. Resource Utilization Efficiency	<ul style="list-style-type: none"> At least one from list on the right 	<ul style="list-style-type: none"> Antibiotic Stewardship Resource Stewardship: High Cost Imaging Resource Stewardship: Therapies Involving High Cost Pharmaceuticals Resource Stewardship: Blood Products

Table 2: PRIME Funding for Designated Public Hospitals

Year 1: Jan 2016 – June 2016	\$700M
Year 2: July 2016 – June 2017	\$700M
Year 3: July 2017 – June 2018	\$700M
Year 4: July 2018 – June 2019	\$630M
Year 5: July 2019 – June 2020	\$535.5M
Total	\$3.265M

Lastly, PRIME requires that participating health systems demonstrate an aggregate movement toward “alternate payment methodologies” for their chosen and assigned Medi-Cal managed care beneficiaries. Such methodologies include various levels of risk assumed by the health system, ranging from partial capitation to full capitation. If PRIME providers fail to collectively reach the thresholds of having 55 percent of their Medi-Cal managed care beneficiaries under alternate payment arrangements by 2019, and 60 percent by 2020, PRIME funding will be reduced by an additional 5% for those years.

Global Payment Program (GPP)

The GPP is a first of its kind program that combines two existing uncompensated care funding streams: Disproportionate Share Hospital (DSH) payments and the Safety Net Care Pool (SNCP). The goal of the GPP is to transform uncompensated care payments to a bundled structure that encourages primary and preventive care over inpatient stays and emergency visits. This funding level is expected to decrease for two reasons: 1) DSH reductions scheduled under the Affordable Care Act become effective in fiscal year 2017; and 2) CMS is requiring an independent assessment of the ongoing need for the SNCP in light of the Affordable Care Act.

ZSFGH averaged approximately \$100 million per year over the past five years in DSH and SNCP payments. Table 3 shows currently available estimates of the total size of the GPP. The SNCP assessment is expected to be completed later this year and will determine the total size of the GPP.

Table 3: Global Payment Program Funding for All Public Hospital Systems

GPP Component	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20
DSH	\$1,203 M	\$1,227 M	\$1,055 M	\$982 M	\$909 M
SNCP	\$236 M	?	?	?	?

The GPP moves uncompensated care to a bundled payment structure through a point-based mechanism that is being developed in the Waiver attachments. Essentially, each public hospital system will have the opportunity to earn an allocation based on its own “global budget” for the uninsured. That global budget will correspond to a threshold number of points, established through an analysis of that system’s historical and projected volumes of services provided to the uninsured. Alongside traditional services (outpatient visits with a physician, inpatient stays, etc.), the GPP will also assign points for non-traditional services (group visits, prevention services, text messaging, etc.). Public hospital systems will have flexibility in how they earn those points, and in the later years of the Waiver, non-traditional services will be weighted more heavily.

For example, two public hospital systems might each establish a global budget of \$2M corresponding to 500,000 points, with an inpatient stay assigned 1,000 points, and an outpatient visit assigned 100 points. Each of these systems would have flexibility in how it earns those 500,000 points, whether it is through 500 inpatient stays, through 5,000 outpatient visits, or any combination thereof.

Whole Person Care (WPC)

Medi-Cal 2020 includes up to \$300 million annually in federal funds for five years to launch county-based Whole Person Care pilots that target high-risk Medi-Cal populations. The aim of the WPC pilots is to improve beneficiary health and wellbeing through more efficient and effective use of resources. WPC pilots are expected to coordinate physical health, behavioral health, and social services, as applicable, in a patient-centered manner. These pilots present a great opportunity for San Francisco to leverage its existing infrastructure and care coordination efforts. Applications will be available later this year.

The lead agency for each pilot could be a county, health authority, or a group of counties. The collaboration must include two or more public entities (i.e. county mental health plan, local public health department, local housing authority, human services agency, etc.), at least one Medi-Cal managed care plan, and two community based organizations. The pilots may target high utilizers of multiple systems, high-cost utilizers of single systems, as well as persons experiencing homelessness. Pilot funding may be used toward infrastructure that integrates services, strategies that reduce necessary utilization, supportive housing services, and other innovations that improve outcomes among the target population.

Dental Transformation Initiative

The Dental Transformation Initiative is funded at a total of \$750 million in combined state and federal incentive payments over five years. The goal of this initiative is to improve the dental health of children enrolled in Medi-Cal through three domains: 1) increased utilization of preventive dental services, 2) expanded treatment of early childhood caries, and 3) increased dental continuity of care. Dental providers will be eligible for incentive payments based on the achievement of metrics in each category; the metrics and baseline data are under development by DHCS.

Assessments and Evaluations

Medi-Cal 2020 includes several studies and evaluations.

- The *Medi-Cal Managed Care Assessment* will evaluate primary, core specialty, and facility access to care for managed care beneficiaries, and produce recommendations for any identified network adequacy issues.
- There will be *two uncompensated care assessments*. The first, noted above in the Global Payment Program section and due in May 2016, will focus on designated public hospitals and will determine the appropriate level of funding for the Safety Net Care Pool in Waiver years two through five. The second, due in June 2017, will focus on uncompensated care across all hospital providers serving Medi-Cal beneficiaries.
- *Two evaluations of the GPP* will monitor the implementation of the program and its impact on the care provided to the remaining uninsured. The first evaluation will be due at the mid-point of the Waiver term, and the second will be due at the end of year four.
- *PRIME evaluation* will be done in two parts, the first as an interim report due at the end of year four, and the second as a final evaluation due at the end of year five.

SFDPH WAIVER PLANNING

As a member of the Board of Directors of the California Association of Public Hospitals and Health Systems (CAPH), SFDPH was closely involved in waiver renewal conversations and advocacy. SFDPH established an 1115 Waiver team nearly a year ago to coordinate internal analysis, advocacy, and implementation. This team, which comprises SF Health Network, Finance, and Policy & Planning staff, has been meeting bimonthly since renewal discussions began in earnest last summer. SFDPH remains involved through CAPH in the finalization of the remaining Waiver details and also continues to prepare for implementation.

SUMMARY

Although Medi-Cal 2020 maintains critical revenue for SFDPH through PRIME, the overall incentive pool is smaller than what was available through DSRIP and the new metrics will, by design, be more difficult to achieve. Similarly, while the Global Payment Program offers more flexibility in delivery care to the uninsured, there is considerable uncertainty introduced by the uncompensated care assessments. However, the Whole Person Care pilots offer an opportunity to draw down new funding for services that are currently not funded by Medi-Cal, such as supportive housing services.