Summary of the Terms and Conditions for California's Section 1115 Waiver Renewal

The waiver has six elements: managed care expansion; preventive dental care for children ($750 million); whole person care pilots ($1.5 billion); substance abuse treatments (Drug Medi-Cal); global budgets for public hospitals; and PRIME upgrades ($7.5 billion) in managed care readiness for county, UC, and district hospitals.

The **managed care expansions** (MCOs) are primarily a continuation of mandatory managed care for children and families, for seniors and persons with disabilities, for low income pregnant women, and for those newly eligible, medically indigent adults (MIAs) under the Affordable Care Act (ACA). The waiver authorizes managed care pilots for California Children's Services (CCS) eligibles in two forms: traditional Medi-Cal managed care or provider-based Accountable Care Organizations (ACOs). It also authorizes continuation of Cal-MediConnect pilots of those dually eligible for Medi-Cal and Medicare. It includes in Medi-Cal managed care many long-term care services such as MSSP, IHSS (In Home Support Services), and Community Based Adult Services (CBAS), as well as institutional care in nursing homes. There are a variety of reports, monitoring, grievance procedures, and safeguards to assure that the MCOs fulfill their mission of improving care and outcomes for these high cost, vulnerable populations. The waiver requires an independent 2016 report on network adequacy in Medi-Cal managed care plans in the different regions of the state. The State has committed that 60% of Medi-Cal managed care beneficiaries enrolled in county safety nets will receive care that is reimbursed by alternative payment methodologies (APMs) by 2020.

The **dental care** for children seeks to reduce caries, increase use of preventive care, and assure access to and continuity of dental care. The State's goal is to increase the share of children receiving preventive dental care from 37% to 47%, and to shift from episodic care for acute dental needs to continuous and preventive dental care for children. Medi-Cal children use dental care at only about half the rate of privately insured children and more frequently use dental care only when the dental care need has become acute. Dental offices that commit to and actually increase Medi-Cal children's use of preventive services by 10% can qualify for and receive bonuses. The dental caries prevention pilot programs will initially be located in those counties where children have high rates of caries and low rates of utilization of preventive dental care; if successful, the pilots may expand statewide. The program will include more frequent exams for children at high risk, topical fluoride varnish, nutritional counseling, and antimicrobials. The continuity of care bonuses are available for dental practices that keep low-income children continuously in their practices for between two and 6 years. Local dental pilot programs are authorized for communities with innovative local efforts to achieve one or more of these goals.

The top 1% of healthcare users account for 30% of the population's medical costs in a year. Some are individuals with co-morbidities such as physical health conditions, severe mental illness, and serious substance use disorders; some are homeless as well. The **whole person pilots** afford an option for local partnerships to integrate/coordinate physical, behavioral, and social services that are otherwise siloed and can be hard for the eligible patients to navigate. The lead agency is the county, a health or hospital authority, or a regional consortium. The participating agencies include: local health plan(s), health and mental health agencies, social services, housing authorities, public health agencies, and local criminal justice or probation agencies. The funding is primarily for integration, coordination, data sharing, patient navigation, and case management; it is <u>not</u> for services otherwise reimbursable under the Medi-

caid program. The goals and metrics are for avoidable hospital and emergency room utilization, reductions in homelessness, and better health outcomes. It can include county housing pools for medically necessary housing services, but cannot be used to pay for room and board for an eligible participant.

The Drug Medi-Cal Organized Delivery System is an organized delivery system that is optional for counties. It offers a full range of services and operates on the assumption that a full range of well-managed substance abuse treatment services will reduce costs across the entire system. It includes: early intervention, outpatient services, intensive outpatient services, partial hospitalization services, clinically managed low-intensity residential services, clinically managed high-intensity residential services, medically monitored intensive inpatient services, medically managed intensive inpatient services, an opioid treatment program, and additional medication-assisted treatments. In addition, withdrawal services would be covered in ambulatory, residential, and inpatient settings. Counties would be responsible for selective provider contracting, ensuring access to covered services, utilization management, and care coordination. Counties operating these delivery systems will be considered a managed care plan under federal law and subject to federal rules on managed care organizations (MCOs). Counties can contract with a local managed care plan(s) to operate the system. DHCS is committed to integrating behavioral and physical health services and is scheduled to submit an approach by April 1, 2016, a concept design by October 1, 2016, and begin implementation by April 1, 2017.

The Global Payment Program (GPP) is a new option only for county hospitals and their contractors, and it is only for their care to the remaining uninsured. County hospitals provide an open door to the uninsured, but often their care is episodic responding to acute medical conditions. GPP These are not new funds, but they are a new way of earning and distributing existing funds. The funds are earned and distributed based on a point system that gives incentives for prevention and timely access to care, as well as disincentives for avoidable hospitalizations and emergency room visits. This gives public hospitals the flexibility and incentives to reconfigure their delivery systems from episodic and hospital-based care towards a balanced system of continuous care for enrolled populations. While total funding for GPP in year 1 is $2.9 billion, that figure could decrease by up to $238 million in federal funds in future years depending on the findings of an independent study that is looking at the extent of uncompensated care remaining in public hospitals after ACA implementation.

PRIME is a successor to, and a big improvement on, DSRIP. It is available to county hospitals, UC hospitals, and district hospitals. Funding for PRIME is $7.5 billion and it is phased down and out over the five-year time frame of the waiver. Its purpose is to assist public hospitals to evolve and improve their participation in managed care, to take risk, and improve value in their systems. Public hospital funding is $1.4 billion annually for 3 years, phasing down by 10% in year 4 and an additional 15% in year 5, after which it terminates. District hospital funding is $200 million annually, and phases out on the same schedule. PRIME hospitals will shift from fee for service to alternative payment methodologies (APMs) such as capitation and other risk-sharing payments. Fifty percent of the managed care payments will be through APMs by January 2018, increasing to 60% by 2020. Public hospitals must participate in three domains: 1) Outpatient Delivery System Transformation and Prevention, 2) Targeted High Risk/High Cost Populations, and 3) Resource Utilization efficiency. District hospitals must participate in only one of the three domains.

- Domain 1. Includes as *mandatory elements*: integration of physical and mental health, ambulatory care redesign for primary care, and ambulatory care redesign for specialty care. Includes as *optional elements*: million hearts initiative, cancer screening and follow-up, obesity prevention, and patient safety.

- Domain 2. Includes as *mandatory elements*: improved perinatal care, integration of post-acute care and complex care management. Includes as *optional elements*: integrated health homes for foster children, transition to integrated care, post incarceration, non-malignant pain management, and advanced illness planning.
- Domain 3. Includes a choice of *one of the following options*: antibiotic stewardship, high cost imaging stewardship, high cost pharmaceutical stewardship, and blood products stewardship.

Projects are awarded based on the merit of the proposal, the depth and breadth of its benefit to Medicaid beneficiaries, and the degree to which it meets PRIME's objectives. Public transparency is required throughout the process. The application process starts nearly immediately. Financing is awarded based on performance in meeting the metrics of the approved proposal.

There is extensive public reporting, monitoring, and independent evaluations of the performance of the public hospitals and district hospitals. The public comment periods are very tight and start very shortly.

Financing match for the whole person care pilots, the continuum of substance abuse services, the Global Payment Program and the Prime Program are through the counties. They cannot generally use federal funds as the match, nor recycled Medicaid funds nor impermissible provider or plan taxes. Financing the match for the dental care pilots is from the state, using a variety of state revenues associated with state designated health programs as the match.