2020 California Waiver

Presenters:

- **Dr. Gary Gray – Natividad Medical Center**
- **Dr. Debi Siljander – Natividad Medical Center**
- **Elsa Jimenez – Health Department**

Agenda:

- **Past and Current Waiver**
- **Global Payment Program**
- **PRIME Initiative**
- **Whole Person Pilot**

2020 California Waiver

What is a Waiver?

- **An agreement between the state and federal government that 'waives' certain federal Medicaid requirements in exchange for testing and promoting policies in line with federal Administration goals**

- **Several states have obtained Section 1115 Waiver**

2020 California Waiver

Period of Waiver

Each Waiver is for a period of 5 years

- **First Waiver: August 2005 through November 2010**
- **Second Waiver: November 2010 through December 2015 (extended)**
- **Third Waiver: January 2016 through December 2020**

3 Key 2020 Waiver Programs

PRIME

- Pay for performance successor to DSRIP
- Delivery system transformation
- Payment via achievement of 60 metric targets

WPC

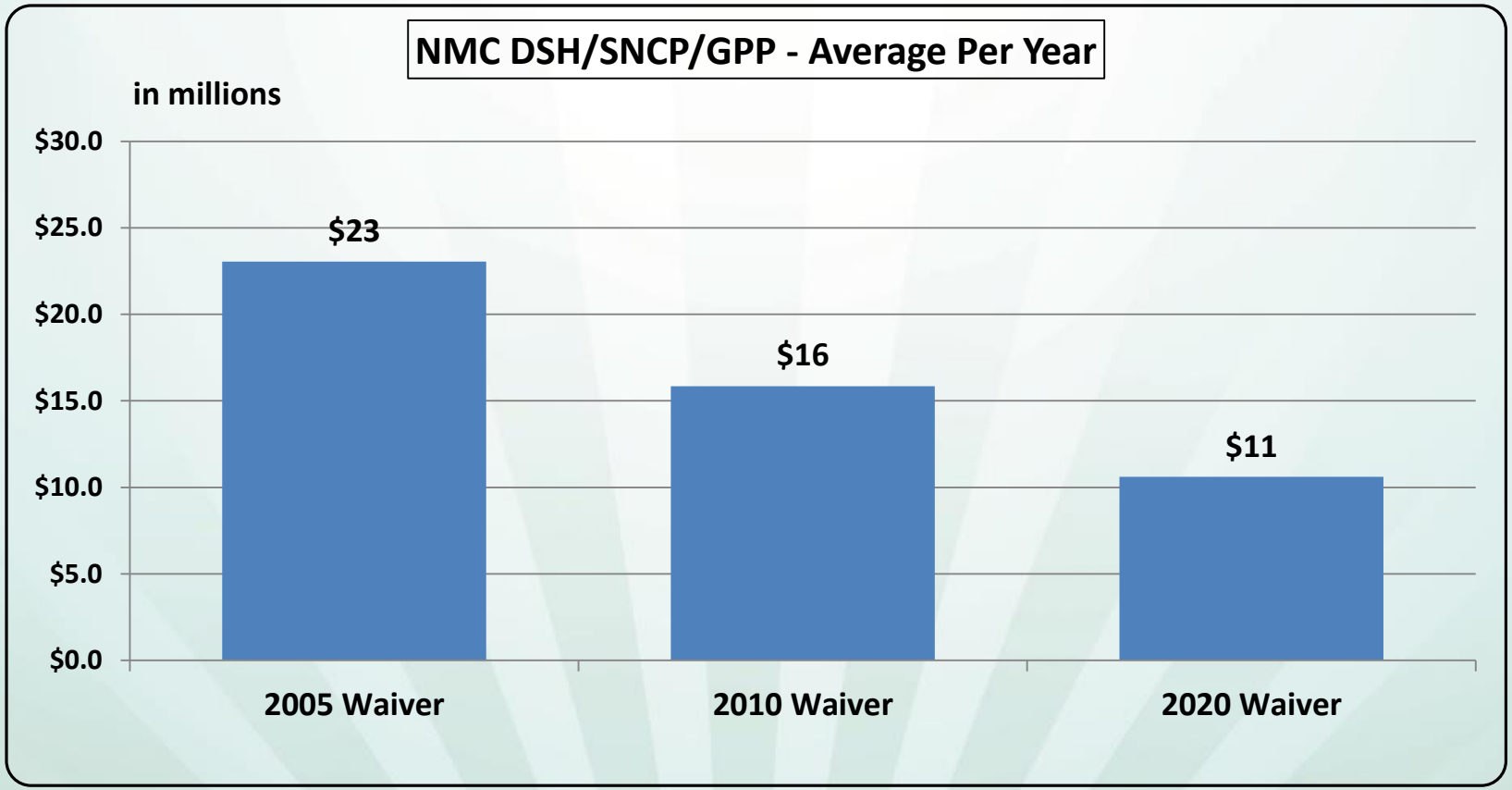
- Coordinated care across multiple services for highest-risk patients
- Payment to support infrastructure needed for integration of services per WPC plan and budget.

GPP

- Changes the payment method for Disproportionate Share (DSH) and Safety Net Care Pool (SNCP) funds.
- Payment for services provided via point system
- Points earned for traditional services and non-traditional complimentary services

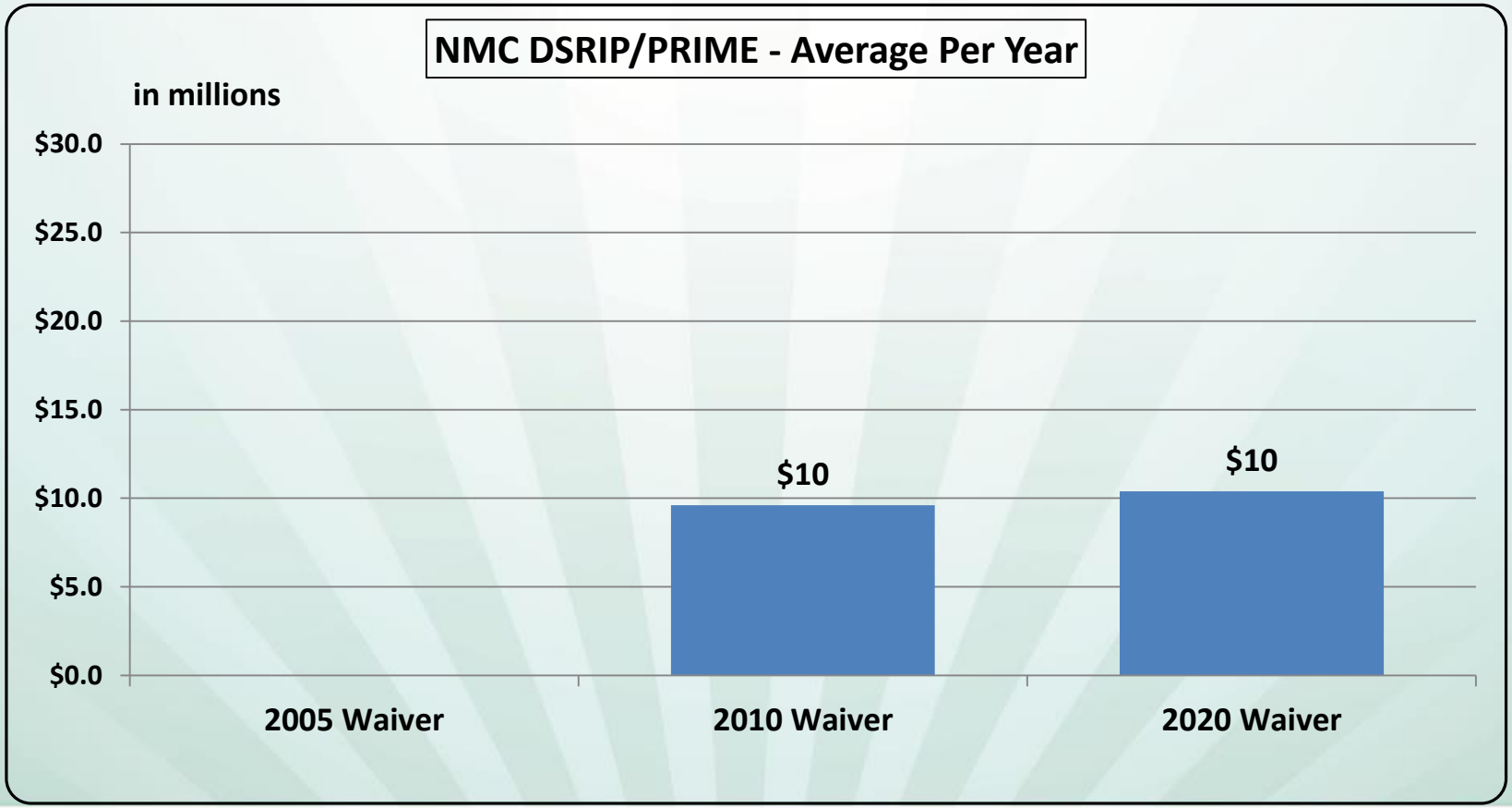
2020 California Waiver

NMC DSH/SNCP/GPP Funds - NMC



2020 California Waiver

NMC PRIME Funds - NMC



Global Payment Program

Global Payment Program

- Traditional provider-based, face-to-face outpatient encounters
- Other non-traditional provider, groups, prevention/wellness, face-to-face
- Technology-based outpatient
- Inpatient facility

PRIME

PRIME Eligible Population?

- Eligible Population (EP)
  - Criteria #1:
    - Patients with two or more visits at NMG or LFM clinics
    - Regardless of age or insurance
  - Criteria #2 – Managed Medi-Cal (CCAH)
    - Assigned to either NMG or LFM
- Target Population (TP)
  - EP with no additional criteria
  - EP plus additional criteria

PRIME - Target Population (TP)

Projects where EP has ***no additional criteria***

- Project 1.1: Integration of Behavioral Health and Primary Care
- Project 1.2: Ambulatory Care Redesign; Primary Care
- Project 1.5: Million Hearts Initiative

Projects where EP ***has additional criteria***

- Project 1.3: Ambulatory Care Redesign; Specialty Care
- Project 2.1: Prenatal Care
- Project 2.2: Integration of Post Acute Care
- Project 2.3: Complex Care for High Risk Populations
- Project 2.6: Chronic Non-Malignant Pain Management
- Project 3.4: Blood Product Management

PRIME Pay-for-Performance Population Management

Eligible Population (EP)

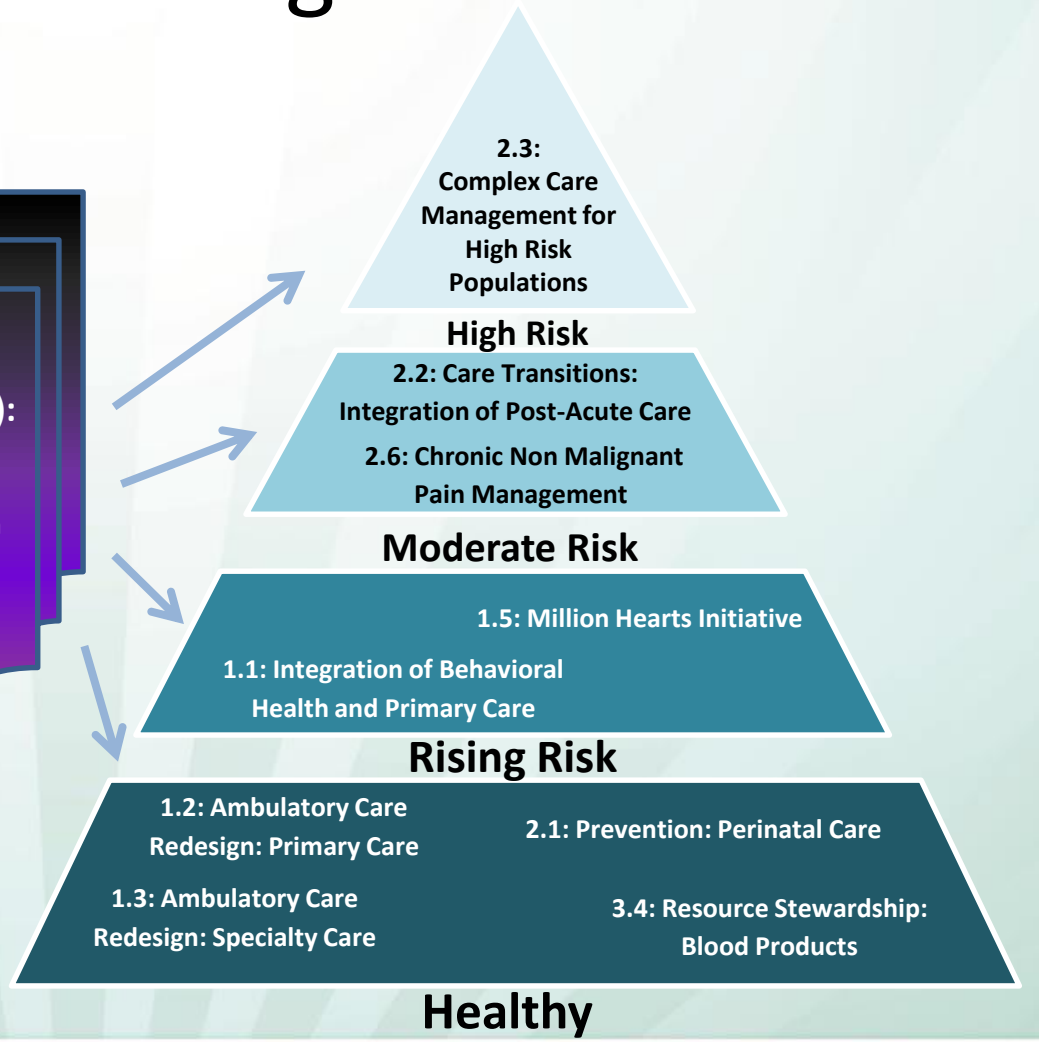
Criteria #1
Two or more visits at NMG or LFM

Criteria #2
CCAH Assigned Lives

Data Warehouse

PRIME Target Population (PT):

- EP with no additional Criteria
- EP with additional criteria



PRIME Project and Metrics

Domain	Project	Required	# of Metrics
1. OP Delivery System Transformation & Prevention	Integration of Behavioral Health & Primary Care	Yes	6
	Ambulatory Care Redesign: Primary Care	Yes	14
	Ambulatory Care Redesign: Specialty Care	Yes	7
	Million Hearts Initiative	Selected	4
2. Targeted High Risk or High Cost Populations	Improvements in Perinatal Care	Yes	8
	Care Transitions: Integration of Post-Acute Care	Yes	5
	Complex Care Management for High Risk Medical Populations	Yes	4
	Chronic Non-Malignant Pain Management	Selected	5
3. Resource Utilization Efficiency	Resource Stewardship: Blood Products	Selected	7

Whole Person Care Pilot

Vision:

The **coordination** of health, behavioral health, and social services in a **patient-centered manner** to **improve** beneficiary h**ealth and well-being** through more **efficient and effective use of resources**

Term:

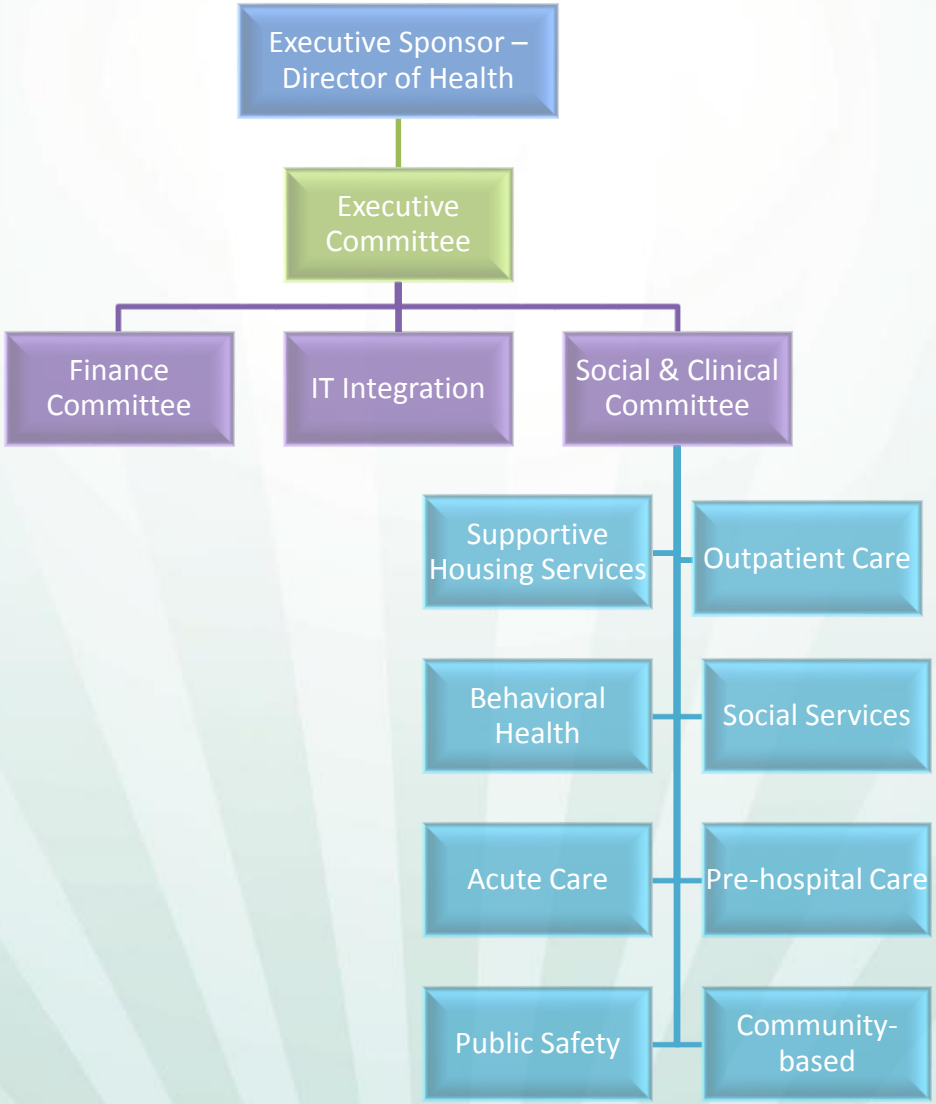
Date of execution of Agreement to June 30, 2021

Population Health Management Process

- Data: Selection of target population and geographic area to be served, data collection, stratification, analysis, and data integration

Safety net providers	Central California Alliance for Health
Prehospital providers	Public Safety providers
Mental Health Plan	Social Service providers

- Patient Alignment to Services and Programs
  - Clinical/Social: Description of services to be available
  - Care Coordination/Case Management: Patient Centric
- Evaluation: Statewide and local performance measure development and monitoring
- Funding: Diagram to show flow of funds, budget development, enrollment cap


Executive Sponsor – Director of Health
Executive Committee
Finance Committee
IT Integration
Social & Clinical Committee
Supportive Housing Services
Outpatient Care
Behavioral Health
Social Services
Acute Care
Pre-hospital Care
Public Safety
Community-based

WPC Partners

- Central California Alliance for Health
- County Departments
  - Health: Behavioral Health, Clinic Services, Public Health
  - Social Services
  - Natividad Medical Center
  - Office of Sheriff/Coroner
  - Probation Department
- Community Partners
  - 3 area hospitals
  - Community and rural clinics
  - Community based organizations (homeless service providers, community engagement providers, etc.)
  - Housing authority and housing developers and providers

Eligible Population

- Medi-Cal beneficiaries or Medi-Cal eligible who are high risk, high utilizers of multiple systems
  - Homeless or risk at homelessness
  - Mentally ill, substance use disorder
  - 4 or more MHU admissions in prior 12 months
  - 2 or more chronic conditions
  - 3 or more ED visits in prior 6 months
  - 2 or more hospital admissions in prior 6 months
- Approximately 100 participants per year, for a total of 500 over the five year Pilot

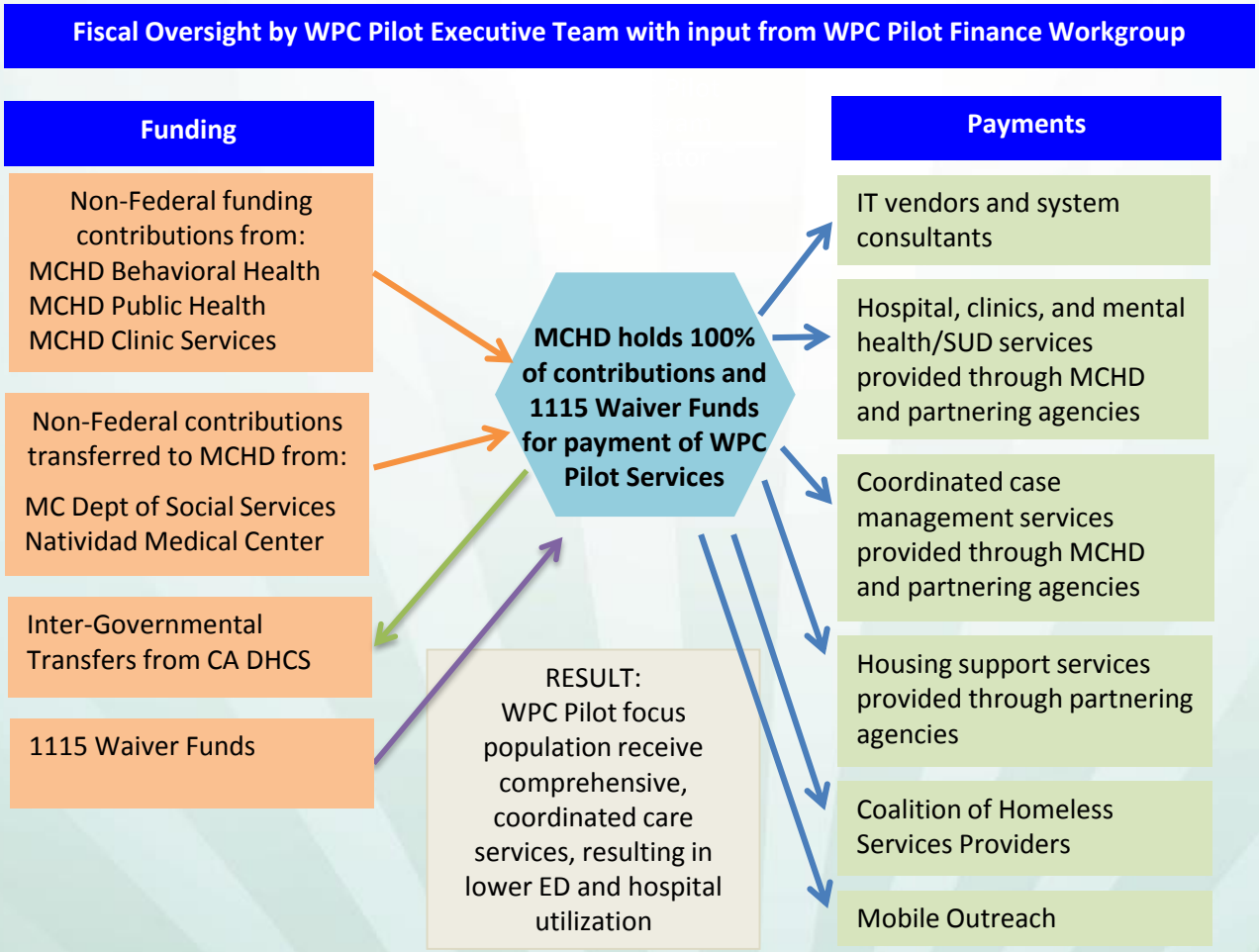
Strategies and Interventions

- Referrals
  - Hospitals, County jail, CCAH, health/service providers
- Core complex care coordination
  - Assessment and referral to primary care medical home, behavioral health services, and housing
- Community based case management
  - Coordinate housing and supportive services
  - Mobile outreach
- Data sharing and integration
  - eMPI (enterprise master person index)
  - Case management solution
  - Data warehousing

Examples of Health Outcome Measurements

Outcome	Measure
Hospital Coordination	Medications list provided to case managers on discharge
Case Management Enrollment	Timely transition from hospital or jail to PCP
Case Management Coordination	Comprehensive care plan provided within 30 days
Mental Health	Screening for depression and suicide risk
Mental Stability	Decreased MHU re-admissions within 30 days
Diabetes, Hypertension	Clinical screening for improved disease management
Substance Use Disorder	Substance use assessment and counseling
Hospital Utilization	Inpatient hospital avoidance
Emergency Department Utilization	Emergency Department avoidance
Adequate Shelter	Referrals for housing services

Funding Diagram



Questions/Comments

Resource:

- http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx