



Medi-Cal Reform 2.0

Health Access Priorities for California's Next Medicaid Waiver

January 12, 2015 Discussion Draft

Executive Summary

The coming renewal of California's section 1115 research and demonstration Medicaid waiver and Delivery System Reform Incentive Program (DSRIP) presents a critical opportunity to build on the state's success in implementing health reform and to tackle longstanding issues in the state's health care safety net.

Health Access seeks a new "Bridge to Reform 2.0" Medicaid waiver (and DSRIP 2.0) which supports our safety net; improves care and provides a medical home for Medi-Cal enrollees and the remaining uninsured; and moves California toward the "quadruple aim" of better care, better health, lower cost and reduced disparities, through both delivery system reform and population health approaches that integrate health care with other human services and community supports. Health Access supports the following vision and goals for Medi-Cal Reform 2.0:

- **ENSURING A SAFETY NET THAT SURVIVES AND THRIVES FOR THE NEWLY EXPANDED MEDI-CAL PROGRAM AND REMAINING UNINSURED**

Past waivers have focused on yielding needed resources for public hospitals and the safety-net, and this priority is as urgent as ever. In light of California's success with Medi-Cal enrollment, the safety net needs the capacity to address the pent-up demand for care presented by new Medi-Cal enrollees, even as it continues to serve the remaining uninsured. A critical part of the Bridge to Reform waiver, the DSRIP program brings additional resources to the safety net with funding levels tied to outcomes on delivery system reforms designed to make the safety net more efficient and effective so they can serve millions more.

- **CONNECTING ALL CALIFORNIANS WITH A MEDICAL HOME THAT STARTS WITH COORDINATED PRIMARY CARE**

Our health care system works better when everyone—both Medi-Cal enrollees and the remaining uninsured—has access to coordinated care in a primary care setting. President Obama recently gave relief from deportation to hundreds of thousands of California immigrants. To help California provide comprehensive managed care for the remaining uninsured (and others the state may determine eligible over the course of the waiver), the federal government should share savings with the state from reduced utilization of

emergency care and related services financed through Restricted-Scope Medi-Cal. A complementary goal would be to restructure the Disproportionate Share Hospital (DSH) and Safety Net Care Pool funding to provide more comprehensive primary and preventive care to the remaining uninsured.

- **PROVIDING INCENTIVES FOR SPECIFIC, PRIORITIZED DELIVERY SYSTEM REFORMS TIED TO POPULATION HEALTH GOALS**

The Medi-Cal Reform 2.0 waiver should embrace the ‘quadruple aim’ and keep the patient at the center of efforts to improve care, reduce costs, improve health and reduce disparities. A major source of financing for the safety-net, and the health system as a whole, a Medi-Cal waiver should provide health care delivery systems with sufficient resources and direction to focus on patient-centered goals—using a shared savings structure, and through related payment, transparency, and policy mechanisms. DSRIP 2.0 should prioritize key health goals already vetted from the Let’s Get Healthy California Task Force report.¹ Such changes should protect consumers and our health system, as they improve care, outcomes, and equity. Patients benefit from care transformations when their social circumstances—transportation needs, access to healthy food, decent housing and safe neighborhoods—are taken into account. DSRIP initiatives, too, need to build on proven medical home models and stretch beyond clinical walls to engage the community supports and resources to improve outcomes for patients, starting with Medi-Cal enrollees and the remaining uninsured. Finally, building on stakeholder consensus (not to mention CMS expectations) that DSRIP 2.0 should have a stronger emphasis on measurable outcomes, all metrics and analytics tied to clinical and population health outcomes should be stratified by race/ethnicity, primary language, income, gender, sexual orientation, and gender identity. Likewise, transparency and reporting mechanisms like dashboards should be accountable and accessible to the communities with the most to gain from delivery system reforms.

- **INTEGRATING HEALTH CARE WITH OTHER HUMAN SERVICES THROUGH WHOLE PERSON CARE**

The premise of “whole person care” is that health care is most effective when it engages services and supports across the silos of health, housing, corrections, and more. At a minimum such “horizontal integration” innovations should include integration of physical health with behavioral health, (mental health and substance abuse); ‘whole person’ care

Key Terms Used in This Paper

A *waiver* is a formal request by a state to the Secretary of Health and Human Services to waive specific Medicaid program requirements to test new ways to deliver care. Since the 1990s, California has made extensive use of waivers to further health reform goals or more recently, to implement reforms ahead of schedule and to extend their reach.

DSRIP (Delivery System Reform Incentive Program) is a related 5-year, federal pay-for-performance quality improvement initiative that is also up for renewal. The program strengthens care delivery throughout 21 public health care systems and makes quality, coordinated care more accessible and efficient for patients.

Authors Note

This is a discussion draft—to flesh out and test certain ideas and concepts, and to get input from our member and allied consumer and community organizations, as well as from other key stakeholders (providers, insurers, and state and county government). We welcome your comments—please share feedback with any of the authors: Beth Capell, Judi Hilman, and Anthony Wright at Health Access.

for those most in need, including those post-incarceration and those with seriously behavioral health issues; and coordination of long term services and supports for seniors and persons with disabilities as well as the “dual-eligibles” (those enrolled in Medicare and Medi-Cal). Counties should have additional incentives to develop innovative connections between health care and housing, health care and corrections, and other population health approaches.

For those less familiar with Medi-Cal and waivers, this paper starts with a quick background of the waiver process and the results and lessons learned from the last waiver, before detailing how the new waiver can meet these four general goals.

Backgrounder on Waivers

What Are Medi-Cal Waivers For?

As Medicaid is a program funded and overseen by the state and federal governments, the next waiver will be an agreement between the state and federal governments about how California’s Medicaid program (Medi-Cal) should be structured and managed going forward. Ideally, waivers are a mechanism for addressing systemic problems in the publicly financed segments of the health care system. What happens in Medicaid can have repercussions across all payers simply by virtue of Medicaid’s size or “clout” as a payer. With over 11 million Californians enrolled in Medi-Cal, whatever Medi-Cal does matters.

On overall health system performance measures California falls exactly in the middle of the pack, 26 out of 51. But in areas that can be impacted by Medicaid waiver initiatives the state comes out closer to the bottom of states, for example, on prevention and treatment (41 out of 51). On telltale measures of quality, *adults with a usual source of care* (44 out of 51) and *children with a medical home* (50 out of 51) California ranks close to the bottom.ⁱⁱ

Recognizing the need to prepare for reform and improve care, California was the first state to undertake a DSRIP program. Part of broader Medicaid 1115 waivers, DSRIPs are designed to transform the way Medi-Cal care is paid for and delivered for the sake of measurable improvements in quality and population health. A critical source of funding for public safety net hospitals, DSRIP programs allow hospital systems to partner with community clinics and community-based organizations to transform care in ways that address population health objectives.ⁱⁱⁱ

The 2010 Waiver: Bridge to Reform Waiver and DSRIP 1.0 Goals

The 5-year “Bridge to Reform” waiver was submitted on June 4, 2010 to CMS and approved on November 2, 2010. The primary goals of the 2010 waiver included:

Strengthen the health care safety net: Like waivers before it, the 2010 Bridge to Reform waiver was first and foremost about the counties and the county-based health care safety nets. In fact, in this and previous waivers all of the non-Federal share of funding was put up by the counties using payment mechanisms that limited the return on the counties’ considerable investment. This waiver shifted from the previous waiver’s limited CPE (Certified Public Expenditures) structure to an actuarial model wherein counties would receive capitated payments based on the risk of their patient mix. The public hospitals would still put up the state’s share to draw down federal matching funds, but they would have flexibility, depending on local funding structures and conditions, to use either IGT (Intergovernmental Fund Transfers) or CPE, or some combination, to pay for care.

Maximize opportunities, primarily via the ACA, to cover the uninsured and simplify eligibility. California was one of only five states to undertake an expansion of Medicaid prior to 2014, and through this waiver it did so on a scale much bigger and more impactful than anywhere in the nation. The waiver allowed counties to use federal Medicaid matching funds to cover hundreds of thousands of Californians through county-based Low Income Health Programs (LIHPs), and to use the LIHPs as gateways to medical homes for the newly insured—connecting patients to care, developing local capacity to deal with the newly insured, and building relationships between patients and providers. From a systems perspective, the emphasis on early expansion and on county-based Low Income Health Programs (LIHPs) as the base for enrollment helped to ease the counties’ burden from serving so many uninsured, i.e. the waiver positioned the counties to finally see paying patients. The benefits of waiver initiatives for the uninsured and for communities facing disparities cannot be overstated.

Promote long term, efficient, and effective use of state and local funds. The waiver arranged for supplemental payments, not to exceed UPL (Upper Payment Limits), to be directed to private hospitals to ensure access to care in rural areas or communities with significant uncompensated care burdens.

Improve quality and health outcomes (DSRIP 1.0). If public hospitals succeeded in strengthening coordinated system of care (medical homes, chronic disease management, investment in health IT), enhancing access to care (primary care access improvements, specialty care improvement, reduction in ER use, better language access), and improved patient safety (reducing hospital readmission rates, preventing admissions for ambulatory sensitive conditions, ensuring equity in care and outcomes), the public health care and safety net systems could keep a portion of their savings to serve more of the uninsured and to serve them better.

Results from the 2010 ‘Bridge to Reform’ Waiver and DSRIP 1.0

California has led the way in implementing the Affordable Care Act, enrolling more than 3 million Californians in Medi-Cal and Covered California, California’s health insurance exchange. Bridge to Reform 1.0 facilitated California’s transition from a state with one of the highest level of uninsured and a relatively low proportion in Medicaid managed care to becoming a leader in implementation by...

- Creating the Low Income Health Program, which, after much preparation, seamlessly enrolled 650,000 Californians into full-scope Medi-Cal on January 1, 2014 from a more limited benefit and network.^{iv}
- Expanding Medi-Cal managed care to rural areas and to seniors and persons with disabilities as well as 800,000 Californians dually eligible for Medicare and Medicaid; and transitioning almost a million children with incomes up to 250% FPL from a standalone CHIP program to Medicaid.
- Providing designated public hospitals critical resources via the DSRIP so that these vital safety net institutions could be competitive in a post-ACA world after decades of underfunding.

DSRIP 1.0 Accomplishments and Lessons

The 2010 DSRIP accomplished many things, but these two will matter most going forward: it helped the public hospital system build a strong foundation for delivery system transformation which helped lay the groundwork in turn for full implementation of the ACA and early expansion. The public hospital systems were at the heart of the state’s first DSRIP and together they achieved 2,100 milestones across 64 different projects, improving patient safety, care coordination and medical homes, electronic health records, and navigation to direct patients to the least expensive settings.^v These and related efforts have made California’s DSRIP a powerful model for other states. Most stakeholders agree the next DSRIP should be more tightly focused on outcomes and population health. Among the lessons learned, these stand out:

- The safety-net is still in a state of flux. The changes stemming from the Affordable Care Act are just some of the many budget, political, policy, and market forces impacting our safety-net, including specifically public hospitals. The new waiver can provide much needed stability through this tumultuous time.
- The current waiver focuses on maximizing new coverage options for the uninsured. Now that so many are covered, attention should shift to the remaining uninsured. We continue to see counties respond very differently to the needs of the medically indigent. Some counties have seen fit to provide comprehensive care to remaining uninsured residents who are undocumented, but they will have difficult continuing to do so without more stable sources of funding.^{vi}

- The transition of seniors and people with disabilities to managed care has been messy at best. The waiver failed to anticipate what it would take to effectively coordinate care for SPDs, especially those with mental illness or developmental disabilities, and the plans clearly needed better direction or incentives to engage community-based organizations to provide the social supports (for example transportation assistance or care management) needed to coordinate care effectively.^{vii} Beneficiaries had trouble understanding the notices they received, making it difficult for them to choose the best plan, and so on. The lack of access to specialists for populations with significant health care needs was troubling and raised questions about the capacity of managed care plans to handle the 800,000 dual eligibles that were transitioned to managed care as part of Bridge to Reform 1.0.

The current waiver expires in October 2015, and planning is underway to negotiate with the federal government for a renewed waiver. Health Access is pleased to serve on three workgroups: provider and plan incentives; safety-net, and DSRIP. We are also monitoring the workgroups on workforce development, housing, and “shared savings.”

Concepts for Bridge to Reform 2.0

The State’s Intentions

The state’s initial waiver concepts and initiative categories are summarized in a table to highlight the overlap across broad waiver objectives:

Bridge to Reform 2.0 Objectives				
Initial Waiver Concepts & Initiatives	Strengthen primary care delivery & access	Avoid unnecessary institutionalization / Integrated System	Whole Person Care	Social determinants of health (SDH)
	<p><i>Shared Savings Initiative:</i> Change the way draw down federal funds to support the safety net and related objectives. Introduce an <i>annual per beneficiary cap</i> absent the waiver. Use savings to fund worthy initiatives like ‘Whole Person Care.’</p>	<p>Payment reform incentive payments</p> <p>Successor DSRIP: to be more outcomes based and focused on population health.</p> <p>Extend ‘Triple Aim’ to more counties.</p>	<p>Shelter for vulnerable populations (homeless, nursing facility residents). Needs vary by demographics.</p>	<p>Housing First and medical home initiatives begin to address SDH.</p>
	<p>Safety net payment reforms (to incentivize medical homes) via a global payment approach or bundled payments around episodes of care). This may include integrating DSH and SNCP \$, if appropriate for certain counties.</p>		<p>Medical Homes (provider-housing partnerships)</p>	

FQHC payment & delivery reform: move from volume-based to risk-based model			
	Continue Coordinated Care Initiative (CCI)		
Workforce Development: this includes a proposal to subsidize malpractice insurance for providers willing to see more low-income patients.	CCS Program Redesign		

Source: DHCS (2014). Concepts for California's Next Medicaid Waiver Renewal.

With respect to DSRIP 2.0 the state's intentions are more tentative but so far complementary to the waiver goals. Here is a summary of the DSRIP 2.0 goals by domain:

Domain 1 Delivery System Transformation: These projects are designed to facilitate measurable improvements in these segments of the care delivery system:

- Ambulatory care redesign for primary and specialty care
- Care transitions and integration of post-acute care
- Integration of behavioral health and primary care

Domain 2 Care coordination for High-Risk, High Utilizing Populations: These projects include:

- Complex care management for high-risk populations
- integrated health homes for foster children
- Transition to integrated care post-incarceration
- Chronic, non-malignant pain management
- Comprehensive advanced illness planning and care

Domain 3 Resource Utilization Efficiency: These initiatives seek to minimize spending and utilization of medically unnecessary or wasteful procedures, including:

- Antibiotic stewardship
- Utilization of high cost imaging
- Therapies involving high cost pharmaceuticals
- Blood products

Domain 4 Prevention: These proposed projects carry over from the Let's Get Healthy California planning process and include:

- The Million Hearts Initiative, obesity prevention, and the Healthier Foods Initiative
- Cancer screening and follow up
- Perinatal care

Domain 5 Patient Safety: These projects promote a culture of patient safety in hospital and other clinical settings through process improvements, assessment of current safety protocols, and ongoing improvements.

Health Access Recommendations for Medi-Cal Waiver 2.0 and DSRIP 2.0

Health Access seeks a Medi-Cal 2.0 waiver which supports our safety net; improves care and provides a medical home for Medi-Cal enrollees and the remaining uninsured; and moves California toward the quadruple aim of better care, better health, lower cost and reduced disparities. We support lower costs for consumers and for the health system as a whole but several decades of underinvestment in the Medi-Cal program necessitate system investments in order to realize the goals of better care, better health and reduced disparities in a reformed system.

Based on results and lessons from the current waiver, Health Access recommendations include:

1. ENSURING A SAFETY NET THAT SURVIVES AND THRIVES. California has traditionally had the largest uninsured population in the nation and one of the highest percentages of uninsured, yet California's safety-net has historically been strained with historically low Medi-Cal reimbursement rates and a low federal government matching rate, less than what many other states get.

This waiver should continue the goal of past waivers to ensure needed resources for public hospitals and the safety-net. California needs a safety-net of Medi-Cal providers that survives and thrives, especially given the significant capacity required to serve the newly insured and the remaining uninsured.

Providers need incentives to be more efficient and effective, but they will fail without sufficient resources to serve the millions more gaining coverage for the first time.

The county health care safety net has proven it can do more with less. They should be allowed to do even more—but not with fewer resources than they are getting now. This waiver will come down to a negotiation between the state and the federal government, and we seek a proposal that stabilizes the health care safety net so that it may serve as the foundation for a reformed health care system.

2. CONNECTING *ALL* CALIFORNIANS WITH A MEDICAL HOME that provides primary care, by improving access to and coordination of comprehensive care both for Medi-Cal enrollees and the remaining uninsured.

The Affordable Care Act allowed California to take gigantic steps forward insuring the uninsured, and not just getting these Californians covered but connected to a usual source of care. The vast majority of coverage in California, including Medi-Cal, is in managed care. This means there is at least a structure in place, if not the reality, to connect every Californian with cost effective primary

care—a medical home. Efforts at Covered California and within Medi-Cal are working and should do more to ensure that the managed care plan connects their patients with a regular source of care.

Just as the last waiver connected hundreds of thousands of Californians to Low Income Health Programs, this waiver should advance the goal of providing medical homes for the remaining uninsured.

The case for federal participation in medical homes for the remaining uninsured is two-fold:

- 1) Capturing federal funding that would have been spent on emergency Medicaid for the populations that gain access to comprehensive managed care benefits and/or a medical home;
- 2) Re-investing the savings resulting from decreased use of emergency departments and from efficiencies of managed care and better coordination of care.

The individual patients would benefit from an ongoing connection to a usual source of care, a medical home that helps them navigate the health care system. The system would have the benefit for providing more efficient primary and preventive care, managing conditions, and creating a structure for those patients to use safety-net services more targeted and effectively. In addition, getting all patients connected with a system of care finally creates broader synergies and efficiencies and capacities for the system as a whole—from reorienting treatment delivery to epidemiology to population health.

- **Maintain, and expand, federal financial participation available under restricted scope Medi-Cal while providing comprehensive care through managed care to the remaining uninsured.**

California has a long and proud history of extending full Medi-Cal coverage to certain populations excluded from comprehensive federal Medicaid benefits. These have included recent legal immigrants, and other “deferred action” categories of “persons residing under the color of law (PRUCOL).” These Californians are covered through state funds and not the regular 50-50 Medicaid state/federal match—but there is a federal interest in this state policy. Without such coverage, the federal government would be “on the hook” if these patients used emergency services through restricted-scope Medicaid. Currently, the state negotiates a statistical adjustment to get federal reimbursement for the emergency services provided to the population covered by “state-only” Medi-Cal. We believe this same logic should be extended to new populations that the state covers as well.

Under President Obama’s recent executive action granting more Californians “deferred action” status, more Californians will soon be eligible for “state-only” Medi-Cal, shifting from fee-for-service emergency coverage to a more managed care approach that includes primary and preventive care. In particular, as California provides comprehensive managed care for the remaining uninsured given relief by President Obama’s immigration order (and others to whom California extends this

coverage), the federal government should continue their coverage of emergency services, and also share savings from any reduced emergency care financed through restricted scope Medi-Cal.

In addition to the federal government maintaining the federal financial participation that California would otherwise have received for restricted scope Medi-Cal, we further propose that California receive the federal financial participation that it would have received for restricted scope Medi-Cal *even if emergency room use declines due to better care coordination*. This can be done through an increase in the statistical adjustment of federal participation for this population, or in a more conditional approach where the federal government shares savings if it sees reductions in the use of limited scope Medi-Cal compared with trend expectations.

While we do not anticipate that all those potentially eligible will get through the hurdles with the United States Citizenship and Immigration Services (USCIS) to obtain deferred action or other status, under current California law those who obtain deferred action are eligible for Medi-Cal, and most would be enrolled in mandatory Medi-Cal managed care plans. We would also propose to further expand Medi-Cal managed care by enrolling those not eligible for full-scope Medi-Cal by reason of immigration status into comprehensive coverage that includes primary and preventive care rather than fee-for-service, restricted-scope Medi-Cal. Recent studies of the LIHP enrollment demonstrate enrollment in managed care reduces emergency room use over time^{viii} so we seek to maintain the level of federal participation that would have resulted from restricted scope enrollment in the absence of managed care.

This proposal would provide California the needed financial incentives to expand managed care to one of the few remaining fee-for-service populations enrolled in California's Medicaid program—the remaining uninsured by reason of immigration status. This would continue the transformation of Medicaid from fee-for-service to managed care begun in previous waivers.

- **Restructure and Improve Funding Flexibility for Hospitals and Community Clinics**

Health Access supports the proposal included in the California Association of Public Hospitals' and DHCS' papers that designated public hospitals should be able to use Disproportionate Share Hospital funding and Safety Net Care Pool funding to provide more comprehensive primary and preventive and whole person care to the remaining uninsured. CAPH further proposes using DSH and Safety Net Care Pool funds in a more flexible and efficient way to provide more comprehensive care to a population that includes the remaining uninsured.

We are interested in this possibility for multiple reasons. Having this flexibility allows resources to be directed more where the need is greatest in terms of services and patients. It also replaces today's misaligned incentives and moves the focus away from care in the most expensive settings. The state has proposed a "global budget for coordinated care for the uninsured" approach which would give county systems some certainty that if they meet certain benchmarks in providing services, they will get a certain level of reimbursement. In contrast with the uncertainty of these funding streams today, this will give counties the comfort to invest in these services in the first place—or continue or expand that investment.

The suggestion of a “points” system is a good step to encourage county systems to provide a broader set of services, especially outpatient, primary, preventive care, care coordination, while allowing flexibility county-by-county on what that combination of interventions looks like. The point system should further incentivize community and consumer input and transparency at the county level.

While we support county-by-county flexibility on interventions, we do think there should be some general expectation or basic standard that reaches across all public health systems. California’s next Medi-Cal waiver should articulate a new standard of care for the Medi-Cal and remaining uninsured: all patients who enter the public health system will be connected with a “medical home.”

We think this builds on the public hospitals’ success as the institutional base for the Low-Income Health Programs. Just as the patients served in the LIHPs were seamlessly enrolled in Medi-Cal, the new county-based programs should be able to target the remaining uninsured and bring them into more efficient systems of care. Some counties are already embarking on similar programs, and would benefit from the support. From Healthy San Francisco to My Health LA to HealthPAC in Alameda, these programs, while not portable “insurance,” provide a medical home that includes primary and preventive care.

Again, we seek the goal that every Californian that enters the health system is assigned a medical home. For those not eligible for federal or state programs, because of income or immigration status, we want to encourage counties to provide a last-resort option that put them in a medical home and system of care with some baseline of standardized benefits and standards, even if it isn’t full, portable, comprehensive coverage.

In this way, we view this proposal as complementary to the proposal to expand managed care to those uninsured by virtue of immigration status.

We also support the proposal of the California Primary Care Association to:

- Create a FQHC payment reform demonstration project to be developed by the community clinics, the public hospitals, and the health plans by aligning incentives for clinic participation in this effort.
- Restore funding for Traditional Clinic Programs, including EAPC, SAMW, RHSD and IHP, with general fund dollars drawing down federal match under the waiver.

We look forward to reviewing proposals from other organizations to strengthen the safety net to provide non-emergency care to the remaining uninsured.

- **Context: Care and Coverage for the Remaining Uninsured**

We prioritize this issue because California is projected to have significant remaining uninsured, even after full implementation of the Affordable Care Act. The remaining uninsured, estimated to be 2-3 million, includes the following:

- The undocumented who fail to take up coverage, even if it is available. Academic research and practical experience indicate that those who are undocumented are often afraid to come out of the shadows because of the risk of deportation. For example, only about half the young adults who are eligible for deferred action under the President's earlier action have cleared immigration hurdles to obtain formal status.
- Those who don't get enough financial help with premium costs. This includes those in the "family glitch" where the worker has employer-based coverage but not family coverage (or it is not affordable), but the family is still barred from subsidies through the Exchange. This also includes those above 300% of the federal poverty level who receive little or no subsidy and have to pay more than 8% of income for a silver plan in a high cost-of-living state. These folks are exempt from the mandate, but they are left with a Hobson's choice between paying unaffordable premiums or going uninsured. Another group is those in moderate income brackets, who facing California's high cost of living, particularly for housing, find premiums and cost-sharing still too burdensome as well.
- The short-term uninsured: federal and state laws allow an individual to go without coverage for as long as 60 days without penalty. Somebody who is in a short coverage gap could have a heart attack, appendicitis, cancer diagnosis, unplanned pregnancy, or another unplanned need for care.
- Those who fail to enroll during open enrollment. The Medicaid program is familiar to many because it has existed for almost 50 years. The entire structure of open enrollment, exchanges, and insurance market rules is new and confusing. Particularly during the five years of the next waiver renewal, some of the remaining uninsured will be those otherwise eligible for coverage who failed to enroll because of ignorance of the new reality.
- Those who are in transition from incarceration to the community: while the federal courts have done much to improve the care received by Californians who are incarcerated, California still has much to do to assure that those who exit incarceration have continuity of care.
- Those who lack documents or a fixed address or who have behavioral health challenges that make it difficult to enroll or maintain evidence of coverage.

We are in the midst of the transition created by the Affordable Care Act: California has done much to enroll those who are eligible for coverage and will continue to do more in the years to come. But for those who remain uninsured for whatever reason, it is in the interest of the state, the health system, and the federal government to ensure a medical home.

3. PROVIDING INCENTIVES FOR SPECIFIC, PRIORITIZED DELIVERY SYSTEM AND POPULATION HEALTH GOALS

Impacting a major financing source for the safety-net, and the health system as a whole, a Medi-Cal waiver should promote patient-centered goals, through multiple efforts—in a renewed DSRIP program, in a shared savings structure, and in other financial, transparency, and policy mechanisms. Such changes should protect consumers and our health system, as they improve care, outcomes, and equity.

We suggest taking key health system and population health goals from the Let's Get Healthy California report and making them touchstones for future delivery system and payment incentives. Let's Get Healthy has been a rigorous planning process involving many state leaders and stakeholders, and the recommendations are notable for the way they fill in the gaps in DHCS's concept paper for DSRIP 2.0.^{ix} Already Let's Get Healthy has identified key areas where there are measurable and trackable data; and it has prioritized health disparities and equity, recognizing that a statewide goal may not be achievable without targeted interventions in specific communities and populations.

DSRIP initiatives need to build on proven medical home models and stretch beyond clinical walls to engage community supports and resources to improve outcomes for patients, starting with Medi-Cal enrollees and the remaining uninsured.

Given the consensus for a stronger emphasis on measurable outcomes in DSRIP 2.0, all metrics and analytics tied to clinical and population health outcomes should be stratified by race/ethnicity, primary language, income, gender, sexual orientation, and gender identity.

Finally, in DSRIPs initiatives around the state, transparency and reporting mechanisms like dashboards should be accountable and accessible to the communities with the most to gain from delivery system reforms. To this end, they should be tested in advance and fine tuned over time.

- **A renewed and revised DSRIP 2.0**

California was the first state in the nation to include a DSRIP proposal in an 1115 waiver. The DSRIP part of the 2010 waiver recognized that different public hospital systems were at different stages of development and evolution toward integrated care and toward becoming providers of choice that not only survive but thrive.

We appreciated that the goals of the DSRIP in 2010 were a mix of process benchmarks trending to outcomes-based measures. The new waiver should have a mix of delivery system goals mixed with broader population health goals.

Health Access recognizes the substantial collaboration that already exists between other providers and the safety net of designated public hospitals and community clinics. Examples include the longstanding commitment on the part of Kaiser Permanente and the Blue Shield Foundation to assisting the safety net; county-wide community benefit planning in some counties; and local efforts that recognize the unique contribution of each institution to provision of care in a given county.

Health Access supports a successor DSRIP that is more standardized, with a greater emphasis on outcomes, and a comprehensive approach to the Quadruple Aim of better care, better health, lower costs, and improved health equity.

- **Incentives that Test Risk Adjustment for Socio-Demographic Status**

It is unrealistic to think that someone who goes home to a SRO in the Tenderloin has the same risk of readmission as someone who goes home to Marin or the hills of Oakland with money in the bank and family support at hand. Yet some proposals would apply the same incentives to health systems without regard to the different needs of the populations served.

It's not just common sense that says that if a health care system sees sicker or more at-risk patients, that system should be recognized in the form of higher reimbursements. The *risk* of health systems should be *adjusted* to reflect this. Recent research by the National Quality proposes that payment incentives and quality measures adjust for differences in socio-demographic status (SDS) related to income, education and occupation, and other important factors like race, ethnicity and limited English proficiency. A substantial peer-reviewed literature demonstrates that these factors affect health outcomes. Being poor is bad for your health. Being a person of color is also correlated with worse health outcomes. Those who are served by Medi-Cal are by definition low income and disproportionately likely to come from communities of color.

Risk adjustment and stratification should be used to assure that a provider is measured against other providers serving the same population in terms of SDS as well as clinical measures, where the literature demonstrates that SDS is correlated with health outcomes.

Other measures, including reduction in health acquired infections, are not demonstrated to be correlated with SDS and should not be adjusted according to the standard adopted by the National Quality Forum. California should be proud of what the public hospitals have done during the last waiver to reduce sepsis and other health acquired infections and should therefore have resources in place to do more along these lines in the next waiver. Everyone deserves safe care.

- **Shared savings that improve care and outcomes while reducing disparities**

The state should find ways to capture savings from measurable progress on Quadruple Aim objectives, but we are concerned about any proposal that puts care at risk for the Medi-Cal population, the population most in need of more extensive care. Heading into the next waiver, the state should take a hard look at the level of state General Fund dedicated to the Medi-Cal program. Are we setting up the program and all of its players (providers, hospitals, and beneficiaries) to fail? When underfunding Medi-Cal backfires or pushes costs to other parts of the system, it's the opposite of fiscal prudence. Health Access opposes a proposal that risks further underfunding of the Medi-Cal program, from either the state or federal government.

Health Access is particularly cautious about a model in which California is at-risk under a PMPM (per member per month) structure because Medi-Cal managed care has struggled to accomplish actuarially sound rates that result in timely access to adequate networks, particularly to specialty care. This history is especially troublesome in light of the expansion of Medi-Cal managed care to dual eligibles as well as seniors and persons with disabilities, as both populations have a greater need of specialty care than the families and children previously enrolled in Medi-Cal managed care. If California gets the PMPM wrong, millions of people could be at risk of untimely and inadequate care. And we risk pushing costs to other parts of the health care system. The time to address these issues is before submission of the next waiver application.

4. INTEGRATING HEALTH CARE WITH OTHER HUMAN SERVICES

Health Access supports innovations that seek to break down the silos between health, housing, mental health. “Horizontal integration” should be a goal advanced by this waiver. The greatest promise in terms of population health goals and real savings is this recognition that the best health interventions may be outside of the medical system and through alignment with counseling, housing, and other human services. This waiver could do a lot to incentivize coordination between different services and silos, using the funding to break down bureaucratic inertia.

The DSRIP 2.0 initiatives should begin with community needs assessments that include social determinants of health—not only in baseline measures but also in determining the type of community services and resources that should be engaged to help patients (as whole persons) benefit from treatment.

- **Integration of physical health with behavioral health**

Five years ago, in discussions that led to the current waiver, integration of physical health with behavioral health seemed a bridge too far. At that time the silos of mental health and substance abuse treatment alone seemed challenging to bridge, forget about integrating both with physical health. Thanks to the persistent efforts of the [Integrated Behavioral Health Project](#) and the California Mental Health Services Authority and their clinical partners (and others busting out of

the usual silos), the dream for this broader integration is within reach—and certainly fair game for B2R 2.0 and DSRIP 2.0.

Health Access strongly supports integration of physical health with behavioral health, both in the Medi-Cal program and in commercial coverage. Former Senator Sheila Kuehl, as chair of the Senate Health Committee, once observed that mental health parity was like the civil rights laws of the 1960s: its enactment was a huge victory that would take decades to make a reality and that would take changing hearts and minds. B2R 2.0 and DSRIP 2.0 provide the best opportunity to achieve this vision of better health and health outcomes for people living with behavioral health challenges.

- **Whole person care, starting with populations mostly likely to benefit**

A small number of individuals are high users of emergency care and other health care as well as behavioral health and social services. A disproportionate share of this small number is at risk for homelessness. We were interested to learn that Medi-Cal funds care for an even smaller number who are nursing home residents who have lost housing during a nursing home stay.

Under federal orders, California has made substantial progress in improving health care for individuals incarcerated in both county jails and state prisons. Realignment of correctional responsibilities has placed further focus on the behavioral health needs of people in county jails. Health Access strongly supports efforts at whole person care aimed at Californians exiting incarceration from *both* county jails and state prisons. California needs to break the cycle of mental health problems, substance abuse and incarceration. It is wrong—morally, financially, and from a public health perspective—that our correctional facilities, both state and county, have replaced the state hospitals of yesteryear as the treatment facilities for so many Californians.

The next waiver can test different approaches to stabilizing individuals through interventions such as “housing first” and “patient-centered health homes.” and see whether they can reduce costs, improve care, improve health and reduce disparities. Populations disproportionately at risk and in need of such intensive services include not only the homeless and those post-incarceration but also veterans and the LGBT community (particularly transgender individuals).

- **Care for Seniors and Persons with Disabilities and Dual Eligibles**

The Congress of California Seniors rightly points out that discharge planning and coordination with long term care services are problematic for seniors and persons with disabilities, including the duals. The current health care system, whether Medi-Cal or commercial, does a poor job of planning for services post-discharge as well as coordinating physical health with long term care services and supports. All too often, seniors end up in nursing homes for short stays or are readmitted to a hospital when a more comprehensive array of services would have let them stay at home safely. We support better coordination of the full range of services that are proven to reduce readmissions and improve outcomes while reducing overall costs. These efforts should also be calibrated and aligned to reduce disparities based on socioeconomic status.

Conclusion

California has an opportunity to present a bold vision of a renewed Medi-Cal program, that covers more Californians, while ensuring a safety-net that ensures access to care, a medical home for all Californians including the remaining uninsured, incentives for an improved health system overall, and one that is better integrated with human services to improve overall health of low-income Californians.

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Endnotes

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