Global Budget/Coordinated Care for the Uninsured

Department of Health Care Services

March 03, 2015

Agenda

- Waiver update
- Recap Key Goal/General Methodology
- Threshold Determination
- Draft Service Categories & Tiers
- Evaluation and Accountability

Waiver Update

All other workgroups have completed, this is final meeting of this workgroup

DHCS is currently drafting the Waiver application.

A public stakeholder webinar will be held in mid-March to walkthrough Waiver application

Final Waiver application will be submitted to CMS by end of March

Submission of application is not the end of the process and we expect ongoing feedback and changes to occur prior to finalization of the Waiver for November 1

Recap of Goals/Methodology

Key Goals/Concepts

- Improve health of the remaining uninsured through coordination of care
- Integrate and reform Medicaid DSH and Safety Net Care Pool funding
- Move away from a cost-based payment methodology restricted to mostly hospital settings
- Encourage public hospital systems to provide greater primary and preventive services, as well as alternative modalities such as phone visits, group visits, telemedicine, and other electronic consultations
- Emphasize the value of coordinated care and alternative modalities by recognizing the higher value of primary care, ambulatory care, and care management as compared to the higher cost, avoidable emergency room visits and acute care hospital stays

Methodology

Development of individual public hospital system "global budgets" from the overall available federal funding (open question of how the allocation would be done and how it would change over time particularly as DSH allotment decreases)

Funding would be claimed on a quarterly basis with the DPH providing the necessary IGT for the non-federal share

Achievement of threshold service targets would be done on a "points" system with a base level of points required for each system to earn their full global budget

Partial funding would be available based on partial achievement of the "points" target

Methodology cont'd

Point valuation would allow for the continuation of traditional services as they exist today, but encourage more appropriate and innovative care

Point values would also be developed for those innovative or alternative services where there is currently little to no reimbursement

Specifically, points for services would be assigned in a manner that recognizes value, where higher values would be assigned to services that meet criteria such as:

- Timeliness and convenience of service to the patient
- Increased access to care
- Earlier intervention
- Appropriate resource use for a given outcome
- Health and wellness services that result in improved patient decisions and overall health status
- Potential to avoid future costs

Threshold Determination

Goals

Thresholds should promote the flexible provision of a wide array of services that result in the right care, at the right place, at the right time

Thresholds should reflect at least the same levels of service to uninsured that would have been provided under current methodologies, but seek to promote increased access and care management

Enable public hospital systems to improve access, reduce waiting times, and improve health outcomes of uninsured communities by funding services based on value

Overview of Methodology

Establish separate thresholds for each public hospital system

Determine units of service of reimbursable activities in the base year

Establish point values per unit of service based on current reimbursement structures, which are generally cost based

Point values are consistent across all public hospital systems; thresholds vary by system and are based on system-specific data

Use FY13-14 services to uninsured as a base year *(most recent complete data available and already accounts to some degree for coverage expansion due to LIHP and first months of full expansion)*

Adjust for changes in utilization of uninsured services due full impact of ACA implementation to approximate hypothetical FY15-16 base

Step 1:
Determine historic point value by service

Aggregate data across all public hospital systems to determine relative ratio of point values

Establish historic point values for each service category on a per unit of service basis (e.g. based on charges)

Hypothetical Example

Category of service	Charges per unit	Resulting point values
Inpatient day	$5,000	50
Emergency room visit	$1,000	10
Primary care visit	$300	3
Specialty care visit	$500	5

Step 2: Determine FY13-14 Base Utilization

Determine service utilization for each system using FY13-14 data

Establish base year points by service category by multiplying base year utilization by historic point values established in step 1.

Category of service	FY13-14 Units of Service	Historic Point Value	Resulting Base Year Points
Inpatient day	2,500	50	125,000
Emergency room visit	5,000	10	50,000
Primary care visit	3,000	3	9,000
Specialty care visit	1,000	5	5,000

Step 3: Determine Hypothetical FY15-16 Base

Use data and other available information to assess percentage adjustments to utilization as a result of full implementation of expansion

Adjust units of service for each service category to account for changes in uninsured service needs based on coverage expansion *(accounting for both full scope and limited scope coverage)*

Category of service	FY13-14 Units of Service	% Adjustment	Hypothetical FY15-16 Units of Service
Inpatient day	2,500	-20%	2,000
Emergency room visit	5,000	-20%	4,000
Primary care visit	3,000	-10%	2,700
Specialty care visit	1,000	-10%	900

Step 4: Establish Initial Threshold

For each system multiply point value by estimated FY15-16 uninsured units of service

Sum point total across all services to establish initial system threshold

Category of service	FY15-16 Hypothetical Base	Historic Point Value	Resulting Points
Inpatient day	2,000	50	100,000
Emergency room visit	4,000	10	40,000
Primary care visit	2,700	3	8,100
Specialty care visit	900	5	4,500
Threshold			***152.600***

Meeting the Threshold

Future point value will be determined based on categories and tiers and will reflect goals of the demonstration.

Public hospital systems will receive points towards their threshold using these transformed point values for service utilization

Systems that meet or exceed threshold receive full global budget amount

Systems that do not meet threshold receive prorated portion of global budget amount in 5-10% bands

Unclaimed amounts may be reallocated to other systems that exceed threshold

Draft Service Categories & Tiers

Overview

Note: This is a draft concept intended for discussion and subject to change based on workgroup and other stakeholder input

Services would be grouped into four categories for purposes of reporting and of developing tiers of point values

- Traditional provider-based, face-to-face outpatient encounters (Traditional OP)
- Other non-traditional provider, groups, prevention/wellness, face-to-face (Other OP)
- Technology-based outpatient (Tech OP)
- Inpatient facility (IP)

Services within tiers are grouped by service intensity

Services tiers across categories that aim to provide the same end result would have relative values of generally equivalent nature

Intent is to provide flexibility in provision of services while encouraging a broad shift to more cost-effective care that is person-centered

Category 1: Traditional OP

This category would consist of the various types of face-to-face provider-based outpatient visits an individual could have at a public hospital system facility

Examples of these types of visits are:

- Traditional primary & specialty care
- Non-physician practitioner
- Mental health visit
- Dental
- Emergency room/Urgent care
- Outpatient procedure/surgery

Category 1 Tiers

Tier A:	• Non-physician practitioners (RN, PharmD, Complex Care Management)
Tier B:	• Provider-based primary and preventive care (PCP, dental, mental health); Provider-based specialty care
Tier C:	• Emergency room visit/Urgent care
Tier D:	• Outpatient surgery, provider performed diagnostic procedures, other high end ancillary services (e.g., chemo, dialysis)

Category 2: Nontraditional OP

This category would consist of the various types of encounters where care is provide by nontraditional providers or nontraditional settings

Examples of these types of services are:

- Home nursing visits post-hospital discharge
- Community health worker encounters
- Paramedic treat and release
- Group visits/Peer support
- Health education/community wellness encounters

Category 2 Tiers

Tier A:	• Community health worker, Health coach, care navigation, health education, wellness, patient support groups
Tier B:	• Group medical visits, wound check, pain management, case management
Tier C:	• Home nursing visits, paramedic treat & release

Category 3: Tech OP

This category would consist of the various types of encounters that rely mainly on technology for providers to provide care

Examples of these types of services are:

- Telephone consultations
- Physician-to-Physician eConsults for specialty care
- Telemedicine
- Call line encounters (nurse advice line)
- Email between physician/patient

Category 3 Tiers

Tier A:	• Nurse advice line, texting
Tier B:	• Telephone & email consultations between provider and patient
Tier C:	• Telemedicine visits (real-time video), provider-to-provider telehealth (e.g. eConsult, store & forward)

Category 4: Inpatient Facility

This category would consist of days spent in inpatient or other facility settings

Examples of these types of services are:

- Acute hospital care days
- Acute psychiatric care days
- Subacute care days
- Skilled nursing facility days
- Recuperative/respite care days

Category 4 Tiers

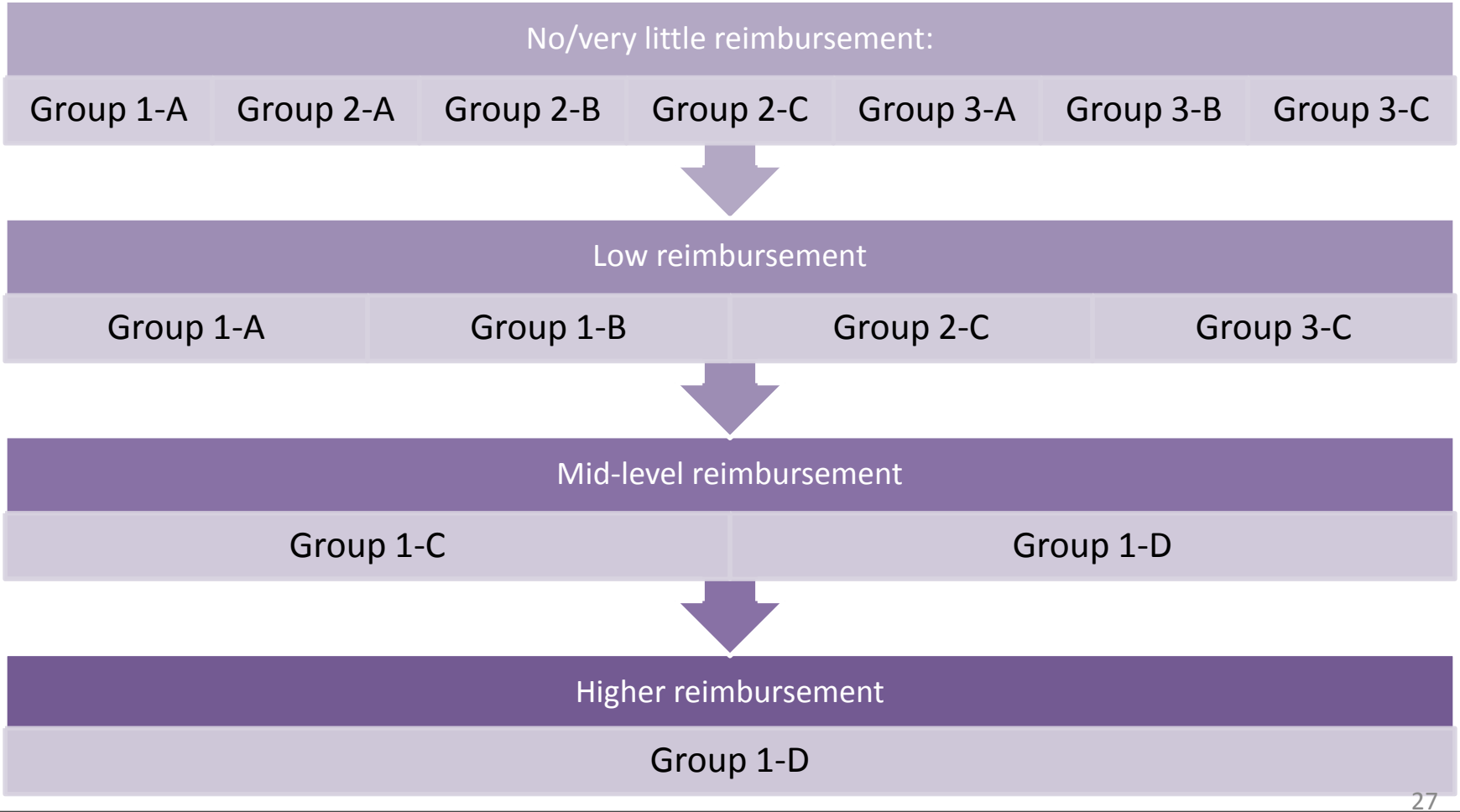
Tier A:	• Recuperative/respite care, sober center, skilled nursing, subacute
Tier B:	• General acute care days (include acute psychiatric days)
Tier C:	• Higher acuity inpatient days in ICU & CCU
Tier D:	• Highest acuity days/services – trauma, transplant and burn

Summary Table of Categories & Tiers

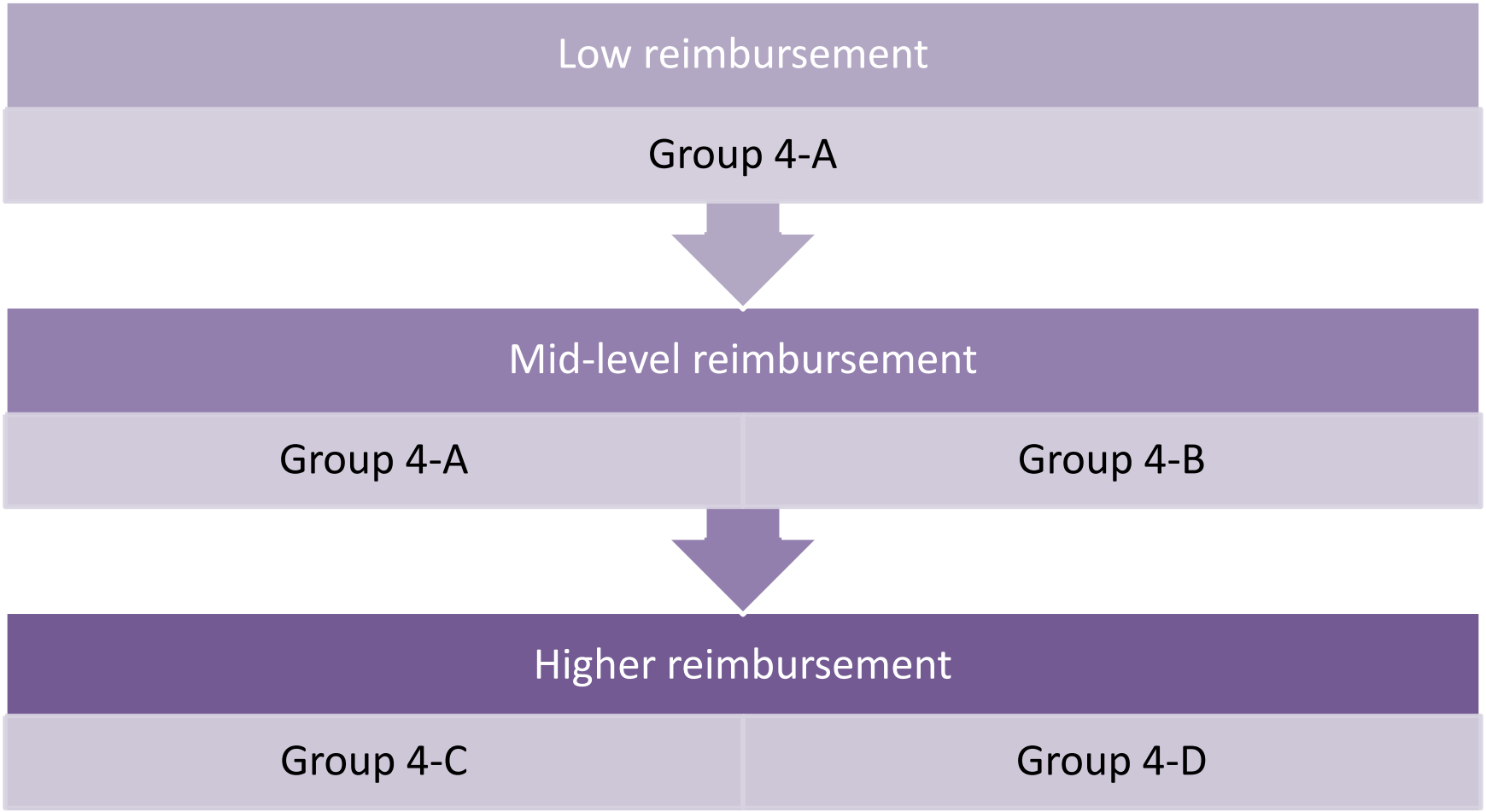
	Category 1 Traditional OP	Category 2 Nontraditional OP	Category 3 Tech OP	Category 4 IP
Tier A	Non-Physician Practitioners	CHW; Navig; Health Ed; Wellness; Support	Advice Line; Text	Respite; SNF; Subacute
Tier B	Primary & Specialty Care	Groups; Pain Mgmt; Case Mgmt	Phone/Email	General Acute
Tier C	ER; Urgent Care	Home Visit; Treat & Release	Telemedicine; eConsult	ICU/CCU
Tier D	OP Surgery; Procedures			Highest Acuity - Burn/Trauma

Categories 1-3:
Current Relative Value in Reimbursement

Labels based on category number and tier level (e.g. Cat 1, Tier A is Group 1-A); groups may appear in more than one category)



Category 4:
Current Relative Value in Reimbursement



Determination of Future Point Values

Future point values will be determined such that systems are incentivized to provide high-value services focused on providing care in the best way possible and most effectively

Service groups that today are afforded no or little reimbursement will be valued at levels recognizing the downstream impact they can have

In addition, service groups that have the same ability to impact overall care delivery and quality will have relatively equal values

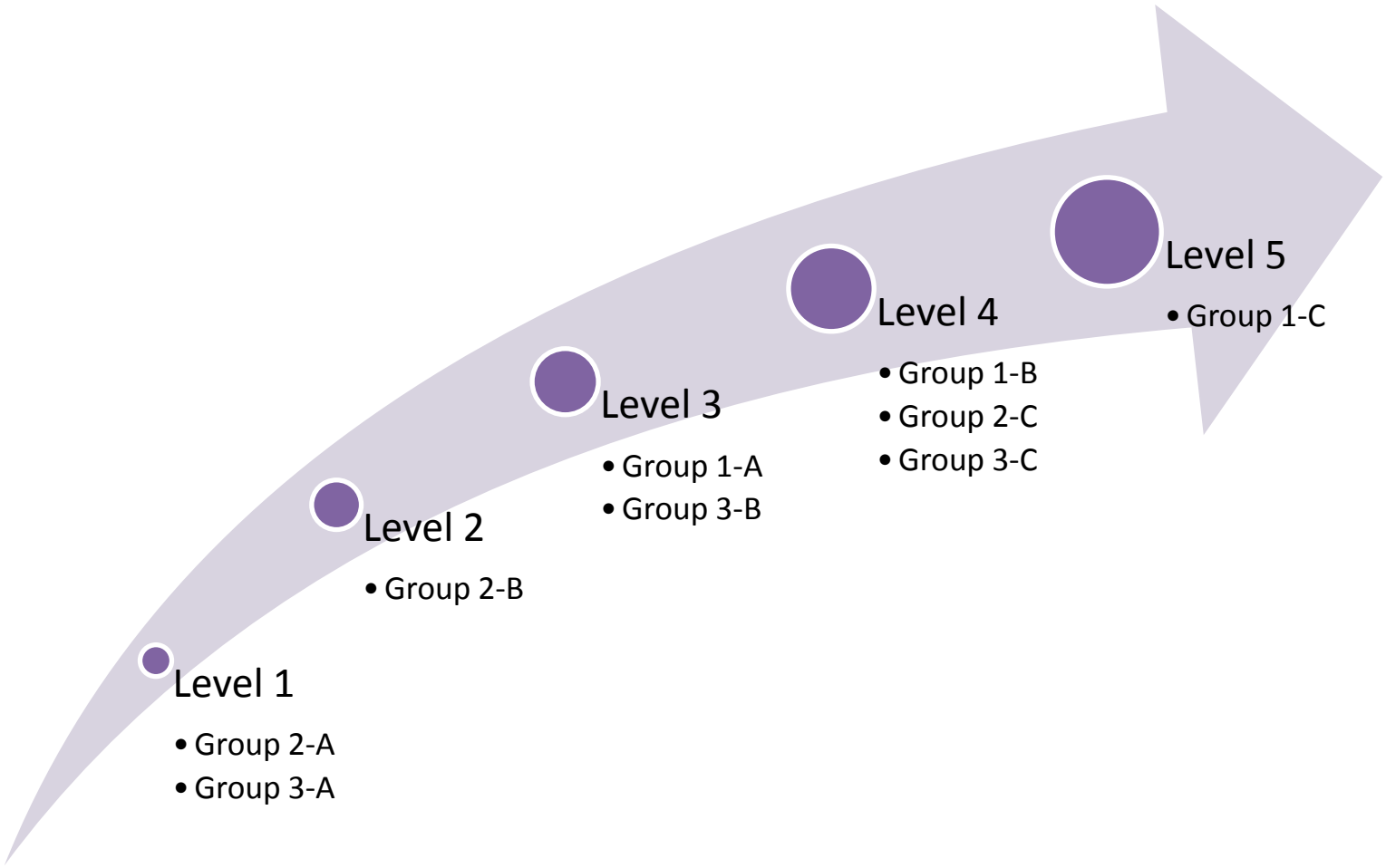
Service groups that may today have over-utilization and are not the most cost-effective or ideal delivery sites will have lower relative value than current reimbursement structures provide

Changes in Relative Value

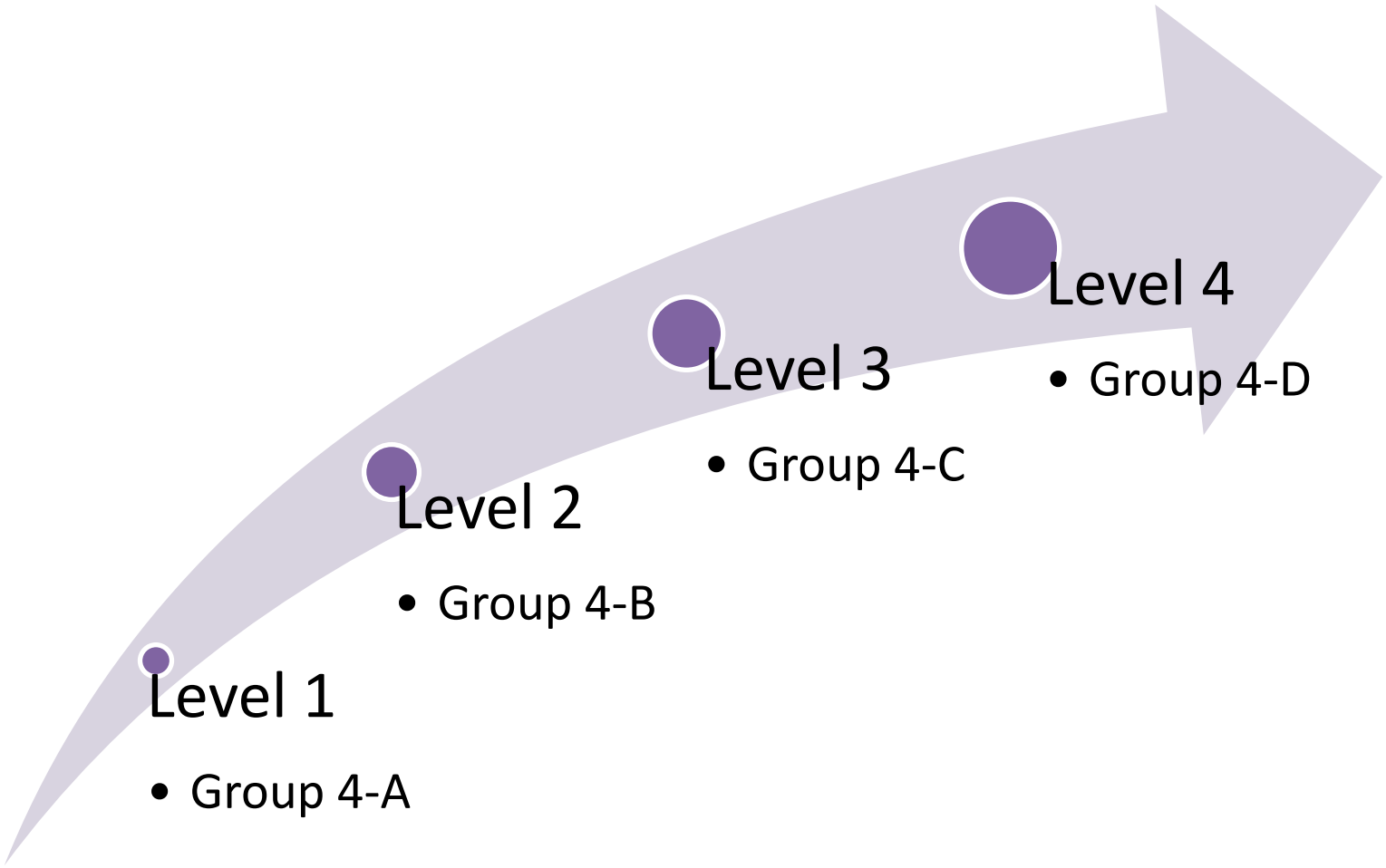
As previously noted, service groups in future point determinations will differ from how they are relatively valued according to current reimbursement methods

Service groups previously not reimbursed that will now have value	• Group 1-A • Groups 2-A, 2-B, 2-C • Groups 3-A, 3-B, 3-C
Service groups increasing in value	• Groups 1-A, 1-B • Group 2-C • Group 3-C
Service groups decreasing in value	• Group 1-C • Groups 4-B, 4-C
Service groups maintaining relative value	• Group 1-D • Groups 4-A, 4-D

Categories 1-3:
Conceptual Future Relative Point Values



Categories 4:
Conceptual Future Relative Point Values



Evaluation & Accountability

Evaluation & Accountability

Under this global payment/coordinated care for the uninsured proposal, California is seeking to demonstrate that shifting payment away from cost and toward value can encourage care in more appropriate settings, to ensure that patients are seen in the right place and given the right care at the right time.

It will be critical to establish clear metrics by which to gauge whether this effort is successful

In support of this evaluation, in addition to the reporting necessary for claiming the funding, the public hospital systems would report data in two core areas: resource allocation and workforce involvement

Additional reporting on meeting the broader goals of the Triple Aim, such as clinical outcomes and patient experience, will take place through other elements of the Waiver

Evaluation & Accountability (cont'd)

Resource allocation – *measures of the shift in balance of care & key utilization areas*

- Ratio of new to follow-up appointments within specialty care
- Average time to discharge from specialty care
- Ratio of primary care to emergency room/urgent care visits
- Mental health/substance use disorder visits
- Inpatient stays related to ambulatory sensitive conditions
- Non-emergency use of the emergency room

Workforce involvement – *investment in alternative uses of workforce to expand access and provide higher quality care for lower long-term costs*

- Use of non-traditional workforce classification (e.g. CHWs)
- Expansion of roles/responsibilities (within scope of practice) for traditional workforce classifications