CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

ISSUE BRIEF: THE GLOBAL PAYMENT PROGRAM

IMPROVING CARE FOR THE UNINSURED IN CALIFORNIA'S PUBLIC HEALTH CARE SYSTEMS

INTRODUCTION

California's county-run public health care systems (PHS[1]) are leading the nation in safety net payment reform by piloting incentives to provide better care for uninsured patients. The Global Payment Program (GPP) is the first payment reform effort of its kind – a reorganization of existing local and federal funding streams to encourage primary and preventive care.

Serving more than 40 percent of the state's remaining uninsured and 25 percent of its Medi-Cal population, California's public health care systems operate in fifteen counties where more than three quarters of the state's population lives.

This brief will provide a summary of the structure and mechanics of the Global Payment Program, explain the reasoning behind its unique design, and show how successful implementation would transform care delivery systems and improve the health of patients.

Promoting Primary Care for Uninsured Patients

Despite the progress made under the Affordable Care Act, the UC Berkeley Center for Labor Research and Education estimates[2] that by the year 2019, three million Californians will remain uninsured. These individuals have historically had limited access to primary and preventive services, often only seeking emergency health care services when their conditions have become more advanced. And though many Californians have health insurance, they may not be covered for certain services that are critical to their health and well-being.

The Global Payment Program creates financial incentives for California's PHS to provide these uninsured and underinsured individuals with more appropriate care in outpatient settings.

The GPP's incentives also encourage PHS to provide effective services that were previously unreimbursed, but which have been shown to help improve health outcomes. Such "non-traditional" services include technology-based consultation, which can promote better provider-to-patient communication. Similarly, "non-traditional" services like group visits can encourage peer learning, and nutrition education or health coaching can empower patients to improve self-care.

Leading Broader Payment and Delivery System Reform Efforts

Broadly, the health care industry is moving away from payment models that reward volume, toward value-driven care that ties payments to health outcomes. For insured patients, examples of value-based models include health plan and provider performance-based arrangements, and risk-based alternative payment models.

Value-based payment models have been a more difficult goal to achieve for uninsured and underinsured individuals served by California's public health care systems, given the fixed pool of federal funds available for uninsured services, and certain restrictions on how those funds could be used. These restrictions have limited PHS' ability to provide more cost-effective services, like primary and preventive care, which can be financed through risk-based structures.

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1. For the purposes of this brief, the terms "public health care systems" and "PHS" refer only to county-owned and operated public health care systems, which are the systems participating in the GPP. Generally, public health care systems also include the five University of California medical centers, which will be participating in other programs under the Medi-Cal 2020 waiver, including PRIME. For more on the waiver, visit caph.org/waiver. A portion of California's DSH allotment will retain its traditional structure for DSH recipients not participating in the GPP.

2. CalSIM Version 1.91 Statewide Data Book 2015-2019

The GPP is a 5-year pilot initiative included as part of California's current Section 1115 Medicaid waiver known as Medi-Cal 2020. The GPP is intended to complement other delivery system transformation efforts that are also focused on strengthening primary and specialty outpatient care. If successful, the combined result of all of these efforts will be redesigned public safety-net delivery systems that provide the right care in the right place at the right time, regardless of how – or whether – a patient is insured.

In designing and implementing the GPP, California's public health care systems seek to offer high-value care to patients and to the county and federal governments that are financing the program. The GPP ties payment to achievement, and assigns a relatively higher value to primary and preventive services than would traditionally be done under a purely cost-based or fee-for-service model.

For more on the Medi-Cal 2020 waiver, visit caph.org/waiver.

Reorganizing Existing Funding to Support Better Care

The GPP does not include any new money, but creates incentives by reshaping the way California's public health care systems receive existing federal funds for care to the uninsured.

Limitations in how public health care systems could receive support for care to uninsured individuals had long reinforced many of the barriers that prevented uninsured individuals from receiving needed preventive care, by restricting the bulk of the funding to the hospital setting, and by not recognizing the value of non-traditional care.

The GPP creates more flexibility in care delivery by supporting a wider array of services in more appropriate settings, and by tying payment to value, as opposed to merely cost.

As stated, the GPP merges two existing federal funding streams that California's public health care systems currently receive to care for the uninsured: Medicaid Disproportionate Share Hospital (DSH) funds and Safety Net Care Pool (SNCP) funds.

Medicaid DSH accounts for a large majority (around 80 percent in fiscal year 2015-2016) of GPP funding. Prior to the GPP, DSH funds could only be used to support services provided to Medi-Cal and uninsured individuals in a hospital setting.

SNCP funds were previously used to support face-to-face care provided to uninsured individuals in inpatient and outpatient settings, and were reduced by a specified percentage to account for the portion of services received by patients who were undocumented.

Prior to the GPP, neither Medicaid DSH nor SNCP provided funding for PHS to support non-traditional modes of care, including health coaching, nurse advice lines and nutrition education.

The GPP removes these restrictions and combines these funds into a larger pool, in order to promote more effective and efficient care to all who remain uninsured.

Box 1: Primary Care Helps Maria Olivera Manage her Conditions

An emphasis on primary and preventive care can make all the difference in the world in the lives of uninsured individuals.

Take Maria Olivera, a 65 year-old widow and grandmother from Los Angeles. Her immigration status disqualifies her for insurance coverage under the Affordable Care Act, but she needs regular care to help her manage her arthritis, her high cholesterol, and other health challenges stemming from a decade working in the garment industry.

Los Angeles County provides primary and preventive care services to uninsured patients through its My Health L.A. (MHLA) program. Through MHLA, Olivera gets free primary and preventive care, access to specialty care, and no-cost medications. She is now actively involved in managing her conditions, and has been given a good bill of health.

"It doesn't make sense to rely on emergency departments and urgent care clinics to be the primary source of care for a person with a primary care issue," says MHLA program director Amy Luftig Viste.

By providing federal support to counties for programs like MHLA, the GPP helps thousands of Californians like Maria get the care they need.

Tying Payments to Value

In addition to removing these restrictions, the GPP shifts payments away from a strictly cost-based system through an innovative restructuring of how PHS earn GPP funds.

As described in Box 2, all eligible GPP services are assigned a point value that still reflects the cost of the service, and considers the relative benefit to the patient for that service, as well as the impact on the delivery system through reduced future health care costs.

Box 2: The Basic Structure of the GPP

- Each PHS is eligible to receive a certain amount of funding in any given year under the GPP. This amount is referred to as a system's "global budget."
- In order to receive its full global budget for that year, each PHS must accumulate enough points to meet or exceed its "service threshold," which is based on historical provision of services to uninsured individuals.
- Each eligible service is assigned a point value. These values will always be consistent across all PHS in a given year.
- Every time a PHS provides an eligible service to a patient who is uninsured, the PHS will earn points based on that service's point value, which will go toward meeting its service threshold.
- Each PHS can design a system of care delivery that takes advantage of the GPP's structure to best meet the unique needs of the community it serves.
- If a PHS meets its service threshold, it will earn its full global budget. If a PHS does not provide enough services to achieve its full service threshold, then it will earn a proportional amount of its global budget.
- If any PHS does not earn its full GPP global budget, other participating PHS can earn additional GPP funding if they demonstrate services above their own threshold.
- Over the five-year course of the program, the relative values will shift, encouraging greater primary and preventive service utilization.
- Over time, as the amount of GPP funding declines the point thresholds will decline as well. See Financing section on page 6 for more details.

HOW IT WORKS

A Wider Array of Services

To provide a framework for the point structure, eligible services are organized into four categories that reflect the traditional inpatient and outpatient services that were available under the prior Medicaid DSH and/or SNCP programs, as well as services and settings that were not eligible for reimbursement under the prior funding structure.

Category 1: Outpatient in traditional settings - includes traditional services like primary and specialty care visits, mental health outpatient visits, outpatient emergency room visits, and non-traditional services like complex care management and RN-only visits.

Category 2: Complementary patient support and care services - includes services like wellness visits, mobile clinic visits, group medical visits, nutrition education, and health coaching.

Category 3: Technology-based outpatient - includes services like telephone consultation with a primary care physician, provider-to-provider electronic consultation, video-observed therapy and online evaluation.

Category 4: Inpatient - includes traditional services like inpatient medical/surgical stays and trauma care, and non-traditional services like recuperative/respite care and sobering center stays.

Assigning Points Based on Relative Values

In order to earn federal GPP funding, each PHS must provide a minimum level of care – or "service threshold" – measured in total points accumulated by a PHS during a given year. These thresholds are based on historical levels of service provided by each PHS to uninsured individuals. In order to achieve their full annual global budget, each PHS must reach its service threshold. Services are assigned initial points based on the following criteria:

Criteria for Relative Point Value Determination
Timeliness and convenience of service to 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 mitigate future costs
Preventive services
Likelihood of bringing a patient into an organized system of care

Emergency room visits and inpatient stays retain a higher value overall in recognition of their higher cost and potentially life-saving nature. Primary and preventive services are assigned greater relative value. Over the five-year course of the program, the relative values will shift, encouraging greater primary and preventive utilization.

See following page for a full chart of services and their assigned point values in year one.

Box 3: Categories, Tiers, and Points for the GPP, Year 1[3]

Category and description	Tier	Tier description	Service type	Traditional / non-traditional	Initial point value
1: Outpatient in traditional settings	A	Care by Other Licensed or Certified Practitioners	RN-only visit	NT	50
			PharmD visit	NT	75
			Complex care manager	NT	75
	B	Primary, specialty, and other non-emergent care (physicians or other licensed independent practitioners)	Primary/specialty **(benchmark)**	T	100
			Contracted primary/specialty (contracted provider)	T	19
			Mental health outpatient	T	38
			Substance use outpatient	T	11
			Substance use: methadone	T	2
			Dental	T	62
	C	Emergent care	OP ER	T	160
			Contracted ER (contracted provider)	T	70
			Mental health ER / crisis stabilization	T	250
	D	High-intensity outpatient services	OP surgery	T	776
2: Complementary patient support and care services	A	Preventive health, education and patient support services	Wellness	NT	15
			Patient support group	NT	15
			Community health worker	NT	15
			Health coach	NT	15
			Panel management	NT	15
			Health education	NT	25
			Nutrition education	NT	25
			Case management	NT	25
			Oral hygiene	NT	30
	B	Chronic and integrative care services	Group medical visit	NT	50
			Integrative therapy	NT	50
			Palliative care	NT	50
			Pain management	NT	50
	C	Community-based face-to-face encounters	Home nursing visit	NT	75
			Paramedic treat and release	NT	75
			Mobile clinic visit	NT	90
			Physician home visit	NT	125
3: Technology-based outpatient	A	Non-provider care team telehealth	Texting	NT	1
			Video-observed therapy	NT	10
			Nurse advice line	NT	10
			RN e-Visit	NT	10
	B	eVisits	Email consultation with PCP	NT	30
	C	Store and	Telehealth (patient - provider)	NT	50

3. Taken from Attachment FF of the Medi-Cal 2020 Special Terms and Conditions: Global Payment Program Valuation Protocol

Box 3: Categories, Tiers, and Points for the GPP, Year 1, continued

Category and description	Tier	Tier description	Service type	Traditional / non-traditional	Initial point value
	C	Store and forward telehealth	Telehealth (patient - provider) - Store & Forward	NT	50
			Telehealth (provider - provider) – eConsult / eReferral	NT	50
			Telehealth – Other Store & Forward	NT	65
	D	Real-time telehealth	Telephone consultation with PCP	NT	75
			Telehealth (patient - provider) - real time	NT	90
			Telehealth (provider - provider) - real time	NT	90
4: Inpatient	A	Residential, SNF, and other recuperative services, low intensity	Mental health / substance use residential	T	23
			Sobering center	NT	50
			Recuperative / respite care	NT	85
			SNF	T	141
	B	Acute inpatient, moderate intensity	Medical/surgical	T	634
			Mental health	T	341
	C	Acute inpatient, high intensity	ICU/CCU	T	964
	D	Acute inpatient, critical community services	Trauma	T	863
			Transplant/burn	T	1,131

Box 4: Hypothetical GPP Example

XYZ County Health System has been assigned its global budget and service threshold for year one.

Example System XYZ	Year 1
Global Budget	$6.75 million
Service Threshold	3 million points

XYZ County Health System must earn 3 million points to receive its full global budget. It can design a system of care delivery that takes advantage of the GPP's incentives, to offer more primary and preventive care and a variety of non-traditional services that complement more traditional care. XYZ County Health System will still receive support for acute and emergency care.

The example below shows how XYZ County Health System might earn its full global budget based these services:

Pts/ ea.	Service	QTY	Total Points
964	ICU/CCU	250	241,000
863	Trauma	750	647,250
776	Outpatient Surgery	250	194,000
160	Outpatient ER	1,500	240,000
100	Primary Care	10,000	1,000,000
100	Specialty Care	5,000	500,000
75	Telephone Consult with Primary Care	800	60,000
50	Group Medical Visit	1,010	50,500
25	Nutrition Education	1,250	31,250
15	Health Coaching	2,400	36,000
	TOTAL		3,000,000

In this example, primary and specialty care visits account for half of the points that XYZ County Health System could use to meet its threshold. Prior to the GPP, these services may have been supported by federal funding, but only for specific patients, seen in specific settings, due to restrictions on how those funding streams could be used.

In addition, non-traditional services such as telephone consultations and group visits, which previously would have been completely unsupported by the funding streams that make up the GPP, now account for almost six percent of XYZ County Health System's points.

XYZ County Health System may have already been offering these non-traditional or complementary services to uninsured patients regardless of federal funding, because they improve patient health and wellness. But XYZ County Health System will now receive federal support for them through the GPP, which will create further incentives to provide even more of these patient-centered services.

Financing Details

In the first year of the GPP, the total PHS pool includes $236 million in federal SNCP funds with an estimated $900 million in existing federal Medicaid DSH funds, for an estimated total of $1.1 billion in federal funds.

Since Medi-Cal is a state-federal partnership, in order to receive federal funds for the GPP, a non-federal share is required. In this program, PHS will each individually provide the non-federal share of funding for the program, for an aggregate of $1.1 billion in local funds.

The initial waiver agreement only guaranteed SNCP funding for the first year. Following the completion of an independent study to determine PHS' ongoing need for federal funds for uncompensated care for the remaining uninsured, CMS approved the renewal of SNCP funding, at the same level, for the final four years of the waiver.

This study, completed by Navigant Consulting in May 2016, found that more than 70 percent of county PHS services are utilized by Medicaid and uninsured patients, with uninsured patients accounting for 11.5 percent. The study found that California's county PHS incurred more than $1.8 billion in uninsured costs during fiscal year 2013-2014. The study factored in service payments, DSH, SNCP, and the provision of non-federal share, and concluded that county PHS receive a net payment of $0.69 for every dollar of Medicaid and uninsured cost.

The data from the study showed that without SNCP, only 79 percent of the cost of caring for uninsured patients at county PHS would have been covered.

The DSH component of the GPP will be reduced over the course of the waiver due to scheduled decreases in total federal Medicaid DSH funding, starting in federal fiscal year 2017-2018, as required by federal law.

The following table illustrates expected variations in DSH funding, with estimates in parenthesis.

	DSH Federal Funds (est.)	SNCP Federal Funds	Total GPP Funds (est.)
Y1	$866 million	$236 million	$1.1 billion
Y2	($910 million)	$236 million	($1.1 billion)
Y3	($792 million)	$236 million	($1 billion)
Y4	($749 million)	$236 million	($985 million)
Y5	($693 million)	$236 million	($929 million)

DRIVING TRANSFORMATION AND MAKING A DIFFERENCE TO PATIENTS

Developing Local Solutions

Each of California's public health care systems is in the process of developing its own approach to the GPP, building off its current systems and structures, and taking into account lessons learned from prior payment and delivery system reform efforts.

Kern Medical - Developing Brand New Programs for the Uninsured

Some participating PHS, like Kern Medical in Bakersfield, are re-designing programs almost from the ground up to take advantage of the opportunities provided by the GPP to improve the health of their patients.

"We need to utilize our resources effectively. The structure of the GPP, and the shift in relative point values over time, will allow us to transform how we deliver care in a way we couldn't have without it," says Russell Judd, President and CEO of Kern Medical.

This transformation can be seen in the newly-created Kern Medical Wellness Program (KMWP), which is currently being rolled out to patients seen in Kern Medical's hospital setting that do not have access to health coverage. The program is open to adults between the ages of 19 and 64, who have lived in the county for at least 30 days, and whose income is below 300% of the Federal Poverty Level.

KMWP members will have free access to a full range of health care services, including family practice, women's health, orthopedics and internal medicine. The program also includes imaging, lab, and pharmacy services, as well as emergency services when needed. Over the next four years, Kern Medical anticipates the program could manage the health of more than 8,000 lives.

Judd says that bringing access to these types of services to the uninsured not only helps those individuals manage their own conditions, it relieves stress on the entire institution.

"We're definitely anticipating seeing a positive impact in our ER," says Judd. "We think the GPP will free up room and resources for patients who truly need emergency services. That will help all of our patients."

"The structure of the GPP, and the shift in relative point values over time, will allow us to transform how we deliver care in a way we couldn't have without it."

– Russell Judd, President and CEO of Kern Medical.

Santa Clara Valley Health and Hospital System - Expanding Successful Programs for the Uninsured

In Santa Clara County, the Santa Clara Valley Health and Hospital System (SCVHHS) is expanding its uninsured program to maximize the benefit of the GPP. The Primary Care Access Program (PCAP) targets individuals 19 years or older living in Santa Clara County with a household income less than or equal to 200% of the Federal Poverty Level, and who are not eligible for another form of health coverage.

PCAP provides free (or very low-cost) preventive care, and any prescriptions, laboratory services, or radiology services ordered by a primary care physician. It also includes inpatient services.

"The GPP will allow us to dramatically grow PCAP, from a pilot program with a cap on the number of patients, into an ongoing, sustainable program with much more capacity," says René Santiago, Deputy County Executive and Director of the county's Health and Hospital System.

SCVHHS has experience bringing these types of services to uninsured individuals. Prior to the creation of the PCAP program, SCVHHS led multiple coverage efforts, including a local coverage program for undocumented children and the Low Income Health Program, which served uninsured adults and seamlessly transitioned them into Medi-Cal through the implementation of the Affordable Care Act. The PCAP program leverages the lessons learned from these prior efforts to more effectively meet the needs of their patient population.

"We know from our experience that there will be an influx of demand when we expand the program, but we're trying to build a solid foundation so that we can help patients quickly establish ongoing relationships with primary care teams. Our goal is to have one standard of patient care for all patients," says Santiago.

Improved Data Collection and Monitoring

To access GPP funding through the new point system, PHS will be required to track and report on services provided to uninsured patients. For many health care systems, this will require significant improvements in both the collection and integrity of data for these patients.

In some cases, due to the previously-uncompensated nature of certain services being provided, this may be the first time systems are recording these services.

Better data and analytics encouraged through the GPP can also support PHS efforts to more effectively coordinate care and manage health. In addition, the collection of data on care provided in non-traditional settings will help inform the future consideration of reimbursement for these services more formally in other programs, like Medi-Cal.

Evaluation

The GPP will be evaluated twice throughout the course of the program to learn about how it is improving the health of uninsured individuals, inform how improvements can be made to the program following the five year demonstration period, and provide an opportunity for other states to learn from the experiences of California's PHS.

CONCLUSION

The GPP is one of the latest in a series of payment and delivery system reform efforts led by California's public health care systems, including the 2010 "Bridge to Reform" waiver's Low Income Health Program, and Delivery System Reform Incentive Program (DSRIP), and the GPP's fellow Medi-Cal 2020 programs, PRIME and Whole Person Care. For more on all of these efforts, visit caph.org/waiver.

Successful implementation of the GPP will result in a marked shift in where and how PHS deliver care to uninsured individuals, with the goal of improving the health of a patient population that has historically lacked access to primary and preventive care.

"California's public health care systems are deeply committed to improving care for all patients, regardless of how or whether they are insured. The GPP was designed to incentivize county health care systems to transform the way they take care of uninsured patients, and we are excited to test this innovative approach." - Erica Murray, President and CEO, CAPH

ABOUT CAPH/SNI

The California Association of Public Hospitals and Health Systems (CAPH) and the California Health Care Safety Net Institute (SNI) represent California's 21 public health care systems and academic medical centers.

As a trade association, CAPH works to advance policy and advocacy efforts that strengthen the capacity of its members to ensure access to comprehensive, high-quality, culturally sensitive health care services for all Californians, and educate the next generation of health care professionals.

SNI, a 501c3 affiliate of CAPH, designs and directs programs that accelerate the spread of innovative practices among public health care systems, public clinics, and beyond. SNI's work informs CAPH's policy and advocacy efforts, and helps these providers deliver more effective, efficient and patient-centered health care to the communities they serve.

ABOUT CALIFORNIA'S PUBLIC HEALTH CARE SYSTEMS

Serving more than 40 percent of the state's remaining uninsured and 25 percent of its Medi-Cal population, California's 21 public health care systems operate in fifteen counties where more than three quarters of the state's population lives.

Though just 6 percent of all health care systems in the state, they serve more than 2.85 million patients a year, provide 10.5 million outpatients visits annually, operate more than half of the state's top-level trauma and burn centers, and train more than half of all new doctors in the state.

ABOUT MEDI-CAL 2020

The Global Payment Program is linked to the other key components of the Medi-Cal 2020 Waiver, both thematically - in terms of focusing on primary and preventive care and tying payments to performance goals, and programmatically - in terms of incentivizing activities that will lead to stronger collaboration, more coordination, and better outcomes for our most vulnerable patients.

For more on the waiver's overall goals and its other key components, visit caph.org/waiver