CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

THE GLOBAL PAYMENT PROGRAM

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

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 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.

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 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.