

HEALTH MANAGEMENT ASSOCIATES

California Medi-Cal 2020: What the State's 1115 Waiver Renewal Means for Providers, Health Plans, and Patients

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February 3, 2016

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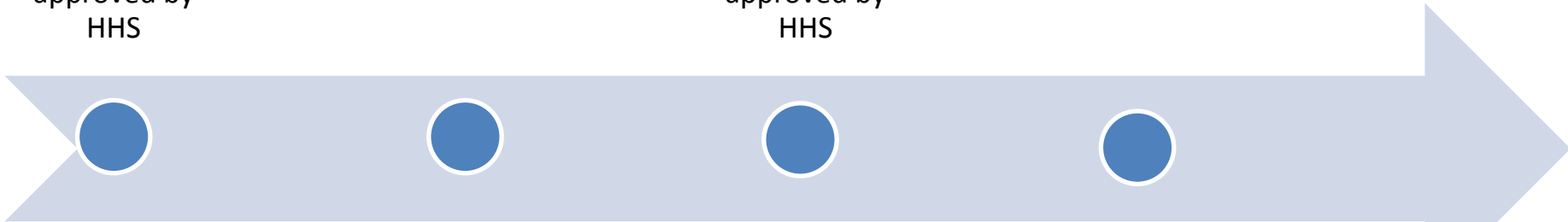
Today's Webinar Agenda

- Overview of the Medi-Cal 2020 Waiver
 - Bridge to Reform Waiver
 - New Medi-Cal 2020 Components
 - Continuation of existing Waiver/Expenditure authorities
- New Medi-Cal 2020 Initiatives
 - PRIME
 - Global Payment Program
 - Whole Person Care (WPC) Pilot
 - Dental Transformation Initiative (DTI)
- Questions and Answers

Medi-Cal Timeline

November
2010, Bridge
to Reform
Waiver
approved by
HHS

December
2015, Medi-
Cal 2020
Waiver
approved by
HHS



B-T-R New Initiatives
Implemented (2011-2015)
Seniors Persons with
Disabilities
Low-Income Health Program
Community Based Adult
Services
Medicaid Expansion
Coordinated Care Initiative

January 2016 –
Beyond
Implementation of
PRIME
Global Payment Program
Whole Person Pilots
Dental Transformation Initiative

Medi-Cal 2020

What Medi-Cal 2020 waivers means for California

- Approval of Medi-Cal 2020 introduces a new Federal commitment to the Medi-Cal program investing in continued transformation of California's Health Care Delivery system
- The new waiver secures \$6.2 billion in Federal funds over the 5- year demonstration
- Provides both Federal approval and funding commitments allowing Medi-Cal to implement four new reform programs under the new 5-year demonstration:
 - PRIME – (Public Hospital Redesign and Incentives in Medi-Cal)
 - Global Payment Program (GPP)
 - Whole Person Care pilot program (WPC)
 - Dental Transformation Initiative

Medi-Cal 2020

- Continues existing Waiver and Expenditure Authorities established under the 2010 Bridge to Reform waiver, such as:
 - Managed care delivery system for Seniors and Persons with Disabilities (SPDs)
 - Coordinated Care Initiative (CCI)
 - Medi-Cal Managed Care Delivery Systems
 - Indian Health Services (IHS) Uncompensated Care Program
 - Drug Medi-Cal Organized Delivery System
 - The Community Based Adult Services (CBAS) Program;
 - California Children’s Services (CCS) Program;
 - Designated State Health Programs (DSHP)

Medi-Cal 2020

- What the new Medi-Cal 2020 waivers means for California?
 - Provides opportunities and incentives to increase coordination of care
 - Allows Medi-Cal to develop alternate payment methodologies (APMs)
 - Provides opportunities to create and test new approaches of purchasing primary and preventative care for the uninsured
 - Shifts the focus of care for the uninsured from costly emergency care to a primary and preventative focus

Medi-Cal 2020: PRIME Overview

PRIME is the successor of California's DSRIP

PRIME expands the participating entities from only Designated Public Hospital (DPH) systems to DPHs and District Municipal Hospitals (DMPHs)

Topics to be discussed:

1. Purpose of PRIME Pool
2. PRIME entities and funding levels
3. What it means for Providers
4. What are the opportunities
5. What are the risks and critical planning issues

Medi-Cal 2020: PRIME's purpose

- PRIME:
 - Is intentionally ambitious and time-limited;
 - Aims to:
 - ❑ Change care delivery to maximize health care value; and
 - ❑ Promote risk-based alternative payment models (APMs).
- PRIME goals:
 - Provide patient-centered, data-driven, team-based care;
 - Advance point-of-care services, complex care management, and population health management;
 - Implement EHR and data analytics to drive improved care; and
 - Improve health outcomes as evidenced by clinical, preventable event, and patient experience metrics.

Medi-Cal 2020: 3 PRIME Domains

Domain 1: Outpatient Delivery System Transformation (which includes integration of physical and behavioral health)

Domain 2: Targeted High Risk or High Cost Populations

Domain 3: Resource Utilization Efficiency

Medi-Cal 2020: PRIME Entities

Prime Entities	Funding	Description
DPH	<ul style="list-style-type: none"> <input type="checkbox"/> DY 11 - \$1.4 billion <input type="checkbox"/> DY 12 - \$1.4 billion <input type="checkbox"/> DY 13 - \$1.4 billion <input type="checkbox"/> DY 14 - \$1.26 billion <input type="checkbox"/> DY 15 - \$1.071 billion <p><i>The pool phases down by 10 percent in the fourth year of the demonstration and by an additional 15 percent in the fifth year of the demonstration.</i></p>	<ul style="list-style-type: none"> • 17 health systems and 21 hospitals, four of which are in Los Angeles County; • Located in mostly urban areas in Northern, Central and Southern California; • Range in size from approximately 160 to 600 beds; • Academic teaching centers providing a broad range of inpatient and outpatient services including specialty care; and • More than 50% are Medi-Cal beneficiaries or uninsured.

DPHs must include projects from 3 domains and contain the specific elements as required under PRIME Projects and Metrics Protocol.

Medi-Cal 2020: PRIME Entities

Prime Entities	Funding	Description
DMPH	<ul style="list-style-type: none"> <input type="checkbox"/> DY 11 - \$200 million <input type="checkbox"/> DY 12 - \$200 million <input type="checkbox"/> DY 13 - \$200 million <input type="checkbox"/> DY 14 - \$180 million <input type="checkbox"/> DY 15 - \$153 million <p><i>The pool phases down by 10 percent in the fourth year of the demonstration and by an additional 15 percent in the fifth year of the demonstration.</i></p>	<ul style="list-style-type: none"> • 43 DMPHs spanning 19 counties across California; • Varying significantly (3 to 500 beds) and in the range of services provided; • Many serve rural and semi-rural populations; • Approximately 21% of patients served at DMPHs are Medi-Cal or uninsured and more than 1/3 of the DMPHs provide over 30% of their care to low-income Californians, with some facilities treating as many as 50 % low-income Californians.

DMPHs are only required to include a project from 1 domain; they may include additional projects in their application; may submit a joint application across DMPHs reflecting a coordinated effort to implement a domain.

Medi-Cal 2020: PRIME timelines

Due Date/Submission Date	Activity/Deliverable
December 31, 2015	CMS approves STCs
60 days post Demonstration approval	CMS and CA approve PRIME attachments
February 1, 2016 (or 30 days post approval of PRIME attachments, whichever is later)	State accepts PRIME project plan applications from eligible PRIME entities
45 days post submission of PRIME Project Plans	State will complete its review of the applications and issue questions, concerns or problems to the PRIME entity applicant
60 days post submission of PRIME Project Plans	State will take action of the PRIME Project applications to approve or disapprove
During the 60 day period between PRIME Project Plan Submission and State Approval/Disapproval	During the 60 day application/state review process for the PRIME applications, DHCS must have conducted at least two public meetings regarding the state's PRIME Project Plan application approval
June 1, 2016	State submits its first quarterly report
April and October (Twice a year)	State Distributes PRIME Project Plan incentive payments to PRIME participating entities
90 days following completion of demonstration Year 14	State submits Draft Interim Evaluation report
180 days after the expiration of the demonstration	State submits preliminary Summative Evaluation report
360 days after the expiration of the demonstration	State submits Draft Final Summative Evaluation report
Quarterly Deliverables – Quarterly Report (60 days after end of the quarter)	
1st Quarter- June 1st	
2nd Quarter- September 1st	
3rd Quarter- December 1st	
4th Quarter – March 3rd	

Medi-Cal 2020: APMs

- CMS and DHCS will measure the success of the PRIME pool, in part, by assessing the progress in shifting participating DPH PRIME entities to APMs through managed care plans (MCPs).
 - Contracts between MCPs and participating DPH PRIME providers will be required by the state to include language requiring the DPH to report on a broad range of metrics to meet quality benchmark goals to ensure improved patient outcomes.
 - PRIME innovations and state payment strategies will allow DPHs and DMPHs to become self-sustaining entities that are not reliant on pool funds beyond 2020.

Medi-Cal 2020: APMs

- To move participating DPH PRIME providers more toward value-based payments,
 - 50 percent of all Medi-Cal managed care beneficiaries assigned to DPHs by their MCP, in the aggregate, will receive all of or a portion of their care under a contracted APM by January 2018 (DY 13);
 - 55 percent by January 2019 (DY 14); and
 - 60 percent by the end of the waiver renewal period in 2020 (DY 15).
- Under PRIME, capitated payments, and other acceptable APMs, would be included to capture all models of APM utilized in calculations that determine overall DPH system advancement toward the established thresholds.
- Four tiers of capitated or alternative payment would exist:
 - 1) partial (primary care only);
 - 2) partial-plus (primary care and some specialty care (varies));
 - 3) global (primary, specialty, ancillary and/or hospital care); and
 - 4) additional payment methodologies approved by the state and CMS as set forth in Attachment R.

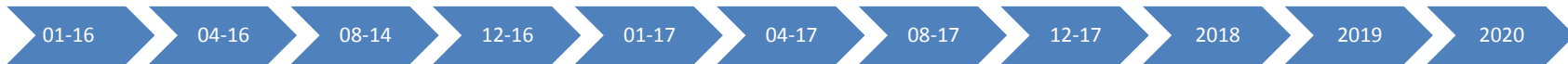
Medi-Cal 2020: PRIME Planning

Each PRIME project should include:

- **Rationale** for the proposed project (evidence-based and reasoning behind project idea);
- **Goals and objectives** of the project (project-specific Triple Aim goals and expected project outcomes);
- **Core components**, or key activities to guide project development and implementation; and
- **Metrics** required for the project, including clinical event outcomes, potentially preventable events, and patient experience measures.

PRIME planning: A DPH Case Study

DHCS releases PRIME attmts; due 03-16	DHCS submits first Q'ly Report 06-16	DHCS will approve within 60 days, 07-16
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DPH will consider domains, metrics, reporting	DPH apply, no later than 04-16	DPH receive PRIME payments April and Oct
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50% of MMC beneficiaries assigned to DPHs by their MCP, in the aggregate, will receive all of or a portion of their care under a contracted APM by Jan 2018 (DY 13);	55 % by Jan 2019 (DY 14)	60 % by Jan 2020 (DY 15).
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Medi-Cal 2020: Global Payment

Global Payment Program

- GPP Vision & Intent
- Eligible providers
- Funding & Payment Schedule
- Programmatic Goals, Objectives & Metrics
- Point Model
- Valuation System
- Point System Categories
- Risks, Concerns, Opportunities & Questions

Medi-Cal 2020 : Global Payment

GPP Vision & Intent

- Assist designated public hospitals (DPH) and their larger Public Health Care Systems (PHCS) to provide health care for the uninsured. The GPP is meant to focus on value, rather than volume, of care provided.
- First Program Year [PY11/State Fiscal Year (SFY) is July 1, 2015 to June 30, 2016]
- PY 11 funding is c. \$2.9 Billion combining Adjusted Disproportionate Share (DSH) with Uncompensated Care Pool (UCB) funds.
- Amounts for future years will be determined after completion of the first required uncompensated care report.

Medi-Cal 2020 : Global Payment

GPP Vision & Intent (Cont.)

- GPP rewards the provision of care in more appropriate venues, rather than through the emergency department or through inpatient hospital settings.
- California will evaluate the success of the GPP for potentially broader application.
- Payments use a value-based point methodology with factors that shift the overall delivery of services for the uninsured to more appropriate settings and reinforce structural changes to the care delivery system.
- Care being received in appropriate settings will be valued relatively higher than care given in inappropriate care settings for the type of illness.

Medi-Cal 2020 : Global Payment

Eligible Providers

- Payments go to Public Health Care Systems (PHCS) with a participating Designated Public Hospital
- A PHCS includes affiliated and contracted providers to a Designated Public Hospital
- Multiple Designated Public Hospitals and their affiliated and contracted providers may comprise a single PHCS for purposes of GPP

Medi-Cal 2020 : Global Payment

Funding & Payment Schedule

Existing California Disproportionate Share Hospital (DSH) funding for participating PHCS and funding from the Uncompensated Care Pool will be combined to make payments to participating PHCS that incur costs for services to the remaining uninsured.

The total computable amount available for the UC component will equal \$472 million in GPP PY1. For GPP PYs 2 through 5 the UC component will be determined by CMS

GPP PY 1 (SFY 15-16) - Adjusted DSH + \$472 million = approximately \$2.9 billion

GPP PY 2 (SFY 16-17) - Adjusted DSH + UC component

GPP PY 3 (SFY 17-18) - Adjusted DSH + UC component

GPP PY 4 (SFY 18-19) - Adjusted DSH + UC component

GPP PY 5 (SFY 19-20) - Adjusted DSH + UC component

Medi-Cal 2020 : Global Payment

Funding & Payment Schedule (Cont.)

A portion of California's DSH allotment shall be set aside for those California DSH facilities that do not participate in the GPP.

Interim GPP payments made to PHCS on a quarterly basis, calculated as 25% of the PHCS's annual global budget.

Reconciliation completed within nine months following the end of each program year.

Medi-Cal 2020 : Global Payment

Programmatic Goals, Objectives & Metrics

The waiver provides goal oriented expected results and evaluation metrics. These factors should guide your interpretation of the waiver and its impact on other providers and payers.

Goals promoting value, not volume are measured by changes from baseline PHCS activity for the number of uninsured individuals served:

1. The number and types of services provided
2. Expenditures associated with the services provided
3. Expenditures that the evaluators estimate were avoided or reduced due to the Global Payment Program
4. The ratio of the GPP funding to uninsured uncompensated care cost pre and post new waiver
5. An assessment of the effects of the GPP on care delivery and costs

Medi-Cal 2020 : Global Payment

Programmatic Goals, Objectives & Metrics (Cont.)

6. The number of uninsured individuals served
7. The number and types of services provided
8. Expenditures associated with the services provided
9. Expenditures avoided or reduced to the GPP. The ration of the GPP funding to uninsured uncompensated care cost pre and post new waiver.
10. How GPP encourages or improves
 - a.) Care in more appropriate settings ensuring that patients are seen in the right place and given the right care at the right time
 - b.) Changes in resource allocation
 - c.) Improvements in workforce involvement and care team transformation under the demonstration

Medi-Cal 2020 : Global Payment

Point Model

- An annual GPP budget is set for each PHCS based upon historic volumes and cost using the “GPP Funding and Mechanics Protocol” [Attachment EE] to be announced no later than February 29, 2016.
- PHCS must provide a “threshold” amount of care, measured in points, to earn their entire annual GPP budget amount.
- Point values for categories of services are the SAME for all providers and PHCSs.
- Each PHCS must meet or exceed its service threshold to be paid its assigned global budget payments.
- GPP payments are proportionately reduced if a threshold is not met.
- Un-awarded GPP funds redistributed to all other PHCS that have met or exceeded their thresholds.
- Point system will transition over program period to reduce traditional services point values.
- High intensity services will continue to be recognized for their value and importance, including recognition in the point system that emergency room visits and inpatient stays may be necessary and appropriate.

Medi-Cal 2020 : Global Payment

Valuation System

- All services eligible for points under the GPP are grouped into the four categories:
 - Traditional Outpatient
 - Non-traditional Outpatient
 - Technology based Outpatient
 - Inpatient and Facility Stays
- Services within the categories are further stratified into tiers based on similar service intensity, activity and/or effort. Each tier has the same point value.
- Point values, and thus payment, are thus standardized for services within a specific stratification making them payment equivalent across sites of care and types of provider groups.
- Relative values will be initially set based on cost and then adjusted to a limited degree based on other measures of value.
- Point values, except for services without cost information, cannot vary from the initial cost-based amount by more than 40% during the GPP.

Medi-Cal 2020 : Global Payment Point System Categories

NOTE: Full description of categories to be published in Attachments EE and FF.

Category 1: Traditional Outpatient - This category includes traditional outpatient services provided by a public hospital system facility:

- Non-physician practitioner;
- Traditional, provider-based primary care or specialty care visit;
- Mental health visit;
- Dental;
- Public health visit;
- Post-hospital discharge;
- Emergency room/Urgent Care;
- Outpatient procedures/surgery, provider performed diagnostic procedures

Category 2: Non-Traditional Outpatient – This category includes non-traditional outpatient encounters, where care is provided by non-traditional providers or in non-traditional settings:

- Community health worker encounters;
- Health coach encounters;
- Care navigation;
- Health education & community wellness encounters

Medi-Cal 2020 : Global Payment

Point System Categories

Category 3: Technology-Based Outpatient – This category includes technology- based outpatient encounters that rely mainly on technology to provide care:

- Call line encounters;
- Texting;
- Telephone and email consultations between provider and patient;
- Provider-to-provider consults for specialty care;
- Telemedicine

Category 4: Inpatient and Facility Stays – This category includes traditional inpatient and facility stays by patients:

- Re recuperative/ respite care days;
- Sober center days;
- Sub-acute care days;
- Skilled nursing facility days

Medi-Cal 2020 : Global Payment Risks, Concerns, Opportunities & Questions

- The funding in years 2 to 5 are not yet known and will be affected by annual calculation of the uncompensated care activity in California.
- The GPP and point system model is not yet fully described. There are “reserved” attachments that must be issued within 60 days of December 30, 2015. Expect a better understanding of the GPP on or before February 29, 2016.
- The point system calculation includes an adjustment for changes in service needs by the uninsured between the Base State Fiscal year and current impacts of ACA coverage expansion. There may be variance in the adjustment factors between California regions that should be early identified.
- CMS must approve each PHCS point threshold.
- Public Hospitals, affiliated and contracted providers, and other providers that provide services to both Medi-Cal and uninsured will experience a concurrent impact of the PRIME waiver program that involves MCO’s alternative payment methodologies and a similar complex value based incentive program.
- Providers will need to manage multiple incentive programs and should seek to innovate and measure results in a way that avoids redundant or inconsistent resource allocation.

Medi-Cal 2020 : Global Payment

Risks, Concerns, Opportunities & Questions (Cont.)

- The broad definition of a PHCS as including “affiliated and contracted providers” opens up the opportunity for Public Hospitals to deploy GPP funds to other community based providers, including alternative care services and establish system of care similar to the PRIME waiver program expected of systems of care for Medi-Cal members.
- District and Municipal Hospitals participating in the PRIME program with Public Hospitals and Managed Care Organizations may find opportunities to integrate systems of care for Medi-Cal and the uninsured that offer efficiency and scale.
- The stratification of services with similar intensity, activity and/or effort to have a common point and payment valuation may encourage public hospitals to relocate care to lower cost PHCS or non-public providers. This incentive could increase access for the uninsured but impact employment and staffing within the system of care of each PHCS.
- Stakeholders should begin to assess the combined impact of GPP, PRIME and the FQHC APM pilot program on provider and payer sectors.
- Stakeholders should review the successful DSRIP projects seeking to leverage those transformation investments to support the new Medi-Cal 2020 waiver.

Medi-Cal 2020: WPC Pilot

Summary

- “The overarching goal of the Whole Person Care (WPC) Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources”

Medi-Cal 2020: WPC Pilot

- Target Populations
 - High-risk, high-utilizing Medi-Cal beneficiaries; may include but not limited to:
 - Repeated incidents of avoidable ER, I/P or NF
 - 2 or more chronic conditions
 - Mental health and/or substance use disorders
 - Currently experiencing homelessness
 - At risk of homelessness
 - Participation is voluntary
- Non Medi-Cal beneficiaries may participate in approved WPC pilots but funding is not eligible for Federal financial participation

Medi-Cal 2020: WPC Pilot

Strategies

- Opportunity for local partnerships to integrate and coordinate otherwise siloed services to improve health outcomes for highly vulnerable group of high utilizing beneficiaries with poor outcomes
 - Integration among county agencies, MCPs and providers
 - Increased care coordination and improved access
 - Reduced inappropriate ER and I/P utilization
 - Improved data collection and sharing among agencies and MCPs
 - Improved quality and health outcomes
 - Increased access to housing and supportive services (optional)
 - Pilots can include county housing pools but cannot pay for room and board expenses

Medi-Cal 2020: WPC Pilot

Structure

- DHCS will accept applications from:
 - County agency, or
 - A city and a county, or
 - A health or hospital authority, or
 - A consortium of the above entities
 - Service Area: a county or more than one county
- “Lead Entities”
 - County agency, or
 - A city and a county, or
 - Designated public hospital, or
 - Municipal public hospital district

Medi-Cal 2020: WPC Pilot

Structure (Cont.)

- Participating agencies
 - Managed care plan (MCP) – at least 1 per service area
 - Must also include:
 - Both County Health Services and Specialty Mental Health Services or Department
 - At least one other public agency or department
 - Must also include at least 2 other key community partners serving this population, such as:
 - Physician groups
 - Clinics
 - Hospitals
 - Community-Based Organizations (CBOs)

Medi-Cal 2020: WPC Pilot

Funding & Payments

- Funding
 - \$1.5 Billion in Federal Funding over 5 years
 - \$3.0 Billion in total funds (maximum funding pool);
 - WPC Pilot Lead Entities will provide the non-federal share through an IGT

Medi-Cal 2020: WPC Pilot

Funding & Payments (Cont.)

- Payments to WPC Pilots
 - PY1 payments not to exceed \$300M in federal funds
 - Used to support initial ID of target population and planning activities
 - PY2-PY5 payments for activities as approved in application process
 - Payments will be contingent on achieving specific deliverables
 - WPC Pilot payments are not for services otherwise reimbursable by Medi-Cal
 - WPC Pilot payments should not be considered “patient care” revenue; no offset against CPEs

Medi-Cal 2020: WPC Pilot

Implications

- Opportunity
 - Increased funding
 - Improved outcomes
 - Reduced ER, I/P and NF costs
- Coordination Among Entities
 - Data collection and data sharing will be critical to success
 - Medi-Cal is delivered through MCPs; Counties, agencies and CBOs will need agreements :
 - Data sharing
 - Risk stratification and participant identification
 - Care coordination with MCP care models
 - Segregation of payments to ensure payments only for non Medi-Cal services

Medi-Cal 2020: DTI

Dental Transformation Initiative (DTI)

- Program Overview
- 3 Domains
 - Domain 1 – Increase Preventative Care
 - Domain 2 – Caries Risk Assessment
 - Domain 3 – Increase Continuity of Care
- Local Dental Pilot Program (LDPP)

Medi-Cal 2020: DTI

DTI - Program Overview

- 5 Year incentive program (with \$740 million* in total funding) to improve dental health and access to dental care for Medi-Cal children
- Incentive payments from the \$740 million DTI Pool support and reward service office locations in both FFS and DMC delivery systems for achievements within 1 or more of the project domains
- 3 Domains & a Local Dental Pilot Program (LDPP)

Program Year (PY)	Dates
PY 1	1/1/2016 – 12/31/2016
PY 2	1/1/2017 – 12/31/2017
PY 3	1/1/2018 – 12/31/2018
PY 4	1/1/2019 – 12/31/2019
PY 5	1/1/2020 – 12/31/2020

*DHCS may earn additional demo authority (up to a max of \$10 million) to be added to the DTI Pool For achieving higher performance improvement.

Medi-Cal 2020: DTI

Domain 1 – Increase Preventative Care

- **Goal** - increase statewide utilization with children (ages 1-20) enrolled in FFS and DMC dental delivery systems by at least 10 percentage points over a 5 year period
- **Providers** – this is a statewide domain, and service office locations are expected to continue to follow claiming and billing guidelines of the Medi-Cal Dental program and to adhere to incentives in this program
- **Incentive** – semi-annual incentive payments for preventive services will equate to a payment of ~75% above the Schedule of Maximum Allowances (SMA) for all preventive services provided to the children above the DHCS pre-determined threshold for the number of beneficiaries served, subject to the annual funding limits

Medi-Cal 2020: DTI

Domain 2 – Caries Risk Assessment (CRA)

- **Goal** – to formally assess and manage caries risk, and to emphasize the provision of preventative services in lieu of more invasive and costly procedures for beneficiaries (age 6 and under) over the 4 year life of this domain
- **Providers** – domain will only be available initially to dentists in pilot* counties that elect and are approved by DHCS to participate in the program – i.e. “opt-in” by completing a no-cost DHCS recognized training program, and submitting verification documentation
- **Incentive** – participating dentists will be authorized to perform an increased number of services per year in accordance with pre-identified treatment plan options for varying degrees of caries risk (low, moderate, and high), and are eligible to receive an incentive payment under this program for each additional service not currently covered under the CA State Plan and frequency limitations listed in the Manual of Criteria

Medi-Cal 2020: DTI

Domain 3 – Increase Continuity of Care

- **Goal** – increase continuity of care for beneficiaries (age 20 and under) over the 5 year waiver period
- **Providers** - domain will only be available initially to dentists in pilot* counties, and service office locations are expected to continue to follow claiming and billing guidelines to the Medi-Cal Dental program and to adhere to incentives in this program – i.e. no “opt-in” requirement
- **Incentive** – flat annual incentive payment amounts in tiers based on length of time a beneficiary maintains continuity of care with the same service office location – tier 1 payments will be provided for beneficiaries who receive at least 2 exams from the same service office location for 2 consecutive years – for each subsequent year, the dollar amount of the incentive payment for an exam of the same beneficiary would be increased

Medi-Cal 2020: DTI

Local Dental Pilot Program (LDPP)

- LDPPs have the opportunity to seek approval from DHCS for a pilot to address one or more of the 3 DTI domains through alternative programs
- DHCS will solicit proposals once at the beginning of the demonstration, and approve no more than 15 LDPPs
- Each pilot application shall designate a responsible county, Tribe, Indian Health Program, UC or CSU campus as the entity that will coordinate the pilot
- **Goal** – the goals will mirror the goals for domains 1 through 3 because the local pilot will include 1 or more of the 3 DTI domains*
- **Providers** – requirements for providers will mirror the 3 DTI domains and depend on which domains the LDPP chooses to include in its local pilot*
- **Incentive** – incentive payments will also mirror the 3 DTI domains and depend on which domains the LDPP chooses for its local pilot*

*Additionally, requirements of the LDPP would be contingent on the design of the pilot program.

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Q & A

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