

California Section 1115 Comprehensive Demonstration Project Waiver A Bridge to Reform: A Section 1115 Waiver Proposal

**Submitted by the
State of California
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Introduction

Medi-Cal, California's Medicaid program, has long been characterized by innovative delivery systems that recognize the diversity of the State and its people. Building on that foundation, the State's Section 1115 Waiver application presented in this document, articulates the way in which California proposes to seize this moment in the history of health care reform to advance additional program changes. Some of these changes involve expanding coverage to the "newly eligible" under health care reform while others seek to develop and implement innovative models for a more comprehensive and coordinated system of care for some of our most vulnerable residents. Still other changes include various strategies to strengthen the State's health care infrastructure to prepare for the additional numbers of people who will have access to health care once health care reform is fully implemented.

California, with a population of 36.9 million, a Medicaid population of 7.5 million, and a burgeoning uninsured population of roughly 6.7 million is a perfect microcosm to begin the long and complicated process of implementing national health care reform. Both the State's size and its diversity require that California, like the nation, begin to move steadily towards the coverage envisioned under the Patient Protection and Affordable Care Act (PPACA). Through a series of steps under a Section 1115 Waiver, California can lead the nation in articulating and resolving the inevitable issues that will present themselves as the State and nation move to implement the most sweeping social reform in 50 years.

California has been a leader in the design and implementation of cost-effective service delivery systems both for its Medicaid and commercially insured populations. California pioneered the use of a managed care delivery system, developed cost-effective selective contracting measures as early as 1982 and has worked with its county governments to utilize county resources, both financial and infrastructure, to expand and extend health care coverage to the uninsured through the Health Care Coverage Initiative (HCCI) created under California's current Section 1115 Hospital Financing Waiver.

Building on its existing infrastructure, California is poised to begin an early implementation of the key coverage expansion and delivery system reform components of the PPACA. As it undertakes this expansion, California also seeks to implement structural reforms to make its

existing Medicaid program more accountable and to streamline and better coordinate the service delivery systems that are providing care to the most vulnerable of its population. In addition, as the State moves more towards reliance on coordinated, capitated care to advance better health outcomes for its residents with the most complex and chronic illnesses, it intends to reduce its reliance on inpatient hospital care and to implement payment reforms that will support and align incentives for cost-effective care.

Through this waiver application, California seeks to accomplish six critical goals:

1. To immediately begin phasing in coverage for the “newly eligible” adults aged 19-64 with incomes up to 133% of the federal poverty level (FPL) who are not otherwise eligible for Medicaid. This coverage will be required for all states effective 2014 and California plans to build on its current county-based coverage initiative so that in 2014, this population can become fully enrolled statewide and receive the federally required benchmark benefit package.
2. To immediately begin phasing in coverage for adults with incomes between 133 and 200% of poverty. The State seeks to build on its county coverage initiative to offer benefits to this population, which may be covered through a basic health plan or health insurance exchange beginning in 2014.
3. To create more accountable, coordinated systems of care with a focus initially on Seniors and People with Disabilities (SPDs) and Dual Eligibles. In years 2 and 3 of the waiver, the State would propose further amendments to include new service delivery system approaches for People with Mental Health and/or Substance Abuse challenges who need Integrated Care and Children with Special Health Care needs as well as to advance a project for the Dual Eligibles under the integrated care models envisioned by the new health care reform legislation.
4. To continue and expand the safety net care pool (SNCP) that is encompassed in the State’s existing waiver so that it may continue to assure support for its safety net hospitals and other critical programs which are paid for through the SNCP.
5. To implement a series of improvements to the existing service delivery systems that will strengthen the infrastructure, prepare the State for full implementation of reform, and test strategies to slow the rate of growth in health care costs throughout the State.
6. To pilot payment reforms within the public hospital system that better align payment and care delivery incentives. These approaches will help stabilize the public safety net systems, and will provide the flexibility necessary to ensure that they are able to continue

providing care to Medi-Cal beneficiaries that transition to managed care and the newly covered populations as health reform is implemented.

It is California's goal not only to lead the nation in moving deliberately and thoughtfully towards full implementation of the Medicaid expansion populations but also to create more accountable, coordinated and modern service delivery systems, affirm and further strengthen the health care safety net, including private and public hospitals and community health centers, reward health care quality and improved outcomes and slow the long-term expenditure growth rate of the Medi-Cal program. As California continues to struggle with multi-billion budget deficits, it is critical for the Medi-Cal program to continue implementing innovative programmatic changes in order to reduce its long-term cost growth trends.

California respectfully suggests that no state is a better laboratory in which to learn as it and the nation move towards implementing the full vision for health care reform. To further its role as a leader in reform, the State proposes that at the end of each quarter during which the waiver is in effect, the State will provide the Centers for Medicare and Medicaid Services (CMS) with an inventory of challenges faced, lessons learned and recommendations that might facilitate the development of operational knowledge that will benefit all states.

The following document presents the key elements of California's waiver proposal including:

- A discussion of the current status and evaluation of the progress to date of the existing HCCI as well as the proposed expansion of that program;
- A discussion of the proposed continuation and enhancement of the SNCP;
- A discussion of the proposed service delivery infrastructure improvements;
- A discussion of the proposed service delivery systems to improve health outcomes for certain vulnerable populations;
- A narrative on budget neutrality;
- A budget neutrality showing;
- A list of the waivers proposed to support this entire project;
- A summary of the state's stakeholder process; and
- An evaluation of the California's current Section 1115 Hospital Financing Waiver.

California offers this set of proposals with the sure knowledge that the steps encompassed will be critical not only for an early expansion of coverage as envisioned by health care reform but also as preparation throughout the State for full coverage both through Medi-Cal and the infrastructure required to support coverage offered through a health insurance exchange.

Background

California's current Section 1115 Hospital Financing Waiver will expire on August 31, 2010. This waiver has played a vital role in preparing California to take the next steps towards full implementation of health care reform. Under that waiver, California has provided partial reimbursement to 21 critical public hospitals for services to the uninsured, thereby strengthening the safety net and supporting growth in the safety net infrastructure; supported critical State programs for vulnerable populations, programs that were essential to the State's infrastructure but that were in danger of dying without federal contribution; and initiated a county coverage initiative in ten of the State's largest counties. Greater payment flexibility afforded by the current waiver with respect to disproportionate share hospital payment distributions to public hospitals and Selective Provider Contracting and supplemental payments to private safety net hospitals and non-designated public hospitals enabled California to strengthen and build upon the local health care safety net systems. The same flexibility will be a component of this new waiver.

Created under California's current Section 1115 Hospital Financing Waiver, the county-based Health Care Coverage Initiative (HCCI) provides coverage to more than 130,000 medically-indigent adults who are not eligible for other public programs. Using a competitive process, California selected 10 counties to receive federal reimbursement of up to \$180 million per year in waiver years 3, 4, and 5 (September 1, 2007-August 31, 2010) to provide coverage to this vulnerable population through an organized system of care. The participating counties—Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura—use certified public expenditures (CPEs) to draw down the available federal funds. California's success in providing coverage to uninsured adults and supporting safety net delivery system redesign through the HCCI demonstrates the State's ability to be a leader in the early implementation of health care reform.

Under the new demonstration waiver, California proposes to expand the HCCI throughout the State as a bridge to the significant changes that will occur in 2014 under federal health reform. California will use the HCCI to expand coverage to a significant portion of the population who will be eligible for the Medicaid expansion or the new statewide insurance exchange and to prepare public and private hospitals, community health centers, and other essential safety net providers for the influx of newly insured individuals under federal reform.

In addition to seeking an expansion of the existing waiver authorities and budget, the State also seeks to build on recent State legislation (ABx4 6) to create more coordinated systems of care and strengthen the ability of its existing managed care plans to provide coordinated care to seniors, people with disabilities, and individuals who are dually eligible for Medicaid and Medicare, eventually incorporating children with special needs and behavioral health integration.

In addition to building new requirements for quality, care coordination, and contract monitoring into the managed care plans, the State also seeks to offer counties technical assistance and financial incentives to explore and expand on the concept of creating advanced medical home models. These medical homes will leverage the use of both EHRs due to the Medicaid Incentive Grants and the new Health Information Exchange technology to assure continuity and quality of care.

Coverage Expansion

With the passage of the PPACA, California is ready and willing to build on its existing county-based coverage initiative and use the infrastructure to move towards full implementation of the Medicaid coverage expansions, as well as to begin looking at the concept of a State-based program for the population with incomes between 133 and 200% of poverty. Coverage will closely align the eligibility, benchmark benefits, cost sharing and immigration status rules for the newly covered population and lead to seamless enrollment into the mandatory coverage that will be required for the below 133% of FPL and the transitioning of those from 133-200% of FPL into the new statewide exchange or directly into a health plan.

The new law gives states the option of covering these groups prior to January 1, 2014 under their state plans and to introduce that coverage on a graduated basis (so long as the plan does not provide coverage for people at higher income levels than those who are not provided coverage) so long as those children of newly eligible parents under the option are enrolled under the State plan, a waiver thereof, or in other health insurance coverage.

It would be entirely consistent with and supportive of the goals of the PPACA for CMS to authorize a state, through a demonstration waiver under section 1115, to begin coverage of these new eligibles on a transition basis, without immediately adhering to the requirements of statewideness, comparability, freedom of choice and related requirements that will be applicable to the new eligibles beginning in January 2014 when their coverage by the state program becomes mandatory (and the federal government begins to pay 100% of the coverage). By allowing almost four years before coverage of the new eligibles is mandated, Congress recognized the substantial time and effort that would be required to gear up for such a major expansion of Medicaid coverage. At the same time, Congress was motivated by a desire to expand coverage as quickly as possible, and to that end, it authorized states willing to do so to begin coverage of the new eligibles immediately on a phased-in basis.

California's proposal advances both of the broad congressional goals. Allowing counties to begin immediately to enhance their existing programs for the new eligibles not only increases coverage but also paves the way for a smooth transition to full coverage in 2014. It would be extremely challenging for a state as large and diverse as California to immediately implement a fully

compliant statewide coverage program; however, CMS can provide California the opportunity to move gradually but steadily towards compliance and everyone has the opportunity to learn along the way.

Congress imposed two explicit conditions on States seeking to implement coverage of new eligibles before 2014: that higher income people not be covered before lower income people, and that children of “newly eligible” parents also have sufficient health care coverage. California’s approach to gradual implementation will respect that condition in each county.

It is common for CMS to grant waivers of statewideness, comparability, freedom of choice and similar requirements to allow states to expand coverage to new categories of Medicaid recipients and there is nothing in the text of the reform laws or in their underlying purpose that would suggest any intention to diminish CMS’s discretion to continue doing so in the next three years. California’s proposal seeks very limited waiver of fundamental requirements added by PPACA; it seeks only waiver of pre-existing Medicaid requirements, many of which CMS has repeatedly waived over the past 20 years to allow states to improve and expand their medical assistance programs.

Under the proposal, as described more fully below, California proposes to treat coverage for the “newly eligibles” (up to 133% of the FPL) as a new optional eligibility group in terms of federal match for the coverage; the 133-200% of FPL group would not be treated as a state plan group but would be funded out of the SNCP. Both programs are described in more detail below.

I. California Coverage Initiative

Current Program Design and Results to Date

Created under California’s current Section 1115 Hospital Financing Waiver, the Health Care Coverage Initiative (HCCI) provides coverage to more than 130,000 medically-indigent adults who are not eligible for Medicaid, Medicare or the Children’s Health Insurance Program. Using a competitive process, California selected 10 counties to receive federal reimbursement of up to \$180 million per year in waiver years 3, 4, and 5 (September 1, 2007-August 31, 2010) to provide coverage to this vulnerable population through an organized system of care. The participating counties – Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura -- use certified public expenditures (CPEs) to draw down the available federal funds.

Current HCCI Counties

For the 10 HCCI counties, the current waiver offers critical support for local efforts to move medically-indigent adults from fragmented, episodic care into organized systems of care that are

focused on primary and preventive services. Since September 2007, the 10 HCCI counties have made great strides in improving how care is provided by safety-net providers by reorienting the locus of care from the inpatient and emergency department setting to the medical home setting. The current counties were provided with significant flexibility to design their HCCI programs to reflect local needs and existing delivery systems. Under the new waiver, however, it will be necessary to evolve the HCCI and create a more standardized framework for participating counties in terms of the eligibility and enrollment process, the benefits offered, the use of medical homes, provider networks that ensure access to care, and improved data collection for program evaluation. The current strengths and weaknesses of the HCCI programs, across each of these parameters, are discussed below.

Eligibility and Enrollment

For the current HCCI counties, the State defined the following standard set of eligibility criteria:

- Citizen or legal resident with at least five years residency in the United States (counties must comply with the Deficit Reduction Act's Medicaid citizenship and identity documentation requirement);
- Income below 200% FPL;
- Individuals with incomes between 101-200% FPL must not have had health insurance within the three months prior to enrollment (with some exceptions);
- Age 19-64 years old;
- Ineligible for Medicaid, Healthy Families, and Medicare; and
- No asset tests are permitted.

In addition, counties also were allowed to define additional eligibility criteria based on their program design (e.g., to target HCCI eligibles with specific chronic medical conditions). A comparison of the counties' eligibility requirements is included in Exhibit A.

While the eligibility criteria are fairly similar across the participating counties and all counties have developed a centralized eligibility system for their HCCI programs, the eligibility determination process varies in terms of how applications are processed and who determines eligibility. Some counties developed electronic applications and systems of record that are used by county health services staff to process applications. In other counties, applications are completed at the provider site (e.g., a local clinic, the emergency department) and forwarded to the county health services agency for processing. One county uses its social services agency to process HCCI applications.

Covered Benefits

Prior to HCCI, most participating counties provided inpatient, outpatient, and emergent care to their medically-indigent populations. Under HCCI, the counties expanded the benefits offered to enrollees, including the addition of outpatient physical, occupational and speech therapy, home health care, mental health services, and prescription medications. As the table included in Exhibit B indicates, the covered benefits offered by the counties are fairly similar, and there is significant overlap with the current Medi-Cal benefits package.

In terms of enrollee cost-sharing requirements, there is a greater degree of variation across the counties. As shown in Exhibit C, only three counties require that enrollees pay a premium to enroll in their local HCCI program, but seven counties require co-payments for selected services.

Medical Homes and Care Coordination

Under the HCCI framework, participating counties are required to assign enrollees to a medical home, either a public hospital system provider, a community clinic, or private provider, which is defined in State statute (California Welfare and Institutions Code section 15904) as “a single provider or facility that maintains all of an eligible person’s medical information and that is a licensed provider of health care services, and that provides primary medical care and prevention services.” All of the counties have gone beyond the statutory requirement and provide aspects of a patient-centered medical home. For example, all of the counties are using a physician-directed team-based approach for care delivery. The counties also include case managers or health educators to assist with chronic care management and care coordination. While all of the counties assign HCCI enrollees to a medical home, only three counties monitor patient utilization of their assigned medical home. In the other seven counties, adherence is encouraged but not required.

The HCCI authorizing statute (California Welfare and Institutions Code section 15904) required that participating counties provide care management to program enrollees, and the HCCI counties have introduced or expanded disease management services for program enrollees. Nine of the counties identify higher-risk enrollees with more severe chronic conditions and target them for disease and care management.

HCCI Provider Networks

A strong provider network is one of the critical underpinnings of an organized delivery system, and all of the HCCI counties have worked to enhance and integrate their provider networks. Each HCCI county’s network, however, reflects the variation across the counties in terms of their safety-net providers. Two of the HCCI counties do not operate county-based hospital systems

and must rely on a provider network comprised entirely of private providers. The other eight counties have developed provider networks centered around the local public hospital system. Among these counties, one has a network exclusively comprised of county providers. In the remaining seven counties, the provider network is a combination of public and private providers. Typically, these counties contract with private community health centers to provide care to HCCI enrollees, although some have contracted with private safety-net hospitals as part of their networks.

Cross-County Data Collection

The HCCI authorizing statute and the current waiver's Special Terms and Conditions require an evaluation of the HCCI. The University of California-Los Angeles is undertaking the evaluation that will assess the HCCI's impact in the following areas: (1) coverage expansion; (2) program revenue and expenditures; (3) expansion of the safety-net system; (4) access and quality of care; (5) efficiencies; (6) sustainability; and (7) implementation. In addition, all of the counties have developed metrics to measure their progress and evaluate the impact of their HCCI programs. By design, the 10 original HCCI counties were allowed to design and implement their own pilot programs. While this allowed California to test a number of different strategies and program designs for covering medically-indigent adults, it also has resulted in a lack of comparable data across the counties, making county-to-county comparisons difficult.

Summary of Current HCCI Efforts

While the current HCCI counties have demonstrated the impact of an organized system of care for medically-indigent adults, counties were given significant flexibility in the design of their programs, and the individual HCCI programs vary from one county to another. To prepare for health reform, it will be necessary to revise and standardize the framework of the HCCI. While the county programs are fairly similar in terms of the eligibility criteria, benefits offered, and the use of medical homes and care coordination, more significant changes will be necessary to the HCCI enrollment process, provider networks, and data collection. These changes are outlined in the following section.

II. The Second-Generation HCCI: Bridge to Health Care Reform

Under the new waiver, the opportunity to participate in HCCI would be expanded to all 58 of California's counties. Health coverage would be provided to uninsured parents and childless adults with incomes up to 200% of the federal poverty level (FPL). HCCI enrollees must be uninsured, between the ages of 19-64 and not otherwise eligible for Medi-Cal or Medicare. The HCCI will be expanded dependent on the availability of county funding to support the coverage provided, as determined by each county. The HCCI would continue in the current 10 counties

and new counties could elect to implement an HCCI program effective September 1, 2010. For enrollees with incomes between 0-133% FPL, the HCCI would sunset on December 31, 2013 at which point the population will become a part of the Medi-Cal program and eligible for full federal support. For enrollees with incomes between 134 – 200% FPL, the HCCI will transition these individuals to enrollment in the statewide health insurance exchange.

California proposes to expand and enhance the HCCI to begin to prepare for health reform by furthering the systems changes that will be necessary for successful implementation and by taking advantage of the option to immediately receive federal reimbursement for covering adults with incomes up to 133% FPL which will otherwise occur on January 1, 2014. Under the demonstration waiver, the HCCI will expand coverage, to the extent that counties determine funding is available, and drive innovations in local delivery systems critical to maintaining and improving access to care in the safety-net. In 2014, the expanded HCCI will serve as an important vehicle to seamlessly transition HCCI enrollees into Medi-Cal or the statewide insurance exchange. Significant interest among non-HCCI counties is anticipated, and the current 10 counties are strongly supportive of the future of HCCI. They also understand the need to standardize the HCCI framework in preparation for 2014.

The State and counties will work together to standardize the eligibility and enrollment process, benefits offered (including cost sharing), and data collection. In addition, provider networks will be developed to ensure access to care, and the HCCI's medical home and care coordination efforts will be strengthened. A table summarizing the current HCCI and the new HCCI is included at the end of this section.

Projected HCCI Expansion

More than 130,000 Californians are currently enrolled in their local HCCI program. California estimates that at least 56 of the State's 58 counties will participate in the next coverage expansion. Total enrollment in the HCCI statewide is estimated to be 512,000 under the new waiver. In the current HCCI, the majority of enrollees has incomes below 133% FPL and will be eligible for the Medicaid expansion; this trend is expected to continue. It is estimated that 385,000 individuals will have incomes below 133%. Enrollment in any county's HCCI program will be limited to the availability of local funds, as determined by each county.

Standardized Eligibility and Enrollment Process

A standardized eligibility and enrollment process is a critical step to ensure the smooth transition of HCCI enrollees into Medi-Cal or the statewide health insurance exchange in 2014. As discussed above, the existing HCCI eligibility rules already do not allow an asset test and require that enrollees meet the Medicaid citizenship and identity documentation requirement. Over time,

HCCI eligibility rules will be further synchronized so that in 2014, the enrollees will be screened and enrolled into Medi-Cal based on Medi-Cal eligibility standards (consistent with the new eligibility rules under PPACA), and participating counties will no longer be allowed to target specific populations.

Participating counties will identify a county-certified system of record (such as One-e-app, C-IV, CalWIN or LEADER) that can interface with the Medi-Cal program as the system of record for their HCCI. Further, HCCI counties will commit to working with their county human services departments during this transition period to 2014 to ensure a transition to a system that interfaces with the Medi-Cal Eligibility Data System (MEDS), to become the system of record for HCCI by the end of 2013 in advance of the transition of the population to Medi-Cal in 2014. An interface with MEDS will allow counties to match social security numbers to establish satisfactory immigration status for HCCI enrollees and will ultimately create an eligibility record in the same statewide system as current Medi-Cal enrollees. Coverage expansion counties will access MEDS, or a system of record that interfaces with MEDS (such as C-IV, CalWIN, or LEADER), in order to enter enrollee data into the system, so that HCCI eligibility records will move to MEDS; therefore HCCI enrollees will not need to complete a new application prior to transitioning to Medi-Cal or the exchange in 2014. Counties will commit to specific milestones to best make this transition and be prepared for health care reform (See Summary Table for a description of these milestones).

HCCI Benchmark Plan

As noted above, there is significant similarity in terms of the benefits offered by the current HCCI counties. Under the new waiver, the HCCI's focus on primary and preventive care will be maintained.

To prepare the HCCI population for Medi-Cal or for coverage in the statewide exchange, the State proposes to establish a minimum HCCI benefits package, for which California seeks designation by the Secretary of Health and Human Services as a benchmark-equivalent plan as defined in Section 1937 of the Social Security Act for implementation. The HCCI programs currently provide a relatively comprehensive set of benefits. The minimum benefits package for the proposed Medicaid coverage expansion will build on the existing benefits, standardizing the benefits offering and providing a transition toward 2014. A complete description of the benefits currently provided by the HCCIs upon which the minimum benefits package will be built is provided in Exhibit B.

We are aware that beginning January 1, 2014, benchmark or benchmark equivalent coverage must provide the essential health benefits described in section 1302(b) of the Affordable Care Act. The Secretary is required pursuant to that section to provide definitions of the following

essential health benefits: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

In light of these impending benchmark requirements, the HCCI benchmark plan will provide a basis for transition to meet the essential health benefits package that will be developed by the Secretary of Health and Human Services for implementation beginning January 1, 2014. Almost all of the services generally identified as requirements in an essential health benefits package are already provided by HCCIs and would be included in a minimum benefits package for the next coverage expansion. These services include, for example, hospital inpatient, outpatient, primary and preventive care, and a wide range of specialty care services in in-network providers.

As part of the transition toward meeting the essential health benefits requirements, California recognizes that progress must continue to be made on access to mental health care. Under the HCCI, counties will provide coverage for mental health, as resources are available, and will expand those services over the course of the next coverage expansion to transition to the 2014 benchmark plan. (See Summary Table for a description of milestones to transition coverage programs to the 2014 benchmark plan.) In addition to these milestones, HCCI counties may elect to submit to the State proposals to pilot methods of integrating physical and behavioral health services and financing, to improve care for patients and strengthen the county safety net system.

While the proposed Medicaid expansion is geared toward a successful transition toward the requirements of 2014, there will need to be specific limitations in the program. Due to county resource constraints and the transitional nature of the expansion toward 2014, California will need to have waived a series of Medicaid requirements. As a specific example, the benefits plan would not include out-of-network emergency care or transportation. A full list of requirements proposed to be waived is included in Attachment 1.

Strengthen HCCI Medical Homes and Care Coordination

The medical home is a central component of California's proposed delivery system reform efforts under the new waiver. Accordingly, medical homes and care coordination will continue to be hallmarks of the HCCI programs and will offer many similar components to the delivery system model for seniors and persons with disabilities in Medi-Cal managed care plans. HCCI enrollees will continue to select a single provider or clinic to serve as the medical home, and this provider will be responsible for coordinating all care for the enrollee.

Participating counties will be required to have systems in place to monitor patient utilization to ensure that enrollees are seeking care at their assigned medical home, and not other settings. HCCI providers within each medical home will work to ensure that patients' care is well-managed and tailored to each HCCI enrollee's needs. Specifically, providers will work to achieve the following goals for a medical home:

- Care is tailored to the patient's health needs;
- A team of providers is responsible for the patient's care;
- Patients are engaged in their own planned, whole-person care;
- Care is continuous, comprehensive and coordinated;
- Care is driven by evidenced based care and supported by technology;
- The patient has access to care;
- The patient and the care team engage in open and effective communication; and
- Reimbursement should adequately reflect the cost and value of medical homes.

Case management services will be particularly targeted to HCCI enrollees who are frequent users of inpatient hospital services in addition to those who have been diagnosed with chronic medical conditions. This will require the participating counties to collaborate with the medical home providers to assess new enrollees' health status and service utilization to identify candidates for case management services.

Expand Provider Networks

California is keenly aware that simply providing coverage to enrollees is not enough; the HCCI must also ensure that enrollees have access to care when and where they need it. As participating HCCI counties transition to a standardized benchmark benefits plan, they must be able to ensure access to those services through an adequate provider network. Under the new waiver, all HCCI counties (both current and new) will be expected to ensure access to services through their provider networks, which will consist of primarily public hospitals, public clinics and community health centers. Other private providers, including private physicians and private hospitals, could be added to HCCI networks at the option of the counties in order to ensure access. In counties that do not operate a public hospital system, the HCCI provider network, by necessity, will be comprised entirely of private providers and public outpatient providers.

The State will work with the current HCCI counties to develop access to care standards by the end of waiver year 1. HCCI standards will be similar to current State standards for Medi-Cal managed care plans that require ratios of enrollees to staff in order to reasonably ensure all services are accessible to enrollees on an appropriate basis. These ratios are at least 1.0 full time equivalent (FTE) physician per 1200 enrollees and 1.0 FTE primary care physician for every 2000 enrollees. Plans that utilize non-physician medical practitioners must be less than 1:1000.

New HCCI counties will be required to demonstrate that their networks are structured in such a way as to ensure access to services prior to implementation.

Standardize HCCI Data Collection and Revise Evaluation Criteria

California seeks to use the HCCI to expand coverage and to prepare for 2014. Accordingly, the evaluation of the new HCCI will focus on health reform readiness. While the State will work with participating counties to develop an appropriate set of metrics, these measures will focus on areas such as enrollment growth, network adequacy and capacity, uniform minimum benefit design and eligibility and enrollment systems. To address concerns with the current HCCI regarding comparability of performance metrics, the State will work with the counties to define a single, common set of metrics for implementation in waiver year 2.

Value Based Purchasing

California seeks the opportunity to pilot methods of incorporating value based purchasing into safety net provider-based coverage through the HCCIs. The State will develop methods of creating incentives for providers to improve process and health outcomes; patient and provider satisfaction; and greater integration and efficiencies. The value-based purchasing component will be developed and implemented by the end of waiver year 1.

Risk-Based Payments

In order to help transition local safety net systems to health care reform, California proposes to consider a shift in reimbursement structure for HCCIs from the current direct CPE structure to an actuarial-based payment method. This structure would introduce an element of financial risk to the HCCIs and provide further incentives to ensure appropriate use of services. Counties will fund the transition to fully capitated payments using one of three financing approaches: IGT/CPE Combination; IGT-Based; or Actuarial Payment to Plan Basis for CPE.

The three approaches are necessary to reflect the diversity of circumstances in California's counties and allow counties and public hospitals to participate in financing the risk-based programs in a way that reflects local structures, funding and concerns. Under any financing approach, however, the payment will be limited to the actuarially-based rate and will place the program at financial risk. Also, to the extent that this proposal results in a higher percentage of the non-federal share being provided by the counties or public hospital systems, this aspect of the proposal will be implemented at the election of the county or public hospital system.

III.

Brief Summary of Financing Approaches

IGT/CPE Combination

This approach uses a combination of IGTs and CPEs to fund the actuarially sound rate. The FFP drawn for the CPE portion is paid as direct reimbursement to designated public hospital systems. Only the IGT-funded portion is used to pay the county or public hospital systems as additional payment for services, and to pay other contracted providers for services.

This approach allows California to reform the payment system for public hospital systems under these programs to a risk-based payment structure through the use of a combination of allowable non-federal share sources. Although a portion of the non-federal share of the rate would be funded through CPE, the total reimbursement for the program would be limited to the total actuarial rate and would not increase if the available CPE increased, therefore the county/public hospital system would be at risk for any increased costs under this proposal. This method of using combined sources of non-federal share (IGT and CPE) is similar to the DSH payment methodology under California's current Section 1115 Hospital Financing Waiver.

IGT-Based

This approach uses IGTs to fund the actuarially sound rate. The State pays the entire rate (including the IGT and FFP) to the County/Public Hospital System as an actuarial sound rate. The public hospital system uses the actuarial rate to pay for services directly or through other contracted providers. This option allows California to reform the payment system under these programs while relying on IGTs from counties and public hospitals to provide the non-federal share.

Actuarial Payment to Plan as Basis for CPE

The County makes the actuarially sound payment to a County plan or other plan and certifies this payment as a CPE. The State claims the CPE and pays the County the corresponding FFP. The County Plan or other plan pays the public hospital systems and other contracted providers.

This approach also allows California to reform the payment system for these programs to a risk-based actuarial approach. This methodology would base the CPE used to draw the federal funding on the actuarial rate paid by the County to the specified plan. The payment of the actuarially sound rate by the County for the services under the program is an allowable expenditure.

Under existing state law, counties are legally the provider of last resort. As the medically indigent population transitions to Medi-Cal in 2014, the financing relationship between the state and counties will likely need to be reviewed and modified to account for the federal health reform financing and responsibility for these medically indigent adults.

Summary Table

The table below compares the current HCCI to the proposed HCCI by the major program elements discussed above.

HCCI Program Elements	Current HCCI	New HCCI
Eligibility and Enrollment	While the eligibility criteria across the HCCI counties are relatively similar, enrollment processes vary.	<p>Eligibility criteria will be modified to be uniform across all participating counties. Counties will commit to the following milestones in order to transition their HCCI eligibility systems to the Medi-Cal eligibility system (MEDS) as the system of record for the HCCI. HCCI enrollees' eligibility records will be coded to allow for a seamless transition to Medi-Cal or the statewide exchange on January 1, 2014. HCCI enrollees will not be required to complete a new application as part of the transition. Specific milestones are as follows:</p> <p>Current HCCI Counties:</p> <ul style="list-style-type: none"> • March 2011: Identify a county-certified system of record that can interface with the Medi-Cal program as the system of record for their HCCI. • March 2012: Submit to the State a plan to work with county human services departments to transition to a system that interfaces with the MEDS system as the system of record for HCCI enrollees. The State will grant access to such a system that interfaces with MEDS to HCCI programs. • December 2013: Demonstrate implementation of transition plan, with HCCI eligibility records transferred to MEDS and stored in a county system of record that interfaces with MEDS. <p>New HCCI Counties:</p> <ul style="list-style-type: none"> • July 2011: As part of implementation plan, identify a county-certified system of record that has demonstrated linkages with the Medi-Cal program as the system of record for their HCCI. • March 2012: Beginning of Waiver Year 3: Submit to the State a plan to work with county human services departments to transition to a system that

HCCI Program Elements	Current HCCI	New HCCI
		<p>interfaces with the MEDS system as the system of record for HCCI enrollees. The State will grant access to such a system that interfaces with MEDS to HCCI programs.</p> <ul style="list-style-type: none"> December 2013: Demonstrate implementation of transition plan, including testing, with HCCI eligibility records transferred to MEDS and stored in a county system of record that interfaces with MEDS.
<p>Benefits Offered</p>	<p>HCCI benefits offered by counties are relatively similar and also tend to mirror the Medi-Cal benefits package.</p>	<p>A uniform, minimum benchmark benefits plan (or benchmark-equivalent plan) will be developed in collaboration with participating counties. In 2014, the benchmark plan will need to incorporate the essential health benefits package to be defined by HHS. Counties will commit to the following milestones as transitions to the 2014 benchmark plan:</p> <p>January 1, 2011: Current CI counties will provide limited mental health services, as determined by the county and as resources permit, as part of a minimum benefits package. (Note: all counties currently provide mental health services through their county mental health department). Participating counties will also develop a mental health needs assessment for enrollees to determine the services in greatest need.</p> <p>January 1, 2012: Expansion counties will provide limited mental health services, as determined by the county and as resources permit, as part of a minimum benefits package. (Note: all counties currently provide mental health services through their county mental health department). Counties will also develop a mental health needs assessment for enrollees to determine the services in greatest need.</p>

HCCI Program Elements	Current HCCI	New HCCI
		December 31, 2012: Current and expansion CI counties will submit to the State a plan to provide additional mental health services based on the findings of the mental health needs assessment.
Medical home/Care Coordination	All enrollees are assigned to a medical home, and all counties have gone beyond the basic medical home requirement to provide aspects of a patient-centered medical home. Three counties require the use of the medical home by enrollees to obtain their health services. The HCCI counties have introduced or expanded disease management services, and nine of the counties identify higher-risk enrollees with more severe chronic conditions and target them for disease and care management services.	Enrollees will continue to be assigned to a medical home, and counties will be required to assess the degree to which medical homes are working to meet specified goals for medical home services. Care coordination will continue to target enrollees with chronic conditions but will also be expanded to target frequent users of hospital services.
Provider Networks	Provider networks vary across the counties and reflect the local safety-net systems. Two counties do not operate public hospital systems, and the HCCI network is comprised solely of private providers. In the other eight counties, the provider network is focused around the local public hospital and clinics, but some counties include private safety-net providers as well.	All counties will be expected to ensure access to care for all services in their benefits package through provider networks that at a minimum include public hospitals (in counties that operate public hospitals), public clinics and community health centers.
Data Collection & Evaluation Criteria	All counties are participating in the UCLA evaluation of the HCCI. However, comparisons across counties are challenging due to differences in the individual HCCI programs and county data collection capabilities.	A single set of evaluation metrics will be developed. These metrics will allow for comparisons across counties and will focus on health reform readiness.
Rates	Counties provide the non-federal share and are reimbursed by the federal government at a matching rate of 50%.	California will consider the possibility of shifting to actuarially based rates for each HCCI that would factor in the cost of providing services to the HCCI population, many of whom have multiple, complex chronic conditions. This structure would introduce an element of financial risk to the HCCIs and provide further incentives to ensure appropriate use of services (see Risk-Based Payments.)

Timeline

September 2010	<p>Secure CMS approval of the Special Terms and Conditions to the Section 1115 Waiver.</p> <p>New HCCIs to identify a county-certified system of record that has demonstrated linkages with the Medi-Cal program as the system of record for their HCCI.</p>
January 2011	<p>Release HCCI program implementation plan to all counties.</p> <p>Current CI counties will provide limited mental health services, as determined by the county and as resources permit, as part of a minimum benefits package. (Note: all counties currently provide mental health services through their county mental health department). Participating counties will also develop a mental health needs assessment for enrollees to determine the services in greatest need.</p> <p>Initiate expansion of enrollment in existing HCCI counties (to the extent resources allow, counties that are able to accelerate enrollment before this date may begin enrolling earlier).</p>
January 2011	<p>Initiate pre-implementation planning process in expansion counties (e.g., development of eligibility and enrollment systems, benefits package, provider network, outreach activities).</p>
June 2011	<p>Begin enrollment of eligible individuals in HCCI expansion counties (to the extent resources allow, counties that are able to accelerate enrollment before this date may begin enrolling earlier).</p>
September 2011	<p>Current HCCIs to identify a county-certified system of record that has demonstrated linkages with the Medi-Cal program as the system of record for their HCCI.</p> <p>Implement single set of performance metrics for all counties.</p> <p>Implement access of care standards for all HCCI provider networks.</p> <p>Implement Value-based purchasing system</p>
January 2012	<p>Expansion counties will provide limited mental health services, as determined by the county and as resources permit, as part of a minimum benefits package. (Note: all counties currently provide mental health services through their county mental health department). Counties will also develop a mental health needs assessment for enrollees to determine the services in greatest need.</p>
March 2012	<p>HCCIs to submit to the State a plan to work with county human services departments to transition to a system that interfaces with the MEDS system as the system of record for HCCI enrollees. The State will grant access to HCCIs for such a system that interfaces with MEDS.</p>

- June 30, 2012 Current and expansion CI counties will submit to the State a plan to provide additional mental health services based on the findings of the mental health needs assessment.
- June - December 2013 All HCCIs will have implemented the transition plan, including testing, with HCCI eligibility records stored in MEDS.

Exhibit A: HCCI Eligibility Criteria by County

	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Eligibility Requirement:										
Age	19-64	19-64	19-64	19-64	21-64	21-64	19-64	19-64	19-64	19-64
US citizen/legal resident	X	X	X	X	X	X	X	X	X	X
> 5 years residence in US	X	X	X	X	X	X	X	X	X	X
Uninsured for > 3 months	X	X	X	X	X	X	X	X	X	X
Ineligible for other public programs	X	X	X	X	X	X	X	X	X	X
Federal poverty level (FPL)	200%	200%	200%	133.3%	200%	200%	200%	200%	200%	200%
Chronic condition diagnosis	X			X		X				
Urgent or emergent condition					X					
Other criteria				X*						

* Applicants age 63-64 and current Los Angeles Department of Health Services users with uncoordinated care also are eligible.

Exhibit B: HCCI Services Available by County

	Coverage Initiative Counties										Current Medi-Cal Benefits	
	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura		% HCCI Counties with Service
	HCCI Key: X = Covered services											
Acupuncture	X							X	X		30%	
Acute rehabilitation	X	X	X	X	X	X	X		X		80%	X
Ambulatory surgical center services	X		X	X	X	X	X	X	X	X	90%	X
Audiology (includes hearing aids)	X	X	X	X	X	X	X	X	X		90%	Limited
Blood bank services	X	X	X	X	X	X	X	X	X	X	100%	X
Dental Services (includes dentures)	X	X	X	X	X	X		X	X	X	90%	Limited
Dental services provided by a physician	X	X	X		X		X	X	X	X	80%	Limited
Durable medical equipment	X	X	X	X	X	X	X	X	X	X	100%	X
Emergency room	X	X	X	X	X	X	X	X	X	X	100%	X
General acute hospital	X	X	X	X	X	X	X	X	X	X	100%	X
Hemodialysis	X	X	X	X	X	X	X		X		80%	X
Home health aide	X		X					X			30%	X
Indian health services						X			X		20%	X
Infusion services	X		X	X	X	X					50%	X
Inpatient drug and alcohol treatment			X				X				20%	X
Laboratory	X	X	X	X	X	X	X	X	X	X	100%	X
Licensed vocational nurse	X		X	X	X		X	X			60%	X
Medical supplies	X	X	X	X	X	X	X	X	X	X	100%	Limited
Non-emergency medical transportation		X	X	X	X	X					50%	X
Non-physician practitioner services (midwives, family nurse practitioners, pediatric nurse practitioner, general nurse practitioner, physician assistants, and nurse anesthetist)	X	X	X	X	X	X	X	X		X	90%	X
Mental health services	X		X	X			X	X	X	X	70%	X
Nursing home care: skilled nursing, intermediate care	X		X		X		X				40%	X
Occupational therapy	X	X	X	X	X	X	X	X	X	X	100%	X
Ophthalmology and optometry services	X	X	X	X	X	X	X	X	X	X	100%	Limited
Optometry	X	X	X	X	X	X		X	X		80%	Limited
Outpatient drug therapy services	X		X	X		X	X	X	X	X	80%	X
Personal care services	X										10%	X
Physical therapy	X	X	X	X	X	X	X	X	X	X	100%	X
Physician	X	X	X	X	X	X	X	X	X	X	100%	X
Podiatry	X	X	X	X	X	X	X	X	X	X	100%	Limited
Prescribed and OTC drugs	X	X	X	X	X	X	X	X	X	X	100%	Limited
Prosthetic and orthotic devices	X	X	X	X	X	X	X	X	X	X	100%	X
Prosthetic appliances	X	X	X		X		X	X	X	X	80%	X
Psychiatric, acute inpatient	X		X	X			X		X	X	60%	X
Psychology	X		X	X			X	X		X	60%	Limited

	Coverage Initiative Counties											Current Medi-Cal Benefits
	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura	% HCCI Counties with Service	
	HCCI Key: X = Covered services											
Radiology	X	X	X	X	X	X	X	X	X	X	100%	X
Registered nurse	X		X	X	X	X	X	X	X		80%	X
Sign language interpretation	X	X	X	X			X	X	X	X	80%	X
Smoking cessation	X		X				X	X	X	X	60%	X
Social worker	X		X	X	X			X	X		60%	X
Speech therapy	X	X	X	X	X	X	X	X	X	X	100%	Limited
Sub-acute care facilities (licensed and certified skilled nursing)	X		X		X		X				40%	X
Telemedicine	X		X				X	X			40%	X
Use of inpatient hospital facilities	X	X	X	X	X	X	X	X	X	X	100%	X
Source: HCCI data compiled by UCLA from original and amended county contracts; Key county personnel; Medi-Cal data provided by DHCS.												

Exhibit C: HCCI Enrollee Cost-Sharing Requirements by County

	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura
Premium Requirement	No	Yes*	No	No	No	No	Yes*	No	No	Yes
Co-Payment Requirement:	Yes	No	Yes*	No	Yes	No	Yes*	Yes	Yes*	Yes
Formulary prescriptions	X				X		X	X		X
Non-formulary prescriptions			X		X		X			
Inpatient hospital care	X		X				X	X	X	X
Outpatient primary care	X				X		X	X	X	X
Outpatient specialty care	X		X		X		X	X	X	X
Emergency department visits	X		X		X		X	X	X	X
Lab or diagnostic services	X		X				X	X		X
Urgent care					X		X	X		X
Other			X		X		X		X	

* For selected enrollees, based on income.

Continuation of the Safety Net Care Pool: Strengthening the Health Care Infrastructure

The SNCP component of the current California hospital waiver has been a success, and should be continued and expanded. The current SNCP covers three program areas: (1) partial reimbursement to designated public hospitals (DPHs) for services to the uninsured; (2) support for six critical state-operated programs that address health care needs of particularly vulnerable populations; and (3) the Health Care Coverage Initiative for expanding health care coverage to otherwise ineligible populations in ten counties.

The SNCP amount in the current waiver was set at \$1.532 billion total computable annually for the first 4 years. In year 5, the SNCP was increased by \$720 million to \$2.252 billion total computable. Of the total computable annual amount for years 3, 4 and 5, a sub-cap of \$360 million per year is committed to the HCCI and may be used only for that purpose.

As shown in the budget neutrality analysis in this application, the State anticipates savings of \$4.8 billion dollars (federal share) over the life of the waiver (\$9.5 billion total computable). Those savings should be added to the existing \$2.252 billion total computable in SNCP for use in further support for the public safety net hospital, and for other purposes described below. In addition, the Section 1115 waiver should advance financing changes, outside the budget neutrality calculation, that strengthen the health care infrastructure for private and public hospitals.

I. Payments to Public Hospitals

Payments to public hospital systems from the SNCP have been funded through certification by the DPHs of their inpatient and outpatient of serving the uninsured. Those costs have grown steadily, both as a result of cost inflation and increased hospital utilization by uninsured persons. The SNCP payments to these hospitals have been vital to their survival, but they are covering diminishing percentages of the hospitals' costs. Increases in these payments are essential to the continued maintenance of these critical components of the State's safety net. Accordingly, the State proposes that the SNCP be increased and that the terms and conditions of its use be modified to permit broadened coverage of public hospital system costs.

Among the appropriate uses of the SNCP for hospital payments are the following:

- Increasing the upper payment limit for payments for serving Medicaid patients to 150% of the Medicare payment level pursuant to a Global Payment Demonstration Pilot Project as explained more fully later in this section.

- Covering short-term stays in Institutions for Mental Diseases (IMDs). Because of the statutory IMD exclusion, Medicaid coverage is denied to adults who need care in an institutional setting as part of a comprehensive plan of care, even though all other components of that care are covered when the patient is not living in the IMD. The policy behind the IMD exclusion is to leave to the State the funding of long term care in mental institutions. That policy has little relevance to situation where a person who is receiving a regimen of care mostly in community settings but requires a short stay in an institutional setting to become stabilized during an acute crisis. CMS's predecessor (HCFA) issued waivers to several states in the early 1990s to allow them to receive FFP for short term stays in IMDs, as part of comprehensive managed care programs. California's plan for coordinated and organized care delivery through county-based delivery systems is comparable to those earlier managed care programs. Use of IMDs in that context should not be discouraged, which can occur in the absence of any federal support for care in that setting. Coverage of up to 60 days for stays in IMDs is an appropriate use of SNCP funds and should be authorized.

II. Supporting Vital Health Programs

The SNCP has provided critical support for various state and local programs for particularly vulnerable populations: the Breast and Cervical Cancer Treatment program, the California Children Services program, the Genetically Handicapped Persons program, the Expanded Access to Care Program, the Aids Drug Assistance Program, the County Medical Services Program, uninsured mental health services and the Medically Indigent Long Term Care Program. The needs of these populations continue to be acute, and continued use of the pool funds to support them is warranted.

The State also seeks authority to use SNCP funds for additional state programs:

- The state's high-risk medical care pool.
- Services provided to developmentally disabled individuals.
- Health care provided to parolees.
- Covering short-term in-patient hospital stays for prisoners. With the increase in the Medicaid eligibility standard to 133% of federal poverty for all non-disabled adults under age 65, there should be a substantial increase in the number of Medicaid-eligible prisoners or parolees that are served in hospitals. From the perspective of the safety net hospitals, these patients are no different than any other low-income patient, and the absence of a funding source for the services provided to them puts further stress on safety net hospitals. Allowing them to be covered through the SNCP would alleviate that stress, and in that way strengthen components whose financial viability is essential to a successful Medicaid program.

- Workforce Development funds. Finally, the state seeks authority to use funds to increasing the number of health care professionals providing primary care and serving in medically underserved areas by receiving reimbursement for workforce development and training programs. These programs are integral to the successful transition to the era of health care reform and have been approved by CMS as part of other state's waivers. The state currently has numerous programs to increase the awareness of health careers to high school and college students, provide scholarships to students that pursue educational programs in primary care fields and provide loan repayments to health care professionals that serve in medically underserved areas for a specified number of years. California, like the U.S. as a whole, is experiencing physician and allied professional shortages, especially in urban inner-city and rural areas. These shortages will be exasperated under health care reform when millions of individuals will gain access to health insurance. California proposes to use existing and potentially increased funding provided to these programs to draw down federal funds. The ability to draw down federal funds for these programs will sustain funding for these programs at a time when they are most needed to help reform the safety net system to transition to a primary care model of care.

III. Delivery System Improvement Pool

California proposes inclusion of a Delivery System Improvement Pool (DSIP) in the waiver to be funded through the SNCP and federal budget savings as described in the Budget Neutrality narrative. This pool would support its public hospital systems in strengthening and improving safety net health care delivery systems. The proposed investment in this core part of the State's health care infrastructure is critical to increasing the efficiency and effectiveness of care provided to vulnerable populations through the safety net health care delivery systems and, more broadly, in preparing for full implementation of health care reform. As greater demands are placed on the health care system, particularly by those patients with multiple chronic conditions who will be managed in a more comprehensive way through this waiver, it is critical that its public hospital systems prepare for reform by expanding their capacity and creating greater efficiencies. Initiatives developed by the public hospital systems that would qualify for funding from the DSIP would be focused in the three areas that encompass the wide-range of activities of delivery system improvement that are vital to a successful transformation of the health care safety net:

1. Strengthening Coordinated Systems of Care
2. Enhancing Access to Care
3. Improving Quality of Patient Care

Each participating public hospital system would be required to develop a plan to build and improve coordinated systems of care for vulnerable populations, including the indigent and Medi-Cal enrollees, within one or more of the targeted categories for investment. The plan

would be required to describe program activities based upon consideration of local situations, needs of the patient population and current status and challenges of the local health care system. The plans would also be required to include specific outcomes and milestones that demonstrate achievement and accountability of real and measurable improvements in care.

Proposed Improvement Activities

1. Strengthening Coordinated Systems of Care

Public hospital systems provide a continuum of care to patients through their existing systems of hospitals and clinics including primary, specialty, outpatient, emergency and inpatient care. Public hospitals would utilize funding from the DSIP to further build and strengthen coordinated systems of care in preparation for expanded coverage and payment reforms that will increase accountability for health care outcomes.

Examples of potential projects in this category include:

Expanding and strengthening the use of patient-centered medical homes so that patients have a regular source of primary, chronic and preventive care that is team-based, tailored to a patient's particular health care needs, and coordinated across the spectrum of the patient's services, and so that patients have a pathway to access the right care at the right time. A public hospital system focusing on medical homes would be held accountable to achieving specific measurable milestones or outcomes, such as a specific percentage of patients enrolled in medical homes.

Public hospital systems that focus on expanding and strengthening the patient-centered medical home would spread some or all of the elements below to their outpatient clinics, using measurable metrics to demonstrate success:

- A multi-disciplinary team utilizing automated disease registries to conduct population management, including panel management, patient stratification, and providing care that is tailored to patients' health needs and cultural backgrounds;
- A focus by the multi-disciplinary team on prevention and wellness, helping patients stay well and aspire toward improving overall health;
- Group medical visits and planned visits to help patients self-manage their health;
- Effective information exchange/care coordination: including all aspects of the health care system (such as primary care and specialty care, emergency and inpatient services) and care is continuous through life and health transitions (such as pediatrics to adult, long-term care); and

- Proactive Care: reminders for recommended care in-person and through outreach for all paneled patients.

Expansion of chronic disease management approaches that have been successfully implemented in select public hospital clinics so that chronic disease management is scaled up to include all clinics within each public hospital system in the State. Examples of potential activities to strengthen and spread this work include:

- Procuring and employing health-information technologies such as disease registries that would result in an improved patient care experience and better health outcomes;
- Increasing group visits and other ways of helping patients manage their own disease and maintain health such as using health educators, nutritionists and other non-physician team members trained in self-management support and health education; and
- Using care managers to target frequent users to lower avoidable inappropriate use of high-cost health services and help patients navigate the system, connect to health and social services, and increase skills to manage their own disease.

A public hospital system focusing on chronic disease management would be held accountable by committing to achieving specific measurable milestones or outcomes, such as demonstrating that patients with chronic disease improve health outcomes.

Investment in health information technology designed to increase care coordination such as efforts to achieve meaningful use of electronic health records (EHRs); implement the technology components of EHRs (such as computerized physician order entry and electronic prescribing) and efforts focused on system interoperability.

2. Enhanced Access to Care

Public hospital systems may also seek DSIP funding to improve access to care for the vulnerable populations in their community. Enhancing access to care could be achieved through a variety of targeted improvements, such as:

Primary care access improvements that help ensure that expanded coverage results in expanded access to care. Primary care is the most critical building block for enhanced access to care and can improve health outcomes, as well as reduce inappropriate utilization and long term health care costs. An example of a plan to improve access to primary care may include redesign of primary care to reduce wait times for appointments, reduce cycle time of primary care visits, increase primary care productivity, reduce no-show rates and increase the overall number of patients seen in primary care. Such a plan would be assessed according to measured improvements in those areas.

Outpatient specialty care access improvements are vital to ensuring the health of patients, particularly the chronically ill with multiple health conditions. California's public hospitals are key providers of specialty care in their communities. To manage demand for specialty care, a public hospital choosing to focus on this area of improvement could use DSIP funding to help purchase and implement a data-driven referral management system that would ensure the appropriate and rational use of specialty appointments and/ or work to increase supply of specialty care by increasing training and expanding scope of practice for primary care physicians and nurse practitioners to include some basic specialty care procedures. Accountability milestones might include demonstrated reduction in backlogs for appointments in targeted specialties.

Emergency room improvements and reductions in utilization that reduce unnecessary utilization through one or more of the following efforts:

- Adding urgent care facilities or hours;
- Improve patient tracking in the emergency department;
- Adding 24-hour nurse advice line to the system of care; and
- Placing care managers in the emergency department to identify and link frequent users with a primary care medical home.

Improving access to language services and tailored, patient-centered care to improve access for the diverse, limited-English proficient populations served, including:

- Improving cultural competence by building cultural competence training into residency and other health professional training programs;
- Increasing linguistic access through supporting and training bilingual staff; and
- Investing in healthcare interpretation technology and building patient navigator programs.

Accountability milestones could include achieving best practice standards for the time it takes for a trained healthcare interpreter to be available for a patient-provider interaction.

3. Improved Quality of Patient Care

Through the DSIP a public hospital could pursue expanded and new targeted quality improvements such as:

Reducing readmission rates through improved care transitions, implementing evidence-based practices that improve discharge processes, post hospital coordination and patient experience. For example, hospitals could change the way patients are educated about their diagnosis throughout the hospital stay and include a formal discharge plan starting

on the day of admission. Hospitals could also expand scheduling systems to allow emergency department and hospital units to schedule clinician follow-up appointments and post-discharge testing. Establishing processes and systems to reliably confirm the medication plan post-discharge, including what to do if a problem arises, could also be pursued by hospitals using the DSIP funding. In some cases, additional FTEs may need to be hired or trained in care transitions to achieve the best possible patient outcomes and lowered costs. A public hospital system focusing on reducing readmission rates would be held accountable by committing to achieving specific measurable milestones or outcomes, such as a demonstrated reduction in 30-day readmission rates.

Preventing admissions for ambulatory sensitive conditions to support the development of tools and processes to monitor, report and improve care delivery and coordination between hospitals and outpatient clinics, including the use of registries and clinical decision support systems that could be implemented and shared between inpatient and outpatient settings. Accountability milestones could include demonstrated reductions in admissions due to hypertension or diabetes.

Ensuring equitable health care and outcomes by developing systems to stratify patient outcomes and quality measures by accurate patient demographic data such as race, ethnicity, gender, primary language and literacy level. Consistent, effective mechanisms would be required to track patient demographic data as well as staff resources to analyze patient outcomes data. Hospitals could apply to use DSIP funds to address disparities identified.

Disbursement of DSIP Funds

The DSIP would be a subcomponent of the overall budget neutrality pool of the waiver. The State and its public hospital systems would provide the non-federal share to draw federal matching funds from the DSIP through the use of intergovernmental transfers. Because DSIP funding is intended to be an investment in public hospital safety net delivery systems to prepare them for health reform implementation, funding public hospitals receive from the DSIP should not be considered revenue for purposes of Medicaid and waiver funding calculations, including the calculation of eligible certified public expenditures and the hospital specific Medicaid DSH payment limits.

Timeline

This timeline would apply for each year of the waiver. DSIP programs and funding would have an annual cycle; however, DSIP plans could encompass single year or multi-year activities.

- January 31, 2011- Public hospitals 1st year DSIP program plans due to State
- May 1, 2011- First year DSIP funding begins
- December 31, 2011-6-month progress report on 1st year DSIP plans due
- June 30, 2012- Annual progress report on 1st year DSIP plans due

IV. Global Payment System Demonstration Project

A final component of the infrastructure investment is a Global Payment System Demonstration Project authorized under Section 2705 of the Patient Protection and Affordable Care Act. The PPACA authorizes the Secretary of HHS, in coordination with the newly created Center for Medicare and Medicaid Innovation (CMI), to approve global demonstration projects in five states for federal fiscal years 2010 through 2012. These payment reform projects offer the promise of realigning incentives and driving providers to offer more cost effective, high quality care. California's large network of public hospital safety net systems provides a unique opportunity to test whether a global payment system can reform the current fee for service payment structure in a way that shifts spending patterns to more cost effective care thereby improving the quality care and health care outcomes. These public hospital systems provide the broad scope of services necessary to successfully test a global payment model, from primary care clinics to trauma centers and tertiary care hospitals.

Under the Global Payment Project, the network of public hospital safety net systems in California would move from fee-for-service Medi-Cal payments to a global capitated payment model. The proposal couples payment reform with delivery system reform. By using principles similar to accountable care organizations, the Global Payment Project would better align payment and care delivery incentives. This approach will help stabilize the public safety net systems, and will provide the flexibility necessary to ensure that they are able to continue providing care to Medi-Cal beneficiaries and the newly covered populations as health reform is implemented. For those public hospital systems that elect to provide the additional nonfederal share for the global payments, the Global Payment Project would be in place for the first two years of the Section 1115 Waiver and would be phased into the waiver during the last three years. Therefore, the Global Payment Project would count against the SNCP in the final three years of the Section 1115 Waiver.

Because the public hospital systems have been largely responsible for the nonfederal share of the services provided to Medi-Cal beneficiaries, the Medi-Cal payments received by those systems have not been sufficient to allow for the innovations and investments necessary to prepare for health reform. The proposed global payment model is consistent with the principles of health reform and provides federal support for the needed innovations and will eliminate any perceived incentives to use inpatient care that might result from the current cost-based payment system. The entire network of public hospital safety net systems would have the flexibility to focus on the development of delivery systems and make the patient care changes to implement better primary and preventive care, medical homes, care coordination and chronic care management. By providing a global payment for all services provided in the public hospital system instead of the existing service specific fee-for-service basis, this demonstration project provides an opportunity to reform public hospital system payments in such a way as to allow more opportunity and flexibility to ensure care is being provided in the most appropriate setting. In addition, this project would begin a transition for the public hospital systems to a risk-based reimbursement approach under which they will be responsible for managing costs under the global payment and would be at risk for increased costs as well as be able to retain any potential savings.

Global Per-Beneficiary Payments

Under the Global Payment Project, each public hospital safety net system would receive a global payment for each unique Medi-Cal beneficiary who receives services in the system, if their services would otherwise have been paid on a fee-for-service basis. Those beneficiaries that are in full managed care plans would be excluded, but those enrolled in a county outpatient managed care plan would be included, with appropriate payment adjustments to account for outpatient managed care plan payments. The services covered for the global payment would be inpatient hospital, outpatient hospital, including emergency room and trauma services, services provided in public freestanding clinics, and physician services in all of the aforementioned public hospital system settings.

The capitated amount will be based on the payments to the public providers for Medi-Cal services rendered on a fee-for-service basis in a base period (state fiscal year 2008/09) determined on a per-unique Medi-Cal beneficiary basis. A critical element of the per-capita payment calculation is that it would assume fee-for-service payments at 150 percent of the upper payment limit (UPL) for hospital services. Under the current Section 1115 Hospital Financing Waiver, payments to the designated public hospitals have been cost-based. Therefore, the per-capita payment would reflect 150 percent of the base-year costs for hospital services. Most of the data needed to make this calculation has been collected through current waiver CPE process. The cost data has been subject to audit and is reliable. Base period costs would be trended forward using the budget neutrality trend factor for public hospital costs.

The proposal to apply a UPL at 150 percent is based on the history of CMS' UPL rules. In January 2001, the aggregate public hospital UPL was set at 150 percent of the Medicare amount in recognition of the special role of these hospitals in serving the Medicaid population. This special UPL was designed to ensure the continued existence and stability of these core safety net providers. It was determined through the rulemaking process at the time that the higher limit was necessary to allow states the flexibility to pay higher rates to these hospitals, and thereby support continued access to care for the Medicaid population. In proposing this special limit it was noted that public hospitals are often established to ensure access to needed care in underserved areas, and frequently provide a range of care not otherwise accessible to the Medicaid and uninsured populations, including expensive specialty services, such as trauma and burn care. This is particularly true in California, where the public hospitals continue to struggle financially to provide this care. Though comprising just six percent of all hospitals statewide, California's public hospitals provide roughly half of the hospital care to the State's 6.7 million uninsured. They also operate 57 percent of all Level 1 trauma centers, 43 percent of all burn units, provide more than 60 percent of the State's psychiatric emergency care, and train nearly half of all new doctors in California. As a critical component of the specialty care delivery system, California public hospitals and health systems also provide care that simply may not be available elsewhere. Examples include care for drug-exposed infants, AIDS, immigrant populations, and other specialty services such as acute rehabilitation.

The higher UPL was also designed to address the stresses and uncertainties faced by public hospitals, given their dependence on public funding sources. The concern in 2001 was that further limits on Medicaid funding for public hospitals threatened their ability to fulfill their mission and fully serve the Medicaid population. These concerns were well founded. The current level of funding does not allow for the investment necessary to improve systems of care and prepare for the implementation of health reform. California's network of public safety net systems remains vulnerable.

The policy considerations that led to a higher UPL for public hospitals in 2001 continue to apply in 2010 in California. Given that CMS has the authority to apply a 150 percent UPL under Medicaid generally, that authority extends to the broad global payment system demonstration authority granted under the Affordable Care Act.

The Payment Process

Global, per-capita amounts would be determined annually for each public hospital system. Final payment amounts would be subject to year-end reconciliation to reflect the number of actual Medi-Cal fee-for-service users who were served in the system. The nonfederal share of the per-capita payments will be provided in one of two ways. The first mechanism would be through a

combination of public hospital (or county or University of California) certified public expenditures (CPE), intergovernmental transfers and the State general funds currently flowing to these providers. The second mechanism would be through the use of intergovernmental transfers and the State general funds currently flowing to these providers. The public hospital system, based on approval from the state, would choose which method of non-federal share to use.

Quarterly payments to the public hospital safety net systems would be estimated in advance, and be subject to year-end reconciliation to the actual number of unique Medi-Cal beneficiaries who received services in the public hospital system. Each quarter, the system would receive a payment representing one-quarter of the estimated global amount due annually. If a portion of the non-federal share is provided through CPE, the system would receive only the federal financial participation related to the portion of the payment funded through CPEs and the remainder of the global amount, including both the federal and non-federal share. We currently estimate under this method that 50% of the global payment will be funded through CPEs.

As noted above, this proposal includes providing per-capita payment amounts for Medi-Cal beneficiaries who are enrolled in an outpatient managed care plan program. These payment amounts will be appropriately adjusted to reflect only the portion of the global payment derived from base-year inpatient hospital services amounts.

To ensure the necessary funding levels for the public hospital safety net systems, it will be important to treat the Global Payment Project revenues appropriately in the context of the various sources of payments. First, because the global payment reflects the application of the UPL at 150 percent, total payments to these public hospitals are not limited to costs. Therefore, the portion of the per-capita payment that is funded through IGTs and State general funds should not be offset against the CPEs that will provide the basis for the rest of the federal matching expenditures.

Similarly, the amounts received through this mechanism should not be offset against uncompensated costs in determining the hospital-specific limits for purposes of calculating the disproportionate share hospital payments. Because the Medi-Cal FFS population will now be funded through the global payment project, neither of the cost of their services nor related revenues would be taken into account in determining DSH funding for the designated public hospitals. In addition, because beneficiaries would be able to seek treatment from other Medi-Cal providers, the managed care requirements of 42 C.F.R. part 438 would not apply to the public safety net systems with respect to this fee-for-service population.

Aligning Payments and Incentives

The Global Payment Project provides California's public safety net systems with the opportunity to strengthen their existing infrastructure and target resources on changes that will allow them to continue caring for the needy in their communities after health reform is implemented in 2014. Those individuals whose care will be paid for under this Global Payment Project will ultimately be assigned to managed care organizations or to an outpatient managed care plan program. Many of the uninsured currently served in these systems will eventually obtain full coverage through Medicaid or the Exchange by 2014. The public hospital safety net systems have every incentive to implement policies and practices that encourage strong ties with their patients. Not only will this approach result in a healthier community, it will help ensure that the patients continue to look to the public systems for their care, either through Medi-Cal managed care organizations or as privately insured individuals.

Notwithstanding this powerful incentive to continue to provide all of the high quality services available in the public system to these patients, California recognizes that the Global Payment Project may create a short-term financial incentive for the public hospital systems to limit costly services provided to those beneficiaries covered by the Project and to encourage those patients to seek any additional care from other providers.

Under this proposal, however, because the nonfederal share for 50% of the global payment will be based on the public hospital's certified public expenditures (CPE), a significant shift of patients and costs out of the public system could result in inadequate CPEs to draw down the full global payments.

Additionally, California would suggest a way to prevent an inappropriate shift under this mechanism. First, although the beneficiaries' freedom of choice of provider will remain in place, the public hospital safety net systems would be expressly precluded from denying care or referring patients covered under the Global Payment Project to providers outside the public safety net system for the purpose of improving the financial results for the system under the Project. Referrals outside of the system would be limited to those necessary in the best interest of the patient and where the services in question are not reasonably available in the public safety net system.

In addition, the state will track the relative utilization by this population between the public hospital system and other providers by assessing the portion of care in a base period occurring in each sector. A similar assessment of the utilization will be made for each year under the demonstration project. The assessments of utilization will take into account the acuity and intensity of the services, including an analysis of the associated costs, and would not be based simply on the number of services occurring within and outside the public hospital system. The

assessment will also account for billing and reporting differences among types of providers. If the utilization patterns indicate a trend toward higher utilization outside the public hospital system than was the case in a base period, and that shift cannot be explained by other changes in the health care delivery system or market in the area, the State will notify the public hospital system of its intent to adjust its global payments to take the shift into account. Such an adjustment would be made only after the public hospital system has had the opportunity to respond and provide relevant information.

Finally, it is anticipated that many changes will take place in the health care market as health reform is implemented over the next few years. In light of this fluid situation, a structure will be established that will provide for a review of the appropriateness of global payment rates over time that takes into account potential changes in the fee-for-service population as well as changes to the availability of providers in the marketplace, including the closure or opening of hospitals and clinics or unanticipated changes in the public hospital safety net system. If significant shifts occur it may be necessary to adjust the global payment rates to account for increases or decreases in cost related to these shifts. A mechanism will be put into place so that, at the initiation of either the State or the public hospital safety net system, prospective adjustments to the rates can be made to reflect significant changes in the market place or population served.

Coordination with the Section 1115 Waiver

It is anticipated that Medi-Cal fee-for-service payments would be steadily reduced through the five years of the Section 1115 Waiver because of the shift of the SPD population to managed care. Given the emphasis on coordinated care for the chronically ill, it is also expected that number and length of inpatient hospital stays will be reduced. The Global Payment Project will ensure that the public safety net systems will have the flexibility to respond to these changes through adjustments to their delivery systems and patient care models.

Under the Affordable Care Act, Global Payment System Demonstration Projects are not subject to the budget neutrality considerations applicable to CMI programs. In addition, the separate appropriations authority for these projects takes them outside of any Section 1115 waiver budget neutrality limit.

It will only be in the last three years of the Section 1115 Waiver, when fee-for-service payments are expected to be substantially lower, that the global payments to the network of public hospital safety net systems would begin to be applied against the budget neutrality limit.

Reporting and Evaluation

It is anticipated that CMS, in coordination with CMI will develop special reporting and evaluation requirements for the Global Payment System Demonstration Projects with which the State will comply. In addition, reporting on the impact of the California's Global Payment Project will be included with the broader reporting and evaluation efforts of the Section 1115 Waiver. In particular, the public safety net systems will report on whether the changes supported through the Global Payment Project had an impact on quality of care measures such as the number of avoidable hospital readmissions and the number of avoidable emergency room visits.

V. Support for Private Hospitals

In California there are certain areas (very rural, very urban poor) where selective contracting acts as a deterrent to access. In recognition of the critical need for hospital access in these areas the current state plan reimburses these hospitals at 90 percent of cost. However, the current state plan does not allow for supplemental payments to non-contracted hospitals. The State seeks authority to make supplemental payments to non-contracted hospitals where such payments are necessary to ensure the stability of facilities that are especially important for access for Medi-Cal and low income patients. The current waiver authorizes supplemental payments, where appropriate, to contracted private hospitals (within the aggregate upper payment limit for private hospitals) and also to non-designated public hospitals (within their aggregate upper payment limit). While that authority has rarely been used, having it gives the State the flexibility to deal with needy situations when and as they arise.

One such situation likely to arise during the coming waiver period involves the new Martin Luther King hospital in Los Angeles. The Los Angeles County Martin Luther King/Drew Medical Center facility was the principal hospital provider in the lowest income area of Los Angeles until it closed in 2007. Plans are now underway to establish a replacement facility that will not be county-operated (though it will have some county support). The facility is expected to open in 2013, on a non-contract basis, and to resume its role as a principal provider for Medi-Cal and low income patients. But because the hospital will be categorized as private it will not be eligible for DSH payments at the 175% of cost level. Supplemental payments above the regular state plan rate for non-contract hospitals will likely be required to provide the facility with sufficient financial support to survive and carry out its mission. The non-federal share of these payments would be provided to the State by transfer from Los Angeles County.

Any such payments to MLK or any other private hospital would be made within the aggregate upper payment limit for private or non designated public hospitals, and would have no impact on the budget neutrality showing for this waiver.

System Delivery Reform and Special Populations

In addition to the transition to full coverage under health care reform, California is also poised to continue to build and improve its service delivery system, especially for four critical populations that include:

- Seniors and Persons with Disabilities;
- Persons with dual Medi-Cal and Medicare Eligibility;
- Children with Special Health Care Needs; and
- Persons with Behavioral Health Disorders and/or Substance Abuse Requiring Integration of Care.

As a part of the 2009-2010 budget, ABx4 6 was enacted with the twin goals of building a better, more comprehensive system of care for these vulnerable populations and also slowing the long-term Medi-Cal expenditure growth rate. The legislation commits the State to pursuing a Section 1115 Waiver to restructure the organization and delivery of health care for the populations that are the most medically vulnerable, high-cost beneficiaries with complex chronic conditions, comorbidities, and the highest needs for coordinated health care.

The approach to dealing with the SPDs and an initial approach to dealing with the Dual Eligibles are described below. The State has begun planning system reform for the second two groups but would respectfully ask CMS to permit amendment of the waiver in the 2nd or 3rd year so that the State can focus on the first two and the expansion of coverage first.

I. Seniors and Persons with Disabilities (SPD)

Seniors and Persons with Disabilities (SPDs) refer to those persons enrolled in Medi-Cal only. SPDs represent a significant share of the total cost of the State's fee-for-service Medi-Cal program. The waiver's goals for SPDs include:

- Improving access and coordination of the most appropriate, cost effective care for SPDs in order to improve health outcomes and contain costs;
- Providing SPDs with a choice of organized systems of care through which to receive these services;
- Supporting and strengthening the local safety net and its integration into organized systems of care through payment reform and outpatient managed care models; and
- Aligning financial incentives to support providers in delivering the most appropriate care and containing costs.

Key program elements include:

Provide seniors and persons with disabilities more organized care. A key element of California's waiver proposal is to provide our senior and disabled beneficiaries with access to care that is better organized and coordinated than the care that is currently available from the fee-for-service (FFS) payment system. Effective care coordination for this population promises to improve the outcomes for these beneficiaries and decrease the overall costs of their care. Meeting these goals is fundamental to achieving the long-term control of the growth in Medi-Cal costs while improving care provided to these medically involved beneficiaries.

Target population is Medicaid-Only beneficiaries. The waiver will serve a target population of approximately 380,000 Medi-Cal SPDs who are not enrolled in Medicare or who do not have an unmet share of cost or other health coverage. It includes those beneficiaries who reside in the 14 counties where managed care exists and enrollment of SPDs is not currently mandatory. This population accounts for \$7.5 billion in Medicaid expenditures annually, including DHCS and other department spending.

Require mandatory enrollment. The waiver will require all seniors and persons with disabilities to enroll in an organized system of care as authorized by ABx4 6 (Statutes of 2009; Welfare and Institutions Code section 14180); however, the current Medi-Cal managed-care exemption process will continue to apply.

Utilize organized delivery system models. The State will begin implementation in the first year of the five-year waiver by enrolling SPDs into existing managed care plans upon approval of the waiver or on January 31, 2011, whichever comes later. This approach builds on the State's existing infrastructure of managed care plans that has been developed over the past 20 years. It will require existing managed care plans to demonstrate compliance with new SPD-specific standards developed by the State and in consultation with stakeholder partners.

County Alternative Option. In addition to enrollment in existing managed care plans, counties will have the option to establish an additional organized system of care that reflects and meets unique local needs and circumstances. This additional choice could be offered along with existing plans as an additional option for SPDs who are required to enroll in organized systems of care, per ABx4 6.

Incorporate essential elements of organized delivery systems. The entities providing services to SPDs will be required to meet more specific standards related to care management and performance measurement. Organized systems of care for SPDs will provide:

Medical home provider. A beneficiary will choose a single provider or community health center to serve as the medical home provider who will be responsible for providing and coordinating care.

Care management and member supports. Care management activities will be a central feature of this system. Predictive modeling and risk-stratification techniques will be used to identify enrollees' needs to be able to provide the level of care management appropriate for their needs. High-needs enrollees will receive the most extensive set of services. Care management services include disease and medication management and community-based care coordination including coordination of referrals and linkages to community resources. In addition, all SPD beneficiaries will have access to member support services that will provide program information, enrollment choices, and medical advice.

Integrated Benefits. Enrolling SPDs in organized delivery systems offers the opportunity to coordinate more effectively the full range of home and community-based services including home health services, In-Home Supportive Services (IHSS) and other services. It will also permit the inclusion of these services within a plan's scope of services.

Monitoring system performance and outcomes. Organized delivery systems will be accountable for provider performance and health outcomes within their systems. These entities will be responsible for collecting and using performance and outcome data to drive changes in care delivery as necessary to ensure that beneficiaries are receiving high quality care that improves health outcomes. These entities will be required to share performance and outcome data with DHCS.

Integrate local safety net providers into organized care delivery models. The transition of SPDs to more organized delivery of care must be done in a way that preserves the ability of safety net providers, including community health centers, private community hospitals, and public hospitals, to continue to perform the important role they play in delivering care to this population and to other low-income Californians.

Transition reimbursement for care in public hospital systems to more risk and population-based financing arrangements. Managed care will allow many public hospital systems to receive reimbursement through capitated or DRG based payments for managing the care of SPDs. This new financing arrangement will shift their reliance away from cost based reimbursement which was required under the past waiver and has the unintended affect of incentivizing high cost, inefficient care to a system that complements delivery system improvements and innovations with payment incentives, including financially rewarding the provision of cost effective care. Some public hospital systems will be ready to immediately move away from cost based

reimbursement for SPDs while other public hospitals will transition from cost based reimbursement by implementing alternative approaches such as outpatient managed care models.

Enhancing the integration and coordination of private, community safety net DSH hospitals.

Private community DSH hospitals are an essential component of the safety net, providing critical access points to care in regions throughout the state that both include and exclude public hospitals. These hospitals provide almost 40 percent of the inpatient care to the SPD population, making it essential to preserve and enhance their viability as part of the development of organized delivery systems for SPDs.

The transition of SPDs to managed care offers the opportunity for private hospitals to test new care delivery frameworks. California envisions the potential for Medi-Cal managed care plans to contract with private community hospitals, physicians, community health centers to create integrated, coordinated and sustainable delivery systems. These new arrangements, based on the concepts of Accountable Care Organizations, may facilitate the development of risk sharing models as well as investments in the private safety net system to develop core infrastructure such as medical home models, care coordination, integrative technology, all of which will be essential in improving the care and outcomes for SPDs.

Expected benefits. The use of organized systems of care will increase accountability, strengthen the health care safety net, reward health care quality and improve health outcomes, and slow the long-term expenditure growth rate of Medi-Cal. SPDs will achieve better health outcomes and better quality of care by receiving the most cost effective, coordinated care. These changes will achieve a reduction in emergency room, inpatient, and pharmacy utilization for the SPD population leading to a significant reduction in costs over the life of the waiver.

Approaches to Implementation

The plan includes two alternative approaches for providing more organized care for SPD beneficiaries; both approaches are for counties with existing Medi-Cal managed care organizations. The plan does not address beneficiaries in non-managed care counties, nor counties where County Organized Health Systems operate.

- Mandatory expansion of the SPD population offering the choice of enrollment into an existing managed care plan. In this model, Medicaid managed care plans may apply to amend their existing contract with the DHCS in order to enroll SPDs subject to the key elements and performance measures described in “*Key Performance Standards for Plans Enrolling SPD Populations*”.
- Mandatory expansion of the SPD population offering the choice of enrollment into existing managed care plans or a “County Alternative Option.” Under this model, a

county may contract with the State to develop and administer a unique model of organized care for the SPD population and would be subject to essential standards and performance measures as described below. The SPD population could choose to enroll in the existing managed care plans or this new alternative delivery system.

Enrollment in organized systems of care will be modeled on the State's current process for mandatory enrollment of children and families. SPDs will have the opportunity to choose the system in which they will enroll. This selection process will be supported by the current Health Care Options contractor who supports beneficiary choices among health plan options by providing information about the available health plans and the available providers under each plan.

SPDs will be provided a choice to enroll in any existing managed care plan offering SPD coverage in counties where these plans exist. In counties where an alternative plan is developed, enrollees can choose existing plans or the County Alternative Option. Similar to the current enrollment process for children and families who do not make an active choice, the enrollment of SPD beneficiaries will be structured according to rules developed by the State in consultation with stakeholders to assign enrollees to an organized delivery system. The enrollment will take into account where possible the enrollees' recent use of providers. These enrollments would also be distributed among participating plans in proportion to the shares of the population that each participating plan currently serves, i.e. a plan serving 60 percent of current enrollees would receive 60 percent of the members who do not state a plan preference. In counties that establish a county alternative option, the default mechanism will include appropriate consideration of the county alternative to ensure the opportunity for its full participation and stability. This share would be an initial starting point and adjusted to take in account the following two additional factors:

- Plan quality, by directing an increased proportion of beneficiaries to plans with better performance, both performance in general and with respect to similar beneficiaries as that performance data become available, and
- A health plan's inclusion of its local health care safety net system in its provider network.

Key Performance Standards for Plans Enrolling SPD Populations

Participating managed health care plans and County Alternative organizations must comply with standards related to key elements as set forth in ABx4 6. Compliance with all existing regulations under Knox-Keene contracting provisions will be required for existing managed care plans. County Alternative Options, depending on their structure, may be required to obtain and maintain Knox-Keene licensure as well. To the extent applicable, all models will require compliance with all DHCS Medi-Cal contracting provisions. Additionally, both models must fully address the following key elements that will provide additional consumer protections for

their enrollees beyond the array of consumer protections currently applicable to Medi-Cal managed care plans. These elements will apply to both existing managed care plans and alternative options.

1. Access

Network Adequacy – DHCS, working closely with the Department of Managed Health Care (DMHC), will determine SPD enrollment capacity based on the provider networks available in managed care plans and on any updated information related to expansions of capacity. Network adequacy for the enrollment of SPDs will require sufficient specialists necessary to care for the specialized needs of this population consistent with the Department of Managed Health Care and DHCS processes and any enhancements DHCS deems necessary to further support the care of the SPDs. Network adequacy will determine each model's SPD enrollment capacity and will be monitored quarterly to ensure enrollment does not exceed capacity.

Access to Information – Current contracts require managed care plan communication with members be provided in ways that meet the cultural and language needs of the members. Additional plan instructions will be added to require the communication be made available in alternative formats or plain language to assure that all members have access to communications that take into account hearing, visual limitations, or other limitations.

Physical Accessibility – DHCS will adopt an enhanced facility site review (FSR) tool that focuses on the access needs of people with disabilities and chronic conditions to be used by plans to assess the physical and non-physical accessibility of their network providers. The plan will make available to members and prospective enrollees the information from the assessment for each provider. The enhanced FSR tool will be implemented by the contracted Medi-Cal managed care health plans and county alternative option models and monitored by DHCS.

2. Transition

Outreach and Education – DHCS will conduct outreach and education activities that provide eligible SPDs with information on Medi-Cal managed care, member choices and consumer protections. DHCS will provide prospective enrollees with enrollment materials at least 60 days prior to the date when beneficiaries are expected to make a choice among available models. DHCS will continue to require advanced review and approval of plan-specific marketing materials.

Phased-In Transition – A coordinated, phased-in transition over the course of 12 months with staggered enrollment will ensure adequate support for these beneficiaries. New Medi-Cal eligibles will be required to enroll into a managed care organization at the time eligibility is

determined. However, the transition of existing Medi-Cal SPD members will be phased in over a 12-month period with enrollment occurring concurrent with the member's annual redetermination. Rollout on a geographic basis may be appropriate in larger counties. In addition, DHCS, in coordination with DMHC, will monitor plan network adequacy to ensure SPD enrollment is limited or shifted to other plans should network adequacy be insufficient to properly support the needs of this additional expansion.

Access to Existing Providers – Members will have the opportunity to select a plan that includes their preferred providers in the network. DHCS will require plans to allow new plan members under active treatment with an out-of-network provider to continue with the existing out-of-network provider for a period of up to 60 days. However, medical exemptions are available to Medi-Cal beneficiaries that have been assigned to managed care plans and are already under treatment for a complex medical condition or pregnancy by a FFS-Only provider until the medical condition stabilizes.

Assignment. Beneficiaries who do not make a plan choice, and for whom utilization data is available to DHCS, will be assigned to plans where there is a match between the plan's network and providers from whom the beneficiary has received treatment.

In cases where SPD beneficiaries have high health care needs, as indicated by the number of active providers and intensity of services and do not choose a plan or alternative option during the required time period, DHCS will assign these members to the plan or alternative option that can provide the greatest continuity of care for the member. The assigned plan or alternative option will be required to reimburse out of plan care at prevailing Medi-Cal rates until the member is assessed and a care plan is established that meets the member's health care needs including access to needed specialty care.

3. Care Management and Coordination

Enhanced Definitions of Care Management and Coordination – Contract language will include added specificity regarding care management and coordination requirements. Enhancements to the definitions of care management and coordination include the assessments of need for care management; use of qualified care managers with experience in meeting the needs of people with disabilities and chronic conditions; and development of care management plans in collaboration with the PCP and the member and their representatives. Requirements will address the timing of identification and assessment of member needs, the linkages between plans or alternative options and community services, consideration of co-morbidities, and improved coordination for carved-out services. DHCS will issue a policy letter for the enhanced definitions in October 2010.

Early Identification of a Member's Health Care Needs – In addition to the DHCS efforts for a member self-assessment at time of enrollment, DHCS will develop information about health status and treatment history based on member-specific FFS utilization data so that, after a beneficiary is enrolled, the enrolling organization can identify those who may require early initiation of assessment and care planning. This process will also serve to safeguard the needs of the most at-risk SPD members as described in “Transition 2c” above.

Care Management Assessment – Based on information from the initial assessment, the plan or county alternative option may be required to develop a formal care plan with annual reassessments and/or reassessments based on a triggering event. Caregivers should be considered in assessing and determining care management needs. Current contract requirements allow plans up to 120-days to conduct the initial member assessment. Available utilization data and members self-assessment at time of enrollment will assist plans and alternative options in identifying high risk members and assist them in making the initial assessment as soon as possible, but not later than 90 days after enrollment.

Cultural Competency Training – Plans, county alternative options and providers must be trained in cultural competency and sensitivity to better serve the SPD and chronically ill population. DHCS has begun to develop a statewide education strategy to train health plans which will allow for plans to train their network providers in order to better provide culturally competent and sensitive care when serving individuals living with disabilities.

Behavioral Health Coordination – DHCS will require its contracted delivery models to ensure coordination for the behavioral health needs of the SPD members and, when appropriate, make coordination with behavioral health services a specific component of the member's overall care management plan.

Coordination of Other Services – All delivery models will be required to provide specific protocols and strategies to demonstrate that care provided by the plan is coordinated with other services that a beneficiary receives from other delivery systems such as services provided those through regional centers, in-home supportive services, and other community-based services. This includes the designation of a liaison with regional centers to assist in the coordination of care for persons with developmental disabilities.

4. Performance Monitoring and Improvement

Expand Required Performance Measures – DHCS will develop and publish results for existing and additional performance measures in ways that provide quality indicators not only for each plan's entire Medi-Cal managed care population, but also specifically for each plan's enrolled SPDs. This may include both appropriate existing HEDIS measures and other department-

developed performance measures. DHCS will expand current annual utilization data submitted by plans for emergency room use, inpatient and outpatient care, and prescription drugs to present results not only for each plan's entire Medi-Cal managed care population shown in standard age bands, but also specifically for SPDs or other eligibility categories. In developing new performance measures and expanding reporting of performance measures and utilization data, DHCS will develop technical specification, sample sizes, audit procedures, and reporting methodology. Initial results of new and expanded performance measures and initial reporting of expanded utilization data will begin in the year after SPDs have been enrolled in the delivery models for at least 12 months.

Augmented Audit Effort – DHCS will expand medical audit reviews of participating plans to include elements specifically related to care for the expanded populations. Medical audit reviews will be enhanced to include evaluations of the delivery model's policies and procedures addressing a patient's request for disability accommodations including providing extended appointment times for individuals with complex medical histories, providing dressing assistance, and assistance in scheduling transportation. Evaluations will also include reviews of accessibility of communication for individuals who have hearing disabilities, and accessibility of provider offices and equipment, and the availability of alternative formats including the use of large print materials, Braille, audio tapes, and electronic formats for the provision of health education materials and patient care instructions.

Additionally, DHCS will augment its financial audit reviews to ensure that a financial statement audit is performed on contracting plans annually pursuant to Generally Accepted Auditing Standards of the United States of America. Additionally, a risk based audit will be performed on each contracting plan tri-annually for the purpose of detecting fraud and irregular transactions.

New HEDIS measures – DHCS will adopt and report on new HEDIS measures that provide qualitative assessments that reflect the specific conditions relevant to the SPD population. DHCS will also expand reporting of results on existing HEDIS measures to include results specifically for SPDs and will adopt and report on new HEDIS measures that provide quality indicators not only for each plan's entire Medi-Cal managed care population, but also reflect the specific care needs of the SPD population. DHCS plans to begin work with its External Quality Review Organization by January 2011, select measures by August 2011, so a first report can be issued August 2012.

SPD Representation – DHCS already requires plans' advisory committees to include members who represent the needs of the SPD population so they can participate in establishing public policy for these populations. DHCS will provide additional oversight through review of meeting agenda and participants.

Enhanced Member Satisfaction Survey – DHCS will enhance the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to specifically reflect concerns of SPDs. DHCS will continue to make the survey results available to plans, members, and other stakeholders.

Quality Improvement Projects (QIPs) – DHCS currently requires plans to undertake quality improvement projects to improve the quality of their services. DHCS will require all delivery models to design quality improvement projects to include interventions relevant to seniors and persons with disabilities and chronic conditions and to report re-measurement results for these segments of the population.

Complaint and Grievance Procedures – DHCS will continue to provide beneficiaries with accessible methods to support the submission and resolution of member complaints and grievances. DHCS requires health plans to implement and maintain a Member Grievance System. In addition, DHCS provides complaint resolution support through the DHCS Ombudsman Program's toll-free telephone line. At any time during the grievance process, whether the grievance is resolved or unresolved, members or their representative may request a State hearing from the California Department of Social Services through the State's Hearing Process. An additional avenue to file complaints is through the Department of Managed Health Care (DMHC) which provides members with a resolution process that includes a toll free number.

DHCS also requires health plans to maintain a complaint and grievance resolution system to address and resolve provider issues. When providers have not achieved resolution through this plan process, they can contact DHCS for grievance and complaint resolution. DHCS provides assistance and contacts the health plan to discuss a resolution. Providers associated with a Knox-Keene licensed health plan will continue to have the option to obtain resolution support through the DMHC who requires licensed plans to maintain a complaint and grievance resolution system designed to assist providers with resolving complaints regarding payment and contract issues.

Development of County Alternative Option

In some managed care counties, the county and local stakeholders may want to further build on the existing managed care infrastructure and offer SPDs the choice to enroll in an alternative organized system of care in addition to existing managed care plans. This alternative would provide SPDs with an additional choice and provide the county with the opportunity to tailor the organized delivery system to meet the unique needs of its beneficiaries or safety net provider system. The county alternative will be developed while the state prepares to establish mandatory enrollment so that an alternative can be offered as soon as mandatory enrollment in organized delivery systems begins in each county. County-based development of organized systems of

care has been a key approach in the past in expanding the reach of managed care in Medi-Cal, the development of coverage initiatives under the current Section 1115 Hospital Financing Waiver, and the development of other coverage expansions such as children's coverage for populations not eligible for Medi-Cal and Healthy Families. Each county will only be allowed to develop one alternative.

Counties that pursue a County Alternative Option will be expected to propose organizational approaches that reflect and meet the unique local needs and circumstances. As one approach, the county alternative option could be structured as an outpatient managed care model (described below) in which the CAO would be responsible for a comprehensive set of outpatient services for which it would be paid on a capitated rate. This additional choice will be offered along with existing plans as an additional option for SPDs who are required to enroll in organized systems of care. A County Alternative Option will contract directly with the State.

The County Alternative Option will meet the requirements for serving SPDs and the chronically ill as applicable to Medicaid managed care plans related to physical accessibility, access to information, network adequacy, care coordination, continuity of care, and performance measurement. It is expected that the alternative option will include financial arrangements in which the responsible organization will be paid through mechanisms that provide more global payments for the care of its enrollees so that there is a component of risk sharing between the State and the alternative option.

Counties that elect to play a role in providing care for Medi-Cal SPDs may also choose to establish agreements with existing Medi-Cal managed care plans in the county to serve as a provider or provider network that would be offered to enrollees in the managed care plan. This arrangement would not be considered a County Alternative Option because enrollment would be in the existing managed care plans.

Outpatient Managed Care Model—Transitioning the Public Hospital System to Managed Care

In counties where public hospital systems are not ready to fully transition away from certified public expenditures for inpatient care, some health plans may offer an outpatient managed care model that uses the public hospital and clinic system to deliver outpatient services. This model is a way to 1) preserve and strengthen the vital role of the public hospital system in serving SPDs in mandatory managed care; 2) provide an additional way to transition care for SPDs into a more organized, coordinated systems approach; and 3) reform the public hospital payment structure from cost based reimbursement to capitation. Under this model, an SPD can elect to receive their outpatient services through a public hospital clinic system and continue to receive inpatient services through the FFS inpatient system. If an SPD elects this benefit option, the health plan

will sub-capitate outpatient based on an actuarial rate to the public hospital system. The actuarial rate paid to the public hospital system would be a combination of general fund, Intergovernmental Transfers, and federal financial participation.

Each SPD would receive a range of comprehensive outpatient services which would be the responsibility of the public hospital system. A review and analysis of cost and utilization patterns of SPDs considering patient need, utilization, capacity, and cost suggests that the following major categories of service should be included in the outpatient managed care benefits package. Inclusion of these services will allow public hospitals to manage a significant piece of the care provided to enrollees' health care services and costs. In addition, all of the proposed services are, in general, already provided to SPDs by public hospital systems.

Major Categories of Outpatient Managed Care Covered Services –

- Outpatient facility services
- FQHC and clinic services
- Outpatient Lab/radiology services
- Primary care physician services
- Specialty care physician services
- Pharmacy (with the exception of most psychotropic drugs)
- Transportation services (emergency and non-emergency)
- Physical therapy
- Durable medical equipment
- Medical supplies
- Emergency Department services

The capitated outpatient financing model will realign incentives within the public hospital system driving more cost effective outpatient care and a reduction in inpatient care. In addition, it will serve as transition to move public hospitals to fully capitated models whereby they no longer rely on certified public expenditures for inpatient financing. During the transition period, California proposes to include components in the outpatient managed care financing structure to incentivize reductions in avoidable inpatient utilization and improved care management and coordination in the outpatient setting. A key incentive arrangement we propose to establish is a shared-savings model wherein the public hospital system would be able to receive a portion of any savings attributable to reduced inpatient and ED utilization. This type of arrangement would ensure that the public hospital system has a financial incentive to reduce unnecessary inpatient and ED utilization.

Timeline of Key Milestones

There are two parallel timelines for the mandatory enrollment of SPD beneficiaries, one in counties where enrollment is only in existing managed care plans and a second where existing plans and County Alternative Options are available.

For counties with only **existing managed care plans**, the timeline and process for DHCS activities will be:

May 2010 – Develop an approach to assess plan capacity and readiness for SPD expansion including the establishment of plan specific enrollment capacity as determined by their network adequacy.

June 2010 – Initiate capacity assessments of plans.

October 2010 – Begin outreach and enrollment campaign for the enrollment of SPDs into existing managed care organizations in non-COHS counties, that is, in those counties in which enrollment in managed care plans is not mandatory.

November 2010 – Contract amendment with existing managed care plans executed.

February 2011 – Begin enrollment of all newly eligible SPD beneficiaries and initiate enrollment of existing beneficiaries into plans.

January 2012 – Complete enrollment of existing beneficiaries in managed care plans, with the exception of counties offering a County Alternative Option.

For counties offering a **County Alternative Option** the timeline and process will be:

June 2010 – DHCS will publish an RFI to identify counties interested in pursuing alternative options.

August 2010 – Due date for response to RFI. The RFI must provide DHCS with sufficient detail to assess the feasibility of establishing a County Alternative Option.

September 2010 – DHCS will release an RFA to selected counties.

November 2010 – Interested counties must respond to the RFA. The RFA must describe in detail the alternative option structure that includes a description of the network to be developed, provider and services capacity, use of the safety-net, coordination of services/carve-outs,

utilization data gathering protocols, etc. In addition, the RFA must be accompanied by statements of local support including one from the County Board of Supervisors.

March 2011 – DHCS will begin to assess capacity and readiness of the County Alternative Option to serve SPD members.

June 2011 – DHCS will execute contracts for County Alternative Options and begin enrollment outreach.

August 2011 – DHCS will begin the initial enrollment in existing plans and the County Alternative model.

In both cases, enrollment will be phased in over the first two years of the pilot with the ultimate goal of mandatory enrollment for all SPD beneficiaries in counties with managed care by the end of 2012.

Framework for Evaluation

The evaluation of this component of the waiver will be designed to test the success of the proposal in expanding enrollment in organized care systems in order to improve outcomes and slow the rate of growth of the cost of care. Key elements of the evaluation are as follows:

- Documentation of structural elements of the available organized systems of care, including capacity, care management approaches, implementation of medical home concepts, and beneficiary supports.
- Measurement of the pace of enrollment of new beneficiaries in care, changes in plan and disenrollment rates.
- Analysis of complaints regarding care systems, including frequency, subject, and resolution.
- Measurement of plan performance based on established HEDIS measures and other process and outcome measures. These measures would compare performance across plans and compare health measures available prior to enrollment to experience after enrollment. This evaluation element should estimate effects on the use of inpatient services, emergency rooms, and other high cost care.
- Beneficiary satisfaction related to plan enrollment based on CAHPS surveys.
- Cost analysis of beneficiary cost growth for groups prior to and after the establishment of organized system of care.
- Measurement of integration of safety net providers into organized systems of care.
- The scope and nature of value-based purchasing related measures.

II. Dual Eligible Integration

Dual eligible beneficiaries are the most chronically ill persons within both Medicare and Medicaid, requiring a complex array of services from multiple providers. Despite the complexity of their needs, the vast majority of dual eligibles remain in the fragmented fee-for-service (FFS) payment system. While managed care plans provide a coordinated system of care for a number of Medi-Cal beneficiaries, only 174,000 of California's 1.1 million dual eligibles are in managed care plans, leaving over 80 percent in fragmented FFS. There is a critical need for new organized systems of care, including flexible payment systems, which allow for more tailored and supportive benefit packages. Furthermore, considering the State and federal government are investing almost \$21 billion annually on dual eligibles, there is also an opportunity to achieve significant federal and State savings through better coordination of benefits and elimination of the incentives to cost shift between Medicare and Medicaid.

The combination of poor health status and low income makes dual eligibles highly dependent on the two public programs for the care they need. Nationally, in 2005, dual eligibles accounted for an estimated \$215 billion in federal and State spending. This represents almost 25 percent of total Medicare spending and 46 percent of Medicaid spending. Dual spending in California is also substantial. Medi-Cal spending on its 1.1 million dual eligibles was \$7.6 billion in California Fiscal Year 2007-08, representing 23 percent of total Medi-Cal expenditures. In 2007, Medi-Cal spending on Long Term Care (LTC) for duals was \$3.2 billion, representing 75 percent of total Medi-Cal LTC expenditures. It is estimated that in 2007, total expenditures for dual eligible beneficiaries in California, for both Medicare and Medi-Cal spending, was \$20.9 billion.

An essential element of California's overall waiver strategy is to move the highest-need, most vulnerable populations into organized, cost effective systems of care. One such population is the group of individuals dually eligible for Medicaid and Medicare. In addition to improving care for over 1 million duals, the implementation strategies outlined below will lead to broader system reform by enhancing Medi-Cal's ability to align with the Medicare program as it pursues payment reform and delivery system redesign.

Implementation Objectives

California seeks to develop an integrated-care program for duals that:

- Creates one point of accountability for the delivery, coordination, and management of health care and long-term supports and services;
- Promotes and measures improvements in health outcomes;
- Maintains appropriate consumer involvement and safeguards;
- Uses performance incentives to encourage providers to improve coordination of care;

- Blends and aligns Medicare and Medicaid services and financing to streamline care, and through shared savings approaches, eliminates cost shifting; and
- Slows the rate of cost growth in both Medicare and Medicaid.

Common Model Components

Integrating Medicare and Medicaid services can help ensure that dual eligible beneficiaries receive the right care in the right setting, rather than receiving care driven by conflicting State and federal rules, siloed funding streams (including Medi-Cal carve outs of home and community based services such as In Home Supportive Services), and the FFS payment system's inherent incentives for over-provision of services and cost shifting. The core components of an integrated model must include:

- Strong person-centered care based in accountable primary care homes;
- Multi-disciplinary care teams that coordinate the full range of medical, behavioral and supportive service needs;
- Comprehensive provider network capable of meeting that full range of needs;
- Robust data sharing and information systems to promote care coordination;
- Strong home and community based service (HCBS) options, including personal care services, that are better integrated into the organized delivery model;
- Greater flexibility for providers to integrate behavioral health services through a single integrated funding stream;
- Strong consumer protections that assure access to longstanding providers and involve consumers in program design; and
- Financial alignment that enables better integration of care.

These types of integrated systems of care provide the following benefits for dual eligibles:

- One set of comprehensive benefits: primary, acute, behavioral, prescription drug, and long-term care supports and services (vs. three different sets of benefits);
- Single administrative elements – ID card, Evidence of Benefits, Provider Directory, etc. (vs. separate materials for Medicaid, Medicare services, prescription drugs);
- Single and coordinated care team/care home (vs. multiple providers with few incentives or pathways to communicate);
- Health care decisions based on the person's needs and preferences (vs. health care decisions uncoordinated and not made from the person-centered perspective);
- Availability of flexible, nonmedical benefits – from savings generated by greater integration - that help individuals stay in the community (vs. absence of these opportunities); and
- A rebalancing of care with greater emphasis on HCBS and care in the community (vs. heavier reliance on both acute and long term care institutional settings).

Medi-Cal is both positioned and prepared to: (1) establish the proper beneficiary safeguards and quality/performance standards; and (2) fulfill its obligation as administrator of the integrated system to actively monitor and enforce them.

Sequencing of Dual Integration and SPD Enrollment in Organized Systems of Care

Section 1115 Waiver Year one – Begin enrollment of SPDs into organized systems of care

Section 1115 Waiver Year two – Implement Pilot Programs for Dual integration in up to four counties

Section 1115 Waiver Year three – Amend the waiver to include expanded strategy to provide full integration of care and funding for Dual eligibles

A Waiver Amendment for Full Integration

In addition to the pilot projects that are described in the next section below, California will continue development of an expanded strategy that 1) provides full integration of funding and benefits, and 2) recognizes and leverages regional diversity and strengths. This strategy will be added into the Section 1115 Waiver as an amendment at a later date. As part of this development, California will continue consultation with stakeholders and CMS regarding how to develop an integrated funding approach. California is seeking inclusion of this integrated approach in its Section 1115 Waiver application to ensure the necessary Medicaid authority and would like to discuss with the federal Center for Medicare and Medicaid Services (CMS) the necessary Medicare authority. Dual eligible funding should also be included in the Section 1115 Waiver.

Efforts for dual integration will build off the enhanced Section 1115 Waiver infrastructure and systems of care for seniors and persons with disabilities (SPD), given the similarity of their care needs. These pilot projects would utilize the same performance standards that are specified in the SPD section of this document. Necessary adjustments will be made to the standards to apply them to the requirements of the Dual eligible population, specifically regarding age demographics, and condition prevalence, complexity and acuity. The standards include network adequacy, access to information, physical accessibility to provider sites, access to existing providers, and other performance standards. (See “Key Performance Standards for Plans Enrolling SPD Populations” in the SPD section of this document.) Consideration would be given to the infrastructures available in California’s multiple regions, yet the key elements of the system of care will be consistent across the delivery system options California is considering (e.g., existing managed care; newly developed enhanced medical home models). Enrollment would be automatic with an opt-out option.

Medi-Cal would act as the administrator of the integrated program and assume the risk for managing the Medicare benefit, subject to discussions between California and CMS. Medi-Cal would be responsible for coordinating payment, coverage, and benefits for all Medicare and Medicaid acute, behavioral, pharmacy, and long-term supports and services, including institutional care and home and community-based services (HCBS). CMS and Medi-Cal would negotiate an appropriate, risk-adjusted global amount or per member per month (PMPM) amount of Medicare funding for participating dually eligible beneficiaries that would be provided by CMS to Medi-Cal to administer the Medicare benefit. The specific elements of risk sharing would be subject to discussion. The positive impact on utilization and health status generated by full integration and improved coordination of care would result in decreased Medicare expenditures relative to what costs would have been in the unmanaged, fragmented FFS system, leading to financial benefits for both CMS and Medi-Cal.

Medi-Cal would contract with entities (new and existing) to perform necessary functions, such as: network development and selection; provider payment and performance review; medical management; administration of enrollee protections; care management functions; health information collection and use; and compliance with other safeguards. Additionally, Medi-Cal would establish network, quality and performance standards; monitor the accountable entities; and report agreed-upon measures to CMS.

Medi-Cal would integrate dual eligible beneficiaries into the organized systems of care that will be developed first for the Medi-Cal-only SPD population. Medi-Cal will ensure that the systems of care align for both populations and include mandatory medical homes, care management, better connection to specialty providers, incentives that reward providers and beneficiaries for achieving the desired clinical, utilization, and cost-specific outcomes. The systems of care will use existing HCBS programs, such as In-Home Supportive Services, to shift care from the institution to the community by leveraging existing HCBS infrastructure and providers where possible. After Medi-Cal-only SPD systems of care are developed, dual eligible beneficiaries will be integrated in phases, according to organizational readiness in various regions of California.

Medi-Cal will work with existing Medi-Cal managed care organizations, which have experience with coordinating beneficiary care, but may require some additional infrastructure and capacity to serve the dual eligible population. Medi-Cal will also focus on partnering with non Medi-Cal plans and large Integrated Practice Associations (IPAs) that have experience with providing care for dual eligible beneficiaries. It will then work with new organizations in areas where the existing the managed care infrastructure is lacking, such as rural areas, to develop capacity to manage care for dual eligibles.

As policy-maker and regulator, Medi-Cal can establish and enforce a level of accountability for meeting federal standards that would not be possible in FFS or with independent health plans operating individually. For example, a critical component is the HCBS long term supports and services (LTSS) infrastructure, an area in which Medicare has limited expertise and capacity. Integration would create a statewide infrastructure and ensure there is a standard system of care for all duals regardless of delivery system.

As the largest purchaser of health care in the State, Medi-Cal is uniquely positioned to blend Medicaid and Medicare funding streams, wring out inefficiencies, and strategically redirect savings to strengthen the overall system (e.g., rate increases, expansion of community based services, etc.). The federal government would benefit from more efficient spending in both Medicare and Medicaid, relative to what expenditures would have been in the unmanaged, FFS systems. Specific to the Medicaid benefit, there is an opportunity to significantly reduce the cost of institutional long term care by rebalancing care with better integration, coordination, and redesigned HCBS. This focus on HCBS services will have a positive spillover effect on Medicare inpatient utilization. Additionally, by blending the funding to include Medicare, Medi-Cal will augment its purchasing power and align incentives in ways that mitigate or eliminate the cost shifting – inappropriate shifting of duals between nursing home and hospital settings.

Pilot Projects

California will establish pilot projects to test dual integration in County Organized Health Systems and other Medi-Cal managed care plans that operate both Medi-Cal managed care plans and Medicare Special Needs Plans (SNPs). The pilot projects will be established pursuant to a Medicare demonstration or a Medicaid demonstration project or waiver or a combination thereof, or other federal authority. No later than January 1, 2012, California shall identify managed care models that may be included in the pilot projects, and shall develop a timeline and process for selecting, financing, and evaluating these pilot projects.

The pilot projects will be established in up to four counties and will include at least 1) one Two Plan managed care model county, and 2) two County Organized Health System managed care model counties. In determining the counties in which to establish a pilot project, California will consider the following:

- Local support for integrating medical care, long-term care, and home- and community-based services networks; and
- A local stakeholder process that includes health plans, providers, community programs, consumers, and other interested stakeholders in the development, implementation, and continued operation of the pilot project.

California would employ an opt-out model whereby dual eligibles would be automatically enrolled into integrated plans that are established or expanded as part of a pilot project.

However, dual eligibles shall have the option to forego receiving (opt-out) Medicare benefits via a managed care plan established as part of a pilot project. California will evaluate the pilot projects by assessing outcomes for enrollees compared to similar beneficiaries enrolled in plans in other counties.

As a responsible purchaser, California would closely scrutinize county program readiness to integrate additional services through the Section 1115 Waiver pilot programs. Two of the COHS programs in California have indicated that they are prepared to operate integration pilots, including:

- Existence of a local stakeholder process and local support for integrating medical care, long-term care, and home- and community-based services (HCBS) networks;
- Operation of dual-eligible Special Needs Plans that receive both Medicaid and Medicare funding; and
- Capitation rates that include responsibility for institutional long term care.

The pilot projects would take the next step by building responsibility for Medi-Cal HCBS into their capitation rates and contracts. The primary goal of this additional capitation and accountability is to provide the pilots with the flexibility to more freely utilize HCBS, rebalance the care system, and deemphasize institutional care. Newly-capitated HCBS services could include:

- 1915(c) HCBS waiver programs, including the Multipurpose Senior Services Program;
- Personal care (In-Home Supportive Services Program);
- Paramedical services;
- Nursing services;
- Therapies, including physical, speech, and occupational;
- Home modification;
- Meals; and
- Adult day care services (Adult Day Health Care Program).

Budget Neutrality Narrative

The budget neutrality showing for the California demonstration follows standard CMS practices for determining demonstration budgets.

Without Waiver Calculations

To establish the “without waiver” spending estimates California determined what the expenditures would have been in the absence of this demonstration for the components of its program that are covered by the demonstration. The components in the “without waiver” scenario are (1) the newly eligible adults, (2) designated public hospital (DPH) payments, (3) special populations, and (4) payments that have their origin in the Los Angeles stabilization and restructuring waiver initially authorized in 1996.

Newly Eligible Adults. These are parents or single adults that do not qualify for Medicaid under the State's current Medicaid plan but whose income is at or below 133% of the federal poverty standard and who fall within the new eligibility category contained in section 1902(a)(10)(a)(i)(VIII), added by section 2001(a)(1) of the Patient Protection and Affordable Care Act (PPACA). Section 1902(k)(2), added by section 2001(a)(4)(A) of PPACA, authorizes states to cover this new eligible group any time after April 1, 2010, and to do so on a phase in basis. Because this group is now a permissible state plan coverage group, the State's election to cover it under the waiver warrants including the costs associated with that coverage in the "without waiver" calculation.

The State has assumed that this coverage would commence at the start of the demonstration period with those persons at or below 133% of federal poverty who are currently being served in the ten counties participating in the Coverage Initiative (CI), estimated to be 130,000 persons, and would expand between the start date and the end of December 2013 through the addition of additional counties and the increase in participants from participating counties. Since coverage of these new eligibles will under PPACA become the financial responsibility solely of the federal government for three years commencing January 1, 2014, the budget neutrality calculation includes no expenditures for this group after that date. The calculation also assumes a starting PMPM cost of \$300.00, which will grow at the rate of 5% per year.

(For the new eligibles the assumptions as to number of participants and the cost of coverage are the same in the "with waiver" calculation as in the "without waiver" calculation. Thus, for budget neutrality purposes this category is budget neutral by definition.)

DPH Payments. To determine the "without waiver" expenditures for designated public hospitals, the State established the level of payments to public hospitals at the end of the five year period prior to the start of the current demonstration waiver. The DPH payments were adjusted to remove those made possible by the "transition excess" above the UPL limit established in the 2001 regulations. Also, payments under SB1732 for seismic reinforcements were excluded for purposes of projecting future payments. To determine an appropriate growth trend rate for Medicaid hospital utilization the state analyzed actual public admissions during the current waiver period, and determined a growth rate of 2% per year, measured by number of admissions.¹ For a cost growth trend the State utilized the trend rate used by CMS in

¹ Usage was calculated using data for fiscal years 2001-2004, since data for fiscal year 2005 was not available.

establishing the upper payment limits for state and non-state public hospitals for the period prior to the current waiver.²

These trend rates were used to carry the calculations forward to the beginning of the new demonstration period, and through the demonstration period (2011-2015). Information provided by the public hospitals confirmed that the number of admissions continued to increase during the current waiver period at slightly above the 2% trend rate used in the budget neutrality calculation for the proposed demonstration. Estimated payments under SB1732 for the demonstration period were added to the totals determined as described above.

Special Populations. The demonstration will involve improved methods of service delivery and service coordination for certain hard-to-serve population--seniors and persons with disabilities, dual eligibles, persons with behavioral health conditions and special needs children. The estimate of the “without waiver” expenditures for these categories is based on the growth rates in number of persons served and cost of service over the five years prior to the FY 2009 base year for each of those categories. The cost growth rates utilized for these categories are:

Seniors and Persons with Disabilities	9.71%
Dual Eligibles	4.55%
Special Needs Children	3.28%.

Utilization (member months) increases for these populations is assumed to be 3% per year. Persons with behavioral health conditions are a subset of the SPDs and Dual Eligible categories and are therefore not listed separately.

Stabilization/Restructuring Payments. The “without waiver” calculation includes two items that originated with the Los Angeles stabilization and restructuring waiver that took effect in 1995. One item is the continuation of the \$360 million (total computable) per year allotment that has been used in the current waiver period to fund the CI. The second (labeled stabilization/restructuring payments) represents continuation for two and on-half years of the \$720 million (total computable) allotment to the State for fiscal year 2010. The continuation of this funding until the State is able to gear up its coverage of new eligibles is critical to the preservation of the current program and prevention of drastic deconstruction of Medi-Cal, whether or not the State pursues its new demonstration.

² The limits were set forth in a letter from CMS Administrator Tom Scully to state Health and Human Services Agency Secretary Grantland Johnson dated February 4, 2003.

With Waiver Calculations

The “with waiver” calculations reflect the various components of the Medi-Cal program that are embraced within the proposed demonstration.

New Eligibles. As indicated above, the number of participants and the cost of their coverage in the “with waiver” calculation are identical to those in the “without waiver” calculation. This category of expenditures ends as of January 1, 2014, when the funding of coverage for all of the new eligibles is assumed by the federal government.

DPH Payments. The figures in the line for public hospital payments in the “with waiver” scenario represent the certified costs of serving Medicaid-eligible patients and are calculated starting with the level of estimated certified costs of those hospitals in the last year of the current waiver.³ The basic payments (CPEs) are trended more moderately than in the without waiver scenario. A cost trend rate of 7% was used, reflecting the expectation of lower costs per admission resulting from the improved care coordination and improvements in hospital payment methods proposed for the demonstration. A utilization growth trend of 1% was used, reflecting the expectation of some reduction in hospital admissions growing out of the improvements in service delivery for the special populations. Estimated SB1732 payments were added to the totals so calculated, in the same amounts as shown in the “without waiver” calculations.

SNCP Payments. This line covers supplemental payments to the public hospitals and the costs of the State-operated programs that have been funded from the SNCP over the past five years: Breast and Cervical Cancer Treatment program, the California Children Services program, the Genetically Handicapped Persons program, the Expanded Access to Care Program, the Aids Drug Assistance Program, the County Medical Services Program, uninsured mental health services and the Medically Indigent Long Term Care Program. These SNCP payments are included at the same level as they were being made in the last year of the current waiver period.

SNCP-Coverage Initiative. This category represents a continuation of the funds from the SNCP dedicated to the Health Care Coverage Initiative--an expansion of county-based coverage for people otherwise not eligible for Medi-Cal. Because of the addition of the new eligibles as a State plan-qualified class, the CI in the new demonstration period will focus on those with incomes between 133% and 200% of federal poverty. The amount estimated for this category is a continuation without increase in the total annual amount allowed for the CI in the current

³ Complete expenditure data for the public hospitals is not available for the fiscal years beginning with FY 2008. Accordingly, expenditures for fiscal years 2008, 2009 and 2010 were estimated by growing expenditures for fiscal year 2007 conservatively by 6 percent each year, which was the rate of increase from 2006 to 2007.

waiver. Expenditures in this category are also expected to end as of January 1, 2014, when those served either become eligible for federally-subsidized insurance under the State's exchange or become enrolled in a Basic Health Plan pursuant to section 1331 of PPACA, the funding for which will be provided by the federal government pursuant to section 1331(d) of PPACA.

Special Populations. The State expects to initiate various measures to improve service delivery to these categories of recipients, which are among the more needy categories in the Medi-Cal program. Program improvements for the SPDs will be initiated in the first year. Accordingly, a savings has been assumed of 4% of costs in the second demonstration year, and 5% of costs in the third demonstration year, and 3% thereafter for this group. Improvements for the duals and special needs children will be introduced on a gradual basis. Thus, for these groups, the calculation assumes a savings of 1% of costs in the third demonstration year and 2% of costs thereafter. In addition, improvements for persons with behavioral health conditions will be introduced gradually in the third demonstration and these interventions are built into the change in the trend rates for SPDs and duals.

Stabilization/Restructuring Payments. This category represents a continuation through the end of calendar 2012 of the payments provided to the State in the current year (the last year of the current waiver) to assist in stabilizing the Medi-Cal program and preventing massive program cutbacks with the attendant dislocations that this would bring. This funding will further stabilize the public and private safety net care system in advance of the implementation of health care reform in 2014. This category is also included in the "without waiver" showing, and thus has no impact on the budget neutrality savings calculation.

Overall Budget Neutrality Showing

The Budget Neutrality showing is made on a total computable as well as a federal share basis. The federal share presentation assumes continuation of the ARRA enhanced match rates through June 2011, as set forth in bills that have passed both Houses of Congress and that are awaiting final reconciliation and enactment. If for any reason the extension of the ARRA enhanced match rates is not enacted into law, the State will resubmit its showing to limit the enhanced match rate period to December 31, 2010.

Overall, the State's analysis shows a net savings during the proposed demonstration period of approximately \$9.5 billion, the federal share of which is \$4.8 billion. This saving would support adding over \$960 million in federal funds each year to permit additional payments to the SNCP.

State of California
Section 1115 Waiver
Total Computable

(6 month extension of ARRA, Duals/SNC -1% DY03 2% DY4-5, SPD -2% DY02, -3% DY03-05, CMS Trend Rate for DPH, DPH 7% WW Trend, DPH wow MM @2% ww MM @ 1%)

<i>WITHOUT WAIVER</i>		Trend Rates	Trended FY09	Trended FY10	FY10-11 DY01	FY11-12 DY02	FY12-13 DY03	FY13-14 DY04	FY14-15 DY05
MEGS	MEG Description								
PMPM									
Adults Newly Eligible	Adults up to 133%	5.00%			\$300.00	\$315.00	\$330.75	\$347.29	
Public Hospital Payments		8.58%	\$28,594.44	\$31,046.41	\$33,708.64	\$36,599.16	\$39,737.53	\$43,145.03	\$46,844.71
SNCP-Hospital (Including SLAMSP)									
SNCP-CI									
SNCP-State Funded									
Special Populations-Duals	FFS/Capitation	4.55%	\$392.70	\$410.57	\$429.25	\$448.78	\$469.20	\$490.55	\$512.87
Special Populations-SPD's	SPD's	9.71%	\$1,030.51	\$1,130.57	\$1,240.35	\$1,360.79	\$1,492.92	\$1,637.88	\$1,796.92
Special Populations-Spec. Needs Child.	CCS	3.28%	\$1,399.79	\$1,445.70	\$1,493.12	\$1,542.10	\$1,592.68	\$1,644.92	\$1,698.87
Member Months									
Adults Newly Eligible					2,996,500	3,918,500	4,610,000	2,535,500	
Public Hospital Payments				111,694	113,928	116,206	118,530	120,901	123,319
SNCP-Hospital (Including SLAMSP)									
SNCP-CI									
SNCP-State Funded									
Special Populations-Duals			13,133,724	13,527,736	13,933,568	14,351,575	14,782,122	15,225,586	15,682,353
Special Populations-SPD's			5,281,180	5,439,615	5,602,804	5,770,888	5,944,015	6,122,335	6,306,005
Special Populations-Spec. Needs Child.			888,456	915,110	942,563	970,840	999,965	1,029,964	1,060,863
Total Member Months			13,133,724	19,994,155	23,589,362	25,128,009	26,454,632	25,034,286	23,172,540

Projected Without Waiver Expenditures

Adults Newly Eligible	\$898,950,000	\$1,234,327,500	\$1,524,757,500	\$880,547,456	\$0
Public Hospital Payments	\$3,840,351,280	\$4,253,054,630	\$4,710,109,146	\$5,216,281,025	\$5,776,848,666
SB 1755 Capital Payments	\$70,000,000	\$65,000,000	\$60,000,000	\$55,000,000	\$50,000,000
SNCP-CI	\$360,000,000	\$360,000,000	\$360,000,000	\$180,000,000	
Stabilization/Restructuring Payments	\$720,000,000	\$720,000,000	\$360,000,000	\$0	
Special Populations-Duals	\$5,980,965,682	\$6,440,692,609	\$6,935,756,447	\$7,468,873,366	\$8,042,968,317
Special Populations-SPD's	\$6,949,444,005	\$7,852,962,068	\$8,873,949,226	\$10,027,677,986	\$11,331,406,485
Special Populations-Spec. Needs Child.	\$1,407,361,672	\$1,497,128,828	\$1,592,621,694	\$1,694,205,476	\$1,802,268,678
Total Without Waiver Ceiling (Total Computable)	\$20,227,072,639	\$22,423,165,636	\$24,417,194,012	\$25,522,585,310	\$27,003,492,145

WITH WAIVER**PMPM**

Adults Newly Elig up to 133%	\$300.00	\$315.00	\$330.75	\$347.29	
Public Hospital Payments	\$20,082.20	\$21,066.63	\$22,099.30	\$23,182.60	\$24,319.01
SNCP-Hospital (Including SLAMSP)					
SNCP-CI					
SNCP-State Funded					
Special Populations-Duals	\$429.25	\$448.78	\$464.71	\$476.56	\$488.71
Special Populations-SPD's	\$1,240.35	\$1,311.18	\$1,372.93	\$1,465.06	\$1,563.36
Special Populations-Spec. Need Children	\$1,493.12	\$1,542.10	\$1,577.26	\$1,597.45	\$1,617.89

Member Months

Adults Newly Elig up to 133%		2,996,500	3,918,500	4,610,000	2,535,500	0
Public Hospital Payments	111,694	112,811	113,939	115,078	116,229	117,391
SNCP-Hospital (Including SLAMSP)						
SNCP-CI						
SNCP-State Funded						
Special Populations-Duals		13,933,568	14,351,575	14,782,122	15,225,586	15,682,353
Special Populations-SPD's		5,602,804	5,770,888	5,944,015	6,122,335	6,306,005
Special Populations-Spec. Need Children		942,563	970,840	999,965	1,029,964	1,060,863

Total Member Months	23,588,245	25,125,742	26,451,180	25,029,614	23,166,613
Expenditures					
Adults Newly Elig up to 133%	\$898,950,000	\$1,234,327,500	\$1,524,757,500	\$880,547,456	\$0
Public Hospital Payments	\$2,265,490,905	\$2,400,309,824	\$2,543,151,791	\$2,694,494,256	\$2,854,843,081
SB 1755 Capital Payments	\$70,000,000	\$65,000,000	\$60,000,000	\$55,000,000	\$50,000,000
SNCP Payments ¹	\$1,172,000,000	\$1,172,000,000	\$1,172,000,000	\$1,172,000,000	\$1,172,000,000
SNCP-CI	\$360,000,000	\$360,000,000	\$360,000,000	\$180,000,000	\$0
Stabilization/Restructuring Payments ¹	\$720,000,000	\$720,000,000	\$360,000,000	\$0	\$0
Special Populations-Duals	\$5,980,965,682	\$6,440,692,609	\$6,869,417,313	\$7,255,925,078	\$7,664,179,703
Special Populations-SPD's	\$6,949,444,005	\$7,566,644,975	\$8,160,724,972	\$8,969,558,907	\$9,858,558,798
Special Populations-Spec. Need Children	\$1,407,361,672	\$1,497,128,828	\$1,577,201,267	\$1,645,311,126	\$1,716,362,242
Total With Waiver Expenditures	\$19,824,212,264	\$21,456,103,738	\$22,627,252,843	\$22,852,836,823	\$23,315,943,824
Cost Share/Spenddown/Premiums reported on 64 Summary					
Total Net Waiver Expenditures	\$19,824,212,264	\$21,456,103,738	\$22,627,252,843	\$22,852,836,823	\$23,315,943,824
Annual Budget Neutrality Margin	\$402,860,375	\$967,061,899	\$1,789,941,169	\$2,669,748,487	\$3,687,548,322
Cumulative Budget Neutrality Margin	\$402,860,375	\$1,369,922,274	\$3,159,863,442	\$5,829,611,929	\$9,517,160,251

¹ These payments will be combined with the cumulative budget neutrality margin and may be used for other purposes beyond uncompensated care, as described in the state's full proposal

Attachment 1: List of Authorizations Sought for California Section 1115 Waiver

Section 1902(a)(1)--statewideness, to permit implementation of coverage of new eligibles on a county-by-county basis.

Section 1902(a)(3)--fair hearing for Coverage Initiative enrollees.

Section 1902(a)(5)—to the extent necessary to allow county health department employees to determine eligibility and operate the Coverage Initiative program.

Section 1902(a)(8) – Reasonable Promptness – to enable California to cap enrollment and maintain waiting lists for individuals enrolled in the Coverage Initiative; and waiver of the requirement to redetermination of all Medi-Cal categories before terminating eligibility and requirement that changes should be reported promptly and redetermination should then take place.

Section 1902(a)(10)(B)--amount, duration and scope, to permit differences between benefits for the new eligibles and the standard Medicaid benefit, and among the new eligibles.

Section 1902(a)(14) – Cost Sharing Requirements – to enable California to impose premiums, enrollment fees, deductions, cost sharing, and similar charges that exceed the statutory limitations upon individuals enrolled in the Coverage Initiative.

Section 1902(a)(17)--comparability, to permit differences in eligibility standards among the counties for the expansion population as authorized under the Special Terms and Conditions and its attachments for the Project, and to permit differences in eligibility standards and eligibility determination procedures among Coverage Initiative programs.

Section 1902(a)(23)--freedom of choice--to require participants to receive benefits through certain providers, and to restrict the choice of providers by groups that could otherwise not be mandated into managed care under section 1932.

Section 1902(a)(34)--three months retroactive eligibility to the extent necessary to limit retroactive coverage to services provided within an approved Coverage Initiative network.

Section 1902(a)(43)-- to the extent necessary to provide more limited EPSDT services for 19 and 20 year old Coverage Initiative enrollees.

Section 1902(k)(1)--(as added by PPACA, Sec. 2001(a)(2)) to the extent necessary to modify the requirement to provide the benchmark benefit package under section 1937 to the expansion

population, and to the extent necessary to allow otherwise exempt individuals to be enrolled in benchmark coverage.

Section 1902(bb)--for the method of calculation of payment to federally qualified health centers to the extent that it would require supplemental FQHC payments under the Coverage Initiative.

Costs Not Otherwise Matchable

New Eligibles--expenditures for health care coverage for individuals currently uninsured and not covered by the State plan with incomes up to 133 percent of the federal poverty standard.

(Hypothetical group)

Managed Care Payments--expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet in full the requirements of section 1903(m) or Section 1932.

Uncompensated Care Costs--expenditures for costs incurred by identified hospitals for hospital and other medical care services not otherwise paid through regular Medicaid payments or disproportionate share hospital payments, limited to the amounts specified in the Special Terms and Conditions.

Coverage Initiative Costs--expenditures for health care coverage for individuals currently uninsured with incomes exceeding 133 percent of the federal poverty standard, limited to the amounts specified in the Special Terms and Conditions.

Supplemental Payments for Non-Contract Hospitals--expenditures for supplemental payments to non-selective contract private and non-designated hospitals, not otherwise authorized by the state plan.

Additional Waivers (If the Selective Provider Contracting Program is retained)

Section 1902(a)--Overall State plan requirements, to the extent the State would be required to describe in its State plan the payment or methodology for the basic payment being made for Selective Provider Contracting Program hospital providers.

Section 1902(a)(5)--single State agency, to the extent necessary to enable the California Medical Assistance Commission to conduct contract negotiations with health care providers.

Section 1902(a)(13)(A)(i) through (iii), to the extent the State would be required to set rates for hospitals using a public process.

Attachment 2: California Section 1115 Waiver Stakeholder Engagement Process

Over the past eight months, California has been engaged in an extensive effort to capture stakeholder input for the purposes of developing a Section 1115 Comprehensive Waiver/Demonstration proposal and Implementation plan. Precipitated by the passage of Assembly Bill 4x 6 in 2009, the California Department of Health Care Services (DHCS) convened a Stakeholder Advisory Committee to engage regarding the preparation of an Implementation Plan. This committee consisted of health and human services advocates, providers and beneficiaries. In addition to the Stakeholder Advisory Committee, DHCS also formed and convened Technical Workgroups as a resource to assist in working through the details of the waiver proposals and implementation plan. Members of the TWGs consisted of recognized stakeholders/experts in their fields, including but not limited to, beneficiary advocacy organizations, organizations representing seniors and persons with disabilities, representatives of rural organizations, hospitals, community clinics, medical providers, behavioral health, and children with special health care needs. DHCS has also engaged California's 103 federally recognized tribes in meeting and electronic medium. Finally, DHCS has actively communicated with a broad array of stakeholders of over through e-mail and website postings that have included all the important documentation that has been developed during the waiver planning. DHCS has also received extensive written comments and input through letters and a waiver-specific e-mail address.

Stakeholder Advisory Committee (SAC)

The SAC members were selected and appointed by the director of DHCS. Meetings are conducted as prescribed in the SAC charter which details the goals and objectives of the committee. All meetings are professionally facilitated and audio recorded. Meetings have occurred in the months of March, May and June of 2010. Future meetings are scheduled for the months of July and September 2010.

Meeting materials and notices are posted on the DHCS Waiver website at least five days prior to each meeting. All SAC members receive their materials via email five days prior to each meeting as well. The SAC members as well as the public can also access meetings by telephone if they are unable to attend in person, although we strongly encouraged in person attendance for the SAC members. All meetings are open to the public and at the conclusion of each meeting there is a public comment period. Written meeting summaries as well as the audio recordings of the meetings are posted on the DHCS Waiver website at the conclusion of each meeting.

Technical Workgroups Meetings

The TWG members were selected and appointed by the director of the DHCS. Meetings are conducted as prescribed in each TWG charter which detailed the goals and objectives of the workgroups. The TWGs provided technical support to DHCS regarding the development of the Section 1115 Comprehensive Waiver/Demonstration Project implementation plan and proposals. Five TWGs were formed and then convened between the scheduled SAC meetings. These TWGs focused on: Seniors and Person with Disabilities, Children with Special Health Care Needs, Behavioral Health Integration, Health Care Coverage Initiative, and Duals Eligibles. The each TWG met on average 4 times during a three month period. All TWG meeting have been concluded.

All meetings were professionally facilitated. Meeting materials and notices were posted on the DHCS Waiver website at least five days prior to each meeting. All TWG members receive their materials via email five days prior to each meeting as well. The TWG members as well as the public could access meetings by telephone if they were unable to attend in person, although we strongly encouraged in person attendance for the TWG members. Written meeting summaries of the meetings were posted on the DHCS Waiver website at the conclusion of each meeting.

Tribal Consultation

California tribes have been involved in the waiver development through a series of presentation/discussion regarding the waiver, posting of waiver updates on the DHCS' web-based "Indian Health Issues Inbox", correspondence and ongoing invitation to participate in the DHCS webcast and teleconferences of stakeholder advisory committee meetings. Presentations/discussions regarding the waiver development were provided at the following meetings between September 2009 and March 2010 that included representatives of California's federally recognized tribes: joint meetings of Indian Health Clinic Directors/Tribal Leaders, DHCS American Indian Health Policy Advisory Panel meeting, Annual California Indian Health Services Tribal Leaders meeting, and "California Area Indian Health Services Tribal Advisory Council" meeting.

Next Steps

Going forward DHCS will continue to engage the SAC, sub-sets of the TWGs, and tribes during the implementation of the various waiver proposals through meetings, conference calls, webinars, and email. Additionally, all other stakeholders will have an opportunity to offer input as well through our open meeting process, website, and waiver email box.

Attachment 3: Evaluation of the Current Section 1115 Hospital Financing Wavier

- See the enclosed ULCA evaluation of the Health Care Coverage Initiative.