

# California Medi-Cal 1115 Waiver Renewal

## Kick-Off Webinar Q&A

July 25, 2014

Mari Cantwell, Chief Deputy Director, Health Care Programs, California Department of Health Care Services opened the webinar and thanked the almost 500 participants for their interest. The concept paper discussed during the webinar and slides presented during the webinar will be posted on the Department of Health Care Services website:

<http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx>

*Cantwell:* presented background information on the current waiver, Bridge to Reform, that expires October 31, 2015, described programs included under the current waiver and reviewed timelines for the 1115 waiver renewal. The focus for the waiver renewal is on transformation of the system and payment reform as described in the concept paper distributed. Budget neutrality requirements (cost of programs under waiver are no more than without the waiver) is a key construct of the waiver. In the current waiver, moving beneficiaries from fee-for-service to managed care created budget neutrality “room” for reinvestment.

*Cantwell:* presented a series of slides that describe proposed elements of the waiver included in the *Initial Concepts for the 2015 Waiver* paper. Detailed descriptions are included on slides posted: <http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx>

- *Payment/Delivery Reform Incentive Payment Programs*
- *Safety net payment reforms that support coordinated and cost effective care for the remaining uninsured*
- *FQHC Payment/Delivery Reform*
- *Successor Delivery System Reform Incentive Payment program*
- *California Children’s Services (CCS) Program Improvements*
- *Medicaid funded Shelter for Vulnerable Populations*
- *Workforce Development*

*Cantwell:* described preliminary thinking about a stakeholder process and timeline to inform the waiver renewal. The existing Stakeholder Advisory Committee will meet on September 11<sup>th</sup> to kick off stakeholder input for the waiver renewal and the process will continue throughout fall 2015. A waiver proposal will be submitted to CMS by early 2015 to allow for negotiations to be final prior to the end of the current waiver for a November start date. The state seeks input on the concepts to include in the waiver as well as input to a useful stakeholder process.

### Questions submitted through the webinar chat function were moderated and answered:

Q: When will the slides be available and where?

*Cantwell:* Slides will be posted later today on waiver renewal website.

<http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx>

Q: In interest of integrated care, will it be possible under the proposed waiver to bill for more than one Medicaid reimbursable service per day?

*Cantwell:* It sounds like this is related to FQHC billing. This is the discussion we are engaged in with CPCA to move away from volume based care delivery and other restrictions related to receiving care that is needed to allow for what makes sense.

Q: Talk about the changes included related to system transformation beyond payment reform to lower cost.

*Cantwell:* We will utilize outcome measures like quality indicators, HEDIS and total cost of care. Can we incentivize coordinated care and create accountable care groups responsible for all care so we can set benchmarks that trigger incentive payments? We are open to how this is structured.

Q: What is current thinking about the total size of waiver renewal?

*Cantwell:* We have not landed on this. It will be based on what is possible through budget neutrality. We hope it could be similar to size of current waiver. CMS is in a different place now that the ACA is implemented and they are financing many aspects under ACA, so the need for waivers is reduced from CMS point of view. It is a challenge to justify the renewal of the waiver.

Q: How will the waiver impact Indian Health Services (IHS)?

*Cantwell:* There is a small area in current waiver that pertains to IHS claiming and we could continue to look at this. We welcome thoughts on this from stakeholders.

Q: How can we provide input on new ideas not included in concept paper?

*Cantwell:* The website has dedicated mailbox; [waiverrenewal@dhcs.ca.gov](mailto:waiverrenewal@dhcs.ca.gov) for written concepts and input. We welcome input via all other aspects of the stakeholder process as well.

Q: How will people be chosen to participate in stakeholder process?

*Cantwell:* We will invite folks who are experts in the specific areas included in concept paper. We appreciate input and ideas about the stakeholder process. We will develop a plan, based on input over next month, and announce at Sept 11<sup>th</sup> Stakeholder Advisory Committee.

Q: How can rural hospitals participate? Will FQHC PPS pilot ideas impact rural clinics?

*Cantwell:* We are interested in how to include non-designated public hospitals, such as rural district hospitals. Because of the requirements to provide a non-federal share, we have not looked at including private hospitals. We are open if there are FQHC/RHC clinics interested in participating in a pilot if it one is implemented. The initial ideas outlined relate to testing concepts in pilots and we do not assume this would be in every clinic.

Q: Tell us about conversations so far with CMS?

*Cantwell:* To date, these are very limited, preliminary conversations where we have floated initial concepts. CMS didn't have a proposal to react to although some of the California's waiver concepts are similar to others, such as Vermont and Oregon. It will be challenging to achieve approval but it is critical to have the opportunity to reinvest in order to slow the cost trend and improve quality.

Q: Given the proposal on coordinated care for the remaining uninsured, how do you define the uninsured population – does this include undocumented, those who did not sign up initially?

*Cantwell:* It is the broad definition we have today under the current waiver. Anyone without coverage for the service they are seeking is uninsured. Yes, undocumented and other uninsured populations unable to obtain coverage or who have limited scope coverage are included. This is an area we will need to discuss with CMS. There are current limitations: the safety net care pool is not able to provide care for undocumented while the Disproportionate Share Hospital pool includes undocumented. This means only hospital based care is included. We want to combine these in a capitated payment to allow flexibility so we can get outside these limitations and improve access and care.

Q: How does the current CalSIM effort coordinate with, overlap or integrate with the waiver renewal?

*Cantwell:* We have a CalSIM planning grant now. The Cal-SIM implementation proposal is aligned with the current waiver but not duplicative. CMS wouldn't allow duplication between CalSIM and the waiver although we can do similar, aligned things.

Q: Where will the non-federal match come from e.g. non DSRIP for non-designated public hospitals?

*Cantwell:* There is current legislation that proposes the non-designated public hospitals would offer their own match. For the incentive payments to managed care plans and providers, the funding would come from the savings achieved.

Q: How often would you propose performing the reconciliation for the per-person, per-year cost of care?

*Cantwell:* Likely this would be on an annual basis with a final true-up at the end of the waiver. This would be similar to the timeline for budget neutrality. If we are successful in a shared savings initiative, we are likely to follow this timeline.

Q: Can you talk more about how you define shelter for concept paper? What other states include this in their waiver and what models exist? What other supportive services for vulnerable populations can be included?

*Cantwell:* We would love input from stakeholders on these concepts. We used shelter and housing interchangeably in the concept document for how we can use Medicaid funding for housing. We are open and interested in looking at supportive services and understand there are

significant non-medical needs in the population. Other states who are proposing this include: 1) New York proposed capital investment and was denied. 2) Minnesota is looking at this currently. There are no approved programs to date to use as a model. John Shen from the Department's Long Term Care Division will lead this concept development and we would appreciate hearing from you as experts.

Q: Talk about other states that California is looking to for ideas for the next waiver? How are you using others' waiver concepts?

*Cantwell:* Some examples are VT, TX, OR, MA and NY. All of these have DSRIP concepts and VT and OR have capitated arrangements. The other states' examples are useful and we are looking at them, but California is different and we will plan the waiver to do what makes sense for California.

Q: What is DHCS thinking about in risks and advantages of the approaches outlined?

*Cantwell:* The key advantage is the ability to retain federal funding or a portion of it while we reduce the overall cost trend in health care. Health reform broadly could trigger increase costs without transformation and reforms. We will argue that without the waiver, this may happen. Underlying the waiver is California wanting to share in any savings we generate through reform. The risk is that the incentive program may not actually generate savings. There is language in the current waiver that we would need to pay the federal government back if we spend more than budget neutrality predicted and assuming this continues, it is a risk.

Q: Is there interest at the Department in combining 1115 waiver and 1915 waiver renewals?

*Cantwell:* This question may be referring to long term care 1915 waivers. I am not up to date on the timeline for when these are up for renewal but we are open to discussing this.

Q: What legislative authority does the Department need to move forward with the 1115 waiver renewal? What is the process to obtain this?

*Cantwell:* For past waiver applications, there has been legislation that authorizes the Department to seek a waiver and then following approval by CMS, implementing legislation is advanced with the specific components of the waiver outlined.

Q: How does the Substance Use Disorder treatment/Drug Medi-Cal Waiver the state is pursuing fit into Waiver Renewal efforts?

*DHCS:* We are seeking a waiver from the Centers for Medicare and Medicaid Services (CMS) to operate the Drug Medi-Cal Program (DMC) as an organized delivery system. This is being pursued as an amendment to the current Bridge to Reform Waiver to become operational in 2015, continuing into the terms of a renewed Waiver. Updates on the DMC Waiver efforts can be found here: <http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-PreviousMeetings.aspx>

**Reminders**

[waiverrenewal@dhcs.ca.gov](mailto:waiverrenewal@dhcs.ca.gov) is the waiver mailbox for concepts and input about stakeholder process.

The webinar recording and slides will be available on the website. We will review all questions we received during today's webinar.

If you would like ongoing information, please sign up for the stakeholder list serve on the web page. We use this to send out information and updates out to the group about the process. Thank you for your comments and your input.