

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER  
HEALTH CARE COVERAGE INITIATIVE (HCCI) TECHNICAL WORKGROUP  
Meeting #2 – Wednesday, March 17, 2010  
12:00pm – 4:30pm  
UC Office of the President, Room LL-3**

The meeting convened at 12:00 Noon.

Attendance

*Technical Workgroup members attending:* Jennifer Abraham, Kern Medical Center; Maya Altman, Health Plan of San Mateo; Tangerine Brigham, City and County of San Francisco Department of Public Health; Kelly Brooks, California State Association of Counties; Sandy Damiano, Department of Health and Human Services, Sacramento County; Irene Dyer, Los Angeles County Department of Health Services; Bob Gates, Orange County Medical Services Initiative; Nancy Kaatz, Santa Clara Valley Health and Hospital System; Lee Kemper, CMSP Governing Board; Elizabeth Landsberg, Western Center on Law and Poverty; Louise McCarthy, Community Clinic Association of LA County; Anne McLeod, California Hospital Association (by phone); Erica Murray, California Association of Public Hospitals and Health Systems; Judith Reigel, County Health Executives Association of California; Cathy Senderling, County Welfare Directors Association; William Walker, Contra Costa Health Services; Anthony Wright, Health Access California; Ellen Wu, California Pan-Ethnic Health Network.

*Others attending:* David Maxwell-Jolly, Director, Department of Health Care Services (DHCS); Gregory Franklin, Director of Medi-Cal Operations and Project Director, 1115 Demonstration Waiver Project, DHCS; Jalyne Callori, DHCS; Caroline Davis, Health Management Associates; Jim Frizzera, Health Management Associates; Bobbie Wunsch, Pacific Health Consulting Group.

*Public in Attendance:* 9 individuals attended in person, and 19 people called in on the listen-only telephone line.

Welcome and Introductions

*Bobbie Wunsch, Pacific Health Consulting Group* welcomed the group and provided an overview of the agenda.

Updates: CMS Discussions, Stakeholder Advisory Committee Meeting

*David Maxwell-Jolly* reviewed issues raised at the Stakeholder Advisory Committee (SAC) meeting on March 10. At that meeting, Elizabeth Landsberg represented the HCCI TWG and offered a summary of the HCCI Workgroup's first meeting.

Conversations with CMS are proceeding simultaneously with the work of the TWGs. One of the most critical elements for this group is the budget neutrality discussion. DHCS is continuing its internal analysis for budget neutrality, and having high-level discussions with

CMS, with a goal of expanding the resources available for things like the HCCIs through growth in the Safety Net Care Pool (SNCP). The timeline is challenging, but the initial meeting with CMS (both Medicaid and Medicare sides) has happened, and the Department expects to meet with CMS regularly from here out.

*Lee Kemper, CMSP*, asked whether the budget neutrality calculations were per project, or across the board. David Maxwell-Jolly said that in the context of the waiver, budget neutrality has more to do with which people are in and which are out than with specific services. The primary task is to figure out the population (size and cost) that will be included. At this point, the largest change would be the inclusion of the SPD population, which would capture many of the people within the BHI services focus. Proposals from the CCS TWG might also mean a change to covered populations. Once populations are determined, DHCS will look at whether planned projects would change costs and generate savings. In this context, BHI and substance abuse (SA) services are the focus. The state doesn't have much non-federal money in SA services, currently, so there's a challenge in finding matchable money, and structuring something that is budget neutral on both the federal and state sides.

*Bill Walker, Contra Costa*, asked about budget neutrality in the context of HCCI expansion, and whether those costs would have to be offset somewhere else. David Maxwell-Jolly said that if there are interventions that generate savings against what would otherwise be incurred, then the state can use those saved federal expenditures for things like HCCI expansion under the terms of the waiver.

*Louise McCarthy, CICALAC*, asked about matchable funds. David Maxwell-Jolly said that matchable funds must be public dollars: local or state, expenditures on current program, money the county is spending elsewhere that they'd like to devote to Medi-Cal. In the substance abuse arena, for example, there is some money in the drug courts that may not be being used to its capacity, and there is drug/alcohol money in TANF. To the extent a county is putting up funding for additional drug and alcohol services, those could be counted as well. If the funds are for non-Medi-Cal beneficiaries, they could be used to claim federal funds for HCCI expansion.

*Ellen Wu, CPEHN*, suggested looking at what the state is currently spending on language access, since that money may be eligible for enhanced reimbursement under the CHIPRA reauthorization.

*Anthony Wright, Health Access*, asked if budget neutrality was calculated in each fiscal year, or over the life of the waiver. David Maxwell-Jolly said that it has been done both ways in the past. Anthony Wright said that, should federal health care reform (HCR) be enacted, there might be some things that California could implement now that would show savings in out-years, after HCR implementation in 2013-14.

#### Take-Aways from First Workgroup Meeting re: Standardization of Key HCCI Elements

*Bobbie Wunsch, PHCG*, asked the group for any additional thoughts since the first meeting about standardization of enrollment/eligibility, benefits, or populations. The Workgroup

referred to documents summarizing the HCCIs' eligibility and enrollment (available at [http://www.dhcs.ca.gov/provgovpart/Documents/HCCI\\_Program\\_Elig\\_Criteria.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/HCCI_Program_Elig_Criteria.pdf)), covered benefits (available at [http://www.dhcs.ca.gov/provgovpart/Documents/MediCal\\_HCCI\\_Cov\\_Srvs\\_Mar2010.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/MediCal_HCCI_Cov_Srvs_Mar2010.pdf)) and demographics (available at [http://www.dhcs.ca.gov/provgovpart/Documents/HCCI\\_Enrollee\\_Demo\\_Mar2010.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/HCCI_Enrollee_Demo_Mar2010.pdf)).

*Cathy Senderling, CWDA*, asked for clarification on whether “enrollment/eligibility” means eligibility standards, or enrollment process. *Elizabeth Landsberg, WCLP*, said that both had been discussed. From a consumer’s perspective, the process goal would be that wherever a person goes to apply, she will be put into the right program. In some HCCI counties, an indigent adult must see a different worker for each of several programs.

*Lee Kemper, CMSP*, said that, in general, the HCCI counties fit into 2 categories: those targeting specific conditions, and those that cover the broader population. The answer to the standardization question might depend on which overall strategy a county uses. Los Angeles has a relatively small initiative relative to its indigent/uninsured population, and focuses on a subset of that group. Other counties have much larger initiatives relative to population. In many cases, responsibility for enrollment is not clear. It would be helpful to know who is doing what and what data is being collected, as part of an overall effort to streamline the programs.

County personnel present described their programs:

- *Orange*: Hospital and clinic staff take applications, since most people enter the program through the emergency department (ED). Information is sent via the Internet to county social services, where the application is processed.
- *Santa Clara*: All enrollment is done by the health department, with no communication with the county Department of Social Services (DSS).
- *San Mateo*: Same as Santa Clara. Since the HCCI is part of the county clinic delivery system, the enrollees are already in the system. Uses One-e-App.
- *Los Angeles*: Health department staff manage the program, and there is no communication with social services.
- *Kern*: Most patients come in with an acute situation. They are screened by patient financial services at the clinic or hospital, and if they appear to be Medi-Cal eligible they are sent to DSS; otherwise, the application stays in patient financial services.
- *Contra Costa*: All applications are taken in county facilities, and there is no communication with DSS.

The following HCCI counties use One-e-App to facilitate eligibility and enrollment with HCCI and other health care programs: Alameda, San Mateo, and San Francisco. *Bob Gates, Orange County*, noted that they are looking at using One-e-App. *Bill Walker, Contra Costa*, also commented that they are looking at using a new version of One-e-App.

*Lee Kemper, CMSP*, noted that making income eligibility determinations is complicated, and that who does it and how it’s done are important questions. It is germane that the counties

do not use Social Services for the HCCI programs, while the rest of the Medi-Cal eligibility is done by social services. *Bobbie Wunsch* agreed, noting that this is particularly important if HCCIs are going to serve as a bridge to expanded Medi-Cal, and/or in the context of expansion.

*Maya Altman, HPSM*, said that the way counties designed their programs – whether broad or narrow – had to do with how much money they received, which constrained or opened up opportunities. The initial process essentially asked counties to identify a dollar amount and apply, and varying resource levels should be considered in any analysis of the HCCIs. *Jalynne Callori, DHCS*, confirmed that the initial program was designed to let the counties decide how much CPE to invest. The only funding restriction was that no county could get more than 30% of the total amount available. Going forward, the process might work differently.

*Bobbie Wunsch, PHCG*, asked how the program might be different moving forward.

*Bill Walker, Contra Costa*, said that the range of benefits offered by the various HCCIs is not so wide, and a standard benefit package should be possible. Funding levels, however, vary widely. If the HCCIs are going to evolve into health care reform, it's hard to see how that effort can be based on covering only certain conditions. While chronic disease programs are clearly valuable, they don't build a system. *Cathy Senderling, CWDA*, echoed this point, asking how the HCCIs could be integrated into an expanded Medi-Cal program. The "boutique" programs in Medi-Cal are both good and bad.

*Elizabeth Landsberg, WCLP*, said that at a minimum, should Health Care Reform pass, there will be hospital- and provider-based presumptive eligibility, and no assets test, and that a no-wrong-door approach is essential to getting people into the right program, no matter where they turn up.

*Louise McCarthy, CCALAC*, clarified that although LA's HCCI looks constrained as far as who is eligible, in reality, the situation is more complicated with people admitted who do not meet the disease-specific requirements. At the same time, some of the benefits listed may not actually be provided if they are not available or the payment is insufficient. *Irene Dyer, Los Angeles*, agreed with the first point in particular, saying that although Los Angeles officially focuses on chronic conditions, the footnote on the UCLA benefits chart means "and everyone else we can get in." The initial funding allowed Los Angeles to focus only on particular conditions, but the county would be open to expansion beyond the condition-defined population.

*Bob Gates, Orange County*, said that logic supports moving toward more comprehensive coverage rather than more disease-specific coverage. In Orange County, much of the money went toward adding primary/preventive care to the existing indigent program, which was essentially emergency-only. He noted that the program would look very different for counties with public hospitals.

*Jennifer Abraham, Kern County*, said that part of the problem with the benefits list is the general nature of the service descriptions: Kern County could say that they offer rehab

services, but, in fact, they do not have a contract with a rehab hospital, and only offer PT in hospitals. A standardized benefit package would require stricter definitions.

*Anthony Wright, Health Access*, said that the HCCI should see itself as the bridge to health reform, at least as far as eligibility and benefits. The goal would be that, come January 1, 2014 when the Medicaid expansion takes effect, California has half a million people ready to start. This is particularly important in the first three years, when the federal government will pay 100% of costs for newly-eligible beneficiaries. A slow build does not make sense, and the HCCIs are one way, among others, to get people ready to move to Medi-Cal when it is available. The question is, with limited money, should the state cast a wide net and try to get as many individuals as possible signed up for something, or should the state and counties build something now that's near Medi-Cal so that the 2014 transition is seamless from a client perspective.

There will be a role for HCCIs even in the Medi-Cal context, since California will still have many people uninsured, but a big question remains of how DRA would affect this strategy. How can that be revisited in the new federal administration? The Workgroup should probably work backward from the question of what the HCCIs should look like in 2015.

#### Overview of HCCI Financing and Payment Mechanisms

*Jim Frizzera, Principal, Health Management Associates*, presented information on HCCI financing options and funding scenarios under the waiver. His presentation is available at <http://www.dhcs.ca.gov/provgovpart/Documents/HCCI%20Financing%20Opts%20Friz%20Presentation.pdf>.

#### **ARRA MOE**

The presentation offered an overview of Medicaid spending and the state-federal partnership. Jim Frizzera offered detail on the Maintenance of Effort (MOE) requirement in the American Recovery and Reinvestment Act of 2009 (ARRA), saying that the relative shares of responsibility of the state and local jurisdictions is required to remain the same throughout the period of enhanced FMAP (at least through 12/31/10, with the possibility of an extension).

*Diane van Maren, Senate Budget and Fiscal Review Committee*, asked whether increased commitment to local spending via CPEs would violate these MOE requirements. Jim Frizzera could not say definitively, though in principle it could be inconsistent with ARRA provisions. However, 1) CMS has not stated a definitive position on its interpretation of the MOE requirement, probably because states are in very different positions and CMS is trying to find an approach that is appropriate to all states in the recession but does not have an adverse impact; 2) while states have frozen Medicaid rates, presumably there have been increases in aggregate spending as more individuals have joined the program. As a result, it is not clear that increased local spending would violate MOE. If a program was funded 100% by local sources on October 1, 2008, even if it is now bigger, but still 100% local, it arguably would not violate MOE provisions.

*Louise McCarthy, CCALAC*, asked whether the MOE requirements apply in the aggregate, or with respect to specific programs. Jim Frizzera responded that the language would likely be interpreted to address overall non-Federal Medicaid spending, but an alternative interpretation could be applied with respect to specific programs.

## **HCCI Financing**

- Federal funds limited to \$180M per year for last three years of current waiver
- Funded by counties through CPEs
- CPEs trigger rigid payment and cost documentation requirements
- Federal funds available as a percentage of total payments/costs

Jim Frizzera gave a short history of the use of CPEs in Medicaid, saying that moving to CPEs allowed for the continuation of the federal match for certain Medicaid payments, which were historically funded through mechanisms challenged by CMS beginning in 2003. The funding mechanisms in question were commonly referred to as “recycling,” which meant the providers were not allowed to retain a portion of their Medicaid payments. CMS worked with States to implement CPEs because simply terminating the Medicaid payment programs would have been too disruptive to health care providers and to the states. The CPE policy affords States similar flexibilities realized through the historical financing mechanisms but requires rigid cost documentation to accurately identify the Federal liability for Medicaid spending

*Bob Gates, Orange County*, noted that under the current waiver, the HCCI has had \$180M per year with no movement between years, and asked whether the year-by-year cap could be changed to a total cap over the life of the waiver. Jim Frizzera noted that HCCI sits within the SNCP, which is under the overall waiver cap. Under the new waiver, it should be possible to move to an aggregate cap for HCCI (within the overall budget neutrality) that could contain year-to-year spending flexibility within the aggregate HCCI cap.

## **Permissible Sources of Non-federal Share of Medicaid**

- CPEs
- IGTs
- Health care –related taxes
- State and/or local GF appropriated to the Medicaid program

### CPEs

- Federal law expressly recognizes Medicaid costs incurred or payments made by State and local government (public) health care providers
- Medicaid costs must be documented in a standardized and auditable format
- Federal matching funds available as a percentage of allowable Medicaid costs
- States, counties have greater flexibility to use Federal funds received from CPEs.

*Erica Murray, CAPH*, noted that DHCS has secured CMS approval to apply the enhanced FMAP to HCCI. However, the state is changing the allocation of the federal reimbursement to the counties by retaining the dollars attributable to the FMAP enhancement for the General Fund. She said that there remains a difference in emphasis. Counties see the CPE as a spent cost. The feds have proof they have a service delivered, and they pay the state back, since the state is their only partner.

Jim Frizzera clarified the federal position. From CMS's perspective, states have discretion with regard to distribution of the federal reimbursement. The CPE policy recognizes that state and/or local revenues have subsidized the costs of treating Medicaid and/or the uninsured and that both the state and federal obligation has been satisfied through the costs incurred for serving such populations. The federal government provides the matching funds "after the fact" based on the documented costs. The federal government assumes that the state will distribute the federal match to the source that originally subsidized the costs of serving the Medicaid and uninsured populations, but does not require such a distribution.

*Elizabeth Landsberg, WCLP*, clarified that the county spends \$1 on an HCCI, and the state can pocket the entire 62 cents in federal reimbursement. Jim Frizzera confirmed this scenario. Elizabeth stated that in fact, though, the point of contention is the enhanced part of the federal match, or 12 cents on the dollar.

### IGTs

- Federal law expressly permits the transfer of State and local government (public) funding to support Medicaid payments
- IGT and other non-federal funds must be equal to the "State share" of the Medicaid payment
- Government (public) health care providers may participate in IGTs
- States generally determine health care providers eligible to participate in IGTs
- IGTs are typically utilized to fund "enhanced" Medicaid payments to targeted Medicaid providers
- Amount of IGT capped at non-federal share of payment to health care providers-state cannot take a share
- All funds (federal + local) must remain with providers and cannot be used to reimburse the county general fund

Jim Frizzera said that there are perception issues around IGTs as well. There is a technical distinction between a permissible IGT and a redirection of Medicaid payment. In other words, if there is a \$100 expenditure for a hospital service, \$50 will come from the federal government and \$50 will be provided by the provider via an IGT. Under this scenario, the state can't keep \$40 and reimburse the hospital for \$60 because that would result in distorting the FMAP. There has been a great deal of discussion of what constitutes a government (public) health care provider; after legal challenges and congressional instruction, CMS policy affords deference to state determinations of a government (public) health care provider absent evidence to the contrary.

*Lee Kemper, CMSP*, asked whether the following summary is correct: for CPEs, the state can decide whether or not the federal reimbursement goes back to the provider, but for IGTs, the federal reimbursement must go back to the provider.

*Anthony Wright, Health Access*, asked whether the choice of which mechanism to use is up to the state, and whether it is possible to use both. Jim Frizzera said that it is the state's choice of which to use, and cautioned that using both mechanisms usually doesn't work to the state's advantage. CPEs require documenting that there are unreimbursed expenditures. If there are also IGTs in the mix, federal rules for CPEs require an offset for any costs already reimbursed via IGTs. This makes it difficult to find the line where it would be to a state's advantage to use both strategies. Jim offered a non-HCCI example: A public hospital has \$100 of Medicaid costs for which no payment was made. If only CPEs are used to claim the federal funds, the federal government will reimburse the state \$50 of the uncompensated Medicaid costs. However, if the local government also transfers \$20 to the state via an IGT which is matched by the federal government, the hospital must reduce its Medicaid expenditures by the \$40 Medicaid payment (funded via the IGT and federal match). This leaves \$60 that the hospital can claim via CPEs, which means an additional \$30 in federal matching funds would be available. The net federal funding available under each scenario is \$50. There could be some optimal combination that would create a net gain, but it would be hard to find.

*Maya Altman, HPSM*, offered an example in which an IGT of \$100 could result in a Medicaid payment of \$200 (with the additional \$100 federal funds). Maya further noted that utilizing that same \$100 of local revenue to instead subsidize costs under the CPE would result in only \$50 of federal matching funds. In that case, why use CPEs? *Erica Murray, CAPH*, responded that the primary consideration with IGTs is cash flow. Public hospitals are looking at how much IGT they can provide and still maintain a workable cash flow.

*Bob Gates, Orange County*, asked whether there must be an actual transfer of funds from local to state government to get the match under an IGT system, and whether IGTs must be expended for Medicaid-eligible population or whether they could be used for waiver populations as well. Jim Frizzera said an actual transfer of funds must occur so they are under the administrative control of the Medicaid agency. IGTs are an option for both traditional Medicaid and waiver populations, including HCCI.

*Louise McCarthy, CCALAC*, said that the matchable funds under IGTs have to come from the county, but the state could be the origin as long as the dollars had not been matched. EAPC is an example.

*Tangerine Brigham, San Francisco*, discussed two kinds of providers – government providers who can transfer and document; and non-profit providers, who cannot. For the latter, to get access to reimbursement under IGT, dollars would have to be transferred to the state by a government (public) entity on behalf of the non-profit providers. Funds transferred by non-profit providers for purposes of Medicaid payments would be considered impermissible (non-bona-fide) provider-related donations

*Elizabeth Landsberg, WCLP*, noted that IGTs are used in FFS or managed care to draw down federal match.

*Maya Altman, HPSM*, said that managed care plans are currently doing IGTs in partnership with the county. The county puts up money, it's matched, then paid into HPSM. There are county dollars matching federal dollars and then going back into the health plan.

*Anthony Wright, Health Access*, clarified that California currently has a mix of CPEs and IGTs. Jim Frizzera confirmed this, and said that there's a mix in most states. In the last waiver, there was a specific shift from IGT to CPE.

### **Health Care-Related Taxes**

- Permissible class of health care items or services
- Broad based or apply to all providers within a permissible class of services
- Uniform such that all providers within a class must be taxed at same rate
- Avoid hold harmless arrangements in which collected taxes are returned directly or indirectly to taxpayers
- 19 permissible classes of health care items, services
- Generally redistributive – broad based and/or uniformity waiver
- Permissible classes, hold harmless cannot be waived
- State can collect up to 5.5% of net patient revenue for each permissible class through FY 2011 (increases to 6% beginning in FY 2012)

Jim Frizzera also stated the following:

- Local taxes are allowable.
- If it's a service or item not on the list of permissible classes, it's considered a bad tax. The permissible list can't be waived: expansion of the list requires federal regulatory change. Right now, there are efforts to add home- and community-based services (HCBS) to the list to update the 1991 law.
- The tax must be broad-based, meaning that if you provide the service, you have to be taxed.
- Uniformity means that everybody must be taxed at the same rate
- Both the broad based and uniformity requirements can be waived. States must demonstrate through statistical testing that Medicaid providers aren't unduly burdened by a tax that excludes certain providers and/or imposes different rates of tax.
- Hold-harmless means taxpayers cannot be guaranteed to receive their tax costs back through Medicaid or any other state payments; restrictions are judged through structural and subjective analysis, not statistical tests.

*Cathy Senderling, CWDA*, asked whether the concept is that the taxes themselves are then matched. Jim Frizzera said that they are not matchable themselves: the money raised can be used to pay for services, and that payment can then be matched.

*Anne McLeod, CHA*, said that such taxes can provide the non-federal share. A hospital tax can (indirectly) draw down federal dollars. But hospitals don't support taxing themselves for any purpose other than returning the full amount to the hospitals, which is very difficult given the prohibition on hold-harmless agreements – there can be no correlation between the money put out and what comes back. These taxes are totally redistributive, which means there are winners and losers. The winners typically are hospitals with a lot of Medicaid business.

*Anthony Wright, Health Access*, noted that the rhetoric in Medicaid financing is frequently about winners and losers, and this is true in discussion of provider fees, Medi-Cal managed care plans, hospitals, nursing homes, and everywhere else. But if the entity levying the tax is the county, then every provider in the county could benefit if there are only a few providers and each of the providers had significant Medicaid utilization, and in that case it's not necessarily a problem. *Jim Frizzera* said that this could work if the tax receipts were used to increased Medicaid payments, that each provider had a high volume of Medicaid patients, and as long as that locality didn't establish a formal policy that "guarantees" that every provider would get all or a portion of their tax back.

### **State Appropriation**

- State does not have general fund revenue for HCCI
- May be possible to use other state funds in budget for HCCI non-federal share
- State could appropriate these funds to HCCI on behalf of participating counties
- State appropriation provides source of non-federal match without triggering federal rules on IGTs and CPEs

*Tangerine Brigham, San Francisco*, asked whether there is a state effort to map all the dollars that localities spend, and whether they're being matched for CPEs. *Jalynne Callori* said that DHCS is looking at that aggressively, and has sent information requests to some counties. The legislature is looking as well.

### **Alternative HCCI Reimbursement**

- Current HCCI reimbursement is cost-based.
- Alternative:
  - Establish rate schedule up to Medicare or commercial rate
  - Establish PMPM cap rate
    - County establishes health plan or uses existing health plan
  - Requires alternative source of non-fed funding

*Jim Frizzera* explained that, under capitation, the state would develop a Medi-Cal rate within an actuarially-certified rate range and contract with plans, the counties would fund the state share of the capitation payment via IGTs, and then the plan would pay providers. Under this methodology, CMS reviews contracts with providers but there are no federal requirements governing the amount the plan pays providers. He also noted that there are no federal Medicaid rules that limit the amount of profit for MCOs. Further, for county

(public) MCOs, the MCO could move any profits back to the county general fund, even if the county general fund originated the non-federal share of the capitation rates (i.e., via an IGT). This requires a level of trust at the local level since no contracts can exist that mandate a redirection of a portion of the capitation payment from the county (public) health plan back to the county general fund. This process of moving profits from county (public) health plans to the county general fund would parallel any other sweep of governmental funding.

*Maya Altman, HPSM*, said that she had thought that the funds received by the county from the county (public) health plans had to be paid back to the hospital. It could be very helpful if they could use this approach for HCBS as part of LTC. *Lee Kemper, CMSP*, clarified: If HPSM were able to retain a portion of the capitation payment, and then submitted it back to the county, could the county transfer the funds to the state so it's matchable again? Jim Frizzera said that it couldn't be matched for the same service for which the original reimbursement was received, but for another service. Maya Altman followed up by asking whether there is any distinction between public plans that are part of the county and public plans that aren't. Jim Frizzera stated this would depend on state law and encouraged plans like HPSM, which is public but not part of local government, to talk to the state about these issues.

*Tangerine Brigham, San Francisco*, asked about provider donations. Jim Frizzera said that federal laws prohibits health care providers from donating to state Medicaid either directly or indirectly – so transfers by non-public health plans are highly suspect and could be considered donations. The prohibition on donations dates from the late 1980s, when providers were borrowing hundreds of millions of dollars to help states support their Medicaid programs. Taxes are allowed, but donations are not. There's an option for a bona-fide provider-related donation, but it can't be tied to a Medicaid payment or any other state payment back to the donor, an entity providing the same services as the donor, or to any other entity related to the donor.

*Jennifer Abraham, Kern County*, speculated about how using different sources could affect the county's responsibilities for paying for patient care. Currently, the Kern HCCI pays for care in the County institution, but can't pay for care all over the county. She wondered if the HCCI's financial responsibility for patient care would increase if they were to go to a non-CPE system.

## **Reimbursement Considerations**

- Current cost-based system:
  - Flexibility in how funds are used
  - Administratively burdensome
  - Limited to defined universe of costs
  - No return on investment
- Rate schedules or capitation payments:
  - Require use of State funds or IGTs

- Ability to reimburse in excess of cost
- Requires UPL demonstration or actuarial rate certification

### Possible HCCI Funding Scenarios and Implications for the Future

#### **Overarching Considerations in Possible HCCI Funding Scenarios**

- Aggregate spending under 1115 waivers limited to budget neutrality cap
  - New population under HCR could grow that cap
- Current 1115 waiver includes Safety Net Care Pool
- Increased spending under HCCI would impact SNCP spending limit
- Increase SNCP spending limit
- Maximize budget neutrality

*Anthony Wright, Health Access*, commented that what is limiting the SNCP from being increased is the STC in the current waiver. *Jim Frizzera* said that the feds imposed a limit on that pool in the transition from IGT to CPE, saying that the federal share should be no greater – but that this was fairly arbitrary, and California might have pushed harder and done better. The pool is dependent on demonstrating supplemental spending – at the time, the cost documentation wasn't there, but California should now be able to show the level of unreimbursed costs for all components of the SNCP.

*Erica Murray, CAPH*, said that the hospitals' hope under the waiver is that there are no more unmatched CPEs, and that federal dollars for these expenditures return to the public hospitals. She noted that even with the discussion of the bridge to HCR, it is important to keep thinking about the costs of the uninsured and those who will remain uninsured.

*Elizabeth Landsberg, WCLP*, asked whether HCCI money came out SNCP because of a theory that more outpatient, medical home type services would decrease hospital costs. *Erica Murray* said that at the time it wasn't entirely clear, but that the HCCI was simply negotiated within the SNCP. *Jalynne Callori* said that the goal in the next waiver is to grow the allotment under SNCP for HCCI. The purpose of HCCI was to show that if people without coverage are offered primary/preventive care, they will stay out of the ED and costs will come down. The state intends to use the HCCI's experience to ask to use SNCP funding in next waiver to expand the program. The SNCP is designed according to how much savings we can show that the programs are going to earn for the state. Those savings would be used to grow the HCCI allotment under the SNCP.

### Break-Out Sessions: HCCI Expansion Criteria

*Bobbie Wunsch* introduced the exercise, the goal of which was to determine what kind of criteria for HCCI expansion should be used, depending on the level of new resources available. She presented the funding options

- 1. Funding Option #1: No Change in Current HCCI Funding**
  - Annual federal allocation remains at \$180 million per year

- Total county CPE amount remains at \$360 million per year
- 2. Funding Option #2: 10% Increase in HCCI Funding**
    - Annual federal allocation grows from \$180 million to \$198 million per year
    - Total county CPE amount grows from \$360 million to \$396 million per year
  - 3. Funding Option #3: 25% Increase in HCCI Funding**
    - Annual federal allocation grows from \$180 million to \$225 million per year
    - Total county CPE amount grows from \$360 million to \$450 million per year
  - 4. Funding Option #4: 50% Increase in HCCI Funding**
    - Annual federal allocation grows from \$180 million to \$270 million per year
    - Total county CPE amount grows from \$360 million to \$540 million per year.

*Bob Gates, Orange County*, said that the options were too conservative. Orange County is ready to expand substantially, either as a bridge to health care reform or just to expand coverage. Currently, Orange is putting up \$15 million, and the county has \$30 million more to match. Tripling the program would be a good start. A number of other Workgroup members supported this strategy; as a result, the exercise was reframed to include discussion of two options: a “modest” increase (1) and a “major” increase (2).

*Louise McCarthy, CCALAC*, asked whether the exercise had to focus on CPEs to the exclusion of other funding strategies; *Bobbie Wunsch* said the exercise was constructed around CPEs. *Jim Frizzera* clarified that CMS would want to know, essentially, the actual services provided that are not being reimbursed and ideas on how services can be delivered more efficiently (i.e. reform ideas), and that the CPE v. IGT strategy is less important. *Irene Dyer* said that the group should think first about what they want.

*Judith Reigel, CHEAC*, asked whether the exercise should assume that there would not be any Medicaid expansion, or if one goal would be to prepare all counties for such an expansion.

*Erica Murray, CAPH*, said that it is essential to think about the entire SNCP. It is a multidimensional puzzle, a package with real impact on public hospitals and available CPEs. *Anne McLeod, CHA*, concurred, saying that it is not possible to look at waiver components in silos. CMS looks at everything under one umbrella, not in separate packages.

*Lee Kemper, CMSP*, offered that the goal of the exercise was to determine, first, whether the Workgroup favored continued support for existing HCCIs under any scenario, and second, whether the Workgroup supports expansion, and if so how.

*Anthony Wright, Health Access*, referred to *Jim Frizzera*’s comments, saying that California’s waiver application is strongest with specific amounts, and therefore tying to some amount that already exists is stronger.

In the context of California's 8.2 million uninsured, even assuming that a Medicaid expansion reaches about two million, and others receive subsidies, there will still be millions who need the safety net. Right now, 160,000 people are enrolled in HCCI, so to have all the likely eligibles ready to go by 2014 would require an increase of enormous magnitude – 6 to 8 times the current program. The application to the Obama Administration will be stronger if California can say, "This is how we would implement HCR." It may be an attractive argument to counties, that they can invest now, and those costs will be offloaded to the federal government in 2014-15.

*Elizabeth Landsberg, WCLP*, noted that if HCR passes, California may have a very different basis for negotiation on budget neutrality. *Lee Kemper* asked if there might be any ability to opt-in early. If a county or group of counties wanted to match federal dollars to fold the soon-to-be eligible Medicaid population in, they might be able to do so without using HCCI.

Based on this conversation, Bobbie Wunsch amended and simplified the financing scenarios as follows. Two small groups were assigned to discuss each one.

Scenario 1: Status quo, or a little more money.

Scenario 2: Significant funding expansion. HCR scenarios could be folded in to this discussion as well.

#### Report Out on Break-Out Sessions

Group One – **Status Quo**: Jennifer Abraham, Louise McCarthy, Kelly Brooks, Erica Murray

In a situation with no or only a little new money, the group would:

- Maintain the existing allocation among current HCCI counties
- Standardize benefits
- Enforce accountability standards through data collection
- Standardize some elements of enrollment processes in order to assure that Medi-Cal eligible individuals reach that program.
- Not move toward capitation, because it would not solve anything

Group Two – **Status Quo**: Bill Walker, Lee Kemper, Nancy Kaatz, Anthony Wright

In a situation with no new money at all:

- Certain counties, which have both public hospitals and an HCCI, have access to federal match in two ways. The group discussed the interplay between drawing down money through DSH v. drawing down through HCCI.
- Currently in HCCI, funds are available only in the year in which costs are incurred. The state should negotiate for a change in the waiver to allow funds to be rolled over. This is important because it can free up money for other existing counties or for new counties.

- Current counties should be maintained *unless* they are not meeting all standards
  - Spending all the money
  - Meeting performance metrics based on UCLA data. The group recognized that the evaluation didn't start until year 2, and the evaluation components weren't built into the programs from the beginning.
- *If* any money is left over, existing counties should be funded for unmatched expenditures.
- The group recognized the equity concerns in this scenario – if a county didn't get in five years ago, are they excluded forever? The group is not unsympathetic to new counties, and hopes that if the money could be rolled over the five years then there might be more options to bring new county programs up.

In a scenario with a little new money (defined as an increase of 10-15%), the group proposed the same plan, but with room for annual program growth in existing counties.

Tangerine Brigham noted that San Francisco didn't spend all its allocation in the first year, and asked if the 5-year rollover was to allow for ramp-up. Lee Kemper said that the group didn't anticipate applying it retrospectively, but would propose a policy under which if a county didn't meet its target in the fourth year of operations (first year of the new waiver), they would be considered not to have met their performance criteria.

Bill Walker said that the state should look at gearing up for HCCI as gearing up for Medi-Cal enrollment, and suggested that if the federal administration is looking for a win, they might want to see early enrollment in something.

Group Three – **Significant Funding Expansion**: Maya Altman, Irene Dyer, Ellen Wu, Cathy Senderling, Sandy Damiano

In a scenario with significantly expanded funding, the state should:

- Continue current counties
- Expand to new counties
- Standardize criteria
  - Coverage to at least 133% FPL to line up with HCR, recognizing that some counties may not be able to get there
  - Define basic benefits package, but don't make counties shift away from the good things they're doing
  - Move toward integrated BH benefit
  - PCMH as needed.
- Link global cap (to counties) to some standards.
- Better connection with the Medi-Cal side of DSS – structure eligibility rules so that people can be moved easily into expanded Medi-Cal coverage. Fix Medi-Cal to bring it in line with what we would want in HCCI (elimination of assets test, DRA).
- The unmatched CPEs that the state can claim should drive the number that California asks for.

- One challenge is what to do with counties that don't have sufficient ability to put up money to provide a basic benefit package or to get all the way to 133% eligibility. Should they do what they can, or is the state setting up a donor county regime?

Group Four – **Significant Funding Expansion:** Elizabeth Landsberg, Jalynne Callori, Tangerine Brigham, Judith Reigel, Bob Gates

- Half of the new money should go to expansions in existing counties, and half to new counties.
- Continuing counties should be held harmless in the first year of the waiver, but after that they should either spend their entire allocation or give the money away.
- Since funding for HCCI comes from presumed savings from inpatient care, existing HCCI counties should have a component that addresses frequent users
- Existing counties should move close to adopting Medi-Cal standards for certain subsets of the population, including SPD
- Performance metrics like those discussed in meeting 1 should be applied across all projects. Each of the existing 10 counties should be evaluated to make sure they're meeting all provisions.
- ED services should be covered out-of-county – In existing/expansion counties, someone could be in a HCCI, get an ED service in another county, and the covering county would reimburse. Data from CHA/CAPH on reciprocity across county lines would be helpful here.
- Long-term sustainability is a big question. None of the current HCCI counties could sustain their programs without the federal dollars.
- The state should see whether additional counties are interested.

#### Next Meeting and Feedback on Today's Meeting

Bobbie asked the Workgroup to identify issues they would like to discuss at future meetings.

- No CPE left behind – how to maximize match.
- Reimbursement methodologies – specifically capitation – to permit system transformation and real change (several participants)
- Administrative costs and reimbursement
- Retroactive coverage (several participants)
- Standardization of application process
- Including mental health services would be a priority with additional funding
- Quality of care/ Quality Improvement
- Care management
- Preparing for HCR – how the HCCIs fit into that effort
- Preparing for HCR – how DSS is preparing to enroll all the new eligibles and how HHS can help the HCCI counties prepare (several participants)
- Financial opportunities for budget neutrality, CPEs, etc. assuming HCR – leveraging what we know is coming to maximize federal investment in this waiver
- Using HCCIs as pre-enrollment vehicles – teeing up enrollment for 2014 (several participants)

- Other pre-enrollment vehicles outside coverage initiatives to meet that goal
- What happens if the waiver isn't renewed by September 1 – contingency planning for current HCCI counties
- Follow-up on Jim Frizzera's presentation
- Where HCCIs integrate with BHI and with SPD TWGs

The next meetings of the HCCI workgroup will be held:

- March 29, 10am – 2:30pm, Sacramento Convention Center, Room 103
- April 29, CPCA

The meeting was adjourned at 4:35.