

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER  
HEALTH CARE COVERAGE INITIATIVE (HCCI) TECHNICAL WORKGROUP  
Meeting #3 – Monday, March 29, 2010  
10:00am – 2:30pm  
Sacramento Convention Center, Room 103**

The meeting convened at 10:00 AM.

Attendance

*Technical Workgroup members attending:* Maya Altman, Health Plan of San Mateo; Tangerine Brigham, City and County of San Francisco Department of Public Health (by phone); 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; Len Finocchio, California HealthCare Foundation; 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; 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:* Gregory Franklin, Director of Medi-Cal Operations and Project Director, 1115 Demonstration Waiver Project, DHCS; Jalyne Callori, DHCS; Caroline Davis, Health Management Associates; Bobbie Wunsch, Pacific Health Consulting Group.

*Public in Attendance:* 14 individuals attended in person, and 11 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. She announced the webinar on dual eligibles and the waiver scheduled for March 30 from 3 pm – 5 pm and available online or in person in Sacramento. A technical workgroup focused on dual eligibles in the waiver will be formed in the next few weeks.

HCCI Financing: Alternative Reimbursement Strategies

*Maya Altman, Health Plan of San Mateo*, presented her thoughts on *HCCI and Capitation*. The complete presentation is available at [http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/HCCI\\_presentation\\_HPSM\\_Mar2010.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/HCCI_presentation_HPSM_Mar2010.pdf). She emphasized that her presentation did not reflect official San Mateo County policy, but rather her own ideas.

- Benefits of capitation
  - Ability to reimburse in excess of costs through an IGT
  - Can include factors for administration, “profit,” and enhanced services
  - Creates better platform for system transformation
  - Simplifies administration
  - Timely payment more likely
  - Builds readiness for federal health reform (ACOs)
  - Aligns with State Medi-Cal reforms
- Challenges of capitation
  - Need an entity that can accept risk
  - Requires actuarial rate certification
  - Need to enhance State capacity for administration
  - Must meet federal retention requirements for IGTs
- San Mateo County current system
  - Inpatient services drive reimbursement
  - Greatest needs in outpatient BH
  - Current capitated programs
    - Medi-Cal
    - Medicare
    - HFP/Healthy Kids
  - Non-risk programs
    - ACE County
    - ACE Coverage Initiative (HCCI)
  - Provider payments
    - Cap to PCPs
    - P4P for quality
    - FFS for all other services
  - Medicare SNP Results
    - Inpatient admissions down 45%
    - ED visits per member down 42%
    - Average stay down 11%
    - All with robust care management
  - Want investments in o/p, BH, SA, HCBS and care management
  - HSPSM at risk for ACE HCCI and ACE County? Have the data to do it now
  - Provider payment reforms?
    - More risk sharing between providers and plan?
    - Payment bundling per health reform?
    - Payment enhancements for Enhanced Medical Homes?
    - Delegation of risk to ACOs?

*Irene Dyer, Los Angeles County, presented on HCCI Payment Reform: Aligning Clinical and Financial Incentives. Her presentation is available at [http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CovInitReimbursement\\_3-29-10.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CovInitReimbursement_3-29-10.pdf). Among her key points:*

- FFS reimburses volume of services. Reduction of inpatient usage does not lead to savings that can be reinvested.

- Capitation rewards efficiency and provides an opportunity for reinvestment
- In LAC, would like to move from episode-based care to panel management, implementing case management and care navigators. Also want to implement remote navigation for some patients, group visits, IT enhancements
- Although some counties are adding these activities without capitation, LAC would like to be able to make the case that savings on one end are reinvested on the other
- Aligning with SPD transition into managed care would allow LAC to combine the Medi-Cal and HCCI programs – one program for both populations. Significant overlap between MIA with chronic conditions and the Medi-Cal SPD population; multiple smaller programs are inefficient to administer.
- Caveats:
  - Capitation rates must be risk-adjusted and actuarially sound: LAC typically treats the sickest patients.
  - Need to account for patient transitions in and out of system: Less opportunity to influence utilization and health outcomes with a transient population, thus harder to see results from investment in preventive and primary care.
  - Must ensure that under-use does not become a problem: Require quality/outcome measures such as HEDIS.
  - Utilization reductions in one population are back-filled by another (usually uninsured): If ED visits were reduced by 25%, ED wait times would decrease across the system, but there would not necessarily be cost savings since there is still high unmet demand.

*Bill Walker* described Contra Costa's managed care experience. The county has a managed care philosophy but much of the reimbursement is through FFS. They function clinically as a managed care organization, but having managed care reimbursement in addition would be helpful. This would require overcoming hurdles related to FQHC financing, as well as the bottom-line issue of rates. While philosophically he would like managed care, at the end of the day it's about rates which need to be appropriate and risk-adjusted.

On the question of CPEs v. IGTs, Bill said that the funding the county has had through the waiver has been insufficient – as a result, Contra Costa has unmatched CPEs. If the county were to increase its spending on HCCI (either through CPEs or IGTs), it would be necessary to make sure all the federal dollars are returned to the county. It's important to recognize who is providing the CPEs or IGTs and who is spending the money. Bill also noted that, overall, the county's spending is decreasing.

*Bob Gates* said that Orange County's situation is very different from Contra Costa's, possibly because they don't have a public hospital. The county has somewhere between \$20 - 30M in unused CPEs. If CMS would approve it, it might be better to use a mixture of CPEs and IGTs to fund the HCCI and to allow the source of the non-federal share to vary by county. There are pros and cons to be considered when making a decision to move from CPEs to IGTs. Bob commented that money is finally flowing through the CPE process, and, at this point, it's working.

*Nancy Kaatz, Santa Clara County*, echoed Bill Walker's comments as Santa Clara has a county hospital. While it would be nice to be in a consistent managed care mechanism, this is difficult when FQHCs are major providers. Santa Clara is putting effort into building medical homes, which promise better care, but it does not make sense in the FQHC context to have fewer visits since this results in lower levels of reimbursement. If all reimbursement mechanisms were aligned, the managed care model would be helpful.

*Maya Altman, HPSM*, offered a clarification: the Medi-Cal plans are required to pay FQHCs the same rates as other clinics. FQHCs receive wrap-around payments from Medi-Cal FFS to make up the difference between the FQHC rate and the rates paid by the plans. From the plan perspective, continuing to pay FFS to FQHCs is not a major stumbling block, since most costs are on the inpatient side.

*Judith Reigel, CHEAC*, emphasized that to make a move to capitation requires an entity willing to accept risk, and that both the existence and willingness of these entities will vary by county.

*Louise McCarthy, CCALAC*, said that non-profit community clinics and FQHCs have a wide variety of experience with managed care, depending on location and structure. FQHCs get wrap-around payments, but still have to know how to negotiate rates with plans. Non-FQHCs, including look-alikes, do not receive the same kind of wrap-around payments. Every plan operates differently: in San Mateo County, HCCI is built into HPSM, and this makes it much easier for the clinics to manage. Overall, FQHC readiness and strength varies significantly by type and location.

Panel management, which Irene raised in the LA context, aligns well with the community clinic system. The clinics have had strong successes in those practices, and find that it eases transitions for patients as they move between systems.

*Erica Murray, CAPH*, said that there is consensus among the public hospitals in wanting to look at an actuarially-based system. Rates would have to be risk-adjusted to appropriately capture the costs. As far as financing, California has seen a swing from greater reliance on IGTs to almost complete reliance on CPEs. CAPH would like to strike a balance, and hopes CMS would be open to such an approach. IGTs raise not only retention issues, but also cash flow concerns. CPEs are real expenditures that counties incur for services that have taken place, and therefore it's inappropriate for them to be used for anything but reimbursement for these services. If Boards of Supervisors are seeing money they've allocated used elsewhere, they won't continue to invest. *Maya Altman, HPSM*, asked for clarification on this last point, and Erica said that it was meant generally: CPEs must be used to reimburse for services provided. Erica also noted that it will be important to consider the financing for the whole waiver when deciding whether to finance HCCI via CPEs or IGTs.

*Anthony Wright, Health Access*, said that the conversation about capitation in HCCIs calls the broader question of what the HCCIs will become after Medicaid expansion. Can they become a medical home within Medicaid, without any special status? As far as financing, the incentives in FFS and managed care run at cross-purposes (over-utilization v. under-

utilization). Managed care requires strong consumer protections to counterbalance under-utilization. Health Access is most interested in finding a middle ground that focuses on quality. In addition, there are inequities between the private and public sectors. The health care reform (HCR) statute includes rules about the responsibilities of private hospitals for community benefits and charity care, and these must be carefully examined.

*Bill Walker, Contra Costa County*, said that regardless of what else happens with HCCIs, they should be aligned such that on January 1, 2014 California is ready to take advantage of 100% federal financial participation (FFP). He raised concerns that the current fiscal situation at the county level threatens Contra Costa's ability to have providers in place come 2014. Currently, only two of nine hospitals in the county have Medi-Cal contracts, and very few private providers accept Medi-Cal. Further, the Board of Supervisors is being urged to make additional cuts to the health care system. If the hospital is not "kept alive" until 2014, no county providers will remain to care for the new Medi-Cal enrollees. .

*Kelly Brooks, CSAC*, said that if behavioral health integration (BHI) is going to be part of the waiver, it should be part of the HCCIs.

*Bob Gates, Orange County*, asked about federal HCCI maintenance of effort (MOE) requirements and whether they protect the county share in health budgets. *Bill Walker* said that the MOE requirement keeps them in play, but that there is a lot of money outside HCCI that is not protected.

*Lee Kemper, CMSP*, asked whether revenue neutrality assumptions change as a result of HCR. *Bob Gates* said that he understands that, if an expansion is made through a waiver that could be made through a state plan amendment, it is considered neutral for the purposes of waiver budget neutrality. Thus, anyone from 0 – 133% FPL covered through HCCI would be budget neutral, while anyone over 133% would count against the HCCI spending cap. *Caroline Davis, HMA*, agreed, saying that, technically, California would include the costs for HCCI enrollees with incomes to 133% FPL in both the "with" and "without-waiver" baselines, which effectively means these costs do not count against the difference between the two baselines.

*Elizabeth Landsberg, WCLP*, said that the idea of taking advantage of the early take-up options under HCR and matching county CPEs with federal dollars is very attractive. She suggested expanding the discussion to include counties that are using CPEs for non-HCCI populations and non-HCCI counties – California should try to match all those dollars. HCCIs currently cover 160,000 individuals, but an estimated 1 million individuals will become eligible for Medi-Cal under HCR.

#### BHI TWG HCCI Pilot Idea

*Lee Kemper, CMSP*, said that the BHI TWG has been looking at strategies for integrated delivery of service for people with behavioral health (BH) and medical needs. The group is trying to address a range of conditions from low- to high-intensity, and has talked about where care is best accessed (through the primary care or BH "door"). The BHI TWG is aware of the considerable overlap with HCCI and SPD TWGs, and wants to make sure that

the HCCI discussion looks at strategies for BH integration. One of the models that the BHI TWG is developing as a pilot is specifically focused on HCCIs. That model would have the following key elements:

- Care management
- Data management
- Consumer engagement
- Clear designation of health care homes

A local entity would drive the non-federal piece, and the presumption is that there would be a way to bring forward some non-matched CPEs to meet the needs of the population. In addition, the BH focus presents other potential financing opportunities, including MHSA. The model would include process, outcome and financial performance measures, and shared incentives that could be reinvested into the system.

*Bill Walker, Contra Costa County*, asked how “radical” the conversation in the BHI TWG has been, and whether the group has discussed total integration of BH into Medi-Cal. Lee Kemper said that that had not been the focus of the discussion, but that people were keenly aware of the overlap. The key issue is the relative need for BH: as a person moves towards a higher level of need, the locus of care is BH service, and that may be where primary care should be provided, too. Lee noted that the responsibility for inpatient MH care is very complicated, and that the paucity of substance use disorder (SU) dollars means that it is not really an available resource in terms of financing.

*Louise McCarthy, CCALAC*, said that a number of counties have already submitted MHSA Innovations plans that look at the integration of SU, MH, and PC services through a variety of approaches. One question is how those plans as written could play into the waiver discussions. Given the extensive stakeholder process involved in development of MHSA plans, could they be amended to draw down additional federal dollars? Lee Kemper said that counties with access to CPEs, where BH could be folded in and become a matchable activity, would probably be extremely interested.

*Bob Gates* said that Orange County is looking at integrating BH into their HCCI. Trying to sort out how much of BH would fit into the HCCI is challenging given data limitations. *Maya Altman, HPSM*, said that San Mateo County is also very interested in integrating BH into their HCCI. San Mateo’s BH services see a high number of uninsured people, and are currently enrolling them in the county ACE program (not HCCI, because that program is full). This gives them access to the 340B benefit, which is a big help for people given the cost of psychiatric drugs.

*Sandy Damiano, Sacramento County*, said that they have some people who are being treated in an integrated manner, but that the need is overwhelming, given the very high bar for qualifying for specialty mental health services.

## Using HCCI as the Bridge to Federal Health Reform

*Bobbie Wunsch, PHCG*, introduced the next section of the meeting, which looked at two questions:

1. How could HCCI (current and/or expansion) be used to accelerate Medi-Cal expansion to 2011 (or perhaps Thursday, April 1, 2010)?
2. What systems need to be in place in the counties to be ready for Medi-Cal expansion in 2014?

Insure the Uninsured Project (ITUP) and Health Access (HA) were introduced as presenters.

*Lucien Wulsin, ITUP*, joined the meeting by phone to present information on *The §1115 Waiver and Federal Reform*. His presentation is available at [http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/ITUP\\_WaiverReform\\_FINAL%2003-26-10.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/ITUP_WaiverReform_FINAL%2003-26-10.pdf), and related materials are also available on the HCCI TWG web page.

- California could use a new 1115 waiver to prepare for swift implementation of federal reform.
- FMAP for Medically Indigent Adults (MIAs) up to 133% FPL is available as of April 1, 2010. This is good news for states that already cover these people in their Medicaid programs.
- It is in California's interest to have as close to 100% of eligible individuals as possible enrolled in the program when 100% FFP is available (beginning January 1, 2014) -- the state should be fully operational at the moment that happens.
- As of 2007, there were an estimated 6.5M uninsured people in California. UCLA estimates that by 2009 that increased to 8.2M. By 2019, with full implementation of HCR, that number is expected to drop to 1.7M. An estimated 1.7M are expected to be eligible for the Medi-Cal expansion.
- As of 2007, there was \$3B in annual funding for county health, not including SNCP. Of that, \$1.8B was spent on uninsured, with most county programs (but not county hospitals) limited to MIAs.
- HCCIs include a number of pieces that could assist in the implementation of federal reform, though the features vary from county to county.
- Options under the new waiver to set up for the transition include:
  - No more budget neutrality caps for coverage of MIAs—so California could lift the funding cap on the 10 HCCI counties for all enrollees up to 133% FPL, allowing the federal reimbursement to be based on all available CPEs or IGTs for eligible MIAs
  - Adding in some or all of the 48 other counties: the 34 CMSP counties have \$285M in federally matchable funds.
- Issues to consider in preparing for federal reform include:

- IGTs or CPE? – IGT generally preferred
- Integrate mental and physical health? – MH realignment dollars could be used
- Move newly eligible Medicaid populations towards/into managed care in preparation for 2014?
- Integrate care between clinics and hospitals? – CA is ready to do this
- Broaden networks? – This should be done in any case
- Interim enrollment cap – limited to available county match?
- Invest in HIT?

*Lee Kemper, CMSP*, asked whether the realignment figures presented in ITUP's Excel files (distributed at the meeting and available on the HCCI TWG website) were for county health services only. *Lucien Wulsin* replied that they represent the gross number for the local health account, not the net number for county indigent services. He estimated that about 60% of the total amount goes to indigent health care.

*Judith Reigel, CHEAC*, noted that for CMSP counties there is a clean break between public health and indigent funding, but that for other counties it varies by year and sometimes month to month. In addition, Proposition 99, included in the ITUP chart, is officially gone as of the last fiscal year.

*Anthony Wright, Health Access*, said that the biggest question mark is immigration status. UCLA reports that 20% of the overall uninsured population is undocumented, but what is it for MIAs? *Lucien Wulsin* said that the percentage varies by region and by counties within a region. He said that the 20% estimate would be low for MIA populations in some areas, particularly Los Angeles.

*Anthony Wright, Health Access*, presented on *California's 1115 Waiver: A Bridge to Health Reform?* His presentation is available at [http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/NatHealth\\_RefBridgeReform032810.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/NatHealth_RefBridgeReform032810.pdf).

- Overall
  - HCR puts a whole new spin on the waiver process.
  - Obama Administration likely to be most receptive to the waiver as a discussion of getting ready for the full implementation of HCR.
- Medicaid Expansion
  - Option to cover Medicaid expansion populations beginning 1/1/2011 but at regular Medicaid match.
- Medicaid Costs
  - Requires states to increase primary care physician rates to 100% of Medicare in 2013 and 2014; federal government picks up 100% of the increase in costs. Disproportionate benefit to states like CA where rates are so low
- Medicaid Benefits
  - States are required to provide “benchmark” benefits, rather than the regular Medicaid package, to newly eligible populations. Benefits *can* be (and should be) as good as the regular Medicaid package.

- Maintenance of Effort
  - States cannot reduce eligibility or make enrollment procedures more restrictive through the end of FY 2019 (for children) or calendar year 2013 (for adults).
- Medicaid Eligibility
  - New income counting rules starting in 2014, based on modified AGI
  - Takes existing disregards into account through 5% bump-up.
  - Had hoped to lose 5-year bar for legal immigrants but did not get that. This population will be eligible for subsidies in exchange beginning 2014.
  - Undocumented people barred from Medicaid and the Exchange.
  - Many HCCI's go to 200% FPL, and there will be overlap with the Exchange. At 134% FPL people will pay 2% of income, and anything above 2% would be subsidized.
- Estimates of Newly Eligible
  - 1.7M newly eligible for Medi-Cal (UC Berkeley Labor Center), based on 2007 numbers – since then movement in both directions
  - Take-up:
    - CBO estimates 50%
    - DHCS estimates 100% -- HA has overall disagreement with DHCS about their cost estimates, based both on this 100% take-up rate and on an assumed, but not required, Medi-Cal rate increase
    - CA will continue to have 2 -3 million uninsured, of whom an estimated 1.2 million will be undocumented
- Waiver Recommendations: Expand Medi-Cal to Targeted Populations, Use Coverage Initiatives as Enrollment Gateway
  - Targeted Populations: Low-income unemployed, Medi-Cal eligible youth aging out, parents whose children have aged out, and childless adults starting with lowest incomes
  - HCCIs: More counties, more people; align enrollment processes and procedures, use 2010-2013 to get ready
- Overall Waiver Arguments
  - Based on concept that Medicaid is a benefit and not a burden. Approach to federal government should be: Medicaid is great, and here's the best way to approach implementation of HCR.
  - Baseline/historical efficiency: Have been approaching waiver with the argument that we've been so efficient for so long, with lowest per-capita expenditure, but that counts against us now since it's our baseline and we don't get credit for the low spending. Now want to add the argument that we want credit for the old population AND the new population – we've shown that we can cover people at lower cost than other states, and we need more federal money to do that.
  - Pent-up demand: In the first few years there will be a spike in demand as people who have been uninsured now have access to care. To the extent that California has a plan that starts up early, we can release the valve slowly so that the first year doesn't mean a utilization spike. Pre-enrollment, early enrollment, early adoption all are ways of finding populations where the state can smooth out the spikes in cost and provider demand.

- County resources: Leading up to 2014, the more people that counties can enroll, the more will be paid for entirely by the federal government in 2014. With sensitivity to the counties' fiscal status, we still need to frontload in order to take advantage of this opportunity.
- Waiver should have contingency plans to move ahead more quickly in the event of an improved state budget, a ballot proposition, or any other development that makes additional funds available
- Waiver Recommendation: Rx Drug Discount Program as Gateway
  - Signed into law in 2006, but never implemented due to inability to find \$8M start-up costs.
  - Implement program in 2010, enroll in 2011, rollover enrollment to Medi-Cal in 2014.
- Waiver Recommendation: Enrollment Simplifications
  - Simplify eligibility determinations in 2011
  - Eliminate assets test in 2012
  - Make auto-enrollment of infants real
  - Establish presumptive eligibility for children, pregnant women, and extend to newly eligible

*Lee Kemper, CMSP*, asked whether it is possible for a region or some counties in the state to implement changes early, or whether changes must be statewide. Anthony Wright said that under a waiver it is possible to make changes that are not statewide.

*Irene Dyer, Los Angeles County*, asked for clarification on the eligibility of legal immigrants in the country less than 5 years for subsidies in the Exchange. Anthony Wright confirmed that they are eligible for subsidies, and that in fact the federal government will spend more money on those subsidies than it would cost to enroll the same individuals in Medicaid.

*Cathy Senderling, CWDA*, asked whether the presumptive eligibility changes were only for newly eligible populations, and not for everyone. Anthony Wright confirmed this, and suggested that California should use the waiver to make presumptive eligibility more inclusive. *Elizabeth Landsberg, WCLP*, said that some presumptive eligibility rules may in fact be more widely applicable, but will check.

*Tangerine Brigham, San Francisco*, asked for details on asset tests. Elizabeth Landsberg said that HCR eliminates the assets test for people 64 and under, but that it can still be applied for seniors in long term care. Anthony Wright clarified that Health Access' recommendation is to eliminate the assets test earlier than required in the law.

*Judith Reigel, CHEAC*, asked whether childless adult undocumented immigrants will have access to restricted scope ED Medi-Cal coverage that's federally matched. Elizabeth Landsberg said she would follow up on this question.

*Louise McCarthy, CCALAC*, asked about the rule allowing people with more than 2 chronic conditions to designate a health care home, with 90% FMAP. This would be relevant to the populations under discussion in the Workgroup. Several others were interested in this question as well, particularly the questions of effective date and whether the enhanced

match would be only for services related to the chronic conditions, or all services through the health care home.

*Bob Gates, Orange County*, said that he would be concerned that counties would invest less, rather than more, in the interim, because they will not have responsibility for health care for many MIAs in 3-4 years, so should stop paying now. While *Bill Walker, Contra Costa County*, agreed that there might be some incentive for Boards of Supervisors to reduce support, he also noted that the availability of additional federal money might help convince counties to continue to fund their programs. *Elizabeth Landsberg, WCLP*, argued that counties spend money on MIAs today, and it is in their interest to start drawing down federal match early. The thinking should be broader than just HCCI, and instead focus on how to get as many people as possible into a system and draw down the maximum possible amount of federal match.

*Caroline Davis, HMA*, agreed that while early adoption of the Medi-Cal expansion could help mitigate higher costs in 2014 by addressing pent-up demand for medical care (this issue was raised by Anthony Wright and echoed by Elizabeth Landsberg), the non-federal funding for HCCI expansion would have to come out of county funds. She asked the county representatives how hard it would be to add people early and increase the amount of the county contributions. *Irene Dyer, Los Angeles County*, said that the county is counting on the waiver to keep services open next year. They are not likely to expand, but hope not to cut back.

*Erica Murray, CAPH*, noted that although much conversation centers on unmatched CPEs, there are also services for MIAs in counties and hospitals that are being matched. Without any new state General Fund, even with “higher” budget neutrality, there is a limit to what is possible. *Judith Reigel, CHEAC*, said that, with every county looking at cuts, it is challenging to balance the need to limit new responsibilities on counties with the need to draw down federal match in a way that creates consistency and a bridge to reform.

*Bob Gates* said that in Orange County they are interested in expanding the types of services and number of people served through their HCCI, recognizing that they’ll be limited to county resources to do that.

*Len Finocchio, CHCF*, asked about access to presumptive eligibility dollars, and whether it would be possible to use those to “float” undocumented adults as the CHDP Gateway currently does for children.

*Maya Altman, HPSM*, said San Mateo County capped HCCI enrollment because they have reached their allocation. They still have unmatched CPEs, and may continue to have some even with cutbacks.

*Bobbie Wunsch, PHCG*, asked whether there would be a way to enroll people in HCCIs with a more limited set of benefits, in order to ease the pressure of pent-up demand. Anthony Wright responded that Health Access doesn’t have any specific recommendations in that regard. They would prefer as broad a scope of benefits as possible, but could accept less. He noted that budget neutrality is in the eyes of CMS, and CMS has a powerful incentive to

get early victories, early enrollments, and early wins in the implementation of health care reform. California has a major impact on national numbers, and the federal government is very receptive.

*Tangerine Brigham, San Francisco*, said she doubted San Francisco could offer different benefits to different Healthy San Francisco enrollees, because it would be too difficult administratively. She commented that CHIPRA gives significant flexibility to comply with the Medicaid Deficit Reduction Act (DRA) citizenship and identity requirements, including the ability to use social security numbers (SSNs) to satisfy both the citizenship and identity requirements via a match with Social Security Administration records. Addressing some of the more restrictive DRA provisions that apply to HCCI would be a good way of planning for the transition into Medi-Cal.

*Cathy Senderling, CWDA*, said that all 58 county departments of social services (DSS) are now using the electronic match with SSA as part of the Medi-Cal eligibility process. If the match returns the proper information, DSS can forgo collecting original documentation of citizenship and identity. Jalyne Callori announced that one of the flexibility provisions negotiated with CMS in the current waiver is the ability to apply the changes to the documentation requirements for citizenship and identity as allowed under CHIPRA to the HCCI, retroactive to February 1, 2010.

*Bob Gates, Orange County*, noted that it would not be hard to screen for Medi-Cal as part of the HCCI application. He also said that Orange County might consider limiting new enrollment to 133% FPL, thus enrolling more people.

*Lee Kemper, CMSP*, said that at the last meeting, the Workgroup talked about scenarios of “a little money” and “a lot of money,” but that now the discussion is about “a lot of money, in a different context.” The discussion regarding HCCI and non-HCCI counties is no longer relevant, and the new question should be what steps *all* counties can take to prepare for 2014, which may be different from county to county. Elements that offer flexibility – CHIPRA, higher reimbursement for complex conditions, etc. – are very important.

The Workgroup discussed the relative impact of using CPEs versus IGTs. The final amount of federal funds received using either approach is the same, but the two mechanisms have significant differences in terms of administrative burden, timing, cash flow, and other issues that may make one preferable to the other in a particular situation.

#### Federal Health Care Reform and HCCI: Break-Out Sessions

*Bobbie Wunsch* introduced the two scenarios for discussion by the Workgroup. The group was divided into two, and met to discuss a series of questions for each scenario. Bobbie Wunsch noted that these discussions would continue in the next HCCI TWG meeting (on April 29).

## Scenario #1: Medi-Cal Expansion Begins April 2010

- States can access FMAP for the Medicaid expansion population beginning April 2010
- Assume the ARRA enhanced match is available through June 30, 2011
- Assume the federal dollars for the expansion population will not be limited under budget neutrality

*Bob Gates, Maya Altman, Kelly Brooks, Nancy Kaatz, Elizabeth Landsberg, Louise McCarthy, Cathy Senderling, Erica Murray*

### HCCI Financing

- How would an early expansion be financed?
- Would CPEs or IGTs be used for the non-federal share?
- What are some other ideas for how the HCCI waiver funds could be used? In the new waiver, what else should the state ask for (e.g., federal funding for outreach, develop eligibility systems)?

### Discussion:

- The group assumed that early expansion would have to be financed with county funds. All counties should be allowed to participate to the extent of available funding.
- If the state enrolls eligible populations early, the \$180M would only be needed for HCCI enrollees between 133-200% FPL.
- Bias against limiting county enrollment to 133% -- while this would be acceptable in Los Angeles, where enrollment is currently limited to 133% FPL, other current and new HCCI counties should be allowed to continue enrolling people to a higher income limit to maintain/extend coverage.
- CPEs v. IGTs:
  - It's about when you put the money up.
  - It's administratively simpler to do IGTs.
  - Could be a county by county solution – doesn't have to be uniform.
  - Depends on CPEs v. IGTs in the rest of the waiver.
- Important to remember that HCCI enrollees are all users – they are more likely to be chronically ill than other populations.
- Capitation could be helpful – there's enough expertise and information now that it would be possible to calculate a decent rate.
- Some interest in using HCCI waiver funds to improve eligibility and outreach systems – IT, structure, operations, connections between HCCI and DHCS -- in order to get ready for 2014.

- State is required to do some development of eligibility systems – HCR law requires internet-based systems, electronic signatures, screening for Medi-Cal and Exchange – California will have to put some State General Fund in.
- Currently, CMSP is the only county program that could convert an HCCI card into a Medi-Cal card on Day One of the Medi-Cal population expansion.

### Eligibility & Enrollment

- How would counties identify potential new enrollees to expand enrollment significantly?
- What would the outreach process look like?
- How would the eligibility and enrollment process need to change due to the additional volume?
- Most HCCI programs limit income to 200% FPL. How would the Medi-Cal expansion to 133% FPL change this (e.g., should counties focus solely on the expansion population to maximize enrollment)?

### Discussion:

- How you find people depends on how your initiative is structured. Current HCCIs have done very different types of outreach and marketing: Santa Clara and Ventura both did outreach, as did Los Angeles.
- HCCIs have enrolled MIAs at the point of service. This would have to be different under expansion.
- Education about coverage (coverage literacy) is essential, particularly since this population has typically received only episodic health care.
- Public hospitals don't want to limit HCCI enrollment to the Medi-Cal expansion population. HCCI enrollees with incomes between 133-200% FPL will qualify for the Exchange, and public hospitals want to make sure people in the Exchange continue to use the public providers. Hospitals don't want the public network to serve only the undocumented and residually uninsured.
- The Cantwell Amendment should be examined to see what options it offers California.
- Eligibility criteria are similar across the HCCI counties, but the current processes differ.

### Role of Health Plans

- Should the newly enrolled HCCI Medi-Cal beneficiaries be enrolled in managed care?

### Discussion:

- If they go into managed care, may create financing problems for the state. The non-federal share of expenditures for this population would shift from county to state funding.

- Would have to limit the network. If a managed care plan uses safety net providers, it might work.

### Provider Networks

- What would local delivery systems need to look like to accommodate the needs of Medi-Cal expansion population?
- How quickly could any changes be put in place?

### Discussion:

- The provider networks have to look the way they do know, with heavy involvement of the safety net networks that ideally are taking advantage of the stimulus to improve HIT systems.
- In rural areas, the capacity issues are enormous.
- The current safety net can't take everyone on. There is pressure against limiting the network, due to access concerns.
- Competitiveness of the public hospitals varies by county.
- Proposing a delivery system improvement pool in this waiver.
- Questions about likely impact of primary care rate increases. May mean that more private sector providers want to take Medi-Cal, but if there still is no specialty network to refer to, private PCPs may still not want to be in.

### Benefits

- What should HCCI benefits look like under the new waiver?

### Discussion:

- There is a trade-off between expanding enrollment and offering a more generous benefits package. Which do you choose?
- Under waiver, the state could create a more restrictive benefits package – not statewide, and without a standard benefit package. Some services available under standard Medi-Cal (including out-of-network ED, dental) could be cost-prohibitive in HCCIs if the goal is to bring in many new people. However, *not* having an out-of-county ED benefit is a big problem for consumers.
- Copays and prior authorization requirements can also be used to control costs: Orange County has tightened requirements significantly.
- Could provide a limited, basic benefit package now, and plan for the package to be provided at full implementation.
- State should recognize that HCCIs are treating conditions of people who will transition to Medi-Cal, and the savings will accrue to the State.
- Creating additional, different programs is an administrative hassle.

## **Scenario #2: Medi-Cal Expansion Occurs January 2014**

- Medicaid eligibility expands to 133% FPL for all non-elderly individuals
- States receive significant federal support to cover new populations (e.g., 100% FMAP in 2014)
- Assume early adoption of expansion under HCCI

*Sandy Damiano, Lee Kemper, Anthony Wright, Judith Reigel, Bill Walker, Ellen Wu, Irene Dyer, Len Finocchio*

#### HCCI Structure and Financing

- What would HCCI look like once Medi-Cal eligibility is expanded statewide and individuals above 133% FPL move into the Exchange?
- If HCCI continues, how would the non-federal share be financed by the counties? Would CPEs or IGTs be used?
- In the new waiver, what should the state ask for to help counties get ready to implement the Medi-Cal expansion (e.g., federal funding for outreach, development of eligibility systems)?

#### Discussion:

- Continue current model of HCCI in waiver through 5<sup>th</sup> year after health reform because many people will not be enrolled.
  - In 2014, those under 133% FPL go to Medi-Cal, and 133-200% FPL go to the Exchange.
  - HCCI programs could become an entity eligible to operate under the Exchange. This likely requires that HCCIs meet Knox-Keene requirements, although it may depend on what the state decides about “benchmark plans.” (Health care reform legislation does not require Medi-Cal scope of benefits in the benchmark plans.)
  - Even if state requires Knox-Keene, some HCCIs could qualify and operate in the Exchange as an option. There will be multiple tiers of plans available so HCCI needs to match up to what tier it would want to offer under the Exchange.
- No need to continue HCCI under waiver once health reform fully implemented because it would only serve undocumented clients, and these costs are not eligible for federal reimbursement.
  - What happens to those who choose not to meet the mandate?
  - Is there a need to continue HCCI funding since there will be people who present for care but don’t sign up? Cantwell Amendment may be a part of this research.

- Summary: Likely that HCCIs will morph within each county when reform is implemented but it will be case by case. Some will likely go away, some will go into Local Initiative (LI), some may become like a new LI (especially in areas without an existing LI).

#### Eligibility & Enrollment

- How would the eligibility and enrollment processes need to change to allow for a smooth transition of HCCI enrollees into Medi-Cal or the Exchange?

#### Discussion:

- Medi-Cal enrollment will be much easier under health care reform because asset tests are waived and other simplifications are implemented. But there will be two types of Medi-Cal eligibility rules: those for newly eligible populations and those who are not (i.e., this will require the continuation of current eligibility rules).
- Need to build the new enrollment requirements into HCCIs and need to standardize HCCIs to new requirements. This will require huge changes in CalWIN, C-IV and LEADER.
- Need to standardize what the required information is, rather than who collects it.
- HCCIs need to have all the information ready to hand over to counties for Medi-Cal.
- Is this the time to consider moving Medi-Cal enrollment out of social services?
- Interim changes that would help include allowing health departments direct access to match SSNs, as welfare offices currently do, to meet revised (easier) DRA requirements under CHIPRA. A work-around could be that local health departments go to welfare offices to check SSNs for HCCI enrollees. California should ask the federal government for money to do this immediately.

#### Provider Networks

- What would local delivery systems need to look like to accommodate the needs of Medi-Cal expansion population?
- How should counties begin to develop the new delivery models necessary to support the Medi-Cal expansion? How could the waiver support delivery system reform?
- How quickly could any changes be put in place?

#### Discussion:

- Capacity is an issue under health care reform independent of HCCIs.
- Need to ramp up participation in private sector.

- Will PCMH implementation help by pushing toward expansion of scope of practice for mid-level practitioners?
- Will we have capacity issues related to language and cultural competency?

*Irene Dyer, Los Angeles County*, raised concerns about transition time: it will not be possible to enroll all eligible individuals on Day One of the implementation of the Medi-Cal population expansion.

*Maya Altman, HPSM*, asked about the Cantwell Amendment. Anthony Wright, Health Access, said that it requires additional research but it did come up in discussion. There has already been some discussion of Local Initiatives operating as a public option in the Exchange. The HCCIs could potentially be a gateway to the LI, or possibly a first step toward a county-run plan.

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

The next (and last scheduled) meeting of the HCCI workgroup will be held on April 29, 2010, from 10 am – 2:30 pm at CPCA's offices on I Street. Directions will be forthcoming and posted on the waiver website.

At that meeting, group leads will summarize the discussions to date, and link this group's work more directly to that of the SPD and BHI Workgroups. The HCR discussion will also continue. David Maxwell-Jolly will give an update on the overall waiver process.

*Len Finocchio, CHCF*, asked when the Workgroup would hear about the status of DHCS discussions with CMS. Greg Franklin said that the next meeting is scheduled for the next few days, and that there are ongoing meetings at the Agency level. *Anthony Wright, Health Access*, asked whether DHCS might put out a status paper along the lines of the county options paper released to the SPD TWG. Greg Franklin said he did not know when such an update might be released.

The meeting was adjourned at 4:35.