

**CALIFORNIA SECTION 1115 COMPREHENSIVE
DEMONSTRATION PROJECT WAIVER**

IMPLEMENTATION PLAN

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Introduction

California's Medi-Cal program covers more beneficiaries than any other Medicaid program. Its history has long been characterized by innovative delivery reform and comprehensive cost containment. Building upon that foundation, the state's Section 1115 waiver application provides an opportunity for the State to advance additional program changes targeting delivery system reform for some of the state's highest cost, most vulnerable residents. In so doing, California can demonstrate the value of integrated care service delivery models for such high-needs, complex populations, strategies to include safety net providers in delivery system reform, and approaches to slow the rate of growth in Medicaid spending. And, with federal investments secured through the Section 1115 waiver, California can lay the foundation to effectively respond to the broader, recently enacted Federal health system reforms that will accelerate the rate and need for health systems delivery and financing change.

The State of California proposes a comprehensive Section 1115 waiver that incorporates four principal elements: (1) promote more organized, accountable delivery models to improve care and control costs for seniors and persons with disabilities, as well as children with significant medical challenges, the dually eligible, and persons with both physical and behavioral needs; (2) support the efforts of safety net providers and organized delivery models to better integrate and restructure their financing and delivery models to promote the inclusion of safety net providers in the delivery systems occurring today and contemplated under pending federal reforms; (3) implement value-based purchasing strategies that drive system improvement and improved outcomes; and (4) enhance the delivery system for the uninsured.

Implementation Plan Organization

This Section 1115 Comprehensive Demonstration Project Waiver Implementation Plan is organized around the four principal vulnerable Medi-Cal populations and the programs that serve them in California:

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

There are two principal rationales for selection of the four target population groups. First, these four populations represent the greatest opportunities for improving outcomes of care through greater care coordination and integration. And secondly, these four groups represent a significant share of the fee for service costs in the State's current Medi-Cal program. Therefore the Waiver provides a significant opportunity to shift the Medi-Cal cost curve and lower the

long-term annual rate of State expenditure growth at a time when public finances are severely constrained.

Additionally, the Implementation Plan discusses the elements of the waiver that will provide support for public hospitals and other safety net providers through the continuation of the Safety Net Care Pool. This is critical for the support of uncompensated care in public hospitals and the expansion of the Health Care Coverage Initiative. The Coverage Initiative provides a means of covering more uninsured, low income Californians in the near-term while providing for a seamless transition to expanded Medi-Cal coverage recently enacted by Federal law and scheduled to be implemented in 2014.

In many cases the beneficiaries in these target populations receive services under the terms of other existing waivers related to the delivery of a variety of specialized services. Unless specifically discussed, the implementation of this plan will not affect the status or the applicability of those existing waiver services.

The following sections provide more information on each of the four proposed programs as well as the Health Care Coverage Initiative and Hospital Financing, described above.

I. Seniors and Persons with Disabilities (SPD)

Background and Problem Statement

Seniors and Persons with Disabilities (SPDs) refer to those persons enrolled in Medi-Cal only (see Dual Eligible section on page 18 for a discussion of those beneficiaries with both Medicare and Medi-Cal coverage). SPDs represent a significant share of the total cost of the State's fee-for-service Medi-Cal program. The waiver's goals for Seniors and Persons with Disabilities include:

- a. Improve access and coordination of the most appropriate, cost effective care for SPDs; improve health outcomes and contain costs;
- b. Provide SPDs with a choice of organized systems of care through which to receive these services;
- c. Support and strengthen the local safety net and its integration into organized systems of care;
- d. Align financial incentives to support providers in delivering the most appropriate care and containing costs.

Key program elements include:

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

- achieving the long-term control of the growth in Medi-Cal costs while improving care provided to these medically involved beneficiaries.
- b) Target population is Medicaid-Only beneficiaries. The waiver will serve a target population of approximately 380,000 Medi-Cal SPDs who are not enrolled in Medicare or who do not have an unmet share of cost or other health coverage. It includes those beneficiaries who reside in the 14 counties where managed care exists and enrollment of SPDs is not currently mandatory. This population accounts for \$7.5 billion in Medicaid expenditures annually, including DHCS and other department spending. Attachment 1 provides 2007-08 enrollment of this SPD population by county.
 - c) Require mandatory enrollment. The waiver will require all seniors and persons with disabilities to enroll in an organized system of care as authorized by ABx4 6 (Statutes of 2009).
 - d) Utilize organized delivery system models. The state will begin implementation in the first year of the five-year waiver by enrolling SPDs into existing managed care plans upon approval of the waiver. This approach builds on the state's existing infrastructure of managed care plans that has been developed over the past 20 years. It will require existing managed care plans to demonstrate compliance with new SPD-specific standards developed by the state and in consultation with stakeholder partners.
 - e) County Alternative Option. In addition to enrollment in existing managed care plans, counties will have the option to establish an additional organized system of care that reflects and meets unique local needs and circumstances. This additional choice could be offered along with existing plans as an additional option for SPDs who are required to enroll in organized systems of care, per ABx4 6.
 - f) Incorporate essential elements of organized delivery systems. The entities providing services to SPDs will be required to meet more specific standards related to care management and performance measurement. Organized systems of care for SPDs will provide:
 - i. Medical home provider. A beneficiary will choose a single provider or clinic to serve as the medical home provider who will be responsible for providing and coordinating care.
 - ii. Care management and member supports. Care management activities will be a central feature of this system. Predictive modeling and risk-stratification techniques will be used to identify enrollees' needs to be able to provide the level of care management appropriate for their needs. High-needs enrollees will receive the most extensive set of services. Care management services include disease and medication management and community-based care coordination including coordination of referrals and linkages to community resources. In addition, all SPD beneficiaries will have access to member

support services that will provide program information, enrollment choices, and medical advice.

- iii. **Integrated Benefits.** Enrolling SPDs in organized delivery systems offers the opportunity to coordinate more effectively the full range of home and community-based services including home health services, In-Home Supportive Services (IHSS) and other services. It will also permit the inclusion of these services within a plan’s scope of services.
- g) **Monitoring system performance and outcomes.** Organized delivery systems will be accountable for provider performance and health outcomes within their systems. These entities will be responsible for collecting and using performance and outcome data to drive changes in care delivery as necessary to ensure that beneficiaries are receiving high quality care that improves health outcomes. These entities will be required to share performance and outcome data with DHCS.
- h) **Integrate local safety net providers into organized care delivery models.** The transition of SPDs to more organized delivery of care must be done in a way that preserves the ability of safety net providers to continue to perform the important role they play in delivering care to this population and to other low-income Californians.
- i) **Expected benefits.** The use of organized systems of care will increase accountability, strengthen the health care safety net, reward health care quality and improve health outcomes, and slow the long-term expenditure growth rate of Medi-Cal. SPDs will achieve better health outcomes and better quality of care by receiving the most cost effective, coordinated care. These changes will achieve a reduction in emergency room, inpatient, and pharmacy utilization for the SPD population leading to a significant reduction in costs over the life of the waiver.

Approaches to Implementation

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

1. *Mandatory expansion of the SPD population offering the choice of enrollment into an existing managed care plan.*

In this model, Medicaid managed care plans may apply to amend their existing contract with the DHCS in order to enroll Seniors and Persons with Disabilities subject to the key elements and performance measures described in “*Key Performance Standards for Plans Enrolling SPD Populations*”.

2. *Mandatory expansion of the SPD population offering the choice of enrollment into existing managed care plans or a “County Alternative Option”*

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

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

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

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

Key Performance Standards for Plans Enrolling SPD Populations

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

1. Access

- a) Network Adequacy – DHCS, working closely with the Department of Managed Health Care (DMHC), will determine SPD enrollment capacity based on the provider networks available in managed care plans and on any updated information related to expansions of capacity. Network adequacy for the enrollment of SPDs will require sufficient specialists necessary to care for the specialized needs of this population consistent with the Department of Managed Health Care and DHCS processes and any enhancements DHCS deems necessary to further support the care of the SPDs. Network adequacy will determine each model's SPD enrollment capacity and will be monitored quarterly to ensure enrollment does not exceed capacity.
- b) Access to Information – Current contracts require managed care plan communication with members be provided in ways that meet the cultural and language needs of the members. Additional plan instructions will be added to require the communication be made available in alternative formats or plain language to assure that all members have access to communications that take into account hearing, visual limitations, or other limitations.
- c) Physical Accessibility – DHCS will adopt an enhanced facility site review (FSR) tool that focuses on the access needs of people with disabilities and chronic conditions to be used by plans to assess the physical and non-physical accessibility of their network providers. The plan will make available to members and prospective enrollees the information from the assessment for each provider. The enhanced FSR tool will be implemented by the contracted Medi-Cal managed care health plans and county alternative option models and monitored by DHCS.

2. Transition

- a) Outreach and Education – DHCS will conduct outreach and education activities that provide eligible SPDs with information on Medi-Cal managed care, member choices and consumer protections. DHCS will provide prospective enrollees with enrollment materials at least 60 days prior to the date when beneficiaries are expected to make a choice among available models. DHCS will continue to require advanced review and approval of plan-specific marketing materials.
- b) Phased-In Transition – A coordinated, phased-in transition over the course of 12 months with staggered enrollment will ensure adequate support for these beneficiaries. New Medi-Cal eligibles will be required to enroll into a managed care organization at the time eligibility is determined. However, the transition of existing Medi-Cal SPD members will be phased in over a 12-month period with enrollment occurring concurrent with the member's annual redetermination. Rollout on a geographic basis may be appropriate in larger counties. In addition, DHCS, in coordination with DMHC, will monitor plan network adequacy to ensure SPD enrollment is limited or shifted to other plans should network adequacy be insufficient to properly support the needs of this additional expansion.

- c) Access to Existing Providers – Members will have the opportunity to select a plan that includes their preferred providers in the network. DHCS will require plans to allow new plan members under active treatment with an out-of-network provider to continue with the existing out-of-network provider for a period of up to 60 days. However, medical exemptions are available to Medi-Cal beneficiaries that have been assigned to managed care plans and are already under treatment for a complex medical condition or pregnancy by a FFS-Only provider until the medical condition stabilizes.
- d) Assignment. Beneficiaries who do not make a plan choice, and for whom utilization data is available to DHCS, will be assigned to plans where there is a match between the plan’s network and providers from whom the beneficiary has received treatment. In cases where SPD beneficiaries have high health care needs, as indicated by the number of active providers and intensity of services and do not choose a plan or alternative option during the required time period, DHCS will assign these members to the plan or alternative option that can provide the greatest continuity of care for the member. The assigned plan or alternative option will be required to reimburse out of plan care at prevailing Medi-Cal rates until the member is assessed and a care plan is established that meets the member’s health care needs including access to needed specialty care.

3. Care Management and Coordination

- a) Enhanced Definitions of Care Management and Coordination – Contract language will include added specificity regarding care management and coordination requirements. Enhancements to the definitions of care management and coordination include the assessments of need for care management; use of qualified care managers with experience in meeting the needs of people with disabilities and chronic conditions; and development of care management plan in collaboration with the PCP and the member and their representatives. Requirements will address the timing of identification and assessment of member needs, the linkages between plans or alternative options and community services, consideration of co-morbidities, and improved coordination for carved-out services. DHCS will issue a policy letter for the enhanced definitions in October 2010.
- b) Early Identification of a Member’s Health Care Needs – In addition to the DHCS efforts for a member self-assessment at time of enrollment, DHCS will develop information about health status and treatment history based on member-specific FFS utilization data so that, after a beneficiary is enrolled, the enrolling organization can identify those who may require early initiation of assessment and care planning. This process will also serve to safeguard the needs of the most at-risk SPD members as described in “Transition 2c” above.
- c) Care Management Assessment – Based on information from the initial assessment, the plan or county alternative option may be required to develop a formal care plan

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

- d) Cultural Competency Training – Plans, county alternative options and providers must be trained in cultural competency and sensitivity to better serve the SPD and chronically ill population. DHCS has begun to develop a statewide education strategy to train health plans which will allow for plans to train their network providers in order to better provide culturally competent and sensitive care when serving individuals living with disabilities.
- e) Behavioral Health Coordination – DHCS will require its contracted delivery models to ensure coordination for the behavioral health needs of the SPD members and, when appropriate, make coordination with behavioral health services a specific component of the member’s overall care management plan. This issue is discussed in much greater detail later in this plan.
- f) Coordination of Other Services – All delivery models will be required to provide specific protocols and strategies to demonstrate that care provided by the plan is coordinated with other services that a beneficiary receives from other delivery systems such as services provided those through regional centers, in-home supportive services, and other community-based services. This includes the designation of a liaison with regional centers to assist in the coordination of care for persons with developmental disabilities.

4. Performance Monitoring and Improvement

- a) Expand Required Performance Measures – DHCS will develop and publish results for existing and additional performance measures in ways that provide quality indicators not only for each plan’s entire Medi-Cal managed care population, but also specifically for each plan’s enrolled SPDs. This may include both appropriate existing HEDIS measures and other department-developed performance measures. DHCS will expand current annual utilization data submitted by plans for emergency room use, inpatient and outpatient care, and prescription drugs to present results not only for each plan’s entire Medi-Cal managed care population shown in standard age bands, but also specifically for SPDs or other eligibility categories. In developing new performance measures and expanding reporting of performance measures and utilization data, DHCS will develop technical specification, sample sizes, audit procedures, and reporting methodology. Initial results of new and expanded performance measures and initial reporting of expanded utilization data will begin in the year after SPDs have been enrolled in the delivery models for at least 12 months.

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

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

- c) New HEDIS measures – DHCS will adopt and report on new HEDIS measures that provide qualitative assessments that reflect the specific conditions relevant to the SPD population. DHCS will also expand reporting of results on existing HEDIS measures to include results specifically for SPDs and will adopt and report on new HEDIS measures that provide quality indicators not only for each plan’s entire Medi-Cal managed care population, but also reflect the specific care needs of the SPD population. DHCS plans to begin work with its External Quality Review Organization by January 2011, select measures by August 2011, so a first report can be issued August 2012.
- d) SPD Representation – DHCS already requires plans’ advisory committees to include members who represent the needs of the SPD population so they can participate in establishing public policy for these populations. DHCS will provide additional oversight through review of meeting agenda and participants.
- e) Enhanced Member Satisfaction Survey – DHCS will enhance the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to specifically reflect concerns of SPDs. DHCS will continue to make the survey results available to plans, members, and other stakeholders.
- f) Quality Improvement Projects (QIPs) – DHCS currently requires plans to undertake quality improvement projects to improve the quality of their services. DHCS will require all delivery models to design quality improvement projects to include interventions relevant to seniors and persons with disabilities and chronic conditions and to report re-measurement results for these segments of the population.
- g) Complaint and Grievance Procedures – DHCS will continue to provide beneficiaries with accessible methods to support the submission and resolution of member

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

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

Development of County Alternative Option

In some managed care counties, the county and local stakeholders may want to further build on the existing managed care infrastructure and offer SPDs the choice to enroll in an alternative organized system of care in addition to existing managed care plans. This alternative would provide SPDs with an additional choice and provide the county with the opportunity to tailor the organized delivery system to meet the unique needs of its beneficiaries or safety net provider system. The county alternative will be developed while the state prepares to establish mandatory enrollment so that an alternative can be offered as soon as mandatory enrollment in organized delivery systems begins in each county. County-based development of organized systems of care has been a key approach in the past in expanding the reach of managed care in Medi-Cal, the development of coverage initiatives under the current 1115 waiver, and the development of other coverage expansions such as children's coverage for populations not eligible for Medi-Cal and Healthy Families. Each county will only be allowed to develop one alternative.

Counties that pursue a County Alternative Option will be expected to propose organizational approaches that reflect and meet the unique local needs and circumstances. This additional choice will be offered along with existing plans as an additional option for SPDs who are required to enroll in organized systems of care. A County Alternative Option will contract directly with the state.

The County Alternative Option will meet the requirements for serving SPDs and the chronically ill as applicable to Medicaid managed care plans related to physical accessibility, access to information, network adequacy, care coordination, continuity of care, and performance measurement. It is expected that the alternative option will include financial arrangements in

which the responsible organization will be paid through mechanisms that provide more global payments for the care of its enrollees so that there is a component of risk sharing between the state and the alternative option.

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

Timeline of Key Milestones

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

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

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

June, 2010 – Initiate capacity assessments of plans.

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

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

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

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

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

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

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

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

November, 2010 – Interested counties must respond to the RFA. The RFA must describe in detail the alternative option structure that includes a description of the network to be developed, provider and services capacity, use of the safety-net, coordination of services/carve-outs, utilization data gathering protocols, etc. In addition, the RFA must be accompanied by statements of local support including one from the County Board of Supervisors.

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

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

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

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

Framework for Evaluation

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

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

II. Children with Special Health Care Needs (CSHCNs)

Background and Problem Statement

Children with Special Health Care Needs (CSHCN) who are served by California Children's Services (CCS) program receive medical services through the program for the treatment only of their CCS eligible medical condition. CCS annually serves 175,000 to 200,000 children, 75% of whom are Medi-Cal beneficiaries. The expenditures for this latter population's medical services were \$1.7 billion during FY 2008-09.

The CCS program is designed for CSHCNs who have complex, chronic and often disabling medical conditions, such as cancer, diabetes, cystic fibrosis, cerebral palsy, congenital anomalies and conditions secondary to premature birth. The program has developed quality standards for pediatric specialty care and standards for approval of individual providers and facilities for participation in the program. Since the 1960s the CCS program has supported the concept of Special Care Centers (SCCs), multi-specialty, multi-disciplinary teams providing care to children with a defined set of medical conditions. These centers, located at tertiary medical centers, provide staffing and services according to program standards.

Financial eligibility for the program limits participation in the program to children enrolled in Medi-Cal or Healthy Families Program (HFP), California's State Children's Health Insurance Program (SCHIP), or whose families have annual incomes of less than \$40,000. Sixty percent of the CCS-enrolled children currently receive Medi-Cal services through Medi-Cal managed care plans ("health plans"), in areas of the state where there is Medi-Cal managed care. The treatment of CCS-eligible conditions is carved out of the health plan's contractual responsibility. Exceptions to the managed care carve-out are the three county-organized health systems (COHS) operating in five counties that assume the fiscal role of the state, and that are at risk for the cost of treatment for CCS-eligible conditions. In counties with COHS, the county CCS program continues to perform its role of eligibility determination and service authorization. The remaining 40 percent of Medi-Cal children enrolled in the CCS Program receive care through the fee-for-service (FFS) payment system.

Children enrolled in HFP and identified by their managed care plans as potentially having a CCS-eligible condition are referred to the local CCS program to determine medical eligibility. If the local CCS program determines the child eligible for CCS, services to treat the CCS condition are generally authorized and provided by the CCS program and its paneled providers. HFP managed care plans are responsible for providing, and paying for, all other medical care the child needs that is unrelated to the CCS condition. This segregated approach makes coordination of care complicated and limits the ability of the managed care plan and the child's CCS providers to have a comprehensive understanding of the child's total health care needs.

Children enrolled as CCS-only (those not enrolled in either Medi-Cal or HFP) receive only the services required for the treatment of CCS-eligible conditions and receive these services on a FFS basis. These children may or may not have other health coverage that pays for some of their

CCS services and/or other medically necessary services not related to their CCS-eligible condition.

The CCS Program currently uses a FFS payment structure administered through the Department's Fiscal Intermediary. This financing structure limits opportunities to incentivize providers to use lower-cost settings of care, when appropriate for the child. The teams at Special Care Centers are able to bill, on a fee-for-service basis, for team meetings and for assessments of children and their families by physicians, clinical nurse specialists, nutritionists and social workers, in addition to medical services.

The CCS-carve out, where coverage for CCS-related conditions is provided separately from a child's other medical care needs, has been identified by an array of stakeholders including families, county staff, providers and DHCS and HFP staff, as a barrier to effective coordination of care and may detract from children's health outcomes. The current CCS Program creates structural barriers and financial disincentives to providing "the right care at the right time in the right place." Parents and providers have noted that the CCS Program should serve the "whole child" and that segregating care for the CCS condition from a child's total health care needs perpetuates fragmentation. Stakeholders further note that a lack of coordination between CCS providers and other providers in contracted health plans (or within the FFS payment system) delays or potentially prevents the delivery of patient-centered care.

Implementation Options

The waiver offers an opportunity to test several delivery models that would promote one of the principal elements of the waiver, establishing organized delivery systems that serve the 'whole child' and improve care while simultaneously working to contain the growth of costs for the population of children receiving services from the CCS program. The four potential models that provide a more unified approach are as follows.

- *Enhanced Primary Care Case Management (EPCCM)*
In this alternative, CCS clients would be enrolled in an EPCCM, in lieu of the existing managed care plans where they exist. This model will test the ability to provide all aspects of care for the CCS eligible population in a FFS environment that is enhanced with many of the elements of managed care. The EPCCM entity would be responsible for implementing a medical home model in which each child and family would designate a personal physician who would be responsible, with EPCCM support, for functioning as an enhanced medical home in coordinating all of the child's health care needs. The EPCCM contracting entity would be responsible for outreach and assessment; the development of the provider network and reimbursement of the providers; and quality monitoring and improvement activities. The entity would receive a per member per month rate for providing all of the health care services. The target population for this model would be CCS-eligible children with chronic medical conditions anticipated to last more than twelve months.
- *Provider-Based Accountable Care Organization (ACO)*

An ACO would be developed as a local health care organization with a defined set of providers (e.g., primary care providers, specialists, hospitals, etc) associated with a defined population of patients that would be accountable for the quality and the cost of care delivered to the population. The core of this organization would be comprised of designated CCS tertiary hospitals and their hospital-based Special Care Centers serving children with complex medical conditions. The ACO would be accountable for a designated scope of care for which they would receive a global payment. The ACO would assume some degree of financial risk, and therefore would have an interest in ensuring that services are provided in a cost-effective manner. The ACO would, for example, conduct enhanced outreach for preventive and primary care, increase the use of appropriate outpatient services and discharge planning. The target population would include a subset of the CCS population with specified chronic medical conditions whose needs are best met by hospital based SCCs. The ACO will test the ability for providers to deliver all services related to a chronic condition under a global payment system (e.g., Malignancies, Sickle cell disease, Cystic fibrosis, Cardiac conditions, and Spinal bifida).

- *Specialty Health Care Plan*

Under this model a managed care plan would be developed and designed specifically to provide the whole range of health care to enrolled CCS clients. These services would include primary and preventive care as well as the specialty care required for the treatment of the CCS-eligible medical condition. This model will test the ability to provide all aspects of care for the CCS eligible population in a specialty health care plan that is designed to serve special needs children. The specialty health care plan would not serve other Medi-Cal beneficiaries. The Department would develop contract performance standards and measures that are reportable and enforceable and specifically tailored to the CCS population with chronic medical conditions. Requirements would include specific clinical programs, specialized provider networks and family-centered care management strategies. The target population for this model would be all CCS-eligible children with chronic medical conditions anticipated to last more than twelve months.

- *Managed Health Care Plan*

In this model, the state would amend its current contract with an eligible Medi-Cal managed care plan to include financial responsibility for the provision of CCS covered services. The plan would be responsible for the management and coordination of all of the health care needs of a child with a CCS-eligible medical condition, improve the continuity of care, better align incentives and optimize health outcomes. There would be specific contract performance standards and measured that are tailored to the CCS population. The managed care health plan would be required to maintain the appropriate provider network specific to the needs of the CCS population and ensure that network providers are CCS approved providers. The target population for this model would be all CCS-eligible children. This model will test the ability to provide all aspects of care for the CCS eligible population in an existing Medi-Cal managed care plan.

Common Model Components

Across all of the proposed delivery models there would be similarities in program structures. In each of the models:

- Enrollment is mandatory for the Medi-Cal CCS beneficiaries. Participation by children who are the CCS only will be determined based on the design of the particular model. Participation by children in the Healthy Families Program will be coordinated with the Managed Risk Medical Insurance Board (MRMIB), the department that administers HFP.
- Covered services will be based on the current range of available benefits and services and overall cost for the each model would be set to be no more than current average spending levels.
- Care coordination is a required service. It should be noted that any of the models could be designed to take advantage of the experience of existing CCS program to provide care coordination.
- Network requirements will be established that include CCS paneled providers and maintenance of the current system of regionalized pediatric specialty and subspecialty services.
- Participation in a statewide quality improvement collaborative will be mandatory;
- Quality monitoring and improvement measures will be consistent across all models.
- A medical home is established that incorporates the following principles:
 - Each child has a personal physician;
 - The medical home takes responsibility for managing the full range of the child's care;
 - Care is coordinated across all of the elements of the health care system and the family and child's community, including other service delivery systems such as regional centers;
 - Data is collected and reported to support care management and quality reviews;
 - Care is accessible, including after-hours.

DHCS will retain oversight responsibilities which include contract management and monitoring. Contracts for each pilot will vary in scope based on the specific model but could include some or all of the following functions:

- Member outreach and education;
- Member services;
- Assignment of the medical home;
- Provider network development, maintenance and credentialing;
- Provider services, training and education;
- Family-centered care coordination services;
- Chronic care and disease management services;
- Medical and utilization management;
- Operation of a nurse advice phone line;
- Claims processing and payment;
- Quality improvement activities;
- Management information systems;
- Reporting.

It is anticipated that at least one site for each model would be considered. Additional sites would depend on the availability of resources to administer and evaluate the additional sites. Principal criteria for pilot selection include:

- Local infrastructure in place to support coordinated care of chronically ill children;
- Adequate provider capacity to appropriately care for the children;
- Local support;
- Capability of proposing organizations to establish the organizational foundation required to implement one of the four pilot models.

Project Timeline

Rollout of the pilots would be as follows:

June, 2010 – Publish a Request for Information to allow interested parties to express intent to apply to establish a pilot site.

August, 2010 – Receipt of proposals for a pilot sites.

November, 2010 – DHCS selection of proposed candidate pilot sites and initiation of negotiations to finalize agreements to implement the pilots.

January, 2012 – Initial implementation of pilots begins.

Framework for Evaluation

For purposes of evaluating the effect of the Waiver, the Department proposes to use an “intervention and comparison group” design to estimate the effects of the program as they relate to key research questions. The evaluation team selects an appropriate population in a location where pilots will not be operating to provide comparative statistics by which to judge the effects that are achieved by the pilots.

III. Persons with Behavioral Disorders and/or Substance Abuse Requiring Service Integration

Background and Problem Statement

A significant share of the seniors and persons with disabilities who will enroll in more organized care delivery systems have serious mental illness (SMI) or substance use (SU). This presents an important challenge to the goal of providing more effective care to these enrollees. The challenges are at least three-fold:

1. Many in this population also have significant co-occurring physical health disorders. Individuals living with SMI are dying 25 years earlier than the population without these problems.

2. Substance abuse is also more prevalent in the SMI population with a 30-50% prevalence overall. For example, nearly 60% of individuals with bipolar disorder and 52% of persons with schizophrenia have co-occurring substance use disorders and these individuals die at an even earlier average age.
3. Nearly 50% of Medicaid beneficiaries with chronic diseases and disabilities have a psychiatric condition. While suicide and injury account for a portion of the increased morbidity and mortality of this population, the majority (60%) of cases can be attributable to medical conditions, such as cardiovascular disease, diabetes, chronic respiratory problems (due in part to a much higher prevalence of smoking), neurological, and infectious conditions.

As a result, persons with serious medical illness and/or substance abuse, especially when coupled with one or more chronic medical conditions, constitute one of the costliest of all groups served by Medi-Cal with among the poorest medical outcomes. Medi-Cal only fee-for-service beneficiaries with serious mental illnesses and/or substance use represent approximately 10% of the total service population but nearly 40% of total Medi-Cal fee-for-service expenditures.

Within this population, there are many more emergency department visits, preventable hospitalizations (non-psychiatric) and outpatient urgent encounters with physicians. In one study done for DHCS, there was a 31.2 % increase in the odds of being hospitalized (non-psychiatric) in a given year for persons with SMI as compared to the general Medi-Cal population without a co-occurring behavioral health condition, which accounted for \$16 million in additional cost. The greater use of emergency room services and the more limited use of primary care behavioral health and medical services are especially pronounced for the African-American, Latino population and for women.

Under the current, fragmented Medi-Cal fee-for-service system, behavioral health providers have limited information about and access to medical provider's diagnoses and treatment plans for their clients, whether parents, children, seniors, or persons with disabilities. Similarly, medical providers either lack the expertise or the access to behavioral health experts to diagnose and manage persons with co-occurring chronic physical illnesses and serious mental health and/or substance use problems.

Implementation Options

For managed care plans and other organized systems to successfully care for all of their beneficiaries with behavioral health problems, it will require new approaches that can better address their needs. These include at a minimum promoting increased communication, information-sharing, and service integration between mental health, primary care, and substance use providers and organizations. This approach also recognizes the importance of the client in the determination of treatment and in the management of his or her health issues.

Efforts to develop more integrated care will proceed along two separate tracks. First, organized delivery systems within the state will be required develop specific strategies to help to coordinate the care they provide with the services their beneficiaries receive through the mental health or the substance abuse treatment systems. This work will be guided by the approaches that have

been developed through the stakeholder discussions and will draw from the key elements identified above. This track will include the development of specific contract requirements to develop the delivery system's approach to care integration.

Second, DHCS will continue to explore opportunities to develop more integrated delivery models that promote care integration by creating organizations that have overall responsibility for treating the full spectrum of health care needs of its clients, including both physical and behavioral needs. The Project Timeline below lays out critical milestones for this second track.

Common Model Components

Several models already exist around the country which demonstrate the efficacy of an enhanced approach to behavioral health integration. Key components of these programs include:

- Implementation of a person-centered healthcare home;
- Client engagement and continuation of meaningful client involvement as an integral part of the client-centered collaboration;
- Implementation of joint treatment plans, contributed to by all service providers, in collaboration with the individual and his/her family and other supports (shared decision-making);
- Development of clinical information systems, i.e. registries, with robust health information exchange capabilities, customized inquiries and embedded clinical evidence-based guidelines, and client-access capabilities;
- Emphasis on care management of beneficiaries with complex health care needs;
- Development and use of appropriate multidisciplinary teams, emphasizing collaborative relationships between different provider groups/cultures. Case managers, behavioral health consultants, peers as providers, client services navigators, pharmacists as medication therapy managers are all part of the workforce necessary.
- Payment reform or flexible financing arrangements to align incentives, reward improved performance and establish sustainable healthcare improvement activities;
- Performance measurement and evaluation, including quality of life measures and client informed outcome measures;
- Training to improve skills of providers in each system of care so that partners in the collaborative care system can be more effective in providing care to persons with behavioral health and primary care issues;
- Recognition of the importance of provision of social supports and family/significant other involvement in treatment;
- Efforts to reduce disparities in the delivery of services.

Project Timeline

August, 2010 – DHCS will continue to develop integrated organizational models.

January, 2011 – DHCS will release a request for application for proposals that would promote integration of physical and behavioral health services for the enrollees in organized system of

care, either in Medi-Cal or the Coverage Initiative. The request will provide guidance regarding the features and requirements for the proposed pilots.

March, 2011 – DCHS will review pilot proposals and initiate more formal discussions with proposers.

May, 2011 – DHCS will negotiate contracts to establish a limited number of pilot sites.

January, 2012 – Initial implementation of the pilot sites will begin.

Framework for Evaluation

The success of efforts by organized systems of care to provider better integrate services will require both a review of the specific measures taken and the impact those measures have on the enrolled populations. DHCS will seek support for an evaluation of these efforts.

The evaluation of more organized integration models will depend on the nature and scope of the models tested and will be developed in conjunction with the design and implementation of those models.

IV. Persons with Dual Medi-Cal and Medicare Eligibility

Background and Problem Statement

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

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

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

Implementation Objectives and Options

California seeks to develop an integrated care model option for duals that:

- Creates one point of accountability for the delivery, coordination, and management of health care and long-term supports and services;
- Promotes and measures improvements in health outcomes;
- maintains appropriate consumer involvement and safeguards;
- Uses performance incentives to encourage providers to improve coordination of care;
- Promotes the use of home and community based long term care services;
- Blends and aligns Medicare and Medicaid services and financing to streamline care, and through shared savings approaches, eliminates cost shifting;
- Slows the rate of cost growth in both Medicare and Medicaid.

California is considering several possible models to better care for the dually eligible population including contracts with Special Needs Plans; expansion of PACE sites; establishing shared savings arrangements; or establishing the authority to act as an integrated care entity. The state proposes to develop an approach that would provide the ability to capitalize on its existing and emerging delivery system infrastructure in various regions of the state.

Common Model Components

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

- Strong patient-centered care based in accountable primary care homes;
- Multi-disciplinary care teams that coordinate the full range of medical, behavioral and supportive service needs;
- Comprehensive provider network capable of meeting that full range of needs;
- Robust data sharing and information systems to promote care coordination;
- Strong home and community based service (HCBS) options, including personal care services, that are better integrated into the organized delivery model;

- Greater flexibility for providers to integrate behavioral health services through a single integrated funding stream;
- Strong consumer protections that assure access to longstanding providers and involve consumers in program design;
- Financial alignment that enables better integration of care.

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

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

By incorporating the components listed above, California can create an integrated system of coordinated care for those receiving publicly financed care who can benefit most. Medi-Cal is both positioned and prepared to: (1) establish the proper beneficiary safeguards and quality/performance standards; and (2) fulfill its obligation as administrator of the integrated system to actively monitor and enforce them.

Project Timeline

The State is in the process of evaluating a spectrum of options that improve the integration of services to this highly vulnerable population while reducing overall costs and providing care across the complete medical and social services spectrum. Based on the goals described above, a set of options will be developed for further evaluation, refinement, and selection:

- Testing implementation of dual integration proposal in the context of County Organized Health Systems or other Medi-Cal managed care plans to take advantage of opportunities presented by these entities that operate both Medi-Cal managed care plans and Medicare special needs plans;
- Continued consultation with stakeholders and CMS regarding how to develop an integrated funding approach;
- Additional discussions with stakeholders on the considerations required to implement the proposed options;
- Development of a strategy for expanding beyond the initial sites

Framework for Evaluation

DHCS will seek support for an evaluation of the initial county proposals by assessing outcomes for enrollees compared to similar beneficiaries enrolled in plans in other counties. Additional evaluation efforts will depend on the nature and scope of the models tested and will be developed in conjunction with the design and implementation of those models.

V. Health Care Coverage Initiative (HCCI)

Coverage Expansion Under National Health Care Reform

With the recent passage of the Patient Protection and Affordable Care Services Act, P.L. 111-148, as amended by the Health Care and Reconciliation Act, P.L. 111-152, California has much to do to prepare for the significant changes that health care reform will bring. A key objective of this demonstration waiver is to help to lay the groundwork for successful implementation of these changes. To that end California proposes to build on its successful Health Care Coverage Initiative and at the same time take advantage of the key coverage expansion components of these laws. The HCCI was created under the current section 1115 Demonstration Waiver to provide coverage to medically indigent adults who are not otherwise eligible for Medi-Cal. The HCCI currently operates in ten counties,¹ and California proposes to expand this successful pilot state-wide. The current HCCI offers coverage and organized care delivery to a share of the population that will become eligible for Medi-Cal in 2014.

Under the proposed expansion of HCCI, health coverage will be provided to uninsured parents and childless adults up to 200 percent of the federal poverty level (FPL), primarily through county-based designated provider groups, in all counties where such groups exist or can be established. Coverage will be expanded to these groups to the extent that county funding is available to fund the coverage expansion.

Coverage will over time align the eligibility, benefits, cost sharing, and immigration status rules for this newly covered population with those required under guidance from the Centers for Medicare & Medicaid Services for implementation of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010. California will use this opportunity to expand coverage now to a substantial share of this new group of eligibles in order to identify and enroll these beneficiaries in a transitional coverage system prior to January 2014. This will lead to seamless enrollment into the mandatory Medi-Cal coverage that will be required for the individuals in this group with incomes less than 133 percent of the FPL and the transitioning of those from 133% to 200% of FPL into the new state-wide exchange or directly into a health plan.

¹ Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, Ventura Counties

HCCI Coverage Groups

Under the proposed HCCI expansion, to the extent that county funding is available, state-wide coverage would be extended to currently uncovered adults ages 19-64 who are either childless or parents of adult children, are not otherwise eligible for Medi-Cal and/or Medicare or the Supplemental Security Income programs, and whose incomes are below 200% of the FPL. These coverage groups align with the current HCCI programs in ten counties.

The HCCI program would continue in the existing ten counties and expand state-wide effective September 1, 2010 through December 31, 2013, when the program enrollees would transition to either Medi-Cal managed care or into a subsidized state-wide health exchange of private plans.

HCCI Program Standards

Multiple features of the state's planned HCCI program will make for a smooth transition into the Medi-Cal expansions in 2014 and subsidized exchange approaches for adults up to 200% of the FPL. In advance of 2014, the programs in all counties will have standardized elements that will facilitate this transition to 2014. Specifically:

- There will be a streamlined and standardized enrollment and eligibility determination system that does not include an asset test and is consistent with the state's Medi-Cal simplified eligibility process. This system will interface cleanly with the Medi-Cal program as well as other health coverage and social services programs managed by the state and counties. This system must be positioned to use internet-based systems for documentation and verification processes required to perform screening for Medi-Cal and health care exchange programs. It must also include direct access to federal systems to match social security numbers for the purposes of implementing federal immigration rules.
- The benefits package will, over time, be standardized and will align with a benchmark plan and will include primary and preventive services, acute care services, mental health and substance abuse services, and pharmacy services, provided through a coordinated care delivery system. The transition to a benchmark plan may vary by county with some counties being able to achieve a benchmark plan immediately and other counties being able to transition to a benchmark plan in advance of 2014. The prior authorization for medical services and cost sharing requirements for the individual counties may vary.
- Medical homes will be assigned to targeted enrollees to ensure that they receive the necessary medical benefits available through a coordinated care delivery system. The case management services provided through a medical home will be targeted to those enrollees who are frequent users of public inpatient hospital services and/or have been diagnosed with chronic medical conditions. The basic structure and services provided by the medical home will mirror the delivery system model for seniors and persons with disabilities in Medi-Cal managed care plans described earlier in this plan.

- Provider networks and delivery systems must include participation of public and private providers in order to meet the capacity required for the health care expansion to the new eligibility group. The growth of the required delivery system must be phased in during the first four years of the new Demonstration to ensure that the provider network is sufficient for the transition of HCCI enrollees into Medi-Cal and other health care plans in January 2014.
- Outreach plans must be designed and implemented by current and expansion counties. These plans must address the need to reach public and private providers to form partnerships for designing a provider network to serve the expansion population. Additionally, these outreach plans must reach potential program enrollees. Taken together, the outreach to both providers and potential enrollees will ensure the maximum level of provider capacity and program enrollment in the program by January 2014. This will assure a seamless transition of providers and program enrollees into the Medi-Cal and exchange plans in January 2014.
- The counties must ensure that they have data systems with the capacity to provide required program data sets that will be used to evaluate the defined specific program performance standards and metrics.

HCCI Financing

Under the planned HCCI Expansion, all participating counties will incur the total cost for providing medical services and related administrative services for outreach, eligibility, enrollment, and information technology. The counties will certify these expenditures for federal funds reimbursement at the allowable FMAP or receive an actuarially sound rate.

We are proposing that federal reimbursement for coverage expansion to those individuals with incomes up to 133 percent of the FPL will be on an open-ended basis without impacting the amount of capped dollars under the Safety Net Care Pool that the state will request under the Demonstration renewal. This level of financing will continue until January 2014 when these beneficiaries will transition to the Medi-Cal program.

Federal reimbursement for coverage expansion to those individuals with income from 133 percent to 200 percent of the FPL will be under the Safety Net Care Pool. This level of financing will continue until January 2014 when federal financial support for these beneficiaries will be available for transition to an exchange or a health plan.

The counties will be reimbursed for their costs using an allocation methodology that is based on uninsured demographics, and age, population, and poverty census data. This data will be updated annually and the allocation amounts adjusted accordingly. The cost data will be reported by the counties using existing cost reporting methods approved by CMS for other cost-based reimbursement payment programs.

HCCI Timeline

September, 2010 – Secure CMS approval of the Special Terms and Conditions to the Section 1115 Demonstration.

January, 2011 – Release HCCI program implementation plan to all counties.

February, 2011 – Initiate expansion of enrollment in existing coverage initiatives.

July, 2011 – Initiate efforts in expansion counties, including outreach efforts, eligibility and enrollment systems, and provider networks and delivery systems.

September, 2011 – Begin enrollment of eligible individuals into the HCCI program newly participating counties.

VI. Hospital Financing

At the initiation of California's existing Section 1115(a) Medi-Cal Hospital/Uninsured Care Medicaid Demonstration, state legislation was enacted to provide the framework to implement certain provisions of the Demonstration (Chapter 560, Statutes of 2005, SB 1100). The Demonstration and the new law significantly changed how reimbursement is made to California's safety net hospitals for providing inpatient hospital care to Medi-Cal beneficiaries and to uninsured individuals. Prior to Federal approval of the Demonstration, reimbursement was made to California's safety net hospitals under the authority of a section 1915(b) waiver that authorized the Selective Provider Contracting Program (SPCP). Through the SPCP, the California Medical Assistance Commission (CMAC) negotiated per diem rates and determined supplemental payments for contracted hospitals that provide acute inpatient hospital care to Medi-Cal beneficiaries.

Under the Demonstration, the Department of Health Care Services (DHCS) reimburses approximately 144 hospitals in three categories of hospitals that are DSH-eligible: 23 Designated Public Hospitals (DPHs), 28 Non-Designated Public Hospitals (NDPHs), and 94 Private Hospitals.

Under the new waiver California proposes to retain the key features that support the financing of hospitals under the existing waiver and the implementing legislation. Designated public hospitals will continue to receive financing through the claiming of federal funds on the basis of certified public expenditures, both from regular federal matching funds and from federal Disproportionate Share Hospital funds. Private and non-designated public hospitals will continue to receive CMAC negotiated rates and supplemental payments and disproportionate share hospital replacement funds. However, over the life of the waiver, the state is still committed to working with the hospital industry to move private hospitals to a DRG like payment system that better aligns incentives.

California proposes to retain the Safety Net Care Pool as a source of funding for costs not otherwise matchable. These funds would be used to continue support for indigent care, both

through support of the Coverage Initiative and designated public hospitals, and for State General Fund relief. Additional funds above the historic levels in the pool will be requested to increase support for these existing purposes and to provide additional infrastructure investments required to prepare for the implementation of health care reform.

Attachment 1

**SPD Project Beneficiaries in Two-Plan and Geographic Managed Care Counties²
2007-08 Average Monthly Enrollment**

County	Plan Structure	SPD Beneficiaries
Alameda	Two-Plan	21,424
Contra Costa	Two-Plan	10,237
Fresno	Two-Plan	14,354
Kern	Two-Plan	12,168
Los Angeles	Two-Plan	158,994
Riverside	Two-Plan	21,019
Sacramento	GMC	23,120
San Bernardino	Two-Plan	28,955
San Diego	GMC	30,376
San Francisco	Two-Plan	16,214
San Joaquin	Two-Plan	11,864
Santa Clara	Two-Plan	16,162
Stanislaus	Two-Plan	8,355
Tulare	Two-Plan	6,566
		379,808

² Note: County-Organized Health System counties are excluded because Medi-Cal coverage for Seniors and Persons with Disabilities is already mandatory in these counties.