SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
Webinar: "California's Bridge to Reform: Our 1115 Demonstration Waiver"
Thursday, November 4, 2010
1:00 PM – 2:00 PM

The Webinar began at 1:00 PM.

Participation

343 individuals participated in the webinar.

Introduction

Bobbie Wunsch, Pacific Health Consulting Group, introduced the webinar structure and participants: Secretary of Health and Human Services S. Kim Belshé, Director of Department of Health Care Services David Maxwell-Jolly, and Medi-Cal Director Toby Douglas.

The goal of the webinar is to outline the key components of the 1115 Waiver, and the work to be done to begin the implementation process. Questions will be taken via webinar, although there will not be time to answer all questions. A recording of the webinar and a written summary will be posted the week of November 8.

The next Stakeholder Advisory Committee (SAC) meeting will be on December 8 at 9:30 AM at the Sacramento Convention Center.

Secretary Belshé said that the waiver renewal has been a multi-year effort, premised on the belief that renewal of the hospital finance waiver presented an opportunity to "think big" in terms of moving beyond hospitals and the ten existing County Initiatives to expanding the Safety Net Care Pool (SNCP), insuring adults, developing care coordination models, and supporting infrastructure changes in order to transform public hospitals. The waiver reflects the belief that California can use the waiver to maximize the transition to federal Health Care Reform. This has not been an easy undertaking, but rather a transformative effort that has involved the Governor the legislature, the SAC and technical workgroups, counties, philanthropic partners (Blue Shield of California Foundation, California HealthCare Foundation, Lucile Packard Foundation for Children's Health, SCAN Foundation, and The California Endowment), and many other stakeholders. The shared commitment to problem-solving has led to the nation's largest-ever Medicaid waiver.

In particular, DHCS colleagues, including David Maxwell-Jolly, Toby Douglas, and their teams, through their leadership, commitment to partnership, and focus on outcomes,

have put together an approach that significantly improves access and quality of care for low-income populations and paves the way to 2014. The waiver represents a big win for medically indigent adults and for the safety net, and now it is time to look toward the implementation challenges, which will require work from all partners.

Key Elements

David Maxwell-Jolly, Director, Department of Health Care Services, echoed Secretary Belshé's acknowledgment of the work of stakeholders and others, and said that DHCS staff had learned a great deal from the SAC/TWG process, which has established a strong foundation for implementation. The agreement reflects a unified effort by the State of California to put forward a comprehensive plan with broad support from throughout the health and advocacy communities, and that DHCS is very pleased with the outcome.

He then outlined key elements of California's Section 1115 Waiver, which was approved on November 2, 2010, and is effective November 1, 2010 through October 31, 2015:

1. Expand coverage to more uninsured adults;
2. Help to preserve the safety net;
3. Improve care coordination for vulnerable populations; and
4. Promote public hospital delivery system transformation.

Expanded Coverage

- Establish the framework to implement Coverage Expansion and Enrollment Demonstration (CEED). CEED builds on the existing ten Coverage Initiatives (CIs); every county will be eligible to participate.
- Coverage for as many as 500,000 persons
- Require transition plan to prepare for enrollment in Medi-Cal in 2014. CMS will require the state to show that the transition will be smooth and that people don't fall through the cracks when coverage shifts to Medi-Cal.
- Funding to support expanded coverage through 2013
  - $2.3 billion for eligibles 0-133 FPL; not funded from Safety Net Care Pool; available on an open-ended basis and does not count toward budget neutrality calculation
  - $600 million for eligibles 133-200 FPL; funded from the Safety Net Care Pool; capped allotment
- Additional requirements: Because coverage for eligibles 0-133 FPL is based on the Affordable Care Act (ACA), there is a set of requirements that goes beyond what California originally proposed.

  - Benchmark-like benefits
  - Due process for eligibility and benefit access: Beneficiaries can appeal enrollment decisions as well as dispute access to benefits.
  - Network adequacy standards: Articulated in the Terms and Conditions, include the requirement that at least one FQHC be part of the network if available in the county.
  - Out of network hospital emergency care: CEED programs must pay for out-of-network emergency care. The Terms and Conditions are not specific about the *level* of reimbursement.
  - Prospective payment system rates required
  - Mental health and substance abuse parity rules will apply according to forthcoming Medicaid rules. CMS is in the process of formulating rules about how federal parity law affects health care delivery under Medicaid, and these rules will apply to 0-133 FPL beneficiaries in the CEEDs. Services can be provided through a separate delivery system.

Preserving the Safety Net

- $3.9 billion available over 5 years
- Continuation of existing Safety Net Care Pool structure based on certified public expenditures
- Covers uncompensated care costs in public hospitals
- Up to $400 million annually for designated state programs: California has traditionally used the SNCP to support some state programs, and this waiver expands that list to include additional workforce programs, services for developmentally disabled individuals, and all county mental health services.
- One additional provision: DHCS will be working with the counties to try to establish Medi-Cal eligibility for persons in state prisons or jails who leave for overnight stays in hospitals.

Better Coordinated Care

- Mandatory enrollment of Seniors and Persons with Disabilities
  - Require assessments of plan networks
  - Phased-in enrollment over 12 months beginning June 2011
  - Require risk assessments of new enrollees
  - Provides additional consumer protections, including readiness plans.
- Pilot programs for children with special health care needs
  - Terms and Conditions lay out the elements for CSHCN pilots per SB 208.

  - Proposals received in response to the RFP will be submitted to CMS for review: they want assurances of adequate service delivery, access to specialty care, and family centered care.
- No mention of dual-eligibles in the Terms and Conditions
  - CMS was interested in California's proposal, and is currently developing its own approach to dual-eligibles.
  - DHCS will report at SAC about its own ongoing duals planning, and on proposals that come from CMS
  - To the extent that California decides to try to do something different with duals, it would require a waiver amendment.

System Transformation

- Creates the Delivery System Reform Incentive Pool within the Safety Net Care Pool to support improvements in public hospital systems
- The federal government is very interested in how to improve the patient experience, quality of care, and outcomes, and control costs. These principles align with California Association of Public Hospitals' work on how to prepare for 2014.
- Reform projects fall in four categories
  - Infrastructure Development
  - Innovation and Redesign
  - Population-Focused Improvement
  - Urgent Improvement in Care
- $3.3 billion available over 5 years: Significant level of investment in making sure that the public hospital system will be able to provide care in the context of expanded coverage.

Budget Neutrality

- Overall, within the context of the waiver, $10 billion in federal matching funds will be available to the State.
- Expanded coverage for 0-133 FPL is not counted as part of budget neutrality under the waiver.
- All other parts – including SNCP expansion and incentive pool – have to be justified on cost neutrality basis.
- Sources of savings to support budget neutrality
  - Public hospital reimbursements below the applicable upper payment limit: not subject to change or recalculation.
  - Savings achieved by enrolling existing beneficiaries in managed care
  - Savings projected from additional managed care enrollments

Major Next Steps

- Develop more specific standards, measures and evaluation protocols for the Delivery System Reform Incentive Pool within 60 days. Incentive Pool payments are not linked to services – they will be provided outside a direct reimbursement system, related to milestones (and, later, outcomes) achieved in the context of plans proposed by hospitals.
- Initiate process for existing Coverage Initiative to transition to CEED projects
- Initiate process for new counties to become CEEDs
- Continuing work to prepare for enrollment of SPDs. Update on all the work on this project will be part of the December 8 SAC meeting.
- Preparation of RFP for the CCS pilots.

Summary

- Strong commitment from CMS to support our preparations for health reform: There was a strong convergence of views between the state and CMS. The Terms and Conditions require early thinking and planning our effort to implement health reform in a number of places which DHCS is happy to do because it's needed.
- Early enrollment of childless adults: This will help California prepare for 2014, and will mean broad-based coverage for hundreds of thousands of new beneficiaries.
- Better care for our most vulnerable beneficiaries
- Significant growth in our support for uncompensated care
- Innovative Incentive Pool to stimulate system transformation

David Maxwell-Jolly expressed again his gratitude for stakeholders' creativity and thoughtfulness, and emphasized that the speed and success of the agreement reflect California's unified position. He said he continued engagement will be essential the successful implementation.

<u>Questions</u>

Bobbie Wunsch, PHCG, noted that the 1115 Special Waiver Terms and Conditions and the CMS 1115 Waiver Approval Letter are available on the Wavier Renewal website (http://www.dhcs.ca.gov/provgovpart/pages/waiverrenewal.aspx).

Bobbie Wunsch then presented questions that were emailed via the webinar website.

CEED

- What is the timeline for CEED?

Toby Douglas, DHCS, said that the next step is for DHCS to work internally and with counties to begin to develop the timelines for transitioning the existing 10 counties and bringing on new ones. The Terms and Conditions lay out timelines by which certain information, including the income levels that counties will use and the processes for complying with cost-sharing and due process requirements, must be provided to CMS. DHCS will provide counties with guidance that will allow them to determine how quickly they can ramp up enrollment and how much funding they can draw down. DHCS' goal is to begin new county CEED programs quickly, without putting anything at risk. *David Maxwell-Jolly* added that existing County Initiatives will have continued access to funding during the transition.

- What are "benchmark-like services" in CEED particularly in the context of mental health and substance abuse?

David Maxwell-Jolly, DHCS, said that the benefits outlined in the waiver are the minimum mental health benefits that DHCS proposed in the waiver application. Counties are free to exceed these minimum benefits. The benefits articulated for beneficiaries at 0 – 133% FPL are found in the Terms and Conditions at page 27.

Toby Douglas, DHCS, added that the only variations from the federal rules are the mental health benefits (as laid out in the Terms and Conditions), and the lack of an EPSDT mandate for individuals ages 19-21. *David Maxwell-Jolly* clarified that the CEED benefit package is not a "benchmark plan" and does not set a precedent for 2014.

Safety Net Care Pool (SNCP)

- How will private safety-net hospitals benefit from the Safety Net Care Pool (SNCP)?

David Maxwell-Jolly said that private safety-net hospitals' success depends on public hospitals remaining intact and serving as key providers of a substantial portion of uncompensated care. Thus, the SNCP is important in that it preserves public hospitals.

In addition, the waiver provides a number of opportunities for private safety-net hospitals to benefit more directly, including from some of the system innovation funding. Specifics will depend on the particular plans put forward and on discussions regarding hospital finance overall along the terms laid out in SB 208. The state needs to revisit the overall hospital finance structure and determine the appropriate allocation of resources.

- Does the $3.9 billion over 5 years for SNCP referenced in Slide 9 include the Incentive Pool funding?

David Maxwell-Jolly replied that it does not – the $3.3 billion Incentive Pool funding is in addition to the $3.9 billion for SNCP.

Seniors and Persons with Disabilities (SPD)

- Within the context of SPDs and care coordination, what constitutes a "risk assessment" and who will provide it?

Tanya Hommann, DHCS, said that the Medi-Cal Managed Care Division (MMCD) is beginning to define the baseline for risk assessment. Both the Terms and Conditions and SB 208 require that a risk assessment tool be to identify SPD enrollees who need additional assistance. The state is prepared to transmit members' utilization data to plans in advance of enrollment, in order to allow plans to conduct risk stratification and assessments. MMCD is engaged in preliminary discussions with plans about what data to include in this process, and will be sharing its baselines with the Stakeholder Advisory Committee (SAC).

- Are residents of ICF/DDs included as part of the mandatory enrollment SPD group, and, if so, will institutional services be part of the capitation rate?

Toby Douglas, DHCS, said that to the extent that individuals are Medi-Cal only beneficiaries, and not dually eligible, they will be included in the mandatory enrollment group. Whether the institutional services are capitated varies from plan to plan. The majority of plans that Medi-Cal currently contracts with do not include Long-Term Care (LTC) beyond 60 days in their contracts, so individuals enrolled in those plans would continue to receive their LTC through ICF or skilled nursing facilities, all acute services through the plan.

- How are In-Home Supportive Services (IHSS) addressed in the waiver, particularly in the SPD context?

Toby Douglas, DHCS, said that many of the Terms and Conditions require care coordination and working with other home and community-based services (HCBS), including IHSS. IHSS will continue to be provided through Public Authorities, but plans will be required to coordinate with them.

Prison and Jail Population

- How specifically will state prison and county jail inmates' medical parole be included in the waiver? What specific standards are there and what is the timeline?

David Maxwell-Jolly, DHCS, said that the state is working to establish this protocol approach, which depends on the expanded coverage initiative programs (CEED) being in place in counties throughout the state. There are many details yet to be worked out, which DHCS will be addressing with Department of Corrections and county representatives. Enrollment for individuals between 0 and 133% FPL is a greater priority.

- How should county sheriffs get involved (question from the California Sheriffs' Association)?

David Maxwell-Jolly said that DHCS will work with the Sheriffs' Association on this issue.

Disproportionate Share Hospitals (DSH)

- How is the DSH program impacted by the new waiver?

Toby Douglas, DHCS, said that the waiver is just one of many pieces of the safety net hospital financing puzzle. DSH is outside the waiver, and is governed through the state plan and allowances under federal law that permit 175% DSH for public hospitals and additional supplemental payments for private hospitals. The waiver therefore has no direct impact on DSH; both are parts of a broader scheme to preserve and improve public and private safety-net hospitals in the state.

DRA Requirements

Toby Douglas, DHCS, said that county CEED programs will have to comply with the DRA both for the 0-133% FPL population and the population at higher income. This has been a barrier for some counties in implementing their County Initiative programs. The state has implemented electronic matching of MEDS and SSA data, which has simplified things dramatically. DHCS hopes to help counties with this issue potentially by moving CEED into the MEDS system (which would also simplify the transition to Medi-Cal in 2014).

County Match

- Will mental health and substance abuse services provided by counties be considered a match in the CEED programs?

David Maxwell-Jolly, DHCS, replied that the Terms and Conditions are clear that services provided by counties beyond the minimum for mental health can also qualify for federal matching funds.

Additional Questions

The following questions were submitted by webinar participants but were not discussed or answered due to time constraints:

Logistics

- What are the date and time for the next webinar?
- Can you make this PowerPoint available to call participants? (asked multiple times)
- Can you provide the web address for the waiver renewal website? (asked multiple times)
- How can we view CMS' Terms and Conditions?
- Which waiver is in effect during the period 9/1/10 - 10/31/10?

CEED

- Will Knox-Keene rules apply to CEED? Specifically, will enrollees be responsible for cost of out-of-plan care not reimbursed by CEED? Will reasonable person standard apply to definition of emergency services?
- How are you going to address an adequate network not only with primary care physicians but with specialists as well? You have the FQHC, but these clinics do not have specialists. In San Diego, it is becoming very challenging to obtain contracts at Medi-Cal rates.
- In the STC, it seems to indicate that no FFP will be available for counties that enroll new HCCI applicants at the exclusion of MCE applicants. Please clarify what this means.
- On page 10 of 116, it talks about payments to contracted hospitals. Please confirm that you mean hospitals contracted with counties. Would counties be made to pay the individual CMAC rate that has been negotiated for each individual hospital?
- Can you provide more information about PPS in general, and specifically, will PPS only be applicable for the 0-133% program under MCE?
- Some counties are saying that the cost of increased benefits (out of network care, for example) in the CEED program may make it much too expensive to actually expand coverage. Does the waiver also provide additional federal match for counties' existing MIA population without any expansion of coverage?
- What is the anticipated likelihood that counties will be able to fund the non-federal share necessary to draw down federal funds to offer expanded coverage for the 133-200% FPL category?
- When will it be required for county initiatives to change from a FFS rate to a PPS rate?
- What is the timeline for CMS development of requirements for CEED projects and

behavioral health services (mental health and substance abuse) parity?

- What is your CEED timeline--for determining requirements for counties, in issuing an RFP, and in awarding funding?
- You shared in the presentation that the soon to be released mental health parity requirements for Medicaid will apply to the MCE CEED (below 133% of FPL). However, no minimum benefit for substance abuse has been set for the CEED MCE. Given this, won't counties that participate at least have to offer a parity benefit for the MCE CEED?
- The Terms and Conditions lay out that it is possible for counties that want to offer more than the minimum core benefit to do so ("Option for Enhanced Services" with reference to mental health and substance use treatment), but this requires an additional proposal from counties. Can you tell us the timeline and process for this?

SPD

- How will this new waiver practically impact an adult with a disability who current utilizes Medi-Cal to receive their medical services?
- If you plan on enrolling individuals in HMOs, what do you propose for the north state (north of Sacramento), where there are no HMOs currently?
- What's going to happen to the patient who lives on their own? How are they going to get service? Are the managed care programs going to provide 24 hour nursing care in the home?

Safety Net Care Pool and Hospitals

- The pediatric safety net is provided primarily in children's hospitals which are regional medical centers. Increasingly, fewer and fewer public hospitals have any pediatric beds. There needs to be attention paid to supporting the pediatric safety net.
- Please comment on the safety net pool. How will the private, community no-for-profit hospitals benefit from the safety net pool? These hospitals provide for the safety net, especially for the pediatric population, who receive most of their care from the regional children's hospitals.
- How will district hospitals be impacted by the waiver?
- Please define 'public hospital.' Is a public hospital just the county-run hospital system?

- Can you describe any significant changes in Medi-Cal payment to NDPHs and private hospitals?
- Will District Hospitals be included in the Public Hospital Safety Net Pool?
- Will hospitals be able to fund coordination efforts with non-profits for case management services under these reforms?
- Are there specific dollar amounts associated with each of the four Delivery System Reform Incentive Pool initiatives? Are the public hospital proposals the only proposals you are currently considering in developing more specific standards, measures, and evaluation protocols?

Other Programs

- Will there be any impact on the AIDS Medi-Cal Waiver Program?
- How will existing AIDS waiver clients be impacted by this new waiver, i.e., will they be required to become part of a new HMO? What happens if there are no HMO's in our geographic area?
- How do some of the other community based waivers fit into this waiver? (E.g. DD waiver, MSSP waiver.) Programs under these waivers have a lot of experience, structures in implementing and managing many of the SPD individuals you are focusing on.
- Could you please let us know how this waiver will affect Medi-Cal patients receiving home health services?
- Is Adult Day Healthcare addressed?
- Could you please explain health home service delivery model addressed in #84 of CMS' Terms and Conditions?

- More people will have Medi-Cal because of this Waiver. Will those folks be able to apply for the HIPP program if they have (or obtain) Other Health Coverage? How many more HIPP enrollees do you expect?
- What will happen to programs such as EPSDT and CCS?
- Will the waiver move integrated long term care forward? If yes, which counties will serve as pilots and when will pilots begin?

Medi-Cal Rates

- Do you have a plan to increase compensation for physicians?
- Medi-Cal currently ranks 49th out of the 50 states for the worst level of

reimbursement for Medi-Cal. How will this be addressed so that Medi-Cal providers can actually be compensated for the true cost of providing care?

State Prison/Medical Parole

- How will the State prison inmate/medical parole population be included in this process? Will there be specific standards at a later time?
- For the prison/jail population, will there be additional funds available for all counties?

Other Issues

- Can you give more information about the health worker training funding that will be available?
- Is there an expectation that there will be an opportunity for implementation of four dual eligible demonstration projects at some point in the future?
- Could you please translate this in layman's terms as to how this affects people in the program?
- I did not see anything in Terms and Conditions in terms of simplification of Medi-Cal eligibility. Does DHCS have plans to simplify outside of the waiver?
- How will these expansions and changes affect fee-for-service delivery of care, both in terms of beneficiaries and providers?
- Regarding DRA requirements and the application of retroactive coverage for Demonstration beneficiaries, will those work exactly the same as they currently do for Medi-Cal in California? Are there any differences in the MCE and HCCI programs as to how DRA and retro will be applied?

<u>Conclusion</u>

Bobbie Wunsch, PHCG, thanked Secretary Kim Belshé, David Maxwell-Jolly, Toby Douglas, and DHCS staff for making the waiver information available via the webinar, and thanked participants.