

COMMENTS ON CALIFORNIA'S DRAFT WAIVER RENEWAL

Federal/State Shared Savings Initiative

We applaud California's efforts to move toward a shared savings arrangement with CMS to gain greater flexibility in program delivery. We also support the State seeking reconciliations on a frequent basis with the federal government to ensure that payments are aligned with the State's actual expenditures. This type of arrangement will showcase California as a leader nationally as discussions continue on how to reform Medicaid, provide states with greater flexibility, and curb growing expenditures.

The State should consider clarifying whether a federal match is still drawn down for covered services or if the capitation payment per beneficiary is inclusive of total payment. In addition, the State should clarify with CMS what types of conditions will be in place if the State wishes to make programmatic changes during the waiver. For Rhode Island's global waiver, the State was subjected to a rigorous and lengthy three-tiered oversight process if programmatic changes were made outside of the standard waiver terms and conditions.

Payment/Delivery Reform Incentive Payment Programs

We would recommend that as the State seeks to implement incentive programs for managed care plans and/or Medi-Cal providers to measure total cost of care and quality for beneficiaries, the State should ensure that metrics are clearly defined to ensure comparable comparisons and reliable data. This is particularly important if the State ties incentive payments to this data.

We also encourage the State to build off of existing quality metrics already in place to avoid undue burden on managed care plans and providers to collect and report additional data. As an alternative, the State should consider re-evaluating the host of measures currently required for monitoring and examine the potential to sunset certain measures that are no longer relevant or particularly effective. These efforts should include an evaluation of existing Medi-Cal measures and alignment to DSRIP metrics or vice versa.

Safety Net Payment Reforms That Support Coordinated and Cost Effective Care for the Remaining Uninsured

No comments.

FQHC Payment/Delivery Reform

We support the State's efforts to transform FQHC payment/delivery and focus on risk-based models and quality improvement as opposed to volume driven service delivery, particularly as a significant number of Medicaid beneficiaries are served by these safety net providers. To ensure that the State has the greatest amount of flexibility possible to transform the FQHC delivery and payment system in the future, we recommend that the State seek to waive PPS requirements and explore options to implement an Alternative Payment Methodology. This can be the first step towards the State working jointly with managed care plans, FQHCs, and the federal government

to explore innovative approaches for driving quality and infusing risk sharing into contracting arrangements.

Successor Delivery System Reform Incentive Payment program

The State has been at the forefront of designing delivery system reform incentive payment program reform (DSRIP), and its program is frequently referenced as a best in practice by other states. We believe there are opportunities to progress the California DSRIP program to improve its success in advancing payment reform across the delivery system.

We would recommend the State consider the following DSRIP program enhancements during its 1115 waiver renewal process.

- Consider expansion of the DSRIP program to other provider types whose patient panel is made up of a threshold percentage of the low-income/Medicaid or uninsured population.
- Create DSRIP incentives and/or requirements that encourage the regional collaboration of delivery system providers across the spectrum of specialties (e.g., hospitals, home health agencies, skilled nursing facilities, behavioral health providers, clinics/FQHCs, etc.) to increase the penetration of reform efforts across the delivery system. DSRIP action plans can be developed and submitted through this collaborative effort and funded accordingly.
- Develop program levers that provide the opportunity for hospitals and other participants to receive up-front funding to assist with the necessary investments to develop and implement DSRIP project plans. This can be done through a grant or application process to receive first round or planning funding at the beginning of the demonstration period and will allow the State an opportunity to review DSRIP project plans prior to implementation. We would encourage the State to allocate funding as a function of an evaluation process to determine project plans most likely to be successful and in alignment with the overarching goals of the DSRIP program.
- Succinctly define overarching DSRIP program goals and require all projects to have components specifically tied to the overall program goals with the same central framework. The broad framework will allow for all DSRIP projects to have the same general trajectory while maintaining some flexibility to customize projects based on regional or community needs. Additionally it is recommended the State develop a core set of measures tied to each overarching DSRIP program goal and mandate projects include core measures to measure performance.
- Develop DSRIP program incentives that increase Medicaid beneficiary volume to providers participating in DSRIP project plans. This has been achieved in other states by attribution of Medicaid beneficiaries to DSRIP participating providers and factoring Medicaid beneficiary volume as component of the DSRIP funding methodology.

California Children's Services (CCS) Program Improvements

We would encourage the State to create a single, statewide system for all CCS eligible children and competitively procure an experienced vendor that demonstrates capabilities with managing complex populations and risk. The State should consider delegating full risk for both Medi-Cal and non Medi-Cal eligible CCS beneficiaries to the procured vendor. For all Medi-Cal eligible children who currently qualify for CCS, we would encourage the State to mandate enrollment and allow the contractor to administer, coordinate, and manage the cost of the comprehensive set

of Medicaid State Plan and CCS covered services. This will remove the current incentives to shift costs between Medi-Cal and the CCS program and can also assist with comprehensive coordination of benefits between other non-publically funded health insurance programs. Additionally creating accountability at the State level will assist with addressing variability in program administration and streamline program efficiencies to create timely access to services at the county level. Thoughtful statewide system reform for the CCS program can build upon the current infrastructure and enhance program design that currently impedes performance.

Medicaid funded Shelter for Vulnerable Populations

We agree with the State's position to advance innovative program design to test the connection between housing stabilization and health care and make available Medicaid funding for coverage of housing. While CMS has set precedence with recent waiver authority decisions (Medicaid dollars are prohibited from being directly invested in housing infrastructures), we believe there are alternative approaches that can be explored by the State to increase funding through coverage opportunities and innovative partnerships with supportive housing providers. For example we would recommend the State evaluate offering room and board as a benefit in long-term services and supports waiver programs. Including room and board as a covered benefit coupled with innovative pilot programs that – for example – enhance the identification of precariously housed or homeless individuals and partnerships with landlords to secure continuous housing availability creates a consistent funding stream for housing for eligible individuals.

The State should encourage innovative Medi-Cal partnerships with supportive housing providers and landlords to incentivize engagement in the Medicaid health system through timely notification of changes in condition to facilitate early interventions and service alignment to support successful community placement. The State should also consider making available tools for assisting supportive housing providers with Medicaid certification and billing and receiving reimbursement for Medicaid covered services. This could be leveraged by managed care plans as well through incentive programs and/or partnerships with supportive housing providers that drive deeper engagement in the health care system. For all programs we would encourage the State to develop metrics to assess performance as well as contribute to the overall evidence that demonstrates the connection between housing and health and well-being which can be used to advance the policy agenda.

Workforce Development

We commend the State's approach to increasing the number of physicians that serve Medicaid beneficiaries, particularly in light of expansion. Regarding the State's proposal to offer malpractice insurance premium subsidies to providers who devote a significant portion of their practices to low income individuals, it is very possible that CMS may not provide federal matching funds for this type of program despite its ultimate goal of improving access.

As an alternative the State may want to consider the following:

- Proposing an alternative incentive program to CMS which might involve maintaining or increasing PCP bump payments (with federal match) to providers who increase the number of Medicaid beneficiaries they see, by a certain percentage, over a given period of time. This approach could help prove or disprove the theory that the bump payments from the federal government have an impact on access. In addition, using the bump

payments as leverage for increasing access would provide valuable data to CMS, and the State could serve as a formal testing ground for how access can be measurably improved through tweaks in PCP payments. This data was not previously collected as part of the Affordable Care Act (ACA) PCP bump.

- Use of physician extenders and/or health workers to more effectively and efficiently manage care. This would require a change to the Medicaid state plan to allow for the reimbursement of services and enable the State to draw down the federal match. This would assist with creating primary care service capacity within the system.

Finally, the State should evaluate options to leverage the ACA and the flexibility it grants FQHCs to establish residency programs for medical students. By taking advantage of this flexibility, the State can increase primary care provider access at safety net FQHC provider sites while providing valuable learning opportunities to medical students. It will also help these providers gain insight into serving Medicaid beneficiaries and other low income populations.

General Comments

We applaud the State's advancement of a variety of managed care strategies throughout California. In light of continued budget pressure in light of Medicaid spending – only exacerbated by the increase in Medicaid enrollment as a result of healthcare reform – we would encourage the State to further analyze the various models implemented to better understand performance. Experimenting with a variety of Medicaid systems has provided the State with a wealth of information to assess and inform future reform strategies. However it has also created a system with wide variability between county based systems and a range of managed care tactics that is likely limiting cost containment opportunities and system improvements. Creating system accountability at the state level, as opposed to the individual county level, using a single managed care model can produce program efficiencies, improved quality and cost savings. Additionally the State should consider reform opportunities that encourage competition in Medi-Cal. Identifying and removing barriers to market entry will help the State to attract experienced contractors that can bring new innovations in care delivery to beneficiaries. A competitive market place should be further supported by clearly defined accountability within health plan contracts that allows for performance measurement and appropriate incentive rewards (including removal from the market if performance is insufficient).

We would also encourage the State to consider additional evaluation and reform strategies that assist with reducing system fragmentation caused by separately administered programs – for example behavioral health and other complex populations (individuals with intellectual/developmentally disabilities) remain in fee-for-service and/or county based systems as opposed to a more comprehensive and integrated delivery model.