

DHCS Stakeholder Webinar
1115 Waiver Renewal
Concept Paper & Application
March 18, 2015



Agenda

Medi-Cal 2020: Concept Paper Walkthrough

- Overview & Goals
- 2010 Bridge to Reform
- Delivery System Transformation and Alignment Programs
- Public Safety Net System Global Payment for the Remaining Uninsured
- State-Federal Shared Savings and Reinvestment
- Budget Neutrality
- Evaluation

Next Steps

Q&A



Overview & Goals



Overview

California's 2010 Waiver was critical to successful implementation of ACA

This Waiver renewal is critical to ongoing success, viability, and long-term sustainable change of the Medi-Cal Program

CRITICAL COMPONENTS FOR CALIFORNIA

Strategies

- Delivery System Transformation & Alignment Programs
- Public Safety Net System Global Payment for the Remaining Uninsured

Financing

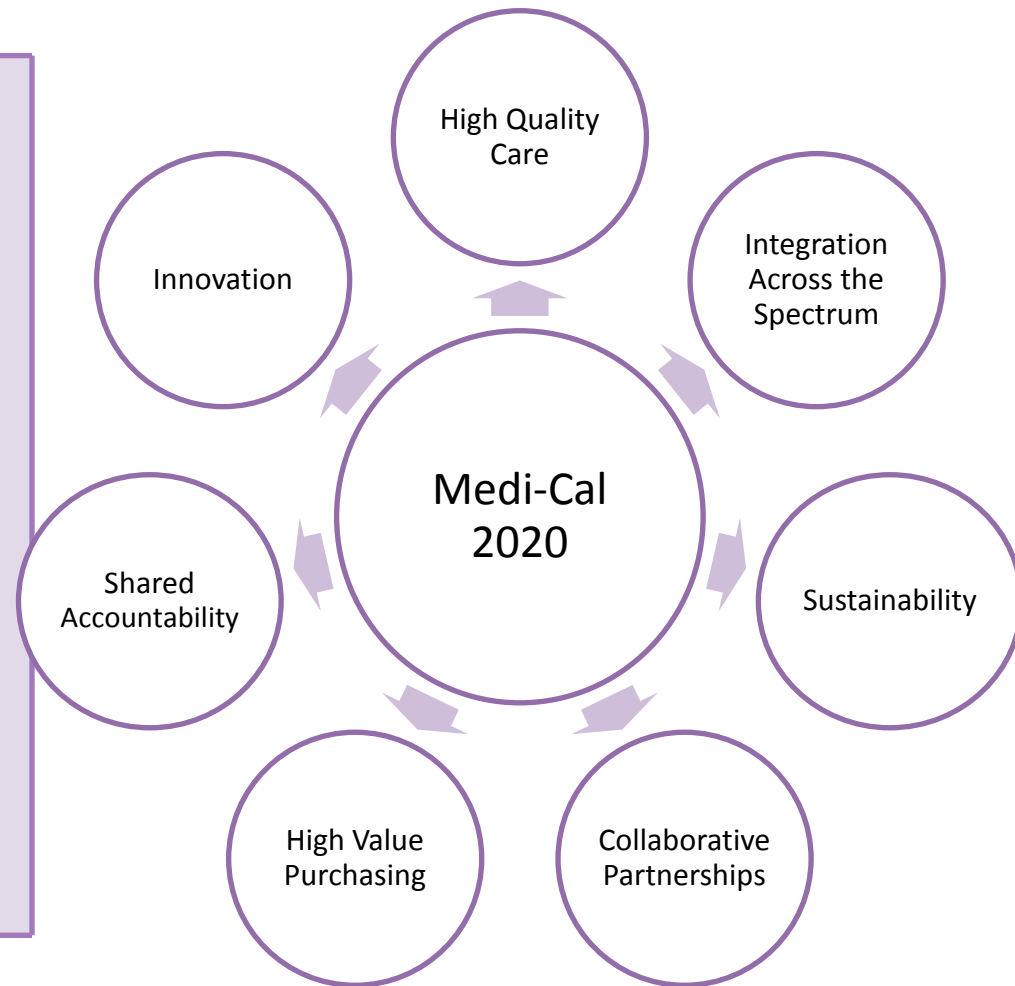
- State-Federal Shared Savings and Reinvestment
- Budget Neutrality
- Continued Federal Funding Support



Medi-Cal 2020: Vision

Vision for 2020

- Continue to build capacity in ways that better coordinate care and align incentives around Medi-Cal beneficiaries to improve health outcomes and reduce disparities, while also containing health care costs.
- Bring together state and federal partners, county systems, plans and providers, and safety net programs to share accountability for beneficiaries' health outcomes.





Core Goals

- 1 Improve health care quality and outcomes for the Medi-Cal population
- 2 Strengthen primary care delivery and access
- 3 Build a foundation for an integrated health care delivery system that incentivizes quality and efficiency
- 4 Address social determinants of health and improve health care equity
- 5 Use CA's sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care



Performance Metrics

Commitment to clear set of performance metrics

- Statewide
- Regional
- Plan & Provider

Still under development

Likely focused on preventable events and improved access to timely care



2010 Bridge to Reform



2010 Bridge to Reform

Low Income Health Program (LIHP)

First in the nation Delivery System Reform Incentive Pool (DSRIP)

Safety Net Care Pool (SNCP) uncompensated care and Designated State Health Program claiming (DSHP)

Statewide expansion of Medi-Cal managed care

Community-Based Adult Services (CBAS)

Coordinated Care Initiative (CCI)

Pending Substance Use Disorder Organized Delivery System



Medi-Cal 2010: Crossing the “Bridge to Reform”

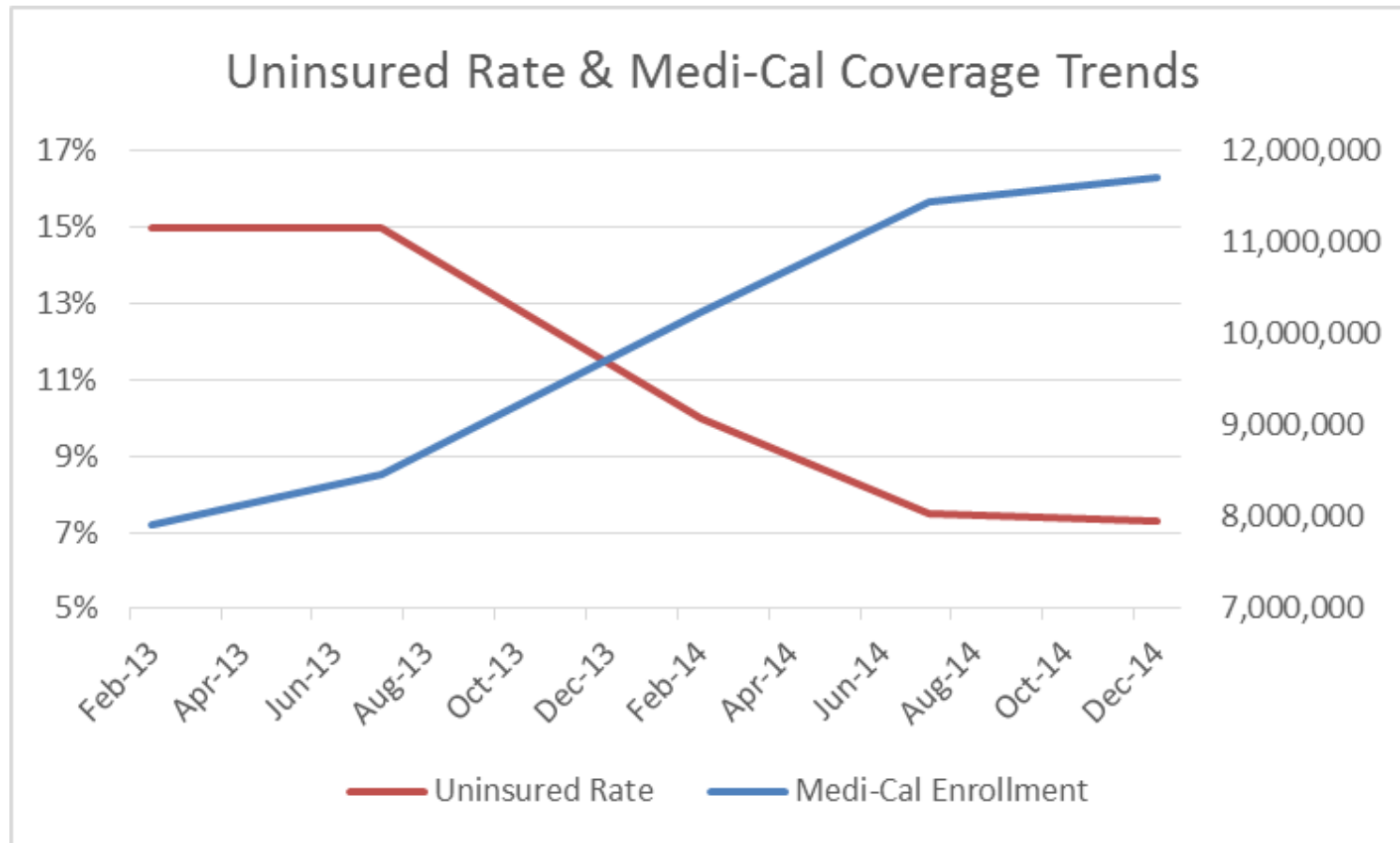
The Bridge to Reform Demonstration has been successful.

Key Achievements

- Cut the uninsured rate in California by **50%** (*29% increase in Medi-Cal enrollment due to expansion – More than 12 million Californians enrolled in Medi-Cal today, about 1/3 of the entire state*).
- Led the nation in implementation of DSRIP; 21 public safety net systems participating
- Completed full implementation of managed care delivery system
- Promoted long-term, efficient, and effective use of state, local and federal funds
- Advanced utilization of home and community-based care
- Sustained the critical role of the safety net

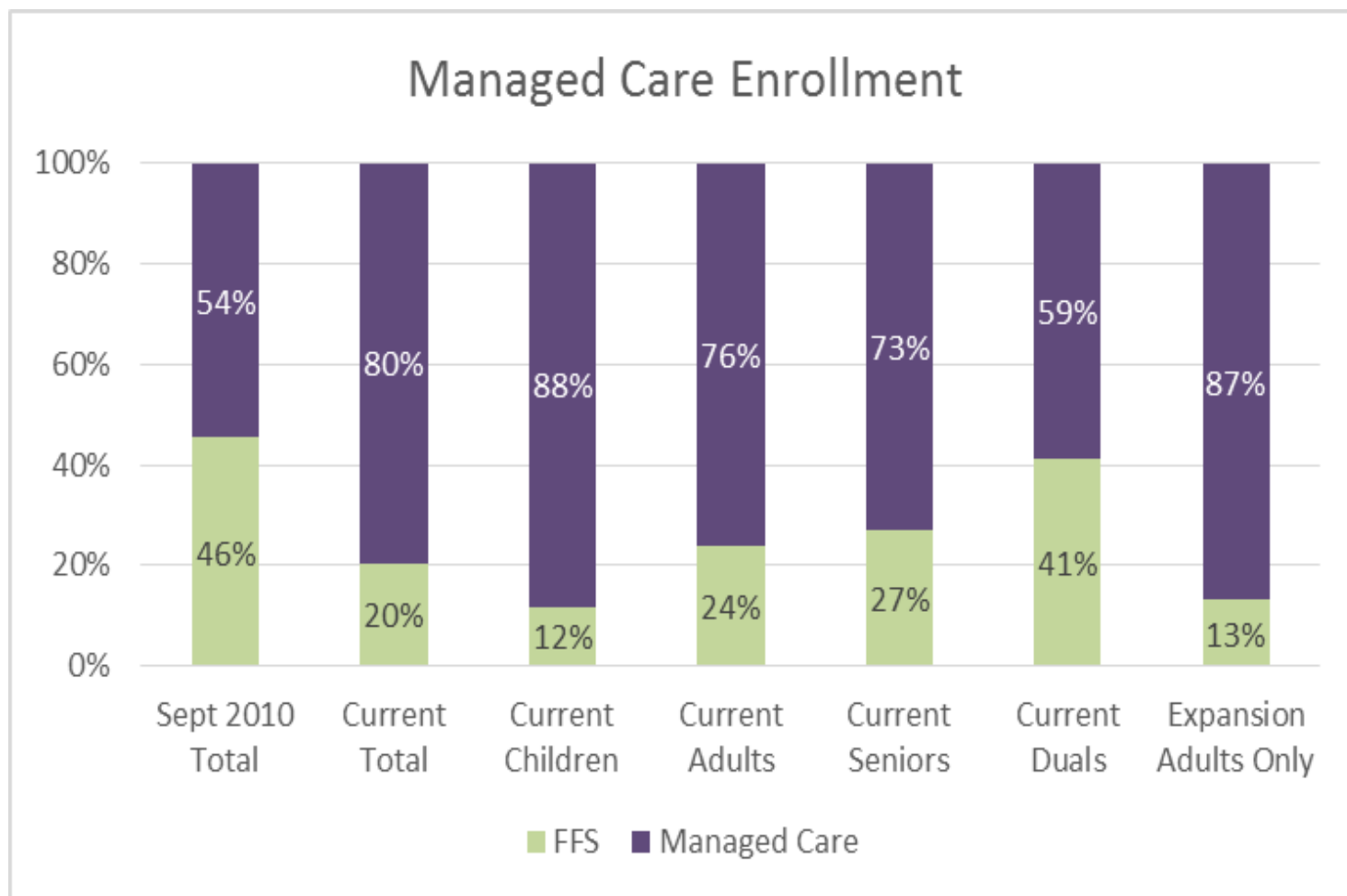


Medi-Cal 2010: Crossing the “Bridge to Reform”





Medi-Cal 2010: Crossing the “Bridge to Reform”





Delivery System Transformation and Alignment Programs

Delivery System Transformation and Alignment Programs



1. Managed Care Systems Transformation & Improvement Program
2. Fee-for-Service Transformation & Improvement Program
3. Public Safety Net System Transformation & Improvement Program
4. Workforce Development Program
5. Increased Access to Housing and Supportive Services Program
6. Whole Person Care Pilots

Managed Care Systems Transformation & Improvement Programs



Focus on coordinated care across physical health, mental health, substance abuse disorder services, and long term care; improve quality and value within the delivery system

Incentive arrangements would require Medi-Cal managed care plans, county behavioral health systems, and providers to work together to achieve specific metrics

Long-term goal to move toward restructuring capitation rate setting by demonstrating through these strategies that these types of shifts result in better outcomes and reduced total cost of care

Supports Waiver goals to:

- Build a foundation for an integrated health care delivery system that incentivizes quality and efficiency
- Improve health care quality and outcomes for the Medi-Cal population
- Use CA's sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care



Managed Care Systems Transformation & Improvement Programs (continued)

Strategy 1: Shared Savings Incentives with MCOs

- Identify targeted populations and/or services for which we would like to see changes in outcomes/cost and increased shared accountability among plans, county services, and providers
- Establish a shared savings incentive arrangement with MCOs, based on projected total cost of care
- Outcome & quality metrics would also be incorporated and certain thresholds met in order to participate in shared savings incentives
- Use Waiver authority and funding to test alternative flexibilities to traditional Medicaid services that address social determinants of health, enhance plan/provider capacity, and foster enhanced care coordination
- MCOs would be permitted to receive shared savings incentive payments for achievements in actual cost of care compared to total cost of care in combination with quality/outcome metric achievements and/or use of non-traditional services that have a demonstrated impact on outcomes



Managed Care Systems Transformation & Improvement Programs (continued)

Strategy 2: Pay-for-Performance (MCOs/Providers)

- P4P programs for Managed Care Plans with standardized core design elements, with flexibility for tailoring to local area or provider sophistication
- Standardized core elements include: quality measures, health equity, patient satisfaction and resource use measures that all plans must adopt as well as an optional set of measures from which plans can choose
- Alignment with State and Managed Care Quality Strategy, the Triple Aim and broad Waiver metrics for Delivery System Transformation and Alignment Incentive Programs
- DHCS chart on potential target areas for health plans (“Three Linked Goals”):
http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MCO3_DHCS2.pdf



Managed Care Systems Transformation & Improvement Programs (continued)

Strategy 3: Physical and Behavioral Health – *Plan/County Coordination Model*

- Medi-Cal managed care plans and county mental health plans working together to support members with identified mental health issues
- Jointly responsible for improving health outcomes and reducing avoidable emergency room visits and hospital stays
- Incentive pool allocated to MCPs and MHPs under two incentive streams
 - First payment to provide necessary incentive to develop processes and procedures in order to effect necessary change (e.g. agreements on data collection, health information exchange, metrics – all subject to DHCS approval)
 - Second set of payments in subsequent periods for meeting joint performance goals in quality and outcomes
- Over time this would evolve to risk based shared savings methods



Managed Care Systems Transformation & Improvement Programs (continued)

Strategy 3: Physical and Behavioral Health Integration – *Provider Integration Model*

- Designed to encourage MCPs and MHPs to implement integrated care models at the provider level for beneficiaries with both chronic health and mental health conditions
- MCPs would offer incentives based on tiers of increasing integration, using coordination or co-location approaches
- Both primary care and mental health providers would be eligible to adopt this model so there is no wrong door for beneficiaries



FFS System Transformation & Improvement Program

Incentives in Medi-Cal Dental

Incentives in Maternity Care

Improve health care quality and outcomes for the Medi-Cal population

Strengthen primary care delivery and access

Build a foundation for an integrated health care delivery system that incentivizes quality and efficiency

Address social determinants of health and improve health care equity

FFS System Transformation & Improvement Program (continued)



Incentives in Medi-Cal Dental

- Aimed at expanding oral health services and improving utilization of preventive services
- Incentives for dental providers who are new to the Medi-Cal system and provide specified levels of access to Medi-Cal beneficiaries
- Incentives for existing Medi-Cal dental providers for increasing the number of Medi-Cal members they treat
- Evaluate impact on access to care and utilization of services

FFS System Transformation & Improvement Program (continued)



Incentives in Medi-Cal Maternity

- Medi-Cal finances approximately 60% of California births which presents an opportunity to promote value in maternity care
- Pilot hospital incentive program for maternity care where incentive payments will be paid for hospitals meeting quality thresholds in four core measures:
 - Early elective delivery
 - Cesarean section rate for low-risk births
 - Vaginal birth after cesarean delivery rate
 - Unexpected newborn complications in full-term babies



Public Safety Net System Transformation & Improvement Program

Builds upon the successes of 2010 DSRIP and lessons learned

The goals are to drive even further change in the public safety net systems while also providing a more standardized approach and outcomes focused metrics to demonstrate statewide changes occurring in public safety net systems

Eligible public safety net systems include:

- 21 designated public hospital systems
- 42 nondesignated public hospital systems – proposal includes a planning period for the these hospital as they did not participate in 2010 program

Improve health care quality and outcomes for the Medi-Cal population

Strengthen primary care delivery and access

Build a foundation for an integrated health care delivery system that incentivizes quality and efficiency

Address social determinants of health and improve health care equity



Public Safety Net System Transformation & Improvement Program (continued)

Five core domains:

- **System Redesign**— focused on redesigning ambulatory care for primary and specialty care, integration of post acute care, integration of behavioral health and primary care
- **Care Coordination for High Risk/High Utilizing Populations** – focused on care management, reducing avoidable acute care utilization, palliative care, patient experience
- **Prevention** – focused on core areas such as cardiac health, cancer, and perinatal care
- **Resource Utilization Efficiency** – focused on appropriate use of antibiotics, high cost imaging and pharmaceuticals
- **Patient Safety** – focused on improving performance on metrics related to potentially preventable events and reducing inappropriate surgical procedures



Workforce Development Program

Address need to transform and expand primary care and specialty care access to serve the Medi-Cal population, given increased competition for providers post-ACA

Expand existing providers' ability to deliver quality care to additional Medi-Cal members and users of CA's safety net

Attract additional workforce to participate in the Medi-Cal program including new categories of health workers with expertise in physical-behavioral health integration and that have cultural and linguistic skill sets for broad community reach

Drive value by leveraging non-physician workforce

- Improve health care quality and outcomes for the Medi-Cal population
- Strengthen primary care delivery and access
- Build a foundation for an integrated health care delivery system that incentivizes quality and efficiency
- Address social determinants of health and improve health care equity
- Use CA's sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care



Workforce Development Program (continued)

Five Core Strategies

- ***Incentives to Increase Provider Participation:***
 - Incentive payments for newly participating providers or providers expanding the number of Medi-Cal beneficiaries served
 - Targeted in geographic areas with greatest need and/or professions/specialties that are most challenging to recruit and retain
- ***Financial Incentives for Non-Physician Community Providers***
 - Administered through MCOs to support inclusion of community health workers and peer support specialists as part of a member's care team, as appropriate



Workforce Development Program (continued)

Five Core Strategies *(continued)*

- ***Screening, Brief Intervention, and Referral to Treatment Training & Certification:***
 - Expand SBRIT services to additional settings
 - Make training and certification available to a broader spectrum of providers
- ***Training***
 - Targeted voluntary training for non-physician health care providers, such as IHSS workers, CHWs, patient navigators, etc.
 - Increased voluntary training program on palliative care for physicians, nurses and other appropriate licensed providers
 - Expanded physician residency training slots at teaching health centers for primary care sites
- ***Incentives to expand use of telehealth***
 - Flexibility to target particular geographic areas or specialties



Increased Access to Housing and Supportive Services Program

Aimed at improving care coordination for the state's most vulnerable populations

New approach to providing care to individuals experiencing homelessness, particularly those with multiple chronic conditions

Inclusion of a set of tenancy-based care management services for plans statewide to support beneficiaries to allow them to stay in their homes

- Build a foundation for an integrated health care delivery system that incentivizes quality and efficiency
- Improve health care quality and outcomes for the Medi-Cal population
- Use CA's sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care
- Address social determinants of health and improve health care equity

Increased Access to Housing and Supportive Services Program (continued)



Target populations:

- Currently homeless or at risk of homelessness, including populations such as veterans **AND**
- Have repeated emergency room use, hospital admissions or nursing facility placements **OR**
- Have two or more chronic conditions **OR**
- Mental health or substance use disorders

Intervention strategies:

- Managed care plans
- Regional housing partnerships

Increased Access to Housing and Supportive Services Program (continued)



Managed care plans

- Provide funding for housing-based care management/tenancy supports (outreach and engagement, housing search assistance, crisis intervention, application assistance for housing and benefits, etc.)
- Allow health plans flexibility to provide non-traditional Medicaid services (discharge planning, creating care plan, coordination with primary, behavioral health and social services, etc.)
- Allow plan contribution of funding to shared savings pool with county partners that could be used to fund respite care, housing subsidies, additional housing-based case management

Increased Access to Housing and Supportive Services Program (continued)



Regional housing partnerships: Allow for health plans and counties to form regional integrated care partnership pilot programs leveraging the range of existing local, state and federal resources in a targeted approach

- Request proposals from counties and plans that partner with providers and community-based organizations
- Support housing as a health care intervention approach
- Incentive payments to create and maintain partnerships in establishing necessary infrastructure, systems, and processes
- Include shared savings pool made up of contributions from plans and counties to support services like respite care to enable timely discharge from inpatient stays or nursing facilities, fund support for long-term housing, finance further expansion of housing-based case management



Regional Integrated Whole-Person Care Pilots

An enhanced model of Regional Partnerships requiring proposals for a geographic region, likely a county or group of counties, jointly pursued by the county and applicable Medi-Cal plans for that region

- Improve health care quality and outcomes for the Medi-Cal population
- Strengthen primary care delivery and access
- Build a foundation for an integrated health care delivery system that incentivizes quality and efficiency
- Address social determinants of health and improve health care equity
- Use CA's sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care

Regional Integrated Whole-Person Care Pilots (continued)



Required partnerships in the pilots

Medi-Cal Plans

County behavioral health systems

Hospitals

Doctors/ Clinics

Other medical providers

Social Services agencies and providers

Public Health agencies and providers

Non-medical workforce

Housing authorities

Criminal justice/Probation

Other community-based organizations

Regional Integrated Whole-Person Care Pilots (continued)



Subject to State and federal approval with potential to test additional flexibilities not currently allowed under Medicaid

Target Population: pilot partnership identified users of multiple health systems; at least 50 patients or the top 1% of emergency/inpatient users

Include approaches across the spectrum of delivery system alignment and transformation (MCO/provider, MCO/county, access to housing and supportive services, workforce development)

Encourage innovation in delivery and financing strategies to improve health outcomes of target populations

Evaluation component will measure:

- health outcomes, health status and disparities
- Success at enrolling individuals for eligible social supports
- impact on total cost of care, scalability, and sustainability beyond Waiver term



Public Safety Net System Global Payment for the Remaining Uninsured

Public Safety Net System Global Payment for the Remaining Uninsured



Transform the traditional Disproportionate Share Hospital (DSH) and Safety Net Care Pool (SNCP) reimbursement structures away from cost-based systems

Establish county-specific global payments that integrate DSH and SNCP funding and serve as lever for whole-person coordinated care

Strengthen primary care delivery and access

Build a foundation for an integrated health care delivery system that incentivizes quality and efficiency

Address social determinants of health and improve health care equity

Public Safety Net System Global Payment for the Remaining Uninsured (continued)



Services and methodology:

- Includes inpatient facility stays, face-to-face and technology-based outpatient visits, and preventative, case management, and health education services
- Items within each of the four categories would be grouped into tiers of similar activity/effort
- Point values will be established for each tier within each category
- Points will be assigned in a manner that recognizes value where high value would be assigned to services that meet criteria such as:
 - Timeliness and convenience of service to the patient
 - Increased access to care
 - Earlier intervention
 - Appropriate resource use for a given outcome
 - Health and wellness services that result in improved patient decisions and overall health status
 - Potential to avoid future costs
- Traditional services will also continue to be recognized for their value and importance, including that emergency room visits and inpatient stays are sometimes necessary and appropriate

Category 1:
Traditional
Outpatient

Category 2:
Non-Traditional
Outpatient

Category 3:
Technology-Based
Outpatient

Category 4:
Inpatient and
Facility Stays



Public Safety Net System Global Payment for the Remaining Uninsured (continued)

Threshold:

- Current services will need to be assigned point values in order to establish the baseline threshold point targets
- Each system would estimate the volume and mix of uninsured services likely to occur based on historical data and projected estimates of uninsured care needs
- Thresholds will vary for each respective public health system; point values would be consistent across all systems

Payment and Allocation:

- Public safety net systems would be paid a global budget amount for services provided to the uninsured
- Systems would be required to meet established service thresholds in order to receive full payment
- Systems could achieve partial payment if it does not meet its threshold, with excess funds made available to other systems that exceed their threshold



Public Safety Net System Global Payment for the Remaining Uninsured (continued)

Evaluation/Accountability: Under this global payment/coordinated care for the uninsured proposal, California is seeking to demonstrate that shifting payment away from cost and toward value can encourage care in more appropriate settings, to ensure that patients are seen in the right place and given the right care at the right time.

It will be critical to establish clear metrics by which to gauge whether this effort is successful.

Resource Allocation: Potential metrics:

- Ratio of new to follow-up appointments within specialty care
- Average time to discharge from specialty care
- Ratio of primary care to emergency room/urgent care visits
- Mental health/Substance use disorder visits
- Inpatient stays related to ambulatory sensitive conditions
- Non-emergent use of the emergency room

Workforce involvement: Potential metrics:

- Use of non-traditional workforce classifications
- Expansion of roles/responsibilities (within scope of practice) for traditional workforce classifications



State-Federal Shared Savings & Reinvestment

State-Federal Shared Savings & Reinvestment



Under the Waiver, a per-beneficiary-per-month cost amount would be established based on predicted costs for those beneficiaries absent the waiver (total funds)

The state would retain a portion of federal funds for the difference between actual expenditures and pre-established per beneficiary amounts

The savings serve as key reinvestment funding that will allow CA to implement many of the other waiver initiatives that will drive this savings as well as quality improvement

Concept is not a per-capita cap that limits entitlement spending; any excess spending over the anticipated per-beneficiary cost would count against budget neutrality margin and reduce Waiver expenditures

Even after reinvestment of funds, ensure overall savings to the Federal government, thereby ensuring that the Waiver is budget neutral



State-Federal Shared Savings & Reinvestment (continued)

	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	
	DY11	DY12	DY13	DY14	DY15	5 Year Total
TOTAL POPULATION EXPENDITURES	\$36,032,479,886	\$38,133,908,104	\$40,352,295,847	\$42,694,203,383	\$45,166,569,554	\$202,379,456,774
HOSPITAL EXPENDITURES						
Public Hospital Payments	\$2,806,624,980	\$2,987,090,966	\$3,179,160,916	\$3,383,580,963	\$3,601,145,218	\$15,957,603,043
Mental Health Supplements	\$5,126,725	\$5,456,374	\$5,807,218	\$6,180,622	\$6,578,037	\$29,148,976
TOTAL HOSPITAL EXPENDITURES	\$2,811,751,705	\$2,992,547,340	\$3,184,968,134	\$3,389,761,585	\$3,607,723,255	\$15,986,752,019
WAIVER EXPENDITURES						
<i>(Prior to Shared Savings)</i>						
Global Budget for the Uninsured	\$2,824,648,102	\$2,474,648,102	\$2,324,648,102	\$2,264,648,102	\$2,524,648,102	\$12,413,240,510
Designated State Health Programs	\$800,000,000	\$800,000,000	\$800,000,000	\$800,000,000	\$800,000,000	\$4,000,000,000
Delivery System Transformation & Alignment Programs	\$1,600,000,000	\$1,600,000,000	\$1,600,000,000	\$1,600,000,000	\$1,600,000,000	\$8,000,000,000
Public Safety Net System Transformation & Improvement	\$1,600,000,000	\$1,600,000,000	\$1,600,000,000	\$1,600,000,000	\$1,600,000,000	\$8,000,000,000
Other Transformation & Alignment Programs	-	-	-	-	-	-
IHS Uncompensated Care	\$1,550,000	\$1,550,000	\$1,550,000	\$1,550,000	\$1,550,000	\$7,750,000
TOTAL WAIVER EXPENDITURES	\$5,226,198,102	\$4,876,198,102	\$4,726,198,102	\$4,666,198,102	\$4,926,198,102	\$24,420,990,510
Total With Waiver Expenditures						
<i>(Prior to Shared Savings)</i>						
	\$ 44,070,429,693	\$ 46,002,653,546	\$ 48,263,462,083	\$ 50,750,163,070	\$ 53,700,490,910	\$242,787,199,303
Annual Budget Neutrality Margin	\$4,004,492,195	\$4,597,680,513	\$5,253,896,620	\$5,979,279,119	\$6,780,527,298	\$26,615,875,745
Cumulative Budget Neutrality Margin	\$4,004,492,195	\$8,602,172,709	\$13,856,069,329	\$19,835,348,448	\$26,615,875,745	\$26,615,875,745



State-Federal Shared Savings & Reinvestment (continued)

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Designated State Health Programs	\$800,000,000	\$800,000,000	\$800,000,000	\$800,000,000	\$800,000,000	\$4,000,000,000
Delivery System Transformation & Alignment Programs	\$3,600,000,000	\$3,600,000,000	\$3,600,000,000	\$3,600,000,000	\$3,600,000,000	\$18,000,000,000
Public Safety Net System Transformation & Improvement	\$1,600,000,000	\$1,600,000,000	\$1,600,000,000	\$1,600,000,000	\$1,600,000,000	\$8,000,000,000
Other Transformation & Alignment Programs	\$2,000,000,000	\$2,000,000,000	\$2,000,000,000	\$2,000,000,000	\$2,000,000,000	\$10,000,000,000
IHS Uncompensated Care	\$1,550,000	\$1,550,000	\$1,550,000	\$1,550,000	\$1,550,000	\$7,750,000
TOTAL WAIVER EXPENDITURES	\$7,226,198,102	\$6,876,198,102	\$6,726,198,102	\$6,666,198,102	\$6,926,198,102	\$34,420,990,510
Total With Waiver Expenditures						
<i>(Post Shared Savings)</i>						
	\$ 46,070,429,693	\$ 48,002,653,546	\$ 50,263,462,083	\$ 52,750,163,070	\$ 55,700,490,910	\$252,787,199,303
Annual Budget Neutrality Margin	\$2,004,492,195	\$2,597,680,513	\$3,253,896,620	\$3,979,279,119	\$4,780,527,298	\$16,615,875,745
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Demonstration Financing & Budget Neutrality

Demonstration Financing and Budget Neutrality



Generally retain structure and calculations as under the 2010 Waiver, with modifications as noted:

Trend existing FFS PMPMs based on existing trend factors for MEGs, split by model type (two-plan/GMC, COHS, CCI, non-CCI):

- Family
- Seniors & Persons with Disabilities, including partial duals
- Full scope dual eligibles

Consider that given experience attained for new adult group, add new MEG for new adults

Maintain separate limit B for designated public hospitals UPL as in 2010 Waiver

Add designated public hospital DSH funding into budget neutrality on both sides. These DSH expenditures would be a component of the funding of the global budget for the remaining uninsured

Demonstration Financing and Budget Neutrality (continued)



With waiver expenditures funded through budget neutrality margin (CNOM) would include:

- Funding of global budget amounts related to former SNCP funding
- Continuation of designated state health programs
- IHS uncompensated care funding (as today)
- Delivery system transformation & alignment programs
- Federal shared savings amounts

Actual MCO PMPMs used for With Waiver as today

Estimated CPE FFS payments for designated public hospitals as today



Demonstration Financing and Budget Neutrality (continued)

- **Table 1: Proposed MEGs, PMPMs and Trend Factors (based on existing BTR)**

			FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20
WOW	MEGS	Trend Rate	DY11	DY12	DY13	DY14	DY15
PMPM							
TPM/GMC							
	Family	5.30%	\$195.78	\$206.15	\$217.08	\$228.59	\$240.70
	SPDs	7.40%	\$928.95	\$997.69	\$1,071.52	\$1,150.81	\$1,235.97
	Duals	3.28%	\$121.84	\$125.84	\$129.97	\$134.23	\$138.63
	New Adult	4.10%	\$527.95	\$549.60	\$572.13	\$595.59	\$620.01
COHS							
	Family	5.30%	\$221.57	\$233.32	\$245.68	\$258.70	\$272.42
	SPDs	7.40%	\$1,737.97	\$1,866.58	\$2,004.71	\$2,153.05	\$2,312.38
	Duals	2.47%	\$450.10	\$461.22	\$472.61	\$484.29	\$496.25
	New Adult	4.10%	\$715.68	\$745.02	\$775.57	\$807.37	\$840.47
CCI TPM/GMC							
	Family	5.30%	\$197.76	\$208.24	\$219.28	\$230.90	\$243.14
	SPDs	7.40%	\$1,128.79	\$1,212.32	\$1,302.03	\$1,398.38	\$1,501.87
	Duals	3.40%	\$774.83	\$801.17	\$828.41	\$856.58	\$885.70
	Cal MediConnect	3.40%	\$774.83	\$801.17	\$828.41	\$856.58	\$885.70
CCI COHS							
	Family	5.30%	\$225.08	\$237.01	\$249.57	\$262.80	\$276.72
	SPDs	7.40%	\$2,183.24	\$2,344.80	\$2,518.32	\$2,704.67	\$2,904.82
	Duals	1.61%	\$663.28	\$673.95	\$684.80	\$695.83	\$707.03
	Cal MediConnect	1.61%	\$663.28	\$673.95	\$684.80	\$695.83	\$707.03
CBAS							
		3.16%	\$1,166.69	\$1,203.56	\$1,241.59	\$1,280.82	\$1,321.30



Demonstration Financing and Budget Neutrality (continued)

- Table 2: Estimated WOW Expenditures**

	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	
	DY11	DY12	DY13	DY14	DY15	5 Year Total
Total Population Expenditures	\$ 41,991,973,636	\$ 44,627,527,507	\$ 47,439,270,963	\$ 50,439,658,680	\$ 53,642,068,892	\$238,140,499,678
DSH	\$ 2,352,648,102	\$ 2,002,648,102	\$ 1,852,648,102	\$ 1,792,648,102	\$ 2,052,648,102	\$10,053,240,510
IP UPL PH	\$ 3,730,300,150	\$ 3,970,158,450	\$ 4,225,439,638	\$ 4,497,135,407	\$ 4,786,301,214	\$21,209,334,860
Total Without Waiver Ceiling	\$ 48,074,921,888	\$ 50,600,334,059	\$ 53,517,358,703	\$ 56,729,442,190	\$ 60,481,018,208	\$269,403,075,049

- Table 3: Projected Member Months and WW Expenditures**

	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	
	DY11	DY12	DY13	DY14	DY15	5 Year Total
Total Member Months	102,305,153	103,328,205	104,361,487	105,405,102	106,459,153	
Total Population Expenditures	\$36,032,479,886	\$38,133,908,104	\$40,352,295,847	\$42,694,203,383	\$45,166,569,554	\$202,379,456,774
Total Hospital Expenditures	\$2,811,751,705	\$2,992,547,340	\$3,184,968,134	\$3,389,761,585	\$3,607,723,255	\$15,986,752,019
Total Waiver Expenditures	\$7,226,198,102	\$6,876,198,102	\$6,726,198,102	\$6,666,198,102	\$6,926,198,102	\$34,420,990,510
Total With Waiver Expenditures	\$ 46,070,429,693	\$ 48,002,653,546	\$ 50,263,462,083	\$ 52,750,163,070	\$ 55,700,490,910	\$252,787,199,303

- Table 4: Historical BTR Enrollment and Expenditures**

	FY 10-11	FY 11-12	FY 12-13	FY 13-14	FY 14-15
	DY6	DY7	DY8	DY9	DY10
Historical Enrollment	51,576,881	58,420,445	63,769,315	66,558,574	83,233,890
Historical Expenditures	\$15,397,202,160	\$19,471,360,377	\$21,129,317,683	\$23,494,057,783	\$30,867,521,032



Medi-Cal 2020 Evaluation Design



Evaluation

Will work with CMS to develop an evaluation design that builds upon and incorporates lessons learned from the current Bridge to Reform waiver

The design will support generalized findings, explore limitations of demonstration design, and evaluate the integrity and appropriateness of the data and analytic methods used

Will include use of comparison groups and baselines when possible



Next Steps



Next Steps

March 27, 2015

- Target submission date of Waiver application

April – Nov. 2015

- DHCS/CMS discussions

May 20, 2015

- Stakeholder Advisory Committee update

Spring/Summer 2015

- Collaborative program development with stakeholders

July 22, 2015

- Stakeholder Advisory Committee update

Fall 2015

- Final STC development

Nov. 1, 2015

- Start of new Waiver

Post-Approval

- Continued stakeholder engagement forums



Q & A



Questions / Comments:

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[http://www.dhcs.ca.gov/provgovpart/
Pages/WaiverRenewal.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx)