California Association of
Public Hospitals and Health Systems

A Proposal for a Renewed Section 1115 Medicaid Waiver

California Association of Public Hospitals and Health Systems (CAPH)

I. Introduction

California's 21 Designated Public Health Care Systems (PHS)[1] play a central role in California's safety net and health care landscape. In California's 2010 "Bridge to Reform" waiver, PHS served as drivers of coverage expansion, local delivery system reform, and as public financing sources of the non-federal share for the Medi-Cal program and for uninsured care, laying the groundwork to prepare for the Affordable Care Act (ACA).

These public health care systems represent the core of the state's health care safety net, delivering care to all who need it, regardless of ability to pay or insurance status. Though just six percent of all California hospitals statewide, PHS serve 2.85 million residents each year, provide nearly 40% all hospital care to the state's 7 million uninsured residents, and 25% of hospital care to the state's Medicaid population. They deliver 10 million outpatient visits per year and operate more than half of the state's top-level trauma centers and two-thirds of the state's burn centers. Furthermore, PHS train 57% of all new doctors in the state. In light of their significant and multiple roles, PHS and their delivery system improvements have a profound impact on the health care and health of millions of Californians.

Armed with key lessons from early coverage expansion, and four years into the first-in-the-nation Delivery System Reform Incentive Program (DSRIP), California's PHS are ready and eager to strengthen our partnership with the State and the Obama Administration under a renewed Medicaid 1115 waiver in support of the successful implementation of the ACA . To that end, we seek the opportunity through a renewed waiver to

[1] California's Designated Public Health Care Systems (PHS) are commonly referred to in official wavier documents as "Designated Public Hospitals" and include the following facilities: Alameda County Medical Center, Arrowhead Regional Medical Center, Contra Costa Regional Medical Center, Kern Medical Center, LA County Harbor/UCLA Medical Center, LA County Olive View UCLA Medical Center, LA County Rancho Los Amigos National Rehabilitation Center, LA County University of Southern California Medical Center, Natividad Medical Center, Riverside County Regional Medical Center, San Francisco General Hospital, San Joaquin General Hospital, San Mateo Medical Center, Santa Clara Valley Medical Center, Ventura County Medical Center, UC Davis Medical Center, UC Irvine Medical Center, UC San Diego Medical Center, UC San Francisco Medical Center, UC Los Angeles Medical Center, including Santa Monica/UCLA Medical Center.

explore innovative, ambitious approaches that link quality improvement, outcomes, and financing together in the public health care safety net in order to best serve the newly covered and the residually uninsured.

CAPH believes the proposed elements described below will support and strengthen public health care systems' ability to fulfill their three-part role in the state's health care system in broad support of the ACA: as competitive providers of choice; as the core of the safety net for those who will remain uninsured; and as an important source of essential community services. By 2020, the proposals below are intended to transform public health care systems into models of integrated systems of care that are high value, high quality, patient-centered, efficient, and equitable, with great patient experience and a demonstrated ability to improve the health care and health status of populations. Realizing this vision, we believe, will also allow public health care systems to retain our essential mission of serving everyone, regardless of ability to pay, including millions of Californians who will remain uninsured even after full implementation of the ACA. Public health care systems must also continue to provide essential community services, such as trauma, burn and medical training. Failure to fulfill any of these critical roles would jeopardize California's ability to successfully implement the ACA.

Proposal Elements

We offer herein our recommendations for a renewed 1115 waiver as they relate to California's public health care systems and the services they provide. In doing so, we recognize that the State is contemplating additional components that will impact other entities that are not discussed here.

The essential components of this approach are:

1. A Successor DSRIP that Rewards Improvement, Health and Value

Building on the foundation and lessons learned from the DSRIP, a successor program would be more standardized, with a heavier emphasis on outcomes, and a comprehensive approach to the advancement of Triple Aim goals the public health care systems.

2. Testing of Innovative Care Models that Improve Quality and Outcomes and Contain Costs

CAPH proposes the creation of pilots to develop "whole-person care" models that support the integration of physical and behavioral health services, along with intense care coordination with social, housing, vocational training and other services that are critical to holistically addressing the needs and care of high risk patients. This model of care would allow for higher value use of limited resources;

contain costs; coordinate care beyond traditional health services; and comprehensively address the concerns and needs of some of the most vulnerable patients cared for in the safety net.

3. Payment Reforms that Ensure Access to Safety Net Services

California's 21 public health care systems are interested in exploring innovative payment reforms that link financing and access to care in the safety net. We propose combining a portion of Medicaid Disproportionate Share Hospital (DSH) funds with Safety Net Care Pool dollars into a global payment to support access to integrated care for low-income populations. We believe this will ultimately help reduce emergency and inpatient services and lower costs. This more flexible payment structure would improve access and quality, especially for the uninsured who seek services in California's public health care systems, and more efficiently use federal and county/public health care system dollars that would otherwise pay for emergency and inpatient services, by redirecting some of these monies to lower-cost outpatient and primary care settings, and alternate modalities such as group or telephonic visits.

4. A Waiver that Offers the Opportunity to Earn Federal Dollars at Existing Levels

As stated, in addition to rewarding delivery system improvements, a renewed waiver must continue to support care for the residually uninsured and the safety net services upon which local communities rely, such as trauma and burn care and medical training. Though the Medi-Cal expansion population is fully federally financed for three years, the impact of these additional funds on the safety net is not likely to fully offset costs associated with the remaining uninsured and the provision of essential community services, particularly in light of declining Medicaid DSH and state funds. As we witnessed in Massachusetts, health care reform resulted in *increased* demand for safety net services. Maintaining the foundation built by the Bridge to Reform will require continued and sufficient federal investment in order to ensure a strong and competitive health care safety net, which is essential to California's successful implementation of health care reform. Therefore, though dollars would be increasingly at risk based on ambitious outcomes, the 2015-2020 Medicaid 1115 waiver must represent an investment that is equivalent to the existing waiver's Delivery System Reform Incentive Program, Safety-Net Care Pool Uncompensated Care Pool (as of 2014-15) and California's Medicaid DSH allotment (taking into account scheduled reductions, per the ACA).

A renewed waiver with these elements can improve the health care services – and as a result, the health – of the Medi-Cal and residually uninsured populations in California, and support the success of the ACA in California.

II. A Successor DSRIP: Building On Success and Incorporating Lessons Learned

California has led the nation in creating a Delivery System Reform Incentive Payment (DSRIP) program, and seeks to lead again with a proposal for an ambitious successor DSRIP. California's existing DSRIP has been a model for the nation that has now been replicated numerous times over, becoming a prominent feature of 1115 Medicaid waivers approved by CMS. Through the existing DSRIP, California's PHS have collectively achieved over 2,100 DSRIP milestones across 64 different projects covering massive improvements throughout their systems. In particular, through the DSRIP's focus on effective primary care and patient-centered medical homes, California PHS have made significant progress in fundamentally changing the way care is delivered, going beyond inpatient care to impact all settings.

While the DSRIP has helped PHS achieve impressive results, much work remains in order to fully transform PHS into high performing health systems that provide everyone with timely access to safe, high-quality, and effective care. In short, PHS have made significant strides towards transforming their systems, but do not yet have capacity to make sustainable impacts across all three aspects of the Triple Aim.

Taking into account the vast improvements that have been made thus far through the DSRIP, it is clear—both from the extensive work being done by PHS and from the experience of other healthcare organizations across the country that have embarked on system-wide change efforts—that the journey of transformation is one not of just several years hard work, but rather one that requires a decade or more of continuously focused, intentionally aligned efforts by every member of each PHS.

Therefore, we believe that a successor program should build on the solid foundation laid by the existing DSRIP through more outcomes- and value-oriented requirements, and through the promotion of all three aspects of the Triple Aim -- better quality, better health, and cost containment -- across California's public health care systems.

Key Elements and Achievements of the 2010 DSRIP

The 2010 DSRIP program included a number of important elements that were critical to California's health reform implementation efforts, and in PHS's work to better align care delivery with the goals of providing the right care, at the right time, in the right place.

These critical DSRIP elements included:

- Recognition that delivery system transformation requires simultaneous improvement in all areas of care delivery. The DSRIP expanded PHS' role as systems of care, by designing quality improvement projects

and milestones that sought to increase integration and improve patient care simultaneously throughout the health systems' primary care clinics, specialty clinics, urgent care centers, emergency departments and inpatient services.

- Expansion of best practices and lessons learned. The foundation for the DSRIP had been built over the prior decade, as PHS had begun implementing effective methods for improving care coordination, patient safety, access, and efficiency. The DSRIP helped expand and hardwire this work on a much larger scale, spreading pilot projects to multiple other parts of the health care system.
- Movement toward value driven care. The performance-based structure of the DSRIP represents a dramatic shift from traditional health care financing. With $3.3 billion in federal funding at risk, PHS are tying a significant portion of their reimbursement to improvements in primary care access, strengthening of care coordination, and reductions in hospital acquired infections.
- Contribution to standardization. The DSRIP has also created a learning laboratory to help inform policy makers and health care systems throughout the country. Specifically, PHS pioneered the development of new reporting processes in population health, and developed new protocols for reducing sepsis, which helped contribute to the national dialogue on patient harm.
- Source of financial support to the Medi-Cal program. As with other elements of the 2010 Bridge to Reform demonstration, PHS provided the non-federal share for federal incentive payments for PHS-specific activities. This investment demonstrated PHS' deep commitment to improving quality and patient experience in the public health care system arena.

The elements described above, in addition to others, helped contribute to California's PHS making significant strides in improved access, quality, and patient safety over the last five years, efforts that PHS must build upon and expand over the next five years. The achievements in this program highlight the scope and scale of this undertaking and demonstrate PHS commitment to continuous improvement for the patients they serve. Specific achievements include:

- Expanded primary care capacity. The DSRIP's focus on primary care complemented efforts to expand coverage through the Low Income Health Program by connecting enrollees to a primary care team to help manage their health. All together, 17 PHS expanded primary care medical homes, 11 expanded primary care capacity, and seven focused on primary care redesign. These activities included offering more weekend and evening appointments, increasing the number of patients assigned to primary care providers, improving panel management, and instituting navigation programs to connect patients from the emergency room to primary care. This work helped collectively enroll more than 650,000 low-

income Californians into coverage and a medical home, with 89% of total LIHP enrollment in counties with a public health care system.

- Increased and more efficient care coordination for patients. Building on their strength as systems of care, PHS improved care coordination for patients by enhancing linkages between primary care, specialty care and the inpatient setting. These efforts included expanding chronic disease management programs, engaging patients in how to improve care delivery and coordination across the system, and piloting targeted approaches for particularly vulnerable patients who were frequent utilizers of the emergency department.
- Improvements in team-based accountability for outcomes. The DSRIP has catalyzed a shift in culture within each PHS, with care becoming more team-based and interdisciplinary. Whether it is RN case managers coordinating with pharmacists as they target high-risk patients, or medical assistants sharing responsibilities in panel management, the care delivery model has significantly increased collaboration across providers and enhanced shared accountability for patient well-being. Furthermore, quality improvement efforts employing LEAN processes, Six Sigma, and the Institute for Healthcare Improvement's Model for Improvement have helped improve cycle times for patients, reduce no-show rates and improve appointment availability.
- Better use of data to drive delivery system improvement and population health management. In tandem with the implementation of Electronic Health Records, PHS used the DSRIP to develop disease registries, standardize quality dashboards in both the inpatient and outpatient setting, and capture race, ethnicity, and language data. Once data systems were accessible, care teams were able to utilize more sophisticated data for population management, including data on individual longitudinal care records for complex care management and self-management, and condition or assigned provider-based reports for panel management efforts.
- Reduction in adverse events. Improving inpatient safety was a critical component of the DSRIP, and patients who access PHS are now less likely to experience adverse events. All PHS are working on reducing sepsis and central line associated blood stream infections, and each has selected at least two additional areas in which to reduce patient harm. These focus areas, combined with the PHS contribution to the national sepsis protocol discussion, have been critical in helping address preventable hospital acquired conditions.

A Successor DSRIP that Supports PHS 2020 Vision

California's public health care systems propose to continue the important work that began under the 2010 waiver to support their vision of becoming models of integrated systems of care that are high value, high quality, patient-centered, efficient, and equitable, with great patient experience and a demonstrated ability to improve the health care and health status of populations. To become these models of care, PHS will continue to invest in building blocks of high-performing integrated delivery systems, and engage in ambitious quality improvement efforts that strengthen our internal capacity for continuous improvement.

Successor DSRIP Goals. By 2020, PHS will have achieved several important goals that will result in the wide-spread adoption and sustainability of current transformation efforts and are foundational to PHS' ability to survive and thrive. The first goal is to ensure that every primary care site is providing barrier-free access to patient-centered, data-driven and technology-enabled, team-based care. Second, PHS will assume greater responsibility for the health of their patient populations by evolving their data-driven care team capabilities to enhance point-of-care services, complex care management, and population health management. In order to be successful in these efforts, the third goal is for PHS to use fully implemented EHRs and highly capable data analytics to drive system-level improvement. Data and reporting will be accurate, reliable, and transparent, and PHS will have information systems that support culturally competent care for all patients. The combination of system-wide transformational efforts, highly leveraged data analytics, and a fundamental redesign of care delivery will set a platform for sustainable innovation and improvement.

Successor DSRIP Structure. To achieve these goals, we propose that the next DSRIP include the following:

- Three high level *Domains* of care improvement, focused on critical aspects of system transformation and high risk populations. Each Domain will contain 4-6 Projects with certain participation requirements;
- A required *standardized metric set* for each Project, preferentially chosen from state or nationally vetted metrics, with ambitious targets and a heavy focus on outcomes;
- *Building blocks* of high performing integrated delivery systems embedded into each Project; and
- Heavier emphasis on *cost containment*, particularly through efficient resource utilization (see Domain 2).

Domains. We propose restructuring the existing DSRIP from four categories of projects across different continuums into three high level Domains. These Domains would include (1) Delivery System Transformation, (2) Resource Utilization Efficiency, and (3) Improved Outcomes for Specific High Risk, High Utilizing Populations.

These Domains will enable PHS to focus improvement efforts on critical aspects of the health care delivery system that advance the Triple Aim.

Domain 1: Delivery System Transformation

Domain 1 projects are broad-based health system redesign initiatives that will enhance care in a variety of ways to fulfill the vision of providing the right care, at the right time, in the right place. PHS will ensure that these systemic efforts and changes are deeply structural and thus sustainable. Proposed Projects are:

1. Ambulatory Care Redesign: Primary Care
2. Ambulatory Care Redesign: Specialty Care
3. Care Transitions: Integration of Post-Acute Care
4. Care Coordination: High Risk, Chronically Ill Populations
5. Integration of Physical and Behavioral Health

All PHS would be required to participate in all Domain 1 Projects, thus creating a powerful alignment of transformation across the California public health care delivery system.

Domain 2: Resource Utilization Efficiency

Domain 2 Projects would focus on improving the evidence-based utilization of diagnostics, treatments or preventive services that have high potential to advance the Triple Aim, particularly containing costs. Proposed Projects are:

1. Antibiotic Stewardship
2. Resource Stewardship: High Cost Imaging
3. Resource Stewardship: High Cost Pharmaceuticals
4. Resource Stewardship: Blood Products
5. Triple Aim Evidence-Based Preventive Services (a multi-PHS effort to standardize and improve the provisions of preventive services through a combined evidence-based and resource stewardship approach)
6. Right Place Care: Rebalancing of Primary Care Capacity in the Health Care System

All PHS would be required to participate in a minimum number of Domain 2 Projects.

Domain 3: Improved Outcomes for Specific High Risk, High Utilizing Populations

Domain 3 Projects focus health systems on establishing and providing high quality care for specific populations of patients at high risk of uncoordinated care, poor health outcomes, poor quality of life and avoidable utilization. Proposed Projects are:

1. Integrated Health Home for Foster Children
2. Transition to Integrated Care: Post Incarceration
3. Chronic Non-Malignant Pain Management
4. Comprehensive End of Life Planning and Care

All PHS would be required to participate in a minimum number of Domain 3 Projects.

Standardized Metrics. Each Project will use a set of standardized, specified and required metrics in order to measure and assess progress in a systematic, comparable way. While each Project will have a menu of activities determined by local priorities, together, improvements on these required, standardized metrics will demonstrate significant Triple Aim advancements by California PHS through the successor DSRIP. Metrics will be preferentially chosen from state or nationally vetted metrics (e.g., NQF, NCQA) as clinically appropriate to each Project.

Building Blocks. In order to foster the further strengthening of PHS as providers of choice that provide high quality, high value care, we propose that for each Project, PHS address how they will advance the following components, as appropriate:

- Patient Engagement
- Data Analytic Infrastructure
- Performance Improvement Strategy and Performance Management Systems
- Workforce Capacity

These efforts, combined with the other elements of this waiver proposal, will support PHS' vision to become models of integrated systems of care that are high value, high quality, patient-centered, efficient, equitable, with great patient experience and demonstrated ability to improve health care and health status of populations.

III. Whole-Person Care for High Users of Multiple Systems

To complement a successor DSRIP's emphasis on improving care for high risk patients, we propose that the renewed waiver allow counties to pilot payment reforms to extend care coordination and management for their highest need patients. Medical problems suffered by the safety net population are often determined and exacerbated by poverty – poor nutrition, substandard or no housing, untreated behavioral health problems, incarceration, and the chronic anxiety of income insecurity. These problems often present episodically to the most expensive part of the health care system – hospital emergency rooms. Public health care systems are looking to the root causes of these medical encounters and working with other public agencies that address the behavioral health and social needs of the safety net populations.

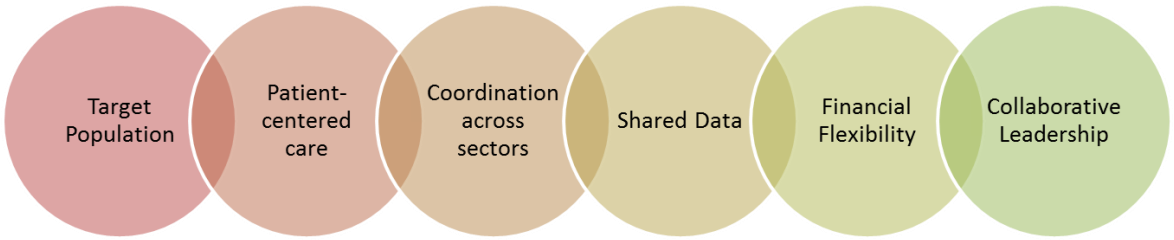
In an ideal world, whole-person care would entail the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources. Today, although county agencies both determine eligibility and provide the majority of services for the safety net population (through human/social services departments, health departments, etc.), the actual services are often fragmented and challenging to navigate. Coordination among these areas often requires strong leadership to overcome institutional barriers. Coordination of care and services, as a result, is highly variable across counties.

The current fragmented system not only affects patients' well-being, but also costs PHS and counties more than may be necessary. Patients may be unnecessarily frequenting the emergency department, or they may be staying longer than needed in acute care settings because the hospital cannot find an appropriate place to discharge the patient. These inefficient uses of resources can stymie safety net health care systems that are trying to be providers of choice in a competitive market. Counties could more efficiently spend resources on the same person by providing cost-effective alternatives like housing, supportive services, and care coordination.

Recently, emphasis on building primary care health homes and the new inclusion of some behavioral health benefits in Medi-Cal has increased the opportunity to provide and coordinate whole-person care for the majority of the safety net population through PHS primary care clinics. However, for many of the high utilizers of multiple systems (HUMS) – e.g., the severely mentally ill and chronically homeless – primary care is not the best setting from which to coordinate care. No matter where safety net patients seek care, the essential task of navigating, coordinating, and managing that care is currently neither systematic nor supported with a stable source of funds beyond fragmented county support.

Our vision for whole-person care is that PHS, in coordination with other local entities, are able to provide whole-person care for the highest-need patients (i.e. their "HUMS" patients) through systematic coordination with partner entities. County agencies would be able to identify these patients with shared data, coordinate their care in real time, and evaluate individual and population progress. Patients/clients would have an individualized care plan and a single accountable, trusted care manager that supports them getting the services they need.

These components of care create a Whole Person Care framework upon which we believe counties could structure more integrated care:



CAPH Proposal

Using this framework, CAPH proposes optional Whole-person Care pilots through a renewed Medicaid 1115 Waiver. CAPH envisions that all pilots would have the following aspects:

- Include all components of the Whole-person Care framework (above)
- Care coordination payments supplementing base payments for services
- Coordination with social services, e.g., housing, job placement, food stamps
- Private support, such as through foundations, to support the pre-waiver preparation work counties would need to do to launch pilots in the next waiver
- Reimbursement for costs not normally allowed in Medi-Cal, such as shelter or respite care.

In addition, pilots would engage in transformative payment structures by selecting one of the following financial structures for the portion of the Medicaid population identified as HUMS patients and enrolled in the pilot:

Tier 1: Coordinated Care for High Users of Multiple Systems – Shared Savings

- Health, behavioral health, social service partners, and a health plan enter into shared savings agreements at the county level for a defined target population and a defined set of services. No federal funding streams are formally changed.
- Counties can vary the scope of their program by expanding the services that are coordinated, by increasing the amount of risk they assume through shared savings (e.g. by also taking downside risk or partial capitation from the plan), and by expanding the range of the targeted population.

Tier 2: Whole-Person Care Accountable Care Organizations – Capitated PMPM Payments

- Allow pilots to assume integrated financial risk (e.g. per-member per-month (PMPM) payment) for health, mental health and substance use, for a targeted Medi-Cal population of HUMS.
- Provide high levels of coordination with social service providers to ensure access to other social services.

The benefits of undertaking a Whole-Person Care Pilot could be significant, improving the health and quality of life of the patients served. Counties would be incentivized to use local resources more effectively, building relationships with positive spillover effects in areas outside the specific scope of the pilot. Public health care systems would build capacity for effectively managing financial risk, and there is significant potential for overall cost reduction. In the 2008 Frequent User Program that eight California counties piloted from 2004-2007 and which had similar goals to this Whole-Person Care pilot, the interventions led to a 61% decrease in emergency department visits and a 62% decrease in inpatient days over two years of client participation, resulting in reductions in ED charges by 59% and in inpatient charges by 69%.[2] The pilot did not continue due to termination of necessary funding. A waiver pilot program could leverage existing funding streams to provide the infrastructure, support, and incentives needed to reinvigorate this important but challenging work.

[2] "Summary Report of Evaluation Findings: A Dollars and Sense Strategy to Reducing Frequent Use of Hospital Services." California HealthCare Foundation and The California Endowment. Available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/F/PDF%20FUHSIEvaluationReportSummary.pdf.

IV. Transforming DSH to Preserve Access for the Residual Uninsured

The third critical component of PHS' waiver proposal is to transform and modernize core financial support to PHS for care to low-income populations. The implementation of the ACA in California created a tremendous opportunity for patients to obtain health coverage that has been elusive for so many years, and for providers to receive payment for previously unreimbursed services. Nevertheless, it is estimated that there could be over three million remaining uninsured each year over the next several years who either are left out of the ACA or find ACA coverage options unaffordable. In addition, it will take several years to understand the true impact of the ACA on public health care systems. Despite these unknowns, cuts to the core funding streams that public health care systems have historically relied upon are either already taking place, or are scheduled to take place, including cuts to state health realignment funds and federal Medicaid Disproportionate Share (DSH) funds.

In order to preserve PHS' core mission as essential safety net providers in a dynamic and unpredictable health care marketplace, CAPH proposes:

1. Creating a Public Health Care System Access Fund (PHS Access Fund) to preserve PHS' ability to serve high volumes of Medi-Cal and uninsured patients throughout their system. The Access Fund would be financed through a global payment comprising a portion of Medicaid DSH funds and funds previously designated as Safety Net Care Pool's Uncompensated Care Pool (SNCP) dollars.
2. Preserving a smaller amount of DSH funds to continue to be claimed in the same manner as today.

In order to receive PHS Access Fund Global Payments, public health care systems would demonstrate a commitment to serving aa targeted number of unique uninsured and Medi-Cal patients while providing sufficient services for that safety net population level. Service provision would be defined in a new way to make the measure appropriate and not reward overutilization, and may include alternate, more efficient methods of care. This system of promoting access to a targeted number of unique patients *and* a minimum service level per unique patient creates an incentive for PHS to improve access for the safety net population through multiple avenues: aligning payment incentives; expanding non-face-to-face service modes; improving follow-up contacts with people who may otherwise use the system once and not return; improving efficiency by reducing ED-based first contacts; improving specialty/diagnostic access; and transferring more non-urgent care to non-ED settings.

The share of DSH and SNCP funding set aside in the PHS Access Fund would seek to maximize all projected available DSH and SNCP funds without offsetting financial consequences. Each PHS's share of the Fund would be

set in advance for each year, providing more certainty of funding levels. Partial fulfillment of metrics would lead to partial payment, but not below a certain point.

The reallocation of DSH funding also achieves payment reform goals by incentivizing care in lower-cost settings. Currently, DSH is only available for uncompensated care costs in a hospital setting, which means that without these proposed changes, the redirection of care into lower-acuity settings can potentially lead to reduced funding. A transformed DSH program and a PHS Access Fund will support the critical goals of the ACA to expand access, improve quality and efficiency, and contain costs.

V. Conclusion

The next Section 1115 Medicaid waiver offers California and the Federal Administration an historic opportunity to continue leading the nation in meeting the challenge and promise of the ACA through the testing of payment and delivery system reforms that can improve care, provide a better patient experience, and contain costs. California has already demonstrated successful leadership with health reform, enrolling millions through Covered California and a significant expansion of Medi-Cal. Health care coverage is a critical, foundational element of reform, yet as we know, coverage alone does not ensure access nor improve health. A renewed Medicaid 1115 waiver is needed in order to best leverage California's coverage expansion with significant payment reforms and delivery system improvements that together will advance all three elements of the Triple Aim.

For California to succeed in implementing the Affordable Care Act, California must work quickly and aggressively to restructure the delivery system and payment models in order to support more efficient care at a reduced per capita cost. Through the renewal of the Medicaid 1115 waiver, alongside a successful statewide SIM effort, we believe we can achieve our goals and realize our vision of becoming the healthiest state in the nation, demonstrating dramatic improvements in quality, experience and cost containment.