

Mari Cantwell
Chief Deputy Director
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

OCT 31 2015

Dear Ms. Cantwell:

I am writing to memorialize our discussions to date on California's request to extend several existing authorities for California's section 1115 demonstration project, entitled "California Bridge to Reform Demonstration," (Project Number 11-W-00193/9) that are set to expire on October 31, 2015. This agreement reflects CMS and the state's commitment to support the ongoing work in the Medi-Cal program, including the public provider delivery system in the state, and to ensuring access to care. CMS and California have agreed in principle on the terms below regarding a five year extension of the demonstration. While this letter lays out the general concepts of our shared approach, and we believe we have sufficient understanding of the concepts to begin drafting the Special Terms and Conditions (STCs), our overall agreement to this demonstration project is subject to the specifics that will be in the STCs.

Safety Net Care Pool: Public Hospital Redesign and Incentives in Medi-Cal (PRIME)

CMS is prepared to authorize a five-year extension of the necessary authorities for a pool focused on delivery system reform in the public provider system. The pool will build off of the 2010 – 2015 Delivery System Reform Incentive Program, but the new, redesigned pool, PRIME, will support the state's efforts towards the adoption of robust alternative payment methodologies (APMs) and support better integration, improved health outcomes and increased access to health care services, particularly for those with complex health care needs.

California will use this pool to fund public provider system projects that will change care delivery and strengthen those systems' ability to receive payment under risk-based alternative payment models. As these delivery system changes occur, the state has committed to adopting alternative payment models that align with HHS' delivery system reform goals where the provider is accountable for quality and cost of care. CMS and the state will measure the success of the DSRIP PRIME pool by the progress in adopting robust alternative payment methodologies for Medi-Cal payments to designated public hospital systems, including shifting risk through capitation from Medi-Cal managed care health plans (MCPs) to designated public hospital systems, and other risk sharing arrangements. Contracts between MCPs and DPHs will include language requiring the provider to report on a broad range of metrics to meet quality benchmark goals. Over the course of the demonstration, payments will increasingly move towards pay for

performance. The public health care systems will become self-sustaining entities that are not reliant on pool funds beyond 2020. To achieve such sustainability, 50 percent of all Medi-Cal managed care beneficiaries assigned to designated public hospital systems in the aggregate will receive all of or a portion of their care under a contracted alternative payment model by January 2018; 55 percent by January 2019; and 60 percent by the end of the waiver renewal period in 2020.

Funding for this pool will not exceed \$7.464 billion in combined federal and state shares of expenditures over a five-year period for designated public hospital systems and district/municipal public hospitals to support reforms to care delivery, provider organization and adoption of alternative payment methodologies. The demonstration will provide up to \$1.4 billion annually for the designated public hospital systems and up to \$200 million annually for the district/municipal public hospitals for the first three years of the demonstration. The pool will then phase down by 10% in the fourth year of the demonstration and by an additional 15% in the fifth year of the demonstration.

The state will develop an evaluation plan for the PRIME program which will assess the impact of the program on the public delivery system and Medi-Cal beneficiaries. This evaluation will also measure a broad range of metrics and data related to the quality of care and health outcomes of all Medicaid beneficiaries, including those with low socioeconomic status, served by participating providers.

Safety Net Care Pool: Uncompensated Care Pool

CMS is prepared to authorize the state's request to test a new global payment approach, the "Global Payment for the Uninsured," to assist designated public hospital systems, recognizing that they provide a disproportionate share of health care services for the uninsured. This approach will establish a Global Payment Program to assist participating designated public hospital systems that provide health care services for the uninsured by focusing on the value, not volume, of care provided, such as providing more primary and preventive services to avoid more costly emergency room and inpatient stays. The state proposes to establish individual public hospital system "thresholds" and "global budgets" for the remaining uninsured population, and will establish a "points" system. The state will use demonstration funds to make a prospective payment to each participating designated public hospital system, conditional on demonstrating that the points earned, which reflect the amounts and types of services provided to the uninsured, matches the funds received. Under this approach, point valuation would allow for the continuation of traditional services as they exist today, but encourage more appropriate and innovative care, and allow for point valuation of non-traditional services.

The authority to implement the new global payment approach is contingent upon CMS review and approval of the specific factors and parameters to be used in establishing the "points" system. Reflecting the innovative nature of this payment approach and to ensure accountability, CMS intends to conduct two evaluations to analyze the provider expenditures under the global payment. The first evaluation (using 24 months of data) will occur at the midpoint of the demonstration. The second will occur as part of the interim evaluation report due at the end of

Year 4. The terms of the demonstration will include the specific evaluation guidelines, but at a minimum, the evaluations will look at the number of uninsured individuals served, the number and types of services provided, the provider expenditures associated with the services provided, and the provider expenditures avoided due to the Global Payment Program. The evaluation will also include an assessment of the ratio of the Global Payment to uninsured uncompensated care cost compared to the FY 2015 ratio of UC and DSH payments to uninsured uncompensated care cost; and assessment of the effects of the Global Payment Program on care delivery and costs, including how and why the ratio of payment to uninsured uncompensated cost has evolved compared to the prior DSH and SNCP methodologies. This evaluation is not intended to be the basis of funding changes to the Uncompensated Care Pool

To maintain budget neutrality, the state will agree that it will not make DSH payments and uncompensated care payments to participating DPHs that would otherwise be permissible under the state plan. The estimated total spending limit for the first year of the global payment approach would be \$2.871 billion in combined federal and state shares of expenditures for designated public hospital systems (note that the actual size of the funding will be linked to the actual state DSH allotment portion that is allocated to participating DPHs). CMS is committed to providing funding for the continuation of this new global payment approach in the remaining four years of the demonstration, and will specify the funding amounts for the uncompensated care portion of the GPP for years two through five once the first report, described further below, is complete. The DSH component of the GPP is authorized for all five years.

Independent Report on Uncompensated Care

As we have discussed, CMS is notifying all states with uncompensated care pools about the information and analysis that is needed as part of an uncompensated care pool renewal request. We are providing here, similar to guidance we have provided to other states with uncompensated care pools, a detailed description of the independent analysis the state should submit, regarding the purpose, effect, and role of the uncompensated care pool. The analysis will be completed in two separate reports and is necessary for CMS to assess the role of the pool in promoting Medicaid objectives. The first report, due May 15, 2016, will focus on those providers who are currently receiving payment through the pool and will help the state and CMS to determine the appropriate level of UC funding at those providers in years two through five of the demonstration. The second report (due June 1, 2017) will focus on uncompensated care, provider payments and financing across providers that serve Medicaid beneficiaries and the uninsured.

As we have previously discussed with the state, CMS uses three principles to review states' uncompensated care pool requests: 1) coverage is the best way to assure beneficiary access to health care for low income individuals and uncompensated care pool funding should not pay for costs that would otherwise be covered in a Medicaid expansion; 2) Medicaid payments should support the provision of services to Medicaid and low income uninsured individuals; 3) and provider payment rates must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care. These principles apply whether or not a

state expands Medicaid. The analysis of the current uncompensated care pool should be performed by an independent entity qualified to make an assessment on the criteria outlined below.

The first report will be used to specify the funding amounts for the uncompensated care portion of the GPP for years two through five. CMS will provide a formal determination of the funding levels for demonstration years two through five within 60 days of receipt of the complete report. The report will review the impact of the uncompensated care pool on those providers who participate in the UC pool with respect to:

- uncompensated care provided;
- Medicaid provider payment rates;
- Medicaid beneficiary access; and
- role of managed care plans in managing care.

The second comprehensive report will examine the factors above with respect to all Medicaid hospital providers in the state, including data from the first report, and will also include a comparable examination of provider financing for those providers who serve the Medicaid population and the low-income uninsured. In addition, the second report will include the role of the PRIME program for designated public hospital systems. The second report will inform discussions about potential reforms that will improve Medicaid payment systems and funding mechanisms and the quality of health care services for California's Medicaid beneficiaries and for the uninsured.

Finally, we support the Whole Person Care Pilots and Dental Transformation Initiative that you have proposed. Whole Person Care pilots would be county-based, voluntary applications to provide more integrated care for high-risk, vulnerable populations. We also support the independent evaluation of beneficiary access and network adequacy in California. We look forward to working with you to finalize the design of these initiatives in the terms of the demonstration.

Other Financing Issues

CMS and the state also recognize that various issues pertaining to Medicaid financing will need to be addressed in the special terms and conditions to assure the success of the demonstration. The new special terms and conditions will continue the 2010-2015 special terms and conditions with respect to the provision of intergovernmental transfers that are in compliance with section 1903(w) of the Social Security Act.

CMS looks forward to drafting special terms and conditions that reflect the elements described above, and to reaching final agreement. In the interim, this letter authorizes a temporary extension of the demonstration until December 31, 2015, which will allow time to finalize the special terms and conditions. Payments made during the interim time period will be counted toward the overall spending limit for DY 11, which will be set forth in the approved extension. All current special terms and conditions apply during the temporary extension period, including

all waiver and expenditure authorities in the current demonstration, which will authorize the state to receive payment for services rendered during the temporary extension period. The current special terms and conditions are subject to revision based on final approval of the demonstration extension beyond December 31, 2015.

We look forward to working with you further on these topics as part of our effort to reach a final agreement on the demonstration extension.

Sincerely,



Vikki Wachino
Director

cc: Henrietta Sam-Louie, Acting ARA Region IX