

Assembly Committee on Health

Dave Jones, Chair

Informational Hearing

MEDI-CAL: CALIFORNIA'S PROPOSED MEDI-CAL SECTION 1115 WAIVER RENEWAL IMPLEMENTATION PLANS AND LESSONS LEARNED

Thursday, December 10, 2009
9:00 am-11:00 am
State Capitol, Room 126

Briefing Paper

Overview

In 2005, the State of California sought a five year federal waiver as a Medicaid demonstration project. The waiver was under the authority of Section 1115(a) of the Social Security Act, and entitled “The Medi-Cal Hospital/Uninsured Care Demonstration Project Act,” (hospital waiver). The implementing legislation was enacted by SB 1100 (Perata), Chapter 560, Statutes of 2005. Under this waiver, hospital financing was fundamentally restructured. The non-federal share of Medi-Cal funds for 22 county and University of California (UC) hospitals known as Designated Public Hospitals (DPHs) was shifted from State General Funds to certified public expenditures (CPEs).

The waiver also created the Safety Net Care Pool (SNCP) to pay for services to the uninsured and for unreimbursed Medi-Cal expenditures delivered through public hospitals, other governmental entities, and state-funded programs. A portion of these funds were contingent on implementation of a Health Care Coverage Initiative (HCCI) pilot program. In October 2007 the federal Centers for Medicare and Medicaid Services (CMS) approved the state’s proposal for the Health Care Coverage Initiatives (HCCI).

In addition, CMS set aside a portion of the SNCP funding contingent on a Medi-Cal expansion of mandatory enrollment in managed care to seniors and people with disabilities (SPDs). Except for County Organized Health Systems (COHS), this provision of the waiver was never enacted. Enacted as part of the 2009-10 State budget, AB 4x 6 (Evans), Chapter 6, Statutes of 2009 requires the state to apply for a new waiver to be approved no later than the conclusion of the current 1115 hospital waiver. As mandated by AB 4x 6, the State of California is preparing a concept paper to submit to CMS requesting a Comprehensive Section 1115 waiver to replace the current Medi-Cal hospital waiver. A Section 1115 Waiver Concept Draft Paper was released on October 19, 2009.

Concept Paper

The concept paper establishes broad goals and objectives. The dimension of the issue is defined:

1) In terms of the challenges that may be faced if there are large populations of newly eligible persons under health care reform; 2) Opportunities for reform; 3) The realities of the economic crisis; and, 4) The need for coordinated care for the most vulnerable Medi-Cal population that are not in managed care (SPDs).

According to the concept paper, the goals are:

- 1) Create more accountable, coordinated systems of care;
- 2) Strengthen the health care safety net;
- 3) Reward health care quality;
- 4) Improve outcomes;
- 5) Slow the long-term expenditure growth rate of Medi-Cal; and,
- 6) Expand coverage to uninsured Californians.

In addition, the concept paper highlights the opportunity to make the Medi-Cal program more efficient, achieve long-term savings as well as lay the ground work for implementation of national health care reforms.

The paper lays out four initiatives:

- 1) Promote Organized Delivery Systems of Care;
- 2) Strengthen and Expand the Health Care Safety Net;
- 3) Implement Value-Based Purchasing Strategies; and,
- 4) Enhance the Delivery System for the Uninsured to Prepare for National Reform.

This hearing has been scheduled to address two aspects of the four initiatives proposed in the concept paper. Specifically:

- 1) To examine the goal of promoting organized delivery systems of care by reviewing the lessons that can be learned from existing systems; and,
- 2) The role and financing of safety net hospitals.

I. Promote Organized Delivery Systems of Care.

Existing Program

The delivery of basic health care services in the Medi-Cal program is either through Medi-Cal managed care or fee-for service (FFS). Within managed care there are three different models; COHS; Geographic Managed Care (GMC); and, the Two-Plan Models in 26 counties. The

Budget Act of 2005 authorized expansions into 13 new counties; four have been implemented; two are scheduled for October 2010; three are in the process of establishing new dates; and, four have been eliminated. Half of all Medi-Cal beneficiaries are mandated to enroll in managed care plans. This population is primarily children, pregnant women, and non-disabled parents. SPDs may choose to enroll in managed care in Two-Plan and GMC counties, but have enrolled in very small numbers. In COHS counties the SPD population is mandated to enroll. The remainder of the SPD population and parents and children in counties without managed care are in FFS Medi-Cal.

Expansion of Managed Care to SPD

The Legislature declined to adopt the Governor's proposal for mandatory enrollment of the SPD population in the 2005 waiver. The Department of Health Care Services (DHCS) has however, been conducting outreach and awareness activities to encourage voluntary enrollment. As part of that effort, DHCS and the UC Berkeley, School of Public Health, Health Research for Action (HRA) are jointly working on SPD outreach activities. HRA developed a comprehensive guide, "What Are My Medi-Cal Choices?" which was tested in a phone survey and pilot study in Alameda, Riverside, and Sacramento counties in 2008. DHCS reports that initial findings from the research show that the guide is an effective way to improve beneficiary knowledge, confidence, and intentions about making more informed Medi-Cal choices. Ninety-eight percent of the tested population found the information in the guide to be useful, and 83% found the guide easy to understand. The pilot guide was revised based on findings from these evaluations.

The guide is currently available in English, Spanish, and Chinese. HRA is translating it into the remaining threshold languages. DHCS is exploring funding options for on-going printing and dissemination of the SPD guide. HRA is currently analyzing DHCS enrollment data collected through December 15, 2008 to determine the impact of the guide on enrollment levels. This analysis was expected to be completed by March 2009; however, there have been some difficulties in the data collection process.

In addition, in February 2005, the California HealthCare Foundation (CHCF) began a project to develop and implement better health plan performance standards and measures for the SPD population and to develop a tool to assess the readiness of health plans to enroll large numbers of people with disabilities and chronic illness. The project was a collaborative effort between CHCF, which provided funding and technical assistance, and DHCS.

The goal of this project was to enhance California's Medi-Cal managed care program to support a health care service delivery system that provides quality care for people with disabilities and chronic illness. The project laid the foundation for efforts to evaluate and to improve how well the Medi-Cal managed care program serves this population. In Phase 1, the project team developed a set of recommendations provided to DHCS for health plan contract performance standards (also called operating standards or contract specifications) and measures that may foster improvements in quality of care for people with disabilities and chronic illness. Another set of recommended strategies for DHCS addressed cross-agency issues that affect quality of

care for people with disabilities and chronic illness (such as care coordination and information sharing).

The final report, “Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions,” provided specific recommendations to strengthen existing standards in managed care to ensure that limited state resources are used most effectively; and, to improve the quality of care provided to people with disabilities. The recommendations encompass new standards in the areas of enrollment and member services, network capacity and accessibility, benefit management, care management, quality improvement, performance measurement, and coordination of carve-out services.

In Phase 2 of the project, the team worked with DHCS to create a set of recommended strategies for DHCS to monitor health plan contract compliance and a tool to assess the readiness of health plans to serve a large influx of new beneficiaries with disabilities and chronic illnesses, known as the “Medi-Cal Health Plan Readiness Tool.” It is intended to supplement the tools and activities the state already uses to assess the readiness of a health plan to serve Medi-Cal beneficiaries. This tool is not designed to be used alone, as it does not reflect existing performance standards and measures used in Medi-Cal managed care.

High-Cost Users

According to DHCS, 10 % of the FFS Medi-Cal beneficiaries account for 74% of the total program costs. On the other hand, the half of the population that is enrolled in capitated health plans account for only 10% of the expenditures. DHCS further points to the fact that almost 70% of the Medi-Cal beneficiaries with disabilities have two or more chronic conditions and almost one-quarter have four or more chronic conditions.

California ranks 34th among states in per beneficiary costs among the blind and disabled. In addition, California spends 25% less per beneficiary than the national per capita amount and the least among the ten largest states. The per-capita costs are 11% below the national Medicaid amount. This paints a picture of a program already underfunded.

DHCS has attempted a number of pilot or small scope strategies to reduce the costs within subsets of the SPD population. These include:

Aggressive Medical Case Management (MCM)

The 1992 Budget Act and accompanying health trailer bill (SB 485 (Committee on Budget), Chapter 722, Statutes of 1992) enacted the MCM program to reduce the number and duration of hospital stays. MCM case managers are registered nurses employed by the state who coordinate and authorize outpatient services which may expedite a Medi-Cal beneficiary’s hospital discharge to a private residence or maintain them in a home-care setting. Nurse case managers do not provide hands-on care but work directly with hospitals, home health agencies, physicians, and other Medi-Cal providers to ensure the appropriate and expedited authorization of medically necessary services. The goals of MCM are to ensure safe hospital discharges, continuity of

medical care in the home-care setting, and to stabilize recipients with complex, chronic and/or catastrophic medical conditions. MCM nurse case managers are stationed in five field offices throughout the state, are assigned to various hospitals, and conduct site visits. The MCM Program served approximately 12,400 Medi-Cal beneficiaries in 2008.

In 2001-02, the assumed gross Medi-Cal savings was \$418,823 per nurse case manager, and the 2002-03 proposal assumed gross Medi-Cal savings of \$467,512 per year per nurse case manager. More recently, DHCS indicates it does not have a specific cost/benefit return on investment formula for the MCM program. Staffing for the MCM program was expanded during the 2001-02 and 2002-03 fiscal years and assumed significant savings

Disease Management Program

The health budget trailer bill of 2003 (AB 1762 (Committee on Budget), Chapter 230, Statutes of 2003) established the Disease Management Waiver to test the effectiveness of providing a Medi-Cal disease management benefit. During implementation, DHCS opted to use a pilot project approach that did not require a waiver. Eligibility for the Disease Management program is limited to those persons who are eligible for the Medi-Cal program as SPDs, or those persons over 21 years of age who are not enrolled in a Medi-Cal managed care plan, or are ineligible for Medicare, and who are determined by the DHCS to be at risk of, or diagnosed with select chronic diseases, including, but not limited to, advanced atherosclerotic disease syndromes, congestive heart failure, and diabetes.

DHCS contracts with two vendors to operate two disease management programs for Medi-Cal beneficiaries. McKesson Health Solutions provides disease management services in Alameda County (3,370 enrollees as of March 31, 2009) and more than 120 zip codes in Los Angeles County (14,125 enrollees as of March 31, 2009) under a three-year \$4 million per year contract. The McKesson contract is in its second year of operation. Positive Health Care (PHC) is a disease management program for Medi-Cal beneficiaries who have been diagnosed with HIV or AIDS. PHC has a three-year \$4 million per year contract and began enrollment in March 2009.

Coordinated Care Management (CCM)

The budget Act of 2006 authorized DHCS to establish the CCM Demonstration Project. CCM I focuses on SPDs who have chronic conditions or who may be seriously ill and near the end of life. CCM II focuses on persons with chronic conditions and serious mental illnesses. The first phase was scheduled to begin in October 2009 and Phase II is scheduled for January 2010. DHCS plans to enter into contracts to implement these programs.

Scope of AB 4x 6 (Evans)

In implementing the requirements of AB 4x 6, DHCS is planning to develop organized systems of care for the most medically vulnerable, high-cost category to slow the long term growth rate, approximately 2 million enrollees. The key elements as spelled out in AB 4x 6 and the concept

paper are mandatory medical home care, coordinated care, and disease management, better connection to specialty providers, as well as incentives that reward providers and beneficiaries for achieving the desired clinical utilization, and cost-specific outcomes. The four phases are:

- 1) Enrollment in organized delivery systems for SPD and children and families in rural counties;
- 2) Children with special health care needs (CCS);
- 3) Dual-eligible beneficiaries (Medi-Cal and Medicare); and,
- 4) Adults with severe mental illness.

Stakeholder Responses

Frequent user programs

Many stakeholders have pointed to The Frequent Users of Health Services Initiative (Initiative) as an example of a delivery system that addresses the needs of high-cost existing and potential Medi-Cal beneficiaries. The Initiative was a five-year, \$10 million project jointly funded by The California Endowment and CHCF. The goal was to promote the development and implementation of innovative, integrated approaches to addressing the comprehensive health and social service needs of frequent users of emergency departments (ED).

Frequent users of acute care hospital EDs are individuals with complex, unmet needs not effectively addressed in the acute care settings of EDs. These individuals face barriers in accessing housing and medical, mental health, and substance abuse treatment, all of which can contribute to frequent ED visits. The Initiative was designed to develop and test new models to serve this population more effectively, replacing a costly and avoidable health care utilization pattern with ongoing, coordinated, and multidisciplinary care provided in more appropriate settings. At the core of the Initiative were six demonstration projects that tested new models of care for frequent users throughout California.

According to an evaluation by The Lewin Group in August of 2008, the programs yielded statistically significant reductions in ED utilization (30%) and hospital charges (17%) in the first year of enrollment. Based on analyses of a subset of individuals for whom two years of data were available, ED utilization and charges decreased by an even greater magnitude in the second year after enrollment. ED visits decreased by 35% in the first year of the program for this subset of individuals, and by year two, utilization decreased by more than 60% from the pre-enrollment period. The Lewin Group evaluation estimates savings from reduced ED and inpatient services to be approximately \$ 32,000 per person after two years.

Grants were awarded in six counties, Alameda, Los Angeles, Orange, Sacramento, Santa Clara, Santa Cruz, Sonoma, and Tulare. The six programs funded through the Initiative developed specific models and interventions to address the range of presenting conditions of frequent users in their area hospitals and communities. A range of models were tested through the Initiative — from various types of intensive case management to less intensive peer- and paraprofessional-

driven interventions — to learn which strategies may be effective in reducing the avoidable use of and reliance on EDs, and in creating a more effective system of care for the frequent user population.

Connection to stabilizing services such as housing, health insurance, and income benefits was an important intermediate outcome of the intervention models, and most of the programs were successful in connecting clients to needed resources. More than 60% of program enrollees had no insurance or were underinsured at enrollment. Most of the remaining 40% were Medi-Cal beneficiaries. Among the clients without adequate insurance at enrollment, nearly two-thirds (64%) were connected to coverage through the county indigent program, and Medi-Cal applications were filed for 25%. Of the Medi-Cal applications submitted, 68% were approved. The Lewin Group concluded that based on these outcomes, the programs were very successful connecting enrollees to needed resources.

Enhanced Medical Home (EMH) Model

Advocates for low-income beneficiaries and providers have also expressed support for the concept of an EMH for this population. The following suggestions and concerns regarding these goals have been raised:

- 1) A medical home should be a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family;
- 2) Patients should be able to choose whether to join a health care home, which would provide incentives to the health care home to conduct outreach and engagement. This is particularly important for beneficiaries with unmanaged chronic conditions and other high-cost high-need beneficiaries;
- 3) The health care home should not act as a gate keeper, preventing patients from seeking care "outside the network" or requiring a referral for specialty care;
- 4) Health care homes should offer care/case management to coordinate care, as well as a means of linking (rather than just referring) patients to medical and social services;
- 5) The intensity and scope of services the health care home offers should vary according to need;
- 6) Care should be integrated across elements of a health care system;
- 7) The health care home should provide an assessment of the patient's needs (medical, behavioral, and social services needs), along with a plan to address the needs;
- 8) Staff of the health care home should be culturally competent; and,
- 9) The health care home should plan for hospital or acute care discharge.

The California Association of Public Hospitals states that public hospital systems meet the standards for an EMH program for the SPD population as described in the Center for Health

Care Strategies (CHCS) report entitled, “Enhanced Medical Homes for Medi-Cal's SPD Population.” This report specifies seven core elements. These are the ability to:

- 1) Provide a medical home for each of the approximate 360,000 FFS SPD, i.e., establish a mandatory relationship with a patient-centered provider of primary care services;
- 2) Identify, assess, and stratify the needs of the target population;
- 3) Tailor care interventions to meet the needs of subsets of the target population, including those experiencing disparities in care associated with race, ethnicity, language, and literacy;
- 4) Address the psychosocial, preventive care, and social support needs of high-risk beneficiaries through effective care coordination and management interventions, and linkages to appropriate community-based services;
- 5) Use innovative health information technology solutions to share data with providers on their panel of patients, practice performance, and their compliance with evidence-based guidelines;
- 6) Measure performance to promote accountability and quality improvement; and
- 7) Structure financing to support the EMH program’s ability to perform the above.

Stakeholders have also suggested that a single statewide approach is not appropriate, neither geographically nor by population, and that a wide variety of models should be included. Geographically, there are wide variations in the capacity and types of safety net providers utilized by the target populations, from rural clinics to urban public hospitals. Furthermore, a significant component of successful models has been the ability of the medical home care coordination to link the client to local resources.

Pilot projects such as the frequent user initiative also found that an EMH model must include risk stratification to be effective. This involves using data to be able to tailor the program to the needs of individuals. The various initiatives have found that among this population the full spectrum of levels of care coordination must be available. Some of the high-cost beneficiaries will require intensive care management whereas others may benefit from less intensive services.

On behalf of managed care plan stakeholders, the California Association of Health Plans (CAHP) has also expressed the interest of its members in participating in an EMH model. CAHP reports that they have adopted many of the Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions developed by CHCF in its 2005 report.

CCS

The Children's Specialty Care Coalition has suggested the following revisions to the concept paper:

Children with special health care needs. California will work with stakeholders to enhance the delivery of health care to children with special health care needs, while preserving the strengths of the current California Children’s Services (CCS) Program, e.g. the maintenance and enforcement of regionalized structure of care, the maintenance of CCS standards, and the provider network. In addition, California will work with stakeholders to conduct careful and thorough analysis of existing claims data to determine the costs of the program and the cost distribution across clients. The state will then work with stakeholders to develop pilot projects to test different models and approaches that will improve the health care systems for children with serious and chronic health care conditions. CCS clients who are in the SPD population shall not be moved into managed care until data and analysis of pilot projects have been completed. The pilot projects will incorporate the core concepts of organized delivery systems into the care received by children less than 21 years of age with special health care needs in the CCS Program (i.e., CCS-eligible children). Responsibilities and incentives for specialty and non-specialty care will be better integrated and aligned to promote clearer accountability, better care coordination, more effective and efficient use of public dollars, and improved health care quality outcomes. Case management and care coordination services will be provided in a way that streamlines the care delivery process and provides more flexibility to ensure the most appropriate care is provided. — The CCS pilots should include, but not be limited to: a clearly defined medical home based on the patient subpopulation, EPSDT standards and benefits, data collection and reporting on quality and outcomes, access to the CCS provider network and appropriate pediatric subspecialists and primary care providers, promotion of outpatient care for specified conditions, improved care coordination and case management in both primary and specialty care services, and effective and efficient use of public funds. The pilot projects will provide adequate funding for both hospital and physician services, to ensure children with special health care needs have access to appropriate medical care services, and to keep pediatric tertiary centers from closing. The Children's Hospital Association also recommends a pilot project using regional Children's Hospitals to act as a medical home for special needs children and that would include the whole child carved out into CCS, not just the condition.

Long-term Care

The Alzheimer's Association has recommended:

- 1) Provider standards require care management to be multi-disciplinary; patient and family caregiver centered; proactive; culturally appropriate; and, focused on medical, social and behavioral needs;
- 2) Providers be required to include annual dementia screening after age 60 or 65;
- 3) After an Alzheimer's diagnosis, the physician or care management team must assess the health need of the family caregiver and his/her capacity to deliver care; and,
- 4) The full spectrum of home and community based service be included, such as Adult Day Health Care (ADHC) and savings generated be used to back fill cuts in other programs such as In-Home Supportive Services.

The California Association for Adult Day Services requests that ADHC be included as a core service and points out that ADHCs are in a position to meet the waiver concept of addressing the psychosocial, preventative care, and social support needs of high risk beneficiaries through effective care coordination and management interventions, and linkages to appropriate community-based services.

II. Role and Financing of Safety Net Hospitals.

Background

The Selective Provider Contracting Program (SPCP) was established by the Legislature in 1982 under a 1915(b) waiver and allowed the California Medical Assistance Commission (CMAC) to selectively contract as long as there was adequate access to hospital beds to serve the Medi-Cal population in a Health Facility Planning Area (HFPA). Except for emergencies, most FFS Medi-Cal beneficiaries in a closed area are required to receive in-patient care at a contract hospital. Selective contracting allowed CMAC to negotiate a competitive rate in place of the traditional “cost-based” reimbursement system used by most states. According to CMAC’s 2009 Annual Report to the Legislature this has saved the State almost \$11 billion in State General Fund savings since 1983. Hospitals in an open area continue to be reimbursed on a cost-based system. The SPCP program continues in a modified fashion under the 2005 hospital waiver.

One of the most significant revisions under the 2005 hospital waiver was to make fundamental changes in Medi-Cal hospital financing for public hospitals. Reimbursement for Medi-Cal per diem for the 21 UC and county DPHs is now based on certified public expenditures (CPEs), rather than General Fund. The in-patient reimbursement rate is no longer negotiated by CMAC and is determined by DHCS. The waiver also created the SNCP which provides a fixed amount of federal funds to cover uncompensated care. CPEs are the expenditures certified by counties, state university teaching hospitals, or other public entities as having been spent on Medi-Cal patients or on the uninsured.

The 2005 hospital waiver was also a response to the increasing federal scrutiny by CMS of Intergovernmental Transfers (IGTs). IGTs are transfers of public funds from one level of government to another. California relied on IGTs as the nonfederal share for various supplemental payment programs such as the SB 1255 Emergency Services and Supplemental Payment Program and disproportionate share hospital (DSH) payments and to backfill the General Fund in the Medi-Cal program. Under the terms of the 2005 hospital waiver, the use of IGTs as the non-federal share of Medi-Cal payments was severely restricted.

CMAC retained authority to continue negotiating rates under the SPCP for private and non-designated public or primarily district hospitals (NDPH) for the provision of hospital inpatient services in the Medi-Cal FFS program.

Annual federal funding to more than 100 public and private hospitals participating in the waiver is more than \$3 billion dollars annually. The source of financial support for patient treatment costs depends on a variety of factors including the ownership status of the hospital, baseline funding provided at the start of the waiver in 2005, the nature of the service provided, and the coverage status of the patient.

In addition, funding amounts are impacted by changes enacted through the annual budget process, related litigation about budget reductions, enhanced funding available via the federal stimulus act, and final reconciliation of funding within the waiver, which lags for several years. The following are general descriptions of some of the major waiver funding sources available to hospitals under agreements with the federal government and enacted in SB 1100:

- 1) Public Hospital Funding (County- and University of California-operated medical centers, 21 facilities total):
 - a) *DSH Fund*. Just over \$1 billion in federal funding is available to public hospitals in the DSH Fund during each year of the waiver to provide care to Medi-Cal and uninsured patients. DSH is a federal designation and funding mechanism available in the Medicaid program to provide supplemental funding to hospitals caring for a significant proportion of indigent patients. The waiver DSH Fund is at a fixed level in a specific year, but may change over time and contains no state General Fund. Hospitals submit CPEs and IGTs to draw down federal funds. IGTs may only be used to fund the non-federal share of DSH payments between 100 and 175% of the uncompensated costs.
 - b) *SNCP Fund*. \$586 million in federal funding is available to hospitals for the care of Medi-Cal patients and the uninsured via the SNCP Fund during each year of the waiver. This fund is capped and contains no General Fund. An additional \$180 million (federal) is available via the SNCP Fund during the final three years of the waiver to the 10 counties participating in the Coverage Initiative to expand health coverage to low-income uninsured Californians through local safety net resources, hospitals, and community clinics.
 - c) *Medi-Cal Cost-Based Reimbursement* paid to public hospitals is approximately \$1 billion annually to support Medi-Cal patient care costs. This cost-based reimbursement in the current waiver replaced public hospital per diem payments that had previously been negotiated by CMAC. Under the waiver, each public hospital has a facility-specific cost-based rate and uses CPE to draw down federal funding. No state General Fund is contained in this fund and this funding source is uncapped, through increases in spending at the facility/local level to enable increased federal funding support.
- 2) Children's, Private, and District Hospital Funding private and public hospitals) (more than 100 facilities):
 - a) *Medi-Cal Per Diem Payments* for private and district hospitals are subject to negotiations with CMAC. Total costs are shared between the federal government and state General Fund Annual federal funding is in the \$900 million range. This funding source is uncapped and depends on the number of Medi-Cal patients who receive inpatient care in a given year and the duration of that care.
 - b) *DSH Replacement Fund*. Approximately \$250 million in federal funding is available annually for private and district hospitals via the DSH Replacement Fund. These funds

provide support for uncompensated care provided to Med-Cal and uninsured patients. The Replacement Fund back fills for DSH funding previously available to private and district hospitals that is now available exclusively to public hospitals in the current waiver. The non-federal share of this fund is provided by the General Fund and is fixed each year by an allocation from the federal government and through the annual budget act.

- c) *Private Hospital Supplemental Fund.* Approximately \$130 million in federal funding is available via the Private Hospitals Supplemental Fund annually to hospitals that meet statutory criteria for specified emergency or educational services, or for specified support of small or rural facilities. This fund replaced the Emergency Services and Supplemental Payment Program; the Medi-Cal Medical Education Supplemental Payment and Medi-Cal Large Teaching Emphasis Hospital and Children’s Hospital Medical Education Supplemental Payment Programs; and, Small and Rural Hospital Supplemental Payment Program.
- d) *NDPH Supplemental Fund.* Approximately \$3.7 million annually in supplemental payments are available to small and rural NDPH hospitals that meet statutory criteria.

The amount of federal matching funds for hospital payments is subject to certain limits. There is a statewide limit on total DSH payments and facility- specific limits. In all states but California, the maximum DSH payment of an individual hospital is the difference between the hospital’s inpatient and outpatient costs of treating Medi-Cal enrollees and the uninsured, and the amounts the hospital receives from Medi-Cal reimbursement plus out-of-pocket payments from the uninsured. However, in California DSH payments for DPHs may equal up to 175% of the difference between costs and reimbursement. The second limit is the “upper payment limit” and is established by hospital category. This is the estimated amount that all hospitals in each category (DPH, NDPH, and private) would receive if they were paid at the Medicare rate.

The concept paper states that the State may also explore transitioning private hospital inpatient services from the current per diem system to a diagnosis or acuity based payment system such as the diagnosis-related group (DRG) system. Until it is able to transition to a new system, California will continue its very successful, cost effective SPCP in the next waiver.

The concept paper lists two ways that the new waiver will strengthen and expand the safety net system that specifically affects public hospitals:

- 1) Provide a role for designated public hospitals (DPHs) in the network of organized systems of care for seniors and persons with disabilities; and,
- 2) Increase federal financial participation for Medicaid inpatient per diem payments to DPHs.

Stakeholders representing private safety net hospitals such The Private Essential Access Community Hospital, Inc and Catholic Healthcare West have sought assurances that their members will be able to participate as the concept paper does not address the role of private DSH hospitals.

Waivers

Section 1115 of the Social Security Act authorizes the federal Secretary of Health and Human Services to allow states to receive federal Medicaid matching funds without complying with all of the federal Medicaid rules. Traditionally designed as research and demonstration programs to test innovative program improvements and to facilitate coverage expansions to populations not otherwise eligible, they are also used to modify benefits structures and financing mechanisms. CMS generally requires “budget neutrality” so that the federal spending would be no more than it would have been in the absence of the waiver. This requirement is particularly onerous for California due to the frugality of the Medi-Cal program. For instance, California spent \$4,528 per beneficiary in 2006. This is 25% less than the national average and ranks least among the ten largest states. The SPCP contracting program has saved billions in federal funds. Until 2009, California traditionally ranked among states with the least generous federal sharing ratio. For all these reasons, California has already cost the federal government less per beneficiary than most states but has not yet been able to capitalize on this in the budget neutrality discussions. California operates under at least 24 other waiver programs, including the Section 1915(b) waiver for managed care and mental health consolidation.

Waiver Renewal Process

AB 4x 6, (Evans) was enacted as part of the 2009-10 budget. It requires DHCS to apply to CMS for a waiver or demonstration project to replace the current Medi-Cal Hospital/Uninsured Care Demonstration Project. AB 4x 6 sets out specific goals, timelines and populations to be covered. The bill requires the waiver or demonstration project to include proposals to restructure the organization and delivery of services to be more responsive to the health care needs of Medi-Cal enrollees for the purpose of providing the most vulnerable Medi-Cal beneficiaries with access to better coordinated and integrated care that will:

- 1) Improve their health outcomes;
- 2) Slow the long-term growth of the Medi-Cal program; and,
- 3) Continue support for the safety net care system and the persons who rely on that system for needed care.

The restructuring proposals may include, but are not limited to, the following:

- 1) Better care coordination for seniors and persons with disabilities, dual eligibles, children with special health care needs, and persons with behavioral health conditions, which includes the establishment of organized delivery systems that incorporate a medical home system and care and disease management;
- 2) Improved coordination between Medicare and Medi-Cal coverage;

- 3) Improved coordination of care for children with significant medical needs through improved integration of delivery systems and use of medical homes; and,
- 4) Improved integration of physical and behavioral health care.

AB 4x 6 also authorizes DHCS to seek authority to enroll beneficiaries into specified organized delivery systems, such as managed care, enhanced primary care case management, or a medical home model, and requires the waiver to include processes, and criteria, by which DHCS will evaluate and grant exemptions, on an individual basis, from any mandatory enrollment of beneficiaries into managed care.

DHCS is required to consult regularly with interested stakeholders and the Legislature in developing the waiver and to submit an implementation plan to the appropriate fiscal and policy committees at least 60 days prior to any appropriation.

DHCS released the draft concept paper on October 19, 2009 and held a public forum on November 2, 2009. A number of stakeholder processes have been occurring on a parallel track:

- 1) Prior to the release of the concept paper (July 2009), Blue Shield Foundation held three facilitated focus sessions and invited a representative group of organizations and advocates who represent seniors and people with disabilities. They have issued a summary of the key points.
- 2) CHCS in partnership with DHCS and supported by CHCF issued a report in September 2009 entitled "Enhanced Medical Homes for Medi-Cal's SPD Population." It is the result of an effort involving feed back from stakeholders and consumer advocates.
- 3) Health Management Associates prepared a paper with support from CHCF that was presented to the State entitled "Considerations for Redesign of the California Children's Services (CCS) Program" that was also the result of a stakeholder process in July of 2009.

As required by AB 4x 6, DHCS will convene a stakeholder committee to advise on preparation of the implementation plan. The stakeholder committee will also advise on the implementation of the waiver until its expiration.

As specified, the stakeholder committee will include, but not be limited to, persons with disabilities, seniors, representatives of legal services agencies that serve clients in the affected populations, health plans, specialty care providers, physicians, hospitals, county government, labor, and others as deemed appropriate. According to DHCS the representation of the stakeholder committee was to be announced in mid-November 2009

DHCS announced plans to convene the stakeholder committee in December 2009. According to DHCS, in the first phase of its work, the committee will meet every six weeks from December through July to provide advice on the development of the waiver implementation plan. DHCS will also convene technical workgroups to focus on various components of the waiver as needed, such as persons with disabilities, dual eligibles, children with special health care needs, persons with behavioral health conditions, coverage initiatives, and value based purchasing.

DHCS is required by AB 4x 6 to submit the application to CMS in sufficient time to allow approval for the new waiver no later than September 1, 2010. AB 4x 6 also requires DHCS to implement only upon submittal of an implementation plan as specified to the appropriate policy and fiscal committees of the Legislature at least 60 days prior to any appropriation. Mandatory enrollment may only occur when funds necessary have been appropriated.

Relevant Legislation

- 1) AB 342(Bass), currently in the Senate Health Committee, requires DHCS to submit a waiver request to implement a demonstration project to improve Medi-Cal and conditions the waiver upon subsequent statutory enactment. This bill is in the Senate Health Committee.
- 2) SB 208 (Steinberg and Alquist), currently in the Assembly Health Committee, is identical to AB 342.