MEDICAID SECTION 1115 WAIVER:
CALIFORNIA BRIDGE TO REFORM DEMONSTRATION

WHAT COUNTIES NEED TO KNOW

Prepared for the CSAC Health and Human Services Policy Committee
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Contents:

Attachments:

MEDICAID SECTION 1115 WAIVER: CALIFORNIA BRIDGE TO REFORM DEMONSTRATION

OVERVIEW

California and the federal government concluded their negotiations on California's five-year, Medicaid Section 1115 waiver on November 2. The new waiver – effective from November 1, 2010 to October 31, 2015 – is titled, "California Bridge to Reform Demonstration."

California could receive approximately $10 billion in federal funds over five years. These federal funds will be invested in California's health care delivery system to prepare for national health care reform and to sustain the Medi-Cal program. The waiver offers California the opportunity to expand coverage to childless adults, promote public hospital delivery system improvements, preserve the safety net, and improve care coordination.

Timeline

The Bridge to Reform Waiver is considered an extension of the 2005 Medicaid Hospital Financing Waiver. As such, each year of the waiver is identified as follows:

	Start Date	End Date
Demonstration Year 6	November 1, 2010	June 30, 2011
Demonstration Year 7	July 1, 2011	June 30, 2012
Demonstration Year 8	July 1, 2012	June 30, 2013
Demonstration Year 9	July 1, 2013	June 30, 2014
Demonstration Year 10	July 1, 2014	October 31, 2015

Key Elements

The waiver includes the following key elements:

- **Coverage Expansion.** The waiver builds on the existing county Coverage Initiatives and expands them to all counties that wish to participate, with new standards and requirements for each program. While the terms and conditions (the legal document governing the waiver) uses different names for coverage of adults with incomes between 0-133 percent and 134-200 percent of the Federal Poverty Level (FPL), it appears the state will be using the term Coverage Expansion and Enrollment Demonstration (CEED) to describe the projects going forward. As part of the CEED projects, counties may enroll persons in state prisons and county jails for inpatient hospital services. Essentially, inmates who leave the grounds of the prison or county jail for an inpatient stay at a community hospital would become eligible for Medi-Cal or a CEED project.

- **Safety Net Care Pool.** A Safety Net Care Pool is continued under the new waiver, with a series of components, including partial reimbursements to public hospitals for uncompensated uninsured care costs; the DSRIP described above; and federal match for designated state programs, for which the state can access up to $400 million annually.

- **Delivery System Reform Incentive Pool.** The waiver includes the potential for $3.3 billion in federal funds over five years for public hospitals through the Delivery System Reform Incentive Pool. This funding will be contingent upon public hospitals' achievement of specific milestones and deliverables related to infrastructure development, innovation and redesign, population-focused improvements and urgent improvement in care. The waiver provides the possibility that portions of these funds could be used for incentive payments to private or district Disproportionate Share Hospitals (DSH) if such a program is developed at the State level.

- **Care Coordination.** The waiver requires mandatory enrollment of seniors and persons with disabilities into Medi-Cal managed care. The waiver also includes a pilot program for the California Children's Services (CCS) program.

Funding Streams

The new waiver continues the funding streams from the 2005 waiver for public hospitals:

- **Medi-Cal Fee-for-Service.** Provides funding for inpatient services provided to Medi-Cal patients enrolled on a fee-for-service basis. Public hospitals draw down the federal matching funds using Certified Public Expenditures (CPEs). As more patients move from fee-for-service into managed care, this funding stream will decline.

- **Medi-Cal Inpatient Fee-for-Service Physician Services.** Provides funding for professional physician services provided to Medi-Cal patients. The Centers for Medicare and Medicaid Services (CMS) specified that physician services are not included in the regular Medi-Cal inpatient fee-for-service reimbursement. Public hospitals draw down the federal matching funds using CPEs. As more patients move from fee-for-service into managed care, this funding stream will decline.

- **Disproportionate Share Hospital (DSH).** Provides funding for hospital-based services – inpatient and outpatient – to uninsured patients, including undocumented immigrants. Public hospitals use a combination of Intergovernmental Transfers (IGTs) and CPEs to draw down DSH payments. Federal DSH funding remains subject to an annual cap, which has historically been approximately $1 billion.

- **Safety Net Care Pool Uncompensated Uninsured Care.** Provides funding for inpatient, physician and hospital- and non-hospital-based outpatient and other services provided to uninsured patients. However, this pool excludes undocumented immigrants. Public hospitals draw down the federal matching funds using CPEs.

- **Coverage Initiatives.** $180 million a year, for three years, was included in the 2005 waiver to create health coverage initiatives. This funding is included in the Safety Net Care Pool. Ten counties created these programs. The counties provide the match to draw down the

federal funds using CPEs. The ten programs have expanded coverage to more than 100,000 adults with incomes up to 200 percent FPL. The new waiver provides $180 million per year for Demonstration Years 6, 7, and 8 and $90 million for Demonstration Year 9 to continue these projects for persons with incomes between 134 and 200 percent FPL. However, it is unclear whether counties will be able to access this funding to expand coverage for this patient population, due to requirements for the coverage expansion. Enrollees currently in existing CIs who have incomes between 134 and 200 percent FPL are anticipated to be grandfathered into coverage. For any funding not used for grandfathered enrollees or programs covering persons between 134 and 200 percent, it may be possible for the $180 million to be rolled over to the SNCP for uncompensated uninsured costs or to increase the Delivery System Reform Incentive Pool, subject to CMS approval.

The waiver also includes new funding streams:

- **Coverage Expansions.** Under the waiver, all counties will have the option to expand coverage. Counties that opt to develop and implement CEED projects will be able to draw down federal funds for these projects. The federal funds designated for the CEED projects to cover adults with incomes from 0 - 133 percent FPL are uncapped. Counties may elect to set income eligibility limits at a level within 0-133 percent FPL in order to minimize wait lists. If counties choose to include persons with incomes up to 133 percent FPL, they may also draw down Coverage Initiative funding described above to cover people with incomes between 134 - 200 percent FPL; however, these dollars are capped.

- **Delivery System Reform Incentive Pool.** The waiver makes available $3.3 billion over five years for the Delivery System Reform Incentive Pool. This pool will be a subset of the Safety Net Care Pool and will be financed using intergovernmental transfers (IGTs). The pool, which will be tied to milestones and achievements, will provide public hospitals with the opportunity to improve and transform their delivery systems. As noted, a portion of this funding could be made available for financing incentive payments to private DSH and district DSH hospitals, if such a program is developed at the State level.

Additionally, please note that public hospitals are continuing to work with the California Department of Health Care Services on the workability of providing IGTs as part of the funding mechanism for payments to health plans for the mandatory enrollment of seniors and persons with disabilities into Medi-Cal Managed care.

MEDICAID SECTION 1115 WAIVER: CALIFORNIA BRIDGE TO REFORM DEMONSTRATION

COVERAGE EXPANSION

The waiver builds on the existing Coverage Initiatives (CIs) and allows all counties to participate.

In 2005, the waiver included $180 million a year for three years to create health Coverage Initiatives (CIs). This funding was included in the Safety Net Care Pool. Ten counties created these programs, including Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. The counties provide the match to draw down the federal funds using CPEs. The 10 programs have expanded coverage to more than 100,000 adults with incomes up to 200 percent FPL.

The new waiver provides $180 million per year for Demonstration Years 6, 7, and 8 and $90 million for Demonstration Year 9 to continue these projects for persons with incomes between 134-200 percent FPL. However, it is unclear whether counties will be able to access this funding to expand coverage for this patient population, due to requirements for the coverage expansion described below. Enrollees currently in existing CIs who have incomes between 134-200 percent FPL are anticipated to be grandfathered into coverage. For any funding not used for grandfathered enrollees or programs covering persons between 134-200 percent, it may be possible for the $180 million to be rolled over to the SNCP for uncompensated uninsured costs or to increase the Delivery System Reform Incentive Pool, subject to CMS approval.

Please recall that AB 342, California's waiver implementing legislation that was passed in October 2010, renames the coverage initiatives the Coverage Expansion and Enrollment Demonstration (CEED) Projects, and this appears to be the term that the state will continue to use. However, the waiver as negotiated with CMS uses the following nomenclature:

Low Income Health Program (LIHP). This is the umbrella title for what is now a two-component program:

- **Medicaid Coverage Expansion (MCE).** Covers adults between 19 and 64 years of age with family incomes at or below 133 percent FPL. This program is considered early expansion of Medicaid for childless adults, which will start in 2014 with 100 percent federal funds for three years. Because of this early Medicaid expansion, federal funds will be uncapped (not part of the $10 billion in total waiver funds) and program capacity will be contingent upon the availability of county matching funds. MCEs will also be subject to all Medicaid rules, except those explicitly waived through the terms and conditions.

- **Health Care Coverage Initiative (HCCI).** Covers adults between 19 and 64 years of age with family incomes between 134-200 percent FPL. Federal funds for the HCCI are capped at

$180 million per year and included in the SNCP. Benefit requirements for the HCCI population are less than those for the MCE.

Eligibility

Terms and Conditions. Each participating county must provide to the state (to be forwarded to CMS): (1) the actual upper income limit elected by the county for their MCE and HCCI program; (2) the projected enrollment under each program; and (3) the projected expenditure for each program, as well as any county-specific eligibility standards or methodologies used. Counties may make adjustments to income levels and establish enrollment caps and wait lists if, based on advance budget projections made by the county, funding will not be sufficient. However, counties may not serve the HCCI population if they have any eligibility restrictions on the MCE population (except for grandfathered current enrollees of HCCIs).

State Law. Sets eligibility at 0-133 percent of the federal poverty level, and allows the option to expand coverage to 134-200 percent of the federal poverty level if federal funds are available. The CEED project is not an entitlement. CEED projects will have the option to set eligibility levels. CEED projects may limit enrollment, to the extent the federal government allows it. If a project opts to change eligibility levels after projects begins, the county board of supervisors and the state must approve the change.

AB 342 also requires standardized eligibility and enrollment procedures that interface with Medi-Cal processes according to milestones to be developed in consultation with county representatives.

Maintenance of Effort (MOE)

Terms and Conditions. The state must demonstrate that non-federal (i.e. county) expenditures for the LIHP is equal to or exceeds FY 2006 county expenditure levels for their Medically Indigent Adult (MIA) programs.

Due Process

Terms and Conditions. The state must develop and implement standards and procedures for hearings and appeals for LIHP applicants and recipients.

Benefit Package

Terms and Conditions. The waiver establishes baseline minimum packages for the MCE and HCCI populations:

MCE Core Benefits	HCCI Core Benefits
Medical equipment and supplies	Medical equipment and supplies
Emergency Care Services (including transportation)	Emergency Care Services
Acute Inpatient Hospital Services	Acute Inpatient Hospital Services
Laboratory Services	Laboratory Services
Outpatient Hospital Services	Outpatient Hospital Services
Physical Therapy	Physical Therapy
Physician services, including specialty care	Physician services
Prescription and limited non-prescription medications	Prescription and limited non-prescription medications
Prosthetic and orthotic appliances and devices	Prosthetic and orthotic appliances and devices
Radiology	Radiology
Mental Health Benefits, including ▪ Up to 10 days per year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital or psychiatric health facility; ▪ Psychiatric pharmaceuticals; ▪ Up to 12 outpatient encounters per year.	
Prior-authorized Non-Emergency Medical Transportation	
Podiatry	

Mental health services may be provided through a carve-out. Counties may receive matching federal funds for additional Medicaid-eligible services beyond those defined in the waiver, subject to approval of CMS. In addition, organ transplants, bariatric surgery and infertility-related services are explicitly excluded benefits.

State Law. Requires a scheduled package of services required under the terms and conditions.

Medical Homes

State Law. Enrollees must be assigned to a medical home (as defined in AB 342).

Delivery Systems/Network Adequacy

Terms and Conditions. CMS considers LIHP delivery systems with a closed network of providers to be a managed care delivery system, and, therefore, must meet network adequacy and timely access standards. The state will establish alternative access standards for rural areas. Office

hours are to be the same as for Medi-Cal as for other patients, including 24 hours a day, seven days as week when medically necessary.

State Law. AB 342 requires a provider network and service delivery system that seeks to promote the "viability of the existing safety net health care system that serves the population to be covered by the CEED project."

Federally Qualified Health Centers (FQHCs)

Terms and Conditions. The waiver requires that LIHPs reimburse FQHCs at their Prospective Payment System (PPS) rates. Additionally, a LIHP must contract with or provide services through at least one FQHC.

Out-of-Network Emergency Coverage

Terms and Conditions. All LIHP programs must provide coverage for out-of-network emergency and post-stabilization care services. LIHP programs may pay out-of-network providers at 30 percent of applicable regulatory fee-for-service rates. Out-of-network providers must accept these rates as payment in full.

Prisoner/County Jail Inmate Coverage

State Law. AB 1628 (Chapter 729, Statutes of 2010) authorizes DHCS the option to require a county that submits an application for a CEED project to agree to include state prison inmates in their CEED project for inpatient hospital services. Essentially, prison inmates who leave the grounds of the prison for an inpatient stay at a community hospital would become eligible for Medi-Cal or a CEED project. The CEED project would be compensated by the Department of Corrections and Rehabilitation (CDCR) for these costs. The intent is that there will be no net increase in county expenditures; CDCR and federal funds would cover the county cost, including administrative costs. Eligibility would be based on the county of last legal residence prior to arrest.

In addition, counties will be able to seek federal reimbursement for the care of adult inmates incarcerated in county correctional facilities for expenditures incurred for inpatient services in community hospitals if the county determines the inmates to be eligible for Medi-Cal or the local CEED projects. Counties that choose this option will remain responsible for the non-federal share of the costs to serve county inmates eligible for Medi-Cal or CEED projects. In order to get the jail inmate benefit, the county must agree to include the state prison population in its CEED project.

Financing

CEED projects can be funded through an actuarially-based rate or through Certified Public Expenditures (CPEs), as done in the current CIs. CEED project funding will be based on funding

voluntarily provided by the participating entity, subject to any limitations imposed by the terms and conditions. Federal financial participation will be available for administrative activities.

Timelines

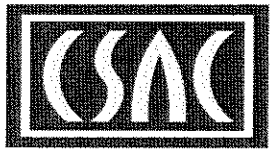
Terms and Conditions. By January 1, 2011, the state must tell CMS which current CIs are going to continue their programs. The terms and conditions do not specify when new counties can initiate LIHP programs.

State Law. Allows existing coverage initiatives to remain in effect until the CEED project is in effect, but for no more than 180 days after DHCS provides notice to applicants of CEED projects.

Authorizes CEED projects to begin providing services on March 1, 2011 or 180 days after federal approval of the wavier, whichever occurs later. Counties or a consortium of counties can submit applications for a CEED project. The Department of Health Care Services must notify counties of the project requirements by January 1, 2011 or 60 days after federal approval, whichever is later. DHCS will have 60 days after it receives a project application to deny or approve the application. The legislation sets up an appeals process for applications that are denied.

State Administrative Costs

State Law. AB 342 requires that participating counties must reimburse the state for the non-federal share of state staffing or administrative costs.



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SAFETY NET CARE POOL

The existing structure of the Safety Net Care Pool (SNCP) is continued under the new waiver and continues to be based on certified public expenditures (CPEs).

The SNCP includes $7.1 billion over five years. The bulk of the money in the pool will be for reimbursing public hospitals for uncompensated care costs. The state will be able to access up to $400 million annually for designated state programs.

Components of the SNCP

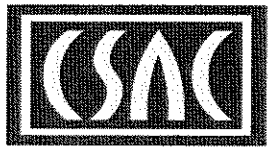
- **State Programs.** The state may claim up to $400 million in federal match for the following programs:
  a) Breast and Cervical Cancer Treatment Program
  b) Medically Indigent Adults/Long Term Care (MIA/LTC) Program
  c) California Children's Services Program, state-only
  d) Genetically Handicapped Persons Program (GHPP)
  e) Expanded Access to Primary Care
  f) AIDS Drug Assistance Program (ADAP)
  g) Department of Developmental Services (DDS)
  h) County Mental Health Services
  i) Workforce Development programs, including
     1) Song Brown Health Care Workforce Training,
     2) Health Professions Education Foundation Loan Repayment
     3) Mental Health Loan Assumption
     4) Training programs for medical professionals at California Community Colleges, California State Universities and the University of California.

- **Uncompensated Care Pool.** The SNCP provides funds for uncompensated care provided to individuals with no source of third party coverage for the services they received by hospitals or other providers. The following chart identifies approximately how much will be available for uncompensated care:

Demonstration Year 6	$415 million
Demonstration Year 7	$415 million
Demonstration Year 8	$380 million
Demonstration Year 9	$300 million
Demonstration Year 10	$235 million

- **Low Income Health Plan: Health Care Coverage Initiative.** California may access $180 million per year in Demonstration Years 6-8 and $90 million in Demonstration Year 9 on expenditures related to coverage expansions for persons with incomes between 134-200 percent FPL. Enrollees currently in existing Coverage Initiatives (CIs) who have incomes between 134 – 200 percent FPL are anticipated to be grandfathered into coverage. For any funding not used for grandfathered enrollees or programs covering persons between 134 – 200 percent FPL, it may be possible for the $180 million to be rolled over to the SNCP for uncompensated uninsured costs or to increase the Delivery System Reform Incentive Pool, subject to CMS approval.

- **Delivery System Reform Incentive Pool.** The waiver includes the opportunity for public hospitals to receive up to $3.3 billion over five years through the Delivery System Reform Incentive Pool (DSRIP). This pool is a subset of the Safety Net Care Pool. The DSRIP is intended to support California's public hospitals' efforts in enhancing the quality of care and the health of the patients and families they serve. Individual public hospital systems will submit proposals for state and federal approval that are focused on improving the experience of care, improving the health of populations, and reducing per capita costs of health care.



MEDICAID SECTION 1115 WAIVER: CALIFORNIA BRIDGE TO REFORM DEMONSTRATION
DELIVERY SYSTEM REFORM INCENTIVE POOL

The waiver includes the opportunity for public hospitals to receive up to $3.3 billion over five years through the Delivery System Reform Incentive Pool (DSRIP). This pool will be a subset of the Safety Net Care Pool. The DSRIP is intended to support California's public hospitals' efforts to enhance the quality of care and the health of the patients and families they serve.

Individual public hospital systems will submit proposals for state and federal approval that are focused on improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Federal funding will be contingent upon the achievement of specific milestones or deliverables in four areas:

- **Infrastructure development.** Includes investments in technology, tools and human resources. Examples of initiatives may include increases in primary care capacity, introduction of telemedicine, enhanced interpretation services, and enhanced improvement capacity.
- **Innovation and Design.** Includes investments in new and innovative models of care delivery that have the potential to impact patient experience, cost and disease management. Examples include expansion of medical homes, expansion of chronic disease management systems, primary care redesign, and redesigns for cost savings.
- **Population-focused Improvement.** Includes investments in enhancing care delivery for the 5-to-10 highest burden conditions in public hospital systems. Examples include improved diabetes care management and outcomes, improved chronic care management and outcomes, reduction of readmissions, and improved quality.
- **Urgent Improvement in Care.** Requires top-level performance on two or three interventions, when there is evidence that major improvement in care is possible within five years. These are hospital-specific initiatives and will be developed jointly by hospitals, the state, and CMS.

The details on the DSRIP categories, mechanics and approval process are not finalized. The state, California Association of Public Hospitals and Health Systems (CAPH) and CMS will be finalizing the pool details in the next 60 days.

Potential Funding Available

The following chart details the federal funding potentially available through the DRSIP:

Demonstration Year 6	$600 million
Demonstration Year 7	$650 million
Demonstration Year 8	$700 million
Demonstration Year 9	$700 million
Demonstration Year 10	$700 million

Public hospitals will provide the nonfederal share for these federal funds through intergovernmental transfers (IGTs).

The Waiver terms and conditions do provide the possibility that a portion of the $3.3 billion in federal funding could be utilized to fund incentive payments to private DSH and district DSH hospitals, if such a program is developed and agreed to at the state level and in consultation with the public hospitals.

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CARE COORDINATION

The waiver allows California to mandatorily enroll seniors and persons with disabilities (SPDs) into Medi-Cal managed care. The waiver also includes a pilot program for the California Children's Services (CCS) program. Last spring, the Administration discussed trying to include a project focused on individuals dually eligible for Medi-Cal and Medicare; however, nothing focused on duals was ultimately included in the final waiver.

Seniors and Persons with Disabilities

Under the waiver, California will be able to mandatorily enroll approximately 380,000 seniors and persons with disabilities into Medi-Cal managed care. These are seniors and persons with disabilities who are not enrolled in Medicare or do not have an unmet share of cost or other health coverage.

The terms and conditions include a number of requirements on the state related to the mandatory enrollment of seniors and persons with disabilities into Medi-Cal managed care:

- Enrollment will begin in June 2011 and continue for a year.
- CMS must approve the plan contracts prior to the state enrolling seniors and persons with disabilities. California must submit its contracts to CMS by April 1, 2011.
- The state is required to use appropriate risk adjustment in the development of its capitation payments.
- CMS is requiring the state to maintain a managed care advisory group comprised of individuals and interested parties impacted by the mandatory enrollment of seniors and persons with disabilities into Medi-Cal managed care. This advisory group will meet throughout the life of the waiver.
- By December 2010, the state must submit an initial outreach and communication strategy and an ongoing outreach and communication strategy by March 2011. CMS is requiring review of any written communication to enrollees prior to the state sending to beneficiaries.
- By November 2010, the state must submit to CMS proposed SPDs sensitivity training curriculum, including anticipated target audiences.
- By November 2010, the state must submit to CMS informational and educational materials to explain the change in service delivery.
- By February 2011, the state must submit to CMS California's proposed Community Presentation. All such presentations must be completed by May 2011.
- The state must submit to CMS its approach for plan default (when a beneficiary does not choose plan, a plan must be assigned).
- Requires the state to work with CMS on its Money Follows the Person Demonstration, "California Community Transitions, " to increase opportunities for eligible individuals to

access home and community based services upon discharge from hospitals and nursing facilities.

- Other requirements include care continuity, person-centered planning and service design, sufficient specialty health care provider pool, geographic accessibility, physical accessibility, interpreter services and transportation.

Additionally, please note that public hospitals are continuing to work with DHCS on the workability of providing IGTs as part of the funding mechanism to provide payments to health plans for the mandatory enrollment of Seniors and Persons with Disabilities into Medi-Cal Managed care.

California Children's Services (CCS)

The waiver allows California to submit a plan to test up to four health care delivery models for children enrolled in the California Children's Services (CCS) program. The state must provide CMS with 180-days notice and CMS must approve the plans. In addition, the plan shall include a sufficient network of appropriate providers and timely access to out of network care. The plan shall also include specific criteria for evaluating the models. The CCS pilots shall be eligible for FFP from the date of CMS approval through December 31, 2015.

The four models of care delivery include:

- An enhanced primary care case management (EPCCM) program
- A provider-based accountable care organization (ACO)
- A specialty health care plan (SHCP)
- Utilization of existing Medi-Cal managed care plans.

The state will be developing a Request for Proposal (RFP) for the CCS pilots.

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OUTSTANDING WORK TO BE DONE

Coverage Expansion

- State must develop a process for existing CIs to transition to CEED projects
- State must develop timelines for new counties to submit applications and approve new coverage expansion projects
- Develop actuarial rates
- State must develop due process, including appeals and hearing process, and get approval from CMS
- State must develop access standards for rural areas

Delivery System Reform Incentive Pool

- State, Public Hospitals, and CMS must develop more specific standards, measures and evaluation protocols for the DSRIP within 60 days

Medi-Cal Managed Care Expansion

- State must continue its work to prepare for the enrollment of Seniors and Persons with Disabilities into Medi-Cal Managed Care
- Terms and Conditions specify a number of documents that the state must draft and submit to CMS for approval, with timelines starting as soon as November 2010

California Children's Services

- State must prepare Request for Proposals (RFP) for CCS pilots

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PUBLIC HOSPITALS IDENTIFIED IN THE WAIVER

County Hospitals

Facility	County
Harbor/UCLA Medical Center	Los Angeles
Olive View Medical Center	Los Angeles
Rancho Los Amigos National Rehabilitation Center	Los Angeles
University of Southern California (USC) Medical Center	Los Angeles
Alameda County Medical Center	Alameda
Arrowhead Regional Medical Center	San Bernardino
Contra Costa Regional Medical Center	Contra Costa
Kern Medical Center	Kern
Natividad Medical Center	Monterey
Riverside County Regional Medical Center	Riverside
San Francisco General Hospital	San Francisco
San Joaquin General Hospital	San Joaquin
San Mateo County General Hospital	San Mateo
Santa Clara Valley Medical Center	Santa Clara
Ventura County Medical Center	Ventura

University of California Hospitals

Facility	County
UC Davis Medical Center	Sacramento
UC Irvine Medical Center	Orange
UC San Diego Medical Center	San Diego
UC San Francisco Medical Center	San Francisco
UC Los Angeles Medical Center	Los Angeles
Santa Monica UCLA Medical Center	Los Angeles

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SENIORS AND PERSONS WITH DISABILITIES

The following is a list of counties where the mandatory enrollment of Seniors and Persons with Disabilities into Medi-Cal Managed Care will occur:

County	Plan Model
Alameda	Two-Plan
Contra Costa	Two-Plan
Fresno	Two-Plan
Kern	Two-Plan
Kings*	Two-Plan
Los Angeles	Two-Plan
Madera*	Two-Plan
Riverside	Two-Plan
Sacramento	Geographic Managed Care
San Bernardino	Two-Plan
San Diego	Geographic Managed Care
San Francisco	Two-Plan
San Joaquin	Two-Plan
Santa Clara	Two-Plan
Stanislaus	Two-Plan
Tulare	Two-Plan

* Kings and Madera expansions are planned for February 2011.

Claiming Federal Reimbursement for Hospital Inpatient Services Received by Eligible Adult Inmate Patients and Other Health Care Services Received by Eligible Parolees

FACT SHEET

Background

The California Department of Corrections and Rehabilitation (CDCR) currently uses 100 percent State General Fund (GF) to pay for inpatient hospital services received by state prison inmates in community hospitals. Federal law generally prohibits claiming Medicaid funds to reimburse for health care services provided to inmates residing in correctional facilities. However, this prohibition does not apply to inpatient hospital services provided to an inmate at a medical facility that is not located on the grounds of the correctional facility (i.e. a "community" hospital), if the inmate is otherwise eligible for Medicaid.

California has not sought available federal matching funds for these services, to the detriment of the GF. This proposal provides an opportunity to secure federal funds by establishing adult inmate eligibility not only for Medi-Cal but also for local county Coverage Expansion and Enrollment Demonstration (CEED) projects authorized under the federal section 1115 Medi-Cal Demonstration Waiver currently under negotiation with the federal government. The Department of Health Care Services (DHCS) and CDCR anticipate that adult inmates eligible for Medi-Cal are likely to be aged (over 65), disabled, or pregnant females, and those adult inmates that do not qualify for Medi-Cal and have incomes up to 133 percent of the federal poverty level will be eligible for the CEED projects. This proposal will provide further State GF savings by requiring local CEED projects to enroll eligible former inmates (parolees) and pay for those services that are currently paid by CDCR. There will be no net increase in county expenditures.

This proposal will also provide an opportunity for counties to realize savings in local county funds. Counties that currently cover 100 percent of the care of adult inmates incarcerated in county correctional facilities will be able seek federal reimbursement for expenditures incurred for inpatient services in "community" hospitals if they determine the inmates to be eligible for Medi-Cal or the local CEED projects. These counties will remain responsible for the non-federal share of the costs to serve county inmates eligible for Medi-Cal or CEED projects.

<u>Eligibility and Enrollment of Adult State Inmates</u>

Under this proposal, CDCR will forward Medi-Cal eligibility applications to DHCS for inmates requiring inpatient services in "community" hospitals. The inmates must be adults incarcerated in State correctional facilities. DHCS staff will review the applications to determine eligibility for Medi-Cal or local CEED projects. If the inmates are Medi-Cal eligible, DHCS staff will enroll them in Medi-Cal for purposes of receiving hospital inpatient benefits. If the inmates are ineligible for Medi-Cal, DHCS will determine whether their county of last legal residence

participates in a CEED project, whether they have income up to 133 percent of federal poverty level and whether they meet other local CEED eligibility criteria for enrollment in the local CEED project. DHCS staff will notify local CEED projects of the newly eligible inmates and request them to complete the enrollment process for purposes of receiving hospital inpatient benefits. CEED projects will be mandated to enroll these eligible inmates.

Payment Processes for Services Received by Adult State Inmates

The "community" hospitals will submit inpatient claims to the DHCS fiscal intermediary (FI) for Medi-Cal eligible inmates. The FI will process the claim at the hospital's Medi-Cal rate. The State Controller's Office will pay the processed claim, and DHCS will draw down federal matching funds.

The "community" hospitals will submit inpatient hospital claims to the local CEED project for CEED eligible inmates. The county will pay the claim at the same rate negotiated by CDCR. The county will certify the expenditure and obtain federal reimbursement through the federal Section 1115 Demonstration Waiver and will also receive reimbursement from CDCR for the non-federal share of the payment. This will ensure that the county does not incur any net increase in expenditures as a result of enrolling state inmates in the CEED project.

Parolees

Counties must enroll eligible former adult state inmates (parolees) in local CEED projects. Under this mechanism, counties will pay for services currently paid by CDCR, and similar to CEED eligible state inmates, they will be able to claim federal reimbursement from CMS and obtain reimbursement from CDCR for the nonfederal share. This results in no net increase to county expenditures and helps the State achieve additional savings for services previously paid by CDCR using 100 percent State GF.

Adult County Inmates

This proposal will also provide an opportunity for county budget savings. The counties currently pay for all of the hospital inpatient costs incurred on behalf of adult inmates incarcerated in county correctional facilities. Under this proposal, Counties will be able to determine Medi-Cal and CEED eligibility for county inmates requiring inpatient services at "community" hospitals. Counties can enroll these eligible adult county inmates in Medi-Cal or local CEED projects and claim federal reimbursement for "community" hospital inpatient claims paid for services rendered to these individuals. This proposal prevents a cost shift to the State by requiring counties to continue to pay the non-federal share.

Budget Savings

This proposal will require a change in budget authority to reflect the budget savings for CDCR and the Medi-Cal expenditures and federal claiming in the DHCS budget. The amount of federal funds that DHCS claims on behalf of the Medi-Cal eligible and CEED eligible state inmates and CEED eligible former inmates represents the amount of State GF savings the State will realize under this proposal.

The Trailer Bill language:

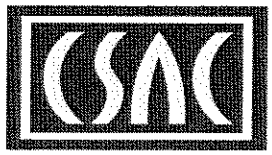
- Authorizes the Medi-Cal program and the CEED projects to claim federal reimbursement for the costs of providing inpatient hospital services to adult Medi-Cal or CEED eligible inmates in State correctional facilities when those services are provided at a "community" hospital that is off the grounds of the correctional facility.
- Mandates counties seeking participation in CEED projects to reimburse "community" hospitals for inpatient hospital services provided to adult state inmates that are CEED eligible.
- Mandates counties seeking participation in CEED projects to enroll and serve former adult inmates (parolees) that are otherwise eligible for such CEED projects.
- Gives counties the option to seek federal reimbursement from the Medi-Cal program or from the CEED project in which the county participates, for the provision of inpatient "community" hospital services to adult inmates involuntarily detained or incarcerated in county correctional facilities.
- Gives DHCS the option to determine eligibility for Medi-Cal and CEED and to process the Medi-Cal applications and disenrollments for adult state inmates in lieu of the counties.
- Requires DHCS and the CDCR to develop a reimbursement process to allow counties to be reimbursed for any uncompensated county expenditure incurred by the CEED projects including the nonfederal share of any reimbursement made for the provision of inpatient hospital services rendered to inmates under the CEED projects and services provided to adult former state inmates that would have otherwise been paid by CDCR.
- Requires CEED projects to reimburse "community" hospitals serving CEED eligible adult state inmates at the rates paid to such hospitals by CDCR prior to enactment of the statute as adjusted under State law or CDCR's contracts.
- Limits the effect of statute only to the extent that all necessary federal approvals are obtained and federal financial participation is available and is not jeopardized.
- Limits implementation only to the extent funding is appropriated in the State Budget.
- Authorizes DHCS to implement this new policy by means of All County Welfare Directors Letters in lieu of formally promulgated regulations.

Benefits of this proposal

In FY 2008-09, CDCR spent $258.9 million GF on inpatient hospital services for inmates admitted to a "community" hospital or similar facility located off the grounds of the State correctional facility. Currently, CDCR pays for these services with 100 percent GF dollars. Given the severe budget challenges the State is currently experiencing, this level of reimbursement is not sustainable. This proposal would enable the State to claim federal reimbursement at the allowable Federal Medical Assistance Percentage for the costs of Medi-Cal and CEED covered inpatient hospital services provided off the grounds of the correctional facility to adult inmates and would result in significant savings to the State. This proposal provides a similar arrangement for the State to realize services received by former inmates and for which CDCR currently pays.

California counties are experiencing fiscal challenges similar to the State. This proposal provides counties with an opportunity to claim federal reimbursement for county borne costs associated with providing hospital inpatient services to adult inmates incarcerated in county correctional facilities.

DHCS will require 20 positions to implement this proposal, which results in workload associated with determining eligibility for the state inmates and administering this program. CDCR will provide the financial resources for this staffing through an interagency agreement with DHCS; however, the savings realized by the State through claiming of federal reimbursement will far exceed the cost of the additional DHCS staff.



MEDICAID SECTION 1115 WAIVER: CALIFORNIA BRIDGE TO REFORM DEMONSTRATION

KEY TERMS

Budget Neutrality: A federal requirement in place since 1983. Budget neutrality means that federal spending over the life of the waiver period must be no greater than federal spending would have been in absence of the waiver. In order to establish budget neutrality, states identify sources of savings in their programs to offset the cost of any program expansion.

California Children's Services (CCS): The CCS program provides diagnosis and treatment services, medical case management and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. CCS also provides medically necessary physical and occupational therapy to special education students. Counties have historically been responsible for eligibility determination and case management services, and have also had a long standing share of cost for the non-Medi-Cal portion of the CCS program.

Centers for Medicare and Medicaid Services (CMS): The federal agency that is responsible for setting regulations and guidelines for Medicare and Medicaid policy. CMS is under the U.S. Department of Health and Human Services.

Certified Public Expenditures (CPEs): Expenditure by a public entity for providing health service under Medicaid. CPEs include only those expenditures made by a governmental entity, with non-federal funds, for services that qualify for federal reimbursement.

Coverage Expansion and Enrollment Demonstration (CEED): The term used in state law (AB 342, Chapter 723, Statutes of 2010) to describe the expanded Coverage Initiatives.

Coverage Initiatives (CI): The term used in the 2005 Medicaid Waiver to describe the 10 projects that expand health coverage to childless adults.

Disproportionate Share Hospital (DSH) Payments: Medicaid disproportionate share hospital (DSH) payments provide financial assistance to hospitals that serve a large number of low-income patients, such as people with Medicaid and the uninsured. Medicaid DSH payments are the largest source of federal funding for uncompensated hospital care.

Delivery System Reform Incentive Pool (DSRIP): The waiver includes the opportunity for public hospitals to receive up to $3.3 billion over five years through the Delivery System Reform Incentive Pool (DSRIP). This pool will be a subset of the Safety Net Care

Pool. The DSRIP is intended to support California's public hospitals' efforts to enhance the quality of care and the health of the patients and families they serve.

Department of Health Care Services: The state Department of Health Care finances and administers a number of individual health care service delivery programs and serves as the lead administrative entity for the Medicaid Waiver in California.

Federal Financial Participation (FFP): Refers to the amount that the federal government contributes for a defined service or benefit.

Federal Poverty Level (FPL): The FPL is a simplification of the poverty thresholds developed by the Census Bureau for administrative purposes — for instance, determining financial eligibility for certain federal programs. The FPL's for varying family sizes are issued each year in the *Federal Register* by the U.S. Department of Health and Human Services.

Federally Qualified Health Center (FQHC): A federally qualified health center is a type of provider defined by the Medicare and Medicaid statutes which receives enhanced Medicare and Medicaid reimbursement rates.

Fee-for-Service: This refers to the traditional method of paying for health care in which health care providers are reimbursed for particular services such as office visits, medical procedures, and prescriptions.

Intergovernmental Transfers (IGTs): Transfers of public funds between governmental entities. The transfer may take place from one level of government to another (i.e. counties to states) or within the same level of government (i.e. from a state university hospital to the state Medicaid agency). In the context of a Medicaid waiver, IGTs are used as a mechanism to draw federal funds using state and local funds.

Low Income Health Program (LIHP): This is the umbrella title under the terms and conditions of the waiver for the coverage expansions for childless adults. It includes a two-component program:

- Medicaid Coverage Expansion (MCE). Covers adults between 19 and 64 years of age with family incomes at or below 133 percent FPL. This program is considered early expansion of Medicaid for childless adults, which will start in 2014 with 100 percent federal funds for three years. Because of this early Medicaid expansion, federal funds will be uncapped (not part of the $10 billion in total waiver funds) and program capacity will be contingent upon the availability of county matching funds. MCEs will also be subject to all Medicaid rules, except those explicitly waived through the STC.

- Health Care Coverage Initiative (HCCI). Covers adults between 19 and 64 years of age with family incomes between 134 – 200 percent FPL. Federal funds for the HCCI are capped at $180 million per year and included in the SNCP. Benefit requirements for the HCCI population are less than those for the MCE.

Medicaid Section 1115 Waiver: Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis.

Medi-Cal Managed Care: A general term used to describe a method of delivering and financing health care that seeks to control health care costs while coordinating an individual's health care. Medi-Cal has three managed care models – county organized health systems, Geographic Managed Care, and the two-plan model.

Prospective Payment System (PPS) Rates: A Medicare and Medicaid hospital payment system based on a per case cost, rather than on a per day, per procedure, or per service basis.

Safety Net Care Pool: The waiver establishes a Safety Net Care Pool (SNCP) to make a fixed amount of federal funds available to reimburse hospitals for care for the uninsured, often called "uncompensated care."

Terms and Conditions, Special Terms and Conditions (STCs): The operational and policy parameters of an approved Section 1115 waiver. The terms and conditions include the specific coverage categories, benefits structure, cost-sharing requirements, and financing mechanisms under which the waiver will operate.