

**CHEAC Memorandum**  
(3 pages)

To: CHEAC General Membership  
From: Judith Reigel, Executive Director  
Date: November 9, 2010  
RE: **Medi-Cal 1115 Waiver**

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As you are aware by now, last week the state and CMS announced agreement on California's 1115 Medi-Cal Waiver, officially called the *California Bridge to Reform Demonstration*. The waiver documentation, including Special Terms and Conditions (STC) can be viewed at: <http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx>

The waiver makes available approximately \$10 billion in federal funds over the period covering November 1, 2010, through October 31, 2015 (except for the coverage initiatives which will end on December 31, 2013). The funds will help California prepare for Health Care Reform through investments in our safety net delivery system and expansion of coverage for low-income adults. Some highlights of the waiver include:

**Medi-Cal Managed Care Expansion:** Through the waiver CMS has given its blessing for California to begin mandatory enrollment of Seniors and Persons with Disabilities (SPDs) into Medi-Cal managed care plans, starting June 2011. The STC includes specific consumer protections and plan readiness requirements for this transition. The estimated savings from moving the SPD population into managed care is one of the factors included in the budget neutrality calculation. If these estimated savings are not fully realized, a portion of the \$10 billion could be at risk.

**California Children's Services (CCS) Pilot Programs:** The STC approves the state's proposal to establish CCS pilot programs using the four models outlined in SB 208 (and included in the state's recent draft RFA) and includes specific criteria for evaluating the pilots. CCS pilot projects are eligible for federal matching funds for all three CCS populations (Medi-Cal, Healthy Families and CCS Only).

**Safety Net Care Pool (SNCP):** The waiver continues the Safety Net Care Pool (SNCP) which now consists of three sections: Coverage Initiatives, Uncompensated Care and Delivery System Incentive Payments.

**Delivery System Reform Incentive Payments (DSRIP):** The waiver creates a new pool of funds (as part of the SNCP) which makes up to \$3.3 million in federal funds available to public hospitals for delivery system improvements in four areas: Infrastructure Development, Innovation and Redesign, Population-focused Improvement and Urgent Improvement in Care. Payments under the DSRIP will be contingent upon hospitals meeting performance milestones under each of these four areas, which are to be developed over the next 60 days through a collaborative process between CMS, DHCS and CAPH.

**Federalized State Health Programs:** The waiver expands the number of state health programs which can now pull down federal matching funds under the SNCP Uncompensated Care section. The list of now allowable state programs are: CCS, Genetically Handicapped Persons Program (GHPP), Medically Indigent Adult Long Term Care (MIALTC), Breast and Cervical Cancer Treatment Program (BCCTP), AIDS Drug Assistance Program (ADAP), Expanded Access to Primary Care (EAPC), County Mental Health Services Program, Department of Developmental Services (DDS) and workforce development programs.

**Coverage Expansion:** The waiver includes expansion of the coverage initiatives, and adds an array of program names. Please recall that AB 342, California's implementing legislation, calls the coverage initiatives Coverage Expansion and Enrollment Demonstration (CEED) Projects, and that appears to be the term that DHCS will continue to use. However, the waiver 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% FPL. This program is considered early expansion of Medicaid for childless adults, which will start in 2014 with 100% federal funds for three years. Because it is considered to be Medicaid, 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% and 200% 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.

Establishing Eligibility Levels: 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 HCCI's). California statute (AB 342) requires that counties must have a Board of Supervisors resolution and approval from the DHCS Director before placing any limitations on enrollment.

LIHP Maintenance of Effort (MOE): 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 MIA programs.

Medical Homes: Enrollees must be assigned to a medical home (as defined in AB 342).

Benefit Packages: The waiver establishes baseline minimum packages, which are somewhat different for the MCE and HCCI populations. The MCE benefits must include minimum mental health services (10 days acute inpatient hospitalization and 12 outpatient encounters per year and psychiatric pharmaceuticals) and non-emergency medical transportation. 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.

Coverage of out-of-network emergency and post-stabilization care services: Required for all LIHP enrollees. LIHP programs may pay out-of-network providers at 30% of applicable regulatory fee-for-service rates. Out-of-network providers must accept these rates as payment in full.

Delivery Systems/Network Adequacy: 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. Please note that AB 342 requires that CEED delivery systems *“seek to promote the viability of the existing safety net health care system that serves the population to be covered.”*

FQHCs: The waiver requires that LIHPs reimburse FQHCs at their PPS rates and that an LIHP must contract with or provide services through at least one FQHC.

Due Process: The state must develop and implement standards and procedures for hearings and appeals for LIHP applicants and recipients.

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

Prisoner/County Jail Inmate Coverage: AB 1628 (the corrections budget trailer bill) authorizes DHCS to develop a process to pull down federal matching funds for state prisoners who receive inpatient hospital services at community hospitals and who, except for their incarceration status, meet Medi-Cal or CEED eligibility criteria. DHCS also has the authority to require CEEDs to enroll eligible prisoners who were residents of that county at the time of arrest in their CEED programs and to act as the fiscal agent by reimbursing the hospital for the inpatient services. Counties would be compensated for the cost of the inpatient services by the state for 50% of the cost and receive federal matching funds for the other 50%. CEEDs would also be reimbursed for administrative costs. As a sweetener for this requirement, CEED counties would also have the ability to pull down federal matching funds for county jail inmates who receive off-site hospital inpatient services if the inmate would otherwise meet Medi-Cal or CEED eligibility criteria.