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A Bridge to Reform:
California's Medicaid Section 1115 Waiver

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By
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I. Executive Summary

The Patient Protection and Affordable Care Act (ACA) creates opportunities and challenges for state policymakers to improve their health care systems. A handful of states embraced health reform immediately and quickly began work on implementation. California was among the first; its planning effort on health reform began on the heels of the ACA, with submission of a comprehensive Medicaid 1115 waiver proposal in July 2010. Called the Bridge to Reform, the federal Centers for Medicare and Medicaid Services (CMS) approved the waiver in November 2010.

With nearly two years now completed under the 2010 waiver, the California experience offers some important findings at both a state and national level. For California policymakers, the findings can help identify issues that still need to be addressed and can help illuminate the health care environment as the ACA coverage expansions approach in January 2014. For federal and state policymakers nationally, the waiver's coverage expansion and delivery system changes may provide a useful roadmap to prepare for the ACA, especially in those states that opt for Medicaid coverage expansion.

Specifically, the 2010 California waiver launched several changes:

- *Expanded Coverage Through the Low Income Health Program (LIHP).* While some states continue to debate whether to expand Medicaid coverage, California has already expanded its health care coverage through the waiver's LIHP, under which as many as 500,000 uninsured residents could be enrolled in county-based coverage programs modeled on Medi-Cal, California's Medicaid program. With enrollment at 383,000 as of May 2012, the program has seen significant growth.
- *Support for Reform in Safety-Net Hospitals.* California's safety-net hospitals depend on Medi-Cal for two-thirds of their revenues.[1] As such, they are thought by some to need considerably more support to prepare for health reform.[2] Through the Delivery System Reform Incentive Pool (DSRIP), the waiver offers incentive payments totaling up to $3.4 billion to hospitals that achieve benchmarks for improving quality of care and patient experience.
- *Promoting of Coordinated Systems of Care.* Under the waiver, certain seniors and persons with disabilities (SPDs) are required to enroll in managed care. This is designed to promote accountability for access, quality, and costs, and to improve care coordination. Under this policy, an estimated 240,000 beneficiaries transitioned from fee-for-service to managed care over a 12-month period. The waiver also calls for the state to create five demonstration projects to transition children from a fee-for-service model in California Children's Services (CCS) to managed care.

Lessons from the California Waiver

Based on the waiver's implementation to date, success with health reform will require states to:

- *Provide Appropriate Resources for Enrollment Processes.* The enrollment process for the waiver's LIHP coverage initiative has been burdensome for some individuals, thereby discouraging participation. Some contend that enrollment has been unnecessarily slow because of insufficient new staffing and structures to conduct application intake and processing. In addition, Medi-Cal and CMS will need to work together to determine how best to transition LIHP enrollees to full Medi-Cal in January 2014. A successful transition plan should include an easy enrollment process and elements that facilitate continuity of care for individuals with established provider relationships.

- *Educate and Provide Oversight Regarding Managed Care.* One of the most important challenges under the waiver has been helping beneficiaries and providers to understand waiver-generated changes, especially the transfer of SPDs from fee-for-service to managed care. At a minimum, a lack of understanding caused confusion among SPDs and in some cases may have resulted in unnecessary barriers to care. Stakeholders believe that Medi-Cal must better communicate with SPDs about their options and rights under managed care and must provide stronger monitoring and oversight of plans.[3]
- *Develop Administrative and Data Infrastructure.* For all aspects of the waiver, policymakers have found a need for greater focus on infrastructure, which will increase with implementation of the ACA. For example, the LIHP requires new claiming procedures, while managed care for SPDs requires systems for sharing claims data between health plans and the state that could be used both to develop accurate payment rates and to promote continuity of care.
- *Set Clear and Uniform Quality Benchmarks.* As the ACA brings a greater focus on quality, state officials and hospitals need to develop comprehensive processes for setting benchmarks for change. As part of the DSRIP, hospital leaders found that clinicians and data managers should have been included very early with policymakers in considering how to develop systems that are more accountable. In particular, this could have helped California to develop a uniform methodology for DSRIP evaluation.
- *Manage Risk and Set Accurate Payment Rates.* By growing managed care, there will be a need to set payment rates that accurately reflect the risk being transferred from Medicaid fee-for-service to health plans. California officials and health plans will need to refine rates both for the management of SPDs and to move forward with the CCS demonstration.

Other states will benefit from recognizing the challenges that California has faced in implementing its waiver and in developing policies and practices that address these challenges.

II. Introduction

In November 2010, the federal Centers for Medicare and Medicaid Services (CMS) approved a request by the State of California to make several major changes to Medi-Cal and to expand county-based coverage programs for low-income, uninsured residents. This landmark Bridge to Reform Section 1115 waiver is notable for its scope and size.[4] It gives state officials authority to pursue fundamental program changes intended to improve health outcomes and to curb spending growth while preparing the state for the sizeable expansion of Medi-Cal expected in 2014 under the Patient Protection and Affordable Care Act (ACA). The waiver is worth up to $10 billion in federal funding over five years.

This report provides an overview and analysis of four major components of the Bridge to Reform waiver: the Low Income Health Program (LIHP), the Delivery System Reform Incentive Pool (DSRIP), the expansion of mandatory managed care for Medi-Cal-only seniors and persons with disabilities (SPDs), and the pilot programs of organized systems of care for children enrolled in California Children's Services (CCS). The analysis is based on a review of federal, state, and county documents pertaining to the waiver and on conversations with key stakeholders.

The findings presented and analyzed here may be useful to stakeholders at both a state and national level. For California policymakers, it is crucial to understand the current state of the waiver as the state moves forward with further health reform. For example, the waiver's expansion of Medi-Cal managed care for SPDs in 2011 can help inform planned expansions of managed care in 2013 to enrollees in rural areas of the state, to children transitioning from Healthy Families (California's version of the Children's Health Insurance Program) to Medi-Cal, to children with special health care needs, and to Medicare-Medicaid enrollees (dual eligibles). For policymakers at the national level and in other states, the waiver's ACA-style coverage expansion and delivery system changes can provide a useful road map for understanding how to prepare for the ACA, especially in those states that opt to expand Medicaid coverage.

Overview of the Waiver

California's Bridge to Reform waiver has three fundamental building blocks:

- *Expands Coverage.* The waiver makes federal matching funds available to all California counties for expanding coverage to residents who are United States citizens or qualified aliens with incomes at or below 200% of the Federal Poverty Level (FPL), 19 to 64 years old, and not otherwise eligible for Medi-Cal or Healthy Families. To qualify for federal matching funds through the new LIHP part of the Bridge to Reform waiver, counties must provide coverage for a standard set of acute care benefits, including limited mental health services, and meet standards relating to geographic access and timeliness of care. California projects that by 2014 as many as 500,000 uninsured individuals will be enrolled in these county-based coverage programs.[5]

- *Supports Reform in Safety-Net Hospitals.* The waiver established the DSRIP to support California's safety-net hospitals in their efforts to expand access to primary care, improve the quality of care and health outcomes, and increase efficiency. Up to $3.4 billion in federal funds are available through the DSRIP, which is primarily — though not exclusively — designed to support public hospitals. In order to qualify for incentive payments, safety-net hospitals must identify local funds that can be used to match federal payments and demonstrate progress in achieving measurable benchmarks.
- *Promotes Coordinated Systems of Care.* Under the waiver, SPDs with Medi-Cal coverage only (no Medicare) have been required to enroll in a managed care plan in 16 counties where managed care enrollment previously had been voluntary for this population. Under this policy, 240,000 beneficiaries were switched from fee-for-service to managed care in 12 months. The state adopted numerous policies to foster continuity of care for these SPDs, promote greater accountability for performance among its health plan partners, improve access to and coordination of care, and protect beneficiary rights. The waiver also authorizes pilot programs to test new models of organizing and financing care for children with special health care needs who are enrolled in Medi-Cal.

Other important components of California's waiver include additional federal funding for uncompensated care costs for services to the uninsured by the state or by public hospitals and for existing state programs that had not been previously eligible for federal matching funds.

Budget Neutrality

Every Medicaid 1115 waiver must be budget neutral for the federal government, meaning that federal spending must be no greater with the waiver approved than it would be without the waiver. Table 1 shows the sources of savings for California's Bridge to Reform waiver.

Savings primarily come from existing Medi-Cal managed care programs, either by incorporating those programs into this waiver or by extending projected savings from the 2005 California waiver. Expansion of managed care to the SPD population is another source of savings, as is the continuation of existing limits to the public hospital Upper Payment Limit.

Table 1. Budget Neutrality, Sources of Federal Savings from Bridge to Reform Waiver (in billions)

SOURCES	SAVINGS
Existing Managed Care Programs	$5.8
Managed Care Expansion/CCS Demonstration	$0.9
Public Hospital Upper Payment Limit	$1.5
Total	**$8.2**

Source: Author analysis in consultation with the California Department of Health Care Services.

Table 2 shows how these savings are to be used to fund new Medi-Cal and related costs. The largest aspect of new Medi-Cal spending under the waiver is for the DSRIP. The next largest recipients of spending are the State Programs for the Uninsured and the fund for Uncompensated Uninsured Care (which collectively make up the Uncompensated Care Pool).

Table 2. Budget Neutrality, Uses of Funds Under Bridge to Reform Waiver (in billions)

FEDERAL MATCHING FUNDS UNDER THE WAIVER	
LIHP (Coverage for 134% - 200% FPL)	$0.7
DSRIP	$3.4
State Programs for Uninsured	$2.0
Uncompensated Uninsured Care—Public Hospitals	$1.9
Total Federal Funds	**$8.0**

Source: Author analysis in consultation with the California Department of Health Care Services.

In total, the waiver may be worth approximately $10 billion to the state because federal funding for Medicaid coverage expansion (part of the LIHP, described in Section III, below) is estimated to be worth $2.2 billion. That figure is not considered in budget neutrality calculations because California could have covered this population outside of the waiver. Technically, therefore, federal policy does not require that there be waiver savings to cover this population.

County Impact

Although Medi-Cal is a statewide program, it operates differently across California's 58 counties. For this and other reasons, the impact of the waiver varies by county. Some counties are affected by all four of the waiver's major components, while others are not affected at all. (See Table 3, and see Appendix A for a detailed summary of the impact by county.)

Table 3. County-by-County Impact of the Waiver, as of August 31, 2012

	CREATED A LOW INCOME HEALTH PROGRAM	INCLUDES HOSPITAL PARTICIPATING IN DSRIP	AFFECTED BY EXPANSION OF MANDATORY MANAGED CARE FOR SPDs	SELECTED FOR CALIFORNIA CHILDREN'S SERVICES PILOT
Alameda	Yes*	Yes	Yes	Yes
Contra Costa	Yes*	Yes	Yes	
Fresno			Yes	
Kern	Yes*	Yes	Yes	
Los Angeles	Yes*	Yes	Yes	Yes
Merced	Yes		COHS§	
Monterey	Yes	Yes	COHS	
Orange	Yes*	Yes	COHS	Yes
Placer	Yes			
Riverside	Yes	Yes	Yes	
Sacramento	Yes	Yes	Yes	
San Bernardino	Yes	Yes	Yes	
San Diego	Yes*	Yes	Yes	Yes
San Francisco	Yes*	Yes	Yes	
San Joaquin	Yes	Yes	Yes	
San Luis Obispo			COHS	
San Mateo	Yes*	Yes	COHS	Yes
Santa Barbara	Yes		COHS	
Santa Clara	Yes*	Yes	Yes	
Santa Cruz	Yes		COHS	
Stanislaus	Yes		Yes	
Tulare	Yes		Yes	
Ventura	Yes*	Yes		
CMSP† Counties (n=35)	Yes			
Number of Counties	**56‡**	**15**	**14**	**5**

* Had a legacy program through the 2005 Health Care Coverage Initiative.

† County Medical Services Program is a consortium of primarily rural counties that offers health coverage to low-income, indigent adults, www.cmspcounties.org.

‡ Includes six counties (Merced, Monterey, Sacramento, Santa Barbara, Stanislaus, and Tulare) with implementation dates still pending.

§ In counties with a County Organized Health System (COHS), all Medi-Cal beneficiaries must be enrolled in managed care.

Source: Author analysis of California Department of Health Care Services documents: *Local LIHPs: Name, Implementation Date, and Upper Income Limit*, December 2011; "Delivery System Reform Incentive Payments (DSRIP)," accessed February 1, 2012, www.dhcs.ca.gov; *Managed Care Implementation for Seniors and Persons with Disabilities: Monitoring Dashboard, November 2011; California Children's Services Demonstration Projects*, presentation to CCS Stakeholder Advisory Committee, November 3, 2011.

III. The Low Income Health Program

By state law, California's 58 counties are the health care providers of last resort for low-income, uninsured adults who are ineligible for Medi-Cal. County programs for these medically indigent adults vary widely in their provided services, duration of coverage, and eligibility requirements.[6] For example, income limits range from 25% of FPL to over 250% of FPL.[7] Some counties serve this population through their own hospitals and clinics, others reimburse private providers for furnishing the required services, and some do both. In general, county programs for medically indigent adults have emphasized acute episodic care and emergency care rather than primary care, prevention, and chronic disease management.[8]

The LIHP makes federal Section 1115 waiver funds available to provide county-based health care coverage to low-income, uninsured adults who are ineligible for Medi-Cal. For counties that choose to participate, the LIHP pays for half the cost of coverage for adults ages 19 to 64 with incomes at or below 200% ($22,340 for an individual in 2012) of FPL. The other half of the cost of coverage under the LIHP is paid by the participating county. Unlike Medi-Cal, there is no contribution from the state General Fund.

The primary goals of the LIHP are to reduce the number of uninsured low-income adults during the three years of the waiver prior to implementation of the Medicaid expansion under health reform in 2014, and to improve access to care and health outcomes among adults enrolled in the program.[9] The process of implementing the LIHP also offers federal and state officials early insight into operational challenges that any state will face if it implements Medicaid expansions under health reform in 2014 and provides the federal government and states with a head start on addressing these challenges.

Among the low-income, uninsured adults who make up the LIHP-enrolled population, about one in five report that they are in fair or poor health, and nearly one in four report at least one chronic condition such as hypertension or diabetes. Some of the subpopulations have especially high health care needs. For example, the chronically homeless have high rates of serious mental illness and substance abuse. People with HIV who do not have an AIDS diagnosis (and are therefore not considered disabled for purposes of Medi-Cal eligibility) have high prescription drug costs.[10]

Waiver Requirements for County LIHPs

There are a number of basic waiver specifications for county LIHPs, which must be met before federal funds are made available.[11]

Eligibility

There are two LIHP eligibility groups. The first, which all counties participating in LIHP must cover, is the Medicaid Coverage Expansion (MCE) group. These are uninsured adults ages 19 to 64 with incomes up to a level set by the county but not to exceed 133% ($14,856 for an individual in 2012) of FPL. The second group, which participating counties may choose to cover if they cover the MCE group, is the Health Care Coverage Initiative (HCCI) group. (HCCI was also the name given to the 2005 Medi-Cal waiver coverage program that was expanded to become the 2010 Medi-Cal waiver's LIHP). These are uninsured adults ages 19 to 64 with incomes above 133% of FPL up to a level set by the county not to exceed 200% ($22,340 for an individual in 2012) of FPL. Counties may not apply an assets test in determining eligibility for either group. Individuals cannot qualify for either group if they are otherwise eligible for Medi-Cal.

Comparing LIHP and HCCI

In 2005, California began an earlier Medicaid waiver that created the Health Care Coverage Initiative (HCCI), a predecessor to the LIHP. HCCI and LIHP share three important features: both provide county-based health care coverage to low-income, uninsured adults with incomes up to 200% of FPL; both allow California to draw down federal Medicaid matching funds for this non-Medicaid coverage; and county participation is voluntary in both.

The HCCI was different from and less ambitious than the LIHP in several ways. Counties participating in the HCCI were given significant flexibility in the design of their programs, with few uniform standards. By contrast, the LIHP imposes much greater standardization across county-based programs in benefit design, network adequacy, and consumer protections. This reflects the view of CMS that, as a key component of the Bridge to Reform, the LIHP should be much more like Medicaid. The 2010 waiver also eliminated three factors that had limited the size of the HCCI: the requirement imposed by some counties that eligibility be linked to a chronic disease; a cap on the number of participating counties; and a cap on federal funding for coverage provided to uninsured adults with incomes below 133% of FPL. (For a side-by-side comparison of the programs' features, see Table 4.)

Table 4. Comparison of Coverage Expansion Provisions, HCCI and LIHP

	HCCI (2005–2010)	LIHP (2010–2014)
Number of Counties Authorized to Participate	10	All 58 counties, plus the California Rural Indian Health Board
Maximum Income Level	200% of FPL	200% of FPL
Other Eligibility Criteria*	Counties could choose to cover only chronic disease conditions	None
Federal Funds Available	Capped at $540 million	Funding uncapped for coverage provided to enrollees with incomes <133% of FPL. For beneficiaries with incomes 134%–200% of FPL, federal funding capped at $630 million over a four-year period.
Federal Medicaid Managed Care Requirements	Not required	Required
Consumer Protections	None specified	Access and appeals rights specified
Out-of Network ER and Post-Stabilization Coverage	Not required	Required for enrollees with incomes <133% of FPL
Network	Minimum standards	• Coverage throughout entire county • At least 1 FQHC clinic (if there is such a clinic in the county) • All FQHC clinics paid Prospective Payment System4 rates • Out-of-network emergency care covered for enrollees with incomes <133% of FPL; providers receive 30% of Rogers Amendment rates† • Primary, specialty, and urgent care access standards • Alternative standards for qualifying areas in counties

* Not including citizenship or legal resident status.

† The Rogers Amendment sets a standard methodology for emergency-based inpatient and post-stabilization services, Federal Deficit Reduction Act of 2005, Section 6085; California Welfare and Institutions Code, Section 14091.3.

Sources: *California Bridge to Reform Demonstration, Special Terms and Conditions, Amended Effective June 28, 2012*, STCs 42–48 and 58–76, www.dhcs.ca.gov. Peter Harbage and Jen Ryan, *Questions and Answers About the 2005 Medi-Cal Hospital Waiver*, California HealthCare Foundation, 2005, www.chcf.org.

There are two reasons for creating the separate groups. First, because the state has chosen to implement the ACA's coverage expansions, Californians with incomes at or below 133% of FPL will be covered through Medi-Cal beginning in 2014, and those with incomes above 133% of FPL will be eligible for coverage through health plans in the California Health Benefits Exchange.[12] It is anticipated that MCE enrollees will be transitioned into Medi-Cal and HCCI enrollees into the exchange beginning in 2014, unless state policymakers decide to implement the ACA's Basic Health Plan option instead.[13]

Second, federal Medicaid matching funds for the MCE group, available to participating counties under the new State Plan option enacted in the ACA, are not capped.[14] In contrast, federal Medicaid matching funds for the HCCI group are capped.

Unlike Medi-Cal, the LIHP is not an individual entitlement. Participating counties have the flexibility to reduce income eligibility levels for new applicants and to cap enrollment. However, a county may not reduce income eligibility levels for new MCE applicants unless it does not cover the HCCI population (counties must maintain eligibility levels for those already enrolled in HCCI).[15] Furthermore, a county may not impose a cap on new enrollment in the MCE group unless it also caps new enrollment in the HCCI group (or does not cover that group at all).[16]

Benefits and Cost Sharing

The benefits that counties must offer to LIHP enrollees are somewhat more limited than those available to Medi-Cal beneficiaries and vary by eligibility group.[17] Each benefit offered must be "sufficient in amount, duration, and scope to reasonably achieve its purpose."[18] As shown in Table 5, the mandatory benefits for MCE enrollees are broader than those for HCCI enrollees. Organ transplants, bariatric surgery, and infertility-related services are expressly excluded from the core benefits for both groups. Counties may, at their option, provide services in addition to the mandatory core services to either group, subject to CMS approval.

Table 5. Core Benefits by LIHP Population

MANDATORY CORE BENEFITS	MCE	HCCI
Emergency Care Services	✔	✔
Acute Inpatient Hospital Services	✔	✔
Outpatient Hospital Services	✔	✔
Physician Services (Including Specialty Care)	✔	✔
Laboratory Services	✔	✔
Prescription and Limited Non-Rx Medications	✔	✔
Radiology	✔	✔
Medical Equipment and Supplies	✔	✔
Prosthetic and Orthotic Appliances and Devices	✔	✔
Physical Therapy	✔	✔
Mental Health Benefits	✔	
Prior-Authorized Nonemergency Medical Transportation	✔	

Source: California Bridge to Reform Demonstration, Special Terms and Conditions, Amended Effective June 28, 2012, STC 63, www.dhcs.ca.gov.

The most significant core benefit available to MCE enrollees but not to HCCI enrollees is mental health care. Each participating county must provide a minimum mental health benefits package to its MCE enrollees consisting of up to 10 days per year of acute inpatient hospitalization, psychiatric pharmaceuticals, and up to 12 outpatient encounters per year. Counties may opt to cover additional mental health services, subject to CMS approval.[19] For most counties, this represents a major expansion in the scope of benefits they provide to their low-income residents.

There is considerable overlap between the core benefits available to MCE enrollees and the "essential" health benefits that must be included in the benchmark benefits packages to be offered to low-income adults covered through the ACA Medicaid expansion beginning in 2014. Only four of these essential health benefits are not included in the MCE benefits package: preventive and wellness services, chronic disease management, pediatric services, and maternity and newborn care. Only the first two of these are relevant to the LIHP population.

A common requirement of medical necessity applies to all LIHP benefits. Services must be "reasonable and necessary in establishing a diagnosis and providing palliative, curative, or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time services are rendered."[20] Additional criteria apply in the case of mental health benefits.[21]

Allowable cost sharing, like benefits, varies by eligibility group. In the case of MCE enrollees, counties may not apply enrollment fees or premiums in any amount, and deductibles and copayments must comply with Medicaid cost-sharing limits.[22] In the case of HCCI enrollees, the aggregate of premiums, deductibles, copayments, and other cost sharing is limited to 5% of family income.[23] (See Table 6.)

Delivery Systems and Network Adequacy

Counties may organize their LIHPs using an open fee-for-service system, a closed managed care system, or some combination of both. Those counties that elect to use county-based delivery systems with closed networks of providers are treated as managed care delivery systems and are subject to many but not all of the regulatory requirements that apply to Medicaid managed care organizations.[24]

For example, the waiver specifies a number of network adequacy and access requirements that all county LIHPs must meet whether or not they are organized as closed networks. These requirements include geographic access to primary care services (within 60 minutes or 30 miles), timely access to care (urgent primary care appointments within 48 hours, specialty care within 30 business days), and cultural competence.[25] Failure to meet these requirements will result in a reduction in federal funds available under the waiver.[26] In addition, all LIHP enrollees, regardless of how their LIHP is organized, have due process rights, including a hearing to challenge the denial, reduction, or termination of benefits, and reinstatement of benefits pending appeal. Prior to the existence of the LIHP, those who were uninsured and used county services had no appeal rights regarding services.[27]

Financing

The LIHP is financed with county and federal funds. The federal government reimburses counties for 50% of the costs they incur in furnishing services to LIHP enrollees. For MCE enrollees, there is no cap on the amount of federal funds available for this purpose. For HCCI enrollees, the amount of federal matching funds is capped at $630 million over the period November 2010 through December 2013.[28] The amount available to each participating county each year is limited to an allocation amount determined by the state.[29]

Costs incurred by county LIHPs, whether for MCE or HCCI enrollees, are considered certified public expenditures (CPEs).[30] These CPEs must be calculated using a funding and claiming protocol approved by CMS.[31] Counties are also eligible for 50% federal reimbursement on the administrative costs of establishing and implementing a county LIHP, using a separate administrative claiming protocol subject to CMS approval.[32]

Participating counties are subject to a maintenance of effort (MOE) requirement to ensure that counties do not simply replace county funds with federal dollars. More specifically, the amount of a county's funds that it spends on its LIHP under the waiver in any year can be no less than the amount it would have spent on health services for low-income adults in the absence of the waiver.[33]

Table 6. MCE and HCCI Programs Compared

	MCE	HCCI
Income Eligibility Level	≤133% of FPL; counties may set lower income levels	134% to 200% of FPL; counties may not operate HCCI unless MCE is at 133% of FPL
Cost Sharing	No premiums and enrollment fees are allowed; copayments must meet Medi-Cal levels, capped at 5% of family income	Must meet Medi-Cal levels; enrollment fees, premiums, and copayments in total are capped at 5% of family income
Federal Funding	Uncapped	Capped

Source: *California Bridge to Reform Demonstration, Special Terms and Conditions, Amended Effective June 28, 2012*, STCs 35.a., 48.a., and 70, www.dhcs.ca.gov.

Progress Made by the LIHP

Program Participation

As of August 2012, 50 counties had implemented LIHPs.[34] Of these, 10 are referred to as "legacy" counties because they operated HCCI programs under the prior (2005) version of the waiver.

Implementation was difficult for the counties. Among other things, they had to submit 25 planning documents for state and CMS approval, including a network provider list, geographic access maps, and cultural competency policies and procedures, as well as a specific MOE commitment.[35] Under the terms of the waiver, federal funding for the LIHPs was available as early as September 2010, but contracts between participating counties and the California Department of Health Care Services (DHCS) necessary to implement the LIHPs were not executed by the counties and by DHCS until September 2011.[36]

As of May 2012, 383,000 low-income adults were enrolled in the county LIHPs. Most LIHP enrollees (77%) reside in one of the 10 legacy counties that had participated in the 2005 HCCI.[37] The overwhelming majority of LIHP enrollees (93%) were MCE-eligibles, with incomes at or below 133% of FPL. (See Table 7.)

Enrollment in California's LIHP is only a small fraction of Medi-Cal enrollment (6%) and of the number of low-income, uninsured individuals in California (8%).[38] Still, enrollment in California's LIHP is far greater than that of any other state that offers Medicaid or Medicaid-equivalent coverage to low-income, non-disabled adults under a Medicaid waiver, or under an ACA option, or both.[39]

Table 7. Enrollment in LIHP Implementation Counties as of May 1, 2012

COUNTY	LIHP EFFECTIVE DATE	UPPER INCOME LIMIT MCE (% OF FPL)	UPPER INCOME LIMIT HCCI (% OF FPL)	ENROLLMENT MCE	ENROLLMENT HCCI	TOTAL LIHP ENROLLMENT
Alameda	7/1/2011	133%	200%	32,874	8,058	40,932
Contra Costa	7/1/2011	133%	200%	10,493	2,123	12,616
Kern	7/1/2011	100%		5,734	521*	6,255
Los Angeles	7/1/2011	133%		129,628	185*	129,813
Orange	7/1/2011	133%	200%	28,640	8,798	37,438
Riverside	1/1/2012	133%		18,166		18,166
San Bernardino	1/1/2012	100%		14,386		14,386
San Diego	7/1/2011	133%		28,931	234*	29,165
San Francisco	7/1/2011	25%		9,850	1,165*	11,015
San Mateo	7/1/2011	133%		7,933	287 *	8,220
Santa Clara	7/1/2011	75%		9,753	897*	10,650
Santa Cruz	1/1/2012	100%		1,750		1,750
Ventura	7/1/2011	133%	200%	7,712	2,713	10,425
CMSP counties (n=35)	1/1/2011	100%		52,191		52,191
Total				**358,041**	**24,981**	**383,022**

* County did not implement HCCI as of October 2011 but reported individuals with income over 133% of FPL who applied between December 1, 2010 and June 30, 2011 as new HCCI enrollees. These six counties reported a total of 3,289 new HCCI enrollees.

Source: DHCS, *LIHP May 2012 Monthly Enrollment and LIHP Applicant Data, 6/15/12,* www.dhcs.ca.gov.[40]

Paying for Ryan White Program Services

One of the purposes of the Bridge to Reform waiver is to identify and resolve policy and operational issues that the state will face in implementing Medicaid eligibility expansion in 2014. One such issue appears to have caught many stakeholders by surprise; it concerns low-income, uninsured adults receiving health care services and prescription drugs through the Ryan White Program for persons living with HIV, including the AIDS Drug Assistance Program (ADAP).[41] This population tends to be high-cost due to the expensive antiretroviral medications many of them require. Among the 10 legacy LIHP counties, there were 8,364 ADAP enrollees with incomes below 125% of FPL in 2010. Expenditures for prescription drugs alone for these enrollees averaged $9,330 per year, per enrollee.[42]

In general, the Ryan White Program is the payer of last resort for this population in relation to other federally funded programs. Thus, if an individual in the Ryan White Program is also eligible for Medicaid, Medicaid is responsible for paying for the services it covers; the Ryan White Program will pay only for services that Ryan White covers but that Medicaid does not. In contrast, the Ryan White Program is the primary payer in relation to county-funded programs. Prior to the LIHP, medically indigent adults with HIV could receive coverage for their HIV medications from ADAP, and HIV-related services from Ryan White Program clinics, at federal rather than at county expense.

The LIHP changed this arrangement. In August 2011, the Health Resources and Services Administration determined that the LIHP is, like Medicaid, the primary payer in relation to the Ryan White Program.[43] CMS concurred with this interpretation and declined to allow the state or the counties to exclude Ryan White beneficiaries from the LIHP.[44] Thus, under federal policy, all Ryan White Program beneficiaries who are eligible for the LIHP in their county must be enrolled in the LIHP. (Ryan White Program funds may be used for copayments for LIHP enrollees and to cover services that the LIHP does not cover.)[45]

This policy clarification, coming just as the legacy counties were in the midst of seeking approval for their LIHP, had led one county, San Francisco, to reduce the upper income limit for its LIHP to 25% of FPL, due to concerns about costs for this population.[46] This policy has also raised a host of operational issues, including continuity of outpatient services and prescription drug coverage for Ryan White Program clients who enroll in the LIHP, the capacity of LIHP provider networks to serve these clients, and the design of LIHP drug formularies. These questions were identified and responded to in the form of Frequently Asked Questions issued by DHCS in August and September 2011.[47] Transition plans were developed for each legacy county and, as of August 1, 2012, all 10 of these counties have begun transitioning their LIHP-eligible Ryan White Program beneficiaries from Ryan White clinics and ADAP to LIHP.[48]

Reorganization of County Delivery Systems

The Bridge to Reform waiver specifies that LIHP programs provide MCE enrollees with primary and specialty physician services and up to 12 outpatient mental health encounters per year, among other core services. The waiver also requires that provider networks be adequate to ensure timely access to these and other core services. These requirements, in combination, have led to changes in the organization of some LIHP county delivery systems. In the 10 legacy counties, some of these organizational changes, such as expansion of primary care capacity, were already underway during the precursor HCCI.[49] Others, such as the integration of primary care and mental health, were prompted in some counties by the new LIHP requirements.

For example, the Los Angeles County Department of Health Services (DHS) operates specialty care clinics separate from its primary care clinics. In some cases, patients assigned to the specialty care clinics as their medical home are using the specialists for primary rather than specialty care. In response, the county DHS is restructuring its clinics so that specialists will be used less for primary care. In addition, the Los Angeles County Department of Mental Health Services placed mental health professionals in five county primary care clinics. This locating of primary care and mental health practitioners at the same site is intended to improve access to care for patients with mental health conditions. Similar collocation of primary care and mental health services has also occurred in Alameda, Contra Costa, and San Diego Counties.[50]

The Role of California Foundations in the Bridge to Reform Waiver

One of the unique features of the California waiver is that several state-based foundations have contributed to the planning, implementation, and evaluation of waiver initiatives. For example, five foundations — Blue Shield of California Foundation, the David and Lucille Packard Foundation for Children's Health, the California HealthCare Foundation, The California Endowment, and The SCAN Foundation — contributed in various ways to a multifaceted and intensive stakeholder process, including facilitation and analytic resources for a stakeholder advisory committee and five workgroups.[51] Foundation staff collaborated with one another and with state officials, and each foundation funded activities consistent with its own objectives. Two of these foundations, Blue Shield of California Foundation and the California HealthCare Foundation, are supporting projects to evaluate the success of waiver activities and identify opportunities for improvement.

Tracking Actual Cost and Utilization Experience

One goal of the Bridge to Reform waiver is to develop an accurate profile of MCE and HCCI enrollees with respect to use of services and per-person, per-month costs, in the context of county LIHP delivery systems. This information is essential to determining county-specific eligibility thresholds and enrollment policies going forward. The information is also crucial to construction of LIHP capitation rates, and ultimately to the development of accurate capitation rates for Medi-Cal expansion in 2014.

Evaluation

The Bridge to Reform waiver requires an evaluation of the impact of each demonstration program on target populations.[52] In the case of the LIHP, the state selected, and CMS approved, the UCLA Center for Health Policy Research to conduct the evaluation, which will focus on four areas: enrollment and retention strategies; coverage expansion; access to and quality of care; and transition of LIHP enrollees into Medi-Cal or the California Health Benefit Exchange starting in 2014. UCLA began evaluation activities September 1, 2011, and will prepare and release findings throughout the demonstration period.[53]

Implementation Challenges for the LIHP

While considerable progress has been made implementing the LIHP, a number of challenges remain. A brief summary of the most significant challenges follows.

Time Designations for the Waiver

For tracking purposes, the current waiver is considered an expansion of the 2005 waiver, and follows a schedule through 2015 where the initial demonstration "year" (DY) of the 2010 waiver is eight months long, and the final DY is 16 months long. The dates of the DYs for the 2010 waiver are as follows:

- DY 6 — November 1, 2010, through June 30, 2011
- DY 7 — July 1, 2011, through June 30, 2012
- DY 8 — July 1, 2012, through June 30, 2013
- DY 9 — July 1, 2013, through June 30, 2014
- DY 10 — July 1, 2014, through October 31, 2015

Enrollment Levels

At the close of demonstration year (DY) 7, the primary issue for counties in executing the LIHP has been getting eligible individuals enrolled. It is generally agreed among stakeholders that there has been a lag in enrollment, resulting in lost access to federal funds, due to requirements that individuals answer extensive questions and provide documentation. In Los Angeles, the county DHS took on this issue directly with a program it dubbed Operation Full Enrollment, which set clear enrollment benchmarks. As a result, the county has more than doubled its LIHP enrollment level over that of the previous legacy program.

ACA Transition Plan

One of the key deliverables under the waiver is a plan for transitioning LIHP enrollees to Medi-Cal as of January 1, 2014. The waiver anticipates that the transition would begin as early as July 1, 2013, and that LIHP enrollees would not be required to submit new eligibility applications.[54] The state submitted its initial transition plan to CMS on August 1, 2012.[55] The plan envisions that all LIHP enrollees eligible for Medi-Cal will be assigned to a managed care plan based on the enrollee's LIHP medical home. In those counties where Medi-Cal managed care is not offered, LIHP enrollees will be enrolled in fee-for-service Medi-Cal.

Claiming Protocols

In order for counties participating in LIHP to receive federal matching reimbursement for half of their program costs, they need to submit those costs using claiming protocols approved by CMS. The waiver specifies two claiming protocols: one for the costs of health services, the other for administrative costs.[56] As of August 2012, nearly two years after CMS approved the waiver, these claiming protocols were still under discussion between CMS and DHCS.[57] The lack of final costs protocols makes it very difficult to determine fee-for-service costs of LIHP programs, leads to fiscal uncertainty for participating counties, and complicates the setting of capitation rates.

IV. The Delivery System Reform Incentive Pool

The Delivery System Reform Incentive Pool (DSRIP) offers federal matching funds to safety-net hospitals in California, aligning investments in infrastructure, refinements in system design, improvements in population health, and needs in urgent care.[58] Designed primarily though not exclusively to support public hospitals, up to $3.4 billion is available over the course of the waiver. This alignment is intended to lead to system transformation — a safety net that is more coordinated, addresses cost containment, provides better clinical and population services, and is better prepared for health reform implementation.

Each of California's 21 designated public hospitals (DPHs), consisting of county public and University of California hospitals, was eligible to submit a DSRIP plan for approval. Nearly 69% of patients served by public hospitals in California are covered by Medi-Cal or are uninsured. Private safety-net hospitals were also eligible for DSRIP funds, but none chose to participate in the program.[59]

To be eligible for DSRIP funds, a hospital was required to submit a plan that described specific improvement projects and related milestones. A hospital is able to draw down a predetermined incentive payment for each milestone reached. A hospital that fails to achieve a milestone will not receive the incentive funding associated with it, regardless of the investment made in the attempt. A shared funding requirement is consistent with how California's DPHs are financed under the waiver: Public hospitals and the counties provide their share, which is then matched by the federal government.

The DSRIP signals that the federal government understands the value and significance of safety-net hospitals in providing quality health care services to vulnerable populations. It also helps to prepare safety-net hospitals for the changes coming under health reform by supporting improvements in operations, customer experience, and quality of care. The DSRIP gives facilities critically needed support to improve hospital operations, serving as a federal-county partnership in delivery system reform. The DSRIP is intended to expand outpatient capacity and improve efficiency in anticipation of growing demand for services as more people are insured under health reform.[60]

The next section of this report summarizes the main provisions in the waiver relating to the DSRIP, progress made during the first 12 months in implementing DSRIP plans, and implementation challenges for the future.

Waiver Provisions Regarding the DSRIP

Improvement Projects

Initially, hospitals eligible for DSRIP funds were required to select five-year improvement projects in the following categories:

- *Infrastructure Development* supports hospitals' overall ability to provide services by strengthening their use of technology, tools, and human resources. These projects are meant to lay the foundation for efforts in the other categories.[61] Hospitals were required to include at least two of these projects in their plans and could choose from a limited set of projects preapproved by CMS.

- *Innovation and Redesign* supports new models of care and efforts to improve the patient experience. These projects are also meant to lay the groundwork for projects in categories 3 and 4 (below). Hospitals must include at least two projects from this category, chosen from a preapproved set.
- *Population-Focused Improvement* requires all plans to include four predefined projects addressing each of the following issues: patient experience, care coordination, prevention, and health outcomes of at-risk populations.
- *Urgent Improvement in Care* includes improved performance on interventions in care delivery that are likely to have measurable and meaningful impact in care within the five-year waiver window. A hospital's DSRIP plan must include two mandatory projects and two more projects from a list of five options.[62]
- *HIV Transition Projects* are intended to better meet the care needs of the HIV population. The DSRIP includes these projects in part to help resolve the Ryan White Program issue regarding the LIHP, as discussed in Section III, above.

The waiver directs hospitals to consider the following factors when selecting their DSRIP improvement projects:

- *Need.* Hospitals are directed to choose projects that target areas where improvement is needed. If a hospital already performs strongly in a given area, it would be prevented from devoting resources to that area.
- *Achievability.* CMS's perspective is that while projects should present a challenge, they should also be clearly achievable. If a hospital cannot demonstrate that it can achieve an improvement project selected, then the associated funds will not be awarded.
- *Incentives.* Predetermined funding amounts are tied to hospital improvements. For a hospital to receive funds, the project must demonstrate a significant effort toward transformational change of the delivery system.

Objectives and Milestones

For each project, hospitals were required to establish specific objectives and milestones. Several principles were used to guide their development.

- Each project has its own measurement specifications. While some measures are hospital-specific, others were included for all hospitals.
- When possible, measures were based on nationally or statewide accepted standards.[63]
- Different types of measures were used. Process measures were used for most Innovation and Redesign projects, recognizing that the initiatives did not guarantee outcomes but focused on achieving best practices. For Population-Focused Improvement and Urgent Improvement in Care projects, measures were tied to a hospital's progress relative to pre-DSRIP performance regardless of the hospital's existing level of achievement.
- A hospital may qualify for a partial payment for partial success. In some cases, if a hospital misses a milestone, it might still get the full payment if the milestone is achieved in the future.

Non-Federal Matching Payment

As a part of Medi-Cal, the DSRIP is a matching program, meaning that the federal government matches local expenditures. Since the 2005 California waiver, matching requirements for California public hospitals for the Disproportionate Share Hospital (DSH) program and the Health Care Coverage Initiative (predecessor to the LIHP) have been primarily filled through CPEs, meaning that hospitals are reimbursed based only on actual expenditures. If CPEs were used under the DSRIP, there would have been little incentive for public hospitals to invest their own funds because they would only receive half of what they spent in return (under the normal federal match rate of 50% for Medi-Cal). As a result, CMS gave hospitals permission to use Inter-Governmental Transfers (IGTs) as the matching funds under the DSRIP. IGTs are cash transfers from the county public hospital to the state General Fund that can then be used to draw down federal matching funds. By delinking CMS matching payments from the actual costs incurred by hospitals, the use of IGTs as the source of local funds enables the DSRIP payments to be structured as incentive payments based on achieving outcomes rather than on how much is spent.[64]

Additionally, DSRIP payments are not considered Medicaid reimbursements for patient care, and therefore do not reduce the Medicaid DSH funds a hospital can receive or the CPEs they can claim for purposes of funding their share of the LIHP program.[65]

Selected DSRIP Plan Highlights: Projects, Milestones, and Funding

The following is a snapshot of three hospital systems and their DSRIP projects that met with success during the first year of the waiver.

University of California, Los Angeles. The UCLA DSRIP plan includes a project to increase training of the primary care workforce. The milestone for year one of this project was to develop an international medical graduate program. The program was established, which allowed UCLA to receive an incentive payment of just over $8.35 million.[66]

San Mateo Medical Center. Expanding medical homes was a focus in the San Mateo Medical Center DSRIP plan. The milestones included establishing a process to track the assignment of patients to primary care provider teams in at least four clinics. This milestone was met and the medical center received $1.59 million from the DSRIP.[67]

Alameda County Medical Center. In order to prevent surgical site infections (SSIs), the first-year milestone of the Alameda County Medical Center's DSRIP plan was to form an interdisciplinary SSI reduction team and charter, identify a physician champion, and propose improvement strategies for consideration by the medical center's quality council. These three aspects of the milestone were achieved, and the medical center received nearly $938,000.[68]

Progress Made with the DSRIP

DSRIP plans have been approved for 15 California counties, with all 21 DPHs participating. The plans are diverse and cover the full range of project categories.[69] (See Appendix B for an overview of the projects included in each plan.) The hospitals are using DSRIP as an opportunity to achieve both structural and cultural change — the waiver encourages a focus and intensity across an entire public hospital system about reforming its delivery system.[70]

The following presents trends from participating hospitals in each of four DSRIP categories.

- *Infrastructure Development.* Two-thirds of the hospitals chose projects to implement disease management registries. More than half chose projects to expand primary care capacity and capabilities.
- *Innovation and Redesign.* Projects to expand medical homes were the most popular in this category. Also, nearly half of the hospitals chose projects to expand chronic care management models and to integrate physical and behavioral health care.
- *Population-Focused Improvement.* All projects in this category must be included in each hospital's DSRIP plan. The category encompasses 70 milestones. However, plans were not required to implement these projects in the first waiver year.
- *Urgent Improvement in Care.* All hospitals must include projects to improve severe sepsis detection and management as well as central line-associated bloodstream infection prevention. Here, most hospitals (76%) chose to include projects that would prevent surgical site infection.

Under the DSRIP, hospitals are implementing 12 to 19 projects simultaneously, averaging 217 milestones per hospital system over five years. In addition, many of these hospitals will implement other non-DSRIP improvement projects during this time.

In the first year of the DSRIP, all DPHs met 100% of their combined 298 first-year milestones and so were eligible to receive 100% of their first-year funding. At the time of the reporting of the first year's results in May 2011, nearly one-third of all DSRIP funds, a little over $1 billion, had been drawn down for projects in categories 1, 2, and 4. (See Table 8.) Category 3 projects did not begin implementation until DY 7, which has only recently concluded; data for DY 7 will be finalized in late 2012.

In general during the first two years, DSRIP plans placed greater weight on achieving success related to the first two categories (Infrastructure Development, and Innovation and Redesign) since these are essential for building toward results in the other two categories (Population-Focused Improvement and Urgent Improvement in Care).

Table 8. DSRIP Funding Allocations: DY 6*

CATEGORY	NUMBER OF PROJECTS	YEAR ONE ALLOCATIONS (MILLIONS)
1: Infrastructure Development	55	$463.7
2: Innovation and Redesign	66	$459.6
3. Population-Focused Improvement	-†	-
4: Urgent Improvement in Care	68	$83.4
Total	**189**	**$1,006.8**

* Most recent year for which full data is available.

† Category 3 figures not yet available.

Source: Author analysis of DSRIP DY 6 year-end reports, California Department of Health Care Services, "Delivery System Reform Incentive Payments (DSRIP)," www.dhcs.ca.gov.

Implementation Challenges for the DSRIP

For the most part, the challenges that arose in the implementation of the DSRIP are to be expected where, for the first time, outcomes in a fee-for-service system are being evaluated and providers are being held accountable for their performance. These are primarily problems of how to collect and report needed data accurately and how to set benchmarks to measure progress within a system.[71]

Comparability of Data Across Systems

While the waiver intended to promote standardization of data collection and measurement, it actually allows for significant discretion in how individual hospitals manage their metrics. This flexibility recognizes that many hospitals have existing data collection systems and that full standardization would be difficult and expensive. Also, much of the early discussion regarding data required more clinical input than occurred during development. There is a sense among state and federal policymakers that there is as yet insufficient standardization for the DSRIP program as a whole, as much of the data are not truly comparable across hospital systems.

CMS Data Reporting

There are concerns about data reporting systems, particularly from CMS. CMS felt so strongly that hospitals had failed to provide all the information needed in the semiannual DSRIP report filed by hospitals in March 2012 that it threatened to withhold DSRIP payments. While CMS ultimately determined that the reports as submitted had met waiver requirements, the issue reflects the difficulty of designing an accountable fee-for-service reporting system.

Benchmark Levels

When hospitals release their final DY 7 report covering the first two waiver years, it is anticipated that several hospitals will show that they have already achieved future benchmarks in some categories — in certain cases, significantly ahead of schedule. If so, this could create controversy to the extent it appears that hospitals did not meet the spirit of the waiver by setting challenging benchmarks. If CMS reads the results in this way, it might seek to renegotiate benchmarks.

Workforce Redesign

Even with the focus on expanding medical homes in the Innovation and Redesign category, primary care delivery proved to be a challenge, particularly because of workforce capacity limits. In many cases, hospitals found that they lacked sufficient numbers of primary care physicians and other professionals to meet patient needs. This means that some hospitals, such as those in the Los Angeles County DHS, are redesigning and reconfiguring their workforces to meet patient needs under the waiver.

Staff Capacity

The waiver required hospital systems to begin implementation of the various projects immediately, to meet six-month milestones. In many cases, staff took on additional DSRIP responsibilities with no additional resources. For example, collecting race, ethnic, and language data required staff to take on additional duties during the registration process. Also, implementing new screening tools to address some urgent care projects was seen as administratively burdensome.

V. Mandatory Enrollment of Seniors and Persons with Disabilities

A third major component of the Bridge to Reform waiver is the expansion of mandatory managed care to Seniors and Persons with Disabilities (SPDs) who are enrolled in Medi-Cal, but not Medicare, in counties that have Medi-Cal managed care.[72] This population was phased into managed care over a 12-month period ending in May 2012, with 240,000 beneficiaries required to transition from the fee-for-service system to a managed care plan. An estimated 140,000 non-Medicare SPDs were already enrolled in managed care plans on a voluntary basis, meaning that this policy's only impact on them was to eliminate their option to switch to the fee-for-service system.

In addition to improving care for SPDs, it is critical for state officials to understand the process and outcomes of SPDs enrollment. This is particularly true as they move forward with the California Coordinated Care Initiative, which will move certain beneficiaries into managed care for long term care services and will move certain beneficiaries enrolled in Medi-Cal and Medicare (called dual eligibles) into managed care. Nationally, 15 states are working with CMS on a dual eligibles demonstration project, while other states report looking at managed care expansions for various populations.

Program Eligibility for SPDs

SPDs are eligible for Medi-Cal if they have income lower than 133% ($1,238 a month in 2012) of FPL.[73] SPDs with higher income may qualify for Share of Cost Medi-Cal.[74] Most of these individuals might also qualify for Medicare coverage based on age or disability but are not enrolled due to a failure to meet other Medicare eligibility standards.

For non-elderly disabled individuals, there are two common reasons for failure to qualify for Medicare. One is that the beneficiary has not been receiving Social Security Disability Insurance (SSDI) benefits for 24 months. These are individuals who would qualify for Medicare following this two-year waiting period established in Medicare eligibility rules. Another common reason is that the individuals lack required work credits. Disabled persons under age 65 need sufficient work credits and must meet other standards to qualify for SSDI benefits, which in turn is linked to Medicare eligibility.

For seniors, the most common reason not to qualify for Medicare is insufficient (individual or spouse) work history, such as for people who did not work a sufficient amount in Medicare tax-paying employment. Approximately 60% of SPDs with Medi-Cal are dual eligibles while 40% have Medi-Cal only.[75]

As with other aspects of the waiver, mandatory managed care for SPDs represents not a fundamental change but an evolution in policy. It is an expansion of the existing managed care delivery system, which operates in 30 of California's 58 counties and has mandatorily enrolled children and families since 1995. In 14 of these 30 counties, managed care is already mandatory for SPDs under a separate federal authority.[76] (See Table 9 for Medi-Cal managed care models.)

While the state and health plans assert that managed care can improve care delivery, many beneficiaries and their advocates have expressed concerns about the impact of the policy of mandatory enrollment. Among these concerns are:

- The implementation process did not provide beneficiaries with sufficient time or information to make an informed choice about plans.
- Many beneficiaries lost longstanding relationships with their providers.
- There have been disruptions in care or changes in treatment.

SPDs Mandatory Managed Care, Background and History

Proposals to expand mandatory managed care to Medi-Cal-only SPDs date back at least 10 years, including a significant but ultimately unsuccessful effort in 2004 by Governor Schwarzenegger. Why was the Brown administration successful? There were many likely contributing factors, including:

- Due to the severity of the state's budget crisis and the limited options for balancing the state's budget, the Democrat-controlled legislature adopted spending cuts to health and social service programs that they had previously rejected.
- In the years between 2004 and 2010, state officials took numerous steps to address concerns raised by beneficiaries and their advocates regarding managed care. Specifically, the state imposed new requirements on health plans in areas such as network adequacy and continuity of care.[77]
- Opposition to managed care softened, in part due to passage of health reform in 2010 under President Obama, which emphasized accountable systems of organized care as a way to control health care costs.
- Public hospital systems, which received billions of dollars in new federal funding through the waiver for delivery system reform, dropped their opposition to managed care expansion.

Table 9. Medi-Cal Managed Care Models

MODEL	APPROACH	NUMBER OF COUNTIES*	COUNTIES PARTICIPATING*
Two-Plan	Beneficiaries choose between a Local Initiative Plan and a private, for-profit plan.	14	Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare
County Organized Health System (COHS)	There is a single nonprofit plan that all beneficiaries must enroll in, including SPDs.	14	Marin, Mendocino, Merced, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, Sonoma, Ventura, Yolo
Geographic Managed Care (GMC)	Beneficiaries choose one plan from several.	2	Sacramento, San Diego

* As of September 1, 2012.

Source: California Department of Health Care Services.

Waiver Provisions Regarding SPDs Managed Care

Enrollment Process

Under the waiver, DHCS began shifting SPDs from fee-for-service to managed care on June 1, 2011. Beneficiaries were switched over a 12-month process, with the month of enrollment into managed care based on the beneficiary's month of birth. Notices were mailed to beneficiaries three months prior to their enrollment dates into managed care, beginning March 1, 2011. Subsequent notices were sent 60 days and 30 days prior to enrollment dates.

The enrollment process included the following steps and beneficiary protections:

- *Beneficiary Notification of Enrollment.* DHCS contracted with a private vendor, Maximus, to serve as an enrollment broker through a program called Health Care Options (HCO). At the beginning of the process, the HCO vendor sent beneficiaries a county-specific information packet, which included health plan information, provider information, and various enrollment forms. The HCO vendor made follow-up calls to beneficiaries under certain circumstances, and was required by DHCS to make offers of individual assistance.
- *Default Enrollment.* When beneficiaries who are required to enroll in managed care do not make an affirmative plan choice, the state chooses a plan for them. For SPDs required to transition to managed care, DHCS analyzed the fee-for-service claims of these beneficiaries in an effort to identify each beneficiary's primary provider. If successful, DHCS chose the health plan whose network included the beneficiary's primary provider. If unsuccessful, DHCS assigned the beneficiary to a health plan based on a performance-based algorithm that rewards plans that score higher on a series of quality indicators and measures of safety-net participation.
- *Continuity of Care.* Whether they chose a plan or one was chosen for them, beneficiaries were permitted to receive care from their existing providers for one year, regardless of whether the provider contracted with the plan, as long as the provider was willing to accept the plan payment rate.
- *Exemptions from Managed Care.* Beneficiaries with specific medical conditions can make a Medical Exemption Request (MER) to the HCO vendor.[78] If the MER is approved, the beneficiary may remain in fee-for-service for up to 12 months to allow for a stable handoff to a plan physician. To qualify for this medical exemption from managed care, the beneficiary must require care for a specific qualifying condition and must be receiving care from a physician who is not in the managed care plan's provider network. DHCS lists nine of these qualifying conditions (including pregnancy, HIV/AIDS, and need for a transplant), but beneficiaries may also qualify for a complex condition not listed.[79] To qualify, the beneficiary cannot already have been enrolled in the plan for longer than 90 days and cannot have received new treatment from a physician under the plan (a health assessment not being considered treatment).
- *Care Needs Assessment and Patient-Centered Care.* Health plans are required to identify new members who need immediate attention or specialty care, to help maintain their health status. Health plans are instructed to review fee-for-service utilization data provided by DHCS to identify potentially high-risk individuals for whom an assessment is required within 45 days of enrollment; for those at lower risk, an assessment is required within 105 days of enrollment.

Beneficiary Protections for SPDs

Although Medi-Cal's contract requirements for participating health plans already typically exceed those required in the commercial market under the state's Knox-Keene Act, several new provisions were added that provide additional beneficiary protections.[80] They include service delivery procedures and beneficiary safeguards.

Service Delivery Procedures

The waiver provides a framework for care to be delivered to SPDs beneficiaries across several areas, with elements including:

- *Promoting Coordinated Care Delivery.* Given the special needs of many SPDs, health plans are required to have the resources and specialists needed to provide appropriate care, including care coordination. In addition, plans must link mental and behavioral health services, as well as connect beneficiaries to personal care and social services, such as housing and energy assistance.
- *Offering Patient-Centered Care.* Health plans must take steps to involve patients (and their families) in the development of their care plans by making certain that beneficiaries are informed about their care options and have the opportunity to work collaboratively on their treatment plans.
- *Delivering Accessible Care.* Health plans must provide care with needed physical accommodations and interpreter services to overcome language and disability barriers. Steps must be taken to make sure that there is sufficient nonemergency transportation for beneficiaries. Plans must also have adequate networks of providers to deliver care within a reasonable time and to meet state standards on geographic accessibility (proximity to providers based on time and distance.) Also, health plans must assess physical accessibility of providers.

Beneficiary Safeguards

In addition to care standards, the waiver sets a number of procedural rules designed to protect the rights of beneficiaries.

- *Grievance Procedures.* Beneficiary grievance and appeal procedures must comply with existing Medi-Cal rules and with California's rules under the Knox-Keene Act, including resolution of grievances and response to appeals.
- *Advisory Groups.* Several waiver provisions call for beneficiaries to participate in various advisory groups at the health plan level to help guide policymaking and waiver implementation.
- *Health Plan Notices.* The waiver requires Medi-Cal to set SPDs-specific standards for a series of notice and information requirements for enrollment, disenrollment, and hearing procedures, including the design of those notices.
- *Transparency.* Plans must make certain operational information publicly available, such as procedures for making clinical and administrative decisions, as well as certain nonproprietary aspects of their state contract.

Progress Made Regarding SPDs Managed Care

The year-long transition of SPDs in 16 counties from fee-for-service to managed care was completed in May 2012. Of these beneficiaries, initially about 40% chose a health plan themselves while 60% had one assigned to them. Despite ongoing efforts by DHCS and its enrollment broker to educate enrollees about their health plan options, this 40% overall chooser rate remained about the same over the 12-month transition period. (See Figure 1.)

Of those SPDs who did not choose a plan themselves, initially about one-quarter were assigned based on an existing relationship with a primary care provider, which those beneficiaries could maintain in their new plan; the other three-quarters of non-chooser SPDs were assigned using a default methodology. By August 2011, however, DHCS was able to more than double the rate at which beneficiaries were assigned to a plan based on a provider linkage, and for the remainder of the enrollment process a slight majority of beneficiaries assigned a plan were placed into one with a known provider link. (See Figure 1.)

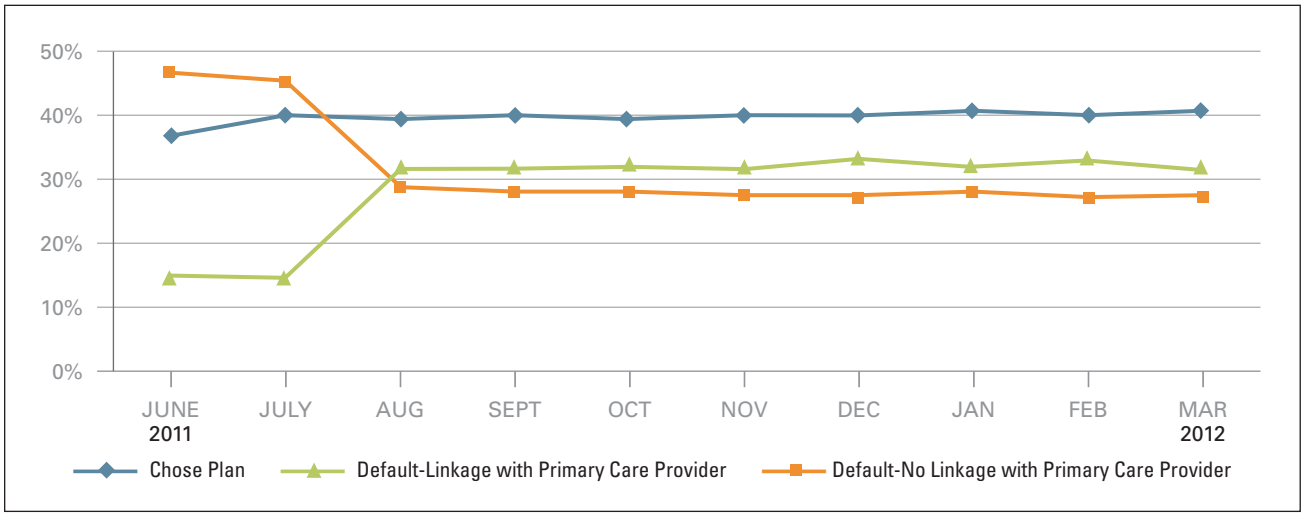
Regarding exemption requests, from June 2011 to April 2012, there were approximately 20,000 MERs, representing about 8% of the enrolled population.[81] Of these, about half the requests were deemed incomplete and required additional follow-up from the physician or the beneficiary. Of the 50% that were decided, 18% percent were approved and 32% denied. (As of September 2012, the turnaround time for an MER was two weeks.)

In terms of grievance indicators for SPDs, from June 2011 to April 2012:

- 866 grievances were filed by SPDs related to access to care.
- Two requests were made to a health plan for a fair hearing related to access.
- 1,923 calls were made to the Department of Managed Care Help Center from SPDs regarding mandatory enrollment (June 2011 to February 2012).[82]

A recent analysis of the implementation activities and experiences of stakeholders in the 16 counties concluded that overall success of the transition could not be determined because there was a lack of performance goals or benchmarks.[83] This makes it difficult to determine whether an affirmative choice rate of 40% is good or poor. Similarly, many measures for which data are collected are open to interpretation. For example, state officials have said that the relatively low contact rates for the ombudsman, low rates of MERs, and low rates of grievances filed with health plans are signs of success. In contrast, some consumer advocates suggest that these low rates of utilization reflect a lack of awareness of these options among SPDs and their providers.

Figure 1. SPDs Managed Care Plan Chooser Rates, June 2011 – May 2012



Source: Author analysis of California Department of Health Care Services, *Managed Care Implementation for Seniors and Persons with Disabilities, Monitoring Dashboard,* September 2012, www.dhcs.ca.gov.

Implementation Challenges Regarding SPDs Managed Care

Medi-Cal and stakeholders faced a number of challenges in the expansion of mandatory managed care for SPDs. For the most part, these challenges concerned external communications and beneficiary protections (e.g., continuity of care). Although the transition is complete, state officials still have the opportunity to consider these challenges as new SPDs enter Medi-Cal and join managed care. There is also value in meeting these challenges for the pending dual eligibles demonstration. (See California's Coordinated Care Initiative and Dual Eligibles, below.) Responding to the challenges, discussed below, can also provide direction on how to address similar problems with future state expansions of managed care.

Inadequate Outreach

Many stakeholders believe that some providers and many beneficiaries did not fully understand the transition process and that more intensive and targeted outreach to both groups was needed. In particular, the decision by DHCS to hold only one in-person educational event for consumers, consumer groups, and health care providers in each of the 16 counties was criticized as inadequate. Stakeholders also raised concerns about a lack of adequate outreach to both in-network and out-of-network providers.

Confusing Medical Exemption Policy

Consumer advocates have complained that the MER rules and process were confusing and inconsistently applied. Advocates provided examples of cases where MERs have been denied even when the application met all of the required criteria, and of cases where care was delayed while MER applications were left pending for more than 90 days. There was also confusion over when the MER should be used versus simply working with a health plan to maintain continuity of care. In interviews for this report, several plans contended that they had the ability to be more responsive than the MER process and asserted that patient concerns could be more effectively addressed at the plan level.

Confusing and Hard-to-Access Notices

Stakeholders expressed a range of concerns about information provided to beneficiaries and providers, from hard-to-understand letters and forms to small type. For example, the DHCS website provides only an English language MER form, and it uses a font size smaller than 10-point, reducing readability.

Difficulty Maintaining Continuity of Care

Stakeholders reported that many beneficiaries had difficulty maintaining continuity of care and that managed care plans were not prepared for the prevalence of complex conditions, including mental illness, homelessness, and developmental disabilities, among the SPDs population. For this population, continuity of care includes access to a primary care doctor, specialists, ancillary providers, durable medical equipment, and prescription medications.

Improper Enrollment

Stakeholders cited examples of Medi-Cal beneficiaries who are also enrolled in Medicare (dual eligibles) being default-enrolled into Medi-Cal managed care (when they are supposed to be exempt) because of coding issues in state computer files.

Difficulty Sharing Beneficiary Claims Data

Concerns have been raised regarding the lack of timely and accurate data from DHCS needed by plans to contact beneficiaries in order to begin assessing their health status. The timeliness with which plans transmitted data to physicians was also a problem. In addition, the review of implementation experiences found that no performance goals were established for the transition, making it extremely difficult to measure the transition's effectiveness.

Challenges with Rate Setting

There are concerns about the level of the payments to be made for the SPDs population due to what has been asserted to be poor data, with some stakeholders contending that the rates are too low and others contending that rates may be too high.

California's Coordinated Care Initiative and Dual Eligibles

Under the Schwarzenegger administration, the State of California sought to include dual eligibles — individuals enrolled in both Medicare and Medi-Cal — in the 2010 waiver, citing the need for coordinated care to improve quality and address costs. However, the proposal was dropped at the request of the federal government, which wanted to allow further development of dual eligibles policy. In addition, some advocates in the state had signaled concern about the vulnerability of this population if it were placed into managed care. There were also significant concerns from patient advocates and others about limiting the care choices of those enrolled in Medicare.

Following establishment of the Bridge to Reform waiver, the Brown administration continued to work with stakeholders to develop a demonstration program of coordinated care for dual eligibles, to improve acute and long term care for this population, and to slow the growth of spending on them. In 2011, California was one of 15 states awarded a federal contract to develop new models of coordinated care for dual eligibles. With 1.1 million such beneficiaries statewide, the Dual Eligibles Coordinated Care Demonstration will involve models through which a single entity will coordinate care for all of a beneficiary's health care needs, including behavioral health, social support, medical care, and long term care. The design of these models could take a number of different forms.

DHCS is working closely with the federal Medicare-Medicaid Coordination Office within CMS to prepare for a launch of this demonstration project between March and June 2013.The demonstration is intended to be implemented in eight counties during 2013: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. While the state is still finalizing the count of the population eligible for the demonstration, that population is currently estimated as 560,000 dual eligibles in the eight counties. About half of those beneficiaries already are enrolled in managed care for Medi-Cal, Medicare, or both.

VI. The California Children's Services Program Demonstration

The fourth major component of the Bridge to Reform waiver is the authorization of pilot programs to improve the efficiency and reduce the cost of delivering services to children with special health care needs enrolled in the California Children's Services (CCS) program. CCS is administered as a partnership between county health departments and DHCS to provide medical case management and authorization of services for people under 21 years of age ("children") with special health care needs who meet certain medical, residential, and financial eligibility requirements.[84]

CCS will pay for services related to specific conditions, including but not limited to congenital heart disease, cancer, hemophilia, sickle cell anemia, chronic kidney problems, cleft lip/palate, spina bifida, cerebral palsy, and muscular dystrophy. Coverage is restricted to care required to treat the child's CCS-eligible condition; other health care costs are the responsibility of the child's health insurance plan or the family.

CCS children may also be enrolled in Medi-Cal, Healthy Families, or private insurance. Approximately 70% of children enrolled in CCS are covered by Medi-Cal, 15% are covered by Healthy Families, and 15% are privately insured or are uninsured.[85] Generally, CCS spending consists of a mix of state, federal, and county funds.

In State Fiscal Year 2009–10, total Medi-Cal fee-for-service expenditures for the CCS program exceeded $487.5 million for the roughly 25,000 children under the age of one served by CCS.[86] For the 133,000 children served ages one and over, total State Fiscal Year 2009–10 expenditures were $1.33 billion. This is approximately $19,500 per child under age one and $10,000 per child age one or over.[87] (See Table 10, which summarizes CCS fee-for-service expenditures by service category.)

Table 10. CCS Fee-For-Service Expenditures, FY 2009–10

SERVICES FOR ALL CONDITIONS	CHILDREN < 1		CHILDREN ≥ 1	
	TOTAL EXPENDITURES	PER CHILD EXPENDITURES	TOTAL EXPENDITURES	PER CHILD EXPENDITURES
Hospitalization	$426,225,063	50,929	659,531,598	31,357
Emergency Department Visits	1,289,744	193	11,892,129	406
Outpatient Procedures	24,722,692	1,518	267,001,852	2,681
Provider Visits	18,444,678	1,085	126,925,067	1,327
Outpatient Prescriptions	16,872,823	1,886	266,564,400	5,301
Total/Average	**487,555,000**	**19,483**	**1,331,915,045**	**10,011**

Source: California Department of Health Care Services, *California Children's Services Program Analysis: Final Report*, www.dhcs.ca.gov.

Although the CCS program has many strengths, its complex financing structure is a source of challenges for children enrolled in Medi-Cal.[88] For example, the division of payment and accountability between specialty care services, which are the responsibility of the CCS program, and primary and acute care services, which are provided through managed care plans, can delay access to care while the payers argue over who is financially responsible. Delays in the county process for authorizing services and variation among counties in medical decisionmaking can also jeopardize timely access to care.

Waiver Provisions Regarding the CCS Demonstration

The waiver states that the goal of the CCS demonstration is to improve health outcomes, achieve greater cost effectiveness, improve coordination of care, improve satisfaction with care, offer timely access to care, and develop family-centered care. The waiver authorizes four demonstration models for the CCS program:

- Medi-Cal managed care plan (MCO)
- Enhanced primary care case management (EPCCM)
- Specialty health care plan (SHCP)
- Provider-based accountable care organization (ACO)[89]

Progress Made in the CCS Demonstration

In April 2011, DHCS issued a Request for Proposals to identify qualified organizations interested in developing demonstration programs. Five CCS county programs submitted proposals and in October 2011 all five proposals were approved. (See Table 11 for details of the five projects.) All five projects share three goals:

- Eliminate the existing managed care carve-out for the county's CCS-eligible population
- Streamline the administrative process by leaving eligibility determination and enrollment to the respective county CCS program
- Better manage the children's health care needs and improve health outcomes by providing improved care coordination

At the end of the waiver's DY 6, the CCS demonstration applicants were notified of their awards. State officials then conducted site visits with the participating managed care plans as well as with the county officials administering the CCS program. The focus of these meetings was to discuss the infrastructure and provider networks required to meet the special health care needs of the children to be served under the project, plus enrollment processes, quality improvement goals, and data tracking mechanisms.

Recently, concerns have shifted at the local level from program infrastructure to payment and risk. There has been a lack of shared understanding between health plans and DHCS about whether the goal was to shift full risk to the plans — even as demonstration applications noted that plans would take on only limited risk. Given the projected payment rates, plans have now generally balked at moving forward. Of the five sites, San Mateo County is the closest to going forward, with the remaining counties lagging. It is unclear if and how concerns regarding risk can be fully addressed such that the CCS demonstration will go forward in all five counties.

Implementation Challenges for the CCS Demonstration

California has not yet implemented these demonstration programs, but the state is facing many of the same implementation challenges it had when expanding coverage to SPDs. In particular, it has been difficult for the state and health plans to decide how to share risk and to develop actuarially sound rates, which will vary by program.

Table 11. CCS Demonstration Projects Overview

DEMONSTRATION PROJECT	MODEL TYPE AND DESCRIPTION	OVERVIEW	POTENTIAL ENROLLMENT	PAYMENT
Health Plan of San Mateo	MCO — inclusion of children with special health care needs in an existing MCO	Provides care coordination driven by the needs of the whole child, including primary care, specialty care, social and psychological needs, as well as any other services necessary to address child and family well-being	Mandatory enrollment for those who meet qualification criteria; 1,800–1,850 children	Capitated rate with plan fully at-risk
Alameda County Health Care Services Agency	EPCCM — responsible for all outpatient care (primary preventive care as well as care that treats the child's CCS-eligible condition); required participation in a provider incentive program for inpatient care	• Builds on the agency's existing medical home-based care coordination, family support, and pediatric education and training • Focuses care coordination team on creating better linkages at pre- and post-hospital discharge and transition, and coordinates services across the entire continuum of care	Mandatory enrollment for those who meet qualification criteria; 5,000 children	Capitation for services specified
Los Angeles Care Health Plan	SHCP — flexibility given to develop an innovative health care delivery model to meet program goals	• Creates partnership among three delivery systems — Children's Hospital Los Angeles, Millers Children's Hospital, and Mattel UCLA — to create a comprehensive provider network for CCS-eligible children • Provides family-centered care by engaging members in health education, treatment decisions, and self-care management • Develops infrastructure to serve child holistically through a medical home approach, including managing nonmedical services	Sample size of 6,200 children; a similar group will be used as a comparison	Capitated rate, with full or partial risk
Children's Hospital of Orange County	ACO — program with a set of providers associated with a defined health condition	• Provides a holistic approach to care, through a medical home and CCS specialty care centers • Determines a child's eligibility by income requirements and existence of one or more of the 10 designated conditions[90] • Bases reimbursement rates on health condition and cycle of care	Mandatory enrollment for those who meet qualification criteria; more than 5,300 children	Capitated rate, with full or partial risk
Rady's Children's Hospital San Diego	ACO — program with a set of providers associated with a defined health condition	• Provides a holistic approach to care through a medical home and CCS specialty care centers • Determines a child's eligibility by family income and existence of one or more of three designated conditions — diabetes mellitus, cystic fibrosis, and sickle cell anemia • Bases reimbursement rates on health condition and cycle of care	Mandatory enrollment for those who meet qualification criteria; approximately 300 children	Capitated rate, with full or partial risk

Source: Dylan Roby, PhD, Daphna Gans, PhD, and Mark Ramirez, UCLA Center for Health Policy Research at the UCLA School of Public Health.

Other Waiver Changes

In addition to the four major programs it created (LIHP, DSRIP, SPD, and CCS), the waiver engendered several other noteworthy changes.

- **Waiver Consolidation.** Since the early 1990s, California has operated under a series of smaller managed care waivers. Called 1915(b) Freedom of Choice waivers, they have been used by the state to require managed care for certain populations while avoiding the complexity of a 1115 waiver. To simplify administration and to create a single set of managed care rules, the 2010 Bridge to Reform waiver incorporated the existing 1915(b) waivers under the 1115 waiver.

  This consolidation has been critical for the waiver's budget. By rolling existing managed care waivers into the 2010 waiver, the state was able to pool savings from these small waivers and apply that savings to added spending. As a result, California increased the amount of the waiver funds that can be directed to other program purposes.
- **Federal Support for State Programs.** The 2010 waiver expands support from the federal Safety Net Care Pool (SNCP) for existing state programs that have been state funded. These federal funds can go to Designated State Health Programs specifically enumerated in the waiver, including CCS, Genetically Handicapped Persons Program, and County Mental Health Services Program. There is a cap on spending of $2 billion in federal funding for the five-year waiver and of no more than $400 million in a given year. These funds will be critical in supporting California health care, especially given recent budget limits.
- **SNCP Uncompensated Care Funding.** Similar to the 2005 waiver, the SNCP includes funding for partial reimbursement to public hospitals for uncompensated costs incurred in providing services to the uninsured.

VII. Conclusion

The California Bridge to Reform waiver provides California leaders and state leaders across the country with a useful picture of many opportunities and challenges they are likely to face as they implement health reform. Within California, the waiver constitutes the basic road map for the beginning of health reform. The findings presented in this paper are offered to help clarify what has been accomplished as well as to identify areas for improvement.

As the nation moves forward with health reform, all states will want to consider the need for:

- Significant resources to educate individual consumers (or beneficiaries) and providers
- More robust administrative systems
- Greater attention to the needs of individuals with multiple or complex conditions, including a combination of physical and behavioral conditions
- Benchmarks for performance that are meaningful and practical from the perspectives of clinicians, plan leaders, and policymakers

The lessons from the Bridge to Reform waiver may be particularly useful regarding a number of upcoming reform efforts, including preparations by safety-net providers and managed care plans for the new delivery system, for the expansion of coverage in 2014, and for the efforts of many states that plan to expand the use of managed care for beneficiaries enrolled in both Medicare and Medicaid.

Appendix A. County-by-County Summary of Waiver Effects

	# OF UNINSURED 2009 (AGES 0–64)	% OF STATE'S UNINSURED	LIHP ENROLLMENT OCT. 2011	DSRIP PLANS	SPDs ENROLLMENT OCT. 2011	CCS PILOT SITE
California	8,350,641		225,576		243,583	
Los Angeles[1]	2,691,457	32.21%	97,315	LA County Department of Health Services, UCLA	96,890	LA Care Health Plan
Orange1	662,419	7.93%	34,852	UC Irvine Medical Center		Children's Hospital of Orange County
San Diego[1]	646,696	7.74%	16,616	UC San Diego	18,655	Rady Children's Hospital
Riverside[2]	546,560	6.54%		Riverside County Regional Medical Center	4,673	
San Bernadino[2]	489,199	5.85%		Arrowhead Regional Medical Center	16,872	
Santa Clara[1]	314,535	3.76%	6,942	Santa Clara Valley Medical Center	11,573	
Kern[1]	228,540	2.74%	6,524	Kern Medical Center	9,232	
Sacramento[7]	224,576	2.69%		UC Davis Medical Center	19,289	
Fresno[10]	213,500	2.56%			11,706	
Alameda[1]	205,350	2.46%	22,441	Alameda County Medical Center	16,161	Alameda County Health Care Services Agency
San Joaquin[5]	183,864	2.20%		San Joaquin General Hospital	9,081	
Contra Costa[1]	161,236	1.93%	12,747	Contra Costa Regional Medical Center	7,931	
Ventura[1]	159,000	1.90%	8,815	Ventura County Medical Center		
Stanislaus[7]	141,778	1.70%			5,161	
San Francisco[1]	120,400	1.44%	10,987	San Francisco General Hospital, UCSF	8,991	
Monterey[4]	112,219	1.34%		Natividad Medical Center		
Tulare[9]	105,984	1.27%			5,199	

Appendix A. County-by-County Summary of Waiver Effects

	# OF UNINSURED 2009 (AGES 0–64)	% OF STATE'S UNINSURED	LIHP ENROLLMENT OCT. 2011	DSRIP PLANS	SPDS ENROLLMENT OCT. 2011	CCS PILOT SITE
San Mateo[1]	91,520	1.10%	8,337	San Mateo Medical Center		Health Plan of San Mateo
Merced[4]	77,104	0.92%				
Santa Barbara[9]	72,568	0.87%				
Santa Cruz[2]	53,743	0.64%				
San Luis Obispo[6]	51,302	0.61%				
Placer[3]	43,800	0.52%				
County Medical Services Programs (CMSP)[2,8]	683,295	8.18%			2,169	

1. Legacy county — LIHP implementation began 7/1/11
2. LIHP implementation began 1/1/12
3. LIHP implementation began 2/1/12
4. LIHP implementation began 3/1/12
5. LIHP implementation began 3/15/12
6. LIHP implementation began 4/1/12
7. LIHP implementation began 7/1/12
8. Madera and Kings Counties have managed care plans with SPDs enrollment
9. LIHP implementation pending
10. Withdrawn from LIHP

Sources:

Columns 1 and 2: Shana Alex Lavarreda et al., *California's Uninsured by County*, UCLA Center for Health Policy Research, August 2010, accessed February 1, 2012, www.healthpolicy.ucla.edu.

Column 3: California Department of Health Care Services, *Local LIHPs: Name, Implementation Date, and Upper Income Limit*, December 29, 2011.

Column 4: California Department of Health Care Services, "Delivery System Reform Incentive Payments (DSRIP)," accessed February 1, 2012, www.dhcs.ca.gov.

Column 5: California Department of Health Care Services, "Managed Care Implementation for Seniors and Persons with Disabilities: Monitoring Dashboard," November 2011.

Column 6: California Department of Health Care Services, *California Children's Services Demonstration Projects*, presentation to the CCS Stakeholder Advisory Committee, November 3, 2011.

Appendix B. Overview of Projects in DSRIP Plans

	ALAMEDA CO. MEDICAL CENTER	ARROWHEAD REGIONAL MEDICAL CENTER	CONTRA COSTA REGIONAL MEDICAL CENTER	KERN MEDICAL CENTER	LA CO. DEPT. OF HEALTH SERVICES	NATIVIDAD MEDICAL CENTER	RIVERSIDE REGIONAL MEDICAL CENTER	SAN FRANCISCO GENERAL HOSPITAL	SAN JOAQUIN GENERAL HOSPITAL	SAN MATEO MEDICAL CENTER	SANTA CLARA VALLEY MEDICAL CENTER	UC DAVIS MEDICAL CENTER	UC IRVINE MEDICAL CENTER	UCLA MEDICAL CENTER	UC SAN DIEGO MEDICAL CENTER	UCSF MEDICAL CENTER	VENTURA CO. MEDICAL CENTER	TOTAL PROJECTS
Category 1: Infrastructure Development																		
Implement Disease Management Registry	X	X		X	X		X		X		X	X	X		X	X		11
Expand Primary Care Capacity	X	X	X	X			X	X	X	X	X		X			X		11
Increase Training of PC Workforce		X	X			X	X	X					X	X			X	8
Enhance Performance Improvement & Reporting Capacity	X				X			X								X	X	5
Expand Specialty Care Capacity	X	X		X			X	X						X				6
Enhance Interpretation Services and CCC			X	X		X									X		X	5
Enhance Urgent Medical Advice				X	X													2
Enhance Coding and Documentation for Quality Data					X										X			2
Collect Accurate REAL Data to Reduce Disparities			X							X		X						3
Introduce Telemedicine													X		X			2
Develop Risk Stratification Capability													X					1
Category 2: Innovation & Redesign																		
Expand Medical Homes	X	X	X	X	X		X	X	X	X		X	X	X*		X		13
Expand Chronic Care Management Models	X	X			X		X				X		X				X	7
Integrate Physical and Behavioral HC			X	X	X			X		X	X						X	7
Redesign Primary Care		X		X			X		X	X			X		X			7

Appendix B. Overview of Projects in DSRIP Plans

	ALAMEDA CO. MEDICAL CENTER	ARROWHEAD REGIONAL MEDICAL CENTER	CONTRA COSTA REGIONAL MEDICAL CENTER	KERN MEDICAL CENTER	LA CO. DEPT. OF HEALTH SERVICES	NATIVIDAD MEDICAL CENTER	RIVERSIDE REGIONAL MEDICAL CENTER	SAN FRANCISCO GENERAL HOSPITAL	SAN JOAQUIN GENERAL HOSPITAL	SAN MATEO MEDICAL CENTER	SANTA CLARA VALLEY MEDICAL CENTER	UC DAVIS MEDICAL CENTER	UC IRVINE MEDICAL CENTER	UCLA MEDICAL CENTER	UC SAN DIEGO MEDICAL CENTER	UCSF MEDICAL CENTER	VENTURA CO. MEDICAL CENTER	TOTAL PROJECTS
Implement/ Expand Care Transition Programs	X											X		X	X	X		5
Conduct Medication Management			X									X		X	X			4
Increase Specialty Care Access/Redesign Referral Process							X	X		X						X		4
Apply Process Improvement Methodology to Improve Quality/Efficiency						X				X		X						3
Establish/Expand Patient Care Navigation Program				X									X					2
Improve Patient Flow in ED/Rapid Medical Eval.	X														X			2
Use Palliative Care Program															X		X	2
Implement Real-Time HAI System													X		X			2
Redesign for Cost Containment											X							1
Redesign to Improve Patient Experience	X		X			X	X			X	X		X					7
Category 3: Population-Focused Improvements																		
Patient/Caregiver Experience (Required)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	17
Care Coordination (Required)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	17
Preventive Health (Required)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	17
At-Risk Populations (Required)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	17

Appendix B. Overview of Projects in DSRIP Plans

	ALAMEDA CO. MEDICAL CENTER	ARROWHEAD REGIONAL MEDICAL CENTER	CONTRA COSTA REGIONAL MEDICAL CENTER	KERN MEDICAL CENTER	LA CO. DEPT. OF HEALTH SERVICES	NATIVIDAD MEDICAL CENTER	RIVERSIDE REGIONAL MEDICAL CENTER	SAN FRANCISCO GENERAL HOSPITAL	SAN JOAQUIN GENERAL HOSPITAL	SAN MATEO MEDICAL CENTER	SANTA CLARA VALLEY MEDICAL CENTER	UC DAVIS MEDICAL CENTER	UC IRVINE MEDICAL CENTER	UCLA MEDICAL CENTER	UC SAN DIEGO MEDICAL CENTER	UCSF MEDICAL CENTER	VENTURA CO. MEDICAL CENTER	TOTAL PROJECTS
Category 4: Urgent Improvement in Care																		
Severe Sepsis Detection & Management (Required)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	17
Central Line–Associated Bloodstream Infection Prevention (Required)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	17
Surgical Site Infection Prevention	X				X		X	X	X	X	X	X		X	X	X	X	12
Hospital-Acquired Pressure Ulcer Prevention	X	X	X	X		X					X	X	X	X	X	X	X	12
Venous Thromboembolism (VTE) Prevention and Treatment			X	X	X	X		X					X					6
Stroke Management		X					X		X									3
Falls-with-Injury Prevention										X								1
TOTAL NUMBER OF PROJECTS PER DSRIP PLAN	17	15	16	17	15	12	17	15	12	16	14	14	19	13	18	14	14	258

* UCLA includes two projects for medical homes, one for adults and one for children.

Source: Author analysis of DSRIP plans submitted to the California Department of Health Care Services, www.dhcs.ca.gov.

Endnotes

1. California HealthCare Foundation, *Medi-Cal Facts and Figures,* September 2009, www.chcf.org.
2. Katherine Neuhausen, MD, and Mitchell H. Katz, MD, "Patient Satisfaction and Safety-Net Hospitals: Carrots, Not Sticks, Are a Better Approach," *Arch Intern Med* 172, no. 16 (2012): 1202–1203, doi:10.1001/archinternmed.2012.3175.
3. The state intends for nearly all full-scope Medi-Cal enrollees to be in managed care, including many high-cost enrollees with complex conditions that require services carved out of managed care (most LTC, specialty mental health, specialty pediatric). Please see www.calduals.org for more information.
4. The Bridge to Reform waiver is available at www.medicaid.gov.
5. David Maxwell-Jolly, California Department of Health Care Services, November 2010, www.dhcs.ca.gov.
6. Trisha McMahon and Matthew Newman, *County Programs for the Medically Indigent in California*, California HealthCare Foundation, October 2009, www.chcf.org.
7. Author review of county programs for the medically indigent.
8. Ashley Cohen, Rebecca Pizzitola, and Lucien Wulsin, *Covering the MIAs: Counties, Federal Reform, and a State Waiver*, Insure the Uninsured Project, March 2010, www.itup.org.
9. According to Department of Health Care Services, *Quarterly Progress Report for the Period 01-01-11 through 03-31-11*, p. 9, the purposes of the LIHP are to "expand the number of Californians who have health care coverage; strengthen and build upon the local health care safety-net system, including disproportionate share hospitals, and county and community clinics; improve access to high-quality health care and health outcomes for individuals; and create efficiencies in the delivery of health care services that could lead to savings in health care costs."
10. Helen Lee and Shannon McConville, *Expanding Medi-Cal: Profiles of Potential New Users*, Public Policy Institute of California, August 2011, www.ppic.org.
11. For a more detailed summary of the LIHP requirements, see Lucien Wulsin and Kiwon Yoo, *ITUP Summary of California's Section 1115 Medicaid Waiver*, Insure the Uninsured Project, January 2012, www.itup.org.
12. In determining whether an individual's income is above or below the 133% FPL threshold, state Medicaid programs and exchanges will be required to disregard an amount of income equal to 5 percentage points of the FPL, making the effective Medi-Cal income eligibility level for nondisabled adults 138% of FPL. Section 1902(e)(14)(I) of the Social Security Act, as added by section 2002(a) of P.L. 111–148.
13. California HealthCare Foundation, *Briefing — The Basic Health Program: What Would it Mean for California?*, April 27, 2012, www.chcf.org.
14. Section 1902(k)(2) of the Social Security Act, as added by section 2001(a)(4) of P.L. 111–148.
15. Waiver Special Terms and Conditions (STC) 58.b.ii.
16. Waiver STC 58.c.
17. Kaiser Family Foundation, *Medicaid Benefits by State: California*, October 2010, www.medicaidbenefits.kff.org.
18. Waiver STC 63.
19. Waiver STC 65.
20. Waiver STC 63.
21. Waiver STC 64.
22. Waiver STC 70. For a summary of Medicaid cost-sharing rules, see Kaiser Family Foundation, *Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries*, August 2010, p. 4, www.kff.org.
23. Waiver STC 70.b.
24. Waiver STC 71. Under the waiver "Expenditure Authority," the following Medicaid MCO requirements do not apply to county-based LIHP delivery systems: disenrollment for cause, choice of plans, payment for emergency services provided by noncontracted providers, network adequacy, state quality strategy, external independent review, and limitations on marketing.
25. Waiver STC 72.
26. Waiver STC 72.g. provides for a 5% reduction in the cap on federal funds for the Safety Net Care Pool "if the State fails to meet a provision related to Network Adequacy and Access Requirements by the LIHP population." (HCCI expenditures would not be subject to this reduction).
27. Waiver STC 76.
28. Waiver STC 35.a.
29. Waiver STC 47.
30. Waiver STC 33.
31. Waiver STC 43, Attachment G.
32. Waiver STC 45, Attachment J.
33. Waiver STC 44. Specifically, "the State must demonstrate that total non-Federal expenditures for LIHP in any Demonstration year is equal to or exceeds the total amount that would have been expended by either the State or local governments in SFY 2006–07 [for any LIHP under the prior demonstration as HCCI programs] or SFY 2009–10 [for any new LIHP], as applicable, in the absence of the Demonstration." Failure by the counties to meet this MOE requirement will reduce federal matching funds for the LIHP program "by the amount of the deficiency."

34. Department of Health Care Services, *Low Income Health Program (LIHP): Implementation Dates and Upper Income Limits as of August 1, 2012*, August 2012, www.dhcs.ca.gov.

35. Department of Health Care Services, "Deliverable Request Page," www.dhcs.ca.gov.

36. The contracts signed by each LIHP county, along with other deliverables, are available at Department of Health Care Services, "LIHP Application, Authorization, and Contracting Documentation," www.dhcs.ca.gov.

37. Department of Health Care Services, UCLA Center for Health Policy Research, and UC Berkeley Center for Labor Research and Education, *Low Income Health Program Initial Transition Plan*, June 28, 2012, www.dhcs.ca.gov.

38. In 2010, Medi-Cal enrollment was 6.935 million, and the number of uninsured Californians with incomes below 200% FPL was 4.928 million. Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," www.statehealthfacts.org.

39. As of January 2012, five states (CA, CT, MN, NJ, and WA) and the District of Columbia had expanded Medicaid coverage to about 600,000 low-income adults under the ACA option or under an 1115 waiver. California accounted for 251,000 of these, or over 40%. Kaiser Commission on Medicaid and the Uninsured, "States Getting a Jump Start on Health Reform's Medicaid Expansion," April 2012, www.kff.org.

40. Department of Health Care Services, *Quarterly Report to CMS Regarding the Waiver, for January 1, 2011*, to *September 30, 2011*, p.10.

41. Kaiser Family Foundation, *Fact Sheet: AIDS Drug Assistance Programs (ADAPs)*, May 2012, www.kff.org.

42. California Department of Public Health. *Introduction to County Low-Income Health Program (LIHP)/AIDS Drug Assistance Program (ADAP) Drug Cost Tables*, August 2011, www.cdph.ca.gov.

43. Letter from Deborah Parham Hopson, Health Resources and Services Administration, August 9, 2011, www.cdph.ca.gov.

44. Letter from Victoria Wachino, Center for Medicaid, CHIP, and Survey & Certification, to Toby Douglas, Department of Health Care Services, July 22, 2011, www.dhcs.ca.gov.

45. Letter from Barbara Araeda-Naranjo, Health Resources and Services Administration, to Ayanna L. Kiburi, Department of Public Health, June 2012, www.cdph.ca.gov.

46. Bill Blum and Tangerine Brigham, *Low Income Health Program and Ryan White Care Program*, San Francisco Department of Public Health, October 2011, www.docs.google.com.

47. California Department of Health Care Services, "Ryan White Services: Informational Documents, Website Links, and FAQs," www.dhcs.ca.gov.

48. Karen Mark, MD, *Ryan White/LIHP Transition*, LIHP Evolution Conference, August 2012, www.dhcs.ca.gov.

49. Dylan Roby et al., *Creation of Safety-Net Based Provider Networks Under the California Health Care Coverage Initiative: Interim Findings*, UCLA Center for Health Services Research, December 2009, www.healthpolicy.ucla.edu.

50. Lucien Wulsin, Kandis Driscoll, and Ashley Cohen, *Section 1115 Waiver Implementation*, Insure the Uninsured Project, January 2012, p. 7, www.itup.org.

51. See Barbara Masters et al., *California's 2010 Medicaid Waiver Stakeholder Process: Impact and Lessons Learned*, California HealthCare Foundation, November 2011, www.chcf.org.

52. Waiver STCs 25 and 26.

53. UCLA Center for Health Services Research, *Low-Income Health Program Evaluation: Frequently Asked Questions & Appendix: Proposed Evaluation Publications and Products*, Version 15, June 27, 2012, www.coverageinitiative.ucla.edu.

54. Waiver STC 23.a.

55. Department of Health Care Services, *Initial Plan Implementing the Affordable Care Act (ACA) in California: Transitioning the Low Income Health Program to ACA Coverage Options*, August 2012, www.dhcs.ca.gov.

56. Waiver STCs 43, 45.

57. D. Novo, *LIHPs as a Path to 2014: A Federal Perspective*, Centers for Medicare and Medicaid Services, August 2012, www.dhcs.ca.gov.

58. STC Attachment Q.

59. While DSRIP is primarily discussed as support for public hospitals, other safety-net hospitals were eligible to participate if approval was sought and granted by CMS. The waiver is clear that Medi-Cal and the federal government may set milestone incentive payments to other safety-net hospitals for activities consistent with DSRIP. In undertaking such a process, Medi-Cal would have to consult with the DPHs and could not "impede the ability of designated public hospitals to meet" DSRIP obligations.

60. Interview with Erica Murray, California Association of Public Health, January 2012.

61. *Ibid.*

62. To read each DSRIP plan, see Department of Health Care Services, "Delivery System Reform Incentive Payments (DSRIP)," www.dhcs.ca.gov.

63. Examples include measures used or approved by the California Hospital Assessment and Reporting Taskforce (CHART), the National Committee for Quality Assurance, the National Quality Forum, and those created by the US Preventive Services Task Force.

64 For more information about IGTs and CPEs, see Peter Harbage and Jennifer Ryan, *Questions and Answers About the 2005 Medi-Cal Hospital Waiver,* California HealthCare Foundation, April 2006, www.chcf.org.

65. STC 35.c.ix.

66. Department of Health Care Services, *DSRIP Semi-Annual Reporting Form*, May 2011, www.dhcs.ca.gov.

67. San Mateo Health System. *DSRIP Semi-Annual Reporting Form*, May 2011, www.dhcs.ca.gov.

68. Alameda County Medical Center, *DY6 Year-End Report*, which can be found at Department of Health Care Services, "Delivery System Reform Incentive Payments (DSRIP)," www.dhcs.ca.gov.

69. California Association of Public Hospitals and Health Systems, *The Delivery System Reform Incentive Program: Transforming Care Across Public Hospital Systems,* June 2011, www.caph.org.

70. The issues and topics summarized in this section came from interviews with Dr. Christina Ghaly, Los Angeles County Health Department Services, and Santiago Munoz, University of California Health Sciences and Services, January 2012.

71. The issues and topics summarized in this section came from interviews with Dr. Christina Ghaly, Los Angeles County Health Department Services; Melissa Stafford Jones, California Association of Public Hospitals; and Santiago Munoz, University of California Health Sciences and Services, and from DSRIP plan DY6 reports, which can be found at Department of Health Care Services, "Delivery System Reform Incentive Payments (DSRIP)," www.dhcs.ca.gov.

72. Other excluded are foster children, those identified as needing long term care, those with other health insurance, those on Share of Cost (SOC) Medi-Cal, and certain children in California Children's Services.

73. Income calculations for Medi-Cal eligibility include some forms of income and exclude others.

74. California HealthCare Foundation, *Share of Cost Medi-Cal*, September 2010, www.chcf.org.

75. Author conversation with Jim Watkins, chief of the Research and Analytical Studies Branch, California Department of Health Care Services, September 13, 2012.

76. Under the County-Operated Health System model, all Medi-Cal beneficiaries in a county are in COHS. See Department of Health Care Services, "Medi-Cal Managed Care," www.dhcs.ca.gov.

77. Kathy Moses, *Raising the Bar: How Medi-Cal Strengthened Managed Care Contracts for People with Disabilities*. California HealthCare Foundation, August 2012, www.chcf.org.

78. STC 81.f.iii. The state must have "a statewide, standardized exception process" for beneficiaries with "significant, complex, or chronic" conditions. In addition to MERs, there are also emergency disenrollments allowed under the waiver for persons enrolled who should not have been (for example, a dual eligible wrongly enrolled). DHCS MER data counts include the count for a limited number of these emergency disenrollments.

79. The categories include: pregnancy, HIV/AIDS, "receiving chronic renal dialysis," receipt of one of three types of transplant, one of two types of cancer, awaiting a surgical procedure, a "complex neurological disorder, such as multiple sclerosis," a complex hematological disorder, and a complex disorder not otherwise listed.

80. Department of Managed Health Care, *Knox-Keene Health Care Service Plan Act of 1975*, www.dmhc.ca.gov.

81. Department of Health Care Services, "Seniors and Persons with Disabilities: Data Reports and Charts — SPD Monitoring Dashboard," July 2012, www.dhcs.ca.gov. Note that a single beneficiary can file more than one MER.

82. Department of Health Care Services, *Seniors and Persons with Disabilities*.

83. Wunsch and Linkins, *A First Look*.

84. Also, CCS administers the Medical Therapy Program (MTP), which provides physical therapy, occupational therapy, and medical therapy conference services for children who have handicapping conditions generally due to neurological or musculoskeletal disorders. These services do not have a financial eligibility requirement. Children who are MTP-only are not included in the demonstration projects.

85. More information available at the California Department of Health Care Services, "California Children's Services," www.dhcs.ca.gov.

86. Paul Wise et al., *California Children's Services Program Analysis*, Stanford Center for Policy, Outcomes, and Prevention, June 2011, www.dhcs.ca.gov.

87. Wise et al., *California Children's Services*.

88. Health Management Associates, *Considerations for the Redesign of the California Children's Services (CCS) Program*, presentation to the State of California, September 2009, www.dhcs.ca.gov.

89. The Specialty Health Care Plan is intended to give applicants the flexibility to define the program as they see fit within the overall program goals. For more information, see California Department of Health Care Services, *California Children's Services Demonstration Projects*, November 2011, www.dhcs.ca.gov.

90. The medical conditions included in this demonstration include cardiac and circulatory diseases, craniofacial, cystic fibrosis and pulmonary diseases, endocrine and metabolic disorders, gastrointestinal, hematology/oncology, hemophilia and sickle cell, immunology/infectious diseases, rheumatology, and spina bifida.