

Medi-Cal Waivers Discussion Guide

OCTOBER 2019

Framing a Conversation on California's Expiring Medicaid Waivers IMPLICATIONS FOR THE FUTURE OF THE MEDI-CAL PROGRAM

PURPOSE OF THIS GUIDE

As noted in the recent ITUP issue brief, *Mapping the Future of Medi-Cal, What's Next?* published in March 2019, California's Medicaid program, Medi-Cal, is at a crossroads as the state navigates the changing federal context, upcoming federal deadlines and daunting system challenges.

Among the most significant issues the state faces are the expiration of two federal Medicaid waivers at the end of 2020: Medi-Cal 2020, California's current Section 1115 waiver, and the 1915 (b) Specialty Mental Health services waiver. The waivers underly major elements of the Medi-Cal program, including managed care programs for physical and behavioral health services (mental health and substance use disorder (SUD) services) and the financing and performance of the state's public health care safety net.

Given the sweeping nature of the existing waivers, and recent changes in federal rules affecting Medicaid waivers and managed care, the upcoming expiration of the waivers raises significant issues for the future of Medi-Cal and could require a major restructuring of key aspects of the program.

This discussion guide is a companion document to the *Mapping the Future* issue brief, and focuses on the waivers, and the state process for addressing the issues presented by the 2020 deadline, as policymakers and stakeholders consider the implications and next steps for Medi-Cal.

Workgroup Discussion Questions

1. *What has worked well with the current Medi-Cal 2020 and Specialty Mental Health waivers? What have been the barriers and challenges to effectively serving the needs of Medi-Cal beneficiaries and administering the programs covered in the waivers?*
2. *What are the fiscal and program implications of increasing the Medi-Cal services and programs delivered through managed care? For Medi-Cal beneficiaries? For counties and the state-county relationship? For managed care plans (MCPs)? For state oversight of the Medi-Cal program and MCP accountability?*
3. *What opportunities are there going forward, through waivers or related program changes, for improving the integration of physical and behavioral services provided through managed care? What lessons learned and best practices can inform those efforts?*
4. *How can the expiring waivers facilitate the review and evaluation of existing program structures and managed care delivery models? Consideration of alternative models, regional approaches or consolidation of existing models?*
5. *As the state-level conversation unfolds over the next year, what transformative goals can the state set to inform and inspire deliberations on the future of Medi-Cal?*

BACKGROUND

Medicaid is a state-federal partnership program funded through a combination of state sources and matching federal funds. States support Medicaid programs financially by providing the “nonfederal share,” which can come from a variety of state and local sources, and is matched by federal funds. The “federal financial participation” (FFP) is based on federal rules and formulas that determine the federal medical assistance percentage (FMAP) for each state and program. (See box below on how California raises the nonfederal share.)

Federal rules effect all aspects of state Medicaid programs including eligibility, benefits, reimbursement and delivery models. Each state develops its Medicaid program to comply with the requirements and to implement federal optional benefits, populations and program approaches within the state’s discretion. The Medicaid State Plan is based on requirements in Title XIX of the Social Security Act (SSA) and is the comprehensive written document created by each state, and approved by the federal government, that describes the nature and scope of each state Medicaid program.

When a state wants to make significant changes to the Medicaid program, it must take one of two steps: either (1) amend the state Medicaid plan to implement changes permissible under federal law, or (2) apply to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver of specified SSA requirements. To illustrate these state options, Figure 1 highlights the state plan and waiver authorities for states to operate Medicaid managed care programs.

How California Raises the Nonfederal Share For Medi-Cal

Because Medicaid is a state-federal partnership program, states draw down federal funds by providing state matching revenues, often referred to as the nonfederal share of Medicaid. The nonfederal share typically comes from a variety of sources but at least 40 percent must be financed by the state and up to 60 percent may come from local governments. In addition to **state general fund** resources, California raises the nonfederal share from the sources listed below.

<p>Certified Public Expenditures (CPEs)</p> <p>State and local government entities certify that they have spent CPE funds on items or services eligible for federal Medicaid matching funds. For example, California counties providing Medicaid reimbursable, specialty mental health services incur the total cost of the services, and certify the total amount of reimbursable expenditures, to secure a federal match.</p>	<p>Intergovernmental Transfers (IGTs)</p> <p>Transfers of public funds between or within levels of government (e.g., county to state). For example, under California’s current §1115 waiver, public health care systems and district hospitals receive federal Medicaid match for meeting quality outcomes under the Public Hospital Redesign and Incentives in the Medi-Cal (PRIME) program, financed by their own IGTs.</p>
<p>Provider Taxes/Fees</p> <p>State-imposed taxes or fees on health care providers. To use provider taxes/fees as the nonfederal share, federal rules require the fee or tax to be broad-based and uniformly imposed. Federal rules also prohibit the state from holding similar providers harmless from the tax/fee burden. For example, the Hospital Quality Assurance Fee (HQAF) Program collects fees from private hospitals in California and uses these funds, matched with federal funds, to enhance Medi-Cal reimbursement for hospital services.</p>	<p>Special Funds</p> <p>Funds created by statute, including through ballot initiatives, restricted by law for specific government activities. For example, by taxing cigarettes and tobacco products, Proposition 56, passed in 2016, created a special fund to help finance health care expenditures, including the nonfederal share of Medi-Cal expenditures.</p>

Figure 1. Comparing Federal Medicaid Managed Care Authorities and Waivers

	STATE PLAN AMENDMENT (SPA) §1932(A)	SOCIAL SECURITY ACT (SSA) §1915(B) PROGRAM WAIVERS	SSA §1115 RESEARCH & DEMONSTRATION WAIVERS
Eligible Beneficiaries	Populations covered in Medicaid under the state's Medicaid plan (state plan), except for certain children with special needs, Medicare beneficiaries, and American Indians	All state plan populations	All state plan populations
Federal Standards and Requirements	Under the federal Medicaid Managed Care Rule (2016), federal managed care standards and requirements apply regardless of the authority under which the program is operated		
General Authority	Exempts states from the requirements of statewideness (program that is operational statewide), comparability (benefits equivalent to fee-for-service) and freedom of choice (enrollee ability to choose any qualified provider). Program must offer at least two managed care plan options; may be limited to one health plan in certain rural areas or through "Health Insuring Organizations" (unique to California, known as County Organized Health Systems)	Provides states with a time-limited waiver from statewideness, comparability and freedom of choice. May be used to provide additional services not provided in fee-for-service and for: <ul style="list-style-type: none"> ▪ Mandatory enrollment in a restricted provider network ▪ Managed care enrollment for traditionally exempt individuals ▪ Choice limited to a single managed care plan 	Broad authority to waive Medicaid requirements, including the flexibilities of §1915(b), as well as other Medicaid requirements, such as: <ul style="list-style-type: none"> ▪ Covered individuals ▪ Covered benefits ▪ Provider payment methods ▪ Enrollee premiums and copayments May also provide federal matching funds for services, activities or costs not otherwise matchable.
Federal Budget Requirements	No requirement for budget neutrality or cost effectiveness as applies to federal Medicaid waivers	Demonstrate cost effectiveness and efficiency (actual expenditures cannot exceed projected expenditures for approval period)	Budget neutrality required (federal expenditures cannot be greater with the waiver than without the waiver)
Approval Period and Renewals	Indefinite approval, renewal not required	Initially approved for two years; five years if dually eligible individuals are included	Initially up to five years but may be shorter or longer
Sources: Social Security Act §1932(a), [42 U.S.C. 1396u-2]; Medicaid and CHIP Payment and Access Commission (MACPAC), Characteristics of Key Medicaid Managed Care SPAs and Waivers, March 2016; MACPAC, The Role of Section 1915(b) Waivers in Medicaid Managed Care, March 3, 2017.			

The Medi-Cal 2020 Waiver

California's current Section 1115 demonstration waiver—known as Medi-Cal 2020—provides federal funding and authorizes major elements of the existing Medi-Cal program. The Medi-Cal 2020 waiver builds on previous waivers the state secured dating back to a federal §1115 waiver in the mid-1990s aimed at increasing federal funding to stabilize the Los Angeles County public hospital system. (See *Appendix A for an historical overview of California's Medicaid waivers.*)

The LA waiver set the stage for future Medi-Cal waivers by expanding the expenditures that qualify for federal matching funds, such as outpatient care for the uninsured, and requiring the County to reshape the delivery system for uninsured and Medi-Cal recipients by improving access to outpatient primary and preventive care and reducing the use of higher cost inpatient and emergency room care.

Over time, California added and refined the programs in the state's §1115 waivers to reflect state priorities and program needs. California's waivers grew in scope, funding and impact on Medi-Cal and the state's health care safety net.

California negotiated waiver provisions that allowed it to draw down federal matching funds not normally permitted under traditional Medicaid rules (not otherwise matchable). In the most recent waivers, including Medi-Cal 2020, California leveraged state and local funds (using county funds to provide the nonfederal share for programs they administer) to increase FFP for UC and county hospitals and create financial incentives for public systems to improve performance and expand access for the remaining uninsured.

In addition to financing for California's public health care systems, and creation of several landmark demonstration programs, such as Whole Person Care and the Drug Medi-Cal Organized Delivery Systems (DMC-ODS), the Medi-Cal 2020 waiver authorizes California's entire Medi-Cal managed care program for physical health care. (See Figure 2 for the key programs included in the Medi-Cal 2020 waiver.)

New federal rules affecting Medi-Cal 2020. Federal §1115 demonstration waivers must be budget neutral to the federal government. That is, the proposed changes in the waiver must not cost the federal government more than the expected costs for the traditional Medicaid population during the time period of the waiver. To measure "budget neutrality," CMS and states reach an agreement on what expenditures might be "without waiver" (the baseline) and then agree on likely expenditures with the waiver.

States that secured §1115 waivers to implement or expand Medicaid managed care identified savings associated with the shift from fee-for-service to managed care delivery systems which freed up federal funds for other program elements of the waiver within the parameters of the budget neutrality requirement. The Medi-Cal 2020 waiver relies on managed care savings to fund other key elements of the overall waiver.

However, new federal rules affecting the calculation of budget neutrality limit the savings states can capture from managed care.¹

Since the 2018 federal changes affecting budget neutrality in §1115 waivers were announced, the state Department of Health Care Services (DHCS) has publicly stated that the new federal rules likely indicate that California will no longer be able to capture managed care savings in a future §1115 waiver.

California is exploring other options to secure federal funding for the existing Medi-Cal 2020 programs that will be affected by the change in federal rules. Importantly, some programs in the current waiver do not contribute to the budget neutrality calculation and therefore would cost the same with or without the waiver. Programs that require federal waiver authority but do not contribute to budget neutrality, such as the Global Payment Program (GPP), DMC-ODS could be included in a future §1115 waiver. (See Figure 3 for more on the programs in California's existing §1115 waiver.)

The 2016 federal Medicaid Managed Care Rule (MMCR) offers opportunities to restructure current waiver programs under the Medicaid managed care umbrella. For example, the MMCR authorizes states to cover nonmedical interventions through managed care (in lieu of services) to address social and structural factors influencing health, such as poverty, lack of access to stable housing and exposure to violence. This option could potentially support some program elements of Whole Person Care (WPC).

Figure 2 summarizes major Medi-Cal 2020 programs. The June 2019 ITUP [Care Coordination Discussion Guide](#) has additional background on care coordination programs in the Medi-Cal 2020 waiver.

Figure 2. Medi-Cal 2020 Section 1115 Waiver Components

PROGRAM	DESCRIPTION	NOTES
Medi-Cal Managed Care	Waives freedom of choice and statewideness, so that beneficiaries receive care through managed care plans and the state operates different managed care models depending on the county or region.	DHCS has stated its intent to combine this program with managed care for mental health and Drug Medi-Cal services into one §1915 (b) waiver. The waiver also includes pilots to integrate California Children’s Services into managed care.
Global Payment Program (GPP)	Streamlines funding sources for county-owned and operated hospitals to serve the remaining uninsured, including Disproportionate Share Hospital (DSH) payments. The GPP merges the Safety Net Care Pool waiver funds with DSH. Establishes an incentive payment method aimed at improving access and quality of primary and preventive care for uninsured patients.	<ul style="list-style-type: none"> ▪ Participating county hospitals provide the nonfederal share through intergovernmental transfers (IGT) ▪ DSH funding component could continue in a new §1115 waiver, although it is likely that the Safety Net Care Pool funds, which use budget neutrality room, will not be available in a new §1115 waiver.
Public Hospital Redesign and Incentives in Medi-Cal (PRIME)	Reimburses public and district hospitals using a pay-for-performance program for year-over-year improvement in access, health outcomes, and integration of physical and behavioral health. In addition, over the course of the waiver, participating public hospitals must gradually increase the portion of patients in alternative payment methodology arrangements through contracts with Medi-Cal managed care plans (MCPs).	<ul style="list-style-type: none"> ▪ Participating public hospitals provide the nonfederal share as IGTs ▪ Integration of some WPC elements into managed care may be possible through directed payment program but must comply with federal rate setting standards that require rates to be reasonable and provide for attainable costs (actuarially sound)
Whole Person Care (WPC) Pilot Program	Coordinates health, behavioral health, and social services of beneficiaries to achieve better outcomes, as coordinated by counties, cities or health facilities. Program helps meet beneficiary needs with non-traditional Medi-Cal benefits like housing supports.	<ul style="list-style-type: none"> ▪ Participating counties provide the nonfederal share as IGTs ▪ Integration into managed care may be possible with directed payments, implementation of “in lieu of services,” or a new enhanced care management benefit in managed care plan contracts
Drug Medi-Cal Organized Delivery System (DMC-ODS)	A program to expand county substance use disorder treatment program offering a full continuum of care through a managed care system.	<ul style="list-style-type: none"> ▪ Participating counties provide CPEs as the nonfederal share to drawdown federal funds ▪ Secures FFP for services not otherwise matchable under Medicaid, such as residential treatment in Institutions for Mental Disease (IMDs)
Health Homes Program (HHP)	Waives freedom of choice so that beneficiaries must get HHP services through managed care plans. Coordinates the full range of physical health, behavioral health and community-based services through comprehensive case management for beneficiaries with chronic health conditions who meet other specified criteria.	<ul style="list-style-type: none"> ▪ Nonfederal share supported with local grant funds ▪ Medicaid state plan benefit eligible for federal Medicaid match
Dental Transformation Initiative (DTI)	Provides direct incentive payments to Medi-Cal dental providers to increase use of preventative dental services for children, prevent and treat more childhood caries, and increase continuity of care.	Nonfederal share supported by state “savings” from the federal match received for designated state health programs as below
Designated State Health Programs (DSHP)²	Authorizes the state to claim FFP for selected state programs up to specific annual dollar limits	CMS has signaled that the state will no longer be able to claim FFP for these state programs.

Specialty Mental Health Services Waiver

In the early 1990s, California significantly expanded Medi-Cal managed care and pursued a similar path for the provision of Medi-Cal specialty mental health services (specific services for individuals with severe mental illness.)

Under the terms of a federal Medicaid 1915 (b) “Freedom of Choice” waiver, California consolidated inpatient and outpatient mental health services into one program through county-administered mental health plans (MHPs). California is currently on its ninth waiver for specialty mental health which expires on June 30, 2020.

California’s 1915(b) Freedom of Choice waiver allows the state to require that Medi-Cal beneficiaries enroll in the single county MHPs to receive specialty mental health services. Under the terms of the waiver, and state realignment,³ counties provide the nonfederal share as CPEs using realignment and other county revenues.

In approving California’s last few 1915(b) waivers, CMS raised overarching concerns with “program integrity” and under the last waiver imposed Special Terms and Conditions (STCs) aimed at improving monitoring and performance of MHPs, including:

- DHCS must have a publicly available mental health plan dashboard which reports performance data for each MHP, including performance for each subcontracted provider.
- Each MHP must have a system for tracking and measuring timeliness of care, including wait times to access providers, and DHCS must establish a baseline for access to services based on this information.
- DHCS must publish corrective action plans imposed on MHPs, based on state compliance assessments.
- DHCS must ensure compliance with any changes in federal law affecting Medicaid during the waiver approval period.

DHCS and stakeholders are currently evaluating different models for delivery of specialty mental health services, including regional models, exploring the carve-in of specialty mental health services into MCPs, or carving in the mild to moderate mental health treatment benefit into county MHPs. These discussions will inform the renewal of the 1915(b) waiver.

DHCS STAKEHOLDER ENGAGEMENT

The expiring Medi-Cal waivers present an opportunity to build on current successes, including many of the demonstrations, pilots and innovations that have characterized California’s Medi-Cal waivers. The scope of the existing waivers, and the complexity of the new federal rules, will necessitate collaborative and in-depth deliberations among policymakers, stakeholders and state DHCS. This section highlights strategies DHCS is using to engage stakeholders in considering the next steps for Medi-Cal.

Care Coordination Assessment Project

In 2018, DHCS initiated the Care Coordination Assessment Project (CCAP) to review care coordination across the Medi-Cal delivery system from a managed care lens. As part of this project, DHCS convened an Advisory Committee comprised of selected stakeholders that met six times in 2018 to discuss care coordination issues and potential policy recommendations.

DHCS set goals for the project, including determining “whether a set of standards and expectations regarding appropriate care coordination activities and requirements can be developed within and among all the Medi-Cal delivery systems.” The project incorporated an internal review of various rules and regulations as well as site visits with key stakeholders across California. The convenings explored elements of care coordination, including screenings, health assessments, data, transitions in care and governance. Learn more about the CCAP at the DHCS [website](#). DHCS recently summarized the findings from the CCAP as outlined below.

Recap of DHCS Care Coordination Assessment Project		
GOAL: Reduce Variation and Complexity Across the System	GOAL: Identifying and Managing Member Risk and Need Through Population Health Management Strategies	GOAL: Improve Quality Outcomes and Drive System Transformation Through Value Based Payments, Incentives and Shared Savings
<ul style="list-style-type: none"> ▪ Plan Accreditation ▪ Mandatory enrollment in managed care vs. FFS ▪ Annual Medi-Cal Health Plan Open Enrollment ▪ Standardizing the benefit statewide ▪ Exploring opportunities for integration and breaking down historical delivery system silos ▪ Standardize/consolidate state required assessments 	<ul style="list-style-type: none"> ▪ Risk Stratification/Assess Enrollees for Risk and Need ▪ Wellness and Prevention ▪ Transitions in Care ▪ Point of Care and Community Based Enhanced Care Management ▪ Addressing Social Determinants of Health ▪ Explore In Lieu of Services 	<ul style="list-style-type: none"> ▪ Funding Flexibility ▪ Value Based Payments ▪ Shared Savings Models ▪ Incentives to drive delivery system transformation ▪ Behavioral Health quality and performance metrics ▪ Behavioral Health payment reform
Source: Department of Health Care Services, presentation to Medi-Cal Stakeholder Advisory Committee, May 2019		

California Advancing and Innovating Medi-Cal (CalAIM)

DHCS recently announced a multi-year initiative to implement “overarching policy changes across Medi-Cal delivery systems” and develop a roadmap for the next 10-15 years of the Medi-Cal program. According to DHCS, the initiative, known as California Advancing and Innovating Medi-Cal ([CalAIM](#)), will build on CCAP goals:

1. Reducing variation and complexity across the delivery systems;
2. Identifying and managing member risk and need through population health management strategies; and
3. Improving quality outcomes and driving delivery system transformation through value-based initiatives and payment reform.

DHCS announced that it will engage stakeholders through 2019 and 2020 on CalAIM, including consideration of the next stage for the programs in the expiring Medi-Cal waivers. DHCS notes that the discussion will include a strategy to renew the Medi-Cal 2020 §1115 waiver, but with fewer program elements going forward.

For example, DHCS has stated its intent to transition all existing managed care authorities into one single Section 1915(b) waiver, including Medi-Cal managed care plans (MCPs), county Mental Health Plans (MHPs), the Drug Medi-Cal Organized Delivery System (DMC-ODS) managed care components and dental managed care plans.

The planning process will also include strategies to continue elements and concepts in the existing waiver using other allowable Medicaid approaches such as in lieu of services and directed payments. For more information on these two options, see the ITUP publication, [Mapping the Future of Medi-Cal](#).

DHCS has established five stakeholder workgroups, organized by topic as outlined in Figure 3.

Figure 3. Outline of DHCS CalAIM Initiative, by Workgroup and Topic

WORKGROUP AND PROPOSAL TOPICS	EXITING PROGRAM REQUIREMENTS	DISCUSSION QUESTIONS
POPULATION HEALTH MANAGEMENT AND ANNUAL OPEN ENROLLMENT		
<p>Population Health Management in Managed Care – Require MCPs to develop population health management strategies that could include initial and ongoing assessment of enrollee risk and need, using risk stratification (identifying high-risk, high-cost enrollees) in care planning, consideration of social determinants of health, assurance of smooth care transitions, and focus on data collection and reporting.</p>	<p>MCPs are required to conduct various health assessments and screenings that evaluate enrollee risk, including initial health assessments for new enrollees and risk assessments for newly enrolled SPDs.</p> <p>MCPs are required to coordinate care transitions for enrollees, but current state contract requirements are general with some exceptions (e.g., for SPDs and enrollees receiving managed long-term services and supports).</p> <p>Some MCPs are beginning to focus on population health and the social and environmental factors that impact health.</p>	<ul style="list-style-type: none"> ▪ How would DHCS align risk stratification and assessment requirements across multiple systems of care (MCPs, county MHPs, DMC-ODS, Regional Centers, etc.)? ▪ Case management by the MCPs has historically been clinically based. How will MCPs transition to addressing enrollees’ social and non-medical needs? ▪ How will DHCS monitor an MCP population health management program? What types of data and reporting would be required? ▪ How can DHCS, MCPs and providers reduce duplication (e.g., care coordination staff at each provider and the MCP)?
<p>Medi-Cal MCP Annual Open Enrollment Implement an annual open enrollment period for Medi-Cal MCPs limiting enrollee choice of health plan to once per year.</p>	<p>Medi-Cal enrollees may switch MCPs monthly. Federal managed care regulations require states to provide a 90-day period for a member to switch health plans after initial selection of an MCP.</p>	<ul style="list-style-type: none"> ▪ Would enrollees be permitted to change MCPs outside of the open enrollment period for cause? What would trigger the ability to switch MCPs? ▪ Would enrollment align with annual redeterminations of eligibility? ▪ How often do enrollees switch now?
NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION		
<p>DHCS is considering requiring MCPs to obtain NCQA accreditation. 25 states currently require Medicaid MCPs to obtain accreditation.⁴</p> <p>NCQA assesses MCPs on the following standards: quality management and improvement; population health management; network management; utilization management; credentialing and recredentialing; enrollees’ rights and responsibilities; member connections; and Medicaid benefits and services.⁵</p> <p>DHCS seeks feedback on the NCQA Medicaid module, long-term services and supports distinction survey, and accreditation deeming policies.</p>	<p>MCPs are not currently required to obtain NCQA accreditation to participate in Medi-Cal.</p> <p>Of the 24 Medi-Cal MCPs, 14 are NCQA accredited, six are not accredited, one (Partnership HealthPlan of California) is in the process of obtaining NCQA accreditation, and two (Aetna Better Health of California and United Healthcare) are scheduled to begin the accreditation process.⁶</p> <p>DHCS deems MCPs with NCQA accreditation as in compliance with provider credentialing requirements as part of the annual DHCS medical compliance audit.</p>	<ul style="list-style-type: none"> ▪ What value would NCQA accreditation bring to the Medi-Cal MCP program? How would it affect the enrollee experience of care or patient outcomes? ▪ How do NCQA standards align with current DHCS standards (e.g., care coordination)? ▪ Would DHCS deem accredited MCPs in compliance with state standards? In what areas? How would “deeming” impact oversight of MCPs? ▪ Other entities accredit MCPs. Should DHCS include a broader set of organizations or solely require NCQA accreditation?

Figure 3. Outline of DHCS CalAIM Initiative, by Workgroup and Topic

WORKGROUP AND PROPOSAL TOPICS	EXITING PROGRAM REQUIREMENTS	DISCUSSION QUESTIONS
ENHANCED CARE MANAGEMENT AND IN LIEU OF SERVICES		
<p>Enhanced Care Management (ECM) DHCS is considering adding an ECM benefit to provide a whole-person approach to care that would encompass both medical and nonmedical needs of high-need Medi-Cal beneficiaries enrolled in managed care. According to DHCS, the new ECM benefit would be designed as a collaborative, interdisciplinary approach to providing intensive and comprehensive care management services to enrollees.</p> <p>DHCS seeks feedback on target populations, beneficiary and provider eligibility criteria for the ECM benefit.</p>	<p>As outlined in Figure 2, Whole Person Care (WPC) pilots seek to coordinate health, behavioral health and social services for targeted populations to improve outcomes. In total, 25 pilots have been approved under the waiver.</p> <p>As outlined in Figure 2, the Medi-Cal Health Homes Program (HHP) is designed to serve eligible beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination.⁷ As of July 1, 2019, MCPs in 11 counties have implemented HHP.</p>	<ul style="list-style-type: none"> ▪ How would the WPC pilots be transitioned to MCPs? ▪ Would the ECM benefit encompass the Health Homes Program (HHP) benefits? Or would HHP continue? ▪ The HHP structure is complex and has been challenging for MCPs and providers (some MCPs have declined to proceed with HHP implementation). How can an ECM benefit be designed so it is not cumbersome to implement? ▪ How will the ECM be financed? ▪ What will be the role of counties and other local entities that currently administer and provide the nonfederal match for WPC?
<p>In Lieu of Services (ILOS) – DHCS is considering allowing MCPs to provide ILOS, services or settings provided as a substitute to avoid other services, (e.g., inpatient hospital admission, nursing facility stay).</p> <p>ILOS expenditures qualify as covered services for MCP rate-setting purposes unless a statute or regulation explicitly requires otherwise.</p> <p>For the proposed ECM benefit, DHCS would incorporate ILOS into case management provided to medium-to-high risk enrollees which may fill gaps in State Plan benefits to address medical or social needs.</p> <p>DHCS seeks input on the payment structure for ILOS related to the proposed ECM benefit.</p>	<p>DHCS does not currently recognize ILOS for MCP rate-setting purposes, although some MCPs provide ILOS to their enrollees.</p> <p>42 CFR §438.3(e)(2) identifies four criteria for when services may be covered by an MCP in lieu of services that are covered under the Medicaid State Plan:</p> <ol style="list-style-type: none"> 1. State determines the alternative service or setting is medically appropriate and a cost-effective substitute; 2. Enrollee is not required to use the alternative service or setting; 3. Approved ILOS is authorized and identified in the MCP contract and offered at the option of the MCP; and, 4. The state takes utilization and actual cost of ILOS into account in developing the component of the MCP capitation rates that represents the covered State plan services. 	<ul style="list-style-type: none"> ▪ What would be the impact of ILOS on MCP rates? ▪ What types of parameters will DHCS create to define acceptable ILOS? How can DHCS monitor and oversee MHP provision of ILOS? ▪ What incentives will there be for MCPs to voluntarily provide ILOS?

Figure 3. Outline of DHCS CalAIM Initiative, by Workgroup and Topic

WORKGROUP AND PROPOSAL TOPICS	EXITING PROGRAM REQUIREMENTS	DISCUSSION QUESTIONS
BEHAVIORAL HEALTH (BH)		
<p>DHCS is considering several changes to Medi-Cal BH, including: (1) integration of county-level mental health (MH) and substance use disorder (SUD) programs under a single contract; (2) changes to the county MH and SUD reimbursement structure; (3) revisions to medical necessity criteria for BH services; and (4) seeking approval of an Institutions for Mental Disease (IMD) waiver so counties can receive federal match to provide residential mental health treatment for Medi-Cal eligible adults with serious mental illness and children with serious emotional disturbance in an IMD (treatment facilities with more than 16 beds).</p>	<p>Specialty mental health services and SUD services are both provided by the counties but under separate waiver authorities and contracting arrangements with DHCS. Both also are carved out of MCPs in most counties.</p> <p>In late 2018, CMS released guidance to states that allows the use of §1115 waivers to obtain federal match for short-term stays in an IMD in return for expanding access to community-based mental health services.⁸</p> <p>DMC-ODS participating counties receive federal match for medically necessary IMD residential treatment for SUDs.</p>	<ul style="list-style-type: none"> ▪ What would be the programmatic impacts on the counties of consolidating specialty mental health and SUD services under a single contract? Fiscal impacts? ▪ What would be the role of county MHPs in an integrated model? DMC-ODS pilots? ▪ What impact would consolidation of MH and SUD services have on care coordination with MCPs? ▪ What are the barriers, concerns and impacts from continuing the use of IMDs in DMC-ODS and extending the use to mental health treatment?
FULL INTEGRATION PILOTS		
<p>DHCS is considering developing a pilot to test the effectiveness of integrating physical health, behavioral health and oral health under a single entity.</p>	<p>MCPs are currently responsible for providing services for enrollees with mild-to-moderate mental health conditions, while county MHPs provide specialty mental health services to Medi-Cal beneficiaries with serious mental illness. Some MCPs and counties have started to explore integrating physical and behavioral health.</p> <p>Oral health services are provided by DHCS through the fee-for-service Denti-Cal program or the Dental Managed Care program which is available only in Sacramento and Los Angeles Counties.</p> <p>Health Plan of San Mateo (HPSM) is working with DHCS to test the integration of Denti-Cal into the MCP.</p>	<ul style="list-style-type: none"> ▪ How will the pilots be structured? ▪ Will all MCPs and MHPs be required to participate in a given geographic area? ▪ What will be the impact on county finances if specialty mental health is integrated into the MCPs? ▪ Will DHCS assume any savings from the pilots? ▪ Will the dental component be modeled on the work HPSM is currently doing? ▪ How will pilot counties be selected? ▪ Will Sacramento and LA Counties be exempt from the demonstration due to the current dental managed care structure in these counties?
<p>Source: Department of Health Care Services, CalAIM overview online October 1, 2019.</p>		

Acknowledgements

This discussion guide was a team effort; composed by Deborah Kelch, MPPA, of ITUP, with contributions and research from Caroline Davis, MPP, of Davis Health Strategies and Meredith Wurden, MPH, MPP, of Wurden Consulting.

Notes

1. Centers for Medicare and Medicaid Services, "[Budget Neutrality Policies for Section 1115\(a\) Medicaid Demonstration Projects](#)," State Medicaid Director Letter. August 22, 2018.
2. Designated State Health Programs (DSHP) are Medi-Cal programs funded entirely with state funds before the waiver: California Children's Services, Genetically Handicapped Persons Program, Medical Indigent Adult Long-Term Care, Breast and Cervical Cancer Treatment Program, AIDS Drug Assistance Program, Department of Developmental Services and Prostate Cancer Treatment Program and several specified workforce development programs.
3. Realignment provides counties with dedicated revenues (a portion of state sales taxes and Vehicle Licensing Fees) as part of the 1991 agreement to shift responsibility for specific health and social services programs from the state to the counties. State legislation adjusted the terms of realignment in 2011 and again in 2013.
4. Department of Health Care Services, "[DHCS Care Coordination Project: NCQA Accreditation](#)," Accessed September 11, 2019.
5. National Committee for Quality Assurance, "[Health Plan Accreditation](#)," Accessed September 11, 2019.
6. National Committee for Quality Assurance, "[Health Plan Report Cards](#)," Accessed September 11, 2019.
7. The HHP provides six core services: comprehensive care management; care coordination (physical health, behavioral health, community based LTSS); health promotion; comprehensive transitional care; individual and family support; and referral to community and social support services, including housing
8. Department of Health and Human Services, "[Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance](#)," State Medicaid Director Letter. November 12, 2018.

APPENDIX A

Historical Overview of Medi-Cal Waivers

The approach and the structure of Medi-Cal waivers has evolved over time based on the needs of the state and shifts in federal policy related to Medicaid waivers. The current Medi-Cal 2020 waiver is the third generation of a Section 1115 waiver, which has its roots in the early 1980s when California sought to control rising Medi-Cal costs by negotiating payment rates with participating inpatient hospitals. The existing 1915(b) Specialty Mental Health Services waiver is the ninth generation of the waiver that authorizes county mental health plans (MHPs) to be the single managed care provider of specialty mental health services.

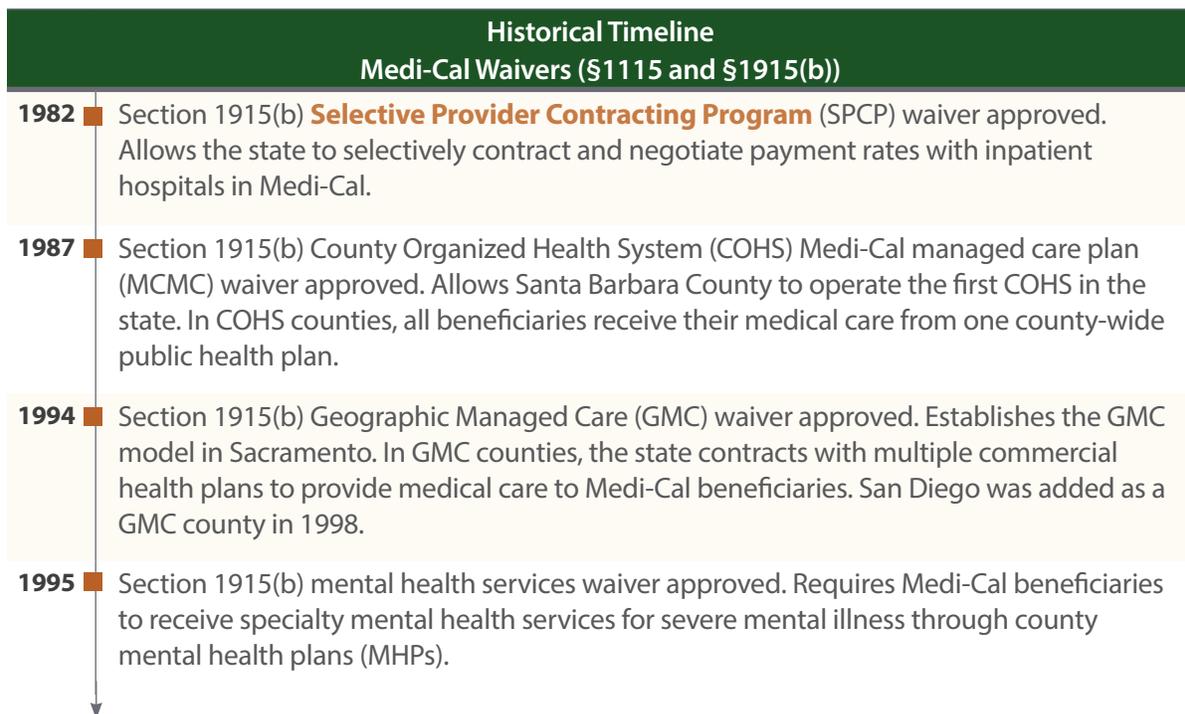
Social Security Act (SSA) Section 1915 program waivers allow states to test alternative delivery system models related to managed care or home- and community-based services, as below:

- 1915(b) “freedom of choice” waivers allow states to operate managed care as negotiated, including restricting beneficiary choice, offering different benefits than in fee-for-service and using different managed care models by region.
- 1915(c) Home and Community-Based Services (HCBS) waivers allow states to meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

SSA Section 1115 research and demonstration waivers provide states with greater flexibility to change the structure and delivery system of the Medicaid program.

California currently operates all three types of waivers and has used multiple federal waiver authorities over the years to shape the Medi-Cal program.

This timeline focuses on historical milestones for the existing §1915(b) waiver and the Medi-Cal 2020 §1115 waiver which expire at the end of 2020.



Historical Timeline

Medi-Cal Waivers (§1115 and §1915(b))

- 1996** ■ Section 1115 **Los Angeles (LA) County Waiver** approved. Provides federal funding to stabilize the LA County public hospital system and requires the County to reform the delivery system to emphasize outpatient care and increase access for the uninsured.
- Section 1915(b) Two-Plan Model Waiver approved. Establishes the Two-Plan Model of managed care in 12 California counties. In Two-Plan counties, beneficiaries can choose from either a county-affiliated Local Initiative or a commercial health plan.
- 1997** ■ First renewal of specialty mental health services waiver for three years, includes inpatient and outpatient professional, case management and other specialty mental health services.
- 2005** ■ Section 1115 LA County Waiver expires.
- Section 1915(b) hospital contracting waiver transitions into new Section 1115 Waiver, the **Medi-Cal Hospital Uninsured Care Waiver**. Continues hospital contracting and makes significant changes in financing of the nonfederal share of public and private hospital care, including initiating Certified Public Expenditures (CPEs) made by public hospital systems. In addition, provides federal funding through the Safety-Net Care Pool (SNCP) for public hospital supplemental payments for care of the uninsured and the Health Care Coverage Initiative (HCCI) to expand coverage options for uninsured Californians.
- 2007** ■ Fifth specialty mental health services waiver renewal incorporates Mental Health Services Act funding and adjusts the therapeutic behavioral health services benefit for children to increase access and improve delivery as required by the terms of a legal settlement.
- 2010** ■ Section 1115 **Bridge to Reform Waiver** approved. Focuses on state preparations to implement the federal Affordable Care Act (ACA) in 2014. Major new components include: (1) Delivery System Reform Incentive Payment (DSRIP) program provides federal funds for public hospitals to improve the delivery system and meet specific performance goals; (2) Low-Income Health Program (LIHP) replaces HCCI and provides federal funding to enroll individuals who will be eligible under the ACA in Medi-Cal; (3) Mandatory enrollment of Seniors and Persons with Disabilities (SPDs) into MCMC plans in Medi-Cal; (4) California Children's Services (CCS) pilots to transition program from a fee-for-service model to an organized delivery system; and (5) Transition of 1915(b) Medi-Cal managed care waivers (for physical health) into the new waiver.
- 2013** ■ Bridge to Reform Waiver amended to expand Medi-Cal managed care into additional 20 counties.
- 2014** ■ Bridge to Reform Waiver amendment creates the Coordinated Care Initiative (CCI) in eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara (Alameda did not implement the CCI). CCI seeks to integrate care across delivery systems and shift services away from institutional settings in favor of home- and community-based settings for the SPD population. CCI includes Cal MediConnect (CMC), for dually-eligible (Medicare and Medi-Cal) individuals who enroll in managed care. Under the CCI, eligible individuals in the pilot counties must enroll in MCMC to receive long-term services and supports (LTSS).

Historical Timeline

Medi-Cal Waivers (§1115 and §1915(b))

2015 ■ Section 1115 **Medi-Cal 2020 Waiver** approved. Continues elements from the Bridge to Reform Waiver (e.g., CCI, CCS pilots, mandatory MCP enrollment for SPDs). New waiver programs include: (1) Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program replaces DSRIP with incentive payments to public and district hospitals that transform care to focus on improving patient outcomes and moving toward payment models based on risk; (2) Global Payment Program (GPP) merges federal SNCP and DSH funding into a single pool with incentives for county health systems to provide care for low-income, uninsured patients in outpatient settings rather than the more costly inpatient and emergency settings; (3) Whole Person Care (WPC) pilots in which counties or other local entities can access federal funds to coordinate Medi-Cal beneficiaries' physical health, behavioral health and social service needs with focus on improving outcomes for the "whole person" and lowering costs; and (4) Dental Transformation Initiative (DTI) focused on improving dental care for children through incentive payments to dental providers.

Medi-Cal 2020 waiver amended to include the Drug Medi-Cal Organized Delivery System (DMC-ODS). The DMC-ODS pilot tests whether access to an organized delivery system for individuals with substance use disorder can improve outcomes and reduce health care costs.

Ninth specialty mental health services waiver renewal for five years until June 30, 2020 requiring the state to enhance quality oversight of county MHPs, including through the use of an external quality review organization.

Sources: Valerie Lewis, "[Medicaid Waivers: California's Use of a Federal Option](#)," Medi-Cal Policy Institute, March 2000. Peter Harbage and Meredith Ledford King, "[A Bridge to Reform: California's Medicaid Section 1115 Waiver](#)," October 2012.

About ITUP

Insure the Uninsured Project (ITUP) is a Sacramento-based nonprofit health policy institute that for more than two decades has provided expert analysis and facilitated convenings for California policymakers and decisionmakers focused on health reform.

The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad-based stakeholder engagement.

ITUP is generously supported by the following funders:

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