HURST+BROOKS+ESPINOSA

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TO: Matt Cate
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Re: Medicaid Section 1115 Waiver Renewal

On October 31, 2015, the state and federal governments announced conceptual agreement on a Medicaid Section 1115 waiver renewal AND a temporary extension of the existing waiver until December 31, 2015. The Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) will be working over the next two months to develop the details of Waiver programs and components through the Special Terms and Conditions (STCs), the legal document governing the waiver.

The total initial federal funding in the renewal is $6.218 billion, with the potential for additional federal funding in the global payment program to be determined after the first year. Funding details are summarized in the chart below.

	Year 1	**5-Year Total**
Global Payment Program	$236 million	$236 million*
Public Hospital Redesign and Incentives in Medi-Cal	$800 million	$3.732 billion
Whole Person Care	$300 million	$1.5 billion
Dental Incentives	$150 million	$750 million
TOTAL	**1.486 billion**	**$6.218 billion**

**The Global Payment Program may increase in Years 2-5 based on a study to be completed in 2016.*

Many of the core elements outlined below were included in the state's revised Waiver proposal that was developed and submitted to CMS in early October. The conceptual agreement includes the following core elements:

Global Payment Program (GPP). The GPP will provide funding for services to the uninsured in designated public hospital systems (DPH) by combining existing funding streams – Disproportionate Share Hospital (DSH) funds and Safety Net Care Pool (SNCP) funding – into a single global payment

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system. The global payments are intended to incentivize the provision of primary and preventive care and to move away from the hospital-focused and cost-based structures on which the funding is currently based. The funding of the GPP will include 5 years of the DSH funding that otherwise would have been allocated to DPHs along with $236M in initial federal funding for one year of the SNCP component. It is anticipated that DSH payments will be approximately $1.1 billion in 2016.

The SNCP component funding for years two through five would be subject to an independent assessment of uncompensated care, which is to be completed within six months of waiver implementation. Please recall that California had proposed that the SNCP component of the funding decrease over the course of the five years from the current level of $236 million annually in federal funding in the first years to $160 million in federal funding in the last year ($1.007 billion in federal funding over the five years). It is not clear how the independent assessment of uncompensated care will impact future SNCP funding.

The continuation of the SNCP funding had been a major point of disagreement during the negotiations. CMS was hesitant to move away from cost based payments for the remaining uninsured.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME). PRIME will be the successor to the existing Delivery System Reform Incentive Payments (DSRIP) program. PRIME funding for delivery system transformation and alignment incentive program will be available for DPHs and district/municipal hospitals (DMPH). The funding will be allocated as follows:

	Designated Public Hospitals	**District/Municipal Hospitals**	**TOTAL**
Year 1	$700 million	$100 million	$800 million
Year 2	$700 million	$100 million	$800 million
Year 3	$700 million	$100 million	$800 million
Year 4	$630 million	$90 million	$720 million
Year 5	$535.5 million	$76.5 million	$612 million
5-Year Total	**$3.2655 billion**	**$466.5 million**	**$3.732 billion**

Whole Person Care Pilot (WPC). The WPC program would be a county-based, voluntary program to target providing more integrated care for high-risk, vulnerable populations. The funding of this program would be up to $1.5B in federal funds over 5 years.

The Administration envisions a competitive application process for counties or groups of counties that are interested in pursuing programs focused on high risk, vulnerable populations that provide a "whole person," integrated approach to their care. Amounts would be awarded based on approved applications submitted by counties. Counties (along with any other public entity with which they partner) would be responsible for the non-federal share through an intergovernmental transfer (IGT). Counties would be required to include, as applicable, private and public partners who share responsibility for the services and outcomes to the targeted populations in their community.

Dental Transformation Incentive Program. The funding of this program is $750M in total funding over 5 years. California proposed to improve dental health for Medi-Cal members, particularly children, by focusing on high-value care, improved access, and utilization of performance measures to drive

delivery system reform. The proposed incentive payments would be focused on three key areas: 1) increasing preventive dental services for children, 2) preventing and treating more early childhood cavities, and 3) promoting continuity of care for beneficiaries.

Independent assessment of access to care and network adequacy for Medi-Cal managed care beneficiaries. California will be comprehensively addressing the question of network adequacy and access to care for Medi-Cal beneficiaries. The assessment will include at a minimum an analysis of compliance with network adequacy and access requirements under California state law that apply to Medi-Cal as well as commercial plans. The assessment will also include a comparison of Medi-Cal plans with commercial plans in the same geographic services areas.

Independent studies of uncompensated care and hospital financing. Additional details on this proposal are not yet available.

Next Steps. The work associated with the Waiver renewal is far from over. DHCS and CMS will continue the difficult work associated with crafting a new waiver and will be developing the details governing each of the core elements. The STCs will contain the detail for each of the core elements and legal authority for each of the programs.

Though cliché, the devil will be in the details. CSAC will be closely monitoring, and providing input where appropriate, on the STCs development knowing that there are ramifications for counties in claiming and program development. CMS and DHCS will be concluding writing of the STCs by December 31, 2015.

State implementing legislation will also be drafted in 2016 once the STCs are finalized and the Legislature returns to Sacramento.