kaiser commission on KEY FACTS
medicaid and the uninsured
THE HENRY J. KAISER FAMILY FOUNDATION

October 2011 Update

KEY FACTS ON CALIFORNIA'S "BRIDGE TO REFORM" MEDICAID DEMONSTRATION WAIVER

There are nearly 7 million uninsured people in California. Under the Affordable Care Act (ACA), this number is projected to fall by more than half by 2016.[1] Medi-Cal, California's Medicaid program, is expected to cover 1.4 million previously uninsured individuals by 2016. This represents an over 10% enrollment increase in Medi-Cal, which covered nearly 10.6 million individuals during fiscal year 2008.[2]

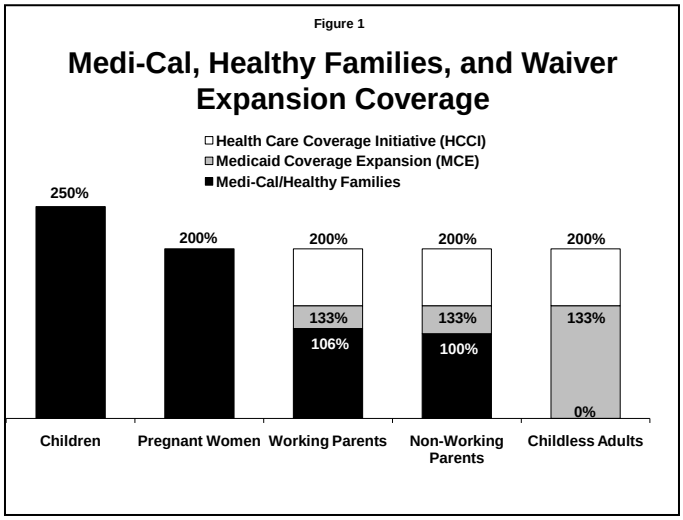
To assist the state and its counties in implementing this expansion, on November 2, 2010, the Secretary of Health and Human Services approved a section 1115 Medicaid Demonstration Waiver entitled "California's Bridge to Reform." The waiver, which is approved for the five-year period ending October 31, 2015, makes up to roughly $8 billion in federal Medicaid matching funds available for expanding coverage to low-income uninsured adults and preserving and improving the county-based safety net. In addition, the waiver allows the state to enroll Medicaid-eligible seniors and persons with disabilities (excluding dual eligibles) into managed care plans. Operational experience from these initiatives may inform implementation in other states and at the federal level.

Low-Income Health Program (LIHP) Coverage Expansion

The state will extend coverage to low-income adults through a Low Income Health Program (LIHP) that will be provided at the option of each county to:

- *Medicaid Coverage Expansion (MCE) adults:* non-pregnant adults between ages 19 and 64 who are not enrolled in Medicaid or CHIP and have family incomes at or below 133% of the Federal Poverty Level (FPL) ($14,484 for an individual in 2011) (or a lower threshold set by the county).
- *Health Care Coverage Initiative (HCCI) adults*: non-pregnant adults between ages 19 and 64 with family incomes between 133% FPL ($14,484 for an individual in 2011) and 200% FPL ($21,780 for an individual in 2011) (or a lower threshold set by the county).

Figure 1



Participating counties may choose to cover only MCE adults or to cover both MCE and HCCI adults. The counties will determine eligibility thresholds for and may impose enrollment caps on both the MCE and HCCI populations. As of August 2011, ten counties had implemented LIHPs, enrolling a total of 196,500 adults (175,500 MCE enrollees and 21,000 HCCI enrollees).

Counties that elect to participate in the LIHP must provide a specified set of core benefits to the MCE population and, if they choose to cover the HCCI population, a narrower set of core benefits. Both core sets of benefits are more limited than the state's traditional benefit package. Cost-sharing for the MCE population must comply with regular Medicaid limits; cost-sharing for HCCI enrollees cannot exceed an aggregate of 5% of family income. Counties may furnish services to MCE and HCCI enrollees through county-based delivery systems with closed networks.

Up to $630 million in federal Medicaid matching funds will be available under the waiver through 2013 to match county LIHP expenditures for HCCI adults. (Federal Medicaid matching funds for MCE adults are not limited since they may be covered without a waiver under the new state plan option created by the ACA that allows states to receive federal Medicaid funds at their regular matching rate to cover adults with incomes up to 133% FPL.) Participating counties will provide the required 50% state share of Medicaid spending in the form of certified public expenditures (CPEs). When the ACA's coverage expansions take effect in 2014, MCE enrollees will transition to Medicaid (at a 100% federal matching rate) and most HCCI enrollees will transition to the Exchange.

Delivery System Reform Incentive Pool

Public hospitals will play an important role in providing care to those newly eligible for Medi-Cal in 2014 as well as the estimated 3.1 million Californians who will remain uninsured after implementation of the ACA. The waiver provides up to $3.3 billion in federal matching funds over five years for a new Delivery System Reform Incentive Pool (DSRIP) to support efforts by public hospitals to improve the quality of care they provide and the health of the populations they serve. There are four areas for which federal funding is available under DSRIP:

- *Infrastructure development*: investments in technology, tools, and human resources (e.g., increases in primary care capacity, telemedicine, enhanced interpretation services).
- *Innovation and redesign*: investments in new and innovative care delivery models (e.g., medical homes, chronic disease management systems, primary care redesign).
- *Population-focused improvement*: investments to enhance care delivery for the five to ten highest burden conditions in public hospital systems for the low-income populations for whom they are responsible (e.g., improved diabetes care management and outcomes, improved chronic care management and outcomes, reduction of readmissions).
- *Urgent improvement in care*: hospital-specific interventions that have substantial evidence of being able to achieve major and measurable improvement in care within five years.

DSRIP projects will be tailored to each hospital system. Federal payments will be tied to hospital systems meeting process measures (e.g., enrollment in a medical home) and outcome measures (e.g., reducing infection rates). Participating hospital systems will provide the non-federal share of payments through intergovernmental transfers (IGTs). Twelve county hospital systems and five University of California hospital systems are participating in the DSRIP program.

Mandatory Enrollment of Seniors and People with Disabilities (SPDs) into Managed Care Plans.

The waiver also allows the state to enroll Medicaid-eligible seniors and people with disabilities (SPDs) in Medicaid managed care programs that meet specified plan readiness requirements, including network adequacy. (Individuals who are dually eligible for Medicare and Medicaid are exempt from this mandatory enrollment.) In most counties, SPDs must be able to choose between at least two plans that meet these requirements. (In counties with County-Operated Health Systems (COHS), the SPD population, like other groups of Medi-Cal beneficiaries, is already enrolled in the COHS, which will have two years to meet the standards specified in the waiver.) Enrollment began June 1, 2011. As of September 2011, over 91,000 SPDs had been enrolled in managed care plans. The waiver specifies annual projections for SPD enrollment in managed care; if these projections are not met, federal Medicaid matching funds available under the waiver are reduced.

[1] Long and Gruber, "Projecting the Impact of the Affordable Care Act on California," *Health Affairs* (January 2011), pp. 63-69.
[2] MACPAC, *Report to the Congress on Medicaid and CHIP* (March 2011), Table 2.

This publication (#8197-FS) is available on the Kaiser Family Foundation's website at www.kff.org.