

medicaid
and the uninsured

October 2011 Update

CALIFORNIA'S "BRIDGE TO REFORM" MEDICAID DEMONSTRATION WAIVER

EXECUTIVE SUMMARY

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. Medi-Cal, California's Medicaid program, is expected to cover 1.4 million of those previously uninsured by 2016.¹ 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, the Secretary of Health and Human Services on November 2, 2010 approved "California's Bridge to Reform" Section 1115 Medicaid Demonstration Waiver, which makes up to roughly \$8 billion in federal Medicaid matching funds available over a five-year period and includes three key initiatives:

Low-Income Health Program (LIHP) Coverage Expansion. The state will extend coverage to low-income adults through LIHPs 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 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 incomes between 133% and 200% FPL (\$21,780 for an individual in 2011) (or a lower threshold set by the county).

The demonstration provides up to \$630 million in federal Medicaid matching funds for HCCI coverage. (Federal matching funds for MCE adults are not limited since they may be covered under the new state plan option created by the ACA to cover individuals with incomes up to 133% FPL.) 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).

Delivery System Reform Incentive Pool (DSRIP). The demonstration provides up to \$3.3 billion over five years to support efforts by 12 county hospital systems and 5 University of California hospital systems to improve the quality of care they provide and the health of the populations they serve. DSRIP funding is available for:

- *Infrastructure development:* investments in technology, tools, and human resources.
- *Innovation and redesign:* investments in new and innovative care delivery models.
- *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 served.
- *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.

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 persons with disabilities, excluding dual eligibles, in Medicaid managed care programs that meet specified plan readiness requirements, including network adequacy. In most counties, SPDs must be able to choose between at least two plans. Enrollment began June 1, 2011, and over 91,000 SPDs had been enrolled as of September 2011.

The California waiver may serve as a model for other states to use a Section 1115 demonstration waiver to facilitate the transition to health reform in 2014. Further, experience from the waiver may help to inform implementation of the ACA by other states, safety net providers, and the federal government.

INTRODUCTION

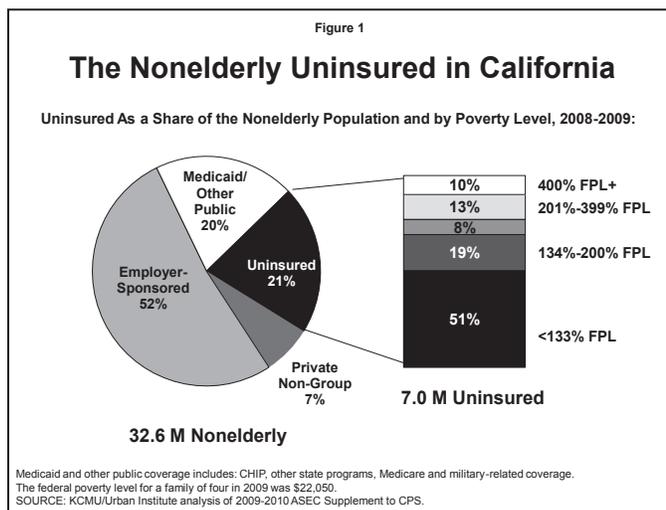
On November 2, 2010, California received approval for its "Bridge to Reform" Section 1115 Medicaid Demonstration Waiver.³ Under this demonstration, up to \$7.7 billion in federal Medicaid matching funds will be available over a five-year period to assist the state and its counties in implementing the health care coverage expansions that will occur in 2014 under the Affordable Care Act (ACA).⁴ The demonstration has three key components: a Low-Income Health Program (LIHP), under which counties extend coverage to low-income adults before 2014; a Delivery System Reform Incentive Pool (DSRIP), under which safety net providers prepare their delivery systems for 2014; and the enrollment of seniors and persons with disabilities (SPDs) currently eligible for Medicaid into managed care plans. This brief provides an overview of the demonstration.

WHAT IS A SECTION 1115 MEDICAID DEMONSTRATION WAIVER?

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to waive provisions of major health and welfare programs authorized under the Act, including certain requirements of Medicaid. Section 1115 also authorizes the Secretary to allow states to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. In both cases, the Secretary must determine that the initiative is an "experimental, pilot, or demonstration project" that "is likely to assist in promoting the objectives of" the Medicaid program.

BACKGROUND

There are nearly 7 million nonelderly uninsured individuals in California. As shown in Figure 1, over half have family incomes below 133% of the federal poverty level (FPL), the minimum Medicaid income eligibility threshold that will apply in all states in 2014 (\$14,484 for an individual, \$29,725 for a family of four in 2011). Moreover, most of the uninsured are adults. This reflects two characteristics of Medi-Cal, the state's Medicaid program—the income eligibility limit for parents is much lower than that for children, and nondisabled, nonelderly adults without dependent children (childless adults) have historically not qualified for coverage.



Under the Affordable Care Act (ACA), the number of uninsured Californians is projected to fall by more than half by 2016. Medi-Cal is expected to cover 1.4 million of those previously uninsured by 2016.⁵ This represents an over 10% enrollment increase in Medi-Cal, which covered nearly 10.6 million individuals during fiscal year 2008.⁶ In addition, an estimated 1.1 million uninsured low-income Californians are projected to enroll in the Exchange with premium subsidies in 2016.⁷ To help the state meet the logistical challenges of enrolling the significant number of new eligibles, the demonstration waiver allows counties to establish Low-Income Health Programs (LIHPs) to begin enrolling these adults well before 2014. These adults, who tend to be single, working-age males, have higher rates of smoking, obesity, and high blood pressure than current Medi-Cal beneficiaries and are likely to benefit from improved access to care.⁸

In many California counties, a principal source of health care for low-income families and individuals, especially those who are uninsured, is county hospitals. (Under state law, counties have the obligation to provide health care to low-income uninsured residents, known as medically indigent adults).⁹ The demonstration waiver provides federal matching funds, known as the Delivery System Reform Incentive Pool (DSRIP), to assist these facilities in upgrading their infrastructure and improving the quality of care they deliver to current and future patients. Even after implementation of the ACA, an estimated 3.1 million people will remain uninsured in California in 2016, of whom 1.2 million will be undocumented immigrants.¹⁰ County hospitals will continue to be providers of last resort for these individuals.

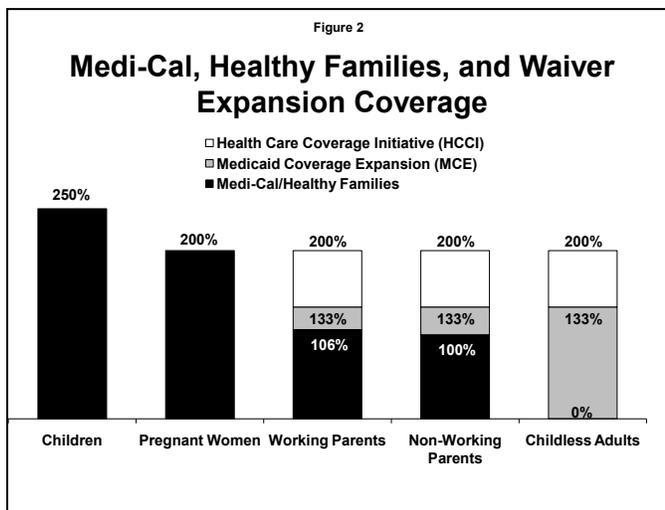
Like many states, California faces a severe state budget shortfall, which has prompted a search for savings in Medi-Cal as well as other state programs.¹¹ Medi-Cal spending is concentrated in certain high-cost populations, including seniors and persons with disabilities (SPDs).¹² Currently, most SPDs receive covered services on a fee-for-service basis. The demonstration waiver allows the state to require these individuals, other than dual eligibles, to enroll in managed care plans. The state’s expectation is that better care management will improve the quality of care that SPDs receive while at the same time reducing Medi-Cal costs.

KEY COMPONENTS OF THE DEMONSTRATION WAIVER

Low-Income Health Program (LIHP) Coverage Expansion

Under the LIHP component of the waiver,¹³ the state will extend coverage to low-income adults through county-based LIHPs that build upon coverage initiatives previously operating in 10 counties.¹⁴ LIHP coverage 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% FPL (\$14,484 for an individual in 2011)(or a lower threshold set by the county); and
- *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).



Participating counties may choose to cover only MCE individuals or to cover both MCE and HCCI individuals. The counties will also be able to set eligibility thresholds for and impose enrollment caps on both the MCE and HCCI populations. As seen in Figure 2, the largest eligibility increases in counties that implement MCE coverage will be for nondisabled, non-elderly adults without dependent children (childless adults), while HCCI coverage will expand coverage more broadly for both parents and childless adults.

Participating counties must provide a minimum set of core benefits to the MCE population, and, if they choose to cover the HCCI population, a narrower set of core benefits to those enrollees (Table 1). The core sets of benefits for both the MCE and HCCI populations are more limited than the state’s traditional Medicaid benefits package. Cost-sharing for the MCE population must comply with regular Medicaid limits; counties may not charge MCE enrollees premiums or enrollment fees. While counties may charge HCCI enrollees premiums, total cost-sharing for HCCI enrollees, including premiums, cannot exceed an aggregate of 5% of family income.

**Table 1:
Minimum Core Benefits and Excluded Benefits for MCE and HCCI Coverage**

	MCE	HCCI
Minimum Core Benefits		
Physician care	Physician services (including specialty care)	Physician services
Hospital care	Acute inpatient hospital services Outpatient hospital services	
Emergency care	Emergency care services (including transportation)	Emergency care services
Mental health care	Mental health benefits (subject to limitations) ¹⁵	
Prescription drugs and equipment	Prescription and limited non-prescription medications Medical equipment and supplies	
Laboratory and x-ray	Laboratory services Radiology	
Therapies and devices	Physical therapy Prosthetic and orthotic appliances and devices	
Other	Podiatry Prior-authorized non-emergency medical transportation	
Benefits Excluded from Coverage		
	Organ transplants Bariatric surgery Infertility-related Services	

Counties also must meet other requirements, including assignment of enrollees to a medical home, network adequacy, geographic accessibility, cultural competence, and due process.¹⁶ Counties may furnish services to MCE and HCCI enrollees through county-based delivery systems with closed networks. If they choose to do so, the delivery system is treated as a Medicaid managed care organization (MCO) and is subject to the same federal regulatory requirements as apply to a Medicaid MCO, including accessibility of services and network adequacy.

The state could cover MCE adults without a waiver under the new adult coverage option enacted by the ACA, which newly allows states to receive federal Medicaid matching funds at their regular matching rate to cover adults up to 133% FPL. The state is providing the coverage under Section 1115 authority because certain aspects of the MCE coverage, such as the ability for counties to cap enrollment and the more limited benefit package relative to that provided to other Medicaid enrollees, do not meet requirements for optional coverage. However, because MCE adults could be covered by the state as an optional group without a waiver, there is no limit on the federal Medicaid funds available to match county expenditures for coverage of this population. In contrast, federal Medicaid funds to match county expenditures for the HCCI population are limited to up to \$630 million through June 30, 2014.

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).¹⁷ Beginning in 2014, when the ACA's coverage expansions take effect, MCE enrollees will be transitioned to Medicaid (at 100% federal matching for three years) and most HCCI enrollees will be transitioned to the Exchange (with premium subsidies financed entirely by the federal government).

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 help support efforts by county and University of California hospitals to improve the quality of care they provide and the health of the populations they serve.¹⁸ 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. Payments will be tied to meeting process measures (e.g., enrollment in a medical home) and outcome measures (e.g., reducing infection rates).¹⁹ Participating hospitals will provide the non-federal share of DSRIP payments through intergovernmental transfers.

Public hospitals view DSRIP as an opportunity to make changes in the way they deliver care that reduces avoidable hospitalizations, reduces medical errors, and improves the health of patients with chronic diseases.²⁰ Twelve county hospital systems and five University of California hospital systems are participating in the DSRIP program. All participating hospital systems met their first-year milestones.²¹

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

The demonstration waiver allows the state to enroll an estimated 380,000 Medicaid-eligible seniors and people with disabilities (SPDs) into Medicaid managed care plans.²² (Individuals who are dually eligible for Medicare and Medicaid are exempt from this mandatory enrollment requirement.) The managed care plans must meet network adequacy and other "plan readiness" requirements specified in the waiver.²³ Enrollment of SPDs in plans began on June 1, 2011, and will continue on a rolling basis over a 12-month period based on the date of birth.²⁴ The waiver specifies annual projections for SPD enrollment in managed care; if these projections are not met, federal Medicaid matching funds available for DSRIP will be reduced. As of September 2011, over 91,000 SPDs had been enrolled into managed care plans. Among those enrolled, 39% made an active choice of plan, while the remaining 61% were assigned to a plan.²⁵

The readiness requirements specified by the waiver for managed care plans are extensive, reflecting the high needs of the SPD population. To ensure network adequacy, the waiver requires that each plan have a sufficient supply and continuum of providers to meet the unique needs of the population served and an accessible network (including specialty providers) within reasonable geographic proximity to the individuals enrolled. Other plan readiness requirements include having the capacity to provide a full range of care coordination services, mechanisms to ensure seamless care with existing providers for 12 months after enrollment, person-centered planning and treatment approaches, physically accessible accommodations, interpreter services, non-emergency medical transportation, and timely access to non-network specialty providers. To permit an assessment of performance, plans will be required to submit, on a monthly basis, comprehensive encounter data on the use of services by SPDs.²⁶

In most counties, SPDs must be able to choose between at least two plans that meet all readiness 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.)²⁷ Individuals will be able to change plans at any time, and the state must inform them about this opportunity. The state is required to make significant efforts to encourage individuals to actively choose a plan. The waiver also sets forth a series of outreach, education, and communications requirements aimed at ensuring that individuals have access to appropriate and adequate information sources and assistance to understand the new system and their choices. If an individual does not select a plan after repeated efforts by the state to encourage choice, the state can enroll an individual into a plan; the state will seek to make a plan selection based on factors such as usual and known sources of care and utilization history.²⁸

The demonstration also allows the state to submit a plan to test up to four health care delivery models for children with special health care needs currently enrolled in the California Children's Services Program.²⁹ These models include: Accountable Care Organizations, Enhanced Primary Care Case Management, Managed Care, and a Specialty Health Plan. On October 12, 2011, the state announced the intent to award five contracts to regional health care organizations for pilot projects under this initiative, which are expected to begin in January 2012.³⁰

WAIVERS OF FEDERAL REQUIREMENTS AND FINANCING

Waivers of Federal Requirements

Under the authority of Section 1115 of the Social Security Act, the Secretary of Health and Human Services has granted a number of waivers of federal requirements for purposes of this demonstration.³¹ For example, the statutory requirement that the Medicaid program be implemented statewide is waived to allow California to implement the LIHP, which will offer different benefits packages in different counties to individuals at different eligibility levels. Also waived is the requirement that services be made available to eligible individuals with "reasonable promptness" to allow LIHP counties to cap enrollment and maintain waiting lists. In addition, the statutory requirement that benefits be sufficient in amount, duration, and scope and comparable for most Medicaid eligibility groups is waived to allow California to vary eligibility standards among counties for the LIHP, to provide more limited benefits under the LIHP than the state provides to other groups, and to offer benefits to seniors and persons with disabilities (SPDs) who are mandatorily enrolled in managed care benefits that are not available to other groups.

Availability of Federal Medicaid Matching Funds

The demonstration waiver makes up to \$7.7 billion in federal Medicaid matching funds available to California over a five-year period (November 1, 2010 through October 31, 2015) for costs that would not otherwise qualify for federal matching payments under the federal Medicaid statute. As shown in Table 2, this amount is distributed as follows:

- **LIHP-HCCI:** Up to \$630 million in federal matching funds is available for costs incurred by counties participating in the LIHP in providing covered services to HCCI enrollees (those with incomes between 133% and 200% FPL) over the period November 1, 2010 through June 30, 2014. (As previously noted, there is no cap on federal funds available for the costs incurred by LIHP counties in furnishing services to MCE enrollees (those with incomes below 133% of FPL) because these adults could be covered without a waiver under the new statutory coverage option enacted in the ACA.³²)
- **DSRIP:** Up to \$3.3 billion in federal matching funds is available over the 5-year period November 1, 2010 through October 31, 2015 for payments to eligible public hospitals for the costs of approved projects for infrastructure development, innovation and redesign, population-based improvement, and urgent improvement in care.
- **Safety Net Care Pool:** The waiver provides a total of up to \$3.8 billion in federal matching funds over the 5-year period November 1, 2010 through October 31, 2015 for the uncompensated medical costs incurred by hospitals and clinics in treating uninsured individuals who are not eligible for Medi-Cal. Of this amount, up to \$2 billion in federal matching funds is available for the costs of certain Designated State Health Programs.³³

**Table 2:
Allocation of Federal Funds Under California’s Medicaid Demonstration Waiver***

Coverage Expansion to Low-Income Adults	Up to \$0.6 billion
LIHP Coverage for HCCI Eligibles	\$0.6 billion
Preserving and Improving the Safety Net	Up to \$7.0 billion
Delivery System Reform Incentive Pool (DSRIP)	\$3.3 billion
Safety Net Care Pool	\$1.8 billion
Designated State Health Programs (DSHP)	\$2.0 billion
Total	Up to \$7.7 billion

*Assumes 50% federal matching rate applies throughout the 5-year period of the waiver (November 1, 2010 through October 31, 2015). However, between November 2010 and June 2011, California’s FMAP is enhanced under ARRA (and its extension); to the extent that the state and counties spend funds under the waiver during this enhanced matching period, total federal Medicaid funds could approach \$8 billion.

Non-Federal Share of Funding

Federal funds made available under Section 1115 Medicaid demonstration waivers are Medicaid matching funds—i.e., they match state expenditures for services and populations that are allowable under the waiver. The state must pay its share of these costs as determined by the Medicaid matching rate formula, which is not subject to waiver. The state share of spending may include spending from a state’s general fund, certified public expenditures (CPEs), and intergovernmental transfers (IGTs). In the case of the California “Bridge to Refrom” demonstration waiver, the state share comes from county CPEs, public hospital IGTs, and state spending on Designated State Health Programs.

The state share of spending for the LIHP program will be provided by the participating counties in the form of CPEs.³⁴ CPEs are public funds (non-federal) that are certified by the contributing public agency (in this case the participating counties) as representing expenditures eligible for federal Medicaid matching under the waiver.³⁵ To limit the displacement of county and state indigent care dollars by federal funds, the waiver requires a maintenance-of-effort of non-federal funding at 2006 levels.³⁶ The waiver documents specify how counties are to calculate, for purposes of CPEs, the costs they incur in providing services to uninsured individuals that would have been covered under Medicaid had they been eligible Medi-Cal beneficiaries.³⁷ These protocols apply with respect to CPEs for both the MCE (under 133% FPL) and HCCI (between 133% and 200% FPL) populations. As discussed above, federal Medicaid matching funds for the costs of serving the HCCI population (between 133% and 200% FPL) are capped at \$630 million. Federal Medicaid matching funds for the costs of serving the MCE population (under 133% FPL) are not capped by the waiver; however, they are available only to the extent that a county is able to provide allowable CPEs.

The state share of spending for the DSRIP program will be provided by the participating public hospital systems in the form of IGTs.³⁸ IGTs are public funds (non-federal) that are transferred from other public agencies (in this case, county and University of California hospitals) to the state Medicaid agency and under its administrative control.³⁹ Federal Medicaid matching funds are available up to the \$3.3 billion limit described above only to the extent that the public hospitals provide the IGTs. Payments from the DSRIP pool are not considered to be reimbursement for services rendered and are therefore not taken into account in calculating the limits on Medicaid DSH payments to these facilities.⁴⁰

Budget Neutrality

Under longstanding administrative practice, Section 1115 waivers must be budget neutral for the federal government. This means that federal Medicaid spending under a waiver must not exceed the amount the federal government would have spent on the state's Medicaid program without the waiver. In general, if a waiver includes new federal spending for coverage expansions to individuals a state cannot otherwise cover through Medicaid or delivery systems improvements, the state will have to achieve offsetting savings for the federal government elsewhere in its Medicaid program.⁴¹

In the case of the California demonstration waiver, the offsetting savings will come, in part, from mandatory enrollment of SPDs in managed care plans. To ensure that these savings are realized, the waiver limits the per capita amounts that the state Medicaid agency can pay managed care plans on behalf of each SPD, limits the annual increases in these amounts, and requires that certain numbers of SPDs are enrolled.⁴² If actual enrollment of SPDs in managed care plans is more than 10% below projections for the year ending June 30, 2012, the amount of federal Medicaid matching payments available to public hospitals for delivery system reforms under DSRIP (or the Designated State Health Programs) is reduced by \$350 million for the period July 2012 through June 2013. The same applies to the subsequent 6-month period ending December 31, 2012; if actual enrollment is more than 10% below projections, federal DSRIP funds will be lowered by \$350 million for the period July 2014 through June 2015.⁴³

REPORTING AND EVALUTION REQUIREMENTS

Reflecting the purpose of Section 1115 Medicaid waivers to demonstrate innovation, the waiver includes a number of reporting and evaluation requirements designed to inform the federal government, the state, and the counties of the progress achieved and challenges encountered as the demonstration is implemented. For example, the state must regularly report its progress and experience implementing the waiver to CMS through monthly phone calls, quarterly reports, progress reports specifically focused on the mandatory enrollment of SPDs into managed care, and annual reports.⁴⁴ The state is also required to conduct an evaluation that will, at a minimum, use outcome measures to assess the impact of the demonstration-related programs on target populations, including the impact of mandatory managed care on the SPD population.⁴⁵

CONCLUSION

Through the Section 1115 demonstration waiver, California and its counties will receive up to approximately \$8 billion in federal Medicaid funds over the next five years. These resources, and the accompanying waivers, will support the extension of coverage to uninsured low-income adults. They will also enable public hospitals in the state improve their systems of care, upgrade the quality of care they provide to individual patients, and improve the health of the communities they serve. Finally, the demonstration waivers will enable the state to enroll seniors and persons with disabilities into managed care plans meeting network adequacy and other readiness standards. All of these initiatives are intended to help prepare the state for the transition to health reform in 2014.

This brief was prepared by Samantha Artiga with the Kaiser Family Foundation's Commission on Medicaid and the Uninsured and Andy Schneider, consultant to the Kaiser Commission on Medicaid and the Uninsured. The authors thank Lucien Wulsin with the Insure the Uninsured Project for his helpful comments.

ENDNOTES

¹ Long and Gruber, “Projecting the Impact of the Affordable Care Act on California,” *Health Affairs* (January 2011), pp. 63-69. The estimates of other researchers differ. Lavarreda et al. estimate that over 3 million previously uninsured Californians will be eligible for Medi-Cal as a result of the ACA expansion; they do not project how many of these eligibles will enroll. See Lavarreda et al., *Two-thirds of California’s Seven Million Uninsured May Obtain Coverage under Health Care Reform* (February 2011) <http://www.healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=478>.

² Alabama, Delaware, Hawaii, Montana, New Hampshire, North Dakota, Rhode Island, South Dakota, Vermont, and Wyoming. MACPAC, *Report to the Congress on Medicaid and CHIP* (March 2011), Table 2.

³ The “Bridge to Reform Demonstration” approved on November 2, 2010 is technically an extension of a 5-year Section 1115 waiver that was initially approved in 2005; the years covered (November 1, 2010 through October 31, 2015) are Demonstration Years 6 through 10. The November 2, 2010 waiver documents (approval letter, Waiver Authority, Expenditure Authority, and Special Terms and Conditions) are posted at <http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx>.

⁴ Kaiser Family Foundation, *Summary of New Health Reform Law* (April 15, 2011), <http://www.kff.org/healthreform/8061.cfm>.

⁵ See note 1.

⁶ See note 2.

⁷ Long and Gruber, op. cit., Exhibit 3. Lavarreda et al., op. cit. estimate that 1.7 million will be eligible for subsidies in the Exchange as a result of the ACA expansions.

⁸ Pourat et al., *Californians Newly Eligible for Medi-Cal under Health Care Reform*, UCLA Center for Health Policy Research (May 2011), <http://www.healthpolicy.ucla.edu/pubs/files/Expansion%20Policy%20Brief%202011.pdf>.

⁹ Under California Welfare and Institutions Code section 17000, counties must provide health services to low-income adults over 18 with no other source of care. Twenty four counties operate their own programs which vary in scope and funding. The remaining 34, mostly rural, counties contract with a private insurer to offer standard coverage through the County Medical Services Program (CMSP). California Health Care Foundation, *County Programs for the Medically Indigent in California* (October 2009) <http://www.chcf.org/publications/2009/10/county-programs-for-the-medically-indigent-in-california>.

¹⁰ Long and Gruber, op. cit., Exhibit 3.

¹¹ Smith et al., *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011* (September 2010), <http://www.kff.org/medicaid/8105.cfm>.¹² California Department of Health Care Services, Research and Analytical Studies Section, *Medi-Cal’s Most Costly FFS Populations: A Look at the Population, Costs, and Diseases* (June 2009), <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Medi-Cal%27s%20Most%20Costly.pdf>.

¹³ *California Bridge to Reform Demonstration, Special Terms and Conditions* (November 2010), STCs 42-47, 58-76. Initial approval letters for all counties are posted at: <http://www.dhcs.ca.gov/provgovpart/Pages/lihp.aspx>.

¹⁴ Kominski et al., *Interim Evaluation Report on California’s Health Care Coverage Initiative* (June 1, 2010), UCLA Center for Health Policy Research, www.healthpolicy.ucla.edu.

¹⁵ *California Bridge to Reform Demonstration*, op. cit., STCs 64 and 65 specify who may receive mental health benefits and the minimum level of services that must be covered.

¹⁶ *California Bridge to Reform Demonstration*, op. cit., STC 72.

¹⁷ California Department of Health Care Services, *LIHP August 2011 Monthly Enrollment*, <http://www.dhcs.ca.gov/provgovpart/Pages/ProgramReports.aspx>.

¹⁸ *California Bridge to Reform Demonstration*, op. cit., STC 35c.

¹⁹ Detailed metrics for DSRIP are found in Attachment Q of *California Bridge to Reform Demonstration*, op. cit., posted at <http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx>. Categories 1 and 2 of Attachment Q relate to infrastructure development, innovation, and Redesign projects. Category 3 sets forth population health metrics, and Category 4 describes urgent improvements in quality and patient safety. The mechanics of the DSRIP program are set forth in Attachment P.

²⁰ California Association of Public Hospitals, *The New Section 1115 Medicaid Waiver: Key Issues for California’s Public Hospital Systems* (November 2010) <http://caph.org/content/upload/AssetMgmt/PDFs/Publications/newwaiverpolicybriefnov2010.pdf>.

²¹ California Association of Public Hospitals and Health Systems, *The Delivery System Reform Incentive Program: Transforming Care Across Public Hospital Systems* (June 2011), http://www.caph.org/content/Highlights.htm?view=7&news_id=27&news=7

²² California Department of Health Care Services, *California Section 1115 Comprehensive Demonstration Project Waiver Implementation Plan* (May 2010), http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Waiver_ImpPlan_5-2010.pdf.

²³ *California Bridge to Reform Demonstration*, op. cit., STCs 77-86.

²⁴ Instructions to beneficiaries are posted at <http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDEnrollment.aspx>.

²⁵ California Department of Health Care Services, *Managed Care Implementation for Seniors and Persons with Disabilities, Monitoring Dashboard* (October 2011) http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/ChartsRptsData/SPD_Dashboard.pdf.

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- ²⁶ *California Bridge to Reform Demonstration*, op. cit., STC 81.
- ²⁷ *California Bridge to Reform Demonstration*, op. cit., STCs 89-90.
- ²⁸ *California Bridge to Reform Demonstration*, op. cit., STCs 79 and 80.
- ²⁹ *California Bridge to Reform Demonstration*, op. cit., STCs 91-92. The state's request for proposals for these demonstrations is available at http://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/OMCPccsDemoRFPDNLDA.aspx.
- ³⁰ California Department of Health Care Services, *Department of Health Care Services Announces Regional Pilot Projects to Enhance Delivery of Health Care to Children*, News Release (October 12, 2011), <http://www.dhcs.ca.gov/formsandpubs/publications/opa/Documents/11-05%20CCS%20Pilot%20Projects.pdf>.
- ³¹ 1115 Waiver Authority, <http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx>.
- ³² Section 2001(a)(4) of the Patient Protection and Affordable Care Act, P.L. 111-148, allows states, effective April 1, 2010, to extend Medicaid coverage to non-pregnant, non-disabled adults under age 65 with incomes up to 133% of the federal poverty level.
- ³³ California Children Services; Genetically Handicapped Persons Program; Medically Indigent Adult Long-Term care; Breast and Cervical Cancer Treatment Program; AIDS Drug Assistance Program (ADAP); Expanded Access to Primary Care; County Mental Health Services Program; Department of Developmental Services; and three workforce development programs administered by the Office of Statewide Health Planning & Development. *California Bridge to Reform Demonstration*, op. cit., STC 35b.iv.
- ³⁴ *California Bridge to Reform Demonstration*, op. cit., STCs 33 and 36.
- ³⁵ 42 CFR 433.51(b)
- ³⁶ *California Bridge to Reform Demonstration*, op. cit., STC 44.
- ³⁷ *California Bridge to Reform Demonstration*, op. cit., Attachment F, Part III.
- ³⁸ *California Bridge to Reform Demonstration*, op. cit., STC 35c. in the matter after vii.
- ³⁹ 42 CFR 433.51(b).
- ⁴⁰ *California Bridge to Reform Demonstration*, op. cit., STC 35.c.ix.
- ⁴¹ An exception concerns "pass-through" population, i.e., optional groups that could be covered by a state without a waiver. States are not required to find offsets to expand coverage to such groups. Under the California waiver, the LIHP coverage for MCE adults (up to 133% FPL) is considered "pass-through financing" since the state could cover this group without the waiver under the new "childless adult" coverage option enacted by the ACA. As such, offsetting savings for the costs of this coverage are not required. In contrast, the state must offset the financing for the coverage of HCCI enrollees as well as the costs related to implementation of DSRIP.
- ⁴² *California Bridge to Reform Demonstration*, op. cit., STCs 108 and 109. Under this per capita limit, the state is not at risk for enrollment growth.
- ⁴³ Technically, these reductions could apply to funding for either the Delivery System Reform Incentive Pool (DSRIP) or the Designated State Health Programs (DSHP). *California Bridge to Reform Demonstration*, op. cit., STC 112.
- ⁴⁴ *California Bridge to Reform Demonstration*, op. cit., STCs 19-22.
- ⁴⁵ *California Bridge to Reform Demonstration*, op. cit., STC 25.

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