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California's $10 Billion "Bridge" to Healthcare Reform: U
1115 Waiver

California has gotten a head start in preparing for the expansion of the Medicaid Program, a centerpiece of federal healthcare
it hears arguments on the Affordable Care Act — will not begin in most states until 2014.[1] California, however, has already b

The Section 1115 Waiver at issue was a State of California proposal that the Center for Medicare and Medicaid Services (CM
$10 billion over the next five years for California to restructure key public health programs and improve the quality of care to M

The size of the grant signals the colossal change that healthcare reform is bringing to the Medi-Cal Program. In addition to ex
the county based "safety net"[4] and extend the capacity of the Medi-Cal Program.

Mandatory Transition from Fee-For Service to Medicaid Managed Care Plans

One critical change that the Section 1115 Waiver is driving is the transition from traditional "fee for service" Medi-Cal to mana
the transition is already underway: since June 2011, SPD beneficiaries are being automatically transferred into Medicaid HMO
Medicaid are exempt from mandatory enrollment.) The implications of this change are significant not only for beneficiaries, bu
to Medi-Cal beneficiaries by virtue of their contracts with the Medi-Cal managed care organizations in each county. In Los Ang
HealthNet.

Low-Income Health Program Coverage Expansion

Another consequence of the Section 1115 waiver is the expansion of health care coverage to as many as 500,000 low-incom
allows each county to choose to extend coverage to either Medicaid Coverage Expansion (MCE) adults, [5] Health Care Cove
implemented LIHP's, enrolling a total of 196,500 adults. Those counties that implement the coverage initiatives are intended t
be significantly streamlined and much more effective.

The program seeks to veer from a more costly reactive approach to proactive health care. Uninsured residents are to receive
forces an emergency room visit. Those eligible will have significantly greater access to care under a "medical home" model[7]
preventive care, and a wide range of specialty care services by contracted providers.[8] By incorporating the use of medical h
will also be better able to implement more systematic efforts to improve the quality and reduce the cost of health care.

Delivery System Reform Incentive Pool (DSRIP)

The Delivery System Reform Incentive Pool (DSRIP) is intended to expand California's safety net system by enabling safety n
of 2014. DSRIP is premised on the essential role that community health centers play in ensuring the success of health care re
population prepare for reform by expanding their capacity for more integrated, coordinated, and efficient care delivery to high

Specifically, California will distribute $3.3 billion over five years to support efforts by public hospitals in four areas: (1) investm
investments in new and innovative care delivery models; (3) investments in population-focused improvement which will enhar
the low-income populations for whom they are responsible; and (4) investments focused on the urgent improvement in care in
achieve major and measurable improvement in care within five years. The fear is that, without this investment, public hospital
Under the DSRIP, each public hospital system will be held accountable to defined standards, and responsible to return federa

Payment Reforms Demand Efficiency

Through the Section 1115 Waiver, California has already to begun the process of transitioning the Medi-Cal program and safe

payment structures that include incentives for providing high-quality care in the most efficient setting.

The next payment reform ahead is the “Global Payment System Project.” Similar to a health maintenance organization (HMO) quality care, again transitioning from an “input-based” fee-for-service model to a global “results-oriented” capitated payment m

It is critical for providers to recognize that, irrespective of what happens in the coming months when the Supreme Court reviev Providers need to be focused on driving towards quality and care coordination goals and getting ready to function in an outco themselves to flourish as healthcare reform moves forward.

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[1] The expansion is estimated to extend Medicaid coverage to roughly 17 million people. See, e.g., http://www.washingtonpost.com/national/health-science/court-review-of-medicaid-expansion-could-have-massive-consequenc

[2] Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize of the Medicaid Program.

[3] Medi-Cal is the State of California’s Medicaid program.

[4] Safety net providers are those who deliver a significant level of health care and other health-related services to the uninsu supported community health centers or clinics.

[5] MCE adults are non-pregnant adults between ages 19-64 who are not enrolled in Medicaid or CHIP and have family incom 2011).

[6] HCCI adults are non-pregnant adults between ages 19-64 with family incomes between 133% FPL ($14,484) and 200% F

[7] Members will choose a single provider or community health center to serve as their medical home provider who will be res management and member supports including disease and medical management and community-based care coordination.

[8] An essential health benefits package will be developed by the Secretary of Health and Human Services for implementation package, for which California seeks designation by the Secretary as a benchmark-equivalent plan as defined in Section 1937 requirements in an essential health benefits package.

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