

STATE OF CALIFORNIA'S CONCEPT FOR A COMPREHENSIVE SECTION 1115 WAIVER TO REPLACE THE CURRENT MEDI-CAL HOSPITAL/UNINSURED CARE DEMONSTRATION PROJECT

This document presents the State of California's concept of potential components for a section 1115 waiver, to be effective September 1, 2010. This new waiver reflects the need to achieve the structural reforms as adopted as part of the State's 2009-10 budget and to prepare for possible national health care reform. Under the terms of the waiver, and consistent with recent legislation passed by the California Legislature and signed by the Governor (ABx4 6¹), California will create more accountable coordinated systems of care, strengthen the health care safety net, reward health care quality and improve outcomes, slow the long-term expenditure growth rate of Medi-Cal (California's Medicaid program), and expand coverage to uninsured Californians.

ISSUE

California's section 1115 waiver for hospital financing and uninsured care will expire on August 31, 2010. This timing presents California with an opportunity to seek a new section 1115 waiver to transform the Medi-Cal program to deliver health care in a more efficient manner that achieves long-term cost savings and to lay the ground work for what will be needed to successfully implement national health care reforms, if pending reforms are ultimately enacted.

The California Medicaid program is poised for change. As part of the 2009-10 budget, ABx4 6 was enacted to slow the long-term Medi-Cal expenditure growth rate through significant restructuring of the Medi-Cal program. This legislation commits the Department of Health Care Services (DHCS) to pursuing a section 1115 waiver that will restructure the organization and delivery of health care for populations that include the most medically vulnerable; high cost Medi-Cal beneficiaries with complex chronic conditions, co-morbidities, and the highest needs for on-going health care. The Governor and Legislature took this action because Medi-Cal expenditures have been increasing at a rate that is much faster than the growth in available revenue due to the greater use of services, increased costs in the health care system, and more individuals becoming eligible for services. ABx4 6 calls for structural reforms to enable Medi-Cal to reduce its growth rate in expenditures and continue serving low-income vulnerable Californians, while increasing program efficiency.

California's Medicaid program will also have an important role in implementing any changes that are part of national health care reform. While action is still pending, it is likely that any significant change would increase demand for health care services, including Medicaid services. Although Congress and the Obama Administration are working to enact health care reform this year, implementation of any Medicaid coverage expansions that are part of the reform plan may not occur for several years. For states and the public health care programs they operate, health care reform presents an

¹ Assembly Bill x4 6, which can be viewed on the California Legislative Counsel's website at http://leginfo.ca.gov/pub/09-10/bill/asm/ab_0001-0050/abx4_6_bill_20090728_chaptered.html.

opportunity to build upon the existing Medicaid program infrastructure to reach currently uninsured low-income populations, while reorganizing the delivery of care in a more efficient and effective way. State Medicaid programs could face increased demand from the enrollment of new populations, many of whom may enter the program with longstanding unmet health care needs. Medicaid programs and safety net systems would face significant fiscal challenges as they expand and adapt to the newly covered populations. Investments in health information technology (HIT) will be critical in improving health care quality and outcomes. It is to every state's advantage to be ready to respond to national health care reform in ways that meet the needs of their unique communities and health care delivery systems.

In California, existing managed care plans provide a coordinated system of care for many Medicaid beneficiaries, but these plans are not currently serving the populations who are proposed to be newly eligible for coverage under health care reform. In addition, managed care does not serve many current Medi-Cal populations that have the highest need for health care services and for whom the benefits of care coordination can be the greatest. As California prepares for the implementation of ABx4 6 and, possibly, national health care reform, it must provide support to the critical safety net infrastructure, which not only provides care to Medi-Cal beneficiaries and uninsured populations but also provides critical trauma services, specialty care, and medical training of new physicians, benefiting all Californians. Finally, California must weigh the positive opportunities of reform against the realities of the State's economic crisis, high unemployment, and large population of uninsured individuals.

Challenges are especially great in providing high quality, coordinated care for the most medically vulnerable populations. While approximately half of Medi-Cal beneficiaries – principally, women and children – receive coverage through organized health systems, most of the other half of Medi-Cal beneficiaries receive care through the fee-for-service (FFS) system. The FFS system often fails to provide consistent and coordinated care for California's most medically vulnerable populations – seniors, persons with disabilities (physical, developmental, and cognitive), children with special health care needs, Medicare and Medicaid dually eligible individuals, and children and adults with serious mental illness and/or substance abuse disorders.

The majority of Medi-Cal spending is for FFS beneficiaries who have multiple chronic health conditions for whom effective health care is critically important.

- Ten percent of Medi-Cal beneficiaries account for 74 percent of the total program costs. Within this population, four percent account for 60 percent of the costs, according to a recent study by the Public Policy Institute of California.²
- Almost 70 percent of the Medi-Cal beneficiaries with disabilities live with two or more chronic conditions, and almost one-quarter of the population have four or more chronic conditions. In addition, over 16 percent of these beneficiaries with

² Medi-Cal Expenditures: Historic Growth and Long-Term Forecasts, June 2005

disabilities have diabetes, compared to seven percent for the U.S. population overall.

- Approximately 30 percent of Medi-Cal beneficiaries with disabilities have received treatment throughout the year for a mental health condition, while close to nine percent are diagnosed with schizophrenia. These individuals are also far more costly than persons with disabilities who do not have a mental health condition.
- Medi-Cal has over one million dual eligibles (persons enrolled in both Medi-Cal and Medicare), who represent one-seventh of the total national enrollment. Based on national studies, compared to Medicare beneficiaries not enrolled in Medicaid, dual eligibles are 100 percent more likely to be in poor health, 50 percent more likely to have diabetes, 600 percent more likely to reside in a nursing facility, and 250 percent more likely to have Alzheimer's disease.³

For many beneficiaries, the Medi-Cal program does not provide care coordination to help obtain needed services.

- While some seniors and persons with disabilities are enrolled in managed care, most of this population receives their care through an uncoordinated FFS system that does not integrate primary, acute, substance abuse, mental health, social and long-term care support needs. These beneficiaries use a mix of services that are administered and paid for by different systems. Those enrolled in managed care plans face a similar dilemma when they require specialty mental health services, which are not provided through managed care contracts, but rather are provided through the county-operated specialty mental health system. In many cases, these programs are unable to integrate care in the most efficient and effective manner to ensure that the right care is provided in the right amount.
- The fragmentation between the Medi-Cal and Medicare systems contributes to poor outcomes and results in care being provided in inappropriate and expensive settings. It is not uncommon for dual eligibles to receive services in a hospital (paid by Medicare), and then be discharged into a skilled nursing facility (paid by Medicare) until they exhaust their Medicare benefit and their coverage is assumed by Medi-Cal. In addition, it is not uncommon for physicians (paid by Medicare) to order numerous therapies, home health benefits, and durable medical equipment (paid by Medi-Cal), without regard for coordination of the beneficiary's overall treatment plan.
- The responsibility for the care for nearly 200,000 children with special health care needs is split between Medi-Cal and the California Children's Services (CCS) program. These children have severe conditions, such as cancer, diabetes, and conditions related to premature birth. The CCS program has complicated eligibility and service authorization requirements. In addition, when enrolled in

³ The Henry J. Kaiser Family Foundation, *Medicare Chartbook*. Third Edition, Summer 2005.

managed care plans, the same child served by the CCS program for treatment of the child's particular CCS-qualifying condition is also served by the Medi-Cal managed care plan for remaining overall health needs. This leads to complex, ineffective coordination and limits the ability of the managed care plan and the child's CCS providers to provide continuity of care.

WAIVER GOALS

The new section 1115 waiver will be designed to meet the waiver goals identified in ABx4 6. This legislation seeks to advance two policy objectives through the pursuit of a comprehensive section 1115 waiver. First, it will restructure the organization and delivery of services to be more responsive to the health care needs of enrollees to improve their health care outcomes and slow the long-term expenditure growth rate of the Medi-Cal program. This action will facilitate the second objective of targeting the State's limited financial resources to preserve essential health services for the most vulnerable Medi-Cal populations, in the most effective manner. The goals in ABx4 6 are:

1. Strengthen California's health care safety net, which includes Disproportionate Share Hospitals (DSH), for low-income and vulnerable Californians;
2. Maximize opportunities to reduce the number of uninsured individuals;
3. Optimize opportunities to increase federal financial participation and maximize financial resources to address uncompensated care;
4. Promote long-term, efficient, and effective use of State and local funds;
5. Improve health care quality and outcomes; and
6. Promote home and community-based care.

Through a new section 1115 waiver, California will begin a transformation of the Medi-Cal program that will position our state to meet ABx4 6's objectives of slowing the long-term rate of growth in Medi-Cal costs, while improving care coordination and health outcomes, as well as to implement national health care reform, if enacted.

WAIVER INITIATIVES

Over the past six months, the Governor and the Legislative leadership have worked together on a coordinated process to educate and engage stakeholders about the existing waiver and the opportunities offered in a new waiver. This coordinated approach has provided important input from stakeholders to help refine the major components of this concept paper.

California will achieve its goals for a new section 1115 waiver through four broad initiatives:

I. Promote Organized Delivery Systems of Care

A key component of the State's effort to align with the ABx4 6 goals of advancing long-term, efficient, and effective use of State and local funds; improving health care quality and outcomes; and promoting home and community-based care is the development of organized delivery systems of care for populations that include the most medically vulnerable, high-cost enrollees. These systems of care will slow the long-term growth rate of the Medi-Cal program costs. They place a strong focus on primary and preventive care and evidence-based services in order to align services and incentives and to provide the right care in the right setting at the right time. The key elements of these systems, as outlined in ABx4 6, are a mandatory medical home, coordinated care (such as care and disease management), better connection to specialty providers, as well as incentives that reward providers and beneficiaries for achieving the desired clinical, utilization, and cost-specific outcomes.

Medi-Cal's managed care program embodies the essential elements of organized delivery systems. These plans place a focus on medical homes and coordinated care for their 3.7 million Medi-Cal members in order to provide the most cost effective and appropriate care and eliminate potentially preventable services, such as hospital admissions and readmissions. Several Medi-Cal managed care plans that serve as County Organized Health Systems provide services to all Medi-Cal beneficiaries in certain counties, including seniors and persons with disabilities. In other counties, plans primarily serve Medi-Cal beneficiaries who are parents and children, but they also serve a large number of seniors and persons with disabilities who voluntarily enroll to receive organized care delivery.

The Medi-Cal beneficiaries who remain outside managed care and receive their care through the FFS system - seniors, persons with disabilities (physical, developmental and cognitive), children with special health care needs, Medicare and Medicaid dually eligible individuals, and children and adults with serious mental illness and/or substance abuse disorders - include the most medically vulnerable, high-cost/high-risk enrollees. Interviews in recent months with stakeholders as part of the 1115 waiver stakeholder process indicate a growing recognition and acknowledgement that the current FFS system does not adequately meet the needs of the most medically vulnerable and the consensus is that the State should offer organized care systems that better coordinate their care and improve health outcomes.

ABx4 6 calls for a restructuring of the organization and delivery of health care for these populations to promote more coordinated, organized, and accountable care delivery models. The key elements of these systems of care will be consistent across the targeted populations and will embody the essential elements of organized delivery systems. However, the type of delivery system that the State uses may vary, as permitted in ABx4 6, from existing managed care models to newly developed enhanced medical home (EMH) models. Through the mandatory enrollment of such medically vulnerable populations in more coordinated, accountable systems of care, ABx4 6 seeks to improve access and care coordination and slow the long-term growth rate of

the Medi-Cal program costs leading to significant savings to the State and federal governments.

Managed care organizations provide an existing organized delivery system structure that will be available to the population of seniors and persons with disabilities that are largely served today in the FFS system, provided such plans can meet the needs of the populations and achieve the State's performance standards. In addition, the State will develop, where appropriate, additional organized systems of care that can be offered to the target population. These systems will incorporate key elements of managed care that have been effective in improving health care outcomes and reducing overall health care costs. Like Medi-Cal managed care models, this new system of care will likely require waivers of various Medicaid State plan requirements because beneficiaries will be required to choose between a Medi-Cal managed care plan or an alternative model. In addition, the systems of care may vary by geography requiring a waiver of "state wideness," to allow delivery of appropriate health care in different geographical regions. These systems will include all the major components, as described below:

- Provider networks. A beneficiary will be assigned to a single provider or clinic to serve as the medical home provider. There will be sufficient capacity in provider networks in which primary care providers and specialists are recruited to enroll/contract with the organized system network.
- Care management and coordination. Care coordination activities will be the central feature of this system. Predictive modeling and risk-stratification techniques will be used to identify enrollees with the highest health care needs. The services provided to high-needs enrollees will include disease and medication management and community-based care coordination including coordination of referrals and linkages to community resources.
- Managing and monitoring service utilization. The system will perform concurrent inpatient review and discharge planning to improve inpatient-to-community transitions and referral requirements for certain diagnostic and specialty services.
- Member supports. Beneficiaries will have access to telephone services that will provide program information, enrollment choices, and medical advice.

During the course of the waiver, the State will enroll beneficiaries in existing and to-be-developed organized delivery systems of care that meet the needs of the following vulnerable Medi-Cal populations in four phases as outlined below:

1. Enrollment in organized delivery systems for seniors and persons with disabilities and children and families, throughout the state, who are not currently enrolled in organized delivery systems. To the extent existing managed care plans are able to meet the needs of the populations and achieve the State's performance standards, these plans can serve as the organized delivery system. As necessary and appropriate to meet diverse geographic and population needs, additional organized delivery systems of care will also be developed.

2. Children with special health care needs. California will work with stakeholders to develop and test approaches to enhance the delivery of care to children with special health care needs, specifically oriented towards pediatric care. The approaches will be designed to preserve the strengths of the current CCS program, such as the access to qualified sub-specialists and tertiary care to treat conditions that require specialized care. California will work with stakeholders to conduct thorough and careful analysis of existing claims data to determine the costs of the program and the cost distribution across clients. California will then work with stakeholders to develop approaches that will improve health care systems for children with serious and chronic health conditions. The approaches will incorporate the core concepts of organized delivery systems into the care received by children less than 21 years of age with special health care needs (i.e., CCS-eligible children). Responsibilities and incentives for specialty and non-specialty care will be better integrated and aligned to promote clearer accountability, better care coordination, more effective and efficient use of public dollars, and improved health care quality outcomes. Case management and care coordination services will be provided in a way that streamlines the care delivery process and provides more flexibility to ensure the most appropriate care is provided.
3. Dual-eligible beneficiaries. The split financial and administrative responsibility for the care for dual eligibles leads to significant problems from both a cost and outcome perspective. California will work with the federal government to integrate and coordinate care for dual eligibles through expansion of programs that have a primary focus on dual eligibles and, as needed, the development of new organized delivery systems in a manner that improves care coordination and recognizes shared savings for this high-needs population. The partnership with Medicare will ensure that the use of home and community-based services, including Medi-Cal waivers and State Plan services, will be better coordinated to more effectively promote the ABx4 6 goal of home and community-based alternatives to institutional care, including nursing facility services.
4. Adults with severe mental illness and/or substance abuse disorders. California will work with the mental health and substance abuse provider communities to ensure that the organized delivery systems meet the needs of persons with severe mental illness and/or substance abuse disorders. The goal will be to establish systems that facilitate integration of behavioral and physical health to create more effective and efficient systems that improve health care quality and outcomes. These systems should allow for a medical home, which provides mental health and substance abuse treatment services in the primary care setting or primary care services in the mental health setting. Phasing in of adults with severe mental illness and/or substance abuse disorders into organized systems of care will build upon the State and nationally recommended framework for service development, which identifies patient need based on their physical and behavioral health risk, acuity, and complexity. Based on this profile, a physical health or behavioral health provider will be assigned as the individual's

medical home and mechanisms will be employed to ensure that a wide range of health, behavioral health, and social supports are available to address the patient's needs.

II. Strengthen and Expand the Health Care Safety Net

California's health care safety net system provides critically important health care services to the state's low-income populations, both those eligible for Medi-Cal and the uninsured. The safety net system is inclusive of public and private providers rendering services across the continuum of care in a variety of settings. The safety net system also provides specialty services, such as trauma and burn services, and medical training for health care providers that benefit all Californians.

California will use the new section 1115 waiver to strengthen and expand the health care safety net system in four keys ways:

1. Provide a role for the safety net system in the network of organized systems of care for seniors and persons with disabilities. California will work with the public and private safety net hospital community, community clinics, and other stakeholders to develop approaches to support the safety net system's transition to more complete participation in existing managed care plans and/or organized and accountable delivery systems, such as EMH systems. This transition would prepare the state's safety net infrastructure for broader federal and State health care reforms, i.e. to be in a better position to serve expanded Medicaid eligibility groups if pending reforms are enacted.
2. Increase federal financial participation for Medicaid inpatient per diem payments to Designated Public Hospitals (DPHs). A new waiver must ensure DPH financial viability and capacity to provide care to newly covered individuals, first through the waiver and then, potentially, through national health care reform. California's DPHs are the largest providers of inpatient and outpatient hospital services to Medi-Cal beneficiaries and uninsured individuals yet they are only reimbursed for half of the costs of providing these services. This low reimbursement rate does not assist the public hospital system's ability to support the wide array of services they provide, including emergency trauma services, pediatric care, and the training of health care professionals. A new 1115 waiver will explore ways to increase the amount of federal financial participation that the state's public hospitals can receive for inpatient hospital services provided to Medi-Cal beneficiaries.
3. Preserve and support State and county health care programs. Under the final year of the current section 1115 waiver for hospital financing and uninsured care, California expects to receive approximately \$1.4 billion through the Safety Net Care Pool (SNCP), which reimburses the State for health care populations and health care services not otherwise claimable under the State's Medicaid

program⁴. Apart from the \$180 million that is used to support the Health Care Coverage Initiative (HCCI) pilot programs, this funding has stabilized and enhanced the State and local health care safety net system by reimbursing costs that are not claimable under Medi-Cal. A significant portion of these funds has been earmarked to the DPHs as reimbursement for uncompensated care costs associated with uninsured Californians that access the DPH health and hospital systems. In addition, the State has accessed the SNCP to claim for costs associated with several State-only programs that provide health care services to uninsured low-income Californians. Under the new section 1115 waiver, the State expects to receive a significant increase in federal funding under the Safety Net Care Pool. California will also continue to use a significant portion of the SNCP to reimburse DPHs and other State and local health care programs for costs and services that are not otherwise claimable under Medi-Cal. This funding will be essential to preserve the State and local health care infrastructure in advance of possible federal health care reform. California may request to expand the list of claimable programs and services beyond the list that is currently available under the existing Hospital Financing waiver.

4. Facilitate the adoption of Health Information Technology (HIT) and Health Information Exchange (HIE). Adoption of these new technologies will help to ensure that safety net providers have the necessary tools and supports to provide cost efficient and effective coordinated care for vulnerable populations through the existing and new organized delivery systems that will improve their health care quality and outcomes. California will leverage and expand on HIT/HIE requirements and funding made available under the American Recovery and Reinvestment Act of 2009 (ARRA) to enhance the development of and infrastructure for organized delivery systems of care. This effort will facilitate the adoption and meaningful use of HIT and HIE among safety net providers caring for Medi-Cal beneficiaries, with a goal of achieving 90 percent adoption of electronic health records by Medi-Cal providers, including public and private safety net hospitals, community clinics, health care providers, dental providers, behavioral health providers, long-term care facilities and home and community based providers. HIT and HIE adoption will drive clinical practice workflow re-engineering, improved care coordination as providers rely on clinical data offered through HIE, and improved patient safety through electronic prescribing methods (e-prescribing).

While the waiver initiatives noted in this document will require openness to rethinking the ways in which parts of the safety net system interact, California will, and must, continue to leverage and support the current strengths of the safety net infrastructure. Behavioral health treatment providers, children's hospitals, pediatric specialty care centers, private safety net hospitals, non-designated (district) public hospitals, community clinics and health centers, skilled nursing and intermediate care facilities,

⁴ California is in the midst of amending the terms and conditions of the current 1115 waiver to receive the enhanced Federal Medical Assistance Percentage (FMAP) rate for all funding under the waiver as well as an additional \$360 million. This additional funding will increase the SNCP to approximately \$1.4 billion during the final year.

and home and community based providers continue to be recognized as critical pieces of California's safety net.

III. Implement Value-Based Purchasing Strategies

California will develop and implement value-based purchasing strategies in the new organized delivery systems of care and the managed care delivery system in order to provide incentives and align with the ABx4 6 goals of advancing long-term, efficient, and effective use of State and local funds; improving health care quality and outcomes; and slowing the long-term growth rate of the Medi-Cal program costs for the State and federal government. Previous efforts to implement such strategies in the Medi-Cal program have been slowed due to a lack of systematically collected data for Medi-Cal FFS beneficiaries and a lack of HIT/HIE infrastructure for providers to share available data with the State. The value-based purchasing initiative will be made possible by newly available data from the organized delivery systems of care and HIT/HIE infrastructure investments in the health care safety net system.

California will work with the federal government and stakeholders to design value-based purchasing strategies for the Medi-Cal program and, more specifically, for use in the new organized delivery systems of care. Such strategies may include: standardized reporting of provider utilization and outcome information; risk sharing; pay-for-performance (P4P) programs for hospitals, managed care plans, new organized delivery system networks, physicians and other health care providers such as long-term care facilities; healthy rewards and incentives for beneficiaries; and nonpayment for healthcare acquired conditions.

The State may also explore transitioning private hospital inpatient services from the current per diem system to a diagnosis or acuity based payment system such as the diagnosis-related group (DRG) system. This new inpatient payment system would create administrative efficiencies, as the State would no longer have to rely so extensively on authorization for services, and would better align incentives by giving hospitals more financial control to provide the most appropriate and cost effective care. California will explore this option during the development of the section 1115 waiver application. Until it is able to transition to a new system, California will need to continue its very successful, cost effective Selective Provider Contracting Program in the next waiver.

IV. Enhance the Delivery System for the Uninsured to Prepare for National Reform

California's current five-year section 1115 waiver for hospital financing and uninsured care provides \$180 million in years three through five (September 1, 2007, through August 31, 2010) for the development and implementation of Health Care Coverage Initiative (HCCI) pilot programs in selected counties to expand services to low-income uninsured adults not otherwise eligible for Medi-Cal. HCCI programs are currently being implemented in ten counties in California to expand the number of Californians

who have health care coverage, strengthen and build upon the local health care safety net system, and improve health outcomes for individuals.

Under the new section 1115 waiver, California will build upon the foundation of the current pilot programs and HCCI goals to:

1. Develop more consistent program standards across HCCI programs that align with the organized delivery systems for seniors and persons with disabilities. This will be accomplished by aligning the HCCI systems of care with the standards that will be essential elements of the organized delivery systems for seniors and persons with disabilities. Currently the HCCI programs operate as ten distinct and very different programs with diverse target populations, conditions, and interventions. Over the course of the five-year waiver term, the HCCI programs will be transitioned to align with the organized care standards including: methods for identifying populations and chronic conditions; use of predictive modeling and risk stratification; HIT utilization; targeted interventions (e.g. disease and medication management and complex care coordination); and data reporting, performance measurement, and quality improvement. At the same time, California will identify and incorporate into the organized delivery systems for seniors and persons with disabilities best practices from HCCI experiences so that both programs reflect lessons from other states as well as California's unique regional experiences.
2. Enable HCCI counties to drive greater system reform by providing counties the option to transition away from cost-based reimbursement to alternative payment methodologies such as capitation. Alternative payment methodologies will provide counties with additional flexibility to reorganize their delivery systems in ways that offer incentives for the appropriateness of care rather than the quantity of care.
3. Streamline and integrate enrollment between HCCI programs and traditional Medi-Cal. Currently HCCI programs enroll uninsured eligible populations into their initiatives through an eligibility and enrollment process separate from the Medi-Cal application process. In most instances, separate workers conduct the eligibility determination. Under the waiver, California will explore ways to transition HCCI from a stand alone eligibility process to an integral component of eligibility for all Medi-Cal programs since this transition will be necessary if the HCCI population becomes Medicaid eligible under national health care reform. This transition under the waiver may require implementation of administrative procedures that will no longer be necessary when all low-income populations are eligible for Medi-Cal.
4. Expand the number of counties participating in the HCCI to serve counties where 90 percent of the state's uninsured reside. Besides the expansion of enrollment slots in existing counties, the State will expand the HCCI to new counties. This expansion will ensure that the infrastructure is being developed in other counties allowing more of the state's population to participate.

WAIVER IMPLEMENTATION

In a state as large and complex as California, it will take time to design and implement more organized, accountable approaches to the delivery of FFS care to seniors and persons with disabilities, as well as children with significant medical challenges, the dually eligible, and persons with both physical and behavioral needs. Under ABx4 6, a stakeholder advisory committee will provide assistance in development of an implementation plan based on this concept paper. Additional stakeholder engagement processes will be utilized to help further inform implementation of the proposed reforms. The stakeholder advisory committee will continue to consult with DHCS on implementation throughout the five year period of the section 1115 waiver. The waiver timetable will also allow for phased implementation of the proposed reforms across the eligible populations.