



Private Essential Access Community Hospitals

Medicaid Waiver Concept Executive Summary

Call to Action

The Governor and legislative leaders have called on the federal government to renew the current Medicaid 1115 waiver with an additional \$2 billion per year for five years in order to support California's safety net and to ensure early and successful implementation of the Patient Protection and Affordable Care Act at the state level. As the state proceeds to renew its Section 1115 Medicaid waiver by September of this year, private community disproportionate share (DSH) hospitals and their partners are well positioned to help the state accelerate the delivery system changes necessary to realize health reform and waiver goals at the local level. Representing private, community safety net DSH hospitals throughout the state, Private Essential Access Community Hospitals (PEACH) proposes the following vision for change:

- Develop community-based, patient-centered delivery networks
- Ensure that the health care system offers vulnerable populations appropriate access, continuity of care and provider choice
- Create predictable and stable funding for the public and private safety net
- Invest in strengthening linkages between hospitals and community providers
- Invest in both public and private safety net delivery system transformation

The Private Safety Net's Unique Position and Risks Associated with its Destabilization

Community DSH hospitals are a cornerstone of the safety net, providing critical points of access to care across multiple regions that both with and without public hospitals. In service to the public, California's community DSH hospitals spent more than \$730 million in unreimbursed costs to treat Medi-Cal and uninsured patients in 2008. These losses are not sustainable by private DSH hospitals and must be remedied in the new waiver. The 2010 waiver must maintain the viability of the private safety net or it risks weakening the local economy and compromising patient access, provider choice and continuity of care.

Enhancing Integration and Coordination through a Financially Stable Private Safety Net

Health reform offers the opportunity to test new care delivery frameworks. Within the context of an expansion of managed care, Accountable Care Organizations (ACOs) are an opportunity for innovation, but must be coupled with resources to stabilize the private safety net. Community DSH hospitals and their partners are motivated, committed, and ready to take the appropriate steps to achieve integration and coordination. To do so, they require:

Investment in the Transformation of Delivery Systems

Private community DSH hospitals require an upfront investment to successfully partner with their physicians, clinics and other community providers to create integrated, coordinated and sustainable delivery systems. Investments should be distributed through three methods: 1) Competitive grants for community DSH hospitals to fund a phased approach to integration and coordination (Figure 1); 2) Add-on supplemental payments for care coordination, initially focusing on community DSH hospitals; and 3) Reimbursement for private DSH hospital care to patients enrolled in coverage initiatives authorized or expanded in the 2010 waiver.

Figure 1 - Coordinated Delivery Network Development: A Phased Approach

Phase I – Stakeholder alignment and core infrastructures (e.g. Medical home, care coordination and transitions processes)

Phase II – Implementation of best practices and integrative technology (e.g. Electronic Medical Records and Health Information Exchanges)

Phase III – Formalization of risk-sharing models and legal frameworks



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Predictable and Stable Funding

The 2010 waiver must provide assurances for a viable safety net over the next five years and reduce unreimbursed costs. Financial stabilization for community DSH hospitals should be achieved by maintaining: 1) annual growth in supplemental and DSH payments for community DSH hospitals at least at the rate of their cost increases and commensurate with public hospitals; and 2) continuation of stabilization payments, but modified to provide equitable apportionment between the public and private pools.

Financing the Vision

Given the state's budget situation and the state's historically low Medicaid spending, it is critical for the state to seek consideration of new budget alternatives under the waiver. To support the private safety net, the following opportunities should be explored:

- *Federal savings resulting from the enrollment of the SPD population into managed care*
Statewide, private safety net hospitals provide 38 percent of all inpatient days of care provided to the SPD population. The portion of savings resulting from the management of these patients by private hospitals should be reinvested into the development of coordinated delivery systems for private hospitals.
- *Room under the private safety net inpatient and outpatient upper payment limits (UPL)*
States receive additional federal funding for the amount under the UPL ceiling by making supplemental payments to hospitals beyond regular Medicaid. Increased payments could be made to private safety net hospitals through this financing method.
- *Sources of state match to draw down federal financial participation*
Expand intergovernmental transfer programs and state general fund savings through federalized payments for state only indigent programs to draw additional federal funds.
- *Redefine Certified Public Expenditures (CPE)*
County work and investment not previously considered in CPE calculations, such as seismic retrofitting, may be included along with other CPEs to provide additional payments for the private safety net.
- *Giving fair weight to both public and private expenditures in Medicaid matching*
To create better balance in the system, private DSH hospital expenditures on uncompensated care and infrastructure activities should be eligible for Medicaid matching. Such expenditures should be included in the state's budget neutrality calculation in the "without-waiver baseline."

The Value of Integrated and Coordinated Systems Anchored by Community DSH Hospitals and Their Partners

There is a clear need and opportunity to invest in both the private and public safety net. By advancing the principles above within the context of the pending 2010 waiver, the state can strengthen the safety net and more quickly realize and permanently sustain positive delivery system changes. As local systems of care are transformed into more responsive, patient-centered networks of care, the state will maximize its potential to draw down federal funds and succeed under health reform. For the state's low income, special needs and most medically vulnerable populations, this effort will preserve patient choice and access to quality, coordinated and financially sustainable systems of care.

More details can be found in the PEACH Medicaid waiver concept paper, *Leading the Nation in Implementing Federal Health Reform: Key Investments in the Private and Public Safety Net*

For more information, please contact:

Catherine Douglas, CEO, at (916) 446-6000 or by e-mail at catherinedouglas@peachinc.org

Visit our website at www.peachinc.org

Leading the Nation in Implementing Federal Health Reform:

Key Investments in the Private and Public Safety Net

May 2010

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I. Call to Action

The passage of federal health reform embodied by The Patient Protection and Affordable Care Act (PPACA) has opened the door for dramatic changes and visionary leadership in the country's health care delivery systems. On April 29, 2010, Governor Schwarzenegger formally affirmed California's support and readiness to partner with the federal government on health reform. Ultimately, success of national health reform will hinge on its implementation at the local levels. California is set to renew its section 1115 Medicaid waiver on September 1, 2010. The state has the opportunity to use this process to become an early innovator and maximize federal support for transforming and strengthening the health care delivery system. With its emphasis on Medicare, Medicaid and extension of coverage to low-income workers, a successful health reform effort can only be accomplished through support for all of California's safety net hospitals—public and private.

Within the ABX4 6 law¹, which lays out the framework for California's hospital financing waiver renewal, the state committed to the goal of strengthening the overall safety net, encompassing both public and private providers. This paper describes opportunities for the state to work with the private disproportionate share hospital (DSH) community and their associated physicians, clinics and ancillary health care providers to, not only achieve this statutory goal, but accelerate broader delivery system and health outcome improvements for California's low income and medically vulnerable patients.

California's privately operated community DSH hospitals serve a uniquely large proportion of low-income Medicare seniors, Medi-Cal beneficiaries, medically vulnerable and uninsured residents, incurring over \$730 million in uncompensated care for Medi-Cal and uninsured patients. Together, these hospitals and their health care provider partners are a critical cornerstone of the safety net and pivotal in successful system transformation. In counties across the state, especially in the 43 counties without a public hospital, communities rely on the private safety net to meet the needs of an increasingly expanding Medi-Cal, Medicare and uninsured population. Given the vital capacity that it provides, failure to give needed support to the private safety net will have devastating consequences on patient access, choice and continuity of care, as well as broader implications on the economic health of communities.

The unique position of community DSH hospitals and their partners represents one of the best opportunities for the state to improve the capacity to serve patients, create sustainable and effective delivery system changes and succeed under federal health reform. Representing private, community safety net DSH hospitals throughout the state, Private Essential Access Community Hospitals, Inc. (PEACH) has set forth the following principles to strengthen the

Figure 1: Required Changes for Successful Delivery System Transformation:

- Develop community-based, patient-centered delivery networks
- Ensure health care system offers vulnerable populations optimal care capacity, continuity of care and provider choice
- Create predictable and stable funding for the public and private safety net
- Invest to strengthen linkages between hospitals and community providers
- Invest in both public and private safety net delivery system transformation.

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.



safety net, preserve patient choice, enhance quality of care and maintain sustainable growth rates with relation to financing:

- With the mandatory expansion of managed care for seniors and persons with disabilities (SPD), it will be critically necessary to enhance coordination and integration for the safety net through the establishment of community-based, patient-centered coordinated networks. These networks, supported by partnerships between private safety net hospital systems and their physicians, clinic and long term/community care provider partners will ensure the success of managed care for the SPD population, as well as other government funded patients.
- The waiver and implementing legislation should ensure that the health care system offers vulnerable populations optimal care capacity, continuity of care, and provider choice.
- The waiver must ensure predictable, stable and equitable funding for the public and private safety net.
- The state should provide flexible development investment to strengthen linkages between hospitals and community providers. This will expand capacity and enable current delivery systems to more effectively care for the anticipated influx of Medicare and Medi-Cal patients under federal health reform.
- The state should take steps to fully fund both private and public safety net delivery system transformation.

II. Unique Position of Community DSH Hospitals and Their Partners

The hospitals that comprise the private hospital safety net are an essential part of California's safety net, the state's economy, and the entire health care delivery system. These community DSH hospitals provide a continuum of services to the entire family, functioning as critical points of access and care across multiple geographic regions with and without public hospitals. Throughout California, community DSH hospitals provide a majority of care to several of the state's most vulnerable populations (Figure 2). DSH community hospitals are the foundation of care within their communities, given their outstanding charity care, unique care capacity, and dedication to caring for the entire family, regardless of coverage type ranging from Medicaid, Medicare and commercial.

Figure 2: The Foundation of Care for Communities

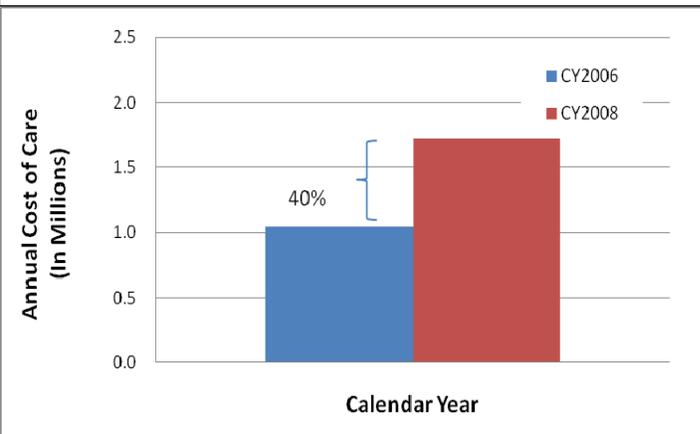
Among all DSH hospital groups across the state, private community DSH hospitals provide:

- **65%** of acute care to low-income infants compared to all the other DSH hospital groups combined
- **67%** of care to seniors
- **47%** of all care to Medi-Cal patients
- **51%** of all emergency medical care

While the public safety net is also a critical component of the safety net, public hospitals are not present in all counties within the state. Among the state's thirty most populous counties, only half have a public hospital. In populous counties without a county hospital such as Orange, San



Figure 3: L.A. County Private DSH Unreimbursed Care



Diego, Fresno and Sacramento, community DSH hospitals and other private safety net providers operate exclusively as the safety net. In the areas where county health systems have a presence, community DSH hospitals and their partners provide the capacity necessary to meet the high demands of ever-increasing medically vulnerable populations in the neighborhoods where patients live. For example, in Los Angeles County, community DSH hospitals' unreimbursed cost of caring for the uninsured has risen nearly 40 percent

since 2006, to more than \$172 million annually (Figure 3).² Even more notable is the fact that, in L.A. County, private community DSH hospitals provide twice as much inpatient care to seniors and persons with disabilities (SPD) as their county hospital counterparts (403,001 bed days vs. 209,271). These two patient populations are among the main populations of focus in the state's waiver,³ and community DSH hospitals are their providers of choice.⁴

Despite their critical role within the safety net, community DSH hospitals lack the investment needed to allow them to better integrate and coordinate with physicians, clinics and long term/community care. Compared to their non-DSH private hospital and public hospital counterparts, private community DSH hospitals receive less support from the state or private funding sources. Historically, non-DSH hospitals relied on their more profitable payer mix, while county hospitals drew upon direct financial infusions from past and current waivers. For example, Intergovernmental Transfers (IGTs), Coverage Initiative dollars and Certified Public Expenditure (CPEs) allocations traditionally go straight to county care delivery systems, to the exclusion of the private safety net (Appendix A – Glossary of Terms).

For nearly twenty years, guaranteed baseline payments, payment growth and funding equity between the public and the private DSH hospitals over the term of the waiver have been the hallmark of California's hospital finance waivers. The state's 2010 waiver must maintain and reflect this core tenet.

A. Risks of Destabilizing the Private Safety Net: Endangering Patient Choice and Well-being

In an environment characterized by escalating costs, increasing demands, regulatory constraints, and a payer mix that consists primarily of Medicare, Medi-Cal and uninsured, community DSH hospitals and their associated physician and clinic partners are

Figure 4: Statewide Uncompensated Care Burden Shouldered by Community DSH Hospitals

- More than **\$730 million** annually in unreimbursed costs, **\$300 million** of which is from shortfalls from care for Medi-Cal patients
- 43% increase in uncompensated care for uninsured patients from CY2006 to CY2008

² Private Safety Net Hospital Unsponsored Care Statistics Report. April 30, 2010.

³ Department of Managed Health Care. *California Section 1115 Comprehensive Waiver Demonstration Project: Implementation Plan*. May 2010.

⁴ Private Safety Net Descriptive Statistics Report. April 23, 2010

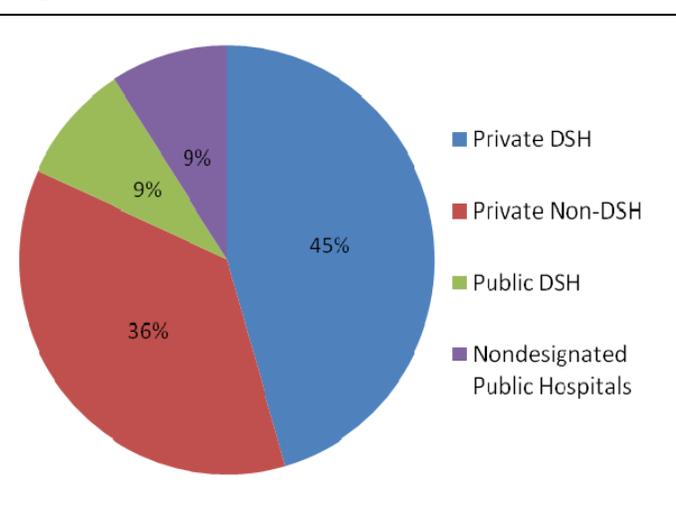


already extremely vulnerable (Figure 4). As established, accessible providers for a large segment of the safety net population, further destabilization and risks to the capacity of these providers will compromise local economies, continuity of care, patient choice and health. The promises embodied in federal health care reform are insurmountable without a strong and fully participatory private safety net.

1. Threat to the local economy and patient access

Community DSH hospitals are dependent on Medi-Cal and Medi-Cal DSH replacement payments as a source of payment for their mostly low-income patient population. The FY2009-2010 community DSH cuts significantly impacted these hospitals, forcing hiring freezes, layoffs, delays and cuts in infrastructure investment.⁵ Indeed, community DSH hospitals are already suffering at a disproportionate rate to their counterparts, representing 45 percent of all hospital closures in the state from 2003 to 2008 (Figure 5).

Figure 5: Hospital Closures in CA from 2003-2008



Over the term of the pending 2010 waiver, Medi-Cal reimbursement levels are anticipated to remain among the lowest in the nation. Hospitals will the growing demand for care from an additional 1.6 million Medi-Cal beneficiaries expected through federal health reform. Thus far, potential new funding opportunities for designated public DSH hospitals under the proposed 2010 waiver could be in excess of \$1.5 billion per year, which will go far towards stabilizing the county and UC hospitals; however, there are currently no funding increases envisioned by the state for private community DSH hospitals in the new waiver.

Given the anticipated influx of new beneficiaries into Medi-Cal, Medi-Cal managed care and Medicare, this omission is tantamount to significant funding decreases for community DSH hospitals over the term of the next waiver. It is even more alarming combined with federal health care funding reductions that will impose permanent 50 percent annual losses in Medi-Cal DSH payments that will be phased-in beginning in 2014. The state's current budget has proposed to reduce existing DSH replacement funding by 10 percent for the second budget year in a row.

Together, these changing circumstances and added pressures threaten to accelerate layoffs, perpetuate hiring freezes,⁶ and could push many private safety net hospitals to close beds or shut doors altogether. Additional hospital closures will mean loss of emergency room capacity, which compromises access to critical emergency and acute care services for the community as a whole.

⁵ 2010 PEACH Integration Readiness Survey Outcomes

⁶ *ibid*



2. Compromised patient choice and continuity of care

Many Medi-Cal and Medicare beneficiaries have an established health care provider that operates as part of the private safety net. These patients rely on their traditional provider for care and these providers—hospitals, clinics, physicians—rely, in turn, on adequate payment to continue caring for patients and to remain financially sustainable. Imposed mandates must not disrupt patients' ability to choose their provider. If mandates are enacted that limit provider choice, continuity of care will diminish and financial instability for private safety net providers will result.

Community DSH hospitals are an anchoring presence within the community. If more community DSH hospitals are forced to close due to a lack of stable funding, many partner physicians will leave the community. This flight and the expected retirement of community DSH hospital partner physicians will further weaken the already fragile private safety net. More importantly, it will have devastating consequences for the families and individuals in communities throughout the state who depend on the private safety net for health care. For this vulnerable patient population, historically constrained by transportation, cultural and linguistic barriers, the forced displacement from their traditional health care provider will undermine their ability to access high quality care providers in their community and maintain continuity of care with their traditional providers. In particular, SPD populations enrolled into managed care programs that rely heavily on these providers will lose their source of care in the absence of new stabilization funds for the private safety net.

3. Inadequate capacity for Medi-Cal and Medicare population and inability to meet health reform goals

Loss of capacity within the private safety net will significantly strain remaining hospitals, adding particular stress on the already overburdened and congested public systems. For example, in Los Angeles County alone, among all DSH hospital groups, community DSH hospitals provide the vast majority of care to seniors (83 percent), Medi-Cal patients (64 percent) and all emergency room care (65 percent).⁷ The safety net system as a whole will suffer, losing its ability to retain physicians and its capacity to meet anticipated increases in demands of an expanded Medi-Cal and Medicare population. As health care costs and the rate of chronic illness continues to rise, this inadequate infrastructure threatens to undermine the state's ability to respond to and keep pace with regulatory mandates, federal opportunities and health reform goals.

B. Opportunity to Invest in Community DSH Hospitals and Their Partners

As organizations dedicated to serving the entire community, particularly the underserved, community DSH hospitals and their physician and clinic partners are well-positioned to take the lead in establishing community-based, coordinated delivery networks that optimize available resources and place the patient at the center of system transformation.

⁷ Private Safety Net Descriptive Statistics Report. April 23, 2010



1. Preparing for health reform opportunities

Federal health reform will also offer funding opportunities to test new care delivery frameworks, such as Accountable Care Organizations (ACOs). Working within the managed care framework, the following components of ACO clinical integration models mirror and can enhance those envisioned under the state's vision of coordinated care for the SPD population:

- Clinical integration among a broad provider spectrum
- Care management and coordination
- Use of interoperable electronic medical records
- Managing and monitoring system utilization
- Providing member support

Large, coordinated delivery networks, such as ACOs, have demonstrated notable quality improvement and cost-savings potential (Figure

6). California must keep pace with the federal government's lead and invest in strengthening its hospital-physician linkages and improving coordination in order to reap these tangible benefits for patients and the system. With their resources, capacity, track record and unique community role, community DSH hospitals and their partners require investment to transform into ACOs. This will improve quality and access to care, enable the state to successfully implement the tenets of PPACA and better position safety net communities to draw down federal demonstration funds.

Figure 6: Higher Health Care Quality and Bigger Savings Found at Large Multispecialty Medical Groups

Health Affairs, May 2010

- Compared against small group practices, large, coordinated specialty groups achieve:
 - **5% to 15%** more improvement in quality of care
 - **3.6% (\$272)** lower annual cost per patient
- **\$15 billion** annual savings could potentially be gained if model and performance can be broadly adopted

2. Strengthening and investing in enhanced primary care capacity and coordination by maximizing current hospital resources

The recently passed federal health reform legislation strongly endorses the establishment of medical homes. Given the requirements and expectations laid out, very few primary care providers would be able to operate as medical homes. At the same time, as health reform will essentially match Medicaid primary care rates with those of Medicare, more physicians will be better incentivized to care for Medi-Cal patients. The state's goal to enroll the SPD population into patient centered managed care and medical home programs coupled with the expanded coverage of patients under health reform will create a significant influx of new beneficiaries into current safety net systems. The state must invest in strategies that strengthen the collaboration among the state, private and public health systems, clinics, physician groups and other community health provider stakeholders in order to enhance current primary, specialty and community-based care resources to meet the increase in demand for services.

Through American Recovery and Reinvestment Act (ARRA) and the PPACA, hospitals have been called out to advance the use of health information technology through information technology infrastructure investments for their physicians. Community DSH hospitals are well positioned to build upon these existing resources and efforts, leveraging long-standing relationships with community physician partners to facilitate the implementation of coordinated



delivery frameworks. These frameworks, supported by tools such as health information exchanges and e-consults, will maximize the integration and collaboration between hospital and community providers. With proper investment and support from the state, community DSH hospitals and their partners represent willing and able change agents that can lead the state's effort to develop approaches to support the safety net system transition to more organized and accountable delivery systems.⁸

3. Establishing early success with first-adopters

In developing a strategy to fundamentally change widespread and deep-rooted systemic inefficiencies, gaps and fragmentation in the health care delivery system for fee-for-service Medi-Cal patients, an incremental approach that maximizes available resources will yield the best results. Early successes within communities most ready for change will help drive the success and expansion of delivery system transformation efforts that achieve measurable improvements in quality of care and cost efficiency.

Through a survey of our member hospitals, PEACH was able to gauge the current interest, vision and activities as related to achieving delivery system integration and coordination. Survey results revealed that the majority of member hospitals are motivated and ready to use this window of opportunity to take the appropriate steps to move towards integration and coordination. Sixty percent of respondents indicated that they have either already begun implementing or have conducted feasibility assessments and/or planning around integration and coordination. Many have initiated dialogue or established partnerships with local clinics, physicians, independent physician associations, and medical groups around the movement towards integration and coordination.

Responding to new regulatory environments, market changes and a desire to institutionalize best practices, two-thirds of survey respondents have either initiated or have plans within the next two years to initiate infrastructure development for integration and coordination. These efforts include, but are not limited to: 1) Enhancing Health Information Technology and Information Exchange; 2) Care Coordination Programs; 3) Hospital-Physician Alignment; and 4) Performance Management and Adoption of Best Practices.

These results are indicative of the motivation and commitment that community DSH hospitals and their partners have for initiating change. By investing in these systems, the state can accelerate their progress and maximize the impact that these investments can have in terms of transforming California's health care delivery system, especially for its most vulnerable patient populations. The establishment of community-based coordinated delivery networks will:

1. Provide more coordinated, cost-efficient and higher quality health care services to both the Medicare and Medi-Cal beneficiaries
2. Position California to maximize the amount of federal demonstration and pilot dollars it can draw down through its hospital systems
3. Ensure success under federal health care reform.

⁸ Department of Managed Health Care. *California Section 1115 Comprehensive Waiver Demonstration Project: Implementation Plan*. May 2010.



III. Proposal to Enhance Integration and Coordination: What Community DSH Hospitals and Their Partners Need

A. Investment in the Transformation of Delivery Systems:

Reimbursement rates for Medi-Cal and Medicare do not cover actual costs. Annually, community DSH hospitals incur \$300 million in uncompensated Medi-Cal costs alone. This, coupled with the large devotion of charity care for uninsured patients (over \$400 million), causes most community DSH hospitals to lose money on operations and stay only marginally viable. These hospitals require upfront investment to successfully partner with their physicians, clinics and other community providers to create integrated, coordinated and sustainable delivery systems. These systems will enhance care and improve the ability to manage the populations served by the respective private DSH hospital communities. Specifically, flexible development money is required to enable private community DSH hospitals to:

1. Implement customized tools, such as electronic medical records, health information exchanges and e-consults
2. Develop hospital-physician alignment systems, such as hospital linked medical home groups, foundations, joint ventures with physicians and other partners, and/or Physician Hospital Organization structures

This new infrastructure will strengthen linkages between the hospital and community providers and expand the capacity to effectively care for the anticipated influx of Medicare and Medi-Cal patients under federal health reform.

1. Investment approach

We propose two methods through which investments can be distributed:

Method 1 – Competitive grants for community DSH hospitals

Funding models could be patterned on the Health Care Coverage Initiative, where funds for integration and coordination would be distributed through a competitive Request for Proposal (RFP) process. Alternatively, funds could be allocated through a negotiation process in the same manner that supplemental funds are currently awarded to private safety net hospitals through the California Medical Assistance Commission (CMAC). These awards can effectively be looked at as structured, phased-in infrastructure investments for delivery system redesign in California over four years.

Taking into consideration the health reform objectives, demonstration project requirements and the state's wavier implementation plan, integration and coordination investments can be broadly broken into three phases:

Phase I – Stakeholder alignment and basic core infrastructures

At its most fundamental level, coordination requires the engagement and alignment of internal hospital leadership and staff with community partners, namely physicians, medical groups, clinics, etc that can serve as medical homes. Referral systems and secure health information exchange capabilities need to be in place to ensure appropriate care transitions and coordination between different care settings for all patients, especially low income, special needs and medically vulnerable populations.



Phase II – Further adoption and dissemination of best practices and integrative technology

The second phase of integration and coordination more fully leverages health information technology through widespread adoption of Electronic Medical Records, E-consult and Clinical IT tools to support enhanced quality and efficiency. The integration of research and teaching within a community-based, coordinated care delivery network promotes rapid adoption of evidence-based practices.

Phase III – Formalization of risk-sharing models and legal frameworks

At the final phase of integration and coordination, hospitals and their partners have formal legal and financial frameworks in place that appropriately align financial incentives with performance, outcomes and quality.

The advantages to applying this funding method are as follows:

- State funds systems that care for the highest volumes of Medi-Cal and uninsured patients thus ensuring the greatest value in care improvements, continuity of care for existing patients and readiness for expanded Medi-Cal populations
- State ensures that it funds those systems most qualified and ready to implement change
- State can define guidelines that ensure pilots and demonstration projects align with larger state and health reform delivery system redesign goals
- State can stagger awards to promote sharing of lessons-learned between organizations and allow those communities most ready to be first-adopters to proceed, while communities less advanced in their planning have time to further prepare

While the state should be integrally involved in the development of the formal RFP process, we recommend that the Local Initiative health plans, where they exist, be tasked with screening proposals, selecting qualified programs, managing the distribution of funds and assessing the success of funded projects. Local Initiatives have extensive and direct experience dealing with the delivery systems and communities in which change will occur, and have the added benefit of being able to leverage current contractual relationships and future contracting capabilities with various provider entities. Further, with access to a large breadth of beneficiary data, they can more effectively measure and drive program improvement. For these reasons, we believe that Local Initiatives are best positioned to administer and manage the RFP process.

Method 2 – Add-on supplemental payments, initially focusing on community DSH hospitals

In addition to the RFP process, the state should parallel its innovation investment with efforts to ensure fundamental provisions and minimal standards for coordination are in place across all health delivery systems. Institutions and communities are at different stages and levels of integration and coordination. Add-on supplemental payments will be critical in ensuring that these institutions and communities will have the capacity to meet heightened demands caused by the influx of Medicaid and Medicare patients into the system.

The state should vet care coordination models and support, financially and operationally, the implementation of practical care coordination standards across the state. To better ensure the implementation and adoption of proven, practical models that provide a sufficient level of coordination within the system, the state should implement a process that will allocate add-on supplemental payments based on a delivery system's ability to meet a standard set of coordination criteria.



Community DSH hospitals possess the infrastructure, established community partnerships and experience in working with key state and local health care stakeholders and should be the initial focus of supplemental funds to support care coordination. Since the private safety net already provides high volumes of care, it stands to make a large impact on achieving enhanced care coordination for low income, special needs and medically vulnerable populations. As criteria evolve over time and minimal standards are continually raised, community DSH hospitals are primed to drive improvements for the safety net across the state.

B. Predictable and Stable Funding

The current waiver guarantees public hospitals baseline funding levels as well as stabilization funds payable through the Safety Net Care Pool. California's community DSH hospitals spend more than \$730 million annually in unreimbursed costs to treat Medi-Cal and uninsured patients.⁹ The 2010 waiver must provide assurances for a viable safety net over the next five years and these unreimbursed costs must be reduced. As previously noted, guaranteed baseline payments, payment growth and funding equity between the public and the private DSH hospitals over the term of the waiver have been the hallmark of California's hospital finance waivers for nearly twenty years. Given the interconnectedness of California's hospital safety net, it is essential that provisions be included in the Terms and Conditions of the waiver and/or implementing legislation that ensure private safety net hospitals have predictable and stable funding that is comparable to their public counterparts. Financial stabilization for community DSH hospitals should be achieved through: 1) Annual growth in supplemental and DSH payments for community DSH hospitals at least at the rate of their cost increases and commensurate with public hospitals; and 2) Continuation of stabilization payments, but modified to provide equitable apportionment between the public and private pools.

IV. The Value of Integrated and Coordinated Systems Anchored by Community DSH Hospitals and Their Partners

Community DSH hospitals, and the physicians and clinics that partner with them, are located in the communities where safety net patients and families live. Investing in the enhancement of these delivery systems will consequently improve access to care and opportunities for local coordination of care. Through the use of telemedicine and concerted efforts to decentralize diagnostics, these integrated and coordinated delivery systems can leverage the emergency, acute care and specialty resources offered through the community DSH hospitals that anchor them. Further, they will be capable of interfacing and coordinating with other systems and networks, such as public systems. The strengthened relationship and connectivity between hospitals and community providers will improve overall coordination, quality and efficiency of care.

Community DSH hospitals and their physician partners are experienced in serving all patients, Medi-Cal, Medicare, privately insured and self-pay alike. The investments highlighted above are intentionally structured to improve overall system efficiency and enhance the capacity to coordinate care for all patients. For example, add-on payments to fund evidence-based care coordination systems will better enable hospital providers to respond to the needs of the Medicare population. In 2013, all hospitals will be penalized through Medicare payment

⁹ Private Safety Net Hospital CY2006 – CY2008 Shortfall Report. April 24, 2010.



reductions for the first set of three diagnosis-related group (DRG) readmissions, with an additional set of three or more DRGs set to be implemented in 2014. The selected conditions will likely be those that stand to benefit most from the fundamental care coordination standards described above for low income, special needs and medically vulnerable populations.

For existing patients, the state's investment in establishing medical homes and stabilizing the private safety net will help preserve their freedom to choose providers, maintain continuity of care and experience higher quality, more appropriate levels of care in the right setting. As newly eligible Medi-Cal beneficiaries authorized through federal health care reform enter the system, they will similarly have access to and benefit from the strengthened infrastructures of more coordinated private safety net systems.

Figure 7: Shifting Paradigms of Care - Value of Investing in Integrated and Coordinated Delivery Systems:

- Preservation of patient choice and access to coordinated, cost-efficient and higher quality health care services
- More responsive, patient-centered delivery system
- Optimized use of existing community relationships and resources
- Maximized potential to draw down federal funds
- Success under federal health care reform.

V. Financing the Vision

There are a number of alternative sources of federal funds and matching state funds that should be sought to support private safety net hospital integration and stabilization, including:

- *Federal savings resulting from the enrollment of the SPD population into managed care*
Estimates are that premiums paid to managed care organizations will generate a 5 percent savings to the state general fund from current FFS expenditure levels. The federal government will achieve the same level of savings if the Federal Medical Assistance Percentages (FMAP) reverts to the 50 percent level, but the state savings would be greater if a higher FMAP is enacted. Statewide, private safety net hospitals provide 38 percent of all inpatient days of care provided to the SPD population. If the state preserves patients' ability to remain with their existing provider, these hospitals will retain a similar share of the patient population in managed care enrollment. The portion of the federal savings that results from the management of these patients by private hospitals should be reinvested in the development of integrated and coordinated delivery systems to provide cost effective services with improved outcomes and accessibility.
- *Room under the private safety net inpatient and outpatient upper payment limits (UPL)*
The Upper Payment Limit (UPL) rule caps Medicaid payments to specific groups of providers at current Medicare payment rates. Since the UPL is linked to Medicare rates, states receive additional federal funding for the amount under the UPL ceiling by making supplemental payments to hospitals beyond regular Medicaid. This usually involves a provider tax arrangement and/or intergovernmental transfers (IGT) of funds from county or municipal governments to state governments. Increased payments could be made to private safety net hospitals using a part of the UPL. The extent of available room will depend upon a number of variables, including room that may have been reserved for Medi-Cal rate increases, supplemental funding increases and any payments under IGT and provider fee programs.



- *Sources of State match to draw federal financial participation*

Private DSH hospitals are slated to receive hundreds of millions in stabilization funding during the current waiver with the state match derived from creative sources of financing. The state has reached a tentative agreement to draw down an additional \$784 million (including ARRA funding) of unexpended federal funds in the current waiver using the same approaches. In total, the state and private hospitals will benefit from over \$1 billion in funds. These funds can be used to provide the framework for enhanced payments to support the private safety net in the transformation of their delivery systems.

Specifically, there is an opportunity to create state general fund savings by utilizing federal funding available in a Safety Net Care Pool, or another federal funding pool, to pay for state funded indigent care services. Existing IGT programs may also be expanded to draw federal funds to make payments to private hospitals. For example, counties have established programs to which they contribute IGTs to provide private safety net hospitals with supplemental and trauma related funding. These programs could be expanded to provide the state match to draw federal funds under the private UPL or as part of a sharing of federal savings for enrolling the SPD population in managed care.

- *Redefine Certified Public Expenditures (CPE)*

With regards to CPEs, there is an opportunity for the state to rework CPE definitions and classifications and these revisions are currently under discussion with respect to the \$784 million of unexpended funding in the current waiver. Specifically, county work and investment previously not considered in CPE calculations may be included to enhance federal match rates. These unaccounted investments include, but are not limited to, the major financial outlays made to enable hospitals to comply with seismic regulations. The state could also use CPEs to draw federal funding for investments to create programs that integrate the public and private safety net. Increasing these baseline calculations represent a way in which the waiver can work towards budget neutrality.

- *Giving fair weight to both public and private expenditures in Medicaid matching*

While expenditures by public hospitals can be matched as CPEs, there are several restrictions on what uncompensated care expenditures at private hospitals can be matched. Both public and private hospitals serve the safety net and both hospital systems are helping county governments meet their legal obligation under the law to care for the uninsured. To create better balance in the system, private DSH hospital expenditures on uncompensated care and infrastructure activities, such as seismic retrofitting, should be eligible for match. The state should engage the federal government in negotiating this point. At a minimum, such expenditures should be included in the state's budget neutrality calculation in the "without-waiver baseline."



VI. Conclusion

California's 2010 Medi-Cal waiver represents an opportunity for state policymakers to fundamentally transform care delivery and help California reemerge as a market leader in the post reform environment. In the face of an increasingly complex and competitive health care environment, the state will benefit most by investing in systems and communities that are most ready for and in need of change.

Community DSH hospitals and their partners provide a critical capacity of service for the state's most vulnerable populations and are primed to take the lead in locally affecting delivery system transformation. Through such efforts as the Health Care Coverage Initiative, California has accomplished notable successes in its efforts to redesign and enhance public safety net delivery systems. This new waiver is an opportunity for the state to build upon and extend these accomplishments to the private safety net by incentivizing the creation of community-based and patient-centered coordinated networks of care. By leveraging existing hospital-physician relationships and the unique position of private safety net hospitals, California will be able to more quickly realize and permanently sustain more cost-effective, integrated and coordinated delivery networks.

The investments and strategies laid out in this paper represent a way California can optimize the unique position and existing resources of community DSH hospitals and their partners to strengthen the entire safety net and improve the overall coordination and efficiency of the health care delivery system. The waiver is the vehicle to achieve this and all available matching sources to draw down the maximum federal share should be used. For the state's low income, special needs and most medically vulnerable populations, this effort will preserve patient choice and access to quality, financially sustainable care.



Appendix A – Glossary of Terms

DSH Hospital – Any hospital that receives federal/state DSH payments. In general, the hospital must serve a higher than average number of Medicaid beneficiaries, and have a low-income utilization rate of 25 percent or more. Of the approximately 600 public and private hospitals in California, 147 receive DSH funds each year.

Federal Medical Assistance Percentage (FMAP) – The federal matching rate paid to states for the operation of Medicaid programs. The FMAP is determined annually using a formula that compares the state's average per capita income level with the national average income level. FMAPs range from 50 percent in the wealthier states (e.g. Maryland, Minnesota, California and New York) to 77 percent in the poorest state (Mississippi).

Upper Payment Limit (UPL) – Under federal law and regulation, state Medicaid payments to hospitals, nursing facilities and other institutional providers are subject to aggregate limits known as upper payment limits (UPLs). The UPL is set at the estimated amount all of the hospitals would receive for treating Medicaid patients if they were paid at Medicare rates, with some adjustments. For inpatient hospital services, there are three UPLs: one for state-operated hospitals, one for county or local government hospitals, and one for private hospitals.

Certified Public Expenditure (CPE) – Costs that a public health care provider certifies it has incurred in furnishing covered services to Medicaid beneficiaries. The federal Medicaid statute and regulations allow the use of CPEs as the non-federal share of Medicaid matching funds. Statutory authority for CPEs is the same as Intergovernmental Transfers (IGTs).

Inter-governmental Transfer (IGT) – Transfers of public funds from one level of government to another (such as from county to state government) or from one agency to another (such as from a state university teaching hospital to a state Medicaid program) to be used as the “non-federal share” for purposes of accessing federal Medicaid matching funds. Federal Medicaid statute and regulations allow the use of IGTs as the state share for Medicaid matching purposes, provided the local funds do not exceed 60 percent of the total.

Safety Net Care Pool (SNCP) – Designated pool of federal matching funds for the costs of treating the uninsured at facilities other than DSH hospitals, or for paying unreimbursed costs of treating Medicaid patients. The Center for Medicare & Medicaid Services (CMS) has made creation of a spending pool a condition of approval of California's waiver. The state has broad discretion in designing the use of SNCP funds. However, funds are not released to the state unless it can match SNCP funds with funds from a CMS approved source, such as CPEs. The amount of federal funds available to the state through the SNCP is capped at the same level for the duration of the waiver (5 years in the case of California), regardless of increases in the number of uninsured or increases in health care costs.

Health Care Coverage Initiative (HCCI) – The HCCI was created under the current section 1115 Demonstration Waiver to provide coverage to medically indigent adults who are not otherwise eligible for Medi-Cal. The HCCI currently operates in ten counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, Ventura Counties.

For more information on these terms and their definitions, please see: Jennifer Ryan and Peter Harbage, “Medi-Cal Hospital Waiver Key Terms,” California Health Care Foundation. August 2005, available at <http://www.cahpf.org/doc.asp?id=143>