

California Medi-Cal Waiver Options

Draft

About the Paper

This paper has been developed as technical assistance to the State of California. As such, it presents a range of options on different paths that could be taken by the state in a waiver request to the federal government. The paper makes no recommendations. Rather, this paper was developed with the understanding that it will be used as the beginning of a process with stakeholders to discuss waiver options. As part of this public process, the concepts presented here were previously presented by the consulting team at a three-hour public event sponsored by the California Senate Office of Research in early June 2009. While the paper is an initial step in waiver development, it is worth noting that the language can still be highly technical and is designed for audiences with background in health care policy and financing.

About Harbage Consulting

Harbage Consulting is an independent health policy consultancy. Peter Harbage, President of Harbage Consulting, has more than a decade of experience working to improve health policy at the federal, state and local level. Working almost exclusively with government agencies and non-profit foundations, Harbage Consulting has published extensively on health reform concepts, the public financing of health care, Medicaid and California-specific health policy issues. Hilary Haycock has held senior communications positions dealing extensively with health care issues. She is currently a graduate student studying health policy at Georgetown University and holds an undergraduate degree with high honors from the University of California at Berkeley.

About Health Management Associates

Health Management Associates is an independent national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, investors, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors. Theresa Sachs is a nationally known expert on design and financing of Medicaid and SCHIP waiver programs with more than 20 years experience in health care. Jim Frizzera worked at CMS (formerly HCFA) for the last twenty years; most recently and is a national expert on Medicaid reimbursement and state financing. Stan Rosenstein has 31 years experience with government health care programs, with the emphasis on Medicaid and was the long time California Medicaid Director with over 13 years as the Medicaid Director or Deputy Medicaid Director and over 21 years as an executive appointee with the State of California.

About the Blue Shield of California Foundation

Blue Shield of California Foundation is committed to making health care effective, safe, and accessible for all Californians, and to ending domestic violence. The Foundation blends community-based philanthropy with strategic innovation to move our state forward. As one of California's largest health philanthropies, the Foundation serves as a catalyst for change, promoting new solutions and bringing together a diverse array of stakeholders.

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Introduction

The purpose of this paper is to discuss possible reform strategies for a comprehensive waiver for California against the backdrop of federal reform priorities. Although the Obama Administration and Congress are continuing to work on reform legislation, already there are indications of where the federal government may be heading in terms of future public policy around publicly-funded health programs.

The paper discusses several different reform approaches, pieces of which the state can select to create a comprehensive approach. Those approaches are organized in terms of building the budget neutrality case that is needed in order to have an approvable Section 1115 waiver.

A significant infusion of federal dollars will be necessary to implement many of the reforms outlined in this paper. In order to provide a “budget neutral” framework for this investment, California must identify federal savings. Given the extremely low baseline that is the hallmark of California’s Medicaid program, some creativity on the parts of both the state and federal governments will be in order. With California’s low per enrollee expenditures and relatively low disproportionate share hospital allotment, it is highly unlikely that sufficient federal funds can be obtained through changes in the program to pay for the cost of covering and caring for childless adults in California. Thus to be fully successful in covering more people, the waiver will require that the federal government give California credit for savings already achieved and provide the state with relatively generous trend rates.

As is illustrated in this paper, California can make an argument that it is reasonable to allow the state to “capture” savings from initiatives –like managed care and fraud and abuse-- that other states implemented through waivers. Treating California as if it had taken the same course as other states would go a long way toward putting the state on equal footing in terms of the capability to finance a significant eligibility expansion. These arguments would be combined with some ideas on financing reform and flexibility that, when taken together, would help in generating savings for the budget neutrality calculation.

Of course, it is not unreasonable to expect the federal government to resist granting such flexibility to California without the state committing to a number of health system reforms, possibly including the following:

- *Service Delivery Reforms* to improve access to the right care in the right setting such as population-based collaborative networks, medical homes, and better care management for individuals eligible for both Medicare and Medicaid (dual eligibles);
- *Quality Improvement Reforms* such as improving care and reducing costs for both Medi-Cal and non-Medi-Cal beneficiaries, and reducing medical errors, never events, and readmissions; and

- *Infrastructure Reforms* such as addressing workforce shortages, health information technology, and e-prescribing.

It is important to note that some of these initiatives may generate cost savings while others may be cost neutral. Most, if not all, require some up-front investment. All are included because of our belief that in one regard or another, they respond to what can reasonably be believed to be the federal government's priorities for health reform. Moreover, these ideas are designed to fit seamlessly together in the context of California's efforts to realign the financial and programmatic incentives in Medi-Cal to promote the delivery of high quality health care in the most efficient delivery system possible.

It is also important to note that although these ideas, particularly around quality, are discussed in the generic Medi-Cal context, it is possible to apply these concepts across systems and populations, including developmental disabilities, behavioral health, and California Children's Services. As stakeholders discuss and refine these ideas, it will be helpful to California policymakers if some consideration can be given to the advantages and disadvantages of the various approaches, and their specific applicability, to the full range of programs.

As the state approaches this waiver, there are several underlying issues in Medi-Cal that could be addressed in a comprehensive waiver.

- *Realigning Provider Payments.* The State should review its overall rate and payment system. The current structure makes access to lower cost services more difficult and instead relies upon providing care in higher cost settings. For example, rate increases are available to hospitals for inpatient services through a negotiated process, but outpatient rates are not negotiated and have historically been frozen or reduced. These incentives should be reversed.
- *Integrating Care Across Programs.* The State should review how care is provided based upon categorical funding. Fragmented funding streams make it very difficult to integrate health care services, mental health, and alcohol and drug treatment. As discussed later, a large percentage of high cost Medi-Cal members have chronic health conditions and mental health diagnoses and could benefit from better integrated care.
- *Identifying New Funding.* The State appears to lack funding to pay for the cost of improving access to care in Medi-Cal or any eligibility expansion. These changes will cost hundreds of millions in new annual spending. The State should ensure that the current ban on establishing a hospital and physician fee is removed from the waiver and these sources of non-federal share are considered an option. Other potential sources of non-federal share include any unmatched state, county or University of California funding. Ways to partner with the counties, as has occurred in the coverage initiative, may create ways to use these funds to accomplish the goals of the waiver.

- *Investing Time and Resources.* Major reform takes time and effort. Current reform initiatives such as the expansion of managed care, creation of managed care performance standards for seniors and people with disabilities, and implementation of disease and chronic care management have taken longer to implement than anticipated. The state must be prepared to dedicate additional administrative resources to the implementation of the waiver, given the existing Medi-Cal work load.

The final underlying context for this paper is the unknown structure and nature of national health care reform. National health reform could fundamentally change California's responsibilities in the Medicaid program and impact the waiver in any number of ways from requiring coverage expansions for childless adults, and potentially doing so with 100 percent federal funds for eligibility expansions or quality improvements occurring after health care reform is adopted, to requiring maintenance of effort contributions.

Please note, there is a companion piece to this paper outlining waivers obtained by other states which may serve as a useful reference for policymakers in deciding how to structure a waiver for California.

Waiver Background

Under authority granted by Section 1115 of the Social Security Act (the Act), the Centers for Medicare and Medicaid Services (CMS) has broad latitude to permit states to pursue a range of program changes. Waivers can encompass a relatively small portion of a state's Medicaid program (e.g. a disease specific intervention or a family planning program) or the entire program including long-term care and the disproportionate share hospital (DSH) program. While some important aspects of the program cannot be waived, there are many options in between these two ends of the spectrum.

In order to better understand the options available to California, it is important to have a working vocabulary of key concepts:¹

- *Special Terms and Conditions*: Each waiver is an agreement between the federal government and a state. The specifications of the agreement are clearly laid out, much like a contract.
- *Budget Neutrality*: Generally waiver agreements state that the waiver's costs over the five-year approval period cannot exceed an estimate of how much the Medicaid program would have spent in absence of the waiver. In technical terms, the "with-waiver" cost to the federal government cannot exceed the "without-waiver" cost projection over five years. There are some waivers, such as California's hospital and uninsured waiver that set budget neutrality at a flat dollar amount. The concept of budget neutrality is not codified in statute or regulation, giving the federal government discretion. In general, the without-waiver ceiling can only include program elements that would otherwise be allowable under the Medicaid statute; this has to be balanced against the with-waiver expenditures including new elements such as services provided or coverage of childless adults.² Budget neutrality can be expressed in terms of an aggregate cap or a per capita cap.
- *Costs Not Otherwise Matchable (CNOM)*: Granted by Section 1115(a)(2) of the Act, CMS may approve the expenditure of federal funds for services that would not normally qualify as Medicaid expenditures. Examples of CNOM authority include the coverage of nondisabled adults without dependent children or the use of federal funds to offset state or local health care expenditures.
- *Aggregate Cap/Block Grant*: This refers to situations where the five-year budget neutrality cap is a pre-determined amount that is not subject to change even if there are extraordinary circumstances such as a downturn in the economy that drives up Medicaid enrollment.

¹ This memo is intended to provide a high-level overview; for more detailed materials please refer to www.caworkingcommittee.org. This website is a repository of instructional and analytical materials that were developed for the Working Committee on Waiver Development and Medi-Cal Expansion in 2007 and 2008.

² The cost of childless adults cannot be included in formulating the without-waiver spending ceiling because states are not permitted to cover this group under the Medicaid statute without a waiver.

- *Per Capita Cap*: Under a per capita cap, the state and CMS agree to certain budget parameters such as a per-member-per-month cost and an inflation factor, but the actual spending ceiling takes into consideration the actual enrollment in the program.
- *Other Financing Methods*: In addition to the budget neutrality requirement, another way of describing the financing of a Section 1115 waiver is how the state will raise the required non-federal share of the projected expenditures. The Medicaid program provides some tools for increasing the state funds available, such as through a tax or fee on providers.

Range of Options

The purpose of this section is to briefly describe some possibilities for waiver structure within the potential range of waiver options.

Narrow Approach – Specialized Coverage

At one end of the spectrum is a narrow program that covers a specialized portion of Medicaid. One example of such a waiver is California’s Family PACT waiver, which provides family planning services to individuals not eligible for traditional Medicaid in an effort to prevent Medicaid funded births. Another is a waiver program that enables participants in need of long term care to hire and direct their own assistance providers with a cash allowance (the so-called “cash and counseling” waivers).

Moderate Approach - Managed Care Savings

A Section 1115 program can also cover a larger population (e.g., families and children, or the Aged, Blind and Disabled (ABD) population) for the purpose of enrolling them in mandatory managed care arrangements and using the program savings for other purposes, such as eligibility expansions. In the early 1990s these waivers were popular because few states had ventured into managed care for Medicaid, and there were significant savings to be accrued. Many of these waivers involved families and children and fewer covered the ABD population.

Need-Specific Approach – Single Policy Change

Similarly, the design of a Section 1115 waiver is driven by a very specific policy need, either on behalf of the state or of the Federal government. An example of this is California’s 2005 hospital waiver, which accomplished the federal goal of converting the state’s method of financing the non-federal share of inpatient hospital expenditures from an intergovernmental transfer (IGT) approach to certification of public expenditures (CPE).

Comprehensive Approach – Program-Wide

At the opposite end of the spectrum from a specialized waiver, a state could conceivably put its entire program into a Section 1115 waiver. Including the entire Medicaid program, with DSH, in Section 1115 waivers is one way states have covered the uninsured. Arizona’s entire Medicaid program, including long term care, operates under Section 1115 waiver authority.

Key Factors to Consider

The broad discretion allowed under Section 1115 waivers will allow California to consider a range of options in designing a program that accommodates the state's needs.

Responding to Geographic Diversity

For example, there is great geographic diversity in California's health care markets. Because CMS can waive the requirement that the Medicaid program be operated the same manner in all areas of the state, California's counties could have different service delivery designs. CMS has been somewhat reluctant to entertain proposals that expand eligibility only in certain areas of the state, but this also is within the realm of possibility. The coverage initiative element of the existing California hospital waiver creates a possible precedent for this approach.

Choosing Size and Scope of the Waiver

It follows logically that the more of a state's program is under the Section 1115 waiver, the bigger the base upon which to build the budget neutrality model. A \$10 billion Medicaid program that generates 2 percent savings under a waiver can yield "savings" of \$200 million, which could then be spent on a coverage expansion to childless adults. If the state only puts \$1 billion of its program under the Section 1115 waiver, the opportunity to accrue significant savings is much less. Of course, the potential payoff has to be balanced with the potential risk. Unforeseen events and projection errors can result in the costs of the waiver being higher than the negotiated budget neutrality limit. The up-front protections against this include an aggressive negotiating posture that secures the best terms possible for the state. If the waiver is implemented and it appears the budget neutrality limit may be exceeded, the state can always seek to renegotiate the terms, take actions to contain costs, or terminate the waiver.

In determining which program elements to include in their waiver, states often stay away from including long term care or the ABD population. However, under the right conditions and with proper management, including these populations under a waiver could generate tremendous savings because so much of a state's Medicaid spending is concentrated in these individuals and the services they receive.

Limitations to Waivers

Although CMS does have broad latitude to waive any provision in Section 1902, and to grant CNOM authority for items that would not normally be matchable under Section 1903, there are limits. CMS has chosen not to waive certain provisions in the interest of furthering its policy objectives. Other provisions, such as funding for nonqualified immigrants or the federal matching rate (FMAP), are specified as not subject to waiver authority.

Opting to Roll Waivers Together

Given that California already has multiple Section 1115 waivers, it is important to point out that having more than one waiver can be complicated and actually disadvantage the state. CMS typically prefers to consolidate waivers, particularly if there is a chance of double-counting budget neutrality savings. This was a small risk under California's current waivers, which only cover hospital services, personal care

services, and family planning. If California develops a more comprehensive waiver proposal, CMS will likely insist that the hospital waiver be merged with the new program. The waiver will also have to address that portion of the family planning waiver population who are income eligible under the new waiver to avoid duplicate coverage. The benefits and disadvantages of this will have to be explored.

Capitalizing on Past Success – Not Being Penalized For It

Toward the end of securing favorable terms for budget neutrality, there are several options that could be customized to California's situation. First, the waiver baseline must be considered. California has a low baseline because of low provider payments, other cost savings initiatives, and also because of existing managed care initiatives. One strategy would be to negotiate an inflated waiver baseline that reflects a more typical state's baseline. This would in effect allow California to benefit from the fact that it has historically held costs low. Another negotiation strategy is around the trend rate, which is the inflation factor that is a component of calculating the waiver ceiling from year to year. California could ask for a trend rate that increases at a level higher than the national spending projections based on the fact that a low cost state cannot hold costs down forever. At a minimum California should ask to get the national inflation rates, not its own relatively low Medicaid inflation history.

1. Eligibility Reform Option

Under federal health care reform, it is possible that the administration will propose that Medicaid (or a similar public program) serve as the means to cover all citizens, nationals, and immigrants with satisfactory immigration status whose income is below the federal poverty level. If such a proposal is advanced, it is likely there would be a maintenance of effort requirement. Some states could be required to provide coverage to populations that they do not currently cover under Medicaid, and states that have already expanded eligibility could be required to maintain those expansions. This expansion could include Medicaid coverage for childless adults.

There are many unknowns associated with health reform at the federal level, including the degree of flexibility states will have in defining income and resource standards, as well as benefit packages, under Medicaid moving forward. Further, it is unclear how the funding split between the federal and state governments will work and how current non-federal funding for this coverage will be considered. The key implication for California and other states considering implementing reforms through a waiver vehicle is that many proposal elements could render waivers unnecessary as many of the waiver expansions could presumably be done under a new Medicaid state plan amendment. Furthermore, it is not known how waivers will factor into any maintenance of effort requirements. For example, under the SCHIP program, states were not allowed to reduce their children's coverage under Medicaid nor get SCHIP funding for any expansions that they had already enacted. Under federal welfare reform, states were prohibited from decreasing their eligibility for the Section 1931(b) program to levels below their 1996 coverage. Also unknown are what federal matching rates will be provided for any required expansions. It is possible, like in SCHIP reform, states will get their regular matching rates for what it covers now and an enhanced rate only for what is covered under the federal expansion.

It is important that California consider how it might align itself to the likely national health care reform, and how health reform might impact both the need and structure of a waiver for an expansion of eligibility. Since the funding ratios and maintenance of effort requirements are unknown, the state will not want to get into a situation where entering into the waiver is disadvantageous. For example, the waiver could provide that in the event of health care reform budget waiver neutrality and the type(s) of waiver spending would be revisited. Also the waiver could be designed that it would not affect any maintenance of effort requirements placed on the State.

It is possible that the nature of national health care reform will be much clearer by the time the State submits a waiver concept paper.

Current Status of California

Like many states, there are different eligibility levels for California's public coverage programs depending on upon the population "bucket" (or eligibility category) into which an individual fits. Medi-Cal currently covers families and children up to 100 percent of the federal poverty level, as well as seniors, persons with disabilities, some children, pregnant women, people with breast and cervical cancer at higher income levels. Further, the Healthy Families program, the Access for Infants and

Mothers (AIM), and the Family PACT program (funded under a separate Medicaid Section 1115 waiver) provide coverage at higher levels for children and pregnant woman.

California's current Section 1115 waiver provides federal matching funds for a number of programs serving childless adults who do not pass the federal disability test. The funded programs are associated with a number of previously state-only programs and services provided at designated public hospitals and clinics. Furthermore, the ten coverage initiatives enroll childless adults in coverage programs where they get enhanced services including a medical home.

There is no federal coverage for county indigent programs that are not associated with a public hospital or the coverage initiative.

Change Options

A Section 1115 waiver can be used to expand coverage for childless adults who are not otherwise categorically eligible for Medicaid. It would be very difficult to use this waiver to cover children who are only eligible for limited scope benefits due to their immigration status. The waiver would not be used for expanding income levels for children already eligible for Healthy Families.

The federal government has been flexible in how coverage for childless adults is provided and what benefits are provided. The state has significant flexibility in designing this program and benefits. This could include:

- *Direct Medi-Cal Expansion.* The state could expand eligibility through the existing Medicaid program, and provide childless adults either the same benefit package as existing beneficiaries, or a more limited package.
- *Privately Managed Coverage.* The state could provide services using a private vendor who would manage all services in similar fashion to the existing County Medical Services Program (CMSP), which provides benefits to medically indigent childless adults in the 32 smaller counties.
- *County-level Coverage Expansion.* The new Section 1115 waiver could expand the number of childless adults the existing ten coverage initiatives can serve and/or expand the number of coverage initiatives to provide coverage in more counties. An alternative would be to structure a county program for coverage in another manner, such as providing funding and allowing counties to opt into the program. The coverage does not have to be statewide; however, having differing programs between counties could lead to people moving between counties to obtain better health care coverage.

2. Service Delivery Reform Options

This section of the paper looks at a variety of changes that could be made in the waiver to address the need for the waiver to be a demonstration and to address the cost of the Medi-Cal program. These are options that can be considered to be done individually or in various combinations.

2-A. Restructuring Delivery Systems into Population-Based Collaborative Networks

As health care reform is contemplated at both the state and federal levels, it will be critical to look at new ways of *delivering* care, not simply new ways to *pay for it*. Increased coverage does not automatically equal increased access, particularly if care continues to be provided through the current delivery system. Creating population-based networks can address the inefficiencies in the current system, and help build capacity where it can be most effective. Public hospital systems, and even local governments, offer a vehicle as the hub of most local safety nets for beginning to look at community-specific delivery system reform, generating models that could be supported by federal and state reform efforts. Already, some counties are moving outside of the traditional public hospital focus into integrated systems of care that recognize the value of solid connections with ambulatory providers (primary and specialty care), the integration of behavioral and acute care, and the collaboration of multiple providers in meeting the needs of a defined population. These efforts could be supported and expanded under a waiver.

Current Status in California

California counties face a perfect storm of factors related to the delivery of health care services for underserved people:

- Counties are obligated through Section 17000 to assure access to health care services for the indigent populations under 200 percent of FPL (although this obligation is interpreted differently throughout the state);
- Some private providers are increasingly unwilling to provide care for the Medi-Cal population;
- Public hospitals and clinics are faced with the same increased cost as other providers; and
- Counties are increasingly burdened by the escalating reliance on local funding as the payer/provider of last resort for both the growth in the uninsured and what is perceived to be the inability of the state to adequately assure access for the Medi-Cal population.

Despite these challenges, local counties are beginning to develop innovative approaches to delivering care for the medically indigent. These initiatives, if supported, could become “laboratories” to determine cost-effective models to assure access as well as coverage. Some examples include:

- San Mateo County has restructured all of its county-funded health care programs (acute care, behavioral health, long-term care, etc.) into one entity to assure maximum integration of effort. The county also has facilitated the development of an innovative delivery system partnership—the “Community Health Network for the Underserved.” This includes the public system, private hospitals, medical groups and Federally Qualified Health Centers (FQHCs) to assure the full

scope of care for more than 100,000 Medi-Cal and uninsured residents of the county, with the Medi-Cal health plan providing management of all of the target patients.

- San Francisco has included both its public system and FQHCs and private hospitals in its Healthy San Francisco coverage initiative.
- Other communities are looking at restructuring approaches to assuring access to specialty services (a major gap in care for both the uninsured and Medi-Cal patients) or entering into partnerships in the operation of public hospitals (i.e., LA County's MLK).

Change Options

In order to create these new delivery models for underserved populations, counties need to go through a two-part redesign process: 1) becoming as lean and effective as possible within their own systems (whether they are direct service providers or payers); and, 2) reaching out to other providers serving their geographic area to construct networks that address the full continuum of care needed for a defined patient population.

In building these networks, the counties, or their health systems, can play an important role as honest brokers in bringing providers together to ensure access to the full scope of primary, specialty, diagnostic, inpatient, mental health and long term care services for the medically indigent. To be successful, networks also must:

- Allow all providers come to the table as equals with clear and predictable expectations of what is being asked of them in terms of providing specific services;
- Provide services in the most appropriate setting, where the investment in improving service delivery has been made and core competencies already established;
- Effectively manage patients to assure appropriate use of services; and
- Give providers credit and incentives for their participation.

Counties have shown that with an investment of time and dollars they can improve their delivery systems. This is being further shown in the current waiver coverage initiatives. The waiver could look at how to use a part of the waiver funding to improve the delivery of care in these large health care systems and how to restructure Medi-Cal reimbursement to change the program payment incentives. For example, these networks should be able to be reimbursed for their care management activities. This type of change in the waiver may be a critical component of receiving more federal funds for safety net hospitals.

Fiscal

System reform will require an upfront initial investment of funds that in the long term should reduce the cost of health care. Without action, more County Boards of Supervisors will be faced with the choice of whether to reduce or close public hospitals and clinics. Closures will further strain an already fragile safety net and increase state general fund cost. For example, shifts in patients from public hospitals to private hospitals will shift the non-federal share of the cost of care to the State and put even greater pressure for rate increases for these hospitals.

2-B. Restructuring the Medi-Cal Fee-for-Service Program and Providing a Medical Home

Medical homes are another innovative way of improving how care is delivered in the Medi-Cal program, particularly for the small number of beneficiaries with significant health care needs who account for a large proportion of costs. Across the nation, other state Medicaid programs also are reconsidering how they provide services to Medicaid's most chronically ill and disabled populations. Nationally, the 15 percent of Medicaid beneficiaries with more than \$5,000 in annual costs account for more than 75 percent of total Medicaid spending.³

Many states have approached the use of a full-risk capitation managed care model for seniors and people with disabilities (SPD) population with caution. While providers and advocates often are resistant to any form of full-risk managed care in Medicaid, this resistance is even greater with regard to proposals to move SPD populations into managed care. The leading concern among those with the responsibility for serving and protecting this most vulnerable population is the potential to limit access to vital and often expensive services.

Given the concerns over full-risk managed care for the SPD population, several states have worked to create innovative programs with a heavy emphasis on creation of a medical home, care management and disease management. These programs go beyond the traditional Primary Care Case Management (PCCM) model that many states have operated for years. For many states, seniors and persons with disabilities are seen as the most appropriate population for intensive care management, given that they are more likely to have a number of chronic conditions, to be involved with multiple state programs and to have high psychosocial needs.

The medical home approach provides enrollees with a source of usual care selected by the patient (e.g., large or small medical group, a single practitioner, a community health center, or hospital outpatient clinic). The medical home should function as the central point among all of the various team members, including the patient, family members, other caregivers, primary care providers, specialists, and other health care and non-clinical services as needed and desired by the patient. Patients receive care management plans and these medical homes work in conjunction with disease/care management programs and information systems.

These programs include various ways to provide additional reimbursement to providers to become a medical home and include managers to oversee and manage the program. The programs include performance measures and as HEDIS does not address care management, a number of states are developing their own performance measures. Some states include performance bonuses.

³ A. Sommers and M. Cohen, *Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?* Kaiser Commission on Medicaid and the Uninsured, March 2006.

Current Status in California

California reports that 10 percent of the Medi-Cal fee-for-service beneficiaries consume 76 percent of total fee-for-service dollars. Among seniors and persons with disabilities (SPD) enrolled in Medi-Cal, 68 percent have more than one chronic condition and 29 percent have a diagnosis for a mental health condition. Currently, almost half a million Medi-Cal SPD beneficiaries (not counting those who are dually eligible for Medicare) continue to receive services in the fee-for-service program. This represents over \$4.6 billion in state and federal spending on non-long term care services.⁴

In order to improve the health care of the fee-for-service population and to help reduce program costs, Medi-Cal operates or is in the process of implementing four care management programs.

1. *The Medical Care Management (MCM) program.* This longstanding program provides assistance by Department of Health Care Services (DHCS) nurses in managing the care of people who have had high cost hospital services. DHCS has had great difficulty in quantifying the benefits of this program.
2. *Two disease management programs.* The first focuses on six chronic health conditions and started in August, 2007. The second focuses on AIDS and was implemented in 2009.
3. *Two coordinated care management programs.* One program focuses on the chronically ill with severe health care conditions, such as those requiring end of life care, and the other program focuses on the chronically ill with a mental health diagnosis.
4. *Ten coverage initiatives.* With the funding provided in California's 2005 Section 1115 waiver, many of these coverage initiatives are now able to provide medical homes for their medically indigent patients who have chronic health conditions.

While these programs offer a lot of promise, none of these programs provide a medical home for the Medi-Cal SPD beneficiary population. Many of the coverage initiatives provide medical homes for the non-Medi-Cal medically indigent population. The first three programs listed above are dependent on enrollees being able to obtain access using the fee-for-service network and providers being willing to provide these services with reimbursement through Medi-Cal rates. Given current Medi-Cal physician reimbursement rates and the rising rate of the uninsured, it is very difficult for a fee-for-service provider to offer a medical home for Medi-Cal patients.

Change Options

DHCS has done considerable research into establishing of medical homes in the Medi-Cal program. To successfully establish medical homes for Medi-Cal beneficiaries, California would need to take two

⁴ Toby Douglas, Deputy Director, California Department of Health Care Services, "Managing the Care and Costs of High Cost Beneficiaries in Medi-Cal FFS," December 15, 2008 CHCF Conference presentation.

steps: Reform the Medi-Cal reimbursement structure and take steps to integrate medical homes into the service delivery system.

Reimbursement Reform Options: As a part of reforming the Medi-Cal reimbursement structure, California needs to make a significant investment in the program by providing additional reimbursement to providers who agree to become medical homes for this population. The state will also need to reform how it reimburses providers to assure beneficiaries have access to needed services. Some reimbursement reform options include:

- Increased reimbursement for primary care providers that could be provided either through rates or reimbursement for case management;
- Better integration of medical homes into FQHCs that could also include increased utilization of specialty care;
- Better utilization of public hospitals and clinics to apply the lessons learned from the coverage initiative to people on Medi-Cal;
- Integration of the mental health program with public hospitals and clinics and FQHCs to make mental health and alcohol and drug screening and treatment a component of medical care; and
- Improved access to specialty care. Participants would need assured access to these services. Increasing reimbursement rates for specialty providers, and perhaps targeting those located in underserved areas, could increase participation.

Expanded Service Reform Options: DHCS would need to work with vendors, local entities such as counties, or health plans to leverage their knowledge and resources to design and implement a medical home program. Any approach would have to build upon existing networks of providers and the safety net. A medical home program should include the following:

- Health information technology capacity to identify and stratify the covered population by risk, using predictive modeling and other tools to anticipate needs and target appropriate levels of intervention to match need;
- Disease management and care coordination for target sub-populations, across all co-morbid conditions including behavioral health, with in-person and other interventions;
- 24-hour toll-free access for beneficiaries to medical advice/nurse hotline;
- Consumer education to support informed self-management and outreach to encourage participation in care management;
- Assistance with, tracking, and follow-up on referrals to other medical or social support services and assistance in reducing rates of missed appointments;
- Communication with consumers, family caregivers and providers to facilitate more effective utilization of services and improved health outcomes;
- Provider education regarding evidence based practices, available services, and quality improvement strategies;
- Formal performance improvement process to systematically identify, address and measure areas for on-going quality improvement; and

- An electronic health record for providers and facilitated electronic information exchange among providers in the network and between primary care and specialty providers.

Fiscal

There is little question that the initial adoption of a medical home will require a financial investment in improving care for people with disabilities on Medi-Cal. This is particularly true as Medi-Cal starts with much lower provider payment rates than other states. However, the results in other states have shown overall budget neutrality or savings over the long term. While costs for ambulatory care and prescription drugs will go up, there should be reductions in emergency room cost and emergency room usage, as well as a reduction in preventable hospitalizations. DHCS data shows that an emergency room visit costs 2.5 times the cost of the same services in a physician's office. Given this cost comparison, there is room for savings in moving care out of the emergency room and into more appropriate, and lower-cost, settings.

2-C. Payment System Reforms to Encourage Ambulatory Not Inpatient Care

Controlling long term health care cost growth by better managing care and shifting care to lower cost settings is an important reform goal both nationally and in California. Medicaid programs often do not give providers the right incentives to achieve these goals. The best example is the Medicaid DSH program. Medicaid DSH is the lifeblood of the safety net hospitals, paying for both uncompensated cost for Medi-Cal patients and the uninsured. In California, the Medicaid DSH program pays 175 percent of uncompensated cost – but only for the uncompensated inpatient and outpatient services performed in a hospital. If a provider seeks to shift this treatment to a clinic or other lower cost setting, the DSH funding is lost. Often this DSH funding is not replaced by any other source of Medicaid funding. In California public clinics may recoup some of by funding through the safety net care pool, but this source of funding only pays approximately 82 percent of cost.

Current Status of California

Reimbursement under the Medi-Cal program creates incentives for care to be delivered in higher cost inpatient settings than in lower cost, non-institutional settings. Services often are reimbursed at a higher percentage of cost if they are delivered in a hospital setting. And as rates for lower cost outpatient care have been frozen or reduced, the only way that hospitals can get increased reimbursement from Medi-Cal is through rate increases for inpatient care. Further, Medi-Cal's per diem inpatient hospital payment system, one of a few in the nation, provides an incentive to keep hospital stays longer and reduces reimbursement to hospitals for providing new and innovative treatments that reduce lengths of stay. Thus, shifting care to a lower cost outpatient setting can threaten a hospital's financial stability.

Change Options

The current payment structure means that any waiver that seeks to shift care from inpatient to outpatient care will be confronted with the inadequacies of the payment structures for outpatient and clinic care. There are several ways that the waiver can address this:

- *Prospective Payment System Rates.* Medi-Cal could fund all public hospital outpatient departments and clinics as FQHCs with prospective payment system rates. This is currently done for five public hospitals. By setting reimbursement to federally allowable levels for outpatient services, shifting to outpatient care will be less costly for hospitals. This avoids the cumbersome nature of certified public expenditures and ensures an annual cost of living increase. Using an intergovernmental transfer to compensate for those costs the state does not pay can keep this option budget neutral to the state.
- *Modify DSH.* Seek a federal law change that allows DSH funding to be used to pay for county and University of California hospital systems costs for clinic and physician services. This would allow a shift of services to lower cost alternatives without a commensurate loss of funding. Note, the DSH funds available would still be limited given California’s relatively low DSH allotment proportionate to statewide uncompensated care.
- *Realign inpatient and outpatient hospital payments.* The Medi-Cal Reimbursement structure for inpatient and outpatient services should be realigned to create more rational incentives to deliver care in the appropriate setting, and provide a means to increase outpatient rates.

Fiscal

Payment reform will require an upfront initial investment of funds that in the long term should reduce the cost of health care. Increases to severely low institutional and non-institutional payment rates can be funded through an expanded application of the existing certified public expenditure process, increased use of intergovernmental transfers, new provider taxes or fees, and an increased commitment of the state general fund.

2-D. Strengthening and Transforming the California Children’s Services Program

The California Children’s Services (CCS) program ensures that low-income children who are residents of California with severe health needs, such as cancer, AIDS, and neonatal intensive care, are able to obtain treatment for those conditions. Children covered by CCS are either eligible for Medi-Cal, Healthy Families, or state/county-only coverage.⁵

Current Status in California

Enrollment in the CCS program has grown significantly, and there are several likely reasons for this. First, the expansion of coverage in Medi-Cal and Healthy Families has likely resulted in more health care conditions being diagnosed and referred to CCS for treatment. In addition, the expansion of managed

⁵ Under the current Section 1115 waiver, the federal government matches the cost of services provided through CCS for children in state/county-only coverage. The state and counties evenly split program costs. These children only qualify for services delivered through CCS.

care for Medi-Cal and Healthy Families enrollees may have created additional incentives to move children into CCS. With the exception of some of the County Organized Health Systems (COHS), treatment of CCS program conditions is carved out of Healthy Families and Medi-Cal managed care plans. The state and counties are responsible for providing CCS services for those children, and receive reimbursements through the Medi-Cal fee-for-service program. This provides some incentive for health plans to refer children to CCS who may have received services directly through Medi-Cal in the past.

As structured, the CCS carve-out makes neither program (CCS nor Medi-Cal) fully accountable for the care of the full child. This leads to confusion in state expenditures. Per the Medi-Cal estimate, Medi-Cal will spend approximately \$7.2 billion in managed care payments for all children, and an additional \$654 million a year for CCS care for children enrolled in managed care. This means that the CCS carve-out is equal to approximately 9 percent of the total cost of the total premium payments for all enrollees in Medi-Cal managed care. This is even more pronounced for infants where the carve-out will pay out \$30 million a year and \$220 million a year for disabled children. As other states do not have a CCS carve-out, this also makes comparison of Medi-Cal rates to the rates of other Medicaid programs difficult as it reflects an apples to oranges comparison. In other words, unadjusted for CCS, Medi-Cal managed care rates are higher than a straight state to state comparison would demonstrate.

The CCS program faces many challenges in serving the growing population of eligible children:

- *Insufficient reimbursement limits access and strains providers.* While CCS physician services receive 39 percent higher rates than the rest of Medi-Cal, CCS providers remain challenged to operate under these rates. The program has experienced delays in its ability to discharge children home due to the inability to obtain services for these children. The providers who deliver the most care in the CCS program, physicians and hospitals, report having financial difficulty and an increasingly difficult time recruiting the needed specialty care providers. Hospital data shows the children's hospitals encounter significant losses, especially because hospitals must pay physician groups to meet call requirements, a cost that Medi-Cal does not allow. Because of CCS's broad coverage, these providers have a far greater percentage of state-sponsored patients than most providers. This makes it very difficult for these providers to compensate by shifting the cost of care to private health insurance.
- *Reimbursement rules create incentives for inpatient care.* Reliance on the Medi-Cal fee-for-service system brings with it the system's bias toward paying for care in an inpatient basis rather than providing care in an outpatient setting (See Section 1-C for more information on that topic).
- *Fragmented coverage creates care coordination challenges.* Medi-Cal managed care and Healthy Families carves out only the CCS services for the child's condition, while all other medical services – including some related to their CCS-eligible condition, are covered by the health plan. This leads to complex coordination issues and limits the ability of medical homes

and specialty care centers to be created for the child. This is particularly problematic in cases where CCS finds that part of an overall treatment plan is CCS qualified and other parts are not. For example, CCS will pay for some of the days a neonate is hospitalized but not other days during the same stay. Children in state/county-only CCS do not have these care coordination issues as they do not qualify for services delivered out of the CCS system.

- *Multiple layers of administration create complexity.* The CCS administrative process is highly complex with multiple entities participating and is under significant stress due to budget reductions. The state establishes policy and operates part of the program including the smaller counties, claims payment, and rate setting. Each large county operates its own program based on state policy, establishing eligibility for children and authorizing services. Since much of CCS's services are provided by regional providers, this means that each regional provider must work with multiple counties, each of which operates in a different manner. Further, counties are having difficulty operating the CCS program especially after major budget reductions. Overlaying this are Medi-Cal and Healthy Families health plans who must work with both the CCS program to get qualified children enrolled in the program and then coordinate who is responsible for what services. With the HFP plan structure, there are multiple plans in these counties.
- *Inadequate funding at state and local level creates pressure.* State law limits county responsibility and treats the program as a benefit limited to the funds available. However, historic practice has been to operate the program as an entitlement. Limited funding for state-only CCS, however, does raise the unanswered question of whether the program is an entitlement, and what fiscal responsibility the state and counties have to provide care for all eligible children.

The CCS program in California is at a critical juncture where most stakeholders, even those strongly supportive, believe that the program requires modernization. The program's fragmentation, multiple layers of administration, combined with budget reductions have put stress on the program and put at risk the state's ability to deliver care to this fragile population.

Change Options

DHCS has several change opportunities that could improve the quality of care and the cost of the program. There are also opportunities to explore a more effective use of program funding. The program is administratively costly and budget reductions in administration could negatively impact timely access to care. Further the fee-for-service program may not lend itself to establishing the correct priorities for how care is delivered.

- *Nature of the carve-out.* Currently the carve-out includes all CCS conditions and carves out the CCS services rather than the child. Having one set of providers for primary care and another set

for treatment of severe health conditions makes it difficult to coordinate or manage care.

Consideration should be given to:

- Whether the entire child should be carved out or just conditions.
 - What conditions should the carve-out apply to and are all CCS conditions the same? For example, should the carve-out for cancer or hemophilia be treated the same as for the treatment of a broken bone?
 - Should some CCS conditions, such as the treatment of a broken bone, continue to be covered by CCS but no longer included in the CCS carve out (and thus be covered by managed care)?
- *Create specialty care centers.* The state could create a centralized place where special needs children can get care. CCS children with chronic health conditions could be completely carved out from the existing fragmented system and put into systems of care with medical homes and specialty care centers.
 - The reimbursement system could be realigned so that the money follows the child to where care can best be delivered. Providers or networks could bear some risk; however risk would have to be limited given the high cost nature of some of these children.
 - Case management and care coordination would be furnished by the specialty centers instead of the CCS offices, in much the same way as in managed care. This could result in significant administrative savings for the state, counties, and providers which could be invested in improving access to care in the CCS program.
 - *Improve funding coordination.* The alignment of state and county dollars in the programs should be revisited. Funding fragmentation and a lack of clarity as to whether CCS is an entitlement has led to gaps in care and provider payment delays. State law limits county responsibility and treats the program as a benefit limited to the funds available. However, historic practice has been to operate the program as an entitlement.

Fiscal

There are savings that may be able to be achieved by new models that reduce administration and through changes to realign service and health care reimbursement. However, CMS does not include administrative cost in waiver budget neutrality calculations, and if they were to be included the entire cost of administration for Medi-Cal would have to be included.

It is highly unlikely that California will be able to both improve care quality and access for children with CCS conditions and remain budget neutral. This is due in large part to depressed provider rates since the early 1980s. As noted in the Governor's health care reform proposal, a key component of reform has to include increases in Medi-Cal provider rates. However, CCS could be included as an element of a global waiver, where budget neutrality is achieved through receiving "credit" for the state's historically low reimbursement.

2-E. Management of Dual Eligibles

It is complex and expensive to provide medical care to the nation's approximately 7 million dual eligible individuals. Dual eligibles often are elderly individuals who receive Medicaid on the basis of income and Medicare on the basis of age; however, about one-third of all dual eligibles are under 65.⁶ Dual eligibles tend to be in poorer health than other Medicare beneficiaries. For example, when compared to other Medicare beneficiaries, 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.⁷

As dual eligibles tend to have more health needs, on average they require more Medicare resources than Medicare-only beneficiaries, and more Medicaid resources than Medicaid-only beneficiaries. For example, in 2002, dual eligibles comprised 17 percent of Medicare beneficiaries, yet accounted for 29 percent of Medicare spending. Dual eligibles comprised 14 percent of Medicaid beneficiaries in 2003, yet accounted for 40 percent of Medicaid expenditures.⁸ This demonstrates that, despite having access to benefits from both the Medicare and Medicaid programs, dual eligibles used more Medicare resources than the average Medicare-only beneficiary and more Medicaid resources than the average Medicaid-only beneficiary.⁹

Challenges Integrating Medicare and Medicaid Services for Dual Eligibles

Medicaid and Medicare have different purposes and coverage designs, and the two programs can work at cross purposes. This often leads to poorly coordinated care for dual eligibles, avoidable costs, and cost shifting. Medicare was designed with a benefit package that resembles employer-sponsored insurance, with a heavy emphasis on services delivered by licensed professionals (such as physicians), and focused on acute care, treatment, and improvement. Medicare was not designed to maintain a person's functional status, nor was it designed to provide long-term custodial and paraprofessional (or so-called unskilled) supports, especially long-term care.

Instead, Medicaid is the major payer for long-term custodial supports aimed at meeting an individual's basic support needs, which might relate to dementia or incontinence, for example. Medicaid incurs these heavy expenses in both institutional settings (such as nursing facilities) and home- and community-based settings (sometimes through waivers, and sometimes in Medicaid state plan services such as home health and the optional Medicaid service of personal care). Under federal law, Medicaid state plans must include coverage of institutional long-term care for those individuals who qualify on the basis of financial tests (for Medicaid) and functional tests (to meet the given state's determination of who requires a nursing facility level of care).

⁶ Toby Douglas, Deputy Director, California Department of Health Care Services, "Managing the Care and Costs of High Cost Beneficiaries in Medi-Cal FFS," December 15, 2008 CHCF Conference presentation.

⁷ The Henry J. Kaiser Family Foundation, *Medicare Chartbook*. Third Edition, Summer 2005.

⁸ *Ibid.*

⁹ *Ibid.*

In addition, Medicaid and Medicare are responsible for reimbursing different sets of medical services for dual eligibles. This fragmentation makes it hard to coordinate care, and the actions of providers in one program can affect the utilization and costs for which they are not accountable. This diminishes the incentive to provide quality care, and may increase the incentive to seek to shift costs between programs, for example:

- Medicare beneficiaries may receive services in a hospital, and are discharged to a Medicare reimbursed skilled nursing facility. Without an active discharge plan, they may spend down to become Medicaid eligible. Better planning might have prevented the patient from becoming dual eligible.
- Medicare-reimbursed physicians often are able to order Medicaid-reimbursed therapies, home health benefits, and durable medical equipment without having to coordinate with Medicaid providers. This could lead to duplication of efforts.
- Medicaid reimburses for some long-term custodial nursing facility stays. Without adequate quality control, those stays may result in avoidable hospitalizations, for example, pressure ulcers, pneumonia or falls. Those hospitalizations are paid for by Medicare.

Role of Special Needs Plans

Medicare Advantage Special Needs Plans (SNPs), a type of Medicare Advantage plan, were authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). SNPs were authorized by Congress so that health plans could target specialized high needs sub-populations within Medicare, and design provider networks and care management approaches focused on the unique characteristics of these sub-populations. One of the designated special needs populations was dual eligibles, because of the issues described earlier. When SNPs first were authorized, CMS had high hopes: “SNPs [for dual eligibles] have the potential to offer the full array of Medicare and Medicaid benefits, and supplemental benefits, through a single plan so that beneficiaries have a single benefit package and one set of providers to obtain the care they need,”¹⁰ without having to secure special demonstration authority from CMS.¹¹

Under the MMA, SNPs only were authorized through December 31, 2008. In the summer of 2008, Congress acted to extend the SNP authority through December 2010. When Congress enacted this extension, though, it tried to correct some missing opportunities under the MMA.

The bill that extended SNP authority, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), introduced a new set of requirements for dual eligible SNPs. Prior to MIPPA, dual eligible SNPs were not required to coordinate in any way with state Medicaid programs – a dual eligible SNP could simply manage its contracted Medicare benefits, ignore Medicaid, and essentially not improve upon the problems associated with the underlying disconnect between Medicare and Medicaid. MIPPA sought to

¹⁰ Centers for Medicare and Medicaid Services, “Improving Access to Integrated Care for Beneficiaries Who Are Dually Eligible for Medicare and Medicaid,” July 27, 2006. Available at <http://www.cms.CMS.gov/apps/media/press/release.asp?Counter=1912>.

¹¹ Paul Saucier and Brian Burwell, *The Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care*. Thomson Medstat, January 2007.

address this lack of coordination. Now, when a dual SNP expands its service area, or first enters a state, it must enter a contract with the state Medicaid agency to negotiate the forms and methods of coordination between the two (regarding one or more of benefits, marketing, enrollment, grievances, third-party liability, etc.)

These new requirements are intended to fulfill the original intent in MMA: improve upon uncoordinated Medicare and Medicaid benefits for dual eligibles.

Considerations for Reform

For the reasons outlined above, there could be a great deal of benefit to both the Medicare and Medicaid programs if services for dual eligibles could be more effectively coordinated. However, there are a number of significant challenges on both the state and federal sides.

On the state side, to the extent that coordination of care is considered to be synonymous with full risk managed care, there could be significant stakeholder pushback associated with any changes related to dual eligibles. Further Medi-Cal must develop a rate methodology that accurately reflects the costs of health benefits provided by a health plan to dual eligibles.

On the federal side, CMS has not gone out of its way to make it easy for states to effectively manage the care of dual eligibles. The agency has historically not allowed the Medicaid program to interfere with the exercise of freedom of choice of providers in the Medicare program. The only instances where true management can occur is where dual eligibles are enrolled in SNPs that receive a capitation payment for both Medicare and Medicaid services for the same individual. However, since Medicare services boundaries do not follow state lines, it is difficult to effectuate this degree of coordination on a statewide basis.

From a waiver perspective, the other drawback is that any savings generated by better management in *one* program will in many cases accrue to the *other* program. In the past, CMS and the Office of Management and Budget have unequivocally resisted efforts by states to claim credit in Medicaid for savings that occur in Medicare or other programs.

Lastly, how national health care reform is financed may change the nature of funding for dual eligibles. Many states have long held that the federal government should have all responsibility for dual eligibles. According to the National Governor's Association, health reform may shift costs of dual eligibles to Medicare in trade for states expanding coverage under Medicaid for everyone under 100 percent of the FPL.

Current Status of California

Twenty-one percent of California seniors are on Medi-Cal, and most of those are dual eligibles. Within Medi-Cal, seniors account for 13 percent of all beneficiaries but 27 percent of all Medi-Cal spending.¹² Most seniors are enrolled in fee-for-service, unless they live in a county with Medi-Cal managed care and have voluntarily chosen to enroll or unless they live in a county with a county organized health system.¹³ Medi-Cal payments represent 48 percent of all nursing home revenues in California, or nearly \$2.8 billion.¹⁴

California has had some success with Medi-Cal plans becoming SNPs and integrating ambulatory care under both Medicare and Medi-Cal into a combined delivery system designed to meet the needs of the dual eligible population. Both PACE plans and SCAN focus on long term care and providing care that enable enrollees to remain at home to the greatest extent possible. Two plans have proposed expanding the services they deliver under Medi-Cal to include and better integrate long-term care.

Due to the way Medi-Cal prices claims, it pays very little for physician, hospital, and pharmacy care for dual eligibles. The largest state expenditures for dual eligibles are in Medicare premium payments, the Medicare Part D “clawback” or state prescription cost contributions to the federal government, nursing home care, home health care, DME, and incontinent products.

Change Options

The payoff of improving care management for dual eligibles could be significant. If CMS allows California to be the first state to save money in Medicare and use it in a section 1115 waiver, a significant source of funding for other reform initiatives could be captured. California could pursue two types of changes in managed dual eligibles, either on a statewide or sub-state basis:

- *Allow the Medi-Cal program to receive a per member per month payment that would cover Medicare and Medicaid services for dual eligibles.* Consolidating and coordinating care delivery for this population through Medicaid should generate some savings. In pursuing such an option, it would be important to address possible stakeholder concerns about giving Medi-Cal any perceived inappropriate control over Medicare payment rates. Medicare is known to be reasonably financed with rates much higher than Medi-Cal rates. There would likely be concern about moving 1 million people from the Medicare payment rates for physicians and hospitals into the Medi-Cal system with much lower rates.
- *Prevent nursing facility placement.* The second would be to use Medicare data as an early warning system for individuals at risk of nursing facility placement – before they are even on the Medicaid radar screen. The diversion effect could be used to pay for services beyond Medicare –

¹² California HealthCare Foundation, “Medi-Cal Facts and Figures: A Look at California’s Medicaid Program,” May 2007. Available at <http://www.chcf.org/topics/medi-cal/index.cfm?itemID=21659&subtopic=CL367&subsection=medical101>.

¹³ Ibid.

¹⁴ Ibid.

such as home and community-based care and “high touch” care management – that would prevent nursing facility placement.

The two ideas above would be contingent on the federal government granting unprecedented flexibility. However, now may be an opportune time to push for such flexibility given the national appetite for reform. If it looks unlikely for California to negotiate such large scale changes, there are other proposals that could be advanced in the waiver context that would still improve the program. An enhanced PCCM model for Medicaid services for dual eligibles, possibly combined with gain-sharing for providers who reduce unnecessary utilization, could improve care coordination. Expanded home and community-based services could also improve quality while reducing costs.

Fiscal

Expanding managed care and redesigning delivery systems could help achieve significant savings. Some states are already exploring some of those changes, including incorporating long term care into managed care systems, and moving away from nursing facilities to home- and community-based programs.

3. Health Savings Account Reform Option

A health savings account (HSA) is a vehicle to set aside funds on a tax-free basis to pay for health care related services. In practice, HSAs are paired with so-called high deductible health plans (HDHPs). Under an HDHP, the insured individual would be subject to high cost sharing, but the funds in the HSA have been set aside to cover these costs.

The main theory behind the HSA/HDHP model is that by being more aware of the cost of health care services, the insured individual will have a greater incentive to reduce costly overuse of unnecessary or duplicative health care services.

Under Section 6082 of the Deficit Reduction Act of 2005 (DRA), Congress provided for up to 10 demonstrations of the efficacy of an HSA model in state Medicaid programs. Under the Health Opportunity Account (HOA) provision of the DRA, states could enroll Medicaid beneficiaries in a coverage model where up to \$2,500 per adult or \$1,000 per child is available in an HSA-type account. After exhausting the funds in the account, participants would be eligible for full Medicaid benefits.

There are limitations on the beneficiaries who can be enrolled into the HOA program: persons age 65 and older, the disabled, pregnant women, and those who have been eligible for less than 3 months cannot be enrolled. In addition, the HOA program does not waive the cost-sharing limitations in effect in Medicaid. This has the practical effect of negating the benefit that many people see in an HSA type arrangement: namely, that the consumer has a personal financial stake in how much is spent on health care.

There has not been a strong take-up of this option. The only state to have tested an HSA-like design for Medicaid is Indiana. The Healthy Indiana Plan (HIP), which was implemented January 1, 2008, created an HSA/HDHP model for uninsured parents and childless adults who are otherwise ineligible for Medicaid or Medicare.

Under HIP, beneficiaries have an HSA-like account called a POWER account, which loosely stands for Personal Responsibility and Wellness account. Only after the POWER account funds, which are \$1,100 per person, are exhausted does the HDHP coverage kick in. Unlike the HOA accounts, the POWER accounts are partially funded by participant contributions, on a sliding scale according to income. The remainder of the account is funded by state and federal funds.

Unused funds in the POWER accounts can be used to reduce the enrollee contribution in the following year, but only if the individual has received all recommended preventive care. This is intended to address any incentive to save money by not accessing preventive care.

Indiana's reasons for pursuing the HSA/HDHP model in a section 1115 waiver instead of through the DRA had to do with the limitation on putting new enrollees into the model (the state wanted to use this

as an eligible expansion vehicle) and the state's desire to require enrollees to make contributions to their own POWER accounts. The contributions are made in the form of monthly premium payments.

Nationwide, HSAs still have low penetration, and there is no research to show how well the model works for a low-income population such as Medicaid families.

Current Status in California

Penetration of HDHPs in the private market is lower in California than nationally. Just 4 percent of workers in employer-sponsored plans are enrolled in HDHP plans compared to an average of 8 percent nationally.¹⁵ Today, Medi-Cal uses the traditional benefit package structure, with very low cost sharing and no deductibles for coverage.

Change Options

California could introduce HOA plans for a childless adult expansion population, limiting the per-member-per-month costs of the coverage expansion. Alternatively, the state could introduce HOA plans for existing populations, such as children, creating savings for other reforms under the waiver. However, those cost savings may be small given the limitations in the Medicaid HOA program which exclude the highest-cost populations and cap cost sharing.

¹⁵ California HealthCare Foundation, "California Employer Health Benefits Survey,

4. Quality Improvement Reform Objectives

This section of the paper looks at a variety of changes that could be made in the waiver to address the need for the waiver to be a demonstration and to address quality improvement reform objectives. These are options that can be considered to be done individually or in various combinations including in combination with the system delivery reform objectives.

4-A. Improvements to Care and Reductions in Cost: Medi-Cal Beneficiaries

President Obama and his Administration have spoken about the need to control the long term cost growth of the Medicare and Medicaid programs. Based upon provisions in the American Recovery and Reinvestment Act (ARRA), it is clear that the Administration is willing to invest now in order to achieve long term savings in Medicaid. While California has done much to reduce the cost of Medicaid, and should be recognized for this effort, it is likely that the waiver will need to focus on how to reduce long term cost growth in Medicaid.

Current Status of California

Like most Medicaid programs, an individual Medi-Cal beneficiary's expenditures differ significantly based on their health status and care utilization patterns. Costs are concentrated among those with lower health status and/or higher care utilization patterns. The average cost for Medi-Cal beneficiaries with disabilities in 2006 was more than \$15,000, compared to between \$2,000 to under \$3,000 for non-disabled children and adults.¹⁶ The top ten percent of high cost Medi-Cal beneficiaries are responsible for generating 76 percent of total program costs.¹⁷

Most beneficiaries with higher health care needs tend to be in fee-for-service Medi-Cal as those beneficiaries are more likely to be the aged, blind and disabled populations for whom managed care is not mandatory.¹⁸ The fee-for-service system tends to encourage the utilization patterns that drive up costs. The Medi-Cal rate structure, with low physician rates limiting access, often results in beneficiaries finding care in settings more expensive than the physician's office, such as emergency rooms and federally qualified health centers. Medi-Cal beneficiaries are more likely to use emergency rooms than even the uninsured.¹⁹ Higher emergency room use has significant consequences for Medicaid costs. The frequent users of the emergency room, with five or more annual emergency room visits a year, cost more than three times as much on an annual basis as the average enrollee with a disability.²⁰ State data

¹⁶ California HealthCare Foundation, "Medi-Cal Facts and Figures: A Look at California's Medicaid Program," May 2007. Available at <http://www.chcf.org/topics/medi-cal/index.cfm?itemID=21659&subtopic=CL367&subsection=medical101>.

¹⁷ Ibid.

¹⁸ Ibid.

¹⁹ McConville, Shannon and Helen Lee, "Emergency Department Care in California: Who Uses It and Why?", Public Policy Institute of California and California Program on Access to Care, April 2009. Available at http://www.ucop.edu/cpac/documents/cpacfindings_mcconville_lee.pdf.

²⁰ Toby Douglas, Deputy Director, California Department of Health Care Services, "Managing the Care and Costs of High Cost Beneficiaries in Medi-Cal FFS," December 15, 2008 CHCF Conference presentation.

show that the cost of treatment in the emergency room is up to two-and-a-half times as expensive to the state as treatment in a physician's office. Furthermore, providing non-emergency care in emergency rooms reimbursed at Medi-Cal payment rates puts significant strain on hospitals in the state.

The fragmented and uncoordinated nature of care for Medi-Cal fee-for-service beneficiaries also may increase costs. With a few exceptions, enrollees are on their own to find providers and forced to manage their own care. Due to budget restraints, Medi-Cal is not able to provide the basic administrative services to its fee-for-service enrollees that one would receive in a managed care program.

Change Options

To obtain meaningful reform, the state must look at how to reengineer the Medi-Cal program to provide greater access to care in lower cost settings, improve how care is delivered and how enrollees' care is managed. Medi-Cal payment systems need to be reviewed to incentivize providing care at the lowest cost option and reduce the program's dependency on the use of the emergency room as the first line of treatment. There are several alternative ways to structure this program, but reforming Medi-Cal rates to put a greater emphasis on primary and preventive care must be an important part of this process. This requirement is similar to the requirement that county organized health systems review their rate structures and, where appropriate, modify them to provide greater access to overall lower cost care.

In assessing options, consideration toward the Department's ability and resources to implement these changes and the length of time required for implementation must be made. Many of these changes require multi-year implementation periods, and might take much longer than estimated. The long implementation timeframe reduces the savings available in a five year Section 1115 waiver time period.

The options range from:

1. *Expand Managed Care.* California could further expand Medi-Cal managed care to cover more people who are seniors or people with disabilities. This option poses a number of tradeoffs:
 - *Generating Cost Savings.* Expanding managed care has created savings nationally, and studies show that Medi-Cal managed care reduces the number of preventable hospitalizations.²¹
 - *California's Managed Care Track Record.* The Department has a number of expansion efforts under way that have taken more time than initially anticipated, and managed care still is not available in all counties. Two counties have chosen not to participate, and the rates in a third county weren't high enough for the plan to be viable.
 - *Opportunity to Drive Quality Improvements.* The Department has an effort under way to better define managed care plan performance standards for this population with the

²¹ California HealthCare Foundation, "Preventing Unnecessary Hospitalizations in Medi-Cal: Comparing Fee-for-Service with Managed Care," February 2004. Available at <http://www.chcf.org/topics/medi-cal/index.cfm?itemID=21723>.

intent that this process be completed before further expansion. The Department continues its process to improve the managed care rate setting process.

- *Integrating Managed Care with Hospital Financing.* Currently, the state reimburses managed care plans for the non-federal share of payments to designated public hospitals. For fee-for-service enrollees, designated public hospitals (per the hospital waiver agreement) are paying the non-federal share of care through the certified public expenditure process. Moving more Medi-Cal enrollees from fee-for-service to managed care will shift the source of the non-federal funds to the state general fund. The new hospital cost to the state general fund will significantly offset the state's savings from managed care. Some of these new general fund costs might be reduced by a voluntary intergovernmental transfer (IGT) from the counties, but the state cannot require them to contribute.

2. *Chronic Care Management.* Many states have been very effective in improving their Medicaid programs by increasing the management of chronic care for these populations. California has under way four pilots to create management programs, as well as the long-running Medical Care Management (MCM) program. An evolution of these programs and measurement of the effectiveness of the MCM program could serve as a basis for reform in Medi-Cal. The program could look at the following elements:

- Targeting patients according to predictors of continued high utilization of services.
- Individualized hospital pre-discharge planning and counseling by multi-disciplinary teams in order to avoid readmissions.
- Higher-intensity interventions that wind down to a level of patient self-management.
- Face-to-face meetings among multi-disciplinary teams using care managers and guidelines and a targeted patient treatment plan.

3. *Lessons Learned from the Coverage Initiatives.* The state's current Section 1115 waiver has created 10 coverage initiatives, many of which are implementing programs to provide care management and medical homes for high cost indigent care populations. While the program has not yet been formally evaluated, preliminary results indicate that these programs are effective in providing more coordinated care and may reduce the cost of care for this indigent population. The state could explore cost-effective ways to expand these programs to Medi-Cal beneficiaries to generate quality improvements and cost savings.

For example, the public hospitals participating in these initiatives are the primary source of care for a significant number of Medi-Cal beneficiaries. (In many cases, the care management benefits provided under the coverage initiative are not provided to people enrolled in Medi-Cal.) From the initial review, it is clear that:

- *The funding is stronger under the coverage initiative.* The federal government reimburses 50 percent of the cost of hospital care, which is often equal to or above the

marginal cost of providing care and a greater reimbursement rate than received through the Safety Net Care Pool.

- *Investment in chronic care increases quality and reduces costs.* It is possible to provide an upfront investment of funding such as is done in the coverage initiative to improve care and generate federal savings.
- *Funding need not be fragmented.* Medi-Cal funding streams could be consolidated with an eye to reducing duplicate or unnecessary treatment.

4-B. Improvements to Care and Reductions in Cost: Non-Medi-Cal Beneficiaries

Medicaid provides an important source of funding for uncompensated care for the medically indigent. With the President's interest in reducing the cost of the Medicaid program and the willingness to invest up-front to obtain savings down the road, it is likely that the waiver will have to address improvements in delivery of care to indigent populations. Much of this care by nature is episodic related to trauma or other one time health episodes, but a significant part of the care is to people with ongoing chronic health conditions.

Current Status of California

Many of the individuals whose services are paid for under the current Section 1115 waiver have chronic health conditions often associated with mental health and alcohol and drug diagnoses. Often, those receiving this care are not eligible for Medi-Cal, or are unwilling or unable to complete the application process. Treating these individuals is a county responsibility and, given the structure of California's health care system, these individuals are often forced to seek out care in higher cost settings such as emergency rooms.

Through the coverage initiative process in the current Section 1115 waiver, California has begun to reform how the medically indigent receive care. Pending evaluation, the results of these initiatives may show success in achieving the goals of improving care and reducing the long term cost of the care.

Change Options

It is likely that the waiver will need to address improvements to care for the uninsured. The federal government will likely seek reforms in how care is delivered in order to shift this care to less costly settings and reduce overall cost.

California's ten coverage initiatives may be a good basis for reforming indigent care programs and creating long term savings. This can only occur in an environment where funding for long term indigent care in hospitals and clinics is secured so that the public hospital system avoids the need to cut services and cost. The entire model of financing hospitals depends on there being sufficient cost to draw down available federal funds through the certified public expenditure process under which no state general funds are necessary, only a documentation of costs in public providers. If these funds are not made available, then public hospitals will be forced to cut services and costs. These reductions will further

erode the funding base for California's health safety net. The waiver could seek to realign financing to move from cost-based reimbursement into a payment structure that rewards system integration and providing services at the lowest cost setting.

4-C. Ways to Reduce Medical Errors, Never Events, and Readmissions

Quality care means providing the right care at the right time in the right place. Far too often, patient care fails to meet this standard. Poor quality can take the form of overuse, underuse, misuse or some combination. One-third of health care that is delivered in the U.S. is estimated to be of questionable value, and nearly half of all Americans do not receive recommended preventive or primary care.²²

The Institute of Medicine's (IOM) groundbreaking 1999 work, "To Err is Human: Building a Safer Health System," clearly outlined the burden of medical errors in the health care system. IOM estimated that between 44,000 and 98,000 people die every year from preventable medical errors. The total cost of medical errors in additional health care, as well as lost economic productivity, is between \$17 billion and \$29 billion per year. Given the exponential growth in health care costs, the burden of medical errors is likely much more today.

The federal Medicare program has begun to use its significant purchasing power to drive quality improvements in the health care system. Medicare has reduced reimbursement rates for certain medical errors called "never events" – these are medical errors that not only could have been prevented, but should never occur. They include operations conducted on the wrong limb, objects left in patients during surgery, certain preventable infections and other conditions patients may contract during a hospital stay.

Medicare has also begun to address the challenge of reducing unnecessary hospital readmissions through a number of pilot programs. Patients who are released from the hospital without adequate follow-up often end up back in the hospital with preventable complications. CMS estimates that 1 in 5 Medicare patients who leave the hospital are readmitted within the month. Furthermore, roughly three-fourths of those readmissions are preventable.²³ An April 2009 study estimates that these readmissions cost Medicare \$17 billion dollars in 2004.²⁴

Medicaid beneficiaries and budgets also are impacted by medical errors, particularly for beneficiaries dually eligible for Medicare and Medicaid, as well as the disabled and medically needy. Studies have shown that hospitals serving higher proportions of Medicaid patients tend to score lower on quality

²² McGlynn, E.A., et al. 2003. The quality of health care delivered to adults in the United States. *The New England Journal of Medicine*, 348(26): 2635-2645.

²³ Centers for Medicare and Medicaid Services, "CMS Proposes to Expand Quality Program for Hospital Inpatient Services in FY 2009," News Release, April 14, 2009.

²⁴ Jencks, Stephen F., Mark V. Williams, and Eric Coleman, "Rehospitalizations Among Patients in the Medicare Fee-For-Service Program," *New England Journal of Medicine*, April 2, 2009 360 (4): 1418-28.

measures than hospitals serving lower proportions of Medicaid patients.²⁵ Because Medicaid is a joint federal-state program, states are responsible for directing quality improvement programs for their own Medicaid programs with some federal support. States may launch demonstrations or pilot initiatives or use payment policies, such as pay for performance (P4P), as contracting requirements for participation in a public program to implement these initiatives.²⁶ CMS and Medicaid programs have begun to address these issues:

- *Hospital Quality and Safety.* Hospital P4P initiatives in Medicaid are still rare but interest is growing, with Arkansas, Pennsylvania and Massachusetts having the only such initiatives in place to date.²⁷ Since CMS announced that Medicare would no longer pay for 28 “never events”²⁸, the Pennsylvania, Michigan, and Wisconsin Medicaid programs have also adopted this payment practice, other states are in the process of implementation, and some Medicaid health plans are following suit.²⁹
- *Promoting Patient Safety Beyond Medicaid.* States have undertaken a variety of other strategies to protect the public’s health and safety that may directly or indirectly involve the Medicaid program. These include: launching patient safety reporting systems, creating patient safety centers, making patient safety part of facility licensure requirements, joining purchaser groups devoted to patient safety, and providing patient safety educational materials to consumers and providers.³⁰ Some states also choose to publicly release data to improve accountability by informing consumers and payers about the quality of health care facilities. As of early 2008, 37 states and the District of Columbia had implemented legislation or regulations that require hospitals and or other facilities to report to a state agency on medical errors or adverse events, or require reporting of judgments or settlements related to physician malpractice.³¹ Eight states have a legislative mandate to publicly report data on measures of patient safety.
- *Pay-for-Performance (P4P).* By 2009, 37 states are expected to have adopted a P4P initiative in managed care. Many states have also adopted P4P in their PCCM programs. Yet, most P4P incentives are considered “weak signals” compared to the underlying payment system on which they are layered.³² In the absence of broader payment reform, which may be

²⁵ Goldman, L.E., E. Vittinghoff, and R.A. Dudley, “Quality of Care in Hospitals with a High Percent of Medicaid Patients,” *Medical Care* 45(6): 579-583.

²⁶ Hess, C. et al. 2008.

²⁷ Center for Health Care Strategies. Descriptions of Selected Performance Incentive Programs, November 2005.

<http://www.cms.gov/MedicaidSCHIPQualPrac/Downloads/spic0206.pdf>; accessed April 9, 2008.

²⁸ National Quality Forum. www.qualityforum.org. Accessed September 22, 2008.

²⁹ “Medicaid will not cover errors in Pa,” *Philadelphia Inquirer*, p. C1, January 23, 2008.

³⁰ National Academy for State Health Policy. 2008. *States’ Roles in Addressing Patient Safety*. www.nashp.org. Accessed September 15, 2008.

³¹ Kaiser State Health Facts. www.statehealthfacts.org.

³² O’Kane, P. “P4P: Part of a Larger Health Reform Agenda,” presentation to the Third National P4P Summit, Los Angeles, February 28, 2008.

beyond the scope of Medicaid programs, P4P is relatively easy to implement, helps to focus attention on a program's health care priorities, and is associated with improving accuracy in data reporting. It is worth noting that in the Congressional Budget Office's comprehensive analysis of how to improve quality and reduce Medicaid costs, the idea most discussed is the pharmacy rebate for Medicaid.

- *Medicaid P4P in Long-term Care.* As the largest purchaser of nursing home services, Medicaid programs have begun implementing P4P initiatives designed to improve quality and the safety of care in their state's skilled nursing facilities. Georgia, Iowa, Minnesota, Ohio, and Oklahoma are examples of states that have implemented a nursing home quality improvement initiative with financial incentives within the last several years; others are actively designing one. CMS plans to launch a Medicare P4P demonstration with nursing homes that builds on these states' efforts.

Current Status of California

California has begun setting the stage for addressing medical errors. Hospitals are now required to report never events – the same types of events Medicare is targeting – to the state, which must begin making the information available over the internet by 2015.³³ The state legislature considered a bill, AB 2146 (Feuer) to prevent Medi-Cal from reimbursing hospitals for the Medicare list of never events, but the legislation did not make it out of committee.

Change Options

There are a number of ways Medi-Cal could consider expanding efforts to improve the quality of care beneficiaries receive, including:

- *Stopping payment for never events.* While research on how other states are implementing these types of payment restrictions is needed, this seems appropriate for a waiver.
- *Addressing and reducing unnecessary hospital readmissions.* There is no data analysis of Medi-Cal hospital readmissions to parallel the Medicare analysis. A waiver could fund such an analysis and develop a payment reform system to reduce unnecessary readmissions.
- *Reimburse more for use of nationally accepted treatment criteria.* Medi-Cal could set a higher reimbursement rate for physicians that document adherence to national treatment criteria. The criteria chosen should result in reduced overall spending.
- *Reduce payment for hospital acquired infections.* Like never events, hospital acquired infections could be targeted for reduced or eliminated cost sharing. More research is needed to see how other states or health systems have approached this issue.

³³ Rau, Jordan, "About 100 Californians a Month Harmed in Adverse Events," *Los Angeles Times*, June 30, 2008.

- *Developing gain-sharing.* There may be an opportunity to develop a gain-sharing demonstration to encourage hospital participation in Medi-Cal quality efforts.

CMS may make the argument that many quality initiatives could be pursued in the absence of a waiver. However, California should consider an approach that presents the state's policy goals and requests for budget neutrality as a "package deal" that is best implemented using the Section 1115 waiver vehicle. Few of the state's reform goals for the waiver will be possible without an increase in funding. An integral part of the strategy for increasing funding and still passing the budget neutrality test is to get credit for California's relatively low historical provider payment rates. Since CMS will not want to grant such flexibility without getting something in return, a set of well thought out quality initiatives should be offered in exchange for this flexibility.

5. Infrastructure Reform Objectives

5-A. Address Workforce Shortages

The U.S. currently faces a healthcare workforce shortage, which is projected to grow in the coming decades. The shortage of physicians is projected to be as high as 124,000 full-time physicians by 2025.³⁴ The nursing shortage is estimated to reach between 400,000 and 800,000 full-time equivalent nurses by 2020.³⁵ The shortage of pharmacists is expected to rise from the current shortfall of 10,400 pharmacists to 38,000 by 2030.³⁶ These shortages are more acute among primary care physicians and in rural areas.

Public programs such as Medicaid and Medicare face an even greater challenge in ensuring beneficiaries have access to physicians and other healthcare providers. Medicare payment rates are 80 percent of private insurance reimbursement rates,³⁷ and Medicaid provider payment rates in 2008 were just 72 percent of Medicare rates.³⁸ Low provider rates, combined with delays in receiving reimbursement, have discouraged physicians in particular from choosing to participate in Medicaid.³⁹ In addition, Medicare and Medicaid payment rates tend to reimburse specialists at higher rates than primary care providers, contributing to the primary care workforce shortage.

Current Status of California

Like the nation, California faces a shortage of healthcare professionals today, and in the foreseeable future. California is estimated to need 43,000 additional registered nurses by 2010 – and another 74,000 by 2020 to meet the healthcare needs of the population.⁴⁰ In 2008, California had just 55 primary care physicians per 100,000 people, less than the rate recommended by the Council on

³⁴ Dill, Michael J. and Edward S. Salsberg, "The Complexities of Physicians Supply and Demand: Projections Through 2025," Center for Workforce Studies at the American Association of Medical Colleges, November 2008. Available at https://services.aamc.org/publications/index.cfm?fuseaction=Product.displayForm&prd_id=244.

³⁵ Keenan, Patricia, "The Nursing Workforce Shortage: Causes, Consequences, Proposed Solutions," The Commonwealth Fund, April 2003.

³⁶ Health Resources and Services Administration, "The Adequacy of Pharmacist Supply: 2004 to 2030," December 2008. Available at <http://bhpr.hrsa.gov/healthworkforce/pharmacy/>.

³⁷ Hackbarth, Glenn M., "Report to the Congress: Medicare Payment Policy," Medicare Payment Advisory Commission, March 17, 2009.

³⁸ Zuckerman, Stephen, Aimee F. Williams and Karen E. Stockley, "Trends in Medicaid Physician Fees, 2003-2008," *Health Affairs*, 28 no. 3 (2009) web 510. See also: Colby D.C., "Medicaid Physician Fees, 1993," *Health Affairs* 13, no. 2 (1994) 255-263; S.A. Norton, "Medicaid Fees and the Medicare Fee Schedule: An Update," *Health Care Financing Review* 17, no. 1 (1995): 167-181; and S. Norton and S. Zuckerman, "Trends in Medicaid Physician Fees, 1993-1998," *Health Affairs* 19, no. 4 (2000): 222-232.

³⁹ Cunningham, P.J. and A.S. O'Malley, "Do Reimbursement Delays Discourage Medicaid Participation by Physicians?" *Health Affairs* 28, no. 1 (2009): w17-w28 (published online 18 November 2008; 10.1377/hlthaff.28.1.w17).

⁴⁰ The Center for Health Professions, "Nurse Shortage Looms in California and Nationwide According to UCSF Study," University of California San Francisco News Release, available at http://www.futurehealth.ucsf.edu/press_releases/rnshortage.html.

Graduate Medical Education of 60 to 80 per 100,000 people.⁴¹ Physicians tend to be concentrated in urban areas of the state, meaning that rural counties tend to have greater shortages of both primary care and specialist physicians.⁴² The growth in California's physician supply in 2015 is estimated to be 4.7 percent, much lower than the estimated 15.9 percent growth in physician demand.⁴³

Existing workforce shortages in California are compounded for Medi-Cal beneficiaries by Medi-Cal provider rates. Provider payment rates in Medi-Cal have long been among the lowest in the nation,⁴⁴ and in recent years have only grown worse in relative terms. Between 2003 and 2008, Medicaid rates across the country grew by 15 percent – still less than inflation, but much higher than the 2 percent increase seen by Medi-Cal providers in California.⁴⁵ On average, Medi-Cal fees are 83 percent lower than the national average for Medicaid programs. For some services – such as office visits for established patients – Medi-Cal reimburses at less than 70 percent of the national Medicaid average and approximately 40 percent of Medicare rates.⁴⁶

Reform Options

Historically, Medi-Cal waiver work has focused on strengthening the nursing workforce. Some of the work being done in Los Angeles is the most innovative anywhere in the country. As part of health reform, there is a growing understanding that primary care physicians and allied health professionals must be added to the workforce.

- *Renew and expand workforce training for nursing.* Review and assess existing California efforts funded currently (or initially) by Medi-Cal to determine what can be expanded. Efforts should be expanded to allied health.
- *Debt forgiveness for certain providers willing to work in Medi-Cal.* To help grow the number of providers, Medi-Cal could initiate debt forgiveness for physicians who meet a certain level of volume in Medi-Cal FFS or who work exclusively in Medi-Cal managed care.

⁴¹ Grumbach, Kevin, MD, Andrew Bindman, MD, and Arpita Chattopadhyay, PhD, "The California Physician Supply Re-Count: Fewer and More Specialized," University of California San Francisco for the California HealthCare Foundation and the University of California Program on Access to Care," October 2008. Available at <http://www.chcf.org/documents/MPM-Sacto10-30-08Grumbach.pdf>.

⁴² Ibid.

⁴³ Center for Health Workforce Studies University at Albany, SUNY (2004). "California Physician Workforce Supply and Demand through 2015." Rensselaer, NY, University at Albany, State University of New York.

⁴⁴ S. Norton and S. Zuckerman, "Trends in Medicaid Physician Fees, 1993-1998," *Health Affairs* 19, no. 4 (2000): 222-232; California HealthCare Foundation, "Comparing Physician and Dentist Fees Among Medicaid Programs, June 2001.

⁴⁵ Zuckerman, Stephen, Aimee F. Williams and Karen E. Stockley, "Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare," California HealthCare Foundation, April 2009. Available at <http://www.chcf.org/documents/policy/Medi-CalFeeComparison.pdf>.

⁴⁶ Ibid.

- *Workforce quality of life.* For all providers, Medi-Cal could undertake assessing specific issues that make Medi-Cal difficult to work with and address those. Given the difficulty of working with private insurance, providers may be more tolerant of low payments from easy-to-work-with programs.

5-B. Health Information Technology

Health care is one of the few industries in America that has not yet reaped the efficiency benefits offered by innovations in information technology. For example, electronic medical records can help reduce medical errors, as well as costly duplication of services for patients when paper records are missing and unavailable. Health information technology (HIT) can also help reduce the administrative costs of health care if it helps providers and insurers share information easily.

This has long been ascribed to the challenges of the current multi-payer insurance system, where providers, insurers and purchasers do not share the same incentives to invest in or benefit from HIT. Notably, adoption of HIT has been mostly limited to the Veteran's Administration and very large health care systems, where there are cost saving incentives to invest in the technology. Many policymakers have reached the conclusion that government will need to provide significant leadership and funding to help spread the use of HIT, and its likely system efficiency improvements.

The federal government has taken a first big step on this front by dedicating by more than \$30 billion in the American Recovery and Reinvestment Act (ARRA) to promote and expand the use of HIT – including ensuring that everyone has an electronic medical record by 2014. This funding will be used to create HIT research and regional extension centers to provide federal implementation assistance, in addition to grants to support state-level activities. A significant portion of the funds will be distributed by state Medicaid agencies as incentive payments to encourage Medicaid providers to adopt electronic health records.

In particular, Medicaid programs across the country have been using financial and other leveraging sources to help participating providers adopt health information technologies as a way to boost quality and improve safety. There is significant work taking place:

- *Health Information Exchanges.* Twenty states currently facilitate Health Information Exchange (HIE) through participation in Regional Health Information Organizations (RHIOs), which often include Medicaid participation as well. The most significant challenge for these efforts is creation of a sustainable business model.⁴⁷

⁴⁷ e-Health Initiative. 2008 HIE Survey. <http://www.ehealthinitiative.org/HIESurvey/2008KeyFindings.msp>. Accessed September 18, 2008.

- *Disease Registries.* Many states have created electronic immunization, cancer and other types of disease registries to improve the coordination and reporting among providers, health plans, Medicaid programs and public health agencies. Michigan and Washington are state leaders in establishing electronic patient registries.⁴⁸

Current Status of California

A small fraction of California's health care providers use health information technology:

- 13 percent of hospitals;⁴⁹
- 20 percent of long term care facilities;⁵⁰
- 13 percent of medical practices and 2 percent of independent practice associations,⁵¹and
- 3 percent of community clinics.⁵²

While data on HIT use among Medi-Cal providers is not available, the very low rate of use by community clinics indicates the challenges safety net providers face in making the significant investment HIT implementation requires. Despite the high start-up costs, California could reap significant benefits from encouraging HIT use by Medi-Cal health plans and providers.

Change Options

More thought is needed on how Medi-Cal can leverage ARRA funding in the context of an 1115 waiver.

Other ideas include:

- *Promote Electronic Medical Records.* On a demonstration basis, create an electronic records network for Medi-Cal and uninsured through public facilities.
- *Create Incentive Payments for EMR.* Medi-Cal could pay providers using EMR more than others.
- *Offer Grant Funding for Disease Registries.* Given the savings potential, it may be possible to argue that Medicaid dollars should fund the creation of a disease registry.

⁴⁸ CDC. Guide to Community Preventive Services: Systematic reviews and evidence-based recommendations. <http://www.thecommunityguide.org/vaccine/vpd-int-target-prov-remind-alone-r.pdf> Accessed September 15, 2008.

⁴⁹ California HealthCare Foundation, "The State of Health Information Technology in California: Use Among Hospitals and Long Term Care Facilities," 2008.

⁵⁰ Ibid

⁵¹ Ibid

⁵² Ibid.

5-C. E-Prescribing

Governor Arnold Schwarzenegger has proposed universal e-prescribing in California by 2010. Nearly half of all Medicaid programs expect to have some level of either e-prescribing, electronic medical records or both in place by 2009.⁵³ This is critical for achieving affordable and safe health care. For example, electronic prescription programs, or e-prescriptions, help prevent adverse drug interactions and improve the accuracy of prescriptions. In “To Err is Human,” the Institutes of Medicine stated that prescription errors in non-hospital settings can result in as many as 7,000 deaths annually.⁵⁴ As the number of Americans on prescription drugs grows, so does the potential for harmful prescription errors. More recently, in 2008, one study found that 51 percent of Americans are taking at least one prescription drug for a chronic condition. The elderly are more likely to take multiple medications, with 25 percent taking five or more medicines regularly, putting them at risk for not just errors, but adverse drug interactions.

However, a small fraction of California’s health care providers use health information technology in prescriptions. In fact, just 25 percent of physicians use electronic prescriptions,⁵⁵ and just 1.2 percent of prescriptions are electronic.⁵⁶ Medi-Cal’s high administrative cost for providing prescription drugs, \$13.18 per prescription, is higher than in any other state.⁵⁷

Current Status of California

The California HealthCare Foundation (CHCF) is spearheading efforts to expand e-prescribing in California. CHCF operates an e-prescribing advisory group and is in the process of convening a stakeholder meeting of all relevant participants. The Foundation is also supporting several pilots under way to expand e-prescribing in California safety net providers and Medi-Cal patients. This includes the Northern Sierra Rural Health Network, which is working with local providers and the SureScripts-RxHub network to provide e-prescriptions for Medi-Cal patients, and L.A. Care Health Plan, a public plan serving low-income populations in Los Angeles County.

Change Options

Given Medi-Cal’s higher administrative costs, it could be possible to redirect some of that administrative spending in a waiver towards e-prescribing. Ideas could include:

- *Incentives for Plans.* Medi-Cal managed care plans could be required to meet e-prescribing benchmarks within their networks, earning bonus payments along the way.

⁵³ Kaiser Family Foundation, Kaiser State Health Facts, available at www.statehealthfacts.org.

⁵⁴ Institute of Medicine, “To Err is Human: Building a Safer Health System,” November 1999.

⁵⁵ California HealthCare Foundation, “The State of Health Information Technology in California: Use Among Physicians and Community Clinics,” 2008.

⁵⁶ Sure Scripts, “National Progress Report on E-Prescribing,” December 2007 and Sure Scripts Pharmacy Health Information Exchange, 2008. Statistics do not include prescriptions through Kaiser Permanente, the Veterans Administration, or faxed prescriptions

⁵⁷ National Study to Determine the Cost of Dispensing Prescriptions in Community Retail Pharmacies, Grant Thornton, LLB, January 2007.

- *E-Prescribing Bonus.* Understanding the benefit to safety net providers, Medi-Cal could for a period of time pay a higher FFS rates for prescriptions filled through e-prescribing.
- *E-Prescribing Grants.* Given the potential savings to Medi-Cal, it is at least conceivable that a waiver could be approved to make grants to safety net providers to achieve e-prescribing.

6. Financing Options

6-A. Financing Arrangements

California's health care system has been chronically underfunded for 25 years, and the current economic and budget crises will make it nearly impossible for the state to make the necessary investment to serve increasing numbers of uninsured while undertaking significant reforms unless new sources of funding can be found in an environment of federal flexibility.

Unlike many other states, California does not use provider taxes to finance hospital or other provider Medicaid costs, and so decades of state budget pressures have limited state general fund expenditures for Medi-Cal. Medi-Cal has had only one across-the-board provider rate increase in the last 24 years. Hospital outpatient rates have been increased just four times in 24 years.⁵⁸ Physician fees in California have also been historically well below the national average. As a result, hospitals rely on inpatient payments as their main source of funding, and increases in the amount and volume of those payments make inpatient hospital expenditures the largest cost driver in the Medi-Cal program. This payment structure does not create incentives to efficiently deliver health care services, which raises program costs and compounds budget problems. California's efforts to minimize state general fund spending on Medi-Cal have also saved the federal government hundreds of millions of dollars, but the state has not received any official "credit" for those savings from the federal government.

At the same time that budget pressures continue to limit available state funding for Medi-Cal, the need for the program is greater than ever. California's latest budget deficit has been reported to be as high as \$24 billion. The continued loss of state and local tax dollars as a result of the economic conditions stifles California's ability to generate the funds necessary to reform its health care delivery system. California's significant rate of uninsured residents continues to grow as economic conditions worsen. The underfunded and inefficient system is straining to support the health care needs of California's vulnerable and low-income populations. Further, California's budget climate, and the uncertainty around it, puts its health care industry at risk for not being able to obtain necessary private investment.

Part of the federal government's commitment to improving the efficient delivery of health care should be a commitment of necessary investments into the California health care system in order to effectuate reform. The Obama Administration should consider giving the state "credit" for the savings achieved through more than 25 years of extremely low hospital and physician Medi-Cal payment rates and the Medi-Cal managed care program. If these federal funds are made available, the State must have a source of funds for the non-federal share of these payments. The state and federal government must work together to identify innovative solutions to help fund reforms to California's health care system.

Current Status of California

⁵⁸ Steinhauer, Jennifer, "California's Solution to \$24 Billion Gap is Going to Bring Some Pain," *New York Times*, June 21, 2009. Available at <http://www.nytimes.com/2009/06/22/us/22calif.html>.

Fee-For-Service Hospital Care

California has tried to maintain inpatient hospital services for Medi-Cal beneficiaries and the uninsured while reducing pressure on the general fund through a number of different programs, including:

- The Selective Provider Contracting Program (1982), operated by the California Medical Assistance Commission (CMAC), created a negotiated inpatient hospital service payment system.
- The SB 1255 hospital supplemental payment program (1989), an enhanced payment program that enhanced rates paid for inpatient hospital services.
- The Medicaid disproportionate share hospital (DSH) program, a program that subsidizes uncompensated hospital care provided to Medicaid beneficiaries and the uninsured.

These programs have resulted in a number of adverse consequences for the Medi-Cal program and California's health care safety net.

- Both private and public hospitals have received low Medi-Cal payment rates for more than 25 years.
- There has been a substantial increase in the fiscal obligations of county taxpayers and the University of California (UC).
- The reimbursement system (i.e., negotiated inpatient hospital rates and supplemental payments for inpatient hospital services) encouraged the delivery of inpatient hospital care in hospitals.
- Hospitals have a way to seek increases to inpatient hospital payment rates, but not outpatient hospital payment rates. For example, hospitals needing funding increases can approach CMAC for inpatient hospital rate increases. Outpatient hospital rates in most years are frozen or reduced and CMAC does not view its role as making up for losses in outpatient hospital care. Hence any hospital that becomes efficient by shifting care from an inpatient hospital setting to an outpatient hospital setting, receives an even lower amount of its cost reimbursed by Medi-Cal.

Disproportionate Share Hospital (DSH) Program

The federal DSH program, which only pays for hospital costs, also creates an incentive for uninsured care to be provided in hospitals. As previously discussed, DSH only compensates hospitals for the uncompensated costs of providing inpatient and outpatient hospital services to Medicaid beneficiaries and the uninsured. Hospitals are still left with significant uncompensated non-hospital costs (e.g., physician care to the uninsured).

California was granted authority under federal law to spend up to 175 percent of the hospital-specific DSH limit for public hospitals, which means that the federal match rate for payments for the uninsured can be up to 87.5 percent. While California would normally receive \$50 from the federal government for every \$100 in matchable uncompensated care costs under the DSH program, the ability to claim more in federal reimbursement than 100 percent of the actual costs effectively raises the federal matching rate by 37.5 percent (i.e., 50 percent federal match of \$175 equals \$87.50). The DSH payment

authority works very well in public hospitals, but cannot be used to pay for uncompensated services provided in non-hospital settings such as public clinics. Moreover, if DSH is converted to waiver payments for either coverage or clinic services, it loses its identity as DSH despite being counted against the state DSH allotment. Without near universal health coverage, converting DSH is not a viable option for California since the funding would not be available to fund the uncompensated costs of providing inpatient and/or outpatient hospital services to unqualified immigrants nor could that portion of the redirected DSH funding be claimed for federal matching funds at 175 percent of the matchable uncompensated care under the hospital-specific DSH limit.

Further, California's DSH allotment is considered low relative to other states. The federal DSH allotments were established based on 1992 spending without regard to the uncompensated care furnished in a state or the size of a state's population. Therefore, under federal law Texas receives a DSH allotment \$400 million greater than California, even though California has more than 12.7 million more residents than Texas.⁵⁹ As another example, Massachusetts' DSH allotment equates to approximately \$47 per resident, while California's DSH allotment equates to approximately \$30 per resident. California's DSH allotment also is well below the levels of eligible uncompensated hospital care state-wide.

Managed Care

In the early 1970s, California established a Medicaid managed care program to promote improved access, reduce costs and help further reduce general fund obligations. This program was expanded in the 1990s. California implemented Medi-Cal managed care under a Section 1915(b) waiver⁶⁰ and not under a Section 1115 Medicaid waiver. This approach was taken in part because California was looking for ways to reduce Medi-Cal expenditures rather than redirect program spending toward coverage expansions or other reforms. For the past several years, California has effectively reduced both state and federal government obligations to the California Medicaid program – in 2006 California had the second lowest per enrollee spending in the nation.⁶¹ However, the state cannot receive "credit" from the federal government for those savings based merely on the authority under which the California Medicaid managed care program operates.

Physician Reimbursements

California has sought to control program cost by largely freezing rates for physicians and many other providers. The last two general across-the-board rate increases for Medi-Cal were in 1985 and in 2000. There have been a few targeted rate increases, but there have also been rate decreases. From 2003 through 2008, Medi-Cal physician fees grew by 2 percent on average compared to 15 percent growth in

⁵⁹ Author calculation based on Kaiser Family Foundation's State Health Facts, available at www.statehealthfacts.org.

⁶⁰ Some portions of the managed care program were moved to the state plan under the provisions of the federal Balanced Budget Act.

⁶¹ California and Arizona took very different paths to control spending. Note that per the California Health Care Foundation, California is slightly below average in its Medicaid spending per state resident, which reflects the combined effect of a low payment rate per enrollee and a broad coverage.

average Medicaid fees nationally and 21 percent general inflation during this period.⁶² As previously discussed, Medicaid programs have historically reimbursed physicians below the fees paid by commercial insurers or Medicare.

California's fees rank 47th overall among states when adjusted for geographic differences in the cost of providing medical care.⁶³ Low Medi-Cal physician rates relative to the national average create continued concern with access to care for California's most vulnerable populations. The insufficient Medi-Cal fees also severely compromise California's ability to create health delivery system reform in lower cost, more coordinated care settings such as the "medical home" model. Physician services are an integral component of health care reform and therefore, physicians must receive equitable reimbursement. Under reform, increased rates to physicians could also include incentives based on quality and performance.

The unintended consequences of these decisions have compromised California's ability today to effectively institute reform of the health care delivery system without the front-end support of the federal government.

Ending Intergovernmental Transfers

Over the past 6 years, the federal government has taken an aggressive role in ensuring that states fund their Medicaid programs through sources considered permissible under federal law. California was impacted by this federal financing initiative and made changes to the manner in which it paid hospitals for services provided to Medi-Cal and uninsured individuals, beginning in 2005.

To eliminate the use of IGTs, California was forced to make two difficult decisions:

1. Payments to the designated public hospitals for most inpatient hospital services using state general fund and most payments using IGTs were replaced by the use of certified public expenditures (CPEs), making counties and the UCs responsible for the non-federal share of services to both Medi-Cal and uninsured patients.
2. Private hospitals could no longer be paid under the SB 1255 and DSH programs using IGTs. To accomplish this in a budget neutral manner, California utilized most of the state general fund historically committed to payments for designated public hospitals and used those state funds as the replacement for IGTs that historically funded private hospitals. This change made private hospital funding entirely dependent on state general fund.

Hospital Financing Waiver

⁶² Stephen Zuckerman, Aimee Williams, and Karen Stockley, *Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare*, Urban Institute, April 2009.

⁶³ Stephen Zuckerman, Aimee Williams, and Karen Stockley, *Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare*, Urban Institute, April 2009.

Under a section 1115 waiver, California converted the SB 1255 program and approximately one half of the DSH program funded by intergovernmental transfers (IGTs) from the county and the University of California (UC) to non-IGT funded programs. The SB 1255 payments had historically been utilized by the state to help subsidize the uncompensated care of furnishing services to Medi-Cal and uninsured individuals in public hospitals. This caused major changes to the manner in which hospitals were reimbursed and has been successful in increasing federal funding to hospitals and related clinics.

The waiver created the “Safety Net Care Pool” (SNCP) from three sources of payments:

1. The dollar difference at that time between the cost of providing hospital care by the designated public hospitals and the Medicaid upper payment limit (UPL) for those hospitals.
2. The remaining UPL transitional spending authorized under federal law in 2000.
3. \$180 million in federal funding, which was the annual average dollar amount in the Los Angeles County Waiver.

California also established the “DSH swap” whereby approximately \$400 million (\$200 million federal) in historical annual DSH payments made to private hospitals were instead paid as supplemental Medicaid payments under the private hospital UPL. The freed up DSH funds were then paid to the public hospitals netting an increased federal funding of over \$200 million annually.

Under the Section 1115 waiver, California was able to:

1. Replace historical general fund commitments to the regular Medi-Cal inpatient hospital payment rates made to public hospitals by utilizing CPEs as the funding source of such Medi-Cal payments;
2. Continue subsidizing both hospital and non-hospital uncompensated care costs for uninsured individuals through the establishment of the SNCP;
3. Convert the financing of the historical DSH payments made to public hospitals up to 100 percent of the hospital-specific DSH limit from IGTs to CPEs;
4. Access its 175 percent DSH authority for public hospitals utilizing IGTs derived from county tax dollars and by replacing historical DSH payments made to private hospitals with Medicaid supplemental payments funded by the state general fund;
5. Establish the Coverage Initiative, which provided federal matching funds for local health coverage programs;

6. Draw down a federal match for state health care programs such as California Children Services (CCS) and Genetically Handicapped Persons Program (GHPP), and nursing home care, freeing up state general fund for use in paying for private hospitals and for state general fund savings; and,
7. Replace IGT payments to private hospitals with general fund matched payments using savings from 1 and 6.

Cost based reimbursement systems, like that in California, are considered by many as a highly inefficient way to pay for care, one that promotes high cost services. That is, the more a hospital spends the more reimbursement it receives. Further, cost based reimbursement systems do not allow hospitals to generate revenue that can be then used for capital investment. Finally, cost based reimbursement systems are also administratively complex. The documentation processes are detailed, labor intensive, and take several years to finalize.

The Medi-Cal payment system with its emphasis on inpatient reimbursement provides a disincentive to moving care to lower cost non-hospital settings. As currently constructed, California's funding is unable to achieve reform of the existing "institutional based" health care delivery system. In addition, the \$766 million annual cap on the SNCP falls far short in addressing the total uncompensated care costs in both hospital and non-hospital settings. Finally, despite California's authority to pay public hospitals 175 percent of their uncompensated care, the Congress has not provided California with an overall federal DSH allotment sufficient to subsidize all of the hospital uncompensated care.

Change Options

California should consider the following options:

1. *Increase the Safety Net Care Pool.* Remove the cap on the SNCP and apply a growth rate to recognize significant growth in hospital and non-hospital uncompensated uninsured care with a phase-in methodology that would reduce spending on uncompensated care over time and direct that spending to premium subsidy (i.e., as more individuals are covered, hospitals and physicians should realize less uncompensated care);
2. *Return to IGT financing structure.* Move away from CPEs under Medi-Cal inpatient hospital, the SNCP, and DSH and replace with permissible IGTs.
3. *Reimburse public hospitals up to 100 percent or 150 percent of the UPL funded with permissible IGTs.*⁶⁴ This approach would recognize the high rate of uninsured and insufficient DSH allotment necessary to subsidize the cost of the uninsured population. The SNCP could be maintained to reimburse other uncompensated care costs not eligible under the hospital-specific DSH and uncompensated physician and other non-hospital costs. California must demonstrate to the

⁶⁴ It is important to note that the regulations published by the Clinton Administration and still supported by its former Administrator set the non-state public hospital UPL at 150%.

federal government that there are sufficient hospital and non-hospital uncompensated costs to absorb the increased payments and may further consider that a portion of the SNCP spending gradually transition to premium payments.

4. *Establish a rate system to promote efficiency.* Evaluate moving from a per diem rate reimbursement system to a discharge payment system similar to other Medicaid programs. This would promote efficiency and reduce the administrative cost of the prior authorization process. This system could be tied to quality to avoid paying for medical errors or avoidable readmissions.
5. *Realign inpatient and outpatient hospital payment rates.* Rebalance payments between inpatient and outpatient hospital services to take away the disincentive for treating people in lower cost settings.
6. *Reassess Medi-Cal provider payments.* Review the way payments are allocated in the Medi-Cal program to assess whether the historical formulas still apply and whether they properly reflect the cost of providing care to the Medi-Cal and uninsured populations.
7. *Remove the current ban on a hospital tax.* A hospital (or other provider) fee has the potential to generate increased Medi-Cal rates. For hospitals (or other provider types), federal law permits the collection of tax revenue up to 5.5 percent of hospital (provider) revenue, which can be used as the non-federal share of increased payments up to the Medicaid upper payment limit (UPL).
8. *Find qualified but unmatched state and local health spending.* Identify additional State and/or local only health programs for which no federal matching currently occurs and request federal match on those programs. The basis for this request would be the ability to generate capital to reform the health delivery systems. Other States have been granted this approach, but it has been on a time-limited basis.
9. *Use DSH funding for public clinics.* Consider seeking a federal law change that would allow DSH to also be used for public clinic systems so that care can be shifted to lower cost settings.
10. *Expand the use of public hospital provider based federally qualified health centers (FQHCs) to increase federal reimbursement.* Currently 5 public hospitals have this status. California could amend its current State plan to add more county provider-based FQHCs. IGTs could be utilized to pay for any additional non-federal cost.
11. *Better integrate managed care payments into payments for the safety net.* Increase the use of IGTs that will have the dual benefit of improving the status of hospitals and acceptance of the managed care program.

Fiscal

California's current budget deficit has been reported to be as high as \$26 billion. The Governor's 2009/10 budget, as adopted by the Conference Committee, proposes to seek federal waivers to cut \$1 billion in the State's funding for the Medi-Cal program by obtaining additional federal funds, tightening eligibility, reducing provider rates, and reducing benefits. The ability to sustain services provided to Medi-Cal beneficiaries and the uninsured and to begin the process of reforming its health care delivery system will require an investment of dollars into the health care system. This approach is consistent with the direction of the Obama Administration. To achieve this reform, California must seek a front-end investment by the federal government, which could be tied to milestones of health care reform that would be implemented over the duration of the Section 1115 waiver demonstration. Under this arrangement, California could initially increase spending in the public and private hospital settings to help subsidize the increasing levels of uncompensated care incurred by the hospitals and eventually redirect that spending to more efficient delivery system settings consistent with national health care reform goals. However, the federal government will only pay for its share of this reform. California must be able to find a source for the non-federal share of these payments to invest in and reform the Medi-Cal program.

In order to create increased spending authority under the Section 1115 waiver, California could request a budget neutrality ceiling that includes "hypothetical spending" in recognition of historic savings realized by the federal government as a result of California's low payment rates and program structure. The hypothetical spending should consider the significant federal savings realized under Medi-Cal managed care program (regardless of the fact that the savings were achieved under a Section 1915(b) waiver and not a Section 1115 waiver), the long-standing low fee-for-service payment rates to hospitals and physicians, and more recently the prohibition on instituting a hospital tax.

Finally, in order to create an initial federal investment to the system, California could use additional health care programs currently funded by State and/or local-only revenues and request federal matching funds in order to begin reform activities. Similar arrangements have been approved in California and other states.

6-B. Financing Charts

Financing Options For Budget Neutrality

Draft Only

	Activity	Justification		Reaction	
		Pro	Con	CMS	Stakeholders
1	Setting a High Growth Factor	California has low growth compared to national trends, which limits access. Access/quality improvements are needed.	California benefits from the low growth rate and could have spent more by choice.	CMS will focus on California's historical trend.	Supportive of the highest level possible.
2	Getting Credit for \$360 Million for Mandatory Managed Care	California has operated a responsible program, has generated federal savings, and deserves credit.	California failed to meet the terms for the funding.	Unclear. Normally, CMS would stand by its deal, but this deal was made by the last administration.	Supportive of including in a waiver.
3	Care Coordination for SPDs	Significant spending occurs on SPDs and there is reason to believe that it is possible to spend less and provide care.	The concern is that "care coordination" will mean limited care.	CMS will be supportive of cost containment efforts, and may demand it. There is limited evidence support cost-containment reduces five-year costs.	Mandatory managed care remains a high contentious issue. Other innovative steps could be more acceptable.
4	Assume Managed Care Rates are at Full Actuarial Value	California spends below the maximum possible in managed care rates. This would give the state credit.	The argument against is that it is a gimmick.	CMS will most likely consider historical rates in the calculation.	Likely No Opinion
5	Pay public hospital rates at UPL (end cost-based); Keep SNCP Funding	* Increases hospital payments to pay for growing number of uninsured. * Recognizes that SNCP pool helps with costs beyond DSH.	Does not necessarily give incentive to contain costs. SNCP created from UPL savings.	Unclear, possibly oppose.	Strong support. This is similar to the request to continue the LAC waiver in the current waiver.
6	Allow Public Hospitals To Be Paid at 150% UPL	* Clinton admin. set level at 150% UPL; Bush admin. reduced to the current 100%. * Gives hospitals the up-front funds for system improvement.	Critics may see it as a giveaway. Has national implications.	Unclear, possibly oppose.	Strong support. Some Congressional Staff have indicated that this was always the intent.

Waiver Scope Options for Budget Neutrality

Draft Only

	Activity	Justification		Reaction	
		Pro	Con	CMS	Stakeholders
7	DSH Under the Waiver	Makes funds available for coverage.	Hospitals depend on DSH for such things as making up for uncompensated care loss and low Medi-Cal payment rates. CA has a low DSH allocation with high uninsured.	Historically, CMS encourages states to include DSH as part of the waiver.	Patients may exit the public hospital system if they become insured. DSH is the only federal support for some.
8	Use Safety Net Care Pool to Purchase Coverage	Coverage can be a more efficient means to deliver care than pooled funds. The Coverage Initiatives funded from the pool do this.	The SNCP has an important and designated role; policymakers maybe concerned about public hospital support.	Most likely viewed favorably.	There will be concern that public hospitals will receive less money and there would be a cost to the GF for state programs.
9	LTC Under the Waiver	By increasing the size of the waiver, a higher growth rate will mean more federal dollars.	Costs are high and difficult to predict. If the wrong growth rate is used, services could be jeopardized.	CMS should not necessarily have an opinion. If the population is included, they will likely want reforms related to it.	Providers/advocates may be concerned that the waiver will cap payments.
10	DD Under the Waiver	* By increasing the size of the waiver, a higher growth rate will mean more federal dollars. * DD waiver savings could be fully leveraged.	Costs are high and difficult to predict. If the wrong growth rate is used, services could be jeopardized.	CMS should not necessarily have an opinion. If the population is included, they will likely want reforms related to it.	Providers/advocates may be concerned that the waiver will cap payments.
11	Mental Health Under Waiver	* By increasing the size of the waiver, a higher growth rate will mean more federal dollars. * Could lead to better integration of physical and mental health.	Costs are high and difficult to predict. If the wrong growth rate is used, services could be jeopardized.	CMS should not necessarily have an opinion. If the population is included, they will likely want reforms related to it.	Providers/advocates may be concerned that the waiver will cap payments.

Possible "Without Waiver" Baseline Adjustments to Support Budget Neutrality

Draft Only

	Past Act	Justification		Reaction	
		Pro	Con	CMS	Stakeholders
12	Hospital Contracting Program	California was the only state to use this cost control approach, and could have used a Section 1115 waiver.	CMS/OIG has raised questions regarding the actual savings of the program.	The hospital contracting waiver required a 1915b and is now under the current 1115. California benefited from SPCP, which may diminish CMS sympathy.	Likely No Opinion
13	Low Medi-Cal Managed Care Rates	* California ranked 29 of 36 states in a rate survey, paying under major states. (2001) * Permissible to increase rates absent a waiver.	* Data is old and difficult to quantify. * California has low managed care rates overall, causing some to dismiss this argument.	CMS policy is that budget neutrality is only affected by policy where a waiver was needed.	Likely No Opinion
14	Pharmacy Rebates	California's pharmacy rebates have greater success than most states. NY got BN credit for CA-type program.	CMS may raise other issues regarding pharmacy spending.	CMS policy is that budget neutrality is only affected by policy where a waiver was needed.	Likely No Opinion
15	Utilization Management	California has Superior Systems Waiver with major savings, that could support BN.	Need to make an argument on how California is different than other states.	CMS policy is that budget neutrality is only affected by policy where a waiver was needed.	Providers will express concern.
16	Anti-Fraud Activities	California has had an aggressive anti-fraud effort. Other states such as NY are starting these programs and getting credit.	Need to make an argument on how California is different than other states.	CMS policy is that BN is only affected by policy where a waiver was needed.	Providers will express concerns about the state program. Press may raise fraud issues.

Possible Waiver Revenue Sources, Beyond GF

Draft Only

	Activity	Justification		Reaction	
		Pro	Con	CMS	Stakeholders
17	Create Allowable Provider Tax (such as: revenue tax, license fee, quality fee)	Could be a significant source of revenue.	The challenge is political as some hospitals earn dollars and others lose dollars. This differential can be minimized.	Such tax is prohibited by the current waiver. It can be renegotiated.	Hospitals have been concerned about winners and losers.
18	Identify Unmatched County/State Spending	Unmatched spending can be used to match federal money.	Working Committee review of counties found few unmatched dollars. Unmatched funds may exist in counties absent a public hospital or CI.	It would be a routine matter to match unmatched spending.	Counties may be concerned re: 1) impact of the Medicaid rules on programs, 2) MOE requirements.
19	Create "Super Pool" (NY model)	Offers flexibility to match and pool dollars- -as NY has with its pool that is outside the state budget process.	This may be administratively difficult to create and operate.	CMS would likely be hesitant, but California would point to New York as a precedent.	Hospitals would be concerned about funding impact.
20	Increase Managed Care Rates by Expanding "Good" Managed Care IGTs.	California spends below the maximum possible in managed care rates.	Rates can be increased, with a permissible actuarial justification that would need to be identified.	Rate increases can be routine and done absent a waiver.	This would require coordination with managed care plans and the counties.
21	Increase provider reimbursement by shifting public hospitals from cost based reimbursement to using "good IGTs".	Cost based reimbursement is burdensome, may no longer be required, and Ca. is now limited in what it can federally claim by the CPE process.	This is a major change to the policy in the prior waiver.	CMs may be concerned about abuses and the size of the SNCP with this change.	Likely support to move out of the CPE process.

Understanding Growth Rate Options

		2008	2009	2010	2011	2012	2013	2014	2010-2014 CAGR
National	President's Budget 09 Growth in Federal Share, All Medicaid Categories	5.6%	6.4%	6.6%	7.1%	7.0%	7.1%	7.1%	
	CBO 08 – Medicaid	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	
	NHE Medicaid – 09	6.9%	9.6%	8.6%	7.8%	7.8%	8.2%	8.4%	
California	PPIC 2005 - Non Disabled	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	8.4%	
	LAO 2009 - Medi-Cal All		3.2%	5.1%	5.7%	6.3%	6.6%	6.9%	6.1
	LAO 2009 – IHSS		11.0%	7.0%	7.8%	8.1%	8.4%	8.3%	7.9
	LAO 2009 –DS		9.2%	8.3%	5.6%	5.5%	5.5%	5.7%	5.6

Note: Calendar year, excepts LAO estimates are State Fiscal Year.

California: Actual Adult FFS Spending, Per DHCS Data

	2004 to 2005	2005 to 2006	2006 to 2007	CAGR
Medi-Cal	-0.7%	4.4%	7.4%	2.7%

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