



## CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

### **California's Next Section 1115 Waiver: Recommendations from the California Association of Public Hospitals and Health Systems**

**October 2009**

#### **I. Introduction/Overview**

California's next Section 1115 Waiver offers an extraordinary opportunity for the state to improve the health of low-income, uninsured and Medi-Cal patients, and to prepare California's health care safety net delivery system for broader reform at the national level. To help accomplish these goals, the next Waiver should be designed to:

- 1) support and strengthen the health care safety net;
- 2) expand coverage to low-income Californians;
- 3) reform the health care safety net delivery system through the further development of medical homes and coordinated care; and
- 4) contain cost growth.

Our vision of the next Waiver is to improve health care and expand coverage and access for low-income individuals, and to help support and sustain California's public hospital systems so that they can continue to provide the breadth and depth of critical health services to the residents of this state. A major focus of this vision is ensuring that uninsured and Medi-Cal patients get the right care where and when they need it. We recognize that providing services in more appropriate settings will create efficiencies and improve the overall quality of care. It also will increase access to care and reduce costs by making sure that patients with non-urgent needs are treated in an outpatient location and not in a more costly emergency-room environment. By providing access to the right care at the right time, we also can reduce unnecessary hospitalizations and readmissions. As public hospital systems, we are committed to this goal and see it as a cornerstone of health care reform. We look to the next Waiver to help us build on our current efforts to strengthen the health care safety net while at the same time allowing us to expand access and coverage to Californians in need.

Realizing this vision requires a continued effort to make fundamental changes to the health care delivery system, with a greater emphasis on managing and coordinating care using a medical home model. Fortunately, many of the components of this concept already exist. Public hospitals are comprehensive delivery systems, offering services that run the gamut of patient needs. Primary, specialty, emergency, inpatient and outpatient care all exist side-by-side in public hospital systems, on their main campuses and out in their local communities. Thus, these systems understand the need for better care coordination, and the ways in which it can improve the patient experience and reduce costs through new efficiencies and streamlined processes.

Public hospitals also have developed significant expertise in treating the safety net patient population and handling the complexity of their social and medical issues. Our patients often have multiple medical concerns as well as other basic needs that must be addressed, such as housing and transportation. Public hospitals also have adopted several effective strategies to improve access to care for their culturally diverse patient population – a majority of whom speak a language other than English as their first language – with programs such as state-of-the-art interpreter services.

California's safety net providers have implemented several delivery system innovations that should serve as important touchstones for the next Waiver. In fact, California's public hospitals have been national leaders in testing and refining effective and efficient care delivery for safety net populations. For example, they have implemented chronic disease management programs in many of their clinics; improved care delivery in outpatient settings to make visits more streamlined and patient-centered; and developed methods of improving access to specialty care.

Armed with the lessons learned from these delivery system innovations, CAPH believes that California has the opportunity to further expand coverage and improve care, with a key component being support for public hospital systems to move from piloting these innovations to institutionalizing new, more effective methods of care delivery. The next Waiver's investment in the safety net delivery system will enable California to spread and strengthen these delivery system and coverage expansion efforts so that low-income, Medi-Cal and uninsured patients will receive care that is more integrated, better managed, and more focused on primary care and prevention services. Public hospital providers are committed to honoring this important investment and to being accountable for the achievement of these goals.

At the same time, it is also important to recognize that the Waiver has and will continue to contain the core funding of public hospital systems for care to both Medi-Cal patients and the uninsured. Unfortunately, the current Medicaid/Uninsured hospital financing Waiver established in 2005 has not over time provided the necessary financial resources to stabilize California's public hospital safety net, due to caps on Waiver funding and a payment structure that generally limits reimbursement to 50 percent of costs. The next Waiver provides an opportunity to build upon delivery system improvements and strategies being developed and implemented in public hospital systems, and to enhance funding to achieve our vision of integrated safety net delivery

systems that improve the health of our patients and communities. Public hospital systems are ready and able to quickly implement these recommendations and will be essential partners for the state to achieve its goals for the next Waiver.

We offer herein our recommendations for the next Waiver as it relates to California's safety net public hospitals and the services they provide. In doing so, we recognize that the state is contemplating a comprehensive Waiver with additional components that will impact other entities that are not discussed here.

We consider this Waiver proposal to be ambitious, but realistic; bold in its vision, yet tempered with the very real need to address the enormous challenges in our safety net health care system – challenges that have been made even greater by the economic crisis gripping our state and our nation. Failing in this endeavor is not an option.

## **II. Public Hospital Systems: The Foundation of the State's Safety Net Delivery System**

California's 19 public hospitals are the core of the state's health care safety net, delivering care to all who need it, regardless of ability to pay or insurance status. Though just six percent of all California hospitals statewide, public hospitals serve 2.5 million Californians each year and provide nearly half of all hospital care to the state's 6.6 million uninsured residents. They deliver 10 million outpatient visits per year and operate more than half of the state's top-level trauma centers and almost half of the state's burn centers. They provide almost 30% of the care provided to California's Medi-Cal population within the hospital setting, and 35% of Medi-Cal visits in hospital outpatient settings. To a large extent, their patient population has complex and multiple medical needs. Forty-three percent of new doctors in the state are trained in public hospitals.

Our public hospitals have a driving mission to provide this wide array of services to meet the needs of their patients and communities. Despite being historically underfunded, they have continued to provide high-quality and often life-saving care and have succeeded in bringing about many of the efficiencies and innovations described in the above section. Given their limited funds, public hospitals have worked diligently to maximize existing resources, streamline and coordinate services, and contain costs. They also are oriented towards shared accountability across all departments and programs. Were our public hospitals to receive adequate support, their ability to transform health care delivery within their systems could truly take hold.

## **III. Vision of a Strengthened Health Care Safety Net: Key Elements**

As stated above, public hospitals have implemented forward-thinking strategies to better integrate services within their systems and with other local providers. The next Waiver provides an opportunity to build upon these strategies to achieve our vision of integrated safety net delivery systems. Our vision is that the shift in the safety net delivery system will continue so that all patients will receive the appropriate level of care in the right setting. At the center of this care for patients with complex chronic conditions, public hospital clinics, community health centers and participating physician offices will serve as patient-centered medical homes, which

will offer coordinated and integrated services across the health care safety net system.<sup>1</sup> With this model, patients can more easily manage their entire continuum of needs and services through improved linkages and communication within the delivery system. The model offers a team-based approach to delivering care, with special attention to chronic care management. Teams will be multi-disciplinary and include the array of staff needed to manage a patient's care, such as physicians, nurses, physician assistants, health educators and dietitians. This shift in the delivery system will require expanded capacity for primary providers and other health professionals in the outpatient setting.

This vision encompasses the following elements:

- Case management for patients with complex needs to ensure that patients are tracked as necessary and assisted in making appointments, adhering to their medication regimen and follow-up care, and navigating the system.
- Panel management: Care will shift from a reactive, episodic, and visit-by-visit basis, to a more planned, proactive approach that looks to identify and address patients' serious unmet health care needs.
- Use of health information technology to facilitate care coordination, communication between providers concerning patients' needs, and stronger connections between clinical and administrative systems to improve care.
- Population health management: Using health information systems such as disease registries and electronic health records, public hospital systems can go beyond the individual focus of mainstream medicine to help improve the health of its entire patient population, by proactively reaching out to patients to ensure that they receive regular preventive care and health screening, and by providing intensive care management for individuals at the highest level of risk.

By incorporating these elements, we can achieve greater improvements and a strengthened capacity to focus on the following:

- Improved access to specialty care, including an adequate number of specialists in low-income and underserved areas, and better communication and coordination between primary and specialty care providers.

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<sup>1</sup> See Pourat et al., "Health Coverage in the Safety Net: How California's Coverage Initiative is Providing a Medical Home to Low-Income Uninsured Adults in Ten Counties, Interim Findings." UCLA Center for Health Policy Research, June 2009.

- Improved care transitions between emergency rooms, hospital inpatient care, outpatient clinics, and home- and community-based services. Such improvements will result in better health outcomes and help reduce inefficiencies.
- Reduced health care disparities: A greater emphasis on primary and preventive care in medical homes and stronger coordination within the delivery system will result in a more patient-centered approach and will help reduce health disparities. Through better methods of collecting and using race and ethnicity data, safety net systems will also identify disparities that need to be addressed.
- Improved end of life care through more culturally competent and cost-effective palliative services.
- Improved performance on key quality indicators, including core measures, diabetes and other chronic disease measures, thereby improving the health status of patient populations served.
- Improved patient experience with health care received and with quality of life as a result.
- Improved efficiency in the clinic setting, with medical appointments that focus on the patient's needs, reduce wait times and maximize productivity.

The next 1115 Waiver should give us the tools and resources needed to demonstrate and evaluate concrete progress, and serve as a transition as we prepare for national health reform. Through the Waiver, we can move further in accomplishing many of the goals that are at the heart of reform, and be ready to meet the shared expectations of health care reform when it is implemented. Because CAPH's Waiver recommendations are grounded in core reform principles and designed to prepare public hospital systems for national health care reform, the proposed delivery system and financing improvements remain relevant should national reform efforts be delayed or not come to pass. We also know that we will continue to need support during and after this next Waiver to continue caring for low-income residents as well as provide the many other essential community services – such as trauma, burn care, and training of the next generation of health care professionals – that benefit all Californians.

#### **IV. Major Components of the Waiver**

Under our vision, all patients – regardless of their insurance status – will receive high-quality, appropriate care at the right time. Although the structure for funding different populations may vary, patients who need it will be able to obtain coordinated care through a medical home. To accomplish this shift in the delivery system in order to support medical homes that provide integrated and coordinated care, CAPH recommends that California's next Section 1115 Waiver contain the following funding components:

A. Improved Care Delivery for Seniors and Persons with Disabilities (SPDs)

During 2006, approximately 1,750,000 Medi-Cal beneficiaries in California were categorized as Seniors and Persons with Disabilities (SPDs) during at least one month of the year.

Approximately 40% of the SPD population, or 448,000, were classified as non-dually eligible fee-for-service (FFS) persons. By virtue of their health conditions, their care is often more complex and costly than that of other Medi-Cal patient populations. Many SPDs have been diagnosed with multiple chronic conditions. For example, amongst the non-dually eligible SPDs, 35% with asthma also have hypertension, and 45% with diabetes and hyperlipidemia also have hypertension.<sup>2</sup>

California's public hospitals have significant experience and expertise in treating the SPD population, and understand that there is potential to improve care delivery for these individuals. CAPH believes that through a medical home model – with its emphasis on outpatient care delivery, coordination of care and case management – public hospitals can help these patients better manage their conditions and reduce avoidable emergency and inpatient utilization.

To demonstrate the efficacy of local medical homes for SPDs, CAPH proposes a series of county-based pilot projects. Each county with a public hospital would select one of the following structures to improve care coordination through case management and a medical home model for the SPDs in its county. Counties under a Two-Plan Model could choose either an Enhanced Primary Care Case Management (EPCCM) approach or to enroll SPDs in Medi-Cal Managed Care.

Enhanced Primary Care Case Management: The EPCCM model would provide coordinated care to a subset of the public hospital SPD FFS patient population. It would encompass a specified range of outpatient services in addition to primary and preventive care. Patients would also receive care coordination and case management to ensure they

can navigate the system and receive care in the appropriate setting. The EPCCM would provide a medical home to every enrollee and would be held to a set of performance standards. It could be targeted to one or more subgroups within the SPD population and likely would not include dually eligible individuals for whom the federal and state governments have other care management demonstration program plans. We believe that this approach could serve to demonstrate reduced unnecessary emergency-room use and inpatient stays within the enrolled patient population.

Under the EPCCM model, public hospital systems would serve as the lead entity, operating not just as medical home providers but also as direct contractors responsible for

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<sup>2</sup> Source: PPT Presentation – Medi-Cal's Most Costly FFS Populations: A Look at the Population, Costs and Diseases. Prepared by DHCS Research and Analytical Studies Section. June 11, 2009.

the overall management of the population enrolled in public hospital system medical homes. Public hospitals are working to provide care from a population management perspective rather than an episodic approach, and thus, have the capacity and commitment, and relationships with key partners, to administer an SPD EPCCM program.

The EPCCM would be structured so that public hospital systems would receive an actuarially sound rate for a defined set of outpatient clinical and case management services. At this time, we anticipate that the nonfederal share of the rate would be funded in part with certified public expenditures (CPEs) and/or intergovernmental transfers (IGTs), in addition to the State General Fund resources already being spent to care for this population. In order to ensure adequate funding, payment rates would recognize the higher costs incurred in providing enrollee services. This structure would result in the EPCCM being at risk for the defined set of services and would create incentives for public hospital systems to provide the most appropriate care and contain costs. To further align incentives, we would propose that the EPCCM include an element wherein the EPCCM and state would share in savings that result from reduced inpatient or ER use.

Other, more traditional primary care-focused PCCMs could co-exist with the approach described above and could be offered by other community providers. In addition, voluntary managed care enrollment would continue to be an option for SPDs residing in counties that select an EPCCM approach.

Medi-Cal Managed Care: Participating counties could elect to implement Medi-Cal managed care for SPDs as is currently available on a voluntary basis. The state would set criteria that counties and participating plans would have to demonstrate they could meet in order to select this option, which could be implemented on a mandatory basis or with a default approach. This option would test a capitated rate for a comprehensive set of services in the inpatient and outpatient setting, as is the current structure in County-Organized Health System (COHS) counties and on a voluntary basis in Two-Plan model counties. Enrollees would also be assigned a medical home under this model and would receive coordinated services and case management.

County-Organized Health System: Counties that already operate a COHS would continue to enroll SPDs in Medi-Cal Managed Care.

Long-term Care Integration: The state has indicated its interest in pursuing long-term care integration for dually eligible individuals in the next Waiver. This option is one that counties could select.

## B. Safety Net Care Pool (SNCP)

CAPH envisions that the SNCP would continue to be a key element of the next Waiver and encompass multiple components as described below.

### 1. Coverage Expansion

The current Waiver's three-year coverage demonstration project, the Health Care Coverage Initiative (CI), has already achieved important successes in expanding health care coverage and access for more than 100,000 low-income adults in 10 California counties. Moreover, the CIs' use of a medical home model has provided enrollees with greater access to primary and preventive care – accomplishments that are particularly important given that the CIs serve primarily a high-utilizing, complex population.

CAPH proposes that the next Waiver include a coverage expansion program that leverages the successes of the existing CI and changes some of the program's structural elements. The next CI should build on the strengths of the safety net delivery system, improve care for our patients, and prepare the state and the system for health care reform that is likely to include expanded Medicaid coverage for low-income childless adults. We envision a CI program that will cover 200,000 – 250,000 enrollees in counties that have county hospital systems.<sup>3</sup> CI enrollees would be assigned to a medical home for their regular primary and preventive care, as they are now. The CIs would offer a standardized benefit package and would be reimbursed with actuarially sound rates that reflect the cost of providing coordinated services.

### *Retained CI Program Elements*

We propose that the next Waiver include a coverage program that retains many of the program elements of the current CI, including:

- Local safety net provider networks: Enrollees will continue to be offered care by providers in public hospital systems and community clinics, and by other providers as necessary.
- Medical home model: Providing patients with medical homes will enable these individuals to receive primary care from a team of providers who will help coordinate their care with other parts of the health care system.

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<sup>3</sup> We would anticipate, and support to the degree that budget neutrality allows, that other counties could participate in the next CI. For example, San Diego and Orange counties could also elect to maintain their CI programs and other counties could develop CI programs, subject to their provision of the appropriate non-federal share and budget neutrality room.

- Incorporation of quality improvement: Many current CI enrollees are benefitting from higher quality, more efficient care being provided in public hospital clinics as a result of quality improvement efforts. These include “Patient Visit Redesign” programs to reduce wait times at clinic visits, enhanced primary-specialty care coordination, and a shift to team-based care for patients with chronic conditions.
- County flexibility to target sub-populations: While all CIs will be restricted to enrolling patients at or below 200% of the Federal Poverty Level, counties can continue to target particular patient populations, especially those with high cost conditions such as asthma, diabetes, and hypertension.

### *Proposed Changes*

The next Waiver offers an opportunity to expand and strengthen the CI in order to help California prepare for a much broader coverage expansion under any national health care reform effort that takes place. Accordingly, proposed changes to the CI for the next Waiver include:

- Expanded number of participating counties: We propose that the next CI continue in Alameda, Contra Costa, Kern, Los Angeles, San Francisco, San Mateo, Santa Clara and Ventura, and also be offered in Monterey, Riverside, San Bernardino, and San Joaquin counties.
- Expanded targeted enrollment: We envision that the next CI would grow to provide health care coverage to an estimated 200,000 - 250,000 CI enrollees in the counties listed above by 2016, using a phased-in approach.
- Greater federal funding: For CIs operated by counties with public hospitals, we propose that the next CI program draw down \$400-\$600M in federal funds annually adjusted by an inflation factor. Public hospital systems and counties participating in the CI program will provide the non-federal share via CPEs, IGTs or a combination of the two. As with the current CI, the program will incur no cost to the state, with the exception of administration and oversight.
- Reimbursement structure: The reimbursement structure for these CI programs would shift from the current direct CPE structure to an actuarially sound payment method. This structure will introduce an element of financial risk to the CIs and provide further incentives to ensure appropriate use of services.
- Greater standardization of benefits: Each CI would be required to provide a basic benefits package of services within its provider network. The package would include at a minimum:
  - Primary and preventive care
  - Inpatient and outpatient services
  - Specialty care
  - Emergency services
  - Pharmacy

- Enhanced performance metric system: We envision that an enhanced performance metric system would assess each CI in the following areas:
  - Patient enrollment in a medical home that uses an efficient, patient-centered approach to care, including provider teams and panel management;
  - Greater care coordination, measured through improved referral processes, between primary care and specialty care services, both within public hospital systems and with local community health centers;
  - Improved patient experience, measured through surveys such as CAHPS;
  - Improved clinical processes and quality measures for patients with chronic conditions, measured through the delivery of appropriate tests and health outcomes; and
  - Reduced avoidable emergency room and inpatient utilization.

All CI programs would be expected to make gains in each of these areas, but given the variation in program maturity, they would not all be expected to achieve the same final outcomes. To support and recognize achievement of these performance measures, counties could utilize fiscal incentives, such as pay for performance and value-based purchasing efforts within their CI programs.

## 2. Delivery System Improvement Pool

CAPH proposes that the Waiver include a pool of funding to enable public hospitals to make an upfront investment in enhanced, sustainable systems needed to improve the coordination and delivery of care. The safety net has been able to implement many innovative programs on a pilot basis over the past several years thanks to grant funding, but these programs have been difficult to replicate system-wide due to the lack of sufficient resources. Efforts such as chronic care management; developing tools to improve access to specialty care, including telemedicine; and projects to improve clinic efficiency have been successful in improving the delivery of care. Another example is the current LEAN project that is underway in four of our public hospitals. This grant-funded effort is designed to improve hospital system efficiencies.

Investment is now needed to allow safety net providers to build the infrastructure required to reproduce these programs throughout their system. Making such an investment now will help save valuable resources in the future.

An improvement pool would support public hospitals' efforts to enhance care delivery and make measurable progress towards one or more of the following goals: expanded access, improved quality and patient care, and enhanced care coordination through a strengthened delivery system infrastructure. The means might include, but would not be limited to, investment in electronic medical records or disease registries to enhance

efforts such as chronic care management, a redesign of clinic flow and use of staff teams in order to improve clinic operational efficiency, better utilization of outpatient clinics and development of transitional care systems in order to assure the best patient health outcomes and reduce unnecessary emergency room use, or Web-based referral systems. For each of the goals, progress would be assessed in specific, concrete and quantifiable measures in order to evaluate delivery system innovations' impact on patient care and access. Funding would be linked to achievement of these milestones, and federal funds would be drawn down with public hospital CPEs and/or IGTs.

CAPH believes that this investment would help lay the foundation for achieving the long-term goals of health care reform, which will require a more efficient and cost-effective – and smarter – delivery system.

### 3. Behavioral and Physical Health Integration Pilots

The low-income, uninsured and Medi-Cal population focused on in this Waiver proposal and in federal health reform measures has a significant prevalence of mental illness and behavioral health service needs, and indeed this population represents a considerable percentage of patients treated by safety net providers. Public hospitals have recognized that a more integrated structure would better meet the myriad needs of these individuals and likely would be more cost-effective as well. Finding a more coordinated approach to caring for this population addresses a key concern of both the Waiver and health care reform.

To that end, CAPH proposes that the next Waiver include funds to support pilot projects to improve integration between physical and behavioral health services, with federal funds drawn down using CPEs and/or IGTs. Specifically, counties with public hospitals would be given the option to test strategies that enable more effective coordination of care and collaboration between clinicians in order to best serve those patients with both physical and behavioral health needs. Strategies for these pilot programs could include, but would not be limited to, providing educational resources to clinicians to facilitate referrals, co-locating clinicians in the same setting, coordinating care across providers and systems, collaborating and jointly deciding on treatment, and jointly planning and financing services.

### 4. Support for Uninsured Costs

In FY 0809, California's public hospitals expended \$800 million for care to the uninsured that was completely unreimbursed due to caps placed on our current Waiver. These costs for services to the uninsured include those for which there is no other source of reimbursement, such as non-hospital clinic services and physician services. CAPH proposes that under the next Waiver a reimbursement pool be maintained for these services and other essential functions provided by public hospitals, with federal funds being drawn down using public hospital system CPEs.

### C. Disproportionate Share Hospital (DSH) Payments

DSH will continue to be a very important source of funding for public hospitals under the next Waiver, to finance the wide array of services in the emergency, inpatient and outpatient settings to uninsured and Medi-Cal patients. Federal Medicaid DSH funds also will support the difference between Medi-Cal provider rates and the actual cost of providing services. DSH funds also will be needed in the next Waiver to help public hospitals treat patients who are undocumented.

We anticipate that the next Waiver will maintain the current Waiver's structure of allocating the federal DSH allotment to designated public hospitals, with private DSH hospitals receiving "DSH replacement" funds from the state. This structure provides the maximum benefit of the DSH program to California due to California's 175% OBRA cap provision in federal statute. Given the role that DSH plays in funding core safety net services for Medi-Cal and uninsured patients in public hospital systems, the large number of uninsured individuals in the state, and California's 175% OBRA cap provision, it is vital that under the Waiver all of California's DSH allotment remain as DSH funding.

The federal funds for this component will be determined based on the federal DSH allotment. As under the current Waiver, public hospitals will fund the non-federal share with a combination of CPEs and IGTs.

### D. Medi-Cal Inpatient Fee-For-Service

To some degree, inpatient Medi-Cal FFS care will remain a component of California's Medi-Cal program. In order to ensure the availability of essential services in the community, we believe that the Section 1115 Waiver should restore the 150% Medicaid Upper Payment Limit (UPL) for California's public hospitals. The 150% UPL for public hospitals was initially set in 2001 before CMS implemented a gradual reduction to a cap of 100% in 2002. The non-federal share for the supplemental payments up to the 150% UPL could be funded through an IGT or through a hospital fee if one is in place. These payments support the wide array of services provided by public hospital systems, including emergency trauma services, pediatric care, the training of health care professionals, and many other services that are vital to communities throughout the state.

### **V. Budget Neutrality**

Budget neutrality is likely to be a key element of discussion concerning the next Waiver, thus we offer here our recommendations for a budget neutrality construct. CMS has consistently applied the policy that a Section 1115 Waiver must not result in federal expenditures that are higher than they would have otherwise been in the absence of such a Waiver, although such a policy is not a legal or regulatory requirement. This concept is what CMS considers to be the budget neutrality limit of the Waiver.

There are several crucial components to a successful calculation for California that will result in the best budget neutrality limit for the Waiver; these include: (1) appropriately accounting for historical savings accrued to the federal government due to California's Medi-Cal cost-saving efforts that have not been previously recognized, and (2) accounting for the difference between the typically lower rate of Medi-Cal growth and the Medicaid trend rate contained in the President's budget.

More specifically, CAPH believes that there is a strong argument to be made that savings achieved since 2005 should allow California to draw down a significant amount of additional federal dollars in the next Waiver. As stated above, California already has been piloting new, innovative methods of care delivery to create a more efficient, cost-effective health care system. Though by no means immune to the issues that plague the entire health care system, California has been able to contain costs through structures such as managed care, effective drug purchasing, care management, anti-fraud activities, and other efforts that have made California a low per-recipient spending state.

In addition, the President's projection of cost growth in the Medicaid program currently is reported as 6.8 percent. Traditionally, the Medi-Cal program has grown at a rate below this figure, typically around 5 percent. This difference would create additional budget neutrality "room." It will be important for California to pursue all approaches to increase budget neutrality so that additional federal funds become available to support the achievement of the next Waiver's goals, which could not be achieved by simply redirecting or reallocating existing federal funds.

In developing the next Waiver and budget neutrality, it also will be important to keep in mind several key factors specific to California. First, California has a very high rate of uninsured and will continue to have a significant number of uninsured after the Waiver renewal and national health care reform. Second, despite having a higher rate of uninsured, California receives much less federal funding (even with DSH and Safety Net Care Pool funds) per resident for the uninsured than other large states that have entered into 1115 Waivers. Third, California has the second lowest per enrollee spending level of any Medicaid program in the nation.

The state has indicated its intent to pursue a broad Medi-Cal Waiver that encompasses much of the state's Medi-Cal program. CAPH believes that the budget neutrality limit for such a Waiver could make available to California several billions of additional federal funds annually.

## **VI. Conclusion**

CAPH believes that the elements described above for public hospital systems in the next Section 1115 Waiver will help California to be well positioned and well prepared as our federal policymakers continue to articulate their positions on national health care reform. Through the next Waiver, the state can improve access and expand coverage to low-income Californians and can help to strengthen the public hospital delivery system, which will be critical to a successful

transition to reform. Our public hospitals have been leaders in redesigning their systems in order to offer more efficient and higher quality care to a larger number of people in a cost-effective manner. The Waiver will allow our public hospitals to build on these accomplishments to make more permanent, systemic changes to continue to better serve their patients. Moreover, the next Waiver will help public hospitals to strengthen their overall capacity to provide essential health services that benefit all Californians.