RENEWING CALIFORNIA'S HOSPITAL FINANCING WAIVER

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Background
The state is currently putting together a waiver renewal concept paper for California's hospital financing waiver. They hope to submit it to the federal government by September or October. The state is looking to use the waiver renewal to fill in about $400 million of the budget deficit and to use it as a bridge to federal health care reform. They need your creative input *now* about what to include in the renewal waiver, as oftentimes the best ideas come from those on the front lines.

The waiver can either make changes to small portions of the Medi-Cal program, such as altering a policy or service, or it can implement broader change. What does California want to do?

Should the waiver be big or small? The bigger the waiver, the bigger the risk or reward; the costs or savings may be higher than predicted multiplied by the size of the waiver. To protect against risk, the state may need to conduct aggressive negotiations backed by a unified voice of support—which is why the state needs to hear from you and your networks now.

What innovative ways can we alter the health care system in California? In 2005, the hospital financing waiver ended the use of IGTs (intergovernmental transfers) in favor of CPEs (certified public expenditures) to help protect the safety net. The counties and UCs pay public hospitals using CPEs under the current waiver, while private hospitals are paid through the General Fund. This change helped to draw down federal funds to help protect the safety net. Do we want to keep this system in place? How could we alter it to make it better?

Under the 2005 waiver, the ten county coverage initiatives were created. Through them, more of the uninsured have been covered. Medically Indigent Adults (MIAs) without other affordable insurance options have received comprehensive care through this portion of the waiver, helping many to secure medical homes and have access to more coordinated care including disease management—although often at a higher per capita cost than originally estimated. Through these initiatives, many counties have begun to see emergency room use drop in favor of cheaper outpatient options, in addition to getting healthy starts on investing in health information technology ventures to cut costs in the long term.

Under the waiver renewal, should we continue the ten county coverage initiatives as they are or expand them to other counties? What aspects should be emphasized or modified according to their levels of success or failure, respectively?

To fill a portion of the state budget deficit, we may have to think big—potentially growing the coverage initiatives to be bigger and cover more or all counties, moving people into medical homes and using managed care particularly for currently exempt populations. Let us know your thoughts.

Waiver Options

Basic Principles

Budget Neutrality: A state must spend no more than it would have spent absent a waiver.

- California has a low per capita spending baseline and growth rate and a low DSH (Disproportionate Share Hospital) allocation, so it's hard to find innovative ways under a new waiver to accrue savings to expand coverage—for instance to childless uninsured adults.
- Unfortunately, administrative savings are not part of calculating budget neutrality, and sometimes savings achieved outside of the state balance sheet, such as to Medicare.

Federal Health Reform

- The current federal administration is in favor of health care reform. If the state wants to push for a large waiver renewal in California, now it the best time to request it—with chances of approval increased by "getting ahead of the train" in defining the details of reform and by aligning California's innovations with federal reform goals. For example, the waiver could establish the infrastructure needed to implement federal reform, in addition to helping stabilize a state with a high and increasing number of uninsured straining the safety net. The main difficulty is finding a state match for any new federal dollars.
- An additional step may include needing to unify all 1115 waivers to avoid double-counting of budget-neutrality savings. This includes things like Family PACT.
- The uncertainties of federal reform present some problems, but contingencies could be written into the renewal request. For example, public program expansions coupled with maintenance-of-effort requirements might leave the state with a more troublesome funding problem than it already has; however, the waiver could specify that changes like this open the door to renegotiating the terms of the waiver. Alternatively, some stakeholders have posed the question of extending the current waiver until we know what happens with federal reform. The difficulty is that efforts are already in play, including the passage of ABX4 6 (Evans), which promotes the waiver renewal.

Time

- Any major change in California's health care system will take time both to implement and to show positive outcomes. Given the restraints of a five-year waiver, the state must be ready to give extra resources to timely and effective implementation of the waiver.
- In addition, major system reform saves spending in the long term. Shorter-term indicators will be needed to prove successful implementation of a waiver—indicators that should be specified in advance along with an evaluation timeline and protocol.

Immigrants and Long Term Care

- Often not included in waivers, although California uniquely has a high number of immigrants and has shown success with using alternatives to long term care in nursing homes.

The table below incorporates ideas presented a recent report commissioned by the Blue Shield of California Foundation[1] with additions from coverage initiative counties, our regional workgroup participants, and listserv respondents. You are strongly encouraged to share with the state and/or ITUP which options you support or oppose in a renewal waiver and to brainstorm additional ideas. For instance, are there aspects of ABX1 1 that could be integrated into the renewal waiver?

Category	Method / Innovation
Eligibility	
	Expand Medi-Cal. Some have suggested covering more Medically Indigent Adults in the ten coverage initiative counties or expanding similar demonstrations to more counties willing and able to put up matching funds. Others have suggested covering all kids, particularly considering the state of the economy in California and nationwide.
Service Delivery	
	Integrate care networks of different facilities and care types, including multidisciplinary teams and behavioral health. Doing this effectively may require pooling resources and funding streams to discourage duplicative care and encourage collaboration.
	Use medical homes. Counties have emphasized that innovative methods need to be brainstormed and tested to encourage the use of medical homes. Even if medical homes are established and patients are assigned to them, patients sometimes still use the emergency room for primary care. Some counties have successfully used nurse advice lines to help navigate patients to the correct facility. Methods like this should be refined and expanded.
	Use care / case management instead of fee-for-service, i.e., managed care or risk-adjusted capitation for populations like dual eligibles, seniors, the disabled, children with severe health needs, and other high-needs and high-cost populations having the greatest potential for benefiting from better coordination. Under the coverage initiatives, counties are considering applying copayments to encourage the use of medical homes over emergency rooms and to limit unnecessary utilization. They will be monitoring the impact for both positive and negative outcomes.
	Use disease management, including self-care. Counties have additionally suggested to tier disease management so that more can benefit from these programs but using less intensive and therefore less costly versions of these programs.
	Streamline currently fragmented benefits of programs like California's Children's Services (CCS) and dual eligibles to simplify administration and coordinate care. For example, have complete managed care for CCS children; carve out the *child* from Medi-Cal or Healthy Families managed café rather than particular services.
	Focus on long-term care, including a shift from using costly skilled nursing facilities to home- and community-based health care options.
	Experiment with HOAs (Health Opportunity Accounts) to encourage individual responsibility in care decision-making.
	Simplify enrollment processes for coverage expansions. One of the biggest barriers to implementing the ten county coverage initiatives under the current waiver was collecting citizenship documentation as required under the Deficit Reduction Act of 2005. Some counties have suggested opening enrollment to everyone under a certain income level to simplify administration, subsequently discounting a percentage of costs assumed to be spent on those who do not meet citizenship requirements. An alternative is eliminating the five-year requirement for immigrants to obtain legal permanent residency. The main drawback is that any discussion about immigrants often can be misconstrued as at attempt to cover undocumented immigrants—and care for the

	undocumented is not included in any proposals for federal reform right now. The state would need to carefully tread on this issue so as not to disrupt the overall need to renew a waiver to help California restructure an ailing public health care system.
	Simplify administration. The Healthy Families Program has administrative costs that are lower than those of Medi-Cal. Some have suggested changing Medi-Cal to achieve the efficiencies of Healthy Families. This may mean simplifying eligibility as well as streamlining administrative processes.
Payment Reform	
	Realign reimbursements to encourage appropriate care. For example, hospitals are better incentivized to provide inpatient care than physicians are to provide outpatient care. Hospital rates have increased over the years, are paid per diem (which encourages longer stays) and DSH hospitals receive supplements to their payment rates. In contrast, physician outpatient care, which is increasingly seen as more outcome-effective, consistently has its rates frozen or reduced. Reversing this pattern is one step to encouraging appropriate care.
	Improve reimbursement to providers to ensure access to primary and specialty care and to establish medical homes—particularly as you increase the number of insured under Medicaid coverage expansions. California rates are already some of the lowest in the nation; meanwhile, the safety net must grapple with higher numbers of undocumented immigrants and uninsured as compared to many other states. Some suggested adjusting DSH and Safety Net Care Pool (SNCP) payments with the recognition that California is impacted by high numbers of undocumented immigrants and uninsured. Another suggestion was increasing reimbursements to something mirroring Medicare, although currently most of the ten county coverage initiatives use rates that mirror Medi-Cal rates. Another suggestion was for states like California with the greatest percentages of uninsured immigrants to be permitted to retain a greater share of DSH over the next five years as it is phased down as a bridge to successful federal health care reform. Another suggestion was to focus on strengthening the employer-based coverage system so that more immigrant low-income workers are offered insurance.
	Use DSH funds for the costs of physician services. DSH funds are currently used only for hospital costs. This excludes non-hospital costs like care provided by physicians or care provided through outpatient settings. Giving California flexibility to use its DSH dollars to pay for these other services will facilitate a smoother transition for the safety net from inpatient to outpatient care.
	Remove the cap on SNCP and apply a growth rate to its funding.
	Return to using permissible IGTs for Medi-Cal inpatient hospital care, SNCP and DSH.
	Reimburse public hospitals up to 100%-150% of the upper payment limit (UPL) with permissible IGTs.
Budget Neutrality and Financing	
	Push for retroactive "credit" for savings California accrued from efforts such as managed care and selective contracting—particularly those that other states have initiated under their waivers. Similar to the proposition that California's low per capita spending and low DSH

	allotment argue for "credit" for decades of savings, California could seek "credit" for the savings generated by the ten county coverage initiatives. Namely, these coverage initiatives have attracted pre-Medicare populations with high health care needs. The counties could argue that they will be handing these populations over to Medicare healthier through their efforts—saving the federal Medicare system money.
	Negotiate a higher baseline of spending for budget neutrality, as opposed to relying on California's historically low per capita spending. This could be achieved by using a more typical state spending average or a growth rate closer to or above the national average, i.e., 15%-21% vs. California's 2% (over the period 2003-2008).
	Draw down and match more federal funding. This involves finding local and state dollars currently unmatched (including "costs not otherwise matchable"), as well as raising revenue to match any new federal funds received. Suggestions included eliminating the ban on a hospital tax currently under the hospital financing waiver; AB 1383 (Jones) is currently seeking to do this with the support of the Daughters of Charity Health Systems, the California Hospital Association and the California Children's Hospital Association. Others suggested seeking waivers for the parts of federal reform that apply to coverage expansions, such as the ten county coverage initiatives (all 58 county programs) for medically indigent adults, and asking for a 100% match for those.
	Expand FQHCs (federally-qualified health centers) or FQHC look-a-likes to draw down more federal reimbursement. Some have suggested prioritizing their expansion first to the most medically underserved areas.
Quality Improvement	
	Improve patient safety by reducing errors, never events, and hospital readmissions.
	Enhance collaboration and establish best practices among providers and facilities using improved communication and provider education.
	Use pay-for-performance and transparency to improve quality and accountability.
	Evaluate implemented changes in real-time to address ongoing improvement needs. Support evaluations with personal stories, including positive feedback from providers and patients.
Infrastructure Reform	
	Address access issues including workforce shortages and availability of lower-cost care options (e.g., primary care, nurse advice lines).
	Invest in and incentivize the use of health IT, including e-prescribing to reduce errors and the use and expansion of disease registries. Additionally, maximize American Recovery and Reinvestment Act dollars.
	Allow regional flexibility. Many counties have noted that they have different preexisting needs and capacities—different delivery systems with specific strengths and weaknesses. A waiver to help build the infrastructure within a variety of counties will need allow adjustments and transitions for the differences among counties and regions, such as current provider networks for MIAs upon which new programs may build, preferences for a county-operated health system vs. a "Two Plan" delivery model, or preexisting investments in health IT.

[1] Harbage Consulting and Health Management Associates. (2009). California Medi-Cal waiver options. Retrieved July 20, 2009 from

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