Section 1115 Medicaid Waiver Renewal

Safety Net Financing

Expert Stakeholder Workgroup

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Meeting Agenda

- Overview of 1115 Waivers; DHCS Objectives for Waiver Renewal
- Disproportionate Share Hospital (DSH) Background
- Safety Net Care Pool (SNCP) Uncompensated Care Funding Background
- Considerations for Future of DSH and SNCP
- Initial DHCS Concept for DSH/SNCP Reform for Designated Public Hospitals
- DSH Replacement for Private DSH Hospitals and DSH Funding for Non-Designated Public Hospitals
- Questions/Comments
- Next Steps/Next Meeting

Overview of 1115 Waivers & DHCS Objectives for Waiver Renewal

Section 1115 Medicaid Waivers

- Allow states flexibility to design demonstration projects that promote the objectives of the Medicaid program
- Typically approved for 5 years; States may submit request for waiver renewal for 3 -5 years
- Must be budget neutral

California's Bridge to Reform Waiver (2010-2015)

- Current Waiver sunsets on October 31, 2015

- Waiver renewal request must be submitted to the Centers for Medicare and Medicaid Services (CMS) at least 6 months before the end of the current waiver

2015 Waiver Renewal Initial Concepts

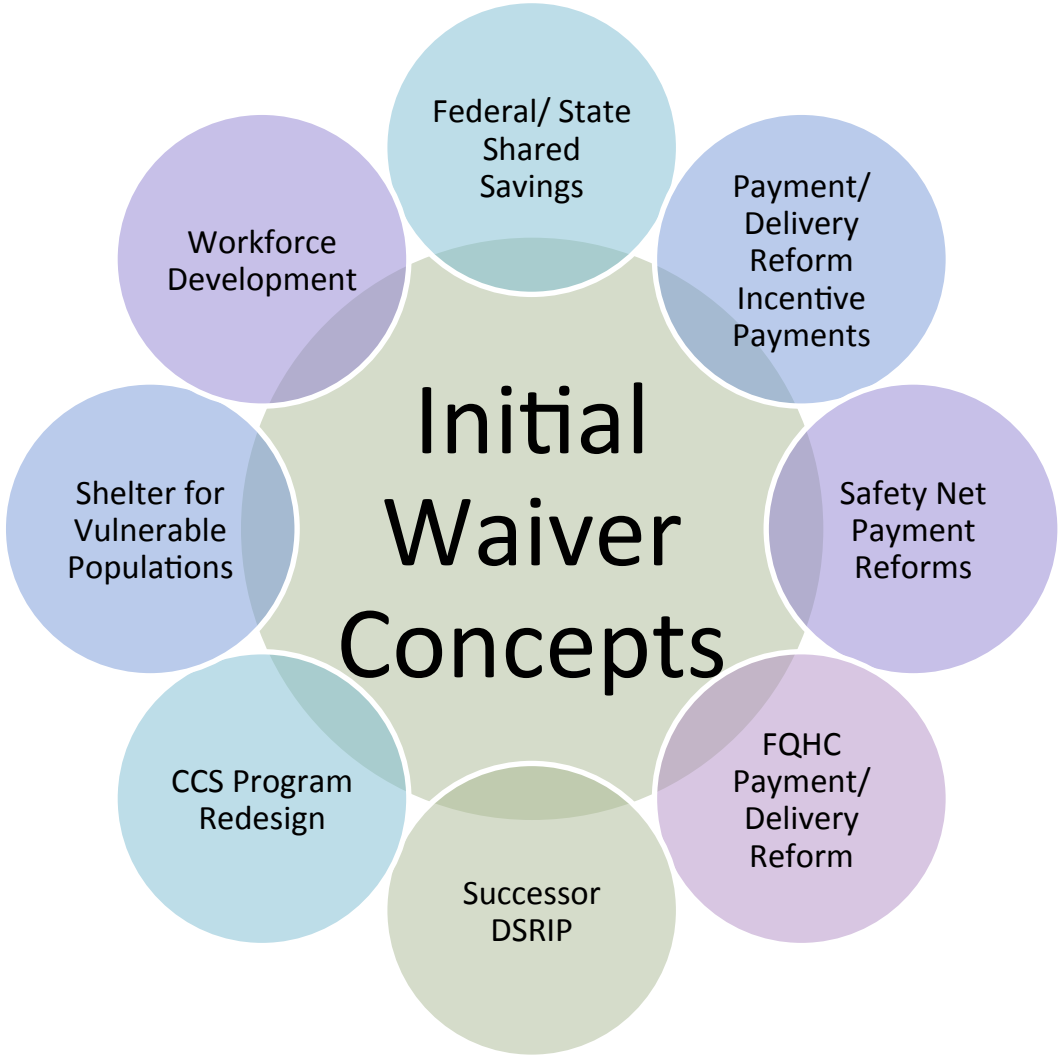
Purpose of Section 1115 Medicaid Waiver Renewal

Shared Goals with CMS

- To further delivery of high quality and cost efficient care for our beneficiaries
- To ensure long-term viability of the delivery system post-ACA expansion
- To continue California's momentum and successes in innovation achieved under the "Bridge to Reform" Waiver

Objectives

- Strengthen primary care delivery and access
- Avoid unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency
- Address social determinants of health
- Use California's sophisticated Medicaid program as an incubator to test innovative approaches to whole-person care


Initial Waiver Concepts
Federal/ State Shared Savings
Payment/ Delivery Reform Incentive Payments
Safety Net Payment Reforms
FQHC Payment/ Delivery Reform
Successor DSRIP
CCS Program Redesign
Shelter for Vulnerable Populations
Workforce Development

DSH Background

DSH Background

DSH payments provide additional reimbursement to those hospitals that serve a significantly disproportionate number of low-income patients (Medicaid and Uninsured).

States receive an annual federal DSH allotment to pay for a portion of the uncompensated care costs of DSH hospitals for care to the uninsured and Medicaid beneficiaries.

This annual allotment is calculated by federal law and includes requirements to ensure that the DSH payments to individual DSH hospitals are not higher than their actual uncompensated costs for care to the uninsured and Medicaid beneficiaries (Omnibus Budget Reconciliation Act (OBRA) limit).

Federal law includes a provision specific to California that provides for the OBRA limit for public hospitals to be 175% of uncompensated costs

DSH Eligibility

Meet the 2 obstetricians requirement or exemption

AND

1) Have a Medicaid inpatient utilization rate (MUR) of at least one standard deviation above the statewide mean; historically the CA MUR required for DSH eligibility has been in the low to mid 40% range
(MUR = Medicaid Days/Total Patient Days)

OR

2) Have a low-income utilization rate (LIUR) higher than 25% and a MUR of at least 1%
(LIUR = Medicaid & Charity Revenues/Total Revenues)

Social Security Act Section 1923

Major Milestones in CA DSH Program

1991

- CA DSH program established (non-federal share provided by public hospitals – counties/ UC/districts)

1993

- Federal law instituted hospital specific OBRA caps at 100% of uncompensated Medicaid/ uninsured costs

1997

- Federal law change to CA public hospitals OBRA limits from 100% to 175% of uncompensated costs;
  CA law change implementing 50/50 split of federal DSH allotment between public/private hospitals

2005

- Federal concerns regarding use of Intergovernmental Transfer (IGT)-based funding lead to first CA statewide 1115 Waiver and enactment of the "DSH-Swap" which led to substantial changes to the program and allocation of DSH funding among eligible hospitals

History of DSH Payments Allocation Methodologies

- Non-federal share provided entirely by public hospitals
- Allocations based on state statutory formula (SB855) that allocated funding to hospitals according to:
  - Per diem amount per Medicaid day
  - Per diem based on the "peer grouping" to which the hospital was assigned (e.g. major teaching, Children's hospital, etc.)
  - Subject to hospital OBRA limit

History of DSH Payments Allocation Methodologies

- Enactment of "DSH swap"
  - Entire federal DSH allotment, except $80, paid to public hospitals (DPH & NDPH)
  - Private hospitals to receive equivalent amount of what DSH funding would have been through "DSH replacement" payments
  - Change in non-federal share: Private and NDPH paid via state general funds; DPH paid using combination of IGT/CPE (Certified Public Expenditure)
- Private hospital DSH replacement paid according to SB855 formula
- NDPH DSH funding paid according to SB855 formula
- DPH DSH funding paid according to new formula (SB1100) linked to overall 1115 Waiver funding formulas that utilized "guaranteed" baseline funding plus allocation of "stabilization funding"

History of DSH Payments Allocation Methodologies

- Continuation of "DSH swap"
- Continuation of SB855 formula for Private hospitals and NDPHs (Non-Designated Public Hospitals)
- New DPH DSH allocation formula based on:
  - Specific allocation amounts
  - Per discharge amounts for Medi-Cal, Low Income Health Program (LIHP) and uninsured discharges
  - Remainder allocated using pro-rata distribution based on DSH eligible

- CA estimated federal DSH allotment approximately $1.2 billion
- DPH DSH payments approximately $1.1 billion (federal funds only)
- NDPH DSH payments approximately $10 million
- Private DSH replacement payments approximately $530 million

SNCP Background

SNCP Background

- $766 million in federal funding each year
- Claimable using CPEs for uncompensated costs of services to the uninsured
- Both hospital and non-hospital costs incurred by public hospitals and their affiliated governmental entities or the State for the uninsured were allowable
- SNCP not available for costs of the undocumented; reduction factor of 17.79% applied to SNCP expenditures as proxy
- Portion of SNCP provided state GF backfill to ensure no additional state GF expenditures due to overall impact of 1115 Waiver and new CMS requirements
- Remainder of SNCP allocated among DPHs using formula linked to overall 1115 Waiver funding formulas that utilized "guaranteed" baseline funding plus allocation of "stabilization funding"

SNCP Background

- First year, available SNCP federal funding increased compared to 2005 waiver ($965 million)
- SNCP declines each year thereafter with final year being $636 million in federal funds
- Continues to be claimable using CPEs for uncompensated costs of services to the uninsured by state and public hospitals
- Undocumented reduction factor reduced to 13.95%
- State portion of SNCP increased from 2005, $400 million each year of SNCP funding is claimed by the State
- Remainder of SNCP allocated among DPHs using new formula based on pro-rata allocation according to SNCP eligible uninsured

Future Considerations for DSH & SNCP

Future Considerations

ACA enacted nationwide DSH reductions

- Originally slated to begin in FY13-14, delayed to FY16-17
- Reductions increase each year until 2022 when they stabilize at which time nationally DSH funding will be approximately 50% of the current total DSH funding.
- ACA DSH reductions affect DSH payments to DPHs and NDPHs and by statute affect Private DSH replacement as well since that funding is linked to CA's DSH allotment

Medicaid expansion significantly changed landscape of Medi-Cal and uninsured

Medi-Cal managed care and funding of DPHs

Demographics of remaining uninsured

CMS perspectives on uncompensated care pools and 1115 waivers

Initial DHCS Concept for DSH/SNCP for DPHs

Drivers of DSH/SNCP Reform

- Overall DHCS objective of payment/delivery system reform towards meeting the goals of the Triple Aim of increased quality, improved outcomes and reduced cost
- Movement away from volume-based and cost-based care toward risk-based care that provides appropriate financial incentives
- Impact of future considerations from previous slides, including :changed landscape of Medi-Cal and uninsured post coverage expansion, changed demographics of remaining uninsured, and CMS perspectives on uncompensated care pools

Goals and Desired Outcomes of DSH/ SNCP Reform

- Move away from cost based/volume-based care delivery to a risk-based model that aligns incentives within the system
- Determine required amount and types of services would incentivize coordination of care
- Encourage and reward provision of primary care for remaining uninsured
- Increase outpatient care and reduce unnecessary emergency room and inpatient
- Seek flexibility under a combined DSH/SNCP pool to provide whole-person care that addresses physical and behavioral health needs

Key Elements of Initial DHCS Concept

- Combine federal DSH and SNCP funding for DPHs into single funding source for services to the remaining uninsured
- Funding no longer based on cost-based CPE claiming
- Shift of funding to a more “risk-based” and/or “bundled” payment structure
- Provide flexibility and incentivize DPHs to provide more coordinated/ managed care for remaining uninsured
- Require access to care for remaining uninsured, including primary care, and demonstrated ongoing provision of services

Overview of Concept

Establish statewide pool of funding for the remaining uninsured by combining federal DSH funding for DPHs and some level of federal SNCP funding based on final years of current Waiver

- For example, if we assume for FY15-16, DPH federal DSH funds of $1 billion plus 2015 level of SNCP of $236M, the total pool would be $1.236 billion in federal funding

Establish individual pools of funding for remaining uninsured for each DPH from the overall pool

- Allocation methodology for development of individual pools could be based on distribution of remaining uninsured among DPH counties or some other methodology that accounts for level of services needed for remaining uninsured. For example, if county A was projected to have 10% of the remaining uninsured among all DPH counties, that county's funding pool would be $123.6 million

Overview of Concept (continued)

DPH's would be eligible to receive quarterly payments from their individual funding pools and would use IGTs as the source of non-federal share

- For example, county A could receive $30.9 million in federal funds payments at the end of each quarter (total payment of $61.8 million including county A's IGT of $30.9 million)

DPH's would be required to provide services to remaining uninsured at specified levels and provide documentation of such services

Required amount and types of services would take into consideration make-up of remaining uninsured, including accounting for limited scope eligibility for emergency and pregnancy services

Overview of Concept (continued)

Required amount and types of services would incentivize coordination of care, provision of primary care to remaining uninsured, and shift away from emergency and inpatient utilization; this could include services provided via contract that the DPH has with a non-DPH provider

Potential inclusion of other metrics over time, including quality and outcomes, to continue to incentivize movement provision of primary care to and coordination of care for remaining uninsured

If a DPH does not meet required service levels and other metrics they would be required to forgo a proportional amount of their funding pool based.

Key Questions

How do we determine appropriate allocation of funding among the DPHs in development of individual funding pools and how that might this change year to year?

What are appropriate service utilization floors and metrics within the pool?

How will the pool incentivize coordination of care and movement toward appropriate utilization (e.g. movement from ER/inpatient to outpatient care)?

How would the program structure account for populations that have partial coverage, e.g. limited scope emergency, pregnancy, or hospital presumptive eligibility?

Should reallocation of funding be permitted if a DPH does not meet required service levels and another DPH exceeds required levels?

What are strategies to integrate behavioral health services through the pool?

Private DSH Replacement & Non-Designated Public Hospital (NDPH) DSH Funding

Private and NDPH DSH

DHCS has not developed a specific proposal to modify the current funding allocation for Private and NDPH DSH providers

DHCS is open to concepts that would also reform these payment streams and provide the same type of incentives and flexibilities to ensure provision of care to remaining uninsured

If so desired, future workgroup meetings could include discussions of potential concepts for Private and/or NDPH DSH funding

Questions and Discussion