CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

Financial Challenges for California's Public Health Care Systems

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Objectives

- Introduce myself, CAPH/SNI
- Observations of PHS statewide
- Put AHS's financial circumstances into context to try to appreciate what is common & what is unique

About CAPH/SNI

- **California Association of Public Hospitals and Health Systems (CAPH)**
  - Advances policy and advocacy efforts that strengthen the capacity of its members and ensures access to high-quality, culturally sensitive, comprehensive care
- **California Health Care Safety Net Institute (SNI)**
  - Designs and directs programs that accelerate and spread innovative practices among public health care systems and helps providers deliver more effective, efficient, patient-centered care

21 Public Health Care Systems

Just **6%** of hospitals in the state, but…

- Provide **35% of all hospital care to Medi-Cal beneficiaries** in the state in their communities
- **Provide 40% of hospital care to the remaining uninsured**
- Operate more than **200 outpatient clinics**
- Serve more than **2.85 million patients annually**

Alameda County
Alameda Health System

Contra Costa County
Contra Costa Health Services:
- Contra Costa Regional Medical Center

Kern County
Kern Medical

Los Angeles County
Los Angeles County Department of Health Services:
- Harbor/UCLA Medical Center
- LAC+USC Medical Center
- Olive View / UCLA Medical Center
- Rancho Los Amigos National Rehabilitation Center

Monterey County
Natividad Medical Center

Riverside County
Riverside University Health System Medical Center

San Bernardino County
Arrowhead Regional Medical Center

San Francisco County
San Francisco Department of Public Health:
- Zuckerberg San Francisco General Hospital
- Laguna Honda Hospital and Rehabilitation Center

San Joaquin County
San Joaquin County Health Care Services:
- San Joaquin General Hospital

San Mateo County
San Mateo Medical Center

Santa Clara County
Santa Clara Valley Health & Hospital System:
- Santa Clara Valley Medical Center

Ventura County
Ventura County Health Care Agency:
- Ventura County Medical Center

University of California (UC)
UC Health:
- UC Davis Health
- UCI Health
- UC San Diego Health
- UCSF Health
- UCLA Health

Includes county-owned and-operated health systems and UC medical systems

April 2019: anticipating waiver expiration

- Public health care systems have been financed through 1115 Medicaid waivers for 15 years

- Since 2005, California implemented three 5-year 1115 Medicaid waivers:

  - 2005: Early Coverage Expansion
    - Health Care Coverage Initiative

  - 2010: Unprecedented Delivery System Reform
    - Delivery System Reform Incentive Program (DSRIP)

  - 2015: More Ambitious Value-Based Reforms
    - Medi-Cal 2020

1115 Medicaid Waivers

- Waiver funding and other supplemental payments are necessary because:
  - Medi-Cal rates are so low
  - The State shifts burden of financing onto counties and public health care systems
    - Resulting in the "50 cents on the dollar" problem – where public health care systems and counties are required to provide the 50% match
- The ACA was a critical game-changer for public health care systems, but PHS are still not covering our costs

Medi-Cal 2020 Waiver

- The current Medi-Cal waiver is worth a total of $7.4B in federal funds over five years

- Three core programs relevant to public health care systems:
    - Public Hospital Redesign and Incentives in Medi-Cal (PRIME)
        - $24.6M per year for AHS
    - The Global Payment Program (GPP)
        - $79.3M per year for AHS
    - Whole Person Care (WPC)
        - $28.3M of federal funding for AC Connect per year

What Could Succeed the Waiver?

- Directed payments – supplemental payments within managed care rates
  - Had already created EPP & QIP
    - AHS disadvantaged by initial lower rates
    - PRIME to roll into QIP
- "CalAIM," a.k.a. Future of WPC
  - Significant State GF in Jan Budget
    - Enhanced Care Management (ECM)
    - In-lieu of services (ILOS)
- GPP
  - Could continue in an 1115 waiver, but without the Safety Net Care Pool

Where Are We Now

- The paradox of self-financing continues: both a solution and a structural problem
- CalAIM is off the table for now (and probably in the near future)
- Anticipating looming DSH cuts, damaging federal regs (MFAR)
- We need at least a 1 year extension of the 1115 waiver
- No obvious next phase after December 2021

Waiver Extension & Other Details

- DHCS in negotiations with CMS
  - Potential problem with budget neutrality
    - HEROES Act language would waive BN
- Seeking to add back the SNCP into the GPP
  - But move PRIME into QIP to leverage additional FMAP
- Also seeking:
  - An "emergency" 1115 waiver to support & stabilize PHS
    - CMS unwilling to consider until other funds allocated
  - Flexibilities for PRIME, QIP, and WPC

Commonalities & Distinguishing Characteristics for AHS

Common

- Structural deficit: victim of our own success
- Strength of local collaboration, esp WPC
- Strong outpatient delivery system, important for PRIME & QIP performance metrics
- Directed payment challenges: delays in payments, uncertainty, actuarial soundness

Unique

- Directed payments still low
- Debt to county