Joint Informational Hearing

Assembly Health Committee (Assemblymember Chan, Chair)
Assembly Budget Subcommittee No. 1 (Assemblymember De La Torre, Chair)
Senate Health Committee (Senator Ortiz, Chair)
Senate Budget Subcommittee No. 3 (Senator Ducheny, Chair)

"MEDI-CAL: HOSPITAL FINANCING IMPLEMENTATION AND COVERAGE INITIATIVE"

Tuesday, February 14, 2006
10:00 a.m. – 12:00 noon
State Capitol, Room 4202

I. Opening remarks from Committee Chairs

II. Medi-Cal Hospital Financing Waiver: Implementation Status

- Stan Rosenstein, Deputy Director of Medical Services, Department of Health Services
- Melissa Stafford Jones, Chief Executive Officer, California Public Hospital Association
- Santiago Muñoz, Executive Director, Division of Clinical Services and Development, University of California

III. Medi-Cal Hospital Financing Waiver: California Medical Assistance Commission (CMAC)—Hospital Payments

- Keith Berger, Executive Director, California Medical Assistance Commission
- Katherine Douglas, President and CEO of Private Essential Access Community Hospitals, Inc.

IV. Hospital Waiver Coverage Initiative: Administration's Proposal and Reaction

- Stan Rosenstein, Deputy Director of Medical Services, Department of Health Services
- Barbara Glaser, Legislative Advocate, California Hospital Association
- Charles Bacchi, Vice President, Legislative Affairs, California Association of Health Plans
- Dorian Seamster, Deputy Director, Policy, California Primary Care Association
- Elizabeth Landsberg, Western Center on Law and Poverty

V. Public Comment

Background Materials

Joint Hearing on Implementation of the Hospital Waiver

I. Overview of the Hospital Financing Waiver

Background (See Appendix for Summary Tables). As a result of federal policy changes, California was required to completely change its method in which Safety-Net Hospitals are financed under the Medi-Cal Program. The Administration negotiated a five-year federal Waiver with the federal Centers for Medicare and Medicaid (CMS) which was completed as of September 1, 2005.

The federal requirements for this Hospital Finance Waiver are contained in the *"Special Terms and Conditions"* document which serves as a contract between California and the federal CMS. Senate Bill 1100 (Perata-Ducheny), Statutes of 2005, provides the state statutory framework for implementing the new Hospital Finance Waiver. A summary of this framework is provided in the Appendix.

Under this new waiver, Public Hospitals will certify their health care expenditures (referred to as "Certified Public Expenditures" or CPE) in order to obtain federal funds, and Private Hospitals will rely solely on the state's General Fund to obtain their federal funds. In addition, Public Hospitals will be able to use Intergovernmental Transfers (IGT's), which was the primary method of funding the state match under the previous financing system, on a limited basis to obtain federal matching funds.

Private Hospitals are receiving their funding as contained within the Waiver framework since General Fund support is used to obtain the federal match. However Public Hospitals are only receiving federal payments for Medi-Cal services, referred to as Medi-Cal per diem payments as discussed below.

II. Key Implementation Issues Impede Flow of Federal Funds

Several Implementation Issues Unresolved. Though the Waiver is approved, it is not yet fully operational. There are several key implementation issues which are still pending. Until these issues get resolved, it is unlikely that full federal funding will proceed as provided for within the Waiver. The most critical implementation issues are as follows:

- ***CPE Still Pending Federal Approval So Funds Not Yet Provided.*** The definition of what constitutes a certified public expenditure is still pending federal CMS approval. Therefore, the federal CMS will not yet provide California with federal funds for its Disproportionate Share Hospital Program

(about $1.032 billion in federal funds) or the Safety Net Care Pool ($586 million in 2005-06).

Public Hospitals are therefore only receiving Medi-Cal per diem reimbursement. Private Hospitals are receiving all of their reimbursements since General Fund support is used to draw the federal match.

- ***State to Develop Process for Public Hospitals to Report CPE.*** The Department of Health Services (DHS) notes that work is proceeding on reporting forms and procedures for the Public Hospitals to provide their individual CPE information to the state, once federal CMS approval is obtained. It is likely this process will take from several weeks to a month to complete.

  In addition, it is unclear at this time whether the DHS will authorize some portion of federal funds to be paid to Public Hospitals from DSH or the Safety Net Care Pool pending completion of the forms and submission of them to the DHS by all of the Public Hospitals.

- ***Public Hospital Cash Flow Concerns.*** Presently, Public Hospitals are only receiving Medi-Cal per diem reimbursement. No supplemental federal funds associated with the Waiver are being provided. As such, several Public Hospitals are experiencing cash flow concerns and are in discussion with the DHS. Normally Public Hospitals would have received about $650 million in payments by this time of the fiscal year.

- ***State Plan Amendments (SPAs) Still Pending.*** The mechanics of the Waiver also require the state to submit three State Plan Amendments (SPAs) to the federal CMS for approval. These SPAs include changes pertaining to (1) CPEs, (2) the Disproportionate Share Hospital Program, and (3) Medi-Cal services provided by physicians, interns and residents, and non-physician practitioners.

  Each of these SPAs needs to be finalized by the DHS and submitted to the federal CMS for approval. It is likely that completion of these will take at least several months.

III. Potential Short-Term Options to Mitigate Cash Flow Concerns

As the DHS continues to work towards full Waiver implementation with the federal CMS and hospitals, there is a need to discuss options to maintain Public Hospital fiscal stability in the short-term. Some hospitals may be able to sustain themselves using reserves made available through their counties, while others may not have this flexibility. Some options which may be available include the following:

- ***Provide a Limited General Fund Loan.*** The DHS has provided General Fund loans (at no interest) in the past under the auspices of the Medi-Cal Program. However these loans/advances have not equated to large amounts and have been narrow in their focus.
- ***Use Safety Net Care Pool Funds First.*** Once the CPE definition is approved by the federal CMS, the DHS may be able to receive federal funds for the Safety Net Care Pool (i.e., Health Care Support Fund, see below). These funds could then potentially be allocated to the Public Hospitals to assist with cash flow concerns. A "settle-up" process could then be done at a later date once the new financing system is in place.

  The mechanics of the Waiver, as contained in SB 1100, envisioned that the Safety Net Care Pool Funds would be expended after Disproportionate Share Hospital Funds were allocated. However at this time it is unknown when DSH funds will be available due to the need to compete the SPA with the federal CMS.

IV. Governor's Proposed Budget for the Hospital Financing Waiver

Background (See Table, below). The Governor's budget proposes two-years of expenditures for the federal funds made available through the Waiver. A portion of these federal funds require a General Fund match. However most of the necessary match to draw the federal funds comes from the Public Hospitals through the form of a certified public expenditure or an IGT. The proposed budgeted expenditures and their corresponding match are shown in the table below.

Summary of Special Funds Contained in the Waiver. SB 1100 establishes several special funds to appropriate and allocate the federal funds. A brief description of each of these is as follows.

- ***The Health Care Support Fund (i.e., Safety Net Care Pool).*** This fund is used to appropriate the Safety Net Care Pool Funds. These funds are capped at $586 million (for year one and two of the Waiver) since the Administration and Legislature mutually agreed not to require the mandatory

enrollment of aged, blind and disabled individuals into Medi-Cal Managed Care as proposed by the Administration.

These funds are to be used for uncompensated care provided to the uninsured.
Funds from this pool cannot be used for services provided to individuals who do not have legal documentation status. As such, the CPE used to match the federal funds must be discounted by 17.79 percent. (The Disproportionate Share Hospital Fund can be used for uncompensated care provided to all individuals, regardless of immigration status.)

As contained in SB 1100 these federal funds are to be allocated to Public Hospitals and certain state-operated programs as specified. Of the amount available to the Public Hospitals as shown in the table below, about $400 million is needed to provide baseline funding for 2005-06. Any remaining amount of funds will be used to fund stabilization, as specified in the enabling statute.

The amount shown for state-operated programs results in a corresponding General Fund savings. This General Fund savings are then re-invested into the Medi-Cal Program to assist in funding Private Hospitals through the Waiver.

- ***Disproportionate Share Hospital (DSH) Funds.*** As directed by SB 1100, DSH Funds will be solely allocated to Public Hospitals using existing formulas. The Public Hospitals will use both CPE and IGTs as appropriate to draw the federal match. The DHS will administer this process.

- ***Physician and Non-Physician Services in Medi-Cal.*** As part of the Waiver agreement, the federal CMS required California to identify costs that are in excess of payments received on a per-visit or per-procedure basis from any Medi-Cal source of reimbursement. As noted above, this change requires a SPA and it is also identified as a separate cost from inpatient expenditures for purposes of the Waiver.

- ***Interim Payments for Medi-Cal "Cost-Based" Inpatient Days.*** Under the Waiver, Public Hospitals must contract with the CA Medical Assistance Commission (CMAC) but will receive cost-based reimbursement for inpatient days provided to Medi-Cal enrollees as determined by the DHS. Public Hospitals must use CPE to match the federal funds.

  The DHS will administer these payments and are to conduct a "settle-up" process with each of the individual Public Hospitals to ensure appropriate payment. The amount of federal funds shown in the Governor's budget for this purpose is a "placeholder" amount and is likely to high of an amount.

- ***Private Disproportionate Share Hospital Fund.*** This fund will be used to appropriate the "replacement" DSH funds to the Private Hospitals. General Fund support is used for the federal match. The amount appropriated is based on the prior year amount as directed by SB 1100.

- ***Private Hospital Supplemental Fund.*** This fund is used to provide replacement SB 1255 supplemental federal funding to Private Hospitals. General Fund support is used to obtain the federal match. The enabling statute specified an amount to be provided to this fund based upon prior payments made to these hospitals.

- ***Distressed Hospital Fund.*** SB 1100 created this new fund. Technically, it is not part of the Hospital Financing Waiver but it was established due to unexpended funds remaining from prior year IGTs which could be used to obtain a federal match under the prior Waiver. The California Medical Assistance Commission (CMAC) will allocate these funds as appropriate, based on criteria established in the enabling legislation.

- **Medi-Cal Inpatient Reimbursement for Private Hospitals.** The CA Medical Assistance Commission (CMAC) will continue to operate the Selective Provider Contracting Program. Medi-Cal inpatient reimbursement is provided to the Private Hospitals as had been done in the past (i.e., reimbursement is made under the Medi-Cal Program using 50 percent General Fund to match 50 percent in federal funds). **As such, these dollars are <u>not</u> reflected in the table below *(next page).***

The following table provides an overview of the Governor's budget, showing the: **(1)** available federal funds under the Waiver; **(2)** required Public Hospital CPE and IGT match to draw their federal funds; **(3)** required General Fund match to draw the federal funds for the Private Hospitals; and **(4)** allocations to be made by type of hospital as identified under the Waiver.

Table: Governor's Budget Appropriations for Hospital Waiver Funding

Overview of Hospital Waiver Funding	**2005-06**	**2006-07**
A. Hospital Care Support Fund *(Safety Net Care Pool-federal funds)*	**$586 million**	**$586 million**
Public Hospitals, including UC system	$528.3 million	$495.8 million
Public Hospitals CPE required to match Federal Funds	($528.3 million)	($495.8 million)
Total for State Programs (This results in General Fund savings which are re-invested to assist in matching federal funds for the Private Hospitals funding.)	$57.7 million	$90.2 million
B. Disproportionate Share Hospital Fund *(Federal Funds)*	**$775.2 million**	**$1.032 billion**
Public Hospitals, including UC system (Federal Funds)	$771 million	$1.028 billion
Public Hospitals CPE required to match Federal Funds	($221.7 million)	($319.9 million)
Public Hospitals Intergovernmental Transfer required	($549.3 million)	($708.1 million)
District Hospitals (Federal Fund amount)	$4.2 million	$4.5 million
District Hospitals (General Fund amount)	($4.2 million)	($4.5 million)
C. Physician & Non-Physician Srvcs in Medi-Cal *(Federal Funds)*	**$95.9 million**	**$98.6 million**
Public Hospitals	$95.9 million	$98.6 million
Public Hospitals CPE required to match Federal Fund	($95.9) million	($98.6) million
D. Interim Medi-Cal "Cost-Based" Payments *(Federal Funds)*	**$662.8 million**	**$1.025 billion**
Public Hospitals *(Place holder amount)*	$662.8 million	$1.025 billion
Public Hospitals CPE required to match Federal Fund	($662.8 million)	($1.025 billion)
E. Private Disproportionate Share Hospital *(Federal Funds)*	**$213.1 million**	**$232.5million**
General Fund match required	($213.1 million)	($232.5million)
Private Hospitals total amount received (federal and GF support)	($426.3 million)	($465 million)
F. Private Hospital Supplemental Fund *(Federal Funds)*	**$118.4 million**	**$118.4 million**
General Fund match required	($118.4 million)	($118.4 million)
Private Hospitals total amount received	($236.8 million)	($236.8 million)
G. Distressed Hospital Fund (CMAC allocation) *(Federal Funds)*	**$13.4 million**	**$13.4 million**
Public Hospitals, Intergovernmental Transfer required (prior year)	($13.4 million)	($13.4 million)
Total amount CA Medical Assistance Commission can allocate	($26.8 million)	($26.8 million)
H. District Hospitals Supplemental Payments *(Federal Funds)*	**$1.9 million**	**$1.9 million**
General Fund match required	($1.9 million)	($1.9 million)
District Hospitals total amount received	($3.8 million)	($3.8 million)
Total Federal Funds Budgeted	**$2.467 billion**	**$3.109 billion**
General Fund Support for Private Hospitals (*Not* including Medi-Cal inpatient per diem costs)	**$337.6 million**	**$357.3 million**
Total CPE *and* IGT provided by Public Hospitals	**$2.071 billion**	**$2.662 billion**

Total Funds (all sources)	**$4.876 billion**	**$6.128 billion**

V. Coverage Initiative

Waiver Requirements. The Centers for Medicare and Medicaid Services' (CMS) Special Terms and Conditions (STC) indicates that $180 million of federal Safety Net Care Pool funds in each of demonstration years three, four and five (September 2007 through August 2010) is available contingent upon the state implementing a Healthcare Coverage Initiative (Coverage Initiative) that will expand health care coverage options for uninsured Californians. The Coverage Initiative can rely upon existing relationships between the uninsured and safety net health care systems, hospitals and clinics. (For state budgeting purposes, the "Hospital Care Support Fund" has been established to receive federal Safety Net Care Pool payments.)

The STC states that the $180 million is an annual allotment and cannot be used in subsequent demonstration years. Additional Safety Net Care Pool funds may be used for the Coverage Initiative at the state's option.

The state agreed to the following milestones as outlined in the STC:

- By January 31, 2006 submit a concept paper on the Coverage Initiative;
- By September 1, 2006 submit a waiver amendment on structure, eligibility and benefits for the Coverage Initiative; and,
- By September 1, 2007 begin enrollment in the Coverage Initiative.

Department of Health Services (DHS) Concept Paper. The January 31, 2006 concept paper developed by DHS and submitted to CMS makes a number of points. First, annual Coverage Initiative expenditures must equal $440 million to maximize the full federal allocation. This is because the federal funding comes from the Safety Net Care Pool. Claims from the pool are reduced 17.79 percent because the federal government assumes those expenditures are for non-emergency care to unqualified immigrants for whom the federal government will not pay.

To illustrate, if in a year total Coverage Initiative expenditures are $360 million, the federal government will pay half reduced by the 17.79 percent reduction, or only $148 million. To get a $180 million federal payment, public expenditures would have to be $440 million. If total expenditures are $440 million, the federal government would pay half reduced by 17.79 percent, which yields approximately $180 million in federal funds.

DHS points out that $540 million in the last three years of the Waiver ($180 million per year) will be the only source of growth in Waiver funding to offset increases in caseload and costs for indigent health care services. As those hospital costs rise, federal payments under the Waiver will otherwise remain flat.

DHS implies that the financial situation of these hospitals should be taken into account in designing the Coverage Initiative.

An additional issue raised by DHS is that programs supported by the Coverage Initiative must be fully operational on September 1, 2007, including full program enrollment. The entire $180 million must be spent annually and cannot be rolled over to subsequent years, except to pay for expenses incurred in the previous year.

In their concept paper, DHS raises the following questions:

- What will be the source of the local and state funds needed to claim the available federal funds?
- How will interested entities be selected to develop and implement Coverage Initiative activities?
    - Will the allocation be based on the number of uninsured and the geographic diversity in respective counties?
    - Will selection be based on program design? Or some other funding allocation?
    - How will the program interact with funding allocations made under existing state law?
- What are the criteria for eligible individuals to participate in the Coverage Initiative?
    - Should the program target uninsured adults not eligible for Medi-Cal?
    - What income limits should apply? 100% of federal poverty level (at or below $9,570 for an individual in 2005), county Medically Indigent Adult income levels, or some other standard?
- Should different or uniform models be tested?
- Should inpatient care be included or excluded?
- Which providers will receive Coverage Initiative funds?

Finally, DHS states that legislation in 2006 is necessary for submission of the required Waiver amendments.

Policy issues to consider. There are two threshold questions that must be answered in order to develop a framework for the Coverage Initiative.

What is the non-federal source of funding and should the Coverage Initiative be designed to direct all federal payments to safety net hospital systems? The non-federal source of funding could be General Funds or local funds, or a combination of both. If it is determined that the Coverage Initiative should be designed to direct federal payments to safety net hospital systems, what will the implications be for counties that operate public hospitals? As indicated by DHS, the federal money that is available for the Coverage Initiative

represents the only source of growth in the last three years of the Waiver for indigent health care services. Since federal payments to public hospitals are capped under the Waiver, and the state will not be at risk for any increases in cost or caseload associated with health care services for indigent populations, counties with public hospitals will shoulder the financial burden associated with responding to these increases. Many additional issues will need to be considered, including those raised below.

Is it reasonable to expect any Coverage Initiative program to be fully operational on September 1, 2007? It is unlikely any new program could be fully operational without adequate lead time and resources for planning and marketing purposes. In addition, the Waiver is time-limited: without an extension the Waiver will end August 2010. This structure may limit the state's ability to create new programs. Policymakers may wish to consider expansions to existing state and local programs that already have infrastructure in place, including very simple enrollment mechanisms, which could more easily be expanded to new populations.

Is $440 million a year for three years enough funding to implement a statewide Coverage Initiative program? Given the limited funding available, policy makers may want to consider pilot projects targeting specific populations or certain geographic regions. Another option may be to test innovations to existing state or county programs that will reduce the population of uninsured individuals who are eligible but not enrolled in existing programs.

How will the state evaluate the success of the initiative? What outcome measurements and performance indicators should be used? There are many benchmarks that could be used, such as a reduction in the number of uninsured, reduction in emergency room visits, reduction in inpatient costs, improved coordinated case management, etc.

How will the Administration proceed with the development of the initiative? The DHS concept paper raises many questions but does not provide answers to those questions. The DHS paper does not contain draft legislation or a timeline for meeting legislative policy or fiscal deadlines other than to mention that legislation in 2006 is necessary before the department can submit Waiver amendments that are due to CMS by September 1, 2006.

Stakeholder Input Sought. On October 19, 2005, DHS requested from stakeholders initial input on the development of the Coverage Initiative concept in preparation for a larger public stakeholder process that was expected before the end of the year. There were no additional public meetings scheduled in 2005. However, Administration officials have indicated that public meetings will be scheduled in Sacramento and Los Angeles in the coming weeks. Approximately 25 responses were submitted to the department by the November 4, 2005 deadline. Recommendations and suggestions contained in some of those

responses are summarized below. A side by side of the Administration's concept paper along with five of the more comprehensive proposals follows the bullets.

General Recommendations

- Focus on uninsured low-income adults with an emphasis on local flexibility and control, test innovative models such as expanded coverage of preventive services, management of chronic diseases, intensive case management of high cost users, and assignment of patients to medical homes.
- Relieve the burden on safety net care providers, build upon existing programs and provide insights to help shape plan designs for the future, fund medical care in a manner that reduces costs and improves quality, and permit local flexibility.
- Support cost-effective, primary and preventive care, ensure adequate, actuarially sound provider reimbursements, ensure culturally and linguistically responsive delivery systems, implement effective quality monitoring and measurements, involve consumers and providers and protect consumer choice.

Supplemental Funding for Existing Local Programs

- Provide funding for "Frequent Users" programs, which provide intensive case management services to individuals who repeatedly seek care inappropriately in hospital emergency departments. Early evaluations indicate a reduction in emergency department visits, hospital inpatient days and significant cost avoidance for hospitals.
- Permit counties that operate their own indigent care programs to match local expenditures with federal funds using their own indigent care standards.

Expand Existing Programs

- Expand state programs using General Fund such as Expanded Access to Primary Care, Major Risk Medical Insurance Program, Genetically Handicapped Persons Program, and County Medical Services Program.
- Expand primary care services and provide fair reimbursement for physicians.
- Create a program to cover children, such as raising income eligibility in Healthy Families to 350 percent of the federal poverty level, and increasing the allowable income levels of families in the California Children's Services program. Improve access to outpatient, urgent and preventative care by supplementing the Outpatient Disproportionate Share fund.
- Fund the coverage of parents of children on Healthy Families.

Protect Safety Net Hospitals

- Maintain the viability of safety net hospitals, recognize the important role of facilities that provide costly tertiary and quaternary care, continue to earmark funding for public hospital payments, keep the project manageable and efficient, and sustain providers that currently serve Medi-Cal and uninsured patients.
- Choose the source of the non-federal share of funds carefully in order to protect funding for safety net hospitals. Anchor the product around public hospitals because they provide a range of services to the uninsured, they are the primary recipients of Waiver funding, and they will likely treat many of the newly covered individuals after the funding expires.

	Administration's Principles and Goals	California Association of Public Hospitals and Los Angeles County	Insuring the Uninsured Project	Health Consumer Advocates	San Diegans for Healthcare Coverage	Working Partnerships USA
Selection Process	Unknown.	Unknown.	Competitive grants to local and regional coalitions.	N/A	Unknown.	Santa Clara County Pilot Project.
Administration	Unknown.	Counties that operate public hospitals or have a UC hospital.	Unknown. Could be determined by coalition.	Expand Medi-Cal and Healthy Families.	Unknown.	Unknown.
Eligibility	Unknown. No linkage to Medi-Cal or Healthy Families. No entitlement.	Uninsured adults (18-64) with income under 100 percent of the federal poverty level: ability to target sub-populations and tailor services to improve care; no linkage to Medi-Cal or Healthy Families, except possibly uninsured parents of	Low wage, uninsured workers with no minor children at home where there is no possible federal funding available, such as farm workers, child care workers, foster parents, garment workers or workers in other low wage industries. Not	All state residents with family income up to 300 percent of the federal poverty level. Simplify existing Medi-Cal and Healthy Families program rules (i.e., standard income deduction, self-declaration of	Working uninsured and their families. Anyone episodically eligible for state programs should remain in coverage program and wrap around state program benefits should be provided.	Uninsured workers and dependents under 300 percent of the federal poverty level who live in Santa Clara County.

	Administration's Principles and Goals	California Association of Public Hospitals and Los Angeles County	Insuring the Uninsured Project	Health Consumer Advocates	San Diegans for Healthcare Coverage	Working Partnerships USA
		children in Medi-Cal or Healthy Families.	Healthy Families parents or uninsured children.	income, no assets test, etc).		
Enrollment	Health card and medical record.	Health card. Total enrollment based on funding.	Unknown.	Accelerate enrollment at the Single Point of Entry and provider based on one-stop simplified e-app through gateway programs.	Unknown.	Unknown.
Benefits	Unknown. Defined benefit package that includes preventive services and early intervention/ provide a medical home (primary care physician).	Inpatient, outpatient and prescription drug services, with an option to focus services to sub-populations such as to bridge gaps in care and provide better care coordination and	Preventive and outpatient services that will improve individual and public health, and reduce demand on hospital emergency rooms combined with coverage	Medi-Cal and Healthy Families.	Essential, basic benefits package that encourages access to early intervention and improved health outcomes, including disease management. Healthy	Comprehensive benefits including preventive care, prescription drug and hospitalization.

	Administration's Principles and Goals	California Association of Public Hospitals and Los Angeles County	Insuring the Uninsured Project	Health Consumer Advocates	San Diegans for Healthcare Coverage	Working Partnerships USA
		case management. Assignment of medical home (PCP) and description of covered services. Option to provide case management services to patients with chronic conditions (diabetes, hypertension, congestive heart failure, asthma), and create patient registries.	for catastrophic hospital costs.		behavior incentives should be incorporated.	
Delivery System	Unknown. Organized delivery system.	Public hospitals and clinics and providers contracted by counties, UC	Local safety net health plans, where possible, with broad flexibility to	Medi-Cal and Healthy Families.	Unknown.	County based, multi-purchaser insurance plan.

	Administration's Principles and Goals	California Association of Public Hospitals and Los Angeles County	Insuring the Uninsured Project	Health Consumer Advocates	San Diegans for Healthcare Coverage	Working Partnerships USA
		hospitals.	develop cost effective and quality networks.			
Non Federal Financing	$260 million, source unknown.	Assumes public hospital and UC CPEs.	Combination of state and local funds; encourage the use of private, employer, and employee funding. No supplanting of existing government funds.	Impose HMO gross premium tax, savings from Medi-Cal managed care reforms, employer payments, premiums and copayments.	State, local funds and private.	Workers, employers, third party, possibly a subsidy from the Santa Clara County Health and Hospital System that can be leveraged with other sources of funds.
Safety Net Providers	Ensure long term viability within existing systems.	Support and sustain public and UC hospitals in counties that contain 80% of uninsured.	Local health plans contract with safety net providers.	Uses safety net to the same extent as current system.	No references.	County could serve as a participating provider.
Cost Sharing	Unknown.	Unknown.	No or small deductible for outpatient and	Based on ability to pay. Nothing for people at or	Based upon family income.	Affordable premiums.

	Administration's Principles and Goals	California Association of Public Hospitals and Los Angeles County	Insuring the Uninsured Project	Health Consumer Advocates	San Diegans for Healthcare Coverage	Working Partnerships USA
			substantial deductible or expenditure cap for inpatient.	below 200 percent of the federal poverty level, current Healthy Family levels for people with family income between 201 and 300 percent.		
Other	Improve access and monitor for health outcomes, promote personal responsibility, screen and enroll for Medi-Cal, Healthy Families or local insurance programs.	Improve system of care for uninsured; counties should be responsible to develop, coordinate and oversee their local programs within state and federal parameters, reduction in inappropriate health care by		Build a basic infrastructure for eventual universal coverage for all residents with income up to 300% of the federal poverty level.	Establish limited pilot projects that demonstrate innovation. Establish crowd-out rules and accounting.	

	Administration's Principles and Goals	California Association of Public Hospitals and Los Angeles County	Insuring the Uninsured Project	Health Consumer Advocates	San Diegans for Healthcare Coverage	Working Partnerships USA
		uninsured, improvement in services to uninsured and Medi-Cal patients, and reduced demand on Medi-Cal. No entitlement.				
Strengths	Unknown.	Permits broad local flexibility. Supports public health systems. Identifies funding mechanism.	Target individuals with no other potential for federal funding. Permits local flexibility.	Better coordinates existing programs. Serves all low-income populations. Provides some support for public health systems.	Promotes public private partnerships. Defines target population.	Promotes public private partnerships. Defines target population.
Weaknesses	Unknown.	Target population is unclear. Specific outcomes	Need time for ramp up. Potential negative impact on safety net	Fiscal estimate unknown, but probably substantial costs to implement.	Need time for ramp up. Potential negative impact to safety net	Need time for ramp up. Unknown impact to safety net providers.

	Administration's Principles and Goals	California Association of Public Hospitals and Los Angeles County	Insuring the Uninsured Project	Health Consumer Advocates	San Diegans for Healthcare Coverage	Working Partnerships USA
		unclear.	providers to the extent enrollees choose other providers. Funding mechanism not specific.	Unknown impact on safety net providers.	providers. Funding mechanism not specific.	Funding mechanism not specific. Is limited to one county.

APPENDIX

Key Sources OF PAYMENTS TO HOSPITALS UNDER THE WAIVER

Public Hospitals (22 Specified)

Medi-Cal "Cost–Based" Reimbursement

- Each hospital receives individual Medi-Cal "cost-based" rate.
- Must contract with CA Medical Assistance Commission (CMAC).
- Use Certified Public Expenditures (CPE) for federal match. No General Fund support.
- If Medi-Cal inpatient volume increases, so does federal funds.

Hospital Care Support Fund (i.e., Safety Net Care Pool)

- $400 million needed to maintain 2004-05 baseline level.
- Use CPE for federal match. No General Fund support for publics.
- Additional funds for equity adjustments and stabilization funding is provided as specified in legislation. Amount available for this purpose is contingent on the amount available after the baseline level is funded and the state receives its share as designated.
- These funds are not yet available since the CPE is not finalized.

Disproportionate Share Hospital (DSH) Payments

- Provides $1.032 billion (federal funds) per existing federal law.
- Use CPE for up to 100% of uncompensated care costs (UCC) and then use Intergovernmental Transfers (IGT) for 100% to 175% of UCC for federal match. No General Fund support for publics.

Private Hospitals, Children's, and District Hospitals

Medi-Cal Per Diem Payments as provided by CMAC

- Use General Fund support for federal funds.
- Volume increases available as Medi-Cal Inpatient needs increase.
- Rate increases contingent upon General Fund and CMAC.

"Replacement" DSH & "Replacement" Graduate Medical Education (GME)

- DSH and GME for these hospitals will no longer be available as previously provided. As such a replacement program was created.
- The 2004-05 baseline level is maintained overall.
- Use General Fund support for federal funds.
- These dollars are being allocated.

Health Care Support Fund for Stabilization.

- Use General Fund support for federal funds.
- Legislation specifies criteria for stabilization funding.

"Distressed" Hospital Fund for Publics, Privates, Children's & Districts

- Accessible by all CMAC contracting hospitals, including Privates and Publics.
- Makes available another $16 million (federal funds) on an annual basis to hospitals deemed "distressed", as contained in legislation and as approved by CMAC.

Hospital Financing Waiver Overview

Prepared by Diane Van Maren, Senate Budget

(Chart: Methods of Hospital Payment by Type of Hospital)

Private & Children's Hospitals

- **Medi-Cal Inpatient Per Diem**. Hospitals contract with the CA Medical Assistance Commission (CMAC) for Medi-Cal Inpatient Per Diem Payments. These payments are made using General Fund support and a corresponding federal match (currently 50/50 percentage split). These federal funds are unlimited and will be available based on Medi-Cal inpatient volume.
- **"Replacement" DSH & "Replacement" GME**. In the aggregate, hospitals will receive payments equal to what they received in 2004-05 for both Disproportionate Share Hospital and Graduate Medical Education funding. These funds are part of the "hold-harmless" or baseline funding process. General Fund support will be used to obtain a federal match from the Safety Net Care Pool for this purpose.
- **"Distressed" Hospital Funds.** This funding will be accessible by hospitals through CMAC as specified in legislation.
- **Baseline Funding.** All contracting hospitals will receive a baseline amount equivalent to their 2004-05 level. This is the first priority of the various funding mechanisms referenced above.

District Hospitals

- **Medi-Cal Inpatient Per Diem**. Hospitals contract with CA Medical Assistance Commission (CMAC) for Medi-Cal Inpatient Per Diem Payments. This method of payment is the same as for Private Hospitals.
- **"Replacement" DSH & "Replacement" GME**. In the aggregate, hospitals will receive payments equal to what they received for 2004-05 for both Disproportionate Share Hospital and Graduate Medical Education funding. The method of payment is the same as for Private Hospitals.
- **"Distressed" Hospital Funds.** This funding will be accessible by hospitals through CMAC as specified in legislation. A key criterion to be eligible is that a hospital must contract with CMAC.
- **Baseline Funding.** All contracting hospitals will receive a baseline amount equivalent to their 2004-05 level. This is the first priority of the various funding mechanisms referenced above.

All *Non-Contract* Hospitals

- **Medi-Cal Inpatient Rate**. All non-contract hospitals will receive an established Medi-Cal inpatient rate

Public & University of CA Hospitals

- **Medi-Cal Inpatient "Cost-Based".** All Public Hospitals (22 specified) must contract with CMAC. Each hospital will receive a "cost-based" rate which reflects their individual hospital expenditures. "Certified public expenditures" (CPE) will be used to draw the federal match. These federal funds are available as long as there is CPE to draw the match. No General Fund support.
- **Disproportionate Share Hospital Payments (DSH)**. Per existing federal law, the DSH federal funds are capped at $1.03 billion. These funds will be solely allocated to the 22 Public Hospitals based on a formula. CPE will be used to draw the federal match. No General Fund support.
- **Safety Net Care Pool Funds**. This pool is capped at $586 million (federal funds) for the first two-years of the Waiver and is used for uncompensated care provided to the uninsured. About $400 million will be used to provide "baseline" funding to the Public Hospitals. CPE's will be used to draw the federal funds for the Public Hospitals.

  The remaining pool amount is used to provide certain equity adjustments and stability funding to hospitals, as well to support certain state-operated programs.
- **"Distressed" Hospital Funds.** This funding will also be accessible to Public Hospitals.