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DISTRICT HOSPITAL LEADERSHIP FORUM



September 10, 2014

Diana Dooley, Secretary
California Health and Human Services
1600 Ninth Street, Room 460
Sacramento, CA 95814

Subject: Task Force Comments on California's Concept for 1115 Waiver Renewal

Via email: ddooley@chhs.ca.gov

Dear Secretary Dooley:

On behalf of California's Disproportionate Share Hospitals (DSH), and the California Hospital Association, we extend our appreciation for your leadership in investing in the state's health care delivery system to prepare for the significant changes resulting from the implementation of the Affordable Care Act (ACA). We appreciate the opportunity to provide you with our comments on the state's proposal, and we look forward to discussions with you and your staff on how to ensure access to health care services for the state's Medi-Cal members and remaining uninsured individuals.

Members of this task force include the California Hospital Association (CHA), the California Association of Public Hospitals and Health Systems (CAPH), Los Angeles County Department of Health Services, Private Essential Access Community Hospitals, Inc. (PEACH), the California Children's Hospital Association (CCHA), the University of California medical centers and the District Hospital Leadership Forum (DHLF). The hospitals represented by these groups serve as the state's primary safety net for its health care system.

California's 2010 1115 "Bridge to Reform" Medicaid waiver has been instrumental in the state's early success with health reform implementation. Through the waiver's Low Income Health Program, more than 650,000 low-income individuals seamlessly transitioned into Medi-Cal and Covered California. Furthermore, the Delivery System Reform Incentive Program (DSRIP) has been critical in helping public health care systems transform and improve care delivery. In 2015, we hope to build on the success of the current waiver so that California can fully implement and achieve the promise of health reform.

In this document, we offer our thoughts and comments on the conceptual framework for the 1115 waiver, as well as some new thinking about how we can work together to position California to ensure continued success in implementing the ACA.

Increasing Federal Funding

California's DSH hospitals are committed to continuing their leadership in developing and implementing transformational efforts to improve care delivery at a lower cost with higher quality. We look forward to advancing a renewed waiver with new and innovative approaches to achieve success with the ongoing implementation of the ACA and other reforms.

We share your goal of finding new funding sources of the non-federal share of Medi-Cal, but we also encourage the state to consider General Fund contributions to waiver concepts that further the Triple Aim of the ACA over the five-year period. For example, early General Fund contributions will, by the end of the five-year demonstration result in General Fund cost savings that will increase prospectively. We believe it is necessary for the state to make appropriate investments to ensure that Medi-Cal beneficiaries have access to high quality, patient-centered and coordinated care regardless of their point of health care access. While the state's concept paper envisions seeking the Centers for Medicare & Medicaid Services' (CMS) approval to use cost savings as a source of state match, we recommend that General Fund investment be dedicated if it can be demonstrated that these investments can begin to be recouped through system transformation and other initiatives that lead to meeting the Triple Aim by the end of the demonstration project.

We would also ask that the state work with the federal government to find ways to improve California's share of federal funding such as increasing the federal funding for the Medi-Cal program. Because of California's low historical spending in the Medi-Cal program, the state is essentially being penalized for its "efficiency" in providing high-quality health care to Californians. California currently ranks 49th in per capita Medicaid spending when compared to all other states in the country. Without California's efficiencies, the federal government would be spending significantly more for the state's Medi-Cal program. We understand that using a federal waiver to maximize federal funding is difficult because spending in a waiver cannot be more than it would be without a waiver (budget neutrality). Because of the state's already low levels of utilization, achieving greater efficiencies is difficult and could create levels of budget neutrality savings far below the funding gap California needs to fill to address reimbursement rates and ensure the growing demand for access to care is met. Further, with a waiver the issue of a source for non-federal share still exists.

A potential solution for the non-federal share could lie within the amount of funding California already puts forward for the non-federal share. California shares equally with the federal government in the cost of the Medi-Cal program – or 50/50 state/federal funding. A rationale could be developed to support a higher federal share of spending up to some other rate, so that California could "get credit" for its efficiencies achieved through managed care, coordinated care, managing complex patients, risk-based payments, etc. This would essentially "gross up" the state share to be used for federal financial participation under the matching formula.

One method to adjust the state's contribution could be a comparison of California versus the national average on utilization measures such as days per 1,000, visits per 1,000, discharges per 1,000, or spending per beneficiary per year. An agreement with the federal government to fund California at a level equivalent to the national average would eliminate the complex task of finding the non-federal share. The federal government could gain from this investment in the

state by finding ways to replicate innovative ways to pay for and deliver care through California's demonstration laboratory. The enhanced federal funding could and should support program reforms for greater care coordination, better patient care experience and improved quality and efficiencies.

Waiver Concept Comments

The federal/state shared savings initiative raises questions and concerns. While we applaud the innovative approach to federalizing federal funding, the task force is uncertain about: an approach that has no "Plan B," or backup solution for the non-federal share this initiative would create; driving down per-beneficiary spending to create savings; and continuing to fund Medi-Cal at a 50% FMAP despite already providing care at the most economically efficient levels in the nation.

It appears from the concept paper that there is no backup source for the non-federal share to fund the other initiatives included in the document (Incentive Payment Programs, Shelter, and Workforce). Finding new ways to maximize federal funding by increasing the federal share should be considered and pursued – if not through a waiver, perhaps in coordination with funding through the Centers for Medicare and Medicaid Innovation (CMMI) or other sources such as the General Fund.

Relying solely on savings achieved by driving down the cost of per-beneficiary spending is a dangerous proposal in a state that already ranks 49th in the U.S. Cutting beneficiary resources at a time when investment is needed falls short of long-term goals to reform the delivery system and gain further improvements in the health of populations, quality and overall costs. We understand the state plans on negotiating a higher-than-current level of per-beneficiary spending with the federal government in the waiver. If this concept is advanced and is considered meritorious by CMS, perhaps the state could incorporate some of our thinking around increasing the federal share into its proposal.

Incentive Payment Programs

We are generally supportive of programs that allow for investments into new systems of care to enhance quality and improve efficiency. A concern is the source of the non-federal share, in that the state is again relying on the success of the shared savings program and the further approval by CMS to allow savings to be used as the non-federal share. In the event the funding mechanism is not allowed or is significantly limited, it should be a priority for the state to find other ways to secure federal funding, including allocating sufficient General Fund resources to ensure these continued improvements in care can move forward. These investment funds should not be considered as payments for services and do not need to be within the bounds of the upper payment limits.

As leaders in advancing solutions for care coordination, case management and initiatives such as patient-centered medical homes, safety-net hospitals should be eligible to receive these funds. Regardless of whether the state is successful in securing non-federal share for this program through the shared savings proposal, funding should be pursued using the concepts described above. We believe there is a great need to improve the care coordination of patients with

physical and behavioral health needs, and many safety-net hospitals are prepared to lead efforts in this area of care, with the appropriate investment funding.

Delivery System Reform Incentive Payments (DSRIP)

The task force supports developing a successor DSRIP program that anticipates the unique needs of the designated public hospitals and that operates at least at the level of the current program to ensure that improvements can be maintained and new goals can be achieved. Further, the non-designated public hospitals (NDPH) stand ready to work with the state to create a DSRIP program that meets their needs to develop systems of care, improves quality, and implements transformational change in support of the goal of meeting the Triple Aim. Funding for the NDPH DSRIP must be at an appropriate level to allow these hospitals to participate in a DSRIP and achieve improvements and work toward goals specific to the size and scope of these hospitals. While there is no DSRIP program for private hospitals envisioned at this time, we believe the state should consider the comments in the preceding sections so as to create a similar program to move all safety-net hospitals forward in this time of change.

California Children's Services (CCS) Program Improvements

We are supportive of efforts to improve care delivery, quality and cost in the CCS program. We encourage the state to work with the CCS providers to develop proposals that meet these goals. However, we encourage the state to focus on improvements in organizing the delivery of care and not rely on cost-savings in this waiver renewal. In fact, investments may be required to implement processes to effectuate the change goals. Any savings generated should be invested back into the CCS program and not used in broader budget neutrality savings' initiatives.

Shelter and Workforce Initiatives

The task force generally supports initiatives that are aimed at improving the social determinants of health so as to avoid expensive utilization of health care services. We are concerned that there is no backup source of non-federal funding, which places this program at risk. Further, state savings should be estimated for the entire waiver period and allowed to "front-load" investments into programs such as the shelter and workforce initiatives. Delays in developing innovative solutions to improve access and reduce the total cost of care could impair overall efforts in achieving those goals.

FQHC Payment/Delivery Reform

Many of our hospitals are involved in current pilots aimed at advancing alternatives to FQHC prospective payment system (PPS) payments. We understand from discussions with the Department that the PPS requirements and the alternative payment methodologies are not being waived. We look forward to being involved in the ongoing implementation of FQHC reforms.

Thank you again for the opportunity to provide comments and thoughts on the development of the 1115 waiver renewal. There are many complexities to these issues, and leaders of this task force are uniquely prepared with the knowledge and experience to provide guidance to the state. We urge you to include us throughout the process, not just through stakeholder involvement, but in the core thinking, development and refinement of the initiatives the state puts forth.

We also urge you to consider or build on our thinking about securing California's fair share in federal funding for Medicaid so that our historical efforts in creating an efficient health care delivery system can benefit from investments to advance our care and payment delivery models even further.

Sincerely,

California Hospital Association

California Association of Public Hospitals and Health Systems

University of California

Los Angeles County

California Children's Hospital Association

Private Essential Access Community Hospitals

District Hospital Leadership Forum

cc: Toby Douglas, Director, California Department of Health Care Services
Mari Cantwell, Chief Deputy Director, Health Care Programs, Department of Health
Care Services