CAPH CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS | SNI CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

Public Health Care System Financing 101

RICH RUBINSTEIN, MALAVIKA NARAYAN AND LIZ MULLEN

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1. Public Health Care System Overview

About CAPH/SNI

- The California Association of Public Hospitals and Health Systems (CAPH) and the California Health Care Safety Net Institute (SNI) represent California's 17 public health care systems and academic medical centers.
- As a trade association, CAPH works to advance policy and advocacy efforts that strengthen the capacity of its members to ensure access to comprehensive, high-quality, culturally sensitive health care services for all Californians, and educate the next generation of health care professionals.
- SNI, a 501(c) 3 affiliate of CAPH, designs and directs programs that accelerate the spread of innovative practices among public health care systems, public clinics, and beyond. SNI's work helps these providers deliver more effective, efficient, and patient-centered care to the communities they serve.

Evolving Role of PHS Over Time

- 1914: Virtually every CA county runs a hospital
- 1964: 50 of 58 counties run 66 hospitals
- 2007: Most recent 2 conversions/closures (MLK/Drew and Tuolumne General Hospital)
- 2023: 12 of 58 counties and 5 UCs run public health care systems

California's 17 Public Health Care Systems

- Alameda Health System
- Arrowhead Regional Medical Center
- Contra Costa Regional Medical Center
- Kern Medical
- LA County Department of Public Health Services
- Natividad Medical Center
- Riverside University Health System
- San Francisco Department of Public Health
- San Joaquin General Hospital
- San Mateo Medical Center
- County of Santa Clara Health System
- Ventura County Health Care Agency
- UC Health
  - UC Davis Health
  - UC Irvine Health
  - UC San Diego Health
  - UC San Francisco Health
  - UC Los Angeles Health

Includes county-owned and -affiliated health systems and the UC medical centers

Who we serve

Though accounting for just 5% of hospitals in the state, public health care systems:

- Serve more than **3.7M** patients annually, a 30% increase since 2014
- Provide **36%** of all Medi-Cal and uninsured hospital care in the state
- Provide over **12M** hospital outpatient visits per year
- Employ nearly **98,000** individuals

Ventura County Health Care Agency

- Nearly **60%** of patients identify as persons of color
- Train **45%** of all new doctors across the state
- Operate **over half** of all California's top-level trauma and burn centers

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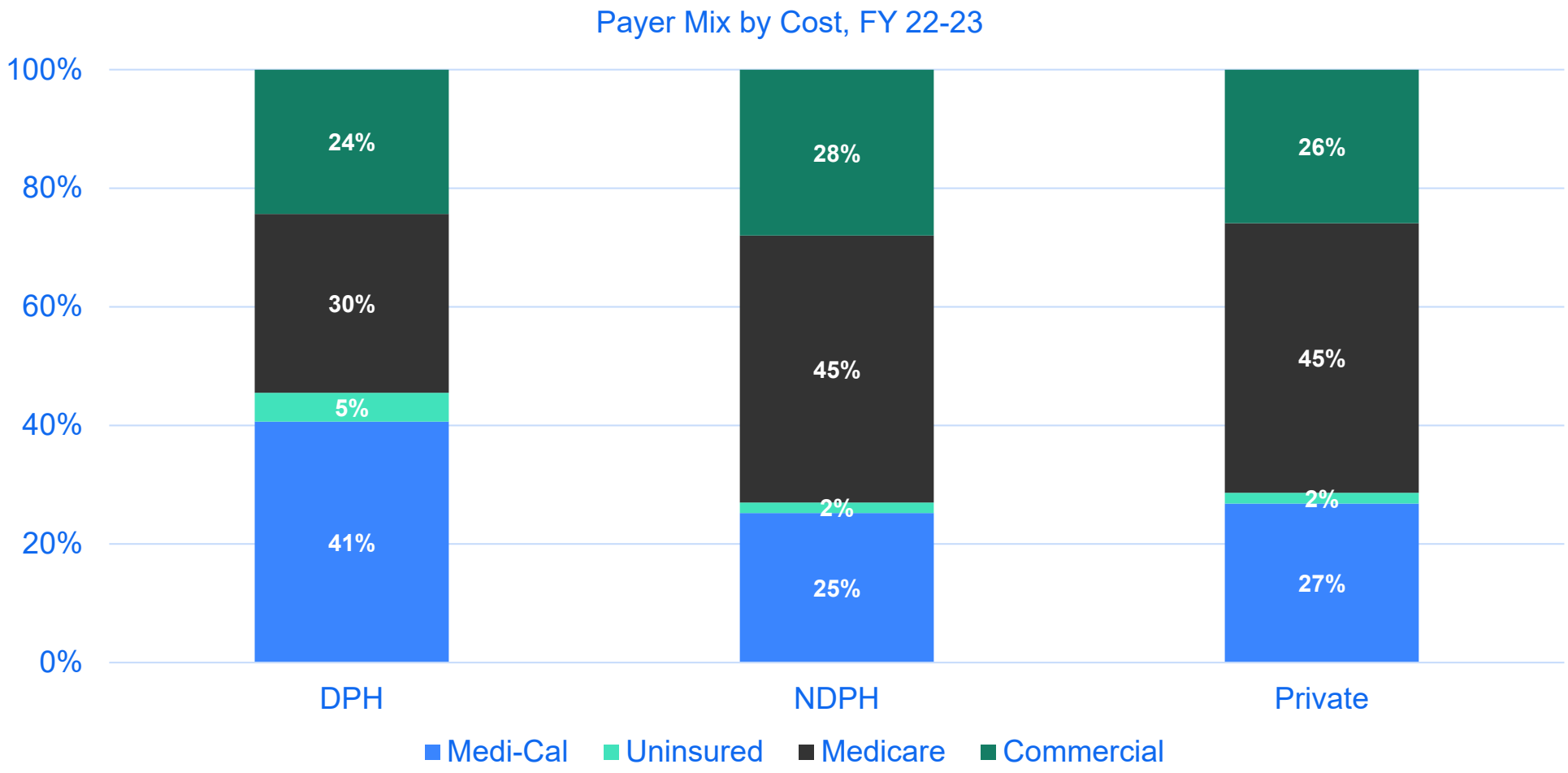
PHS: Core Providers of Care to Medi-Cal and Uninsured



Source: HCAI FY 2022-23 Hospital Annual Financial Data
DPHs: 15 county-owned and operated hospitals and six University of California medical centers
NDPHs: Non-designated public hospitals, often referred to as district hospitals
Privates: All non-DPH, non-NDPH, non-children's comparable general acute hospitals

2. Public Health Care System Financing

Medi-Cal in California

- Medicaid: Federal-State joint program, with costs shared
- Affordable Care Act vastly increased eligible population
  - About 25% of enrollees are in newly-eligible groups
- Increasing role of managed care
  - About 75-80% enrolled in managed care plans, usually automatically
  - More enrollees and services have been and will continue to be transitioned into managed care over the next few years – including duals, state-only, transplants, long term care, sub-acute etc.
- Fee-for-service mechanisms retain significant role even with increased focus on managed care – churn and waiting period
  - Large proportion of payments for services remain FFS

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Medi-Cal Non-Federal Share

- Under shared financing mechanism, federal government requires match to pay federal funds (the non-federal share)
- Federal Medical Assistance Percentage (FMAP) determines non-federal share
  - 50% for Traditional Medi-Cal population (in CA)
  - 90% for Newly-eligible Medi-Cal (ACA), permanent after gradual decrease from 100%
- Potential sources of these matching funds:
  - State general fund
  - Public governmental entities (PHS)
  - Private entities (in limited circumstances, chiefly hospital fee program)
  - MCO tax (negotiating with state for funds that could be used for the non-Federal share)

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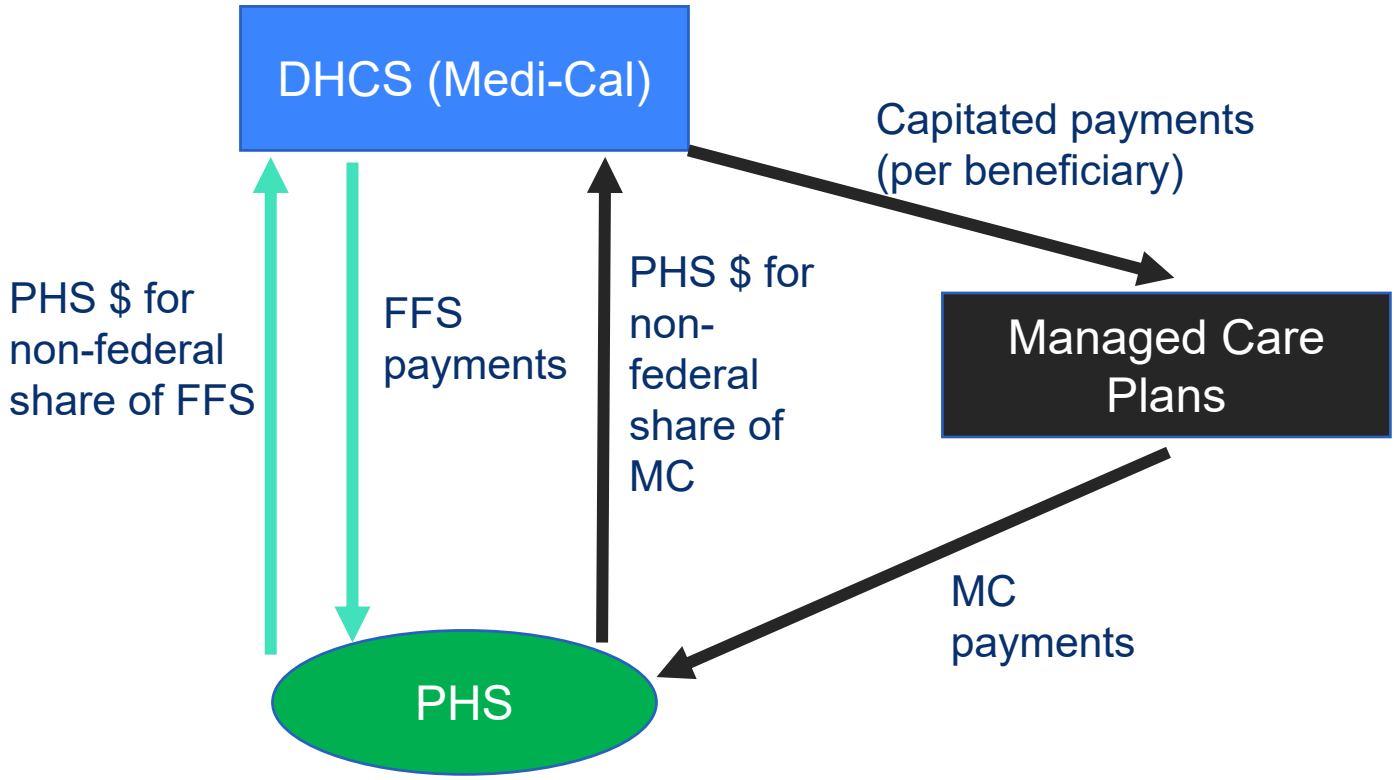
PHS in Medi-Cal Context

- "Self-financing": PHS provides both services and puts up financing for those same services

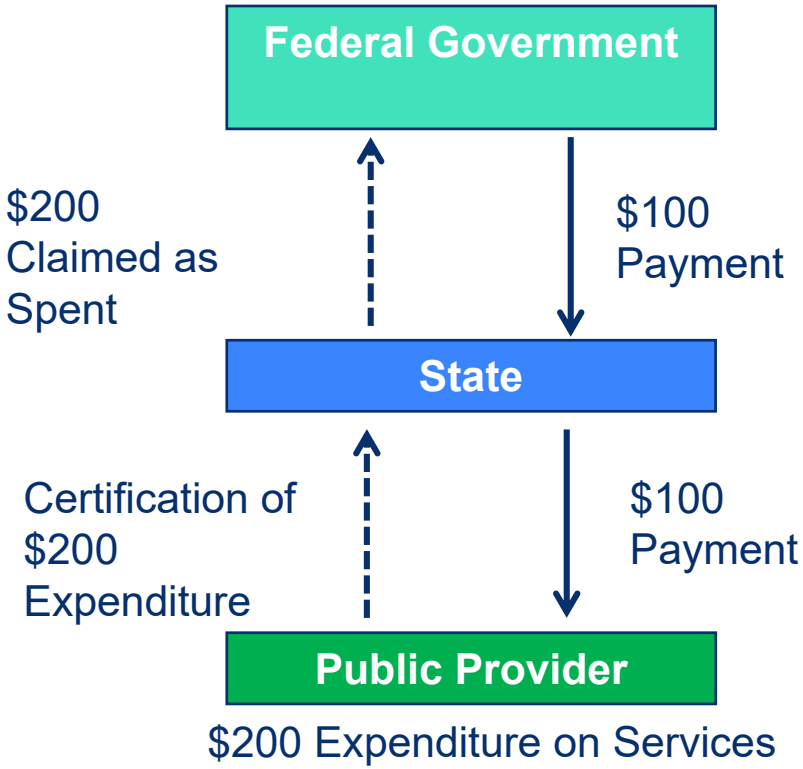


Funding the Non-Federal Share

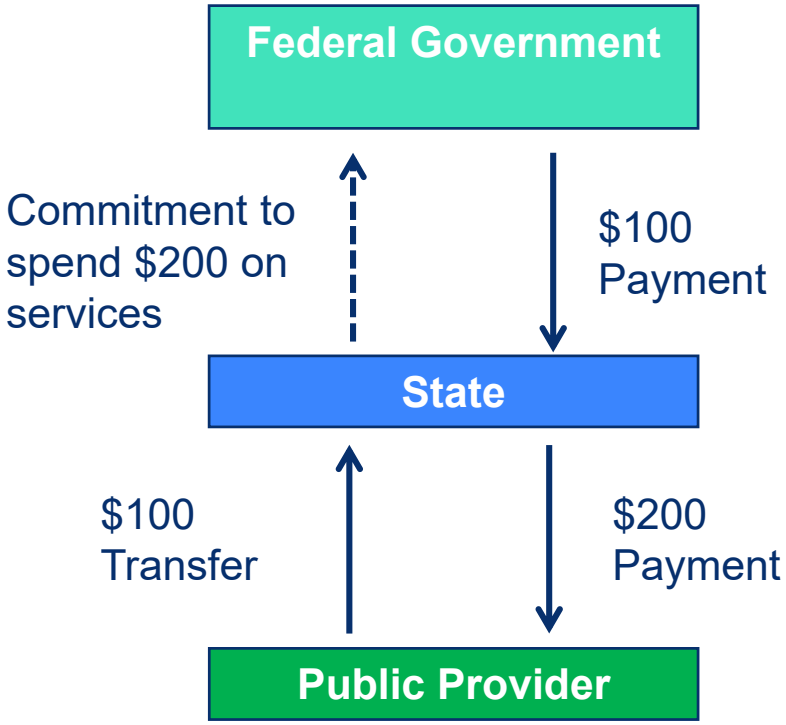
- Two primary ways that PHS fund the non-federal share
  - **CPEs:** Certified Public Expenditures
  - **IGTs:** Intergovernmental Transfers

CPE and IGT Comparison

CPE Mechanics

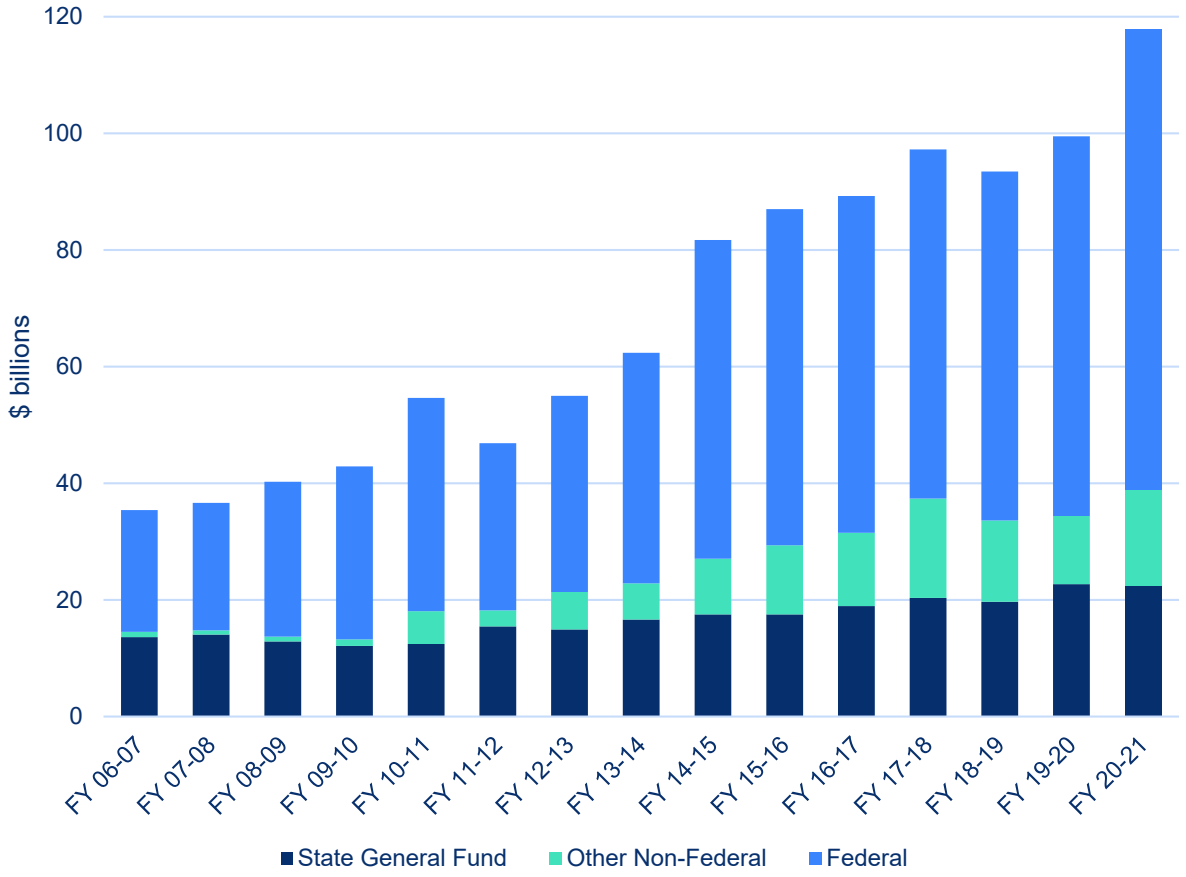


IGT Mechanics



Supporting Medi-Cal

- State general funds increase slowly or remain flat
- Increased reliance on self-financing over time to maximize federal funding
- Growing importance of federal funds



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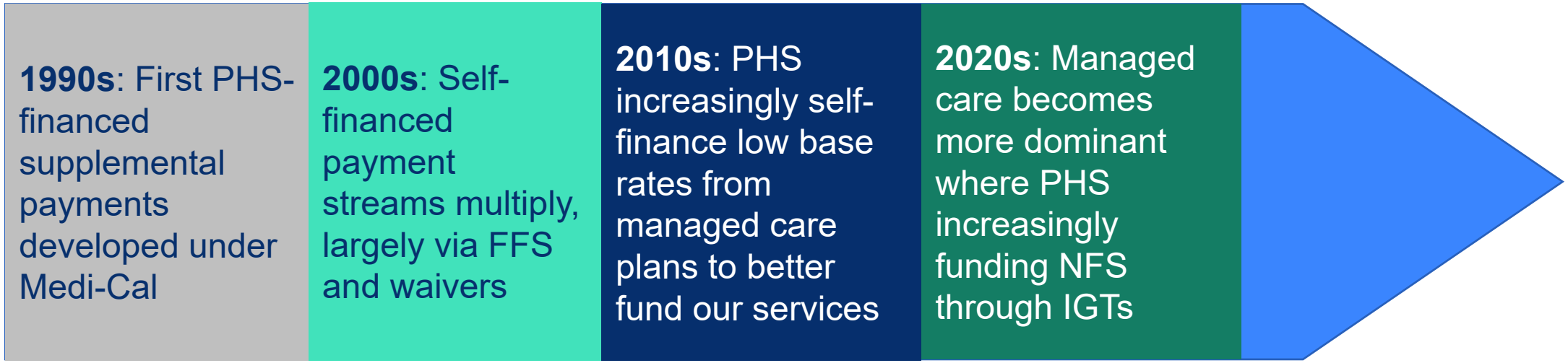
Source: May Medi-Cal Local Assistance Estimates

Mounting Role of Self-Financing Over Time



For PHS, supplementals now represent a majority of their Medi-Cal and uninsured payments

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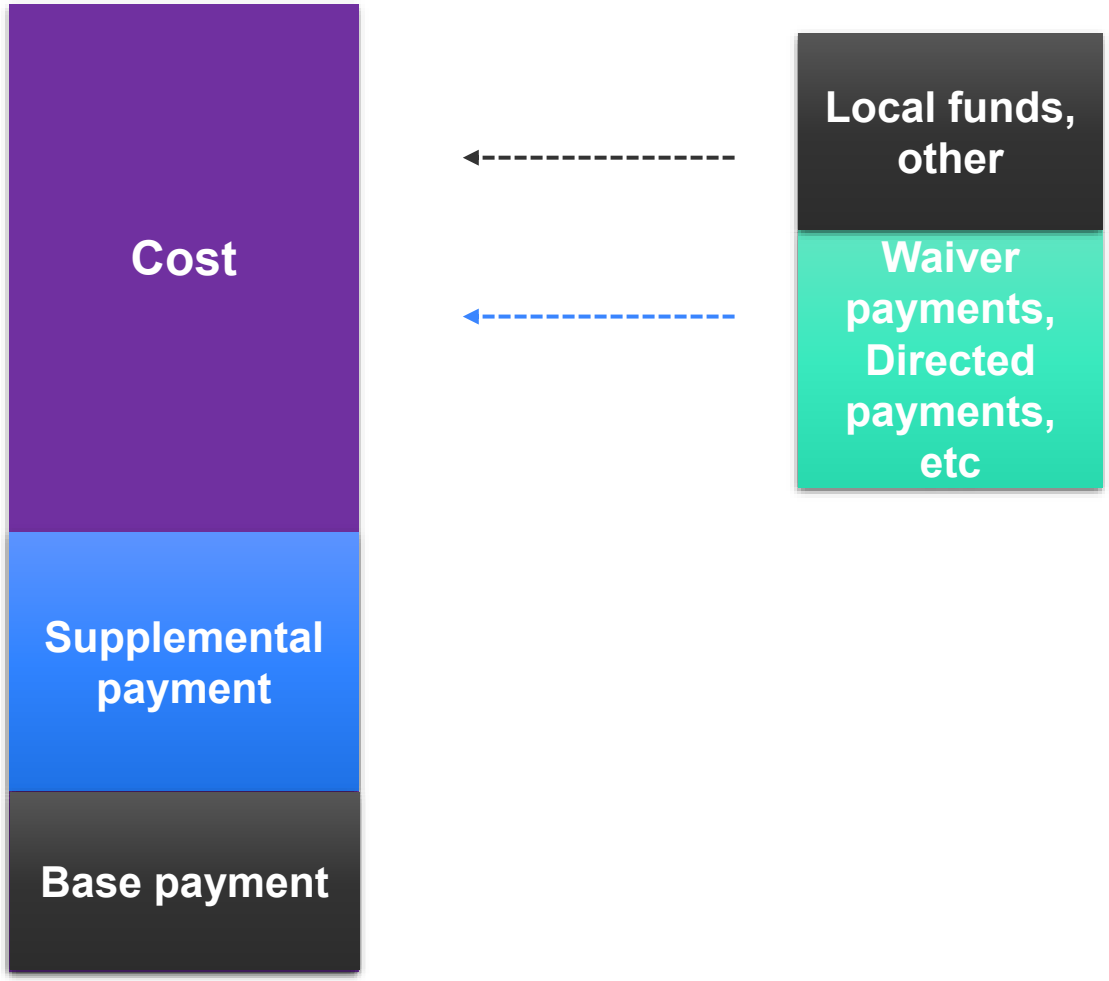
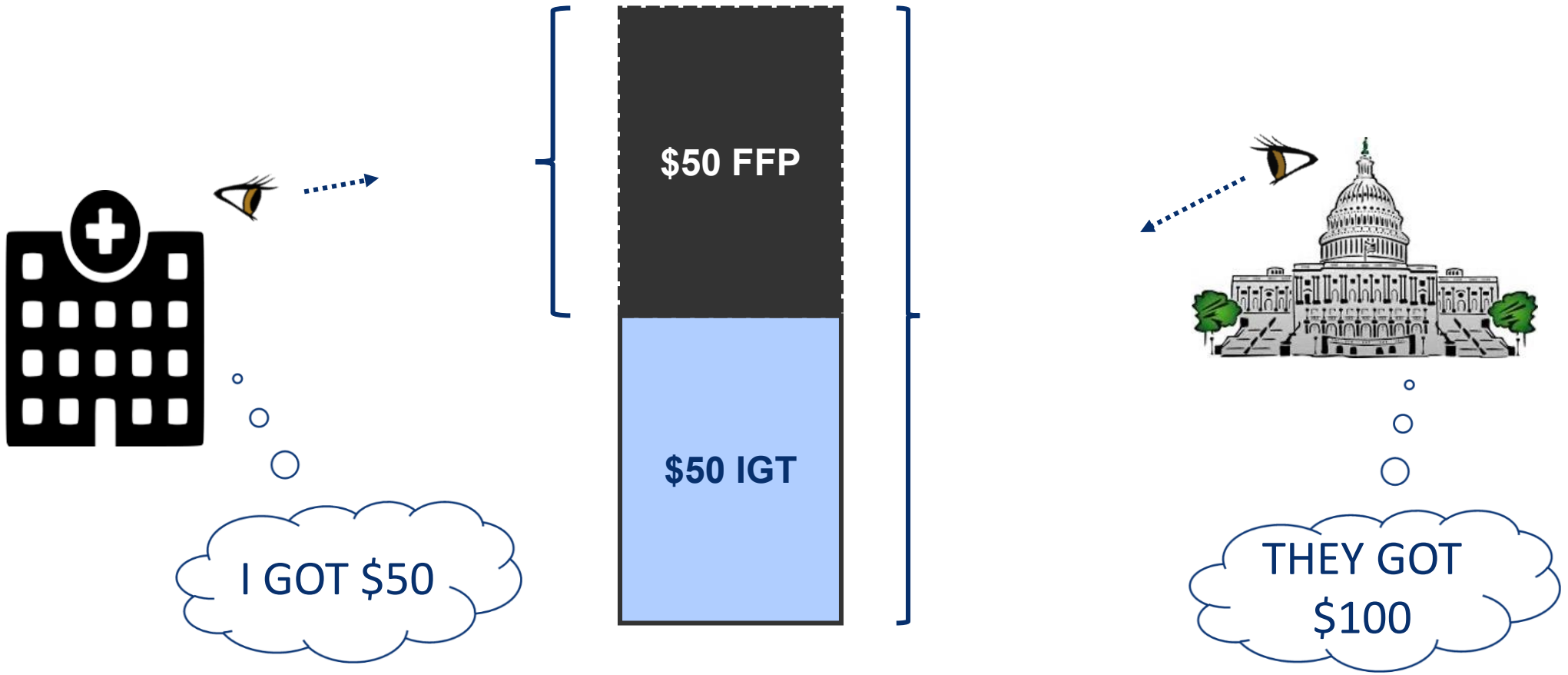
Financing for Medi-Cal Services – With Self-Financing

- PHS must consistently seek payment streams to offset low base rates and the costs of serving the safety net



Illustrative only!

Diverging Viewpoints on Payments Received



Pros and Cons of Self-Financing

- Gives PHS unique role in developing, sustaining key programs
- Persistent loss, aka “the 50%”
  - Other funding sources: 1991 health realignment, others
- Cash transfer requirements
- Reporting requirements

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3. 1115 Waivers

What is a Medicaid 1115 Waiver?

- Section 1115 of Social Security Act allows states more flexibility in running and financing their Medicaid programs, specifically by:
  - Waiving rules normally in Medicaid to demonstrate innovative approaches to care
  - Granting authority to spend Medicaid dollars on people or services not normally covered in the Medicaid program ("Costs Not Otherwise Matchable" or "CNOM")
- Waivers can cover all or part of a state's Medicaid program
- Requires HHS/CMS approval

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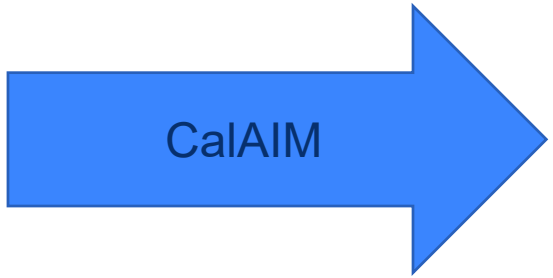
Evolution of 1115 Waiver Programs



	2010 Bridge to Reform (2010-2015)	Medi-Cal 2020 Waiver (2015-2021)	Waiver Programs – 2022- 2026
Coverage Innovations	Low Income Health Program (LIHP)	Global Payment Program (GPP)	Global Payment Program (GPP) – provide non-traditional services to align with CalAIM
Quality and Delivery	Delivery System Reform Incentive Pool (DSRIP)	Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Whole Person Care (WPC)	Providing Access and Transforming Health (PATH) – incentives to support ECM / Community Supports transition

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4. Medi-Cal Supplemental Programs

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Coverage in California

- Post-ACA coverage
  - Roughly 5 million in CA gained coverage through ACA, about 3.5 million through Medi-Cal expansion
  - Over 3 million Californians remain uninsured
- Public health care system perspective
  - Declines in uninsured
  - Increased enrollment in Medi-Cal, state-only expansion
    - Over 50 state-only expansion started in May 2022
    - 26-49 expansion in Jan 2024
  - Continued role in funding a growing Medi-Cal program

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Importance of Managed Care

- Increasing enrollment
- Long-term state direction: new services and strategies should be implemented via health plans
- 2017 federal regulation obligated DHCS and PHS to redesign multiple financing streams that flow through managed care plans
- 2024 federal regulation further provides guidelines on how some of these programs are handled

Key Managed Care Supplemental Payments Examples

Name	Description
Enhanced Payment Program (EPP)	Fixed pools for DPHs, prorated based on managed care encounters or revenue for fully capitated providers
Quality Incentive Program (QIP)	Fixed pools for DPHs, distributed by number of managed care lives served/assigned, earned by meeting quality metric targets
Graduate Medical Education (GME)	Calculations similar to Medicare GME (direct & indirect) for teaching costs, but for Medi-Cal Managed Care services

Importance of Data

- PHS financing increasingly relies on accurate, reliable, service level reporting

* E.g., state fee schedule, or negotiated w/ Medi-Cal plan

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5. Looking Ahead

Opportunities and Challenges Going Forward

Opportunities

- Continue to demonstrate waiver, CalAIM and QIP/EPP success
- MCO tax work could lead to financial support
- Leading way on equity work but what will it look like in Trump Administration

Challenges

- Continued uncertainty at the federal level: approval of continuing and new programs, including waiver and supplemental payments (waiting on approval of MCMC rule)
- Self-financing creates a structural gap in PHS financing, ongoing effort to close and minimize that gap but is growing over time
- Staffing shortages and increased staffing costs
- CalAIM services – challenge working with plans and getting services approved and paid at rates sufficient to cover investments.
- Placement – 10-30% of beds should be discharged

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Beyond the waiver focus

- Supplemental payments through managed care are now much larger annually than 2022 waiver ask (EPP, QIP, DPNF, transplants, etc.)
  - Cash flow concerns – working on solutions
  - Need to ensure DPNF and transplant have soft landings
  - Continue to rightsize EPP and QIP – approvability under Trump Administration a concern
- Structural gap => need to increase state general fund support, not just FFP, as many of our supplemental programs are hitting their ceiling
  - Need increased supplemental and base rates as well as new waiver or other funding to close gap – MCO tax, new waiver programs, MCMC incentive payments
  - Immigration concerns could lead to substantial reduction in elective services and continued volume of Medi-Cal L/S and PE services – impacts DSH, GPP and potential sizing of MC supplementals

Future of Financing

- Data on cost, utilization, quality and outcomes will be more crucial than ever for DHCS
- Centrality of managed care plans
  - Supplementals
  - CalAIM
  - Duals
  - Placement
  - No more carveouts and little FFS
- OHCA – coming up with exemptions or reasonable limitations on PHS revenue growth
- Working with new administration to continue trends of supplemental funding for PHS in California while coming up with new funding to address ongoing need
- Focus on costs –CEPA just the beginning

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6. Key Takeaways

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Key Takeaways

- PHS have unique, major role in serving low-income Californians (Medi-Cal, uninsured)
- Vast majority of PHS funding is self-financed, across wide array of Medi-Cal subprograms
  - Governmental status means PHS can contribute nonfederal share (IGTs, CPEs) in place of state
  - This ability both empowers and constrains PHS
- Payment programs constantly evolving – or being replaced – due to swings in federal regulations, priorities, etc.
- 1115 waivers are an important way PHS drive and fund strategic change, with major successes to date, but other paths also exist (managed care plans vital)
- New challenges continue to arise for both Medi-Cal and PHS in sustaining their role – looming deficits need to be addressed

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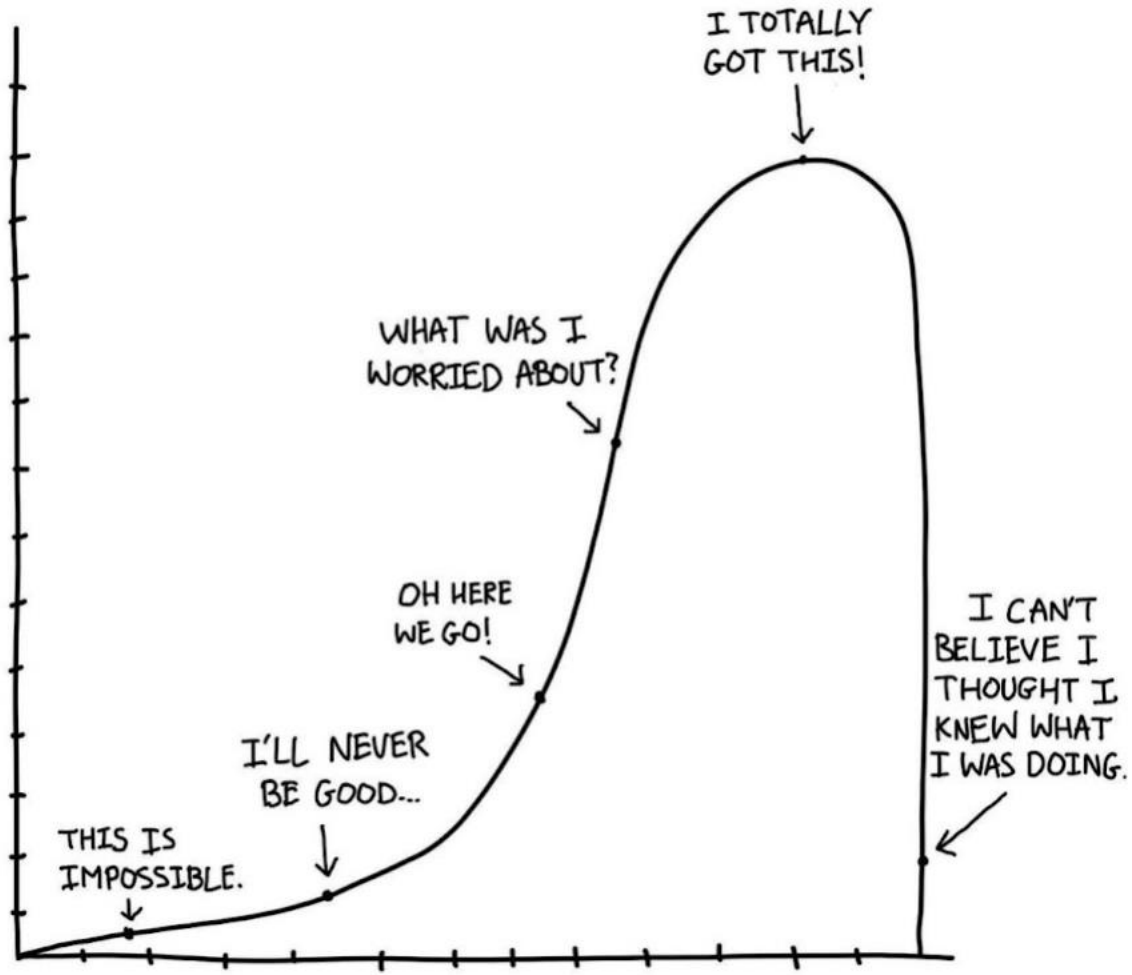
LEARNING CURVE



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Questions?

Contacts:
Rich Rubinstein rrubinstein@caph.org
Malavika Narayan mnarayan@caph.org
Liz Mullen lmullen@caph.org