



HOSPITAL FINANCING WAIVER RENEWAL: AN OPEN DISCUSSION

May 2009

Since 1983, California has had a Hospital Financing Waiver to help public and private safety net hospitals continue to serve the vulnerable by providing stable, predictable funding through selective contracting. It has been in various forms with each renewal since it began. As part of the 2005 waiver renewal, IGTs (intergovernmental transfers) were replaced by CPEs (certified public expenditures). In addition, \$540 million was set aside for county "coverage initiatives." Under SB 1448, California implemented these coverage initiatives, providing an opportunity for counties to compete for the funds. Ten counties received funding to expand coverage to uninsured adults ineligible for public programs, focusing on preventive and primary care, care and disease management, and the use of medical homes and improved communication (e.g., health IT).

The waiver will expire by August 31, 2010 without an approved renewal. Negotiations to renew this waiver are beginning, with the state's concept paper due to the federal administration this fall. **The state is still looking for your input on what kind of waiver request to make before they put together this concept paper.**

In April, we asked:

1. Should California seek a small or large waiver?

Small

Large

2. If California seeks a large waiver, what should we do differently under the waiver?

Cover the MIAs

Move more individuals into managed care

Expand the ten county coverage initiatives to include more counties

Other (Please describe)

In addition, we have started to facilitate discussions on the waiver options at our regional workgroups.

From our first round of responses and the North Central, Inland Empire, and Orange County Regional Workgroups that took place in April and May, we have learned that:

Large Waiver

A large waiver is preferred and seems possible given a supportive federal administration and if state leaders effectively collaborate on a waiver tied to broader state reform. In essence, the waiver could be a part of a longer term and bigger vision that alone it may not be able to create. It could facilitate some of the pieces needed to achieve sustainable, comprehensive reform including thoroughly integrating facilities and improving coordination and communication among providers by putting incentives in place to efficiently provide continuous care. However, in pursuing a larger waiver, we must figure out how to finance the matching funds to pull down



additional federal dollars. A hospital-based fee or some type of assessment on providers and/or insurers may be a good way to raise more money.

Continuation and Possible Expansion of the Coverage Initiative

As mentioned, the current waiver has coverage initiatives that cover some Medically Indigent Adults (MIAs) in ten California counties. The renewal waiver request should continue these initiatives, with the possibility of expanding them to other counties either in this renewal or in future ones. Some counties spent above and beyond the required federal match dollars, so the ability to expand is clear. This expansion could involve a few more or all California counties.

Some pointed out that expanding the waiver to including statewide coverage initiatives should first consider the strength of the current programs, particularly in terms of sustainability. If the current coverage initiatives do not show positive results within their three-year implementation window (by fall 2010), is this proof that they cannot work? Or, was the evaluation period too short to measure such long-term measurements as improved health outcomes from things like chronic disease management? Should the measures of success be modified? This begs the question of either continuing the current programs for a longer period of time, in addition to possibly adding a few more counties, to gather more data before launching new initiatives statewide that may not be sustainable and only add to the confusion of navigating through a system with several changing and varied options for care. On the other hand, should we take the risk of not seeking a large waiver from a reform minded federal administration?

Tiering

If adding additional counties, one party suggested tiering the waiver. In other words, rather than imposing the same protocols on all counties to increase use of medical homes, etc., counties would have the flexibility to hone in on changes (and related outcomes for evaluation) that reflect their current levels of readiness, though still within the context of comprehensive system changes and broader state reform. Additionally, these changes may be implemented either at the county level or regionally. For example, in places like San Francisco, it might make more sense to broaden the initiative to the Bay Area.

Integration and HIT

The new waiver should revise the minimum benefits package for MIAs by encouraging care that treats a whole person based on an understanding of population health and prevention. Part of this involves emphasizing the importance of medical homes and improving the continuity of care. This would likely involve coordinating medical care across multiple facilities and better integrating it with mental health and substance abuse treatment and allowing reimbursement for providing these services. Doing so is likely to stabilize frequent users of emergency departments and those with chronic illnesses and enhance their abilities to navigate the health system and to be compliant with medical recommendations.

Additionally, there should be a specific focus on upgrading technology, equipment and staffing/capacity for the safety net to meet the needs of those newly uninsured by the recession and the potentially newly insured that universal health care coverage may bring. We should work to ensure that EMRs and other forms of HIT are used to link clinics and hospitals and enhance their communication to improve health outcomes and reduce waste.



Redesigned Payment Systems and Funding Streams

Another important part of a new waiver involves understanding how to reorganize funding streams and avoid duplicative financing schemes that focus on utilization rather than health outcomes. For example, current DSH (disproportionate share hospital) funding is only for hospitals and their services—not the services provided by doctors at DSH hospitals or the clinics feeding into them. The new waiver should sever the relationship between facilities and funding streams to move towards truly coordinated and continuous care. This could be modeled after Kaiser Permanente, a system in which Kaiser owns its own hospitals, has a health plan and contracts with its own medical group to provide care. In addition, these broader redesigns should ensure all stakeholders have incentives to treat MIAs and other uninsured populations rather than specific portions of the payer mix. Otherwise, moving in the direction of prevention and disease management—methods that may have cost benefits that are not direct (nor short term) to the provider or facility or health plan managing the disease—will be difficult to implement.

Finding ways to pool resources and the payer mix to have a sustainable system is important. This could involve expanding the County Organized Health Systems, adopting performance-based reimbursement, and/or consolidating funding and initiatives. In places where current systems, such as CMSP, are continued because of funding, flexibility should allow these counties to consider innovative system reforms without the risk of losing current funding.

Additionally, a large waiver should look into expanding the role of Federally Qualified Health Centers (FQHCs) in the safety net. The establishment of new FQHCs should be prioritized to areas where medically underserved populations who otherwise would not have access to existing FQHCs for care can best be reached.

Managed Care

More individuals should be moved into managed care to help contain skyrocketing costs, particularly during poor economic times. This could include the disabled.

Coverage For All Kids

The waiver should consider integrating efforts to cover all children. This could start on a pilot basis as is currently done with MIAs, working with schools and other stakeholders to ensure each child has a medical home and access to mandated immunizations at a bare minimum.

ITUP strongly encourages you to continue to hold meetings and collect ideas from larger groups and to respond to those suggested so far, and to share them with us and/or state policy makers.

Best,
The ITUP Team