CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

# Financial Services Training

## Module 1:

## Public Health Care Systems (PHS) Financing

2021

# FST Schedule

| Module | Date | Topic |
|---|---|---|
| 1 | Wednesday, May 5<br>from 11:00 - 1:30 | Introduction to Public Health Care System (PHS) Financing |
| 2 | Tuesday, May 11<br>from 11:00 - 1:30 | Managed Care Financing |
| 3 | Wednesday, May 19<br>from 10:00 - 12:30 | Claiming, Reporting, & Revenue Maximization |
| 4 | Wednesday, May 26<br>from 11:00 - 1:30 | Realignment and Waivers |


# Instructions:

- Hover your mouse at the top of the screen
- Click on **Annotate**
- Click on **Stamp** and place a marker to share where you are

# Presenters

**John Minot**,
Director of Policy

**Haleigh Mager-Mardeusz**,
Senior Policy Analyst

**Aaron Mendelson**,
Senior Finance and Policy Analyst

**Ben Kane**,
Senior Finance and Policy Analyst

# Objectives

1. Describe the safety-net landscape, the unique role of PHS, and Medi-Cal structure
2. Explain what is distinctive about public health care systems and their financing structures in the context of the broader landscape
3. Present the basic structures of Medi-Cal fee-for-service and managed care in California
4. Outline the features of public health care systems' major financing streams
5. Show how and why self-financing is such a limiting constraint and how public health care systems have striven to improve reimbursement within these constraints

# Safety Net Role & Landscape

# 21 Public Health Care Systems

**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 and county affiliated health systems and UC medical systems*

# History of Public Health Care Systems (PHS) in California

- 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)
- 2020: 12 of 58 counties and 5 UCs run public health care systems

# Snapshot of PHS in CA: Similarities & Differences

- Size
- Payer Mix
- Structures with county (e.g., CoCo, SFDPH,  authority model, etc.)
- Other differences: NorCal vs SoCal, county vs UC, service mix: trauma, training, specialty

# What Makes PHS Unique Among Other Providers?

# What Makes Public Health Care Systems Unique?

- Majority of patients are Medi-Cal or uninsured
- Systems of care: they provide hospital/inpatient care, primary care, specialty services, trauma care, rehabilitation, etc.
  - Providers of critical services that patients cannot access anywhere else
- Clinical education: together they train half of all new doctors in the state
- Legal responsibility for counties to provide care to the uninsured (Section 17000)
- Medi-Cal financing

# PHS' Safety Net Role

- Serve more than 2.85 million patients annually
- Provide about 40% of California hospital care to uninsured, despite being 6% of hospitals in CA
- Provide 35% of hospital care to state's Medi-Cal beneficiaries
- Primary care provider for more than ½ million Medi-Cal enrollees that benefited from the Medi-Cal expansion under the ACA
- Deliver over 10 million outpatient visits/year

# Question

- True or False
  - PHS operate over half of all Level I trauma centers in the state.

# Critical Community Services

| Hospital Category | # General Acute Care Hospitals | # All Facilities | # DSH Hospitals† | # Level I Trauma Centers | #Staffed Burn Beds |
|---|---|---|---|---|---|
| DPH | 23 | 23 | 23 | 8 | 57 |
| NDPH | 40 | 40 | 20 | 0 | 0 |
| Children's | 11 | 11 | 10 | 0 | 0 |
| Private* | 279 | 374 | 104 | 6 | 41 |
| Total | 353 | 448 | 157 | 14 | 98 |

* All hospitals other than DPHs, NDPHs, and children's hospitals.
† DSH eligibility as determined by DHCS.

Source: OSHPD AFD 2018-19 (2017-18 for burn beds).

# Other Safety Net Providers

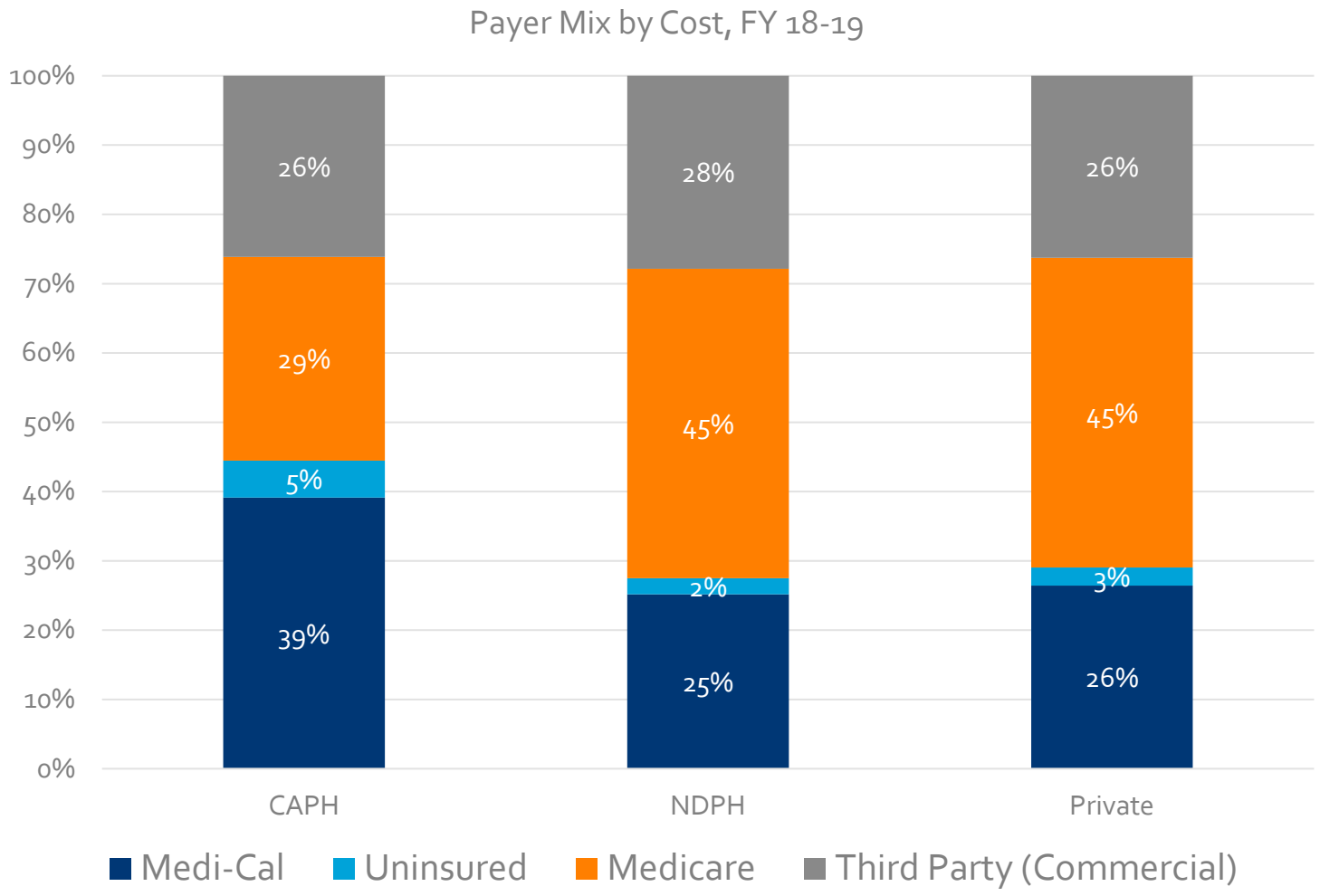
- **District Hospitals (a.k.a., NDPHs) –**
  - Health care districts established post WWII, some built hospitals
  - Similarities: "public," ability to contribute non-federal share
  - Differences: no Section 17000 mandate; not structurally systems of care, wider range of characteristics
  - Represented by ACHD, DHLF

# Other Safety Net Providers

- **Private DSH Hospitals**
  - Unknown number, changes annually, ~40, heavy concentration in LA
  - Different payment mechanisms: e.g., DRGs
  - Represented by PEACH
- **Community Health Centers**
  - 1,150 total licensed clinics; 735 are FQHCs
  - Represented by CPCA, RHCs
- **Children's Hospitals**
  - 8 in the state, one affiliated with UCSF
  - Represented by CCHA

# County Structure

# PHS: Core Providers to the Uninsured




Source: OSPHD FY 18-19 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

# Section 17000

"*Every county and every city & county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease of accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions*."

# Four Models of County Indigent Care in CA

1. **Provider counties** operate PHS
   - Alameda, Contra Costa, Kern, LA, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, Ventura

2. **Payer counties** contract with UC hospitals and/or private hospitals and clinics to provide indigent services
   - Fresno, Merced, Orange, San Diego, San Luis Obispo

# Four Models of County Indigent Care in CA

3. **Hybrid counties** operate public outpatient clinics but not PHS, and contract with UC and/or private hospitals for inpatient care
   - Placer, Sacramento, Santa Barbara, Santa Cruz, Stanislaus, Tulare

4. **County Medical Services Program (CMSP) counties** contract with the CMSP governing board to administer health care services for eligible beneficiaries
   - 35 mostly rural counties

# Medi-Cal Structure

# ACA Landscape

- **Post-ACA coverage**
  - Roughly 5 million in CA gained coverage through ACA
    - ~1.2 to 1.4 million via Covered CA plans
    - ~3.5+ million via Medi-Cal expansion
  - Over 3 million Californians remain uninsured

- **Public health care system perspective**
  - Declines in the uninsured
  - Increased enrollment in Medi-Cal
  - Continued role in funding a growing Medi- Cal program
  - Uncertainty with ACA funding at the federal level (ACA repeal, threats to supplemental payments, etc.)
  - Limited role in Covered California

# Medi-Cal Structure in CA

- **Medicaid: Federal and state governments share the cost**

- **Federal Medical Assistance Percentage = FMAP**
  - Traditional Medi-Cal population: 50% FMAP (in CA)
  - Newly-eligible Medi-Cal: 90% FMAP
- **Beneficiaries receive services via FFS and/or managed care plans**
  - 75-80% of CA beneficiaries are now in managed care

# PHS as Providers in FFS and Managed Care

- In some instances, PHS may have had as much as 47% of Medi-Cal managed care assigned lives in their county
- FFS is still a major payer: 47% of non-dual Medi-Cal days in PHS are FFS (carve outs, specialty mental health, hospital presumptive eligibility, limited scope)
- While most beneficiaries are in managed care, that may not be the majority of spending

# Medi-Cal Structure in CA

- **Two Plan**
  - 12 counties, including 9 PHS counties
- **County Organized Health Systems (COHS)**
  - 22 counties, including San Mateo, Orange, Monterey, Ventura
- **Geographic Managed Care (GMC)**
  - San Diego, Sacramento
- **Regional and county-specific**
  - 20 primarily rural counties – no PHS

# History of CAPH/SNI

# 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 21 public health care systems and academic medical centers.

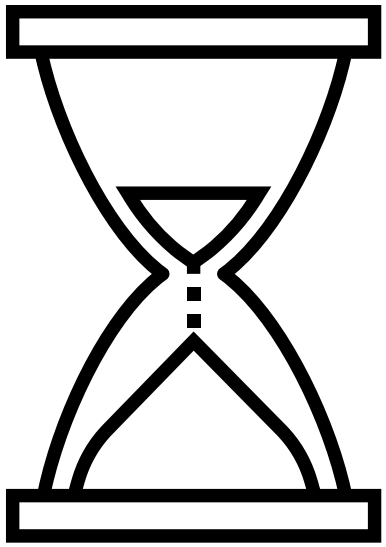
- As a trade association, CAPH works to advance policy and advocacy efforts that strengthen the capacity of its members to ensure access to comprehensive, high-quality, culturally sensitive health care services for all Californians, and educate the next generation of health care professionals.

- 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.

# History of CAPH/SNI

- **1983**: CAPH founded
- **1999**: CAPH Board creates SNI
- **2002**: AB 915 enacted, self-financed cost-based outpatient supplemental payment
- **2005**: First 5 year, PHS-focused 1115 Medi-Cal waiver approved
- **2015:** CAPH/SNI achieve CMS approval of 3 programs: PRIME, GPP, and WPC, proposal, in a $6.2B+ 5-year waiver renewal
- **2017:** Creation of three new supplemental payment programs EPP,QIP, and GME

# Break!

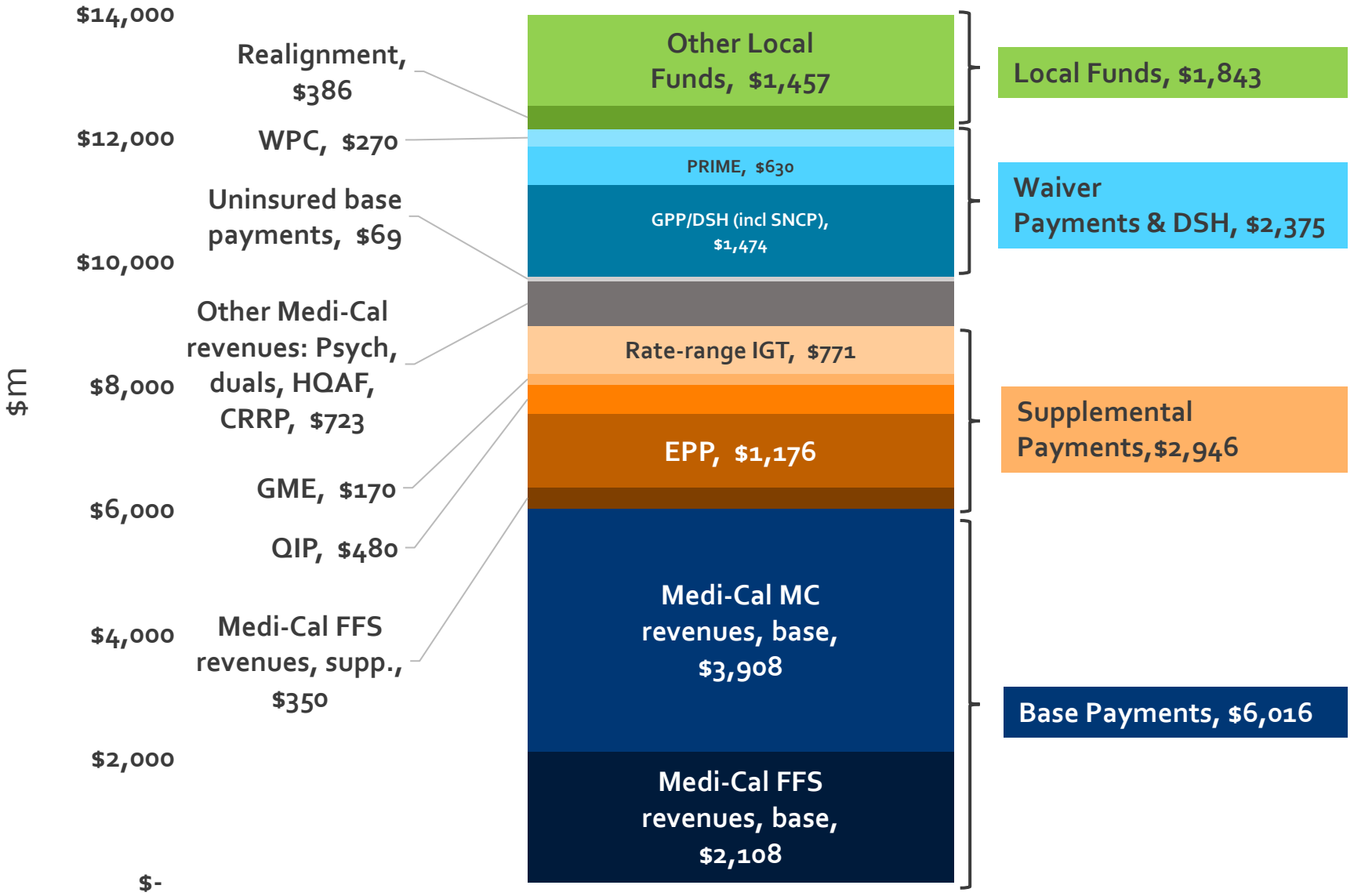


# PHS Financing Mechanisms

# Audience Question

- What is unique about public health care system financing?

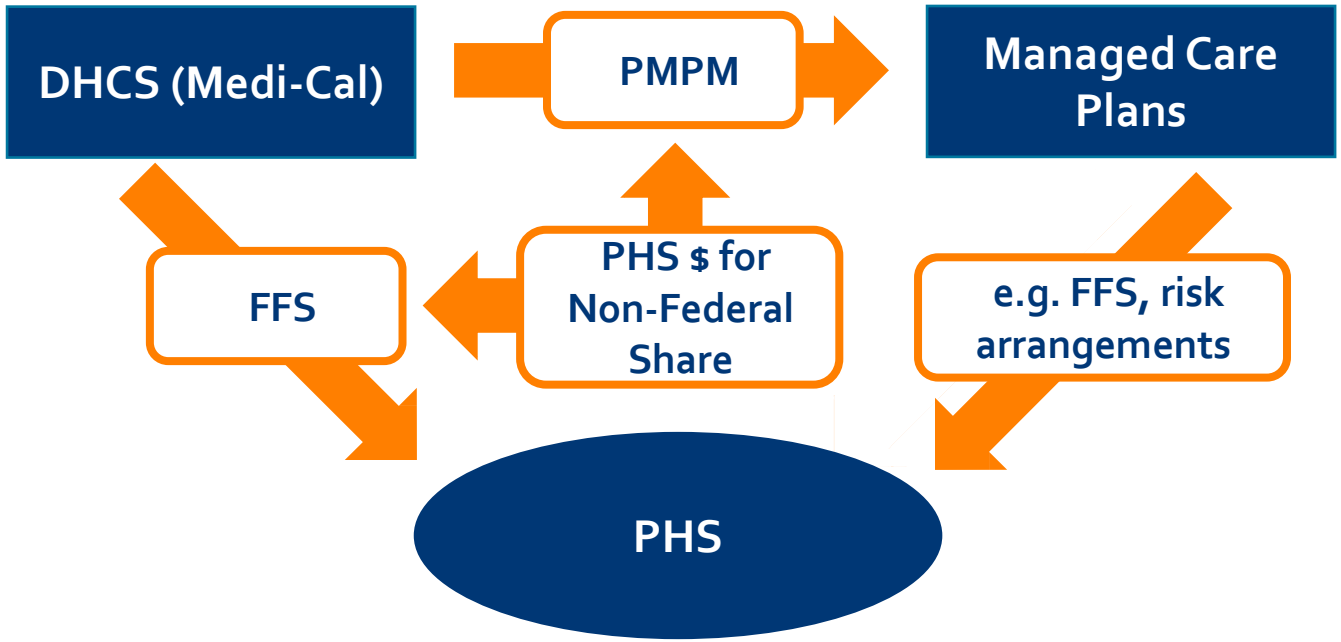
# PHS Funding Sources for Medi-Cal/Uninsured, FY 18-19




Source: P14s, AB85 submissions, other data

# "Self-financing"

- PHS Provide Both Medi-Cal Services and Financing



# Medi-Cal Non-Federal Share

- Sources of Non-Federal Share in CA (aka "matching funds")
  - State General Fund
  - Local public sources, like counties/public hospitals
  - Private providers, via Provider Fee
  - Foundations

# Federal Medical Assistance Percentage (FMAP)

- How the non-federal share is determined
- Not all Medi-Cal populations are the same!

| Population | Also known as… | FMAP |
|---|---|---|
| **Old-eligible** | Pre-ACA, SPD & TANF, traditional, classic | 50% |
| **New-eligible** | Post-ACA, MCE, childless adults, optional expansion | 90%* |
| **CHIP** | Children above Medi-Cal poverty thresholds | 65%* |

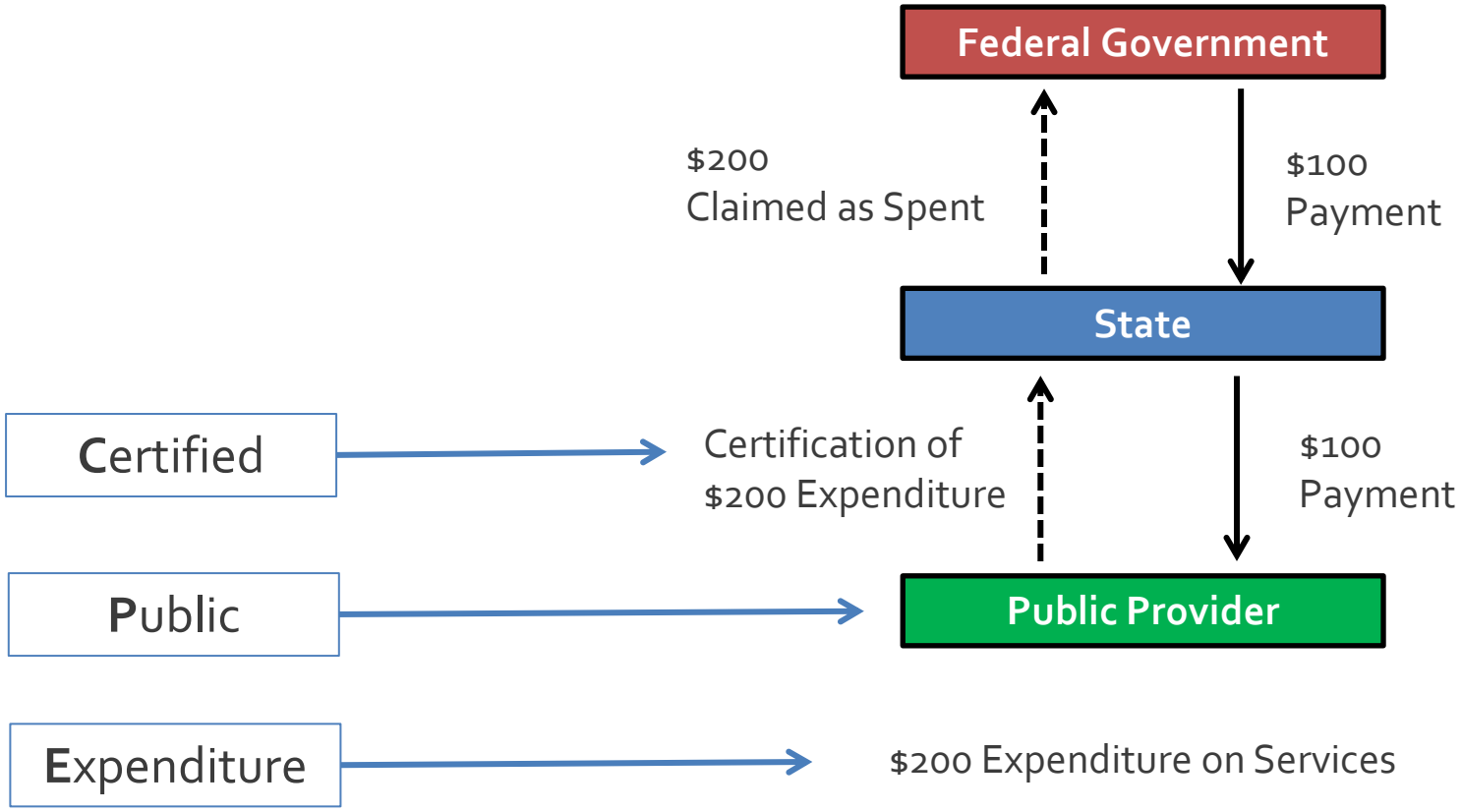
*As of 2021, previous years vary; not taking into consideration enhanced FMAP for COVID

For our examples in the next slides, we will assume a 50% FMAP

# Funding the Non-Federal Share

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

# CPE Mechanics



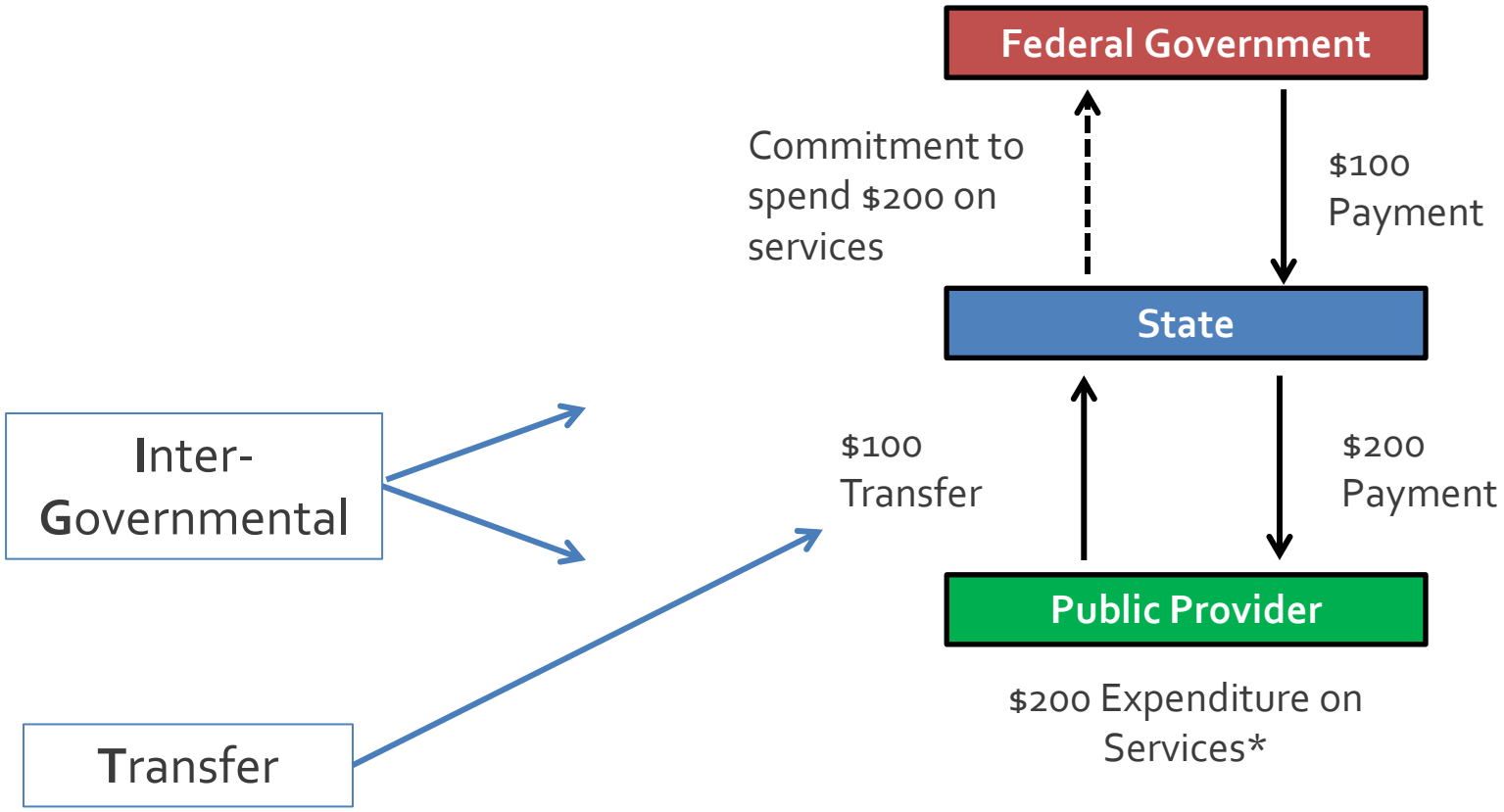
# CPE Example

- Medi-Cal FFS patient has a 5-day stay.
- Cost is 4,000/day.
- Aid code indicates patient is not new-eligible.

# CPE Takeaways

- CPEs mean the health care system makes an expenditure and is paid after the fact
- Reimbursement = 50% of costs
- The other 50% is a PHS contribution to Medi-Cal
- The federal government views us as receiving 100% reimbursement, so we cannot claim the remaining 50% as unreimbursed care

# IGT Mechanics




* May also be used for performance-based payments

# IGT Example

- QIP earnable amount allocated to your system is $10m FFP this year
- Your system achieved 90% of its metric targets.
- Assume 50% FMAP

# IGT Takeaways

- Health care system commits to making an expenditure on services before the fact
- PHS provides its contribution (i.e. 50% of the amount) in advance, receives gross amount (100%) back
- In most cases, required to count the gross amount toward patient care
- After services are provided, like CPEs, reimbursement still = 50% of total amount (depending on FMAP)

# CPE vs. IGT

| CPE | IGT |
| --- | --- |
| Expenditure happens before payment | Either before or after expenditure |
| Payment limited to cost | Can be value-based, not tied to cost |
| Does not require cash transfer | Requires cash transfer of non-federal share |
| **Non-federal share of revenue is still considered revenue.** | |

# Sources of Non-Federal Share of PHS Revenues: Medi-Cal and Uninsured

| Payment Stream | State General Fund | PHS via CPE | PHS via IGT |
|---|---|---|---|
| Medi-Cal IP FFS | | X | |
| Medi-Cal Hospital OP / Professional FFS | X | X* | |
| Medi-Cal Managed Care | X | | X* |
| FQHC (FFS & MC) | X | | |
| DSH | | X | X |
| 1115 Waiver (GPP / WPC / PRIME) | | | X |
| Managed Care Supplementals (EPP / QIP / RRIGT / GME) | | | X |

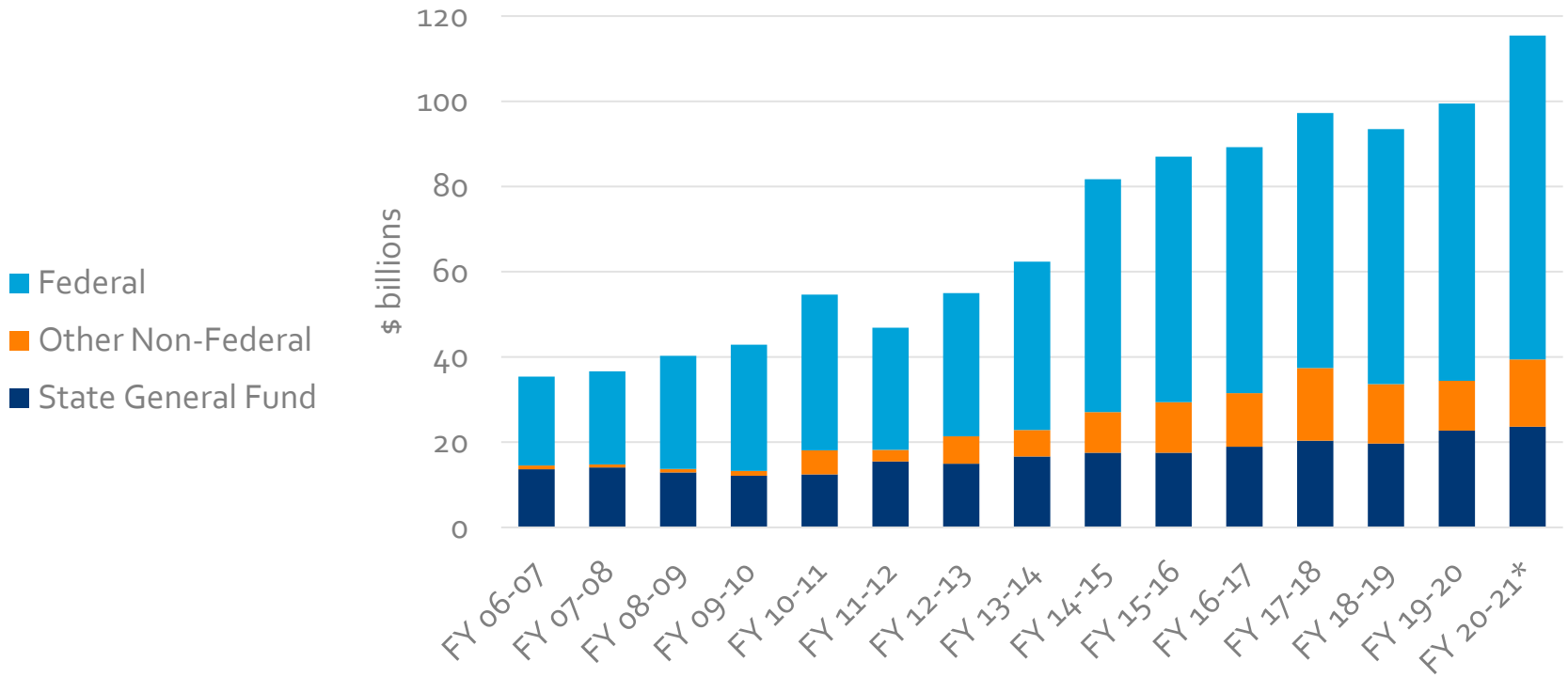
*Payments that supplement the base rate. Base rates are usually funded with state general fund and pay below cost. Supplementals are usually financed by the provider to draw partial federal compensation for shortfalls.

# Mounting Role of Self-Financing Over Time

- 1990s: First PHS-financed supplemental payments developed under Medi-Cal
- 2000s: Self-financed payment streams multiply, largely under FFS and waivers
- 2010s: PHS increasingly finance rates to managed care plans as well
  - FY2018-19:
    - 68% of PHS Medi-Cal revenues self-financed via CPEs or IGTs under various programs
    - Remainder mostly state-financed

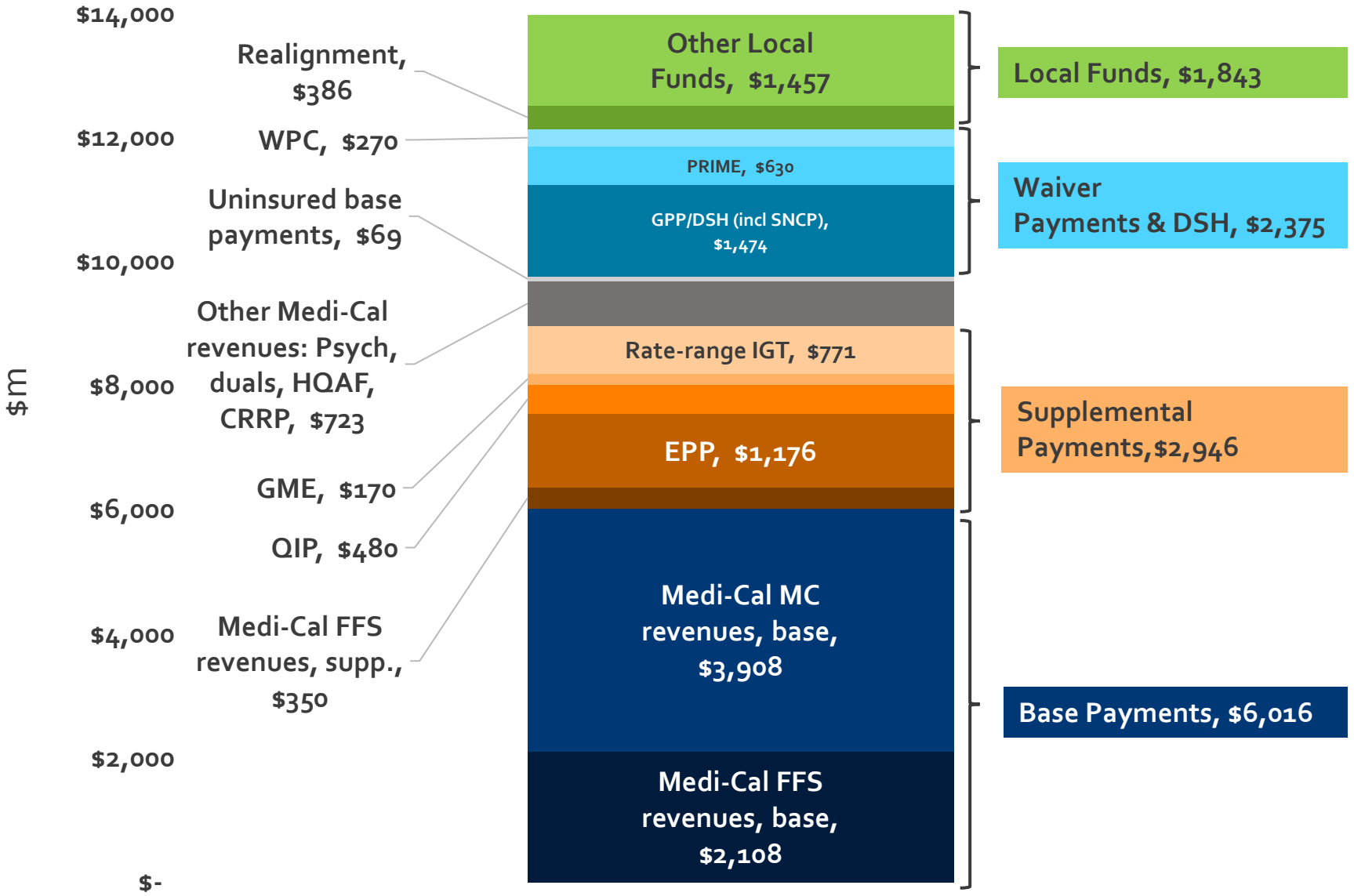
# State Support for Medi-Cal

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



# PHS Financial Streams

# PHS Funding Sources for Medi-Cal/Uninsured, FY 18-19




Source: P14s, AB85 submissions, other data

# Fee-for-Service Payments

## Reimbursement Methodology

- Services are unbundled and paid for separately by the state
- Typically, no managed care plan involved

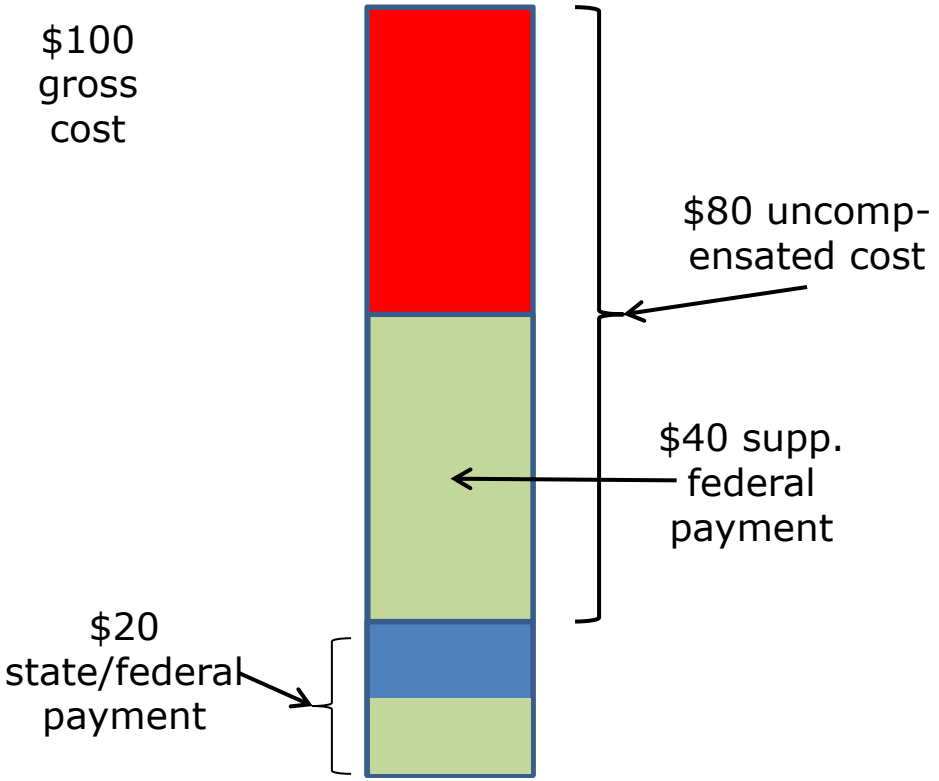
## Payment Level and Structure

- PHS most often paid "up to cost"
  - base claim payment + supplemental up to cost
- PHS finance some FFS base payments and most FFS supplemental payments.
- Typically drawn down with CPEs

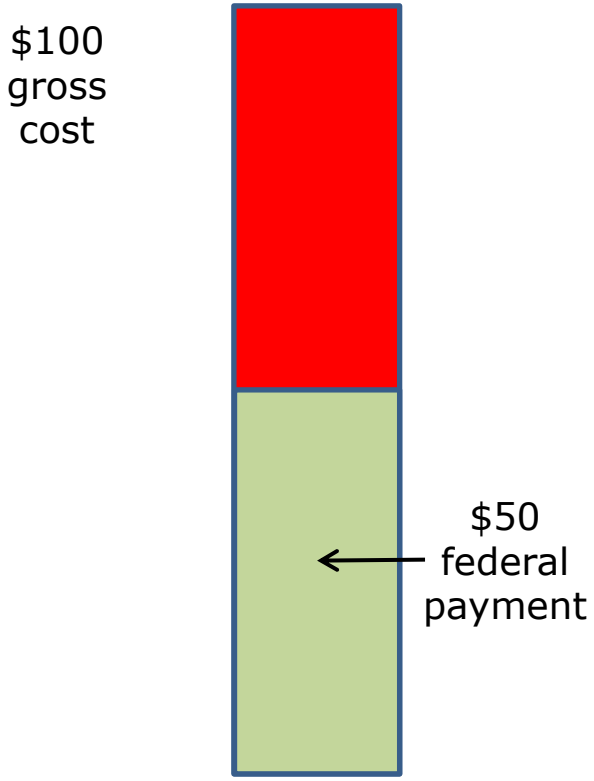
## Populations

- FFS important even with shift to managed care
  - Certain aid codes/populations might always be FFS
    - Services "carved out" from plans that DHCS pays through FFS
    - Individuals "churning" on/off Medi-Cal

# FFS Payments




Service where hospital funds supp. payment




Service where hospital funds base payment

# FFS Payments

| Service type | Supplemental payment | Description |
|---|---|---|
| IP | n/a | Base payment equal to costs |
| OP | AB 915 | Supplemental for hospital-based non-FQHC OP services, claimed through the AB 915 form |
| | OP DSH | Supplemental add-on to claims for DSH-eligible hospitals (very small) |
| Physician | PNPP (Phys. SPA) | Supplemental for physician and non-practitioner payments, claimed through the P14s |
| DP-NF | DP-NF | Supplemental for DP-NF, claimed through DP-NF claim form |
| Psych (IP/ER) | n/a | Base payment equal to costs, except admin days |

# Discussion

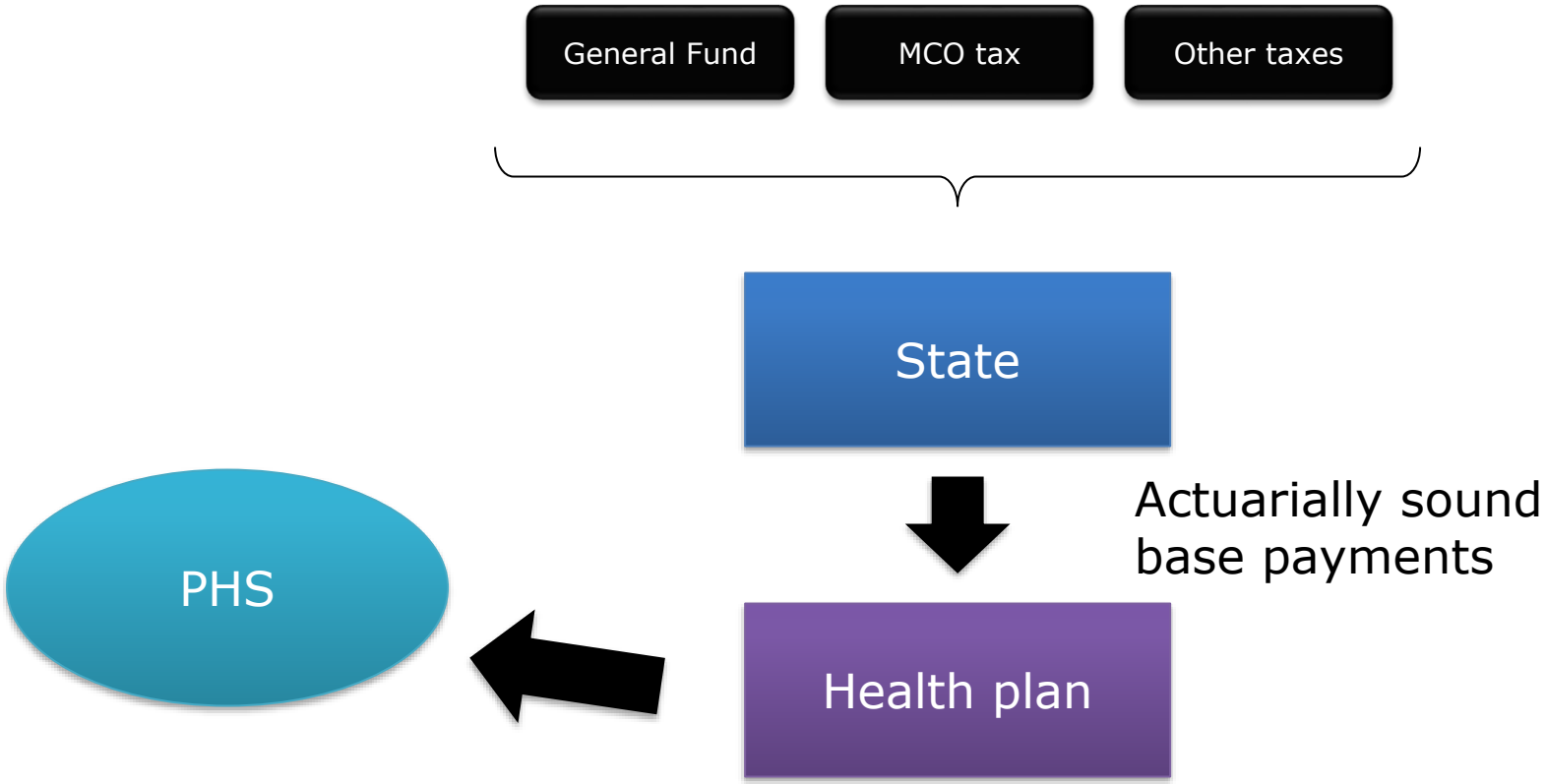
- With the shift towards value-based payment programs, is FFS likely to remain important to PHS?

- In what ways does self-financing FFS payments limit PHS? In what ways does it help?

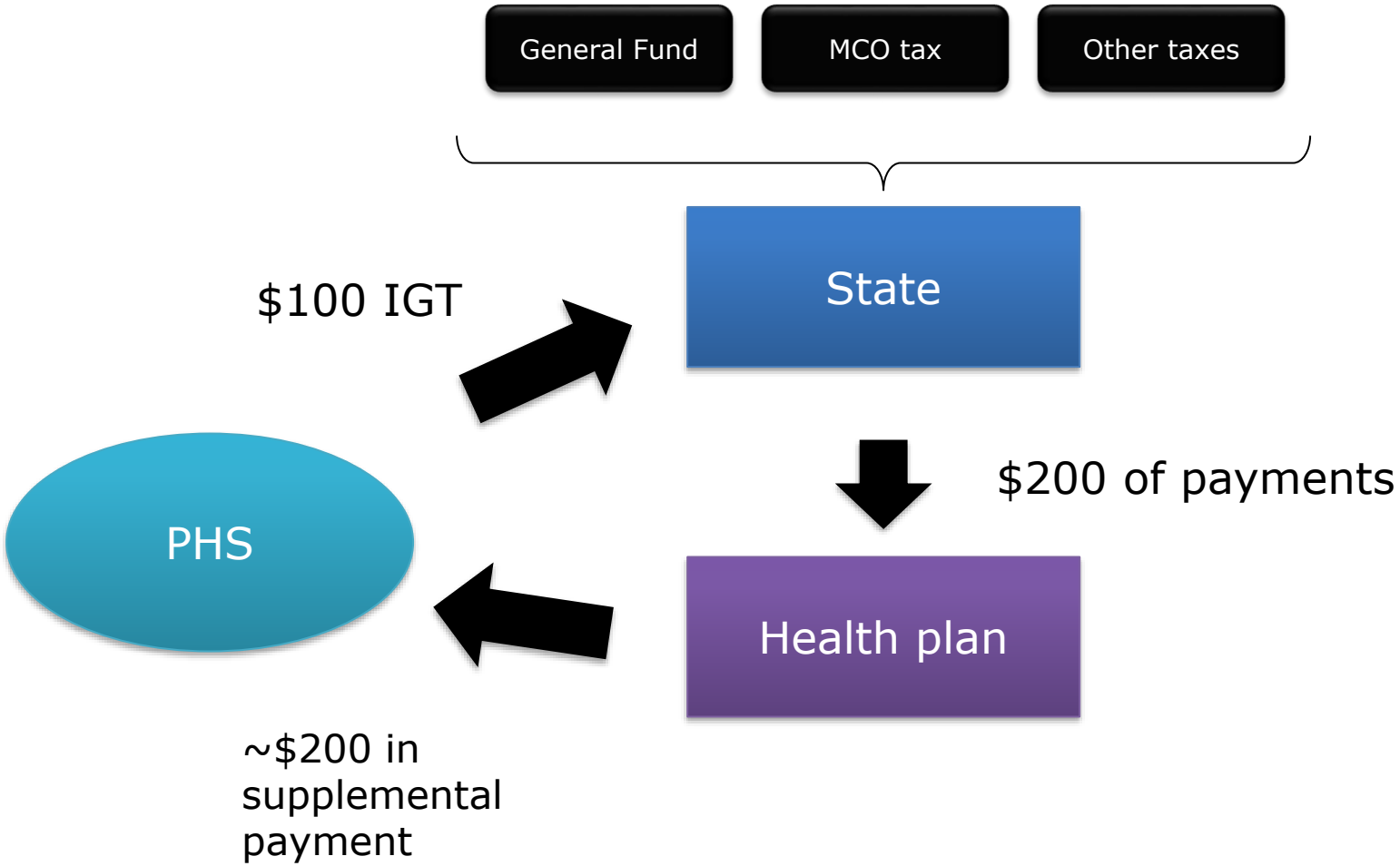
# Managed Care Payments

| Reimbursement Methodology | Payment Level and Structure | Populations |
| --- | --- | --- |
| • State pays plans capitation payments to cover populations<br>• Plans pay PHS directly | • Base payments from plans:<br>  • Per diem, bundled payments, full capitation, FFS, etc.<br>• PHS also finance supplemental payments via plans<br>• Payment must come through and be approved as part of actuarially sound rates<br>• not fully "trued up" to cost as under FFS | • ACA Expansion populations<br>• Most pre-ACA eligible adults and children<br>• Undocumented young adults (under 26)<br>• Some dually eligible for Medicare and Medi-Cal |

# Managed Care Base Payments



# Managed Care Supplemental Payments



# Managed Care Supplemental Payments

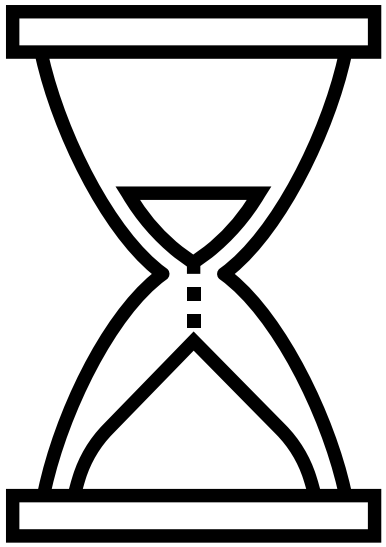
| Name | Description | Effective rate of return (PHS) |
|---|---|---|
| Rate-range IGT | Range between lowest & highest actuarially sound rates state may pay plans; state fee on IGT 20% (one exception) | Blended (~70%) |
| Enhanced Payment Program (EPP) | Fixed pools for DPHs, prorated based on managed care encounters or revenue for fully capitated providers | Blended (~70%) |
| Quality Incentive Program (QIP) | Fixed pools for DPHs, distributed by num. managed care lives served/assigned, earned by meeting quality metric targets | Blended (~70%) |
| Graduate Medical Education (GME) | Calculations similar to Medicare GME (direct & indirect) for teaching costs, but for Medi-Cal Managed Care services. | Blended (~70%) |

# Discussion

- How do managed care payments differ from FFS payments in their payment limits?

- Combined with the shift towards greater managed care enrollment, how does this affect PHS finances?

# Break!



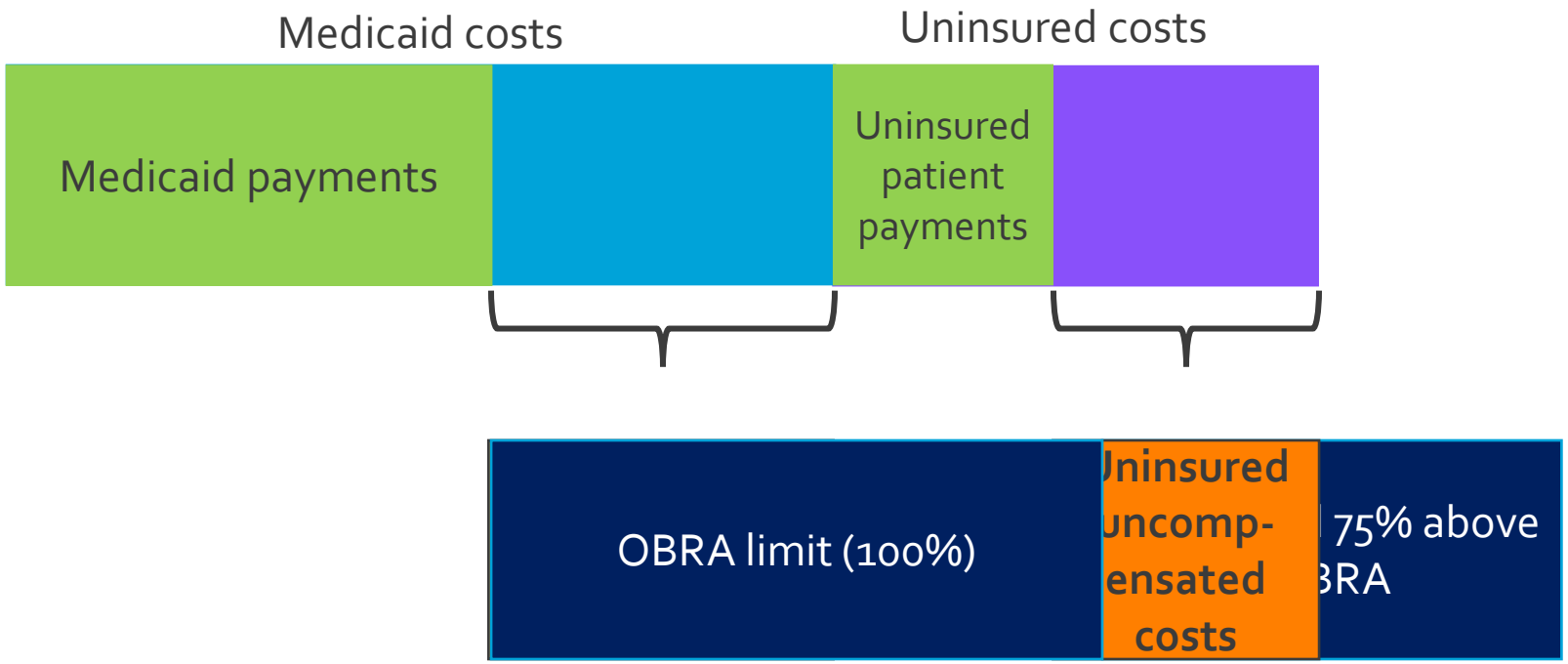
# Medicaid Disproportionate Share Hospital Program (DSH)

- Only major supplemental payment guaranteed permanently by federal law
- Covers uninsured including undocumented – but hospital-centric
- ~$1.2B federal funds annually to CA to distribute to safety net
- Limit on payment to an eligible hospital: "OBRA limit"
  - Total payment not to exceed 100% of uncompensated safety net costs
  - Except for most CA PHS, 175% instead of 100%
- ACA cuts now take effect 2023

# CA's OBRA Limit in Practice

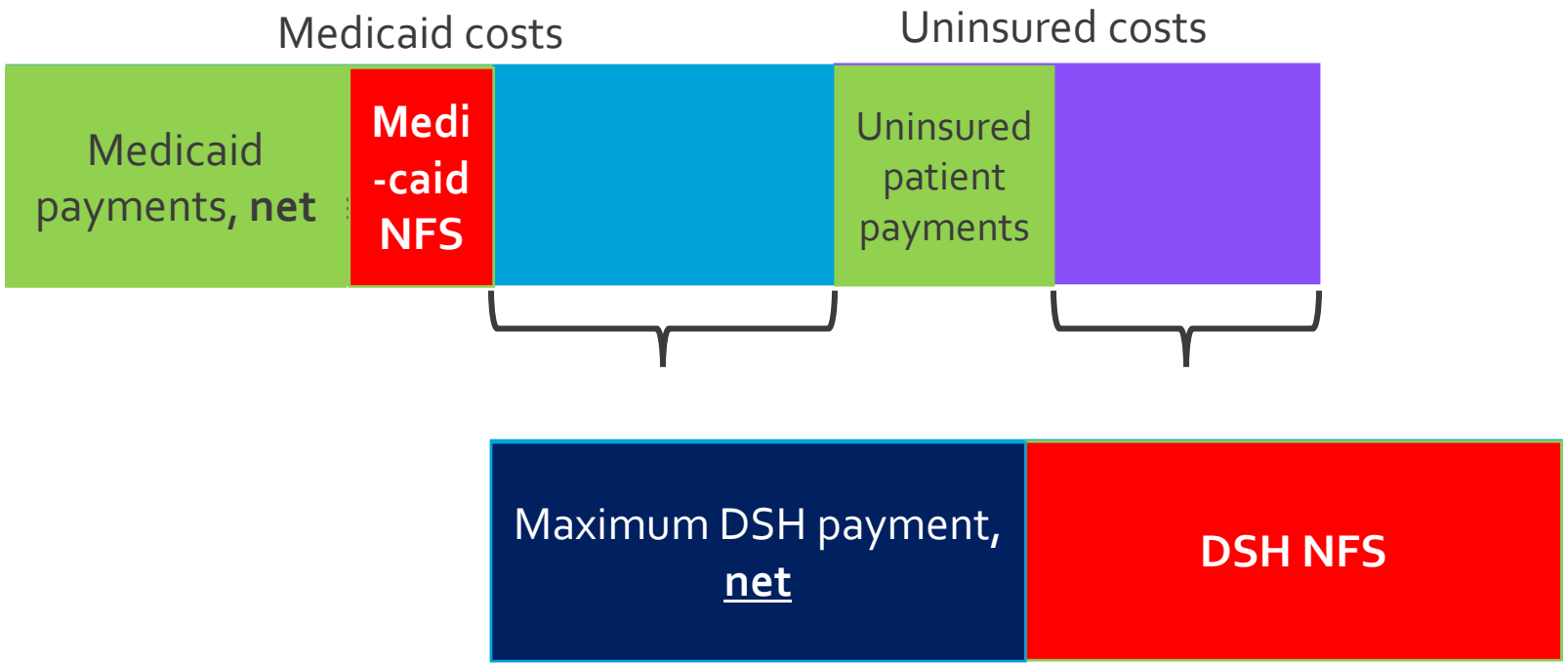
## CA's OBRA Limit

(No more than 175% of unreimbursed costs for Medicaid and uninsured services)



# OBRA Limit Adding Self-Financing

DSH limits overall reimbursement to total uncompensated Medi-Cal and uninsured costs, after offsetting all other Medi-Cal and uninsured revenues, **including** portions that are self-financed non-federal share.



# Global Payment Program

- County PHS only (currently), since 2015
- Approx. $1.1b FFP/year by combining:
  - DSH funding available by law (except for UCs)
  - Safety Net Care Pool, additional 1115 waiver funding
- Flexibilities
  - No longer cost-based
  - Services provided, including non-traditional
  - Location provided, not tied to hospital
- Federal DSH cuts would reduce GPP size
- CMS must approve both GPP extension & SNCP funds past 2020
- Does OBRA apply anymore for the county PHS?

# Discussion

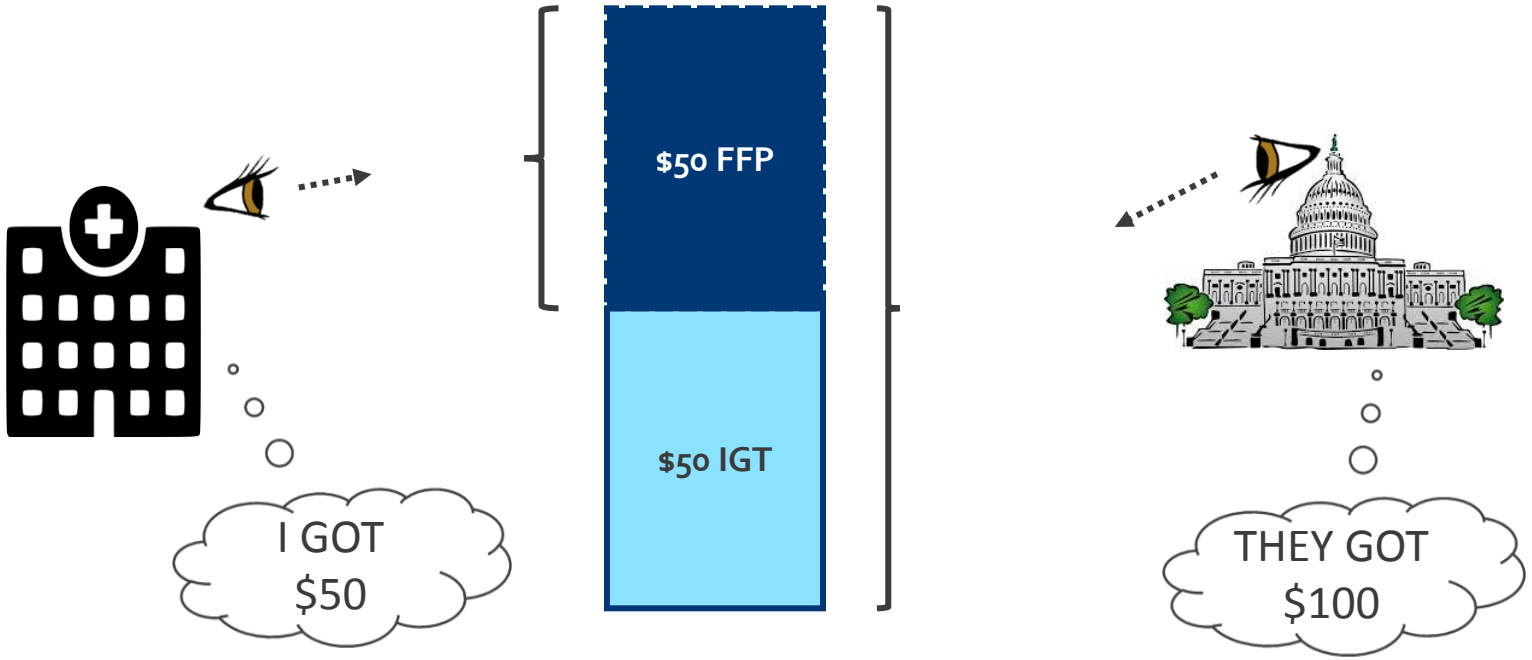
- How was the changing health care environment impacting DSH when GPP was created in 2015?

- How does GPP continue to help PHS?

# Other Revenue Sources

| Name | Description |
|---|---|
| PRIME (expired) | 1115 waiver incentive program for PHS. Max was $700m FFP through FY17-18; was phased down before expiration 2020, amounts rolled into QIP. |
| Whole Person Care (WPC) | 1115 waiver program for counties, $300m FFP/yr. Payment for pilots coordinating services. (To CalAIM) |
| Incentive payments | Incentive payments for achieving certain metrics or deliverables (usually from health plans) |
| County Funds | General fund, tobacco settlement, other local taxes, etc. (not Medicaid revenue) |
| Health Realignment Funds | Amount from State sales and vehicle taxes, that is apportioned to counties for indigent health care. (Subject to AB85) |

# Self-Financing: Diverging Viewpoints



# Discussion

- How is PHS financing viewed under federal rules vs reality of our payments?
- How does this impact how we ask for additional federal funds?
- How is self-financing enabling PHS and how is it a burden?

# Pros and Cons of Self Financing?

Discussion

# FQHC Payment Mechanisms

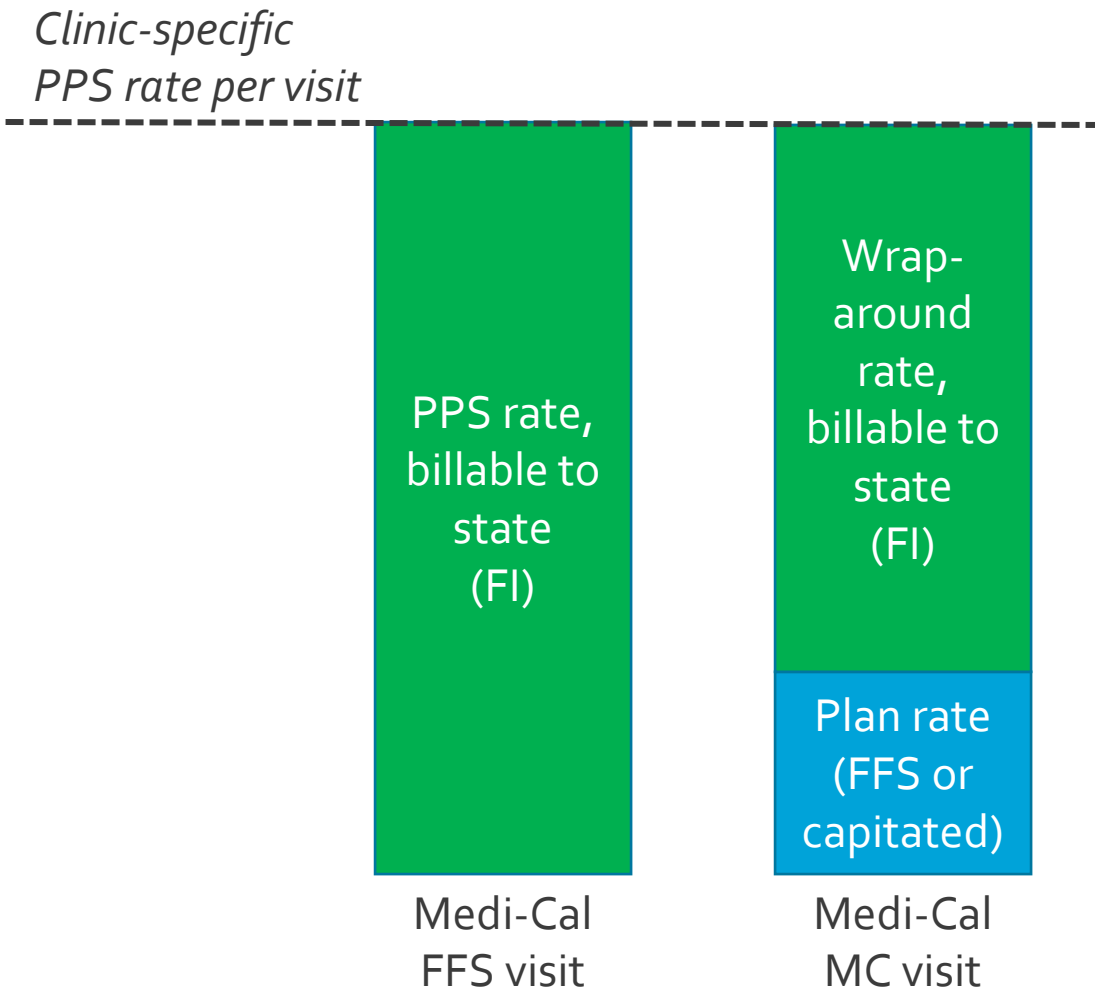
# FQHC Payments

Medicaid Prospective Payment System (PPS) began in 2000, with passage of Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA)

- State and federal funds only
- Fixed payment for each Medicaid visit to a given FQHC
  - Rate varies only by clinic, not duration or type of services
- Generally much higher rate than a regular clinic visit
- Not necessarily equal to cost

# FQHC – Managed Care

- For each FQHC to get its PPS rate even in managed care:
  - Plans pay market-based primary care rate to FQHCs
  - FQHCs bill difference between plan rate and PPS rate to state ("wraparound")
  - State reconciles to PPS annually in case wraparound was high or low



# Declining FQHC Payments

- Rates set based on costs at a specific point in time, then trend up automatically (~1%/yr) unless clinic applies for new rate
- Due to challenges to rate-setting methodology by current DHCS auditors, most FQHCs have opted not to update rates
  - DHCS including productivity standards, rate-setting, providing services "outside of four walls" and other SPA changes in the works
  - As a result, most PHS FQHC rates have fallen below costs over time

**Discussion:** What other policy reasons may cause FQHCs to be jeopardized in the future?

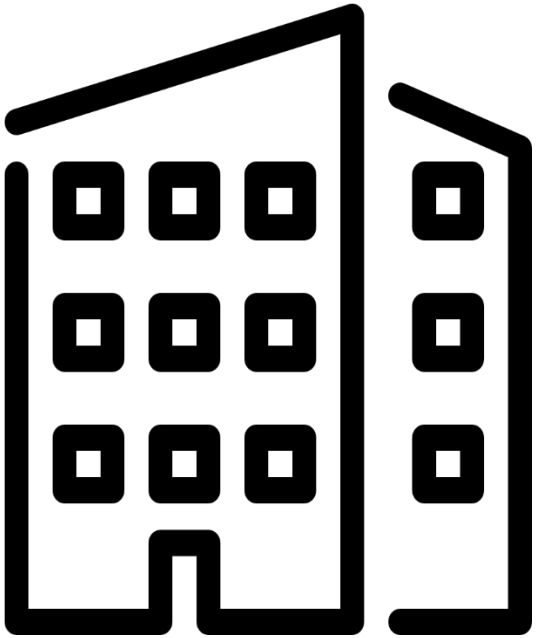
# Key Takeaways

- 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
- Managed care supplemental payments have grown in importance
- How well are we doing now in terms of getting our costs covered? According to whom?

# FST Schedule

| Module | Date | Topic |
|---|---|---|
| 1 | Wednesday, May 5<br>11:00 - 1:30 | Introduction to Public Health Care System (PHS) Financing |
| 2 | Tuesday, May 11<br>11:00 - 1:30 | Managed Care Financing |
| 3 | Wednesday, May 19<br>10:00 - 12:30 | Claiming, Reporting, & Revenue Maximization |
| 4 | Wednesday, May 26<br>11:00 - 1:30 | Realignment and Waivers |

# Optional Office Hours



- CAPH staff will be hosting regular office hours
- Bring any and all questions related to the training
- Module 1 Office Hours will be on **Friday, May 7 from 1:00 – 2:00 pm**

# Evaluation

- Please let us know how we did by filling out the evaluation:

See link in the chat