CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

Realignment and Waivers

Module 4

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FST Schedule

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

Module 3 Takeaways

- A wide array of financial and administrative data comes together to result in claimable costs/CPEs for reimbursement purposes
- Some of this can fall into autopilot and it should periodically be rechecked for validity and interaction problems
- The bucketing of payers for P14 columns is a complex exercise incorporating logical and legal steps
- Look to key outputs like gross claimable costs and cost/day to understand any swings and to be comfortable legally attesting to your reports

Module 4 Objectives

Objectives are to understand:

- What 1115 waivers are
- Their historical importance and role in PHS financing
- Key programs
- The history of the county-state relationship
- Realignment and the AB85 formula

1115 Waivers in California

Overview

- What are waivers?
- Waivers throughout time
- Evolution of waiver programs in 2021 and 2022

Different Types of Waivers

Medicaid

- **1115: what we'll focus on today**
- 1915(a) (b) and (c) – used for managed care and home and community-based services
- 1135 waivers – a number have been approved during COVID

Exchange

- 1332: allows modifications to Exchanges within certain guardrails; can be used in conjunction with 1115 waivers, but cannot be used to change Medicaid program requirements

What is an 1115 Waiver?

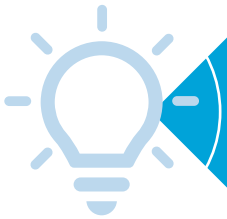
- Section 1115 of the Social Security Act gives the HHS Secretary authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program
- Allows states to waive certain federal statutory Medicaid program requirements or draw down funds not otherwise matchable
  - Waive rules in order to demonstrate innovative approaches to care (authority to waive rules)
  - Authority to spend Medicaid dollars on people or services not normally covered in the Medicaid program

Why 1115 Waivers in CA?

- Financing constraints for CA's public health care systems
  - Limitations on State's investment in Medi-Cal
  - Self-financing ("50¢ on the dollar")
  - OBRA Limits
- Waivers have been a source of supplemental funding
  - Help to close the gap between the costs of providing care and PHS revenue

1115 Waiver Components

Source of Non-Federal Share



Demonstration Project

Budget Neutrality

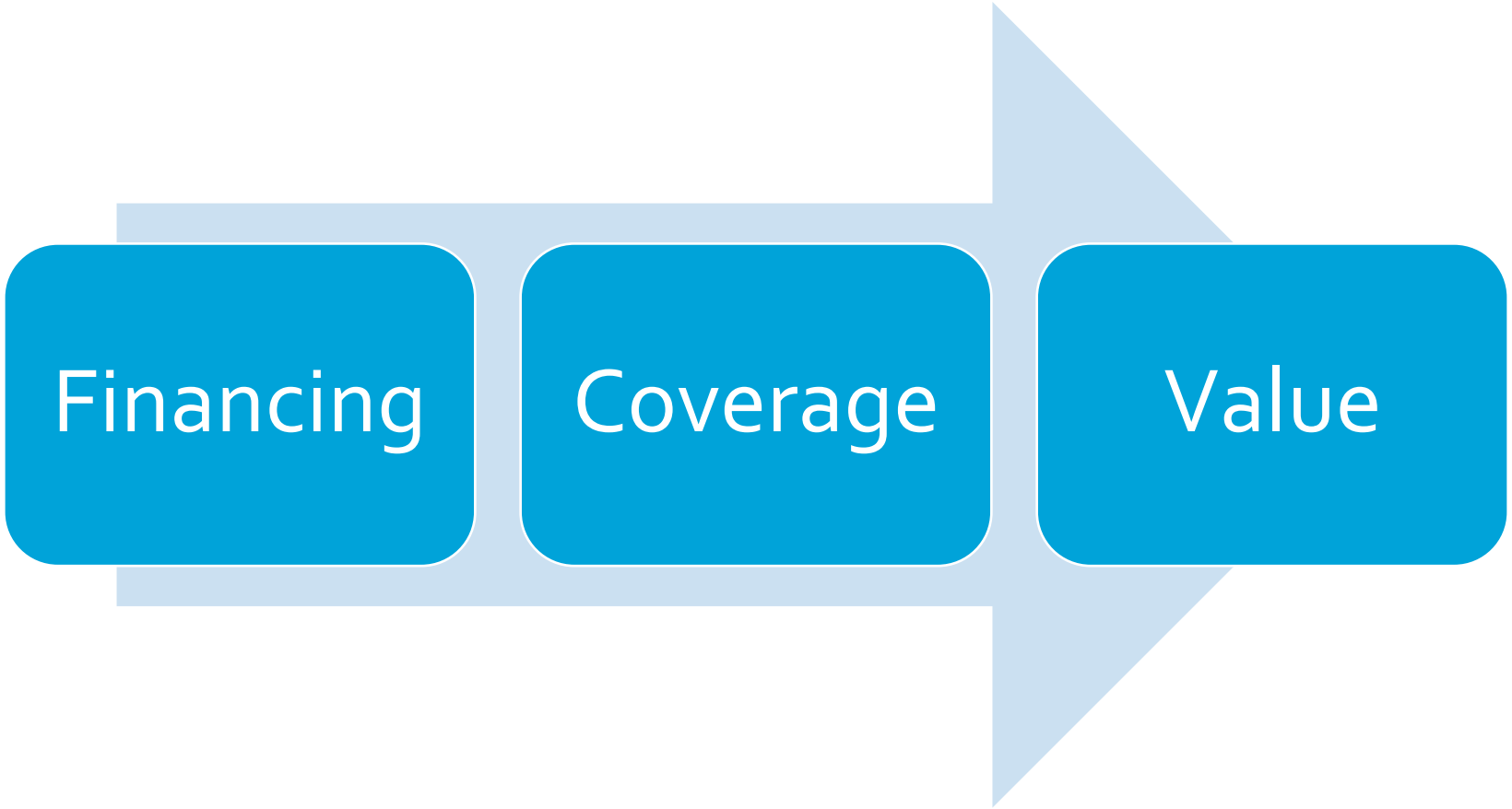
Demonstration Project

- Common programmatic elements in a demonstration:
  - Coverage expansion
  - Financing care for the uninsured
  - Pay-for-performance programs for quality and outcomes
  - Rethinking continuum of care
  - Addressing social determinants of health

Budget Neutrality

- Savings incurred from the demonstration project must create room to fund the opportunity
- There are federal guidelines, but it's also a negotiation, led by the State (technical and political)
- New CMS guidance puts significant constraints on budget neutrality
  - Desire to limit waiver spending
  - Re-basing cost savings associated with managed care

Trend in CA Waivers



2010 Bridge to Reform (2010-2015)

- Helped CA prepare for health reform (ACA)
- Low Income Health Program (LIHP) – expanded, at county option, the 10 county Coverage Initiatives
  - Take advantage of ACA's early Medicaid expansion provision, both with/out waiver
- Nation's first Delivery System Reform Incentive Pool (DSRIP) for public health care systems
- Move Seniors and Persons with Disabilities (SPDs) into managed care
  - Creation of SPD IGT – supplemental payment to get up to cost for SPDs (eliminated in 2017 – replaced with EPP and QIP)

2010 Waiver Impact, Implications

- $10B in federal funding
  - Increase in PHS share of costs covered with federal funds
  - No State General Fund
- Consensus on a successful LIHP
  - More than 700k enrolled, seamlessly transition to Medi-Cal and Covered CA
  - 89% of enrollees were in counties with a PHS
- DSRIP precedent set – first in the country
  - Significant improvements: increased enrollment into medical homes, expanded primary care/specialty care capacity, reduced inpatient harm

Medi-Cal 2020 Waiver (2015-2020)

- Total funding: $6.2 billion over 5 years
  - Funding phased down over time
- Public health care systems as the sole participants or main drivers for all PHS funded programs
- Heavy shift to demonstrating outcomes – CMS wants to see value for their investment
  - Demonstrate outcomes on standardized metrics
  - Substantial reporting requirements
  - Emphasis on evaluations

Medi-Cal 2020 Waiver Programs

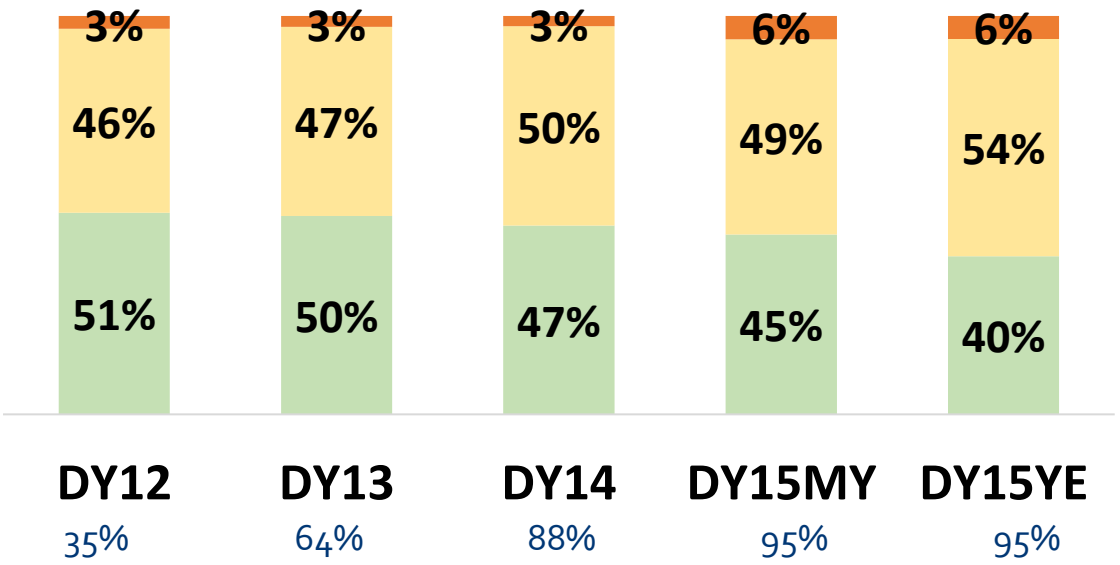
- PRIME
  - Pay-for-performance successor to DSRIP
  - Focus on high quality, integrated care
  - Strengthening use of data
- Global Payment Program (GPP)
  - Improved access to services for the remaining uninsured
  - Combines existing funding streams to create incentives
- Whole Person Care (WPC)
  - County-based pilot program
  - Coordinated, targeted care for high-risk, vulnerable
- Dental Transformation Initiative (DTI)
  - Improved and more consistent dental care for children

PRIME

- Pay-for-performance program to improve quality across three domains of care:
  - Outpatient delivery system transformation and prevention
  - Targeted high risk or high-cost populations
  - Resource utilization efficiency
- Mix of required and optional projects within the domains
- Multiple opportunities to claim funds
- DPH and NDPH (district and municipal hospitals) funding pools are separate
- Alternative Payment Methodology (APM) requirement (individual system and aggregate)

PRIME Performance

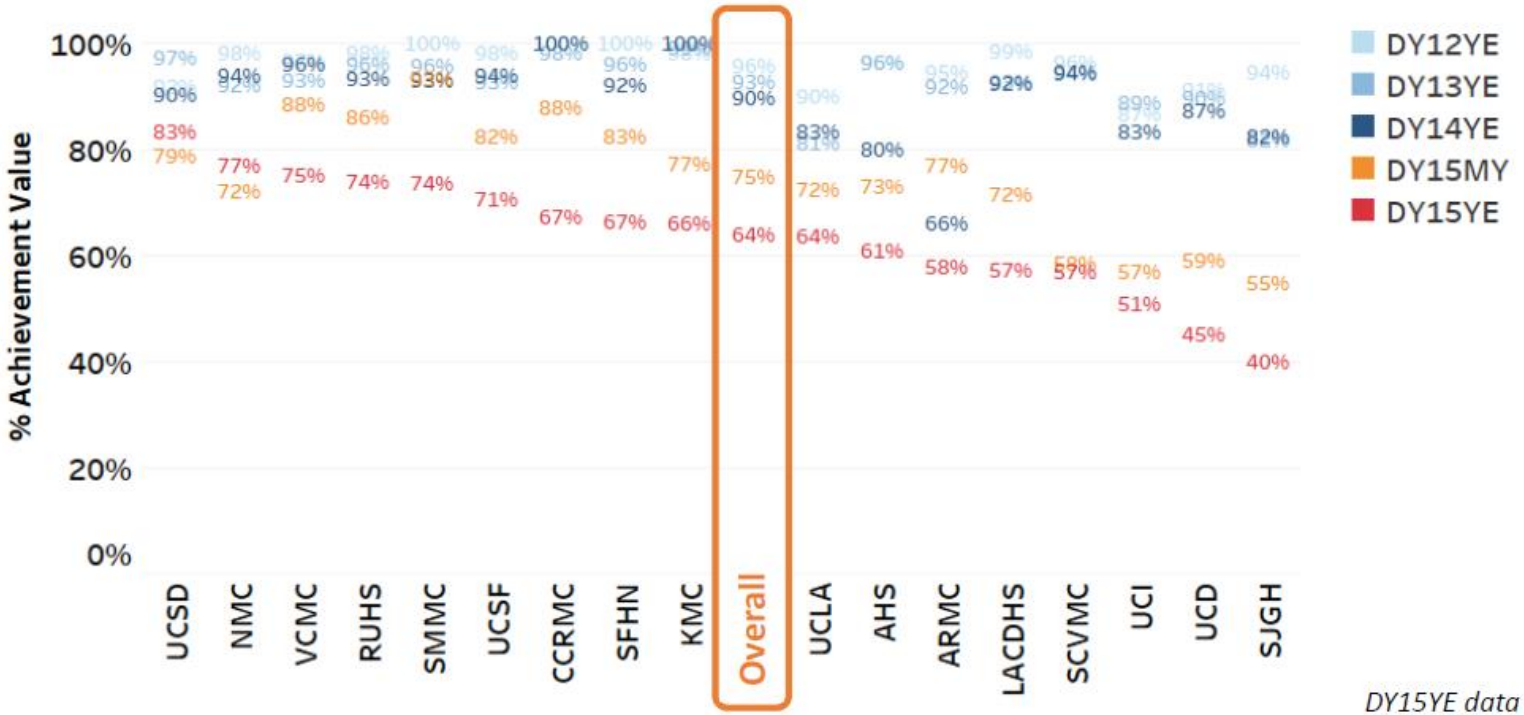
Overall DPH achievement relative to benchmarks is steady despite the majority of benchmarks getting harder year over year and despite the increasing number of P4P metrics.



DY15MY and DY15YE data not yet DHCS approved

PRIME Performance (and Impact of COVID)

- 58% of metric performances worsened from DY15 Mid Year to Year End
- Overall % achievement decreased from 75% to 64% from DY15 Mid Year to Year End



DY15YE data not yet DHCS-approved

PRIME Impact

Tobacco Screening and Counseling

An additional **100,300** **patients** screened

Colorectal Cancer Screenings

An additional **30,200** **patients** screened

Depression Screenings

An additional **262,600** **patients** screened

Influenza Immunizations

An additional **32,600** **patients** received flu shots

Improving High Blood Pressure Control

An additional **17,800** **patients** achieved blood pressure control

Improving Diabetes Control

An additional **5,600** **patients** achieved diabetes control

Sexual Orientation & Gender Identity Data

An additional **391,700** **patients** with data collected

Specialty Care Touches

An additional **146,700** **patients** received specialty care via non-face to face encounters

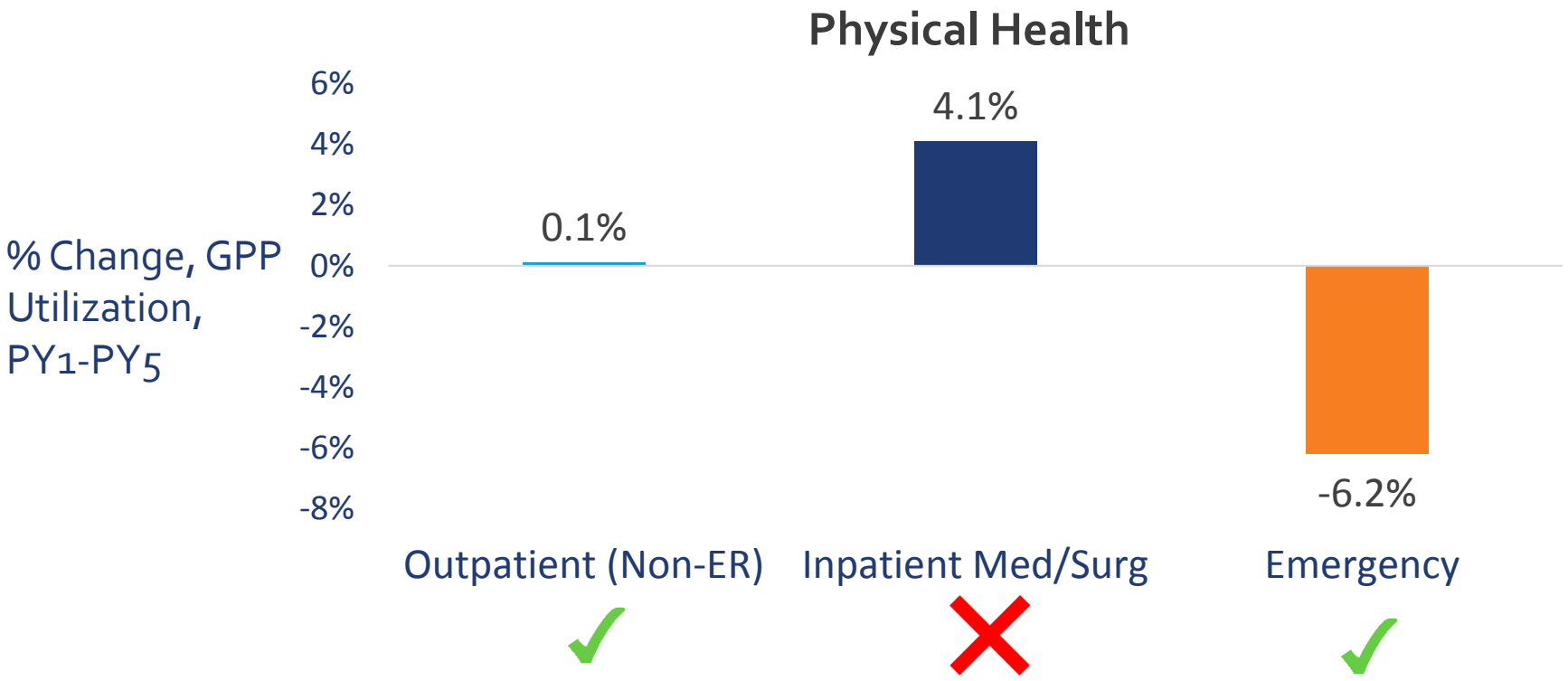
GPP

- Reorganization of existing funds (DSH from federal allotment, SNCP from budget neutrality room)
  - Eliminated restrictions on what types of funds could be used for what types of services
  - Earn funding via a new GPP points system
  - Earn funds/points by providing GPP services (inpatient, outpatient, behavioral health, non-traditional services)
- Waived OBRA (!!) - expanded access to supplemental payments
- County PHS systems participating, UCs stayed w/ DSH

GPP Performance

Aggregate PHS Performance	Year
102%	PY 1 (FY 15/16, Final)
97%	PY 2 (FY 16/17, Final)
104%	PY 3 (FY 17/18, Final)
106%	PY 4 (FY 18/19, Final)
103.9%	PY 5 (FY 19/20, Final)
Threshold Range	**# of PHS in range, PY5**
<75%	1
75%-90%	1
90%-100%	2
100%+	8

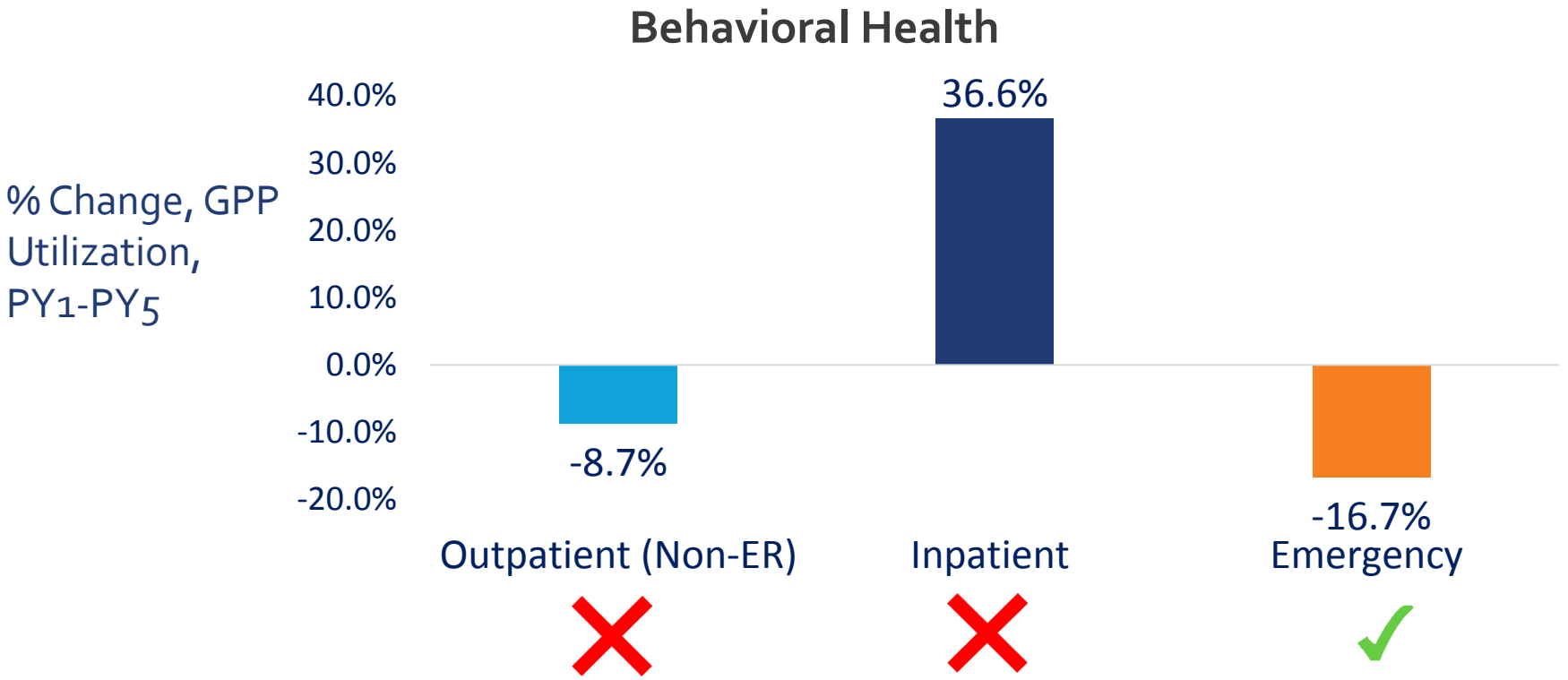
GPP Service Mix To Date
PY1-5, Physical Health



# systems trending in the right direction (of 12)	6	5	8

✓ Majority of PHS saw decreases in Emergency utilization

GPP Service Mix To Date
PY1-5, Behavioral Health

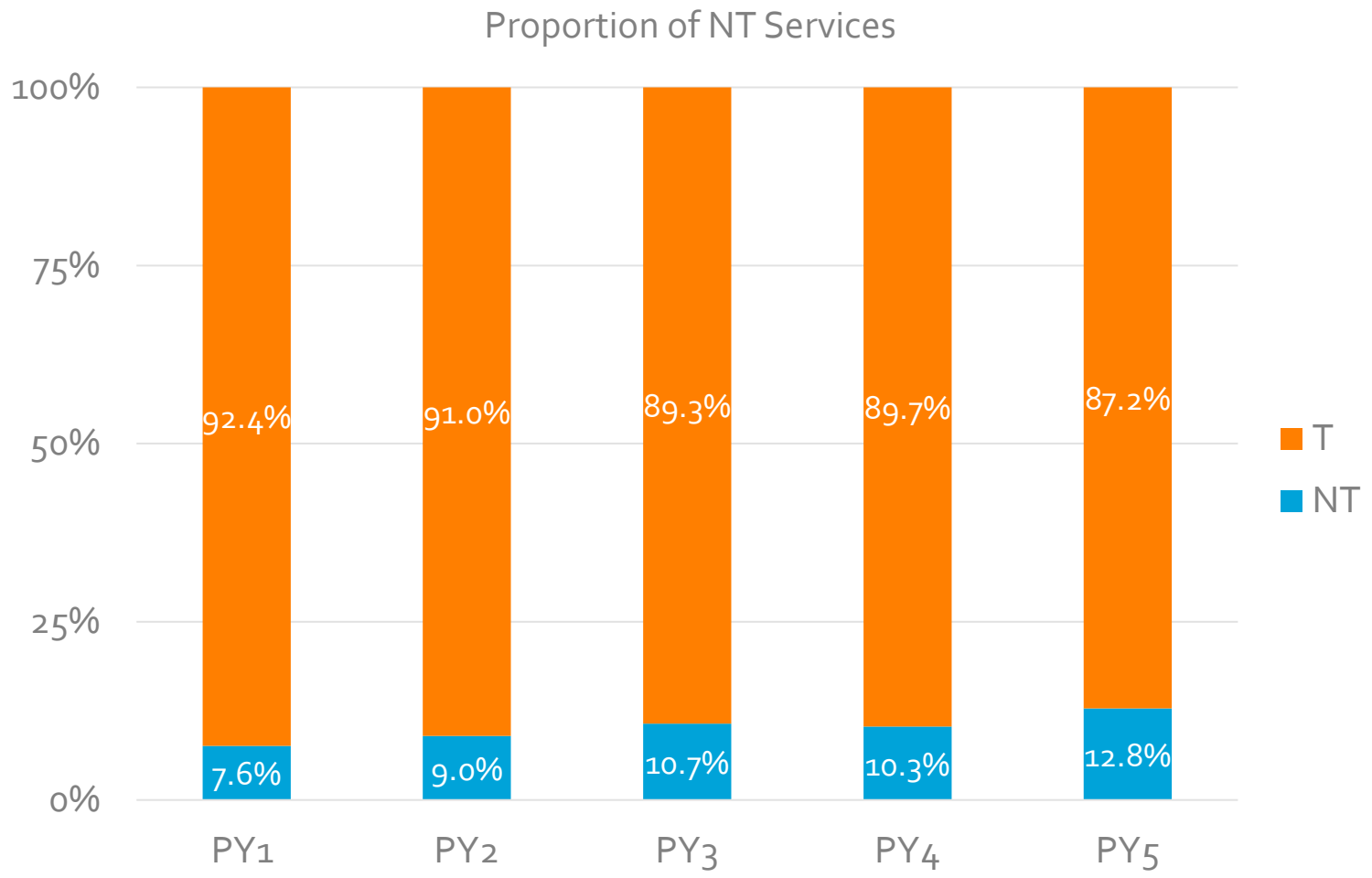


# systems trending in the right direction (of 12)	2	5	6

✗ Most systems saw decreases in outpatient BH services and increases in BH IP

✓ Over half decreased their BH emergency services

GPP Non-traditional (NT) Services



Whole Person Care

- $1.5b in federal funds available over 5 years
- County-based pilots to integrate physical and behavioral health services with non-medical services for patients with complex medical and social needs (homeless, high-cost, post-incarceration populations)
- Requires partnerships across multiple agencies, including county health services, county mental health, at least one Medi-Cal managed care plan, at least one other public agency, and other key community partners (housing, criminal justice, clinics, etc.)
- Pilots uniquely designed to best suit the specific needs of its community (target population, meeting patient needs, sharing data, coordinating services across sectors)

Whole Person Care

- Funding flexibility to invest in areas not traditionally covered under Medicaid:
  - Infrastructure
  - Social supports – housing supports, respite, sobering centers, outreach teams
- Mix of cost and outcomes-based reimbursement based on pre-approved budgets, including funding for non-Medi-Cal services

Whole Person Care Outcomes

- Significant progress in care coordination processes and infrastructure
  - E.g., formal data sharing agreements with key partners, universal consents, electronic data sharing platforms, working towards sharing social services and BH data and real-time notifications
- Better care
  - Improved rates of follow-up after hospitalization for mental illness
  - Initiation and engagement in alcohol and other drug dependence treatment
  - Timely provision of care plans, suicide risk assessments
- Better outcomes (trending toward)
  - Improvements in self-reported overall and emotional health, controlled blood pressure, diabetes control
  - Trends varied for utilization: ED visits, all cause readmissions, and inpatient admissions increased steeply before enrollment, increased at a slower rate in PY1, then decreased by PY2

Evolution of the Waiver Programs

Global Payment Program

- Set to expire June 30, 2020
- CMS approved extension (Jul – Dec 2020) and then renewal (2021)
- Seeking new five-year program to begin Jan 2022

PRIME

- Expired June 30, 2020
- Integration of existing metrics and financing w/QIP (Jul-Dec 2020)
- Funding integrated with **new** QIP Jan 2021

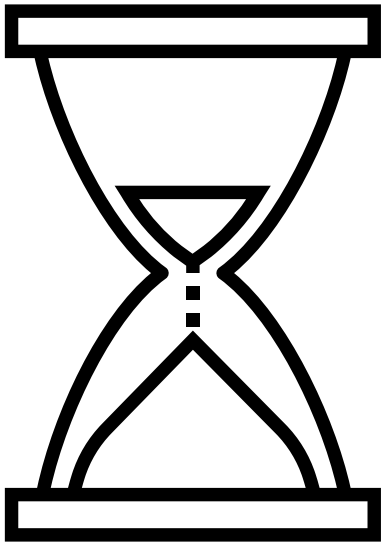
Whole Person Care

- Set to expire December 31, 2020
- CMS approved renewal (2021)
- Continue via CalAIM, managed care – Enhanced care mgmt (ECM) and In-lieu of Services (ILOS)

Waiver Programs - 2021 and 2022+

- Waiver programs had been set to expire in 2020
  - DHCS initial plan to implement CalAIM in 2021
- Due to COVID…
  - 2021 now serving as a transition year
  - Many elements of CalAIM set to start 2022, such as WPC → ECM/ILOS
- New Section 1115 Proposal
  - Submit to CMS by June 2021, to start 2022
  - GPP Equity Pool
  - Incentive payments
    - 30-day in-reach for justice-involved population
    - PATH incentives to support ECM/ILOS transition
  - Potentially other programs

Break!



We'll start again…

History of the State-County Relationship

Overview

- History of the State-County Relationship
- 1991 Realignment
- Takeaways

History of County Health Funding

- 1933 (Section 17000)

  "Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or 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."

History of County Health Funding

- 1965: Creation of Medicare and Medicaid
  - Increased coverage, reduced county cost
  - Does not cover most adults 21-64 (assumed to have means of coverage; if not, county responsibility)
- Counties begin sharing with state responsibilities of covering previous uninsured population
- Long back-and-forth begins

Changes 1965-1991

Year	Change in policy	Underlying shift
1965	Medi-Cal created – state assists with formerly county-indigent beneficiaries	County => state
1971	State takes most of remaining uninsured into Medi-Cal without FFP ("Medically Indigent Program")	Further county => state
1978	Proposition 13 drastically slashes state and local tax revenue	
1982	MIP moved to back to counties, with annual state appropriations	State => county
1991	Appropriations replaced with annual formula allocation of state tax revenue	State => county

1991 Realignment

- Final agreement between state and counties in budget crisis:
  - Effective increases in sales tax, vehicle license fees, other revenues
  - Different components to support counties' health, mental health, and social services
  - Idea: more local control and flexibility in return for dedicated, ongoing revenues (no more need for annual appropriations)
  - "Poison pills" to undo if certain problems emerged

Fairness Issues stemming from 1991

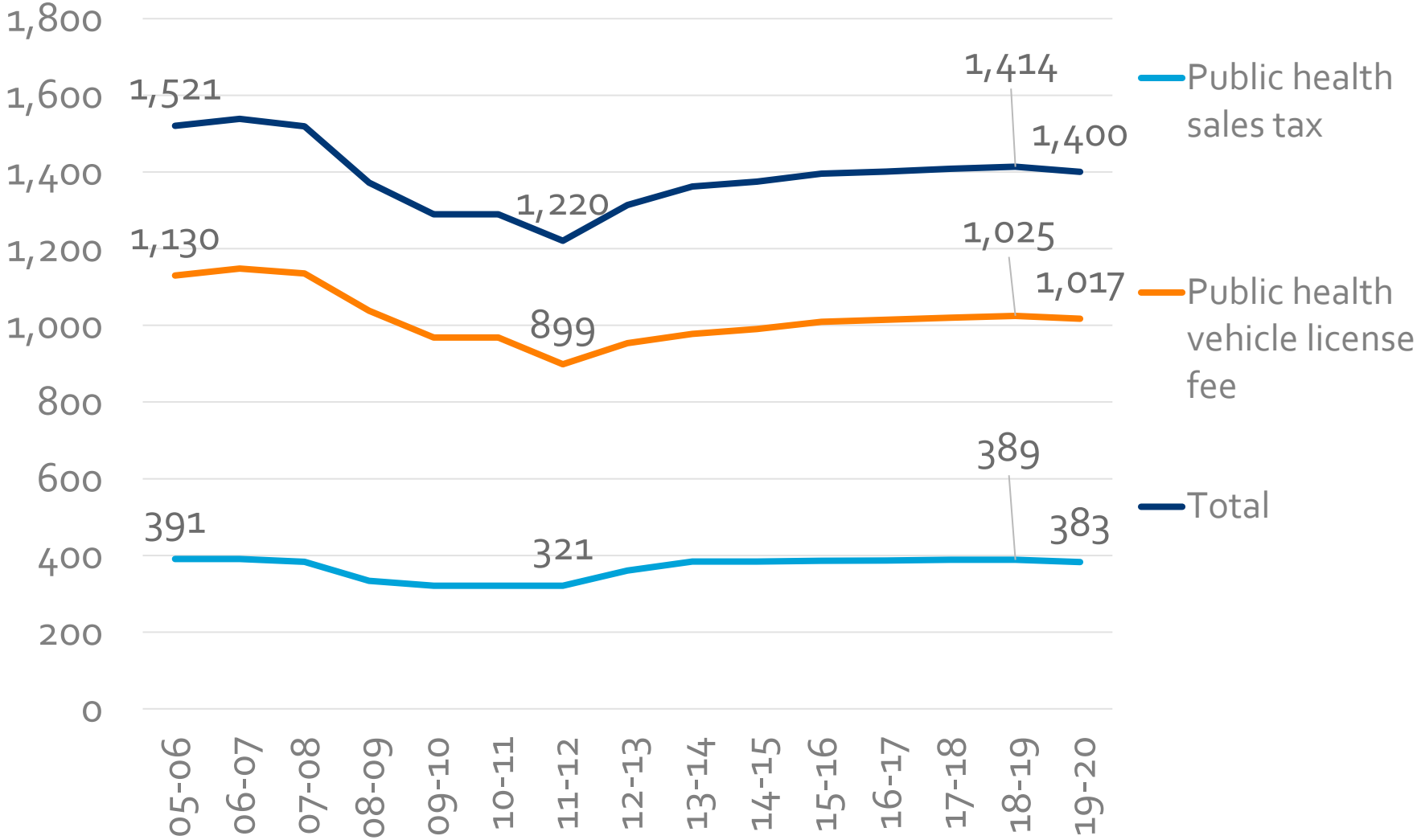
- Distribution of VLF/ST revenues among counties fixed in 1991 incorporating population at the time, and other factors

- Never reopened

More Stable, But Not Enough Revenue

- Not subject to legislative appropriation year-to-year; funding streams became dedicated
- Dependent on VLF/ST collections
- In recession, tax revenues go down while demand for services goes up (countercyclical)
- Complex formula meant that health portion of realignment funds, after dropping in recession, often did not recover during economic growth

Sales taxes & vehicle license fees allocated to health
$m, all counties, 05-06 through 19-20



- Revenues still lower in FY18-19 than before prior recession

Post-1991 Realignment Discussions

- 2011: Governor Brown's public safety, behavioral health & social services (AB 109)
- 2013: ACA; revisit 1991 accounts (focus of this training)
- 2017: IHSS
- 2020: County realignment backfill agreement

How Affordable Care Act Reopened 1991 Realignment

- State empowered to take adult population from county responsibility into Medi-Cal
  - 1965 all over again
- State counties to pay "their share" despite 100%=>90% federal match
  - State tied Medi-Cal expansion to getting portion of realignment funding back
- Disagreement on underlying county windfalls or needs for more
- Deal in 13-14 state budget: state may take back or "redirect" realignment from counties based on a formula measuring experience of costs and revenues after the fact (**AB 85**)
  - Different arrangements for counties without public hospitals to redirect funds

Shift in costs: county → **state+federal**

Not to be confused with…

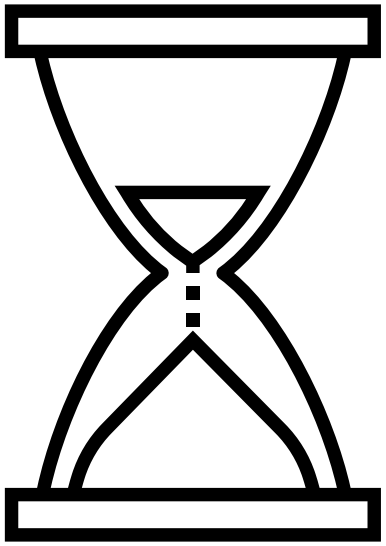
- Different policy initiative in 2011 often also called "the realignment deal"
- Sent more state prisoners to county jails along with state funds
- Affected:
  - Mental health realignment
  - Social services realignment
  - County jail funding
  - **But did not affect** "public health" realignment which was revised in 2013 (AB85)

Discussion

- What are some of the key takeaways you have so far?

- Survey questions

Break!



We'll start again…

Realignment Formula

Agenda

1. Objectives
2. Formula
3. Process
4. Revenue Enhancements
5. Historical Results and Takeaways

Learning Objectives – 2013 Realignment/AB 85

- Understand why the 2013 realignment deal exists
- Know what is impacted by realignment, and what is outside the scope of the agreement
- Understand how financial decisions made by the hospital system impact realignment
- What does it mean for the strategic organizational implications for your system?

2013 Realignment: Why a Formula?

- Two options:
  1. give 60% of realignment back to the state, or
  2. use a formula to determine giveback

- Formula allows public health care systems to account for tremendous uncertainty
  - Measures "gains" or "losses" under ACA for Medi-Cal & uninsured services
  - If gains, share with the state

- Formula will measure actual experience at net, but will take time to collect data and run formula

- All PHS counties chose the formula approach

Formula

- For each year:

  Medi-Cal and Uninsured Revenues
  + Historic Determinations of Local Funding, Realignment
  - Medi-Cal and Uninsured Costs

  If gains, share 80% with state
  If losses, return $0 to the state

- LA – has own formula – some of items in here apply but other variables as well.

Other Important Aspects of Formula

- Maximums and minimums:
  - Maximum amount counties pay back is the historic indigent health realignment percentage
  - Minimum payback is zero, if losses are greater than realignment can cover

- Cost containment limit: if costs grow "too fast," the excess costs are left out of the equation

- Counties' public hospital health systems have provisions under Medi-Cal expansion to support continued safety-net status (e.g. rate-range payment and default enrollment of newly eligible)

What Costs are Counted?

- Medi-Cal (FFS & MC) + Uninsured
  - Hospital
  - Non-hospital
  - Out-of-network
  - Related administrative costs

Medi-Cal Costs

6	**Medi-Cal Costs**					
	Medi-Cal FFS					
6a		Inpatient FFS	Old-eligible			
			New-eligible			
6b		Hospital Outpatient FFS	Old-eligible			
			New-eligible			
6c		FQHC Medi-Cal Costs (non-managed-care members)				
6d		Non-Hospital Service Costs	Old-eligible			
			New-eligible			
6e		Physician Costs	Old-eligible			
			New-eligible			
6f		Intergovernmental Transfers to Fund Private Entities				
6g		New mandatory other entity IGT required by the state				

	Medi-Cal Managed Care					
6h		Inpatient Costs	Old-eligible			
			New-eligible			
6i		Hospital Outpatient Costs	Old-eligible			
			New-eligible			
6j		Outpatient Non-Hospital Costs	Old-eligible			
			New-eligible			
6k		Physician Costs	Old-eligible			
			New-eligible			
6l		FQHC Costs				
6m		Out-of-Network Costs	Old-eligible			
			New-eligible			
6n		Allowable Administrative Costs	Old-eligible			
			New-eligible			
6o		Whole Person Care Costs				

What Counts as Revenue?

- Medi-Cal base payments
- Medi-Cal supplemental payments
- Waiver payments (PRIME, GPP, etc.)
- Uninsured patient payments
- Local revenues
- All revenues reported at net

Revenue or Cost

		REVENUE OR COST			
		*All revenues and costs unless otherwise noted exclude nursing facilities, duals, mental health, substance use disorder, and jail inmate services. * All revenues should be net of any IGT or CPE (represents FFP only)	Old-eligible/ New-eligible	Base Year FY 2014-15	Subject Year FY 2017-18
		Medi-Cal Revenues			
		Medi-Cal FFS Revenues			
1a		Inpatient Fee for Service (FFS) Revenues	Old-eligible		
			New-eligible		
1b		Outpatient Hospital FFS Revenues	Old-eligible		
			New-eligible		
1c		FQHC PPS Revenues			
1d		Outpatient Non-Hospital Revenues	Old-eligible		
			New-eligible		
1e		AB 915 (OP Hospital Supplemental), FFP Only	Old-eligible		
			New-eligible		
1f		Physician FFS Revenues	Old-eligible		
			New-eligible		
1g		Physician SPA Revenues, FFP Only	Old-eligible		
			New-eligible		
		Medi-Cal Managed Care Revenues			
1h		Inpatient Revenues	Old-eligible		
			New-eligible		
1i		Hospital Outpatient Revenues	Old-eligible		
			New-eligible		
1j		Outpatient Non-Hospital Revenues	Old-eligible		
			New-eligible		
1k		Physician Revenues	Old-eligible		
			New-eligible		
1l		FQHC Revenues			
1m		Other Revenues	Old-eligible		
			New-eligible		

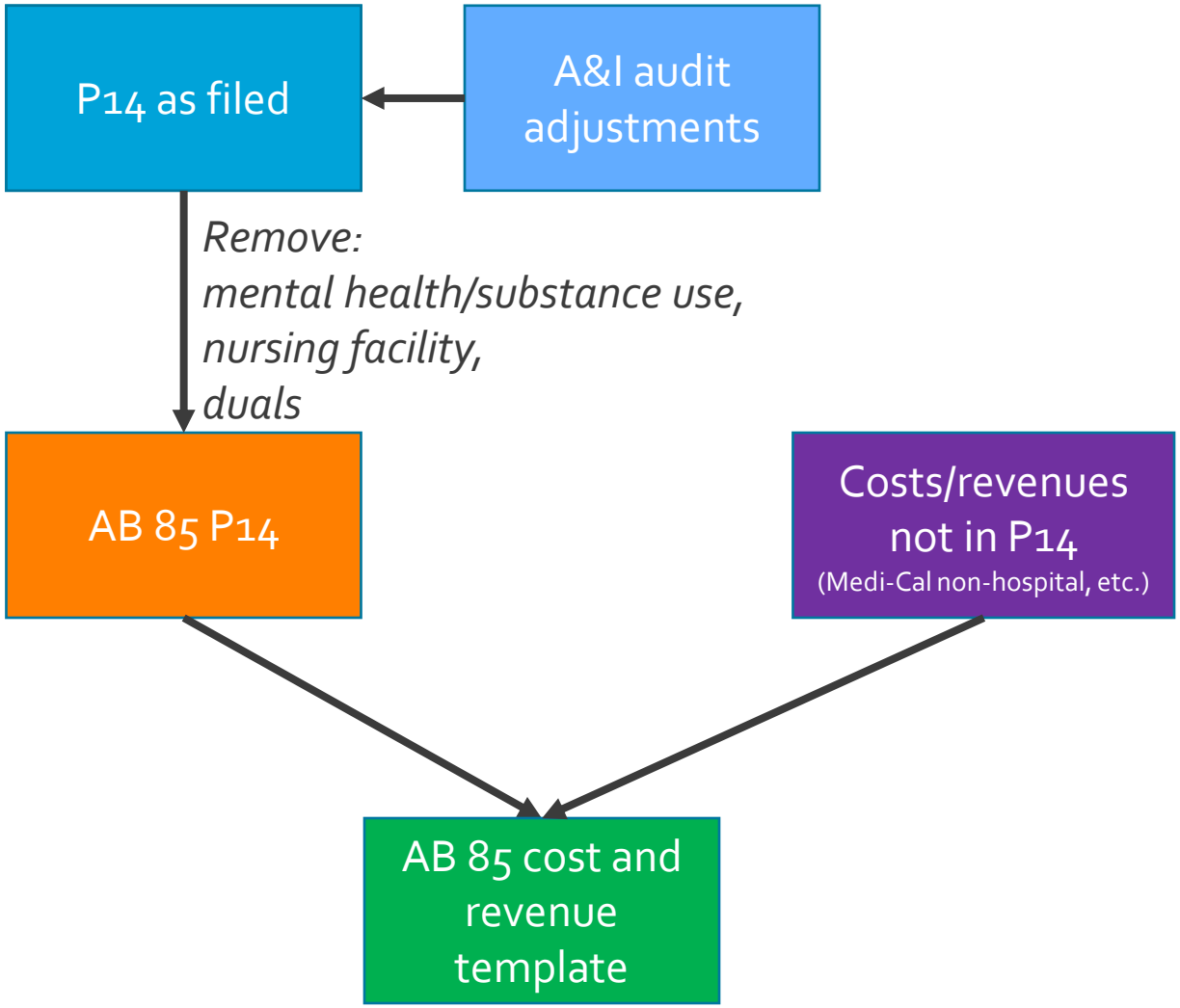
Other Supplemental Revenues

		Other Supplemental Revenues			
1n		Enhanced Payment Program (EPP)			
1o		Quality Incentive Program (QIP)			
1p		Graduate Medical Education (GME)			
1q		SB 1732 Revenues			
1r		Traditional Rate Range IGT Revenues, FFP Only			
1s		Global Payment Program (GPP) Revenue, FFP Only			
1t		Whole Person Care (WPC) Revenues			
2		**Medicaid Demonstration Revenues**			
2a		Public Hospital Redesign & Incentives in Medi-Cal (PRIME), FFP Only			
3		**Uninsured Revenues**			
3a		Uninsured Patient Payments			
3b		Maddy Fund Revenues			
4		**Hospital Fee Direct Grants**			

What is Excluded?

- Mental health services
- Substance use disorder services
- Services for dual eligibles (Medicare+Medi-Cal)
- Services for prison, jail inmates
- Nursing facility services
- “Traditionally” public health services

AB 85 template: from AB 85, P14 and other sources



What Counts as Revenue – Local Revenues

- Rather than account for our funding in gross terms like the federal government, this agreement looks at "actual" funds net of any self-financing – state and federal dollars

- However, formula also looks at local (county) dollars which the federal government does not consider for its programs

- Local funds are partially "actual," partially calculated from formulas and historical amounts

Put It All Together

For each year:

Medi-Cal and Uninsured Revenues
+ Historic Determinations of Local Funding, Realignment
- Medi-Cal and Uninsured Costs

If gains, share 80% with state, up to maximum
If losses, return $0 to the state

Exercise

- What is the payback (redirection) for a county in the following situation?
  - Total revenues* are $30m
  - Total costs are $20m
  - Maximum payback is $20m

Cost Cap

- Cost Cap Concept
  - Ensure PHS don't try to "game" the formula by adding more services/costs
  - Costs above the cost-cap limit will not be considered in the formula (increasing giveback)

Cost Cap - Exceptions

- Volume increase (adjusted days)
- "Quick-check"
- Exempted costs
  - Automatic categories
    - EHR
    - Seismic upgrades
    - Natural disasters / terrorism
    - New state/federal mandates
    - Court orders or settlements
- "Other:" petition to DHCS

Key Flaw in AB85

- What is the conceptual flaw of AB 85?

  It assumed as a premise that the amount of realignment we were getting prior to AB85 was sufficient to provide care to remaining uninsured

Processes

Appeals

- If you disagree with any aspect of DHCS's determination of the formula, you can:
  - Request an expedited Administrative Law Judge Review (must do within 30 days of receiving adverse decision from DHCS)
    - Process must be completed within 6 months of filing administrative appeal
- If ALJ process is not satisfactory, PHS can use other traditional legal remedies

Single-Year Process

2020

2024

Single year process (assuming actual year is FY 2122)	
-1 year (pre-work)	A. Submit projections for January budget (Sept '20) B. State determines interim redirection amounts (Jun '21)
Actual year	C. State begins reducing monthly realignment by the interim redirection amounts (Aug/Sept '21)
+1 year	D. Submit actual data for January budget (Nov '22) E. Quick check for cost containment limit (Feb '23) F. Final actual data submission, including P14s (Jun '23)
+2 years	G. DHCS initial determination for PHS input (Dec '23) H. Complete audits of cost report, P14 (May '24) I. DHCS finalizes redirection (Jun '24)

Revenue Enhancements

Provisions of AB 85 Designed to Enhance Revenue

1. MCE-to-cost, supplementing base MCE rates from plans so they approximate PHS MCE costs (PHS provide non-federal share)
2. 75% of MCE rate-range (PHS provide non-federal share)
3. 50% of default MCE lives (primary care assignment from the plan)
   - Was 75% from Jan. 2014 to Dec. 2017

Provisions #1 and #2 became inapplicable 7/1/2017 under new federal managed care rule, replaced with QIP and EPP

Historical Results

Early Experiences

- Significant fluctuations between estimated, final
- Better than 60/40 split

	Max Redirection	Initial Estimated Withhold	Estimated Withhold (1 year after end of FY)	Final Withhold (2 years after end of FY)
FY 13-14	$167m	167	35	29
FY 14-15	658	334	570	600
FY 15-16	669	324	522	551
FY 16-17	652	144	440	437
FY 17-18	684	239	N/A	525
FY18-19	684	307	280	TBD
FY19-20	693	88	TBD	TBD
FY20-21	627	149	TBD	TBD

Realignment Scenario

Question 1

True/False: You would need to make a special request for a cost cap exemption to ensure your EHR costs are not treated as inappropriate cost growth for the purposes of the AB 85 formula.

Question 2

True/False: It would be better to count as many of the EHR costs as possible in the AB 85 formula.

Question 3

True/False: If there is another economic downturn, we can assume our costs will be higher, and therefore that we'll be able to keep more realignment.

Takeaways

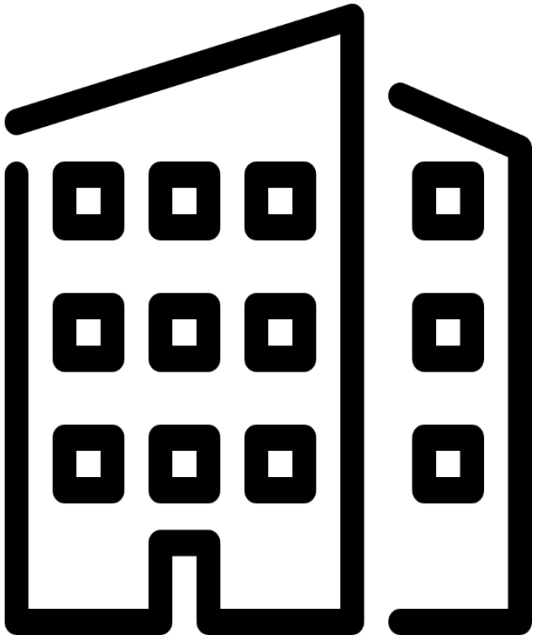
1. Facilities should consider the impact of AB 85 in their major financing decisions.

2. Certain revenues and costs are excluded from AB 85 calculations, such as behavioral health, nursing facility, jail health, etc.

3. Careful planning for large expenditures can reduce resulting AB 85 redirection.

4. AB 85 redirection obligation needs consideration as we develop new financing streams.

Optional Office Hours



- CAPH staff will be hosting regular office hours, continuing this **Friday May 28 from 11:00am – 12:00 pm**
- Bring any and all questions related to the training

Evaluation

Please let us know how we did by filling out the evaluation using the following link or QR code:

https://www.surveymonkey.com/r/2021FSTmodule4