CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

Joint Informational Hearing
Assembly Health Committee and Budget Subcommittee #1 on Health and Human Services,
Senate Health Committee and Senate Budget Subcommittee #3 on Health and Human Services

MEDI-CAL: HOSPITAL FINANCING IMPLEMENTATION AND COVERAGE INITIATIVE

Testimony
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Good morning. I am Melissa Stafford Jones, President and CEO of the California Association of Public Hospitals and Health Systems. CAPH appreciates the Legislature's ongoing oversight and efforts related to the hospital financing waiver in order to ensure that low-income and uninsured Californians continue to have access to the essential services safety net hospitals provide.

The hospital financing waiver and demonstration project negotiated by the state and federal government last year established an entirely new system that governs how and how much public hospitals are paid for the care they provide to Medi-Cal beneficiaries and the uninsured. The waiver involves fundamental changes for public hospitals, counties and the state's overall health care system. Today I'd like to provide you with an update on how those changes are occurring in the development of the new system and the impact on public hospitals and their ability to care for patients and communities.

Unfortunately, many of the inherent problems with the waiver that we have articulated and anticipated are coming to light. In particular, the new system is so complex that it is proving much harder to implement than perhaps the state or federal government contemplated. The resulting delay in getting the new system up and running is giving us the first concrete example of the cost-shift to counties that is an underpinning of the agreement. And, the federal government's approach to defining the methodology on which public hospital funding will be based, is revealing their intent to contain their own obligation to paying for services that our members provide. I will touch on each of those developments in my remarks today.

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We are now almost eight months into the first fiscal year of the waiver and the new program infrastructure is not yet in place and no waiver payments to public hospitals have been made. As you know, following the passage of SB 1100, key components of the deal remained to be negotiated with CMS. Central among these was Paragraph 14 of the Terms and Conditions, which defines what costs will count as Certified Public Expenditures (or CPEs) and how those costs will be accounted for.

CAPH and our member public hospitals along with the state have been working since September to establish a CPE methodology that ensures we can draw down maximum federal funding within the confines of the waiver. The process for developing Paragraph 14 has been complex and often unwieldy. CMS has raised multiple policy, technical and legal issues at each stage of the negotiations, and work has been required to understand and analyze the ramifications of CMS's demands. During the process of developing Paragraph 14, it has become clear that the federal government plans to use the opportunity presented by the development of a new CPE system to narrow allowable costs at public hospitals and thus diminish the federal obligation to support their services.

The litany of issues that we have had to work through with CMS is long. For example, CMS indicated that it did not want to pay for the costs of interns and residents under the waiver. Many public hospitals are major teaching hospitals, and not being able to count these costs would have a serious impact. Further, these teaching costs had been part of the old system and paid for by Medicaid, so to not pay for them here would have been a step backward from our prior program. Ultimately, the state prevailed on this issue, but it took time and intense effort to maintain these costs as part of Paragraph 14, when these costs should have never even been at issue.

A second issue is that CMS demanded that hospital-based physician costs not be counted as part of hospital costs. The result is that physician costs for undocumented patients are not being paid for through any of the pools and counties must simply absorb those costs. Another result of this action is that it may limit the amount of DSH funding public hospitals can receive. CAPH disagrees with CMS's position that physician costs are not hospital costs and we do not believe that CMS has a legal, policy or technical basis for their position. CMS has indicated it will pay for physician costs through a separate State Plan Amendment, but that SPA is yet to be agreed to and CMS has already raised several issues and questions that raise concern as to whether public hospitals will be fully reimbursed for physician costs. We understand from DHS that in one other state it has taken more than a year to resolve physician payment issues with CMS.

As Paragraph 14 negotiations have continued, public hospitals have not been paid any supplemental payments for care they are providing to Medi-Cal and uninsured patients. Public hospitals are due approximately $650 million in funds from the Safety Net Care Pool and DSH, and that is the amount just to get to baseline funding levels. Public hospitals have continued to receive per diem payment for Medi-Cal inpatient fee for service, but these payments total only an estimated $380 million. The result is a growing cash flow crisis that jeopardizes health care services and places heavy financial burdens on counties to keep their public hospitals afloat. I will speak more to the specifics of the cash flow crisis in public hospitals in just a moment.

CMS has stated that federal funds would not be paid until Paragraph 14 is final. Yet, they persist in making changes and raising questions that require careful analysis. Although we do not agree with several of CMS's demands on Paragraph 14, public hospitals have deferred to the state to finalize Paragraph 14 because of the escalating cash flow crisis several public hospitals face. That CMS has had us over a barrel is an understatement.

Thus, three weeks ago, the state forwarded to CMS a final draft of Paragraph 14 that in CAPH's view had 99% of what CMS wanted. Yet even with that, CMS has raised additional issues, including that Paragraph 14 and the associated SPAs be applicable for only one year. That would mean that Paragraph 14 and the three SPAs necessary to implement the waiver deal, which are not complete nearly eight months into the year, would sunset on June 30 of this year. This would put us in the position of having to renegotiate the entire methodology with CMS for year 2 and having no way to make payments in Year 2 of the waiver, so once again we would face a severe cash flow crisis. The state and public hospitals agree that this timing limitation proposed by CMS is unacceptable and we are working to address it. We appreciate the state's recent communication to CMS on this matter and hope it will be resolved.

The ongoing negotiations leave public hospitals in a position with no clear date for resolution of Paragraph 14 and when they can anticipate receiving payments. The practical result is that public hospitals face a cash flow crisis. To date, they have not been paid adequately for services provided this fiscal year to Medi-Cal and uninsured patients, resulting in an absence of approximately $650 million in federal funds owed them. Under the new waiver, public hospitals should have received that money in DSH and Safety Net Care Pool funds for the first two quarters that ended December 31st. Private hospitals' federal payments are matched with state General Fund, not CPEs, as SB1100 directs. Therefore, private hospitals are receiving their DSH and supplemental payments.

Public hospitals, however, have been forced to borrow money from their counties in order to continue to provide services, make payroll and keep the lights on. Collectively public hospitals are in debt to their counties hundreds of millions of dollars and tens of millions individually. Public hospitals for the most part operate as enterprise funds separate from the county and they must pay interest on the money they borrow from their counties. Due to the magnitude of the loans, this interest is not insignificant. Let me describe the situation at Kern Medical Center as an example. You may remember Peter Bryan, the CEO of Kern Medical Center, who has appeared before these committees and the Legislature in the past to discuss the impact of the waiver on his hospital. Kern Medical Center has had to borrow $54 million from the county. Just last week Peter had to borrow an additional sum to make payroll. San Joaquin Medical Center has also had to borrow from the county to stay afloat. The medical center indicates that the interest cost related to this borrowing is $1 million, which will in effect be deducted from the estimated $2 million in new funding it expects under the waiver this year, when the money finally starts to flow.

The cash flow crisis represents the shifting of risk and responsibility for funding public hospitals through the state's Medi-Cal program from the state to the individual counties. Even before the waiver is implemented, counties are put in a position of fronting the federal share of Medi-Cal payments, in addition to paying their own portion. Counties should not be required to take on this

responsibility, as Medi-Cal is a state-federal partnership. For many counties, the cost-shift argument that circulated during the many months of waiver negotiations is finally hitting home. With no certainty as to when federal payments to public hospitals under the waiver will begin, counties' ability to sustain critical public hospital services is increasingly in question.

Last fall CAPH began alerting the state of the growing cash flow crisis in several public hospitals. We appreciate the state's recent steps to address this, but note that the situation is not yet resolved. Eight counties have requested a cash advance from the state pursuant to an offer from DHS to consider state interim payments—essentially a zero percent loan—to public hospitals, and additional requests may be forthcoming. The cash advance requests to date total $210 million. The standards and criteria for approval of the cash advance payments are not clear, however, and public hospitals are awaiting decisions from DHS on this matter. CAPH would ask the Legislature's support and assistance in assuring that state cash advances are made available quickly to prevent cuts in services at several public hospitals.

The Department of Health Services is also working to expedite last fiscal year's DSH payments, which have not yet been paid. We appreciate this action; however, the funding to public hospitals under this mechanism will likely be $80 to $90 million, a fraction of the $650 million due under the waiver. Further, payments under the prior DSH program will require IGTs from counties, which will temporarily worsen the cash flow situation.

To further complicate matters, finalization of Paragraph 14 will allow Safety Net Care Pool funds to begin flowing, but the pool provides only a portion of funding owed to public hospitals, approximately $400 million in the first year to achieve baseline. The largest source of funding for public hospitals under the waiver is in the DSH program, worth $1 billion. But DSH funds cannot begin to flow until there is a new approved DSH State Plan Amendment, and that remains a work in progress. CMS has raised numerous questions about the draft DSH SPA the state first submitted September 30. CAPH is working closely with the state to address the issues raised by CMS and re-draft the DSH SPA, but the issues are legally and technically complex. Based on the experience with CMS on Paragraph 14, it would not be unreasonable to anticipate that it could be months before the DSH SPA is approved and DSH money begins to flow. And as I mentioned earlier, the same is true of the physician SPA, and certain physician payments, previously made through hospital payments, will not be replaced until the physician SPA is completed.

Once Paragraph 14 is finalized, CAPH and our members have been urging the state to utilize a simplified cost certification process in order to prevent further payment delays. The cost finding and certification process CMS is requiring under Paragraph 14 is very complex and involves multiple steps. Even if Paragraph 14 were to be approved tomorrow, it likely would take eight weeks until federal funds from the Safety Net Care Pool begin flowing. The state has agreed to work with public hospitals to implement a simplified cost attestation once Paragraph 14 is done and we appreciate that commitment. We have also requested that the state work with us to determine if it is possible for DSH funds to begin flowing prior to finalization of the new DSH SPA as a way to relieve the cash flow crisis and growing burden on counties.

Concluding Comments

The experience of developing the CPE methodology in Paragraph 14 underscores the significant and fundamental changes to hospital financing required under the new waiver. We now find ourselves nearly eight months into the fiscal year without a program in place to implement the waiver. The Medicaid deal has not delivered yet on its objective to stabilize safety net hospitals, despite intense efforts by the state and public hospitals to implement it. We note that the waiver has yet to produce federal funds for public hospitals and are growing increasingly concerned about the timeline for realizing these critical funds.

In fact, CMS has indicated that it plans to develop new national policies on matters related to our waiver, so further changes may yet be required. The President's recent budget proposal also includes cuts to Medicaid based on limiting payments to public providers, which directly intersects with our new system.

Last year public hospitals identified policy shifts and implications that appeared to be inherent to the structure of the waiver, including shift of risk and responsibility to counties and potential for narrowing of allowable costs for public hospital care. We opposed the waiver for those very reasons. Unfortunately, these issues have emerged in the initial months of implementation.

Moreover, the many issues I described today relate to the basic program for Year 1 of the waiver. Public hospitals remain concerned that technical changes to the waiver in year 3, combined with the structure of rising costs claimed against capped funding pools, will result in inadequate funding to public hospitals to maintain services to Medi-Cal and uninsured patients. That will be an important to discussion to have once the waiver is implemented and we are in a position to evaluate its performance.

Thank you for the opportunity to appear before you today. I'd be happy to answer any questions.