

## **Testimony to the Senate Budget Committee**

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Good Morning. I am Melissa Stafford Jones, President & CEO, of the California Association of Public Hospitals and Health Systems. Thank you for the opportunity to speak with you this morning about the historic opportunity we all have under the Affordable Care Act to expand coverage and access to care for millions of low-income Californians.

California's public hospital systems form the core of the state's health care safety net (along with our community clinic colleagues). Serving over 2.4 million primarily Medi-Cal and uninsured patients, public hospital systems are integrated systems of care that provide a comprehensive range of health care services, including primary and preventive care, outpatient specialty care, emergency and inpatient services, rehabilitative services and in some instances long term care. Public hospital systems serve a diverse patient population and are leaders in language access and cultural competence of care. Though sometimes the image that comes to mind of public hospitals are tall gray inpatient hospital towers, and inpatient care is an essential component of the care we provide, public hospital systems in fact serve many more people in our extensive networks of outpatient clinics that provide primary, preventive and outpatient specialty care.

Public hospital systems provide 10 million outpatient visits per year and the focus of much of their work over the last several years has been outpatient care: establishing medical homes, ensuring that each patient has a primary care provider, improving chronic disease management particularly for patients with diabetes, implementing information technology tools such as the use of electronic registries to support proactive management of individuals and patient populations with chronic disease, improving access to primary and specialty care through multiple approaches, integrating primary care and behavioral health, building the capacity of clinics to develop and implement ongoing improvements in care delivery and developing a team-based approach to primary care that brings the full scope of resources need to bear including the physician, nurse, medical assistant, health educator, social worker and sometimes the pharmacist. In addition, public hospital systems have been working to improve the quality, safety and patient experience of inpatient hospital care.

Public hospital systems have an important role to play in the successful implementation of reform with what we see as a three-part mission:

1. Systems of choice. Public hospital systems recognize that under reform they must be systems of choice and earn the opportunity to serve their patients in Medi-Cal and the Exchange. Public hospital systems as we speak are working to transform the delivery of health care by improving quality, increasing the value of care delivered, improving the patient's experience of care, improving the health status of the patients and communities they serve.
2. Care to the remaining uninsured. As you heard earlier this morning from Mr. Jacobs, unfortunately even with full implementation of health reform, UC researchers estimate that likely 3-4 million Californians will remain uninsured. Serving those who remain

uninsured will continue to be part of the core mission of public hospital systems, as well as a county mandate under Section 17000.

3. Community wide services such as trauma, burn and training of the next generation of doctors and other health care professionals. Public hospital systems today are major providers of high cost, highly specialized services that serve entire communities and will continue to have this role under reform. Public hospital systems comprise over half of all level I trauma centers in California, and over half of hospitals with the ability to provide burn care. They train 40% of new doctors in the state.

Given their role as the core safety net in which they see the health care needs and challenges for low-income and uninsured Californians every day, 24 hours a day, and their deep commitment to provide high quality, effective care to ALL Californians, California public hospital systems strongly support the full expansion of Medi-Cal by January 1, 2014. In fact, public hospital systems and counties have been at the center of California's efforts to implement an early Medi-Cal expansion through the Low Income Health Program and its predecessor Coverage Initiative program. Through the LIHP more than 500,000 previously uninsured Californians now have LIHP coverage and a medical home.

We now have a historic opportunity to continue to improve the lives and health of nearly one million Californians through the Medi-Cal expansion. Public hospital systems were very pleased to see the proposal in the Governor's budget to fully expand Medi-Cal and we support ABX1 1 and SBX1 1, the bills moving in special session to accomplish ACA implementation including the Medi-Cal expansion.

As you know, in the Governor's budget, he identified two options for expanding Medi-Cal: a state-wide option and a county-based option. CAPH and our members have been carefully studying and assessing these options since the release of the budget and continue to do so. Based on our assessment thus far, at this point in time we think that a state-based approach is preferable in that it could assure that all 58 counties will be up and running in the same timeframe by January 1 and newly eligible individuals will be able to gain the benefit of Medi-Cal coverage. At the same time, several of our member systems believe that allowing a limited number of county based demonstration projects could achieve the goal of coverage expansion on the same timeline. By building on their LIHP programs, they could demonstrate further improvements to the Medi-Cal program by testing payment and structural reforms and improved access to care. One example of how they might do this is through a Medicaid safety-net ACO. We look forward to continuing discussion with the Administration and Legislature on these issues.

One of the additional key questions being asked is what are the financing implications to public hospital systems of reform and how much realignment could the counties give up. As we all know, health reform brings massive change to the entire health care system including the safety net; it is truly a new era in health care with massive changes in coverage, financing, payment structures, insurance rules and marketplace dynamics. We have not yet seen the full impact and implications of these massive changes and probably won't for several years.

From a safety net perspective, a key challenge in assessing the financial implications is the sheer number of variables. And beyond the number of variables is the challenge that we truly don't know how most of these variables will play out: each of these variables could be a potential positive opportunity, a potential challenge or is just a great unknown; they will all have a

tremendous impact on public hospital systems and we likely won't know their actual impact until reform is underway and happening. For public hospital systems, here are some of the key variables we are trying to think through that impact the financing discussion.

1. **What will the trajectory and pace of coverage expansion be?** We greatly appreciate the tremendous work done by Mr. Jacobs and his colleagues to project enrollment in various programs under reform. A key variable is what the trajectory of coverage expansion looks like; is it an initial spike in early 2014 and then a slow climb after that? Is it a steady, sharp acceleration curve that quickly gets to maximum enrollment? Is it a slow increase that takes many years to reach high levels of enrollment? Overall, will coverage expansion in the next several years actually look like what we predict today?
2. **Affordability.** For people above 138% fpl, will coverage through the Exchange be affordable? Not just for a single month but for individuals and families to pay the monthly premiums and out of pocket costs for the course of the entire year so that they can maintain coverage? Families that can only afford the premium for a few months out of the year may get coverage, obtain the services they need, then stop paying their premiums and lose coverage for the rest of the year. They would not be able to re-enroll in coverage until the next open enrollment period, so in the interim they would be uninsured.
3. **How truly simple and streamlined with eligibility and enrollment be?** The answer to that will clearly impact the number of uninsured who gain and maintain coverage.
4. **How many uninsured will remain?** The first three variables are key factors in this variable. As we know, Mr. Jacobs projects 3-4 million uninsured in 2019.
5. **How will the payer mix change in public hospital systems?** Today, in county hospital systems,  $\frac{3}{4}$  of patients are Medi-Cal or uninsured. Many assume that we will retain our current Medi-Cal patients, that many of our uninsured will gain Medi-Cal coverage and consequently our uninsured payer mix will decline significantly. Public hospital systems hope that is the case and are working hard to improve their systems of care to achieve that result; but it may or may not be what happens, there is no guarantee of it. We simply don't know whether it will happen that way when reform is implemented.
6. Another reason we may not see an automatic decrease in the amount of uninsured care provided by public hospital systems under reform, particularly in the early years, is **that market patterns of care to the uninsured could shift.** We know that the number of uninsured overall in the state is going to decline in the coming years, but it is not automatic that there will be a commensurate 1:1 decline in care to the uninsured in public hospital systems. Many of the uninsured patients we serve are part of the groups that are most likely to remain uninsured. Further, with reform, many expect provider capacity to be strained, which could increase the likelihood that the remaining uninsured would be redirected to public hospital systems.
7. **Medi-Cal rates.** Another variable that will affect the financial impact of reform on public hospital systems is the Medi-Cal rates for the newly eligible populations. An important point that is often misunderstood is that the 100% FMAP for the new eligibles does NOT mean that public hospital systems will be paid 100% of the cost of care for these patients. This is because the 100% FMAP will be on whatever RATE the state pays for care, not 100% of costs of care for providers. Today under the LIHP, public hospitals receive reimbursement that is 50-cents on the dollar of their costs. Given Medi-Cal rates today for other populations, it is not out of the realm of possibility that Medi-Cal rates for

new eligibles could be in that same low range; as a result, there won't necessarily be a large net financial gain to public hospital systems. This is not an intuitive conclusion so I wanted to stress that 100% FMAP is not an automatic financial gain to provider counties or public hospital systems, though of course we do hope to have a robust conversation regarding appropriate and adequate rates for care to the expansion population.

8. The last variable I would note is less of a variable and more of a fact: **funding to phhs for care to the uninsured has ALREADY been cut.** The Affordable Care Act cuts Medicaid DSH funding starting in 2014, with DSH cut by more than 40% by 2018. Also, reductions in the Safety Net Care Pool, which provides limited federal matching funds for uninsured care by phhs, have already started and continue through the current Medicaid 1115 waiver, with the level of funding in the SNCP in the next waiver unknown.

These variables make it very complex to pre-determine what the financial impact of reform will be on public hospital systems, in what year any financial improvements may materialize, and what amount of funding will be needed to ensure care is available for the remaining uninsured and for the continuing financing of the non-federal share for other portions of the Medi-Cal program.

CAPH and public hospital systems *are* prepared to have a serious discussion regarding paying for the Medi-Cal expansion to the newly eligible population. We recognize that many of our currently uninsured patients will gain coverage and it is a reasonable approach to think now about how public hospital systems could participate in the financing of coverage for that population when the state starts incurring actual costs in 2017.

At the same time, we also know that the UC projections are that even in 2019 there likely will be 3-4 million Californians that remain uninsured and we need to ensure that we have a safety net available to care for them. Public hospital systems will need sufficient resources to care for those who remain uninsured, particularly since federal funding to phhs for that purpose is already slated to decline dramatically over the next few years.

We urge that policymakers move carefully and cautiously as you consider how and when funding streams and relationships between the state and counties should be changed, particularly given that the state has no additional costs for the Medi-Cal expansion for the first three years. We are hopeful that our collective commitment will be "do no harm" to those who remain uninsured and the public safety net that by mission and mandate serves them. CAPH urges that policymakers pursue a thoughtful process that considers and balances the actual cost to the state of the Medi-Cal expansion and the resources needed to ensure that the public hospital system safety net can continue to care for those Californians who remain uninsured. Given all the variables, a key element of any approach would be a process to continue to assess along the way as reform is implemented whether any approaches put in place this year make sense over time as we have more experience and actual data with reform.

We have an incredible opportunity before us to improve the health and lives of millions of Californians. As providers of care to millions of low-income Californians, CAPH and our members are deeply committed to these efforts and we look forward to working with the Legislature and the Administration to accomplish successful implementation of health reform. Thank you.