CALIFORNIA HEALTHCARE FOUNDATION

Examining the 2005 Medi-Cal Hospital Waiver

ISSUE BRIEF

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Introduction

In September 2005, the State of California, with the approval of the federal government, fundamentally altered the way the Medi-Cal program pays for hospital care. Under the authority of a waiver[1] granted by the Centers for Medicare and Medicaid Services (CMS), state officials implemented sweeping changes to the process of financing inpatient treatment at the private and public hospitals that contract with Medi-Cal.

At its most basic level, the new system shifts funding responsibilities for Medi-Cal inpatient hospital payments (Table 1).[2] The key alterations are to the non-federal share of Medicaid matching funds for 22 Designated Public Hospitals (DPHs).[3] Specifically, the state General Fund will no longer be the primary source of funding for these hospitals. Rather, primary responsibility for the non-federal share of the Medi-Cal inpatient hospital expenditures will fall to the county governments, which own and operate the DPHs, and the University of California, which administers state-funded teaching and research hospitals.[4] The amount of federal matching funds is determined based on the hospitals' expenditures.

The new waiver (see box) also restricts use of intergovernmental transfers for the non-federal share of Medicaid funds, and creates a Safety Net Care Pool (SNCP), sometimes referred to as "the Pool," which provides a fixed amount of available federal dollars that can be used to cover uncompensated health care costs.

While it is anticipated that additional federal money will be available to safety-net hospitals under the waiver in years 1 and 2 than the previous system provided, there is no guarantee that sufficient federal support will be extended in future years.

Implementation of the waiver required the state legislature to pass the Medi-Cal Hospital/Uninsured Demonstration Project Act, or SB 1100, signed into law by Governor Arnold Schwarzenegger. This issue brief summarizes the major changes that resulted, specifically:

- Funding for the Non-Federal share of Medi-Cal Payments to Hospitals
- Disproportionate Share Hospital (DSH) Funding
- The Safety Net Care Pool
- Related Medi-Cal Redesign Changes

This issue brief concludes with an examination of several key issues that the Legislature will need to consider in the 2006 session.[5]

About the Section 1115 Waiver

California's new five-year waiver is a "section 1115" waiver—a reference to the part of the Social Security Act that authorizes the Secretary of Health and Human Services (HHS) to set aside provisions of Medicaid law and approve projects that test policy innovations likely to further the objectives of the Medicaid program. These "research and demonstration" waivers are typically granted for a five-year period.

Medicaid waivers enable states to receive federal Medicaid matching funds without complying with all of the usual requirements set forth in the federal Medicaid statute. Some, including 1115 waivers, also allow states to receive federal matching funds for "costs not otherwise matchable"—that is, for populations or services that are not recognized by the federal Medicaid statute as costs in which the federal government will participate. These waivers are to be "budget neutral," so that federal spending under the waiver is no greater than federal spending in the absence of the waiver.

California is not the only state that has negotiated this type of waiver with the federal government involving Medicaid financing of hospital care. CMS is aggressively reviewing Medicaid financing in all states and requiring states to discontinue fiscal arrangements that it considers inappropriate. As of June 2005, CMS reported that 26 states had revised their Medicaid financing arrangements to address its objections.[6]

Changes Under the Waiver

Brief History of California Hospital Financing

Prior to 1982, California hospitals served the Medi-Cal population under a cost-based reimbursement system. In that year, the state legislature changed the payment system due to a large state budget deficit and excess inpatient capacity. Rather than allowing any willing facility to provide inpatient care to Medi-Cal beneficiaries, California secured competitive contracts with individual hospitals through the establishment of a Selective Provider Contracting Program (SPCP). Payments to these hospitals were negotiated, ensuring that the state would receive the best possible per-diem price for care. To help protect the hospitals' financial viability, the state in 1989 created the Emergency Services and Supplemental Payment Program (commonly known as the SB 1255 program). By using non-state public funds, typically county funds, this program would draw down federal matching dollars to support Medi-Cal's contract hospitals without using General Fund money. As with SPCP, these payments were negotiated. In 2004–2005, approximately $1.9 billion was paid to target hospitals under SB 1255.

Funding for the Non-Federal Share of Medi-Cal Payments to Hospitals

The waiver modifies the mechanisms that can be used to finance Medi-Cal payments to hospitals, consistent with the CMS trend limiting the permissible sources for the non-federal share of Medicaid expenditures. Although intergovernmental transfers[7] are legal under federal law, the waiver now only permits them to be used for certain DSH payments to designated public hospitals and to provide supplemental payments to private hospitals. CMS has determined that such transfers are inappropriate if they enable a state to draw down federal Medicaid matching funds without actually expending state (or local) funds as the non-federal share, a practice often referred to as "recycling."

Under the waiver, Medi-Cal per-diem reimbursement for designated public hospitals will be determined using a cost-driven approach based on each hospital's certified public expenditures in caring for eligible beneficiaries. The non-federal share of hospital inpatient per diem payments will no longer be generated by intergovernmental transfers or the state General Fund and will no longer be negotiated by the California Medical Assistance Commission (CMAC).

In general, certified public expenditures, or CPEs, are expenditures certified by counties, state university teaching hospitals, or other public entities within a state as having been spent on covered services to Medicaid beneficiaries and the uninsured. The process for calculating CPEs is highly technical and

involves ensuring that the costs a hospital reports appropriately reflect the total actual spending on Medi-Cal patients and the uninsured.[8] For example, the cost reports may not accurately include all spending by UC hospitals on physician care for Medi-Cal patients and the uninsured.

The state and CMS will also need to resolve the reconciliation process for cost reports, determine whether or not Medi-Cal cost reports will be used in the first year of the waiver, and establish the timing of federal payments. Once resolved, CPEs will be reimbursed by the federal government at California's Medicaid matching rate, meaning that only 50 percent of hospitals' Medi-Cal inpatient cost will ultimately be reimbursed.[9] (While some progress has been made, as of this writing, the exact process and methodology for defining CPEs is still under negotiation with the federal government.)

For all intents and purposes, this new system of spending limits renders the existing federal "upper payment limit" for public hospitals meaningless. Under the prior system, there is a complex system of hospital-specific and state-wide aggregate caps that limit the amount of federal reimbursement. Under the new system, the spending cap is now to be based on allowable Medicaid inpatient hospital costs as calculated under the Medicare cost report.[10]

CMAC will continue to negotiate payments for private and non-designated public safety net hospitals. The non-federal share of funds for Medi-Cal inpatient per diem payments will primarily come from the General Fund, through the annual appropriations process.[11] Federal funds available for private hospital payments will still be capped by their aggregate upper payment limit.[12] While the limit leaves considerable room to increase payments to private hospitals, it is not anticipated that private hospital spending will increase.

Disproportionate Share Hospital (DSH) Funding

Under the waiver, DSH funds will continue to be distributed among all public hospitals. California's state-specific federal DSH allotment and the "175 percent DSH cap" on payments to public hospitals will remain intact and unchanged.

Traditional DSH payments will no longer be available to the state's 105 private hospitals that serve a disproportionate share of Medi-Cal and uninsured patients. Private hospitals will be eligible to receive DSH-like

Table 1. Snapshot of Key Financing Changes

OLD SYSTEM	NEW SYSTEM
Medi-Cal per diem negotiated by CMAC, with non-federal share from state General Fund and IGTs	Designated Public Hospitals (DPH): Medi-Cal per diem and non-federal share of funding based on county and UC certified public expenditures (CPEs)* Private Hospitals: Same as old system
Non-federal share of DSH (SB 855) funds from IGTs	DPHs: Non-federal share of DSH funds based on CPEs (up to 100 percent of costs) and IGTs (between 100 and 175 percent of costs) Private Hospitals: New DSH-like payments, non-federal share uses General Fund
Non-federal share of supplemental payments from IGTs, based on payment amounts determined by CMAC	DPHs: Safety Net Care Pool, based on CPEs Private Hospitals: Non-federal share of supplemental payments with General Fund as match

*Funding from state General Fund permissible, but not expected.

Note: For an in depth discussion and more detailed tables of changes made under the waiver and SB 1100, see Peter Harbage and Jennifer Ryan, "2005 Medi-Cal Hospital Waiver Questions and Answers", California HealthCare Foundation, Forthcoming, February 2005.

payments through new financial mechanisms—also referred to as "DSH Replacement" or "Virtual DSH"—from the state General Fund as the non-federal source of Medicaid matching funds.

Separating public and private payments will enable the state to maximize DSH payments to public hospitals, while at the same time providing private hospitals with equivalent payments outside of California's capped DSH allotment. The upper payment limit specific to private hospitals serves as the cap on DSH-like and supplemental payments to private hospitals. While there is significantly more room to spend federal dollars under the private hospital payment limit, the state would have to contribute funding beyond what it spends for Medi-Cal beneficiaries in order to draw down additional federal funds.

Finally, the waiver explicitly permits DSH payments to be made for costs associated with providing non-emergency services to unqualified immigrants.

The Safety Net Care Pool

As part of the new financing arrangement in the waiver, California will receive a capped annual allotment of federal funds to create a Safety Net Care Pool (SNCP) that will be used to help cover uncompensated care costs for providing medically necessary health care services to the uninsured.

The pool takes the place of the SB 1255 program that provided supplemental payments to both private and public hospitals. However, there are some important differences. For example, available federal SNCP funding is capped at $766 million each year, regardless of increases or decreases in the number of uninsured in California or the cost of providing care for these individuals. The ability to leverage SNCP funds depends on the state's ability to identify the necessary public (state or county/UC) funds (under the waiver and SB 1100, in the form of certified public expenditures) to draw down the federal matching funds. In the past, California had been able to increase supplemental payments for public hospitals in order to generate the federal match. The SNCP replaces some of the previously existing supplemental funding programs for public hospitals.

While the state will have flexibility to determine how the SNCP funds will be used, the non-federal share of the funds will be subject to CMS review and approval. The state will not be able to impose a tax on hospitals or other providers to generate the non-federal share of funds, but CMS has indicated that certified pubic expenditures will be acceptable as non-federal share. The state will have the right to use the expenditures from the designated public hospitals to draw down SNCP funds under certain conditions.[13] The funds can be made available to a variety of providers including public hospitals, community health centers, and others.

With regard to private hospitals, SNCP funds will be indirectly available when California "federalizes" its state-funded health programs.[14] Private hospitals will also receive additional supplemental payments that will replace the funds previously provided under the SB 1255 program. These funds are available either through an intergovernmental transfer or from the state General Fund, though it is envisioned that the General Fund will be the primary source, and the payments will be subject to the private hospital upper payment limit.

Finally, as outlined in SB 1100, the federal SNCP funds will be used to ensure baseline funding for inpatient hospital reimbursement, at Fiscal Year 2004–05 levels, to private and public hospitals. To the extent there are remaining federal funds and the associated expenditures claim these funds,

stabilization funds will then be distributed to the hospitals according to the allocations identified in the legislation. The allocation provisions for stabilization funding are for two years.

Related Medi-Cal Re-Design Changes

The waiver ties certain funding under the Safety Net Care Pool to specific Medi-Cal reform activities.

- **Managed Care Provisions.** Through the SNCP, the waiver makes $180 million per year available for the first two years. These funds are contingent upon the state meeting a series of milestones associated with the mandatory enrollment of seniors and people with disabilities into Medi-Cal managed care. This element of the waiver is part of the Schwarzenegger Administration's "Medi-Cal Redesign" plan; however, the Legislature has not enacted the enabling legislation to allow the state to begin this process. If legislation authorizing a transition to a mandatory managed care delivery system for seniors and persons with disabilities is not enacted by August 31, 2006, then none of the $180 million of the SNCP funds will be available to the state in the first year. If there is no such legislation by August 31, 2007 (the end of Waiver Year 2), then all $360 million will be unavailable to the state.

- **Healthcare Coverage Initiative.** For Waiver Years 3, 4, and 5, $180 million per year in federal funds under the SNCP must be used to finance a still undefined Healthcare Coverage Initiative that would expand health coverage options for the uninsured.

The federal funds allocated under these two provisions must be spent on health care services in the given waiver year; there is no rollover capability as there has been for Healthy Families.

Pending Issues for the Legislature

In the coming year, there are five primary issues around implementation of the waiver that the Legislature will need to consider. As with all waiver issues, state officials have the option of trying to renegotiate provisions with CMS.

Managed Care Provisions

As of December 31, 2005, the state has lost approximately $24.5 of the $360 million tied to the waiver's managed care provisions. This reduction will continue to increase as the additional milestones associated with these provisions are missed. Some, including advocates for Medicaid beneficiaries, have expressed concerns that the mandatory managed care enrollment provisions for seniors and people with disabilities could create access barriers and reduce revenues to safety net hospitals. Safety net inpatient hospital revenues could decline in three ways: if hospital use is lower under managed care; if beneficiaries in managed care are more likely to use private hospitals (instead of public hospitals) than if they remain in Medi-Cal fee-for-service; or if payment rates from managed care plans are lower than the cost-based reimbursement under fee-for-service Medi-Cal.[15] At the same time, the Schwarzenegger administration has argued that their experience with Medi-Cal managed care indicates that an expansion would improve beneficiary access and the quality of care while containing Medi-Cal spending. The Legislature will have the opportunity to weigh these tradeoffs again this year as it considers the governor's latest proposal to expanding mandatory managed care for people with disabilities in two counties.

The Healthcare Coverage Initiative

The process of deciding how to spend the $540 million allocated for the Healthcare Coverage Initiative will be a major issue in the upcoming legislative session. The waiver calls for a concept paper to be submitted

to the federal government by January 31, 2006,[16] followed by a full plan in September 2006. As with all of the waiver issues, the timeframes for legislative review and input are tight and could pose challenges.[17] Depending on how long the negotiation process takes, the Legislature could, as with SB 1100, be left with little time to act.

Distressed Hospital Provisions

Under SB 1100, a Distressed Hospital Fund was created to assist hospitals in danger of closing. The law gives the California Medical Assistance Commission the ability to determine which hospitals will be eligible for these funds. The Legislature will want to keep track of this issue as it will be a source of significant interest among hospitals seeking eligibility.

Funding Distribution Decisions

SB 1100 created a five-year distribution of baseline funding for participating safety net hospitals and a two-year framework for distribution of stabilization funding to be divided among private and public hospitals. The precise distribution of stabilization funding among designated public hospitals has only been determined for Year 1 of the waiver. However, as Year 2 of the waiver will begin September 1, 2006, the Legislature will need to consider future funding decisions during the current session. This could involve making difficult trade-off decisions around funding for private and public hospitals.

Monitoring Progress and Planning for the Future

The waiver has made sweeping changes in the financing of California's safety net hospitals. In response to the complexity of the waiver and the compressed implementation timeframes, SB 1100 granted the Department of Human Services broad authority and exemptions from the normal regulatory process to implement the needed changes. As such, the Legislature should consider how best to monitor the implementation process and the impact on safety net hospitals.

In the immediate term, the primary concerns seem to have been addressed. An agreement has been reached on the definition of certified public expenditures, thereby allowing funds to flow and ending the delay that had put a hold on $400 million hospital payments. While important details remain, the immediate stumbling blocks have been removed.

For the long term, the primary concern is whether the CPEs that are identified will be sufficient to fully finance the safety net hospital system. Policymakers will need to be aware of the anticipated level of CPEs into the future. As SB 1100 was being completed, some observers called for General Fund backfill to be available as a non-federal source of matching funds as a minimum step to ensure adequate hospital funding. The calls for such a policy may be renewed if needed CPEs do not materialize. In addition, the impact on hospital financing will need to be assessed as Medi-Cal inpatient costs are reimbursed at the 50 percent federal matching rate under the new system, likely putting the designated public hospitals under significant financial strain. Finally, health care costs may increase beyond the capped amount of funding available through the SNCP, thereby putting additional pressure on hospitals. There is likely a need for state policymakers and stakeholders to begin planning now for options to modify or possibly replace the waiver within the next three to five years.

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Endnotes

1. Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority waive provisions of Medicaid law and approve projects that test policy innovations likely to further the objectives of the Medicaid program. These "research and demonstration" waivers are typically granted for a five-year period.
2. There will be some effect on hospital outpatient funding though DSH and SNCP for the uninsured. However, clinics are theoretically already paid cost-based reimbursement. The waiver focuses primarily on inpatient payments.
3. The "22 designated public hospitals" (DPHs) refers to a list of 22 governmentally-operated hospital systems provided in Appendix C of the Specials Terms and Conditions of the waiver. These hospitals include the state's major public hospitals and are treated differently than the state's other public district hospitals. Non-"DPH" hospitals are commonly referred to as "non-designated." "Public hospital" as used in this brief refers to any government-operated hospital or hospital system.
4. The University of California operates five DPHs.
5. This brief is based on an analysis originally drafted and disseminated in August 2005, as the final terms of the 2005 hospital waiver were being negotiated. This update addresses issues relevant in the 2006 legislative session.
6. Testimony of Dennis Smith, Center for Medicaid and State Operations, Senate Finance Committee Hearings on Medicaid Fraud and Abuse (June 28, 2005), p. 3.
7. IGTs are transfers of public funds from one level of government to another (e.g. from a county to a state), or from one state entity to another (e.g. from a state university teaching hospital to a state Medicaid program). These funds have been frequently used as a source of the non-federal share of Medicaid matching funds.
8. Under Item 30 of the waiver, uninsured CPEs count towards DSH payments.
9. Uninsured and uncompensated care payments for DSH and the SNCP are also derived from CPEs for DPHs.
10. This is essentially the definition of a CPE. A final definition is still pending per Item 14.
11. Under the waiver, the non-federal share of payments to private hospitals maybe in the form of an IGT, under certain rules. Counties must choose to use IGTs and there must be a certification that none of the IGT dollars are returned to the government.
12. The UPL is an aggregate cap on Medicaid payments that is determined based on the amount that Medicare would have paid for the same mix of services.
13. According to Item 40 of the STCs, this is permissible if the CPEs are not claimed for any other purpose and the recipient provider does not return the funds to the state.

14. This is according to Section 14166.22 of SB 1100.
15. The effect of mandatory managed care is unknown at this point. While there may be a reduction in revenues, there are plausible scenarios under which hospital revenue would be unaffected or could even increase.
16. The concept paper has been submitted by DHS. The state's proposal, "Healthcare Coverage Initiative Concept Document," is available at: **www.dhs.ca.gov/mcs/mcpd/mcreform/html/ActivitiesProgramInit.htm#Hospital_Financing**.
17. For more information, see *The 2005 Hospital Waiver Coverage Initiative: Discussion and Analysis of 22 Key Questions to Launching the CI*, The California Endowment, February 2005 (**www.calendow.org/policy/MedicalAnalysis.stm**).