Questions and Answers about the 2005 Medi-Cal Hospital Waiver

Prepared for
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Prepared by
Peter Harbage, Harbage Consulting
and
Jennifer Ryan, National Health Policy Forum

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About the Authors

Peter Harbage is president of Harbage Consulting, a Sacramento-based health policy consulting firm. He can be reached at peterharbage@yahoo.com. Jennifer Ryan is a senior research associate with the National Health Policy Forum in Washington, D.C. She can be reached at jmryan@gwu.edu.

About the Foundation

The California HealthCare Foundation, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care.

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I. Introduction

In 2005, the Centers for Medicare and Medicaid Services (CMS) approved a new Medicaid Section 1115 waiver for California. The waiver has major implications for the financing of inpatient hospital services under Medicaid and of uncompensated care. This report is one of a three-part series that seeks to explain the 2005 waiver. More specifically, this document answers common questions about the waiver and its implications, and it provides recommendations for state policymakers for the 2006 legislative session. It is published in conjunction with two California HealthCare Foundation issue briefs: *Examining the Medi-Cal Hospital Waiver* and *Medicaid Hospital Waivers: Comparing California, Florida, and Massachusetts*.

This Q&A reflects the final 2005 Medicaid Section 1115 waiver and its terms and conditions. It is based on an August 2005 version, which was completed before the waiver was finalized and prepared under grants by The California Endowment and the California HealthCare Foundation.

II. Questions and Answers about California's 2005 Medicaid Waiver

Overview of Federal Medicaid Section 1115 Waiver

This section provides an overview of Medi-Cal and waivers in general.

What is Medicaid (Medi-Cal)?

Medicaid is a federal-state partnership designed to provide health insurance to low-income people. State governments administer the program within broad federal parameters. The federal government provides matching funds to the states by reimbursing a percentage of program costs, referred to as the federal medical assistance percentage (FMAP). Nationally, Medicaid serves nearly 53 million beneficiaries at a combined federal/state cost of $320 billion. Medi-Cal is California's version of the national Medicaid program, serving about 6.7 million beneficiaries at an estimated cost of $34 billion a year, including about $13 billion from the state's General Fund, for fiscal 2006.[1]

What is the Section 1115 waiver authority?

Medicaid Section 1115 waivers were originally designed as "research and demonstration" programs intended to promote innovation in Medicaid and to demonstrate possible program improvements. Waivers have most typically been used to facilitate coverage expansions to populations otherwise not eligible for Medicaid but have more recently been used to modify other aspects of the Medicaid program such as the benefits structure and financing mechanisms.

Named for Section 1115 of the Social Security Act, the waiver authority:

- Is completely at the discretion of the federal secretary of Health and Human Services (HHS).
- Enables states to receive federal Medicaid funds without complying with all of the requirements in the Medicaid statute (i.e., requirements that are "waived" by the federal government).
- Allows states to receive federal funds for "costs not otherwise matchable." This means that states can receive federal dollars for activities that would not otherwise qualify for federal funds, such as expanding coverage to populations that are not otherwise Medicaid-eligible or providing targeted services to certain segments of the Medicaid population (such as family planning services).
- Cannot be used to waive the federal matching rate or rules governing the source of the non-federal share of Medicaid funds.

What are some examples of Section 1115 waivers?

Between January 2001 and March 2005, a total of 14 waivers were approved by HHS.[2] During this period, California received approval for two Section 1115 waivers, including its never-implemented expansion of the California Healthy Families Program to cover parents and the

2004 In-Home Supportive Services Plus waiver. Examples of active Section 1115 waivers in other states include:

- Utah: Under then-Gov. Mike Leavitt (now HHS secretary), this program offers a limited benefit package through Medicaid to adults not otherwise eligible for Medicaid.
- Wisconsin: Called BadgerCare, this program expands coverage to children and families not otherwise eligible for Medicaid.
- Massachusetts: Originally implemented in 1997, the waiver allows MassHealth to provide Medicaid coverage to an additional 300,000 low-income people.

What are the rules governing Section 1115 waivers?

The statutory language of Section 1115 is broad and actually applies to all HHS programs. Therefore, most of the rules have been developed as guidelines rather than statutory requirements. No federal regulations govern Section 1115 waivers. For example, the "budget neutrality" requirement, described below, appeared in the Code of Federal Regulations in 1993, but is not a legal requirement.

What is "budget neutrality" for Medicaid Section 1115 waivers?

Budget neutrality is an important component of every waiver. The policy requires that federal spending over the life of the waiver (five years for new waivers or three years for renewals) must be no greater than federal spending would have been in the absence of the waiver. This is determined by projecting two lines of spending into the future:

- The "without waiver baseline" is the estimated spending that would have occurred under the existing Medicaid program structure, taking into account a growth rate.

- The "with waiver baseline" is the estimated spending that would occur with the waiver in place.

For a waiver to be considered budget-neutral and therefore approvable, the "with waiver baseline" must be equal to or lower than the "without waiver baseline."

What happens if a state spends more than the estimated amount on a Section 1115 waiver?

If actual spending exceeds the "without waiver" baseline at the end of the five-year term of the waiver, the state is responsible for those expenditures and may be required to return overpayments of federal funds. Waivers are not intended to be "blank checks" for states to expand their Medicaid programs.

Federal Funding under the 2005 Waiver

This section outlines the changes in the payment systems and the federal funding that will be available under the hospital financing waiver.

What does the 2005 waiver do?

Under the waiver, the state will shift the major sources of non-federal Medicaid funds for certain public hospitals from an intergovernmental transfer (IGT)-based system to a system primarily using certified public expenditures (CPEs). Private hospitals and publicly operated district hospitals will likely be financed primarily from the General Fund as the non-federal share. The waiver also establishes a Safety Net Care Pool (SNCP) that will make a fixed amount of federal funds available to help reimburse public hospitals that care for the uninsured. These and other complex changes are described in greater detail below.

The general framework of the waiver is that:

- Federal payments for inpatient hospital services provided to Medi-Cal beneficiaries is now cost-driven, reimbursed by the federal government at half of the CPEs spent.
- There will be different limits on the federal government's financial liability for hospital payments.
- Federal Medicaid reimbursement for public hospital spending for the uninsured is generally capped.
- Private hospital spending is dependent on General Fund appropriations and the ability of the state to use SNCP funds for state programs and is subject to the aggregate private hospital federal upper payment limit (UPL).
- All qualifying public hospitals will receive payments from the Disproportionate Share Hospital (DSH) allotment.
- Qualifying private hospitals will receive DSH-like payments funded from the General Fund and federal funds.
- Sources of non-federal funds are clearly separated between public and private hospitals in the waiver; however, Senate Bill (SB) 1100 brings them back together and links public and private hospital funding levels.
- There are no changes for non-DSH hospitals that do not contract with the state through the California Medical Assistance Commission (CMAC).

Why did California seek a Section 1115 waiver?

California negotiated a new five-year Section 1115 waiver to replace the two-year Selective Provider Contracting Program (SPCP) waiver. The SPCP waiver allowed the state to limit hospitals' participation in Medi-Cal through selective contracting and to make supplemental payments to a subset of participating hospitals to help them cover uncompensated Medi-Cal costs and address unique, unexpected, and temporary needs of individual hospitals. SPCP has saved Medi-Cal hundreds of millions of dollars annually while allowing for additional supplemental funding programs for safety net hospitals.[3]

Under the new Section 1115 waiver, the state will maintain its hospital contracting program and also address the concerns of the federal Centers for Medicare and Medicaid Services (CMS) about California's method of financing the state share of its Medicaid payments to hospitals.

What hospitals are affected by the 2005 waiver?
In California, 146 safety net hospitals rely on supplemental federal funding to offset uncompensated care costs, teaching expenses, trauma care, and other state and community health care needs. Safety net hospitals are operated by counties, the University of California, district hospitals, children's hospitals and private hospitals. The financing changes in the waiver primarily affect a group of 22 designated public hospitals (DPHs), consisting of 17 county-operated hospitals and five state-operated hospitals as part of the University of California.

These hospitals are represented by the California Hospital Association, California Association of Public Hospitals and Health Systems, University of California, Private Essential Access Community Hospitals, California Children's Hospital Association, and the Association of California Healthcare Districts.

What are the sources of funding for hospitals under the 2005 waiver?

Under the 2005 waiver, the sources of funding for hospitals include:

- Medicaid per-diem inpatient hospital payments
- Disproportionate Share Hospital payments
- Safety Net Care Pool payments
- SB 1732 payments

Some of these sources were altered by the 2005 waiver, while others are new sources of funding. Each of these sources is described below in more detail.

Medicaid per-diem hospital payments
Before the 2005 waiver, Medicaid per-diem payments to hospitals with SPCP contracts were negotiated with the California Medical Assistance Commission (CMAC) and varied from hospital to hospital. Under the 2005 waiver, payments will be determined in one of three ways depending on the type of hospital:

- *Designated public hospitals.* The per-diem payments for DPHs are no longer negotiated by CMAC. Reimbursement is based on each hospital's certified public expenditures (CPEs) for services provided to Medi-Cal patients. (See explanation of CPEs below.) By tying public hospital payments to CPEs, hospitals are being shifted to a cost-driven reimbursement system. This means that hospitals are reimbursed based on their actual costs for providing care to Medi-Cal patients only, with the federal government reimbursing hospitals 50 percent of their CPEs based on the 50 percent Medicaid matching rate. There is an exception for payments made under SB 1732, a state capital-costs program described below.
- *Private hospitals.* Medicaid per-diem payments to provide hospitals are negotiated by CMAC and will primarily be paid for with state General Fund dollars and federal funds.

- *Non-designated public hospitals (non-DPHs.)* The per-diem payments for SPCP-contracted public hospitals (primarily district hospitals) that do not use the CPE methodology continue to be negotiated by CMAC and will likely be financed primarily by the General Fund and federal funds.

Table 1 provides a summary of changes to Medicaid inpatient hospital per-diem payments.

Table 1. Medicaid Per-Diem Hospital Payments

	Payment Program	Federal Authority	Purpose	Providers Affected	Amount Paid to Providers	General Fund	IGT	CPE
Current	**Medi-Cal per-diem payment**	Selective Provider Contracting Program (SPCP) waiver	Payment for inpatient services provided to Medi-Cal fee-for-service beneficiaries	Public and private hospitals with SPCP contracts	Determined by negotiation with CMAC	X		
New System	**Public Medi-Cal per-diem payment**	Requires new Medicaid state plan amendment (SPA)	Same	DPHs	Based on allowable costs, not negotiation	Allowed, not planned		X
	Private and non-DPH Medi-Cal per-diem payment	2005 Medicaid Section 1115 waiver	Same	Private hospitals with SPCP contracts and other non-DPH	Based on negotiation with CMAC	X	Allowed, not planned	

Disproportionate Share Hospital Payments

By federal law, the maximum amount of Disproportionate Share Hospital (DSH) payments that may be made to an individual hospital is 100 percent of the difference between (1) the hospital's unreimbursed costs of treating Medicaid and uninsured inpatients and outpatients and (2) the amount of reimbursement the hospital receives from Medicaid (other than DSH) and from uninsured patients out-of-pocket. By federal law, California's DSH payments may equal up to 175 percent of this amount for most public hospitals (called "the 175 percent DSH cap").

The waiver will restructure the funding sources of the DSH program by limiting traditional DSH payments from the federal capped California DSH allotment exclusively to public hospitals. (See Table 2 for a summary of changes.) In what is known as the "DSH swap," private DSH hospitals will receive DSH-like supplemental payments that will most likely be financed by the General Fund and federal Medicaid funds. The federal DSH allotment and the provisions of the 175 percent cap will remain intact.

- *Public hospitals.* $233 million of the state's annual DSH allotment that had previously been paid to private hospitals will now be available for payment to public hospitals and must be distributed.
- *Private hospitals.* Payments to private hospitals are to come out of the General Fund and federal funds available under the private UPL, instead of through IGTs and the DSH allotment. The source of the state funds is now the General Fund and is dependent on the annual budget process.
- *Other non-DPHs.* DSH payments will be made from the DSH allotment, and the General Fund will be used as the non-federal source of Medicaid matching funds.

Table 2. Changes to the DSH Program

	Payment Program	Federal Authority	Purpose	Providers Affected	Amount Paid to Providers	General Fund	IGT	CPE
Current	**DSH (SB 855)**	SPA	Supplemental payments to hospitals for uncompensated care	Eligible public and private hospitals	State statutory formula		X	
New System	**Revised DSH**	Requires new SPA	Same	Eligible DPHs	State statutory formula with flexibility		From 100% to 175% of uncompensated costs	From 0% to 100%
	New private DSH-like	Probably requires new SPA	Same	Eligible private	Set by DSH formula, paid outside of fixed DSH allotment	X		

Safety Net Care Pool and Other Supplemental Payments

For years, the Emergency Services and Supplemental Payments Fund, known as SB 1255, has been an important source of supplemental funding for many DSH hospitals. Under SB 1255, voluntary IGTs from public entities were used for the non-federal share of Medi-Cal funds. These dollars were distributed to public and private hospitals through negotiations with CMAC. These funds were not counted against California's DSH allotment.

The 2005 waiver replaces the SB 1255 program with a Safety Net Care Pool (SNCP) for DPHs. (See Table 3 for a summary of changes.) For private hospitals and non-DPHs, supplemental program payments previously paid through SB 1255 will continue in a modified form; however, these payments will be provided using the General Fund rather than IGTs and will not come through the SNCP.

Although the state has broad discretion in designing the use of federal SNCP funds, the state will be required to use CMS-approved sources of funds. The state will not be able to impose a tax on hospitals or physicians to serve as a source of these funds. The waiver specifies that CPEs from

public entities would be acceptable. It has not been determined which providers would be eligible to receive these funds, but it could include public hospitals, clinics, doctors, and others.

Although federal SNCP funding is capped at the same amount for each year of the waiver at $766 million—regardless of increases (or decreases) in the number of uninsured and changes in the costs of serving these individuals—a total of $900 million of the SNCP ($180 million each year) is contingent upon the state taking certain "Medi-Cal redesign" steps over the course of the five-year waiver. The SNCP is not the first time a funding cap has been used in Medicaid. DSH allotments and UPLs are also capped financing mechanisms.

Table 3. Shifts in DSH and Supplemental Payments

	Payment Program	Federal Authority	Purpose	Providers Affected	Amount Paid to Providers	General Fund	IGT	CPE
Current	**SB 1255 and Graduate Medical Education (GME)**	2003 SPCP waiver	SB 1255: Supplemental payments for inpatient hospital uncompensated care GME: Supplemental payments to support Medi-Cal medical education	Specified public and private hospitals	Determined by negotiation with CMAC		X	
New System	**New Safety Net Care Pool**	2005 Medicaid Section 1115 waiver	Supplemental payments for care to the uninsured	Designated public providers	Set by available CPEs	Allowed, not planned		X
	Non-designated hospital supplemental payments	2005 Medicaid Section 1115 waiver	Supplemental payments for uncompensated care	Eligible private and non-DPH	Set by CMAC negotiation	X	Allowed, not planned	

SB 1732 Payments
SB 1732 is a relatively small fund used for capital improvements and construction for certain eligible hospitals. The waiver proposal does not include changes to this capital-costs program. (Please see Table 4 for a summary of changes.)

Table 4. SB 1732 Payment Comparison

	Payment Program	Federal Authority	Purpose	Providers Affected	Amount Paid to Providers	General Fund	IGT	CPE
Current	**SB 1732**	2003 SPCP waiver	Capital cost reimbursement payments for eligible DSH hospitals	Specified public and private hospitals	Statutory formula	X		
New System	**SB 1732**	2005 Medicaid Section 1115 waiver	Same	Same	Same	Same		

What federal dollars are available under the 2005 waiver?
Several major sources of federal financing will be available under the 2005 waiver. Following are descriptions of each spending authority and a brief discussion of arguments for why these funding sources could be considered either "new," meaning that it is additional money to California, or "old," meaning that the dollars were already available to California.

- **Continuing Former Los Angeles County Funding**
  Five years: $900 million; one year: $180 million

  The non-hospital-based clinic funding for the now-expired L.A. waiver was being phased out over the last five years. The funding in the last year of the L.A .waiver was $85 million. Under the 2005 waiver, the five-year average of the L.A. funding ($180 million per year) will continue for each year going forward from 2005 until 2010. However, the funding will no longer be dedicated to L.A County. These funds will represent $900 million of the $3.83 billion in total funding available through the SNCP under the 2005 waiver.

  New money. After the L.A. waiver was terminated, the state had promised to not ask the federal government for the L.A.-focused funding again, so this money could be considered unexpected and new.

  Old money. In April 2005, L.A. waiver spending was $85 million. Because the state was already spending this money, it is not new.

- **DSH Swap**
  Five years: $1.165 billion; one year: $233 million

The DSH swap means that public hospitals will receive all DSH (SB 855) payments and private hospitals will receive "DSH-like" (or "virtual DSH") payments. By separating public and private hospitals, the state will be able to maximize DSH payments to public hospitals while providing private hospitals equivalent payments outside of California's capped DSH allotment. This means that the state will be able to spend $233 million more in federal dollars for the public hospitals than it was able to do in fiscal 2005.

New money. The waiver allows limited DSH funds to be targeted to public hospitals only and keep private hospitals fully funded by using entitlement dollars. It is unlikely that the state would have received CMS approval for the DSH swap using IGTs because CMS has stopped approving state plan amendments that include IGTs.

Old money. The state could have taken this action years ago absent a waiver. It is likely that a proposed State Plan Amendment to target DSH funds could have been approved under an earlier presidential administration.

- **Growth in Private Per-Diem Payments**
  Five years: about $800 million; one year: varies

  Under the 2005 waiver, hospital inpatient per-diem payments have the authority to grow to the aggregate upper payment limit (UPL)—the cap on all payments that can be made — for private hospitals. For private hospitals, this is potentially much larger than the growth rate negotiated for the 2003 SPCP hospital waiver, which limited both the growth in cost and caseload to the president's budget growth rates, limiting payments each year to fixed dollar amounts. The total amount available under this authority is about $800 million. This room for growth exists because all per-diem rates are less than estimated Medi-Cal allowable costs and the UPL is based on Medicare reimbursement principles that result in higher levels than Medi-Cal allowable costs.

  New money. Payments for services to Medi-Cal beneficiaries are no longer capped for private hospitals as they were under the 2003 SPCP waiver. Allowing costs to go up to the UPL has the affect of creating "new" room for payments to private hospitals.

  Old money. The argument could be made that there will be no new money from this change because it requires that non-federal dollars be spent in order to draw down the extra federal dollars that are available under the private hospital UPL. Because the non-federal dollars are not readily available from the state's General Fund, it would seem unlikely that "new" federal dollars could be accessed.

- **Stopping the UPL Phase-Out (called "the $218 million")**
  Five years: $574 million; one year: varies

  At present, a portion of current Medi-Cal hospital spending exceeds the UPL for hospitals not owned by the state. That spending above the UPL is being phased out over an eight-year transition period as mandated by the federal Beneficiary Improvement and

Protection Act of 2000. The phase-out is 15 percent each year, until the overage (called the "exceedence") reaches zero, which would otherwise occur in Year 5 of the new waiver. The waiver offsets this phase-out and maintains the 2004 funding level of $218 million, which helped determine the size of the SNCP. However, because these payments were phasing out, the exact amount of money available to California varies from year to year, with more funding available as the waiver progresses.

New money. According to federal law and regulation, this spending would have phased out and was not in the federal budget baseline. The waiver continues this funding without the required phase-out as part of the SNCP.

Old money. California spent $218 million last year, and the state would have had to find a way to sustain this funding level. Also, with the new CPE structure, hospital costs, rather than the UPL, have effectively become the payment cap for public hospitals. As a result, this spending "room" is meaningless.

Non-Federal Funding under the 2005 Waiver

This section provides information on how California can provide the non-federal share of Medicaid funds for the hospital financing waiver. California receives a 50 percent federal matching rate for Medicaid expenditures based on permissible sources of non-federal funds.

What are the sources of the non-federal share under the waiver?

To draw down any federal Medicaid funds, California must have appropriate sources of state matching dollars available. Under federal Medicaid law, at least 40 percent of the non-federal share must come from a state's General Fund. Potential sources for financing the state share of Medicaid funds under the waiver include:

- Intergovernmental transfers
- Certified public expenditures
- Permissible provider taxes
- State General Fund

As discussed below, each category is treated differently under the waiver and is subject to different permissible uses.

What is an intergovernmental transfer?

Intergovernmental transfers (IGTs) are legal 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). Under the federal Medicaid statute and regulations, public funds received by state Medicaid programs as the result of IGTs from public agencies, including qualified public hospitals, may be used as the non-federal share of Medicaid spending for purposes of receiving federal matching payments.

CMS has taken the position that IGTs are inappropriate if they enable a state to draw down federal matching funds without actually expending state (or local) funds as the non-federal share (known as "recycling"). No current federal regulations or laws support this new position; however, CMS has stopped approving waivers and state plan amendments that include IGTs and has proactively required states with approved state plans to modify their programs.

What IGTs are allowed under the waiver?

For 15 years, California's supplemental hospital payment system has been based on IGTs. The counties and the University of California transfer money to DHS to serve as the source of the non-federal share of hospital payments. The practice of using IGTs will largely be ended under the 2005 hospital waiver, except under limited circumstances. This is reflective of a larger federal effort to eliminate the use of "inappropriate" IGTs nationally, and California is no exception.

Under the hospital waiver, IGTs from qualified public entities (such as counties) to the state may be used as the non-federal share of any Medicaid payments to private hospitals for inpatient services. In addition, IGTs may continue to be used as the non-federal share of DSH payments

for amounts between 100 percent and 175 percent of uncompensated care costs, as are protected and specified by federal law. All portions of these IGT-funded payments—both the federal and state funds—must be used by the hospital to cover hospital expenses. No portion of this payment can be transferred back to a unit of government.

What are certified public expenditures?
Federal Medicaid law and regulations authorize the use of certified public expenditures (CPEs) as the non-federal share of Medicaid spending. CPEs are funds certified by counties, state university teaching hospitals, or other public entities within a state as having been spent on the provision of covered services to Medicaid beneficiaries and the uninsured (the latter for DSH payments only).

Instead of actually transferring public funds to the state Medicaid agency (through an IGT), a county could certify that the hospital it operates has incurred costs in treating Medicaid inpatients. The state Medicaid agency can use the amount of costs certified by the county hospital as the non-federal share for purposes of claiming federal matching funds. Because CPEs represent the cost of treating Medi-Cal patients, the fact that the federal government reimburses for CPEs at the 50 percent matching rate means that hospitals are paid for half of the cost of Medi-Cal inpatient care. CMS does not have a current statutory proposal to modify or limit CPEs, and it has approved the use of CPEs in lieu of IGTs as the non-federal share of Medicaid funds in other states (e.g., Massachusetts).

What CPEs are allowed under the waiver?
CPEs from the DPHs for inpatient costs of treating Medicaid are permitted. CPEs may be used as the non-federal share of Medi-Cal per-diem payments, the federal DSH allotment, and the SNCP allotment. In addition, CPEs for the uninsured may count toward DSH. The process and method for determining CPEs was recently agreed to with the Federal government under Item 14 of the special terms and conditions of the waiver. In general, costs are determined using the Medicare-audited CMS-2552-96 hospital cost report. The waiver's special terms and conditions give the state the right to use CPEs only if they are not claimed for any other purpose and the provider does not return to the funds to the state (Item 40). As of this writing, several issues are still pending with the federal government. For example, the state is working with the federal government to ensure that hospital payments to physicians are included in the CPE calculation.

Are there enough CPEs in the first year of the waiver?
Item 14 of the special terms and conditions says that no federal funds can be claimed using CPEs until there is a CMS-approved document including "a description of any use estimates or adjustment factors that will be used to modify actual cost findings." While there has been a recent agreement on Item 14, it is still a challenge to know what might be available through CPEs because of the technical nature of the calculation. However, based on available data and the accepted understanding of what to expect, a sufficient amount of CPEs should be available in the first year to match last year's spending, plus several hundred million dollars more.

Are there enough CPEs in the later years of the waiver period?
It is too soon to tell whether enough CPEs will be available to generate a sufficient amount of Medicaid funds in the longer term. The waiver uses a combination of CPEs and IGTs for DSH payments between 100 percent and 175 percent of cost. On one hand, it could be argued that as the number of uninsured individuals grows over time, the level of corresponding costs will grow, thereby resulting in increased CPEs, and providing access to more federal funds to pay for services provided. On the other hand, with fixed caps on the DSH and SNCP allotments, once these sources are exhausted, hospital funding could fall, resulting in service reductions and possibly facility closures.

Why can't a CPE approach guarantee sufficient federal spending for public hospitals?
There are several concerns with the CPEs. First, hospitals will be reimbursed at the California Medicaid matching rate of 50 percent, meaning that half of inpatient costs will be covered by the federal government and that the hospitals will not be paid for total Medi-Cal spending. Second, the federal government could change the definition of CPEs at any time and restrict states' ability to use them. Third, to support all county hospitals, the new system requires the redistribution of new federal funding from counties with a high level of CPEs for their public hospitals to counties with CPE levels that are insufficient to cover all public hospital costs. (It is not anticipated that University of California facilities will be CPE donors.) It could be a political challenge for a county to accept that portions of its CPEs are being transferred to benefit counties with fewer CPEs. As a result, some counties may choose to reduce their commitment to health care programs. Several county boards of supervisors have resolutions opposing the waiver. Finally, there is no guarantee that there will be sufficient CPEs to draw down all available federal funds.

What is a permissible provider tax?
Federal Medicaid law allows states to raise revenue to pay the non-federal share of Medicaid costs by imposing taxes or fees on hospitals, nursing homes, managed care organizations, and other classes of providers as long as the taxes meet certain requirements. Among other things, the tax must apply to all providers in the class (including non-federal, non-public providers), it must be imposed uniformly, and the state may not hold providers harmless against its costs. Federal Medicaid statute and regulations allow use of revenue from permissible provider taxes as the non-federal share of Medicaid funds.

What provider taxes are allowed under the waiver?
Under the waiver, California has agreed not to impose new state provider taxes on inpatient or outpatient hospital services or physician services during the five-year term of the waiver. All other categories of permissible provider taxes may be used if the state so desires.

What General Fund spending would be allowed under the waiver?
California has authority to use the state General Fund as a source of the non-federal share to secure federal Medicaid funds. However, SB 1100—the state legislation implementing the waiver—does not include any new, additional General Fund money to be used for pubic hospitals.

Distribution of Federal and State Payments and New State Law

This section outlines the payment distribution under the 2005 waiver and SB 1100.[4]

What is SB 1100?

Known as the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, SB 1100 is the statutory framework for implementing the 2005 Medi-Cal waiver agreement with the federal government.

What is the overall funding structure under SB 1100?

The legislation is intended to create a structure that provides stable and predictable funding to the greatest extent possible. It establishes a set level of "baseline funding" to keep hospital financing flat from year to year, with adjustments permitted for changes in the volume of patients. Hospitals would be eligible for more federal funds as a result of increased volume. In addition, there is a process for addressing "stabilization funding." As part of SB 1100, California's DSH funding is substantially revised.

What is the difference between baseline funding and stabilization funding?

Baseline funding is the amount of money that both public and private safety net hospitals should receive every year in an effort to maintain a base level of funding. It is a minimum level, adjusted by the amount of services provided. Stabilization funding is any amount of new revenue from the waiver that is available to hospitals above baseline spending.

Will public and private hospitals be paid at the same rate under the 2005 waiver as before?

Funding from one year to the next is not guaranteed, but the intent of SB 1100 is to maintain baseline funding for hospitals to the extent patient volume and service delivery are maintained.

How are stabilization funds distributed between public and private hospitals?

Of the stabilization funds allocated under the waiver, 60 percent will be targeted to the state's 22 DPHs. The remaining 40 percent will be targeted to the approximately 105 eligible private hospitals. There are small set-asides of funding in the waiver that will cause slight adjustments to these percentages.

Is there a plan for dividing payments among public and private hospitals?

Yes, but the time frames vary by type of funding:

- *Baseline funding.* To help promote stability, SB 1100 creates a five-year distribution of baseline funding for all participating safety net hospitals.

- *Overall stabilization funding.* Because of operational and political complexities, only a two-year distribution plan exists for stabilization funding between public and private hospitals.

- *Public hospital-specific stabilization funding.* Because of further uncertainties in the hospital payment system, the specific distribution levels for stabilization funding among the public hospitals have been determined only for the first year of the waiver.

The hospitals' baseline funding amount for fiscal 2005 is estimated to total $3.9 billion, of which $2.1 billion was received by public hospitals, $1.8 billion by private hospitals, and $13 million by district hospitals.

What is the role of CMAC and SPCP in funding distribution under the waiver?
Given the funding distribution formulas and anticipated use of CPEs, SB 1100 reduces the overall role of CMAC and SPCP in determining hospital payments for public hospitals. CMAC will still negotiate per-diem rates and supplemental payments for private hospitals. Plus, CMAC has added responsibility for the "distressed hospital" fund (explained below).

Is maintenance of effort required for counties under SB 1100?
No. Counties are not required to spend a set amount of money under the waiver. However, under Section 14166.5(c)(5) of SB 1100, if county costs are reduced by 20 percent or more, DHS can reduce the baseline funding.

What are the "distressed hospital" provisions?
Under SB 1100, hospitals designated as "distressed" are eligible for additional funding. This ensures that special payments can be made to qualifying hospitals even if they do not otherwise qualify for DSH payments.

What is the definition of a "distressed hospital"?
The language in SB 1100 is broad. The term "distressed hospital" includes hospitals that:

- Serve a substantial volume of Medi-Cal patients, measured either as a percentage of the hospital's overall volume or by the total volume of Medi-Cal services furnished.
- Is a critical component of the Medi-Cal program's health care delivery system.
- Is facing a significant financial hardship that may impair its ability to continue its range of services for the Medi-Cal program.

Federal funds are available if the payments are made to private hospitals but not for payments to public facilities. CMAC will make final determinations about eligibility. CMAC is currently soliciting input from hospitals and other interested parties on issues that should be considered in determining eligibility for the distressed hospital fund. How these criteria are defined and applied will determine how many hospitals will be considered financially distressed.

How much funding is available to distressed hospitals?
The current estimate is approximately $100 million over the life of the waiver.

Other Elements of the 2005 Waiver

This section answers questions about two separate policy issues. As with all waiver issues, the state has the option of trying to renegotiate waiver provisions with CMS.

- Issue No. 1: Mandatory managed care
- Issue No. 2: Coverage initiative

Mandatory Managed Care

What are the managed care provisions in the waiver?

Under the waiver agreement, $360 million of federal SNCP funding in the first two years of the demonstration ($180 million per year) is available to the state contingent upon implementation of the governor's 2005 managed care budget proposal, with mandatory enrollment of seniors and people with disabilities into managed care beginning January 2007. This amounts to about 9 percent of the total potential funds available through the SNCP.

If legislation authorizing a transition to a mandatory managed care delivery system for seniors and people 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 no such legislation is enacted by August 31, 2007, then none of the $360 million will be available to the state.

What other milestones are related to the managed care provisions?

In the first year of the waiver:

- September 30, 2005: $90 million of SNCP funds will be available if managed care legislation is enacted by this date.

- May 31, 2006: $90 million of the SNCP funds will be available if the state submits a Medicaid state plan amendment (SPA) or waiver request associated with the managed care expansion by this date.

- August 31, 2006: In the event that either provision is fulfilled after the milestone date but before this date, a prorated portion of the SNCP funding will be available.

In the second year of the waiver:

- March 31, 2007: $60 million of the SNCP funds will be available if the state completes submission of all necessary Medicaid SPA changes or waiver requests associated with managed care expansion by this date.

- August 31, 2007: $60 million of the SNCP funds will be available if the state finalizes necessary managed care contracts and rate submissions by this date.

- Before January 2007: $60 million will be available if expanded, mandatory enrollment of seniors and people with disabilities into Medi-Cal managed care begins.

Has the state missed any managed care milestones?
As of January 1, 2006, the legislature has not enacted managed care legislation as specified in the waiver. As of April 1, 2006 the state has therefore lost about $49 million of the $360 million. The reductions will continue and could reach a total of $90 million by August 2006 under this provision of the waiver terms and conditions. It is unlikely that the milestone to submit SPAs and waiver amendments by May 31, 2006, regarding managed care will be met because the state needs authorizing legislation before it can submit these SPAs and waiver amendments.

Healthcare Coverage Initiative

What are the coverage initiative provisions?
As part of this waiver, $540 million is set aside within the SNCP during years 3–5 ($180 million is available each year to be spent during that year) of the demonstration to design a coverage initiative to reach out to California's 6.6 million uninsured individuals. Under an agreement with the federal government, California will use the initiative to "expand coverage options for individuals currently uninsured." To achieve this, the agreement specifies that the coverage initiative "may rely upon the existing relationships between the uninsured and safety net health care systems, hospitals, and clinics." Within a broad set of parameters, California has flexibility to design the coverage initiative, subject to federal approval.

What are the milestones for the coverage initiative?
The following deadlines for the state are to be met under the waiver:

- January 31, 2006: Submit a concept paper on the coverage initiative. The state has completed this requirement.

- September 1, 2006: Submit a waiver amendment on structure, eligibility, and benefits for the coverage initiative.

- September 1, 2007: Begin enrollment in the coverage initiative.

Impact and Perspectives

This section summarizes the waiver's impact and reaction of public groups.

Why was the 2003 SPCP waiver regarded as a state victory while the 2005 hospital waiver is so controversial?

The 2003 waiver had a lower potential upside in total available federal funding. At the same time, the 2003 waiver offered the certainty that those waiver dollars would be available while requiring less commitment of state and county dollars. This is because the 2003 waiver maintained the existing payment systems, such as IGTs.

In contrast, California's 2005 hospital waiver represents a major shift in how hospitals that serve Medi-Cal beneficiaries and the uninsured are financed. This shift brings significant uncertainty and complexity. While it appears that Year 1 of the waiver should be stable, it is difficult to predict what federal spending will be in Year 5. At best, funding through the SNCP will be flat, and California's DSH allotment is projected to be flat or near flat. In the view of many, this uncertainty outweighs the potential benefit that new money may be available in the waiver.

What is the bottom line on "new" federal money and the waiver?

Through the waiver, the federal government has imposed a ceiling on the amount of federal funds the state can receive, but there is no floor or minimum guarantee of federal funds because of the uncertainty around the source of non-federal funds. Without an identifiable source of a legitimate non-federal share to secure the available federal funds, no new spending can take place. Although sufficient CPEs may be available in Year 1, no guarantees exist in future years. Other federal factors create uncertainty as well, such as the prospect of mandatory managed care for the waiver.

Is the 2005 hospital waiver the "best deal possible"?

The governor has said that the 2005 waiver is the best deal for the state. In contrast, others have said that the waiver is nothing short of a clear and present danger to the effective functioning of California's health care system.

Each state Medicaid program, and each Medicaid waiver, is unique. As such, it is difficult to make comparisons across states. Given the variety of competing policy goals and perspectives on hospital financing, there is value in talking about different perspectives on the waiver. This section provides some background on the opinions that various interest groups have expressed. This is not intended to be an exhaustive list of the opinions of each stakeholder group; rather, it is intended to give a sense of that group's perspective.

- *From the perspective of Gov. Arnold Schwarzenegger's administration, what does the waiver accomplish?* The waiver is the best deal possible in the face of a CMS crackdown on IGTs. If the SPCP waiver had simply been renewed, the state would have lost funding for the $218 million DSH swap and the $180 million that had been part of the L.A.

waiver. The state is fortunate that the new system of supplemental payments will not count against the DSH cap for the first two years of the waiver.

- *From the federal perspective, what does the waiver accomplish?* Although there are additional federal dollars available at the beginning of the waiver, the federal liability for Medi-Cal is bounded to a much greater degree than it was previously because of the switch to CPEs. It is also likely that the waiver will reduce funding compared to the current system because of the caps on the SNCP. The federal policies reflected in the waiver include:
    - Providing California with some additional authority for federal funds (through the DSH swap, stopping the UPL phase-out, and eliminating the state's liability of caseload/utilization growth that it had under the 2003 spending caps).
    - Eliminating most IGTs.
    - Restricting supplemental payments to public hospitals by capping payments under the SNCP.
    - Placing public hospitals into what is essentially a "cost-based" reimbursement system, thereby limiting the availability of federal funds.
    - Prohibiting otherwise permissible provider taxes on hospitals' inpatient and outpatient services, as well as physician services.

- *From a public hospital perspective, what are some of the concerns about the waiver?* The waiver creates financial uncertainty for public hospitals primarily by limiting the state's flexibility to determine sources of non-federal Medicaid funds and by capping the federal dollars that can be made available for services provided to the uninsured through the new SNCP. Some of the challenges for public hospitals include:
    - Capping public hospital funding (such as the Safety Net Care Pool) and potentially reducing funding (as would be the case with a managed care expansion in Medi-Cal).
    - Creating significant uncertainty about the state's ability to receive future funding because of the lack of policy controlling the use of CPEs.
    - Limiting public hospital growth to increases in hospital costs for Medi-Cal fee-for-service patients, although these costs will probably decline substantially over the period of the waiver.
    - Creating significant uncertainty and funding challenges by eliminating most IGTs, which are legal but seen as unacceptable by the federal government.
    - Under the SNCP coverage initiative in years 3, 4, and 5, there is no guarantee that the $180 million otherwise available to hospitals each year will be used for hospital funding.

- *From a private hospital perspective, what does the waiver mean?* Although all hospital groups seem to share the same core concerns, private safety net hospitals are especially concerned about being subject to the annual appropriations process to earn their supplemental payments, instead of being able to rely on IGTs from county hospitals as has historically been the case. There is no clear way to access all of the federal dollars available under the private hospital UPL.

- *From a county perspective, what does the waiver mean?* Counties have expressed concerns that the waiver places all of its weight on CPEs to serve as the source of non-federal expenditures. To support all county hospitals, the system would require the redistribution of new federal funding from counties with a high level of CPEs to those counties with CPE levels that are insufficient to cover all hospital costs. Several county boards of supervisors have adopted resolutions opposing the waiver.

- *From the perspective of advocates for Medi-Cal and uninsured patients, what does the waiver mean?* In particular, consumer advocates seem concerned about the state's ability to have sufficient CPEs to draw down all available federal dollars. The advocacy community also expressed concerns with the mandatory managed care provisions, citing a possible negative impact on quality of care delivered to beneficiaries along with a negative financial impact on hospitals.

III: Looking Ahead: Recommendations for State Policymakers

The waiver and SB 1100 have made sweeping changes in the funding of California's safety net hospital system. As hospitals contend with implementation issues large and small, policymakers will need to continue to play a role.

In the immediate term, the primary concerns seem to have been addressed. Recently, an agreement was reached on the CPE definition, thereby allowing $400 million in supplemental funds to flow that had been held under Item 14 of the waiver's special terms and conditions. While important details remain to be resolved, the immediate stumbling blocks around the waiver have been addressed.

There will also be a need to consider funding distribution issues. There is a five-year distribution of baseline funding for participating safety net hospitals and a two-year distribution of stabilization funding between private and public hospitals. The precise distribution of stabilization funding for individual public hospitals has only been determined for one year and will need to be determined for future years. The legislature will need to consider future funding decisions as the waiver moves forward.

For the long term, the primary concern is whether identified CPEs will be sufficient to fully finance the safety net hospital system. Policymakers will need to be aware of the anticipated level of CPEs in the future. As SB 1100 was being completed, some observers called for General Fund backfill to be available as a non-federal source of funds to offer 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 because Medi-Cal inpatient costs are reimbursed at 50 percent by the federal government under the new CPE system, a level that is likely to put the DPHs 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.

Extensive monitoring of the waiver's implementation is needed. Given the complexity and compressed implementation time frames, SB 1100 granted DHS broad authority to implement required changes, including emergency regulatory authority and exemptions from the normal regulatory process. The legislature should consider how best to follow implementation of the waiver and the related legislation, and to monitor the impact on the safety net.

Appendix: Acronyms Used

BIPA	Beneficiary Improvement and Protection Act of 2000
CMAC	California Medical Assistance Commission
CMS	Centers for Medicare and Medicaid Services (U.S.)
CPE	Certified public expenditure
DHS	Department of Health Services (California)
DSH	Disproportionate Share Hospital
DPH	Designated public hospital
FMAP	Federal medical assistance percentage
GME	Graduate Medical Education
HHS	Health and Human Services (U.S.)
IGT	Intergovernmental transfer
Non-DPH	Non-designated public hospital
SB	Senate bill
SNCP	Safety Net Care Pool
SPA	State plan amendment
SPCP	Selective Provider Contractor Program
UC	University of California
UPL	Upper payment limit

Endnotes

1. “Medi-Cal Facts and Figures,” California HealthCare Foundation, 2006.
2. Kaiser Family Foundation, 2005.
3. California Medical Assistance Commission Annual Report, 2005.
4. Sponsored by Sen. Don Perata, D-Oakland.