

# Medi-Cal Hospital Waiver Key Terms

Jennifer Ryan and Peter Harbage

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**175% Disproportionate Share Hospital Cap (175% DSH Cap)**—In 1997, Congress provided a special exception for California’s DSH hospitals. The provision increased the nationwide hospital-specific cap that limits DSH payments to 100 percent of unreimbursed costs of care for Medicaid and uninsured patients to 175 percent in California. Although certain “high volume” hospitals have received similar increases, California has the only statewide exception to the rule. This provision is worth several hundred million dollars to per year.

**Budget Neutrality**—This Medicaid section 1115 waiver requirement has been mandated by federal policy since 1983. Budget neutrality means that federal spending over the life of the waiver period must be no greater than federal spending would have been in absence of the waiver. In order to establish budget neutrality, states identify sources of savings in their programs to offset the cost of any program expansion. Typical sources of offsets include managed care savings, redirecting disproportionate share hospital (DSH) payments, and savings generated through modifications to the benefit package or increases in beneficiary cost sharing.

**Budget Neutrality Cap**—The expenditure limit placed on a waiver that is based on projections of what federal costs would have been in absence of the demonstration (also called the “without waiver costs”). The cap may apply to some or all service

expenditures and may also include DSH payments.

**California Medical Assistance Commission (CMAC)**—The California Medical Assistance Commission was established in 1983 to negotiate contracts with hospitals for specific services under the Medi-Cal program on behalf of the Department of Health Services (DHS). The Commission is composed of seven voting members appointed to four-year terms; three are appointed by the Governor, two by the Senate President Pro Tempore and two by the Speaker of the Assembly. In addition, there are two ex officio members: the Directors of the Department of Health Services and the Department of Finance.

Major Commission activities include:

- Negotiating contracts for Medi-Cal fee-for-service hospital inpatient services across the state;
- Negotiating contracts with hospitals for supplemental payments under special programs for certain hospitals; and
- Developing and negotiating managed care contracts for services to Medi-Cal beneficiaries in certain counties.

For additional information, see

[www.cmac.ca.gov](http://www.cmac.ca.gov).

**Centers for Medicare and Medicaid Services (CMS, formerly known as HCFA)**—The federal agency within the Department of Health and Human Services that administers the Medicare and Medicaid programs.

**Certified Public Expenditure (CPE)**—Costs that a public health care provider certifies it has incurred in furnishing covered services to Medicaid beneficiaries. The federal Medicaid statute and regulations allow the use of CPEs as the non-federal share of Medicaid matching funds. Statutory authority for CPEs is the same as IGTs.

**“Costs Not Otherwise Matchable”**—Term that refers to the provision found at Section 1115(a)(2) of the Social Security Act (SSA) that permits the federal Secretary of Health and Human Services to provide matching payments for state costs that would otherwise not be matched under Section 1903, the section that contains Medicaid funding requirements. This authority has been widely used to enable states to cover (and receive federal matching funds for) populations and services that Medicaid would not otherwise cover.

**Disproportionate Share Hospital (DSH) Payments**—Federal Medicaid law requires states to “take into account the situation of hospitals which serve a disproportionate share of low-income patients with special needs.” DSH payments are made in the form of federal allotments to states, which in turn make additional payments to public and private hospitals serving a “disproportionate share” of Medicaid and uninsured patients. DSH payments are intended to make up for the uncompensated care costs incurred by these hospitals -- often found in rural or inner-city areas – and are critical to their financial viability. States have discretion in

distributing DSH funds to the hospitals, within certain parameters. Congress has taken steps to regulate the amounts of DSH payments to certain hospitals over the years. In 1993, Congress imposed hospital-specific DSH caps that limited payments to 100 percent of unreimbursed costs of care for Medicaid and uninsured patients. However, in 1997, that cap was increased to 175% in California. (See *175% DSH Cap* above.)

**DSH Hospital**—Any hospital that receives federal/state DSH payments. In general, the hospital must serve a higher than average number of Medicaid beneficiaries, and have a low-income utilization rate of 25 percent or more. Of the approximately 600 public and private hospitals in California, 147 receive DSH funds each year.

**Federal Medical Assistance Percentage (FMAP)**—The federal matching rate paid to states for the operation of Medicaid programs. The FMAP is determined annually using a formula that compares the state’s average per capita income level with the national average income level. FMAPs range from 50 percent in the wealthier states (e.g. Maryland, Minnesota, California and New York) to 77 percent in the poorest state (Mississippi).

**Federal Financial Participation (FFP)**—The term used when states are reimbursed for Medicaid expenditures on behalf of certain populations or for certain services.

**Growth Rate**—In calculating budget neutrality for a Section 1115 waiver, a “growth rate” is applied to the base year expenditure data in order to project future costs. Growth rates are determined by using historical caseload and expenditure data from the previous five-year period.

**Health Insurance Flexibility and Accountability (HIFA)**—A CMS initiative that was announced in 2001 and provides states additional flexibility with respect to benefits and cost sharing than was previously permitted under the Medicaid (or SCHIP) Section 1115 waiver authority. HIFA has also been defined by the Bush Administration’s keen interest in including a “premium assistance” component to all waivers—a structure that encourages interaction between the Medicaid program, the employer community, and the individual in covering the cost of health coverage.

**Inter-governmental Transfer (IGT)** — Transfers of public funds from one level of government to another (such as from county to state government) or from one agency to another (such as from a state university teaching hospital to a state Medicaid program) to be used as the “non-federal share” for purposes of accessing federal Medicaid matching funds. Federal Medicaid statute and regulations allow the use of IGTs as the state share for Medicaid matching purposes, provided the local funds do not exceed 60 percent of the total.

**Maintenance of Effort (MOE)**—A requirement that establishes a baseline level of coverage or spending that must be maintained going forward into the waiver period. MOE requirements are often a part of waiver approvals (and new legislation) and are intended to protect existing beneficiaries and providers that rely on public programs.

**Medicaid (Title XIX of the Social Security Act)**—A state operated and administered health coverage program that is funded jointly by the federal and state governments. Medicaid provides medical benefits to low-income children and families; to the elderly and individuals with disabilities, and to

certain individuals with extreme medical needs. Within broad federal guidelines, states determine the eligibility parameters, benefits covered, provider payment rates and program structures.

**Non-federal Match**—In the state-federal Medicaid matching relationship, states must provide a share of “matching funds” in order to be eligible to receive the federal match (FFP) as determined by the FMAP (see definition above). There are several permissible sources for the non-federal share, including county and local funds, certain taxes, and DSH funds, but this has been a key point of controversy during waiver negotiations with CMS.

**Omnibus Budget Reconciliation Act (OBRA) of 1993 Limit**—In the Omnibus Reconciliation Act of 1993, Congress imposed hospital-specific DSH caps that limited payments to 100 percent of unreimbursed costs of care for Medicaid and uninsured patients. The law provided a transition period for “high-volume” DSH hospitals, capping payments at 200 percent in fiscal year (FY) 1995 and 100 percent in FY 1996. However, in 1997, Congress raised the hospital-specific caps for public hospitals in California to 175 percent of unreimbursed costs and the limit has remained at that level to date.

**Provider Taxes**—Beginning in the 1980s, states began using revenues from the imposition of fees, assessments and other taxes on health care providers to generate the non-federal share of Medicaid matching funds. While taxes may be imposed on certain classes of providers (e.g. hospitals, nursing facilities, and managed care organizations), the taxes must be broad based and imposed uniformly on all providers within the class. In addition, providers may not be “held harmless for the

costs of the tax,” that is, guaranteed that a portion of the tax revenue would be returned to the provider after the federal matching funds were received. Section 1903(w) of the Social Security Act governs provider taxes.

**Public Hospitals**—California’s 24 public hospitals make up the core of the state’s health care safety net, delivering care to all who need it, regardless of ability to pay, immigration status, or insurance coverage. Although public hospitals make up just 6% of California’s hospital system, they:

- Provide more than 50% of the hospital care to the state’s 6.5 million uninsured individuals;
- Operate more than 60% of the state’s top-level trauma and burn centers;
- Serve as teaching hospitals, training half of the physicians in the state;
- Provide more than 60% of the state’s psychiatric emergency care; and
- Deliver 11 million outpatient visits per year.

For more information see [www.caph.org](http://www.caph.org).

**Recycling**—A term of art that refers to the practice of establishing IGT arrangements for the purpose of reducing or eliminating any actual state or local contribution toward the cost of Medicaid services. For example, if a state Medicaid program makes a Medicaid payment to a county hospital and the county hospital returns some or all of the payment to the state Medicaid agency as an IGT, this is considered a recycling of funds. The Bush Administration is seeking a statutory change to prohibit federal matching for any funds that are not retained by the government provider (in our example, the county hospital) for the purpose of furnishing Medicaid services.

**Safety Net Care Pool (SNCP)**—Although there is no statutory requirement for provision of a designated pool of federal

matching funds for the costs of treating the uninsured at facilities other than DSH hospitals, or for paying for non-Medicaid coverage for them, CMS has made creation of a spending pool a condition of approval of California’s waiver. The proposed structure is modeled after Massachusetts’ program. Massachusetts established a SNCP that can be used to pay for the costs of treating the uninsured, as well as paying providers for unreimbursed costs of treating Medicaid patients. Although the state has broad discretion in designing the use of SNCP funds, they are not made available unless Massachusetts comes up with matching funds from a CMS approved source. The waiver specifies that CPEs from public entities would be acceptable. The amount of federal funds available to the state through the SNCP is capped at the same level for the duration of the waiver (5 years in the case of California), regardless of increases in the number of uninsured or increases in health care costs.

**State Children’s Health Insurance Program (SCHIP)**—The Balanced Budget Act of 1997, established Title XXI of the Social Security Act – the SCHIP program -- to provide states with \$39 billion in “enhanced federal matching funds” over ten years. The program is targeted at uninsured children in families with incomes up to 200 percent of the Federal Poverty Level. States had the option to expand existing Medicaid programs, create separate SCHIP programs (as California did with Healthy Families) or use a combination of the two approaches. Several states have received approval for 1115 waivers within SCHIP programs.

**Section 1115 of the Social Security Act** — The provision that enables states to receive “waivers” of federal Medicaid requirements. The two key provisions for Medicaid purposes are Section 1115(a)(1) and (a)(2).

- Section 1115(a)(1) allows the Secretary of HHS to waive provisions of section 1902 of the Medicaid statute, the section that contains the Medicaid state plan requirements. Section 1902 outlines the elements that must be included in the state plan and sets the federal parameters within which states must operate the programs. States use waivers of this portion of the statute to specify, for example, an alternate method for calculating eligibility, or a modified benefit package.
- Section 1115(a)(2) contains the “costs not otherwise matchable” authority that enables states to receive federal matching funds for populations or services that Medicaid does not normally cover. (See “*Costs Not Otherwise Matchable*” above.)

For actual text of the statute see

[http://www.ssa.gov/OP\\_Home/ssact/title11/1115.htm](http://www.ssa.gov/OP_Home/ssact/title11/1115.htm).

**Selective Provider Contracting Program (SPCP)** —Prior to the inception of the Selective Provider Contracting Program (SPCP) in 1982, California hospitals served the Medi-Cal population under a cost-based reimbursement system. Two major issues drove the state legislature to look at alternative reimbursement methods—a large state budget deficit and a significant excess capacity of hospital inpatient beds in the state. Through the SPCP, the Department of Health Services (DHS) contracts on a competitive basis with those hospitals that desire to provide inpatient services to Medi-Cal beneficiaries at a negotiated per diem rate for all hospital inpatient services. In utilizing principles of competition and the negotiation process, DHS is able to optimize the availability of cost-effective hospital inpatient services under the Medi-Cal

program and provide hospitals with incentives to better manage and control their costs. The SPCP has operated successfully for over 20 years, and the competitive contracting process has assured continued hospital access for Medi-Cal beneficiaries. In fiscal year 2002-03, SPCP saved the State General Fund an estimated \$683.0 million in Medi-Cal inpatient hospital payments. Since the inception of SPCP, the program has saved the State General Fund \$6.8 billion.

**Special Terms and Conditions**—The operational and policy parameters of an approved Section 1115 waiver. The terms and conditions include the specific coverage categories, benefits structure, cost-sharing requirements, and financing mechanisms under which the waiver will operate. It is not uncommon for the terms and conditions to be finalized after the “official” waiver approval has been announced.

**Upper Payment Limit (UPL)**—Under federal law and regulation, state Medicaid payments to hospitals, nursing facilities and other institutional providers are subject to aggregate limits known as upper payment limits (UPLs). The UPL is set at the estimated amount all of the hospitals would receive for treating Medicaid patients if they were paid at Medicare rates, with some adjustments. There is currently no UPL on the amount of Medicaid payments that can be made to any individual publicly owned or operated hospital. In the case of inpatient hospital services, there are three UPLs: one for all state-operated hospitals, one for all county or local government hospitals, and one for all private hospitals.

**Waiver** — Enacted in 1962 as part of the Social Security Act, section 1115 gives broad authority to the Secretary of HHS to approve “any experimental, pilot or demonstration project which, in the

judgment of the Secretary, is likely to assist in promoting the objectives” of the programs covered by the SSA. While waivers are primarily associated with the Medicaid program today, this authority has also been used in Medicare, the Supplemental Security Income (SSI) program, the former Aid to Families with Dependent Children (AFDC, now TANF) program, and SCHIP.

**With Waiver Costs**—Total program expenditures including a growth rate and the

costs associated with covering any new populations. These costs are compared to the “without waiver costs” to determine budget neutrality.

**Without Waiver Costs**—Projections of what federal expenditures would have been in absence of a waiver program. These costs are the basis for calculating the budget neutrality cap (see definition above).

*For more information, see:*

- *David Rousseau and Andy Schneider, “Current Issues in Medicaid Financing – An Overview of IGTs, UPLs and DSH,” Kaiser Commission on Medicaid and the Uninsured, Washington, DC, April 2004, available at [www.kff.org/medicaid/7071.cfm](http://www.kff.org/medicaid/7071.cfm).*
- *Cynthia Shirk, “Shaping Public Programs Through Medicare, Medicaid and SCHIP Waivers: The Fundamentals,” National Health Policy Forum Background Paper, September 15, 2003, available at [www.nhpf.org/pdfs\\_bp/BP\\_Waivers\\_9-03.pdf](http://www.nhpf.org/pdfs_bp/BP_Waivers_9-03.pdf)*
- *Robert W. Seifert, “The Uncompensated Care Pool: Saving the Safety Net,” Massachusetts Health Policy Forum, October 2002, available at [http://www.forumsinstitute.org/pubs/mass/Pool\\_Issue\\_Brief.pdf](http://www.forumsinstitute.org/pubs/mass/Pool_Issue_Brief.pdf)*
- *Robert E. Mechanic, “Medicaid’s Disproportionate Share Hospital Program: Complex Structure, Critical Payments,” National Health Policy Forum Background Paper, Washington, DC, September 14, 2004, available at [http://nhpf.org/pdfs\\_bp/BP%5FMedicaidDSH%5F09%2D14%2D04%2Epdf](http://nhpf.org/pdfs_bp/BP%5FMedicaidDSH%5F09%2D14%2D04%2Epdf)*

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