

Medi-Cal Hospital Waiver Implementation

***The 3 Waivers:
Medicaid Hospital Financing in
California, Iowa, and Massachusetts***

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Introduction

The State of California has completed negotiations with the federal government over the financing of hospital care under Medi-Cal. At stake during these negotiations were several billion dollars in federal funds over the next five years. The outcomes have far-reaching implications for low-income Californians, the hospitals that serve them, State and county budgets, and California's health care economy.

California is not the only state that is negotiating with the federal government over Medicaid financing of hospital care. The Centers for Medicare & Medicaid Services (CMS), which administers Medicaid at the federal level, is aggressively reviewing Medicaid financing in all states and requiring states to discontinue fiscal arrangements that it considers inappropriate. As of June, CMS reported that 26 states had revised their Medicaid financing arrangements to address its objections.¹ Presumably, two of the states to which CMS was referring were Iowa and Massachusetts, both of which have made extensive changes to their Medicaid hospital financing arrangements in the context of section 1115 demonstration waivers – the same negotiating context in which California finds itself.

The purpose of this policy brief is to better understand the California waiver by comparing some of its features with the Iowa and Massachusetts waivers. We selected Iowa and Massachusetts because each state's waiver contains important policy precedents regarding Medicaid hospital financing; each waiver was negotiated within the past eight months, giving a reasonably current picture of CMS policy; no other waivers affecting hospital financing have been approved this year; and the results of the negotiations are in writing and available to the public.

We want to emphasize that it is not the purpose of this brief to judge which of the three states extracted the best "deal" from the federal government – or, for that matter, whether any state got a good deal. We also want to make clear that our comparison is limited to a careful review of the "terms and conditions" documents for each waiver. Many details of a section 1115 waiver are not reflected in a "terms and conditions" document, and due to time constraints we were unable to capture that additional information here. As a result, the comparison does not present a complete picture of any of the waivers. (As of this printing, California does not yet have a signed approval letter from CMS. However, the expectation is that such a letter is forthcoming.)

As the Legislature's Joint Informational Hearing on July 13 made abundantly clear, the California waiver is enormously complex, with hundreds of moving parts. Although Iowa and Massachusetts are smaller states with smaller Medicaid programs, their waivers are highly complex as well. Table 1, which compares the three waivers in summary form, is an effort to simplify this complexity without distorting it. The rest of this policy brief explains this summary table. A detailed side-by-side of the texts of the "terms and conditions" documents for all three waivers appears in Table 2 at the end of this brief.

Overview

Section 1115 demonstration waivers enable states to receive federal Medicaid matching funds without complying with all of the usual requirements set forth in the federal Medicaid statute. Section 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 federal Medicaid statute as costs in which the federal government will participate. These waivers must be "budget neutral," so that federal spending under the waiver over five years is no greater than federal spending in the absence of the waiver. Finally, the Secretary of Health and Human Services (HHS) has complete discretion in granting section 1115 waivers. States may ask, but the Secretary is under no statutory obligation to honor the request and has broad discretion to attach terms and conditions to the use of federal funds under the waiver.

California has negotiated a new five-year waiver, effective September 1, 2005, that will replace its longstanding Selective Provider Contracting Program (SPCP) waiver. The SPCP waiver allowed the State to limit the participation of hospitals in Medi-Cal through selective contracting and to make supplemental payments to a specified subset of participating hospitals for the costs of caring for Medi-Cal patients. Under the new waiver, the State will maintain its hospital contracting program, but in response to CMS concerns about California's method of financing the state share of its Medicaid payments to hospitals, the State will shift the source of funds from intergovernmental transfers (IGTs, discussed below) to certified public expenditures (CPEs, also below). The waiver also establishes a Safety Net Care Pool (SNCP) that will make a fixed amount of federal matching funds available to purchase care for the uninsured.

Iowa was granted approval of a five-year section 1115 demonstration waiver on the waiver's start date, July 1, 2005.² The waiver, known as IowaCare, allows the State to receive federal Medicaid matching funds for certain uninsured populations, including adults ages 19 through 64 with incomes below 200 percent of the federal poverty level who receive services through state university or county hospitals. The waiver also requires the State to end its various supplemental payments to hospitals and nursing facilities and to appropriate state funds to pay the non-federal share of Medicaid.

Massachusetts has been operating a section 1115 Medicaid demonstration waiver known as MassHealth since 1997. The waiver was scheduled to expire June 30,

2005, but on January 26, it was extended for an additional three years (the standard length for a section 1115 waiver extension). As in the past, the waiver continues to allow federal support for coverage of various low-income populations, but it also phases out IGTs that the State had previously used as non-federal share and replaces them with CPEs. It also establishes a Safety Net Care Pool (SNCP) to enable the state to pay for services to the uninsured and unreimbursed Medicaid costs.³ If the state meets the non-federal share requirements, the SNCP will continue to provide it an estimated \$650 million in federal funds per year (from DSH and other existing sources), and it will enjoy new flexibility in distributing these funds. This funding pool has been cited as one of several building blocks for universal coverage in Massachusetts.⁴

**TABLE 1
MEDICAID SECTION 1115 HOSPITAL FINANCING WAIVERS:
SUMMARY COMPARISON**

	California	Massachusetts	Iowa
	Medi-Cal Hospital Financing/Uninsured Care Demonstration (Proposed Terms and Conditions dated August 16, 2005)	MassHealth (Final Terms and Conditions January 26, 2005)	IowaCare (Final Terms and Conditions July 1, 2005)
Overview	5-year restructuring of supplemental payments to hospitals for Medicaid and uninsured costs; change source of non-federal share	3-year extension to cover uninsured; establish new pool for care of uninsured by providers or insurance; change source of non-federal share	5-year waiver to cover uninsured through state university and county hospitals; change source of non-federal share
Changes in DSH program?	Yes (for both public and private hospitals)	Yes	No
Creates Safety Net Care Pool (SNCP)?	Yes (federal funds capped at same level each year)	Yes (federal funds capped at same level each year)	No
Limits on use of IGTs as non-federal share?	Yes	Yes	No
Specifies use of CPEs?	Yes	Yes	No
New limits on use of provider tax?	Yes (hospital, outpatient, or physician services)	No	Yes (hospital, physician, other)
“Recycling” specifically prohibited?	Yes	No	Yes
New limits on payments to individual public providers?	Yes	No	Yes

DSH Program

Federal Medicaid law requires states to make additional payments to public and private hospitals serving a “disproportionate share” of Medicaid and uninsured patients.⁵ For hospitals treating high volumes of such patients, these disproportionate-share hospital (DSH) payments can be essential to fiscal stability. The amount of federal matching funds available for these payments is subject to two limits, one state-specific, and one facility-specific (the “175 percent limit”). In all states but California, the maximum amount of DSH payments that may be made to an individual hospital is 100 percent of the difference between (1) the hospital’s costs of treating Medicaid and uninsured inpatients and outpatients and (2) the amount of reimbursement the hospital receives from Medicaid (other than DSH) and out-of-pocket from uninsured patients. In California, by federal law, DSH payments may equal 175 percent of this amount for public hospitals.⁶ Although Medicaid DSH has in the past been subject to revision by Congress, there is no current CMS proposal to modify the DSH statutory provisions.

Changes to DSH

- Proposed California waiver: Restructures the State’s program generally by limiting DSH payments to public disproportionate-share hospitals, while private DSH hospitals would largely receive supplemental payments through other mechanisms (called the “DSH swap”). The waiver would not affect California’s state-specific allotment of federal DSH funds or the 175 percent limit on payments to public hospitals.
- Massachusetts waiver renewal: Folds that state’s DSH program into the new Safety Net Care Pool (SNCP).
- Iowa waiver: Does not expressly modify the State’s DSH program.

IGTs

Intergovernmental transfers (IGTs) are transfers of public funds from one level of government to another (e.g., from a county to a state), or from one agency to another (e.g., from a state university teaching hospital to a state Medicaid program). Under the federal Medicaid statute and CMS regulations, public funds received by state Medicaid programs as the result of IGTs from public agencies, including public hospitals, may be used as the state share of Medicaid spending for purposes of receiving federal matching payments.⁷ 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 non-federal share.

Changes to IGTs

- Proposed California waiver: Limits the state’s use of IGTs as the non-federal share of DSH payments to matching the difference between 100 percent and 175

percent of a public DSH hospital's uncompensated costs. The state may also use IGTs to fund its share of payments to private hospitals. Historically, the State has relied heavily on IGTs from counties and the University of California to fund the non-federal share of its DSH program and supplemental payment program.⁸

- Massachusetts waiver renewal: Eventually phases out four different IGTs that the State had used to fund the non-federal share of some costs. Massachusetts may use IGTs, if the funds are derived from state and local taxes and are transferred by units of government.
- Iowa waiver: Does not expressly limit the use of IGTs, although CMS retains the authority to do so by stipulating that all sources of non-federal share of funding are subject to its approval.

CPEs

Federal Medicaid law and regulation authorize the use of certified public expenditures (CPEs) as the non-federal share of Medicaid spending.⁹ CPEs are funds certified by counties, university teaching hospitals, or other public entities within a state as having been spent on the provision of covered services to Medicaid beneficiaries. For example, instead of actually transferring public funds to the state Medicaid agency via IGTs, a county could certify that the hospital it operates has incurred costs in treating Medicaid inpatients and outpatients. 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. CMS is not currently proposing a statutory amendment to modify or limit CPEs, and it has approved the use of CPEs in lieu of IGTs as non-federal share by states.

CPE Provisions

- Proposed California waiver: Specifies that the State may use CPEs of 22 public hospitals as the non-federal share for purposes of drawing down federal inpatient Medi-Cal per diem payments, DSH funds, and Safety Net Care Pool. These CPEs replace IGTs from these facilities for most purposes. The CPEs are to be calculated on the basis of the Medicare CMS-2552-96 hospital cost report. The waiver requires that CMS approve a Protocol specifying the methodology for calculating CPEs.
- Massachusetts waiver renewal: Provides for the use of CPEs of public hospitals for inpatient and outpatient services to Medicaid and uninsured patients, as calculated using the CMS-2552-96 cost report.
- Iowa waiver: Contains no reference to CPEs. It does, however, specify that the State certify all "State/local monies" used as matching funds and that all sources of non-federal match are subject to CMS approval.

Inappropriate IGTs and “Recycling”

As noted, CMS objects to some IGT arrangements on the grounds that they “recycle” funds so as to reduce or eliminate any actual state or local contribution toward the cost of Medicaid services. For example, if a state Medicaid program makes a payment to a county hospital and the county hospital returns some or all of the payment to the state Medicaid agency as an IGT, CMS views this as recycling of funds. CMS 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.¹⁰

Recycling Changes

- Proposed California waiver: Requires that public or private hospitals receiving DSH, DSH-like, or SNCP payments retain the full amount of the payment and not return the funds to the State or any other unit of government.
- Massachusetts waiver: Documents do not address this issue.
- Iowa waiver: Requires the termination of various supplemental payments to state hospitals or nursing homes if the providers do not retain the total amount of Medicaid payments for which federal matching is claimed.

Payments to Providers

Under federal regulation, state Medicaid payments to hospitals, nursing homes, and other institutional providers are subject to aggregate limits known as upper payment limits (UPLs).¹¹ 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. In each case, the UPL is set at the estimated amount all the hospitals under the UPL would receive for treating Medicaid patients if they were paid at Medicare rates. Currently, in California, there are several different limits on the amount of Medicaid payment that may be made to government-owned or -operated hospital, including a spending cap specified in the 2003 SPCP waiver, the aggregate UPL and the facility-specific 175% DSH cap. CMS is seeking a statutory change to prohibit federal matching of payments to an individual state or local hospital that exceeds the facility’s actual costs of treating Medicaid patients.¹²

Provider Payment Provisions

- Proposed California waiver: Reimbursement to the 22 governmentally-operated hospitals identified in the waiver will be based on allowable Medicaid inpatient hospital costs as calculated under the Medicare 2552-96 cost report.

- Massachusetts waiver renewal: Contains no provisions limiting payments to individual government hospitals to cost.
- Iowa waiver: Imposes a limit on payments to individual government hospitals. Costs are to be calculated using the CMS 2552-96 reporting form.

Provider Taxes

Federal Medicaid law allows states to raise revenues 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, but only if the taxes meet certain requirements.¹³ Among other things, the tax must apply to all non-Federal, non-public providers in the class, it must be imposed uniformly, and the state may not hold providers harmless against its costs. CMS is seeking to change federal law to limit the amount of revenues that a permissible provider tax may collect for use by states as non-Federal share.¹⁴

Changes in Provider Taxes

- Proposed California waiver: Prohibits the State from imposing a tax on inpatient hospital, outpatient, or physician services during the five-year term of the demonstration. The State would not be precluded from imposing taxes on other classes of providers, or on managed care organizations.
- Massachusetts waiver renewal: Does not prohibit the State from imposing taxes on any provider class for purposes of raising revenues to fund Medicaid.
- Iowa waiver: Prohibits the State from imposing new taxes on hospitals, nursing facilities, physicians, or pharmacies during the five-year term of its demonstration.

Safety Net Care Pool

As discussed above, federal Medicaid law requires states to make payments to DSH hospitals to help defray the costs of serving uninsured patients. However, Medicaid law does not provide for a designated pool of federal matching funds for treating the uninsured at facilities other than DSH hospitals, or paying for non-Medicaid coverage for uninsured citizens. There is no CMS proposal to change federal Medicaid law to create new pools of federal matching funds to cover the uninsured who are ineligible for Medicaid.

SNCP Provisions

- Proposed California waiver: Establishes an annual allotment of federal matching funds, called a Safety Net Care Pool (SNCP), that the State can use to pay for the costs of treating the uninsured. The State has broad discretion in using

Federal SNCP funds, but these dollars only become available after the State provides matching funds from a CMS-approved source. The waiver specifies that CPEs from public entities would be acceptable. Federal SNCP funding is capped at the same amount for each year of the waiver, regardless of increases (or decreases) in the number of uninsured. During the first two years of the waiver, \$180 million per year in SNCP funding is conditioned upon implementation of “Medi-Cal Redesign.” Over the last three years of the waiver, \$540 million of the SNCP must be used to support a broadly defined “coverage initiative,” and the provider groups to receive the \$540 million are not specified.

For the first two years of the waiver, SNCP payments will not be offset against the facility-specific 175% DSH cap. For the remainder of the waiver, SNCP payments will count towards each facilities 175% DSH cap.

- Massachusetts waiver renewal: Contains the same SNCP structure as the proposed California waiver. The State must furnish non-Federal funds acceptable to CMS; CPEs are neither specified nor precluded as such a source. Federal funds available to the State in the SNCP are capped at the same amount for each year of the waiver renewal regardless of increases (or decreases) in the number of uninsured. The state may use 10% of the SNCP funds for capacity building and infrastructure.
- Iowa waiver: No SNCP established.

**TABLE 2
MEDICAID SECTION 1115 HOSPITAL FINANCING WAIVERS:
SELECTED FEDERAL AND STATE FINANCING ISSUES**

	California (DHS Proposed Terms and Conditions August 16, 2005)	Massachusetts (Final Terms and Conditions January 26, 2005)	Iowa (Final Terms and Conditions July 1, 2005)
Overview	Establishes new 5-year Medi-Cal Hospital/Uninsured Care 1115 demonstration beginning September 1, 2005.	Renews 8-year-old MassHealth 1115 demonstration beginning July 1, 2005 for 3 years.	Establishes new 5-year IowaCare 1115 demonstration beginning July 1, 2005.
Summary of Major Waiver Actions	Revises financing for Medicaid hospital care costs; extends selective hospital contracting program (SPCP); revises state DSH program; establishes a level-funded Safety Net Care	Extends coverage to various populations of low-income adults 19 – 64 for additional 3 years, beginning July 1, 2005; converts State’s DSH allotment and certain supplemental payments	Extends coverage to low-income adults 19 – 64 and other populations through provider network at State University and county hospitals; terminates

	Pool (SNCP); phases out some existing IGTs and allows use of CPEs as non-Federal share; prohibits any new hospital, outpatient, or physician taxes during term of demonstration	into a level-funded Safety Net Care Pool (SNCP); phases out all existing IGTs and allows use of CPEs as non-Federal share; does not prohibit new provider taxes during demonstration.	“inappropriate” IGT/ supplemental payment arrangements; does not create a Safety Net Care Pool (SNCP); prohibits any new provider taxes during demonstration.
Dis-proportionate Share Hospital (DSH) Payments			
DSH: Size and Eligible Uses	Annual DSH allotments not included in SNCP amount (see below). Federal funds, “shall be available for DSH payments to governmentally-operated hospitals...” (30a) “A defined DSH pool available for payments to private hospitals” to extent necessary under federal law (30c)	Annual DSH allotment for SFY 2005 (\$574 million) included in SNCP amount (see below). “The DSH reimbursement methodologies authorized under the State Plan expire July 1, 2005.” (Attachment B, 6.a.)	“Disproportionate share hospital payments will be limited to the State’s DSH allotment and applicable hospital-specific DSH limits and shall be funded consistent with federal statute and regulations.” (IX.42.b.)
DSH: DSH-equivalent payments to private hospitals	Payments to private hospitals “may also include supplemental payments previously made to those hospitals subject to the upper payment limit (UPL) for private hospitals. (23a)	No specification.	No specification.
DSH: Sources of Non-Federal Matching Funds	The non-federal share of DSH payments to public hospitals in amounts up to 100% of uncompensated Medicaid and uninsured costs may be based on CPEs from 22 specified public hospitals or on State general funds; above 100%, on IGTs	No specification.	No specification.

	(under federal statute, DSH payments in California can equal 175% of a hospital's uncompensated Medicaid and uninsured costs) (30b, 31)		
DSH: Immigrant Uses	DSH payments can be made for "costs associated with non-emergency services rendered to unqualified aliens." (30b)	No specification.	No specification.
Inter-governmental Transfers (IGTs)			
IGTs: Phase-out as non-Federal Share of Medicaid Spending	<p>Effective July 1, 2005, IGTs may not be used as the non-federal share of DSH payments to public hospitals at or below 100% of uncompensated Medicaid and uninsured costs. (30a)</p> <p>IGTs may continue to be used as non-federal share of DSH payments to public hospitals above 100% of uncompensated Medicaid and uninsured costs. (31)</p>	<p>State "may use intergovernmental transfers to the extent that such funds are derived from state and local taxes and are transferred by units of government." (Attachment B, 6. h.)</p> <p>The non-Federal share of Medicaid payments to Boston Public Health Commission and Cambridge Public Health Commission "may continue to be funded by transfers from BPHC and CPHC" for the period July 1, 2005 through June 30, 2006." (Attachment B, 6. e.)</p>	See Prohibitions on "Recycling" below
IGTs: Use for payments to private entities	IGTs from local governments to the State may be used as the non-federal share of any Medicaid payments to private hospitals for inpatient services (23c)	No specification.	No specification.
Certified Public Expenditures (CPEs)			

<p>CPEs: Definition as non-Federal share of Medicaid spending</p>	<p>The methodology for calculating CPEs are to be specified in a Protocol subject to approval by CMS (14).</p> <p>CPEs may be based upon all sources of funds available to public entities that operate public providers including patient care revenues for Medicare and Medicaid except impermissible provider taxes (14, 27, 36, Attachment B).</p>	<p>“Only units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended to satisfy the costs eligible for Federal matching funds under Medicaid.” In the case of hospitals, “such costs are identifiable under the Medicare-Medicaid cost report (CMS-2552-96),” which reflects “costs related to the provision of inpatient hospital and outpatient hospital services to Medicaid and uninsured patients.” (Attachment A, 4.)</p>	<p>No reference to CPEs. “The State shall certify State/local monies used as matching funds for the demonstration...All sources of the non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval.” (VII. 31.)</p> <p>The State Legislature is required to appropriate certain amounts to the State Medicaid agency for use as the non-Federal share of Medicaid payments (IX. 45., 47.)</p>
<p>CPEs: Immigration uses</p>	<p>CPEs shall be based upon, “Medicaid eligible costs incurred by [public] facilities in providing health care services to Medi-Cal eligible beneficiaries” (26g)</p>	<p>No specification</p>	<p>No specification</p>
<p>Prohibitions Against “Recycling” of Payments to Providers</p>	<p>Every public hospital must “retain the full amount of the payment resulting from the use of” IGTs. “No portion of the payments funded by federal, county, or state, funds made to governmentally-operated hospitals will be returned to any unit of government.” (31c)</p> <p>Public hospitals receiving DSH payments may not transfer to another unit of government more than, “the non-Federal portion of the payment funded by</p>	<p>No specification</p>	<p>State must terminate, by June 30, 2005, inpatient hospital supplemental payments, supplemental DSH payments, supplemental GME payments, and supplemental payments to nursing facilities if providers “do not retain the total [amount of payments claimed by the state for federal matching].” (IX. 42. a.)</p>

	<p>the intergovernmental transfer.” (31b)</p> <p>”The non-Federal share of payments to private hospitals may be funded by transfers from units of local government, at their option, to the state. Any payments funded by [IGTs] shall remain with the hospital and shall not be transferred back to any unit of government.” (23c).</p>		
New Limits on Payments to Individual Public Providers	<p>Reimbursement to 22 governmentally-operated hospitals identified in Attachment C, “will be based on allowable Medicaid inpatient hospital costs...derived from the most recently audited Medicare 2552-96 cost report.” (26)</p> <p>Existing aggregate upper payment limits (UPLs) and continue to apply.</p>	No new limitation on amount of payments to individual public providers (existing aggregate upper payment limits (UPLs) continue to apply)	State must limit total Medicaid payments (including GME and any other supplemental payments) for each lowa-government operated hospital (and nursing facility) to “actual medical education and medical assistance costs of each such facility as reported on the Medicare 2552-96 hospital and health care complex cost report (CMS Form-2552-96).” (IX. 42. b.)
Provider Taxes as source of non-Federal share of Medicaid spending	State will not impose a “tax, fee, or assessment” on “inpatient hospital, or outpatient or physician services” the revenues from which will be used as non-Federal share during the term of the demonstration (25).	“With regard to the DSH portion of the SNCP, DSH payments will continue to be funded using hospital and MCO tax revenue and state appropriations.” (Attachment B, 6. e.)	State may not impose “any” new health care provider taxes to finance non-federal share of Medicaid during the demonstration, “including, without limitation, taxes on hospitals, nursing facilities, physicians or pharmacies.” (IX. 41)
Safety Net Care Pool (SNCP)			

SNCP: Purposes and Uses	SNCP established “for the provision of health care services to uninsured populations.” SNCP funds may be used for “health care expenditures (medical care costs)...incurred by the State, or by hospitals, clinics, or other provider types for uncompensated medical care costs of medical services provided to uninsured individuals.” (34).	SNCP established “for the purpose of reducing the rate of uninsurance.” May be used to pay for services to uninsured as well as unreimbursed costs for Medicaid beneficiaries “through any type of provider (e.g., hospitals, clinics, etc.) or through insurance products.” Up to 10% available for “capacity building and infrastructure.”	No SNCP
SNCP: Immigration Uses	SNCP funds “cannot be used for costs associated with the provision of non-emergency care to unqualified aliens,” defined as “17.79% of total provider expenditures or claims for services to uninsured individuals.” (37).	No specification	No SNCP
SNCP: Available Funds	<p>Maximum SNCP amount will be \$766 million in federal funds each year of the waiver. (Attachment B)</p> <p>In years 1 and 2, \$180 million per year is conditioned on expanding managed care enrollment. (41)</p> <p>In years 3 to 5, \$180 million per year is conditioned on Coverage Initiative to be specified, “that will expand coverage options for individuals currently uninsured.” (42)</p>	SNCP payments capped at amount equal to (1) annual DSH allotment plus (2) the amount of supplemental payments to BPHC and CPHC for SFY 2005 (projected \$1.23 billion per year). (Attachment B, 6. a.)	No SNCP
SNCP: Sources of Funds	State must have permissible sources for the non-federal share, including CPEs, in order to access federal funds in the SNCP. (36)	“Beginning July 1, 2006, the Commonwealth may only access federal funds in the SNCP if the source of the state share of funds has received prior	No SNCP

	In the event there are not enough CPEs CMS must review and approve any alternate sources. (38)	approval from CMS.” (Attachment B, 6.f.)	
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CITATIONS

¹ Testimony of Dennis Smith, Center for Medicaid and State Operations, Senate Finance Committee Hearings on Medicaid Fraud and Abuse (June 28, 2005), p. 3.

² IowaCare waiver terms and conditions and related materials are posted at <http://staffweb.legis.state.ia.us/lfb/medicaid/medicaid.htm>

³ For a more detailed discussion of the waiver renewal see Massachusetts Medicaid Policy Institute, *The MassHealth Waiver* (April 2005), www.massmedicaid.org/briefs.html.

⁴ Blumberg et al., *Building the Roadmap to Coverage: Policy Choices and the Cost and Coverage Implications* (June 2005), pp. 10, 14, www.roadmaptocoverage.org.

⁵ Section 1902(a)(13)(A)(iv) of the Social Security Act, 42 U.S.C. 1396a(a)(13)(A)(iv).

⁶ Section 701(c)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (H.R. 5661, as enacted by P.L. 106-554).

⁷ Section 1903(w)(6) of the Social Security Act, 42 U.S.C. 1396b(w)(6); 42 CFR 433.51(b).

⁸ Item 26 of the waiver states, “Reimbursement to governmentally-operated hospitals identified in Attachment C will be based on allowable Medicaid inpatient hospital costs.” One interpretation of this language is that the state may not use IGTs from these hospitals to fund the non-federal share of payments to these hospitals. There is no express language prohibiting IGTs other than for DSH payments at or below 100%.

⁹ Section 1903(w)(6) of the Social Security Act, 42 U.S.C. 1396b(w)(6); 42 CFR 433.51(b).

¹⁰ Testimony of Dennis Smith, June 28, 2005, p. 4.

¹¹ 42 CFR 447.272

¹² Testimony of Dennis Smith, June 28, 2004, p. 7. The Administration estimates that limiting payments to public providers to cost, and prohibiting “recycling,” would save the federal government \$5.9 billion over 5 years.

¹³ Section 1903(w) of the Social Security Act, 42 U.S.C. 1396b(w), 42 CFR 433.50 et seq.

¹⁴ Testimony of Dennis Smith, June 28, 2004, p. 5. The Administration estimates that limiting the revenues that may be collected by provider taxes will save the federal government \$3.17 billion over the next 5 years.