

# **Medi-Cal Hospital Waiver Implementation**

***Understanding the 2005 Hospital Financing Waiver  
Questions and Answer***

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## **SECTION I: FEDERAL MEDICAID SECTION 1115 WAIVER OVERVIEW**

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 persons. State governments administer the program within broad the 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 over 50 million beneficiaries at a combined federal/state cost of nearly \$220 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 in total funds (with about \$13 billion in state General Fund) for State Fiscal Year 2005-2006. (PPIC, 2005).

### **What is the purpose of a Medicaid Section 1115 waiver?**

Medicaid Section 1115 waivers were originally designed as "research and demonstration" programs intended to promote innovation in Medicaid and 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.

### **What is the Section 1115 Waiver authority?**

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 implementing other innovative demonstration projects.
- Cannot be used to waive the FMAP or other rules governing the source of the non-federal share of Medicaid funds.

### **What are some examples of 1115 Waivers?**

Between January 2001 and March 2005, a total of 14 waivers were approved by HHS. (KFF, 2005)

Examples of active Section 1115 waivers include:

- Utah: Under then Governor 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, MassHealth provides Medicaid coverage to an additional 300,000 low-income persons.

### **What are the rules governing Section 1115 waivers?**

The statutory language of Section 1115 is very broad and actually applies to all HHS programs. Therefore, most of the rules have been developed as guidelines rather than statutory requirements. There are no federal regulations in place that govern section 1115 waivers. For example, the “budget neutrality” requirement -- which provides that federal spending under a waiver must be no greater than it would have been if the waiver were not in place – has federal policy since 1983, but is not a legal requirement.

### **What is “budget neutrality” for Medicaid Section 1115 waivers?**

Budget neutrality is one of the key components 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.”

### **How do states generally show that a Section 1115 waiver is budget neutral?**

States can demonstrate budget neutrality in three different ways. They can show that the “without waiver” spending would be relatively high (for example, the state will try to show that there would be high spending growth under the existing program); they can argue that the “with waiver” spending will be very low (for example, the state will show that they will save money by implementing mandatory managed care); or states can assert both criteria.

### **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 waiver, then 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.

## **PART II: CALIFORNIA'S 2005 HOSPITAL FINANCING WAIVER**

This section provides details on some of the major changes in financing California's public hospitals.

### **What is the background of the 2005 waiver?**

California has negotiated a 5-year Section 1115 waiver to replace the 2-year Selective Provider Contracting Program (SPCP) Section 1915(b) waiver. The SPCP waiver allowed the state to limit hospitals' participation in Medi-Cal through selective contracting and to make supplemental payments to specified (not all) participating hospitals to help cover uncompensated Medi-Cal costs and address unique, unexpected and/or temporary needs at individual hospitals.

Under the new waiver, the state will maintain its hospital contracting program, but in response to the Center for Medicare and Medicaid Services' (CMS) concerns about California's method of financing the state share of its Medicaid payments to hospitals, the state will shift the major sources of non-federal Medicaid funds for 22 designated public hospitals from state General Fund and inter-governmental transfers (IGTs) to certified public expenditures (CPEs). Private hospitals and district hospitals will be financed with state General Funds 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 reimburse for care for the uninsured. Other complex changes are being made as well.

### **What is the operational framework of the 2005 waiver?**

The general framework of the waiver is that:

- There will be different limits on the federal government's financial liability for hospital payments.
- Public hospital spending for the uninsured is generally capped or bounded. Spending for services to Medi-Cal beneficiaries is reimbursed at cost.
- Private hospital spending dependent on General Fund appropriations and is not as closely scrutinized.
- Sources of non-Federal funds are clearly separated between public and private hospitals.
- There are no changes for non-DSH hospitals that do not contract with the state through CMAC.

### **Under the waiver, what are the available hospital funding mechanisms?**

- Per Diem Payments
- Disproportionate Hospital Share (DSH) Payments
- "Virtual" DSH Payments
- Safety Net Care Pool Payments
- SB 1732 Payments

**How will hospital per diem payments be handled under this waiver?**

Today, hospital per diem payments are negotiated with the California Medical Assistance Commission (CMAC) and vary from hospital to hospital. Under the waiver:

- *Public Hospitals:* The per diem payments for 22 designated public hospitals will no longer be negotiated by CMAC. Reimbursement will be 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, the state effectively transfers hospitals to a “cost-based reimbursement” system. This means that hospitals will be reimbursed based on their actual costs for providing care to Medi-Cal patients only. (SB 1732 payments may be an exception to this, see below.)
- *Private Hospitals:* The per diem payments are still to be negotiated by CMAC and will primarily be paid for with General Fund dollars.
- *Non-CPE Public Hospitals:* The per diem payments for public hospitals and district hospitals that do not use the CPE methodology will continue to be negotiated by CMAC and will be financed by the state General Fund.

**What are the changes to the hospital per diem payments?**

	<b>Payment Program</b>	<b>Federal Authority</b>	<b>Purpose</b>	<b>Providers Affected</b>	<b>Amount Paid to Providers</b>	<b>GF</b>	<b>IGT</b>	<b>CPE</b>
<i>Current</i>	<b>Medi-Cal Per Diem Payment</b>	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 California Medical Assistance Commission (CMAC)	X		
<i>New System</i>	<b>Public Medi-Cal Per Diem Payment</b>	Requires New Medicaid State Plan Amendment (SPA)	Same	Specified 22 public hospitals	Based on allowable costs	X		X
	<b>Private Medi-Cal Per Diem Payment</b>	The 2005 Waiver	Same	Private hospitals with SPCP contracts	Based on negotiation with CMAC	X	X	

**What is the Disproportionate Share Hospital (DSH) Swap?**

By federal law, 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 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% DSH cap).

The waiver will restructure the DSH program by limiting traditional DSH payments exclusively to public hospitals. Private DSH hospitals will receive DSH-like supplemental payments

financed by the state General Fund and federal Medicaid funds. The federal DSH allotment and the 175% cap will remain in tact.

- *Public Hospitals:* While there have been suggestions to restructure the DSH formula, there are few specific details available. \$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 would come out of the state general fund, instead of IGTs and the DSH allotment. The primary concern is that source of the state match is now dependent on the annual budget process, creating the possibility of a funding shortfall in lean budget years.

**What are the changes in the DSH swap?**

	Payment Program	Federal Authority	Purpose	Providers Affected	Amount Paid to Providers	GF	IGT	CPE
<i>Current</i>	<b>DSH (SB 855)</b>	SPA	Supplemental payments to hospitals for uncompensated care	Eligible public and private hospitals	State statutory formula		X	
<i>New System</i>	<b>Revised DSH Public (SB 855)</b>	Requires New SPA	Same	Eligible public hospitals	State statutory formula. (Changes may be called for by hospitals.)		From 100% to 175% of uncompensated costs	From 0 to 100%
	<b>New Private Supplemental (Virtual DSH)</b>	Likely Requires New SPA	Same	Eligible private hospitals	Set by DSH formula, paid outside of fixed DSH allotment	X		

**What is the relationship of SB 1255 and GME to the Safety Net Care Pool (SNCP)?**

For years, the SB 1255 and GME programs have been the key supplemental payment programs for hospitals that rely on IGTs and payments negotiated by the CMAC to generate the non-federal share of Medicaid matching funds.

Under the proposed California waiver, this program will essentially be replaced for the 22 public hospitals by an annual allotment of federal matching funds -- called a Safety Net Care Pool (SNCP) -- which the state can use to pay for the costs of treating the uninsured. SB 1255 payments for private hospitals can continue, however they will use General Funds rather than IGTs for the state match.

While the state has broad discretion in designing the use of federal SNCP funds, the state will be required to use CMS-approved matching funds. This includes all government funds, except for illegal provider taxes or donations. The state will not be able to impose a tax on hospitals or

physicians as a source of this match. The waiver specifies that CPEs from public entities would be acceptable. It has not been determined which providers will be eligible to receive these funds, but it could include public hospitals, clinics, doctors, and others.

While the 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 -- a total of \$900 million of the SNCP is contingent upon the state taking certain “Medi-Cal redesign” steps over the five-year waiver.

**What are the changes in SB 1255?**

	<b>Payment Program</b>	<b>Federal Authority</b>	<b>Purpose</b>	<b>Providers Affected</b>	<b>Amount Paid to Providers</b>	<b>GF</b>	<b>IGT</b>	<b>CPE</b>
<i>Current</i>	<b>SB 1255 and GME</b>	2003 SPCP Hospital 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	
<i>New System</i>	<b>New Safety Net Care Pool</b>	2005 Hospital Waiver	Supplemental payments for care to the uninsured	Unknown: Public providers; possibly private hospitals and other providers	Unknown: Possibly set formula or CMAC negotiation	X		X
	<b>SB 1255 Private Supplemental</b>	2005 Hospital Waiver	Supplemental payments for uncompensated care	Private Hospitals	Unknown: Possibly set formula or CMAC negotiation	X	X	

**What is SB 1732?**

SB 1732 is a relatively small pot of money that is used for capital improvements and construction for certain eligible hospitals. The waiver proposal does not include changes to the capital cost program.

	<b>Payment Program</b>	<b>Federal Authority</b>	<b>Purpose</b>	<b>Providers Affected</b>	<b>Amount Paid to Providers</b>	<b>GF</b>	<b>IGT</b>	<b>CPE</b>
<i>Current</i>	<b>SB 1732</b>	2003 Hospital Waiver	Capital cost reimbursement payments for eligible DSH hospitals	Specified public and private hospitals	Statutory Formula	X		
<i>New System</i>	<b>SB 1732</b>	2005 Hospital Waiver	Same	Same	Same	Same		

**How is budget neutrality calculated for the 2005 hospital financing waiver?**

While the documentation is limited, it seems that California focused on showing that the “without waiver” spending was going to be very high. If California were to implement a hospital provider tax, federal Medicaid spending could greatly increase over the allowable waiver spending. However, Provision 25 of the Special Terms and Conditions of the waiver prohibits California from creating certain provider taxes that are otherwise permissible. Therefore, the “with waiver” spending would be lower than the “without waiver” spending because California cannot generate revenue from a hospital provider tax to fund the cost of health care services.

### **SECTION III: FEDERAL FUNDING AUTHORITY UNDER THE 2005 WAIVER**

This section outlines the range of federal funding that will be available under the hospital financing waiver.

#### **What are the federal funding sources for the waiver?**

Normally, budget neutrality for waivers depends on a calculation of how much is being spent per beneficiary per month absent the waiver and then under the waiver. The California waiver breaks that format and instead seems dependent upon the size of various pots of money.

There are several major sources of federal financing that will be available under the waiver. Following are descriptions of each spending authority and a brief discussion of arguments for why these funding sources could be considered “new” or “old”

- ***Continuing Former LA County Funding***  
Five Year: \$900M; One Year: \$180 Million

The non-hospital based clinic funding for the now expired LA waiver was being phased-out over the last 5 years. This funding in the last year of the LA waiver was \$85 million. Under the 2005 Section 1115 hospital financing waiver, the five-year average of the LA funding (\$180 million per year) will continue for each year going forward from 2005 – 2010. The funding is not dedicated to LA. This will represent a total of \$900 million in the SNCP under the 2005 waiver

*New Money:* From a baseline perspective, this money should have zeroed out and was not in the federal baseline. The state had promised never to ask the federal government for the LA-focused funding again.

*Old:* In April 2005, LA waiver spending was \$85 million. Since the state was already spending this money, it is not new.

- ***DSH Swap***  
Five Year: \$1,165 million; One Year \$233 million

As discussed in Section II, the DSH swap means that public hospitals will receive all DSH (SB 855) payments while private hospitals will receive “virtual DSH” (or “DSH-like”) payments. By separating public and private payments, the state will be able to maximize DSH payments to public hospitals while providing private hospitals with 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 state FY 2004-05.

*New Money:* The waiver was needed to target limited DSH funds to public hospitals only and keep private hospitals fully funded by using entitlement dollars. Also, the state never could have received CMS approval for the DSH swap using IGTs as CMS had stopped approving state plan amendments with IGTs.

*Old Money:* This is an action that the state could have taken years ago absent a waiver. If had this action been years ago, then it is likely that a proposed State Plan Amendment could have been approved under an earlier presidential administration.

- ***Growth in Per Diem Payments***

Five Year: About \$800 million; One Year: Varies

Under the 2005 Section 1115 hospital waiver, hospital in-patient per diem payments have authority to grow at either cost for public hospitals or at the upper payment limit for private hospitals. This means that these limits grow as the caseload increases and is only constrained by the growth in costs plus inflation in the public hospitals and for private hospitals at the Medicare growth rate. For private hospitals, this is 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.

*New Money:* Payments for services to Medi-Cal beneficiaries are no longer capped for caseload and cost. California could have been given a fixed dollar cap for all payments which could have caused increased Medi-Cal payments to reduce the amount of the SNCP (as was prescribed in the Massachusetts Section 1115 waiver.)

*Old Money:* California cannot use any savings in Medi-Cal payments to fund increased spending on the uninsured. To the extent that Medi-Cal costs do not increase at a rate less than the President's trend rate, this funding is not available to increase payments for the uninsured.

- ***Stopping the UPL Phase-out (Called the "\$218 million")***

Five Year: \$574 million; One Year: Varies

At present, there is a portion of current Medi-Cal hospital spending that exceeds the Upper Payment Limit (UPL) for California non-state government owned hospitals. By law, that spending above the UPL is being phased out over an 8-year transition period as mandated by federal law (Beneficiary Improvement and Protection Act (BIPA) of 2000). This phase out is 15 percent each year, until the overage (called the "exceedence") reaches "zero" which would otherwise occur in the last year of the new waiver. The waiver offsets this phase-out and maintains the 2004 funding level – the \$218 million.

However, since these payments were phasing out, the exact amount of money made available to California varies from year to year, with more funding becoming 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 a 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 continue this funding moving forward. Also, with the new CPE structure, hospital costs are now effectively the payment cap for public hospitals, not the UPL. As a result, this spending “room” is meaningless.

## **SECTION IV: SOURCES OF NON-FEDERAL FUNDING UNDER THE 2005 WAIVER**

This section provides information on how California can provide non-federal share for the hospital financing waiver.

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

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

- Intergovernmental Transfers (IGTs)
- CPEs
- Permissible Provider Taxes
- State General Fund

However, as discussed below, each category is treated differently under the waiver and has different permissible uses.

### **What is an IGT?**

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 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"). There are neither current federal regulations nor laws to support this new position.

### **What IGTs are allowed under the waiver?**

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

However, 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, as specified in federal statute, IGTs may continue to be used as the non-federal share for DSH payments for amounts between 100 percent and 175 percent of uncompensated care costs, as are protected and specified by federal law. In all cases, these IGT funded payments, both the federal funds and the IGT, must remain in the hospital and be used to fund hospital expenses. No portion of this payment can be transferred back to a unit of government.

**What are Certified Public Expenditures (CPEs)?**

Federal Medicaid law and regulation 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. For example, 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 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 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 by states (e.g. Massachusetts). One of the state's primary consultants is currently circulating a proposal to members of the Senate and Congress to codify aspects of CPEs into federal law.

**What CPEs are allowed under the waiver?**

CPEs from the 22 designated public hospitals for inpatient and outpatient costs of treating Medicaid and uninsured patients would be permitted. In addition, for public hospitals, CPEs may be used as the non-federal share of Medi-Cal per diem payments, the federal DSH allotment, and SNCP funds. The exact process and methodology for determining CPEs is still to be determined under Provision 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.

**What is a permissible provider tax?**

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. Among other things, the tax must apply to all providers in the class (including non-federal, non-public), it must be imposed uniformly, and the state may not hold providers harmless against its costs. Federal Medicaid statute and regulations allow use of revenues from permissible provider taxes as the non-federal share.

**What provider taxes are allowed under the waiver?**

Under the waiver, California has agreed to not impose new state provider taxes on inpatient hospital or outpatient and physician services during the 5-year term of the waiver. All other categories of provider taxes may be used if the state so desires.

**What General Fund spending would be allowed under the waiver?**

California has broad authority to use the state General Fund as a source of the non-federal share to secure federal Medicaid funds.

## SECTION V: SELECTED POLICY OPTIONS FOR THE LEGISLATURE

After providing a list of federal, DHS, and legislative actions needed to move forward and implement the waiver, this section discusses questions around two separate policy issues:

- Policy Question 1: Principles of a hold harmless policy and funding distribution questions; and,
- Policy Question 2: Ensuring availability of needed CPEs.

**What administrative decisions are needed in order to complete the waiver negotiations?**

	<b>Federal Approval/Action Needed</b>	<b>DHS Approval/Action Needed</b>	<b>Legislative Approval/Action Needed</b>
<b>Finalize Terms and Conditions</b>	Yes	Yes	No
<b>Finalize with CMS process for determining CPEs</b>	Yes	Yes	No
<b>Finalize with CMS IGT methodology for 175% DSH</b>	Yes	Yes	No
<b>Create CPE Payment Model for Public Hospitals</b>	Yes	Yes	No

**What legislative policy decisions are needed in order to complete the waiver implementation process?**

	<b>Federal Approval/Action Needed</b>	<b>DHS Approval/Action Needed</b>	<b>Legislative Approval/Action Needed</b>
<b>Define and create a “hold harmless” provision</b>	No	Yes	Yes
<b>Define and create system for distributing “growth” (or “remainder” CPEs</b>	No	Yes	Yes, Key Action: Create statutory program
<b>Define and Create New “Virtual DSH” program for private hospitals</b>	Yes SPA Needed	Yes	Yes, Key Action: Create statutory private supplemental program, basis of payment, and administrative entity
<b>Revise DSH Program</b>	Yes SPA Needed	Yes	Yes, Key Action: Revise DSH statute to incorporate CPEs and revised use of IGTs
<b>Create 1255/GME-like program for the private and non-CPE public hospitals</b>	No	Yes	Yes, Key Action: Create statutory private and non-CPE public supplemental program, basis of payment, and administrative entity

<b>Decide on Managed Care Implementation</b>	No	Yes	Yes, Key Action: Decide on authorization of mandatory managed care for ABD population
<b>Decide on Creating Safety Net Care Pool</b>	No	Yes	Yes, Key Action: Authorize creation of the pool
<b>Decide on Coverage Initiative</b>	No (Ultimately CMS will have to approve initiative)	Yes	Yes, Key Action: Authorize creation of the initiative

**POLICY QUESTION 1: PRINCIPLES OF A HOLD HARMLESS POLICY AND FUNDING DISTRIBUTION QUESTIONS**

**How will individual hospitals fare under the waiver?**

The multitude of changes in the waiver make it difficult to model at this point how much funding any given hospital will receive. Under the Administration’s approach, there are still many variables that need to be addressed – such as CMAC decisions in negotiating supplemental payments, the use of the DSH funds for uncompensated care costs below 100 percent, the use of DSH funds for uncompensated care costs between 100 percent and 175 percent, the use of the SNCP funds and the availability of CPEs.

The state and hospital associations have long agreed that there would be a “hospital hold harmless” provision designed to protect hospitals’ funding levels, but there is still little agreement about what this actually means and how it might work, given the various scenarios.

**What has to be decided for the hold harmless to happen?**

Critical questions include:

- Who does a hold harmless apply to?
- What sources of payments (per diem payments, DSH [below 100 percent; and between 100 percent and 175 percent] and SNCP) can be used to help maintain the hold harmless?
- What is the best mechanism to implement the hold harmless?
- How can it be assured that there are enough non-federal sources of funds available to support needed hospital payments?

**Who does a hold harmless apply to?**

All three major hospital classes under the waiver could be considered for a hold harmless policy for:

- The 22 public hospitals,
- The SPCP-contracting private hospitals,
- The non-CPE public hospitals,

Instead of addressing hold harmless issues for each class of hospitals, which would be unwieldy for this paper, the following questions specifically look at the hold harmless issues for the 22 public hospitals. This is done as an illustrative example. The issues discussed around the public hospital hold harmless (mechanism and distribution) will generally apply to all three hospital categories, and will require decisions from policymakers will have to make decisions around all of these categories of funding.

**For public hospitals only, what are the available sources of financing and how can they be directed to help achieve a hold harmless?**

Under the 2005 hospital financing waiver, there are three main sources of funding for payments of services provided by public hospitals. While all of these can contribute to fulfilling the hold harmless, not all of the sources can be distributed across hospitals as is needed to hold all hospitals harmless.

- The Safety Net Care Pool is available to be redirected among public hospitals to support the hold harmless. There is currently no distribution formula for the SNCP, so the state is free to design a process that directs these dollars to hospitals needing additional support in order to maintain a hold harmless.
- DSH funding is another source of support. With additional funding available for public hospitals within DSH, there is some logic to creating a new distribution formula. However, if the state maintains the current DSH distribution formula, the dollars would be locked in to their current distribution and therefore not be available for redistribution. The 175% DSH cap payments are a key tool in holding hospitals harmless.
- The per diem payments will be dependant on Medi-Cal spending and the amounts of CPEs generated by the 22 public hospitals. There is no mechanism for the state to direct these funds to different hospitals.

(Note: Some public hospitals (mainly district hospitals) will be paid as if they are private hospitals and will negotiate with CMAC for per diem rates (if they are contracting hospitals), and they will have access to the virtual DSH funds using the state General Fund.)

**For public hospitals, how could a hold harmless be created?**

The question for the state is how to distribute the SNCP funds and the DSH funds to support a hold harmless. Following are three options for distributing these dollars:

- **CMAC** -- Funding decisions would be made by CMAC, as is currently done. Since 1983, CMAC has negotiated contracts with hospitals for Medi-Cal fee-for-service hospital inpatient services statewide and for supplemental payment programs, such as SB 1255 and GME. Under this approach to a hold harmless for public hospitals, CMAC would be responsible for deciding what proportion of SNCP dollars should go to a given hospital. DSH could also be distributed by CMAC. Since per diem payments will be decided by costs, CMAC will likely have no role in decisions there. Supporters say that

CMAC has worked well and should continue in its negotiating capacity. Opponents say that this approach fails to guarantee that each hospital will actually be held harmless.

- **Hard Number/Formula** – Under this option, the state would create a specified number for funding a hospital, and that SNCP and DSH funding would be divided appropriately to fulfill that number. Another option is to create a formula to distribute the funds, dependent on certain variables. Supporters say that a set number is the only way to guarantee that hospitals will receive the support they need. Opponents argue that a hard number approach denies the state (CMAC) the ability to respond effectively to the unique needs of an individual hospital. (With regard to a private hospital hold harmless, opponents argue that there will still be a need to be a negotiated per diem rate and that a hard number approach undermines the state’s ability to keep costs down.)
- **CMAC Bounded** – A third option would be to give CMAC authority over SNCP and/or DSH funds, but then bound that authority by certain factors that will help reduce uncertainty around a hold harmless. The legislature could:
  - *Create a “risk corridor”*: CMAC’s ability to direct funding would be constrained by specific limitations on how much the funding could change from year to year (for example, +/- 3%, allowing for other factors such as changes in operating status). The “corridor” could be set at any desired level, such as no less than -3% and no more than plus 8%.
  - *Legislate specific considerations*: While existing law limits CMAC’s decision-making authority and requires specific items to be considered in making funding decisions, it could be possible to further strengthen and refine the legislative guidance given to CMAC.
  - *Reporting Requirements*: The Legislature could require CMAC to make facts and statistics about the negotiating process available. While such a process could weaken the CMAC’s negotiating strength, it would make for a more open and understandable process.

This approach combines the pros and cons of the first two options, but it still would not give hospitals a hold harmless guarantee.

**For public hospitals, what are the policy trade-offs for implementing hold harmless mechanisms?**

	<b>CMAC - Current System</b>	<b>Hard-Number/Formula</b>	<b>CMAC Bounded</b>
<b>Hospital Guaranteed at least previous years’ funding level</b>	No	Possible - Depends on formula construction (Should be able to guarantee first year)	Moderate – Hospital funding could only move within corridor
<b>Transparent Process</b>	No	Yes – Provides wide understanding of	No – Association with CMAC means opaque

		hospital funding	process
<b>Allows for New Entrants</b>	Yes	Possible - Depends on formula construction	Yes
<b>Predictability in Hospital Funding</b>	No	Some - Even with a formula, there will still be variation	Some – Funding changes limited within a range
<b>Maximizes Ability of State to Contain Hospital Costs through Negotiation</b>	Yes	No – Hospitals protected from negotiating	Limited Negotiating Ability
<b>Allows for Funding Changes in Relation to Hospital Changes (Closure, Patient Volume and Acuity)</b>	Yes	Possible - Depends on formula construction but unlikely to adjust for unforeseen circumstances	Yes

**Does there have to be a hold harmless policy?**

No. The state could instead pursue a policy of county/UC system responsibility, meaning there would be no hold harmless for county/UC system hospitals and each county/UC system would be responsible for maintaining its own funding. Such an approach however would undoubtedly mean reductions in services at some hospitals and possibly closures of others.

**For private hospitals, is there any general guidance on hold harmless?**

Most of this section uses public hospitals as an example of the questions and policies surrounding a hold harmless. With regard to private hospitals, they most likely have sufficient funds to be held harmless in the aggregate. The private hospitals will receive money through CMAC per diem payments and virtual DSH and replacement supplemental payments in an effort to keep them whole. The basic limiting factor will be identifying sufficient non-federal share. Private hospitals would need to be held harmless through statutory provisions.

**Hold harmless funding is only one question, what other funds must be distributed?**

After the hold harmless, there may still be additional dollars available under the 2005 hospital financing waiver to be distributed (sometimes called “growth” or “remainder” dollars). To address this, policymakers will be able to consider all of the mechanisms highlighted in the public hospital hold harmless example (process vs. formula) as tools for distributing any remainder dollars.

- *22 Public Hospitals:* With as much as \$766 million in federal funds devoted to the SNCP every year, it is likely that some of the SNCP dollars will need to be distributed to both public and private hospitals. These SNCP growth funds could then be used to create General Fund savings for use in increasing payments to private hospitals (and potentially other providers associated with the 22 public hospitals.)

- *Private Hospitals:* There will need to be a mechanism for any remaining virtual-DSH funding and replacement supplemental funding to be distributed among private hospitals.
- *Non-CPE Public Hospitals:* These facilities will need replacement supplemental funding distributed to them as well.

Please keep in mind, the distribution system for the hold harmless and for any additional federal funds can be mixed and matched. For example, a formula could be used to guarantee the hold harmless and then a CMAC negotiation process could be used to distribute additional federal funds available.

## **POLICY QUESTION 2: ENSURING AVAILABILITY OF NEEDED CPEs**

### **Are there enough CPEs in the first year of the waiver?**

It is still unknown. Provision 14 of the 2005 waiver Terms and Conditions says that no CPEs will be available until there is a CMS-approved agreement document including, “a description of any use estimates or adjustment factors that will be used to modify actual cost findings.” Absent a final agreement, it is a challenge to know what might be available in terms of CPEs.

However, based on available data and based the accepted understanding of what to expect from CPEs, there should be enough CPEs available for the purposes of hold harmless in the first year to match last year’s spending, plus several hundred million more. However, it seems unlikely that there are currently enough CPEs available to pull down ALL available federal dollars. The waiver allows the state to pay private hospitals at Medicare rates, which would require \$250 million in new state General Fund dollars (CPE cannot be used for a match for private hospitals). 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 hold harmless and cover all hospital costs.

### **Are there enough CPEs in the out years?**

The answer is very unclear. The waiver works using a combination of CPE and IGTs for DSH payments between 100 and 175% 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 enabling more federal funds to be accessed for payment of services provided. On the other hand, with fixed caps on the DSH and SNCP, once these sources are maxed out, hospital funding could fall resulting in service reductions and possibly facility closures.

### **Why can’t a CPE approach guarantee sufficient federal spending?**

Primarily because the federal government could change the definition of CPEs and restrict states’ ability to use them at any time. In fact, there is no certainty of the definition even today.

In addition, the current strategy calls for the state to redistribute CPEs in order to redistribute federal dollars. However, counties have various competing demands and variable fiscal positions. It could be a political challenge for a county to accept that their CPEs are being transferred to benefit counties with fewer CPEs and perhaps a lower commitment to health programs.

**How can the state assure that there is sufficient non-federal match for the hold harmless (whether maintaining spending or maximizing federal dollars)?**

Given the uncertainty about the availability of CPEs, the state can take four approaches:

- County/UC System Maintenance of Effort (MOE)
- General Fund Backfill
- County/UC System Responsibility: Each county/UC System is responsible for its own funding.
- Combination of all three

**What are the issues around requiring an MOE?**

The MOE policy would require counties to maintain their SFY 04/05 spending so that additional CPEs can be transferred by the state to counties that need additional CPEs as part of a hold harmless strategy. As a result, the policy only affects the 22 public hospitals and places no additional burdens on private hospitals (or the non-CPE public hospitals).

- Equity: Some will argue that a MOE requirement is unfair. Why should County A continue to fund health care services only to have the corresponding federal funds shifted to County B who isn't putting in as much funding?
- Future Support: Absent a MOE, counties/UC systems are free to reduce their health care spending, which they may need to do for budget reasons and still continue to get the same level of federal funding. There is no way to predict what might happen as there is no required MOE under the current system. Without an MOE, a county could move from contributing its own CPEs into the health system to relying on another county's CPE.
- Legal Challenge: There is a question if the MOE amounts to a local mandate under Prop 1A for counties, making the mandate unenforceable. The state could be fully liable for the needed General Fund dollars. The MOE approach is a major shift in state/local funding.

**What are the issues around a General Fund backfill?**

Under this approach, the state would guarantee the availability of General Fund dollars as part of achieving hold harmless. In essence, General Fund backfill would amount to a safety blanket, but there are issues requiring consideration:

- Budget: Are sufficient General Funds available? Does this become an ongoing commitment on the resources of the General Fund year after year?
- Amount: How many General Fund dollars would be needed to guarantee a hold harmless or growth in the future?
- Creating a Trigger: Would the General Fund guarantee be assumed to be available in the first instance, or would there need to be CPEs to trigger the dollars? It is possible to set aside these dollars and then find that there is no need for them to achieve hold harmless.

### **What are the issues with a county/UC system responsibility approach?**

Under this approach, no CPE-generated federal funds would be shifted among the public hospitals. However, a “cold turkey” with no CPE rebalancing or no General Fund guarantee could result in hospital closures or reductions of services, depending on the other demands of the county/UC system General Fund. In fact, this approach would be a major shift in the existing state/local funding structure. Some counties/UC systems have more effectively maximized IGTs under the current system, leaving them at a significant disadvantage under this policy approach.

### **How could all three approaches be combined?**

It could be possible to combine aspects of all three approaches. The goal would be to create a system where there eventually be no need to shift dollars among counties. The process would essentially involve the state creating a General Fund reserve and simultaneously implementing an MOE on counties. Essentially, this would offer the protection of a backfill a MOE in the early years of the waiver, and would then phase out over time, promoting county/UC system responsibility. The backfill would be available for use, but the MOE may keep it from being needed.

## **SECTION VI: SUMMARY AND ALTERNATIVES TO THE 2005 HOSPITAL WAIVER**

This section summarizes the waiver's impact and discusses possible alternatives to the waiver.

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

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

In contrast, the 2005 hospital waiver represents a major shift in how California finances hospitals for Medi-Cal and the uninsured. This shift brings significant uncertainty and complexity. While there is some certainty that year 1 of the waiver should be stable, there is no way to know what year 5 will look like in terms of federal spending under the waiver.

### **What is the bottom line on “new” federal money and the waiver?**

While it seems clear that some new federal spending authority exists, more guidance is needed around the identification of CPEs and the right mix of funding from the various state sources to ensure the hold harmless concept. With the new authority, if there is no identifiable source of a legitimate non-federal share to secure the available federal funds, then no new spending can take place. While sufficient CPEs may be available in Year One, there are no guarantees about future years.

The new funding systems increases uncertainty around federal support. For example, SB 1255 was a critical part of the safety net, allowing money to be raised as needed; under the 2005 waiver, public hospitals will only be able to be reimbursed for costs, meaning hospital payments can only grow as spending for Medi-Cal fee-for-service patients increases. However, if the state expands Medi-Cal managed care, then this spending will likely decrease (maybe substantially) over the period of the waiver.

Another characteristic of the waiver is that the federal funding authority seems front loaded in terms of public hospital spending. In Years 1 and 2, SNCP payments made to hospitals eligible to receive 175% DSH in lieu of DSH payments will not be offset against DSH eligible uncompensated care costs for purposes of determining the hospital specific DSH limit – effectively increasing the 175% DSH cap above 175%. This is not true in years 3, 4, and 5. In addition, under the SNCP Coverage Initiative in Years 3, 4, and 5, there is no guarantee that \$180 million otherwise available to hospitals each year will be used for hospital funding.

### **Is the 2005 hospital waiver the “best deal possible”?**

The governor has said that the 2005 waiver is the best waiver deal in the nation. 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. Given the variety of competing policy goals and

perspectives on hospital financing, there is value in talking about at least two of the different perspectives on the waiver.

- ***From the federal perspective, what does waiver accomplish?*** Overall, it seems likely that the waiver will reduce federal Medi-Cal payments over the full five year of the waiver. The waiver also makes inappropriate recycling more difficult for California. 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.
  - Continuing the 2003 SPCP waiver’s policy of capping supplemental payments to hospitals by capping payments under the Safety Net Care Pool.
  - Placing public hospitals into what is essentially a “cost-based” reimbursement system, thereby limiting the funds going to public hospitals.
  
- ***From a public hospital perspective, what does the waiver mean?*** The waiver creates financial uncertainty for public hospitals primarily by limiting the state’s flexibility to determine sources of non-federal match and by capping federal dollars available. Some of the challenges created by the waiver for public hospitals include:
  - Capping public hospital funding (Safety Net Care Pool and DSH) and potentially reducing funding (as in the case of a managed care expansion in Medi-Cal).
  - Creating significant uncertainty in the state’s ability to receive future funding due to the lack of policy dictating use of CPEs.
  - Limiting public hospital growth to increases in hospital costs for Medi-Cal fee-for-service patients, although these costs will likely decline substantially over the period of the waiver.
  - Freezing supplemental payments, a major shift from the payments that have grown over the last 10 years (though it is likely that the UPL cap could have had the same impact absent the waiver).
  - Creating significant uncertainty and funding challenges by eliminating most IGTs, which are legal but seen as unacceptable by the federal government.
  - Limiting payments to public hospitals to costs while not limiting payments to private hospitals in a parallel manner.

With these trade-offs in mind, the waiver negotiation will likely result in additional federal funding being available to California in years 1 and 2 –funding the state would not otherwise have had access too.

**Although there are no obvious financing alternatives to the waiver in the short term, are there longer term options that could be considered?**

Yes, there are several alternatives that could be considered over the long-term. In addition, there are potential improvements to the existing waiver that could be pursued.

## Alternatives

Though each option would face a variety of political challenges and would be challenging to implement, there are alternatives to the waiver.

- **Create a New Permissible Provider Tax** -- California could use a permissible provider tax to generate a significant amount of non-federal funding sources, which in turn would allow California to increase per diem rates and pull down an equally significant amount of federal funds. California could design a new tax, pass implementing legislation, and then withdraw from the Section 1115 waiver when the tax is implemented. California can withdraw from the waiver at any time and without cause. Massachusetts still uses MCO provider taxes to manage the Medicaid program and Missouri has done some expert work in managing a permissible provider tax. Even a 3 percent tax on hospitals could generate significantly more federal revenue than the 2005 hospital waiver. However, regardless of which provider class is taxed (hospitals, insurance companies, doctors), there will be winners and losers.
- **Reinstitute Intergovernmental Transfers** – IGTs continue to be legal, to the extent they are used in the manner intended by Congress and can be used by states. The SPCP and 1115 waiver itself gives CMS leverage over IGTs and as a condition of waiver approval, which is discretionary to CMS; CMS has simply said that IGTs that are used inappropriately are not permitted. If the waiver were terminated, California could likely begin use of acceptable IGTs. Absent the waiver, the process for re-implementation of IGTs could most likely take more than a year and could occur as follows:
  - California submits a Medicaid state plan amendment (SPA) to increase hospital funding using IGTs and indicates intent to terminate the section 1115 waiver when the SPA is approved.
  - CMS will determine California's intent and will have to decide to approve or disapprove the SPA.
  - CMS, as a matter of policy, would likely reject the plan to use IGTs. There are different reasons that CMS could use for the denial. In any event, California could then take CMS first to administrative appeal and then to court.
  - During this appeal, it is possible that CMS could take punitive steps against California to reduce available payments, and thought would need to be given to what those steps could include. Note: Minnesota has an appeal of a denial of an IGT SPA pending and the outcome of this appeal is not yet known (SPA denied about 1 year ago).
- **Straight General Fund** -- Theoretically, California could forget about all the complexity of the 2005 hospital waiver and choose to fund hospitals on a daily bed rate using General Fund dollars. Many states fund public hospitals in this way. Since financing care for the uninsured is such an important part of the waiver, hospital payment rates would have to assume cost-shifting by hospitals from the uninsured to Medi-Cal, which would have a significant impact on spending. Such a shift would require a significant amount of state General Funds.

## Improvements

- **Mine for CPEs** -- As a new concept, it is possible that there are significantly more CPEs available around the state and at the local level than have been realized. If the waiver is going to continue, there may be techniques available for pooling and mining for additional sources of CPEs.
- **Quality Pool – Change Incentives for Hospitals** -- If the waiver continues, the “Coverage Initiative” could be changed to a “Quality Pool.” This approach would use Medi-Cal as a tool to promote quality. It would inherently create an incentive for hospitals to promote the highest quality of care in the most efficient way. Under the current proposal, hospitals are rewarded for spending more rather than providing better care. A quality pool could reward hospitals for being more cost-efficient and demonstrating better health outcomes. Since Medicare is doing extensive work on quality, there is reason to believe that CMS would seriously consider a quality initiative. Policymakers would need to decide which hospitals should be eligible, and a decision could be made to target this to a certain class of hospital, such as DSH hospitals.

### **But once the new hospital financing laws are passed in California, is there any way to pursue another policy?**

If the Legislature wanted to be sure that alternatives are pursued in the future, options exist:

- Include sunset provision in any new law passed;
- Require a study of the impact of the waiver on health care delivery and outcomes; and,
- Create a commission to develop proposals to strengthen the financial position of safety net hospitals.

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