California HealthCare Foundation

Medicaid Hospital Waivers

Comparing California, Florida, and Massachusetts

ISSUE BRIEF

April 2006

Introduction

In 2005, the State of California fundamentally altered the way it pays hospitals for treating Medi-Cal patients. The changes, which took effect on September 1 and have a term of five years, were made under the authority of a federal waiver involving several billion dollars in federal funds. Implementation of the waiver will 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 has negotiated this type of waiver with the federal government involving Medicaid financing of hospital care.[1] The Centers for Medicare and 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 2005, CMS reported that 26 states had revised their Medicaid financing arrangements to address its objections.[2] Among these states are Florida and Massachusetts, which face similar implementation issues as California.

The purpose of this issue brief, which compares the California waiver to the Florida and Massachusetts waivers, is to assist California policymakers in understanding the major implementation issues they face in the first year of the waiver. In particular, the brief will focus on the issue of what funds California is allowed to use (or certify) as state match and how the federal funds in the Safety Net Care Pool established under the waiver are to be deployed. Because all three states are negotiating these issues with CMS, the resolution of an issue in California may well serve as precedent for the resolution of that issue in Florida or Massachusetts, and vice versa.

Florida and Massachusetts were selected because each state's waiver contains important policy precedents regarding Medicaid hospital financing; each waiver was negotiated during 2005, giving a reasonably current picture of CMS policy; and the results of the negotiations are in writing and available to the public.[3] An earlier draft version of this issue brief, completed in August 2005, compared California, Massachusetts, and Iowa.[4] Two months later, Florida received a Medicaid waiver that includes a large hospital financing pool similar to the Safety Net Care Pool in the California and Massachusetts waivers. Because of the size of the Florida Medicaid program—it ranked fifth in total Medicaid spending and sixth in Medicaid inpatient hospital spending in FY 2004[5]—and because the Iowa waiver does not include a Safety Net Care Pool, this brief focuses on Florida.

It is not the purpose of this issue 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. Furthermore, the intent of this comparison is

limited to a careful review of the "terms and conditions" documents for each waiver. Many details of Federal Medicaid waivers are not reflected in a "terms and conditions" document, and time constraints prevented capturing that additional information here. As a result, the comparison does not present a complete picture of any of the waivers.

The California waiver is enormously complex, with hundreds of moving parts. Although Florida and Massachusetts are smaller states with smaller Medicaid programs — California accounted for 10.8 percent of national Medicaid spending in FY 2004, compared with 4.5 percent for Florida and 3.1 percent for Massachusetts (and 0.8 percent for Iowa) — their waivers are highly complex as well.

This issue brief begins with an overview of each state's waiver and provides a comparison of the three waivers in Table 1. The next sections provide additional detail, including a side-by-side comparison of the Special Terms and Conditions (STCs) for all three waivers in Table 2. The paper then concludes with a brief discussion of open issues in Table 3.

Overview

California's new five-year waiver, known as a "section 1115" waiver for the part of the Social Security Act that authorizes it, replaces the state's longstanding Selective Provider Contracting Program (SPCP) waiver under section 1915(b). 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.

Medicaid waivers enable states to receive federal Medicaid matching funds without complying with all of the usual requirements set forth in the federal Medicaid statute. Waivers, including 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 the federal Medicaid statute as costs in which the federal government will participate. These waivers are to be "budget neutral," so that federal spending under the waiver is no greater than federal spending in the absence of the waiver. Finally, the Secretary of Health and Human Services (HHS) has complete discretion in granting 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.

Florida was granted a five-year section 1115 waiver by CMS on October 19, 2005, and the state's legislature approved the waiver in December 2005.[6] Implementation is scheduled to begin on July 1, 2006 in two counties, Broward and Duval, and is to be extended to all Florida counties in by 2010. The waiver allows the state to require most categories of Medicaid beneficiaries to enroll in private "Medicaid Reform Plans," which will have the flexibility to provide "customized" benefit packages that have a maximum per-year benefit limit. Beneficiaries will be also be able to opt out of Medicaid to enroll in an employer-sponsored insurance program.[7] Of relevance to the California waiver, the Florida waiver requires the state to end its supplemental payment program

to hospitals and establishes a Low-Income Pool that will make a fixed amount of federal funds available to pay for uncompensated medical care costs incurred by providers serving the uninsured.

Massachusetts has been operating a section 1115 Medicaid demonstration waiver known as MassHealth since 1997. The waiver was scheduled to expire on 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 intergovernmental transfers that the state had previously used as non-federal share and replaces them with certified public expenditures. It also establishes a Safety Net Care Pool (SNCP) to enable the state to pay for services to the uninsured and unreimbursed Medicaid costs.[8] If the state can raise the non-federal share under the new requirements, the SNCP will provide an estimated $650 million in federal funds per year (from disproportionate share hospitals and other existing sources). The waiver offers new flexibility in distributing these funds; for example, the hospital funds no longer have to be used for hospitals only. This funding pool has been cited as one of several building blocks for universal coverage in Massachusetts.[9]

Table 1 summarizes the three states' waivers.

Disproportionate-Share Hospital (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.[10] For hospitals treating high volumes of such patients, these disproportionate-share

Table 1. Medicaid Section 1115 Hospital Financing Waivers: Summary Comparison

	CALIFORNIA Medi-Cal Hospital Financing/Uninsured Care Demonstration Special Terms and Conditions August 31, 2005	FLORIDA Florida Medicaid Reform Section 1115 Demonstration Special Terms and Conditions October 19, 2005	MASSACHUSETTS MassHealth Special Terms and Conditions January 26, 2005
Overview	Five-year restructuring of supplemental payments to hospitals for Medicaid and uninsured costs; change source of non-federal share; establish new pool for care of uninsured	Five-year restructuring of Medicaid from a defined benefit to a defined contribution program; establish new funding pool for care of uninsured	Thee-year extension to cover uninsured; establish new pool for care of uninsured by providers or insurance; change source of non-federal share
Changes in DSH program?	Yes (for both public and private hospitals)	No	Yes
Creates Safety Net Care Pool (SNCP)?	Yes (federal funds capped at same level each year)	Yes (called the Low Income Pool; federal funds capped at same level each year)	Yes (federal funds capped at same level each year)
Limits on use of IGTs as non-federal share?	Yes	Yes	Yes
Specifies use of CPEs?	Yes	No	Yes
New limits on use of provider tax?	Yes (hospital, outpatient, or physician services)	No	No
"Recycling" specifically prohibited?	Yes	No	No
Cost limits on payments to individual public providers?	Yes	Yes	No

hospital 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. 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.[11] 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

- **California waiver.** Restructures the state's program generally by limiting DSH payments to 22 designated public hospitals and district hospitals, while private DSH hospitals would largely receive DSH replacement payments through other mechanisms (called the "DSH swap"). The waiver does not affect California's state-specific allotment of federal DSH funds or the 175 percent limit on payments to public hospitals.
- **Florida waiver.** Does not expressly modify the state's DSH program.
- **Massachusetts waiver renewal.** Folds that state's DSH program into the new Safety Net Care Pool (SNCP), thereby capping the state's DSH allotment for the life of the waiver.

Intergovernmental Transfers

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.[12] 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.[13]

Changes to IGTs

- **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 these transfers to fund its share of payments to private hospitals, but they must come from local governments and not public 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.
- **Florida waiver.** Prior to implementation of demonstration on July 1, 2006, the state must terminate current inpatient supplemental payment upper payment limit (UPL) program, which involves IGT financing. CMS must approve all sources of non-Federal share funding to be used to make use of federal funds in the Low-Income Pool.
- **Massachusetts waiver renewal.** 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.

Certified Public Expenditures

Federal Medicaid law and regulation authorize the use of certified public expenditures (CPEs) as the non-federal share of Medicaid spending.[14] 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 could then use the amount of costs certified by the county hospital as the non-federal share for purposes of claiming federal matching funds for payment to hospitals. 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

- **California waiver.** Specifies that the state may use CPEs of 22 designated public hospitals as the non-federal share for purposes of drawing down federal inpatient Medi-Cal per diem payments, DSH funds, and funds from the Safety Net Care Pool. These CPEs replace IGTs from these facilities for most purposes. While the exact methodology is under negotiation with the federal government, CPEs are to be calculated using costs reported on the Medicare CMS-2552-96 hospital cost report. The waiver requires that CMS approve a protocol specifying the methodology for calculating CPEs, which was done in early 2006.
- **Florida 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 share of funding are subject to CMS approval.
- **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.

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.[15] The conference report on the Deficit Reduction Act of 2005 H. Rept. 109-362 does not include the proposed CMS change.

Recycling Changes

- **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.
- **Florida waiver.** STCs do not address this issue.
- **Massachusetts waiver renewal.** STCs do not address this issue.

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).[16] 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 payments that may be made to hospitals owned or operated by the government. These include a spending cap specified in the 2003 SPCP waiver, the aggregate UPL cap, and the facility-specific 175 percent 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.[17] The conference report on the Deficit Reduction Act of 2005 H. Rept. 109-362 does not include the proposed CMS change.

Provider Payment Provisions

- **California waiver.** Reimbursement to the 22 designated public hospitals identified in the waiver will be based on allowable Medicaid inpatient hospital costs to be calculated under the Medicare 2552-96 cost report.
- **Florida waiver.** Requires submission of a State Plan Amendment limiting inpatient hospital payment for patients who are eligible for Medicaid to the costs of caring for those individuals as reported on the CMS 2552-96.
- **Massachusetts waiver renewal.** Contains no provisions limiting payments to individual government hospitals to cost.

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.[18] 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.[19] The Deficit Reduction Act of 2005 currently includes a change in the current criteria for taxes that can permissibly be imposed on managed care plans.

Changes in Provider Taxes

- **California waiver.** Prohibits the state from imposing an otherwise permissible tax on inpatient hospital, outpatient, or physician services during the five-year term of the demonstration. California would not be precluded from imposing taxes on other classes of providers, or on managed care organizations.
- **Florida waiver.** Does not prohibit the state from imposing permissible taxes on any provider class for purposes of raising revenues to fund Medicaid.
- **Massachusetts waiver renewal.** Does not prohibit the state from imposing permissible taxes on any provider class for purposes of raising revenues to fund Medicaid.

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 for purchasing 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

- **California waiver.** Establishes an annual allotment of $766 million in federal matching funds, called a Safety Net Care Pool (SNCP), which the state can use to pay for the costs of treating the uninsured. California has broad discretion in using federal SNCP funds, but these dollars only become available after the state provides non-federal 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," involving the mandatory enrollment of elderly and disabled beneficiaries in managed care. 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 count in the calculation of the facility-specific 175 percent DSH cap. For the remainder of the waiver, SNCP payments will count in the calculation of each facility's 175 percent DSH cap.

- **Florida waiver.** Establishes a Low-Income Pool (LIP) with an annual allotment of $1 billion in total expenditures (federal and state) for health care costs incurred by the state, hospitals, clinics, or other provider types in caring for the uninsured. At Florida's current 59 percent federal match rate, the state can draw down $590 million per year from the LIP, but only if its source of non-Federal funds is acceptable to CMS. CPEs are neither specified nor precluded as such a source. Federal funds available to the state in the LIP are capped at the same amount for each year of the waiver renewal regardless of increases (or decreases) in the number of uninsured. Florida may use 10 percent of the LIP funds for hospital expenditures other than services to the uninsured, such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, and rural, pediatric, teaching or specialty hospital services.

- **Massachusetts waiver renewal.** Establishes a Safety Net Care Pool for the purpose of reducing the ranks of the uninsured. The SNCP consists of total federal and state expenditures of up to $1.23 billion per year (projected) for each of the remaining three years of the waiver. At the current Massachusetts matching rate of 50 percent, this would enable the state to access $615 million in federal matching funds per year if the state's source of non-federal funds is acceptable to CMS. CPEs are neither specified nor precluded as such a source. Unlike the California SNCP and the Florida LIP, the Massachusetts SNCP includes the state's annual DSH allotment. Because total expenditures in the SNCP are capped at the same amount each year, 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 percent of the SNCP funds for capacity building and infrastructure.

Table 2 provides a detailed comparison of the Terms and Conditions for all three states.

Table 2. Medicaid Section 1115 Hospital Financing Waivers: Selected Federal and State Financing Issues

	CALIFORNIA Special Terms and Conditions August 31, 2005	FLORIDA Special Terms and Conditions October 19, 2005	MASSACHUSETTS Special Terms and Conditions January 26, 2005
Overview	Establishes new five-year Medi-Cal Hospital/Uninsured Care 1115 demonstration approved beginning September 1, 2005.	Establishes new five-year Medicaid Reform Section 1115 Demonstration approved beginning July 1, 2006.	Renews eight-year-old MassHealth 1115 demonstration approved beginning July 1, 2005 for three years.
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 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.	Converts Medicaid from defined benefit to defined contribution program; does not revise state DSH program; creates a Low-Income Pool (LIP); terminates supplemental inpatient hospital payment UPL program; does not prohibit new provider taxes during demonstration.	Extends coverage to various populations of low-income adults ages 19 to 64 for an additional three years, beginning July 1, 2005; converts state's DSH allotment and certain supplemental payments 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.
Dis-proportionate Share Hospital (DSH) Payments			
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) The state shall submit a SPA creating "A defined DSH pool available for payments to private hospitals" to extent necessary under federal law. (30c)	No specification.	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, 6a)
DSH-equivalent Payments to Private Hospitals	"Replacement program payments… will be satisfied through a new supplemental payment for Medicaid inpatient hospital services provided to Medicaid-eligible individuals not enrolled in managed care." (23b) And payments, "shall not exceed, in the aggregate, the upper payment limit for private hospitals established under CMS regulations." (23b)	No specification.	No specification.
Sources of Non-federal Matching Funds	The non-federal share of DSH payments to public hospitals in amounts up to 100 percent of uncompensated Medicaid and uninsured costs may be based on CPEs from 22 specified public hospitals or on state general funds; above 100 percent, on IGTs (under federal statute, DSH payments in California can equal 175 percent of a hospital's uncompensated Medicaid and uninsured costs). (30b, 31)	No specification.	No specification.
Immigrant Uses	DSH payments can be made for "costs associated with non-emergency services rendered to unqualified aliens." (30b)	No specification.	No specification.

Table 2. Medicaid Section 1115 Hospital Financing Waivers: Selected Federal and State Financing Issues, cont.

	CALIFORNIA Special Terms and Conditions August 31, 2005	FLORIDA Special Terms and Conditions October 19, 2005	MASSACHUSETTS Special Terms and Conditions January 26, 2005
Inter-governmental Transfers (IGTs)			
Phase-out as Non-federal Share of Medicaid Spending	Effective July 1, 2005, IGTs may no longer be used as the non-federal share of DSH payments to public hospitals at or below 100 percent of uncompensated Medicaid and uninsured costs. (30a) IGTs may continue to be used as non-federal share of DSH payments to public hospitals above 100 percent of uncompensated Medicaid and uninsured costs. (31)	IGTs not expressly referenced, but state is required to terminate, by July 1, 2006, its existing supplemental payment upper payment limit (UPL) program, which involves IGTs, if it wants access to LIP funds (XVI. 100b)	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, 6h) 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, 6e)
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)			
Definition as Non-federal Share of Medicaid Spending	The methodology for calculating CPEs is to be specified in a Protocol subject to approval by CMS (14). 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)	No specification.	"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)
Immigration Uses	CPEs shall be based upon, "Medicaid eligible costs incurred by [public] facilities in providing health care services to Medi-Cal eligible beneficiaries." (26g)	No specification.	No specification.
Prohibitions Against "Recycling" of Payments to Providers	Every public hospital must "retain the full amount of the [DSH] 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) Public hospitals receiving DSH payments, "will provide annual assurances that any transfer of funds from a government-operated hospital or related governmental unit or entity will be no greater than the non-Federal portion of the payment funded by the intergovernmental transfer." (31b)	No specification.	No specification.

Table 2. Medicaid Section 1115 Hospital Financing Waivers: Selected Federal and State Financing Issues, cont.

	CALIFORNIA Special Terms and Conditions August 31, 2005	FLORIDA Special Terms and Conditions October 19, 2005	MASSACHUSETTS Special Terms and Conditions January 26, 2005
Certified Public Expenditures (CPEs), cont.			
Prohibitions Against "Recycling" of Payments to Providers, cont.	"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)		
New Limits on Payments to Individual Public Providers	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) Existing aggregate upper payment limits (UPLs) continue to apply.	State must submit a State Plan Amendment "limiting inpatient hospital payment for Medicaid eligibles to Medicaid cost as defined in the CMS 2552-96." (XVI. 100c) Hospital cost expenditures from LIP will be paid at cost "utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs." (XV. 97)	No new limitation on amount of payments to individual public providers (existing aggregate upper payment limits (UPLs) continue to apply).
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)	No specification.	"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, 6e)
Safety Net Care Pool (SNCP)			
Definition	SNCP established "to ensure continued government support 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)	Low-Income Pool (LIP) established for health care expenditures "incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured." Funds may be used for "premium payments, payments for provider access systems, and insurance products for such services provided to otherwise uninsured individuals." (XV. 94) "Provider access system" is "providers with access to the LIP and services funded from the LIP." (XVI. 101)	SNCP established for the purpose of reducing the uninsured population 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."
Purposes and Uses	No specification.	Up to 10 percent of LIS available for capacity building and infrastructure, hospital trauma and neonatal services, and rural, pediatric, and teaching or specialty hospital services. (XV. 96)	Up to 10 percent of SNCP available for "capacity building and infrastructure." (Attachment B, 6d)
Immigration Uses	SNCP funds "cannot be used for costs associated with the provision of non-emergency care to unqualified aliens," defined as "17.79 percent of total provider expenditures or claims for services to uninsured individuals." (37)	LIP funds "cannot be used for costs associated with the provision of health care to non-qualified aliens." (XV. 95)	No specification.

Table 2. Medicaid Section 1115 Hospital Financing Waivers: Selected Federal and State Financing Issues, cont.

	CALIFORNIA Special Terms and Conditions August 31, 2005	FLORIDA Special Terms and Conditions October 19, 2005	MASSACHUSETTS Special Terms and Conditions January 26, 2005
Safety Net Care Pool (SNCP), cont.			
Available Funds	Maximum SNCP amount will be $766 million in federal funds each year of the waiver. (Attachment B) In years 1 and 2, $180 million per year is conditioned on expanding managed care enrollment. (41) In years 3 to 5, $180 million per year must be used on Coverage Initiative to be specified, "that will expand coverage options for individuals currently uninsured." (42)	LIP amount is a capped annual allotment of $1 billion "total computable" expenditures for each year of 5-year demonstration period. (XV. 91). Federal share of annual $1 billion determined by state's federal matching rate for the year.	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 in total computable expenditures). (Attachment B, 6a). Federal share of annual $1.23 billion determined by state's federal matching rate for the year (50 percent in FY 2006).
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) In the event there are not enough CPEs CMS must review and approve any alternate sources. (38)	State "shall not have access to [LIP] funds until the source of non-Federal share has been approved by CMS." (XV. 99)	"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 approval from CMS." (Attachment B, 6f)

Open Issues

The special terms and conditions for the California waiver do not resolve all of the issues between the state and CMS relating to the financing of hospital services. In particular, they do not specify a working definition for the CPEs that the state can use to claim federal matching funds, nor does it specify how SNCP funds will be used to fund a Healthcare Coverage Initiative. Progress on these issues continues outside of the waiver. As shown in Table 3 on the next page, parallel issues remain open in the Florida and Massachusetts waivers as well. If Florida is to meet its scheduled July 1, 2006 implementation date, and if Massachusetts is to begin full implementation of its SNCP as scheduled on July 1, 2006, these issues will have to be resolved during the next few months. California policymakers may wish to consider coordinating their negotiations with CMS on these issues with policymakers in the other two states.

About the Authors

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Table 3. Medicaid Section 1115 Hospital Financing Waivers: Open Issues

	CALIFORNIA Special Terms and Conditions August 31, 2005	FLORIDA Special Terms and Conditions October 19, 2005	MASSACHUSETTS Special Terms and Conditions January 26, 2005
Sources of Non-federal Funds			
CPEs	"Procedures and methodologies" to be used to determine costs eligible for federal matching through CPEs to be set forth in a Funding and Reimbursement Protocol, which must be "completed and approved by CMS prior to the state claiming any federal matching funds associated with certified public expenditures." (14)	No specification.	"To the extent that the Commonwealth desires to utilize the CPE mechanism for services not reflected on the CMS-2552, CMS must approve the cost reporting vehicle for which the Commonwealth would certify such costs as eligible for FFP, prior to Federal matching of any such costs." (Attachment A. 4)
Access to Federal SNCP Funds	State can use CPEs from governmentally-operated entities to access federal SNCP funds. (36). If such CPEs are insufficient to access all available SNCP funds and fully utilize California's DSH allotment, state must propose "alternate legitimate funding mechanisms," subject to CMS review and approval. (38)	Four months prior to implementation (scheduled for July 1, 2006), state must submit for CMS approval the source of non-Federal share used to access federal funds in the Low-Income Pool. (VI. 99)	"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 approval from CMS." (Attachment B, 6f)
Use of SNCP Pool Funds	The costs of hospital and non-hospital based services paid from SNCP funds are to be defined in the Reimbursement and Funding Protocol described above. (39) $180 million in SNCP funds in years 3, 4, and 5 is reserved for a Coverage Initiative to "expand coverage options for individuals currently uninsured." The state must submit to CMS 1) a concept paper on the Coverage Initiative by January 31, 2006 and 2) a waiver amendment on the structure, eligibility and benefits for the Coverage Initiative by September 1, 2006. (44)	State must submit to CMS a "Reimbursement and Funding Methodology" document for LIP expenditures and LIP parameters defining state authorized expenditures from the LIP and entities eligible to receive reimbursement." (XV. 93.) CMS must approve the document prior to implementation. (XVI. 100a)	Payments from the SNCP may be used for unreimbursed Medicaid costs; inpatient and outpatient hospital and non-hospital expenditures for the uninsured/SNCP population; infrastructure expenditures (subject to a 10 percent cap); and "any expenditures related to new insurance products that may be developed by Massachusetts and approved by CMS." (Attachment B, 6d)

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Endnotes

1. California was granted a waiver under section 1115 for the Social Security Act. For purposes of this brief, all references to waiver are to those granted under section 1115 unless otherwise specified.
2. Testimony of Dennis Smith, Center for Medicaid and State Operations, Senate Finance Committee Hearings on Medicaid Fraud and Abuse (June 28, 2005), p. 3.
3. The Special Terms and Conditions for each waiver are posted on the CMS website under "Medicaid Waiver and Demonstrations List," **www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp**.
4. Schneider and Harbage, *The 3 Waivers: Medicaid Hospital Financing in California, Iowa, and Massachusetts* (August 23, 2005), **www.cahpf.org/doc.asp?id=65**.
5. Kaiser Commission on Medicaid and the Uninsured, State Health Facts Online, **www.statehealthfacts.org**.
6. Materials on the Florida waiver, including the Special Terms and Conditions, are posted on the CMS website at **www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp**.
7. For an explanation of the Florida waiver, see Winter Park Health Foundation Policy Brief, *Understanding Florida's Medicaid Waiver Application* (September 2005), **www.wphf.org**; Kaiser Commission on Medicaid and the Uninsured, *Florida Medicaid Waiver: Key Program Changes and Issues* (December 2005), **www.kff.org/medicaid/upload/7443.pdf**.
8. For a more detailed discussion of the waiver renewal see Massachusetts Medicaid Policy Institute, *The MassHealth Waiver* (April 2005), **www.massmedicaid.org/briefs.html**.
9. Blumberg et al., *Building the Roadmap to Coverage: Policy Choices and the Cost and Coverage Implications* (June 2005), pp. 10, 14, **www.roadmaptocoverage.org**.
10. Section 1902(a)(13)(A)(iv) of the Social Security Act, 42 U.S.C. 1396a(a)(13)(A)(iv).
11. 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).
12. Section 1903(w)(6) of the Social Security Act, 42 U.S.C. 1396b(w)(6); 42 CFR 433.51(b).
13. Testimony of Dennis Smith, June 28, 2005, p. 4.
14. Section 1903(w)(6) of the Social Security Act, 42 U.S.C. 1396b(w)(6); 42 CFR 433.51(b).
15. Testimony of Dennis Smith, June 28, 2005, p. 4.
16. 42 CFR 447.272
17. 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 five years.
18. Section 1903(w) of the Social Security Act, 42 U.S.C. 1396b(w), 42 CFR 433.50 et seq.
19. 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 five years.