



# Medicaid Section 1115 Demonstration Waivers: Comparing California, Massachusetts, and New York

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## Introduction

California's Medi-Cal Hospital Uninsured Care 1115 waiver, which took effect on July 1, 2005 and expires on August 31, 2010, fundamentally altered the way Medi-Cal pays hospitals and provided \$180 million in federal funds for each of three years to provide coverage for low-income uninsured individuals. These changes were made under the authority of Section 1115 of the Social Security Act, which permits the federal government to waive certain Medicaid statutory requirements and allows states to receive federal matching funds for Medicaid services that would otherwise not be eligible for federal funding. The Medi-Cal Hospital Uninsured Care waiver involves several billion dollars in federal funds and is reshaping health services for low-income Californians, the hospitals that serve them, state and county budgets, and California's health care economy.

This fall, state officials are expected to submit a concept paper to the federal government describing the desired goals and features of a renewal of the waiver. The concept paper is an important step toward ensuring that California is able to renew its waiver before the current waiver expires, and initiating discussions with federal officials regarding the future of the coverage expansion provisions of the waiver before an enrollment freeze begins on March 1, 2010. State policy makers are considering a range of possibilities for a renewed waiver, including altering the structure of the current waiver, which directs significant federal funds to safety-net hospitals but provides limited funding to cover

the uninsured, towards a more comprehensive waiver that promotes expansion of coverage to the uninsured and access to better coordinated care for Medicaid beneficiaries.

This issue brief compares California's waiver to the 1115 waivers of two states with innovative and more comprehensive waivers: Massachusetts and New York. Massachusetts illustrates how a state has used the 1115 waiver to substantially expand Medicaid coverage to the uninsured and attain nearly universal coverage. New York has also used its waiver to reorient the state's health care spending away from inpatient facilities towards delivery systems focused on outpatient and primary care.

Although these states are different from California in important ways (see Table 1 on page 2), the goal of this brief is to learn how these states are using 1115 waivers to achieve a range of program goals, and to present a broad range of possibilities to California's policymakers and stakeholders as the state moves forward to renew its waiver.

Following a summary of key findings, this issue brief examines the three states' 1115 waivers, including descriptions of each waiver's purpose and key provisions. The final two sections of the brief discuss the key similarities and differences among the three waivers, and consider future possibilities for California's waiver.

**Table 1. Key State Characteristics, 2006–2007**

	CA	MA	NY
Population*	36.2 million	6.3 million	19.0 million
Uninsured Rate*	18.5%	7.9%	13.6%
<b>Medicaid</b>			
Enrollment†	6.4 million	1.0 million	4.1 million
Expenditures‡	\$36.0 billion	\$10.3 billion	\$44.3 billion
Spending per Enrollee§	\$4,528	\$8,300	\$9,656

Sources: Kaiser Family Foundation, [www.statehealthfacts.org](http://www.statehealthfacts.org), based on analysis of Medicaid enrollment and expenditure data from the Center for Medicare and Medicaid Services, and of population and health insurance coverage data from the Census Bureau's Current Population Survey. California HealthCare Foundation, *Medi-Cal Facts and Figures*, September 2009.

\*Two-year average of 2006 and 2007.

†As of December 2006.

‡Federal Fiscal Year 2007 (October 1, 2006 through September 30, 2007).

§Federal Fiscal Year 2006; excludes payments that are not allocated to beneficiaries, such as disproportionate share hospital payments and administrative expenditures.

## Key Findings

An evaluation and comparison of the 1115 waivers of California, Massachusetts, and New York yield the following key findings:

- The waivers in California and Massachusetts both phase out the use of most Intergovernmental Transfers (IGTs) as a source for the non-federal share of Medicaid expenditures. This shift stems from IGT payments coming under scrutiny by the Center for Medicare and Medicaid Services (CMS).
- While all three waivers allow states to use certified public expenditures (CPEs) as the non-federal share of Medicaid expenditures, only California has used CPEs as the major source of funds for Medicaid hospital payments.
- Both California and Massachusetts established Safety Net Care Pools, which allow federal funds to be used to pay for the cost of covering populations or services not otherwise eligible for federal matching funds under Medicaid.
- Massachusetts and New York, unlike California, used savings associated with expansions of Medicaid

managed care to achieve budget neutrality while financing the cost of expanding Medicaid coverage to the uninsured or services not otherwise eligible for federal matching funds.

- Both Massachusetts and New York, unlike California, negotiated waivers that allow federal payments to grow over time, versus an absolute cap on federal participation.

While California lawmakers have expressed an interest in pursuing a more comprehensive waiver like those in Massachusetts and New York, doing so is complicated by the state's budget crisis, the peculiar incentives created by CPEs, federal health care reform proposals that may significantly alter Medicaid policy and funding streams, and uncertainty about whether or not CMS will allow California to use hospital taxes to generate non-federal matching funds.

Moreover, Massachusetts and New York have distinct advantages over California when it comes to identifying federal savings that can be re-invested elsewhere through an 1115 waiver. One is that Medicaid spending per enrollee in New York and in Massachusetts is among the highest in the nation, whereas California spends less per enrollee than any other state. It is much easier for high-cost states to reduce their spending and use these program savings to finance coverage expansions or other program improvements than it is for states like California that have already achieved significant Medicaid savings.

In addition, the federal government's contribution to help states offset indigent care costs is two to three times higher per resident in Massachusetts and New York than it is in California, despite the fact that a larger share of California's population is uninsured. The higher allotments for Massachusetts and New York (on a per resident basis), give these states an advantage over California in terms of funding indigent care or leveraging these funds to expand coverage to the uninsured.

## Section 1115 Demonstration Projects

Section 1115 of the Social Security Act provides the Secretary of the U.S. Department of Health and Human Services (HHS) broad discretion to authorize demonstration projects likely to assist in promoting Medicaid objectives. These projects are intended to demonstrate and evaluate a new idea or policy that has not been demonstrated on a widespread basis. Examples include expanding eligibility to individuals not otherwise eligible under the Medicaid program, providing services that are not typically covered, or using innovative service delivery systems.<sup>1</sup>

Section 1115 waivers (and other 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.<sup>2</sup> They also allow states to receive federal matching funds for “costs not otherwise matchable” (e.g., costs to serve populations or provide services that would not otherwise qualify under federal statute for federal matching funds). Section 1115 projects are generally approved to operate for five-year periods, and states may submit renewal requests to continue the projects for additional periods of time.

Medicaid waiver programs must be “budget neutral” to the federal government over the life of the waiver program. To meet the budget neutrality test, estimated federal spending under the waiver cannot exceed the estimated federal spending of the state’s existing Medicaid program under current law and program requirements. For example, federal expenditures associated with expanding coverage to a population not already covered under the state’s Medicaid program must be offset by reductions elsewhere within the Medicaid program. Several common methods used by states to generate cost savings for the waiver component include moving part of the Medicaid population into managed care; redirecting certain health care provider payments to provide health care coverage; limiting benefit packages for certain eligibility groups; providing targeted services to certain ineligible individuals to divert them from qualifying for full Medicaid coverage; and using cost sharing to reduce the amounts the federal government must pay.

## California: Medi-Cal Hospital Uninsured Care Waiver

In 2005, California received approval from the CMS for its Medi-Cal Hospital Uninsured Care 1115 Waiver.<sup>3</sup>

The purpose of this waiver was to replace financing arrangements deemed inappropriate by the CMS, retain federal funding that had been provided under another 1115 waiver for Los Angeles County, and fund initiatives to expand coverage for the uninsured.

The waiver imposed new limitations on Medi-Cal payments to hospitals, and dramatically changed how Medi-Cal reimburses a subset of “designated public hospitals” for the costs of caring for Medi-Cal patients and the uninsured.<sup>4</sup> It also provided \$766 million annually in federal funds to a Safety Net Care Pool to maintain funding for the state’s safety-net hospitals and to fund the cost of care to the uninsured. This included \$180 million per year for a three-year Health Care Coverage Initiative to expand health care coverage for low-income uninsured individuals in ten counties.

The following subsections discuss the key elements of California’s waiver in more detail.

### Phase-Out of IGTs

When California’s 1115 waiver came up for renewal in 2005, the urgent issue was to identify a source of funds other than Intergovernmental Transfers (IGTs) as the non-federal share of Medi-Cal payments to hospitals. 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). Historically, California relied heavily on IGTs from counties and the University of California to fund the non-federal share of its DSH program and hospital supplemental payment programs. California also uses IGTs to fund, in part, other programs such as the In-Home Supportive Services Program.

Although IGTs are legal,<sup>5</sup> they came under increasing federal scrutiny when, in 2003, CMS began an initiative

## Disproportionate Share Hospital (DSH) and Other Supplemental Payments

Federal Medicaid law requires states to make payments to public and private hospitals that serve a “disproportionate share” of Medicaid and uninsured patients.<sup>6</sup> These payments, known as “disproportionate share hospital payments” or DSH payments, supplement standard Medicaid payment rates. Medicaid law does not, however, provide federal matching funds for treating the uninsured at facilities other than disproportionate share hospitals, nor does it provide matching funds for providing coverage to those otherwise ineligible for Medicaid, or for purchasing (or subsidizing) private or other public coverage for uninsured citizens.

The amount of federal matching funds available for these DSH payments is subject to a statewide limit on total DSH payments and also to a facility-specific limit. In all states but California, federal law establishes the maximum DSH payment for an individual hospital as the difference between (1) the hospital’s inpatient and outpatient costs of treating Medicaid enrollees and the uninsured, and (2) the amounts the hospital receives from Medicaid (other than DSH) reimbursements and out-of-pocket payments from uninsured patients. In California, by federal law, DSH payments for most public hospitals may equal up to 175 percent of the difference between costs and reimbursement.<sup>7</sup>

In addition to DSH payments (which are the only Medicaid payments that directly cover the costs of providing health care to uninsured patients, including undocumented immigrants), states may make additional Medicaid supplemental payments to hospitals, nursing homes, and other institutional providers up to a federally designated “upper payment limit” (UPL).<sup>8</sup> 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. The UPL is set at the estimated amount all the hospitals in each group would receive for treating Medicaid patients if they were paid at Medicare rates.

States may also increase funding to hospitals or other providers indirectly by making supplemental Medicaid payments to managed care plans, which in turn increase reimbursements to hospitals. Medicaid rates paid to managed care plans must be actuarially based. Payments to hospitals by managed care plans do not fall within federal UPL rules, but they are considered when calculating each hospital’s maximum DSH payment.

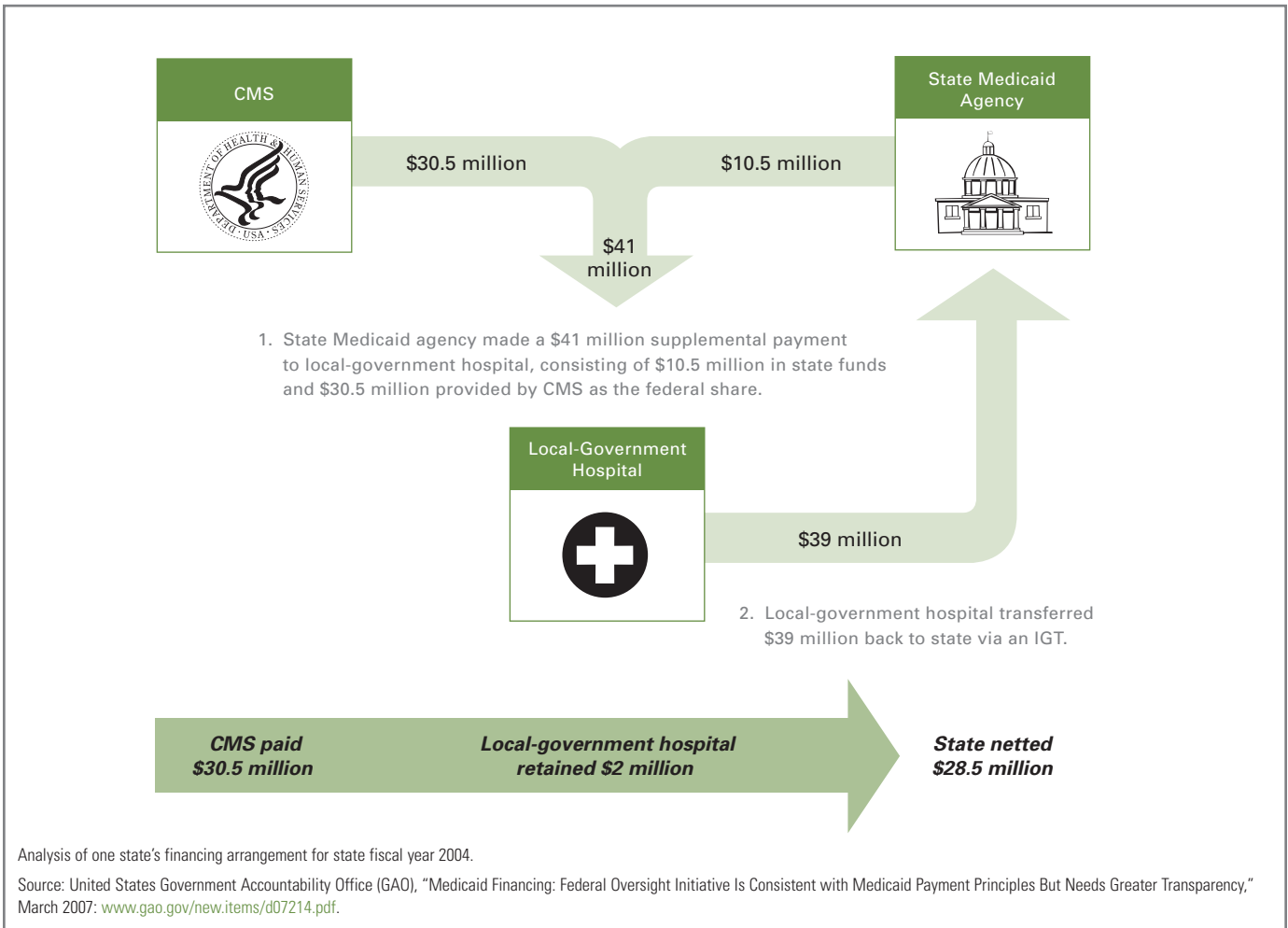
to determine the extent to which states had Medicaid financing arrangements that enabled a state to draw federal matching funds without actually expending state or local funds as the non-federal share of Medicaid expenditures. As illustrated in Figure 1, some of these arrangements netted states millions of dollars. CMS was mostly concerned with certain supplemental payments to government-owned providers such as county hospitals for which the providers returned all or a portion of the supplemental payment to the state. Other cases involved providers receiving Medicaid payments in excess of their actual costs for providing medical services and returning those funds to a state or local governmental entity.

By 2007, faced with the threat of losing federal matching funds, 29 states terminated 55 Medicaid financing arrangements that CMS considered inappropriate. Most states sought to implement these changes through

their state plan amendment processes. California, Massachusetts, and New York, among others, chose the Section 1115 waiver process to address issues with their financing arrangements.<sup>9</sup>

Under the terms of the 2005 California waiver, IGTs may be used only to fund the non-federal share of disproportionate share hospital (DSH) payments between 100 and 175 percent of a designated public hospital’s uncompensated costs. The state may also use IGTs to fund its share of Medi-Cal payments to private and district hospitals; however, the source of non-federal matching funds for supplemental payments to private hospitals was changed from IGTs to state general funds. The waiver also requires that public or private hospitals receiving DSH or Safety Net Care Pool payments retain the full amount of the payment and not return the funds to the state or any other unit of government.

**Figure 1. GAO Example of an Inappropriate State Financing Arrangement**



### CPEs Replace Some IGTs

In lieu of IGTs it deemed inappropriate, CMS has allowed states to use certified public expenditures (CPEs) as the non-federal share of Medicaid expenditures.<sup>10</sup> CPEs are expenditures that have been 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 through an IGT, a county can certify the costs incurred in treating Medicaid inpatients and outpatients in a hospital it operates. The state Medicaid agency can then include those certified costs as part of the non-federal share of Medicaid payments for the purposes of claiming federal matching funds.

California's waiver specifies that the state may use CPEs from designated public hospitals (i.e., county and University of California hospitals) as the non-federal share for purposes of claiming federal matching funds for inpatient Medi-Cal per diem payments, DSH funds, and funds from the Safety Net Care Pool. Although state and local officials were initially concerned that public hospitals would not have sufficient expenditures to make the shift from IGTs to CPEs work, thus far this has not been the case.

Although the CPE approach has been used successfully in California, it is not without serious drawbacks. For example, state lawmakers have a disincentive to expand managed care or invest general fund resources

in initiatives that would reduce inpatient utilization and costs if they increase outpatient costs. This is because the non-federal share of Medicaid expenditures for outpatient care and managed care is financed with general fund dollars, whereas inpatient care provided by county and University hospitals is financed with CPEs. In other words, expanding managed care would increase general fund expenditures, whereas much of the savings would accrue to the counties who finance CPEs.

### Safety Net Care Pool Created to Expand Coverage

When faced with the possibility of losing federal matching funds related to financing arrangements deemed inappropriate by CMS, California negotiated with CMS to maintain federal funding levels under an alternative financing arrangement, which included establishing a Safety Net Care Pool to pay for services to the uninsured and unreimbursed Medicaid costs. California was among the first states to establish a Safety Net Care Pool under Section 1115 demonstration waiver authority. California has broad discretion in using federal Safety Net Care Pool funds, but these funds become available only after the state provides non-federal matching funds from a CMS-approved source.

The waiver provides an annual allotment for the Safety Net Care Pool of \$766 million in federal matching funds (totaling \$3.83 billion over five years) to pay for treating uninsured persons who presently utilize public health systems for medical care, and to allow the state to claim federal funds for a number of state-funded programs for the uninsured. The waiver made a portion of these funds (\$180 million per year) contingent on a Medi-Cal managed care expansion in the first two years of the waiver (which was not realized), and on implementation of a “Coverage Initiative” in the last three years of the waiver, as described below. Federal funding for the Safety Net Care Pool is capped at the same amount for each year of the waiver, regardless of increases (or decreases) in the number of uninsured.

In October 2007, CMS approved the state’s proposal to use Safety Net Care Pool funds to pay for a Coverage Initiative that would cover uninsured individuals with income at or below twice the Federal Poverty Level, and who are not currently eligible for Medi-Cal, Healthy Families, or Access for Infants and Mothers. Individuals enrolled in the Coverage Initiative have access to primary care and care management services delivered through public hospitals and other governmental entities.

As of March 2009, there were ten counties designated to participate in the Coverage Initiative.<sup>11</sup> As of August 31, 2008 (the end of the first year of the three-year initiative), just over 85,000 people had been enrolled and an estimated \$95 million in federal funds had been claimed, about \$85 million less than allowed under the waiver. Unspent funds do not roll over to future years.<sup>12</sup> Enrollment continues to climb (nearly 129,000 were enrolled as of April 2009) and the state expects to draw a greater share of federal funds in year two.

### New Hospital Categories for Payment

Under the terms of California’s waiver, three general categories of hospitals were established for reimbursement purposes: designated public hospitals (DPHs) which are hospitals owned by counties and the University of California; non-designated public hospitals (mainly district hospitals); and private hospitals. Instead of using an aggregate upper payment limit (UPL) for designated public hospitals, California’s waiver limited Medi-Cal payments to cost (certified public expenditures), and allowed the state to transfer the federal share of Medicaid payments equal to the difference between the cost of treating Medi-Cal beneficiaries at the time the waiver was negotiated and what payments would have been had the state paid Medicare rates to the Safety Net Care Pool. (Payments to hospitals from the Safety Net Care Pool are also cost-based with a discount taken for an assumed level of care provided to undocumented immigrants, for whom federal matching funds are not provided.) Reimbursement



for designated public hospitals is calculated based on the Medi-Cal hospital cost report.

The California Medical Assistance Commission continues to determine reimbursement for non-designated public and private hospitals that contract with Medi-Cal through the Medi-Cal Selective Provider Contracting Program, as it did prior to the 2005 waiver. The waiver allows these hospitals to be paid up to the applicable UPL, which provides significant room for increased payments to these providers to the extent that the state can provide the non-federal share of these payments.

### Managed Care Expanded

During the first two years of California's five-year waiver, \$360 million in federal Safety Net Care Pool funds were set aside contingent on expanding mandatory Medicaid managed care to the aged, blind, and disabled population. California has been expanding managed care geographically since the current waiver was approved in 2005, but it did not initiate an expansion of mandatory managed care enrollment for seniors and people with disabilities beyond counties with a County Organized Health System.<sup>13</sup> As a result, the state did not receive the \$360 million in federal funds that were tied to the expansion of mandatory managed care.

### Provider Tax on Hospitals Prohibited

Federal Medicaid law allows states to raise revenue to pay the non-federal share of Medicaid costs by imposing taxes or fees on hospitals, nursing homes, managed care organizations, and other classes of providers, but only if the taxes meet certain requirements.<sup>14</sup> To qualify as non-federal matching funds, the tax must be broad-based (e.g., apply to all providers in the class) and uniform (e.g., all providers pay the same rate). In addition, the tax may not hold providers harmless against its costs (in other words, a provider is not "guaranteed" the return of their tax costs through increased Medicaid payments) nor may it exceed 5.5 percent of revenues for a particular class of provider. States may request a waiver of the broad-based

and uniformity requirements, which allows states some ability to minimize the tax burden that would otherwise be imposed on providers that do not participate in Medicaid or have low Medicaid volume. All but five states imposed at least one health care-related provider tax in 2009.<sup>15</sup>

The prohibition in California's waiver on implementing hospital provider taxes as a source of Medicaid matching funds is stricter than the requirements applied to most states, which are allowed to seek approval to use hospital provider taxes. During waiver negotiations, the U.S. Office of Management and Budget insisted that the terms and conditions of California's waiver prohibit the state from imposing an otherwise permissible tax on inpatient hospital, outpatient, or physician services during the five-year term of the demonstration in order to limit the overall level of federal funding and guarantee budget neutrality under the waiver. California is not precluded from imposing taxes or fees on other classes of providers, or on managed care organizations.

### Massachusetts: MassHealth Waiver

Massachusetts has been operating a Section 1115 demonstration waiver since 1997.<sup>16</sup> The state's MassHealth waiver was originally designed to expand Medicaid managed care and reinvest the state and federal savings to extend public and private coverage to low-income individuals who would otherwise be uninsured. The waiver was extended for three years in 2003 and again in 2005. Massachusetts' third waiver extension was approved in December 2008. The Massachusetts 1115 waiver now covers more than one million low-income people, and the state reports that since April 2006, the uninsured rate in Massachusetts has dropped from somewhere between 6 and 10 percent to less than 3 percent of the state population.<sup>17</sup>

### IGTs Replaced

Faced with the threat of losing federal matching funds due to IGTs being deemed inappropriate by CMS,

Massachusetts (like California) chose the Section 1115 waiver process to address issues with its financing arrangements. The Massachusetts waiver restricts the use of IGTs to only those funds that are derived from state and local taxes and transferred by units of government, and it provides for the use of CPEs of public hospitals for inpatient and outpatient services to Medicaid and uninsured patients. The waiver phased out four specific IGTs that the state had used to fund the non-federal share of some costs, including IGTs from two managed care organizations sponsored by Massachusetts' two largest safety-net hospital systems: Boston Medical Center and Cambridge Health Alliance. These IGTs were replaced with supplemental payments, the non-federal share of which is funded with state general revenue.

### Implementation of Safety Net Care Pool

A principal policy objective of the Massachusetts waiver is to shift government subsidies away from direct payments to health care providers for delivering care to the uninsured, towards subsidizing the purchase of health insurance coverage for the low-income uninsured. To facilitate this transition, the 2005 waiver extension created a new Safety Net Care Pool.

The Massachusetts Safety Net Care Pool is funded by federal and state expenditures that had previously been used to fund DSH payments and to pay for supplemental payments to the managed care organizations sponsored by Boston Medical Center and Cambridge Health Alliance. About half of the state's allotment of DSH payments was diverted to the Safety Net Care Pool. The 2005 waiver extension provided \$1.34 billion per year in funding for the Safety Net Care Pool, half of which (\$670 million annually) is federal funds.

Funds from the Safety Net Care Pool are used to offset uncompensated hospital care costs, to pay for designated state health programs, and to subsidize premiums for Commonwealth Care, a program that provides sliding-scale premium subsidies for private health plan coverage

for uninsured persons at or below 300 percent of the federal poverty level. Commonwealth Care members access free or low-cost health services through the same four health plans that serve Medicaid managed care. Commonwealth Care is run by the Commonwealth Health Insurance Connector Authority, a new entity that was created to help Massachusetts residents and businesses find and pay for health insurance.

Massachusetts' Safety Net Care Pool is designed so that as the share of funds used to subsidize coverage for uninsured residents through Commonwealth Care grows, the share going to offset unreimbursed hospital costs declines. Indeed, Safety Net Care Pool payments for unreimbursed hospital services have decreased from \$656 million in 2006 to an estimated \$406 million in 2009.<sup>18,19</sup> The 2008 waiver extension phases out federal support for safety-net providers participating in the demonstration, and requires the state to document that the program is moving in the direction of providing health care coverage for people rather than being a payment vehicle for providers. It also increases annual federal funding for the Safety Net Care Pool by \$97 million to keep pace with Commonwealth Care premium inflation and enrollment growth.

### Savings from Expansion of Mandatory Managed Care

As part of the 1997 MassHealth waiver, Massachusetts expanded mandatory managed care for Medicaid beneficiaries. Medicaid managed care is now mandatory for children, parents, and people with disabilities, and is voluntary for beneficiaries who are dually eligible for Medicaid and Medicare. Managed care enrollees may choose to receive services from a state-operated primary care case management program or from among four managed care organizations.

Massachusetts' Medicaid managed care expansions have resulted in significant savings to the federal government, but the state has been limited in its ability to reinvest



those savings due to insufficient matching funds from state and local sources. Under the 2005 renewal, Massachusetts was allowed to access a large portion of these federal savings and apply them to the Safety Net Care Pool. In essence, the federal government credited Massachusetts with these savings by contributing federal dollars to the Safety Net Care Pool.

### Provider Payments

When the Medicaid managed care expansion was first proposed, Massachusetts' two largest safety-net hospital systems—Boston Medical Center and Cambridge Health Alliance—were concerned that the shift to managed care would result in Medicaid patients being treated elsewhere, reducing DSH payments these hospitals use to finance care for their uninsured patients. To address that concern, each of the hospital systems created their own Medicaid managed care organizations (MCOs) and Massachusetts created a new managed care supplemental payment program that supported these MCOs, in addition to an existing hospital supplemental payment program that benefited the two hospital systems. By 2006, the state was distributing \$1.6 billion a year in supplemental federal and state Medicaid funds to the two hospital systems and their affiliated MCOs.<sup>20</sup>

CMS expressed concern about these financing arrangements, so Massachusetts used its 2005 waiver extension to discontinue the managed care portion of the supplemental payment program and instead use the state and federal share of that money, along with about half of its DSH allotment, to fund the Safety Net Care Pool. In order to ease the transition as these changes were implemented, CMS allowed Massachusetts to create a temporary three-year supplemental payment program (with an annual \$287 million in state and federal funds) to support Boston Medical Center and the Cambridge Health Alliance. The special payments end in 2009, and the December 2008 waiver extension phases out all other federal direct payments to safety-net providers participating in the demonstration.

### New York: Partnership Plan and Federal-State Health Reform Partnership Waivers

New York has two 1115 waivers. The first, called the Partnership Plan, was approved in 1997 with the goal of enrolling most Medicaid beneficiaries in managed care, including children and adult family members living in New York City and in 23 of the state's 62 counties. It was amended in 2001 to provide comprehensive health coverage to low-income uninsured adults through a program called Family Health Plus, and to integrate the financing and delivery of Medicare and Medicaid benefits for beneficiaries dually eligible for both programs through a program called New York Medicaid Advantage.

The second waiver, called the Federal-State Health Reform Partnership (F-SHRP), was approved in September 2006 to reorient the state's health care spending away from inpatient facilities towards delivery systems focused on outpatient and primary care.<sup>21</sup> Under F-SHRP, the state made a commitment to reduce excess capacity in acute care hospitals and nursing homes; expand primary care; implement chronic disease management programs; expand Medicaid managed care; and invest in health information technology. The state must invest \$3 billion over five years on waiver-approved initiatives to receive \$1.5 billion in federal funds. If the state does not draw the full federal amount (up to \$300 million per year), any unused funds may not roll over to future years.

### CMS Policy on IGTs and CPEs Clarified

CMS used the New York waiver as an opportunity to reinforce its policy on IGTs and CPEs, although neither of these financing mechanisms were an issue in New York. The waiver includes boilerplate language that declares a state may use IGTs to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure, and no prearranged agreements (contractual or otherwise) may

exist between health care providers and state and/or local government entities to return and/or redirect any portion of the Medicaid payments. Normal operating expenses that are unrelated to Medicaid and for which there is no connection to Medicaid payments (including the payment of health care-related provider taxes), are not considered returning or redirecting a Medicaid payment.

New York's 1115 waiver also includes boilerplate language related to the use of CPEs. The waiver states that units of government, including government-operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

### Savings from Managed Care Expansion and System Restructuring

Federal funds under the F-SHRP waiver are contingent on New York meeting specific milestones for the waiver-approved initiatives, which include implementing a Medicaid preferred drug list, increasing anti-fraud activities, adopting other Medicaid cost-containment initiatives, and creating a single point-of-entry system for Medicaid recipients needing long term care. The state is also required to demonstrate Medicaid program savings resulting from health system restructuring (such as savings due to decreased hospital utilization resulting from eliminating excess acute care capacity), and from a managed care expansion. The F-SHRP waiver also expanded mandatory Medicaid managed care for children and families from 23 counties to an additional 14 counties.

New York originally proposed the F-SHRP waiver as an amendment to the Partnership Plan waiver, but shifted to a new waiver because CMS insisted on new savings and would not permit the use of accrued savings under the Partnership Plan. State officials did not believe they could generate sufficient savings associated with F-SHRP's expansion of managed care and its health care restructuring initiatives during a three-year extension

period, and therefore proposed F-SHRP as a new waiver with five years to achieve savings needed to finance other program changes.

To ensure they achieved the \$1.5 billion in federal savings during the five-year life of the waiver, New York proposed shifting the aged, blind, and disabled (ABD) population out of the Partnership Plan and into the F-SHRP waiver. New York officials successfully argued that if CMS would withhold funding from California because it was unable to enroll the ABD population in managed care, then it should give New York credit for savings related to the mandatory enrollment of this population. CMS allowed the state to transfer authority to enroll the ABD population into mandatory managed care from the Partnership Plan waiver to the F-SHRP waiver and count managed care savings from the approval date of the F-SHRP waiver to meet the F-SHRP waiver's budget neutrality requirements.

Under the terms of the F-SHRP waiver, Medicaid managed care per-member per-month (PMPM) rates are the basis for calculating the annual budget neutrality expenditure cap. The state is at risk for the per capita cost for beneficiaries eligible for the demonstration, but not for the number of beneficiaries eligible, which could change as a result of changing economic conditions that impact enrollment levels. New York's Medicaid capitation rates for children are more than five times higher than Medi-Cal's. Consequently, it should be much easier for New York than it is for California to control the rate of spending growth without adversely impacting access to or quality of care.

## How California Compares

California’s waiver shares a few common elements with the Massachusetts and New York waivers. These include:

- All three waivers reflect a response to a concerted effort by CMS to restrict the use of most IGTs as a source for the non-federal share of Medicaid expenditures. The waivers clarify that IGTs may only involve funds derived from state or local tax revenues that are transferred by units of government within the state and, under all circumstances, health care providers must retain 100 percent of the claimed expenditures.

- All three waivers specifically allow states to use CPEs as the non-federal share of Medicaid expenditures, but only California does this on a large scale to support Medicaid hospital payments.
- Both California and Massachusetts established Safety Net Care Pools, which allow federal funds to be used to pay for the costs of covering populations or services not otherwise eligible for federal matching funds under Medicaid.

California’s waiver differs from the Massachusetts and New York waivers in several important ways, beginning with differences in purpose (Table 2). The primary

**Table 2. Medicaid Section 1115 Waivers: Summary Comparison**

	<b>CALIFORNIA</b> MEDI-CAL HOSPITAL UNINSURED CARE	<b>MASSACHUSETTS</b> MASSHEALTH	<b>NEW YORK</b> PARTNERSHIP PLAN AND FEDERAL-STATE HEALTH REFORM PARTNERSHIP (F-SHRP)
Effective Dates	September 1, 2005 to August 31, 2010	July 1, 1997 to June 30, 2011	Partnership: October 1, 1997 to September 30, 2009 F-SHRP: October 1, 2006 to September 30, 2011
Primary Purpose	Restructure hospital financing arrangements deemed inappropriate by CMS, including supplemental payments to hospitals for Medicaid and uninsured costs; and increase federal funding for safety-net hospitals.	Shift government subsidies away from direct payments to health care providers for delivering care to the uninsured and instead subsidize health insurance coverage for the low-income uninsured.	Restructure the state’s health care delivery system to reorient health care spending away from inpatient facilities to outpatient and primary care-focused delivery systems.
Expands Medicaid Managed Care	✓	✓	✓
Expands Coverage	✓	✓	✓
Creates a Safety Net Care Pool	✓	✓	
Changes to Disproportionate Share Hospital Payments	✓	✓	
Limits Intergovernmental Transfers	✓	✓	✓
Authorizes Certified Public Expenditures	✓	✓	✓
Adjusts Upper Payment Limits/ Other Provider Payments	✓	✓	✓
Restricts Provider Taxes	✓		

Source: Health Management Associates analysis of CMS Medicaid 1115 waiver approval documents: [www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/08\\_WavMap.asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/08_WavMap.asp).

purpose of the 2005 California waiver was to replace financing arrangements deemed inappropriate by CMS and increase federal funding for the state's safety-net hospitals. (An additional purpose was to retain federal funding that had been provided under another Section 1115 waiver for Los Angeles County.) By contrast, the waivers in Massachusetts and New York have more expansive goals, aiming to restructure the health care delivery systems in those two states by shifting government spending trends and expanding coverage.

Other key differences include the following:

- Massachusetts and New York expanded Medicaid managed care through their waivers and were allowed to reinvest the federal share of savings associated with these expansions on Medicaid costs otherwise not eligible for federal matching funds, such as coverage for the uninsured. California implemented its managed care expansions during the same period, but these expansions were not done under an 1115 waiver, so California gets no credit for these savings. As of June 2007, 60 percent of Medicaid beneficiaries in Massachusetts were enrolled in managed care, 62 percent in New York, and 51 percent in California.
- In Massachusetts, as a result of its coverage expansions, the uninsured rate has dropped from between 6 and 10 percent of the state's residents to less than 3 percent. In contrast, California's waiver did not significantly reduce the number of uninsured in the state. It provided only a modest coverage expansion through the Coverage Initiative, and it did not finance care for any existing Medi-Cal coverage groups.
- Unlike California, Massachusetts and New York shifted public money from institutional providers, including hospitals and nursing homes. Massachusetts used these funds to help pay for premiums to cover the uninsured, and New York used the funds to expand access to community-based services.
- Massachusetts and New York, unlike California, negotiated waivers that allow federal payments to grow over time, versus an absolute cap on federal financial participation.
- California's waiver prohibits the state from imposing an otherwise permissible tax on inpatient hospital, outpatient, or physician services. Massachusetts and New York impose provider taxes on hospitals.

## Looking Ahead

When California's 1115 waiver was approved in 2005, the urgent issue was to come up with an alternative method of financing hospitals because the method at the time was challenged by CMS. CMS worked with California through the 1115 waiver process to develop an alternative financing method and an increased federal funding commitment, but system reform was limited to the Coverage Initiative and a modest expansion of managed care.

For the 2010 renewal, California lawmakers have expressed an interest in pursuing a more comprehensive waiver like those in Massachusetts and New York. The process of doing so, however, is complicated by the state's budget crisis, the peculiar incentives created by CPEs, federal health care reform proposals that may significantly alter Medicaid policy and funding streams, and uncertainty about whether or not CMS will allow California to use hospital taxes to generate non-federal matching funds. It is expected that the Obama Administration, which has made health reform one of its highest policy priorities, will have different objectives for Medicaid 1115 waivers than the Bush Administration, under which the most recent 1115 waivers for all three states were negotiated.

Furthermore, Massachusetts and New York have distinct advantages over California when it comes to identifying federal savings that can be re-invested elsewhere through an 1115 waiver. One reason for California's comparative disadvantage is that Medicaid spending per enrollee in

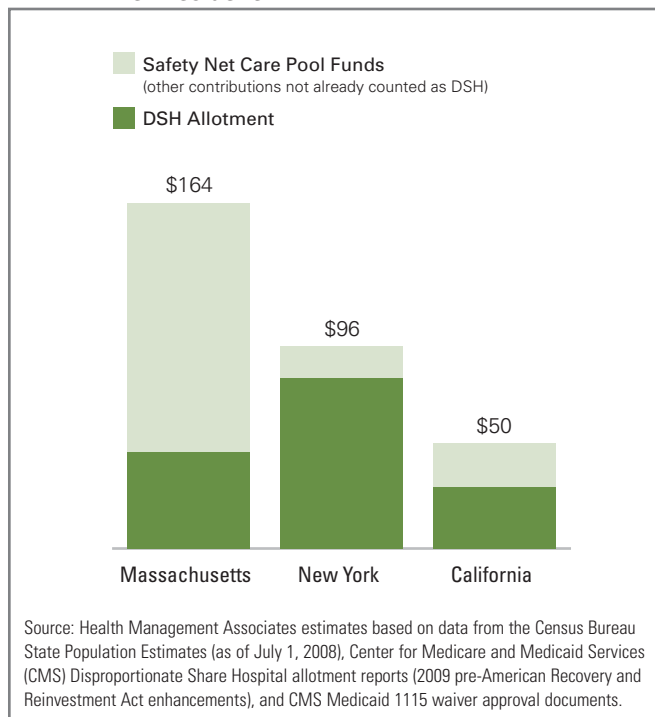
New York and in Massachusetts is among the highest in the nation (\$9,656 and \$8,300, respectively, in 2006), whereas California spends less per enrollee than any other state (\$4,528). It is much easier for high-cost states to reduce their spending and use these program savings to finance coverage expansions or other program improvements than it is for states like California that have already achieved significant Medicaid savings.

A second disadvantage for California is that the federal government’s contribution to help states offset indigent care costs is three times higher per resident in Massachusetts and almost twice as high per resident in New York as it is in California (Figure 2), despite the fact that a larger share of California’s population is uninsured.<sup>22</sup> DSH allotments were first established by Congress in 1991 based on each state’s historical DSH spending; California’s lower DSH allotment reflects the fact that historically California had been less aggressive than these and other states in claiming Medicaid DSH funds. The higher DSH allotments for Massachusetts and

New York (on a per resident basis) give these states an advantage over California in terms of funding indigent care or leveraging these funds to expand coverage to the uninsured.

Another important difference between California and these other states is California’s higher maximum DSH payment, which allows the state to make DSH payments to most public hospitals up to 175 percent of the difference between costs and reimbursement. This complicates the tradeoff in California between federal funding for DSH payments versus federal funding for coverage. States like Massachusetts and New York trade off federal dollar for federal dollar—an even trade. California, however, would receive only 50 cents in federal matching funds for each dollar spent for Medicaid coverage, instead of the 87.5 cents in federal matching funds it receives for each dollar of DSH-claimable expenditures.<sup>23</sup> Furthermore, DSH payments can be used to compensate public hospitals for treating undocumented immigrants, whereas federal matching funds are not available to provide Medicaid coverage to this population.

**Figure 2. Federal Contributions for Indigent Care, Per Resident**



If California can overcome these challenges, expanding the waiver to include more of the Medi-Cal program—and leveraging the precedents set in other states like Massachusetts and New York—could be a meaningful step toward increasing federal support for safety-net hospitals and clinics and expanding coverage to the uninsured.

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## ABOUT THE FOUNDATION

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit [www.chcf.org](http://www.chcf.org).

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## ENDNOTES

1. Centers for Medicare and Medicaid Services, “Section 1115 Research and Demonstration Projects,” [www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03\\_Research&DemonstrationProjects-Section1115.asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp). (accessed June 15, 2009).
2. Medicaid is jointly financed by states and the federal government. States spend money on Medicaid services for Medicaid beneficiaries and on supplemental payments to hospitals that provide a disproportionate share of indigent care. They report these expenditures to the federal government and receive federal matching funds based on the state-specific Federal Matching Assistance Percentage (FMAP).
3. The terms and conditions of California’s waiver are posted on the CMS Web site under “Medicaid Waiver and Demonstrations List” at [www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp).
4. Designated public hospitals include hospitals owned by the University of California (Davis, Irvine, San Diego, San Francisco, Los Angeles, and Santa Monica), Los Angeles County (Harbor/UCLA, Olive View, Rancho Los Amigos, and USC), and other counties (Alameda County, Arrowhead Regional, Contra Costa Regional, Kern, Natividad, Riverside County, San Francisco General, San Joaquin General, San Mateo County, Santa Clara Valley, and Ventura County).
5. 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. See Section 1903(w)(6) of the Social Security Act, 42 USC 1396b(w)(6); 42 CFR 433.51(b).
6. Section 1902(a)(13)(A)(iv) of the Social Security Act, 42 USC 1396a(a)(13)(A)(iv).
7. Section 701(c)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (PL 106-554).
8. 42 CFR 447.272.



9. United States Government Accountability Office (GAO), “Medicaid Financing: Federal Oversight Initiative is Consistent with Medicaid Payment Principles but Needs Greater Transparency,” (GAO-07-214), March 2007: [www.gao.gov/new.items/d07214.pdf](http://www.gao.gov/new.items/d07214.pdf).
10. Section 1903(w)(6) of the Social Security Act, 42 USC 1396b(w)(6); 42 CFR 433.51(b).
11. Alameda, Contra Costa, Kern, Los Angeles, Orange, Santa Clara, San Diego, San Francisco, San Mateo, and Ventura.
12. Department of Health Care Services, “Health Care Coverage Initiative Enrollment and Health Care Expenditures”; and California Association of Public Hospitals and Health Systems, “Policy Brief: California Public Hospitals and the Health Care Coverage Initiatives: A Model for Health Care Reform,” Oakland, CA, April 2009.
13. For additional information on Medi-Cal’s three models of managed care, see “Medi-Cal Managed Care” at [www.chcf.org/topics/medi-cal/index.cfm?itemID=20396&subtopic=CL157&subsection=medical101](http://www.chcf.org/topics/medi-cal/index.cfm?itemID=20396&subtopic=CL157&subsection=medical101).
14. Section 1903(w) of the Social Security Act, 42 USC 1396b(w), 42 CFR 433.50 et seq.
15. Kaiser Commission on Medicaid and the Uninsured, “Provider Taxes in Place in the 50 States FY2008 and FY2009.”
16. MassHealth is also the name of Massachusetts’ Medicaid program. The terms and conditions of the MassHealth Waiver are posted on the CMS Web site under “Medicaid Waiver and Demonstrations List” at [www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp).
17. Urban Institute, “Estimates from the 2008 Massachusetts Health Insurance Survey,” December 2008: [www.urban.org/publications/411815.html](http://www.urban.org/publications/411815.html).
18. Massachusetts Taxpayers Foundation, “Health Reform: The Myth of Uncontrolled Costs,” May 2009: [www.masstaxpayers.org/publications/health\\_care/20090501/massachusetts\\_health\\_reform\\_the\\_myth\\_uncontrollable\\_costs](http://www.masstaxpayers.org/publications/health_care/20090501/massachusetts_health_reform_the_myth_uncontrollable_costs).
19. In 2009–10, California will spend approximately \$480 million of its Safety Net Care Pool funds on unreimbursed hospital, clinic, and physician services. As previously noted, California’s population is five times larger than the population of Massachusetts.
20. US Government Accountability Office, “Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments,” GAO-08-614, May 2008.
21. The terms and conditions of New York’s waiver are posted on the CMS Web site under “Medicaid Waiver and Demonstrations List” at [www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp).
22. Federal spending to pay for indigent care, including Disproportionate Share Hospital (DSH) payments, Safety Net Care Pool (SNCP) funds, and other waiver programs is approximately \$164 per resident in Massachusetts (\$299 million DSH and \$767 million SNCP for 6.5 million residents), \$96 per resident in New York (\$1,573 million DSH and an additional \$300 million allowed under the waiver for 19.4 million residents), and \$50 per resident in California (\$1,074 million DSH and \$766 million SNCP for 36.7 million residents).
23. California can make DSH payments to most public hospitals of up to \$1.75 for every dollar of DSH-claimable expenditures (i.e., the difference between hospital costs, or certified public expenditures, and reimbursement), up to its DSH allotment. The state receives half the amount of its DSH payments, up to 87.5 cents, from the federal government for every dollar of DSH costs. In contrast, the state normally receives only 50 cents from the federal government for every dollar spent on Medicaid-covered services (increased to 61.6 cents under the temporary enhanced matching rates provided under the American Recovery and Reinvestment Act of 2009).