



California's Current Section 1115 Waiver & Its Impact on the Public Hospital Safety Net

Executive Summary

The current Section 1115 Medicaid waiver, which was intended to stabilize California's health care safety net, has failed to live up to that goal. For public hospitals across the state, the reimbursement structures of the waiver cover roughly half of the costs of providing care to their Medi-Cal and uninsured patients. The next Section 1115 waiver must provide sufficient reimbursement to truly stabilize public hospitals and support them in their ongoing efforts to provide the highest quality care to their patients and improve care through more coordinated, effective, efficient service delivery. The ongoing economic crisis has only increased the need for this support. This brief provides an overview of the current waiver and an analysis of its impact on California's public hospitals' ability to care for their patients.

Introduction

California's current Section 1115 Medicaid waiver provides the structure for federal reimbursement to public and private safety net hospitals for care to Medicaid (Medi-Cal in California) and uninsured patients. The current five-year waiver took effect on September 1, 2005, and is set to expire on August 31, 2010.

The current waiver was granted under Section 1115 of the U.S. Social Security Act, which allows states to waive some of the usual requirements for the Medicaid program and to conduct demonstration projects that test goals of Medicaid, such as coverage expansion. The negotiation of the Section 1115 waiver between the California Department of Health Care Services (DHCS) and the federal Centers for Medicare and Medicaid Services (CMS) resulted in a five-year waiver with a goal of stabilizing California's fragile health care safety net.

The current waiver completely restructured the method of reimbursement to California's public and private safety net hospitals, bringing new risks, limits and challenges to our safety net system. CAPH has conducted a comprehensive analysis¹ of the waiver, which reveals that its goal of stabilizing California's safety net hospitals has not been achieved. The waiver's low reimbursement levels, as well as its heavy use of Certified Public Expenditures (CPEs), have resulted in a situation in which public hospitals themselves provide the source of non-federal share in order to draw down partial reimbursement. Moreover, public hospitals' costs of providing care to Medi-Cal and uninsured patients are significantly under-reimbursed. In fact, federal reimbursements cover only about half of costs of the care provided to Medi-Cal and uninsured patients in public hospital systems. The net result of the use of CPEs and the overall caps that have been placed on waiver funding

¹While the hospital financing waiver provides the structure for financing for both public and private safety net hospitals, this paper concentrates largely on the impact of the waiver on public hospital systems, which are categorized under the waiver as designated public hospitals.

is that public hospitals have provided nearly \$10.5 billion of uncompensated care to patients over the five-year life of the waiver.

CAPH's analysis makes it clear that the insufficient funding in the current Section 1115 waiver has significantly weakened the financial stability of public hospital systems across California. For example, many public hospitals have been forced to eliminate or decrease services, including the closure of a trauma recovery center, the elimination of a transplant program, and the closing of primary care and dental clinics. In addition, thus far in fiscal year (FY) 0910, public hospital systems are experiencing an aggregate budget deficit of over \$725 million, leaving them in a precarious financial situation and forcing them to make tough decisions regarding the possible elimination of programs and services.

During the same time period, public hospitals have experienced rising patient demand in their emergency rooms and outpatient clinics as a result of the severe economic downturn, which is a byproduct of increasing numbers of unemployed and uninsured Californians seeking needed medical care.

California's public hospital systems now look to the State's next Section 1115 waiver as an opportunity to improve reimbursement rates so that they can continue to improve the delivery of care for patients, making it more coordinated, patient-focused and efficient. These goals can be accomplished through the waiver with increased federal reimbursements that go much further in covering the cost of providing services, and with support for public hospital systems' ongoing efforts to expand access by strengthening coordinated systems of care.

Support for the Essential Public Hospital Safety Net

The waiver provides the major source of funding for California's public hospital systems, which represent the core of the health care safety net, delivering care to all who need it, regardless of ability to pay or insurance status. Although they comprise only six percent of all hospitals in California, public hospitals serve 2.5 million Californians each year and provide nearly half of all hospital care to the state's 6.7 million uninsured. Medi-Cal and uninsured patients account for more than two-thirds of public hospitals' patient mix. Public hospitals

21 Designated Public Hospital Systems Under the Current Section 1115 Waiver

Alameda County Medical Center

Contra Costa Regional Medical Center

Kern Medical Center

Harbor/UCLA Medical Center

UCLA Medical Center – Santa Monica*

UCLA Medical Center – Westwood*

Olive View Medical Center

Rancho Los Amigos National Rehabilitation Center

LAC+USC Medical Center

Natividad Medical Center

University of California Irvine Medical Center

Riverside County Regional Medical Center

University of California Davis Medical Center

Arrowhead Regional Medical Center

University of California San Diego Medical Center

San Francisco General Hospital and Trauma Center

University of California San Francisco Medical Center*

San Joaquin General Hospital

San Mateo Medical Center

Santa Clara Valley Medical Center

Ventura County Medical Center

**These hospitals are not members of CAPH*

operate more than half of the top-level trauma centers and almost half of the state's burn centers. California's public hospital systems deliver 10 million outpatient visits per year and train 43 percent of all new physicians in the state.

California's Section 1115 Waiver Structure

When it was enacted in 2005, the waiver substantially altered the structure for financing safety net hospitals in California. At the time, public hospitals in particular were struggling to meet the needs of patients due to inadequate reimbursement and negative financial margins. Consequently, an intended goal of the 2005 waiver was to support safety net hospitals with additional funding.

In order to assess the impact of the current waiver on public hospitals, it is important to first understand the new structures it imposed.

- **Public Hospitals Provide Matching Funds for Federal Reimbursements**

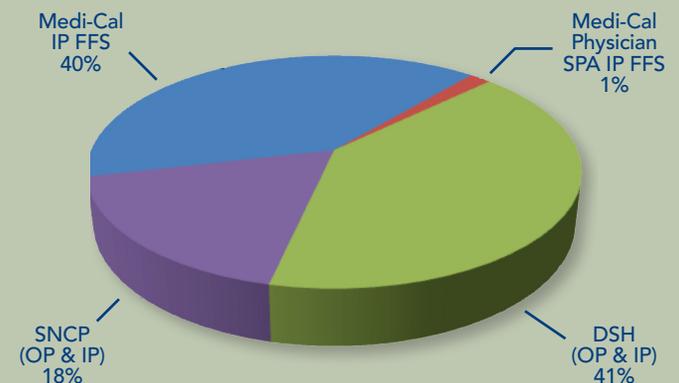
When it was enacted in 2005, the waiver revised a Medi-Cal financing system in which State General Fund monies had served as the non-federal share to draw down matching federal Medicaid funds for inpatient services provided in public hospitals. Under the new system for the 2005-2010 waiver, counties and UC hospitals became responsible for providing the non-federal share of inpatient services to Medi-Cal. This change replaced the more than \$350 million in State General Fund monies provided to these hospitals in FY0405 with local money. This process is accomplished by reporting the costs of care provided to Medi-Cal beneficiaries and to the uninsured (known as CPEs.) This shift has meant that for the majority of their Medi-Cal funding, public hospital systems – rather than the State of California – provide the non-federal share and incur costs for which they receive reimbursement for about only half of their costs.

By placing the responsibility for providing the non-federal share of services to Medi-Cal patients on public hospitals, the waiver shifted the State's role to the local level, and created a funding partnership between public hospitals and the federal government, with no State General Fund involvement.

Figure 1.

Public Hospital Waiver Reimbursement by Funding Source

(FY06-FY10 Cumulative)



- **Four Funding Streams**

Under the waiver, public hospitals spend money providing care and then use CPEs to draw down federal funding from four different funding sources, two of which are capped. Figure 1 shows the breakdown of the source of funding to public hospitals for the cumulative five-year waiver period:

1. **Medi-Cal Inpatient Fee-for-Service**

Covers inpatient services provided in public hospitals to Medi-Cal patients enrolled on a fee-for-service basis. Public hospitals receive the federal matching rate in reimbursement for their costs by using CPEs.

2. **Medi-Cal Inpatient Fee-for-Service Physician Services**

Covers professional physician services provided to Medi-Cal patients; CMS mandated that these

services could not be included in the regular Medi-Cal inpatient fee-for-service reimbursement. Public hospitals receive the federal matching rate in reimbursement for their costs by using CPEs.

3. Medicaid Disproportionate Share Hospital (DSH) Funding

Covers hospital-based services, both inpatient and outpatient, to uninsured patients, including undocumented immigrants, and can also be used to help make up shortfalls from low Medi-Cal rates in managed care and for mental health services. Total federal DSH funding is subject to an annual DSH allotment cap, which ranged from about \$1 billion to \$1.1 billion in federal funding each year over the term of the waiver.

The waiver also changed the structure of the receipt of DSH payments, such that public hospitals now receive California's federal DSH allotment, and private DSH hospitals receive an amount in DSH replacement funds that is equivalent to what they otherwise would have received in DSH funds. This change was made to maximize the receipt of federal dollars. The public (county and UC) hospitals receive nearly all of the total federal DSH funding and provide the non-federal share through a combination of CPEs and Intergovernmental Transfers (IGTs). DSH is the only funding source in the current waiver that allows limited use of IGTs.²

4. Safety Net Care Pool (SNCP) and the Coverage Initiatives (CIs)

Covers inpatient, physician, and hospital- and non-hospital-based outpatient and other services

provided to uninsured patients, except undocumented immigrants. Public hospitals provide the non-federal share of the SNCP through the use of CPEs. The SNCP is capped at \$766 million annually in federal reimbursement³ and does not include an inflation factor to account for rising costs. The California budget for FY0910 included a direct cut in the SNCP, resulting in a loss of \$54 million to public hospitals that was redirected to the State in order to help backfill its budget deficit. The Governor's proposed budget for FY1011 includes the same cut to public hospitals' funding.

Of the \$766 million, \$180 million annually in federal reimbursements in Years 1 and 2 were tied to the implementation of specific managed care milestones, including a proposed mandatory shift to managed care for Medi-Cal beneficiaries categorized as Seniors and Persons with Disabilities (SPDs). However, this shift did not occur. As a result, those funds did not come to the SNCP in Years 1 and 2, and thus the total amount of federal reimbursement in the SNCP was limited to \$586 million.⁴

For Years 3, 4 and 5 of the waiver, \$180 million annually in federal reimbursement was tied to the creation of the Health Care Coverage Initiative, which was enacted by the State Legislature in 2006 through SB 1448 (Kuehl). The State selected 10 counties to conduct CI programs and draw down the \$180 million in reimbursement. As with the SNCP, counties and public hospitals provide the non-federal share for CI funding through the use of CPEs. Each CI is designed to expand cov-

²IGTs are transfers of public funds from one level of government to another that are used as the non-federal share of Medicaid spending. The federal government has instituted more restrictions over the past several years on the use of IGTs.

³CAPH believes that the increased FMAP from the American Recovery and Reinvestment Act (ARRA) should be applied to the SNCP and therefore should have resulted in increased funding to the SNCP; however, to date, CMS has not allocated those funds. As noted in the Governor's January 2010 proposed budget, DHCS is seeking the additional funding as part of its federal efforts for state budget relief.

⁴DHCS is seeking the \$180 million in federal funds from Years 1 and 2 for use by the State itself (not for safety net hospitals) as part of its efforts to address the state budget gap.

erage to adults up to 200% of the Federal Poverty Level (FPL). The CIs have expanded coverage to more than 100,000 low-income adults. CIs assign each enrollee to a medical home in a public hospital system clinic, a community health center or private physician’s office, for regular primary and preventive care. Some counties with public hospital systems were not selected to participate in the CI and as a result cannot draw down these federal funds.

• **“Baseline” & “Stabilization”**

The current waiver guarantees a minimum amount of funding for all public hospitals at a level called “baseline” that is based on their FY0405 Medi-Cal reimbursement.⁵ Baseline amounts are funded from the above four sources, and are adjusted annually based on changes in the cost of uninsured and inpatient Medi-Cal fee-for-service care.

In addition to baseline, the waiver includes funding called “stabilization,” which includes all Medi-Cal funding in the waiver paid to public and private DSH hospitals above their baseline amounts. Stabilization amounts vary each year, based on the total amount of funding available and the amount of that funding that is needed to achieve baseline levels. Public and private hospitals draw their respective stabilization funds from different sources: public hospitals draw from the Safety Net Care Pool, while private hospitals receive their funding from the State General Fund and from federal funds.

Stabilization is allocated based on formulae, including a series of allocations to public and private hospitals, as well as to non-designated public (a.k.a. district) hospitals. The remainder of stabilization

is intended to be split between public and private DSH hospitals 60 and 40 percent, respectively.

Results of the Waiver for Public Hospitals

CAPH conducted a comprehensive analysis of the waiver’s impact based on the most current data available.⁶ The analysis looked at estimates of costs and payments for the public hospitals over the course of the five years of the waiver.

Figure 2 shows the aggregate amount of baseline and stabilization funding for the 21 public hospitals in each year of the waiver. When the waiver was enacted, these hospitals were already under serious

Figure 2.
Public Hospital Baseline & Stabilization Funding
(Dollars in millions)

	Baseline	Stabilization	Total	% Change from Prior Year
FY 0506	1,959	279	2,238	14.2%
FY 0607	2,093	234	2,327	4.0%
FY 0708	2,234	189	2,424	4.2%
FY 0809	2,384	361	2,745	13.3%*
FY 0910	2,523	269	2,791	1.7%
Cumulative 5 Year Total	11,193	1,333	12,526	

* Note: Majority of Increase in FY0809 related to ARRA-enhanced FMAP

Chart shows only small funding increases in most years due to the waiver funding caps.

financial strain. The waiver did provide significant increased funding the first year, approximately \$279 million – a 14% increase over the previous year. However, the increases in the next two years were much smaller (about 4% each year) due to the capped DSH and SNCP funding. During the five-year pe-

⁵ Private and non-designated public hospitals (districts) also have “baseline” funding amounts, in the aggregate for each group.

⁶ Analysis was conducted using the most recent data available from the 21 public hospitals and from DHCS. Data for fiscal years 2009 and 2010 are based on fiscal year 2008 data trended forward (the same basis by which payments are made for those years). When the 2005 waiver was enacted, there were 23 designated public hospitals, however for purposes of consistent cross-year comparison the analysis excluded both cost and payment information for Tuolumne General Hospital (closed on June 30, 2007) and Los Angeles’ Martin Luther King Jr. Hospital (closed on August 15, 2007).

riod of the waiver, costs for public hospitals exceeded the rate of increased funding, as a result of medical inflation and rising patient volume and demand for services. An additional temporary increase (13%) occurred in fiscal year 2009 due to the Federal Medical Assistance Percentage (FMAP) and DSH increases provided in ARRA, funding that was intended to respond to the dire financial consequences of the economic downturn. The increase in the FMAP turned out to be critical to public hospitals' survival, given the tremendous increases in the numbers of uninsured and the growing demands placed on the safety net. Because of the continued economic crisis, public hospitals anticipate a need for the increased FMAP funds to be extended through June 2011.

Figure 3.

Waiver Payments Compared to Cost

(Dollars in millions)

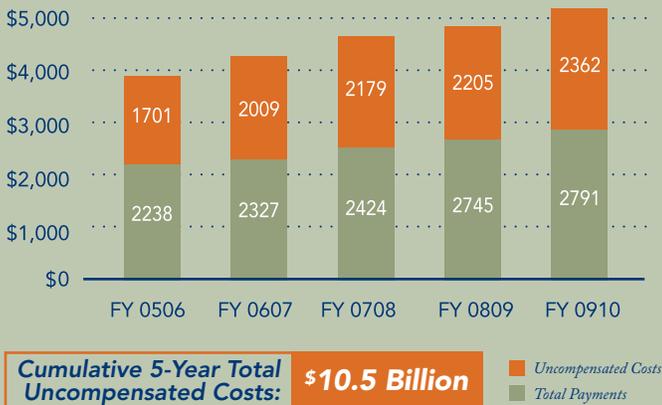


Figure 3 demonstrates that the waiver has left substantial, and growing, gaps between reimbursements and the costs that public hospital systems have incurred in providing services to Medi-Cal and uninsured patients. As the figure shows, public hospital systems received very low reimbursement for the costs of the services they provide and in fact, the amount of unreimbursed costs grew significantly over the five years of the waiver, resulting in nearly \$2.4 billion in unreimbursed costs in FY0910 alone. Overall, this low reimbursement resulted in \$10.5

billion in unreimbursed costs for the 21 public hospital systems over the life of the waiver. The cause of this substantial amount of unreimbursed cost is two-fold – a factor of the use of CPEs and a factor of the funding limits contained in the waiver.

This analysis of the current waiver enables CAPH to draw several broad conclusions:

➤ *The CPE System Does Not Come Close to Covering the Cost of Care*

The waiver is largely financed through a system whereby public hospitals incur costs for which they receive just a portion in federal reimbursement. Such a financing structure, which falls well short of covering the cost of care, leaves public hospitals with a significant amount of unreimbursed costs. Of the \$10.5 billion in unreimbursed costs, more than \$7 billion is due to the inherent reimbursement structure of CPEs. Potentially, this gap could be remedied in part if the federal government approved the use of alternative reimbursement structures in the next waiver.

➤ *State Funding for Public Hospital Care Has Largely Disappeared*

The CPE method requires counties to provide the non-federal share for inpatient care to Medi-Cal patients in public hospitals, which had previously been funded through the State General Fund. Consequently, the State's role in the Medi-Cal program and in supporting care to the uninsured in public hospitals has dramatically declined. Public hospitals serve a major role in providing care to Medi-Cal and uninsured patients: roughly a third of all care to Medi-Cal patients in the state, and nearly half of all hospital care to the state's 6.7 million uninsured.

➤ *The Waiver's Capped Funding Has Impeded Public Hospitals' Financial Stability*

As noted above, the waiver did include additional funding for public hospitals in the first year. Since then, however, the caps on federal reimbursements

have failed to keep pace with the rising demand and costs of health care. In fact, over the five-year waiver period, public hospitals are estimated to have incurred nearly \$3.3 billion in eligible costs for which they have been unable to receive any federal reimbursement, due to the caps in the waiver (see Figure 4).

Figure 4.

Eligible Costs Beyond Waiver Caps

(Dollars in millions)

	FY 0506	FY 0607	FY 0708	FY 0809	FY 0910	Cumulative 5 Year Total
Eligible Costs Beyond Waiver Caps	375	621	624	710	968	3,298

Annual sums of public hospital costs that were eligible for federal reimbursement but unclaimed due to waiver caps.

As a result of the capped funding and the use of CPEs, only a limited percentage of public hospitals' costs are covered by the federal reimbursements under the waiver. In fact, public hospitals receive reimbursement for just roughly half of their costs.

➤ *Public Hospitals Unable to Receive Full Amount of Stabilization Funds*

A further demonstration that the waiver has failed to stabilize public hospitals is that the funding caps have prevented public hospitals from being able to receive their intended portion of stabilization funds. The legislation that enacted the waiver, SB 1100 (Perata), stated that public and private safety net hospitals were to receive 60 and 40 percent, respectively, of stabilization funds. However, the analysis for FY0708 demonstrates that public hospitals were not able to receive their portion of these funds due to the cap on the SNCP, which is the only source of stabilization for public hospitals. This situation occurred because the private hospitals received increased state and

federal funding for Medi-Cal services to such a degree that the amount of SNCP was insufficient for public hospitals to achieve a 60% share of total stabilization. Our analysis shows that instead of receiving their 60% share, public hospitals received only 39% of stabilization (a shortfall of \$58 million). This situation would have continued and grown, were it not for increased temporary federal funding to public hospitals from ARRA.

➤ *Minimal Support for Delivery System Improvement*

As stated, 10 counties participate in the Coverage Initiatives and receive federal reimbursement for expanding coverage to low-income adults and assigning them to a medical home. The structure of the CI helped participating public hospital systems to strengthen efforts already underway to provide improved care for their patients. For example, many clinics within California public hospital systems were transforming their clinics to serve as medical homes – regular sources of outpatient care – and were targeting patients with chronic illnesses, such as diabetes and asthma. Patients are treated by teams of qualified clinic professionals who not only treat the symptoms, but also plan and coordinate the full scope of their patients' health care needs.

These delivery system improvements are critical to meeting patients' needs, particularly as public hospitals look ahead to hold themselves accountable for providing high quality, coordinated care and to the challenges of meeting patient demand in an expanded Medi-Cal system. Despite the available funding and successes of the CIs, the current waiver has contained insufficient support for public hospitals to improve and strengthen the safety net delivery system. To date, these efforts to improve care coordination within public hospital systems' wide array of primary, specialty, emergency and surgical settings have largely been supported by

public hospital systems themselves, and by generous grants from private foundations. In order to make these improvements systemic and impactful for safety net patients, additional federal resources will be necessary, and building on the success of the CI program in the next waiver is critical.

➤ *Dire Consequences Without Stimulus Package*

The funding increases provided through ARRA – an 11.59 percentage point increase to the FMAP and a 2.5% increase to Medicaid DSH – have been critical to public hospital systems during the current economic downturn. Without these increases, California’s public hospitals would have faced an even greater funding crisis. Figure 5 shows the impact of the ARRA provisions and reveals that the waiver funding would have been significantly worse for public hospitals had ARRA not been enacted. For example, without the FMAP increase in ARRA in the final year of the waiver, public hospitals would have had less than half of their costs reimbursed. And without the ARRA provisions, public hospitals would have received \$442 million less in reimbursement. In other words, the structure of the waiver has been inadequate for public hospitals; the increased funds from ARRA averted a funding crisis that would have resulted in the loss of essential public hospital services for many Californians.

The Next Section 1115 Waiver

CAPH has developed a series of recommendations⁷ for the next waiver that we believe will provide remedies for the current waiver’s structures that have impeded public hospitals’ financial stability. New structures are necessary in order to improve care for patients and help strengthen the public hospital safety net.

With these new structures and with additional federal funding, public hospital systems can build upon innovations that already are transforming care for their patients – moving from a model in which individual physicians treat sick patients on an episodic basis, to a wellness model that helps prevent disease and treats patients, particularly those with complex and chronic conditions, through proactive, coordinated team-based care. Ultimately, this model will help all patients get the right care when and where they need it, with a medical home that serves as their source for routine care and coordination with other needed services. Greater care coordination will create efficiencies and improve the overall quality of care in California. CAPH looks forward to working with the State, other stakeholders, and the federal government to help improve health and health care delivery in our state.

Figure 5.

Fiscal Years 2009 and 2010 Results Comparing With and Without ARRA

(Dollars in millions)

	FY 0809 (with ARRA)	FY 0910 (with ARRA)	Total (with ARRA)	FY 0809 (without ARRA)	FY 0910 (without ARRA)	Total (without ARRA)	FY 0809 Difference	FY 0910 Difference	Total Difference
Total Payments	2,745	2,791	5,536	2,545	2,549	5,094	-200	-242	-442

Chart shows that without ARRA provisions public hospitals would have received \$442 million less in reimbursement.

⁷See “California’s Next Section 1115 Waiver: Recommendations from the California Association of Public Hospitals and Health Systems,” October 2009 at www.caph.org.