



COVERING THE MIAS: FEDERAL REFORM AND A STATE WAIVER

Ashley Cohen, Rebecca Pizzitola and Lucien Wulsin

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California is currently seeking to renew a §1115 Medicaid waiver set to expire on August 31, 2010. Medicaid waivers from the federal government grant states permission to experiment with their Medicaid programs in ways they believe can make their programs more efficient and effective. California's waiver, known commonly as the hospital financing waiver, broadly alters payment mechanisms in order to strengthen the sustainability of its safety net, while narrowly working to improve the state's health care system infrastructure through ten county health care coverage initiatives (CIs). Under a renewal, the state hopes to continue and strengthen CIs while expanding the waiver to fund initiatives in more or all of California's other 48 counties in order to cover more of their uninsured—starting with medically indigent adults (MIAs). In combination with federal reforms signed into law under HR 3590, the Patient Protection and Affordable Care Act, the opportunity to cover more MIAs in the near future is significant.

The question that has come into play now that health care reform has passed and signed into law is what is the best way to fund care and coverage of the MIAs. Under federal health reform, California can implement HR 3590 elements to expand Medicaid to insure more parents and MIAs in a Medicaid managed care format, if counties choose to fund the match (which they already do under the current waiver for the ten county CIs). *This would double current county spending on care to the MIAs.* This assumes, however, that counties can not only allocate this funding, but also additionally meet the requirements set forth in HR 3590 for better care—such as provider choice and timely access to integrated care. Alternatively, the state can put its emphasis on renewing its Medicaid waiver, under which counties would still likely wish to put up funding to draw down matching federal dollars but maintain some level of flexibility with which to transition sequentially to meet federal reform requirements. For example, a large part of an improved health care system involves integrating the public and private, hospital, clinic and managed care sectors, which takes time. Additionally, the waiver could draw on and allocate a hospital fee¹ that has the potential to raise nearly \$2 billion, which can then be federally matched.

The small County Medical Services Program (CMSP) counties already meet many of the federal health reform requirements to qualify for a federal match. Counties like Orange and San Diego are close but not quite there; for example, while they have a broad array of providers in their networks to meet patients' need for care; they would have to expand their benefits to cover more preventive and primary care services and in our view should use their local managed care organizations. Inland Empire counties have limited to no contracts between their county

¹ AB 1383 (Jones) enacted a hospital fee in 2009, a bill supported by many hospitals but suffering from opposition from the Howard Jarvis Taxpayers Association who maintained this was a tax requiring a two thirds vote. The legislation might need further amendments to be approved by the federal government or this could be cured in the waiver negotiations. See: Legislative Counsel. (2009). Bill Analysis. Retrieved March 29, 2010 from http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1351-1400/ab_1383_cfa_20090921_143451_asm_floor.html.



clinics/hospitals and their private counterparts for care of the uninsured; whereas their Bay Area counterparts are developing public-private networks within a managed care framework. Not only will some counties be differentially prepared for federal reform requirements, but others may be unwilling to transition to a more integrated system without substantial federal assistance. Considering the varying levels of county readiness for reform, it may be most viable to seek a large Medicaid waiver to give less prepared counties time to build their infrastructures to be in line with federal requirements, perhaps by meeting staggered benchmarks to pull in more private providers and shift to managed care. In addition, if such a waiver were to include a manageable cap on enrollment and county financing, counties that are already struggling with budgetary concerns could ensure that new implementations are not so expansive as to harm their programs' sustainability and local budgets.

Despite the appeal of financing better coverage to more MIAs through a renewed waiver or through the Medicaid expansion, California will continue to struggle with the costs of hospital care to undocumented immigrants. Disproportionate share hospital (DSH) funding can be used to help cover hospitals' costs for uncompensated care, but federal matching through a waiver or Medicaid expansion cannot be used for non-emergency care to undocumented immigrants because Medicaid eligibility for the full complement of Medicaid services is restricted to citizens and legal permanent residents. With the state's substantial immigrant population, California providers will continue to struggle with the costs of care for undocumented immigrants outside of hospital emergency rooms.

California's Hospital Financing Waiver

Payment Mechanism Changes

Hospitals that are part of the safety net and serve low-income populations, such as Medicaid beneficiaries and the uninsured, provide a vital service that would not be possible without financial assistance, since Medicaid typically reimburses below, or at best, at the actual cost of care. All Californians have a right to care through emergency rooms, but many low, moderate and middle income uninsured and underinsured often cannot pay the hospital charges for this care. Prior to the 2005 waiver, the California Medical Assistance Commission (CMAC) negotiated payment rates for most Medicaid hospitals. Often, they sought to pay under cost in an attempt to save money for the state; hospitals relied on DSH payments to cover the difference. To further help these hospitals continue to provide services for low-income populations, supplemental payments were granted through programs such as SB 1255,² the Medical Education Fund, SB 1732,³ and most notably, through Disproportionate Share Hospital (DSH) from the federal government with certain county governments paying the match.^{4,5}

² Under SB 1255, voluntary transfers from public entities were matched by federal Medicaid dollars and then allocated to safety net hospitals to help cover the costs of providing care to Medicaid beneficiaries and the uninsured.

³ SB 1732 provides additional funding to DSH for capital construction costs.

⁴ The federal government allots DSH funds to each state, and the state distributes among qualified hospitals as either supplemental payments or payment adjustments to what these hospitals receive for their care to Medicaid beneficiaries.

⁵ Dam, K. and L. Wulsin. (2008). A Summary Of Health Care Financing For Low-Income Individuals In California, 1998-2008. Retrieved March 25, 2010 from

Unfortunately, unlike federal matching Medicaid dollars for services, DSH is capped; under reform the federal allocations are scheduled to decline, and DSH is therefore not a long-term solution to supplementing the costs of care paid below cost.

State Supplemental Payments to California Hospitals, 1999 to 2006 ⁶					
Year	Total	SB 1255	SB 1732	Medical Education	AB 761
1999-2000	\$1,427,300,000	\$1,200,000,000	\$ 94,900,000	\$132,400,000	\$0
2000-2001	\$1,641,798,000	\$1,377,555,000	\$108,943,000	\$154,650,000	\$650,000
2001-2002	\$1,663,419,000	\$1,344,715,000	\$159,354,000	\$159,350,000	\$0
2002-2003	\$1,882,400,000	\$1,600,000,000	\$123,700,000	\$158,700,000	\$0
2003-2004	\$1,977,698,000	\$1,718,714,000	\$107,209,000	\$157,700,000	\$75,000
2004-2005*	N/A	\$1,611,286,000	N/A	N/A	N/A
2005-2006*	N/A	\$1,615,320,000	\$124,900,000	N/A	N/A

*Estimated.

DSH Payments in California, 1999 to 2005 ⁷					
Year	Total	Federal	Public Net	Private Net	County/Public IGT
1999	\$2,094,117,647	\$1,068,000,000	\$617,165,976	\$551,467,927	\$1,026,117,647
2000	\$1,898,039,216	\$968,000,000	\$503,265,859	\$486,993,451	\$930,039,216
2001*	\$2,040,034,000	\$1,020,017,000	\$530,408,840	\$510,008,500	\$1,020,017,000
2002	\$2,110,415,174	\$1,055,207,587	\$519,258,646	\$506,191,250	\$1,055,207,587
2003	\$1,814,513,110	\$907,256,550	\$444,340,426	\$433,158,384	\$907,256,550
2004	\$2,478,178,000	\$1,239,089,000	N/A	N/A	\$1,239,089,000
2005	\$2,001,530,000	\$1,000,765,000	N/A	N/A	\$1,000,765,000

*Estimated

Under the 2005 hospital financing waiver, monies from SB 1255 and the Medical Education Fund were replaced for public hospitals with assistance from the new Safety Net Care Pool (SNCP), specifically to be used for hospital and ambulatory care to the uninsured. Public hospitals (including the UC hospitals) were to be paid at cost for their inpatient care. Counties, rather than the state, were required to pay the match for DSH, SNCP and Medicaid inpatient care in county hospitals. An additional \$180 million annually was allocated for the first two years to assist California providers with the costs of implementing managed care for the aged and disabled – a managed care expansion that was never implemented. Private hospitals would receive money through a DSH-like program, through the Private Supplemental Program in lieu of SB 1255 and through inpatient rates negotiated with CMAC; the state would pay the matches. The Distressed Hospital Fund, established under the hospital financing waiver in 2005, has further helped cover costs.

Funds for hospital construction made available through SB 1732 remained unaltered under the waiver. DSH payments (which are capped in several ways by the federal government) are no longer given to all safety net hospitals, but rather only public ones. Instead, private safety net

http://www.itup.org/Reports/Coverage%20and%20Financing%20for%20Low%20Income%20CA-ins%27/FINAL_HCF%20REPORT%202008.pdf

⁶ Ibid.

⁷ Ibid.

hospitals were funded under the waiver through a new program known as Virtual DSH, financed by state general funds as the match for federal funds.

2006 DSH and Supplemental Payments Under the §1115 Waiver of 2005 ⁸				
Net County DSH	Safety Care Pool	Private Virtual DSH	Private Supplemental	Distressed Hospital Fund
\$1.032 billion	\$586 million	\$477 million	\$292 million	\$13 million

To solve part of the payment problem, the new waiver altered some payments to be at cost—specifically those for inpatient care to Medicaid beneficiaries in public hospitals, recognizing that this strengthened the safety net by drawing down more federal funding in place of capped DSH funds. The positive and negative impacts of this were greatest on the counties, since counties are responsible for paying the match for public hospitals for inpatient care in the fee-for-service system. The state of California pays the match for hospital care for those in managed care, creating a strong incentive for the counties and a large disincentive for the state to shift additional populations into managed care. Hospitals with freestanding clinics have been converting their clinics to federally qualified health centers (FQHCs) in order to be paid at cost for outpatient care as well; those without FQHC status are still receiving payments below cost.

The method of county matching changed under the 2005 waiver. In the past, counties primarily used intergovernmental transfers (IGTs) to fund their match. Specifically, state and local revenues were passed between different levels of government to help cover the cost of caring for Medicaid beneficiaries and the uninsured. For the federal government, this method has been problematic, as states have tried to maximize federal funding and used funds for unapproved purposes,¹⁰ such as double dipping.

County Reported CPEs on the Uninsured (2006) ⁹	
CMSP	\$174,523,681
Public Hospital (LA)	\$724,513,211
Public Hospital (All Other)	\$651,997,133
Other	\$232,156,479
Total	\$1,783,190,504

In essence, some states paid above-cost for care provided by a hospital or other facility to draw down more federal matching, with the excess being sent back to the state or local treasury—and potentially used again for added reimbursements.¹¹ This type of activity inspired the federal

⁸ Ibid.

⁹ Insure the Uninsured Project. (2010). 2006 County Funding Breakdown. Retrieved April 5, 2010 from http://www.itup.org/Reports/1115/2006_County_Funding_Breakdown.xls.

¹⁰ Kaiser Family Foundation. (2005). Medicaid Financing Issues: Intergovernmental Transfers And Fiscal Integrity. Retrieved March 26, 2010 from http://www.google.com/url?sa=t&source=web&ct=res&cd=2&ved=0CBAQFjAB&url=http%3A%2F%2Fwww.kff.org%2Fmedicaid%2Fupload%2FMedicaid-Financing-Issues-Intergovernmental-Transfers-and-Fiscal-Integrity-Fact-Sheet.pdf&ei=T_CsS_nXJIH8tAOD1YD7Cw&usg=AFQjCNEBVp3l_V1MCF2EuykuW-wXy3ztgw&sig2=3K7uEIA_wb7-UB9q-Najg.

¹¹ United States General Accounting Office. (2004). Intergovernmental Transfers Have Facilitated State Financing Schemes. Retrieved March 26, 2010 from <http://www.google.com/url?sa=t&source=web&ct=res&cd=3&ved=0CBgQFjAC&url=http%3A%2F%2Fwww.gao.gov%2Fnew.items%2Fd04574t.pdf&ei=5vSsS7XQDJDesgOY9MWIDQ&usg=AFQjCNE0TPStyKj85iZl5bS5Mljz7Lr4jg&sig2=u5f2pra3SrHJVtmW84OHQ>.



government to limit IGTs through subsequent state waivers. Instead, California at the insistence of the federal government began to use certified public expenditures (CPEs) to secure federal matching,¹² which required local government providers to certify expenses but only up to the actual cost of care.

This contrasts to a more flexible system of using IGTs, whereby the state or county submits a request for matching without necessarily showing proof of the actual expenditure—although now states must demonstrate that the provider retained and spent the full payment, preventing transfer back to the state treasury. The federal and local Medicaid match cannot be diverted to legitimate county needs other than medical costs that can be covered by Medicaid.

Health Care Coverage Initiatives

Ten counties received competitive grants under the waiver and have implemented CIs that cover more of their low-income adult residents that are ineligible for public or private insurance and meet income requirements (up to 200% of FPL). This population is referred to as medically indigent adults (MIAs), a population which counties have the responsibility to care for using a mix of state and federal revenues including realignment funds,¹³ tobacco funds, DSH payments, SNCP funding, and a county match.

Since September 2007, each of the ten CI counties has implemented programs that put more of their MIAs into programs emphasizing prevention and primary care centered on medical homes. This waiver allotted \$180 million annually for the final three years of the waiver to match county payments for their initiatives. This has shifted counties' historical emphasis on episodic urgent and emergency care for MIAs in favor of better coordinating care by improving communication between providers and facilities to harness the power of a more integrated approach to care. The focus for many started with collaboration and included the development and deployment of health information technology (HIT). Some of the ten counties improved their preexisting MIA programs by increasing eligibility levels and/or expanding benefits (e.g., Orange County), while others started new programs for high risk components of this population (e.g., San Diego County).

Waiver Renewal Request

Under the renewal waiver, California has set out a series of goals to 1) improve the state's health care delivery system, and 2) expand coverage to more MIAs.¹⁴ Generally, the state is seeking to build a more accountable system of care that focuses on prevention and primary care for its Medicaid beneficiaries and its uninsured. This care would be centered in medical homes to facilitate care coordination (including care and disease management using hospital, home and community-based care). For high cost populations like children with special health care needs, dual eligibles, and adults with severe mental illnesses, the waiver would encourage the use of

¹² CPEs are funds certified as having been used for Medicaid beneficiaries or the uninsured.

¹³ Realignment funds are financed through state sales taxes and vehicle license fees.

¹⁴ California Department of Health Care Services. (2009). State of California's Concept Paper For A Comprehensive Section 1115 Waiver To Replace The Current Medi-Cal Hospital/Uninsured Care Demonstration Project. Retrieved March 26, 2010 from <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Final%20Concept%20Paper%202012-16-09.pdf>.



managed and coordinated care to better integrate care, improve health outcomes and reduce costs.¹⁵ HIT is highlighted as a method to better link providers and enhance communication, as well as to monitor, improve and reward quality and better health outcomes.

The renewal waiver would also continue efforts to strengthen the safety net, facilitate the transition to Medi-Cal managed care under federal reform and increase the number of insured MIAs. This includes improving the current ten county CIs and expanding CIs to many or all of California's 58 counties. The state is looking to institutionalize more consistent county health program standards that align with those being proposed for seniors and the disabled, and to streamline enrollment processes.

The §1115 Waiver and the Patient Protection and Affordable Care Act

In anticipation of the hospital financing waiver expiring, the state has prepared for a waiver renewal that works with or without federal health care reform to improve the health care system in California and cover more of the state's uninsured. With the successful passage of HR 3590, federal health care reform is now law and is on course to complement and augment state and county efforts to cover MIAs. Under a new waiver, counties can make better use of federal funding to cover more MIAs and improve the state and county's delivery systems.

Increased Federal Funding for MIAs

Under reform, the federal government will increase the Federal Medical Assistance Percentage (FMAP) for MIAs with incomes at or below 133% of the FPL. Beginning in April, 2010, the federal government will pay a 50/50 match, then from January 1, 2014 to December 31, 2016, the government will pay 100% of the cost of covering the newly eligible MIAs, followed in 2017, 2018, and 2019 by 95%, 94% and 93%, respectively. The federal government will pay 90% of the costs thereafter, with the state or its counties funding the match.

Presently, no counties receive federal financial assistance that comes close to this offer. The ten CI counties are currently receiving a 50% match for their Coverage Initiatives under the hospital financing waiver up to a federal cap of \$180 million annually. In 2014, states will have a 100% FMAP for all the newly insured up to 133% FPL, and all states must alter their Medicaid programs to insure their citizens, including MIAs, up to 133%. Until then, states have less financial incentive to expand coverage to their MIAs. California could receive a 62% Medicaid match for beneficiary costs through the remainder of 2010, with a 50% match thereafter, on top of a temporary 2.5% increase in DSH payments.¹⁶

If the waiver is simply extended, the ten CI counties included in the current hospital financing waiver will continue to receive federal matching dollars up to the cap at a percentage specified in the current waiver). California could ask for an uncapped match for MIAs with incomes up to

¹⁵ Because the state reimburses for the care of beneficiaries in managed care, this change would increase the state's financial responsibility for the Medicaid population. Such a change will likely require rebalancing county and state payment streams and responsibilities.

¹⁶ This assumes that California meets federal requirements, including maintaining eligibility requirements despite budget deficit difficulties. California Department of Health Care Services. (2009). American Recovery and Reinvestment Act of 2009. Retrieved March 30, 2009 from <http://www.dhcs.ca.gov/Pages/A.aspx>.



133% of FPL from the start of a renewed waiver (September 2010) or even retroactive to April 2010 as opposed to waiting until the end of year three of a five-year waiver, i.e., January 2014. This could significantly lighten the burden on CI counties, all of whom quickly learned under the current waiver program how much larger the demand was compared to the \$180 million annual federal allocation.

County Health Funding Streams (2005) ¹⁸	
Realignment	\$1,492,186,884
Net County DSH	\$890,117,083
County Match	\$339,771,970
Tobacco Settlement	\$332,327,450
Proposition 99	\$49,240,132
Total	\$3,103,643,519

The impact of federal reform expanding coverage for MIAs is to provide an new match and remove the budget neutrality requirement for this aspect of the waiver. California no longer needs to engage in a convoluted argument that asks for credit for California’s history of Medicaid “savings,” which have accrued by having Medicaid per capita spending at one of the lowest rates in the country.¹⁷ More flexibility can be built into a renewed waiver with the elimination of the \$180 million annual funding cap on care to MIAs, so that counties are able to draw down federal funds to match all their CPEs (or IGTs) on MIAs.

One question is how much IGT or CPE is available to bring in a federal match. Only the counties themselves can answer this to their own satisfaction, but they should make this information transparent so that informed policymaking can result. ITUP calculated that \$1.8 billion was reported to be spent by California counties for care to the uninsured in 2005, as discussed above. In 2005, California counties had \$2.2 billion in realignment, county match and tobacco litigation settlement, not including their DSH and SNCP funds, which, since they are federal funds, cannot be used to match other federal funds. Not all of the uninsured cared for in county systems were MIAs, but most county programs limit their care to MIAs. An additional \$2 billion in hospital fees is available under AB 1383 (Jones) to bring in at least an equal volume of federal match for the purpose of increasing hospitals’ Medi-Cal reimbursements up to Medicare levels.

Regardless of whether California covers its MIAs as part of federal reform or under a renewed waiver, the state has an opportunity to take advantage of additional available federal funds. Counties can cover more of their MIAs now if they are able to put up a 38% (then 50%) match and improve their current programs and health systems to meet federal standards; otherwise, they can improve care, quality and access and replace current MIA spending with federal dollars starting in 2014. Under federal reform, we project that the number of uninsured will drop to roughly 1.7 million.¹⁹ The costs of covering the newly insured will shift entirely from county expenditures to federal funds beginning in 2014.

¹⁷ In conjunction with the federal government, California spent \$2,740 per enrollee, slightly above half the national average, coming in second to last in total per capita spending after Arizona. See: Kaiser Family Foundation. (2006). Medicaid Payments Per Enrollee, FY2006. Retrieved March 30, 2010 from <http://www.statehealthfacts.org/comparetable.jsp?typ=4&ind=183&cat=4&sub=47&sortc=5&o=a>.

¹⁸ Insure the Uninsured Project. (2010). 2006 County Funding Breakdown. Retrieved April 5, 2010 from http://www.itup.org/Reports/1115/2006_County_Funding_Breakdown.xls.

¹⁹ Insure the Uninsured Project. (2010). County Funding Spreadsheet. Retrieved March 22, 2010 from http://www.itup.org/Reports/Health%20Reform/County_Funding_Excel.xls.



The Exchange

Beginning in 2014, state health benefits exchanges (Exchange) will be established. The Exchange will be open to MIAs with incomes between 133% and 400% FPL, to provide a choice of plans, providers and levels of insurance coverage that meet federal requirements. The Exchange will offer refundable tax credits on a sliding scale linked to the lower cost plans at each level of benefits. The Exchange will also be open to new legal immigrants, but not the undocumented. Safety net plans and providers can and hopefully will choose to participate in the Exchange. To be successful, these plans and providers must offer a strong combination of affordability and quality to accompany their existing advantages of language, location and familiarity.

Transitioning to Federal Reform

Federal reform includes many provisions similar to those being implemented at the county level under CIs and systems already in place for CMSP counties. The ten CI counties have already expanded their provider networks, linked hospitals and clinics, and established medical homes to better coordinate and manage care for their enrollees. They have begun to invest in and use HIT and nurse advice lines to enhance collaboration and communication among providers in order to improve the quality of care—including reducing duplication and minimizing the use of emergency departments for nonemergent care.²⁰ And several counties have become increasingly cognizant of the importance of making a series of steady improvements to contain costs over the long run. For example, many are now seriously looking at integrating both physical and mental health, so that those suffering from mental illness have greater support in managing their other chronic health conditions; these local expenditures for mental health can also now be used to draw down a federal match.

Based on their efforts, many of the ten CI counties are closer to meeting the federal requirements of health care reform in terms of offering timely access to coordinated care systems among a wider network of providers, introducing care management and transitioning to managed care. These counties have begun to align with the elements of required change in HR 3590—“health” homes, quality improvement, an emphasis on prevention and primary care, improving the public health workforce, and investing in and disseminating HIT, among others. These are the founding steps to make health care more efficient and effective.

With the help of a greatly expanded waiver renewal, counties can continue to restructure their systems ahead of federal reform changes that will be implemented in 2014. They can also pilot systems that will evolve to meet federal requirements, such as for online record management, electronic matching of federal and state data, and digital notifications of eligibility and recertification. These pilots will help counties get a head start on digitizing patient information, in addition to receiving funding allocated to HIT through HR 3590.²¹ They can identify and enroll MIAs so that the state takes full advantage of the new federal match. Since high-risk populations generally utilize the greatest amount of care in the first few years of coverage, early

²⁰ The type of technology has included disease registries (Alameda), e-referrals (Orange), and encounter summary sheets (Los Angeles).

²¹ Democratic Policy Committee. (2010). The Patient Protection and Affordable Care Act. Retrieved March 22, 2010 from http://dpc.senate.gov/dpcdoc-sen_health_care_bill.cfm.



treatment will bend the curve of their future costs of coverage, and avoid a spike in use due to pent-up demand during the first years of reform.²² Like any significant infrastructure changes, implementing the use of health homes will require significant planning and testing; it is a process, not an overnight solution that can be readily dropped into place—a further reason for California to get a head start on federal reforms through an expanded waiver. California faces the choice of embracing a process of incremental change through the waiver or hoping California’s counties and safety net systems will be prepared for federal reform without any federal assistance prior to 2014.

²² Health Access California. (2010). The Bridge To Reform: How Can California Be Ready For Reform & Expansion On Day One, Through The Medicaid Section 1115 Waiver. Retrieved March 28, 2010 from <http://health-access.org/files/expanding/The%20Bridge%20to%20Reform%20Medicaid%20Section%201115%20Waiver%203-28-10.pdf>.