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## **Medicaid Section 1115 Demonstration Projects: Emerging Trends in Safety Net Financing**

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National Association of Public Hospitals and Health Systems  
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## I. Introduction

Throughout the history of the Medicaid program, states have been permitted to use the substantial flexibility provided by Section 1115 of the *Social Security Act* to create demonstration projects to test policy innovations likely to further the objectives of the Medicaid program. Section 1115 grants the Centers for Medicare and Medicaid Services (CMS) the authority to waive compliance with certain Medicaid requirements, and thus the resulting demonstration programs are often known informally as “waivers.” Over the past 15 years, states have increasingly relied on these waivers to achieve programmatic goals.<sup>1</sup>

This paper focuses on an emerging trend among states to use Section 1115 demonstrations to restructure Medicaid payments supporting safety net providers (i.e. “safety net financing”). This trend is an outgrowth of current CMS scrutiny of state methods of financing the non-federal share of Medicaid expenditures, particularly through intergovernmental transfers (IGTs).<sup>2</sup> On the one hand, these demonstrations have given CMS the opportunity to achieve longstanding policy goals by limiting the use of IGTs, securing greater oversight of state programs, and gaining certainty about federal expenditures. At the same time, states have taken advantage of the flexibility inherent in the Section 1115 authority to develop new mechanisms to retain critical support for the safety net that had otherwise been challenged by CMS. Whether this tradeoff ultimately will work to the advantage of the states, impacted safety net providers, and patients served by the safety net remains unclear.

## II. Background

In traditional Medicaid programs (i.e. without Section 1115 waivers), states have developed a variety of mechanisms to support safety net hospitals and health systems that serve large volumes of Medicaid and uninsured patients. These mechanisms include Medicaid disproportionate share hospital (DSH) payments,<sup>3</sup> which implement the Medicaid statute requirement that states “provide rates that take into account ... the situation of hospitals which serve a disproportionate number of low-income patients ....”<sup>4</sup> Many states also provide other supplemental payments to safety net hospitals pursuant to regulatory upper payment limits (UPLs)<sup>5</sup> and statutory requirements.<sup>6</sup> Over the years, supplemental Medicaid payments have become an essential funding source for America’s safety net hospitals and health systems, enabling them to provide critical access to health care services for vulnerable poor and uninsured patients.

Although the Medicaid statute requires that the cost of Medicaid payments to providers be shared between the state and the federal government, it does not require that the state provide the entire non-federal share from its general funds.<sup>7</sup> Throughout the 40-year history of the Medicaid program, states have obtained a portion of the non-federal share of Medicaid payments through IGTs or certifications of public expenditures (CPEs)<sup>8</sup> by other governmental entities. IGTs and CPEs are frequently used to finance supplemental safety net hospital payments, in part because public hospitals are typically already using public funds to provide otherwise unreimbursed care.

In recent years, CMS has sought to restrict certain state financing practices that it deems improper, including the use of IGTs. For example, CMS has expressed substantial concern that states have employed improper “recycling” techniques to shift the costs of the Medicaid program

away from state government and towards the federal government. While CMS has not defined “recycling” extensively, it has targeted funding arrangements whereby states pay providers for Medicaid services but then require those providers to “return” some or all of the payment through IGTs. CMS also has challenged “over-transfers,” i.e., IGTs that exceed the amount of the non-federal share required to finance particular supplemental payments. And it has objected to IGTs and CPEs from entities and providers it deems insufficiently public to participate in Medicaid financing. The legal basis for many of the CMS oversight activities in this regard is highly questionable and its new approach represents a marked departure from its prior financing policies.<sup>9</sup> Nevertheless, CMS has not issued any new rules or regulations regarding the source of the non-federal share. Instead, it has undertaken individualized reviews and has engaged in state-by-state negotiations to resolve perceived problems.

CMS also has proposed legislative reforms to Medicaid financing, although Congress has not acted on these suggestions. In the Administration’s fiscal year 2005 and 2006 federal budgets (released in February 2004 and 2005, respectively), CMS proposed both to restrict the use of IGTs and to limit public provider reimbursement to cost. Despite lack of congressional approval, CMS has continued to insert these ideas into state negotiations, including negotiations regarding Section 1115 demonstrations.

CMS has made previous attempts to obtain preapproval authority over the sources of state non-federal share financing. For example, in late 2002, CMS agreed to drop a \$2 billion challenge to a Missouri provider tax in exchange for such prospective oversight. The resulting Missouri Medicaid Partnership Plan (MPP) (which is not a Section 1115 demonstration) requires the state to submit a proposed Medicaid budget, including sources of the non-federal share, to CMS for approval before any federal funds become available. In early 2004, CMS attempted to extend this preapproval requirement to other states.<sup>10</sup> The backlash from states was swift and substantial, however, and the agency eventually withdrew the proposal.

Through the new financing waivers, CMS has achieved many of the policy goals that it has been unable to obtain through legislation or administrative action. At the same time, the waivers have enabled states to retain some funding that, under new CMS policies, otherwise may have been lost. Assessing the value of this trade-off requires a closer examination of the details of the four demonstrations.

### **III. Safety Net Financing Issues in the Context of Section 1115 Demonstrations**

In 2005, California, Florida, Iowa, and Massachusetts all obtained approvals of Section 1115 demonstration projects that made major adjustments to each state’s system of safety net financing. For example, Massachusetts, California, and Florida established safety net care pools (SNCPs) or low-income pools to replace existing methods for providing institutional support to safety net providers. The safety net provider network used in Iowa’s Section 1115 demonstration is a different model for providing safety net support.

Although none of these programs have been fully implemented, these states believe that, through the demonstrations, they have retained federal funding that otherwise could have been lost (or

... tied up in litigation) due to CMS opposition to financing practices. At the same time, however, the states have agreed to new limits and constraints on safety net funding not otherwise required by Medicaid law. Although the safety net funding at issue is the “lifeblood” for many of the impacted hospitals, the safety net hospitals themselves are not official parties to the negotiations. In some negotiations, the states have acted despite fervent opposition from safety net hospitals. The final impact on safety net hospitals is not yet clear.

The remainder of this section provides detail regarding various financing aspects of the new demonstration projects. The ultimate result of these demonstrations is unclear, in part because many of the waiver approval documents defer decisions about implementation details, preserving CMS’ right to approve or reject details later.<sup>11</sup> Therefore, much remains to be seen regarding how these negotiated terms will affect states and providers.

### **New Mechanisms for Providing Safety Net Financing**

The most positive aspect of the recent series of Section 1115 demonstrations from the safety net hospital perspective is the creation of new mechanisms for supporting the safety net. These mechanisms do not necessarily represent an expansion of funding for the safety net, but rather a replacement for funding that will be phased out as a condition of demonstration approval. In general, the demonstrations permit states to retain access to Medicaid funding levels generally equivalent to prior supplemental payment mechanisms.

#### **Safety Net Care Pools and Low Income Pools**

The recent Section 1115 demonstrations approved in Massachusetts, California, and Florida all incorporated the notion of a special safety net-oriented reimbursement pool. Through creation of these pools, CMS has allowed these states to retain challenged federal funding essential to supporting the states’ safety net through a restructured pool mechanism in which providers are compensated based on documented costs, up to a certain annual capped dollar amount. Although particulars vary, the pools generally may be used to compensate providers for a far broader range of costs than is currently allowable under federal Medicaid law, including non-hospital costs for the uninsured, unreimbursed Medicaid and uninsured costs for services that are not covered under the state’s Medicaid plan, and investments in infrastructure and capacity building that are not tied to patient care services. In addition, some states appear to have retained the ability to provide supplemental cost-based payments for Medicaid managed care enrollees despite regulatory prohibitions.

California and Massachusetts negotiated their SNCPs in the context of an effort to resolve longstanding safety net hospital financing disputes with CMS, and financing changes were the major, immediate focus of the two demonstrations (with managed care and health coverage expansions to follow). Although Florida did not explicitly have major safety net hospital financing disputes with CMS, Florida hospitals had concerns about the impact the broad changes proposed in the state’s Section 1115 demonstration proposal might have on supplemental Medicaid payments to support the safety net and, with the support of the Florida legislature, sought protections provided through the establishment of a low-income pool. Although not the only possible means for addressing these concerns, the pools provided states with an avenue by which to preserve safety net funding as other changes to Medicaid were being made within the state.

All of the pools are limited by a fixed annual dollar cap. The amount of the caps were the subject of intense negotiation in each state, and whether the caps agreed to are adequate to allow for sufficient growth in uncompensated costs is an open question. Outside of the statutory state-by-state DSH allotments, these caps represent the first time that Medicaid reimbursement to providers is restrained by an aggregate cap which could ultimately reduce payments to all providers below the cost-based amounts that are otherwise allowable. This risk is especially significant if the state uses the flexibility in the pool to provide payments to non-hospital providers or plans that previously had not had access to safety net funding. In addition, as discussed in more detail below, in some of the states a portion of the pool funding is contingent, meaning that even the capped amount is not guaranteed. These features of the pools introduce a new element of risk into safety net funding that is making some of the impacted hospitals nervous.

At the same time, a SNCP may provide several potential benefits. Given the strict limitations of DSH allotments,<sup>12</sup> it may be useful to have an additional avenue outside of DSH to provide reimbursement for uninsured patients. In addition, the SNCP may provide an alternative source of reimbursement for costs not eligible for DSH funding. For example, DSH payments may not be used for non-hospital costs or for investments in infrastructure and capacity building not tied to patient care costs, whereas CMS has allowed the SNCPs to provide such support.

In Florida and Massachusetts, up to 10 percent of the SNCP may be used for payments not tied to patient care costs. Florida's special terms and conditions (STCs)<sup>13</sup> specify that low-income-pool reimbursement pursuant to this 10 percent sub-cap is available "for the improvement or continuation of specialty health care services that benefit the uninsured and underinsured, such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, rural hospital services, pediatric hospital services, teaching or specialty hospital services, or safety net providers."<sup>14</sup> Massachusetts has a similar provision.<sup>15</sup> In California, capital costs may be included, pursuant to an existing California program to provide supplemental capital payments.<sup>16</sup> Thus, the range of uncompensated costs for which states operating pools may compensate providers is significantly expanded to include non-hospital costs of serving the uninsured and infrastructure and capacity-building investments not tied to the provision of actual services.

Another potential benefit of SNCPs may be the ability for providers in states adopting major managed care expansions to retain access to supplemental funding. Generally, regulations prohibit states from making payments (except DSH and medical education payments) directly to providers for services related to Medicaid managed care organization (MCO) enrollees when an MCO is already being paid to deliver services to those same enrollees.<sup>17</sup> However, SNCPs may in some cases be used either directly or in combination with DSH to provide supplemental, cost-based payments even for managed care enrollees.<sup>18</sup>

With respect to DSH, California and Florida retain their DSH programs as separate funding streams outside of the new pools. Massachusetts, on the other hand, has incorporated its DSH allotment into the SNCP. It is not clear whether combining the two is or is not advantageous. SNCPs typically allow payments not necessarily permitted under DSH (e.g., infrastructure investments not tied to patient costs, non-hospital costs), and DSH payments may be used for



purposes not permitted by some of the SNCPs (e.g., the cost of providing uncompensated care to undocumented aliens). If all of these costs can be claimed through a single pool and the pool can provide direct payments for managed care enrollees, then incorporating DSH into the pool should not have a material impact on overall payments.

As noted above, in all of the states where SNCPs have been established, the funding for these pools is capped, allowing CMS not only to control but also to predict future spending levels. Although the spending caps are based on historic spending and in some cases account for program growth, they place new limits on safety net financing at a time when the number of Medicaid and uninsured individuals continues to rise. The limits on SNCP funding differ from the traditional limits on demonstration expenditures. Most typically, demonstrations are subject to so-called “budget neutrality” expenditure caps derived from estimates of the amount the federal government would have spent on the state’s Medicaid program in the absence of the waiver. In contrast, the SNCPs (explicitly or implicitly) calculate budget neutrality utilizing an aggregate spending limit based, at least in part, on the historic Medicaid supplemental payments, even though CMS had challenged many of those payments as inappropriate. Although it is very significant that the aggregate caps facilitate ongoing access to historic supplemental provider payments that might otherwise have been lost, it is unclear whether the SNCP payments will be adequate, since, for example, the caps may not accommodate unanticipated growth in the number of uninsured.

### **Coverage Expansions Involving Safety Net Provider Networks**

A radically different approach to creating a new safety net financing mechanism is represented by the Iowa Section 1115 demonstration. Rather than creating an SNCP, Iowa expanded coverage to uninsured adults up to 200 percent of the federal poverty level. However, unlike typical coverage expansions, this expansion will be provided almost exclusively through the state’s two major public hospital systems, the University of Iowa Hospitals and Clinics and Broadlawns Hospital; the benefit package is largely restricted to services available through those two providers.<sup>19</sup> Although CMS has frequently permitted other states to limit benefits for Medicaid expansion populations, such a restricted provider network is rare and may well be unique.

In exchange for this coverage expansion, Iowa agreed to eliminate a series of established and pending supplemental payment provisions in which providers do not retain the total amount claimed by the state, including inpatient UPL payments, supplemental DSH payments, supplemental graduate medical education payments, nursing facility UPL payments and supplemental physician payments.<sup>20</sup> Instead, Iowa will limit hospital and nursing facility reimbursement to costs.<sup>21</sup>

In effect, by agreeing to revise pending state plan amendments (SPAs)<sup>22</sup> to limit payments to costs for both traditional Medicaid patients as well as IowaCare patients, the state substituted reimbursement now available for the new demonstration enrollees for supplemental payments that historically have either helped safety net providers bear high uncompensated costs or accrued to the benefit of the state. Because Iowa has a low DSH allotment (based on low DSH spending at the time DSH allotments were fixed into federal law), the coverage expansion allows the hospitals to receive reimbursement for patients that previously had not even been covered by DSH.

However, the expansion is not without risks for the participating providers. The demonstration will be financed by the state and local funds already dedicated to the University of Iowa and Broadlawns Hospital, subject to CMS approval, and associated with federal funds. In the case of Broadlawns, the portion of its county tax levy for operations and maintenance is being redirected to the state and used to pay demonstration costs. The tax levy, which was never before matched with federal Medicaid dollars, had been dedicated to the cost of care for uninsured Polk County residents at Broadlawns. Not all Polk County uninsured residents will be enrolled in the demonstration, however, so it will be essential for Broadlawns to have access to funding for that uncovered population. Broadlawns and the state are continuing to address these and other funding issues, which will be critical to the success of the demonstration.

For example, currently the two participating providers receive reimbursement for the newly enrolled population and minimal DSH payments for uncompensated care costs. Although a portion of Broadlawns' dedicated tax levy has been redirected to fund the coverage expansion, IowaCare may not enroll enough people to provide reimbursement to offset loss of the tax levy. Iowa's DSH allotment is not sufficient to cover the uncompensated costs associated with individuals over 200 percent FPL who cannot enroll in the expansion as well as individuals below 200 percent who choose not to enroll. Therefore, there is a mismatch of funding that may have an adverse impact on the participating providers. Moreover, since IowaCare may attract previously uninsured Iowa residents from outside Polk County, the tax levy that was previously used to support only county residents now will be spread to others, without any certainty as to whether the money will be sufficient.

Similar to the situation with the SNCs, the calculation of budget neutrality under the Iowa demonstration is different from the typical budget neutrality calculation in that the baseline includes historic UPL spending that CMS has considered inappropriate in the absence of the waiver. The overall limit on spending for the expansion population under the Iowa demonstration appears to account for UPL payments previously used by public providers to fund care for the uninsured. In essence, Iowa negotiated a coverage expansion that does not take money out of the Medicaid program despite the termination of certain IGTs and supplemental payments that were challenged by CMS.

As is the case with the SNCs, concerns remain regarding implementation of the Iowa demonstration project. The success of the demonstration for public providers relies to a large extent on the conversion of previously uninsured populations into reimbursable expansion populations. However, the demonstration imposes enforceable premiums on all expansion enrollees. Since these individuals historically received the same services for free from the same providers, it has understandably been difficult to collect premiums. CMS waived federal law to give Iowa the authority to disenroll expansion eligibles who fail to pay their premiums for 60 days.<sup>23</sup> To the extent that the state disenrolls individuals who fail to pay premiums, public providers could be left with exactly the uncompensated care that was supposed to be alleviated by the demonstration yet without the preexisting sources of financing that historically covered uncompensated care costs.

## Limits on Payments to Public Providers

One key element of the demonstrations has been the elimination of certain payments to providers. For example, the Massachusetts SNCP requires the elimination of special payments to safety net MCOs.<sup>24</sup> The Florida low-income pool requires the elimination of UPL payments to hospitals.<sup>25</sup> As noted above, Iowa agreed to eliminate a series of established and pending supplemental payment provisions.<sup>26</sup> In addition, as indicated by Administration budget proposals over the past two years, CMS has been particularly interested in limiting payments to public providers to costs in order to curtail potentially inappropriate Medicaid spending. CMS has used the recent Section 1115 demonstration projects as a way to impose such limitations on payments to public providers.

Various demonstration projects explicitly limit reimbursement to cost. For example, the California STCs specify that reimbursement to government-operated hospitals will be based on allowable Medicaid inpatient hospital costs as derived from the Medi-Cal as filed cost report.<sup>27</sup> The Iowa waiver requires the state to submit new state plan amendments limiting total Medicaid payments to actual medical assistance and education costs as reported on the CMS-2552 cost report.<sup>28</sup> The Florida waiver stipulates that low-income pool payments for hospital and non-hospital expenditures may not exceed costs, as calculated from the Medicare cost report (CMS-2552), “plus mutually agreed upon additional costs.”<sup>29</sup> Similarly, as Massachusetts transitions to the use of CPEs to finance its safety net pool, it must receive preapproval of all CPEs and assure CMS that CPE amounts are derived from the CMS-2552 report. Any costs outside of the CMS-2552 must be reported through a cost reporting vehicle that is also preapproved by CMS.<sup>30</sup>

At the same time, an inevitable consequence of the move to limit providers to costs is the question of how “costs” will be defined. It remains to be seen whether California, Iowa, Florida, and Massachusetts will easily come to agreement with CMS about definition of costs and whether the definition of costs will be expansive enough to assure that the providers will be kept whole as compared to pre-waiver supplemental payments. This is particularly true in Florida and Massachusetts where costs outside of the Medicare cost report context are explicitly contemplated.

## Limits on the Source of the Non-Federal Share

As discussed above, CMS has recently expressed substantial concern regarding state financing mechanisms. The recently approved financing waivers have given CMS a way to limit state financing mechanisms the agency dislikes without having to amend federal law or policy, and without having to clearly articulate standards. For example, under current law, public entities may permissibly transfer funds to be used as the non-federal share of Medicaid payments. Nevertheless, many of the demonstrations recently approved by CMS place limits on the use of IGTs or directly encourage the use of CPEs.

### Limits on IGTs and CPEs

Under some of the recently approved demonstrations, CMS has curtailed the use of IGTs in ways similar to those it has imposed through state plan negotiations. For example, in California, the conditions of the demonstration project prohibit the use of IGTs from SNCP providers to fund the non-federal share of SNCP payments.<sup>31</sup> Additionally, the California waiver stipulates that IGTs may only be used as the non-federal share of DSH payments

above 100 percent of uncompensated care costs<sup>32</sup> and the state must provide annual assurances that any such IGTs will be no greater than the non-federal portion of the payment they fund.<sup>33</sup> IGTs from units of local government also may be used to fund the non-federal share of base Medicaid payments to private hospitals, but any such payments must remain with the hospital and not be transferred back to the unit of government.<sup>34</sup> The demonstration STCs actually specify by name the government-operated hospitals that are eligible to certify public expenditures and requires CMS preapproval before any hospitals can be added to the list.<sup>35</sup> Finally, California, like all of the other states described here, must secure CMS preapproval of the source of the non-federal share of funding,<sup>36</sup> as discussed in more detail below.

The Massachusetts waiver stipulates that after July 1, 2006, the Commonwealth “may use intergovernmental transfers to the extent that such funds are derived from state and local taxes and are transferred by units of government.”<sup>37</sup> This provision does not explicitly prohibit the use of IGTs that are not derived from state or local taxes, and presumably Massachusetts could seek and obtain CMS preapproval for lawful IGTs that are not derived from state or local taxes. The explicit permission to use IGTs that are derived from state or local taxes implies that such IGTs would receive CMS preapproval; CMS’ likely response to other legal IGTs, however, is unclear.

The question of which public entities may provide non-federal share funding for Medicaid expenditures has been an ongoing source of dispute between states and CMS. CMS has increasingly argued that certain providers are not sufficiently public to make IGTs or CPEs under existing law and regulations.<sup>38</sup> In particular, CMS has aggressively questioned hospitals operated as public authorities, hospitals operated by a 501(c)(3) entity but owned by a local government, and public benefit corporations with respect to their capacity to make IGTs.

Interestingly, none of the demonstrations definitively resolve this issue. The Massachusetts STCs, for example, provide that “only units of government, including governmentally operated health care providers” may certify expenditures for federal match.<sup>39</sup> It is unclear what the meaning of “governmentally operated health care providers” is, however. In addition, the Massachusetts STCs specify that these providers “may certify that State or local tax dollars have been expended to satisfy costs eligible for Federal matching funds under Medicaid.”<sup>40</sup> The document does not, however, clearly limit CPEs to only those expenditures paid for by State or local tax dollars, and it goes on to clarify that certifiable costs are identified through the Medicare cost report or other cost reporting vehicle.<sup>41</sup>

The Florida STCs do not include any details or commentary on permissible or non-permissible IGTs or CPEs, other than to state that all such sources must be compliant with federal statutes and applicable regulations.<sup>42</sup> Preapproval of these sources is required, however. The Iowa waiver includes language that has become standard in all recent CMS 1115 demonstration STCs<sup>43</sup> (not just safety net financing waivers) requiring the state to certify all sources of non-federal share funding in the demonstration, requiring CMS preapproval of all such sources, and obligating the state to address any unacceptable sources within time frames specified by CMS.<sup>44</sup>

Through the preapproval process, many unanswered questions surrounding permissible sources of IGTs and CPEs will be clarified. The stakes are high for these states, since demonstration funding is tied to CMS preapproval, and the preapproval must necessarily incorporate a resolution of these issues. Without the waivers, states are finding it increasingly difficult to use IGTs or CPEs that CMS has not specifically approved; the waivers formalize CMS' approval authority over these financing mechanisms.<sup>45</sup>

### **Encouraging Use of CPEs**

As CMS has increasingly questioned the use of IGTs, consultants and some policymakers have suggested that CPEs could be used to lessen or eliminate the reliance on IGTs. CPEs are perceived as less susceptible to abuse and, therefore, they have been seen by some as something of a panacea. However, CPEs are much more restrictive than IGTs because actual Medicaid costs must be identified in association with CPEs, which are subject to retrospective audit. IGTs, on the other hand, are not limited by costs and are far more flexible.<sup>46</sup> Despite the fact that CMS does not have the legal authority to require states to use CPEs instead of IGTs, the STCs governing the California demonstration preclude the use of IGTs in certain circumstances, leaving the state with no alternative local funding source other than CPEs.<sup>47</sup> Moreover, both the California and Massachusetts waivers include relatively detailed discussions about *how* to certify public expenditures which, while not technically mandating the use of CPEs, appear to presume that CPEs will be used instead of IGTs.

Hospitals transitioning to CPEs will need to develop acceptable CPE methodologies in conjunction with their states and CMS. The methodology is critical, and must ensure that there will be sufficient non-federal-share funding through CPEs to replace funding previously provided through IGTs. As more states negotiate financing waivers with CMS, it remains to be seen whether CMS will continue to require or encourage broader use of CPEs.

### **Limits on Provider Taxes**

Federal Medicaid law allows states to impose taxes on hospitals (and other classes of providers) as a way to raise the necessary funds to provide the non-federal share of Medicaid expenditures. Nevertheless, the California and Iowa waivers each contain provisions prohibiting some or all provider taxes during the term of the demonstration.<sup>48</sup> Given that provider taxes, properly structured, are perfectly legal, the states' agreement not to impose any new provider taxes represents another financing concession that CMS appears to have extracted from these states.

### **Preapproval Requirements**

Even when CMS has not explicitly required that states eliminate IGTs or that they transition to CPEs, CMS has attempted to resolve concerns over financing by demanding preapproval of non-federal-share financing sources as a condition of federal funding.<sup>49</sup> The four demonstrations with important safety net financing elements include some form of CMS preapproval of the source of the non-federal share of Medicaid matching funds before the state can access federal Medicaid funds.<sup>50</sup> In contrast to Massachusetts and California, which not only agreed to preapproval of non-federal-share financing but also made specific concessions about the source of the non-federal share in their demonstration projects (see above),<sup>51</sup> Florida and Iowa agreed to CMS



preapproval of the sources of the non-federal share without agreeing to any specific restrictions on the source of funding beyond those mandated by federal law.<sup>52</sup>

In addition to preapproval of the sources of non-federal-share funding, Florida and California also must receive CMS approval of a “Reimbursement and Funding Methodology” document.<sup>53</sup> Under the MassHealth demonstration, although a specific document is not mentioned in the terms and conditions, CMS also must preapprove payment methodologies.<sup>54</sup> CMS thus has the discretion to approve or reject not only the source of the non-federal share but also the payment methodology. The demonstration terms do not spell out the conditions under which CMS will grant preapproval. The states’ leverage in these negotiations may be reduced, having already agreed to the overarching policy changes sought by CMS (enhanced CMS oversight authority, capped funding, limits on public provider payments). Moreover, states are eager to implement approved demonstration projects to achieve their own programmatic or budgetary goals and may be less resistant to CMS demands. Because the providers who are directly impacted by the details being preapproved have no formal “seat at the table,” they are at the mercy of the state in resolving their concerns.

### Funding Contingencies

Some of the demonstrations make funding contingent upon completion of certain tasks and/or meeting certain milestones. While CMS has always required states to satisfy certain procedural requirements before new demonstration projects could be implemented, the type of contingencies appearing in the recent safety net financing demonstrations are of a different character and raise the possibility that safety net financing could be withheld even as other parts of the demonstration proceed. Moreover, some of the waivers make safety net funding contingent on the achievement of goals unrelated to such funding, injecting an unprecedented degree of risk and uncertainty into the stability of these crucial sources of support. Both the Florida and California waivers condition a significant portion of the safety net funding on the state’s compliance with identified milestones for each year of the demonstration.<sup>55</sup> For the first two years of the California demonstration, \$180 million of federal funding for the SNCP is contingent upon the state meeting certain milestones with respect to its managed care Medi-Cal redesign program, unrelated to the SNCP itself.<sup>56</sup> It has already become clear that the state will miss the milestones for year one, sacrificing \$180 million in federal funds that had been intended for public hospitals, and it appears increasingly likely it will be unable to meet the milestones for year two as well. For the last three years, the \$180 million from the pool may only be used for coverage expansions and not for provider supplemental payments.<sup>57</sup>

Under the Florida waiver, the first-year funding of the low-income pool program is contingent on the state meeting certain pre-implementation milestones, which generally involve obtaining preapproval of funding and payment methodologies as well as the elimination of hospital UPL payments. Thereafter, CMS has set out specific milestones designed to monitor and improve the effectiveness of the pool, which the state is required to achieve each year of the demonstration; \$300 million of the \$1 billion annual pool funding is contingent upon achievement of those milestones. The milestones for the final year include a requirement that the demonstration program be operating on a statewide basis – a milestone not tied to the operation of the low-income pool itself.<sup>58</sup>

These funding contingencies are troublesome. To the extent that a state is unable to fulfill specified milestones, it may have agreed to terminate IGTs or UPL payments, but it also may be unable to implement the financing mechanisms designed to substitute for the terminated financing mechanisms.

#### **IV. Conclusion**

Although waivers approved in California, Florida, Iowa, and Massachusetts may herald an important new approach to providing Medicaid support for the safety net, a variety of outstanding questions remain about these demonstration projects. As states implement the waivers over the coming year, the impact of the financing changes will become clearer, as will CMS' position regarding some of the open questions. Moreover, it remains to be seen whether additional states will take up the trend and succeed in negotiating terms that avoid some of the limits and risks agreed to by the pioneering states.

On the positive side, these demonstrations have preserved federal funding that was otherwise at significant risk. This is no small accomplishment given ongoing efforts by CMS to restrict the use of IGTs and limit payments to public providers. In many states, demonstration projects may present opportunities to preserve funding that CMS otherwise would have targeted for elimination. Moreover, the demonstrations provide an opportunity to receive funding for costs that are otherwise unreimbursable through Medicaid.

On the other hand, in exchange for the preservation of federal funding, the states with demonstration projects have made significant concessions to CMS. The new support mechanisms often are tied to limits on payments to public providers, limits on the source of the non-federal share, preapproval requirements and funding contingencies. Furthermore, overall caps on safety net spending impose a new constraint on support for public hospitals, especially if uncompensated costs rise beyond predicted levels. At this point, it is unclear whether the benefits of the new safety net financing mechanisms outweigh the concessions.

It may be some time before the long-term implications of recent safety net financing changes are evident. Nonetheless, as more and more states consider demonstration projects as a means to restructuring safety net financing, the experience of the four states receiving approval in 2005 can serve both as a model and as a caution in structuring future proposals. The flexibility inherent in the Section 1115 process permits CMS to extract concessions from states but also presents opportunities for states to negotiate favorable terms and conditions; therefore, strategic negotiations based on an understanding of potential risks may help minimize such concerns. Section 1115 demonstration projects appear to represent an opportunity for both CMS and states to achieve important Medicaid policy goals.

## Notes

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- <sup>1</sup> See S. Artiga & C. Mann, *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2005).
- <sup>2</sup> IGTs involve the transfer of non-Federal public funds from a governmental entity (including, for example, a locally owned hospital or nursing facility or a state-owned hospital) to the state Medicaid agency, for the purpose of providing the non-federal share of a Medicaid expenditure in order to draw down federal matching funds. IGTs are often used in connection with payments to hospitals that receive disproportionate share hospital (DSH) funds and upper payment limite (UPL) transactions.
- <sup>3</sup> DSH payments are made either by Medicare or a state's Medicaid program to hospitals that serve a "disproportionate share" of low-income patients, including Medicaid patients and uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing care to Medicare and Medicaid beneficiaries. Medicare DSH payments are based on a federal statutory qualifying formula and payment methodology and are add-ons to prospective payment system payments. For Medicaid DSH, there are certain minimum federal criteria, but qualifying formulas and payment methodologies are largely determined by states.
- <sup>4</sup> 42 U.S.C. § 1396a(a)(13)(A)(iv).
- <sup>5</sup> 42 C.F.R. §§ 447.272, 447.321. UPLs are limits (set by CMS regulations) on the amount of Medicaid payments a state may make to hospitals, nursing facilities, and other classes of providers and plans. Payments in excess of the UPLs do not qualify for federal Medicaid matching funds. The UPLs for institutional providers are generally keyed to the amounts that can reasonably be estimated would be paid, in the aggregate, to the class of providers in question using Medicare payment rules.
- <sup>6</sup> 42 U.S.C. § 1396a(a)(30)(A).
- <sup>7</sup> See 42 C.F.R. § 433.51. This regulation derives from statutory Medicaid provisions that make clear that funds from local sources may be used to provide the non-federal share of Medicaid payments, 42 U.S.C. § 1396a(a)(2), and that the Secretary of Health and Human Services is largely prohibited from restricting the use of local funds "transferred from or certified by units of government within a State as the non-Federal share ... regardless of whether the unit of government is also a health care provider." 42 U.S.C. § 1396b(w)(6)(A).
- <sup>8</sup> CPEs are funds certified by the state or other units of government as the non-federal share of Medicaid expenditures. 42 CFR 433.51(b). For example, if a county-run hospital incurs costs in delivering covered inpatient and outpatient services to eligible Medicaid patients, the county or its hospital could certify those expenditures as the non-federal share of Medicaid expenditures, and the state could rely on this certified amount to draw down federal Medicaid matching funds.
- <sup>9</sup> See Memorandum from Powell, Goldstein, Frazer & Murphy, LLP, to the National Association of Public Hospitals and Health Systems (June 8, 2004) (available at [http://www.naph.org/Content/ContentGroups/Advocacy\\_Issues/Regulatory/NAPH\\_IGT\\_Legal\\_Analysis\\_6-8-04.pdf](http://www.naph.org/Content/ContentGroups/Advocacy_Issues/Regulatory/NAPH_IGT_Legal_Analysis_6-8-04.pdf)).
- <sup>10</sup> Emergency Clearance: Public Information Requirements Submitted to the Office of Management and Budget. 69 Fed. Reg. 922 (Jan. 7, 2004) (hereinafter, "the 2004 preapproval proposal").
- <sup>11</sup> In general, once CMS has approved a demonstration project, it issues both an approval letter and a set of accompanying special terms and conditions (STCs) – see note 13 for definition. Nonetheless, some details are not included in the STCs, which sometimes instead reference other documents that must be developed by the state and approved by CMS to further govern demonstration project implementation and operation.
- <sup>12</sup> DSH allotments are derived from the Medicaid statute and do not substantially relate to state needs. See 42 U.S.C. § 1396r-4(f).
- <sup>13</sup> STCs accompany a demonstration approval letter and set forth the nature, character, and extent of federal involvement in the demonstration project as well as obligations that the state must meet throughout the life of the demonstration.
- <sup>14</sup> Florida Medicaid Reform Section 1115 Demonstration (2005), Special Terms and Conditions [hereinafter Florida STC], ¶¶96.
- <sup>15</sup> MassHealth Demonstration (2005), Special Terms and Conditions [hereinafter Massachusetts STC], Attachment B, ¶¶6c, d.
- <sup>16</sup> Medi-Cal Hospital/Uninsured Care Demonstration (2005), Special Terms and Conditions [hereinafter California STC], ¶¶22-29.
- <sup>17</sup> 42 C.F.R. § 438.60.



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- <sup>18</sup> Hawaii recently received approval of an amendment to its QUEST demonstration program that allows the state to provide direct supplemental hospital payments for both managed care and fee-for-service patients. These payments are not DSH payments because Hawaii does not have a DSH allotment. Hawaii QUEST Demonstration (2005), Special Terms and Conditions, Attachment E.
- <sup>19</sup> An exception exists for most pregnant women, who may receive obstetric and newborn services from any Medicaid-certified provider. Iowa's demonstration project also provides home and community-based services to children with chronic mental illnesses and is intended to help move toward community-based settings for delivering State mental health programs. These facets of the demonstration project are not discussed here.
- <sup>20</sup> IowaCare Section 1115 Demonstration (2005), Special Terms and Conditions [hereinafter Iowa STC], ¶ 42a. See also Iowa STC ¶43 (limiting SFY 2005 payments for the high cost adjustment payments for state owned hospitals with over 500 beds) and Iowa STC ¶44 (revising the methodology used in SFY's 2004 and 2005 to provide supplemental payments to qualifying physicians at publicly owned acute care teaching hospitals).
- <sup>21</sup> Iowa STC, ¶42b.
- <sup>22</sup> SPAs are changes that a state makes to its Medicaid State Plan. These amendments can affect Medicaid eligibility, services, and/or reimbursement within that state. The state must submit a state plan amendment to CMS for approval.
- <sup>23</sup> See *Expenditure Authorities for Iowa's IowaCare Demonstration*, "Exceptions to Medicaid Requirements for Demonstration Populations & Services," July 1, 2005. CMS approval documents do not mention co-payments. To the extent that University of Iowa Hospitals or Broadlawns charged co-pays to uninsured patients prior to the demonstration, the providers may continue charging co-pays as long as they do not exceed permissible levels established by Medicaid law. Furthermore, although Iowa received explicit approval to disenroll individuals who fail to pay their premiums for 60 days, it has not received any waiver of federal authority that would allow the state to permit providers to deny services for failure to pay co-payments.
- <sup>24</sup> Letter from Mark B. McClellan, Administrator, Centers for Medicare and Medicaid Services to Ronald Preston, Secretary, Executive Office of Health and Human Services, Jan. 26, 2005; see also Massachusetts STC, Attachment B, ¶¶6e, f.
- <sup>25</sup> Florida STC, ¶¶97, 100b.
- <sup>26</sup> See note 20.
- <sup>27</sup> California STC, ¶26.
- <sup>28</sup> Iowa STC, ¶42.
- <sup>29</sup> Florida STC, ¶97.
- <sup>30</sup> Massachusetts STC, Attachment B, ¶¶6f, g.
- <sup>31</sup> California STC, ¶36.
- <sup>32</sup> California STC, ¶¶30, 31. By federal statute, California is permitted to make DSH payments to hospitals for 175 percent of uncompensated costs (California has a permanent 175 percent DSH cap, whereas all other states had higher caps for two state fiscal years). Under the terms of the new waiver, the state may use CPEs to fund 100 percent of hospital uncompensated costs and IGTs only for the portion above 100 percent of costs.
- <sup>33</sup> California STC, ¶31b; see also ¶31c (requiring California to provide assurances that the hospitals will retain the full amount of the IGT and that no portion of the IGT will be returned to any unit of government).
- <sup>34</sup> California STC, ¶23c.
- <sup>35</sup> California STC, Attachment C.
- <sup>36</sup> California STC, Attachment A, ¶3; Florida STC, ¶¶111, 112.
- <sup>37</sup> Massachusetts STC, Attachment B, ¶6h.
- <sup>38</sup> See, e.g., Letter from Mark McClellan, CMS Administrator, to Senator Charles Grassley, Chairman, Senate Finance Committee, April 28, 2004.
- <sup>39</sup> Massachusetts STC, Attachment A, ¶4.
- <sup>40</sup> Ibid.
- <sup>41</sup> The California STCs, by comparison, expressly state that CPEs "may be based upon all sources of funds available to government entities that directly operate health care providers." See California STC, ¶27.
- <sup>42</sup> See Florida STC, ¶¶99, 100d.
- <sup>43</sup> Iowa STC, ¶31. See also note 50, *infra*. Iowa agreed to provide assurances that providers will retain 100 percent of supplemental payments provided through proposed state plan amendments that were pending as the demonstration negotiations were ongoing.

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- <sup>44</sup> CMS has allowed the state to resubmit such amendments with revised payment methodologies as long as the payments were terminated by June 30, 2005, the day before the demonstration took effect. See Iowa STC, ¶¶43, 44.
- <sup>45</sup> States have limited leverage to insist on funding sources over CMS' objections in either context. Outside of the waiver context, states would have the right to appeal disallowances. Presumably they retain such right under the demonstration if CMS unreasonably withholds approval of funding sources that are permissible under federal law.
- <sup>46</sup> This is particularly true when payments to providers exceed costs. To the extent that CMS is also requiring that payments to public providers be limited to cost, see Section III.B, these concerns are lessened, although not abated.
- <sup>47</sup> California STC, ¶¶30, 36.
- <sup>48</sup> California STC, ¶25; Iowa STC, ¶41.
- <sup>49</sup> Interestingly, CMS appears to be successfully negotiating on a state-by-state basis through the demonstrations for the preapproval rights that it was unable to obtain by fiat on a nationwide basis in 2004. See note 10 and accompanying text.
- <sup>50</sup> Preapproval requirements have also begun appearing in STCs governing a variety of other demonstration projects that are not focused on safety net financing. Indeed, CMS appears to be systematically updating demonstration STCs with preapproval language when extending or amending various demonstration projects. In recent months, new preapproval language has appeared in STCs governing demonstration projects in the following states: Hawaii, Kentucky, Maryland, Minnesota, Oklahoma, Rhode Island, and Vermont.
- <sup>51</sup> See Massachusetts STC, Attachment A, ¶5, Attachment B, ¶6f (preapproval language), Attachment A, ¶4, Attachment B, ¶6h (specific concessions); California STC, ¶¶ 36, 38 (preapproval language), ¶31 (specific concessions).
- <sup>52</sup> See Iowa STC, ¶¶30, 31; Florida STC, ¶¶99, 100d, 111, 112.
- <sup>53</sup> Florida STC, ¶100a; California STC, ¶14.
- <sup>54</sup> Massachusetts STC, Attachment A, ¶4.
- <sup>55</sup> Iowa is required to submit an Implementation Plan including milestones and performance benchmarks, but funding is not explicitly tied to achievement of the milestones. See Iowa STC, ¶¶51, 52
- <sup>56</sup> California STC, ¶¶41-42.
- <sup>57</sup> California STC, ¶43.
- <sup>58</sup> Florida STC, ¶¶100-105.