National Association of Public Hospitals and Health Systems

1301 Pennsylvania Ave. NW, Suite 950
Washington, DC 20004

Medicaid Section 1115 Demonstration Projects: Financing Opportunities and Considerations for Public Hospitals and Health Systems

In 2005, four states – Massachusetts, California, Iowa, and Florida – received approval for demonstration projects that restructure Medicaid safety net hospital financing. In part, this trend is an outgrowth of enhanced scrutiny by the Centers for Medicare and Medicaid Services (CMS) of Medicaid reimbursement and financing mechanisms, including the use of intergovernmental transfers (IGTs). The demonstration projects, authorized under Section 1115 of the *Social Security Act*, have allowed CMS to achieve its longstanding policy and budgetary goals: namely, to control the use of IGTs while simultaneously preserving state access to safety net funding that CMS had otherwise targeted for elimination. In doing so, however, CMS has mandated that states agree to enhanced oversight, a new set of cost-based limits, and capped and/or contingent safety net funding. Because details of the demonstrations have yet to be finalized, it remains to be seen whether these trade-offs will ultimately accrue to the benefit of the impacted hospitals.

Three of the four states – Massachusetts, California, and Florida – established a "safety net care pool" or "low income pool" to continue providing roughly the same level of support to safety net providers as was previously provided through other financing mechanisms. Iowa expanded eligibility to uninsured populations through a provider network composed exclusively of public hospitals in order to maintain funding for these institutions. In some cases, the restructuring of safety net funding was the result of deep disputes with CMS over Medicaid financing issues; in one state (Florida) it resulted from a desire to preserve funding that otherwise would be lost to managed care. While the demonstrations may represent an opportunity for public hospitals in similar circumstances, there are several risks and open questions surrounding the waivers that also must be considered. This issue brief summarizes these opportunities and risks.

Opportunities for Public Hospitals and Health Systems

Section 1115 may present opportunities for states and public hospitals to preserve funding for the safety net in the face of CMS efforts to restrict or eliminate IGTs and supplemental upper payment limit (UPL) payments.

- **Preservation of funding targeted for elimination.** Replacing CMS-targeted Medicaid reimbursement with a safety net care pool or with an expansion of Medicaid to the uninsured can preserve critical safety net funding in a manner acceptable to CMS.
- **Reimbursement of broader uncompensated costs.** Without a waiver, the only costs for uninsured patients reimbursable through Medicaid are for inpatient and outpatient hospital services, and these costs are only reimbursable through Medicaid disproportionate share hospital (DSH) payments. Safety net care pools permit reimbursement for a broader array of uncompensated costs. For example, the costs of providing to the uninsured physician services, clinic services, and any other services that CMS does not consider to be inpatient or outpatient "hospital services" may be reimbursed through the pools. The pools also may be used to pay for services for Medicaid and uninsured patients not covered under the state's

Medicaid plan. This flexibility is particularly important given the increasing attempts by CMS to narrow the scope of costs reimbursable through DSH. Moreover, since CMS has imposed cost limitations on pool payments to public providers, an expansive definition of costs is crucial to maintaining or expanding funding as compared to pre-demonstration levels. Such flexibility also may minimize the limitations that hospital-specific DSH caps and/or insufficient statewide DSH allotments may place on uncompensated care reimbursement.

- **Direct payments for managed care enrollees.** Medicaid managed care regulations prohibit direct payments to providers outside of capitated rates, unless the payments are for DSH or for medical education. Consequently, as states move to expand Medicaid managed care, UPL payments to safety net hospitals are in jeopardy. The safety net care pools may preserve UPL funding that otherwise would be lost to managed care. CMS appears to permit states to use the pools to provide "Medicaid shortfall" funding for the unreimbursed Medicaid costs of patients enrolled in managed care. Such funding may be provided directly by the pool or by shifting uninsured costs from Medicaid DSH to the pool, freeing up Medicaid DSH dollars to cover more Medicaid shortfall.
- **Payments for infrastructure costs.** CMS has allowed some of the states to provide up to 10 percent of safety net care pool payments to hospitals for capital costs or other investments in infrastructure, such as capacity building and support for specialty health care services that benefit the uninsured. These payments need not be tied to specific patient care services provided, and in this respect represent an unprecedented use of Medicaid funding.
- **Replacing supplemental Medicaid reimbursement with Medicaid coverage.** Based on the Iowa precedent, states may wish to consider proposing that select public hospitals serve as a limited provider network for a Medicaid expansion population. Such a proposal may be particularly appealing in states negotiating the permissibility of IGTs and UPL payments because of the apparent preference of CMS for expanded coverage to support uncompensated care costs rather than supplemental Medicaid reimbursement.

Risks and Considerations

When assessing whether and when to pursue discussions about safety net financing demonstrations with their states, public hospitals and health systems should be aware of the following considerations:

- **Significantly enhanced CMS oversight.** In exchange for reimbursement flexibility that appears to keep states and providers "whole," CMS has required states to grant the agency additional oversight authority. In particular, states have agreed to some combination of the following concessions: (1) annual caps on funding for the safety net; (2) greater CMS authority over funding mechanisms and payment methodologies, including preapproval of sources of non-federal share funding, (3) restructured sources of non-federal share funding (e.g., lessening or eliminating the use of IGTs, increasing reliance on certifications of public expenditures, or CPEs, and limiting the use of provider taxes), and (4) limiting public provider payments to cost.
- **Funding contingencies.** In addition to the various forms of oversight that states have accepted in exchange for programmatic flexibility, some (but not all) of the states also have agreed to funding contingencies wherein a portion of demonstration funding is held back pending the completion of certain milestones. The safety net funding in these states is contingent on the realization of demonstration goals and achievements that may or may not be related to such funding, injecting an unprecedented degree of risk and uncertainty into the stability of these crucial sources of support.

- **Negotiating position.** State negotiating leverage is partially determined by the circumstances under which demonstrations are negotiated. If CMS is insisting that the state terminate aspects of its current safety net financing system, the state may have less leverage to insist on favorable terms. Nevertheless, not every state has agreed to every concession proposed by CMS, and thorough familiarity with the concessions made and not made in the four demonstrations will strengthen a state's hand in negotiating the terms of future demonstration projects. Unique circumstances in each state undoubtedly will influence a state's negotiating leverage, and some states will thus be able to temper certain forms of CMS oversight. Each newly negotiated demonstration project provides a new benchmark that all states can learn from as they prepare for negotiations with CMS. In addition, safety net hospitals must be acutely aware of their support within the state and likely internal competing interests since safety net providers are not formally a party in the demonstration negotiation.
- **Adequacy of safety net funding.** To date, CMS has insisted on fixed dollar caps on safety net funding in each of the demonstrations. The amount of the cap is crucial to the success of the demonstration and must adequately account for growth in both utilization and costs. To the extent that the pools expand the types of uninsured costs that may be reimbursed, including uninsured costs for non-hospital providers, they could create new demand for a pool of funds that previously had been dedicated exclusively for hospitals. It is therefore important to ensure that hospitals have first priority on pool funding.
- **Various channels to propose safety net financing changes.** Safety net financing restructuring opportunities can be explored as a stand-alone new demonstration project, as part of a project already under development, or as an amendment to an existing demonstration. Safety net financing demonstration proposals also may emerge from negotiations with CMS over disputed Medicaid state plan financing provisions. Therefore, public hospitals may wish to familiarize their states with available opportunities if state officials are already in the midst of negotiations with CMS that could jeopardize funding.
- **Discretionary nature of CMS demonstration project approval.** When states submit state plan amendments (SPAs) to CMS, the agency must act on the SPA within defined timeframes. Additionally, states are entitled to approval if the SPA does not violate federal law, and states can appeal denials. By comparison, CMS has considerable discretion regarding the approval of Section 1115 demonstration projects and this too increases the bargaining power of CMS as states seek to satisfy CMS demands in exchange for project approval. CMS is unlikely to approve proposals that it perceives to be designed simply to access new sources of federal funding. Nevertheless, CMS is likely to be motivated by the opportunity to eliminate financing that it finds questionable while simultaneously achieving enhanced oversight and, possibly, reducing the number of uninsured.
- **Additional demonstration proposal features.** In some cases, CMS has identified financing concerns and worked with states to create new forms of safety net support that satisfy both CMS and the state. States should consider incorporating unique or novel approaches to improving health care outcomes, quality, and efficiency into a demonstration proposal. Including cutting-edge proposals will give states more leverage in their negotiations and enhance the likelihood that CMS will approve a proposal to adjust safety net financing on terms favorable to the state. For example, CMS appears to have an interest in supporting and testing strategies related to consumer-directed care, health savings accounts, disease management, and quality measurement and may be particularly receptive to proposals that incorporate such characteristics along with safety net financing modifications. Beyond simply satisfying CMS, integrating ongoing public hospital-based initiatives into such proposals could help secure additional reimbursement for existing programs.

Conclusion

The use of Section 1115 demonstration projects to supplant existing forms and methods of safety net financing is a new and evolving development. The recently approved demonstration projects are not yet fully operational, and it remains to be seen how successful they will be in preserving or enhancing support for the safety net. In the short-term, demonstrations allow states to retain safety net funding targeted for elimination, though often at the expense of accepting fixed limits on the amount of future support. Although these negotiations appear to enable CMS to achieve policy goals along with budgetary control, it is impossible to accurately predict CMS receptivity to future safety net financing proposals. Beyond the financing preapproval requirements that CMS appears to insist upon, there are no guarantees about the balance between flexibility and oversight that states will be able to negotiate with CMS initially or during subsequent negotiations during the life of the demonstration project. Nevertheless, as CMS continues to impose ever-increasing restrictions on Medicaid financing mechanisms, this new use of Section 1115 demonstration authority suggests opportunities for states and public hospitals to work together to preserve essential safety net funding.