

## **Joint Informational Hearing**

Assembly Health Committee and Budget Subcommittee #1 on Health and Human Services,  
Senate Health Committee and Senate Health Committee #3 on Health and Human Services

### **MEDI-CAL: HOSPITAL FINANCING WAIVER**

Wednesday, July 13, 2005  
10:00 a.m. – 1:00 p.m.  
State Capitol, Room 126

- I. Administration (30 Minutes)**
  - a. Sandra Shewry, Director, Department of Health Services
  - b. Stan Rosenstein, Deputy Director of Medical Services, Department of Health Services
  
- II. Disproportionate Share Hospital Task Force Representatives (1 hour 20 minutes)**
  - a. Martin Gallegos, California Hospital Association
  - b. Denise Martin, California Public Hospitals and Health Systems and Peter Bryan, Kern Medical Center
  - c. Jonathan Freedman, Los Angeles County
  - d. William Gurtner, University of California
  - e. Catherine K. Douglas, Private Essential Access Community Hospitals and Gerald T. Kozai, St. Francis Medical Center
  - f. Sue Maddox, California Children's Hospital Association and William Haug, Children's Hospital Central California
  - g. Ralph Fergeson, Association of California Healthcare Districts
  
- III. Local Government (20 minutes)**
  - a. James Keene, Executive Director, California State Association of Counties
  - b. Rich Gordon, Chair of the Urban Counties Caucus and Member of the San Mateo County Board of Supervisors
  - c. Douglas D. Bagley, Riverside County Regional Medical Center
  
- IV. Other Stakeholders (30 minutes)**
  - a. Beth Capell, Service Employees International Union
  - b. Angela Gilliard, Western Center on Law and Poverty
  - c. Lisa Folberg, California Medical Association
  - d. Anthony Wright, Health Access California
  
- V. Public Comment**

# **Background Materials**

**Joint Hearing:**

**Proposed Hospital Financing Waiver**

Convened By

**Senate Budget Subcommittee #3 on Health & Human Services  
Senator Ducheny, Chair**

**Assembly Health Committee  
Assembly Member Chan, Chair**

**Assembly Budget Subcommittee #1 on Health & Human Services  
Assembly Member De La Torre, Chair**

**Senate Health Committee  
Senator Ortiz, Chair**

Wednesday, July 13, 2005  
10:00 AM to 1:00 PM

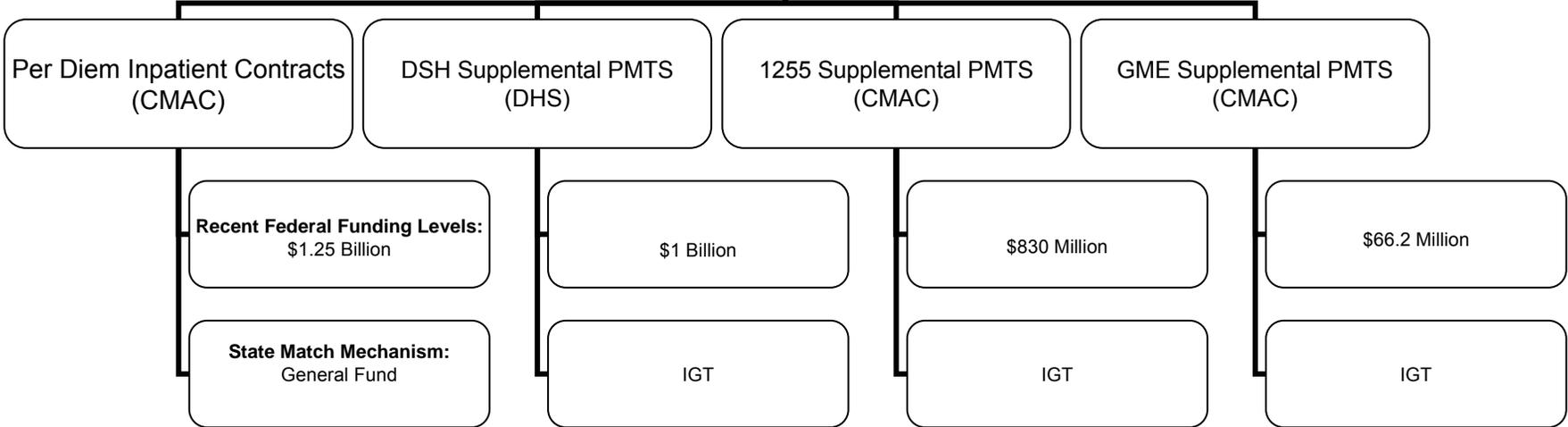
## **TABLE OF CONTENTS**

<b><u>I. Summary of Hospital Fiscal Charts</u></b>	<b>3 to 6</b>
• Current System of Funding (Prepared by Assembly Health Committee)	3
• System Under Proposed Waiver (Prepared by Assembly Health Committee)	4
• Sources of Payments to Hospitals (Prepared by the Department of Health Services)	5
• Safety Net Care Pool Chart (Prepared by the Department of Health Services)	6
<b><u>II. Summary of Current System of Public Funding Hospitals</u></b>	<b>7</b>
<b><u>III. Summary of Key Waiver Components</u></b>	<b>9</b>
<b><u>IV. Summary of Key Implementation Products and Timelines</u></b>	<b>19</b>

### **Additional Attachments**

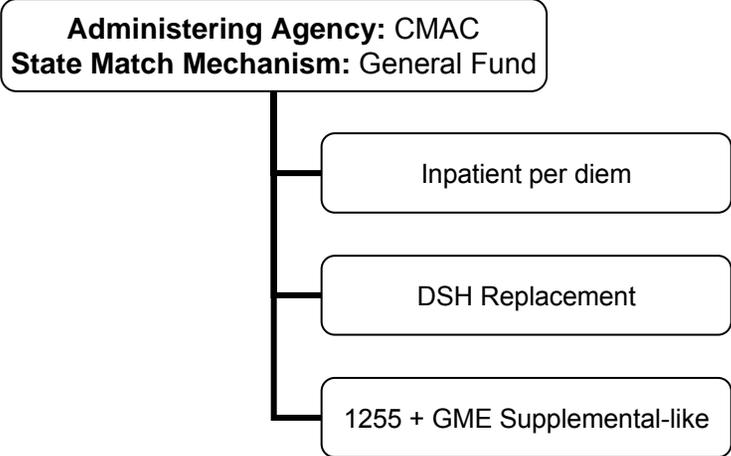
- **List of the 146 “Safety Net” Hospitals**
- **Administration’s Draft of Waiver Terms & Conditions (as of July 2, 2005)**
- **Administration’s Draft of General Distribution Principles (as of July 11, 2005)**

# Current System for Funding Public and Private Hospitals

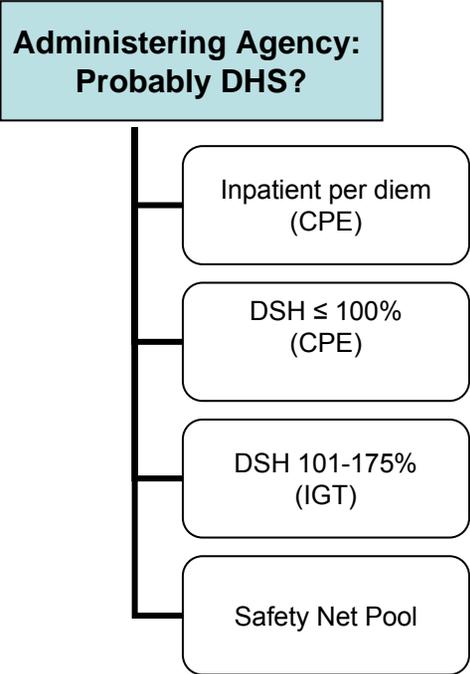


# System Under Waiver

## Privates, Children's & District Hospitals

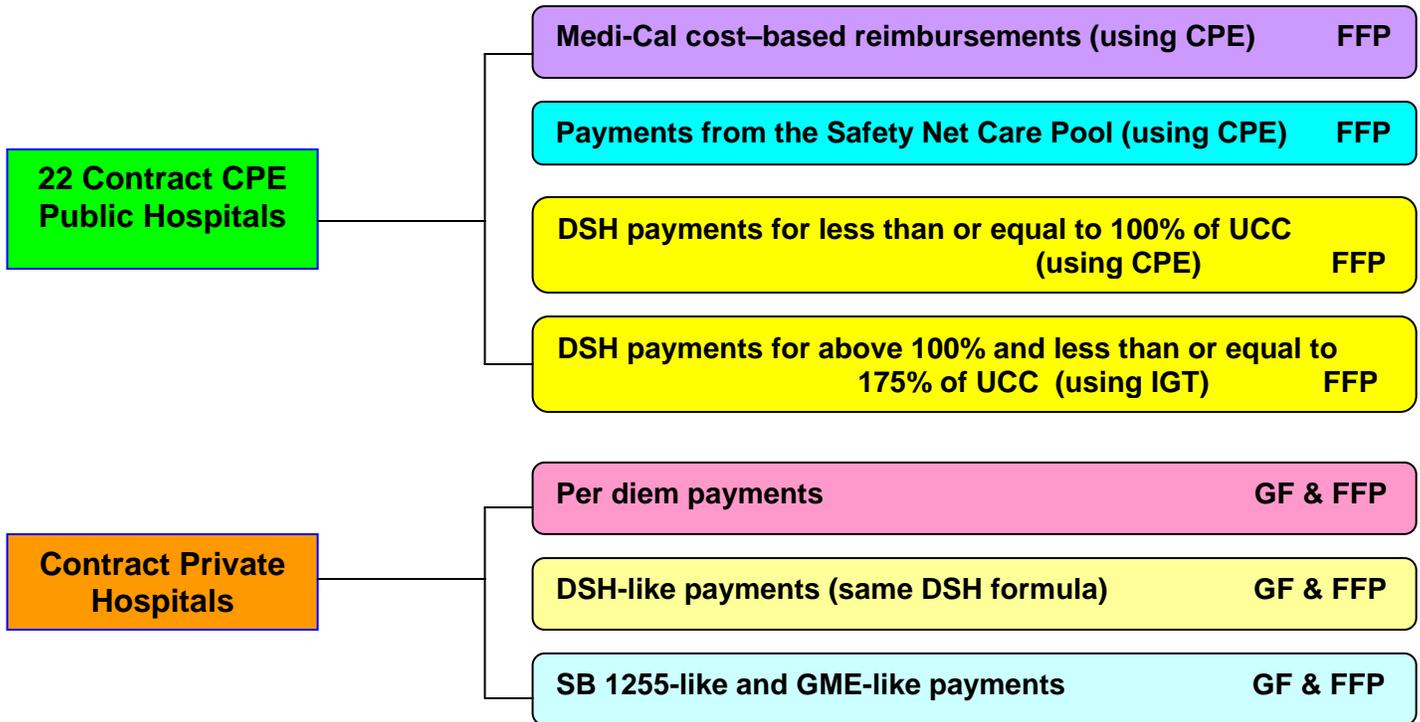


## Publics

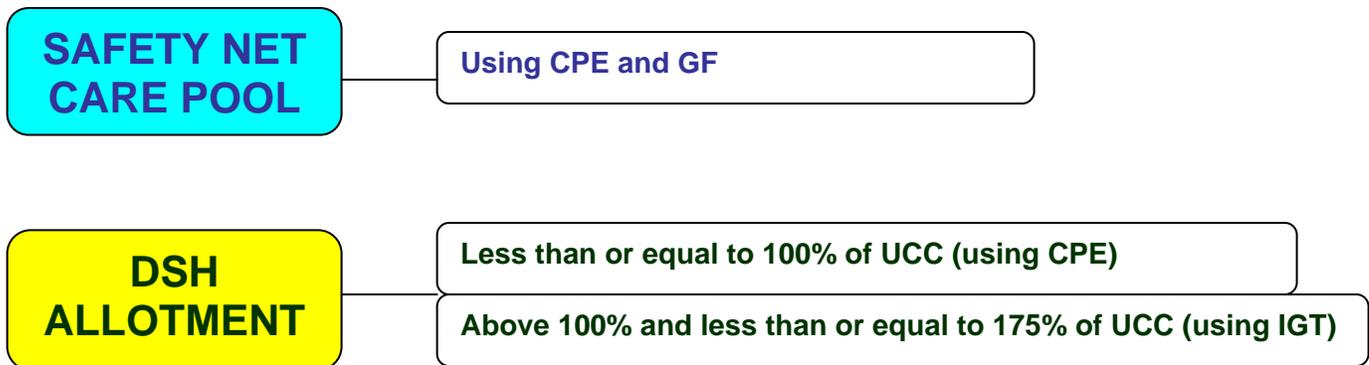


# SOURCES OF PAYMENTS TO HOSPITALS

## Payment Sources for Two Categories of Hospitals



## Payment Sources for Uncompensated Care Costs



### KEY:

- GF: General Funds
- FFP: Federal Financial Participation
- DSH: Disproportionate Share Hospital
- CPE: Certified Public Expenditures
- UCC: Uncompensated Care Costs
- IGT: Intergovernmental Transfers

## **II. Summary of Current System of Public Funding for Hospitals** **(See Chart on Page 3)**

**A. Current Waiver Has Expired:** The public financing of California's hospitals, particularly 146 "safety net" hospitals, relies on supplemental federal funding obtained through several funding mechanisms which operate primarily through the use of Intergovernmental Transfers and the State's existing Waiver authority. These supplemental federal funds assist in funding uncompensated care, trauma center care, medical education and training and related medical expenses associated with hospital inpatient care. **Our existing Waiver expired as of December 30, 2004; however, the Administration was able to obtain a 6-month extension until June 30, 2005.**

**No additional extension has been requested by the Administration other than a 30-day extension of our hospital contracting program operated by the California Medical Assistance Commission (CMAC).** The federal CMS granted this limited extension since the contracting program also saves federal funds as well as State General Fund moneys.

The federal CMS has clearly stated that no other aspect of the existing Waiver would be extended. **Subsequently, a new Waiver needs to be crafted and legislation needs to be adopted by the end of Session. If this cannot be achieved, about \$2 billion in supplemental federal funds cannot be allocated to safety net hospitals.** A summary of the current system is discussed below.

**B. Medi-Cal Hospital Inpatient Per Diem Reimbursement:** Existing Medi-Cal hospital inpatient reimbursement is made by the State using two distinct methods of payment arrangement. **Both methods of hospital inpatient reimbursement use General Fund support and federal matching funds as the sources of funding.**

**First,** many hospitals choose to contract with the State through the California Medical Assistance Commission (CMAC). **This program, known as the Selective Provider Contracting Program (SPCP), requires a federal Waiver to operate.** Through this program the State contracts on a competitive basis with certain hospitals in selected geographic areas that want to provide inpatient services to Medi-Cal recipients at a negotiated per diem rate for all hospital inpatient services. CMAC negotiates rates with the hospitals through confidential discussions. **Hospitals that contract through CMAC are eligible to access supplemental federal funds, as discussed in item B, below.**

The SPCP has been in existence since 1982 and has saved billions in state and federal funds. The average statewide Medi-Cal *contract* rate was \$1,029 per day using 2003-04 data. The average statewide Medi-Cal *non-contract* rate was \$2,080 per day (2003-04 data). **As such, for 2003-04 alone, the General Fund savings attributable to the SPCP are \$703 million.** In other words, these are funds that would have been spent had California not implemented this program.

**Second**, the State also provides Medi-Cal hospital inpatient reimbursement to “non-contracting” hospitals. These rates are based upon a methodology contained in California’s Medicaid (Medi-Cal) State Plan. “Non-contracting” hospitals are *not* eligible to access supplemental federal funds and receive a higher reimbursement rate as noted above.

**C. Summary of Existing Supplemental Federal Funding:** Federal Medicaid financing, presently provided through the state’s Disproportionate Share Hospital Program (SB 855 funds), the Emergency Services and Supplemental Payments Program (SB 1255 funds), Graduate Medical Teaching Program, and the Capital Project Debt Reimbursement Program, is an essential ingredient to California’s overall health care system. Without these supplemental federal funds, California’s hospital system would indeed collapse.

**California currently receives just over \$2 billion for these supplemental federal funds as shown below. CMAC allocates these supplemental federal funds to about 146 safety net hospitals that contract with the State, as well as meet other specified criteria.** The DHS calculates the DSH allocation using a complex formula which is outlined in existing State statute.

- (1) \$1.032 billion Disproportionate Share Hospitals (DSH);
- (2) \$830 million for the Emergency Services and Supplemental Payments Program;
- (3) \$66.2 million for Graduate Medical Teaching Program; and
- (4) \$97.4 million for the Capital Project Debt Reimbursement Program.

All of these federal funds require a corresponding match of funds (one-to-one). **Presently these supplemental federal fund programs operate through the use of “Intergovernmental Transfers” (IGT) and the state’s existing Selective Provider Contract Waiver.** Under the IGT process, governmental entities which operate hospitals—counties, the UC system, and hospital districts—transfer a specified amount of funds to the State by means of an IGT. The State places these transfers into a special fund and then obtains federal matching funds.

The State returns the IGT amounts back to the counties and UC system, except for \$85 million (“State Administrative Fee”) which has been used to offset General Fund support to the Medi-Cal Program. **No General Fund support has ever been provided by the State to obtain these supplemental federal funds.**

### **III. Summary of Proposed Waiver Components (See Charts on Pages 4, 5, & 6)**

**A. Status of the Proposed Waiver:** Discussions on the proposed Hospital Waiver began in June 2004 after the federal CMS told California it would not renew our existing Waiver. Though the Administration announced an agreement with the federal government on June 22, 2005, this announcement does not constitute a completed Waiver agreement. **The “Terms and Conditions” of the Waiver must still be finalized with the federal CMS and State legislation must be adopted (two-thirds vote) by the end of Session in order for a Waiver to be in place.** (A more complete description of these products is contained in Section IV of this document.)

**The DHS sent a draft of the Terms and Conditions to the federal CMS on July 2, 2005.** The federal CMS will modify these draft Terms and Conditions in discussions with the DHS over the next few weeks or so. Once approved by the federal CMS, the federal Office of Management and Budget (OMB) as well as the federal Secretary of Health and Human Services (Secretary Leavitt) will need to approve them. The DHS contends that federal approval will take two weeks; however, it is likely that additional time will be needed.

In addition, the Administration has received a 30-day extension of our CMAC hospital contracting program since the Administration’s authority to operate this program expired with the Waiver (as of June 30th). It is very likely that the Administration will also solicit another 30-day extension for the contracting program at the end of July.

**B. Significant Changes to Hospital Inpatient Uncompensated Care Costs:** The proposed Waiver makes significant fundamental changes to how California presently supports uncompensated care costs incurred for hospital inpatient services. Under the current system, the funding mechanisms are intertwined and shared across the safety-net hospitals (publics and privates).

**Under the proposed Waiver, all of the existing supplemental federal funding programs (i.e., DSH, SB 1255, and Graduate Medical Education), except for the Capital Project Debt Reimbursement Program, will be completely re-crafted.**

**Two completely separate funding mechanisms will be used to support uncompensated care costs. One stream of funding will be used for public hospitals.** This stream of funding will consist of federal payments secured through the use of “Certified Public Expenditures” (CPE) and limited Intergovernmental Transfers (i.e., county revenues and UC system revenues).

**The other stream of funding will be used for private hospitals.** This stream of funding will consist of federal payments matched with General Fund support. **The components of each of these funding streams is outlined below.**

**1. The Safety Net Care Pool for Public Hospitals (See Chart on Page 6):**

**General Description of the Pool:** Under this component of the proposed Waiver, a **capped pool of \$766 million (federal funds) would be available annually for the life of the Waiver (i.e., a total of \$3.830 million over the five year period).** Of the total amount, \$900 million or \$180 million annually is tied to meeting specified federal requirements as discussed below.

This pool of funds is generally intended to replace the existing SB 1255 Program and Graduate Medical Education Program funding for public hospitals which are eliminated under the proposed Waiver. **However unlike the existing SB 1255 Program and Graduate Medical Education Program, the Safety Net Pool can be used for expenditures other than those provided in a hospital inpatient setting.**

**The Safety Net Care Pool can only be expended for uncompensated care that is *not* Medi-Cal related.** The pool is broadly defined and could be used for medical expenditures which are *not* hospital based. **As such, the State could access these funds, as well as other medical providers as defined by the State.**

**In order to access these federal funds, public hospitals would need to use “certified public expenditures” (CPEs).** Under this proposed CPE approach, public hospitals and UC hospitals would “certify” they have expended public funds to provide services to indigent individuals. Many issues remain as to the viability of this proposed CPE approach. These issues are discussed separately further below.

**It should be noted that the State could also identify CPEs to draw down federal funds from the Safety Net Care Pool as well.** The Administration has made reference to a variety of State-Only General Funded programs which serve indigent individuals that could be used towards the CPE requirement. Examples provided have included the Expanded Access to Primary Care (EAPC) Clinic Program, the AIDS Drug Assistance Program (non-federal portion), the California Children’s Services (CCS) Program (non-federal portion), as well as some others.

In addition to a county (public hospital), a UC hospital, a city and the State, the State may add other governmental entities (including hospital authorities, hospital districts or similar entities) to the list of entities that could be eligible to receive Safety Net Care Pool funds.

**Federal Requirements for Receipt of \$900 Million:** The proposed Waiver makes \$900 million of the total \$3.830 million (federal funds) amount contingent upon **(1)** implementation of the mandatory enrollment of aged, blind and disabled individuals into Medi-Cal Managed Care, and **(2)** implementation of a “healthcare coverage initiative”.

Specifically, \$360 million (federal funds) or \$180 million over the first two-years of the Waiver is tied to the passage of legislation for the mandatory enrollment of aged, blind

and disabled individuals into Medi-Cal Managed Care (voluntary enrollment is the current practice). **The draft Terms and Conditions document (see pages 5 and 6) contains designated milestones as to what needs to be achieved to receive these funds and by what dates. If the specified milestones are not met within the designated timeframes, a lesser amount of funding is offered on a pro rata basis. However if the milestone is not achieved based on the revised timeframe, then no funding is provided during these two years of the Waiver (i.e., \$180 million for two years, or \$360 million).**

In order for California to obtain the full \$180 million in the first year of the Waiver (July 1, 2005 to June 30, 2006), legislation needs to be enacted by no later than September 30, 2005 to expand the number of counties in the state covered by the Medi-Cal Managed Care Program, as well as to require the mandatory enrollment of aged, blind and disabled individuals. In addition, by no later than May 31, 2006, California must also submit a State Plan Amendment (SPA) or Waiver request associated with this managed care expansion.

**Additional milestones are specified in order to receive the next \$180 million amount for the second-year of the Waiver.** These milestones require the continued implementation of the Medi-Cal Managed Care expansion, including the submission of managed care contracts and rates to the federal CMS.

**With respect to the last three years of the Safety Net Care Pool, a total of \$540 million (i.e., \$180 million for three years) is contingent upon implementation of a “healthcare coverage initiative” that would expand coverage options for individuals currently uninsured.** Under this initiative, the \$180 million for each of the last three years of the Waiver is considered annual allotments. Therefore, if these funds are not spent during these years, they are forfeited by California. **The draft Terms and Conditions document (see page 7) specifies the milestones to be met for this initiative as well.**

The Administration states that the healthcare coverage initiative may rely upon the existing relationships between the uninsured and safety net health care systems, hospitals and clinics. A “concept paper” on this initiative would have to be submitted by the State to the federal CMS by January 31, 2006. Subsequently, the State would then need to submit a Waiver amendment on the structure, eligibility and benefits design for this product by September 1, 2006. **Implementation of the healthcare coverage product is assumed to commence as of July 1, 2007.**

**Use of Safety Net Care Pool for Services to Undocumented Individuals:** The federal CMS has informed the Administration that Safety Net Care Pool funds cannot be used for costs associated with the provision of non-emergency care to undocumented individuals. As such, the draft Terms and Conditions document contains a provision which implements this limitation.

Specifically, paragraph 21 on page 5 of the document states that 17.79 percent of total provider expenditures or claims for services to uninsured individuals will be treated as expended for non-emergency care to undocumented individuals. This percentage and proposed concept is presently used under California's FamilyPACT Waiver. It should be noted that Disproportionate Share Hospital funds can be used for all uncompensated care services provided to uninsured individuals, including individuals who lack documentation status.

**Use of "Certified Public Expenditures" to Obtain Safety Net Care Pool Funds:** Under the proposed CPE approach, public entities—primarily public hospitals and UC hospitals-- would "certify" they have expended public funds to provide healthcare services to indigent individuals (*not* Medi-Cal or Medicare enrolled individuals).

The CPE covered services would likely include inpatient and outpatient hospital services, clinic services, physician services provided in hospitals and clinics, and other ancillary services, such as durable medical equipment. **However, the specific requirements regarding implementation of this CPE mechanism are pending further definition and development at both the federal and State levels. Additional clarity is needed in several areas, including (1) what exactly will be counted as a CPE, (2) how will federal and State audit exceptions be handled, and (3) how will CPEs be distributed or shared across California in order to ensure that all of the available federal funds are being accessed.**

The draft Terms and Conditions document (paragraph 22, page 5) contains a provision that notes if there is insufficient CPEs from the public hospitals to access all of the Safety Net Care Pool funds, as well as to fully utilize California's DSH allotment, then the federal CMS and State will agree on modifications to the reimbursement methodologies as necessary in order to access all funds (i.e., Safety Net Care Pool and California's DSH allotment). **This is because the State already knows that public hospitals will not have sufficient CPE to draw all of these funds for distribution by the State.**

**Based on preliminary information obtained from the public hospitals and provided by the Administration, there are at least five county hospitals that do not have enough CPE in order to draw down their existing amount of federal funds that they presently receive through the current system of payment.**

**Distribution of Safety Net Care Pool Funds:** A core question of the entire Waiver is how will the \$766 million in available federal funds be distributed across California's hospitals, as well as potentially to other provider groups or state-operated programs.

The draft Terms and Conditions document (pages 5 to 6) provides the State with broad authority regarding access to these funds as well as distribution of the funds. For example, paragraph 24 of this document enables the State to redistribute Safety Net Care Pool funds received from hospitals' CPE in any manner as long as the recipient hospital

does not return any portion of the federal funds to any unit of government. **As such, the crafting of legislation for the distribution of the Safety Net Care Pool funds will be critical to how the overall Waiver operates. The Administration also released draft General Distribution Principles on July 11, 2005. These draft principles will need to be debated and likely incorporated as part of the legislative package.**

2. Disproportionate Share Hospital “Swap” Component (See Charts on pages 4 & 5):

**What is Disproportionate Share Hospital Funding?** Under existing federal law, states receive supplemental federal funding through the Disproportionate Share Hospital (DSH) Program. **California’s annual federal fund allotment is \$1.032 billion. This is a capped amount, and requires a funding match in order to draw down the available federal funds. DSH funds are used for uncompensated care costs incurred by hospitals that serve a disproportionate share of either Medi-Cal patients or indigent care patients.** Existing state statute specifies how DSH funds are to be distributed in California.

**These DSH funds are available outside of the proposed Waiver but become intertwined with the Waiver because of the DSH “swap”.**

**What was the Prior Method for Accessing DSH?** Under the previous system, counties and the UC system made Intergovernmental Transfers (IGTs) to the State in order to draw down the DSH federal allotment. The State then returned the IGT amounts back to the counties and UC system, except for \$85 million (“State Administrative Fee”) which was used to offset General Fund support to the Medi-Cal Program. According to the Administration, this return of the IGTs back to the counties and UC system is what the federal CMS considered to be a “recycling” of funds, or “bad” IGTs. As such, the federal CMS did not want the State to continue this practice.

The Administration contends that the State could have either continued to have the counties and UC system make these IGT payments to the State without the State returning the IGT amount, or use State General Fund support obtained from funds used for the hospital inpatient per diem payments made to the public hospitals (22 hospitals) for this match.

**What is the DSH Swap under the Proposed Waiver?** A key component of the proposal is known as the Disproportionate Share Hospital (DSH) “swap” (i.e., a funding shift or “swap”). **According to the Department of Health Services, this proposed swap will enable California to obtain \$226 million in additional federal funds that are not available today.**

**Under this swap, all General Fund support for public hospitals (22 of them) would be shifted to support the private hospitals.** In lieu of General Fund support, the public hospitals would be solely reliant on using “certified public expenditures” (CPEs) and a limited Intergovernmental Transfer (IGT) process to draw down their federal match.

This swap in funding would mean that public hospitals would receive the state’s DSH federal funding allotment and the private hospitals would receive a “DSH-look-alike” amount consisting of General Fund moneys and a federal match (at 50 percent).

**Mechanically, How Would this Work?** To effectuate the swap, several changes to our existing financing structure need to be made. **These changes are as follows:**

- **Shift General Fund Moneys:** All General Fund support paid by the state to the public hospitals for Medi-Cal inpatient days would be redirected to private hospitals, effective as of **July 1, 2005**.
- **Certified Public Expenditures (up to 100 percent of cost):** The public hospitals would use CPE's to draw down federal funds for their Medi-Cal inpatient days. **CPE's would be used for public hospital expenditures that are up to 100 percent of their costs.**
- **Intergovernmental Transfer Funds (IGT) (Above 100 percent of cost):** The public hospitals would use limited IGT's to draw down federal funds for DSH. **IGT's would be used for public hospital expenditures that are from 101 percent of their costs up to 175 percent of cost (i.e., the "upper payment limit").**
- **Disproportionate Share Administrative Fee:** Presently, the state offsets \$85 million in state General Fund support through a mechanism known as the "state administration fee". Under this swap, this fee would be eliminated but other available General Fund support would be used so that there is no deficiency.
- **Supplemental Federal Funds:** Existing supplemental federal funds known as "SB 1255 Funds" (i.e., Emergency Services and Supplemental Payments Program) and Graduate Medical Education (GME) will no longer exist as presently constructed. **Instead, private hospitals will have "look-alike" funding that uses General Fund support to match federal funds. Public hospitals that previously received these supplemental federal funds will utilize the Safety Net Care Pool and DSH funding.** The public hospitals will utilize CPEs and IGTs to draw the federal match.

***How Does the DSH Swap Proposal Pencil Out Using Real Figures?*** On July 5th, the Administration provided the first fiscal estimate of the swap to legislative staff. Their figures note that **California is short by \$19.2 million in General Fund support in order to make this component operational.** This is shown in the table below.

**Table I Administration’s DSH Swap Calculation & SBFR Staff Comment**

<b>Description of “Swap” Components</b>	<b>Estimated Dollars</b>	<b>Staff Comment</b>
<b>A. Public Hospital Payments &amp; Shift</b>		
<b>1.</b> Total estimated 2005-06 payments to public hospitals for Medi-Cal inpatient days.	\$819.3 million (Total Funds)	This estimate of payments, provided by the public hospitals to the DHS, is based on continuation of the current system.
<b>2.</b> General Fund amount that is available and is to be shifted from the public hospitals.	\$409.7 million (General Fund)	This amount is 50 percent of the \$819.3 million estimate. The public hospitals will need to identify certified public expenditures (CPE) and IGT’s to replace the General Fund amount.
<b>B. Private Hospital Payments</b>		
Total estimated 2005-06 payments to private hospitals for “SB 1255-Look-Alike” and Graduate Medical Education (GME)-Look-Alike purposes.	\$235.4 million (\$117.7 million GF)	This estimate reflects the same amount as the actual payments provided in 2004-05 to private hospitals for these purposes. The DHS states that the 2004-05 payments reflect an increase of \$94 million over 2003-04 payments.
<b>C. General Fund Usage</b>		
<b>1.</b> Amount needed for private hospitals to maintain “DSH Look-Alike” at 2004-05 level.	\$226.1 million (General Fund)	Total payment to the private hospitals for the “DSH” Look-Alike” would be \$452 million (total funds). General Fund is needed to draw the federal match. There is no federal cap on these dollars. But receipt of any federal dollar requires General Fund.
<b>2.</b> Amount needed for private hospitals to maintain “SB 1255 Look Alike” and “GME Look Alike”.	\$117.7 million (General Fund)	Total payment to private hospitals for these two look-alike programs would be \$235.4 million (total funds). There is no federal cap on these dollars. But receipt of any federal dollar requires General Fund.
<b>3.</b> Amount needed to replace the DSH State Administrative Fee.	\$85 million (General Fund)	Presently, the state uses \$85 million in DSH funds to backfill for General Fund support in Medi-Cal. This backfill would need to be eliminated under the DSH swap. As such, the General Fund shift needs to include this expenditure in order to not have a deficiency.
<b>Total Amount of General Fund Need</b>	<b>\$428.8 million</b>	Previously, IGT’s from public hospitals had been used to obtain federal funds for the private hospitals.
<b>D. Projected General Fund <u>Shortfall</u></b>	<b>\$19.1 million</b>	Based on the amount of General Fund support available, this shift results in a shortfall of \$19.1 million, if the private

		hospitals are to receive the same level of funding as provided in 2004-05.
--	--	--

Prior to providing this information, the Administration had stated there would be sufficient General Fund resources available for this transaction. In fact, the Administration had contended that \$44 million or so in General Fund resources would be remaining to expend on other hospital-related expenditures after the DSH swap had occurred. Clearly, this is no longer the case.

**The Administration now notes that their original calculation did not take into account the amount of increases provided to private hospitals in 2004-05.**

Specifically, the DHS states that private hospitals received an overall increase of \$94 million in 2004-05 through SB 1255 and GME payments (i.e., supplemental federal fund payments allocated through the CMAC contracting process) over 2003-04. **This level of increase was greater than what the DHS had anticipated and as such, was not captured in their original calculation.**

*Issues Raised by the General Fund Shortfall in the DSH Swap:* The Administration contends that the newly identified funding shortfall will be further discussed as the State moves to address the distribution of funds across the safety net hospitals overall through the crafting of legislation. However, this lack of General Fund support raises several issues.

**First, it highlights the need for the Administration to run fiscal modeling profiles using hospital specific data to see if the proposed Waiver works.** It was initially thought that the DSH swap would work with General Fund moneys remaining in reserve, but it does not. **Running fiscal models would assist in identifying concerns and would enable them to be more readily addressed.**

**Second,** it brings into question the Administration’s proposal to hold hospitals harmless from fiscal decreases. The Administration has stated that they are committed to ensuring that baseline funding for safety net hospitals (146 hospitals) remains intact and that rates are not reduced. However the DSH swap needs to be fully operational for this to occur. Otherwise it is likely that certain hospitals would need to receive less funding than provided in 2004-05.

**Third,** it raises the issue of providing an increase in General Fund support to backfill for the shortfall. **Fourth,** it raises the question of using certain State-operated General Fund programs, such as the Expanded Access to Primary Care Clinic (EAPC) Program or others, as a “certified public expenditure” (CPE) in order to obtain a match from the Safety Net Care Pool to save General Fund which would then be reinvested back to address the shortfall in the DSH swap.

**C. Medi-Cal Inpatient Payments under the Waiver:** Payments to hospitals for Medi-Cal inpatient days will be done through two separate methods. Federal funds provided for these Medi-Cal inpatient payments will *not* be capped. This is because Medicaid (Medi-Cal) is an entitlement program and needs to adjust for caseload fluctuations and the need for hospital inpatient care services. However, the method for obtaining this federal match will be contingent upon the availability of both State General Fund support, as well as public hospital CPEs (i.e., county revenues and UC revenues). **No State General Fund support will be provided to public hospitals for the receipt of these federal funds.**

**Private inpatient hospital services** will continue to be funded either through the CMAC Selective Provider Contract Program (for “contract” hospitals), or through payments provided under the State’s Medi-Cal Plan (for “non-contract” hospitals). These payments will include, where applicable, all supplemental payments previously made to private safety net hospitals (124 private hospitals), including SB 1255 funds, Graduate Medical Education and DSH. In essence “look-alike” or “virtual” payments will be made for these previous programs that will no longer exist as presently constructed.

**All payments made to private hospitals will use state General Fund moneys along with a federal match (i.e., “traditional” Medi-Cal funding). However, transfers from units of local government (such as from counties or cities) at their option to the State can be made to provide payments to private hospitals. Further, it should also be noted that the Waiver explicitly states that the State will not impose a provider tax, fee, or other assessment on inpatient hospital services or physician services that would be used as the “non-federal” portion of any Medi-Cal payment.**

**Public hospital inpatient services will be reimbursed on a “cost-based” payment, effective as of July 1, 2005. Under this arrangement, public hospitals will use CPEs to draw down the federal match.** The draft Terms and Conditions (paragraph 8, page 2) contains a provision which would enable the State to make estimated payments to public hospitals on the basis of costs reported to the State on their most recently filed Medi-Cal cost report, with adjustments necessary to reflect certain additional costs which are subject to certain updating factors. A prospective per diem rate of reimbursement would then be established annually for each public hospital. The State would then reconcile payments to actual costs as determined from an audited cost report.

**There are several issues regarding how these proposed changes to the Medi-Cal inpatient payments will be effectuated.** First, the same concerns regarding the definition and availability of CPE, as discussed above, also apply here. Second, there are many transition issues related to moving from General Fund support to CPE as of July 1, 2005. For example, it would seem that a General Fund loan would need to be provided as a “float” until CPEs can be identified to draw the federal funds for the public hospitals. **Further discussions on the mechanics of these changes are clearly needed.**

**D. Other Various Aspects of the Waiver:** First, the proposed Waiver raises fundamental questions regarding governance issues between the federal government and the State, and between the State and the counties. These questions include the following:

- Can the federal CMS mandate that California implement mandatory enrollment of aged, blind and disabled individuals into Medi-Cal Managed Care as a condition for receiving federal funds?
- Can the State require counties to expend their realignment funds and other county revenues on county hospitals in order to maintain their CPE level or to maintain a certain level of IGTs without a state/local mandate concern? How will flexibility (versus a mandate) be maintained?
- Can public hospitals be required to provide funding to private hospitals in order for the State to be able to draw down our entire federal funding stream available to the State as a whole? How would “hold harmless” provisions be maintained?

Second, there are many operational issues that need to be resolved and modeled in order to fully understand how the proposed Waiver would work. These issues include the following:

- How will “hold harmless” funding for safety net hospitals (146 hospitals) be initially realized and maintained?
- Will California have enough CPE and IGT funding available to draw down the full amount of federal funds? If not, how will State General Fund support be recognized (use of CPE or new funding)?
- How will the DSH funding be modified and how will these funds be distributed?
- How will the Safety Net Care Pool be distributed on a statewide as well as individual hospital basis?

#### **IV. Summary of Key Implementation Products and Timelines**

**A. Waiver Terms & Conditions:** The terms and conditions of a Waiver serve as the governing agreement with the federal Centers for Medicaid and Medicare (CMS). The DHS sent a draft of the terms and conditions to the federal CMS on July 2, 2005.

The federal CMS will modify the terms and conditions in discussions with the DHS over the next week or so. Once approved by the federal CMS, the federal Office of Management and Budget (OMB) as well as the federal Secretary of Health and Human Services (Secretary Leavitt) will need to approve them. The DHS contends that federal approval will take two weeks; however, it is likely that additional time will be needed.

**B. Extension of CMAC Hospital Contracting:** The Administration has received a 30-day extension (to August 1, 2005) to continue the existing CMAC hospital inpatient Selective Provider Contracting Program. It is likely that another 30-day extension will be needed by the Administration since a Waiver will not be in place by this time.

**C. Legislation Required for Fiscal Aspects:** Legislation to modify the state's existing process for the receipt of federal funds as well as the allocation of funds will need to be adopted by the **end of the Session**. This legislation will be complex and will require a two-thirds urgency vote for implementation.

**D. Legislation Requested for Mandatory Enrollment of Managed Care:** The Administration will be seeking broad authority to proceed with the mandatory enrollment of aged, blind and disabled into Medi-Cal Managed Care. Presently such enrollment is done on a voluntary basis. This proposed requirement is presently contained within the terms and conditions document submitted to the federal CMS. A total of \$360 million in federal funds (\$180 million for year one and year two of the Waiver) is presently contingent on proceeding with this mandatory enrollment. The Administration will be seeking approval of legislation by the **end of Session**.

**E. Legislation for "Coverage Product":** The Administration will also be seeking legislation for a coverage product, which is as yet undefined. **The federal CMS will be requiring the state to submit a "concept" paper by January 2006.** As such, it is likely that the Administration will be seeking either policy legislation or trailer bill legislation during the **next Session**. A total of \$540 million (\$180 million annually for the last three years of the Waiver) is presently contingent on this aspect.

**F. State Plan Amendments:** The DHS will need to submit at least two State Plan Amendments (SPAs) to the federal CMS. These include changes to the Disproportionate Share Hospital (DSH) process, including the DSH "swap", and changes for how public hospitals access federal Medi-Cal inpatient hospital funds. Both of these SPAs will need to be provided to the federal CMS for their approval by **no later than September 30, 2005**.



**Proposed  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
SPECIAL TERMS AND CONDITIONS**

**NUMBER:**

**TITLE:            Medi-Cal Hospital/Uninsured Care Demonstration**

**AWARDEE:       California Department Of Health Services**

**Demonstration Term**

1. This demonstration is approved for the five-year period, from July 1, 2005, through June 30, 2010.

**Compliance with Medicaid Law and Regulations**

2. The State agrees that it will comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
3. All requirements of the Medicaid program expressed in law and regulation, not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, or not inconsistent with the terms and conditions of this demonstration, will apply to the Medi-Cal Hospital/Uninsured Care demonstration.
4. The State will, within the time frame specified in law, come into compliance with any changes in Federal statutes or regulations affecting the Medicaid program that occur after the approval date of this demonstration. If mandated changes in Federal statutes or regulations require state legislation, the change will take effect on the day such state legislation becomes effective, or in the absence of such legislation, on the last day such legislation was required. Because of the fixed nature of the Safety Net Care Pool being established by this demonstration, no modification of the Safety Net Care Pool amounts is contemplated as a result of possible changes in Federal statutes or regulations during the period of this demonstration. If Federal statutes or regulations are adopted that either limit public hospital payments to a greater extent than under current statutes or regulations, or that restrict the use of intergovernmental transfers beyond current restrictions, and if the Centers for Medicare & Medicaid Services (CMS) has authority under section 1115 of the Social Security Act to waive the new requirements, payments made as contemplated by this demonstration will be considered to be in compliance with such modified statute or regulation.

## Inpatient Hospital Services

### Payments for Medicaid-Eligible Patients

5. The State is authorized to continue the Selective Provider Contracting Program (SPCP) during the term of this demonstration, subject to Item 6 and other applicable Terms and Conditions of this demonstration. This component of the demonstration is referred to as the "Inpatient Hospital" component.
6. Private inpatient hospital services will continue to be funded either through the Inpatient Hospital component for hospitals that contract with the State, or through payments under the State Plan. Payments to private hospitals shall include per diem payments, all supplemental payments previously made to those hospitals, including the payments made under the Graduate Medical Education program and the Emergency Services Supplemental Payment program (also known as the SB 1255 program), and the amounts that would have been paid under the California Disproportionate Share Hospital (DSH) program (also known as the SB 855 program), and shall not exceed, in the aggregate, the upper payment limit for private hospitals established under CMS regulations. The supplemental payments made to private hospitals pursuant to this paragraph are deemed to satisfy the minimum payment requirements of section 1923 of the Social Security Act, and shall not be considered DSH payments for purposes of applying the DSH allotment of section 1923(f) of the Social Security Act. Payments to private hospitals may be funded by transfers from units of local government, at their option, to the State. Any payments funded by intergovernmental transfers shall remain with the hospital and shall not be transferred back to any unit of government. During the term of the demonstration, the State will not impose a provider tax, fee or assessment on inpatient hospitals, or physician services that will be used as the non-Federal portion of any Title XIX payment.
7. By September 30, 2005, the State shall submit the necessary State Plan amendments to reflect that, effective July 1, 2005, Federal Financial Participation (FFP) for inpatient hospital services rendered to Medi-Cal beneficiaries by the 22 public hospitals identified in **Attachment C** shall be based on the certified public expenditures (CPE) of those hospitals. Other public hospitals may be paid either in the same manner as private hospitals (either through the Inpatient Hospital component, or under the State Plan), or on a CPE basis. Nothing in these terms and conditions, or in the State Plan, shall preclude the State from providing State General Funds to the public hospitals to compensate them for the non-federal share of certified expenditures.
8. The State is authorized to make estimated payments to public hospitals on the basis of costs reported to the State on the most recently filed CMS 2552-96 cost report, with adjustments necessary to reflect additional costs as set forth in **Attachment D**, and subject to appropriate updating factors. The State may use such prior year costs as a proxy for current year costs, or utilize ratios from prior year cost reports applied to current year costs or services. Hospitals must attest to the accuracy of the data utilized by the State to estimate current year costs, including additional costs identified in **Attachment D**. The filing of the hospitals' cost reports for the current year, including the additional costs referenced in **Attachment D**, shall constitute certification of the hospitals' actual

expenditures. The State will reconcile estimated payments to actual costs determined for the particular year from the audited cost report, when it becomes available (including the additional costs identified in **Attachment D**.) Reconciliation will be made on a date-of-service basis. Any adjustments required may be implemented prospectively through adjustments to payments in the year in which the adjustment is finally determined.

9. Expenditures certified as the basis for Federal claiming may be based upon all sources of funds available to public entities that operate public providers. However, these sources of funds shall not include provider taxes or donations that are impermissible under section 1903(w) of the Social Security Act, or other federal funds. For this purpose, Federal funds do not include patient care revenue received as payment for services rendered under programs such as Medicare or Medicaid.
10. The State may continue to make payments to hospitals that meet the eligibility requirements for participation in the Construction/Renovation Reimbursement Program, pursuant to California Welfare and Institutions Code section 14085.5. To the extent that the State continues to make these payments, or makes payments for specific services outside of the State Plan or contract rate, the costs associated with such payments shall not be included in the CPEs of the hospitals.
11. The State shall not receive FFP for supplemental payments to public hospitals for inpatient hospital services in excess of costs recognized under Item 9 and **Attachment D**. This does not preclude payments to these hospitals under Item 10, from the Safety Net Care Pool, or from DSH funds.

### DSH Payments

12. By September 30, 2005, the State shall submit the necessary State Plan amendment to reflect that, effective July 1, 2005, the statewide DSH allotments under section 1923(f) of the Social Security Act shall be available exclusively for DSH payments to public hospitals. FFP shall be available for DSH payments made to public hospitals based on: (1) payments funded by the State General Fund; or (2) CPEs of the 22 public hospitals identified in **Attachment C** (and other public hospitals, as approved by CMS). DSH payments under this Item 12 may be made for uncompensated Medicaid and uninsured costs, including costs associated with non-emergency services rendered to unqualified aliens. CPEs will be determined in accordance with Item 8.
13. In addition to the FFP available for DSH payments authorized under Item 12, and to the extent authorized by Federal statute, payments not to exceed 175 percent of the uncompensated care costs for serving Medicaid and uninsured patients may be made to public hospitals. The non-Federal share of payments above 100 percent of uncompensated care costs may be funded by intergovernmental transfers from the hospitals, or from units of government with which they are affiliated.
14. With respect to DSH payments made pursuant to Item 13, the State will provide assurances that each qualifying governmentally operated hospital will transfer an amount no greater than the non-Federal portion of the payment funded by the intergovernmental

transfer. The State will provide assurances that public hospitals will retain the full amount of the payment resulting from the use of intergovernmental transfers. Federal, county, or State funds paid to public hospitals will not be returned to any unit of government. Retention of such funds by the public hospitals for use in either the current or subsequent fiscal year is allowable. "Retention", when applicable, is established by demonstrating that the retained earnings account of the hospital, at the end of any year in which it received DSH payments funded by intergovernmental transfers, has increased over the prior year's balance by the amount of any DSH payments received in excess of 100 percent of uncompensated care costs (to the extent that the hospital had earnings during the year of up to the amount of such DSH payments). These retained hospital funds may be commingled with county funds for cash management purposes, provided that such funds are appropriately tracked.

15. The State may add medical centers operated by the University of California to those hospitals that are eligible to receive DSH payments, subject to the DSH payment limits established pursuant to section 1923(g) of the Social Security Act.
16. The State is free to redistribute DSH funds it receives which are based on hospitals' CPEs, provided that the recipient hospital does not return any portion of the payment received to any unit of government. Retention of such funds by the hospitals for use in either the current or subsequent fiscal year is allowable. For purposes of applying the DSH payment limit of section 1923(g) of the Social Security Act, amounts so redistributed shall be counted as payments to the hospital receiving the funds, rather than the hospital whose CPE generated the FFP.

### **Safety Net Care Pool**

17. A Safety Net Care Pool will be established to ensure continued government support for the provision of health care services to uninsured populations. Safety Net Care Pool funds may be used for health care expenditures incurred by the State, or by hospitals, clinics, or other provider types for uncompensated care costs of services provided to , uninsured individuals, as agreed upon by CMS and the State. Safety Net Care Pool funds will also be available for a Coverage Initiative in Demonstration Years 3, 4 and 5.
18. The 22 public hospitals listed in **Attachment C**, the State, a county, or a city are eligible to receive Safety Net Care Pool funds based upon CPEs. The State may, however, add other governmental entities (including providers established under state statues authorizing hospital authorities, hospital districts, or similar entities) to this list, with prior approval of CMS.
19. The State must have (and must demonstrate to CMS, as requested) permissible sources for the non-federal share of payments from the Safety Net Care Pool, which sources can include CPEs from public entities. Expenditures certified as the basis for federal claiming may be based upon all sources of funds available to public entities that operate public providers. However, these sources of funds shall not include provider taxes or donations that are impermissible under section 1903(w) of the Social Security Act, or other federal

funds. For this purpose, federal funds do not include patient care revenue received as payment for services rendered under programs such as Medicare or Medicaid.

20. For purposes of determining a hospital's uncompensated care costs pursuant to section 1923(g) of the Social Security Act, payments from the Safety Net Care Pool shall be treated in the same manner as DSH payments under that section.
21. The Safety Net Care Pool funds cannot be used for costs associated with the provision of non-emergency care to unqualified aliens. To implement this limitation, 17.79 percent of total provider expenditures or claims for services to uninsured individuals will be treated as expended for non-emergency care to unqualified aliens. Nothing in this item is intended to restrict payments for the provision of care to unqualified aliens pursuant to section 1923 of the Social Security Act.
22. In the event that the use of CPEs by public hospitals is insufficient to access all funds in the Safety Net Care Pool and fully utilize California's DSH allotment, CMS and the State will agree on modifications to the reimbursement methodologies, as necessary to access all funds referenced in this paragraph.
23. Hospital costs paid from the Safety Net Care Pool will be determined in accordance with Item 8. For non-hospital based services, CMS and the State will agree upon cost-reporting formats similar to those agreed upon for use by Federally Qualified Health Centers.
24. The State is free to redistribute Federal Safety Net Care Pool funds it receives which are based on hospitals' CPEs, provided that the recipient hospital does not return any portion of the payment received to any unit of government. Retention of such funds by the hospitals for use in either the current or subsequent fiscal year is allowable.

### **Medicaid Program Redesign**

25. For each of the first two years of the demonstration, receipt of \$180 million of Safety Net Care Pool funds will be conditioned on compliance with milestones associated with the Medi-Cal redesign proposal. These milestones are as follows:
  - a) Demonstration Year 1 (July 1, 2005 – June 30, 2006).
    - \$90 million of the Safety Net Care Pool funds will be available if managed care legislation is enacted to expand the number of counties in California covered by Medi-Cal Managed Care, and to require the enrollment of Medi-Cal only seniors and persons with disabilities into Medi-Cal Managed Care no later than September 30, 2005, and an additional \$90 million will be available if the State submits a Medicaid State Plan amendment, or submits Medicaid waiver requests associated with managed care expansion, by May 31, 2006.
    - In the event managed care expansion legislation is enacted after September 30, 2005, but before June 30, 2006, a pro rata portion of the initial \$90 million will be available based on the number of months that elapsed after September 30, 2005,

before managed care expansion legislation was enacted.

- In the event Medicaid State Plan amendments, or Medicaid waiver requests associated with managed care expansion, are submitted after March 31, 2006, but before June 30, 2006, a pro rata portion of the second \$90 million will be available based on the number of months that elapsed after May 31, 2006, before the amendments or waiver requests were submitted.
- If managed care legislation is not enacted during Demonstration Year 1, none of the \$180 million of the Safety Net Care Pool funds will be available to the State.

b) Demonstration Year 2 (July 1, 2006 – June 30, 2007).

- \$60 million of the Safety Net Care Pool funds will be available if the State continues submission of Medicaid State Plan amendments, or Medicaid waiver requests associated with managed care expansion, beginning July 1, 2006, through March 31, 2007.
- An additional \$60 million will be available if the State makes managed care contract and rate submissions between July 1, 2006, and June 30, 2007.
- A third \$60 million will be available if expanded enrollment in managed care begins by January 2007.
- If expanded enrollment in managed care begins after January 2007, but before June 30, 2007, a pro rata portion of the third \$60 million will be available based on the number of months that elapsed after January 31, 2007, before the expanded enrollment begins.
- If managed care legislation is not enacted in Demonstration Year 1, but is enacted in Demonstration Year 2, all terms applicable to Demonstration Year 1 will apply in Demonstration Year 2 in order for the State to access Demonstration Year 2 Safety Net Care Pool funds, and Demonstration Year 1 funds will not be available to the State.
- If managed care legislation is not passed by June 30, 2007, Demonstration Year 2 funds will not be available to the State.

26. The \$180 million portions of the Safety Net Care Pool for each of the first two demonstration years are considered annual allotments and are not available for use in subsequent demonstration years (i.e., Demonstration Year 1 funds are not available for use in Demonstration Year 2). This does not preclude the State from using Demonstration Years 1 or 2 funds to pay for activities performed or services rendered during Demonstration Years 1 or 2 after the end of the respective demonstration year.

## **HealthCare Coverage Initiative**

27. Receipt of \$180 million of the Safety Net Care Pool funds in each of Demonstration Years 3, 4 and 5 is available solely to fund a Healthcare Coverage Initiative (Coverage Initiative) that will expand coverage options for individuals currently uninsured. The Coverage Initiative may rely upon the existing relationships between the uninsured and safety net health care systems, hospitals, and clinics. The State may utilize additional portions of the Safety Net Care Pool funds for this purpose, but no portion of the \$180 million amount for each of the three years may be used for any demonstration expense other than the Coverage Initiative. The \$180 million portions of the Safety Net Care Pool funds for each of the last three demonstration years are considered annual allotments and are not available for use in subsequent demonstration years, if these funds are not spent during the demonstration years. This does not preclude the State from using Demonstration Years 3, 4 or 5 funds to pay for activities performed or services rendered during Demonstration Years 3, 4 or 5 after the end of the respective demonstration year.
28. The State agrees to meet the following milestones for the Coverage Initiative:
  - January 31, 2006 — Submit a concept paper on the Coverage Initiative.
  - September 1, 2006 — Submit a waiver amendment on structure, eligibility and benefits for the Coverage Initiative.
  - July 1, 2007 — Begin enrollment in the Coverage Initiative.

## **Administration/Reporting/Other**

29. The State will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame. Within six months of the date of the award of this demonstration, the State will implement appropriate controls approved by CMS to ensure oversight of demonstration claiming and expenditures. Within one year of the date of the award of this demonstration, the State will implement an accounting and reporting system acceptable to CMS.
30. The State will submit a draft annual report documenting accomplishments, status, and policy and administrative difficulties relating to the demonstration. The State will submit the draft annual report no later than 120 days after the end of each demonstration year. Within 60 days of receipt of comments from CMS, the State will submit a final report for the demonstration year to CMS. Beginning in Demonstration Year 3, the annual report will include data on the number of individuals covered by the Coverage Initiative.
31. Within 120 days following the end of the demonstration, the State will submit a draft final report to CMS for comments. The State will take into consideration CMS's comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS's comments.

32. During the term of the demonstration, the State will not impose a provider tax, fee or assessment on inpatient hospitals or physician services that will be used as the non-federal portion of any Title XIX payment.

## Evaluation

33. Within 180 days of the award of this demonstration, the State will submit to CMS for approval a draft evaluation plan, with specific requirements, time-lines, cost estimates, and a mechanism for monitoring progress of the waiver.
34. CMS will provide comments on the draft evaluation plan within 60 days of receipt, and the State will submit a final evaluation plan within 60 days of receipt of CMS's comments. The State will implement the evaluation plan, and will submit to CMS a draft of the evaluation report 120 days prior to the expiration of this demonstration. CMS will provide comments within 60 days of receipt of the draft evaluation report. The State will submit the final evaluation report prior to the expiration date of the demonstration.

## Demonstration Phase-In

35. The following provisions apply to the phase-in of the demonstration:
  - a) The existing SPCP waiver is extended through July 31, 2005.
  - b) For the 22 public hospitals identified in **Attachment C**, the State intends to modify the contracts entered into pursuant to the existing SPCP waiver within 120 days following the award of this demonstration, to be effective for services rendered on or after July 1, 2005. During the 120-day period:
    - The modified contracts for these 22 public hospitals will be negotiated consistent with the provisions of this demonstration; and
    - The State is authorized to continue to make per diem payments pursuant to the provisions of the existing SPCP contracts. These payments shall be adjusted retroactively to the amounts determined under the payment methodology prescribed in this demonstration.
  - c) Notwithstanding the award of this demonstration, the State is authorized to make final payments in connection with any amounts due to hospitals participating under the existing SPCP waiver for dates of service through June 30, 2005, or under the State's DSH program for State Fiscal Years 2003-04 and 2004-05. The State may make these payments using the current method of funding the non-federal share of such payments with intergovernmental transfers.

## **Demonstration Phase-Out**

36. The following provisions apply to the phase-out of the demonstration:
- a) The State will submit a plan for phase-out of the demonstration to CMS at least six months prior to initiating phase-out activities and, if desired by the State, the State will submit an extension plan (or an application for renewal of the waiver) on a timely basis to prevent termination of the Coverage Initiative if the demonstration is extended or renewed by CMS. Nothing herein will be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than six months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval.
  - b) During the last six months of the demonstration, the enrollment of individuals in the Coverage Initiative who would not be eligible for Medicaid under the current State Plan will not be permitted unless the demonstration is extended by CMS.

## **Suspension or Termination of Demonstration**

37. After a hearing, CMS may suspend or terminate the demonstration, in whole or in part, at anytime before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
38. The State waives none of its rights to challenge CMS's finding that the State materially failed to comply with the terms and conditions of the demonstration. CMS may withdraw waivers or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest. If a waiver or expenditure authority is withdrawn, or if the entire demonstration is terminated, CMS will be liable only for normal closeout costs.
39. The State may suspend or terminate this demonstration, in whole or in part, at any time before the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. If the demonstration is terminated, or if any relevant waivers are suspended by the State, CMS will be liable only for normal closeout costs.

**General Financial Requirements Under Title XIX**

1. The State will provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Medi-Cal Hospital/Uninsured Care demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in **Attachment B** (Monitoring Budget Neutrality for Medi-Cal Hospital/Uninsured Care).
2. The following describes the reporting of expenditures subject to the budget neutrality cap:
  - a) In order to track expenditures under this demonstration, California will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which expenditures were made). The term, "expenditures subject to the budget neutrality cap," is defined below in item 2b.
  - b) For purposes of this section, the term "expenditures subject to the budget neutrality cap" will include all expenditures from the Safety Net Care Pool. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and will be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.
  - c) Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
  - d) All claims for expenditures subject to the budget neutrality cap must be made within two years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to activities or service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

3. The standard Medicaid funding process will be used during the demonstration. California must estimate reimbursable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of reimbursable demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the Form CMS-37.12 for both the Medi-Cal Assistance Program (MAP) and Administrative Costs (ADM). CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

CMS will provide FFP at the applicable Federal reimbursement rate for the following, subject to the limits described in **Attachment B**:

- a) Administrative costs, including those associated with the administration of the Medi-Cal Hospital/Uninsured Care demonstration.
  - b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.
  - c) Net Safety Net Care Pool expenditures during the operation of the Medi-Cal Hospital/Uninsured Care demonstration.
4. The State will assure CMS that State/local monies used as the non-federal share of funds for the demonstration meet all applicable federal requirements, and will further assure CMS that such funds will not be used as the non-federal share of the funding for any other Federal grant or contract, except as permitted by law.

**Monitoring Budget Neutrality for the  
California Medi-Cal Hospital/Uninsured Care Demonstration**

1. California will be subject to a limit on the amount of Federal title XIX funding that the State may receive for Safety Net Care Pool expenditures during the period of approval of the Medi-Cal Hospital/Uninsured Care demonstration. The Pool amount will be \$766 million (federal funds) for each year of the demonstration. In each year, use of \$180 million of the Pool amount, which is referred to as the Uninsured Care component, will be subject to the provisions of Paragraphs 25 through 28 of the terms and conditions. For the balance of the Pool amount each year, any unexpended portion may be expended for Pool purposes in subsequent demonstration years.
2. If at the end of this demonstration period, the budget neutrality limit has been exceeded, the excess Federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test will be based on the time elapsed through the termination date.

**Public Hospitals to be Reimbursed on a  
Certified Public Expenditure Basis**

**5 State Government-Owned University of California (UC) Hospitals**

1. UC Davis Medical Center
2. UC Irvine Medical Center
3. UC San Diego Medical Center
4. UC San Francisco Medical Center
5. UC Los Angeles Medical Center

**17 Non-State Government-Owned**

**5 Los Angeles County (LA Co.) Hospitals**

1. LA Co. Harbor/UCLA Medical Center
2. LA Co. Martin Luther King Jr./Drew Medical Center
3. LA Co. Olive View Medical Center
4. LA Co. Rancho Los Amigos National Rehabilitation Center
5. LA Co. University of Southern California Medical Center

**12 Other Public Hospitals**

1. Alameda County Medical Center
2. Arrowhead Regional Medical Center
3. Contra Costa Regional Medical Center
4. Kern Medical Center
5. Natividad Medical Center
6. Riverside County Regional Medical Center
7. San Francisco General Hospital
8. San Joaquin General Hospital
9. San Mateo County General Hospital
10. Santa Clara Valley Medical Center
11. Tuolumne General Hospital
12. Ventura County Medical Center

**Additional Allowable Costs for  
Hospitals Using Certified Public Expenditure Methodology  
(For Purposes of Adjusting the CMS 2552-96 Cost Report)**

<b>Hospital Cost Element</b>	<b>ALLOWABLE FOR:</b>	
	<b>Medicaid Costs</b>	<b>Uninsured Care Costs (DSH/Safety Net Care Pool)</b>
Provider-based physician costs, including contracted physician costs, not reduced by Medicare reasonable compensation equivalency (RCE) limits	X	X
Intern and resident costs in accredited programs, not reduced by RCE limits	X	X
Non-physician practitioner costs	X	X
Net costs of clinics under the hospital's license, which are classified in the cost report as "Nonreimbursable Clinics"	X	X
Public hospital pensions	X	X
Physician billing and other administrative costs	X	X
Patient and community education programs, excluding cost of marketing activities	X	X
Investigational drugs	X	X
Dental services	X	X
Telemedicine	X	X
Drugs and supplies provided to non-Medi-Cal patients		X
Costs associated with securing free drugs for indigent persons		X
Patient transportation		X
Services contracted to other providers, including services to treat uninsured patients		X
Physician private offices costs that exceed fair market value rent that are paid by the physician		X

## GENERAL DISTRIBUTION PRINCIPLES FOR CALIFORNIA'S MEDI-CAL HOSPITAL/UNINSURED CARE DEMONSTRATION

The principles delineated in this document are intended to provide guidance in the distribution of federal funds available under the Medi-Cal Hospital/Uninsured Care demonstration to California's safety net hospitals. These principles will inform the development of the State legislation necessary to implement this demonstration. The implementing legislation, and not this document, will govern the implementation of this demonstration.

Under this demonstration, the State will establish special funds, as necessary, from which to distribute the federal funds (i.e. private hospital supplemental funds, Disproportionate Share Hospital [DSH] funds, and Safety Net Care Pool [Pool] funds).

- The Department of Health Services (DHS) will calculate amounts for distribution, and will distribute the following: (1) Certified public expenditure (CPE) payments to the 22 public hospitals; (2) DSH funds to public hospitals; (3) "DSH-like" funds to the private hospitals; and (4) Pool funds. DHS will also pay non-contract hospitals.
- The California Medical Assistance Commission (CMAC) will continue to enter into contracts with private hospitals and public hospitals that do not certify their public expenditures, on behalf of DHS, and will negotiate per diem and supplemental payments for these hospitals, in accordance with the provisions of the existing Selective Provider Contracting Program (SPCP) that will be retained under this demonstration. CMAC will also enter into contracts, on behalf of DHS, with CPE public hospitals that wish to be eligible to receive funds from the Pool.

As used in this document, the term "*22 public hospitals*" refers to 17 hospitals operated by counties, and 5 hospitals operated by the University of California (UC) System.

**Attachment A** is a list of these hospitals.

### GENERAL PRINCIPLES

#### 1. HOLD HOSPITALS HARMLESS

- Ensure that, during the term of this demonstration, no hospital will lose the net Medi-Cal revenue that it would have received under payment processes that were in existence in State Fiscal Year (FY) 2004-05, and subject to Principle #4. Each hospital's net Medi-Cal revenue will be based on the hospital's Medi-Cal and uninsured service delivery level and that hospital's expenditures. The net Medi-Cal and uninsured revenue is referred to as the hospital's "net baseline" funding.

#### 2. UTILIZE FEDERAL FUNDS EFFICIENTLY IN ORDER TO MAXIMIZE THE USE OF

**SUCH FUNDS**

- Employ funding strategies that maximize the use of federal funds under the demonstration.
- For hospital payments, use federal funding that is not “limited” to a fixed allotment (i.e., regular Medicaid entitlement funding) before using limited funds available under this demonstration (i.e., the Pool) or the DSH program.
- Provide maximum flexibility in the use of funds under the demonstration by using DSH funds freed up from the “DSH swap” to pay for some of the 22 public hospitals’ costs previously paid for by the Emergency Services Supplemental Payment program (SB 1255). These DSH funds will be treated as an offset against the Pool funds and will be available to the 22 public hospitals. Annually, this will make \$226 million available for allocation under the Pool. Combined with the annual \$180 million of new funds conditionally available in the Pool, there will be \$406 million of unallocated funds available in the Pool annually.

**3. DISTRIBUTE FEDERAL FUNDS AVAILABLE UNDER THIS DEMONSTRATION TO EACH HOSPITAL BASED ON THE HOSPITAL’S MEDI-CAL AND UNINSURED SERVICE DELIVERY VOLUME AND ACUITY**

- Consistent with federal payment limits, distribute the federal funds available under this demonstration to hospitals based upon the amount of care they provide to Medi-Cal beneficiaries and uninsured individuals.
- Ensure that funding distribution to hospitals is dependent on each hospital’s volume and acuity of service provided to Medi-Cal beneficiaries (fee-for-service and managed care enrollees) and uninsured individuals – the higher the volume and acuity of services provided, the higher the payment amount. Conversely, the lower the volume and acuity of services provided, the lower the payment amount.

**4. ENSURE COUNTY AND UNIVERSITY OF CALIFORNIA (UC) SYSTEM “MAINTENANCE OF EFFORT” TO THE 22 PUBLIC HOSPITALS BASED ON FY 2004-05 CONTRIBUTIONS**

- Each public hospital that reduces its certified public expenditure (CPE) amount due to a decrease in funds contributed to the hospital by the county or the UC system below the amount contributed in FY 2004-05 will have its net baseline funding amount decreased by an amount equal to the decrease in funding contributed by the county or by the UC system.

**5. LIMIT PAYMENTS FROM THE POOL TO HOSPITALS AND THEIR ASSOCIATED**

**CLINICS THAT ARE MEDI-CAL PROVIDERS**

- Require hospitals and their associated clinics that receive Pool funds to accept Medi-Cal fee-for-service and managed care beneficiaries and conduct Medi-Cal eligibility assessments and enrollment processes, as applicable, for Medi-Cal coverage to uninsured individuals in order to receive Pool funding.

**6. DISTRIBUTE NEW FUNDING ABOVE STATE FISCAL YEAR 2004-05 EXPENDITURE LEVELS BETWEEN ELIGIBLE PUBLIC AND PRIVATE HOSPITALS**

- In order to maintain the delicate working relationship between public and private hospitals, new funds will be distributed between eligible public and private hospitals. Net payments to the 22 public hospitals will consist of federal funds only, and net payments to private hospitals will consist of federal funds and State General Funds (GF).
- CMAC will negotiate the amount of new funds to be distributed to private hospitals, and eligibility criteria for these funds may differ from the existing SB 1255 program eligibility criteria.

**7. USE DEMONSTRATION FUNDS TO MAKE STATE GENERAL FUNDS AVAILABLE TO INCREASE SUPPLEMENTAL PAYMENTS TO PRIVATE HOSPITALS**

- Establish, in State law, the availability of GF as the source of the non-federal share of supplemental payments for private hospitals. A portion of the new federal funds authorized under this demonstration will be dedicated to increasing the amount of State GF available to provide supplemental payments to private hospitals. This will be accomplished by using Pool funds as the federal share of formerly 100 percent State-funded programs for which federal funds can be claimed under the demonstration.

**8. PROVIDE STATE GENERAL FUND TO THE 22 PUBLIC HOSPITALS FOR MEDI-CAL SERVICES, WHEN POSSIBLE AND APPROPRIATE**

- Nothing in this demonstration, or in State statute, will preclude the provision of State GF to the 22 public hospitals in order to help pay for the cost of providing care.

**9. THE \$180 MILLION GAINED FROM THE EXPANSION OF MEDI-CAL MANAGED CARE FOR EACH OF THE FIRST TWO YEARS OF THE DEMONSTRATION WILL BE USED TO SUPPORT SERVICES PROVIDED BY CLINICS ASSOCIATED WITH THE 22 PUBLIC HOSPITALS; THE 22 PUBLIC HOSPITALS; AND PRIVATE HOSPITALS**

- In order to maximize federal funds, improve access to and quality of care for Medi-Cal beneficiaries, and contain the rate of growth in the Medi-Cal program, the State Legislature should adopt legislation that meets the federal conditions for managed care expansion to seniors and persons with disabilities, as outlined in the Special Terms and Conditions.
- The original identified **source** of the \$180 million that is available for each of the first two years of this demonstration was clinic-based funding for the uninsured. This is the only source of federal funding in this demonstration that was not related to hospital payments (for Medi-Cal and the uninsured).
- *If this \$180 million is available for each of the first two years of the demonstration:* Priority for distribution of funds will be to support clinic-based services provided by the 22 public hospitals. Remaining funds should be distributed to fund the 22 public hospitals, private hospitals, and other health care services if necessary to draw down all available federal funds.
- *If this \$180 million is not available for each of the first two years of the demonstration:* For the first two years, all funding in this demonstration will be limited to the 22 public hospitals and to private hospitals, and no clinic funding will be available.

#### 10. REQUIRE HOSPITAL ACCOUNTABILITY

- Consistent with the Terms and Conditions of this demonstration, hospitals will be required to utilize accounting processes that minimize audit exceptions and recoveries/offsets related to CPEs and intergovernmental transfers (IGTs). Federal, State or county funds paid to hospitals on the basis of IGTs shall remain with the hospital and shall not be transferred back to any unit of government.

*Attachment A***22 Public Hospitals****5 State Government-Owned University of California (UC) Hospitals**

1. UC Davis Medical Center
2. UC Irvine Medical Center
3. UC San Diego Medical Center
4. UC San Francisco Medical Center
5. UC Los Angeles Medical Center

**17 County*****5 Los Angeles County (LA Co.) Hospitals***

1. LA Co. Harbor/UCLA Medical Center
2. LA Co. Martin Luther King Jr./Drew Medical Center
3. LA Co. Olive View Medical Center
4. LA Co. Rancho Los Amigos National Rehabilitation Center
5. LA Co. University of Southern California Medical Center

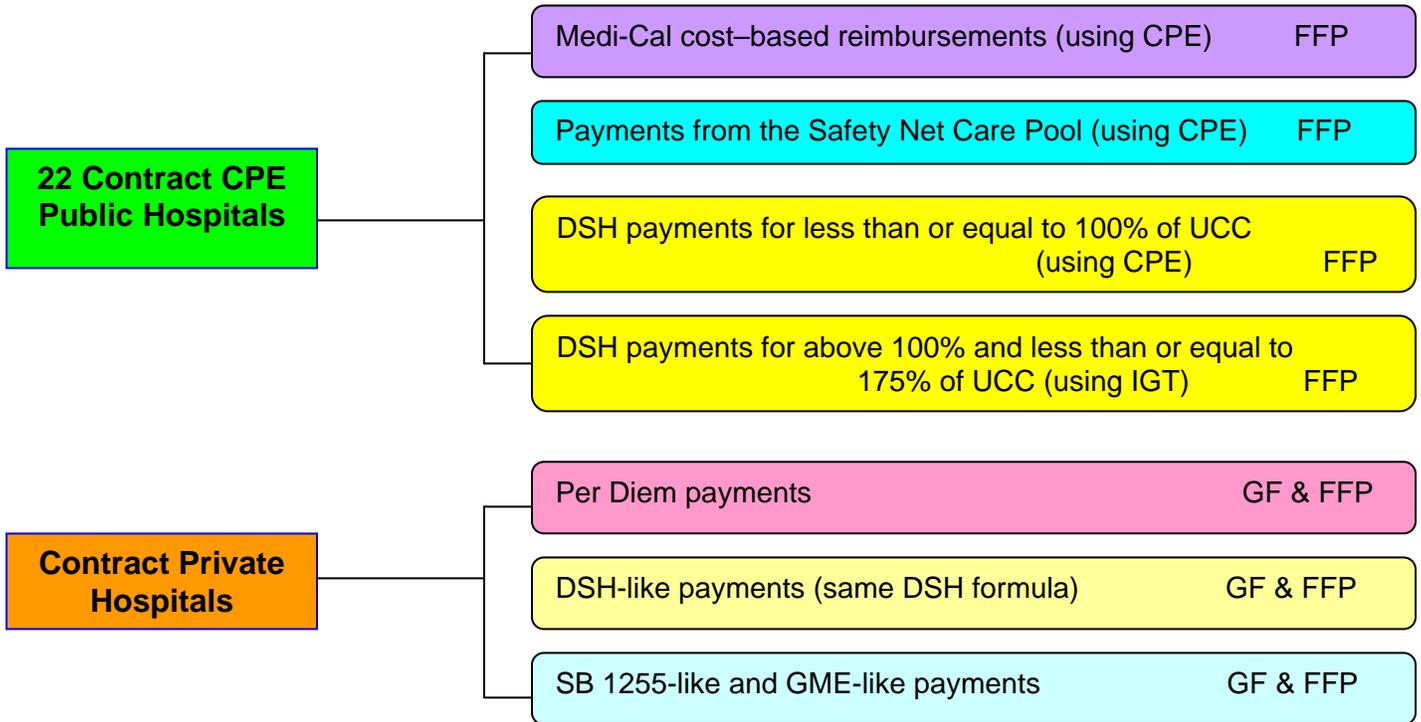
***12 Other Public Hospitals***

1. Alameda County Medical Center
2. Arrowhead Regional Medical Center
3. Contra Costa Regional Medical Center
4. Kern Medical Center
5. Natividad Medical Center
6. Riverside County Regional Medical Center
7. San Francisco General Hospital
8. San Joaquin General Hospital
9. San Mateo County General Hospital
10. Santa Clara Valley Medical Center
11. Tuolumne General Hospital
12. Ventura County Medical Center

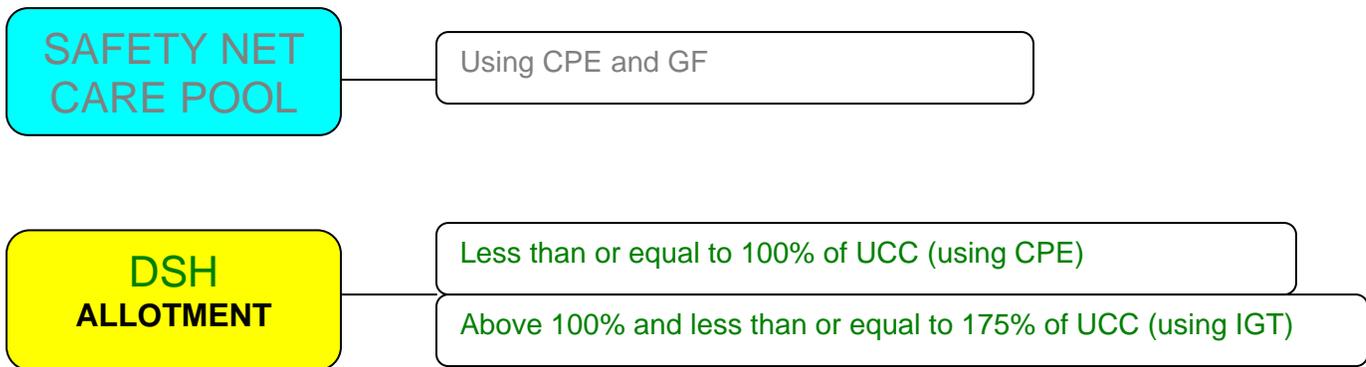
SOURCES OF PAYMENTS TO HOSPITALS

ATTACHMENT B

Payment Sources for Two Categories of Hospitals



Payment Sources for Uncompensated Care Costs



KEY:  
**GF:** General Funds  
**FFP:** Federal Financial Participation  
**DSH:** Disproportionate Share Hospital  
**CPE:** Certified Public Expenditures  
**UCC:** Uncompensated Care Costs  
**IGT:** Intergovernmental Transfers