Health Care Coverage Initiative: Financing Options & Funding Scenarios Under 1115 Waiver

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How States Finance Medicaid

Medicaid is a shared obligation between State and Federal governments

States may share a portion of their fiscal obligation to the Medicaid program with local government

States must finance their share of the Medicaid program through permissible funding sources.

Medicaid is a shared obligation between State and Federal government

Federal medical assistance percentage (FMAP) - the Federal government's share of Medicaid expenditures

FMAP varies by State - based on a relationship of a State's per capita income to national per capita income

Minimum FMAP is 50%; maximum FMAP is 83% (highest FMAP for FY 2010 is MS at 75.67%)

American Recovery & Reinvestment Act of 2009

Enhanced Federal matching funds available 10/1/08 through 12/31/10

California's regular FMAP is 50%; enhanced FMAP is 61.6%

Could be extended by Congress until June 30, 2011

Maintenance of Effort requirements

Health Care Coverage Initiative (HCCI) Financing

Federal funds limited to $180 million per year for last 3 years of current waiver

Funded by counties through certified public expenditures (CPEs)

CPEs trigger rigid payment and cost documentation requirements

Federal funds available as a percentage of total payments/costs

Permissible sources of non-federal share of Medicaid expenditures

Certified Public Expenditures (CPEs)

Intergovernmental Transfers (IGTs)

Health Care-Related Taxes

State and/or Local General Fund revenues appropriated to the Medicaid program

Certified Public Expenditures (CPEs)

Federal law expressly recognizes Medicaid costs incurred or payments made by State and local government (public) health care providers

Medicaid costs must be documented in a standardized and auditable format

Federal matching funds available as a percentage of allowable Medicaid costs

States, counties have greater flexibility to use Federal funds received from CPEs

Intergovernmental Transfers (IGTs)

Federal law expressly permits the transfer of State and local government (public) funding to support Medicaid payments

IGT and other non-federal funds must be equal to the “State share” of the Medicaid payment

Government (public) health care providers may participate in IGTs

States generally determine health care providers eligible to participate in IGTs

Intergovernmental Transfers (IGTs)

IGTs typically utilized to fund “enhanced” Medicaid payments to targeted Medicaid providers

Amount of IGT capped at non-federal share of payment to health care providers-state cannot take a share

All funds (federal + local) must remain with providers-cannot go back to county GF

Health Care-Related Taxes

Permissible class of health care items or services

Broad based or apply to all providers within a permissible class of services

Uniform such that all providers within a class must be taxed at same rate

Avoid hold harmless arrangements in which collected taxes are returned directly or indirectly to taxpayers

Health Care-Related Taxes

19 permissible classes of health care items, services

Generally redistributive – broad based and/or uniformity waiver

Permissible classes, hold harmless cannot be waived

State can collect up to 5.5% of net patient revenue for each permissible class through FY 2011 (increases to 6% beginning in FY 2012)

Local taxes are allowable

State Appropriation

State does not have general fund revenue for HCCI

May be possible to use other state funds in budget for HCCI non-federal share

- State could appropriate these funds to HCCI on behalf of participating counties

State appropriation provides source of non-federal match without triggering federal rules on IGTs and CPEs

Alternative HCCI Reimbursement

Current HCCI reimbursement is cost-based

Alternatives:

- Establish rate schedule up to Medicare or commercial rate
- Establish capitation rate – per member/per month
  - County establishes health plan or uses existing health plan

Requires alternative source of non-federal funding

Reimbursement Considerations

Current cost-based system:

- Flexibility in how funds are used
- Administratively burdensome
- Limited to defined universe of costs
- No return on investment

Rate schedules or capitation payments:

- Require use of State funds or IGTs
- Ability to reimburse in excess of cost
- Requires UPL demonstration or actuarial rate certification

HCCI Funding Scenarios

Overview

Scenarios provide illustrative funding levels

Guide for discussion of possible HCCI expansion

Any increase in federal HCCI allocation would require equal increase from participating counties

Overarching Considerations

Aggregate spending under 1115 waivers limited to budget neutrality cap

Current 1115 waiver includes Safety Net Care Pool

Increased spending under HCCI would impact SNCP spending limit

Increase SNCP spending limit

Maximize budget neutrality