California's Health Care Coverage Initiative: 1115 Waiver Financing Options

Prepared for

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Introduction

This paper summarizes the various options for financing and reimbursing the Health Care Coverage Initiative (HCCI) under California's new Medicaid 1115 waiver. It also provides background on Medicaid financing and the underlying financing and reimbursement structure for the current HCCI.

Background

Medicaid is jointly financed by the federal and state governments. Federal funds are claimed based on total program expenditures with the federal government reimbursing the State who then reimburses the local entity. The federal contribution (known as the federal matching rate or federal match) differs by state. Normally, California's Federal Medical Assistance Percentage (FMAP) is 50 percent (i.e., the federal government contributes $1 for every $1 contributed by the state). Under the federal stimulus bill (the American Recovery and Reinvestment Act of 2009, known as ARRA), however, all states received a temporary increase in their FMAP percentages, and California's is approximately 61.6 percent.[1]

It is critical to understand that Medicaid is not a grant or matching program. Rather, federal reimbursement is based upon total expenditures using a state's specific FMAP rate. While HCCI enrollees are not considered Medi-Cal members, HCCI financing follows the Medicaid structure as outlined below.

Federal Share

HCCI's federal share is capped at $180 million per year for the last three years of the current waiver period (September 1, 2007-August 31, 2010). Under the new waiver, federal funding will likely be capped again (e.g., via a total annual cap as under the current waiver or a five-year expenditure cap). Ideally, the HCCI cap, like most waiver caps, would be over the entire five-year period to provide flexibility for program start-up costs. Under the current HCCI structure, only expenditures for HCCI enrollees can be used to claim the federal share of the funding.

Non-Federal Share

Since the federal government will only reimburse its share of the cost of a Medicaid expense, the state or another "government entity" must provide the non-federal share of the expenditure. In other words, for California to claim

[1] The ARRA FMAP adjustments are scheduled to sunset on December 31, 2010, although it appears Congress may extend the provision through June 30, 2011.

federal Medicaid funds, a non-federal, government entity must finance 50 percent (or 39.4 percent under ARRA) of the total expenditure. This non-federal financing is required to draw down the federal waiver funds: for every expenditure made under the waiver, there must be a non-federal source of funds.

The federal government has delegated to the states the responsibility to define the types of organizations that can be considered government entities and are allowed to provide the non-federal share. In the past, California has agreed to allow the following types of entities to provide the non-federal share of funding:

- The State;
- Counties;
- The University of California (which the federal government considers part of the State);
- Health and hospital districts;
- Local Education Agencies, including county and school districts;
- First 5 Commissions;
- Government entities created by the Joint Powers Act that have access to tax revenue; and
- Public authorities.[2]

As discussed below, government entities can use various sources of funds to provide the non-federal share and are not limited to using tax revenue. Provider fees (or taxes) that meet federal requirements are an allowable source of funding for the non-federal share. Any reimbursement that a government entity makes to a private entity for allowable services can be claimed for reimbursement of the federal share. Federal rules do not allow expenditures by private entities, either for-profit or non-profit, to be matched directly. Finally, federal rules severely restrict the use of private provider donations to be used either directly or indirectly for the non-federal share of payments. Non-provider donations, however, are allowable.

Current HCCI Financing and Payment Structure

Be design, HCCI pays for coverage for people who do not normally qualify for Medi-Cal. Accordingly, it is financed in the current Section 1115 waiver as "costs otherwise not matchable" under the Medicaid program, and it can be expected that this will not change under the new waiver.

[2] Alameda County Medical Center is operated by the Alameda County Hospital Authority. In the past, the Department of Health Care Services has approved allowing County Organized Health Systems to provide the non-federal share of Medi-Cal payments.

Under HCCI, the participating counties provide the non-federal funds used to draw down the federal reimbursement through the use of certified public expenditures (CPEs). The HCCI counties certify the cost of making allowable expenditures on behalf of HCCI enrollees and then seek reimbursement through the State for the federal portion of their total costs. This cost-based claiming methodology defines the rate and how counties are reimbursed for services that are provided. Under the CPE arrangement, counties are limited to receiving reimbursement that is not greater than the federal share of their cost of providing services.

County expenditures occur in two ways: (1) the county acts as the provider of service and certifies the cost of these services; or (2) the county is the payer for services and certifies the payment to the provider as the cost of these services. In either case, the federal government reimburses for the expenditure at the applicable FMAP rate for the cost of services provided.

To meet federal requirements, counties must ensure that costs are claimed only for allowable services and administration and that costs are time-studied and fully documented. Cost reimbursement under CPEs is subject to cost audits that may occur up to three years after the end of the reimbursement period.

Finally, cost reimbursement does not readily allow for either capital investment in space or equipment (whose claiming must be amortized over the life of the equipment, which could be longer than the waiver) or for any return-on-investment to allow for future investment.

Financing Sources for Non-Federal Share

There are several alternative sources that could be used to finance the non-federal share of HCCI in the new waiver. These alternatives are outlined below. Under the new waiver, it is possible that one, or more, of these methods could be used to provide the non-federal funding for HCCI.

CPEs

The current method of financing the non-federal share of HCCI could be continued under the new waiver. Under CPEs, the counties are assured the federal share of all allowable costs up to their HCCI allotment. From the State and federal governments' perspective, HCCI counties would continue to have the incentive to control costs as they are providing the non-federal funds.

Because the counties have already incurred the expense prior to submitting the request for federal reimbursement, federal rules do not restrict how federal funds are used once they are claimed. For example, the federal funds can go to the

county general fund and be used for non-health care purposes. (Note that this is a key difference between CPEs and intergovernmental transfers which are discussed below.)

If CPEs are retained as the source of the non-federal share, the counties and State would continue to be subject to complex cost accounting and claiming procedures, and the counties would continue to be at-risk for audits. The counties would not be eligible to receive funding that would allow for capital investments or a return-on-investment.

Intergovernmental Transfers (IGTs)

An IGT is a transfer of funds to the Department of Health Care Services from another government entity for the purpose of providing the non-federal share of Medi-Cal payments. Specifically authorized by federal law, IGTs currently are used by the Medi-Cal program in a variety of areas, including the disproportionate share hospital (DSH) program, the In-Home Supportive Services (IHSS) program, and to finance portions of Medi-Cal managed care payments.

Under IGTs, a county, or other jurisdiction, can provide the non-federal share for a payment that is based largely on a rate rather than on cost. Because IGTs are not cost-based, they can be used to pay rates that are greater than cost, and they are not subject to the requirements and audits associated with cost-based reimbursement. Further, they can be used to provide a rate of return for the HCCI programs. For example, in the Medi-Cal managed care program, IGTs are used to increase the plan rate from the lower bound of the rate range certified by the Medi-Cal actuaries to the upper bound of the rate range, effectively providing for a larger trend factor and a higher rate of return. In turn, the managed care plans use these enhanced payments to supplement payments to providers.

To avoid abuses of IGTs, the federal Centers for Medicare and Medicaid Services (CMS) has established retention rules that require that both the federal and non-federal share of the IGT payment stay with providers or health plans and not "recycle" back either to the government entity that made the IGT or to the State. In other words, the ability of the transferring entity to make an IGT is limited to the amount of money that it is contributing to the providers who are the beneficiaries of the payment. For example, if the transferring entity is providing $1 million in support to the intended providers, the maximum amount of the IGT is $1 million, and the highest total computable payment would be $2 million (assuming a 50 percent FMAP rate). The entire $2 million payment would have to remain with the health care providers and could not be transferred back to the

county general fund. Because of this rule, if the county wanted to increase its total payment to $3 million through an IGT, the county contribution would have to increase to $1.5 million.

Provider Fees

Under certain circumstances, federal law allows fees on providers to be used as the source of the non-federal share of Medicaid payments. Fees can be collected on a statewide basis or on a county-level basis. Following federal rules, these fees could become a source of the non-federal share of payments. Counties could either use the fee as a source of funding for an IGT or for paying expenses that would be certified for federal reimbursement at the FMAP rate.

Private Donations

Federal law generally bars the use of provider donations as the source of the non-federal share of Medicaid payments. However, non-provider donations (e.g., grants from foundations) can be used as the source of the non-federal share. To the extent that these are available, counties could use the donations either as a source of funding for an IGT or for paying expenses that would be certified for federal reimbursement at the FMAP rate.

State Appropriation

The State could establish a rate of payment and use state funds and federal funds to reimburse the HCCI counties. This is the most direct basis for financing the non-federal share and provides the greatest flexibility because the use of state funds is not subject to the restrictions and requirements placed on the use of IGTs or CPEs. While it is clear the State does not have the funding to assume the responsibility for providing the HCCI non-federal share, the state budget is complex, and there may be opportunities to redirect existing funding from another source to support the HCCI.

Alternative HCCI Reimbursement Strategies

While current HCCI reimbursement is cost-based, it may be possible to move to a rate-setting methodology under the new waiver. Note that this would require a change in the source of the non-federal share for HCCI as CPEs are, by definition, cost-based, and CMS historically has required that any rate paid for services that are based on a CPE be reconciled to not exceed cost.[3]

[3] For example, payments for Medi-Cal services provided by Local Education Agencies (LEA) must be reconciled to not exceed the LEA's total cost.

Under the new waiver, the following alternative reimbursement structures could be used for HCCI:

- Counties could be reimbursed based on a rate schedule for each service provided. For example, the State could establish a rate for each allowable service (e.g., an office visit) based upon the current Medi-Cal rate, the Medicare rate, or commercial insurance rates. While there are payment limits on the size of the rates, rates could exceed cost and provide reimbursement that allows for a return-on-investment.
- Counties could be reimbursed on a per member per month (PMPM) basis for all or part of the HCCI services provided. Under this methodology, the rates would have to be certified as actuarially-sound. Payments could be structured based on the Medi-Cal managed care methodology in which the rate is based on the cost of providing care and includes factors for administration and return-on-investment. In addition, the rate could include additional components to reimburse counties for enhanced services such as case management.

These payment strategies would eliminate much of the administrative burden associated with HCCI's current cost-based reimbursement system. Rate-setting could be done in a way that ensures efficiency yet promotes quality of care and allows for a return-on-investment to continue improving the delivery of care. However, these payment strategies would put the counties at full risk for costs that exceed the rates paid, whereas the federal government shares in any unanticipated costs under the current HCCI structure.