

California Safety Net Care Pool 1115 Waiver

Establishing a Safety Net Care Pool

- The purpose of the California Safety Net Care Pool 1115 demonstration waiver is to promote Medi-Cal reform through managed care expansion, stabilize the public hospital system, and expand healthcare coverage to the uninsured. CMS would limit federal financial participation in the demonstration pool to \$3.830 billion in federal funds, of which \$540 million is reserved for expanding healthcare coverage as follows:

<i>Safety Net Care Pool</i>							
	Waiver Year 1	WY 2	WY 3	WY 4	WY 5	Totals	
Subtotal from Uncompensated Care Spending	\$766	\$766	\$766	\$766	\$766	\$3,830	CMS
DSH Funds Allocated to SNCP	\$0	\$0	\$0	\$0	\$0	\$0	CMS
Annual Federal Funds in Millions	\$766	\$766	\$766	\$766	\$766	\$3,830	CMS

Using the Safety Net Care Pool to Expand Healthcare Coverage

California will be required to use \$540 million of the Safety Net Care Pool to expand healthcare coverage as follows:

<i>Healthcare Coverage Initiative</i>							
	Waiver Year 1	WY 2	WY 3	WY 4	WY 5	Totals	
Annual Federal Funds in Millions	\$0	\$0	\$180	\$180	\$180	\$540	

The Healthcare Coverage Initiative will expand coverage options for the individuals currently uninsured. The state retains the discretion to dedicate more than the minimum to the Coverage Initiative, however if the state cannot develop, implement and enroll Californians into this program, funds that go unused in the Coverage Initiative could not be used elsewhere in the waiver.

The Coverage Initiative would be phased in, and could rely upon the existing relationships between the uninsured and safety net health care systems and clinics. There are several models under development that offer a limited benefit package and a defined provider system. CMS and the state will work closely on the development of the Coverage Initiative to achieve the implementation goals and assure a successful phase-in of the Coverage Initiative.

General Terms and Conditions

- \$180 million of annual, total pool funds will be “at risk” in each year of the waiver. That is, if the established milestones were not met, the state would not be able to access this amount of federal funds. For each of the first two years of the waiver, receipt of the \$180 million will be tied to the State meeting milestones associated with the expansion of Medi-Cal managed care. For each of the last three years of the waiver, receipt of the \$180 million would be tied to the State meeting milestones for providing the Coverage Initiative, and these funds can only be used on this Initiative. This funding is considered an annual allotment and

cannot be spent in subsequent demonstration years (i.e. demonstration year 1 funding cannot be accessed in any other year than the first year).

Demonstration Year 1

For purposes of demonstration year one, which is State fiscal year 2006 (i.e. July 1, 2005 through June 30, 2006), there are 2 milestones that must be met in order to access the full \$180 million funding tied to managed care expansion:

- (i) \$90 million would be available if managed care legislation is passed no later than September 30, 2005; and,
- (ii) \$90 million related to the submission of Medicaid State plan amendments or Medicaid waivers associated with managed care expansion beginning in March 2006.

None of the \$180 million will be available if managed care legislation is not enacted during demonstration year one.

In the event legislation is passed after the initial milestone of September 30, 2005, but before June 30, 2006, the pro rated Federal share funding would be available for meeting the first milestone based on the number of months that have elapsed after September 30, 2005, before the date the milestone is achieved.

In the event Medicaid State plan amendments or Medicaid waivers associated with managed care expansion are submitted after the initial milestone of March 2006, but before June 30, 2006, the Federal share funding would be available for meeting the second milestone, based on the number of months that have elapsed after March 31, 2006, before the milestone is achieved.

Demonstration Year 2

For purposes of demonstration year two, which is State fiscal year 2007 (i.e. July 1, 2006 through June 30, 2007), there are 3 milestones that must be met in order to access the full \$180 million funding tied to managed care expansion:

- (i) \$60 million would be available for the continued submission of Medicaid State plan amendments or Medicaid waivers associated with managed care expansion beginning July 2006 through March 2007;
- (ii) \$60 million related to managed care contract and rate submission from July 2006 through June 30, 2007; and,
- (iii) \$60 million related to expanded enrollment in managed care beginning January 2007.

If managed care legislation is not passed in demonstration year one, but is passed in demonstration year 2, all terms applicable to demonstration year one milestones would apply in demonstration year 2 to access demonstration year 2 funds. Under these circumstances demonstration year 2 milestones are not applicable. Demonstration year one funds would not be available to the State.

In the event that the State met the demonstration year 1 milestones, but expanded enrollment in managed care begins after January 2007, but before June 30, 2007, the pro rata Federal share funding would be available for meeting the third milestone in demonstration year 2, based on the number of months that have elapsed after January 31, 2007, before the expanded enrollment begins.

If managed care legislation is not passed by June 30, 2007, demonstration year two funds would not be available to the State.

Demonstration Years 3, 4 and 5

\$180 million of federal safety net pool funding will be available in each of these demonstration years for purchasing a coverage product through the State's Coverage Initiative.

- (i) If the State does not have a product to offer through the Coverage Initiative during demonstration year three, the state will not be able to access \$180 million of federal funds in the safety net pool during that demonstration year.
 - (ii) The State is similarly restricted regarding the use of \$180 million in federal funding for each of demonstrations years four and five.
 - (iii) The State may spend a larger portion of the safety net pool (more than \$180 million) on the Coverage Initiative in each of these three years. If the State spends a less than \$180 million on the Coverage Initiative during demonstration years three, four and five, the portion of the \$180 million is not available for other expenditures or for use in other demonstration years.
- Twenty-two governmentally operated providers (i.e., providers operated by the State, or a county, city, or other governmental entity) may access the safety net care pool through the use of Certified Public Expenditures (CPEs). The state must demonstrate that it has permissible sources of allowable matching funds for the non-federal share of payments from the pool to providers not using a CPE methodology. The State may access the Pool using State appropriations, and may add other governmentally operated providers to the 22 referred to above with the prior approval of CMS.
 - Safety net care pool funds may be used for health care expenditures incurred by uninsured individuals in hospitals, clinics, or for other provider types as agreed upon by CMS and California. Safety net care pool funds will also be available for a coverage initiative in demonstration years three, four and five and the State must have allowable matching funds for the non-Federal share.
 - The state agrees to submit Medicaid State plan amendments by September 30, 2005 with effective dates of July 1, 2005 to modify Medicaid reimbursement for 22 or more governmentally operated providers for all inpatient hospital services provided by those providers to comply with federal matching requirements. All reimbursement to these facilities will use CPEs (base Medicaid, DSH, safety net care pool payments) and will be limited to cost, with two exceptions: payments under the Construction/Renovation Reimbursement Program, also known as the SB 1732 program, which are made with state appropriated funds; and DSH payments between 100 and 175 percent of cost, as prescribed in federal law, which can be made using intergovernmental transfers. 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 further assurance that providers receiving said payments retain the full amount of the payment resulting from the use of intergovernmental transfers. Federal, county or state funds paid to government facilities will not be returned to the State or to a unit of local government. (Retention of such funds by the qualifying hospitals for use in the current or a subsequent fiscal year is allowable.)

The safety net care pool cannot be used for costs associated with provision of non-emergency care to undocumented aliens. Specifically, total allowable provider expenditures or claims would be reduced by 17.79% before seeking payments from the pool.

- Elements of the Selective Provider Contract Program (SPCP) waiver will be subsumed by the 1115 demonstration waiver. Waivers relative to state-wideness, freedom of choice, and negotiated rates would continue under the new Section 1115 waiver. CMS will work with the state to review the current SPCP terms and conditions for the SPCP waiver and transition all relevant portions of that waiver. For ease of reference, this component of the section 1115 waiver would be referred to as the “SPCP component.”
- Private inpatient hospitals will continue to receive their funding through either the SPCP component, for hospitals that contract with the state, or through payments under the State Plan. Payments for private hospitals shall include all supplemental payments to these hospitals, including those currently made under the DSH program, and shall not exceed, in the aggregate, the upper payment limit for private hospitals.
- Under the SPCP component of the Section 1115 waiver, private hospitals meeting federal DSH standards will receive their federally required minimum DSH payments in the form of supplemental payments funded by the State General Fund.
- There will be a separate budget neutrality agreement to monitor spending related to hospitals that are paid through the SPCP component (contracting and negotiated rates). This agreement will be based on what would have been spent up to the upper payment limit, including historical levels of spending in these hospitals, and any new supplements that would replace DSH funding.

Milestones for State to Achieve

The state agrees to meet specific milestones regarding:

Health Insurance Coverage Initiative

- January 31, 2006--California will submit a concept paper on the Coverage Initiative
- June 30, 2006—California will submit waiver amendment on structure, benefits, and eligibility
- July 1, 2007—begin enrollment

Managed Care Milestones

- passage of state legislation no later than September 30, 2005;
- submission of CMS waiver/SPA package expanding managed care from March 2006-March 2007;
- contract and rate submission to CMS from July 2006 to October 2007; and
- actual enrollment beginning January 2007

Payment Reform and Evaluations

The state agrees to the following to be included in the waivers terms and conditions:

1. The State agrees to use CPEs based on Medicaid eligible costs to claim Federal matching funds under Medicaid. Allowable costs for certification will be based on each facility's Medicare/Medicaid 2552 cost report, as adjusted to reflect additional medical expenses agreed to by CMS and the State and defined within the demonstration terms and conditions, and is subject to reconciliation effected by prospective adjustments. The State must submit the necessary State Plan amendments by September 30, 2005 with effective dates of July 1, 2005.

2. During the term of the waiver, 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.
3. During the term of the waiver, the state is prohibited from making any supplemental inpatient Medicaid payments to the government facilities that are eligible to access the safety net care pool. This does not apply to payments under the SB 1732 program or to above-100%-of-cost payments under the DSH program.
4. The state must develop an evaluation plan with specific requirements, time-lines, cost estimates, and a mechanism for monitoring progress of the waiver.
5. The state also agrees to implement an accounting and reporting system acceptable to CMS within one year of the waiver implementation date.
6. The state must develop a plan, subject to CMS approval, to implement proper controls to ensure oversight over waiver claiming and expenditures within 6 months of waiver approval.
7. Subject to the terms set forth above, the state will no longer utilize funding mechanisms that would result in Medicaid payments to any providers being returned to the State or unit of local government. (Retention of such funds for use in the current or a subsequent fiscal year is allowable.)

Reporting Requirements

- The state must report, in a timely manner, enrollment or persons served under the pool.
- The state must submit, in a timely manner, expenditure reports claimed under the pool.