**Medicaid Historic Growth Rates State by State**

An analysis of Medicaid expenditures between FY 1989 and preliminary expenditure reports for FY 1994, indicates a wide degree of variation in the rates of growth both across and within States over the five year period. The expenditure growth patterns included on the attached table depict the severity of the variations among States. The data are State reported unadjusted expenditures reflecting both Federal and State shares of Medicaid spending. It is important to note that Disproportionate Share Hospital (DSH) spending is included in the expenditures and contributes to the variations in growth rates. The Urban Institute has compiled Medicaid data which extracts DSH spending and could be used to perform a similar analysis without the DSH impact. The basic pattern of variation would be the same although some of the 1991/2 variations might not be as extreme.

## GROWTH IN MEDICAID EXPENDITURES*

## TOTAL COMPUTABLE

| STATE | 1989 % INC | 1990 % INC | 1991 %INC | 1992 %INC | 1993 %INC | 1994 %INC |
|---|---|---|---|---|---|---|
| ALABAMA | 16.2% | 46.9% | 33.8% | 39.8% | 8.6% | 8.1% |
| ALASKA | 28.6% | 15.1% | 17.1% | 11.6% | 50.9% | -3.7% |
| ARIZONA | 109.5% | 43.9% | 32.9% | 44.6% | 19.6% | 13.9% |
| ARKANSAS | 20.2% | 18.7% | 17.8% | 27.3% | 10.0% | 5.6% |
| CALIFORNIA | 8.1% | 19.5% | 17.3% | 36.7% | 20.5% | -4.3% |
| COLORADO | 1.4% | 11.4% | 35.2% | 31.6% | 28.0% | -11.6% |
| CONNECTICUT | 19.2% | 17.6% | 21.7% | 52.2% | -10.3% | 21.5% |
| DC | -4.8% | 17.5% | 13.4% | 20.5% | 11.1% | 20.4% |
| DELAWARE | 12.9% | 10.0% | 47.5% | 20.2% | 13.5% | 12.8% |
| FLORIDA | 26.4% | 26.8% | 30.0% | 24.8% | 18.8% | 9.6% |
| GEORGIA | 10.3% | 22.3% | 26.6% | 25.2% | 12.9% | 18.0% |
| HAWAII | 12.4% | 14.0% | 23.9% | 31.8% | 12.1% | 17.8% |
| IDAHO | 11.9% | 19.6% | 32.1% | 27.2% | 10.3% | 7.2% |
| ILLINOIS | 12.0% | 13.7% | 1.5% | 70.2% | 17.2% | 7.9% |
| INDIANA | 14.8% | 22.6% | 20.7% | 25.9% | 25.3% | 1.4% |
| IOWA | 12.8% | 18.5% | 21.8% | 13.3% | 8.9% | 13.8% |
| KANSAS | 16.0% | 36.5% | 28.8% | 32.9% | 17.7% | -7.6% |
| KENTUCKY | 15.5% | 20.5% | 43.6% | 25.1% | 0.9% | 2.. |
| LOUISIANA | 23.2% | 21.9% | 40.1% | 66.3% | 17.3% | 4.. |
| MAINE | 12.1% | 18.0% | 32.6% | 25.4% | 13.8% | 12.5% |
| MARYLAND | 7.0% | 19.8% | 21.4% | 32.7% | 1.9% | 13.9% |
| MASS BLIND | 0.7% | 29.2% | 2.8% | 6.6% | 0.7% | 4.8% |
| MASSACHUSETTS | 12.9% | 30.1% | 45.1% | -7.2% | -3.5% | 20.3% |
| MICHIGAN | 5.8% | 20.8% | 25.8% | 15.3% | 14.7% | 12.7% |
| MINNESOTA | 6.4% | 13.5% | 17.5% | 14.7% | 11.3% | 15.3% |
| MISSISSIPPI | 14.3% | 22.8% | 30.1% | 32.1% | 9.1% | 13.1% |
| MISSOURI | 14.1% | 15.6% | 73.0% | 39.2% | -2.4% | 13.5% |
| MONTANA | 10.2% | 7.5% | 29.9% | 12.7% | 22.1% | 6.3% |
| NEBRASKA | 15.1% | 14.7% | 25.1% | 17.6% | 18.1% | 9.8% |
| NEVADA | 13.9% | 34.9% | 23.9% | 90.2% | 7.1% | 7.8% |
| NEW HAMPSHIRE | 14.2% | 14.7% | 67.2% | 179.2% | -61.7% | 97.8% |
| NEW JERSEY | 11.2% | 18.7% | 35.0% | 42.0% | 7.1% | -4.1% |
| NEW MEXICO | 9.8% | 15.4% | 28.1% | 38.2% | 12.2% | 14.1% |
| NEW YORK | 10.1% | 12.6% | 41.2% | 8.2% | -4.2% | 16.6% |
| N. CAROLINA | 22.0% | 23.9% | 37.4% | 19.8% | 16.3% | 12.0% |
| N. DAKOTA | 8.8% | 9.5% | 15.1% | 12.0% | 4.4% | 7.9% |
| OHIO | 15.1% | 3.8% | 33.4% | 26.1% | 8.9% | 5.4% |
| OKLAHOMA | 10.3% | 11.8% | 17.1% | 21.8% | 3.9% | -3.1% |
| OREGON | 22.7% | 20.0% | 24.8% | 18.0% | 16.9% | 17.3% |
| PENNSYLVANIA | 9.2% | 9.4% | 39.1% | 44.3% | 5.2% | -0.6% |
| PUERTO RICO | 3.8% | 3.7% | 0.0% | 0.0% | 0.0% | 47.5% |
| RHODE ISLAND | 12.0% | 17.7% | 41.9% | 22.5% | 6.1% | -2.1% |
| S. CAROLINA | 20.9% | 44.7% | 45.6% | 20.8% | 10.1% | 15.0% |
| S. DAKOTA | 14.8% | 18.5% | 15.9% | 19.6% | 11.6% | 9.9% |
| TENNESSEE | 13.0% | 20.3% | 33.8% | 26.5% | 13.5% | 0.1% |
| TEXAS | 11.8% | 35.2% | 30.2% | 49.1% | 16.0% | 16.0% |
| UTAH | 10.4% | 23.2% | 28.6% | 19.4% | 13.7% | 10.1% |
| VERMONT | 17.7% | 17.5% | 25.1% | 25.4% | 5.0% | 9.9% |
| VIRGIN ISLANDS | 10.5% | -4.7% | 6.4% | 15.9% | -9.2% | 41.5% |
| VIRGINIA | 8.4% | 23.3% | 20.7% | 25.1% | 12.4% | 4.9% |
| WASHINGTON | 9.0% | 20.7% | 24.4% | 32.1% | 13.4% | 12.6% |
| WISCONSIN | 11.2% | 16.1% | 17.3% | 14.6% | 5.3% | 7.4% |
| WYOMING | 20.1% | 21.5% | 39.4% | 26.7% | 12.5% | 19.4% |
| W. VIRGINIA | 9.1% | 16.0% | 41.5% | 62.4% | 27.5% | 4.4% |
| TOTAL | 12.1% | 18.6% | 30.6% | 27.4% | 8.7% | 8.5% |

*Unadjusted HCFA-64 expenditures

**Preliminary FY 1994


Children's Defense Fund

**FAX:** (202) 662-3550

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**CITY/STATE:**

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## Federal funds received through Medicaid: Actual vs. capped funding

| REGION AND STATE | 1988 | 1989 | 1990 | 1991 | 1992 |
|---|---|---|---|---|---|
| Boston: Region 1 | | | | | |
| Connecticut | $418,282,834 | $513,412,794 | $602,598,280 | $814,949,278 | $830,766,911 |
| Maine | $217,619,764 | $247,693,838 | $281,672,578 | $340,527,195 | $400,424,990 |
| Massachusetts | $1,021,658,500 | $1,196,514,948 | $1,365,134,741 | $1,414,157,646 | $1,623,862,848 |
| New Hampshire | $82,834,785 | $91,520,325 | $121,523,706 | $145,570,300 | $168,254,797 |
| Rhode Island | $182,143,924 | $209,229,671 | $243,864,629 | $353,102,834 | $412,505,716 |
| Vermont | $75,077,157 | $84,987,486 | $78,448,729 | $121,904,577 | $136,171,705 |
| New York: Region II | | | | | |
| New Jersey | $858,947,606 | $960,089,774 | $1,149,023,731 | $1,361,893,172 | $1,387,928,269 |
| New York | $4,604,714,229 | $5,095,541,041 | $5,938,695,820 | $6,827,246,569 | $7,578,289,713 |
| Philadelphia: Region III | | | | | |
| Delaware | $52,276,588 | $58,000,466 | $61,587,673 | $93,028,491 | $109,838,614 |
| District of Columbia | $180,197,468 | $121,893,408 | $122,870,278 | $215,608,802 | $238,872,423 |
| Maryland | $421,373,290 | $468,165,322 | $545,146,527 | $607,383,906 | $754,983,419 |
| Pennsylvania | $1,290,144,357 | $1,411,399,095 | $1,639,332,453 | $1,894,793,715 | $2,394,670,997 |
| Virginia | $388,008,986 | $420,720,581 | $492,536,462 | $609,215,212 | $755,653,103 |
| West Virginia | $212,135,044 | $246,764,739 | $276,623,247 | $417,717,335 | $617,313,261 |
| Atlanta: Region IV | | | | | |
| Alabama | $325,412,502 | $372,050,283 | $446,068,012 | $585,763,886 | $770,174,910 |
| Florida | $827,123,609 | $1,055,031,272 | $1,291,297,878 | $1,545,935,119 | $1,703,683,029 |
| Georgia | $705,562,580 | $769,721,569 | $1,289,058,982 | $1,103,688,987 | $1,327,740,232 |
| Kentucky | $498,089,242 | $590,267,160 | $712,615,413 | $875,734,638 | $1,123,954,774 |
| Mississippi | $330,050,775 | $378,483,149 | $469,951,661 | $603,405,333 | $704,680,496 |
| North Carolina | $657,448,773 | $792,007,592 | $961,995,769 | $1,189,225,333 | $1,380,099,759 |
| South Carolina | $334,449,384 | $406,113,078 | $542,959,633 | $660,686,448 | $836,252,821 |
| Tennessee | $628,447,685 | $681,965,397 | $809,740,388 | $1,018,434,400 | $1,186,929,047 |
| Chicago: Region V | | | | | |
| Illinois | $928,343,937 | $1,051,661,300 | $1,212,010,062 | $1,303,641,388 | $1,959,903,435 |
| Indiana | $639,191,022 | $736,855,295 | $855,992,288 | $1,017,445,436 | $1,420,330,427 |
| Michigan | $1,020,292,532 | $1,089,941,978 | $1,197,027,461 | $1,375,133,889 | $1,491,161,580 |
| Minnesota | $592,710,603 | $586,508,771 | $743,833,579 | $795,632,141 | $889,964,884 |
| Ohio | $1,394,397,972 | $1,572,321,603 | $1,865,729,898 | $2,107,031,545 | $2,437,418,722 |
| Wisconsin | $580,818,188 | $663,901,722 | $740,029,337 | $821,685,727 | $954,392,513 |
| Dallas: Region VI | | | | | |
| Arkansas | $320,316,639 | $364,190,561 | $446,883,628 | $516,800,726 | $669,450,473 |
| Louisiana | $528,860,974 | $736,168,091 | $961,346,469 | $1,283,497,608 | $1,870,092,531 |
| New Mexico | $154,958,574 | $167,845,150 | $198,860,757 | $251,140,002 | $355,651,840 |
| Oklahoma | $368,235,667 | $419,222,952 | $469,524,651 | $567,210,273 | $710,081,112 |
| Texas | $1,106,602,125 | $1,313,993,085 | $1,702,830,418 | $708,587,582 | $1,112,749,127 |
| Kansas City: Region VII | | | | | |
| Iowa | $296,328,826 | $328,817,007 | $387,781,399 | $481,980,252 | $550,694,524 |
| Kansas | $186,574,527 | $208,753,869 | $275,072,921 | $317,138,141 | $367,092,397 |
| Missouri | $406,869,997 | $468,323,576 | $531,012,824 | $661,369,193 | $812,912,427 |
| Nebraska | $135,828,733 | $154,661,180 | $189,047,847 | $244,471,841 | $301,813,199 |
| Denver: Region VIII | | | | | |
| Colorado | $232,155,778 | $226,126,003 | $268,729,340 | $360,551,470 | $439,648,450 |
| Montana | $94,181,255 | $109,316,320 | $121,687,757 | $138,603,233 | $155,322,690 |
| North Dakota | $104,348,829 | $118,595,144 | $130,857,437 | $158,856,246 | $183,933,586 |
| South Dakota | $87,598,777 | $101,560,552 | $117,736,195 | $140,315,138 | $167,253,932 |
| Utah | $136,291,461 | $148,662,168 | $184,250,483 | $233,162,186 | $274,465,920 |
| Wyoming | $18,879,012 | $34,470,168 | $38,884,426 | $61,446,865 | $78,671,731 |
| San Francisco: Region I | | | | | |
| California | $2,612,886,639 | $2,749,082,438 | $3,253,467,695 | $3,184,781,501 | $4,025,943,589 |
| Hawaii | $83,232,911 | $86,026,086 | $104,269,665 | $128,503,341 | $141,795,314 |
| Nevada | $47,556,128 | $52,546,655 | $74,295,329 | $87,903,510 | $135,859,415 |
| Seattle Region X | | | | | |
| Alaska | $69,528,500 | $62,101,731 | $69,560,001 | $80,097,251 | $93,441,535 |
| Idaho | $86,740,847 | $97,710,484 | $118,918,425 | $164,275,116 | $201,089,023 |
| Oregon | $205,744,909 | $255,226,595 | $326,581,670 | $410,645,990 | $473,923,338 |
| Washington | $453,522,511 | $510,614,177 | $513,178,239 | $606,809,979 | $729,486,117 |
| | | | | | |
| All states | $27,204,998,763 | $30,566,777,648 | $36,540,122,784 | $40,833,266,840 | $49,309,808,576 |

## Federal funds received through Medicaid: Actual vs. capped funding

| REGION AND STATE | 1993 | 1993 w/ 5% cap | 5 yr loss | 1 yr loss | 1yr % loss |
|---|---|---|---|---|---|
| Boston: Region I | | | | | |
| Connecticut | $911,936,918 | $533,846,669 | $1,246,823,647 | $378,090,249 | 41.46% |
| Maine | $440,440,710 | $277,744,093 | $448,148,410 | $162,696,617 | 36.94% |
| Massachusetts | $1,362,801,179 | $1,303,923,906 | $1,034,897,821 | $58,877,273 | 4.32% |
| New Hampshire | $186,082,098 | $105,720,509 | $232,351,024 | $80,361,589 | 43.19% |
| Rhode Island | $380,731,023 | $232,466,932 | $542,650,707 | $148,264,091 | 38.94% |
| Vermont | $140,656,415 | $95,819,591 | $124,575,792 | $44,836,823 | 31.88% |
| New York: Region II | | | | | |
| New Jersey | $1,724,320,322 | $1,096,258,993 | $1,599,716,146 | $628,061,329 | 36.42% |
| New York | $8,651,227,188 | $5,876,911,870 | $7,374,849,849 | $2,774,315,317 | 32.07% |
| Philadelphia: Region III | | | | | |
| Delaware | $125,782,250 | $66,719,646 | $144,933,285 | $59,062,604 | 46.96% |
| District of Columbia | $265,417,383 | $229,982,706 | ($80,827,705) | $35,434,676 | 13.35% |
| Maryland | $789,383,495 | $537,790,960 | $720,271,580 | $251,572,534 | 31.87% |
| Pennsylvania | $1,938,677,069 | $1,648,587,455 | $1,793,568,257 | $292,089,614 | 15.07% |
| Virginia | $811,442,839 | $495,206,715 | $838,373,888 | $316,234,124 | 38.97% |
| West Virginia | $805,708,768 | $270,744,046 | $1,133,338,319 | $534,964,722 | 66.40% |
| Atlanta: Region IV | | | | | |
| Alabama | $851,554,250 | $415,317,977 | $1,137,596,374 | $436,238,273 | 51.23% |
| Florida | $1,942,000,207 | $1,055,642,612 | $2,739,048,440 | $886,357,595 | 45.64% |
| Georgia | $1,515,135,764 | $900,496,525 | $1,911,730,279 | $614,639,238 | 40.57% |
| Kentucky | $1,223,873,248 | $635,702,116 | $1,836,374,879 | $587,971,132 | 48.05% |
| Mississippi | $707,606,820 | $421,237,718 | $949,201,640 | $286,369,101 | 40.47% |
| North Carolina | $1,606,495,145 | $839,089,747 | $2,115,383,139 | $767,405,398 | 47.77% |
| South Carolina | $890,509,287 | $426,851,582 | $1,396,075,100 | $463,857,705 | 52.07% |
| Tennessee | $1,336,175,581 | $802,076,193 | $1,387,046,138 | $534,099,388 | 39.97% |
| Chicago: Region V | | | | | |
| Illinois | $2,233,170,585 | $1,184,828,250 | $2,374,216,188 | $1,048,342,335 | 46.94% |
| Indiana | $1,487,756,538 | $815,787,718 | $1,809,849,403 | $671,968,820 | 45.17% |
| Michigan | $1,585,065,717 | $1,302,180,547 | $798,682,290 | $282,885,170 | 17.85% |
| Minnesota | $978,918,699 | $756,465,614 | $556,002,834 | $222,453,085 | 22.72% |
| Ohio | $2,617,638,512 | $1,779,644,423 | $2,509,964,820 | $837,994,090 | 32.01% |
| Wisconsin | $1,016,861,682 | $741,287,544 | $827,014,496 | $275,574,138 | 27.10% |
| Dallas: Region VI | | | | | |
| Arkansas | $742,473,769 | $408,814,220 | $881,349,947 | $333,659,549 | 44.94% |
| Louisiana | $2,117,720,887 | $874,975,510 | $3,900,420,304 | $1,442,745,357 | 68.13% |
| New Mexico | $400,704,850 | $197,770,771 | $475,146,262 | $202,934,079 | 50.64% |
| Oklahoma | $726,971,346 | $469,972,393 | $756,539,097 | $256,998,953 | 35.35% |
| Texas | $1,582,476,760 | $1,412,335,890 | $229,924 | $170,142,870 | 10.75% |
| Kansas City: Region VII | | | | | |
| Iowa | $552,685,584 | $378,199,017 | $582,684,754 | $174,486,567 | 31.57% |
| Kansas | $409,232,046 | $238,121,628 | $493,600,238 | $170,110,417 | 41.57% |
| Missouri | $923,589,967 | $519,280,675 | $1,036,583,741 | $404,289,292 | 43.77% |
| Nebraska | $338,942,727 | $173,355,708 | $440,870,327 | $165,587,019 | 48.85% |
| Denver: Region VIII | | | | | |
| Colorado | $489,999,659 | $296,296,139 | $438,108,340 | $193,703,520 | 39.53% |
| Montana | $203,844,440 | $120,201,799 | $182,343,011 | $83,642,641 | 41.03% |
| North Dakota | $196,926,351 | $133,178,232 | $183,747,114 | $63,748,119 | 32.37% |
| South Dakota | $184,842,135 | $111,800,705 | $203,467,484 | $73,041,431 | 39.52% |
| Utah | $307,528,352 | $173,946,278 | $357,317,937 | $133,582,074 | 43.44% |
| Wyoming | $84,188,200 | $24,094,935 | $188,107,006 | $60,093,264 | 71.38% |
| San Francisco: Region IX | ($82,812,844) | | | | |
| California | $4,415,809,474 | $3,334,779,042 | $2,469,344,230 | $1,081,030,432 | 24.48% |
| Hawaii | $146,254,440 | $106,228,629 | $123,938,758 | $40,025,811 | 27.37% |
| Nevada | $150,952,789 | $60,695,009 | $225,841,191 | $90,257,780 | 59.78% |
| Seattle Region X | ($26,235,772) | | | | |
| Alaska | $108,699,689 | $88,737,949 | $10,501,911 | $19,961,746 | 18.36% |
| Idaho | $214,048,358 | $110,705,744 | $292,778,572 | $103,342,614 | 48.28% |
| Oregon | $497,195,254 | $262,588,434 | $769,858,824 | $234,606,820 | 47.19% |
| Washington | $825,073,842 | $578,822,419 | $553,664,288 | $246,251,423 | 29.85% |
| | | | | | |
| All states | $54,258,012,591 | $34,721,235,776 | $53,776,017,774 | $19,845,825,431 | 36.21% |

**Federal funds received through Medicaid: Actual vs. capped funding**

| REGION AND STATE | 1993 | 1993 w/ 7% cap | 5 yr funding loss | 1 yr funding loss | 1 yr % loss |
|---|---|---|---|---|---|
| Boston: Region 1 | | | | | |
| Connecticut | $911,936,918 | $586,663,313 | $1,099,848,291 | $325,273,605 | 35.67% |
| Maine | $440,440,710 | $306,222,977 | $371,681,629 | $135,217,733 | 30.70% |
| Massachusetts | $1,362,801,179 | $1,432,928,897 | $675,909,574 | ($70,127,718) | -5.15% |
| New Hampshire | $186,082,098 | $116,180,071 | $203,244,708 | $69,902,026 | 37.57% |
| Rhode Island | $380,731,023 | $255,466,276 | $478,649,352 | $125,264,747 | 32.90% |
| Vermont | $140,656,415 | $105,299,597 | $98,195,336 | $35,356,818 | 25.14% |
| New York: Region II | | | | | |
| New Jersey | $1,724,320,322 | $1,204,718,451 | $1,297,900,916 | $519,601,870 | 30.13% |
| New York | $8,651,227,188 | $8,458,349,911 | $5,758,854,904 | $2,192,877,277 | 25.35% |
| Philadelphia: Region III | | | | | |
| Delaware | $125,782,250 | $73,320,620 | $126,564,445 | $52,461,630 | 41.71% |
| District of Columbia | $265,417,383 | $252,736,271 | ($144,145,118) | $12,681,112 | 4.78% |
| Maryland | $789,363,495 | $590,997,836 | $572,210,306 | $198,365,658 | 25.13% |
| Pennsylvania | $1,938,677,069 | $1,809,494,200 | $1,340,240,006 | $129,182,869 | 6.66% |
| Virginia | $811,442,839 | $544,202,675 | $702,036,095 | $267,240,164 | 32.93% |
| West Virginia | $805,708,788 | $297,530,373 | $1,058,798,747 | $508,178,394 | 63.07% |
| Atlanta: Region IV | | | | | |
| Alabama | $851,554,250 | $456,407,868 | $1,023,253,603 | $395,146,381 | 46.40% |
| Florida | $1,942,000,207 | $1,160,083,649 | $2,448,415,460 | $781,916,558 | 40.26% |
| Georgia | $1,515,135,764 | $989,588,032 | $1,663,811,158 | $525,547,731 | 34.69% |
| Kentucky | $1,223,673,248 | $698,595,928 | $1,461,357,313 | $525,077,319 | 42.91% |
| Mississippi | $707,606,820 | $462,913,285 | $833,229,083 | $244,693,534 | 34.58% |
| North Carolina | $1,606,495,145 | $922,105,914 | $1,884,350,151 | $684,389,230 | 42.60% |
| South Carolina | $890,509,287 | $469,082,562 | $1,278,556,969 | $421,426,725 | 47.32% |
| Tennessee | $1,336,175,561 | $881,430,388 | $1,166,223,492 | $454,745,193 | 34.03% |
| Chicago: Region V | | | | | |
| Illinois | $2,233,170,585 | $1,302,050,395 | $2,048,016,619 | $931,120,190 | 41.69% |
| Indiana | $1,487,756,536 | $896,498,474 | $1,585,251,786 | $591,258,062 | 39.74% |
| Michigan | $1,585,065,717 | $1,431,013,057 | $440,174,014 | $154,052,660 | 9.72% |
| Minnesota | $978,918,699 | $831,307,282 | $347,737,410 | $147,611,417 | 15.08% |
| Ohio | $2,617,638,512 | $1,955,715,289 | $2,020,004,149 | $661,923,223 | 25.29% |
| Wisconsin | $1,016,861,682 | $814,627,554 | $822,927,805 | $202,234,128 | 19.89% |
| Dallas: Region VI | | | | | |
| Arkansas | $742,473,769 | $449,260,658 | $768,797,750 | $293,213,113 | 39.49% |
| Louisiana | $2,117,720,867 | $741,754,874 | $3,714,590,231 | $1,375,965,993 | 64.97% |
| New Mexico | $400,704,850 | $217,337,416 | $420,697,239 | $183,367,434 | 45.76% |
| Oklahoma | $726,971,346 | $516,469,573 | $627,149,211 | $210,501,773 | 28.96% |
| Texas | $1,582,478,760 | $1,552,066,726 | ($388,605,639) | $30,412,034 | 1.92% |
| Kansas City: Region VII | | | | | |
| Iowa | $552,685,584 | $415,616,508 | $478,561,345 | $137,069,076 | 24.80% |
| Kansas | $408,232,046 | $261,680,425 | $428,242,068 | $146,551,620 | 35.90% |
| Missouri | $923,568,967 | $570,656,218 | $893,598,604 | $352,913,749 | 38.21% |
| Nebraska | $338,942,727 | $190,506,824 | $393,143,108 | $148,435,902 | 43.79% |
| Denver: Region VIII | | | | | |
| Colorado | $489,999,659 | $325,610,488 | $356,533,923 | $164,389,170 | 33.55% |
| Montana | $203,844,440 | $132,094,082 | $149,249,797 | $71,750,358 | 35.20% |
| North Dakota | $196,926,351 | $146,354,351 | $147,081,309 | $50,572,000 | 25.68% |
| South Dakota | $184,842,135 | $122,861,817 | $172,687,207 | $61,980,318 | 33.53% |
| Utah | $307,528,352 | $191,155,824 | $309,428,126 | $116,372,528 | 37.84% |
| Wyoming | $84,188,200 | $26,478,781 | $181,473,338 | $57,709,408 | 68.55% |
| San Francisco: Region I | ($82,812,844) | | | | |
| California | $4,415,809,474 | $3,664,708,677 | $1,551,233,537 | $751,100,797 | 17.01% |
| Hawaii | $146,254,440 | $116,738,463 | $94,692,549 | $29,515,977 | 20.18% |
| Nevada | $150,952,789 | $66,699,929 | $208,991,018 | $84,252,860 | 55.81% |
| Seattle Region X | ($28,235,772) | | | | |
| Alaska | $108,699,669 | $97,517,318 | ($13,926,869) | $11,182,371 | 10.29% |
| Idaho | $214,048,358 | $121,658,525 | $262,299,753 | $92,389,832 | 43.16% |
| Oregon | $497,195,254 | $288,567,878 | $697,564,604 | $208,627,376 | 41.96% |
| Washington | $825,073,842 | $636,088,782 | $394,506,488 | $188,985,059 | 22.91% |
| | | | | | |
| All states | $54,256,012,591 | $38,156,415,293 | $44,216,782,375 | $16,210,645,914 | 29.88% |

National Health Law Program, 202/887-5310.
Source: HCFA 2082 statistical reports.



February 3, 1995


Children's Defense Fund

**FAX:** (202) 662-3550

**FACSIMILE TRANSMITTAL SHEET**

**TO:** Jennifer Klein

**FIRM:**

**CITY/STATE:**

**FAX NUMBER:** 456-2878

**FROM:** JIM WEILL

**DEPT:** GENERAL COUNSEL

IF YOU HAVE A TRANSMITTAL/RECEIVING PROBLEM, PLEASE CALL (202) 662-3571

**DATE:** 2-10-95 **TIME:**

**NUMBER OF PAGES SENT (INCLUDING COVER SHEET):** 4

**COMMENTS:**

25 E Street, NW
Washington, DC 20001
Telephone 202 628 8787
Fax 202 662 3510

## Federal funds received through Medicaid: Actual vs. capped funding

| REGION AND STATE | 1988 | 1989 | 1990 | 1991 | 1992 |
|---|---|---|---|---|---|
| Boston: Region 1 | | | | | |
| Connecticut | $418,282,834 | $513,412,794 | $602,598,280 | $814,949,278 | $830,766,911 |
| Maine | $217,619,764 | $247,693,838 | $281,672,578 | $340,527,195 | $400,424,990 |
| Massachusetts | $1,021,658,500 | $1,196,514,948 | $1,365,134,741 | $1,414,157,646 | $1,623,862,846 |
| New Hampshire | $82,834,785 | $91,520,325 | $121,523,706 | $145,570,300 | $168,254,797 |
| Rhode Island | $182,143,924 | $209,229,671 | $243,864,629 | $353,102,834 | $412,505,716 |
| Vermont | $75,077,157 | $84,987,486 | $76,446,729 | $121,904,577 | $136,171,705 |
| New York: Region II | | | | | |
| New Jersey | $858,947,606 | $960,089,774 | $1,149,023,731 | $1,361,893,172 | $1,387,928,269 |
| New York | $4,604,714,229 | $5,095,541,041 | $5,938,695,820 | $6,827,246,569 | $7,578,289,713 |
| Philadelphia: Region III | | | | | |
| Delaware | $52,276,588 | $58,000,466 | $61,587,673 | $93,028,491 | $109,838,814 |
| District of Columbia | $180,197,468 | $121,893,408 | $122,870,278 | $215,608,802 | $238,872,423 |
| Maryland | $421,373,290 | $468,165,322 | $545,146,527 | $607,383,906 | $754,983,419 |
| Pennsylvania | $1,290,144,357 | $1,411,399,095 | $1,639,332,453 | $1,894,793,715 | $2,394,670,997 |
| Virginia | $388,008,986 | $420,720,581 | $492,536,462 | $609,215,212 | $755,653,103 |
| West Virginia | $212,135,044 | $246,764,739 | $276,823,247 | $417,717,335 | $617,313,261 |
| Atlanta: Region IV | | | | | |
| Alabama | $325,412,502 | $372,050,283 | $446,069,012 | $585,763,886 | $770,174,910 |
| Florida | $827,123,609 | $1,055,031,272 | $1,291,297,878 | $1,545,935,119 | $1,703,683,029 |
| Georgia | $705,562,590 | $769,721,569 | $1,289,056,982 | $1,103,688,367 | $1,327,740,232 |
| Kentucky | $498,089,242 | $590,267,160 | $712,615,413 | $875,734,638 | $1,123,954,774 |
| Mississippi | $330,050,775 | $378,483,149 | $469,951,661 | $603,405,333 | $704,680,496 |
| North Carolina | $657,448,773 | $792,007,592 | $961,995,769 | $1,189,225,333 | $1,380,099,759 |
| South Carolina | $334,449,384 | $406,113,078 | $542,959,633 | $660,686,446 | $838,252,821 |
| Tennessee | $828,447,685 | $881,965,397 | $809,740,388 | $1,018,434,400 | $1,188,929,047 |
| Chicago: Region V | | | | | |
| Illinois | $928,343,937 | $1,051,681,300 | $1,212,010,062 | $1,303,641,388 | $1,959,903,495 |
| Indiana | $639,191,022 | $736,855,295 | $855,992,286 | $1,017,445,436 | $1,420,330,427 |
| Michigan | $1,020,292,532 | $1,089,941,978 | $1,197,027,461 | $1,375,133,889 | $1,491,161,580 |
| Minnesota | $592,710,603 | $586,508,771 | $743,833,579 | $795,632,141 | $889,964,884 |
| Ohio | $1,394,397,972 | $1,572,321,603 | $1,865,729,898 | $2,107,031,545 | $2,437,418,722 |
| Wisconsin | $580,818,188 | $663,901,722 | $740,029,337 | $821,685,727 | $954,392,513 |
| Dallas: Region VI | | | | | |
| Arkansas | $320,316,639 | $364,190,561 | $446,883,626 | $516,800,726 | $669,450,473 |
| Louisiana | $528,860,974 | $736,168,091 | $961,346,469 | $1,283,497,608 | $1,870,092,531 |
| New Mexico | $154,958,574 | $167,845,150 | $198,860,757 | $251,140,002 | $355,651,640 |
| Oklahoma | $368,235,667 | $419,222,952 | $469,524,651 | $567,210,273 | $710,081,112 |
| Texas | $1,106,602,125 | $1,313,993,085 | $1,702,830,418 | $708,587,582 | $1,112,749,127 |
| Kansas City: Region VII | | | | | |
| Iowa | $296,328,826 | $328,817,007 | $387,781,399 | $481,980,252 | $550,694,524 |
| Kansas | $186,574,527 | $208,753,869 | $275,072,921 | $317,138,141 | $367,092,397 |
| Missouri | $406,869,997 | $468,323,576 | $531,012,824 | $661,369,193 | $812,912,427 |
| Nebraska | $135,828,733 | $154,661,180 | $189,047,847 | $244,471,841 | $301,813,199 |
| Denver: Region VIII | | | | | |
| Colorado | $232,155,778 | $226,126,003 | $268,729,340 | $360,551,470 | $439,649,450 |
| Montana | $94,181,255 | $109,316,320 | $121,687,757 | $138,603,233 | $155,322,690 |
| North Dakota | $104,348,629 | $118,595,144 | $130,857,437 | $156,856,246 | $183,933,586 |
| South Dakota | $87,598,777 | $101,560,552 | $117,736,195 | $140,315,138 | $167,253,932 |
| Utah | $136,291,461 | $148,662,168 | $184,250,483 | $233,162,186 | $274,465,920 |
| Wyoming | $18,879,012 | $34,470,168 | $38,884,426 | $61,446,865 | $78,671,731 |
| San Francisco: Region I | | | | | |
| California | $2,612,886,639 | $2,749,082,438 | $3,253,467,695 | $3,184,781,501 | $4,025,943,589 |
| Hawaii | $83,232,911 | $86,026,086 | $104,269,665 | $128,503,341 | $141,795,314 |
| Nevada | $47,556,128 | $52,546,655 | $74,295,329 | $87,903,510 | $135,859,415 |
| Seattle Region X | | | | | |
| Alaska | $69,528,500 | $62,101,731 | $69,560,001 | $80,097,251 | $93,441,535 |
| Idaho | $86,740,847 | $97,710,484 | $118,918,425 | $164,275,116 | $201,089,023 |
| Oregon | $205,744,909 | $255,226,595 | $326,581,670 | $410,645,990 | $473,923,338 |
| Washington | $453,522,511 | $510,614,177 | $513,178,239 | $606,809,979 | $729,486,117 |
| | | | | | |
| All states | $27,204,998,763 | $30,566,777,648 | $36,540,122,784 | $40,833,266,840 | $49,309,808,576 |

National Health Law Program, 202/887-5310.
Source: HCFA 2082 statistical reports.



February 3, 1995

**Federal funds received through Medicaid: Actual vs. capped funding**

| REGION AND STATE | 1993 | 1993 w/ 5% cap | 5 yr loss | 1 yr loss | 1yr % loss |
|---|---|---|---|---|---|
| Boston: Region 1 | | | | | |
| Connecticut | $911,936,918 | $533,846,669 | $1,246,823,647 | $378,090,249 | 41.48% |
| Maine | $440,440,710 | $277,744,093 | $448,148,410 | $162,696,617 | 36.94% |
| Massachusetts | $1,362,801,179 | $1,303,923,906 | $1,034,897,821 | $58,877,273 | 4.32% |
| New Hampshire | $186,082,098 | $105,720,509 | $232,351,024 | $80,361,589 | 43.19% |
| Rhode Island | $380,731,023 | $232,466,932 | $542,650,707 | $148,264,091 | 38.94% |
| Vermont | $140,656,415 | $95,819,591 | $124,575,792 | $44,836,823 | 31.88% |
| New York: Region II | | | | | |
| New Jersey | $1,724,320,322 | $1,096,258,993 | $1,599,716,146 | $628,061,329 | 36.42% |
| New York | $8,651,227,188 | $5,876,911,870 | $7,374,849,849 | $2,774,315,317 | 32.07% |
| Philadelphia: Region III | | | | | |
| Delaware | $125,782,250 | $66,719,646 | $144,933,285 | $59,062,604 | 46.96% |
| District of Columbia | $265,417,383 | $229,982,706 | ($80,827,705) | $35,434,676 | 13.35% |
| Maryland | $789,363,495 | $537,790,960 | $720,271,580 | $251,572,534 | 31.87% |
| Pennsylvania | $1,938,677,069 | $1,648,587,455 | $1,793,568,257 | $292,089,614 | 15.07% |
| Virginia | $811,442,839 | $495,208,715 | $838,373,888 | $316,234,124 | 38.97% |
| West Virginia | $805,708,768 | $270,744,046 | $1,133,338,319 | $534,964,722 | 66.40% |
| Atlanta: Region IV | | | | | |
| Alabama | $851,554,250 | $415,317,977 | $1,137,596,374 | $436,236,273 | 51.23% |
| Florida | $1,942,000,207 | $1,055,642,612 | $2,739,048,440 | $886,357,595 | 45.64% |
| Georgia | $1,515,135,764 | $900,496,525 | $1,911,730,278 | $614,639,238 | 40.57% |
| Kentucky | $1,223,679,248 | $635,702,116 | $1,636,374,879 | $587,971,132 | 48.05% |
| Mississippi | $707,606,820 | $421,237,718 | $949,201,840 | $286,369,101 | 40.47% |
| North Carolina | $1,606,495,145 | $839,089,747 | $2,115,363,139 | $767,405,398 | 47.77% |
| South Carolina | $890,509,287 | $426,851,582 | $1,398,075,100 | $463,657,705 | 52.07% |
| Tennessee | $1,336,175,581 | $802,076,193 | $1,387,046,138 | $534,099,388 | 39.97% |
| Chicago: Region V | | | | | |
| Illinois | $2,233,170,585 | $1,184,828,250 | $2,374,216,188 | $1,048,342,335 | 46.94% |
| Indiana | $1,487,756,536 | $815,787,716 | $1,809,849,403 | $671,968,820 | 45.17% |
| Michigan | $1,585,065,717 | $1,302,180,547 | $798,682,290 | $282,885,170 | 17.85% |
| Minnesota | $978,918,699 | $756,485,614 | $556,002,834 | $222,453,085 | 22.72% |
| Ohio | $2,617,638,512 | $1,779,644,423 | $2,509,964,820 | $837,994,090 | 32.01% |
| Wisconsin | $1,016,861,682 | $741,287,544 | $827,014,496 | $275,574,138 | 27.10% |
| Dallas: Region VI | | | | | |
| Arkansas | $742,473,769 | $408,814,220 | $881,349,947 | $333,659,549 | 44.94% |
| Louisiana | $2,117,720,887 | $674,975,510 | $3,900,420,304 | $1,442,745,357 | 68.13% |
| New Mexico | $400,704,850 | $197,770,771 | $475,146,262 | $202,934,079 | 50.64% |
| Oklahoma | $726,971,346 | $469,972,393 | $756,539,097 | $256,998,953 | 35.35% |
| Texas | $1,582,478,760 | $1,412,335,890 | $229,924 | $170,142,870 | 10.75% |
| Kansas City: Region VII | | | | | |
| Iowa | $552,685,584 | $378,199,017 | $582,684,754 | $174,486,567 | 31.57% |
| Kansas | $403,232,046 | $238,121,628 | $493,800,238 | $170,110,417 | 41.67% |
| Missouri | $923,569,967 | $519,280,675 | $1,036,563,741 | $404,289,292 | 43.77% |
| Nebraska | $338,942,727 | $173,355,708 | $440,870,327 | $165,587,019 | 48.85% |
| Denver: Region VIII | | | | | |
| Colorado | $489,999,659 | $296,296,139 | $438,108,340 | $193,703,520 | 39.53% |
| Montana | $203,844,440 | $120,201,799 | $182,343,011 | $83,642,641 | 41.03% |
| North Dakota | $196,926,351 | $133,178,232 | $183,747,114 | $63,748,119 | 32.37% |
| South Dakota | $184,842,135 | $111,800,705 | $203,467,484 | $73,041,431 | 39.52% |
| Utah | $307,528,352 | $173,946,278 | $357,317,937 | $133,582,074 | 43.44% |
| Wyoming | $84,188,200 | $24,094,935 | $188,107,006 | $60,093,264 | 71.38% |
| San Francisco: Region IX | ($82,812,844) | | | | |
| California | $4,415,809,474 | $3,334,779,042 | $2,469,344,230 | $1,081,030,432 | 24.48% |
| Hawaii | $146,254,440 | $106,228,629 | $123,938,756 | $40,025,811 | 27.37% |
| Nevada | $150,952,789 | $60,695,009 | $225,841,191 | $90,257,780 | 59.79% |
| Seattle Region X | ($28,235,772) | | | | |
| Alaska | $108,699,689 | $88,737,943 | $10,501,911 | $19,961,746 | 18.36% |
| Idaho | $214,048,358 | $110,705,744 | $292,778,572 | $103,342,614 | 48.28% |
| Oregon | $497,195,254 | $262,588,434 | $769,858,824 | $234,606,820 | 47.19% |
| Washington | $825,073,842 | $578,822,419 | $553,864,288 | $246,251,423 | 29.85% |
| | | | | | |
| All states | $54,256,012,591 | $34,721,235,776 | $53,776,017,774 | $19,645,825,431 | 36.21% |

National Health Law Program, 202/887-5310.
Source: HCFA 2082 statistical reports.



February 3, 1995

**Federal funds received through Medicaid: Actual vs. capped funding**

| REGION AND STATE | 1993 | 1993 w/ 7% cap | 5 yr funding loss | 1 yr funding loss | 1 yr % loss |
|---|---|---|---|---|---|
| Boston: Region 1 | | | | | |
| Connecticut | $911,836,918 | $586,663,313 | $1,099,848,291 | $325,273,605 | 35.67% |
| Maine | $440,440,710 | $306,222,977 | $371,681,629 | $135,217,733 | 30.70% |
| Massachusetts | $1,362,801,179 | $1,432,928,897 | $675,909,574 | ($70,127,718) | -5.15% |
| New Hampshire | $186,082,098 | $116,180,071 | $203,244,708 | $69,902,026 | 37.57% |
| Rhode Island | $380,731,023 | $255,466,276 | $478,649,352 | $125,264,747 | 32.90% |
| Vermont | $140,656,415 | $105,299,597 | $98,195,336 | $35,356,818 | 25.14% |
| New York: Region II | | | | | |
| New Jersey | $1,724,320,322 | $1,204,718,451 | $1,297,900,916 | $519,601,870 | 30.13% |
| New York | $8,651,227,188 | $6,458,349,911 | $5,756,854,904 | $2,192,877,277 | 25.35% |
| Philadelphia: Region III | | | | | |
| Delaware | $125,782,250 | $73,320,620 | $126,584,445 | $52,461,630 | 41.71% |
| District of Columbia | $265,417,383 | $252,736,271 | ($144,145,118) | $12,681,112 | 4.78% |
| Maryland | $789,363,495 | $590,997,836 | $572,210,306 | $198,365,658 | 25.13% |
| Pennsylvania | $1,938,677,069 | $1,809,494,200 | $1,340,240,006 | $129,182,869 | 6.66% |
| Virginia | $811,442,839 | $544,202,675 | $702,036,095 | $267,240,164 | 32.93% |
| West Virginia | $805,708,768 | $297,530,373 | $1,058,798,747 | $508,178,394 | 63.07% |
| Atlanta: Region IV | | | | | |
| Alabama | $851,554,250 | $456,407,868 | $1,023,253,603 | $395,146,381 | 46.40% |
| Florida | $1,942,000,207 | $1,160,083,649 | $2,448,415,460 | $781,916,558 | 40.26% |
| Georgia | $1,515,135,764 | $989,588,032 | $1,663,811,158 | $525,547,731 | 34.69% |
| Kentucky | $1,223,673,248 | $698,595,928 | $1,461,357,313 | $525,077,319 | 42.91% |
| Mississippi | $707,606,820 | $462,913,285 | $833,229,083 | $244,693,534 | 34.58% |
| North Carolina | $1,606,495,145 | $922,105,914 | $1,884,350,151 | $684,389,230 | 42.60% |
| South Carolina | $890,509,287 | $469,082,562 | $1,278,556,969 | $421,426,725 | 47.32% |
| Tennessee | $1,336,175,581 | $881,430,388 | $1,166,223,492 | $454,745,193 | 34.03% |
| Chicago: Region V | | | | | |
| Illinois | $2,233,170,585 | $1,302,050,395 | $2,048,016,619 | $931,120,190 | 41.69% |
| Indiana | $1,487,756,536 | $896,498,474 | $1,585,251,786 | $591,258,062 | 39.74% |
| Michigan | $1,585,065,717 | $1,431,013,057 | $440,174,014 | $154,052,660 | 9.72% |
| Minnesota | $978,918,699 | $831,307,282 | $347,737,410 | $147,611,417 | 15.08% |
| Ohio | $2,617,638,512 | $1,955,715,289 | $2,020,004,149 | $661,923,223 | 25.29% |
| Wisconsin | $1,016,861,682 | $814,627,554 | $822,927,805 | $202,234,128 | 19.89% |
| Dallas: Region VI | | | | | |
| Arkansas | $742,473,769 | $449,260,658 | $768,797,750 | $293,213,113 | 39.49% |
| Louisiana | $2,117,720,887 | $741,754,874 | $3,714,590,231 | $1,375,965,993 | 64.97% |
| New Mexico | $400,704,850 | $217,337,416 | $420,697,239 | $183,367,434 | 45.76% |
| Oklahoma | $726,971,346 | $516,469,573 | $627,149,211 | $210,501,773 | 28.96% |
| Texas | $1,582,478,760 | $1,552,068,726 | ($388,605,639) | $30,412,034 | 1.92% |
| Kansas City: Region VII | | | | | |
| Iowa | $552,685,584 | $415,616,508 | $478,561,345 | $137,069,076 | 24.80% |
| Kansas | $408,232,045 | $261,680,425 | $428,242,068 | $146,551,620 | 35.90% |
| Missouri | $923,569,967 | $570,856,218 | $893,598,604 | $352,913,749 | 38.21% |
| Nebraska | $338,942,727 | $190,506,824 | $393,143,108 | $148,435,902 | 43.79% |
| Denver: Region VIII | | | | | |
| Colorado | $489,999,659 | $325,610,488 | $358,533,923 | $164,389,170 | 33.55% |
| Montana | $203,844,440 | $132,094,082 | $149,249,797 | $71,750,358 | 35.20% |
| North Dakota | $196,926,351 | $146,354,351 | $147,081,309 | $50,572,000 | 25.68% |
| South Dakota | $184,842,135 | $122,661,817 | $172,687,207 | $61,980,318 | 33.53% |
| Utah | $307,528,352 | $191,155,824 | $309,428,126 | $116,372,528 | 37.84% |
| Wyoming | $84,188,200 | $28,478,791 | $181,473,338 | $57,709,408 | 68.55% |
| San Francisco: Region I | ($82,812,844) | | | | |
| California | $4,415,809,474 | $3,664,708,677 | $1,551,233,537 | $751,100,797 | 17.01% |
| Hawaii | $146,254,440 | $116,738,463 | $94,692,549 | $29,515,977 | 20.18% |
| Nevada | $150,952,789 | $88,699,929 | $208,931,018 | $84,252,860 | 55.81% |
| Seattle Region X | ($28,235,772) | | | | |
| Alaska | $108,699,689 | $97,517,318 | ($13,928,869) | $11,182,371 | 10.29% |
| Idaho | $214,048,358 | $121,658,525 | $262,299,753 | $92,389,832 | 43.16% |
| Oregon | $497,195,254 | $288,567,878 | $897,564,804 | $208,627,376 | 41.96% |
| Washington | $825,073,842 | $636,088,782 | $394,508,488 | $188,985,059 | 22.91% |
| | | | | | |
| All states | $54,256,012,591 | $38,156,415,293 | $44,216,782,375 | $16,210,645,914 | 29.88% |

National Health Law Program, 202/887-5310.
Source: HCFA 2082 statistical reports.



February 3, 1995

# DEPARTMENT OF HEALTH AND HUMAN SERVICES
## ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
### OFFICE OF HEALTH POLICY

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2878

# DataWatch

## Managed Medicaid Cost Savings: The Arizona Experience

by Nelda McCall, C. William Wrightson, Lynn Paringer, and Gordon Trapnell

**Abstract:** This paper reports on estimated cost savings for acute care beneficiaries in the Arizona Health Care Cost Containment System (AHCCCS) over its first nine years of operation, fiscal years 1983–1991. AHCCCS has similar eligibility and service coverage as a traditional Medicaid program has but capitates health plans to provide medical services to beneficiaries. The results indicate that the program yielded $100 million in savings over estimates of what a traditional Medicaid program would have cost in Arizona. In addition, AHCCCS experienced a smaller rate of increase in program expenditures over time, so that cost savings have increased as the program has matured.

The Arizona Health Care Cost Containment System (AHCCCS) is an innovative Medicaid program that provides services to eligible poor persons in Arizona. Begun in 1982, the program receives federal funding as a Health Care Financing Administration (HCFA) demonstration project.[1]

Unlike traditional Medicaid programs that rely primarily on fee-for-service as a means of paying providers, AHCCCS capitates payments to health care plans. The plans in turn arrange for the delivery of services from physicians, hospitals, and other providers using a variety of payment methods. These methods include fee-for-service (with or without risk sharing), capitation, and salary. The plan capitation rates are set through a competitive bidding process.

Qualified organizations such as health maintenance organizations (HMOs) and individual practice associations (IPAs) submit bids to the state for the provision of medical services. The state specifies the types of services to be provided, the groups eligible, and the conditions under which an organization must operate if it wishes to serve as an AHCCCS health plan. The bids submitted include the capitation rates that the organization is willing to accept from the state in exchange for providing care. Rates are submitted separately by county and category of eligibility. The state evaluates the bids, negotiates the capitation payment amounts, and offers con-

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tracts to the winning organizations.[2]

Under AHCCCS, each beneficiary chooses or is assigned to a primary care physician for care management and is required to pay small copayments for some services. The original legislation required that most of the program's administrative functions be contracted to a private administrator, but the state assumed this function early in the program (in March 1984).[3] Until October 1991 the state was capitated by the federal government and was at risk for any excess spending over the capitation payments. The state now receives reimbursement from the federal government on a cost basis identical to traditional Medicaid program reimbursement.[4]

**Program evaluations.** Because of its interest in this innovative program, HCFA has funded two evaluations.[5] These include studies of implementation issues (administration, method of setting capitation payments, eligibility, level of care determination, quality assurance, plan effectiveness, administrative costs, and management information systems) and of program outcomes (cost, utilization, access and satisfaction, and quality).[6]

The findings reported in this DataWatch are summarized from six detailed reports to HCFA as part of these funded evaluations.[7] These reports compare the cost of AHCCCS with that of a traditional Medicaid program. First we describe the methodology used to calculate the cost of AHCCCS and to estimate the cost of a traditional Medicaid program in Arizona. Next we present the results of the cost analysis for fiscal years 1983–1991. We conclude with a discussion of the policy implications of the analysis,

## Methodology

The Omnibus Budget Reconciliation Act (OBRA) of 1981 made it possible for states to waive some Medicaid statutory requirements such as freedom of choice of provider in efforts to design more cost-effective programs. In their review of twenty-five managed care program evaluations, Robert Hurley and colleagues found calculated cost savings in the 5–15 percent range.[8] Many of the twenty-five analyses were made from data presented in waiver applications; many included only information for the first year of the program; most relied on aggregate data reports or estimates of expenditures rather than on per person data; and few considered administrative costs.[9] The analysis reported here covers the first nine years of AHCCCS, presents a per person approach to calculating program and comparison group costs, and includes administrative costs.

The specific methodology employed in this analysis examines the actual cost (medical service plus administrative) of AHCCCS as compared with an estimate of what the cost would have been if Arizona had adopted a traditional Medicaid program. To accurately estimate the latter, we exam-

ined the costs of such programs in other states that provide a similar set of services to a similar population group.

States have a considerable amount of discretion in setting eligibility criteria for their Medicaid programs, and thus the income and health status characteristics of the eligible populations can vary significantly from state to state. Therefore, the comparison group is restricted to those eligibility groups for which the states receive federal matching dollars and which have been in existence since fiscal year 1983 (Aid to Families with Dependent Children [AFDC] and Supplemental Security Income [SSI] eligibles).

Omitted from the analysis are medically indigent and medically needy individuals receiving federal matching funds and state-supported eligibility groups. Arizona does not have a federal medically indigent/medically needy population, and state-only groups' eligibility criteria vary substantially from state to state. Native Americans on reservations also are omitted. Also excluded from this analysis are women and children who became eligible after the passage of the Sixth Omnibus Budget Reconciliation Act (SOBRA). The SOBRA program was added to Medicaid in 1988 and thus represents a group for which data on costs do not exist before 1988. The AFDC and SSI eligibles included in this analysis account for two-fifths of total AHCCCS eligibles in fiscal year 1991.

The costs examined here include both medical services and administration. Because of the unique features of AHCCCS, it is possible that administrative costs might differ significantly from those of traditional Medicaid programs. To develop an accurate assessment of cost savings, it is therefore important to examine all of the costs associated with service provision. The method used to aggregate the cost of AHCCCS and to estimate traditional Medicaid program costs in Arizona is described below.

## Costs Of The AHCCCS Program

**Medical service costs.** Total medical service expenditures by AHCCCS for AFDC and SSI beneficiaries in fiscal year 1991 were $304.2 million. Capitation payments accounted for more than 90 percent of total AHCCCS program costs in fiscal year 1991, or $277 million. These payments represent the amount paid to participating health care plans to provide services to beneficiaries on a prepaid capitation basis.

Fee-for-service claims accounted for 4 percent of program costs ($13 million). Fee-for-service payments are made directly to providers for services rendered to eligible persons who are not enrolled in a prepaid health plan. These persons include those newly eligible for the program and residents of areas where AHCCCS does not have a capitated provider.

To protect the health plans against individual catastrophic expenses, the

program provides reinsurance for claims that exceed a per person deductible during a twelve-month fiscal year period. In fiscal year 1991 the deductible ranged from $10,000 to $30,000, depending on the size of the health plan. Once the deductible is met, the state pays 80 percent of the allowable costs in excess of the deductible, and the plan is responsible for the remaining 20 percent. In fiscal year 1991 reinsurance payments represented almost 2 percent of total AHCCCS program costs ($5.8 million).

In some instances, plans receive payment from the state for care rendered to newly enrolled members who meet special conditions such as being hospitalized at the time of enrollment, receiving active chemotherapy or radiation therapy, or being in the last two weeks of a high-risk pregnancy. In these instances, a plan's financial liability for the new enrollee is "deferred," and the state pays for services. In fiscal year 1991 deferred liability payments accounted for 1 percent of total program costs ($4.2 million).

AHCCCS eligibles who also are eligible for Medicare are "bought into" Part B of Medicare. Arizona pays the Medicare Part B premium on behalf of these persons to enroll them into Medicare's Supplementary Medical Insurance Program, which covers ambulatory care. For these persons, Medicare becomes the first payer. Plan financial liability thus is limited to the Medicare copayment and deductibles on Part B services, as well as any services that are not covered under Part B of the Medicare program but are covered under AHCCCS. In fiscal year 1991 Part B premiums paid by AHCCCS were $4.7 million.

An offset to program expenditures are third-party collections. AHCCCS collects revenue from third-party payers such as workers' compensation, auto insurance companies, and private insurance. In fiscal year 1991 the amounts recovered from third parties totalled $635,000.

**Administrative costs.** In addition to medical service costs, there are significant administrative costs associated with running a program such as AHCCCS. Managing the bidding process, overseeing quality of care, and monitoring the financial integrity of the plans require considerable resources. Unfortunately, it is not possible to separate the administrative costs associated with the specific AHCCCS population groups being studied (AFDC and SSI) from the administrative costs of the other eligibility groups. Therefore, the analysis assumes that administrative costs are distributed across eligibility groups in relation to their direct service costs.

To calculate the administrative costs for the population eligible for federal matching dollars, overall AHCCCS administrative costs are calculated as a percentage of medical service costs. In fiscal year 1991 this was 11.6 percent. This is then multiplied by the medical service costs associated with providing care to those eligible for federal matching dollars, making total administrative costs for this population group $35.3 million.

## Costs Of A Traditional Medicaid Program

To estimate the cost of a traditional Medicaid program in Arizona, we used cost data from other state Medicaid programs with eligibility criteria similar to AHCCCS that had reliable cost reporting systems. Because the cost per Medicaid eligible varies considerably from state to state, we used data from as many other states as possible to develop the cost estimates.

A comparison cost was developed separately for each category of eligibility (AFDC and SSI aged, blind, and disabled). This was important because there are clear differences in health status, need for services, and the resulting cost of care among different categories of eligibility. HCFA requires that each state report costs separately for these eligibility groups. We used data from the HCFA-64 and HCFA-2082 reports.

**Comparison state selection criteria.** The first criterion for selecting a comparison state was that the state possess a well-functioning Medicaid Management Information System that had been in place for at least two years before the start-up of AHCCCS. Data from such systems are likely to be more reliable. The second criterion was that the comparison states be similar to Arizona in terms of eligibility criteria. For instance, the AFDC population eligible for AHCCCS did not include families with unemployed parents; thus states that did provide coverage for these persons were eliminated. With respect to developing comparison state estimates for the SSI aged, blind, and disabled, states were selected that had eligibility criteria similar to AHCCCS.

**Adjustment process.** We calculated the per capita medical service cost in each comparison state and then adjusted them for differences between Arizona and other states in the per capita cost of services and in the rural/urban distribution of eligibles.[10] Next we adjusted the state data for differences between cash and accrual accounting methodology used in reporting. AHCCCS expenditure data were available on an incurred basis, while traditional Medicaid program numbers on the federal reporting forms are cash based. A third adjustment was made to the per person per month costs of care for SSI eligibles who are eligible for both Medicare and Medicaid (dual eligibles). The larger the percentage of the SSI population that are dual eligibles, the lower the Medicaid cost per eligible. This is because Medicare pays for some services that Medicaid would pay for if the beneficiary were not dually eligible. For services covered by Medicare, Medicaid pays for the Medicare deductible and coinsurance, as well any part of the bill after Medicare coverage limits have been reached.

A mean cost per member per month was calculated for providing Medicaid services to each eligibility category by summing the cost per member per month over each of the comparison states and dividing by the number of

comparison states.

The final calculation was to estimate the administrative costs associated with a traditional Medicaid program. Data on Medicaid administrative costs were obtained for each of the states that had a certified Medicaid Management Information System. These costs were not broken out separately by category of eligibility or by whether the beneficiary was in long-term care. It was assumed that the percentage was consistent across eligibility groups and long-term care utilization status. Thus, the medical service and administrative costs were summed across comparison states, and the total administrative costs were divided by the total medical service costs.

## Results

**Medical service costs.** In fiscal year 1983 medical service costs per person per month under AHCCCS ranged from about $62 for an AFDC beneficiary to $153 for an SSI disabled beneficiary (Exhibit 1). Under a traditional Medicaid program in fiscal year 1983, estimated costs per person per month ranged from about $59 for an AFDC beneficiary to $156 for an SSI disabled beneficiary (Exhibit 2). In fiscal year 1983 the actual average AHCCCS monthly cost for an SSI disabled beneficiary was lower than the estimated traditional Medicaid program cost; but, for an AFDC beneficiary, the actual average AHCCCS monthly cost was higher. By fiscal year 1991 the costs per person per month had risen to about $113 for an AFDC beneficiary under AHCCCS and about $258 for an SSI disabled beneficiary. The corresponding estimates for a traditional Medicaid program in

**Exhibit 1**
**Medical Care Expenditures Per Person Per Month, By Category Of Eligibility And Year, Arizona Health Care Cost Containment System (AHCCCS), Fiscal Years 1983–1991**

| | | SSI[b] | | | |
|---|---|---|---|---|---|
| Fiscal year | AFDC[a] | Aged | Blind | Disabled | All categories |
| 1983 | $ 62.01 | $ 66.70 | $148.79 | $153.10 | $ 80.77 |
| 1984 | 57.84 | 69.90 | 153.43 | 163.64 | 80.31 |
| 1985 | 61.16 | 72.25 | 155.86 | 158.76 | 83.84 |
| 1986 | 63.76 | 92.38 | 170.50 | 182.72 | 93.63 |
| 1987 | 63.95 | 122.77 | 188.00 | 208.49 | 99.39 |
| 1988 | 73.93 | 134.14 | 199.15 | 215.72 | 107.01 |
| 1989 | 78.03 | 149.26 | 206.21 | 226.97 | 108.38 |
| 1990 | 100.68 | 156.80 | 219.69 | 244.30 | 125.11 |
| 1991 | 113.20 | 176.65 | 240.77 | 257.73 | 136.68 |

Source: AHCCCS Administration.
[a] Aid to Families with Dependent Children.
[b] Supplemental Security Income.

**Exhibit 2**
**Estimated Medical Care Expenditures Per Person Per Month Of A Traditional Medicaid Program In Arizona, By Category Of Eligibility, Fiscal Years 1983–1991**

| | | SSI[b] | | | |
|---|---|---|---|---|---|
| Fiscal year | AFDC[a] | Aged | Blind | Disabled | All categories |
| 1983 | $ 58.54 | $ 68.16 | $147.25[c] | $155.69 | $ 78.96 |
| 1984 | 60.22 | 76.05 | 147.25[c] | 167.11 | 83.22 |
| 1985 | 68.90 | 85.87 | 147.25[c] | 173.65 | 93.61 |
| 1986 | 70.33 | 99.28 | 161.09[c] | 185.75 | 99.34 |
| 1987 | 77.95 | 113.29 | 161.09[c] | 208.33 | 108.43 |
| 1988 | 81.34 | 133.64 | 145.12 | 239.50 | 116.88 |
| 1989 | 92.77 | 145.38 | 162.32 | 270.75 | 126.89 |
| 1990 | 106.18 | 170.45 | 197.67 | 306.81 | 139.38 |
| 1991 | 126.56 | 214.04 | 241.04 | 393.92 | 168.44 |

Source: Health Care Financing Administration, HCFA-64 and HCFA-2082 data for selected comparison states.
[a] Aid to Families with Dependent Children.
[b] Supplemental Security Income.
[c] Because the group is so small, estimates of traditional program costs for the SSI blind in these years were not made. The numbers used for the comparison are the rates agreed to by Arizona and the Health Care Financing Administration (HCFA) in determining HCFA financial participation.

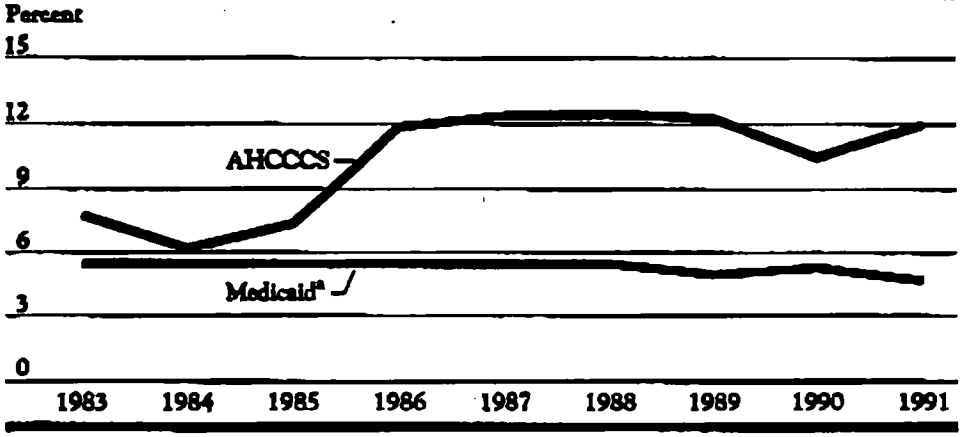
Arizona were about $127 and $394. With the exception of fiscal year 1983, AHCCCS medical service costs across all categories were always lower than the estimated costs of a traditional Medicaid program in Arizona.

Although medical service costs were higher in the traditional program estimate than under AHCCCS, these higher costs could have been offset by lower administrative costs. A managed care program such as AHCCCS must allocate resources to management oversight activities. Indeed, the results in Exhibit 3 support this.

**Administrative costs.** AHCCCS administrative costs ranged from a low of almost 6 percent of medical service costs in fiscal year 1984 to a high of 12 percent in fiscal years 1987 and 1988 (Exhibit 3). By contrast, administrative costs for a traditional Medicaid program ranged from 4 percent of medical service costs in fiscal year 1991 to 5 percent in fiscal years 1983–1988. Thus, while medical service costs were lower under AHCCCS than estimated traditional Medicaid costs, these cost savings were achieved in part at the expense of higher administrative costs.

**Cost savings.** In fiscal year 1983 AHCCCS cost $3.7 million more than a traditional program (Exhibit 4). However, as the program matured, it began to show substantial cost advantages over a traditional Medicaid program.[11] This occurred despite the increase in actual AHCCCS administrative costs and a decrease in the comparison states' administrative costs as a percentage of medical service costs. In fact, the biggest cost savings registered for AHCCCS ($51.5 million) was in fiscal year 1991—the same time that AHCCCS administrative costs were estimated to be $19.2 mil-

**Exhibit 3**
**Administrative Expenditures As A Percentage Of Medical Service Expenditures, Arizona Health Care Cost Containment System (AHCCCS), Fiscal Years 1983–1991**




Sources: AHCCCS Administration; and HCFA-64 data.
[a] Comparison states for each year include all states used in that year for any of the category of eligibility comparisons.

lion greater than in a traditional Medicaid program in Arizona. Thus, it appears that the proportionately larger fraction of resources allocated to administration do in fact result in significantly lower medical service costs and a continuing increase in the level of overall cost savings.

**Program costs by eligibility category.** In fiscal year 1983 AHCCCS

**Exhibit 4**
**Savings Of The Arizona Health Care Cost Containment System (AHCCCS), Thousands Of Current Dollars, Fiscal Years 1983–1991**

| Fiscal year | Medical care savings | Administrative excess[a] | Net savings |
|---|---|---|---|
| 1983 | –$ 1,768 | –$ 1,910 | –$ 3,678 |
| 1984 | 3,185 | –452 | 2,733 |
| 1985 | 10,679 | –1,197 | 9,482 |
| 1986 | 6,535 | –6,530 | 4 |
| 1987 | 11,807 | –8,354 | 3,453 |
| 1988 | 14,424 | –10,217 | 4,207 |
| 1989 | 30,820 | –11,753 | 19,067 |
| 1990 | 27,036 | –10,996 | 16,040 |
| 1991 | 70,690 | –19,170 | 51,520 |
| Total savings | $173,408 | –$70,579 | $102,828 |

Sources: AHCCCS Administration; and HCFA-64 data.
Note: Numbers may not add due to rounding.
[a] Administrative excess equals actual AHCCCS administrative costs minus (average Medicaid program administrative cost percentage times actual AHCCCS medical care cost).

program costs were higher than the cost estimates for a traditional Medicaid program in Arizona for every category of eligibility except the SSI aged (Exhibit 5). Even for the SSI aged, AHCCCS did not show any cost advantage over the estimate of a traditional Medicaid program. However, as time progressed, substantial cost savings began to emerge. For every y after the initial year, overall AHCCCS costs were lower than the cost estimates for a traditional Medicaid program. Still, this pattern of cost savings was not reflected in every eligibility category. Only among AFDC eligibles did the pattern of cost savings mirror the overall pattern. Cost savings for the SSI aged, while positive overall, were negative in fiscal years 1987–1989. In fiscal years 1986 and 1987, as well as in the first program year, AHCCCS program costs for the SSI disabled were higher than the cost estimates for a traditional Medicaid program.

It is not clear why the cost savings for the different eligibility categories varied from year to year. One possible explanation is that, to some extent, it is an artifact of the bid cycles. When AHCCCS awarded multiple-year contracts to plans, it often specified that the bid rates for the years after the first contract year would be increased at a rate tied to the medical care price index or some other index of inflation. As a result, AHCCCS payments to plans were increased by the same percentage by eligibility category, regardless of the cost experience of the plans for the various eligibility catego

One of the most significant aspects of Exhibit 5 is the general pattern of increased cost savings or reduced levels of loss over time for each eligibility

**Exhibit 5**
**Savings Of The Arizona Health Care Cost Containment System (AHCCCS), By Category Of Eligibility And Year, Thousands Of Current Dollars, Fiscal Years 1983–1991**

| | | SSI[b] | | | |
|---|---|---|---|---|---|
| Fiscal year | AFDC[a] | Aged | Blind | Disabled | All categories |
| 1983 | –$3,497 | $ 0 | –$28 | –$ 153 | –$3,678 |
| 1984 | 1,606 | 638 | –47 | 536 | 2,733 |
| 1985 | 5,156 | 1,454 | –86 | 2,958 | 9,482 |
| 1986 | 2,210 | 133 | –145 | –2,193 | 4 |
| 1987 | 9,546 | –1,817 | –287 | –3,989 | 3,453 |
| 1988 | 2,782 | –989 | –483 | 2,897 | 4,207 |
| 1989 | 12,404 | –1,407 | –375 | 8,445 | 19,067 |
| 1990 | 804 | 577 | –194 | 14,852 | 16,040 |
| 1991 | 10,248 | 2,623 | –101 | 38,750 | 51,520 |
| Total savings | $41,259 | $1,212 | –$1,746 | $62,103 | $102,828 |

Sources: AHCCCS Administration; and HCFA-64 data.
Note: Numbers may not add due to rounding.
[a] Aid to Families with Dependent Children.
[b] Supplemental Security Income.

category. This is particularly true for the AFDC population and the SSI disabled population. The total cumulative savings over the first nine years of the program calculated in actual dollars was $102.8 million. Of this, $62.1 million in savings was generated by SSI disabled, and $41.3 million was generated by AFDC eligibles. Long-term cost savings were negligible for SSI aged eligibles and negative for SSI blind eligibles.

The key to long-term cost savings is not only to generate year-to-year cost savings, but also to hold down the rate of cost increases over time. If AHCCCS can successfully maintain a rate of cost increase that is lower than that of a traditional Medicaid program, then the absolute level of cost savings will rise over time. Exhibit 6 shows that for the SSI aged, SSI disabled, and AFDC populations, the rate of increase in AHCCCS costs has been below the rate of increase in the estimates of traditional Medicaid program costs. Over the nine years the average annual per capita growth rate was about 7 percent for AHCCCS and 10 percent for the estimate of a traditional program. Overall, AHCCCS experienced a 69 percent increase in monthly per capita medical service costs over the first nine years of the program, compared with an estimated 113 percent increase in these costs under a traditional Medicaid program. These results are important because they seem to indicate that savings are accelerating over time.

## Policy Implications

Policymakers need to be aware that major structural reforms in programs such as Medicaid may not result in immediate cost savings. Programs involving major reforms may have high start-up costs associated with

**Exhibit 6**
**Spending Increases In The AHCCCS Program Compared With Increases In Estimates Of Traditional Medicaid Program Spending In Arizona, By Category Of Eligibility, Fiscal Years 1983–1991**

| | AHCCCS | | Traditional Medicaid program | |
|---|---|---|---|---|
| | Total | Average | Total | Average |
| AFDC[a] | 82.6% | 7.8% | 116.2% | 10.1% |
| SSI[b] | | | | |
| Aged | 164.8 | 12.9 | 214.5 | 15.4 |
| Blind | 61.8 | 6.2 | –[c] | –[c] |
| Disabled | 68.1 | 6.7 | 152.9 | 12.3 |
| Both AFDC and SSI | 69.2 | 6.8 | 113.3 | 9.9 |

Sources: AHCCCS Administration; and HCFA-64 data.
Note: Numbers may not add due to rounding.
[a] Aid to Families with Dependent Children.
[b] Supplemental Security Income.
[c] Not available.

developing appropriate infrastructure (for example, management information systems, provider networks, and bidding processes). Once this infrastructure is in place, cost savings can begin to emerge.

Another lesson is that while overall program cost savings are associated with AHCCCS, the administrative costs are higher than those associated with a traditional Medicaid program. Indeed, AHCCCS administrative costs as a percentage of medical service costs are about double those of a traditional Medicaid program. This may indicate that to be effective in achieving program savings, managed care programs need to develop strong administrative structures that allocate substantial resources to providing adequate oversight and managing program resources.

The study results do have some important limitations. First, the s- ment of cost savings is based on a comparison of AHCCCS with other state Medicaid programs. Because Arizona never had a traditional Medicaid program prior to AHCCCS, it is not known what the program would have cost had Arizona actually implemented a traditional Medicaid program in place of AHCCCS. A second limitation of the study is the restriction of the study population to acute care beneficiaries. This DataWatch excludes the Arizona Long-Term Care System (ALTCS) population, although that analysis is currently in process.[12] Another limitation is that the analysis was conducted only for AFDC and SSI eligibles. It did not include the medically indigent/medically needy or SOBRA women and children. This done so that similar populations across states and over time could be compared. A final limitation is the estimation required to calculate administrative costs. Although AHCCCS separates its administrative costs ciated with serving acute care beneficiaries from those associated with long-term care beneficiaries, other state Medicaid programs do not do this. Neither program separates out administrative costs by category of eligibility. The analysis assumed that as a percentage of medical service costs, administrative costs were identical for all eligibility categories and all types of beneficiaries, but this assumption may not be accurate.

Notwithstanding these important limitations, it does appear that a restructuring of traditional Medicaid programs along the lines of AHCCCS holds significant promise for controlling the rapidly rising costs of the program. Not only do program costs appear to be lower under AHCCCS but the rate of increase in costs also appears to be lower, leading to increasing cost savings over time.

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7. G. Trapnell et al., *Comparison of AHCCCS Program Cost with That of a Traditional Medicaid Program for Fiscal Year 1983 and Fiscal Year 1984* (Menlo Park, Calif.: SRI International, 1986); G. Trapnell et al., *Comparison of AHCCCS Program Cost with That of a Traditional Medicaid Program for Fiscal Year 1985* (Menlo Park, Calif.: SRI International, 1987); G. Trapnell et al., *Comparison of AHCCCS Program Cost with That of a Traditional Medicaid Program for Fiscal Year 1986 and Fiscal Year 1987* (Menlo Park, Calif.: SRI International, January 1989); McCall et al., *Evaluation of AHCCCS: Final Report*; Wrightson et al., "Cost," in *First Outcome Report*; and Wrightson et al., "Cost," in *Second Outcome Report*.
8. R. Hurley, D. Freund, and J. Paul, *Managed Care in Medicaid: Lessons for Policy and Program Design* (Ann Arbor, Mich.: Health Administration Press, 1993).
9. Ibid.
10. Methodological details on the adjustment process are available from Laguna Research Associates, 455 Market Street, Suite 1190, San Francisco, California 94105.
11. It should be noted that disproportionate-share hospital payments are included as part of medical service costs for comparison states that have such payments. Disproportionate-share hospital payments in Arizona did not begin until fiscal year 1992. This may affect savings estimates in fiscal year 1992 and later years.
12. J. Wilkin and A. Wade, "Costs of the ALTCS Program," in N. McCall et al., *Evaluation of the Arizona Health Care Cost Containment System: Fourth Outcome Report* (San Francisco: Laguna Research Associates, forthcoming).

January 25, 1995

# MEDICAID CAP TALKING POINTS

These talking points assume a Medicaid cap proposal with the following features:

- a *per capita* cap rather than an aggregate cap
- a cap which applies only to "acute care" services as defined in the Senate bipartisan bill
- a *per capita* cap which is state-specific
- a cap which sets one level of *per capita* spending for AFDC and "AFDC-related" persons and another spending level for persons who receive SSI or who are "SSI-related" persons.
- a cap which is adjusted annually by the M/CPI
- the cap's base year is 1994

If any of these assumptions prove wrong, then there may be additional talking points.

1. **The state movement toward managed care, under which persons receive health care for a pre-set fee and cost increases are controlled, makes a federal cap unnecessary:** States already are moving in the direction of a *per capita* cap. Today one quarter of all beneficiaries are enrolled in managed care plans. More than 30 states already operate, have applied to operate, or will apply for permission to operate, statewide systems of mandatory managed care for Medicaid patients under Section 1115. The State of Arizona's experience with AHCCCS, under which annual *per capita* cost increases have been well controlled, shows that states can and will do the job without federal threats and unfunded mandates to control spending. There is no need to radically change Medicaid spending through federal policy, since the cap is effectively already occurring.

Moreover, a cap could discourage managed care organizations from going into states with low historic rates or from expanding their operations in such low-rate states.

2. **The cap penalizes those states that historically have been able to spend the least. Included in this group are poor states with large rural areas:** By tying the cap's spending base year to historical spending patterns, the cap effectively locks states into whatever Medicaid coverage and benefit decisions they have made in the past and would deprive them of any federal funding to increase benefits or adjust coverage to permit higher utilization.

The states that have played by the rules and have spent judiciously will find themselves

unable to absorb the impact of the caps. States that have gotten the most "padding" in the form of DSH payments and other add-ons to their reimbursement will have the least problem absorbing the cap. The cap penalizes the states that have been the most efficient and that have taken the least advantage of supplemental payments under Medicaid.

3. **A cap that reaches services persons with chronic illnesses and disabilities living in the community would be particularly harmful to children with special health care needs**: One in twenty children has some type of health problem that limits normal daily activities. Most of these children are neither in institutions nor confined to home and community-based care settings. They fully participate in school and can lead normal lives with the proper assistance. Yet many of the services they need would be characterized as "acute" rather than "long term care" and thus would be subject to the cap. In a tight budget, these are the first services that might have to go. Examples are physical and speech therapy for infants and toddlers with developmental disabilities, services for children with both physical and mental illnesses and conditions, medical equipment, and other services for children with special needs.

4. **In many states a Medicaid spending cap could have adverse consequences for private health insurance premiums and key health providers**: Medicaid patients use many of the same hospitals, laboratories, pharmacies, surgeons and medical equipment suppliers as privately insured persons. Increasingly they are enrolled in the same managed care plans that enroll privately insured persons. If Medicaid revenues begin to fall rapidly in relation to prior levels, providers will try to past the costs along in the form of higher charges to insurers. If they do, rates will rise. If they cannot, certain key providers such as children's hospitals could find their future uncertain.

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

From: Chris Jennings
Phone: 6-5560

To: Jen

Date: 1/16/95

Remarks: FYI. Tom Scully gave this to me — he's talking to Republicans about this.

# Reforming Medicaid and Medicare: Moving $300 Billion per year of Federal Spending Into A Market Driven System

**Government "fee-for-service" reimbursement is inefficient and wasteful.**

**Paying health plans and providers on a per capita basis for each covered person—as in the private sector—will result in more efficient use of scarce federal health dollars.**

## MEDICAID

The proposal will give states virtually "no strings" funding to run their Medicaid programs and the flexibility both to control costs and to provide better health and long term care services. States generally act as "fee-for-service" claims payers in Medicaid and face minimal incentives to manage costs. At least in part because of the old-style structure of delivering and financing Medicaid covered services, program expenditures have increased at an annual rate of between 10% and 38% in recent years.

Numerous states—including Arizona and New York—have realized substantial savings by turning to managed care and paying health plans a "lump sum" or monthly per capita payment. By sharing the risk of cost growth with health plans, this approach encourages the delivery system to utilize services efficiently. In contrast, the "fee-for-service" system encourages providers to do more—because they are paid per procedure or per visit rather than per patient.

### Proposal

Continue to pay each state the existing federal share of Medicaid costs, but under a new per capita payment system. The per capita payment would be state specific, would vary according to recipient characteristics (e.g., pregnant women, children, disabled, etc.), and would be based on FY 1995 Medicaid per capita costs.

The per capita amount would be inflated in future years by a decreasing factor added to the HCPI. For example: FY 96: HCPI +5; FY 97: HCPI +4; FY 98: HCPI +3; FY 99: HCPI +3; FY 00: HCPI +3.[1]

Medicaid would continue to be an individual entitlement program. Eligibility rules would stay the same. States would be free, however, to restrict eligibility to currently mandated groups. Actual monthly federal payments to the states would equal the product of the number of Medicaid recipients in the state times the per capita state allotment, weighted to reflect caseload characteristics.

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[1] Health CPI (HCPI) would be a new index that is based on the weighted averages of the Medicare Economic Index (MEI) and the Medicare Hospital Market Basket (MB).

From 1960 until 1990, health care costs increased about 4% faster than the CPI. Thus using the higher HCPI and adjusting the index to HCPI plus 3% after a phase in would approximate historical growth patterns and set an attainable cost containment target for Medicaid.

States that are able to provide services for less than the per capita allocation would not lose any federal matching funds.

## MEDICARE

Medicare provides quality care to millions of seniors. But it is built upon inefficient "fee-for-service" medicine. Despite deep cuts in provider fees over the last 15 years, Medicare's annual inflation has generally exceeded 10-12%, and is projected to remain at about 10% for the rest of the decade.

Fewer than 10% of all seniors are in any type of managed care health plan. Most seniors who are in managed care plans are in highly structured HMOs. ***The most prevalent, flexible, and consumer friendly types of managed care—preferred provider and point of service networks are not generally available to seniors.*** Only the very limited Medicare Select program—15 state demos with an outdated design—offers this option to seniors. Further, there are few incentives for seniors to join managed care plans.

### Proposal

Let the market work in Medicare -- without threatening or changing the existing benefits of any senior.

- All seniors would be eligible to have HCFA buy them a qualified health plan. Any qualified plan that provided the core Medicare benefits could compete for seniors during a federally-coordinated open season, as is common in the under 65 market and in FEHBP.

- **Any senior that wants to be covered by old-style Medicare may have their per capita payment assigned to HCFA. No senior would be required to join a managed care plan, and no senior would be required to change their health coverage.**

- One option would be to make HCFA's fee-for-service program compete for beneficiaries like any other health plan. Because benefits would remain the same, if HCFA were unable to provide coverage for the per capita rate, it will be free to increase beneficiary cost sharing or to ask Congress to adjust provider payments.

- The per capita payment amount would be established regionally beginning in 1996. In subsequent years the payment would be adjusted (just as Medicaid above) as follows: FY 96: HCPI +5; FY 97: HCPI +4; FY 98: HCPI +3; FY 99: HCPI +3; FY 00: HCPI +3.

Projected year-to-year "baseline" expenditure growth during this period will still exceed 6%. This per capita payment system will encourage the growth of managed care. It will also encourage the growth of other benefit plans—including fee-for-service—that can compete with HCFA.

**The incentives in the Medicare program will change and market forces will be used to control costs. The reductions in projected spending are substantial. Additionally, specific focused Medicare provider entitlements also could be reduced (e.g., indirect medical education and disproportionate share hospital payments).**

## Savings Summary ($ in billions)

| | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 5-Yr | 7-Yr |
|---|---|---|---|---|---|---|---|---|---|
| Medicaid | | | | | | | | | |
| Full Per Capita Program | 6.7 | 7.2 | 7.6 | 7.6 | 8.5 | 10.4 | 11.8 | 37.6 | 59.7 |
| DSH Reduction | 1.5 | 3.0 | 4.5 | 6.0 | 7.5 | 7.5 | 7.5 | 22.5 | 37.5 |
| **subtotal** | **8.2** | **10.2** | **12.1** | **13.6** | **16.0** | **17.9** | **19.3** | **60.1** | **97.3** |
| Medicare | | | | | | | | | |
| Full Per Capita Program | -- | 0.7 | 1.7 | 6.8 | 13.3 | 19.4 | 25.3 | 22.5 | 67.2 |
| DSH Reduction | 0.5 | 1.0 | 1.2 | 1.6 | 1.8 | 1.8 | 1.8 | 6.1 | 9.7 |
| **subtotal** | **0.5** | **1.7** | **2.9** | **8.4** | **15.1** | **21.2** | **27.1** | **28.6** | **76.9** |
| **TOTAL** | **8.7** | **11.9** | **15.0** | **22.0** | **31.1** | **39.1** | **46.4** | **88.7** | **174.2** |
| Other Possible Medicare Savers | | | | | | | | | |
| Extend MSP rules | -- | -- | -- | 1.2 | 1.8 | 1.9 | 2.0 | 3.0 | 6.9 |
| Continue Home Health Freeze | 0.3 | 0.6 | 0.7 | 0.7 | 0.7 | 0.8 | 0.9 | 3.0 | 4.7 |
| Extend 25% Part B Premium | -- | -- | -- | -0.6 | 1.0 | 2.8 | 5.0 | 0.4 | 8.2 |
| Reduce IME to 3% | 2.2 | 2.7 | 3.0 | 3.1 | 3.3 | 3.6 | 3.9 | 14.3 | 21.8 |
| Income-relate SMI Premium | 0.3 | 1.2 | 1.6 | 2.0 | 2.3 | 2.6 | 3.0 | 7.4 | 13.0 |
| 20% Coins./clinical labs | 0.8 | 1.2 | 1.4 | 1.5 | 1.6 | 1.8 | 2.0 | 6.5 | 10.3 |
| 30% coinsurance on Medigap covered Part B claims | 1.0 | 1.5 | 2.0 | 2.5 | 3.0 | 3.5 | 4.0 | 10.0 | 17.5 |

# Medicare Reforms:
# Providing Private Plans Choices and
# Bringing Competition to the Medicare System

## Current Policy:

Medicare enrollees now have the option of choosing managed care by enrolling in Medicare "risk contracts" (i.e., Humana, US Healthcare, or Pacificare), but fewer than 9% do so—as opposed to almost 80% of those under 65 years old. Over 90% of seniors use Medicare as a single payor fee-for-service insurer. The provider sends in the bill and it is paid at a federally set rate. This type of coverage has become a dinosaur among private health plans.

Why?

- Because few seniors understand managed care and because the managed care options are very limited. For most seniors, only traditional "closed network" HMOs are available (except in the 15 Medicare Select demo states), and none of the most popular forms of managed care—preferred provider organizations and point-of-service plans—are available.

- In some parts of the country Medicare managed care is profitable, in others it is not. The HCFA payment mechanism , the AAPCC, is a disaster and needs to be restructured.

- Efficient Medicare managed care providers can't charge seniors less—nor can they return the savings in lower premiums to beneficiaries. As a result, all risk contractors in an area are paid exactly the same amount and they must try to attract seniors by expanding benefits (i.e., no cost sharing, drug benefits).

- Market leverage is limited, because most seniors have Medigap plans that cover drugs, copays and deductibles—and it is difficult to convince them of the better value when they see no personal financial benefit.

- Finally, seniors are understandably afraid of change and of having access to their physician limited.

## Proposed Policy:

- Replace the AAPCC with an improved per capita payment system that will encourage the growth of managed care alternatives nationwide.

- Develop an adjustment mechanism to account for gender, age, and chronic conditions.

- Pay these plans—and as an option the regular Medicare program—100% of a new Regional Average Cost Per Capita (RACPC).

- Allow all seniors to keep their existing coverage, when they turn 65, if they choose. By default, enroll seniors who do not choose to remain in their current plan or to join another private pan in the regular Medicare program. **All seniors can choose to stay in the regular Medicare program.**

- HCFA would certify any plan that offered the standard Medicare benefit and that meets defined quality standards. Each plan would have to publish a standard rate (as they do in FEHBP) available to all seniors during a HCFA-administered annual open season and take all seniors in its defined area of operation.

- Allow health plans to offer a rebate to seniors savings below the RACPC. The senior would receive 75% of the savings, the US Treasury 25% of the savings.

***For example*** the average senior in Dayton, Ohio, under the current AAPCC methodology, would be eligible for about $5,100 per year in 1995, if he/she enrolls with a Medicare "risk" HMO plan. The health plan now receives 95% of that amount to provide full Medicare benefits and any additional benefits it can.

Under this proposal, if Blue Cross of Ohio could offer a POS Medicare plan for $4,400 (a strong likelihood), a senior could receive a $525 rebate; and the Treasury would also receive a $175 per member savings.

Existing Medicare risk contracts already show that substantial cost savings can be achieved—but the system doesn't allow it.

**Index the Medicare Per Capita Payment to Ensure Reasonable Cost Growth.**

Medicare costs can be controlled, and will be by private health plans. Managed care plans can readily provide quality care under the following RACPC index (identical to the Medicaid index proposal): FY 96: HCPI +5; FY 97: HCPI +4; FY 98: HCPI +3; FY 99: HCPI +3; FY 00: HCPI +3.

HCFA also could be challenged to manage its fee-for-service plan within these per capita limits. Should HCFA not be able to contain costs and live within these limits (and the confines of the Medicare trust funds), through regulation it would be authorized to make any or all of the following program adjustments for one year:

- Increase Part B coinsurance—now 20%;

- Increase the Part B deductible—now $100;

- Increase the Part A hospital deductible—now $716;
- Request that Congress adjust provider payment rates.

## Savings Summary ($ in billions)

| | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 5-Yr | 7-Yr |
|---|---|---|---|---|---|---|---|---|---|
| Medicare | | | | | | | | | |
| Full Per Capita Program | -- | 0.7 | 1.7 | 6.8 | 13.3 | 19.4 | 25.3 | 22.5 | 67.2 |
| DSH Reduction | 0.5 | 1.0 | 1.2 | 1.6 | 1.8 | 1.8 | 1.8 | 6.1 | 9.7 |
| **Total** | **0.5** | **1.7** | **2.9** | **8.4** | **15.1** | **21.2** | **27.1** | **28.6** | **76.9** |
| Other Medicare Savers | | | | | | | | | |
| Extend MSP rules | -- | -- | -- | 1.2 | 1.8 | 1.9 | 2.0 | 3.0 | 6.9 |
| Continue Home Health Freeze | 0.3 | 0.6 | 0.7 | 0.7 | 0.7 | 0.8 | 0.9 | 3.0 | 4.7 |
| Extend 25% Part B Premium | -- | -- | -- | -0.6 | 1.0 | 2.8 | 5.0 | 0.4 | 8.2 |
| Reduce IME to 3% | 2.2 | 2.7 | 3.0 | 3.1 | 3.3 | 3.6 | 3.9 | 14.3 | 21.8 |
| Income-relate SMI Premium | 0.3 | 1.2 | 1.6 | 2.0 | 2.3 | 2.6 | 3.0 | 7.4 | 13.0 |
| 20% Coins./clinical labs | 0.8 | 1.2 | 1.4 | 1.5 | 1.6 | 1.8 | 2.0 | 6.5 | 10.3 |
| 30% coinsurance on Medigap covered Part B claims | 1.0 | 1.5 | 2.0 | 2.5 | 3.0 | 3.5 | 4.0 | 10.0 | 17.5 |

MEDICAID REFORM:
GIVE STATES FLEXIBILITY IN DESIGNING HEALTH CARE AND LONG TERM CARE COVERAGE FOR THE LOW INCOME AND DISABLED

## Current Policy:

Health care, long term care, and related services for low income and disabled individuals is financed through the Medicaid program using a formula that matches state funds with federal funds based on state median income (range: 50% to 83% federal). The Medicaid program operates in accordance with federal statute and regulations that specify eligibility categories, covered services, and other requirements. Eligibility is limited to recipients of AFDC and SSI benefits and certain other children and pregnant women. Federal statute requires that all states cover certain services. States also may receive federal matching funds when they cover certain defined optional services. For most recipients, care is provided on a fee-for-service basis. Increasingly, however, states are turning to managed care to provide care for lower cost. Medicaid also finances a part of the care of uninsured individuals though special "disproportionate share" payments to some hospitals.

In FY 1994, federal Medicaid expenditures were $83.0 billion. The program has increased by as much as 38% in a single year, and is projected to increase by an average of about 11.8% per year between FY 1996 and FY 2000. This compares with average growth in private sector health spending of 6.6% between 1991 and 1993.

## Proposal

Under this proposal, the federal government would continue to finance the same proportion of Medicaid program costs and states would no longer be subject to most statutory and regulatory requirements. Payments, however, would no longer be open-ended, but would become a per capita entitlement with both federal and state shares allocated on a per recipient basis.

**Financing.** For health care, long term care, related services, and the cost of administering the program, but not disproportionate share hospital payments, the federal government would pay states an indexed per capita amount for each eligible recipient. In this way, the federal government would share in costs related to growth of the eligible population and medical inflation.

The per capita payment would be based on program costs in FY 1995. In subsequent years the payment would be increased (just as Medicaid above) as follows: FY 96: HCPI +5; FY 97: HCPI +4; FY 98: HCPI +3; FY 99: HCPI +3; FY 00: HCPI +3.[1]

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[1] Health CPI (HCPI) would be a new index that is based on the weighted averages of the Medicare Economic Index (MEI) and the Medicare Hospital Market Basket (MB).

For example, under the current system, in FY 1994 Ohio paid $325 per month to cover a Medicaid recipient residing in Dayton. If Medicaid growth to the level of the HCPI by 2002, in FY 1996, to cover the same Dayton resident, Ohio will spend $360 per month instead of $363. In 2002, the cost to Medicaid of covering a Dayton resident will be $492 per month, rather than $568.

Under this scenario federal Medicaid spending will decline by $6.7 billion in FY 1996, $37.6 billion over five years, and $59.1 billion over seven years.

The per capita federal payment would include both health care and long term care components. Additionally, the payment would vary by recipient characteristic; for example, higher payments would be made for the disabled and for pregnant women. This structure ensures that states receive the level of federal funding appropriate for its eligible population, irrespective of changes in size or composition.

**Eligibility.** Federal funds would be available to help States provide health care coverage to currently eligible individuals. States would have the incentive to cover the eligible population for less than the combined federal/state per capita payment so that savings could be used to extend coverage to more people.

**Covered Services.** States largely would be free to structure the package of covered services. They would continue to be required to cover a very basic health benefits and long term care package.

**Disproportionate Share Hospital (DSH) Payments.** States are not required to spend DSH funds on health care. In fact they can, and have, spent DSH payments on every imaginable thing, from roads and bridges to public buildings, to covering state deficits. Under this proposal federal DSH payments would be phased down to 25% of the FY 1995 level by FY 2000.

## Savings Summary ($ in billions)

| | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 5-Yr | 7-Yr |
|---|---|---|---|---|---|---|---|---|---|
| Medicaid | | | | | | | | | |
| Per Capita Program | 6.7 | 7.2 | 7.6 | 7.6 | 8.5 | 10.4 | 11.8 | 37.6 | 59.7 |
| DSH Reduction | 1.5 | 3.0 | 4.5 | 6.0 | 7.5 | 7.5 | 7.5 | 22.5 | 37.5 |
| **Total** | **8.2** | **10.2** | **12.1** | **13.6** | **16.0** | **17.9** | **19.3** | **60.1** | **97.3** |

Outline
Capped Payments To States

Issue: Expect Republicans to make proposal because they need the savings. Expect at least some Governors to support because of flexibility.

Background: Outline who Medicaid covers; growth

Discussion: Advantages to cap payment is that, by capping payments below baseline growth, federal government can achieve savings. States get flexibility. Congress gets savings without proposing specific cuts in eligibility, payments or services. Decisions about where to cut devolved to states.

Concerns:

Changing program to cap payment likely will result in eligibility cuts. [Managed care expansion not sufficient to generate significant savings. Cuts in provider payments and services difficult]

Program is only source of coverage that is growing; cap could increase number of uninsured

A cap below baseline would effectively end states ability to restructure their programs to expand coverage.

Cuts in Medicaid that reduce eligibility or provider payments could result in cost shift to other payers -- increasing private premiums.

Some states will be less able to manage their programs under an annual cap approach. State programs vary significantly in eligibility, payment rates, services and ability to implement effective managed care.

# DRAFT

**Alternative Block Grants for Medicaid**
(Dollars in billions, Fiscal Years)

| | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | Avg Annual Growth |
|---|---|---|---|---|---|---|---|---|---|
| Total Medicaid Expenditures | 84.8 | 92.2 | 100.5 | 110 | 120.1 | 131.5 | 143.9 | 157.3 | |
| DSH | 10.4 | 11.1 | 11.9 | 12.7 | 13.6 | 14.5 | 15.5 | 16.5 | |
| Expenditures Net of DSH | 74.4 | 81.1 | 88.6 | 97.3 | 106.5 | 117.0 | 128.4 | 140.8 | |
| Growth w/ DSH | | 1.087 | 1.090 | 1.095 | 1.092 | 1.095 | 1.094 | 1.093 | **1.092** |
| Growth w/o DSH | | 1.090 | 1.092 | 1.098 | 1.095 | 1.099 | 1.097 | 1.097 | **1.095** |
| Recipeint Growth * | | 1.042 | 1.038 | 1.038 | 1.037 | 1.038 | 1.038 | 1.038 | **1.039** |
| Per Capita Growth w/DSH | | 1.043 | 1.050 | 1.055 | 1.053 | 1.055 | 1.055 | 1.054 | **1.052** |
| **Growth: Program - 1.0%** | | | 1.080 | 1.085 | 1.082 | 1.085 | 1.084 | 1.083 | |
| Expenditures | | | 99.6 | 108.0 | 116.8 | 126.8 | 137.4 | 148.9 | |
| Savings | | | -0.9 | -2.0 | -3.3 | -4.7 | -6.5 | -8.4 | **-25.8** |
| **Growth: Program - 2.0%** | | | 1.070 | 1.075 | 1.072 | 1.075 | 1.074 | 1.073 | |
| Expenditures | | | 98.7 | 106.0 | 113.6 | 122.1 | 131.2 | 140.8 | |
| Savings | | | -1.8 | -4.0 | -6.5 | -9.4 | -12.7 | -16.5 | **-50.9** |
| **Growth: Program - 2.5%** | | | 1.064 | 1.069 | 1.066 | 1.069 | 1.068 | 1.067 | |
| Expenditures | | | 98.1 | 104.8 | 111.7 | 119.5 | 127.6 | 136.2 | |
| Savings | | | -2.4 | -5.2 | -8.4 | -12.0 | -16.3 | -21.1 | **-65.4** |

* Note: In the absence of projections past 2000, the 2000 growth rate was assumed to remain constant in 2001 and 2002

Medicaid projections based on President's FY 1996 budget.

12-Jan-95

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**Medicaid Block Grant Effects: FY 2000**
**Assuming that starting in FY 1997, expenditures grow at program growth minus 2%**
(Dollars in billions)

DRAFT

| | Costs |
|---|---|
| **Cost To States if States Make Up the Difference** | 9.4 |
| ***Percent Increase in Current State Spending*** | 9.5% |
| **Cuts in Provider Payments, Services & Recipients** | |
| **A. All Provider Cuts** | |
| **Cuts for Hospitals, Nursing Homes & Physicians** | |
| Hospitals (MSR) | -4.7 |
| Nursing Homes (MSR) | -3.9 |
| Physicians (MSR) | -0.8 |
| **Cuts for Hospitals and Nursing Homes Only** | |
| Hospitals (MSR) | -5.2 |
| Nursing Homes (MSR) | -4.2 |
| **DSH** | |
| Freezing at FY 1995 Level (Pres FY96) | -3.1 |
| Eliminating Program (Pres FY96) | -10.9 |
| **B. All Services Cuts** | |
| **Services:** | |
| Dental (MSR) | -1.4 |
| Drugs (MSR) | -9.3 |
| Home Health & Hospice (MSR) | -1.8 |
| Medicare Premiums & Cost Sharing (MSR) | -3.5 |
| Personal Care Services (MSR) | -3.4 |
| HSA "Wrap" Services (MSR) | -5.9 |
| **C. All Recipient Cuts** | |
| AFDC Adults: 5.2 m (MSR) | 0.0 9.3 |
| NonCash Kids (OBRA Expansion): 8 m (MSR) | 0.0 9.9 |
| QMBs/SLMBs (MSR) (1) | -3.5 |
| Medically Needy: (MSR) | Higher than 10 |

NOTE: THIS TABLE CONTAINS A MIX OF MIDSESSION REVIEW AND PRES. FY 96 BASELINE ESTIMATES. THIS WILL BE UPDATED WHEN THE DETAILS FROM THE PRES. FY 96 BASELINE BECOME AVAILABLE.

(1) Since there are no data that separately estimate costs associated with QMBs/SLMBs, this estimate is the full cost fo Medicare premiums and cost sharing.

NOTE: All of these effects vary significantly across states.

12-Jan-95
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**Alternative Block Grants for Medicaid**
(Dollars in billions, Fiscal Years)

DRAFT

| | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | Avg Annual Growth |
|---|---|---|---|---|---|---|---|---|---|
| Total Medicaid Expenditures | 84.8 | 92.2 | 100.5 | 110 | 120.1 | 131.5 | 143.9 | 157.3 | |
| DSH | 10.4 | 11.1 | 11.9 | 12.7 | 13.6 | 14.5 | 15.5 | 16.5 | |
| Expenditures Net of DSH | 74.4 | 81.1 | 88.6 | 97.3 | 106.5 | 117.0 | 128.4 | 140.8 | |
| Growth w/ DSH | | 1.087 | 1.090 | 1.095 | 1.092 | 1.095 | 1.094 | 1.093 | **1.092** |
| Growth w/o DSH | | 1.090 | 1.092 | 1.098 | 1.095 | 1.099 | 1.097 | 1.097 | **1.095** |
| Recipeint Growth * | | 1.042 | 1.038 | 1.038 | 1.037 | 1.038 | 1.038 | 1.038 | **1.039** |
| Per Capita Growth w/DSH | | 1.043 | 1.050 | 1.055 | 1.053 | 1.055 | 1.055 | 1.054 | **1.052** |
| **Growth: (Per Capita - 1.0%) x Recipient Growth** | | | 1.080 | 1.084 | 1.081 | 1.085 | 1.084 | 1.083 | |
| Expenditures | | | 99.5 | 107.9 | 116.7 | 126.6 | 137.2 | 148.6 | |
| Savings | | | -1.0 | -2.1 | -3.4 | -4.9 | -6.7 | -8.7 | **-26.8** |
| **Growth: (Per Capita - 2.0%) x Recipient Growth** | | | 1.069 | 1.074 | 1.071 | 1.074 | 1.074 | 1.072 | |
| Expenditures | | | 98.6 | 105.9 | 113.4 | 121.8 | 130.7 | 140.2 | |
| Savings | | | -1.9 | -4.1 | -6.7 | -9.7 | -13.2 | -17.1 | **-52.7** |
| **Growth: (Per Capita - 2.5%) x Recipient Growth** | | | 1.064 | 1.069 | 1.066 | 1.069 | 1.068 | 1.067 | |
| Expenditures | | | 98.1 | 104.8 | 111.7 | 119.5 | 127.6 | 136.2 | |
| Savings | | | -2.4 | -5.2 | -8.4 | -12.0 | -16.3 | -21.1 | **-65.4** |
| **Growth: CPI x Recipient Growth** | | | 1.071 | 1.071 | 1.069 | 1.070 | 1.070 | 1.070 | |
| Expenditures | | | 98.8 | 105.8 | 113.1 | 121.0 | 129.5 | 138.5 | |
| Savings | | | -1.7 | -4.2 | -7.0 | -10.5 | -14.4 | -18.8 | **-56.7** |

* Note: In the absence of projections past 2000, the 2000 growth rate was assumed to remain constant in 2001 and 2002
Medicaid projections and CPI projection based on President's FY 1996 budget.
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# DRAFT

**Medicaid Block Grant Effects: FY 2000**
**Assuming that starting in FY 1997, expenditures grow at recipient growth x per capita growth minus 2%**
(Dollars in billions)

| | Costs |
|---|---|
| **Cost To States if States Make Up the Difference** | 9.7 |
| ***Percent Increase in Current State Spending*** | 9.8% |
| **Cuts in Provider Payments, Services & Recipients** | |
| **A. All Provider Cuts** | |
| **Cuts for Hospitals, Nursing Homes & Physicians** | |
| Hospitals (MSR) | -5.0 |
| Nursing Homes (MSR) | -4.1 |
| Physicians (MSR) | -0.5 |
| **Cuts for Hospitals and Nursing Homes Only** | |
| Hospitals (MSR) | -5.3 |
| Nursing Homes (MSR) | -4.4 |
| **DSH** | |
| Freezing at FY 1995 Level (Pres FY96) | -3.1 |
| Eliminating Program (Pres FY96) | -10.9 |
| **B. All Services Cuts** | |
| **Services:** | |
| Dental (MSR) | -1.4 |
| Drugs (MSR) | -9.3 |
| Home Health & Hospice (MSR) | -1.8 |
| Medicare Premiums & Cost Sharing (MSR) | -3.5 |
| Personal Care Services (MSR) | -3.4 |
| HSA "Wrap" Services (MSR) | -5.9 |
| **C. All Recipient Cuts** | |
| AFDC Adults: 5.2 m (MSR) | -9.3 |
| NonCash Kids (OBRA Expansion): 8 m (MSR) | -9.9 |
| QMBs/SLMBs (MSR) (1) | -3.5 |
| Medically Needy: (MSR) | |

NOTE: THIS TABLE CONTAINS A MIX OF MIDSESSION REVIEW AND PRES. FY 96 BASELINE ESTIMATES. THIS WILL BE UPDATED WHEN THE DETAILS FROM THE PRES. FY 96 BASELINE BECOME AVAILABLE.

(1) Since there are no data that separately estimate costs associated with QMBs/SLMBs, this estimate is the full cost fo Medicare premiums and cost sharing.

NOTE: All of these effects vary significantly across states.

12-Jan-95
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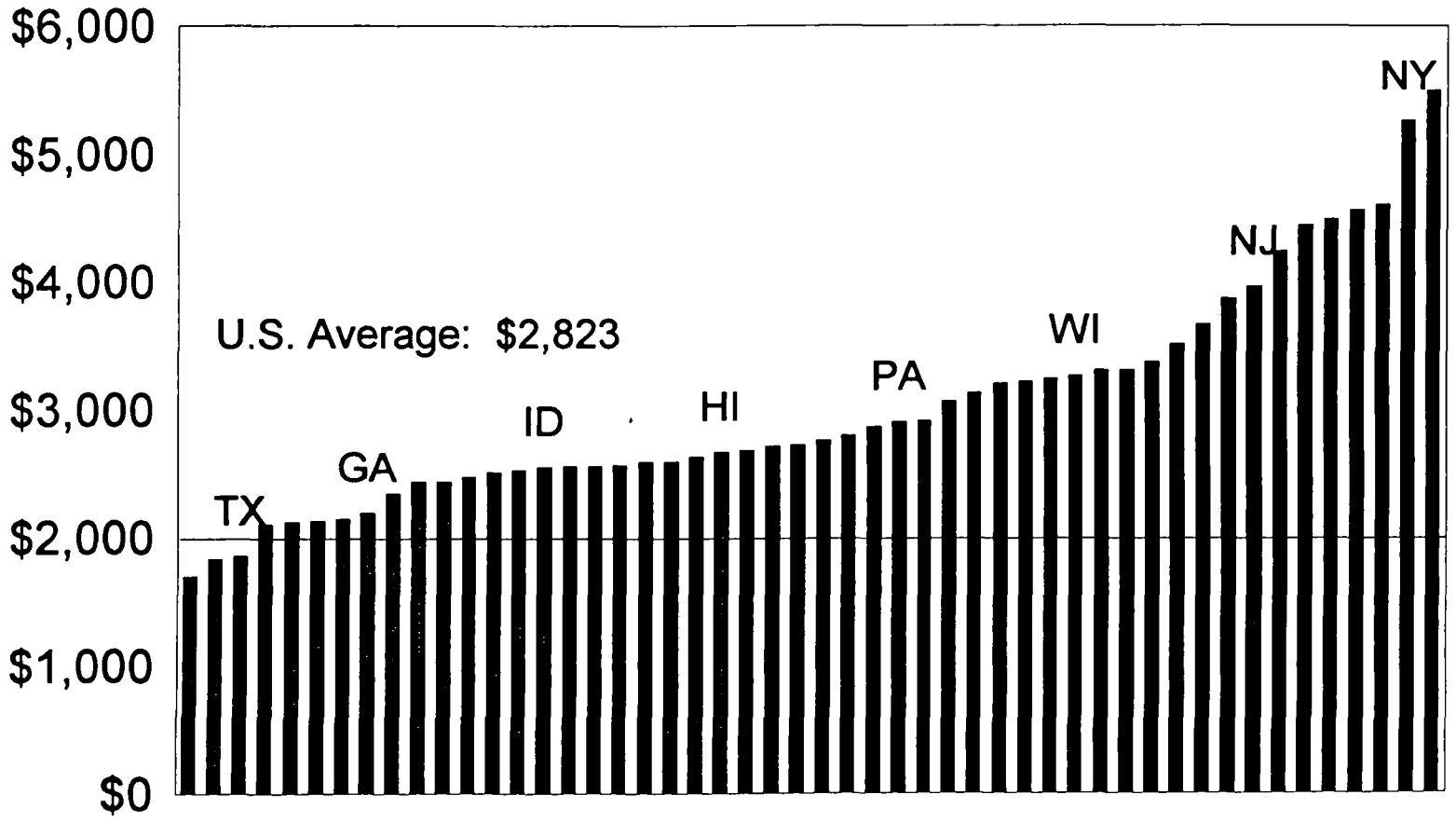
# Medicaid Expenditures Per Enrollee
## 1993




* Note: Excludes Disproportionate Share Expenditures
Data from The Urban Institute and HCFA

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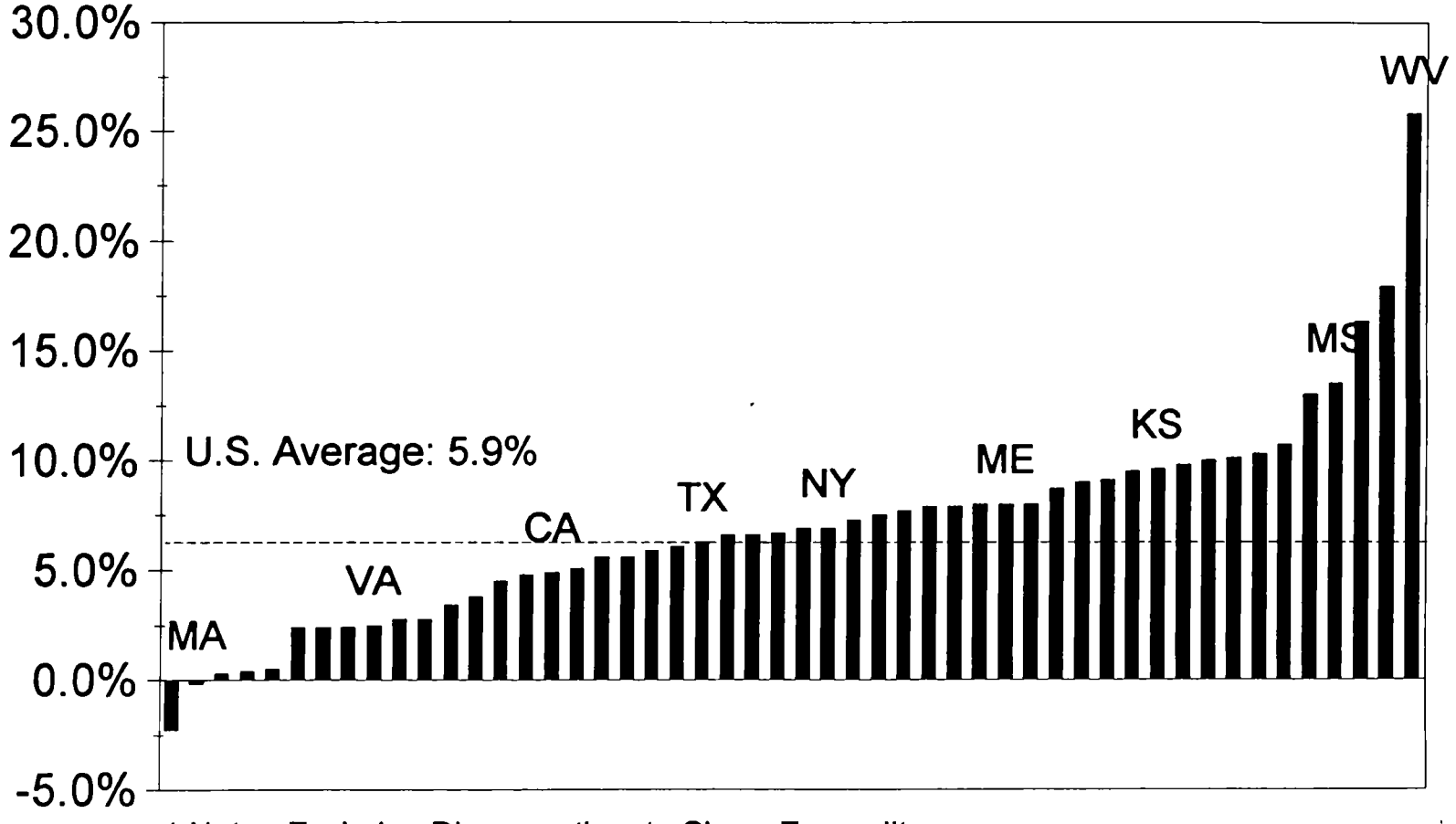
# Medicaid Per Capita Expenditure Growth

## Average Annual Growth Rates, 1990-1993




* Note: Excludes Disproportionate Share Expenditures
Data from The Urban Institute and HCFA

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## Medicaid Block Grant Methods

1. **Overall Federal Fiscal Effects:**
This exercise uses the President's FY 1996 baseline. We estimated the savings resulting from various block grant options assuming introduction in FY 1997. We chose 2002 as the last year of the exercise since the Republican proposals have stated a set of savings estimates using this time period. All of the estimates come from OAct with two exceptions. Recipient growth projections and CPI projections end in the year 2000; we assumed that the growth rates in 2001 and 2002 are the same as those in 2000.

Using these data, alternative growth rates for the Medicaid block were chosen and applied to FY 1996 expenditures to yield the proposals' expenditures and savings.

2. **State Effects:**
   a. State average annual per capita growth rates, 1990-1993: Data from the Urban Institute. These data exclude DSH and recipient growth, both of which were high during this period. The Urban Institute data were used since they exclude 1990 DSH expenditures (note: prior to 1992 , HCFA does not have 64 form data that separately reports DSH).

   b. State per capita expenditures 1993: Data from the Urban Institute (note: these data were chosen because they are consistent with the data used for the other state effects estimates). These expenditures exclude DSH.

3. **Scenarios:**
These estimates are based on the point in time, year 2000 estimated expenditures. Three scenarios are examined, in which the Medicaid cuts are fully taken from provider payments, services, and recipients. Combinations of these three ways of implementing cuts will also be estimated.

**Provider payment cuts.** There are three steps to these estimates:

1. Grouping service expenditures into four categories: (a) hospital (inpatient general, mental hospital, outpatient); (b) nursing facilities (nursing facilities, ICFMR Public and Private); (c) Physicians (physician services); and (d) other (all other service categories). Expenditures in FY 2000 for these categories were summed.

2. Subtracting the amount of the cut due to the cap: These cuts were proportionally distributed. The aggregate amount of the cut was multiplied by the proportion of expenditures going to hospitals, nursing facilities, and physicians.

3. DSH: The estimate of the savings from the DSH freeze are from OAct. The effect of the elimination of the program is calculated by taking the estimate for the full DSH program in 2000 and assuming a behavioral offset of 25% -- the same assumption used for the freeze.

**Services:**

These estimates are from OAct's projected expenditures by service categories for the year 2000. They were chosen for display because their expenditures are large enough to potentially offset the cuts due to the block grant.

**Recipients:**

The counts and costs associated with the AFDC adults and non-cash kids come from OAct's projections.

## Overview

- Medicaid managed care is a strategy that many states have used to reduce Medicaid costs.
- Approximately one-third of Medicaid recipients (excluding the elderly and disabled) are now in some form of managed care. Enrollment in Medicaid managed care is growing rapidly among AFDC recipients and non-cash children.
- A few states are beginning to experiment with managed care for disabled enrollees. HCFA is encouraging these efforts, but it is too early to tell what type of savings could be achieved.
- The administration also has been actively promoting Medicaid managed care through its 1915(b) and 1115 waiver processes.

## Potential Savings

- Studies have found that Medicaid managed care saves approximately 5% over baseline costs.
- Given the trend toward managed care without changes to current law, these savings are currently being realized. Additional savings from increasing the pace of Medicaid managed care enrollment are likely to be small.
- Additional savings due to Medicaid managed care are also limited by the nature of the Medicaid services and populations. A significant proportion of Medicaid expenditures are for the elderly and disabled, who use services that are not typically more efficient under managed care arrangements.
- Preliminary estimates show that if all AFDC and non-cash kids were in managed care by the year 1999, the additional savings through 2005 would be approximately $3.7 billion.

THE WHITE HOUSE

WASHINGTON

December 14, 1994

MEMORANDUM FOR CAROL RASCO

FROM: CHRIS JENNINGS CJ
KIM O'NEILL KON

SUBJECT: Background Information on Medicaid

We understand that the President requested information on Medicaid in a meeting earlier today. While the memo you received from HHS provided general background information about Medicaid, we thought you might be interested in reviewing our longer version of that memo which reviews issues specifically related Medicaid block grants.

We are in the process of coordinating a more detailed analysis of policies associated with Medicaid block grants, which we will forward on to you as soon as it is completed.

Attachments

cc: Jeremy Ben-Ami

# MEDICAID PROGRAM AND POSSIBLE BLOCK GRANT

## Background on Medicaid

The Medicaid program provides acute health care and long term care services to low-income families, the disabled, and the elderly. The program is jointly funded by the federal government and the states, with the federal "match" varying from 50% to 78% depending on average income in a state.

Any low-income family receiving AFDC, or elderly or disabled person receiving SSI, is automatically eligible for Medicaid. Certain categorical groups not eligible for cash assistance -- including low-income pregnant women and children -- may also eligible for Medicaid, with income thresholds generally varying from state to state.

Certain services and eligibility levels are specified in federal law, while others are funded on a matched basis by the federal government at the option of states.

## Where Medicaid Dollars Go

- Medicaid is a program that serves five groups of people:
  - Low income mothers
  - Children
  - Non-elderly disabled people get health insurance and long-term care.
  - Poor elderly people get Medigap-like insurance to supplement Medicare.
  - Disabled elderly get long-term care.
- A disproportionate share of Medicaid funds are spent on elderly and disabled people:
  - Low income kids and adults account for 73.1% of Medicaid enrollees, but consume only 32.8% of total Medicaid spending.
  - Nonelderly disabled people comprise only 15.5% of Medicaid enrollees, but account for 38.7% of spending.
  - Elderly people make up only 11.5% of Medicaid enrollees, but account for 28.4% of spending.
- The Medicaid program is projected to grow at about 10.5% annually through the end of the decade (this may change slightly with new baseline). About two-fifths of the growth is projected growth in enrollment.
  - The disabled population on Medicaid is projected to grow by 8.2% per year.
  - The welfare population is projected to grow by less than 2% per year.
  - Enrollment in Medicaid of non-welfare children under poverty is projected to grow at 4% per year.

- The increase in per capita spending for Medicaid beneficiaries is projected to be about 6.5% annually; about the same as the projected per capita increase for private health insurance.

## A Medicaid Block Grant

The Republicans, as part of their budget proposal, are likely to propose significant cuts in the Medicaid program. To be better able to influence the debate on this issue, it has been argued that the administration needs to propose some cuts in Medicaid as part of its budget. One option that has been put forward is for the administration to propose a Medicaid block grant.

Under a Medicaid block grant, the program could remain an entitlement, but it would be an entitlement to states rather than to individuals. The block grant would grow each year at a defined rate; to produce federal savings, the rate of growth would have to be lower than current federal projections. States would likely have broad flexibility to determine what kinds of services to provide and who receives them.

## Arguments For a Block Grant Proposal

- Would permit the Administration to propose significant reductions in federal Medicaid spending (by capping growth in total spending) without identifying specific cuts that would provoke significant opposition.

- Proposing some reductions in Medicaid demonstrates the administration's commitment to re-evaluating existing government programs and allows the administration to oppose more significant cuts without being perceived as defending the status quo.

- Would provide states with relief from unfunded mandates.

- Would give states greater flexibility to respond to local circumstances.

- States willing to increase spending would have broad flexibility under a block grant approach to pursue strategies to reform their health care systems.

- A block grant proposal may be popular with governors.

## Arguments Against a Block Grant Proposal

- Significant reductions in Medicaid would very likely lead to reductions in coverage or services.

  Medicaid is growing faster than private health spending because of enrollment growth -- not program inefficiency. (The per capita growth in Medicaid is about the same the per capita growth in private health insurance). There is no reason to expect that the Medicaid program can contain costs more successfully than the private sector. As a result, capping the program to achieve significant savings (e.g., Medicaid population plus general CPI) would inevitably lead to reductions in coverage or services.

- Proposing a cap on Medicaid (with or without a block grant) would provoke vocal criticism from many groups that are part of the Democratic base. And, despite the welfare image of the program, 67% of all Medicaid spending is for the elderly, blind, and disabled. A block grant proposal could engender significant opposition from these groups.

- Some states may atempt to control costs through further cuts in provider payments, which could reduce access or shift costs to the private sector.

- The administration has criticized the Republicans for failure to be specific in many of their budget and tax proposals. We may be subject to the same charge if we go with something that looks like a cap.

- The process of determining how much each state gets, how much the block grant increases over time, whether DSH continues, and what strings may be attached will be controversial and will pit some states against others.

- Block grants eliminate the federal floor for Medicaid eligibility and services and encourage states to reduce their programs to avoid becoming magnets for the poor and sick.

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~~CONFIDENTIAL~~ **MEMORANDUM**

**TO:** **Hillary Rodham Clinton**
**RE:** **Medicare/Medicaid and the budget**
**DT:** **12/14/94**
**cc:** **Melanne**

In this morning's budget discussion, Alice will lay out where we fall short in achieving the current goals of a tax cut (approximately $50 billion), a worker retraining initiative (approximately $25 billion), and avoiding a deficit problem. Apparently, we face a significant shortfall (particularly when you consider some of our possible assumed savings are unlikely to be politically viable), which will require painful decisions -- decisions that may bring back into play some significant cuts in Medicare and, possibly, Medicaid.

I believe one of the desires of this (and/or previous) meetings has been to come to closure on exactly what is the size/scope of the tax cut, so that the President can talk about it with some specificity on Thursday. The one point I think is important to emphasize is that publicizing a specific number may well signficantly constrain our budget options and may push us to look at significant cuts in the health entitlements for financing. **My primary point here is to suggest that, if finalizing a tax cut policy has the potential to drive other budget numbers, you may consider asking what implications any such decision has on health care savings proposals. For example, does this by definition tie our hands into any specific funding need from the health programs beyond the extenders and, if so, what are the specific implifications in terms of dollars necessary and impact on health policy politics (whether for our budget or in future negotiations on the Hill).**

It is now clear that, as far as Leon and OMB are concerned, both sets of Medicare extenders [$19 billion over 5 years and $125 over 10 years] that we have been talking about as possible health reform financing sources are already being assumed in the budget baseline. In other words, these Medicare savings are being used as funding sources for the non-health care spenders or to help reduce the deficit problem.

Because of the budget pressures, it does not come as a surprise that these extenders are apparently being assumed for non-health purposes in the budget baseline (although some of our supporters, including Senator Kennedy -- who just met with the President today, will be upset). What would create disproportionately greater problems is a move for significantly greater cuts from Medicare and possibly Medicaid to address real or perceived shortfalls.

Apparently Alice will be presenting a whole range of Medicare and Medicaid savings that may amount to over 85 billion dollars more OVER 5 years. I believe she is preparing this information because (1) she thinks we should be placing these on the table now so that we can define ourselves in terms of being willing to step up to the plate and show our desire to both reduce the deficit and have small investments in health reform; (2) she believes Leon and Bob are open to additional Medicare (particularly provider) cuts; (3) she has heard Laura talk about the possible need for an entitlement summit and possible implications of a small Medicare entitlement cap; and (4) she thinks we need money or at least more options on the table to make the numbers eventually work out.

The fears I have about Alice's presentation can be narrowed to one word: **LEAKS. If there is any public perception that we are talking about major Medicare/Medicaid cuts (particularly if they are not signficantly redirected for reform), we will hear a major outcry from our traditional base of consumer advocates and the elderly, the hospitals, and many other providers.** I would like to suggest that you emphasize this point.

**You may also want to ask her when we will have the new Medicare/Medicaid baseline numbers incorporated into the baseline (which apparently will lower the deficit -- perhaps by tens of billions of dollars -- and thus hopefully reduce pressure on us to cut programs for deficit reduction).** [She is pushing HHS for these numbers now, but their absence means that we will have to recalibrate our deficit numbers and proposed savings numbers in a very short period of time].

Lastly, it is possible that the subject of a Medicaid block grant or other Medicaid savings proposals may come up. There may be some political and policy appeal to these proposals. Because of the states strong desire for flexibility and the Governors ongoing discussions with the Republicans (and the President), the President may understandably be somewhat intrigued. As you know, however, there are tremendous implications with proposals such as these and I would only ask that we have an informed discussion on the matter preceeded by a DPC/NEC Map Group meeting to help us prepare.

In case the Medicaid blockgrant issue is raised, I am attaching some background information and some pros & cons on it for your use. (I do this although I understand from Melanne's intelligence that most of the budget participants -- other than Gene and perhaps the President -- are not seriously focusing on this proposal at this point).

I am sure I am giving you too much, but I thought this information might be helpful for both the morning budget meeting (if you go) and your afternoon meeting with Bob, Alice and Laura.

## ASSUMPTIONS FOR COVERAGE OPTIONS

- We assume private administration of all options (except Welfare to Work and State Flexibility).
- Within the private program we have to assume relatively significant insurance market reforms (we need to develop the specifics). How can we call this private?
  1. King
  2. Giving people $ to buy into individual mkt -- but have to integrate individual market
- We assume the rejection of subsidy options that are significant (e.g., the Mainstream proposal cost $600–$800 billion).
- We assume targeting to middle income, which means that we reduce costs by slowing in the phase-in of the programs and phasing in the programs by age.

For kids to enter a kids market, Gary says we don't have to reform the rest of the mkt.

# POSSIBLE USES OF FUNDS

Fiscal Years, Dollars in Billions
1995–2004

| | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 1995-1999 | 1995-2004 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DEFICIT REDUCTION | NA | NA | NA | NA | etc | | | | | | | |
| KIDS<br>~~Private Insurance~~<br>Through age 5<br>Full to 185% of poverty<br>Phased to 300% of poverty | 0 | 0 | NA | NA | etc | | | | | | | |
| KIDS<br>~~Private Insurance~~<br>Through age 18<br>Full to 185% of poverty<br>Phased to 300% of poverty | 0 | 0 | NA | NA | etc | | | | | | | |
| UNEMPLOYED — based on monthly family income<br>~~Private Insurance~~<br>Six months only<br>Full to 100% of poverty<br>Phased to 250% of poverty<br>Unemployement comp. included | 0 | 0 | NA | NA | etc | | | | | | | |
| UNEMPLOYED AND KIDS<br>Private Insurance<br>Kids:<br>Through age 18<br>Full to 185% of poverty<br>Phased to 300% of poverty<br>Unemployed<br>[Same as above] | 0 | 0 | NA | NA | etc | | | | | | | |
| WELFARE TO WORK | 0 | 0 | NA | NA | etc | | | | | | | |
| UNEMPLOYED AND KIDS AND WELFARE TO WORK | 0 | 0 | NA | NA | etc | | | | | | | |
| SELF-EMPLOYED DEDUCTION<br>Quick phase-in to 100% | | | | | | | | | | | | |
| SELF-EMPLOYED DEDUCTION<br>Slower phase-in to 100% | | | | | | | | | | | | |
| LONG TERM CARE? | | | | | | | | | | | | |
| STATE FLEXIBILITY? | | | | | | | | | | | | |

Health/Welfare Waiver Meeting
November 8, 1994

Kathi Way
Bruce Reed
Bell Sawhill
Nancy Ann Min
Keith Mason
John Hart
Susan Brophy
Kevin Thurm
Linda Moore
Ellen Haas
Mary Jo Bane
Emily Bromberg
David Ellwood
Melissa Skolfield
John Monohan
Bruce Vladik
Kathleen Buto
Diana Fortuna
Patty Morris
Wendell Primus
Ann Rosewater
Judy Feder
Ken Apfel
Michael Wald
Richard Tarplin
Sharon Kiely
Karen Guss

Jen —

There was a mtg. on welfare+medicaid waivers run by Kathi Way on Nov. 8. Here is a list of who was there and the material that was distributed.

KG

P.S. My notes are attached.

**Draft Outline of Waiver Issues and Future Directions**

I. Welfare Waivers
- A. Background
  1. The waiver process
  2. Accomplishments to date
  3. Expectations for the immediate future
- B. Key Issues
  1. Legal challenges
  2. Interaction with national welfare reform
  3. Congressional oversight
  4. Implementation/feasibility
  5. Budget issues
  6. Recipient protection

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- A. Background
  1. The waiver process
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- B. Key Issues
  1. Legal challenges
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  3. Congressional oversight
  4. Implementation/feasibility
  5. Budget issues
  6. Recipient protection

III. HHS Strategy for the Future
- A. Emphasize and articulate better a broad set of principles for each type of waiver--waivers would be specifically considered in light of these principles
- B. Tighten and clarify position/methodology on a few key issues

IV. Welfare Waivers
- A. Broad Principles:
  1. The principles in the Work and Responsibility Act
     a. Independence, work and responsibility
     b. Support for and protection of those who play by the rules
     c. Promotion of well-being of families and children
  2. Genuine innovation
  3. Operational feasibility
  4. Cost neutrality
  5. Careful evaluation
  6. Open and inclusive review process

B. Specific Policy Implications

1. Time limits must be followed by work and/or safety nets
2. Medicaid cannot be cut off as part of a sanctioning process
3. Sanctions must be progressive and curable
4. Family caps need exceptions for rape and incest and provide some way of filling the gap through work or child support
5. Work slots should pay the minimum wage

C. Other strategic issues

1. Seek to promote innovations we are particularly interested in through work with states, using other 1115 demonstration authority
2. Avoid waivers which seem mostly designed to avoid Congressional intent, or which are not likely to offer new insights, especially when highly controversial.

V. Medicaid Waivers

A. Broad Principles:

1. The principles in embodied in health reform efforts
   a. Expanding coverage
   b. Maintaining quality and access to services
   c. Protecting existing beneficiaries
   d. Encouraging efficiency
2. Genuine innovation
3. Operational feasibility
4. Cost neutrality
5. Careful evaluation
6. Open and inclusive review process

B. Specific Policy Implications

1. Specific protections for persons in managed care plans
2. Existing beneficiaries not removed from Medicaid
3. Services to persons outside the emonstration services not cut to provide new services to those in the demonstration.
4. Beneficiaries get some choice of plans.
5. Assurance of quality control and monitoring in place

C. Other Issues

1. Create a more systematic mechanism for determining and evaluating cost neutrality.
   a. baseline rules including growth
   b. what can be matched
   c. DSH rules
   d. reconcilliation process
2. Seek to promote innovations we are particularly interested in through work with states, using 1115 demonstration authority
3. Avoid waivers which seem mostly designed to avoid Congressional intent, or which are not likely to offer new insights, especially when highly controversial.

DRAFT - NOVEMBER 7, 1994

## WELFARE REFORM DEMONSTRATIONS - ACF PROGRAMS

**PURPOSE:** This paper describes the status of the Administration for Children and Families (ACF) section 1115 welfare reform demonstrations as well as some of the common characteristics that have emerged from their approval and implementation.

**BACKGROUND**

The Clinton Administration has now approved twenty one demonstrations in twenty States. Seven are fully statewide. These are California, Georgia, Iowa, North Dakota, South Dakota, Vermont and Wisconsin. Six states, Connecticut, Florida, Illinois, Michigan, Virginia and Wyoming have some provisions that are statewide but others that are being tried only in pilot sites. Eight states, Arkansas, Colorado, Hawaii, New York, Oklahoma, Oregon, Pennsylvania and Wisconsin have demonstrations in which all components are being implemented less than statewide. In addition, we are currently reviewing twenty three waiver applications from twenty one states (this includes four States already listed above which are seeking additional waivers). An additional nineteen welfare reform demonstrations being implemented in thirteen states were authorized by previous administrations (this includes six States which have received approval of additional waivers under this Administration). Waiver authority has been granted for periods ranging from three to eleven years, with most projects operating five years or less.

ACF involvement in considering proposed demonstrations often begins before a formal application is submitted, as federal and state staff discuss the proposal in regard to the innovations proposed, waivers needed, and the evaluation and cost neutrality requirements. When applications are submitted, proposed demonstration policies are reviewed in detail by a team composed of ACF staff and other Federal reviewers to identify issues and needed clarifications. The process of reaching an agreement with a State often requires involved discussions with the state to suggest improvements, and sometimes requires that policies be modified to insure that the demonstration's purpose meets the objectives of the Act and to bring them in line with our principles, especially in light of our responsibility to recipients. We follow a number of principles in considering waiver applications: avoiding harm to recipients within the demonstrations, rigorous evaluation, cost neutrality, and encouraging the testing of policies which are in line with the principles of the Work and Responsibility Act. ACF continues to work closely with the State after approval to help facilitate implementation and ensure rigorous evaluation of the program.

It also became clear some time ago that our open policy should be formalized. ACF and HCFA recently issued, in the Federal

Register (September 27, 1994), policy guidelines and requirements for public notice of waiver requests. The guidelines in this notice clarify the policy and procedures we believe are most productive and fair, and which will further promote the fullest possible airing of the proposed policies. Although most of the applications before us recently have had the period of public debate called for in the notice, this formal requirement will insure that such a process always occurs. It also commits us to publishing information about new applications in the Federal Register so that an even wider audience will be alerted, and it will establish a 30 day period for interested parties to provide comments before a decision to approve or disapprove is made.

**MAJOR THEMES**

The President's campaign positions on welfare reform and the public dialogue that was part of the development of the Work and Responsibility Act have had a very significant effect on the level of state interest and the content of demonstration proposals. Thus, the major themes of many of the state initiatives are those of Work and Responsibility. At the same time they are not exclusively so, and even where the goals are the same, many of the details are importantly different.

o **Making Work Pay**

A very common approach in many state efforts is to increase the amount of earned income an individual can receive and still retain welfare benefits. In addition, increases in the levels of assets one can accumulate and still retain eligibility, and easing the ability of recipients to become self-employed are common.

o **Enhancing JOBS/Culture Change**

Many state projects seek to strengthen the JOBS program as the centerpiece of a broader cultural change to make the welfare system more employment-focused. Common elements include eliminating some or all exemptions from mandatory participation and increasing sanctions for non-cooperation, combined with enhancing services and participation levels that could be done without waivers.

o **Time Limits**

Although time-limiting benefits is a common theme of many projects, most projects have not followed the Work and Responsibility model of following the time limit with a work for wages position. Much more common have been approaches in which the time limit is a signal for heightened attention to moving recipients toward employment, but which doesn't actually mandate work, or in which the time limit is followed by workfare. Only a few states are moving toward a work-for-wages model, and then only on a relatively small scale.

o **Family Caps**

Four States have received waivers to eliminate additional AFDC benefits to families due to the birth of a child conceived while, or shortly after, receiving AFDC (Arkansas, Georgia, New Jersey and Wisconsin). These family cap provisions apply Statewide, except in Arkansas (where it applies in 2/3 of the State). In Georgia, the family cap is restricted to families which have been receiving AFDC for at least 24 months.

o **Linking Personal Responsibility to Benefits**

In addition to linking benefits to behavior as part of an effort to promote self-sufficiency and participation in work programs, a number of States are linking benefits to personal responsibility in other ways. Sixteen states have received waivers that link benefits to school attendance or performance. An additional four states (Colorado, Florida, Georgia and Maryland) have received waivers to reduce benefits to families whose children have not received required immunizations.

o **Improving Governmental Assistance**

Many states are seeking to more closely link AFDC and Food Stamp benefits in order to improve and simplify the programs.

o **Cost Neutrality**

The principle of federal cost neutrality over the life of the project has been observed in all welfare reform demonstrations. In almost every case, a randomly assigned control group who receive services under the old rules has been used to determine what costs would have been in the absence of the project.

# APPROVED STATE WELFARE REFORM WAIVER PROVISIONS

Effective: November 4, 1994

| Provision | State |
|---|---|
| o Time Limit Benefits | CO, CT, FL, IA, SD, VT, WI(1)(7)(8) |
| o Limit Benefits for Additional Children | AR, GA(2), NJ, WI(3)(8) |
| o Eligibility for Pregnant Women With No Other Children, in 1st and 2nd Trimester | CA(3), ND |
| o Increase Income Disregard (Amount/Duration) | CA(2), CO, CT, FL, IA, IL, MI, MO, MN, NJ, OR(2), PA, SD, UT, VA(2), VT, WI(2)(3)(7) |
| o Increase Resource Limit | AL, CA(3), CO, CT, FL, IA, IL, MI, MO, NY(2), OR(2), PA, SD, UT, VA(2), VT, WY |
| o Disregard Resources in Special Accounts | CA(3), CT, IA, NY(1), NY(2), OR(2), PA, VA(2), WI(5) |
| o Increase Vehicle Asset Limit | CA(3), CO, CT, FL, IA, NY(2), OH, SD, UT, VA(2), VT, WI(6) |
| o Eliminate 100 Hour Rule | AL, CA(2), CT, FL, IA, IL, MI, MO, NY(2), PA, VT, WI(3)(7) |
| o Eliminate Labor Force Attachment Requirement | AL, CT, FL, IA, IL, MI, OR(2), PA, VT, WI(3) |
| o Impose Workfare Requirement | CT, IL, MO, VT, WI(7), WY |
| o Require Immunizations | CO, FL, GA(1), MD |
| o Limit JOBS Exemptions | AL, AR, CT, FL, IA, IL, MI, ND, NJ, OK, OR(1), UT, VT, WI(3), WY |
| o JOBS Participation for Non-Custodial Parents | AL, FL, IL, MI, NJ, NY(2), OR, UT, WI(3) WY |
| o Change in JOBS Sanction | AL, CO, CT, GA(2), IA, IL, NJ, OR, VT, WI(3)(7), WY |
| o Extend Job Search | CT, HI, IA, MI, MN, NY(2), VT |
| o Benefits Linked to School Attendence/Performance | AR, CA(3), CO, CT, FL, IL, MD, NY(2), OH, OR, OK, PA, VA(1), VT, WI(1)(3), WY |
| o Cash-out Food Stamps | AL, CO, MN, MO, NY(1), OR(2), PA, UT, WI(7) |
| o Expand Transitional Benefits | CO, CT, FL, IA, IL, MN, NY(2), VA(2), WI(2)(7) |

End Notes: State Codes followed by ( ) = State has more than one waiver demonstration approved.

LEGEND:

| | |
|---|---|
| AL = Alabama - | Avenues to Self-Sufficiency through Education and Training Services (ASSETS). |
| *AR = Arkansas - | Reduction in AFDC Birth Rates Project. |
| CA = California - | (1) Automated Finger Print Image Reporting and Match (AFIRM); |
| | (2) Assistance Payments Demonstration Project (APDP); |
| | *(3) Work Pays Demonstration Project (WPDP). |
| *CO = Colorado - | Colorado Personal Responsibility and Education Program (CPREP). |
| *CT = Connecticut - | A Fair Chance. |
| *FL = Florida - | Family Transition Program (FTP). |
| GA = Georgia - | (1) Preschool Immunization Project (PIP); |
| | *(2) Personal Accountability and Responsibility Project (PAR). |
| *HI = Hawaii - | Creating Work Opportunities for JOBS Families. |
| *IA = Iowa - | Iowa Family Investment Plan (IFIP). |
| *IL = Illinois - | Fresh Start Initiative. |
| MD = Maryland - | Primary Prevention Initiative (PPI). |
| *MI = Michigan - | To Strengthen Michigan Families (TSMF). |
| MN = Minnesota - | Minnesota Family Investment Plan (MFIP). |
| MO = Missouri - | 21st Century Communities. |
| NJ = New Jersey - | Family Development Program (FDP). |
| NY = New York - | (1) Child Assistance Program (CAP); |
| | *(2) JOBS First. |
| *ND = North Dakota | Early Intervention Program (EIP). |
| OH = Ohio - | Learning, Earning and Parenting (LEAP). |
| *OK = Oklahoma - | Oklahoma's Learnfare Project. |
| OR = Oregon - | (1) JOBS Waiver Project; |
| | *(2) Jobs Plus. |
| *PA = Pennsylvania - | Pathways to Independence. |
| *SD = South Dakota - | Strengthening South Dakota Families Initiative. |

| | |
|---|---|
| UT = Utah - | Single Parent Employment Demonstration Project (SPED). |
| VA = Virginia - | (1) Virginia Incentives to Advance Learning (VITAL); |
| | *(2) Welfare Reform Project. |
| *VT = Vermont - | Family Independence Project (FIP). |
| WI = Wisconsin - | (1) Learnfare Demonstration; |
| | (2) Modified Earned Income Disregard Project; |
| | (3) Parental and Family Responsibility Project; |
| | (4) Two-Tier Benefit Project; |
| | (5) Special Resource Account Project; |
| | (6) Vehicle Asset Limit Project; |
| | *(7) Work Not Welfare Demonstration (WNW); |
| | *(8) AFDC Benefit Cap (ABC). |
| *WY = Wyoming - | New Opportunities/New Responsibilities. |

* = Approved by Clinton Administration.

# SUMMARY OF ACTIONS ON WAIVER APPLICATIONS - CLINTON ADMINISTRATION

RECEIVED - 53 Applications from 36 States
(9 Applications from 7 States were left pending from the previous Administration)

APPROVED

States Applications - 21 Applications from 20 States

Arkansas (Welfare Demonstration Project)

California (California Work Pays Demonstration Project)

Colorado (Colorado Personal Responsibility Project)

Connecticut (A Fair Chance)

Florida (Family Transition Program)

Georgia (Personal Accountability and Responsibility Project)

Hawaii (Creating Work Opportunities for JOBS Families)

Illinois (Work Pays Project)[1]

Iowa (Iowa Family Investment Plan)

Michigan (To Strengthen Michigan Families Demonstration - Expansion Project)

New York (Jobs First Demonstration)

North Dakota (Early Intervention Program)

Oklahoma (Oklahoma's Learnfare Program)

Oregon (JOBS Plus Demonstration)

Pennsylvania (Pathways to Independence)

South Dakota (Strengthening South Dakota Families Initiative)

Vermont (Family Independence Project)

Virginia (Welfare Reform Project)

Wisconsin (Work Not Welfare Demonstration)

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[1] Added component to Illinois Fresh Start Demonstration

Wisconsin (AFDC Benefit Cap Demonstration Project)

Wyoming (New Opportunities and New Responsibilities Welfare Reform Demonstration)

DENIED

States Applications - 3 Applications from 3 States

Illinois (Relocation to Illinois Project)

Massachusetts (Child Care Co-Payment Project)

Wyoming (Wyoming Relocation Grant)[2]

WITHDRAWN OR REVIEW TERMINATED

States Applications - 6 Applications from 4 States

Illinois (Stepparent Encouragement Project)

Illinois (One Step at a Time Project)

Ohio (Automobile Assets Disregard Project)

South Carolina (Private\for Profit Work Experience Project)

Texas (Two Parent Families Demonstration Project)

Texas (Teen Opportunity Project)

PENDING

States Applications - 23 Applications from 21 States

Arizona (Employing and Moving People Off Welfare and Encouraging Responsibility Program)

California (California Work Pays Demonstration Project - Amendments)[3]

California (AFDC and Food Stamp Compatibility Demonstration Project)

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[2] Waiver requested as part of New Opportunities and New Responsibilities Welfare Reform Demonstration approved above.

[3] Would add provisions to the previously approved California Work Pays Demonstration Project.

Georgia (Work for Welfare Project)

Indiana (Manpower, Placement and Comprehensive Training Program)

Kansas (Actively Creating Tomorrow for Families Demonstration)

Maine (Project Opportunity)

Maryland (Maryland Welfare Reform Project)

Massachusetts (Employment Support Program)

Mississippi (A New Direction Demonstration Program)

Missouri (Missouri Families Mutual Responsibility Plan)

Montana (Achieving Independence for Montanans Project)

Nebraska (Welfare Reform Waiver Demonstration)

New Hampshire (Earned Income Disregard Demonstration Project)

New Mexico (Untitled Project)

North Dakota (Training, Education, Employment and Management Project)

Oklahoma (Mutual Agreement, A Plan for Success)

Ohio ("A State of Opportunity" Project)

Oregon (Expansion of the Transitional Child Care Program)

Oregon (Increased AFDC Motor Vehicle Limit Demonstration Project)

Pennsylvania (School Attendance Improvement Program)

South Carolina (Self-Sufficiency and Parental Responsibility Program)

Washington (Success Through Employment Program)

DRAFT - November 7, 1994

# STATE MEDICAID DEMONSTRATIONS

**PURPOSE:** This paper describes where the Health Care Financing Administration (HCFA) is on statewide, section 1115 Medicaid waiver demonstrations as well as some of the common characteristics that have been identified in the projects so far.

## BACKGROUND

To date, HCFA has approved section 1115 waivers for statewide health care reform demonstrations in six States: Tennessee, Oregon, Rhode Island, Hawaii, Kentucky, and Florida, in addition to the long standing statewide waiver in Arizona. We have received and are currently reviewing waiver applications from an additional eight States: South Carolina, Ohio, Massachusetts, Missouri, New Hampshire, Delaware, Minnesota, and Illinois. HCFA has also begun initial discussions with several other States, including New York, Oklahoma, Utah, Texas, and Louisiana.

Currently, approximately 8 percent of total Medicaid expenditures is spent under waivers in States with approved statewide demonstrations. Adding in States with pending waiver applications raises this percentage to approximately 18 percent.

HCFA collaborates with States throughout the development and review of their demonstration proposals. HCFA often meets with a State in its planning phase to discuss broad guidelines that support the goals of the 1115 waiver process and alert the State to possible stumbling blocks in its concept. During review of waiver applications, HCFA works as a team with other HHS components and OMB. Throughout the review process, HCFA works toward approval with the State in a true "give and take" sense, to shape the proposal in mutually acceptable ways and assure that the demonstration will achieve the goals of the State and of HCFA. HCFA continues to work closely with the State after approval to ensure a timely and smooth implementation of the new program.

## MAJOR THEMES

States, in general, seem to be utilizing 1115 waivers to experiment with ways to expand and simplify Medicaid eligibility and provide services in a cost effective manner through various managed care arrangements.

- **Expanding Coverage**

Most States have proposed to increase coverage for the uninsured in their demonstrations by expanding and streamlining eligibility for Medicaid. These expansions provide insurance coverage -- often through commercial managed care plans -- to the population groups that are most likely to be uninsured and to go without critical preventive services.

The eligibility expansions range from expansions for pregnant women and children only (which is possible without waivers under current law), to eligibility for everyone under 300 percent of the Federal poverty level. The number of newly-covered persons in operating demonstrations ranges from several thousand in Rhode Island to roughly 350,000 in Tennessee. The streamlining changes include eliminating Medicaid eligibility categories and asset tests.

o **Managed Care**

States are employing various forms of managed care. The arrangements in the approved projects range from utilizing fully capitated managed care organizations for all enrollees (e.g., Hawaii, Tennessee, Rhode Island) to using combinations of fully capitated plans, partially capitated plans, and primary care case managers or gatekeepers.

The range of services to be provided under the demonstrations varies as well. Most States are choosing to include only acute services in their projects and are leaving long term care and services for certain special populations as is. This is partly because States are often looking at reform of long term care services separately, and partly due to limited experience developing capitation rates for disabled and other special populations, but the approach still leaves a significant portion of Medicaid services, and therefore Medicaid costs, outside the statewide demonstration project.

o **Cost Savings**

A major goal of many of the proposals is to control the rising costs of health care and, specifically, the rapid rise in Medicaid expenditures. In the demonstrations, savings are expected to come primarily from improved program efficiencies associated with managed care, such as reduced unnecessary use of emergency rooms and inpatient hospital services and increased preventive services. Most States are using their cost savings to fund expansions in their program.

Managed care can produce onetime savings when the capitated rate is a certain percentage below the equivalent fee for service costs for the covered population. Savings can also result from a gradual reduction in the rate of increase in per capita costs over the life of the project as service delivery systems become more efficient and the provision of primary and preventive services increases.

State are also seeking waivers as a mechanism for redirecting their Medicaid and State financing. Some States would like to divert Medicaid payments from disproportionate share hospitals (DSH) to pay for services for the uninsured. Other States are looking for Federal payments to supplement previously State-only expenditures.

o **Data Collection/Evaluation**

Another important common element of the State demonstrations is HCFA's requirement that States collect 100 percent encounter data. These data, which are not routinely collected from managed care plans, will ensure that we have data equivalent to what is collected in the fee-for service sector and enable HCFA to evaluate quality and access during the life of the waiver. To this end, HCFA staff have developed a draft set of standard data elements to collect from Medicaid managed care plans, which should be useful in making comparisons across States.

HCFA has already let two contracts, one to evaluate Oregon, and a second to evaluate the first five other States. These evaluations will build on the data collected and are essential to determining the extent to which States have achieved their research goals.

## STATUS OF STATE HEALTH REFORM INITIATIVES
November 7, 1994

| STATE | INITIAL CONTACT/ CONCEPT DISCUSSIONS | PROPOSAL RECEIVED/ TECHNICAL REVIEW | CLEARANCE/ DECISION | AWARD ANNOUNCEMENT/ ACCEPTANCE OF T&Cs | OPERATIONAL DEVELOPMENT | OPERATIONAL START |
|---|---|---|---|---|---|---|
| OR | | | | 03/19/93 / 04/16/93 | | 02/94 |
| TN | | | | 11/18/93 / 12/16/93 | | 01/94 |
| HI | | | | 07/15/93 / 08/02/93 | | 08/94 |
| KY | | | | 12/09/93 / 02/03/94 | X | |
| RI | | | | 11/01/93 / 11/02/93 | | 08/94 |
| FL | | | | 09/15/94 / 10/14/94 | X | |
| OH | | X | | | | (07/95) |
| SC | | X | | | | (07/95) |
| MA | | X | | | | |
| NH | | X | | | | (01/95) |
| MO | | X | | | | |
| MN | | X | | | | |
| DE | | X | | | | |
| IL | | X | | | | |
| WA | X | | | | | |
| UT | X | | | | | |
| OK | X | | | | | |
| LA | X | | | | | |
| NY | X | | | | | |
| TX | X | | | | | |

**Date in parentheses represent expected dates.

# SECTION 1115 WAIVER ACTIVITY
# STATEWIDE HEALTH REFORM

| STATE | INITIATIVE |
|---|---|
| **APPROVED** | |
| OREGON | Expand access to uninsured; cost containment through managed care; benefit package defined by priority list.<br><br>Oregon will be implementing Phase 2 which involves including the aged, blind, and disabled, and the addition of chemical dependency services to the demonstration. A January 1, 1995 start date is planned. |
| TENNESSEE | Expand access to uninsured through expansion of Medicaid. TENNCARE establishes a system of managed care similar to the current plan for State employees. There are no income or asset limits, but Tennessee will cap the program at 1.5 million enrollees. |
| HAWAII | Hawaii's HealthQuest provides seamless coverage of those on public programs, as well as the current uninsured. Through Medicaid expansions (300% FPL, elimination of categorical and asset tests) and a managed care delivery system, the State expects to expand access and control costs. |
| KENTUCKY | The Kentucky Health Care Reform Plan calls for universal access through: Medicaid eligibility to 100 percent FPL, elimination of certain categorical requirements, through managed care, primary care case management. |
| RHODE ISLAND | Rhode Island was given Medicaid waivers allowing for the extension of Medicaid eligibility to pregnant women and children up to 250% FPL and enrollment of all recipients in a capitated managed care delivery system. |
| FLORIDA | Florida's Agency for Health Care Administration (AHCA) has been granted section 1115 waivers to permit Federal financial participation for the Florida Health Security Program (FHS). FHS will utilize a managed competition model and will provide health insurance for 1.1 million uninsured Floridians with incomes at or below 250% of the FPL. Health plans will be offered by Accountable Health Partnerships (AHPs) and sold by Community Health Purchasing Alliances (CHPAs). |

# SECTION 1115 WAIVER ACTIVITY
# STATEWIDE HEALTH REFORM

| STATE | INITIATIVE |
|---|---|
| | **RECEIVED** |
| OHIO | Ohio has submitted an 1115 waiver application which would allow them to implement OhioCare. Under OhioCare, Medicaid eligibility would be expanded to include the uninsured population with incomes up to 100% of FPL. Ohio expects to enroll approximately 500,000 additional recipients. The State will enroll all new eligibles and current Medicaid recipients into managed care programs throughout the State. |
| SOUTH CAROLINA | South Carolina has submitted an 1115 waiver application which would allow them to implement the South Carolina Palmetto Health Initiative. The program will extend Medicaid eligibility to include residents with incomes up to 100 % FPL. South Carolina expects to cover approximately 280,000 additional recipients. All Medicaid recipients will be enrolled in managed care programs. |
| MASSACHUSETTS | Massachusetts has submitted an 1115 waiver application, entitled MassHealth. The demonstration has nine component strategies which are intended to cover the 524,000 uninsured in Massachusetts. The proposed strategies address needs specific to the mixture of social economic groups that are uninsured in Massachusetts, which include the employed, the short-term unemployed, and the long-term employed. The proposal includes direct strategies that provide public health care and indirect strategies that seek to promote market forces and responsible decision making by providing financial incentives in the form of tax credits to employers, tax deferred medical saving accounts for insured individuals, and subsidies in the form of insurance vouchers for employees with incomes up to 200% of the FPL. |
| NEW HAMPSHIRE | New Hampshire submitted a proposal entitled, "The Granite State Partnership for Access and Affordability in Health Care". The State proposes the expansion of Medicaid eligibility to adults with incomes below the AFDC cash standard, along with the introduction of a public insurance product for low-income workers. Also, the State proposes to implement a number of pilot initiatives to help to ultimately redesign the State's health care delivery system. |
| MISSOURI | Missouri's Department of Social Services has submitted an 1115 waiver proposal that will provide managed care medical services to the State's Medicaid population and to the uninsured. |

| STATE | INITIATIVE |
|---|---|
| | RECEIVED |
| MINNESOTA | Minnesota has submitted a waiver proposal which has three major components: (1) integration of low-income and uninsured programs; (2) expansion of the managed care delivery system; and (3) linkage of Medicare to overall State health care reform efforts. The proposal presented a two phase implementation plan for each of the components. Phase 1 will be implemented in 1995, while Phase 2 is the conceptual framework for the development of elements of reforms to be implemented in subsequent years. |
| DELAWARE | Delaware has submitted a 1115 waiver proposal which will increase access to health care services through managed care plans by expanding Medicaid coverage to the State's uninsured adult population up to 100 percent of the Federal poverty level. This statewide proposal will include a comprehensive benefit package emphasizing primary and preventive care. |
| ILLINOIS | Illinois has submitted an section 1115 waiver to develop MediPlan Plus. Under this program the State will develop a series of networks either local or statewide, and tailor the health care systems to the needs of local urban neighborhoods or large rural areas. This program will allow the State to work with established or new HMO's, provider-based managed care community networks, FQHCs and RHCs to develop health networks. |

Wisconsin (AFDC Benefit Cap Demonstration Project)

Wyoming (New Opportunities and New Responsibilities Welfare Reform Demonstration)

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DRAFT - November 7, 1994

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Another important common element of the State demonstrations is HCFA's requirement that States collect 100 percent encounter data. These data, which are not routinely collected from managed care plans, will ensure that we have data equivalent to what is collected in the fee-for service sector and enable HCFA to evaluate quality and access during the life of the waiver. To this end, HCFA staff have developed a draft set of standard data elements to collect from Medicaid managed care plans, which should be useful in making comparisons across States.

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| STATE | INITIAL CONTACT/ CONCEPT DISCUSSIONS | PROPOSAL RECEIVED/ TECHNICAL REVIEW | CLEARANCE/ DECISION | AWARD ANNOUNCEMENT/ ACCEPTANCE OF T&Cs | OPERATIONAL DEVELOPMENT | OPERATIONAL START |
|---|---|---|---|---|---|---|
| OR | | | | 03/19/93 / 04/16/93 | | 02/94 |
| TN | | | | 11/18/93 / 12/16/93 | | 01/94 |
| HI | | | | 07/15/93 / 08/02/93 | | 08/94 |
| KY | | | | 12/09/93 / 02/03/94 | X | |
| RI | | | | 11/01/93 / 11/02/93 | | 08/94 |
| FL | | | | 09/15/94 / 10/14/94 | X | |
| OH | | X | | | | (07/95) |
| SC | | X | | | | (07/95) |
| MA | | X | | | | |
| NH | | X | | | | (01/95) |
| MO | | X | | | | |
| MN | | X | | | | |
| DE | | X | | | | |
| IL | | X | | | | |
| WA | X | | | | | |
| UT | X | | | | | |
| OK | X | | | | | |
| LA | X | | | | | |
| NY | X | | | | | |
| TX | X | | | | | |

**Date in parentheses represent expected dates.

# SECTION 1115 WAIVER ACTIVITY
# STATEWIDE HEALTH REFORM

| STATE | INITIATIVE |
|---|---|
| **APPROVED** | |
| OREGON | Expand access to uninsured; cost containment through managed care; benefit package defined by priority list.<br><br>Oregon will be implementing Phase 2 which involves including the aged, blind, and disabled, and the addition of chemical dependency services to the demonstration. A January 1, 1995 start date is planned. |
| TENNESSEE | Expand access to uninsured through expansion of Medicaid. TENNCARE establishes a system of managed care similar to the current plan for State employees. There are no income or asset limits, but Tennessee will cap the program at 1.5 million enrollees. |
| HAWAII | Hawaii's HealthQuest provides seamless coverage of those on public programs, as well as the current uninsured. Through Medicaid expansions (300% FPL, elimination of categorical and asset tests) and a managed care delivery system, the State expects to expand access and control costs. |
| KENTUCKY | The Kentucky Health Care Reform Plan calls for universal access through: Medicaid eligibility to 100 percent FPL, elimination of certain categorical requirements, through managed care, primary care case management. |
| RHODE ISLAND | Rhode Island was given Medicaid waivers allowing for the extension of Medicaid eligibility to pregnant women and children up to 250% FPL and enrollment of all recipients in a capitated managed care delivery system. |
| FLORIDA | Florida's Agency for Health Care Administration (AHCA) has been granted section 1115 waivers to permit Federal financial participation for the Florida Health Security Program (FHS). FHS will utilize a managed competition model and will provide health insurance for 1.1 million uninsured Floridians with incomes at or below 250% of the FPL. Health plans will be offered by Accountable Health Partnerships (AHPs) and sold by Community Health Purchasing Alliances (CHPAs). |

# SECTION 1115 WAIVER ACTIVITY
# STATEWIDE HEALTH REFORM

| STATE | INITIATIVE |
|---|---|
| | **RECEIVED** |
| OHIO | Ohio has submitted an 1115 waiver application which would allow them to implement OhioCare. Under OhioCare, Medicaid eligibility would be expanded to include the uninsured population with incomes up to 100% of FPL. Ohio expects to enroll approximately 500,000 additional recipients. The State will enroll all new eligibles and current Medicaid recipients into managed care programs throughout the State. |
| SOUTH CAROLINA | South Carolina has submitted an 1115 waiver application which would allow them to implement the South Carolina Palmetto Health Initiative. The program will extend Medicaid eligibility to include residents with incomes up to 100 % FPL. South Carolina expects to cover approximately 280,000 additional recipients. All Medicaid recipients will be enrolled in managed care programs. |
| MASSACHUSETTS | Massachusetts has submitted an 1115 waiver application, entitled MassHealth. The demonstration has nine component strategies which are intended to cover the 524,000 uninsured in Massachusetts. The proposed strategies address needs specific to the mixture of social economic groups that are uninsured in Massachusetts, which include the employed, the short-term unemployed, and the long-term employed. The proposal includes direct strategies that provide public health care and indirect strategies that seek to promote market forces and responsible decision making by providing financial incentives in the form of tax credits to employers, tax deferred medical saving accounts for insured individuals, and subsidies in the form of insurance vouchers for employees with incomes up to 200% of the FPL. |
| NEW HAMPSHIRE | New Hampshire submitted a proposal entitled, "The Granite State Partnership for Access and Affordability in Health Care". The State proposes the expansion of Medicaid eligibility to adults with incomes below the AFDC cash standard, along with the introduction of a public insurance product for low-income workers. Also, the State proposes to implement a number of pilot initiatives to help to ultimately redesign the State's health care delivery system. |
| MISSOURI | Missouri's Department of Social Services has submitted an 1115 waiver proposal that will provide managed care medical services to the State's Medicaid population and to the uninsured. |

| STATE | INITIATIVE |
|---|---|
| | RECEIVED |
| MINNESOTA | Minnesota has submitted a waiver proposal which has three major components: (1) integration of low-income and uninsured programs; (2) expansion of the managed care delivery system; and (3) linkage of Medicare to overall State health care reform efforts. The proposal presented a two phase implementation plan for each of the components. Phase 1 will be implemented in 1995, while Phase 2 is the conceptual framework for the development of elements of reforms to be implemented in subsequent years. |
| DELAWARE | Delaware has submitted a 1115 waiver proposal which will increase access to health care services through managed care plans by expanding Medicaid coverage to the State's uninsured adult population up to 100 percent of the Federal poverty level. This statewide proposal will include a comprehensive benefit package emphasizing primary and preventive care. |
| ILLINOIS | Illinois has submitted an section 1115 waiver to develop MediPlan Plus. Under this program the State will develop a series of networks either local or statewide, and tailor the health care systems to the needs of local urban neighborhoods or large rural areas. This program will allow the State to work with established or new HMO's, provider-based managed care community networks, FQHCs and RHCs to develop health networks. |

11/8 Waiver mtg.

Ellwood: welfare waivers and Medicaid waivers are different

**welfare** (Mary Jo Bane)

A. 21 waivers in 20 states have been approved (most waivers not whole state waivers)
23 are pending
6-8 more likely in coming months

B. four goals of waiver process
1. helping to get Work and Resp. bill passed
a. don't give out too many waivers -- bill will be moot
b. don't alienate governors
c. don't alienate other constituencies
d. these three things are in tension

2. help states get a head start in achieving our goals for welfare reform

3. learn things from states' experiences that will help us implement fed'l reform (e.g. how to run a work program)

4. be committed to our principles

5. goal of cost neutrality is assumed

C. applying principles to waivers
1. process waivers slowly -- balance B.1(a), (b) & (c)
2. work w/states to make state waivers look as much like Clinton plan as possible
3. At this point, too late to change the rules. Question is how explicit we want to be w/states about our criteria. MJB's preference is to treat previous waiver decisions like case law rather than to write out principles.

D. (Ellwood): standards -- along w/C above, look at top of page two of outline distrib. at mtg. These are things that we say no to.

E. Kathi: we should also think about making the case for why we need fed'l welfare reform

**Medicaid** (Bruce Vladeck)

A. we do not have a policy in this area

B. there are 7 or 8 waivers in pipeline and ? already in place
1. currently, about 500,000 more people have health coverage than would had the waivers not been granted
2. currently, 10% of M expenditures are under waivers. If pipeline requests are approved, another 12-15% in M outlays

C. standards (to extent that they exist)
1. do no harm
a. to date, we have not permitted the benefits being received currently to be reduced for the people now receiving them. However, note that states can drop optional benefits they have opted into (for the most part) as long as proper procedures are followed.

2. protecting quality of service
a. Congress is sensitive to this issue. Waxman expected to introduce bill next session.
b. most states want waiver of current rule than forbids Medicaid-recipient only plans
c. we are demanding enough data from states to make independent judgment of whether quality is suffering. Some states are resistant.

3. budget neutrality
a. we'll look at, but not necessarily accept, alternative methodologies of calculation
b. state M expenditures are volatile
c. we don't yet have systematic method of measuring this.

D. issues:
1. evaluate waivers on case-by-case basis or come up w/principles
2. how much state flex. do we want?
a. M program already gives states lots of flex.
b. in best proposals, states have ways to recycle fed'l $ into expanding coverage
c. more questionable proposals -- states just want out of one requirement or another so dress it up as waiver request
3. at what point does a national policy begin to exist based on waivers that are out there (exceptions consume the rule)

E. Ellwood: unlike in W, in M there is danger of states trying to trick feds into giving them big block grant/locking in big baseline just to get more money for selves. On other hand, for health care reform reasons, we may want to reward states that are, for example, expanding coverage, by being generous w/them

**food stamps** (Ellen Haas)

A. 8 waivers approved, 8 pending (although only 7 have been granted)

B. Ag has given out 7 broad criteria for waivers (get from them)

C. political issue: food stamps are safety net

**timing**

W/large # of new governors, we expect waiver applications to slow down for a couple of months. However, the tide will rise again -- definitely by fall of 1996 if not sooner.

**legal issues**

A. Michael Wald: right now, 6 waiver lawsuits out there (5 W, 1 M)

1. none of current lawsuits likely to stop waiver practice, altho N.J. case likely to go back to admin procedure for more findings on family cap
2. as waivers are granted, likelihood of success on claim that programs are no longer national increases. But we are several years away from courts actually putting a stop to things.

B. Bane & Ellwood: getting harder to make case that waivers are demonstration projects. This is a problem b/c only authority for demonstrations. Court could come in and knock us way back.

**next steps**

A. Kathi:

1. define budget neutrality
2. get principles down

B. Mary Jo: use hard waiver ques. (Calif. and Ind.) as way of coming up w/problems. But she rebuffs Kathi's offer of working together -- says let us work in HHS and we'll get back to you.

C. hold separate mtgs on W and M waivers because they are different issues.

1. Kathi: but let's come together at some point b/c authority for both waivers is in sec. 1115.

D. Sawhill: address what we do if state is not meeting budget neutrality stds.

E. Vladeck: we need to talk about numbers