

# WITHDRAWAL SHEET

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**Date:** 5/8/04

DOCUMENT NO. & TYPE	SUBJECT/TITLE	DATE	RESTRICTION
1. Memo	To Kevin Thurm from Michael Wald re: Beno v. Shalala, 2p	7/22/94	P5
2. Memo	To Carol Rasco from Robert S. Litt and Dawn Johnsen re: Florida Health Security/Anti-Kickback Statute, 3p	8/5/94	P5

### RESTRICTIONS

**P1** National security classified information [(a)(1) of the PRA].

**P2** Relating to appointment to Federal office [(a)(2) of the PRA].

**P3** Release would violate a Federal statute [(a)(3) of the PRA].

**P4** Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA].

**P5** Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA].

**P6** Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA].

**PRM** Personal records misfile defined in accordance with 44 USC 2201 (3).

**B1** National security classified information [(b) (1) of the FOIA].

**B2** Release could disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA].

**B3** Release would violate a Federal statute [(b)(3) of the FOIA].

**B4** Release would disclose trade secrets or confidential commercial financial information [(b)(4) of the FOIA].

**B6** Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA].

**B7** Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA].

**B8** Release would disclose information concerning the regulation of financial institutions [(b)(9) of the FOIA].

**B9** Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA].

OPTIONAL FORM 99 (7-91)

## FAX TRANSMITTAL

# of pages 2

To: <i>Carol Raseo</i>	From: <i>Diana Fortuna</i>
Dept./Agency	Phone #
Fax #	Fax # <i>2 pages - FYI</i>

THE WHITE  
WASHIN

NGN 7540-01-317-7368

5099-101

GENERAL SERVICES ADMINISTRATION

MEMORANDUM TO: The First Lady

FROM: Diana Fortuna *[Signature]*  
Domestic Policy Council *file*

SUBJECT: Status of Illinois Medicaid Waiver in  
Preparation for Chicago trip

DATE: February 14, 1995

The purpose of this memo is to brief you on the status of Illinois's request for a Medicaid waiver in advance of your trip to Chicago.

The state submitted a waiver request to HHS and the Health Care Financing Administration on September 15, 1994. The 120th day was January 13. The plan, entitled "Medi-Plan Plus," would require most Medicaid recipients to join managed care plans. Negotiations on the waiver are nearing conclusion, and approval should be announced in the next two to three weeks. Secretary Shalala called the Governor last Friday to reassure him that the process is going very well, although she did not indicate that approval was a certainty.

Governor Edgar has been very anxious to secure approval, in large part because his budget assumes savings from the implementation of managed care. Also, the state's bond rating was recently downgraded, and the rating agency pointed to problems in the Medicaid program as part of the rationale.

Illinois has a very troubled Medicaid program. In the past, it has tried to cope with cash shortfalls by simply not paying bills for months at a time. There is also a long history of quality problems in the program. As a result, many are skeptical that the state can successfully mount such an ambitious managed care program.

Sister Sheila Lyne, head of the city of Chicago's health department, has written HHS to express her concern that the waiver could hurt quality of and access to care because of the state's poor track record. She is also concerned that clinics run by the city could be hurt in the changeover. HHS officials are meeting with her next week. The Illinois Primary Care Association, which represents federally qualified health centers, strongly opposes the waiver because of concerns about whether FQHCs can compete in managed care. (In most states where we have approved Medicaid waivers, the FQHC association has opposed it on these grounds, and the National Association of Community Health Centers is suing us on this issue.) They are also concerned that

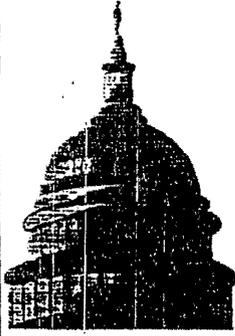
the state will direct most of the business to the Chicago HMO, which has strong Republican ties.

Illinois' plan differs from other major Medicaid waivers we have approved in that the expansion of Medicaid coverage to new populations is very small (only a few thousand people). However, HCFA was ultimately persuaded that the State's fiscal problems are such that a coverage expansion was not affordable. HCFA also argued that the state should have applied for a 1915(b) waiver rather than an 1115 waiver, since enrollment in managed care can be accomplished through the former, and the only advantage of an 1115 waiver is to avoid the tougher quality standards in an 1915(b) waiver. The state ultimately compromised and agreed to meet the more stringent 1915(b) quality standards for clients outside of Cook County.

At the beginning of the process there was significant tension between the State and HCFA over the ambitious timeline the State wanted to follow. When the state submitted its proposal, it was about to issue a request for proposals to identify likely providers in time for an April start-up, but HCFA instructed the state to wait for Federal approval before doing so. This exchange was covered extensively by the press at the time. The initial stories were critical of the Federal government's delay of the program, but the coverage shifted within a week or two and then criticized Governor Edgar for trying to move too fast. There were editorials favorable to HCFA in the Chicago Tribune and in the Sun-Times. More recently, the Governor has again criticized HCFA for delays, but the coverage has again suggested that Federal caution is prudent.

cc: Carol Rasco

*file waiver  
(KY Medicaid)*



**COMMONWEALTH OF KENTUCKY**

**OFFICE OF THE GOVERNOR**

**FAX TRANSMITTAL**

**BRERETON C. JONES**

**GOVERNOR**

DATE: 10/3/95

FAX SENT TO: CAROL RATHSCO

PHONE NUMBER: \_\_\_\_\_

FAX NUMBER: 202 456-2878

SUBJECT: You can imagine our surprise when one of our Medicaid staffers received this fax - I am also sending it to Diana Fortuna. Thanks for your help - we would like to discuss this memo.

FAX SENT BY: FRANKLIN JELSONA (502) 564-2611

TOTAL PAGES (INCLUDING COVER SHEET): 2

**OFFICE OF THE GOVERNOR**  
**THE CAPITOL**  
**700 CAPITAL AVENUE**  
**FRANKFORT KY 40601**  
**FAX (502) 564-2517**

**IF YOU DO NOT RECEIVE ALL PAGES OR HAVE QUESTIONS CONCERNING THIS FAX, PLEASE CALL (502) 564-2611, EXT. 351.**

CHR Secretary's Office ID:5025643866

OCT 02 '95 14:37 No.002 P.02

OPTIONAL FORM NO. 10 (7-93)

FAX TRANSMITTAL

# OF PAGES 1

To: Larry McCarthy	FROM: Cathy Kasriel
Dist: KY Div. of MCO Services	Phone: 404-331-5028
Fax: 502-564-3232	Fax: 404-331-0068
FORM NO. 10-81-217-7280	5010-111 GOVERNOR'S SERVICES ADMINISTRATION

From: NBOULMET--CO2  
10/02/95 11:51:02  
To: GQ35 --HCFAATL

From: Maria Boulmetis  
Subject: Kentucky -Forwarded

Kathy FYI

\*\*\* Forwarding note from BVLADACK--AWPOFF1 08/29/95 17:28 \*\*\*  
 To: LZAWISTO--CO2  
 BFRIED --CO3  
 KRING --DC1  
 SRICHARD--CO2  
 KBUTO --DC1  
 MHOLLAND--DC1

From: Bruce Vladeck  
Subject: Kentucky

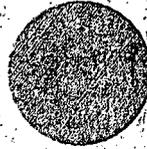
After a meeting at the White House earlier this afternoon, the Secretary called Governor Jones and told him that she was prepared to approve his single-consortium plan, provided they could satisfy us that the choice of providers within the plan was substantive and real, in addition to requiring real and substantive access and quality protections. What this means is that we have the opportunity to ask the State to really operationalize bene choice of provider, both at initial enrollment and periodically thereafter, and we are free to be as demanding as we wish to be in terms of the kinds of information the benes must have, the frequency of choice, education about choices, etc. In addition, the Governor has agreed that all public discussion of this plan will talk about it in terms of multiple provider choice under a single network umbrella.

The Secretary told the governor that our staff would be in touch with his Monday morning. She also expressed a desire to come to closure next week. Lu or a member of her staff should call the contact person in Kentucky on Monday.

Let me know if anyone has any questions or needs any further clarification.

P.S. The Governor also agreed to a T&C that any savings from managed care under the waiver could only be used for coverage expansions.

THE WHITE HOUSE  
OFFICE OF DOMESTIC POLICY



CAROL H. RASCO  
Assistant to the President for Domestic Policy

To: \_\_\_\_\_ (202 - ASAP)

Draft response for POTUS  
and forward to CHR by: \_\_\_\_\_

Draft response for CHR by: \_\_\_\_\_

Please reply directly to the writer  
(copy to CHR) by: \_\_\_\_\_

Please advise by: \_\_\_\_\_

Let's discuss: \_\_\_\_\_

For your information: \_\_\_\_\_

Reply using form code: \_\_\_\_\_

File: \_\_\_\_\_

Send copy to (original to CHR): \_\_\_\_\_

Schedule?  Accept  Pending  Regret

MAN 2/13/95

Designee to attend: \_\_\_\_\_

Remarks: cc: Foley Fortuna Emerson

ORIGINAL CHR - Red dot

File  
File MN XIX  
Waiver

THE WHITE HOUSE  
WASHINGTON

September 7, 1995

MEMORANDUM FOR HAROLD ICKES

FROM: CAROL H. RASCO *CHR*  
DIANA FORTUNA

Subject: Medicaid Waivers and Worker Protections

**I. Jennifer's Memo to Harold**

As to paragraph three where Sec. Reich's argument is stated about a changed NGA: that won't hold water with the governors. NGA works in a way such that the governors who were the lead negotiators on this agreement in 1993 are still in NGA, are now the leadership from both political parties. I can't stress enough how important this factor is.

**II. HHS/LABOR Memo**

In general: Option two is the option that most clearly respects the agreements negotiated with the governors at the direction of the President. Option three opens the door to all kinds of groups that will want to be included in the mandate to be shown as included in the waiver development process which will lead to excessive (as perceived by the states) regulation of the waiver process which in itself is supposed to be a relief from regulation.

In the introduction and background sections, the memo does not always present both sides of the argument. On page 2 of the memo, the list of reasons why hospitals serving poor people are not attractive to HMOs does not mention the fact that these hospitals do have some advantages that often make them essential partners for HMOs coming in to seek Medicaid business. This is because they are often the only hospitals in these neighborhoods and the populations are accustomed to getting health care there.

Last paragraph on page 2, 5th line: It is not clear what the phrase "and other indigent persons" means. The uninsured are not being enrolled in managed care.

First bullet on page 3: replace "are likely to" with "will"; Medicaid will not cover all the medically indigent.

On page 4, add to the "pros" under Option 1: HCFA can and already does to some extent address the concerns of essential community provider hospitals in its waiver review process, through its emphasis on assuring access and quality.

Also, the cons should point out that the Governors would object to the argument that they would not consider these issues on their own (although the unions would respond that many Republican Governors really don't care about their workers).

THE WHITE HOUSE  
WASHINGTON

September 7, 1995

SEP - 7 1995

MEMORANDUM FOR THE PRESIDENT

CC: LEON PANETTA  
CAROL RASCO

FROM: Harold Ickes (HI)

SUBJECT: Medicaid waivers and worker protections

On 11 August 1995, you met with Gerald McEntee, International President of American Federation of State, County, and Municipal Employees, AFL-CIO ("AFSCME") on a number of issues including one that he is very concerned about -- the adverse affect on employees of medicaid waivers being granted by the Administration. The short of his brief was that medicaid waivers should not be approved by the Administration absent their containing adequate protection for current employees.

Both Mr. McEntee and John Sweeney, International President of Service Employees International Union, AFL-CIO ("SEIU"), have met several times jointly with Secretary Shalala, Secretary Reich, and others, as well as myself, to discuss this issue. The membership of both unions, which are staunch supporters of this Administration, have a large number of healthcare workers. At my request, HHS and Labor have discussed a number of alternative solutions to this situation and have prepared a draft memorandum with 4 alternatives, the first of one is do nothing more than is being done now. Attached is a self-explanatory 16 August 1995 memorandum to me from Jennifer O'Connor regarding "medicaid waivers and worker protections" and a 7 page draft memorandum discussing the problem and describing 4 options.

This has long been a festering problem with both of the unions and as things stand is not likely to go away.

Let's discuss at your convenience.

August 16, 1995

MEMORANDUM FOR HAROLD ICKES

FROM: JENNIFER O'CONNOR   
SUBJECT: MEDICAID WAIVERS AND WORKER PROTECTIONS

Attached is a memorandum from the Department of Health and Human Services, produced with input from the Department of Labor, which addresses options for changing the current Medicaid waiver approval process so that worker protection issues are taken into account. It describes four options for addressing the effects of Medicaid waivers on health care employees: 1) do nothing; 2) strongly encourage states during the waiver process to implement budget neutral transitional assistance; 3) require states to show that employees are included in the waiver planning process and to show how the reforms will affect the hospital workforce, and/or to show how they will address those effects; 4) develop a transition assistance program by either requiring states to assist employees or by furnishing federal funds to assist employees.

The memorandum discusses the pros and cons of each option. Secretary Shalala prefers option 2 and the pros and cons to that section explain her preference.

Secretary Reich prefers option 3, which he thinks should be even stronger than currently worded in the attached memorandum. He recommends requiring states to: 1) show employees were included in the waiver planning process, 2) show how reforms will affect employees and 3) show how they will address those effects. He comments that option 4 costs money, which AFSCME has not asked for, and option 2 will not satisfy AFSCME and will be perceived to be a decision to do nothing. He also thinks the argument that option 3 represents a breaking of the President's 1993 commitment to the National Governor's Association (NGA) is flawed because the 1993 NGA was an entirely different group of governors, most of whom were Democrats; the Secretary comments that the political landscape is so changed that we can legitimately change our policy.

## Introduction

Ongoing efforts by private sector payers to control health care costs have led to large-scale dislocations in the employment of health care workers. These painful effects in the labor market may be exacerbated by current and potential federal government actions, including Medicaid waivers granted to states implementing aggressive managed care programs and probable congressional budget cuts to the Medicare and Medicaid programs. In combination, these private and public sector actions may dislocate hundreds of thousands of health care workers by the end of the decade, especially in hospitals.

Traditionally, when the federal government's actions have been expected to cause dislocations even of relatively small groups of workers, labor protection provisions have been implemented to assist dislocated workers. In at least 27 different federal statutes, various types of assistance intended to alleviate adverse employment effects caused by direct federal action or by other causes have been enacted. Industries in which workers have received such protections have included railroads, airlines, public transit, mining, communications, and mental health. Recently, the President proposed similar steps for 26,000-36,000 workers affected by the terms of the Forest Summit. In fact, notable by its absence is the broad health care sector which has one of every twelve jobs in the United States.

Indeed, the Health Security Act (HSA) proposed significant labor protections to redress the effects on workers that would have resulted had the HSA been enacted. Yet, with the failure of Congress to enact the HSA, the federal government has not provided meaningful protections for health care workers who will lose their jobs in the coming months and years.

## Issues

During negotiations with states seeking Medicaid demonstration waivers, are there any steps the Department of Health and Human Services should take to address these trends? Should statutory authority be sought for health workforce protections?

## Background

Reducing cost growth is generally one of the major goals of states pursuing Medicaid demonstration waivers<sup>1</sup>. A principle technique is to require managed care enrollment (e.g., HMOs) by current Medicaid beneficiaries and others brought into the program through expanded Medicaid eligibility (typically low-income and indigent persons). Private HMOs that contract with the state to enroll and manage care for these beneficiaries lower their costs by reducing their use of high-cost health services, and by substituting

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1. States use two types of waivers to enroll Medicaid beneficiaries in mandatory managed care programs. Under Section 1115 of the Social Security Act, the Department has broad authority to permit States to implement demonstration projects to test variations to Medicaid policies, including enrolling people into managed care as long as the change is "consistent with the purposes of the Social Security Act." Second, under Section 1915(b), States may require Medicaid recipients to enroll in mandatory managed care programs if the programs meet statutorily established criteria for quality, access and cost-containment. To date, although most public attention has been focussed on 1115 waivers, most of the expansion of Medicaid managed care has been achieved through 1915(b) waivers. The Administration has supported automatic approval of 1915(b) waivers.

preventive and primary care services. And they steer these public enrollees to contracting providers the HMOs believe will help achieve these reductions. This pattern mirrors what private employers hire HMOs to accomplish. Hospital inpatient and outpatient costs account for about 35-40% of Medicaid costs, making them an obvious target for HMO cost-cutting.

Hospitals compete for HMO contracts substantially on the basis of costs. To position themselves to compete, hospitals are seeking increased productivity and efficiency by, among other steps, cutting labor costs (estimated at 60% of hospital costs): they do this by removing and consolidating staffing layers; reducing numbers of semi-skilled and unskilled workers and substituting a smaller number of skilled persons who can be cross-trained for several jobs; automating; and switching to more part-time and as-needed staffing arrangements. The restructuring of the health care delivery system may result in the elimination, nationally, of 500,000 hospital jobs (many in urban areas) by the end of the decade; some congressional proposals for cutting Medicaid and Medicare could accelerate this dislocation. An estimated 80 percent of the most vulnerable jobs are held by women, and 20 percent are held by African-Americans.

Public hospitals, and nonprofit hospitals which serve similar roles in their communities, are in an especially poor position to secure managed care contracts. In general, private HMOs do not find these publicly-oriented hospitals to be highly desirable business partners because:

- their physical plants are often outdated, deteriorating, and located in areas that are undesirable to and at some distance from the HMO's private sector enrollees;
- the community continues to expect the hospitals to perform other public missions (e.g., care for violent trauma, the homeless, the mentally ill/substance abusers, illegal aliens, and people remaining uninsured) for which they are generally underpaid (hence, requiring cross subsidies);
- their historic mission as advocates for the poor may make them undependable agents for reducing costs by reducing utilization of inpatient, diagnostic and specialty clinic services;
- their resources are often insufficient to finance changes necessary to enhance efficiency, overcome physical deterioration, and update technological capacity; and
- any plan to change these institutions is likely to involve local government and the public, and, therefore, is apt to be contentious and take a long time for approval.

Representatives of the American Federation of State, County and Municipal Employees (AFSME) and the Service Employees' International Union (SEIU) are raising deep concerns to top officials in DOL, HHS and the White House about the effect of Medicaid demonstrations upon their members. In particular, they are concerned that rapid enrollment of Medicaid recipients (and other indigent persons) in mandatory managed care programs, and the redirection of public funds away from hospitals and into capitation payments to HMOs, will undermine the financial viability of certain "safety net" inner city providers (particularly public, although including many non-profit hospitals) which rely heavily upon Medicaid reimbursement and other public funding.

Since the beginning of the Administration, in response to governors' longstanding criticisms of the slow pace and inflexibility of HHS's waiver review process, HHS has implemented a streamlined review process and has committed itself to according the states broad design flexibility, policies reinforced publicly on numerous occasions by the President. (In 1994, guidelines reflecting these policies -- and expanded state public notice requirements -- were published in the Federal Register.) Governors of both parties are likely to react negatively to any Administration change in policy which would reduce state flexibility and, in their view, further micro-manage state affairs, by requiring that special consideration be given in demonstrations to these "essential community providers" or, more directly, to the employees of those institutions.

### Discussion

Public and public service-oriented non-profit hospitals lie at the intersection of two important concerns: (1) the jobs of their employees and (2) the access of low-income people to needed health services. Historically, these institutions have provided inpatient and clinic services in areas which other institutions and individual providers have chosen to avoid, have often provided services which other facilities have considered insufficiently profitable, and have provided costly services to people who could not pay. Indeed, other facilities often transfer patients to these public and nonprofit hospitals.

Furthermore, these institutions will continue to play an important role even as the health system is reshaped by states' managed care demonstration programs:

- o Substantial numbers of poor persons are likely to remain ineligible for even expanded state Medicaid programs; some clients will cycle in and out of eligibility; some needed services will not be covered by the managed care plans; and some HMOs' providers will not be within acceptable access. The result will be a continuing indigent health care burden. But with reduced loads of paying patients and probable caps on or absolute reductions in disproportionate share (DSH) payments, the resources available to public hospitals will be even more limited than in the current climate.
- o The number of care-managing physicians and primary care providers may prove inadequate to successfully implement state managed care programs. During the time period in which primary care capacity is developed, public hospitals and their outpatient clinics offer important "safety valve" access.
- o The success of states' managed care efforts is not assured. If, for example, public revenues do not grow enough to sustain a capitation rate sufficiently high to attract private HMO and provider participation, and the program is pared back in eligibility or covered benefits, a public sector fail-safe mechanism will be important.

These considerations suggest that the federal government may have a continuing strong interest in how, in the context of their Medicaid demonstrations, states propose to take account of the special needs and contributions of institutions that have been serving large numbers of public beneficiaries.

Preserving these institutions may also assist in the protection and transition of many of their workers who would be at particular risk of harm from changes in the health care market. In the long run, however, while workforce reductions can be ameliorated or delayed, jobs will certainly be lost in hospitals, and possibly even more broadly across the health care sector.

In considering alternatives for addressing the effects of Medicaid waivers on "safety net" providers and/or their employees, the federal government confronts a broad spectrum of options. At one end, HHS could continue permitting States broad flexibility which allow them to choose whether to stand aside from shake-outs in the hospital sector caused by the Medicaid demonstration, and take no special steps with respect to these hospital providers or their workers. At the other end, HHS could require states to address directly the workforce effects of their waivers by developing and funding retraining programs for displaced workers, and/or statutory authority could be sought for any of a range of measures related to income maintenance, job training, or employer-based protections. Between these poles lie a range of Federal, State and employer measures to address the transitional needs of public service institutions and their health care workers.

Option 1: Leave unchanged the current breadth of state Medicaid demonstration flexibility and current HHS waiver review practice of leaving health service system redesign (and treatment of public-oriented hospitals) to state initiative within the broad requirement of "adequate" access.

- Pros:
- o Consistent with commitment to maximum state flexibility.
  - o Keeps the federal government out of state provider payment negotiations, and relationships between state and local governments.
  - o Puts maximum pressure on the public hospitals to enter a frank reappraisal of their needs to reform, and enter an open dialogue with the state on this matter.
- Cons:
- o Can result in precipitous and wrenching fiscal adjustments to public hospitals as their funds and their traditional clients are abruptly rechanneled to managed care providers.
  - o Provides no relief to at-risk public hospital workers.
  - o May mean the federal government will be drawn into participating publicly to bail out safety net public hospitals after the waiver has begun (e.g., recent dispute over Tennessee's payments to the public hospital in Memphis).

Option 2: Call each waiver-requesting state's attention to the special circumstances of public hospitals and public beneficiary-serving non-profit hospitals, and strongly encourage states to implement some form of budget neutral transitional assistance for safety net providers.

In pre-submission consultations with states, a stage at which states are customarily seeking reactions and alternatives, HHS could signal to states its interest in safety net providers during waiver negotiations, with the goal of securing protections. Examples could include extra state payments (e.g., from special funding pools) for safety net hospitals during a transitional period; assistance to safety net providers in becoming HMO contract providers; where states assign beneficiaries who fail to select a managed care plan, inclusion of safety net providers among assignment entities; and enhanced payments for safety net providers that serve members of managed care plans.

- Pros:
- o Eases transition pressure on beneficiary access in under-served areas.
  - o May indirectly assist the workers of these institutions.
  - o Provides an opportunity for public hospitals to arrange an orderly transformation of missions and performance.
  - o Emphasizes that federal interest is in delivery system integrity, beneficiary access and orderly change.
  - o Consistent with HCFA's recent waiver-related negotiations with states (e.g., Massachusetts, Illinois, Tennessee) over public hospitals.
  - o Consistent with Administration's position in Health Security Act.
- Cons:
- o May be seen and characterized as a breach of HHS's commitment to greater state flexibility in Medicaid demonstrations.
  - o Eases pressures on public hospitals to move vigorously in reforming their missions and performance; delays can result in continued inefficiencies and unnecessary costs.
  - o Could meet with Congressional resistance.
  - o Will not provide explicit response to concerns of at-risk workers.

Option 3: As part of the waiver negotiation process, HHS could require that states show that hospital employees were included in demonstration planning discussions, describe how the reforms can be expected to affect the hospital workforce, and/or discuss how states intend to take account of those affects.

Examples of steps that States might take could include inclusion of employees on waiver planning and advisory councils; analysis in the proposal of expected workforce impact data; explicit inclusion of health system worker complaints and questions in "hotline" analyses; and inclusion of workers on post-implementation quality review and feedback-and-correction work groups.

- Pros:
- o Responds specifically to at-risk workers' interests.
  - o Could require no additional federal costs by defining any related costs as falling within waiver budget neutrality requirements.
  - o Would be consistent with the Secretary's March letter to the Governor of New York reflecting concerns about public providers and their workforces.
  - o Would provide workers and their representatives with a seat at the table from which to seek substantive waiver protections.
  - o Would not be an unfunded mandate.

- Cons:
- o Will be seen by states as:
    - a serious breach of HHS's commitment to greater state flexibility in waiver reform design;
    - raising issues outside the scope of the Medicaid program.
    - requiring their intervention in labor-management relationships between local governments and workers.
  - o Will be interpreted as federal micro-management.
  - o Could open the door to other entities (e.g., medical schools, specialized hospitals, specialist physicians) lobbying for protections.
  - o Would likely meet Congressional resistance.

Option 4: Develop a program of assistance for these dislocated hospital workers.

4A: Explicitly require that states provide for assistance. For example, states might impose requirements on the hospitals including advance notice of layoff, preferential call-back, and retention of seniority and fringe benefits. Alternatively, states might be required to directly finance worker assistance programs.

- Pros:
- o Responds directly to workers' needs under broad-scale reforms.
  - o Could keep retraining costs outside of the waiver budget neutrality limits (thus not diminishing funds available for beneficiary services).

- Cons:
- o Same as Option 3; plus, without federal financing, will be characterized as an unfunded federal mandate.

**4B:** Directly furnish federal assistance to dislocated hospital workers. Steps which might be taken by the Federal Government could include obtaining statutory authority for special unemployment insurance compensation, worker training and retraining assistance, job search and income guarantees.

**Pros:** o Responds directly to unions' proposals.

o Can be undertaken in combination with other options.

o With federal financing, avoids "unfunded mandates" objections.

**Cons:** o Same as Option 3, plus would necessitate either finding offsetting budgetary savings or justifying added costs.

o Could be difficult to restrict to workers from hospitals serving large numbers of public beneficiaries.

Julie - Per Emails  
See me today -

EXECUTIVE OFFICE OF THE PRESIDENT

07-Sep-1995 02:40pm

**TO:** Carol H. Rasco

**FROM:** Diana M. Fortuna  
Domestic Policy Council

**SUBJECT:** Comments on labor memo

Carol: I certainly agree with your comments, and would add the following if you think it's appropriate. I have attached my comments to your memo to use or delete as you think appropriate.

In the introduction and background sections, the memo does not always present both sides of the argument. On page 2 of the memo, the list of reasons why hospitals serving poor people are not attractive to HMOs does not mention the fact that these hospitals do have some advantages that often make them essential partners for HMOs coming in to seek Medicaid business. This is because they are often the only hospitals in these neighborhoods and the populations are accustomed to getting health care there.

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On page 4, add to the "pros" under Option 1: HCFA can and already does to some extent address the concerns of essential community provider hospitals in its waiver review process, through its emphasis on assuring access and quality.

Also, the cons should point out that the Governors would object to the argument that they would not consider these issues on their own (although the unions would respond that many Republican Governors really don't care about their workers).

Jennifer:

to you

I. As to paragraph three in ~~your~~ <sup>Jennifer's</sup> memo, where ~~you~~ <sup>she</sup> outlines Sec. Reich's argument about a changed NGA... that ~~won't~~ <sup>won't</sup> hold water with the governors. NGA works in a way such that the governors who were the lead negotiators on this agreement are still in NGA, are the leadership from both political parties. I can't stress enough how important this factor is.

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Option two is the option that most clearly respects the agreements negotiated with the governors at the direction of the President.

Insert heading HHS/Labor Memo

In general: (2 # above)

Then Diana's things

THE WHITE HOUSE  
WASHINGTON

SEP - 1 1995

August 31, 1995

MEMORANDUM FOR CAROL RASCO  
DIANA FORTUNA

FROM: JENNIFER O'CONNOR 

SUBJECT: MEDICAID WAIVERS AND WORKER PROTECTIONS

CC: HAROLD ICKES

The Departments of Health and Human Services and Labor worked together on proposals to address worker protection issues in the waiver process. Attached is the document they produced, along with a note from me summarizing Secretary Reich's additions which did not make it into the memorandum. Harold would appreciate any comments you have on the proposals. He would like to share your views, along with the attached, with the President.

August 16, 1995

MEMORANDUM FOR HAROLD ICKES

FROM: JENNIFER O'CONNOR *MO*

SUBJECT: MEDICAID WAIVERS AND WORKER PROTECTIONS

Attached is a memorandum from the Department of Health and Human Services, produced with input from the Department of Labor, which addresses options for changing the current Medicaid waiver approval process so that worker protection issues are taken into account. It describes four options for addressing the effects of Medicaid waivers on health care employees: 1) do nothing; 2) strongly encourage states during the waiver process to implement budget neutral transitional assistance; 3) require states to show that employees are included in the waiver planning process and to show how the reforms will affect the hospital workforce, and/or to show how they will address those effects; 4) develop a transition assistance program by either requiring states to assist employees or by furnishing federal funds to assist employees.

The memorandum discusses the pros and cons of each option. Secretary Shalala prefers option 2 and the pros and cons to that section explain her preference.

Secretary Reich prefers option 3, which he thinks should be even stronger than currently worded in the attached memorandum. He recommends requiring states to: 1) show employees were included in the waiver planning process, 2) show how reforms will affect employees and 3) show how they will address those effects. He comments that option 4 costs money, which AFSCME has not asked for; and option 2 will not satisfy AFSCME and will be perceived to be a decision to do nothing. He also thinks the argument that option 3 represents a breaking of the President's 1993 commitment to the National Governor's Association (NGA) is flawed because the 1993 NGA was an entirely different group of governors, most of whom were Democrats; the Secretary comments that the political landscape is so changed that we can legitimately change our policy.

## Introduction

Ongoing efforts by private sector payers to control health care costs have led to large-scale dislocations in the employment of health care workers. These painful effects in the labor market may be exacerbated by current and potential federal government actions, including Medicaid waivers granted to states implementing aggressive managed care programs and probable congressional budget cuts to the Medicare and Medicaid programs. In combination, these private and public sector actions may dislocate hundreds of thousands of health care workers by the end of the decade, especially in hospitals.

Traditionally, when the federal government's actions have been expected to cause dislocations even of relatively small groups of workers, labor protection provisions have been implemented to assist dislocated workers. In at least 27 different federal statutes, various types of assistance intended to alleviate adverse employment effects caused by direct federal action or by other causes have been enacted. Industries in which workers have received such protections have included railroads, airlines, public transit, mining, communications, and mental health. Recently, the President proposed similar steps for 26,000-36,000 workers affected by the terms of the Forest Summit. In fact, notable by its absence is the broad health care sector which has one of every twelve jobs in the United States.

Indeed, the Health Security Act (HSA) proposed significant labor protections to redress the effects on workers that would have resulted had the HSA been enacted. Yet, with the failure of Congress to enact the HSA, the federal government has not provided meaningful protections for health care workers who will lose their jobs in the coming months and years.

## Issues

During negotiations with states seeking Medicaid demonstration waivers, are there any steps the Department of Health and Human Services should take to address these trends? Should statutory authority be sought for health workforce protections?

## Background

Reducing cost growth is generally one of the major goals of states pursuing Medicaid demonstration waivers<sup>1</sup>. A principle technique is to require managed care enrollment (e.g., HMOs) by current Medicaid beneficiaries and others brought into the program through expanded Medicaid eligibility (typically low-income and indigent persons). Private HMOs that contract with the state to enroll and manage care for these beneficiaries lower their costs by reducing their use of high-cost health services, and by substituting

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1. States use two types of waivers to enroll Medicaid beneficiaries in mandatory managed care programs. Under Section 1115 of the Social Security Act, the Department has broad authority to permit States to implement demonstration projects to test variations to Medicaid policies, including enrolling people into managed care as long as the change is "consistent with the purposes of the Social Security Act." Second, under Section 1915(b), States may require Medicaid recipients to enroll in mandatory managed care programs if the programs meet statutorily established criteria for quality, access and cost-containment. To date, although most public attention has been focussed on 1115 waivers, most of the expansion of Medicaid managed care has been achieved through 1915(b) waivers. The Administration has supported automatic approval of 1915(b) waivers.

preventive and primary care services. And they steer these public enrollees to contracting providers the HMOs believe will help achieve these reductions. This pattern mirrors what private employers hire HMOs to accomplish. Hospital inpatient and outpatient costs account for about 35-40% of Medicaid costs, making them an obvious target for HMO cost-cutting.

Hospitals compete for HMO contracts substantially on the basis of costs. To position themselves to compete, hospitals are seeking increased productivity and efficiency by, among other steps, cutting labor costs (estimated at 60% of hospital costs): they do this by removing and consolidating staffing layers; reducing numbers of semi-skilled and unskilled workers and substituting a smaller number of skilled persons who can be cross-trained for several jobs; automating; and switching to more part-time and as-needed staffing arrangements. The restructuring of the health care delivery system may result in the elimination, nationally, of 500,000 hospital jobs (many in urban areas) by the end of the decade; some congressional proposals for cutting Medicaid and Medicare could accelerate this dislocation. An estimated 80 percent of the most vulnerable jobs are held by women, and 20 percent are held by African-Americans.

Public hospitals, and nonprofit hospitals which serve similar roles in their communities, are in an especially poor position to secure managed care contracts. In general, private HMOs do not find these publicly-oriented hospitals to be highly desirable business partners because:

- their physical plants are often outdated, deteriorating, and located in areas that are undesirable to and at some distance from the HMO's private sector enrollees;
- the community continues to expect the hospitals to perform other public missions (e.g., care for violent trauma, the homeless, the mentally ill/substance abusers, illegal aliens, and people remaining uninsured) for which they are generally underpaid (hence, requiring cross subsidies);
- their historic mission as advocates for the poor may make them undependable agents for reducing costs by reducing utilization of inpatient, diagnostic and specialty clinic services;
- their resources are often insufficient to finance changes necessary to enhance efficiency, overcome physical deterioration, and update technological capacity; and
- any plan to change these institutions is likely to involve local government and the public, and, therefore, is apt to be contentious and take a long time for approval.

Representatives of the American Federation of State, County and Municipal Employees (AFSME) and the Service Employees' International Union (SEIU) are raising deep concerns to top officials in DOL, HHS and the White House about the effect of Medicaid demonstrations upon their members. In particular, they are concerned that rapid enrollment of Medicaid recipients (and other indigent persons) in mandatory managed care programs, and the redirection of public funds away from hospitals and into capitation payments to HMOs, will undermine the financial viability of certain "safety net" inner city providers (particularly public, although including many non-profit hospitals) which rely heavily upon Medicaid reimbursement and other public funding.

Since the beginning of the Administration, in response to governors' longstanding criticisms of the slow pace and inflexibility of HHS's waiver review process, HHS has implemented a streamlined review process and has committed itself to according the states broad design flexibility, policies reinforced publicly on numerous occasions by the President. (In 1994, guidelines reflecting these policies -- and expanded state public notice requirements -- were published in the Federal Register.) Governors of both parties are likely to react negatively to any Administration change in policy which would reduce state flexibility and, in their view, further micro-manage state affairs, by requiring that special consideration be given in demonstrations to these "essential community providers" or, more directly, to the employees of those institutions.

### Discussion

Public and public service-oriented non-profit hospitals lie at the intersection of two important concerns: (1) the jobs of their employees and (2) the access of low-income people to needed health services. Historically, these institutions have provided inpatient and clinic services in areas which other institutions and individual providers have chosen to avoid, have often provided services which other facilities have considered insufficiently profitable, and have provided costly services to people who could not pay. Indeed, other facilities often transfer patients to these public and nonprofit hospitals.

Furthermore, these institutions will continue to play an important role even as the health system is reshaped by states' managed care demonstration programs:

- o Substantial numbers of poor persons are likely to remain ineligible for even expanded state Medicaid programs; some clients will cycle in and out of eligibility; some needed services will not be covered by the managed care plans; and some HMOs' providers will not be within acceptable access. The result will be a continuing indigent health care burden. But with reduced loads of paying patients and probable caps on or absolute reductions in disproportionate share (DSH) payments, the resources available to public hospitals will be even more limited than in the current climate.
- o The number of care-managing physicians and primary care providers may prove inadequate to successfully implement state managed care programs. During the time period in which primary care capacity is developed, public hospitals and their outpatient clinics offer important "safety valve" access.
- o The success of states' managed care efforts is not assured. If, for example, public revenues do not grow enough to sustain a capitation rate sufficiently high to attract private HMO and provider participation, and the program is pared back in eligibility or covered benefits, a public sector fail-safe mechanism will be important.

These considerations suggest that the federal government may have a continuing strong interest in how, in the context of their Medicaid demonstrations, states propose to take account of the special needs and contributions of institutions that have been serving large numbers of public beneficiaries.

Preserving these institutions may also assist in the protection and transition of many of their workers who would be at particular risk of harm from changes in the health care market. In the long run, however, while workforce reductions can be ameliorated or delayed, jobs will certainly be lost in hospitals, and possibly even more broadly across the health care sector.

In considering alternatives for addressing the effects of Medicaid waivers on "safety net" providers and/or their employees, the federal government confronts a broad spectrum of options. At one end, HHS could continue permitting States broad flexibility which allow them to choose whether to stand aside from shake-outs in the hospital sector caused by the Medicaid demonstration, and take no special steps with respect to these hospital providers or their workers. At the other end, HHS could require states to address directly the workforce effects of their waivers by developing and funding retraining programs for displaced workers, and/or statutory authority could be sought for any of a range of measures related to income maintenance, job training, or employer-based protections. Between these poles lie a range of Federal, State and employer measures to address the transitional needs of public service institutions and their health care workers.

Option 1: Leave unchanged the current breadth of state Medicaid demonstration flexibility and current HHS waiver review practice of leaving health service system redesign (and treatment of public-oriented hospitals) to state initiative within the broad requirement of "adequate" access.

- Pros:
- o Consistent with commitment to maximum state flexibility.
  - o Keeps the federal government out of state provider payment negotiations, and relationships between state and local governments.
  - o Puts maximum pressure on the public hospitals to enter a frank reappraisal of their needs to reform, and enter an open dialogue with the state on this matter.

- Cons:
- o Can result in precipitous and wrenching fiscal adjustments to public hospitals as their funds and their traditional clients are abruptly rechanneled to managed care providers.
  - o Provides no relief to at-risk public hospital workers.
  - o May mean the federal government will be drawn into participating publicly to bail out safety net public hospitals after the waiver has begun (e.g., recent dispute over Tennessee's payments to the public hospital in Memphis).

Option 2: Call each waiver-requesting state's attention to the special circumstances of public hospitals and public beneficiary-serving non-profit hospitals, and strongly encourage states to implement some form of budget neutral transitional assistance for safety net providers.

In pre-submission consultations with states, a stage at which states are customarily seeking reactions and alternatives, HHS could signal to states its interest in safety net providers during waiver negotiations, with the goal of securing protections. Examples could include extra state payments (e.g., from special funding pools) for safety net hospitals during a transitional period; assistance to safety net providers in becoming HMO contract providers; where states assign beneficiaries who fail to select a managed care plan, inclusion of safety net providers among assignment entities; and enhanced payments for safety net providers that serve members of managed care plans.

- Pros:
- o Eases transition pressure on beneficiary access in under-served areas.
  - o May indirectly assist the workers of these institutions.
  - o Provides an opportunity for public hospitals to arrange an orderly transformation of missions and performance.
  - o Emphasizes that federal interest is in delivery system integrity, beneficiary access and orderly change.
  - o Consistent with HCFA's recent waiver-related negotiations with states (e.g., Massachusetts, Illinois, Tennessee) over public hospitals.
  - o Consistent with Administration's position in Health Security Act.
- Cons:
- o May be seen and characterized as a breach of HHS's commitment to greater state flexibility in Medicaid demonstrations.
  - o Eases pressures on public hospitals to move vigorously in reforming their missions and performance; delays can result in continued inefficiencies and unnecessary costs.
  - o Could meet with Congressional resistance.
  - o Will not provide explicit response to concerns of at-risk workers.

Option 3: As part of the waiver negotiation process, HHS could require that states show that hospital employees were included in demonstration planning discussions, describe how the reforms can be expected to affect the hospital workforce, and/or discuss how states intend to take account of those affects.

Examples of steps that States might take could include inclusion of employees on waiver planning and advisory councils; analysis in the proposal of expected workforce impact data; explicit inclusion of health system worker complaints and questions in "hotline" analyses; and inclusion of workers on post-implementation quality review and feedback-and-correction work groups.

- Pros:
- o Responds specifically to at-risk workers' interests.
  - o Could require no additional federal costs by defining any related costs as falling within waiver budget neutrality requirements.
  - o Would be consistent with the Secretary's March letter to the Governor of New York reflecting concerns about public providers and their workforces.
  - o Would provide workers and their representatives with a seat at the table from which to seek substantive waiver protections.
  - o Would not be an unfunded mandate.

- Cons:
- o Will be seen by states as:
    - a serious breach of HHS's commitment to greater state flexibility in waiver reform design;
    - raising issues outside the scope of the Medicaid program.
    - requiring their intervention in labor-management relationships between local governments and workers.
  - o Will be interpreted as federal micro-management.
  - o Could open the door to other entities (e.g., medical schools, specialized hospitals, specialist physicians) lobbying for protections.
  - o Would likely meet Congressional resistance.

Option 4: Develop a program of assistance for these dislocated hospital workers.

4A: Explicitly require that states provide for assistance. For example, states might impose requirements on the hospitals including advance notice of layoff, preferential call-back, and retention of seniority and fringe benefits. Alternatively, states might be required to directly finance worker assistance programs.

- Pros:
- o Responds directly to workers' needs under broad-scale reforms.
  - o Could keep retraining costs outside of the waiver budget neutrality limits (thus not diminishing funds available for beneficiary services).
- Cons:
- o Same as Option 3; plus, without federal financing, will be characterized as an unfunded federal mandate.

**4B:** Directly furnish federal assistance to dislocated hospital workers. Steps which might be taken by the Federal Government could include obtaining statutory authority for special unemployment insurance compensation, worker training and retraining assistance, job search and income guarantees.

**Pros:** o Responds directly to unions' proposals.

o Can be undertaken in combination with other options.

o With federal financing, avoids "unfunded mandates" objections.

**Cons:** o Same as Option 3, plus would necessitate either finding offsetting budgetary savings or justifying added costs.

o Could be difficult to restrict to workers from hospitals serving large numbers of public beneficiaries.

Jennifer:

As to paragraph three in your memo where you outline Sec. Reich's argument about a changed NGA...that won't hold water with the governors. NGA works in a way such that the governors who were the lead negotiators on this agreement are still in NGA, are the leadership from both political parties. I can't stress enough how important this factor is.

Option three opens the door to all kinds of groups that will want to be included in the mandate to be shown as included in the waiver development process which will lead to excessive (as perceived by the states) regulation of the waiver process which in itself is supposed to be a relief from regulation.

Option two is the option that most clearly respects the agreements negotiated with the governors at the direction of the President.

AUG 30 1995

THE WHITE HOUSE  
WASHINGTON

Copy was given  
to Gen and Chris  
on 8/30/95

August 28, 1995

MEMORANDUM FOR CAROL RASCO

CC: LEON PANETTA

FROM: Harold Ickes (AI)

SUBJECT: Medicaid waivers

~~Also~~  
Pls. cc: Dima

On 11 August 1995, Gerald McEntee, the International President of the American Federation of State, County, and Municipal Employees, AFL-CIO ("AFSCME"), met with the President. I attended that meeting. He is very concerned about the medicaid waivers which permit moving medicaid recipients into managed care facilities because there is no "job protection" provisions in those waivers. He particularly concerned about the proposed New York waiver which will affect a large number of employees represented by his union.

He specifically requested of the President that he begin discussions with the Governors about the fact that labor is not represented at "the table" when these requested waivers are drafted or in the process of deciding what provisions to contain in the waivers.

The President agreed that something needed to be done about this.

Mr. McEntee pointed out that under the arrangement, the President apparently made with the National Governor's Association concerning medicaid waivers, there is no way for representatives of employees to get involved in the negotiations regarding the waivers.

Mr. McEntee said that the waiver process should be the same as for the federal government where there is a process to accomodate representatives of employees. The President asked Mr. McEntee to send a memo to me about how the federal system works in that regard.

In any event, this is an ongoing problem which is going to continue to fester unless we can try to find a solution to it.

I know that HHS has worked on this and has sent a preliminary memo, drafted jointly by the Department of Labor regarding this issue.

We need to discuss within the next week.

THE WHITE HOUSE  
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO  
Assistant to the President for Domestic Policy

To: Copy to Chris 8/28

Draft response for POTUS  
and forward to CHR by: \_\_\_\_\_

Draft response for CHR by: \_\_\_\_\_

Please reply directly to the writer  
(copy to CHR) by: \_\_\_\_\_

Please advise by: \_\_\_\_\_

Let's discuss: \_\_\_\_\_

For your information: \_\_\_\_\_

Reply using form code: \_\_\_\_\_

File: \_\_\_\_\_

Send copy to (original to CHR): \_\_\_\_\_

Schedule?  Accept  Pending  Regret

Designee to attend: \_\_\_\_\_

Remarks: \_\_\_\_\_

Real folder

ALSO CC DIANA

AUG 25 1995

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration



The Administrator  
Washington, D.C. 20201

AUG 24 1995

TO: Carol Rasco  
Assistant to the President for Domestic Policy  
Through: Kevin Thurm KT

FROM: Administrator  
Health Care Financing Administration

SUBJECT: Capital Taxes for Inpatient Hospital Services

**Background**

In August 1991, Medicare began implementing a prospective payment system for hospitals' capital-related costs. Prior to that time, Medicare had paid for hospitals' capital costs on a cost-related basis. Under the prospective payment system (PPS) for capital, a pre-determined amount based on an average price is paid for each inpatient hospital discharge. The average is used so that payment is independent of specific hospital decisions about capital acquisitions. This method provides incentives for efficient spending.

Through the transition period, which extends from FY 1991 through FY 2001, hospitals generally receive a gradually decreasing portion of their historic capital costs and a gradually increasing portion of payment based on the Federal rate. The Federal rate was based on the FY 1992 national Medicare capital cost per case, including capital-related tax costs. The hospital-specific portion of payment reflects a hospital's actual historic costs, including its property tax costs, if any. Payment will be fully based on the Federal rate for all hospitals at the end of the transition. (About 25 percent of hospitals will, however, receive full Federal rate payment in FY 1996 because it has become more advantageous for them.)

At the time of the final rule in 1991, the proprietary hospitals argued that the proposed capital prospective system contained an inequity: while capital-related taxes constitute a non-discretionary cost imposed only on an identifiable group of hospitals, those costs were built into the Federal capital rate and spread across all hospitals. In discussion with representatives of the proprietary hospitals, a commitment was made to propose a special adjustment for tax costs for public comment. In the 1991 final rule, we expressed our general opposition to singling out specific costs for special treatment. We indicated,

however, that we would collect data on capital-related tax costs and, if after study we determined special treatment was feasible, we would propose an adjustment for public comment.

### **Problems with a Capital Tax Adjustment**

Despite our misgivings about singling out specific components of capital costs for special treatment, we felt committed to offer a proposal for public comment once we had collected the necessary data. Our analysis indicated, however, that implementing a tax adjustment posed several serious problems. We specifically stated in our proposal that we had not been able to resolve these problems, and that we were presenting the proposal in the hopes that public discussion would produce an appropriate solution.

Those problems involved the difficulty of assuring equitable treatment to all hospitals while simultaneously protecting the Medicare Trust Fund from an open-ended commitment to increase Medicare payments. The capital-related tax costs of hospitals that paid taxes prior to FY 1992 were included in setting the Federal rate paid to all hospitals. However, other hospitals have become subject to property taxes since that time (and even more may do so in the future), primarily because of state action to extend property taxes to previously tax-exempt facilities.

In order to protect the Trust Fund, we proposed to provide an adjustment only to hospitals whose tax costs were included in the original rate computation. Budget neutrality was guaranteed simply by removing those tax costs from the overall rate. We recognized that such a measure provided different treatment for tax-paying hospitals, depending merely upon when they became subject to taxes. However, extending the adjustment to all tax-paying hospitals posed a dilemma: either make an open-ended commitment from the Trust Fund to increase Medicare capital payments as more hospitals become subject to taxes, or preserve budget neutrality by progressively reducing payments to other hospitals (beyond the level where the tax costs originally included in the rate had been removed), thus creating an inequity in the treatment of non-tax-paying hospitals. We also expressed concern that an open-ended adjustment could make the Trust Fund vulnerable to manipulation of the kind that the Medicaid program has experienced with respect to donations and taxes in recent years. We specifically requested public comment on these problems.

We received 169 comments (2 national hospital associations and 167 tax-paying hospitals) in support of implementing a tax adjustment and 8 comments (3 national hospital associations, 3 state or regional associations, and 2 individual hospitals) opposed. Commenters in support of an adjustment suggested extending the adjustment to all tax-paying hospitals by reducing future payments to hospitals that do not pay taxes. The

commenters opposed to the adjustment offered arguments that confirmed our original misgivings. They objected to singling out costs for special treatment under a prospective system. Several mentioned other costs that would, in their view, deserve similar treatment if we were to adopt an adjustment for taxes. They also objected that a tax adjustment might merely replace a possible inequity to one group of hospitals with an inequity to a different group (e.g., reducing payments to all hospitals to pay for the adjustment).

A tax adjustment would predominantly benefit tax-paying proprietary hospitals. Tax-paying proprietary hospitals on average would gain about \$65 per discharge more than they would lose from the reduction to the capital rate. While a number of tax-paying nonprofit hospitals would qualify for an adjustment, those hospitals on average would gain only slightly more from an adjustment (about \$6 per discharge) than they would lose from the reduction to the capital rate (about \$5).

The proprietary hospitals have always argued that they have higher capital costs because of their tax-paying status. Our estimates for FY 1996, however, indicate that proprietary and voluntary hospitals will have similar costs (\$724 and \$718 per discharge, respectively) and similar payment-to-cost ratios (1.02 and 1.04, respectively). Implementation of a tax adjustment would decrease the payment-to-cost ratio of voluntary hospitals moderately (to about 1.03), and increase the ratio for proprietary hospitals significantly (to about 1.10).

### Final Regulation

Based on comments and our concern about the implications of a cost-based adjustment within the PPS system, we are not proceeding with an adjustment for capital-related taxes. The law requires us to publish the annual PPS rates by September 1. The Federal Register document and payment rates are being prepared without the tax adjustment and cannot be changed if the September 1 deadline is to be met. Therefore, it is too late to make a change this year.



Bruce C. Vladeck

MEMORANDUM

TO: Carol and Laura  
FR: Chris J. and Jen K. *file*  
RE: Medicaid Waiver Info for Economic Summit  
cc: Gene, Bill, Jeremy, Tom, Diana

March 28, 1995

Attached for your use at the Economic Summit is a copy of the latest edition of the health care waiver status report. It was produced by HHS and hopefully will prove useful in your preparation for the upcoming meetings.

Following up on our meeting, I relayed to Nancy Ann your concern about any health care meeting with Leon until we have had a chance to talk with the First Lady and bring her up-to-speed. I also advised her of your suggestion that we schedule the Medicaid briefing to be given to all three of you at once. (I suggested next Tuesday or some other time after then that is mutually convenient.)

Nancy Ann said she would (and I am sure she will) pass along the message. I might suggest, however, that you mention this to Alice yourselves when/if you see her over the next couple of days.

**INFORMATION ON  
MEDICAID AND WELFARE WAIVERS  
As Of March 27, 1995**

**ARKANSAS**

Welfare Waiver

Under Arkansas' demonstration, AFDC parents age 16 or younger will be required to attend school regularly or face reductions in benefits if they fail to do so. If appropriate, teen-age parents can meet the requirement by attending an alternative educational program.

In addition, Arkansas will implement a policy of not increasing AFDC benefits when additional children are born into a family receiving welfare. Family planning and group counseling services focusing on the responsibilities of parenthood will be included in the demonstration.

Submitted: January 14, 1993  
Approved: March 5, 1994

**FLORIDA**

Medicaid Waiver

The Florida Health Security Program is a voluntary, employer-based, discounted premium program designed to provide access to private health insurance for employed but uninsured Floridians. The program will use a managed competition model and will provide health insurance for 1.1 million uninsured Floridians with incomes at or below 250 percent of the federal poverty level. Health plans (indemnity and HMO) will be offered by Accountable Health Partnerships and administered by Community Health Purchasing Alliances. HCFA is working with the state on required state legislation.

Submitted: February 10, 1994  
Approved: September 15, 1994

Florida's "Family Transition Program" eliminates the quarterly income report requirement during the twelve months the Medicaid transition benefit is given to recipients who lose AFDC

eligibility due to earnings. However, recipients are required to report income increases, and lose the remainder of the transition benefit when income exceeds 185 percent of the Federal Poverty Level.

*Submitted: September 21, 1993.*

*Approved: January 27, 1994.*

### Welfare Waiver

Florida is implementing a "Family Transition Program" for AFDC recipients in two counties. Under the plan, most AFDC families will be limited to collecting benefits for a maximum of 24 months in any five-year period.

Individuals who exhaust their transitional AFDC benefits but are unable to find employment will be guaranteed the opportunity to work at a job paying more than their AFDC grant. The demonstration also provides a longer period of eligibility -- 36 months in any six-year period -- for families at a high-risk of becoming welfare dependent.

Medicaid and child care benefits will be available in the demonstration. Local community boards will play a large role in overseeing the program.

Other elements of the demonstration include an increase in the earnings disregard formula and asset ceilings, as well as a statewide requirement that AFDC parents must ensure that their children have been immunized.

*Submitted: September 21, 1993.*

*Approved: January 27, 1994.*

## GEORGIA

### Welfare Waiver

Georgia is initiating the "Personal Accountability and Responsibility Project" (PAR) which strengthens federal work requirements that must be met in order to receive cash benefits. Georgia's welfare agency will now be able to exclude from an AFDC grant any able-bodied recipient between the age of 18 to 60 who has no children under the age of 14 and who willfully refuses to work or who leaves employment without good cause. The rest of the family will continue to be eligible for AFDC benefits.

The plan will also allow the state to deny additional cash benefits for additional children born after a family has been on welfare for at least two years if the child was conceived while

the family was on welfare. However, PAR would allow recipients to "learn back" the denied benefits through the receipt of child support payments or earnings.

Medicaid and Food Stamps eligibility will continue for all family members. In addition, Georgia will offer family planning services and instruction in parental skills to AFDC recipients.

Georgia's waiver request was received on May 18, 1993, and granted on Nov. 2, 1993.

*Submitted: May 18, 1993*

*Approved: November 2, 1993*

## **KENTUCKY**

### **Medicaid Waiver**

The Kentucky Medicaid Access and Cost Containment Demonstration is a statewide program to expand Medicaid eligibility to 100 percent of the federal poverty level, regardless of categorical eligibility or assets. All those eligible will be enrolled in managed care plans similar to the state's current primary care case management program (KenPAC), or through alternative managed care plans. Future managed care options may include Health Maintenance Organizations, Preferred Provider Organizations, and specialized case management. The benefit package is the same as Kentucky's current Medicaid benefit package. Kentucky's waiver request was approved in December 1993; however recent action by the Kentucky legislature makes the implementation date uncertain at this time.

*Submitted: March 30, 1993*

*Approved: November 8, 1993*

## **LOUISIANA**

### **Medicaid Waiver**

Louisiana has submitted a proposal that is currently being evaluated by HHS. Louisiana Health Access, a statewide section 1115 demonstration proposal, submitted on January 3, 1995, has goals of emphasizing primary and preventive care, increasing access to quality care, and controlling the State's spiraling costs.

# MISSISSIPPI

## Welfare Waiver

Mississippi's reform plan promotes health and education for children receiving welfare assistance and supports work efforts by their parents. The demonstration includes a wide component and two projects, "Work First" in six counties, and "Work Encouragement" in two counties.

The wide component requires all children aged six through 17 to attend school and all children under age six to be immunized and receive regular health checkups. It also extends AFDC eligibility for two-parent families by allowing mothers or fathers to work more than 100 hours a month.

The "Work First" component provides subsidized, private-sector employment for job-ready participants. A special fund created from participants' AFDC and food stamp benefits will reimburse employers' wages. The State will provide supplemental payments to recipients when their total income is less than the combined AFDC and Food Stamp benefits they would otherwise receive. In addition, each "Work First" participant will have an "individual development account" for family savings, to which employers will contribute one dollar per hour of work. The State will also pass on to the family all the child support payments it collects on its behalf.

The "Work Encouragement" component allows recipients to keep more of their earnings and still receive AFDC, by raising the earned income limit from 60 to 100 percent of state-established need levels. Time limits on income disregards will also be waived.

The "Work First" component will be implemented in Adams, Harrison, Jones, Lee, Hinds and Washington Counties. The "Work Encouragement" component will be implemented in Leflore and Oktibbeha counties. Under both the "Work First" and "Work Encouragement" components, courts may require unemployed, non-custodial fathers to participate in the JOBS program to meet child support obligations.

The demonstration will be in effect for five years.

*Submitted: December 10, 1993*

*Approved: December 22, 1994*

# **SOUTH CAROLINA**

## **Medicaid Waiver**

South Carolina's Palmetto Health Initiative (PHI) seeks to expand Medicaid eligibility to individuals with income up to 100 percent of the Federal poverty level (FPL), and children up to age 18 in families with income up to 133 percent FPL. Each enrollee would select either a fully capitated health plan, or a partially capitated primary physician plan, thereby giving each enrollee direct access to a primary care provider. PHI also seeks to streamline the eligibility process and reduce administrative overhead. South Carolina anticipates an additional 280,000 individuals could be provided health care under the waiver. South Carolina also proposes to implement a managed care program, with a focus on home and community-based services, for persons requiring, or at risk of requiring, placement in a nursing facility.

The Health Care Financing Administration will be working with South Carolina over the next year to develop the infrastructure necessary for the proposed demonstration. HCFA will consider the state's request for waivers once the state has successfully completed a set of agreed upon milestones.

*Submitted: March 1, 1994*

*Concept Approved: November 18, 1994*

## **Welfare Waiver**

South Carolina's Self-Sufficiency and Personal Responsibility Program sets work requirements and provides transitional assistance for program participants. After completing Individual Self-Sufficiency Plans (ISSP's) to help prepare them to become self-sufficient, AFDC recipients have 30 days to find a job in a designated vocational area. If they fail to secure such employment, recipients receive an additional 30 days on AFDC to find any private sector job, after which time they must participate in a community work experience program in order to continue to receive AFDC benefits. Progressive sanctions for non-compliance, up to and including removal of the entire family from assistance, are components of this program.

To aid in the transition to work, recipients who would otherwise no longer be eligible for AFDC because of employment can receive reduced benefits for up to 12 months. Families remain eligible for Medicaid and child care during this phase-down period, and regular transitional Medicaid and child care benefits begin at the end of this period.

The program also raises resource limits to \$3,000 and exempts the cash value of life insurance policies, one vehicle and interest and dividend payments. Children of recipients are required to attend school regularly and obtain appropriate immunizations.

The demonstration will operate in Berkeley, Dorchester, Charleston, and Barnwell Counties for a period of five years.

Submitted: June 13, 1994  
Approved: January 9, 1995.

## TENNESSEE

### Medicaid Waiver

TennCare is a statewide program to provide health care benefits to Medicaid beneficiaries, uninsured state residents, and those whose medical conditions make them uninsurable. All TennCare enrollees receive services through capitated managed care plans that are either health maintenance organizations or preferred provider organizations. Enrollment will be capped at 1,500,000, including approximately 310,000 previously uninsured. If the cap is reached, those in mandatory Medicaid coverage groups and the uninsurables will continue to be enrolled. TennCare's benefits are more generous than those offered under current Medicaid for acute care, and the plan emphasizes preventive care. The Health Care Financing Administration will monitor implementation of the program throughout the 5-year period.

Submitted: June 17, 1993  
Approved: November 18, 1993

## VIRGINIA

### Medicaid Waiver

Virginia's welfare reform demonstration gives cases who lose AFDC eligibility due to earnings a 3-year Medicaid transition benefit in four localities and a 2-year transition benefit in the rest of the state. Cases are required to report income quarterly and lose the remainder of the transition benefit if income exceeds 185 percent of the federal poverty level in the first year or 150 percent of the federal poverty level in the second or third year.

Submitted: July 13, 1993.  
Approved: November 23, 1993.

## Welfare Waiver

Virginia's "Welfare Reform Project" will encourage employment by identifying employers who commit to hire AFDC recipients for jobs that pay between \$15,000 and \$18,000 a year and by providing additional months of transitional child care and health care benefits. A second statewide project will: enable AFDC families to save for education or home purchases by allowing the accumulation of up to \$5,000 for such purposes; encourage family formation by changing the way a stepparent 's income is counted; and allow fulltime high school students to continue to receive AFDC benefits until age 21. Further, in up to four counties,

AFDC recipients who successfully leave welfare for work may be eligible to receive transitional benefits for child and health care for an additional 24 months, for a total of 36 months. In one location, Virginia will offer a guaranteed child support "insurance" payment to DC families who leave welfare because of employment to assist the family in maintaining economic self-sufficiency.

*Submitted: July 13, 1993.*

*Approved: November 23, 1993.*



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington D.C. 20201

**FACSIMILE**

FEB - 9 1995

DATE 2/9

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Rasco  
Assistant to the President  
for Domestic Policy

456-2216

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm  
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: ( ) 456-2878

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 7

COMMENTS:



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

February 9, 1995

## MEMORANDUM FOR THE HONORABLE CAROL RASCO

FROM: KEVIN L. THURN 

SUBJECT: Telephone Call From Governor Carlson Complaining About HCFA's Delay In Resolving Minnesota's Medicaid Section 1115 Waiver

We understand Governor Carlson is likely to call Leon Panetta today to complain about the difficulties his State is having reaching agreement on budget neutrality for his Medicaid waiver. His proposal, submitted on July 28, 1994, raises three major, precedent setting budget neutrality policy issues relating to 1902(r)(2) expansions, managed care savings, and welfare savings. The State's current proposal would create a budget gap for this waiver of approximately \$535 million over five years.

- o While the Department would like to help Minnesota, changing our budget neutrality criteria would have severe implications for the national budget. Today, Bruce Vladeck met with Minnesota staff again to offer another proposal for achieving budget neutrality. While the State is considering this proposal, it is not optimistic that it will be accepted.
- o HCFA has worked very hard to find alternative methodologies that would enable the State to achieve budget neutrality without violating federal budget neutrality principles. Attached is a listing of the options that HCFA has presented to the State and its responses. While the State is still formally considering two of these alternatives, State staff have indicated they are not optimistic.
- o While the Department always remains open to considering new State proposals, we do not believe there are any other viable, budget-neutral options available.
- o We recommend that you encourage the Governor to urge his staff to continuing working with HCFA and consider alternatives that do not create costly, unmanageable federal precedents.

Attachment A: HHS Options Offered to Minnesota

Attachment B: Budget Neutrality Issues in the MinnesotaCare Proposal

### **MinnesotaCare Budget Neutrality Options Offered to the State**

Under the State's budget neutrality proposal, Minnesota will be saving over \$375 million during the demonstration period while the Federal government will spending an additional \$500 million. Through budget neutrality negotiations, HCFA has made a number of proposals to the State. For a variety of reasons, the State has been unwilling to accept any of these proposals. These proposals are outlined below.

#### **Reducing With-Waiver Costs**

- **Phase-in**

The State could pursue an implementation schedule that phases-in current state-enrollees into the demonstration, such as low-income adults.

Status: Rejected by the State -- would not be accepted by the Legislature.

- **Lowering Per-Capita Rates**

The State projected MinnesotaCare Families with Children per capita spending using an annual growth rate of ten percent, which we believe may over-estimate spending for this population. These rates could be reduced to mirror trends for the AFDC population.

Status: Currently being considered by the State.

- **Premium Structure**

HCFA suggested that the State consider increasing the share of MinnesotaCare premiums paid by individuals and families.

Status: Rejected by the State -- State's actuaries decided that individual and family premium shares were already high enough.

#### **Increasing Without-Waiver Costs**

- **Immediate Implementation of Existing 1902(r)(2) State Plan**

Minnesota's holds an approved State Plan Amendment to extend Medicaid coverage to all children under age 18 with incomes below 275 percent of poverty. The State could begin covering these children through the Medicaid program, and then include these expenditures in their without-waiver estimates. This would require new State dollars.

**Status: Rejected by the State -- could not implement insurance barriers under regular Medicaid rules.**

- **Covering Full 1902(r)(2) Population in Demonstration**

**Under MinnesotaCare, not all the 1902(r)(2) children would be covered through the demonstration due to insurance barriers. HCFA has required other States to include this population in the demonstration if they seek credit for these children in their without-waiver costs.**

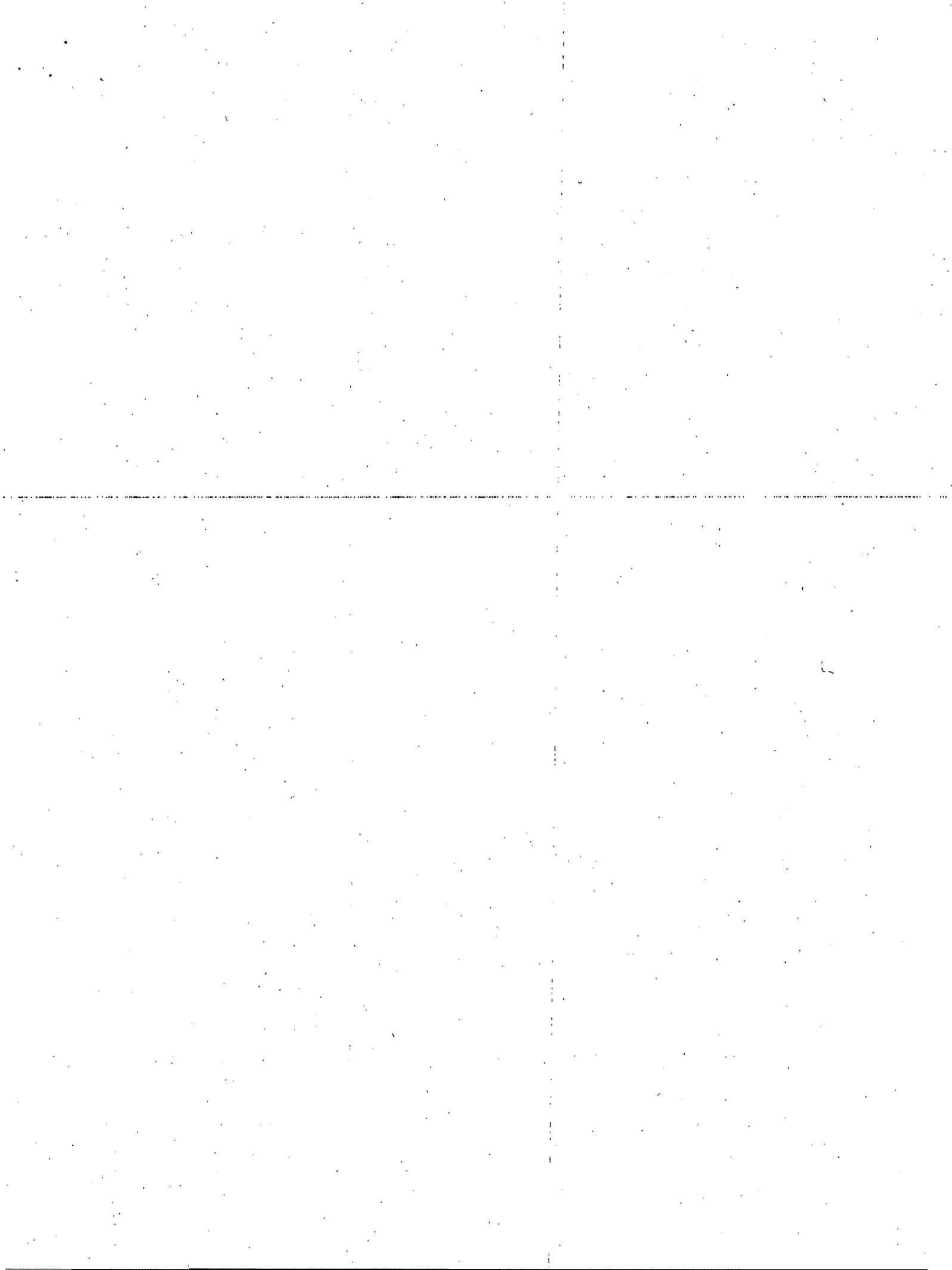
**Status: Proposed to the State on February 9. The State is currently considering this option, but is not optimistic.**

**Other Alternatives**

- **Planning Grant for Phase II**

**HCFA offered the State a planning grant that would allow them to develop integrated plans for Phase I and Phase II of the waiver, which would allow them to establish budget neutrality over both phases of the demonstration.**

**Status: Rejected by the State -- State wants to begin Phase I immediately, although the proposal is not budget neutral.**



## **Budget Neutrality Issues in the MinnesotaCare Proposal**

### Background

Minnesota is seeking demonstration waiver authority to extend Medicaid eligibility to 275 percent of poverty for families with children and 125 percent of poverty for other adults, expand Medicaid eligibility to include the State's current program for low-income uninsured residents (MinnesotaCare), and mandate managed care enrollment across the entire expanded program. Minnesota estimates that Medicaid program costs will total \$20.86 billion over the demonstration period, including long term care.

Creating a budget-neutral framework for these proposals is problematic for two reasons: (a) the State is seeking Federal matching payments for an already-existing, 100% State-funded program; and (b) the State already holds a demonstration waiver for managed care in the Twin City area, so additional savings from managed care would be limited. These two elements complicate efforts to establish an upper line for budget neutrality that provides Minnesota with sufficient resources for the demonstration while avoiding any policy precedents that, if followed by any other States, could cause serious budget problems for the Federal Government in the future.

### Discussion

At this point, the Administration and Minnesota are considering a budget neutrality approach with four options. These features are discussed below.

- **1902(r)(2) Expansion**

Minnesota currently covers pregnant women and infants with incomes up to 275 percent of poverty using 1902(r)(2) disregards. Instead of using 1902(r)(2) to expand eligibility to children over age one, the State provides coverage to many children through the current State-only MinnesotaCare program.

The State has proposed including projected spending for all children under 275 percent of poverty, who would be eligible under 1902(r)(2), in the without-waiver baseline. However, because MinnesotaCare eligibility rules require children to have been uninsured for four months and not to have had access to employer-subsidized coverage for 18 months, many children who would be Medicaid-eligible using an income test under 1902(r)(2) are not eligible for MinnesotaCare. These rules will not change under the demonstration.

The Department is concerned about estimating hypothetical enrollment through a 1902(r)(2) expansion for without-waiver costs since over 88,000 of these children in FY 2000 will not be covered by MinnesotaCare. The State argues that all of these children would be eligible for Medicaid if these insurance barriers were not in place and are therefore a legitimate hypothetical expansion.

The State is seeking without-waiver credit of \$872 million for a hypothetical 1902(r)(2) expansion. Under this scenario, they would be credited for covering 168,258 children in FY 2000. We have estimated that a more restrictive alternative -- crediting savings only from children who enroll in MinnesotaCare (79,951 children in FY 2000) -- would contribute \$470 million to the State's without-waiver costs over five years. This approach would result in a baseline \$402 million lower than their request.

We are also analyzing whether potential 1902(r)(2) children who are covered through employer groups could be considered as hypothetical Medicaid enrollees in the baseline. If Federal subsidies cover a portion of their premiums, these children could be brought into the demonstration. Employer and individual premium payments would be considered the State's contribution -- an approach that we approved for Florida Health Security. Premium subsidies could replace MinnesotaCare's insurance barriers and therefore provide employers with an incentive to assure that children remain privately covered.

### ● PMAP Program

Minnesota's Prepaid Medical Assistance Program (PMAP) has provided Medicaid coverage under a prepaid, capitation model in selected counties since 1985. The current PMAP demonstration authority has been Congressionally mandated to run through June 1996. Because Minnesota has a mature Medicaid managed care program in its most populous counties, its ability to largely finance a Medicaid expansion through managed care savings is limited.

Minnesota argues that demonstration authority for the PMAP program is dependent upon Congressional action and will expire in 1996. They therefore conclude that the without-waiver projections should include reverting PMAP enrollees to the fee-for-service system in 1996. In essence, this approach would enable them to credit the PMAP savings that they are realizing under the current Medicaid program to their proposed demonstration.

If we accept this premise, we would be establishing a new precedent for States with substantial managed care programs. So far, the Administration has chosen to assume that States would continue existing managed care programs in the absence of a demonstration project. Recently, we did not allow Massachusetts to exclude existing managed care savings from without-waiver projections. Given the recent growth in

Medicaid managed care programs, we are concerned that permitting this hypothetical would establish a substantial precedent for additional States. In addition, we do not accept the State's assertion that HCFA could not extend PMAP demonstration authority beyond 1996. The State estimates that the expiration of PMAP authority in 1996 would add \$313 million to without-waiver costs.

- **Welfare-Related Savings**

On January 27, Minnesota presented a new element within its budget neutrality proposal to the Department. Under this approach, Minnesota estimates the impact that the current MinnesotaCare has had on the welfare caseload -- that is, welfare cases decrease because health coverage is available through an alternative program -- and seeks to credit savings from both AFDC cash payments and Medicaid payments to the demonstration program. The Federal government would therefore inflate the without-waiver baseline by the amount of these savings -- in essence assuming that MinnesotaCare does not now exist and projecting increased Medicaid and welfare payments in the absence of the program.

Minnesota has projected these savings as \$205.6 million over the waiver period (\$78.7 million AFDC, \$126.9 million Medicaid). HCFA's concerns with this approach include the difficulty of projecting these savings, establishing a new precedent for other States, and crediting savings from an already-existing program to the demonstration. In addition, applying savings from AFDC cash payments to without-waiver costs is a new concept that not only requires policy deliberation but would also have implications for any welfare-reform demonstration the State may choose to pursue.

- **Growth Rates**

Minnesota uses a variety of growth rates to project without-waiver spending. Instead of using straight historical data, they make several conservative adjustments to various eligibility categories when projecting spending across the demonstration period. HCFA estimates that using the State's average historical growth rates would increase

without-waiver projections by \$195 million.

HCFA has also analyzed strategies for lowering the State's with-waiver costs by reducing per capita growth rates for the MinnesotaCare program. This adjustment could reduce with-waiver costs by \$112 million over five years.

The advantage to changing growth rates is that our projection of without-waiver spending trends represents a best guess at future trends, rather than an estimate of a known program. We may be able to identify special market conditions, or some other rationale, for adjusting the trend rates used in the State's submission.

### Other Demonstrations

On another front, HCFA has recently reached agreement with Minnesota on its Long Term Care Options program, an 1115 demonstration which will provide integrated acute and long term care services for beneficiaries who are dually eligible for Medicare and Medicaid through combined capitation payments to the State. This agreement represents a significant compromise between Minnesota and HCFA on payment rate and budget neutrality issues for this demonstration. We anticipate announcing this award in the near future.

We have also discussed awarding Minnesota a planning grant for Phase II of the MinnesotaCare program. The State's plans for Phase II could realize Medicaid savings and therefore meet the budget neutrality test.

We have looked to the the Long Term Care Options program and another Medicaid long term care demonstration on quality assurance for additional Medicaid-related savings. These programs will yield only \$3.7 million and \$800,000 respectively over five years.

### Conclusions

IIHS approval of the MinnesotaCare proposal hinges upon establishing a budget-neutral framework for the demonstration. We estimate that the State needs to close a gap of approximately \$535 million over five years to reach budget neutrality.

Our analysis and dialogue with the State have resulted in the options outlined above. We intend to work with the State on the premium subsidy proposal for low-income children not covered under current MinnesotaCare eligibility rules. We believe this approach holds promise and represents our best option at this time. We will advise the State of this during our meeting today.

If this proposal does not work out -- either for policy reasons or because it does not sufficiently make up the shortfall -- we will turn to the above options. While we would recommend adjusting the State's with waiver proposed growth rates over any other option, we do not believe this approach will yield sufficient funds on its own. All of the other options have serious disadvantages and may establish uncomfortable precedents for future States, but we believe that the Administration may need to choose between using one or more of these options and disapproving this proposal.

THE WHITE HOUSE  
WASHINGTON

*man*  
2 pg. attachment  
to go w/ each memo;  
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MEMORANDUM FOR THE PRESIDENT

FROM: Carol H. Rasco

SUBJ: Waivers *file*

DATE: July 24, 1994

FLORIDA: Following my last message to you about the impending call Attorney General Reno would make to Governor Chiles, I had a call late Friday evening from Governor Chiles' DC staff member who said they are all VERY appreciative of the work of the White House. AG Reno called the Governor's office and not only told them she felt the matter could be closed by having a flat commission for the insurance agents, but that she would like to have Justice Dept. officials sit down with Florida's legal advisors to discuss the matter fully for one last time. Jay Peterson who serves as Chiles' legal counsel is to meet by midweek this coming week with John Hogan of Justice who is also formerly from Florida. The parties know each other, trust each other and fully recognize they are looking at legal issues, not policy issues. I have asked Bruce Lindsey to call Buddy McKay as a follow up to his discussions with Buddy last week to make certain Buddy is aware of these latest developments.

NINTH CIRCUIT: HHS has advised Justice they do not feel there is a need for an appeal. I have attached the HHS memo outlining the rationale. In the meantime, HHS is confident they have in this administration created the necessary record in granting waivers and on the broader issue of public notice in rule making/waiver granting, HHS has been working on that issue with NGA/others anyway. We will continue to monitor this situation to make certain it does not become a false impediment to timely issuance of waivers.

I will be giving you per your request a regular update on the waivers described on the "pending" chart in your briefing materials for the NGA meeting.

cc: Leon Panetta  
Lloyd Cutler  
Phil Lader  
Harold Ickes  
Bruce Lindsey  
Marcia Hale  
Joel Klein

copy  
Other can go regular  
speed.

THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 1  
LISTED IN THE WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER.

THE FOLLOWING PAGE HAS HAD MATERIAL REDACTED. CONSULT THE  
WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER FOR FURTHER  
INFORMATION.

File: Florida Waiver

THE WHITE HOUSE

WASHINGTON

August 4, 1994

MEMORANDUM FOR LEON PANETTA

FROM: Carol H. Rasco *CHR*

SUBJECT: Request from Governor Chiles

Governor Chiles has asked for a joint meeting early next week with you and me. Please read below for an update on the waiver and proposed action steps.

Before I could even call the Florida Governor's D.C. office this morning to sort through your call with Buddy McKay, the director of the D.C. office called me. She had received a report on the Buddy McKay call and says he is on vacation, he had not received an update in almost 10 days. Certainly this fits as the matter was in our General Counsel's office approximately 10 days ago as Joel Klein at Lloyd's direction was assisting me in pulling Justice and HHS together.

HHS, Justice and Florida officials met about a week ago, and Florida was told by all (and our General Counsel concurred to me privately) that the issue of competitive commission rates for insurance agents is not allowable under the law. Florida left the meeting (a) very appreciative of Justice and in particular, Walter Dellinger, and their knowledge and attitude, and (b) with a request by Justice to draw up an alternative on a "range" for insurance agent commissions.

According to my staff, the indication is that Governor Chiles is adverse to the "range" as an option and has his health staff preparing another alternative. The D.C. director alluded to this when she said to me this morning that Florida does not feel HHS and probably even Justice will accept the alternative being written by Florida.

Besides the "range," the other alternative available is the "safe harbor" concept the HHS Secretary can provide Florida. Because this allows an exception to the law, the safe harbor concept is very frightening to HHS due to the onslaught of requests it might create by other states. I agree at this point with HHS in regard to the dangerous precedent that would be set in allowing a safe harbor.

Governor Chiles has, as of this morning, asked for a joint meeting with you and me next week on Monday evening late when he arrives in D.C., early Tuesday a.m., or he will stay over Tuesday evening after his fundraiser for a late meeting that evening or early Wednesday.

The D.C. director volunteered to me that she has warned Governor Chiles that White House schedules next week may be awful due to health reform escalation. In the meantime, there is nothing new you and I can say to him at this point on the commission issue given that (a) Justice, HHS and our own General Counsel have said it cannot be approved as written and (b) Florida doesn't seem to want to move on the "range" concept.

I propose:

1. We tell Florida we cannot meet Monday evening, but we will call on Monday to confirm a time for Tuesday a.m. (he is available until 10:00 a.m. Tuesday).

or

We can tell them you are booked solid, I will see him during one of his available times.

2. I will have a meeting tomorrow of HHS, Justice, OMB, WH General Counsel and my staff to make sure they (primarily HHS) are all once again fully aware of the need to finalize this waiver. I will call the meeting with the stated purpose of being briefed for the meeting with the Governor so there is no reason for anyone to characterize the meeting otherwise.
3. You may need to make a call to Donna Shalala after my meeting listed above (2) if I feel HHS needs further emphasis placed on the waiver.



U. S. Department of Justice

CC J. Angell  
K. Way  
J. Klein

Office of Legal Counsel

Washington, D.C. 20530

DATE: August 5, 1994

FACSIMILE TRANSMISSION SHEET

FROM: Dawn Johnsen

OFFICE PHONE: (202) 514-3744

TO: Carol H. Rasco

OFFICE PHONE: (202) 456-2216

NUMBER OF PAGES: 3 PLUS COVER SHEET

FAX NUMBER: (202) 456-2878

REMARKS:

I already <sup>can</sup> have a copy - send this to John A. & K. Way

IF YOU HAVE ANY QUESTIONS REGARDING THIS FAX, PLEASE CONTACT KATHLEEN MURPHY OF KEVIN SMITH ON 514-2057

OFFICE OF LEGAL COUNSEL FAX NUMBER: (202) 514-0563  
FTS NUMBER: (202) 368-0563

THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 2  
LISTED IN THE WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER.

orig: CRR = POTUS  
xl: Joel Klein  
briefing file

**FACT SHEET****Welfare and Medicaid Waiver Demonstrations  
and the Beno Case****Background**

Beno v. Shalala involves a challenge by AFDC beneficiaries to one element of a California welfare demonstration project approved in 1992 by the Department of Health and Human Services (DHHS) pursuant to Section 1115 of the Social Security Act. On July 14, 1994, the Ninth Circuit Court of Appeals ruled that, in approving the demonstration, the Department had not established an adequate administrative record regarding one of the waivers of federal law related to the demonstration. The court held that because the record did not reflect that HHS had taken into account public comments opposing this specific waiver the Department must reconsider this waiver in light of these objections. On July 29, the Administration decided not to seek further review of this decision.

**The Clinton Administration's Commitment to State Innovation**

The Clinton Administration is strongly committed to reforming our health care and welfare systems and to working with states that wish to conduct welfare and Medicaid demonstration projects. Since January 1993, HHS has approved five health care reform waivers and sixteen welfare reform waivers. With this commitment in mind, HHS and the Department of Justice carefully reviewed the court's decision in Beno.

**Rationale for the Clinton Administration's Decision**

Based on the facts of this case, the nature of the court's decision, and a desire to remain fully supportive of state health care and welfare innovation, the Administration believes that further review by the court would not be beneficial to the Department's ability and discretion to support state experimentation.

The legal holding is very limited. The decision requires only that the Department create some administrative record to support its decision. Further, the Appeals Court did not reach other important issues regarding the validity of this waiver that were vigorously argued by plaintiffs in the lawsuit, and that would be open for review in a rehearing. In light of these considerations, the Administration believes that requesting further review is not appropriate in this case.

### Effect on California's Welfare Reform Demonstrations

California is conducting several welfare reform demonstrations. The court's decision does not require California to discontinue the Assistance Payment Demonstration Project, the subject of the lawsuit. In particular, the decision has no effect on the waivers granted by the DHHS to California that enable working recipients to keep more of their earnings and that permit more two-parent families to qualify for benefits. These waivers were not challenged in the lawsuit and remain in effect. Further, the decision does not invalidate California's reductions in AFDC benefits.

The decision also has no impact on California's other welfare demonstration project -- Work Pays which includes Cal-Learn -- that received approval by HHS this year.

Under the court's decision, HHS will be required to reconsider the previously granted waiver that relates to California's submission of new Medicaid state plans, the only waiver vacated by the court.

### Effect on State Waiver Demonstrations

The Clinton Administration has followed procedures consistent with the court's holding in reviewing demonstration proposals and granting waivers. Thus the opinion does not call into question other states' waivers that this Administration has approved.

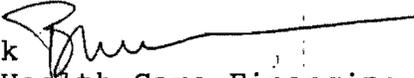
### Relationship to Welfare Reform

The court's decision has no effect on the Administration's welfare reform proposal, the Work and Responsibility Act of 1994, which retains the authority to provide waivers for welfare demonstrations under Section 1115 of the Social Security Act.

The Administrator  
Washington, D.C. 20201

November 4, 1993

NOTE TO CAROL RASCO

FROM: Bruce C. Vladeck   
Administrator, Health Care Financing AdministrationSUBJECT: TennCare Waiver Proposal -- Status

As you know, HCFA has been reviewing a proposal from the State of Tennessee that would waive Federal Medicaid requirements in order to provide coverage to Medicaid eligibles and uninsured in the State. While we are making every effort to provide maximum flexibility to states as they redesign their health care delivery systems, we have been concerned about the financing approach, beneficiary confusion, and the implementation schedule that the State has promoted. The State has provided responses to a number of our questions about TennCare, most recently on October 29. The Governor is pressing for a positive decision right away.

Last night we laid out for Tennessee the conditions under which we would approve a waiver. (Attached is the material we faxed to them.) The following are the key features of our offer, along with the reactions I expect from the State:

- o HCFA Offer: Our approach reflects significant movement on our part in three areas since the State's original proposal. We have agreed to (1) provide limited Federal matching funds for a new form of Certified Public Expenditures (CPE); (2) provide limited Federal matching funds for services provided to residents of institutions for mental diseases (IMDs), consistent with the Health Security Act, and (3) allow certain premium payments by patients who would not otherwise be eligible for Medicaid to count as the State's share of Medicaid costs. We have endeavored to limit the precedent these three developments might set in other states, although it is probably not possible to eliminate it.

Expected Reaction: The State should regard the first item as a positive development, and will perceive some improvement on the second item. On the third item, we had previously communicated our position to them, but they had argued against the very reasonable limitation we had placed on them. Our most recent response reiterates our position, which they will not regard as progress.

- o HCFA Offer: We clarified to the State that we will not provide Federal match for capitation payments for individuals who are eligible for TennCare but not enrolled in the program. However, I should note that we are prepared to match the costs of uncompensated care (similar to disproportionate share payments) to the extent that these are actual State cash expenditures that account for costs borne by participating providers.

Expected Reaction: As we discussed in our meeting the other day, the State's latest proposal suggests that they may regard this a new and significant restriction, even though it should have been obvious to them based on all our previous statements. Tennessee may be interested in our alternative, but may have difficulty raising the State resources to support this approach.

- o HCFA Offer: Rather than dictating an implementation date to the State, we outlined for them the process we would require prior to implementation. In addition, we will require them to repeat the enrollment/plan selection process after contracts with providers have been signed and approved by HCFA.

Expected Reaction: We are mildly optimistic that the State will react positively to this approach.

- o HCFA Offer: We had previously argued that Tennessee must increase the capitation rate to providers because it is not adequate to ensure access and quality of care. (This is the core issue that has prompted 100-200 letters to us per day from Tennessee physicians.) In our new approach, we agree that HCFA should not be in the position of dictating Medicaid rates to states (a position with which we were never entirely comfortable), but we require that the State be able to assure access and monitor quality in the TennCare program.

Expected Reaction: Should be positive.

Finally, it is important to note that, even if Tennessee concurs with all of our conditions, the State still has a shortfall of funds for the program. Estimates of the magnitude of the shortfall can vary widely depending upon assumptions about the number of enrollees, treatment of CPE, capitation rates, and the need for any supplemental pools, but it is in the range of \$100-\$350 million per year.

The State will probably view the limitations that we have listed as significant. Nevertheless, these limitations are essential to assure that we maintain the current percentage shares of financing borne by the Federal and State governments and to protect beneficiaries during the transition.

We are preparing additional background documents and talking points on these issues for you to share with your colleagues.

cc: Kevin Thurm

## HCFA POSITION ON TENNCARE ISSUES

The following provides details of our position on TennCare financing. These details reflect our longstanding view that we may only match allowable costs, rather than the originally-proposed block grant approach. We also provide further specification of our matching policy for certified public expenditures. In addition, we provide additional clarification on several non-financing issues.

### Financing Issues

- o We will provide Federal Financial Participation (FFP) at the applicable Federal medical assistance percentage (FMAP) for the actual capitation payments made by the State to the Managed Care Organizations (MCOs) for each TennCare enrollee.
- o We will provide FFP at the applicable FMAP for actual expenditures certified by public hospitals for TennCare enrollees only to the extent that the public hospital is able to document that it has an actual expenditure for providing service to a TennCare enrollee which exceeds the amount paid to that hospital from the MCO for the cost of providing the service to that TennCare enrollee.
- o These public hospital expenditures will be matched on an as-incurred basis, not paid as an add-on to the capitation rates.
- o We will provide FFP at the applicable FMAP for actual expenditures for providing services to a TennCare enrollee residing in an IMD for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days.
- o We will provide FFP at the applicable matching rates (FMAP and administrative rates) for the actual ongoing non-TennCare costs (i.e. long-term care, HCBS waivers, Medicare cost sharing, administration) of the Medicaid program.
- o We will provide FFP for supplemental pools only to the extent that FFP matches actual State cash expenditures to account for costs borne by participating providers.
- o Premium revenues must be offset on an individual by individual basis, not in the aggregate, as the State has proposed. Any premium payments paid by an individual TennCare enrollee in excess of the State share of the State's capitation payment made to the MCO on behalf of that individual TennCare enrollee must be offset in full against the otherwise allowable Federal share of the State's capitation payment made to the MCO for that individual TennCare enrollee.

Non-financing Issues

- o We are prepared to accept the State's assurances as to the adequacy of its capitation rates. At the same time, we will require close monitoring of access, patient satisfaction, and quality of care. In order to verify that there is sufficient access to care throughout the State, we must have sufficient time for HCFA review and approval of MCO contracts, as appropriate, after approval of the waiver but prior to the implementation of the TennCare program. In addition, the State will provide copies of subcontracts between the MCOs and providers if required by HCFA for its review.
- o Substantial changes have been made in the TennCare project, from agreements reached in our discussions and actions taken by the State. To confirm our mutual understanding of the actual program for which waivers may be granted, an updated description of the TennCare program is necessary. In addition to covering eligibility, benefits, and service delivery provisions, a revised financing proposal must clearly delineate the sources and sufficiency of State funding to support TennCare. Prior to implementation, the State must provide satisfactory assurance to HCFA that it has adequate State resources to support the program as revised.
- o Once the final configuration of the proposal is clear, we will develop the budget cap that is customary in demonstration projects to address the growth rate in Federal spending related to TennCare.
- o The State will establish an implementation date that provides sufficient time for the State to arrange MCO contracts, assure the adequacy of MCO-provider networks, set up systems, and complete administrative provisions. It must allow time for HCFA to conduct appropriate pre-implementation review, and for corrective actions by the State if appropriate.
- o The State will repeat the enrollment/plan selection process after contracts with MCOs and providers have been signed.

MEMORANDUM FOR CAROL RASCO

FROM: Kathi Way

DATE: 8/3/93

RE: Medicaid State Waivers *file*

Unlikely as it may seem, I think we have concluded the discussions with NGA on establishment of guidelines for state waivers for demonstration. The final draft of the document gives states considerable flexibility to demonstrate new approaches for delivery of welfare and health care services to constituents. The changes regarding state flexibility are most apparent in the following areas, duration, evaluation, and cost neutrality. HHS has agreed to consider a longer duration for waivers and specified their intent to work with states to gain legislative approval for permanent change when demonstrations prove successful. HHS has agreed that the requirements for a control group do not easily apply to health care demonstrations and are not the only means by which welfare reform demonstrations can be evaluated. Finally, HHS has agreed to consider cost neutrality over the life of the waiver rather than on a year-by-year basis.

I believe HHS is sincerely committed to a more timely review of state requests henceforth, but currently there is a backlog that is of some concern. The combination of administrative staff changes and work on an "improved" waiver process has slowed considerably HHS's turnaround time. To ease concerns in the states that are certain to show during the annual NGA meeting, I have asked HHS to prepare letters for each of the Governors with a waiver request pending. That letter would clearly state the status of the request and express the intention to deal with the issues quickly. In addition, John Monahan is preparing a 2-3 page document by beginning of next week to detail for us the status of each state's pending waiver.

There is one remaining issue that could not be resolved with NGA. Currently, the use of managed care HMOs for medicaid recipients requires the HMO have no more than 75% of the membership from medicaid recipients. States are allowed a one time waiver from that requirement to allow HMOs to solicit additional membership to meet the requirement. NGA has requested relief from that requirement in total. Frankly, neither NGA nor HHS has another suggestion for determining quality. I have to tell you that I have questions about the ability of states to ensure

quality for HMO recipients when the portion of medicaid recipients gets close to 100%. HHS has embarked on a test to assess quality in a different manner but the results are 2-3 years away. Neither John nor I can move Carl on this issue. I thought I might call Ray next week to seek his thoughts. Any suggestions you have would be appreciated.

Finally, I believe NGA will spend some amount of time speaking positively about the working relationship with the new administration at the NGA meeting. I will stay in touch with Carl over the next week to assure there is no slippage on this issue. Also, I will forward to you a copy of the letter to states with outstanding waiver requests and a copy of John's letter to Governors as I receive them. Call me if you need additional information.

file TN? Medicaid  
Wavers

cc: Kathi Way  
Bruce Reed

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION



PHONE: (202)690-8794 FAX: (202)690-6518

Date: 5/21/93

From: DAVID ELLWOOD

To: CAROL RASCO

Division: OASPE

Division: WHITE HOUSE

City & State:

City & State:

Office Number: 690 6443

Office Number:

Fax Number:

Fax Number: 456 2878

Number of Pages + cover 3

REMARKS:

## MEMORANDUM

To: Carol Rasco

From: David F. Elwood

Re: AFDC and Medicaid Waivers

Date: May 21, 1993

---

I wanted to provide you with a brief update on Waivers prior to your meeting with the NGA. We had a meeting with ACF and HCFA people in an attempt to hammer out a consistent waiver policy for all of HHS. We had before us the ACF draft which you have and some preliminary drafts of HCFA. Although AFDC and Medicaid waivers often go to different agencies, and although there is little indication that states are unhappy with the AFDC/ACF waiver process, many in the department expressed concern that any changes/clarification in the AFDC waiver process would immediately be interpreted as indicating the direction that Medicaid will go as well, and might be misinterpreted. As you know HCFA folks have been meeting with NGA representatives in an effort to significantly improve the Medicaid 1115 Demonstration waiver process. We do not want to create any concern or confusion regarding these negotiations.

If we go forward with a letter to the Governors, we have tentatively decided to send only one letter to each Governor which discusses both types of waivers. It may come from the Secretary or the President depending on your preferences. Initially there were significant areas of agreement, but some areas of disagreement between ACF and HCFA remain. But we did reach a loose consensus. I am confident that we can reach a joint position within the Department next week. Given the President's and your strong interest in this issue, I think it would be prudent to discuss this issue with you sometime soon to be certain you are comfortable with the direction we are moving.

In the meantime, the question arises as to what you should say to the Governors. The talking points below point to the broad consensus that is emerging here. My own preference is that you not get too specific. We have not fully cleared these either internally nor with you and the President. But this gives some indication of how far you could go if you are comfortable with the ideas.

- o The Administration has been engaged in very productive negotiations with the NGA. We expect to have a waiver policy complete in the next few weeks. While there are still details to be worked out, and you would like to avoid getting into specifics, you can say a few things.
- o First, we are establishing a very different relationship between the states and federal government, one of greater trust, more information sharing, and better

service.

- o We are absolutely committed to making the Medicaid 1115 waiver process faster, more straightforward, and more friendly. We believe we can dramatically improve things.
- o States need to understand that the legislation and the legislative history make very clear that 1115 waiver authority is for demonstrations, not simply a mechanism for increasing state flexibility. (Demonstrations are typically designed to test specific new ideas for a specified period of time.) The Congress is very concerned that waivers be granted for genuine demonstrations of new ideas, not as a device to avoid rules and projections legislated by the Congress. If Congress perceives that 1115 waivers are being abused, we could easily lose this waiver authority.
- o The President has indicated that demonstrations need to be carefully evaluated. That is, after all, the goal of demonstrations. Still we will not have rigid rules requiring a particular type of evaluation strategy in all cases. We will seek evaluation strategies that are appropriate to the demonstration.
- o Cost neutrality remains an objective and expectation, but it will likely be applied over the life of the demonstration.
- o States should be aware that health and welfare reform are likely to establish new statutory and fiscal relationships between the states and the federal government. Some states may wish to wait until the central elements of these plans emerge before moving forward with major new demonstrations. The administration is strongly supportive of state initiatives and will, of course, continue to evaluate and grant waivers under the current authority.

I hope this is of use. I'll talk to you soon. I can be reached at home this weekend at

P6/(b)(6)



EXECUTIVE OFFICE OF THE PRESIDENT  
OFFICE OF MANAGEMENT AND BUDGET  
WASHINGTON, D.C. 20503

THE DEPUTY DIRECTOR

July 14, 1993

*KWay-fyi*  
*Sent 7/15/93*  
*pv 3:15pm*  
*logged*

MEMORANDUM FOR LEON PANETTA

FROM: Alice M. Rivlin *Alice*

SUBJECT: Status of State of Hawaii Request for a Medicaid Waiver

OMB has advised the Health Care Financing Administration and the Executive Secretary of the Department of Health and Human Services that we have no concerns about HHS' intent to approve a 5-year Medicaid demonstration for the State of Hawaii. (This became my call because Nancy-Ann is recused.)

Under the proposed "Health QUEST" demonstration, Hawaii plans to expand Medicaid eligibility to individuals whose income is at or below 300 percent of poverty and to provide their care through capitated, managed care plans. The demonstration would be conducted Statewide and is scheduled to begin April 1, 1994.

If Health QUEST is approved, Hawaii will be the second State to receive Federal approval to undertake health care reform that results in near universal coverage. The Administration approved demonstration waivers for Oregon in March that will extend coverage to those under the poverty line, as well as those employed. Other States have also expressed interest in substantial reform of health care coverage. Kentucky and Tennessee recently submitted demonstration requests to HHS and proposals are expected soon from Florida, Minnesota, Vermont, and Washington.

Our position on Hawaii's Health QUEST is based on the understanding that Hawaii has agreed to certain "budget neutrality" requirements that would place annual limits on Federal Medicaid costs under the demonstration. These annual limits are designed to ensure that Federal costs do not exceed what would have been spent in the absence of the demonstration. Hawaii has agreed to conform its demonstration to any national health reforms that may be enacted.

cc: Carol Rasco  
Ira Magaziner  
David Kleinberg

TO: Mack McLarty  
Roy Neel  
Nancy Hernreich

FROM: Carol H. Rasco *CHR*

SUBJ: Tennessee

DATE: November 3, 1993

I have now spoken to the two people at HHS with whom the Governor AND his officials continue to speak just as there are three to four of us here called daily by the Governor. After piecing all parts together it appears fairly clear to me that :

1. Despite the calls here to us that have stated that HHS had not called Tenn. since the Friday submission of a revision, two officials of HCFA spoke both on Monday and Tuesday to Manning (financial person in Tenn. heading up this effort for the Governor and the person the Gov. has repeatedly told me with whom to work) with updates from the HCFA side and Manning working on the Tennessee side. Manning continues to tell Bruce at HCFA that he can't control the Governor and his calls up here.

2. John Monahan of Intergovernmental at HHS talked with the GOVERNOR on Monday evening, and they exchanged calls again yesterday. John will be calling the Governor as usual today.

3. Bottom line to date: We have games being played here from Tennessee, and the concern at HHS is that with the promise of an appointment with the President, Tenn. may be instructed by the Governor's office to hold on any final deal until the President tells them indeed they have to raise more money and phase in the program. However, HHS will continue to push on Tenn. as HHS knows we can't continue to refuse an appt. for the Gov.

4. Bottom line overall: I do believe we can't hold off the Governor much longer from the President, and I have told HHS to be prepared to see that meeting happen early next week and to start an iterative set of briefing notes for use with the President in preparation for the meeting so that we will have the most up to date information possible for him to use.

Finally, I FIRMLY believe Secretary Shalala MUST be in the meeting the President has with the Governor. I also should be there. Rationale? The President must be prepared to firmly back the department in their conditions for Tenn.'s waiver...more money in hard cash on the table and an elongated phase in. Without these two items as the plan currently stands, the harm to overall health care reform will be very serious. The press will be watching this waiver not only at the time of a decision but throughout its implementation which will parallel the Congressional debate.

THE WHITE HOUSE  
WASHINGTON

November 8, 1993

MEETING WITH GOVERNOR MCWHERTER

DATE: November 8, 1993  
LOCATION: Oval Office  
TIME: 4:20  
FROM: Carol H. Rasco

Bruce R.  
VP - Zimm  
Roy Neal  
Mark

I. PURPOSE

You will meet with Governor McWherter at his insistence to discuss his pending Medicaid waiver, TennCare. He does not want HHS or HCFA individuals present and has stated repeatedly to me that if the President tells him he has to do what HCFA has directed in order to have the waiver approved - more money and a delayed timeline - then he will accept those facts. We have delayed this meeting as long as we possibly could.

II. BACKGROUND

TennCare was submitted to HHS on June 16, 1993. This proposal to cover Medicaid clients as well as the uninsured up to a certain percentage of poverty was designed by Tennessee as they began to face the sunset date of April 1, 1994 of their provider tax which has allowed them to create one of the most generous Medicaid programs in the country. Without the provider tax they face serious cutbacks in the program.

Late in the summer HHS told Tennessee they would meet a self-imposed September 17 decision date. That date passed but work continued between HCFA and Tennessee officials. Governor McWherter came to see Secretary Shalala and myself individually about three weeks ago. Work has continued in good faith between Tennessee and HCFA since that time. Attached is the latest status report from HCFA. Late Friday evening the chief financial officer in Tennessee, Mr. Manning, with whom we have all been working CONFIDENTIALLY told Kathi Way of my staff that he wanted us to be aware that Bruce Vladeck of HCFA has been working in total good faith the last three weeks and that Vladeck/Manning are in agreement on the financing, but the Governor will still seek to have you as President intervene.

A set of the most expected questions/requests from Governor McWherter will be prepared by the time of the meeting based on the latest negotiations.

The most critical point to keep in mind is that this meeting must not be seen by the Governor as one in which he came in and got the final approval and/or changes in the conditions; that is the job of HHS. If he does see it as a meeting in which he gets you to make changes, you are opening the door for other states to stop their work with HHS/HCFA and come directly to you.

Senators Sasser and Mathews have both expressed interest in the waiver to HHS, and I had a lengthy conversation with Mathews by phone recently. He reminded me of his support and that of the Governor for you. I have also had a call from Congressman Dingell who reminded me of his sub-committee's watchful eye on this waiver as well as other Medicaid plans used by states and the fact that approval of the TennCare waiver will prompt an immediate investigation into the approval; he indicated he understood the Secretary of HHS was being pressured by the White House to approve the waiver. I assured him the White House expected HHS with whom the authority rests to grant waivers to review the applicable laws and regulations in evaluating any waiver.

### III. PARTICIPANTS

President Clinton  
Possibly Vice-President Gore  
Governor McWherter: We have not been notified by his office as to anyone accompanying him.  
Carol Rasco

### IV. PRESS PLAN

No press coverage.

### V. SEQUENCE OF EVENTS

Governor McWherter will want to present his case refuting the HCFA demands on cash and redoing the enrollment of clients. He should be allowed to talk and then you will need to firmly tell him that in order to carry out the federal responsibility to cover the clients and preserve the integrity of health care reform overall he must meet the necessary match requirements as well as provide an orderly move into the program.

### VI. REMARKS

None required.



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care Financing Administration

November 4, 1993

The Administrator  
Washington, D.C. 20201

NOTE TO CAROL RASCO

**CONFIDENTIAL**FROM: Bruce C. Vladeck  
Administrator, Health Care Financing Administration

SUBJECT: TennCare Waiver Proposal -- Status

As you know, HCFA has been reviewing a proposal from the State of Tennessee that would waive Federal Medicaid requirements in order to provide coverage to Medicaid eligibles and uninsured in the State. While we are making every effort to provide maximum flexibility to states as they redesign their health care delivery systems, we have been concerned about the financing approach, beneficiary confusion, and the implementation schedule that the State has promoted. The State has provided responses to a number of our questions about TennCare, most recently on October 29. The Governor is pressing for a positive decision right away.

Last night we laid out for Tennessee the conditions under which we would approve a waiver. (Attached is the material we faxed to them.) The following are the key features of our offer, along with the reactions I expect from the State:

- o HCFA Offer: Our approach reflects significant movement on our part in three areas since the state's original proposal. We have agreed to (1) provide limited Federal matching funds for a new form of Certified Public Expenditures (CPE); (2) provide limited Federal matching funds for services provided to residents of institutions for mental diseases (IMDs), consistent with the Health Security Act, and (3) allow certain premium payments by patients who would not otherwise be eligible for Medicaid to count as the State's share of Medicaid costs. We have endeavored to limit the precedent these three developments might set in other states, although it is probably not possible to eliminate it.

Expected Reaction: The state should regard the first item as a positive development, and will perceive some improvement on the second item. On the third item, we had previously communicated our position to them, but they had argued against the very reasonable limitation we had placed on them. Our most recent response reiterates our position, which they will not regard as progress.

- o HCFA Offer: We clarified to the state that we will not provide Federal match for capitation payments for individuals who are eligible for TennCare but not enrolled in the program. However, I should note that we are prepared to match the costs of uncompensated care (similar to disproportionate share payments) to the extent that these are actual state cash expenditures that account for costs borne by participating providers.

**CONFIDENTIAL** *ew*

2

Expected Reaction: As we discussed in our meeting the other day, the state's latest proposal suggests that they may regard this a new and significant restriction, even though it should have been obvious to them based on all our previous statements. Tennessee may be interested in our alternative, but may have difficulty raising the state resources to support this approach.

- o HCFA Offer: Rather than dictating an implementation date to the State, we outlined for them the process we would require prior to implementation. In addition, we will require them to repeat the enrollment/plan selection process after contracts with providers have been signed and approved by HCFA.

Expected Reaction: We are mildly optimistic that the State will react positively to this approach.

- o HCFA Offer: We had previously argued that Tennessee must increase the capitation rate to providers because it is not adequate to ensure access and quality of care. (This is the core issue that has prompted 100-200 letters to us per day from Tennessee physicians.) In our new approach, we agree that HCFA should not be in the position of dictating Medicaid rates to states (a position with which we were never entirely comfortable), but we require that the State be able to assure access and monitor quality in the TennCare program.

Expected Reaction: Should be positive.

Finally, it is important to note that, even if Tennessee concurs with all of our conditions, the State still has a shortfall of funds for the program. Estimates of the magnitude of the shortfall can vary widely depending upon assumptions about the number of enrollees, treatment of CPE, capitation rates, and the need for any supplemental pools, but it is in the range of \$100-\$350 million per year.

The State will probably view the limitations that we have listed as significant. Nevertheless, these limitations are essential to assure that we maintain the current percentage shares of financing borne by the Federal and State governments and to protect beneficiaries during the transition.

We are preparing additional background documents and talking points on these issues for you to share with your colleagues.

cc: Kevin Thurn

### HCEA POSITION ON TENNCARE ISSUES

The following provides details of our position on TennCare financing. These details reflect our longstanding view that we may only match allowable costs, rather than the originally-proposed block grant approach. We also provide further specification of our matching policy for certified public expenditures. In addition, we provide additional clarification on several non-financing issues.

#### Financing Issues

- o We will provide Federal Financial Participation (FFP) at the applicable Federal medical assistance percentage (FMAP) for the actual capitation payments made by the State to the Managed Care Organizations (MCOs) for each TennCare enrollee.
- o We will provide FFP at the applicable FMAP for actual expenditures certified by public hospitals for TennCare enrollees only to the extent that the public hospital is able to document that it has an actual expenditure for providing services to a TennCare enrollee which exceeds the amount paid to that hospital from the MCO for the cost of providing the service to that TennCare enrollee.
- o These public hospital expenditures will be matched on an as-incurred basis, not paid as an add-on to the capitation rates.
- o We will provide FFP at the applicable FMAP for actual expenditures for providing services to a TennCare enrollee residing in an IMD for the first 90 days of an inpatient episode, subject to an aggregate annual limit of 60 days.
- o We will provide FFP at the applicable matching rates (FMAP and administrative rates) for the actual ongoing non-TennCare costs (i.e. long-term care, HCBS waivers, Medicare cost sharing, administration) of the Medicaid program.
- o We will provide FFP for supplemental pools only to the extent that FFP matches actual State cash expenditures to account for costs borne by participating providers.
- o Premium revenues must be offset on an individual by individual basis, not in the aggregate, as the State has proposed. Any premium payments paid by an individual TennCare enrollee in excess of the State share of the State's capitation payment made to the MCO on behalf of that individual TennCare enrollee must be offset in full against the otherwise allowable Federal share of the State's capitation payment made to the MCO for that individual TennCare enrollee.

**CONFIDENTIAL**<sup>2</sup>

2

Non-financing Issues

- o We are prepared to accept the State's assurances as to the adequacy of its capitation rates. At the same time, we will require close monitoring of access, patient satisfaction, and quality of care. In order to verify that there is sufficient access to care throughout the State, we must have sufficient time for HCFA review and approval of MCO contracts, as appropriate, after approval of the waiver but prior to the implementation of the TennCare program. In addition, the State will provide copies of subcontracts between the MCOs and providers if required by HCFA for its review.
- o Substantial changes have been made in the TennCare project, from agreements reached in our discussions and actions taken by the State. To confirm our mutual understanding of the actual program for which waivers may be granted, an updated description of the TennCare program is necessary. In addition to covering eligibility, benefits, and service delivery provisions, a revised financing proposal must clearly delineate the sources and sufficiency of State funding to support TennCare. Prior to implementation, the State must provide satisfactory assurance to HCFA that it has adequate State resources to support the program as revised.
- o Once the final configuration of the proposal is clear, we will develop the budget cap that is customary in demonstration projects to address the growth rate in Federal spending related to TennCare.
- o The State will establish an implementation date that provides sufficient time for the State to arrange MCO contracts, assure the adequacy of MCO-provider networks, set up systems, and complete administrative provisions. It must allow time for HCFA to conduct appropriate pre-implementation review, and for corrective actions by the State if appropriate.
- o The State will repeat the enrollment/plan selection process after contracts with MCOs and providers have been signed.

NATIONAL GOVERNORS' ASSOCIATION

Roy Romer  
Governor of Colorado  
Chairman

Carroll A. Campbell Jr.  
Governor of South Carolina  
Vice Chairman

P. 1/2  
Raymond C. Scheppach  
Executive Director

Hall of the States  
444 North Capitol Street  
Washington, D.C. 20001-1572  
Telephone (202) 624-5100

File:

Medicaid  
Waivers



DATE: 3/2/94

TELECOPIER TRANSMISSION FORM

TO: CAROL RASCO

TELECOPIER NUMBER: 456-2878

FROM: Ray Scheppach

NUMBER OF PAGES: 2 (Including this cover)

REMARKS \_\_\_\_\_

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IF YOU HAVE PROBLEMS WITH THIS TRANSMISSION, PLEASE CALL:

202/624-5317

**NATIONAL  
GOVERNORS'  
ASSOCIATION**

Carroll A. Campbell Jr.  
Governor of South Carolina  
Chairman

P. 2/2  
Raymond Scheppach  
Executive Director

Howard Dean  
Governor of Vermont  
Vice Chairman

Hall of the States  
444 North Capitol Street  
Washington, D.C. 20001-1512  
Telephone (202) 624-5300



March 2, 1994

The Honorable Donna Shalala  
Secretary of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Shalala:

We are writing to express our strong concern about the apparent breakdown in the consultation process between the Department and Governors regarding issues of concern to states in the Medicaid program. Earlier this week, we were informed by the press that Bruce Vladeck had announced during a speech that the Administration was preparing to institute a federally-mandated public notice requirement for Medicaid waivers and for 1115(a) research and demonstration waivers. NGA staff had been told of this possibility informally about a month ago and had strongly objected to the proposals. The staff were reassured that the Department discussions were in the formative stages and that no actions would be taken without much greater input from Governors. Obviously, this did not happen.

We cannot stress enough, the importance of meaningful consultation with Governors in such decisions. The President has committed to a partnership between the Governors and the Administration that is more than rhetoric.

We strongly urge you to withhold any decisions on the public notice issue until we have an opportunity to consider your ideas in more depth, and we look forward to better communications with you in the future.

Sincerely,

Carroll A. Campbell Jr.  
Governor of South Carolina

Howard Dean  
Governor of Vermont

cc: President Bill Clinton

cc. to Way fyi  
Fax all but  
preceding page  
to Schoppach  
Tell him I thought  
he & Carl would  
like to see this.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington D.C. 20201

MAR - 2 REC'D

# FACSIMILE

DATE MAR 2 1994

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Rasco  
Assistant to the President  
for Domestic Policy

456-2216

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm  
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: ( ) 456-2878

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 9

COMMENTS:



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

MAR 2 1994

MEMORANDUM TO CAROL RASCO

From: Kevin Thurm 

RE: Bruce Vladeck's Speech

Attached please find a copy of Bruce's prepared remarks for yesterday's speech; please note page 4 where he spoke about the public notice issue.

In the Qs and As, Bruce recalled saying things like (and I grossly paraphrase) "we are looking at getting greater public input on big waiver applications..." "HCFA is not committed to requiring public hearings but is looking at various mechanisms for public input..." "We will abide by the NGA agreement and anything we do will be consistent with and in the spirit of that agreement."

Bruce told me that he spoke with Carl Volpe today about this matter; he said they are now square and that there's a commitment to keep NGA involved in the process.

If you need any further information, please do not hesitate to contact me.

REMARKS BY  
BRUCE C. VLADECK, ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION

MARCH 1, 1994

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

\*This text serves as the basis for the Administrators oral remarks and should be used with the understanding that material may be added or omitted during presentation.

Good morning. Thank you for that introduction -- and thank you for your exemplary work as Executive Director of Manet Community Health Center. I'm sure you know that HCFA, PHS, and your home state of Massachusetts all join in applauding your outstanding efforts and the work of your four facilities.

And it's a pleasure to be here today and to be part of your annual Policy and Issues Forum.

To say that much of the policy talk these days centers around health care reform is indeed an understatement. For good reason, health care reform is the dominant concern.

Judging from the looks of your agenda, you've already had a healthy dose of reform "talk," with networks and managed care the espoused watchwords. I understand that my colleague from the PHS, Marilyn Gaston, spoke of PHS' special initiatives designed to help health centers form networks.

I've been asked to speak about the role of health centers under President Clinton's Health Security Act. Considering the importance of networks and managed care under the President's proposal, it should come as no surprise that I, too, will talk some about networks.

Understandably, as health centers you are clamoring to figure out how reform will affect you and how to respond. The ball game will be a new one. As a matter of fact, I think you'll agree that right now we're in the middle of at least the first inning.

Universal coverage will certainly change your role as safety net providers -- it will create opportunities for expansion of health centers and improvement in the services you provide. Indeed, while the President's Health Security Act will guarantee universal coverage, just having an insurance card does not guarantee care -- rather the guarantee of care is dependent upon providers like yourselves.

The President's health care reform bill endorses principles that I know are important to you as key providers of our nation's health care safety net. And it contains provisions that help ensure continuity of care for the people you serve.

Predictably, the environment of change creates some anxiety. The anticipation of reform and the uncertainties it presents are difficult -- but as health care professionals, we must all rise to the occasion.

Rather than resisting change, I entreat you to evaluate, strategize, and take action. Consider the realistic scenarios. Build on your strengths. And, become involved in networks.

In this regard, we have much to learn from the experiences of health centers across the country. Health Center involvement in today's Medicaid managed care arrangements provide perhaps the closest example of the kind of environment health centers will operate under in a reformed system.

Today I want to talk about the positive lessons we can draw from these experiences in several states -- I want to propose to you examples of health centers which in my opinion, have demonstrated a unique ability to adapt to the changing health care environment.

Before talking about these important lessons, I want to talk about some of the specifics of reform -- about the basics of what reform does for all of you as health centers.

### Reform

Make no mistake about it. The main message from the Administration in terms of reform and health centers is that we are absolutely aware of the vital and prominent role that you play in providing health care to our nation's most vulnerable people.

For that reason, the President's reform proposal designates FQHCs as Essential Community Providers, and requires health plans to contract with them for the first five years of health care reform. In this way, continuity of care for vulnerable people -- individuals who know you and trust you and who depend on you for their health care services -- will not be threatened.

Not only will plans be required to have arrangements with Essential Community Providers, but there are also specific safeguards which guarantee that you will be treated fairly in terms of your participation in the network and in terms of the amount of payment you will be entitled to receive.

Additionally, new federal loans will provide opportunities for health centers to expand, build networks, and coordinate care for vulnerable populations. These loans will be used for things like the development of community-based health plans, for capital improvements, technology and equipment upgrades, and other things that will help make you attractive to patients and improve your ability to compete for contracts with health plans.

And Health Security Act's commitment to primary care and to the expansion of the National Health Service Corps will help expand services in underserved areas.

The challenge facing you and other safety net providers will be to coordinate your efforts and work with health plans to ensure that needy groups receive critical services.

I know that many of you have great concerns about the reality of health center involvement in networks. Some of the difficulties you have faced with state reform efforts certainly don't serve to alleviate these concerns.

We understand your concerns with the process that states are using to pursue major reform initiatives. In fact, we've been involved with NACHC and other groups to explore how we can improve the process for public input on waivers -- to provide greater opportunity for public input -- and we'll let you know the details of this as soon as possible.

Ultimately, we believe that ongoing, constructive interaction between states and health centers -- where the most meaningful and effective communication can occur -- is the best way to ensure appropriate public input in the waiver process. So we encourage you to work hard to cultivate this sort of relationship with your state officials. Of course, HCFA is always available to talk with you about this and help whenever possible.

And as I have said, there are states that I will talk about in a minute, where Community and Migrant Health Centers and other FQHCs have seen positive results with the concept of managed care networks -- states where health centers and managed care organizations have been able to build constructive working relationships.

While these examples are not flawless, and certainly the necessary collaboration is not easy, the fact is that to a great extent they are working. Without question, these cases illustrate the wave of the future for health centers.

#### Network Examples

Indeed, in a number of instances, health centers have been able to position themselves as skillful negotiators, planners, and marketers. In doing so, they've overcome the barriers of health center participation in managed care. Risk contracting by consortiums of health centers and the creation of separate contracting entities to assume risk for health centers are among the various alternatives available.

Without question, network arrangements must assure that you are adequately compensated for the services you provide -- that your compensation is adjusted for the severity of health problems you see and for the range of services you provide. Fulfilling network requirements in terms of staff and other criteria necessary to qualify as plan providers must also be satisfied. And, of course, there is the issue of competing with other providers for contracts with managed care plans.

As a New Yorker transplanted in Washington, I go to New York to get good bagels. I also go back to my home state when I want to see how a microcosm of our country's health care system has addressed certain issues -- in this case, how the state is handling the issue of health centers and managed care networks.

New York has made a concerted effort to get health centers involved in managed care networks. The State has provided grants to health centers to help them develop the necessary structure and expertise for managed care involvement.

New York has developed a number of approaches to integrate providers into Medicaid managed care delivery systems. Most relevant to health centers and other FQHCs, the health centers form a separate corporation which assumes the risk for all services beyond the primary care actually provided by the health centers.

The contracts have low stop/loss limits which can gradually be raised as the health center gains more experience in the managed care environment. The separate corporation makes it possible to have less stringent reserve requirements than for HMOs -- partly because of the lower stop/loss arrangement.

Massachusetts has also recognized health centers' strengths in delivering primary care to the state's Medicaid population. Like New York, Massachusetts provided grants to health centers to help them gear up for participating in managed care. For example, the grants helped centers set up the data systems and other administrative infrastructure necessary to participate in a managed care program.

Starting with non-risk contracts in the first year, risk based managed care contracts were phased in over several years. Health centers developed networks and referral contracts with area hospitals and specialists.

The end result of this initiative is the Neighborhood Health Plan, a consortium of health centers that serves more Medicaid enrollees than any other Medicaid participating HMO in the state.

More recently, health centers in Oregon, Hawaii and Rhode Island have begun developing community networks by teaming up with hospitals. The hospital partners serve as referral facilities and sources of capital in these states where health care reform programs are being implemented.

The common thread that binds these examples together is innovation. Innovation and the ability of these centers to build on their roles as "essential" providers, while at the same time working hard to be "desirable" as well -- desirable to the people they serve, desirable to the others involved in the networks, and importantly, desirable to payers.

These centers have worked to overcome obstacles like the problems I mentioned earlier -- negotiating equitable reimbursement arrangements, fulfilling HMO standards of participation, and positioning themselves to successfully compete with other area providers.

Health centers and states have met these challenges through innovation and cooperation -- doing so as the means to the mutual end -- to provide care to the poor or those living in underserved areas. To use a term I know you are all very familiar with -- to provide a "medical home" for those who would otherwise be without one.

And this is one of the biggest strengths on which you must build. The ability you have demonstrated -- the experience you have cultivated over a period of more than twenty years, and the health professionals you enlist to serve poor and underserved populations -- to reach out to our nation's most vulnerable and provide them with necessary care. Further, by virtue of the definition of the populations you take care of -- the underserved -- you already have a presence in areas where other providers do not.

#### WRAP-UP

I want to emphasize again that successful health centers are moving from the old way of doing business, providing episodic health care services, to a system where everyone -- patients, providers, and payers alike -- has a stake in outcomes, outcomes that are maximized through the coordination of care. Networks make this necessary coordination possible -- and provide the continuum of care that will be particularly beneficial to the populations served by health centers.

Health Centers are already essential. But in order to thrive in a reformed health care system, I urge you again to demonstrate your desirability, too. Some of your colleagues are already capably doing this.

We are all working toward the same goals. We're on the same team. While we may not always agree, we're all seeking to assure access to appropriate, affordable and quality health care for all.

HCFA is working to help health centers adapt. We're investing significantly in risk adjustment research which will help assure that you are equitably compensated for the populations you enroll. Many of the rate-setting possibilities we are exploring have health status adjusters that would provide higher compensation to plans that enroll populations with higher health care costs and greater health care needs. When available, these methodologies will help ensure that the populations you serve are fairly treated in a reformed health care system.

And I'd like to suggest that you all take a close look at the guidelines recently released by HCFA's Medicaid Bureau for setting up quality assurance systems in Medicaid managed care. You'll find that they provide useful instruction in terms of what managed care organizations will increasingly look for in their network providers.

And as new ideas arise and health centers, together with states, experiment with new approaches, please talk with us. Now is the time for you to strategically think and prepare -- to recognize the realities of a reformed system and constructively address the probable changes.

Thank you. Time permitting, I'd like to open the floor up for questions and comments.

*file*  
**DRAFT**

- A new analysis of Medicaid block grants conducted by the Urban Institute for the Kaiser Commission on the Future of Medicaid finds that if the growth in federal Medicaid payments to states is capped at 5% per year, states would lose over \$84 billion in federal funds between 1996 and 2000.
- New York, California, Texas and Florida would lose the largest amount. New York would lose almost \$9 billion; California almost \$7 billion; Texas \$5.5 billion; and Florida \$5 billion.
- States in the South and Mountain regions would have the biggest percentage reductions in federal payment. Reductions will average over 18% in states such as Florida, Georgia, Arkansas, Montana, West Virginia and North Carolina.
- The study suggests that it is very unlikely that cuts of this magnitude could be offset through managed care, provider payment reductions or elimination of optional benefits -- states would very likely be forced to reduce coverage or increase their own spending to offset the substantial reduction in federal Medicaid contributions.

DRAFT

## The Impact of a Five Percent Medicaid Expenditure Growth Cap

John Holahan  
David Liska  
March 15, 1995

Controlling the growth in Medicaid spending is a pivotal part of Congressional efforts to reduce the federal deficit. One proposal that has emerged is a 5% cap on the growth in federal Medicaid expenditures. This would be a uniform cap applied to all states on all Medicaid spending including acute care, long term care, disproportionate share payments and administrative costs. It would give states amounts equal to their current federal spending plus 5% for each year beginning in 1995 on into the indefinite future. We have discussed the distributional effects of these policies elsewhere.<sup>1</sup> This report addresses the aggregate spending impacts.

The most important findings in this analysis are:

- Federal Medicaid spending would fall as a result of a 5% expenditure growth cap by 20.1% in the year 2000. Cumulative reductions in federal expenditures would amount \$84.2 billion over the 1996 to 2000 period. If state spending also grew by 5% over the period, total Medicaid expenditures would fall by \$51.0 billion relative to the baseline projection of \$254.9 billion.
- The impact of a 5% cap is greatest for states in the South and Mountain regions. This is because these states are expected to grow faster than the national average in the absence of an expenditure cap.
- States with high levels of disproportionate share hospital (DSH) payments will grow more slowly than average, all else being equal; as a result, expenditure caps will have less of an effect on these states. This is because these states are already subject to caps on DSH spending resulting from federal legislation enacted in 1991 and 1993.
- A 5% expenditure growth cap also has more serious implications for lower income states because of the structure of federal matching contributions. Because federal Medicaid payments can amount to over 70% of total expenditures in low income

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<sup>1</sup>Holahan, John and David Liska, "State Variations in Medicaid: Implications for Block Grants and Expenditure Growth Caps," (Washington, D.C.: The Kaiser Commission of the Future of Medicaid, Policy Brief, March 1995).

states, replacing any lost federal funds would require greater percentage increases in state spending in these states. For example, while states on average would have to increase spending by 27.2% in order to replace all federal funds, Mississippi and West Virginia would need to increase state spending by more than 80%, assuming they attempted to maintain current spending levels.

To estimate the impact of a 5% cap we project Medicaid beneficiary and expenditure growth from 1993 to the year 2002. We make separate projections for growth in different beneficiary groups and for changes in spending per beneficiary for acute and long term care services for different groups, e.g., the aged, disabled, adults and children. We also use regional adjusters to account for differences across geographic areas in the rate of growth of beneficiaries and of spending per beneficiary.<sup>2</sup> This allows us to develop estimates of beneficiary and spending growth that are state specific and more likely to reflect actual growth patterns that will vary considerably across states. The results of our spending projections are shown in Tables 1 through 3.

We estimate that under current law, the number of beneficiaries will grow from 36.3 million in 1995 to 43.4 million in 2000 and 45.7 million in 2002. We estimate that spending will grow from \$159.8 billion in 1995 to \$254.9 billion in the year 2000, and \$304.0 billion in 2002. Both of these projections are within the range forecast by the Congressional Budget Office and the Health Care Financing Administration's Office of the Actuary.

Table 1 projects that Medicaid expenditures would experience an average annual increase of 9.8% in the absence of any change in policy. This includes increases in benefits (10.4% per

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<sup>2</sup>These adjustments allow us to account for much of the differentials in beneficiary and spending growth across states in the recent past (1988-1993). States of course differ somewhat within regions in their past experience and future policies adopted by specific states could result in different patterns than we have projected. It is, of course, not possible to know all of the likely events that could impact any state's future expenditures. We have little choice but to assume the past is the best guide to the future. (More detail on the estimation methods is available from the authors.)

year), disproportionate share payments (5.0% per year), and administration (8.4% per year).

Table 1 also shows that acute care spending is likely to grow faster than long term care.

Between 1993 and 2002 acute care services are projected to increase by 11.4% per year; while long term care is expected to increase by 8.9% annually. These differences are consistent with growth rates in the recent past and reflects increases in those beneficiaries likely to be heavier users of acute care services as well as slow growth in long term care spending per beneficiary.

Table 2 suggests that spending on the blind and disabled (11.1% per year) and adults and children (11.3% per year) will grow more rapidly than spending on the elderly (8.9% per year). This reflects larger increases in enrollment among the former groups as well as more use of faster growing acute care services. The smaller increases in spending on the elderly reflects the impact of the projected slower growth in long term care.

Table 3 shows that expenditures in the South Atlantic, West South Central, Mountain, and Pacific (excluding California) regions will grow more rapidly than in the New England, West North Central and East North Central regions. We have also made separate adjustments for California and New York because of their size and impact on overall spending growth in the program. California is expected to experience growth roughly in line with the national average while New York is projected to grow somewhat more slowly. Finally, states with high disproportionate share expenditures are affected by 1991 and 1993 legislation that limits growth in these payments. State whose disproportionate share payments exceed 12% of their Medicaid expenditures are essentially frozen. Other states are permitted to grow at the same rate as their Medicaid expenditures.

Table 4 shows the impact of a 5% cap on changes in federal expenditures over the 1996-2000 period as well as for the year 2000. The results show that federal spending would decline

by \$84.2 billion or 13.7% over the 1996 to 2000 period, relative to baseline projections. The results also show that a 5% cap would mean a 20.1% reduction (\$29.5 billion) in federal expenditures in the year 2000. The higher percentage reduction reflects the growing impact of a 5% cap over time.

The distribution of federal spending reductions across states is uneven, reflecting three factors. First, states where expenditures for acute care are substantially greater than long term care will experience greater reductions from a 5% cap because those states are estimated to have had more rapid growth. Second, states in the South and Mountain regions, in part related to more beneficiary growth and the greater importance of acute care, have greater percentage reductions in federal spending under a 5% cap. For example, Florida, Georgia, Montana, North Carolina and West Virginia will have the largest percentage reductions, over 18% between 1996-2000. Reductions in federal Medicaid spending in these states in the year 2000 will exceed 25%.

States with high disproportionate share payments in 1993 will have lower reductions in spending because current restrictions on use of disproportionate share payments constrain their overall rates of growth in the absence of the cap. For example, states with large disproportionate share payments, such as New Hampshire (1.5%), Kansas (8.4%), Missouri (6.3%), Connecticut (8.4%), or Alabama (9.5%) will experience smaller effects from the 5% cap than other states in their regions because of the importance of disproportionate share payments.

In terms of absolute dollars, the states with the largest reductions in federal payments (1996-2000) are New York (\$8.9 billion), California (\$6.9 billion), Texas (\$5.5 billion) and Florida (\$5.0 billion).

Table 5 shows reductions in state spending, assuming that states only allow their spending to increase by 5%. If states successfully reduce spending by this amount, cumulative savings would amount to \$60.9 billion over the 1996 - 2000 period or a reduction of 13.3%. In the year 2000 savings would be \$21.5 billion (19.8%).

The pattern of reductions across states are the same as described above. States in the South and Mountain regions would have the largest percentage reductions. States with high disproportionate share payments would have the smallest reductions. Since many of the latter states (high DSH) have financed disproportionate share payments with provider taxes and donations, which in many cases do not involve transfers of real resources these savings are really "on paper."

Table 6 shows that total (federal and state) expenditures would be reduced by \$51.0 billion in the year 2000 relative to the baseline of \$254.9 billion, or by 20%. Unfortunately, states may have a very difficult time reducing Medicaid spending by these amounts. Reductions in Medicaid spending of 20% or more are very likely not achievable simply by enrolling people in managed care or otherwise controlling utilization, reducing provider payment rates or eliminating optional services. States would most likely have to reduce enrollment in order to achieve these savings.

Because of the difficulties in making these kinds of reductions, many states will end up using their own revenues to replace some of the lost federal revenues. In Table 6 we show estimates under the assumption that states will replace all federal dollars. This table allows us to ask the question "How much will states have to increase spending if they were to replace all funding no longer coming from the federal government?" We do not presume that states will, in fact, replace all lost federal dollars; we only estimate the effect if they wished to do so.

The results show that states would have to increase their own spending by \$84.2 billion (1996-2000) or by 18.5% to replace all federal funds that would have been spent without the cap. In the year 2000, states would have to increase spending by 27.2% (\$29.5 billion) in order to replace all federal funds.

The states that would have to increase their spending the most (1996 - 2000) in absolute dollars again include New York, California, Florida and Texas. However, the states that would have increase their spending the most in percentage terms over this period would be West Virginia (62.7%), New Mexico (49.2%), Mississippi (57.2%) and Arkansas (51.0%). The percentage increases for these states are substantially larger in the year 2000. For example, spending increases would exceed 80% in Mississippi and West Virginia in 2000 relative to the baseline if these states attempted to maintain current spending levels. They clearly would not do so, but these estimates indicate the kinds of program impacts that could result.

The large impacts on these states occurs because these states have very high matching rates--federal contributions would amount to over 70% of their Medicaid spending. Reductions in federal dollars therefore require large increases in spending relative to their current outlays. In contrast, states such as New York and California which have very large increases in absolute dollars have relatively small increases in percentage terms (11.5% and 12.2% respectively in 1996 - 2000). As before, states with large disproportionate share payments would have to make much smaller increases in state expenditures to offset the reduction in federal dollars. This follows from the fact that their rates of growth in the baseline are already low; consequently, their reductions from the 5% federal cap would be substantially smaller as well.

Tables 7 and 8 show our projected growth in beneficiaries from 1993 - 2002 by eligibility group and by region, respectively. Tables 9 - 11 provide estimates of changes in federal and state spending for the 1996 - 2002 period.

**Table 1**  
**Medicaid Expenditure and Beneficiary Projections, 1994-2002**  
**By Type of Service**

Expenditures (billions)	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Average
											1993-2002
<b>Total</b>	131.2	144.8	159.8	176.3	193.9	213.3	233.6	254.9	278.3	304.0	
Growth	-	10.3%	10.3%	10.3%	10.0%	10.0%	9.6%	9.0%	9.2%	9.2%	9.6%
<b>Benefits*</b>	109.5	122.6	136.9	152.2	168.5	186.1	204.9	223.9	244.8	267.7	
Growth	-	12.0%	11.7%	11.2%	10.6%	10.5%	10.1%	9.3%	9.3%	9.4%	10.4%
<b>Benefits by Service</b>											
Acute Care	64.0	72.5	81.8	92.0	102.7	114.5	128.9	139.6	153.6	169.0	
Growth	-	13.2%	12.9%	12.4%	11.7%	11.5%	10.9%	10.0%	10.0%	10.0%	11.4%
Long-term Care	44.2	48.6	53.5	58.5	63.8	69.5	75.5	81.7	88.3	95.5	
Growth	-	10.1%	9.9%	9.4%	9.0%	8.9%	8.8%	8.1%	8.1%	8.2%	8.9%
<b>DSH</b>	16.9	17.2	17.7	18.3	19.2	20.3	21.4	22.7	24.4	26.3	
Growth	-	1.6%	2.7%	3.6%	4.8%	5.4%	5.5%	6.2%	7.5%	7.7%	5.0%
<b>Administration</b>	4.8	5.0	5.2	5.7	6.3	6.9	7.5	8.3	9.1	10.0	
Growth	-	3.9%	3.9%	9.7%	8.7%	8.7%	8.7%	9.8%	9.8%	9.8%	8.4%
<b>Beneficiaries (thousands)</b>											
<b>Total</b>	32,534	34,511	36,321	37,947	39,502	41,027	42,316	43,400	44,515	45,664	
Growth	-	6.1%	5.2%	4.5%	4.1%	3.9%	3.1%	2.6%	2.6%	2.6%	3.8%

\*totals include Arizona

**Table 2**  
**Medicaid Expenditure and Beneficiary Projections, 1994-2002**  
**By Beneficiary Group**

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Average 1993- 2002
<b>Expenditures (billions)</b>											
<b>Total</b>	131.2	144.9	159.8	176.3	193.9	213.3	233.8	254.9	278.3	304.0	
Growth	-	10.3%	10.3%	10.3%	10.0%	10.0%	9.6%	9.0%	9.2%	9.2%	9.6%
<b>Benefits*</b>	109.5	122.6	136.9	152.2	168.5	186.1	204.9	223.9	244.8	267.7	
Growth	-	12.0%	11.7%	11.2%	10.6%	10.5%	10.1%	9.3%	9.3%	9.4%	10.4%
<b>Benefits by Beneficiary Group</b>											
<b>Elderly</b>	34.3	37.8	41.6	45.4	49.4	53.8	58.4	63.1	68.3	73.9	
Growth	-	10.3%	10.0%	9.3%	8.8%	8.7%	8.6%	8.1%	8.2%	8.2%	8.9%
<b>Blind &amp; Disabled</b>	39.5	44.3	49.7	55.8	62.1	69.1	76.8	84.4	92.8	102.0	
Growth	-	11.8%	12.3%	12.3%	11.3%	11.2%	11.1%	9.9%	9.9%	9.9%	11.1%
<b>Adults &amp; Children</b>	28.6	32.1	36.0	40.4	45.3	50.6	55.9	61.6	67.8	74.7	
Growth	-	12.4%	12.1%	12.1%	12.1%	11.7%	10.5%	10.2%	10.2%	10.2%	11.3%
<b>Pregnant Women &amp; Children</b>	5.8	7.0	8.0	8.8	9.6	10.5	11.4	12.2	13.0	14.0	
Growth	-	19.6%	15.0%	10.0%	9.0%	8.9%	8.6%	7.2%	7.2%	7.2%	10.2%
<b>DSH</b>	16.9	17.2	17.7	18.3	19.2	20.3	21.4	22.7	24.4	26.3	
Growth	-	1.6%	2.7%	3.8%	4.8%	5.4%	5.5%	6.2%	7.5%	7.7%	5.0%
<b>Administration</b>	4.8	5.0	5.2	5.7	6.3	6.9	7.5	8.3	9.1	10.0	
Growth	-	3.9%	3.9%	9.7%	9.7%	9.7%	9.7%	9.8%	9.8%	9.8%	8.4%
<b>Beneficiaries (thousands)</b>											
<b>Total</b>	32,534	34,511	36,321	37,947	39,502	41,027	42,316	43,400	44,515	45,664	
Growth	-	6.1%	5.2%	4.5%	4.1%	3.9%	3.1%	2.6%	2.6%	2.6%	3.8%

\*Totals include Arizona



Table 4

## Medicaid Expenditure Projections, 1996-2000

## Federal Expenditures

## Federal Expenditure Growth Capped at 5% per Year Starting 1996

(millions of dollars)

	1996-2000				2000			
	Baseline	5% Federal Cap			Baseline	5% Federal Cap		
		Expend.	Change	%Change		Expend.	Change	%Change
Total	615,875	531,782	(84,193)	-13.7%	146,462	118,979	(29,483)	-20.1%
Alabama	9,142	8,273	(869)	-9.5%	2,121	1,820	(301)	-14.2%
Alaska	1,278	1,064	(215)	-16.8%	307	234	(73)	-23.7%
Arizona	7,785	6,612	(1,175)	-15.1%	1,869	1,454	(414)	-22.2%
Arkansas	7,219	5,953	(1,266)	-17.5%	1,739	1,309	(429)	-24.7%
California	56,287	49,408	(6,879)	-12.2%	13,356	10,869	(2,488)	-18.6%
Colorado	5,271	4,426	(845)	-16.0%	1,265	974	(291)	-23.0%
Connecticut	8,649	7,925	(724)	-8.4%	2,004	1,743	(260)	-13.0%
Delaware	1,127	961	(166)	-14.7%	269	211	(58)	-21.5%
District of Columbia	2,945	2,516	(429)	-14.6%	706	553	(153)	-21.6%
Florida	26,390	21,394	(4,996)	-18.9%	6,389	4,706	(1,683)	-26.3%
Georgia	16,846	13,703	(3,144)	-18.7%	4,077	3,014	(1,062)	-26.1%
Hawaii	1,772	1,474	(298)	-16.8%	425	324	(101)	-23.8%
Idaho	1,918	1,639	(277)	-14.5%	457	361	(96)	-21.1%
Illinois	21,731	18,870	(3,060)	-14.1%	5,194	4,107	(1,087)	-20.9%
Indiana	15,105	12,971	(2,133)	-14.1%	3,608	2,853	(754)	-20.9%
Iowa	5,151	4,530	(621)	-12.1%	1,218	987	(221)	-18.2%
Kansas	3,963	3,632	(331)	-8.4%	919	799	(120)	-13.0%
Kentucky	11,823	10,023	(1,901)	-15.9%	2,869	2,205	(664)	-23.1%
Louisiana	22,461	19,722	(2,739)	-12.2%	5,255	4,338	(917)	-17.4%
Maine	3,976	3,647	(328)	-8.3%	925	802	(122)	-13.2%
Maryland	8,767	7,422	(1,345)	-15.3%	2,105	1,633	(472)	-22.4%
Massachusetts	16,576	14,421	(2,155)	-13.0%	3,946	3,172	(773)	-19.6%
Michigan	20,656	17,730	(2,927)	-14.2%	4,943	3,900	(1,043)	-21.1%
Minnesota	9,705	8,625	(1,080)	-11.1%	2,293	1,897	(396)	-17.3%
Mississippi	8,189	6,945	(1,244)	-15.2%	1,954	1,528	(427)	-21.8%
Missouri	9,943	9,314	(629)	-6.3%	2,277	2,049	(229)	-10.0%
Montana	2,268	1,832	(436)	-19.2%	546	403	(143)	-26.2%
Nebraska	2,923	2,560	(363)	-12.4%	692	563	(129)	-18.6%
Nevada	1,887	1,636	(251)	-13.3%	449	360	(89)	-19.8%
New Hampshire	2,538	2,500	(38)	-1.5%	565	550	(16)	-2.7%
New Jersey	18,527	16,669	(1,858)	-10.0%	4,321	3,667	(654)	-15.1%
New Mexico	3,943	3,257	(687)	-17.4%	951	716	(234)	-24.7%
New York	77,313	68,385	(8,928)	-11.6%	18,339	15,043	(3,296)	-18.0%
North Carolina	18,781	15,119	(3,662)	-19.5%	4,542	3,326	(1,216)	-26.8%
North Dakota	1,643	1,448	(195)	-11.9%	388	319	(68)	-17.8%
Ohio	26,707	23,061	(3,645)	-13.6%	6,360	5,073	(1,287)	-20.2%
Oklahoma	7,249	6,069	(1,180)	-16.3%	1,735	1,336	(400)	-23.0%
Oregon	5,825	4,845	(980)	-16.8%	1,393	1,066	(327)	-23.5%
Pennsylvania	25,165	22,189	(2,975)	-11.8%	5,983	4,881	(1,102)	-18.4%
Rhode Island	3,584	3,137	(447)	-12.5%	850	690	(160)	-18.9%
South Carolina	10,072	8,871	(1,201)	-11.9%	2,355	1,951	(404)	-17.1%
South Dakota	1,559	1,364	(195)	-12.5%	370	300	(70)	-18.9%
Tennessee	15,807	13,395	(2,412)	-15.3%	3,789	2,947	(842)	-22.2%
Texas	39,767	34,284	(5,482)	-13.8%	9,380	7,542	(1,848)	-19.7%
Utah	3,329	2,812	(516)	-15.5%	797	619	(178)	-22.3%
Vermont	1,307	1,146	(161)	-12.3%	310	252	(58)	-18.8%
Virginia	8,506	7,010	(1,496)	-17.6%	2,048	1,542	(506)	-24.7%
Washington	11,910	9,947	(1,963)	-16.5%	2,855	2,188	(666)	-23.3%
West Virginia	8,919	7,180	(1,739)	-19.5%	2,165	1,579	(585)	-27.0%
Wisconsin	10,840	9,359	(1,482)	-13.7%	2,583	2,059	(524)	-20.3%
Wyoming	831	705	(126)	-15.2%	198	155	(43)	-21.8%

Table 8

## Medicaid Expenditure Projections, 1996-2000

## State Expenditures, Without States Maintaining Total Baseline Spending

## Expenditure Growth Capped at 5% per Year Starting 1996

(millions of dollars)

	1996-2000				2000			
	Baseline	5% Cap			Baseline	5% Cap		
		Expend.	Change	%Change		Expend.	Change	%Change
Total	458,180	395,318	(60,864)	-13.3%	108,429	86,860	(21,469)	-19.8%
Alabama	3,653	3,308	(347)	-9.5%	848	-727	(120)	-14.2%
Alaska	1,278	1,084	(215)	-18.8%	307	234	(73)	-23.7%
Arizona	4,031	3,423	(608)	-15.1%	967	753	(214)	-22.2%
Arkansas	2,483	2,047	(435)	-17.5%	598	450	(148)	-24.7%
California	58,287	49,408	(8,879)	-12.2%	13,356	10,869	(2,488)	-18.6%
Colorado	4,415	3,707	(707)	-16.0%	1,059	818	(244)	-23.0%
Connecticut	8,649	7,925	(724)	-8.4%	2,004	1,743	(260)	-13.0%
Delaware	1,127	961	(166)	-14.7%	269	211	(58)	-21.5%
District of Columbia	2,945	2,516	(429)	-14.6%	708	553	(153)	-21.8%
Florida	21,565	17,483	(4,082)	-18.9%	5,221	3,846	(1,375)	-26.3%
Georgia	10,290	8,370	(1,920)	-18.7%	2,490	1,841	(649)	-26.1%
Hawaii	1,772	1,474	(298)	-16.8%	425	324	(101)	-23.8%
Idaho	775	663	(112)	-14.5%	185	146	(39)	-21.1%
Illinois	21,731	18,870	(3,060)	-14.1%	6,194	4,107	(1,087)	-20.9%
Indiana	8,791	7,550	(1,242)	-14.1%	2,100	1,561	(439)	-20.9%
Iowa	3,059	2,690	(369)	-12.1%	723	592	(131)	-18.2%
Kansas	2,848	2,610	(238)	-8.4%	880	574	(86)	-13.0%
Kentucky	4,706	3,956	(750)	-15.9%	1,132	870	(262)	-23.1%
Louisiana	8,011	7,034	(977)	-12.2%	1,874	1,547	(327)	-17.4%
Maine	2,458	2,253	(203)	-8.3%	571	498	(76)	-13.2%
Maryland	8,767	7,422	(1,345)	-15.3%	2,105	1,633	(472)	-22.4%
Massachusetts	16,576	14,421	(2,155)	-13.0%	3,946	3,172	(773)	-19.6%
Michigan	18,336	14,021	(2,314)	-14.2%	3,909	3,084	(825)	-21.1%
Minnesota	7,963	7,077	(886)	-11.1%	1,882	1,557	(325)	-17.3%
Mississippi	2,175	1,845	(331)	-15.2%	519	406	(113)	-21.8%
Missouri	6,557	6,142	(415)	-8.3%	1,502	1,351	(151)	-10.0%
Montana	930	751	(179)	-19.2%	224	165	(59)	-26.2%
Nebraska	1,844	1,615	(229)	-12.4%	436	355	(81)	-18.6%
Nevada	1,723	1,493	(230)	-13.3%	410	328	(81)	-19.8%
New Hampshire	2,538	2,500	(38)	-1.5%	565	550	(16)	-2.7%
New Jersey	18,527	16,669	(1,858)	-10.0%	4,321	3,667	(654)	-15.1%
New Mexico	1,398	1,153	(243)	-17.4%	337	254	(83)	-24.7%
New York	77,313	68,385	(8,928)	-11.5%	18,339	15,043	(3,296)	-18.0%
North Carolina	9,710	7,817	(1,893)	-19.5%	2,348	1,719	(629)	-26.8%
North Dakota	632	557	(75)	-11.9%	149	123	(27)	-17.8%
Ohio	17,620	15,215	(2,405)	-13.6%	4,196	3,347	(849)	-20.2%
Oklahoma	3,156	2,642	(514)	-16.3%	755	581	(174)	-23.0%
Oregon	3,511	2,921	(591)	-16.8%	840	643	(197)	-23.5%
Pennsylvania	20,193	17,806	(2,388)	-11.8%	4,801	3,917	(884)	-18.4%
Rhode Island	3,098	2,711	(386)	-12.5%	735	598	(139)	-18.9%
South Carolina	4,058	3,574	(484)	-11.9%	949	786	(163)	-17.1%
South Dakota	660	577	(83)	-12.5%	157	127	(30)	-18.9%
Tennessee	7,587	6,429	(1,158)	-15.3%	1,818	1,414	(404)	-22.2%
Texas	21,944	18,919	(3,025)	-13.8%	5,182	4,182	(1,020)	-19.7%
Utah	1,092	923	(169)	-15.5%	261	203	(58)	-22.3%
Vermont	875	768	(108)	-12.3%	208	189	(39)	-18.8%
Virginia	8,508	7,010	(1,498)	-17.6%	2,048	1,542	(506)	-24.7%
Washington	9,737	8,132	(1,605)	-16.5%	2,334	1,789	(545)	-23.3%
West Virginia	2,772	2,232	(540)	-19.5%	873	491	(182)	-27.0%
Wisconsin	7,101	6,131	(971)	-13.7%	1,692	1,349	(343)	-20.3%

**Table 6**  
**Medicaid Expenditure Projections, 1996-2000**  
**Federal and State Expenditures**  
**Total Expenditure Growth Capped at 5% per Year Starting 1996**  
(millions of dollars)

	1996-2000				2000			
	Baseline	5% Cap			Baseline	5% Cap		
		Expend.	Change	%Change		Expend.	Change	%Change
Total	1,072,155	927,098	(145,057)	-13.5%	264,891	203,939	(50,952)	-20.0%
Alabama	12,795	11,578	(1,218)	-9.5%	2,969	2,547	(422)	-14.2%
Alaska	2,557	2,127	(430)	-16.8%	614	468	(146)	-23.7%
Arizona	11,817	10,035	(1,783)	-15.1%	2,836	2,207	(628)	-22.2%
Arkansas	9,701	8,000	(1,702)	-17.5%	2,337	1,760	(577)	-24.7%
California	112,575	98,817	(13,758)	-12.2%	26,712	21,737	(4,975)	-18.6%
Colorado	9,688	8,134	(1,552)	-16.0%	2,324	1,789	(535)	-23.0%
Connecticut	17,289	15,851	(1,448)	-8.4%	4,008	3,487	(521)	-13.0%
Delaware	2,254	1,922	(331)	-14.7%	539	423	(116)	-21.5%
District of Columbia	6,890	5,031	(858)	-14.6%	1,412	1,107	(305)	-21.6%
Florida	47,955	38,877	(9,078)	-18.9%	11,610	8,552	(3,058)	-26.3%
Georgia	27,138	22,073	(5,064)	-18.7%	8,567	4,855	(1,711)	-26.1%
Hawaii	3,544	2,948	(596)	-16.8%	851	648	(202)	-23.8%
Idaho	2,692	2,302	(390)	-14.5%	642	508	(135)	-21.1%
Illinois	43,461	37,341	(6,121)	-14.1%	10,388	8,214	(2,174)	-20.9%
Indiana	23,896	20,521	(3,375)	-14.1%	5,707	4,514	(1,193)	-20.8%
Iowa	8,210	7,221	(990)	-12.1%	1,941	1,588	(353)	-18.2%
Kansas	6,811	6,242	(568)	-8.4%	1,579	1,373	(206)	-13.0%
Kentucky	16,630	13,979	(2,651)	-15.9%	4,001	3,075	(926)	-23.1%
Louisiana	30,472	26,756	(3,716)	-12.2%	7,130	5,886	(1,244)	-17.4%
Maine	6,431	5,900	(531)	-8.3%	1,496	1,298	(198)	-13.2%
Maryland	17,535	14,844	(2,691)	-15.3%	4,209	3,265	(944)	-22.4%
Massachusetts	33,162	28,843	(4,309)	-13.0%	7,892	6,345	(1,547)	-19.6%
Michigan	36,992	31,751	(5,241)	-14.2%	8,853	6,984	(1,869)	-21.1%
Minnesota	17,669	15,703	(1,966)	-11.1%	4,175	3,454	(721)	-17.3%
Mississippi	10,364	8,790	(1,575)	-15.2%	2,474	1,834	(540)	-21.8%
Missouri	16,500	15,458	(1,045)	-8.3%	3,779	3,400	(379)	-10.0%
Montana	3,199	2,583	(615)	-19.2%	770	588	(202)	-26.2%
Nebraska	4,766	4,176	(591)	-12.4%	1,128	918	(210)	-18.8%
Nevada	3,610	3,129	(481)	-13.3%	858	688	(170)	-19.8%
New Hampshire	5,077	5,000	(77)	-1.5%	1,131	1,100	(31)	-2.7%
New Jersey	37,054	33,338	(3,716)	-10.0%	8,642	7,334	(1,309)	-15.1%
New Mexico	5,339	4,410	(930)	-17.4%	1,287	970	(317)	-24.7%
New York	154,628	136,771	(17,855)	-11.5%	36,878	30,086	(6,591)	-18.0%
North Carolina	28,491	22,936	(5,555)	-19.5%	6,890	5,045	(1,845)	-26.8%
North Dakota	2,275	2,005	(270)	-11.9%	537	441	(96)	-17.8%
Ohio	44,328	38,276	(6,050)	-13.6%	10,555	8,420	(2,136)	-20.2%
Oklahoma	10,405	8,711	(1,694)	-16.3%	2,490	1,916	(574)	-23.0%
Oregon	9,336	7,768	(1,570)	-16.8%	2,233	1,708	(525)	-23.5%
Pennsylvania	45,358	39,995	(5,363)	-11.8%	10,784	8,798	(1,986)	-18.4%
Rhode Island	6,881	5,848	(833)	-12.5%	1,585	1,286	(299)	-18.9%
South Carolina	14,130	12,446	(1,684)	-11.9%	3,304	2,738	(567)	-17.1%
South Dakota	2,219	1,941	(278)	-12.5%	527	427	(100)	-18.9%
Tennessee	23,394	19,824	(3,569)	-15.3%	5,607	4,361	(1,246)	-22.2%
Texas	61,711	53,204	(8,507)	-13.8%	14,572	11,704	(2,868)	-19.7%
Utah	4,421	3,736	(686)	-15.5%	1,058	822	(236)	-22.3%
Vermont	2,182	1,914	(268)	-12.3%	518	421	(97)	-18.8%
Virginia	17,013	14,021	(2,992)	-17.6%	4,096	3,084	(1,012)	-24.7%
Washington	21,647	18,080	(3,568)	-16.5%	5,188	3,977	(1,211)	-23.3%
West Virginia	11,691	9,412	(2,279)	-19.5%	2,837	2,070	(767)	-27.0%
Wisconsin	17,942	15,490	(2,452)	-13.7%	4,274	3,407	(867)	-20.3%

Table 43

## Medicaid Expenditure Projections, 1996-2002

## State Expenditures, With States Maintaining Total Baseline Spending

## Federal Expenditure Growth Capped at 5% per Year Starting 1996

(millions of dollars)

	1996-2002				2002			
	Baseline	Expend.	5% Cap Change	%Change	Baseline	Expend.	5% Cap Change	%Change
Total	703,947	870,809	166,862	23.7%	129,359	174,982	45,624	35.3%
Alabama	5,552	7,255	1,704	30.7%	985	1,445	460	46.6%
Alaska	1,980	2,393	413	20.8%	366	475	108	29.8%
Arizona	6,255	8,594	2,339	37.4%	1,163	1,806	643	55.3%
Arkansas	3,852	6,280	2,429	63.1%	715	1,351	636	88.9%
California	87,038	101,273	14,235	16.4%	16,092	20,201	4,109	25.5%
Colorado	6,841	8,487	1,646	24.1%	1,268	1,708	440	34.7%
Connecticut	13,200	14,722	1,522	11.5%	2,371	2,820	449	18.9%
Delaware	1,744	2,071	327	18.8%	322	411	89	27.6%
District of Columbia	4,568	5,428	861	18.8%	849	1,087	239	28.1%
Florida	33,543	43,067	9,524	28.4%	8,261	8,735	2,474	39.5%
Georgia	16,003	22,012	6,009	37.5%	2,987	4,553	1,566	52.4%
Hawaii	2,745	3,318	573	20.9%	508	659	151	29.6%
Idaho	1,197	1,741	544	45.4%	220	367	147	66.6%
Illinois	33,641	39,772	6,131	18.2%	6,225	7,922	1,697	27.3%
Indiana	13,602	17,859	4,257	31.3%	2,514	3,686	1,173	46.7%
Iowa	4,705	5,953	1,248	26.5%	858	1,205	347	40.4%
Kansas	4,335	5,014	679	15.7%	773	968	195	25.2%
Kentucky	7,308	11,055	3,746	51.3%	1,381	2,377	1,016	74.7%
Louisiana	12,220	17,422	5,202	42.6%	2,186	3,532	1,346	61.6%
Maine	3,755	4,456	703	18.7%	678	891	213	31.4%
Maryland	13,600	16,263	2,663	19.6%	2,526	3,253	726	28.8%
Massachusetts	25,605	29,961	4,356	17.0%	4,716	5,935	1,219	25.8%
Michigan	25,315	31,202	5,888	23.3%	4,896	6,333	1,638	34.9%
Minnesota	12,255	14,481	2,226	18.2%	2,239	2,876	637	28.4%
Mississippi	3,359	5,771	2,412	71.8%	618	1,258	640	103.7%
Missouri	9,903	11,195	1,292	13.1%	1,733	2,102	369	21.3%
Montana	1,440	2,253	813	56.4%	268	470	204	76.8%
Nebraska	2,837	3,583	726	25.6%	518	719	201	38.7%
Nevada	2,661	3,167	505	19.0%	491	631	141	28.7%
New Hampshire	3,772	3,861	89	2.3%	635	664	29	4.6%
New Jersey	28,258	31,954	3,696	13.1%	5,058	6,074	1,018	20.1%
New Mexico	2,169	3,496	1,327	61.2%	404	755	351	86.9%
New York	119,220	137,674	18,454	15.5%	21,879	27,172	5,294	24.2%
North Carolina	15,075	21,956	6,881	45.6%	2,801	4,552	1,751	62.5%
North Dakota	871	1,360	389	40.1%	176	283	107	60.7%
Ohio	27,209	34,468	7,260	26.7%	5,006	7,001	1,995	39.9%
Oklahoma	4,877	7,138	2,261	46.4%	898	1,489	591	65.8%
Oregon	5,422	7,276	1,854	34.2%	996	1,473	477	47.9%
Pennsylvania	31,170	37,318	6,148	19.7%	5,731	7,492	1,761	30.7%
Rhode Island	4,775	5,677	902	18.9%	875	1,128	252	28.8%
South Carolina	6,188	8,474	2,286	36.9%	1,108	1,699	593	53.6%
South Dakota	1,017	1,412	395	38.8%	187	297	110	59.1%
Tennessee	11,736	16,452	4,715	40.2%	2,166	3,430	1,264	58.4%
Texas	33,814	44,571	10,757	31.8%	8,202	9,125	2,924	47.1%
Utah	1,690	2,696	1,006	59.5%	312	581	269	86.2%
Vermont	1,351	1,678	328	24.3%	248	341	93	37.3%
Virginia	13,130	16,051	2,861	21.7%	2,446	3,192	746	30.5%
Washington	15,067	18,841	3,773	25.0%	2,783	3,774	991	35.6%
West Virginia	4,317	7,629	3,312	76.7%	808	1,667	859	106.3%
Wisconsin	10,971	13,928	2,957	27.0%	2,021	2,835	815	40.3%
Wyoming	628	872	244	38.8%	115	180	65	56.0%

Table 7

## Medicaid Expenditure Projections, 1996-2000

## State Expenditures, With States Maintaining Total Baseline Spending

## Federal Expenditure Growth Capped at 5% per Year Starting 1996

(millions of dollars)

	1996-2000				2000			
	Baseline	5% Cap			Baseline	5% Cap		
		Expend.	Change	%Change		Expend.	Change	%Change
Total	456,180	540,373	84,193	18.5%	108,429	137,912	29,483	27.2%
Alabama	3,653	4,522	869	23.8%	848	1,149	301	35.6%
Alaska	1,278	1,493	215	16.8%	307	380	73	23.7%
Arizona	4,031	5,205	1,175	29.1%	967	1,381	414	42.8%
Arkansas	2,483	3,749	1,266	51.0%	598	1,027	429	71.8%
California	56,287	63,166	6,879	12.2%	13,358	15,844	2,486	18.6%
Colorado	4,415	5,259	845	19.1%	1,059	1,350	291	27.5%
Connecticut	8,849	9,373	524	5.9%	2,004	2,264	260	13.0%
Delaware	1,127	1,293	166	14.7%	269	328	58	21.5%
District of Columbia	2,945	3,374	429	14.6%	706	859	153	21.6%
Florida	21,585	26,561	4,976	23.2%	5,221	6,904	1,683	32.2%
Georgia	10,290	13,434	3,144	30.6%	2,490	3,552	1,062	42.7%
Hawaii	1,772	2,070	298	16.8%	425	527	101	23.8%
Idaho	775	1,053	277	35.8%	185	281	96	52.1%
Illinois	21,731	24,791	3,060	14.1%	5,194	6,281	1,087	20.9%
Indiana	8,791	10,925	2,133	24.3%	2,100	2,854	754	35.9%
Iowa	3,059	3,680	621	20.3%	723	945	221	30.6%
Kansas	2,848	3,179	331	11.6%	680	780	120	18.1%
Kentucky	4,706	6,607	1,901	40.4%	1,132	1,796	664	58.6%
Louisiana	8,011	10,750	2,739	34.2%	1,874	2,791	917	48.9%
Maine	2,456	2,784	328	13.4%	571	694	122	21.4%
Maryland	8,767	10,113	1,345	15.3%	2,105	2,577	472	22.4%
Massachusetts	16,576	18,730	2,155	13.0%	3,946	4,719	773	19.6%
Michigan	16,336	19,262	2,927	17.9%	3,909	4,953	1,043	26.7%
Minnesota	7,963	9,043	1,080	13.6%	1,882	2,277	396	21.0%
Mississippi	2,175	3,420	1,244	57.2%	519	946	427	82.2%
Missouri	6,557	7,187	629	9.6%	1,502	1,731	229	15.2%
Montana	930	1,356	426	45.8%	224	367	143	64.0%
Nebraska	1,844	2,206	363	19.7%	436	565	129	29.5%
Nevada	1,723	1,974	251	14.6%	410	499	89	21.7%
New Hampshire	2,538	2,577	38	1.5%	565	581	16	2.7%
New Jersey	18,527	20,385	1,858	10.0%	4,321	4,975	654	15.1%
New Mexico	1,396	2,083	687	49.2%	337	571	234	69.6%
New York	77,313	86,241	8,928	11.5%	18,339	21,635	3,296	18.0%
North Carolina	8,710	13,372	4,662	53.5%	2,348	3,564	1,216	51.8%
North Dakota	632	827	195	30.8%	149	218	69	46.3%
Ohio	17,620	21,265	3,645	20.7%	4,196	5,482	1,287	30.7%
Oklahoma	3,156	4,338	1,180	37.4%	755	1,155	400	52.9%
Oregon	3,511	4,491	980	27.9%	840	1,167	327	39.0%
Pennsylvania	20,193	23,169	2,975	14.7%	4,801	5,903	1,102	23.0%
Rhode Island	3,098	3,544	447	14.4%	735	895	160	21.8%
South Carolina	4,058	5,259	1,201	29.6%	949	1,353	404	42.6%
South Dakota	660	855	195	29.6%	157	227	70	44.7%
Tennessee	7,587	9,998	2,412	31.8%	1,818	2,660	842	46.3%
Texas	21,844	27,427	5,582	25.6%	5,182	7,030	1,848	35.7%
Utah	1,092	1,609	516	47.3%	261	439	178	68.1%
Vermont	875	1,036	161	18.4%	208	266	58	28.0%
Virginia	8,506	10,002	1,496	17.6%	2,048	2,554	506	24.7%
Washington	9,737	11,700	1,963	20.2%	2,334	3,000	666	28.6%
West Virginia	2,772	4,511	1,739	62.7%	673	1,258	585	87.0%
Wisconsin	7,101	8,583	1,482	20.9%	1,692	2,216	524	31.0%
Wyoming	407	500	93	22.8%	100	125	25	25.0%

**Table 8**  
**Medicaid Beneficiary Projections, 1994-2002**  
**by Beneficiary Group**

Beneficiaries (thousands)	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Average 1993- 2002
<b>Total</b>	32,534	34,511	36,321	37,947	39,502	41,027	42,316	43,400	44,515	45,664	
Growth		6.1%	5.2%	4.5%	4.1%	3.9%	3.1%	2.6%	2.6%	2.6%	3.6%
<b>Beneficiaries by Group</b>											
Elderly	3,687	3,818	3,942	4,052	4,164	4,276	4,383	4,484	4,590	4,701	
Growth		3.5%	3.3%	2.8%	2.8%	2.7%	2.5%	2.3%	2.4%	2.4%	2.7%
Blind & Disabled	4,968	5,249	5,555	5,879	6,159	6,444	6,731	6,950	7,175	7,408	
Growth		5.7%	5.8%	5.3%	4.8%	4.6%	4.5%	3.2%	3.2%	3.2%	4.5%
Adults & Children	19,108	19,975	20,798	21,656	22,528	23,360	23,962	24,512	25,075	25,651	
Growth		4.5%	4.1%	4.1%	4.0%	3.7%	2.6%	2.3%	2.3%	2.3%	3.3%
Pregnant Women & Children	4,367	5,035	5,567	5,883	6,157	6,436	6,712	6,914	7,121	7,335	
Growth		15.3%	10.6%	5.7%	4.7%	4.5%	4.3%	3.0%	3.0%	3.0%	6.8%

*Totals include Arizona*

**Table 9**  
**Medicaid Expenditure and Beneficiary Projections, 1994-2002**  
**By Region**

Beneficiaries (thousands)	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Average 1993- 2002
<b>Total*</b>	32,534	34,511	36,321	37,947	39,502	41,027	42,316	43,400	44,515	45,664	
Growth		6.1%	5.2%	4.5%	4.1%	3.9%	3.1%	2.6%	2.6%	2.6%	3.8%
<b>Beneficiaries by Region</b>											
<b>New England</b>	1,610	1,700	1,781	1,853	1,921	1,991	2,050	2,102	2,156	2,212	
Growth		5.6%	4.7%	4.0%	3.7%	3.6%	3.0%	2.6%	2.6%	2.6%	3.6%
<b>Middle Atlantic</b>	2,635	2,741	2,845	2,947	3,052	3,163	3,284	3,349	3,437	3,528	
Growth		4.0%	3.8%	3.6%	3.6%	3.6%	3.2%	2.6%	2.6%	2.6%	3.3%
<b>South Atlantic</b>	4,983	5,512	6,027	6,472	6,874	7,239	7,522	7,717	7,917	8,123	
Growth		10.6%	9.4%	7.4%	6.2%	5.3%	3.9%	2.6%	2.6%	2.6%	5.6%
<b>East South Central</b>	2,549	2,713	2,857	2,978	3,091	3,205	3,306	3,390	3,476	3,566	
Growth		6.4%	5.3%	4.2%	3.8%	3.7%	3.2%	2.5%	2.6%	2.6%	3.8%
<b>West South Central</b>	3,743	4,069	4,372	4,634	4,878	5,101	5,280	5,413	5,550	5,691	
Growth		8.7%	7.4%	6.0%	5.2%	4.6%	3.6%	2.5%	2.5%	2.5%	4.8%
<b>East North Central</b>	5,077	5,230	5,339	5,441	5,558	5,698	5,837	5,991	6,149	6,312	
Growth		3.0%	2.1%	1.9%	2.1%	2.5%	2.5%	2.6%	2.6%	2.6%	2.4%
<b>West North Central</b>	1,852	1,941	2,014	2,077	2,139	2,205	2,267	2,327	2,388	2,452	
Growth		4.8%	3.8%	3.1%	3.0%	3.1%	2.8%	2.6%	2.7%	2.7%	3.2%
<b>Mountain</b>	975	1,057	1,134	1,200	1,261	1,316	1,361	1,396	1,431	1,468	
Growth		8.5%	7.3%	5.8%	5.0%	4.4%	3.4%	2.5%	2.5%	2.6%	4.7%
<b>Pacific</b>	1,133	1,211	1,286	1,352	1,414	1,473	1,522	1,561	1,601	1,642	
Growth		6.9%	6.1%	5.1%	4.6%	4.2%	3.3%	2.6%	2.6%	2.6%	4.2%
<b>California</b>	4,834	5,060	5,269	5,477	5,685	5,886	6,054	6,206	6,363	6,525	
Growth		4.7%	4.1%	4.0%	3.8%	3.5%	2.9%	2.5%	2.5%	2.5%	3.4%
<b>New York</b>	2,740	2,844	2,939	3,038	3,139	3,241	3,328	3,408	3,491	3,577	
Growth		3.8%	3.4%	3.4%	3.3%	3.3%	2.7%	2.4%	2.4%	2.4%	3.0%

\*Totals include Arizona

**Table 10**  
**Medicaid Expenditure Projections, 1996-2002**  
**Federal Expenditures**  
**Federal Expenditure Growth Capped at 5% per Year Starting 1996**  
(millions of dollars)

	1996-2002				2002			
	Baseline	5% Federal Cap			Baseline	5% Federal Cap		
		Expend.	Change	%Change		Expend.	Change	%Change
Total	950,442	783,580	(166,862)	-17.6%	174,593	128,970	(45,624)	-26.1%
Alabama	13,894	12,180	(1,704)	-12.3%	2,466	2,006	(460)	-18.6%
Alaska	1,980	1,567	(413)	-20.8%	388	258	(108)	-28.6%
Arizona	12,082	9,743	(2,339)	-19.4%	2,247	1,604	(643)	-28.8%
Arkansas	11,200	8,771	(2,429)	-21.7%	2,080	1,444	(636)	-30.6%
California	87,038	72,803	(14,235)	-16.4%	18,092	11,983	(4,109)	-25.5%
Colorado	8,168	6,522	(1,646)	-20.1%	1,514	1,074	(440)	-29.1%
Connecticut	13,200	11,678	(1,522)	-11.5%	2,371	1,822	(449)	-18.9%
Delaware	1,744	1,416	(327)	-18.8%	322	233	(89)	-27.6%
District of Columbia	4,568	3,707	(861)	-18.8%	849	610	(239)	-28.1%
Florida	41,047	31,624	(9,524)	-23.2%	7,682	5,189	(2,474)	-32.3%
Georgia	26,200	20,191	(6,009)	-22.9%	4,889	3,323	(1,566)	-32.0%
Hawaii	2,745	2,172	(573)	-20.9%	508	357	(151)	-29.6%
Idaho	2,959	2,415	(544)	-18.4%	544	398	(147)	-26.9%
Illinois	33,641	27,511	(6,131)	-18.2%	6,225	4,528	(1,697)	-27.3%
Indiana	23,370	19,113	(4,257)	-18.2%	4,319	3,145	(1,173)	-27.2%
Iowa	7,923	6,675	(1,248)	-15.7%	1,445	1,099	(347)	-24.0%
Kansas	6,030	5,351	(679)	-11.3%	1,076	881	(195)	-18.1%
Kentucky	18,515	14,768	(3,746)	-20.2%	3,447	2,431	(1,016)	-29.5%
Louisiana	34,262	29,060	(5,202)	-15.2%	6,129	4,783	(1,346)	-22.0%
Maine	6,077	5,373	(703)	-11.6%	1,098	884	(213)	-19.4%
Maryland	13,800	10,936	(2,863)	-19.8%	2,526	1,800	(726)	-28.8%
Massachusetts	25,805	21,250	(4,356)	-17.0%	4,716	3,498	(1,219)	-25.8%
Michigan	32,011	26,125	(5,886)	-18.4%	5,937	4,300	(1,638)	-27.6%
Minnesota	14,936	12,710	(2,226)	-14.9%	2,729	2,092	(637)	-23.3%
Mississippi	12,645	10,233	(2,412)	-19.1%	2,325	1,884	(540)	-27.5%
Missouri	15,016	13,724	(1,292)	-8.6%	2,628	2,259	(369)	-14.1%
Montana	3,512	2,700	(813)	-23.1%	649	444	(204)	-31.5%
Nebraska	4,498	3,772	(726)	-16.1%	822	621	(201)	-24.4%
Nevada	2,916	2,410	(505)	-17.3%	537	397	(141)	-26.2%
New Hampshire	3,772	3,684	(89)	-2.3%	635	606	(29)	-4.6%
New Jersey	28,258	24,562	(3,696)	-13.1%	5,058	4,043	(1,016)	-20.1%
New Mexico	6,125	4,799	(1,327)	-21.7%	1,141	790	(351)	-30.8%
New York	119,220	100,766	(18,454)	-15.5%	21,879	16,585	(5,294)	-24.2%
North Carolina	29,159	22,278	(6,881)	-23.6%	5,416	3,667	(1,751)	-32.3%
North Dakota	2,523	2,134	(389)	-15.4%	458	351	(107)	-23.4%
Ohio	41,241	33,881	(7,260)	-17.6%	7,588	5,593	(1,995)	-26.3%
Oklahoma	11,204	8,943	(2,261)	-20.2%	2,063	1,472	(591)	-28.7%
Oregon	8,994	7,140	(1,854)	-20.6%	1,652	1,175	(477)	-28.9%
Pennsylvania	38,843	32,696	(6,148)	-15.8%	7,142	5,381	(1,761)	-24.7%
Rhode Island	5,525	4,622	(902)	-16.3%	1,013	761	(252)	-24.9%
South Carolina	15,358	13,072	(2,286)	-14.9%	2,745	2,151	(593)	-21.6%
South Dakota	2,404	2,010	(395)	-16.4%	441	331	(110)	-25.0%
Tennessee	24,454	19,738	(4,715)	-19.3%	4,513	3,249	(1,264)	-28.0%
Texas	61,275	50,518	(10,757)	-17.6%	11,239	8,315	(2,924)	-26.0%
Utah	5,150	4,144	(1,006)	-19.5%	951	682	(269)	-28.3%
Vermont	2,016	1,688	(328)	-16.2%	370	278	(93)	-25.0%
Virginia	13,190	10,330	(2,861)	-21.7%	2,446	1,700	(746)	-30.5%
Washington	18,431	14,657	(3,773)	-20.5%	3,404	2,412	(991)	-29.1%
West Virginia	13,892	10,580	(3,312)	-23.8%	2,600	1,741	(859)	-33.0%
Wisconsin	16,747	13,790	(2,957)	-17.7%	3,085	2,270	(815)	-26.4%

**Table 11**  
**Medicaid Expenditure Projections, 1996-2002**  
**State Expenditures, Without States Maintaining Total Baseline Spending**  
**Expenditure Growth Capped at 5% per Year Starting 1996**  
(millions of dollars)

	1996-2002				2002			
	Baseline	5% Cap			Baseline	5% Cap		
		Expend.	Change	%Change		Expend.	Change	%Change
Total	703,947	582,497	(121,449)	-17.3%	129,359	95,873	(33,485)	-25.9%
Alabama	5,552	4,871	(881)	-12.3%	985	802	(184)	-18.6%
Alaska	1,980	1,567	(413)	-20.8%	366	258	(108)	-29.6%
Arizona	6,256	5,044	(1,211)	-19.4%	1,163	830	(333)	-28.6%
Arkansas	3,852	3,016	(835)	-21.7%	715	496	(219)	-30.6%
California	87,038	72,803	(14,235)	-16.4%	16,092	11,983	(4,109)	-25.5%
Colorado	8,841	5,463	(1,378)	-20.1%	1,268	899	(369)	-29.1%
Connecticut	13,200	11,578	(1,522)	-11.6%	2,371	1,922	(449)	-18.9%
Delaware	1,744	1,416	(327)	-18.8%	322	233	(89)	-27.6%
District of Columbia	4,568	3,707	(861)	-18.8%	849	610	(239)	-28.1%
Florida	33,543	25,761	(7,783)	-23.2%	6,261	4,240	(2,021)	-32.3%
Georgia	16,003	12,333	(3,670)	-22.9%	2,887	2,030	(857)	-29.7%
Hawaii	2,745	2,172	(573)	-20.9%	508	357	(151)	-29.6%
Idaho	1,197	977	(220)	-18.4%	220	161	(59)	-26.9%
Illinois	33,641	27,511	(6,131)	-18.2%	6,225	4,528	(1,697)	-27.3%
Indiana	13,602	11,124	(2,478)	-18.2%	2,514	1,831	(683)	-27.2%
Iowa	4,705	3,964	(741)	-15.7%	858	653	(205)	-24.0%
Kansas	4,335	3,846	(488)	-11.3%	773	633	(140)	-18.1%
Kentucky	7,308	5,829	(1,479)	-20.2%	1,361	959	(401)	-29.5%
Louisiana	12,220	10,365	(1,855)	-15.2%	2,188	1,708	(480)	-22.0%
Maine	3,755	3,320	(435)	-11.6%	678	546	(132)	-19.4%
Maryland	13,600	10,936	(2,663)	-19.6%	2,526	1,800	(726)	-28.8%
Massachusetts	25,605	21,250	(4,356)	-17.0%	4,718	3,498	(1,219)	-25.8%
Michigan	25,315	20,660	(4,655)	-18.4%	4,698	3,400	(1,295)	-27.6%
Minnesota	12,255	10,428	(1,826)	-14.9%	2,239	1,716	(523)	-23.3%
Mississippi	3,359	2,719	(641)	-19.1%	618	447	(170)	-27.6%
Missouri	9,903	9,050	(852)	-8.6%	1,733	1,490	(244)	-14.1%
Montana	1,440	1,107	(333)	-23.1%	266	182	(84)	-31.5%
Nebraska	2,837	2,380	(458)	-16.1%	518	392	(127)	-24.4%
Nevada	2,661	2,200	(461)	-17.3%	491	362	(128)	-26.2%
New Hampshire	3,772	3,684	(89)	-2.3%	635	606	(29)	-4.6%
New Jersey	28,258	24,562	(3,696)	-13.1%	5,058	4,043	(1,016)	-20.1%
New Mexico	2,169	1,699	(470)	-21.7%	404	280	(124)	-30.8%
New York	119,220	100,766	(18,454)	-15.5%	21,879	16,585	(5,294)	-24.2%
North Carolina	15,075	11,518	(3,557)	-23.6%	2,801	1,896	(905)	-32.3%
North Dakota	971	821	(150)	-15.4%	176	135	(41)	-23.4%
Ohio	27,209	22,419	(4,790)	-17.6%	5,008	3,690	(1,316)	-26.3%
Oklahoma	4,877	3,893	(984)	-20.2%	898	641	(257)	-28.7%
Oregon	5,422	4,304	(1,118)	-20.6%	896	708	(187)	-20.9%
Pennsylvania	31,170	26,237	(4,933)	-15.8%	5,731	4,318	(1,413)	-24.7%
Rhode Island	4,775	3,995	(780)	-16.3%	875	658	(218)	-24.9%
South Carolina	6,188	5,267	(921)	-14.9%	1,108	857	(251)	-22.6%
South Dakota	1,017	850	(167)	-16.4%	187	140	(47)	-25.0%
Tennessee	11,736	9,473	(2,263)	-19.3%	2,166	1,559	(607)	-28.0%
Texas	33,814	27,877	(5,936)	-17.6%	6,202	4,588	(1,613)	-26.0%
Utah	1,690	1,360	(330)	-19.5%	312	224	(88)	-28.3%
Vermont	1,351	1,131	(219)	-16.2%	248	188	(60)	-24.2%
Virginia	13,190	10,330	(2,861)	-21.7%	2,446	1,700	(746)	-30.5%
Washington	15,067	11,883	(3,085)	-20.5%	2,783	1,972	(810)	-29.1%
West Virginia	4,317	3,288	(1,029)	-23.8%	808	541	(267)	-33.0%
Wisconsin	10,971	9,034	(1,937)	-17.7%	2,021	1,487	(534)	-26.4%

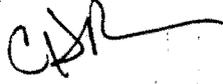
**Table 12**  
**Medicaid Expenditure Projections, 1996-2002**  
**Federal and State Expenditures**  
**Total Expenditure Growth Capped at 5% per Year Starting 1996**  
(millions of dollars)

	1996-2002				2002			
	Baseline	Expend.	5% Cap		Baseline	Expend.	5% Cap	
			Change	%Change			Change	%Change
Total	1,654,389	1,366,077	(288,312)	-17.4%	303,952	224,843	(79,109)	-26.0%
Alabama	19,445	17,061	(2,384)	-12.3%	3,451	2,808	(643)	-18.6%
Alaska	3,960	3,135	(825)	-20.8%	733	516	(217)	-29.6%
Arizona	18,336	14,788	(3,550)	-19.4%	3,410	2,434	(976)	-28.6%
Arkansas	15,051	11,783	(3,264)	-21.7%	2,795	1,940	(855)	-30.6%
California	174,076	145,606	(28,470)	-16.4%	32,184	23,955	(8,219)	-25.5%
Colorado	15,009	11,985	(3,024)	-20.1%	2,781	1,973	(809)	-29.1%
Connecticut	28,400	23,358	(3,044)	-11.5%	4,742	3,844	(898)	-18.9%
Delaware	3,487	2,833	(655)	-18.8%	644	466	(178)	-27.6%
District of Columbia	9,135	7,414	(1,722)	-18.8%	1,887	1,220	(677)	-35.4%
Florida	74,591	57,285	(17,306)	-23.2%	13,923	9,429	(4,495)	-32.3%
Georgia	42,203	32,524	(9,679)	-22.9%	7,876	5,353	(2,523)	-32.0%
Hawaii	5,489	4,343	(1,146)	-20.9%	1,018	715	(301)	-29.6%
Idaho	4,156	3,392	(764)	-18.4%	764	558	(206)	-28.9%
Illinois	67,283	55,021	(12,261)	-18.2%	12,450	9,056	(3,394)	-27.3%
Indiana	36,972	30,237	(6,735)	-18.2%	6,832	4,977	(1,856)	-27.2%
Iowa	12,628	10,640	(1,989)	-15.7%	2,304	1,751	(552)	-24.0%
Kansas	10,365	9,193	(1,167)	-11.3%	1,849	1,514	(335)	-18.1%
Kentucky	25,823	20,598	(5,225)	-20.2%	4,808	3,390	(1,418)	-29.5%
Louisiana	46,482	39,425	(7,057)	-15.2%	8,315	6,489	(1,826)	-22.0%
Maine	9,831	8,693	(1,138)	-11.6%	1,776	1,431	(345)	-19.4%
Maryland	27,199	21,873	(5,326)	-19.6%	5,053	3,800	(1,453)	-28.8%
Massachusetts	51,211	42,500	(8,711)	-17.0%	9,432	6,995	(2,437)	-25.8%
Michigan	57,328	46,785	(10,542)	-18.4%	10,833	7,700	(2,933)	-27.6%
Minnesota	27,190	23,138	(4,052)	-14.9%	4,968	3,808	(1,160)	-23.3%
Mississippi	16,004	12,951	(3,052)	-19.1%	2,942	2,132	(811)	-27.6%
Missouri	24,919	22,774	(2,145)	-8.6%	4,361	3,748	(613)	-14.1%
Montana	4,952	3,807	(1,146)	-23.1%	915	627	(288)	-31.5%
Nebraska	7,335	6,152	(1,183)	-16.1%	1,340	1,013	(327)	-24.4%
Nevada	5,577	4,610	(967)	-17.3%	1,028	759	(269)	-26.2%
New Hampshire	7,545	7,368	(177)	-2.3%	1,270	1,213	(58)	-4.6%
New Jersey	68,515	49,123	(19,392)	-28.3%	10,116	8,085	(2,031)	-20.1%
New Mexico	8,294	6,498	(1,796)	-21.7%	1,545	1,069	(475)	-30.8%
New York	238,440	201,532	(36,908)	-15.5%	43,757	33,170	(10,587)	-24.2%
North Carolina	44,234	33,796	(10,438)	-23.6%	8,219	5,582	(2,636)	-32.3%
North Dakota	3,493	2,955	(539)	-15.4%	635	486	(148)	-23.4%
Ohio	68,450	56,400	(12,049)	-17.6%	12,594	9,283	(3,311)	-26.3%
Oklahoma	16,081	12,836	(3,245)	-20.2%	2,961	2,113	(848)	-28.7%
Oregon	14,415	11,444	(2,972)	-20.6%	2,648	1,883	(764)	-28.9%
Pennsylvania	70,013	58,832	(11,081)	-15.8%	12,874	9,700	(3,174)	-24.7%
Rhode Island	10,300	8,617	(1,682)	-16.3%	1,888	1,418	(470)	-24.9%
South Carolina	21,548	18,338	(3,207)	-14.9%	3,851	3,018	(832)	-21.6%
South Dakota	3,422	2,860	(561)	-16.4%	628	471	(157)	-25.0%
Tennessee	36,190	29,211	(6,979)	-19.3%	6,878	4,808	(1,870)	-28.0%
Texas	95,089	78,396	(16,693)	-17.6%	17,440	12,903	(4,537)	-26.0%
Utah	6,840	5,504	(1,336)	-19.5%	1,263	908	(357)	-28.3%
Vermont	3,367	2,820	(547)	-16.2%	619	464	(154)	-25.0%
Virginia	26,381	20,659	(5,722)	-21.7%	4,892	3,400	(1,492)	-30.5%
Washington	33,498	26,640	(6,858)	-20.5%	6,186	4,385	(1,802)	-29.1%
West Virginia	18,209	13,868	(4,341)	-23.8%	3,408	2,283	(1,126)	-33.0%
Wisconsin	27,718	22,824	(4,894)	-17.7%	5,105	3,757	(1,349)	-26.4%

THE WHITE HOUSE  
WASHINGTON

February 2, 1996

MEMORANDUM FOR THE PRESIDENT

FROM: Carol H. Rasco   
SUBJECT: New Hampshire Medicaid Waiver

You had asked about an item in the weekly summary from Cabinet Affairs on a New Hampshire Medicaid waiver (attached).

Although the description in the report seemed to suggest that the waiver is ready for approval, in fact the state has revised its request a number of times, and at the moment there is no pending waiver request that HHS can approve or deny.

The state originally submitted a waiver request in June 1994, but dropped the plan a few months later when the Commissioner of Health and Human Services left. Since that time, the state has sent HHS three additional "concept papers" -- in June 1995, September 1995, and January 1996. HHS has provided the state with technical assistance along the way, and a formal waiver proposal is expected from the state within the next few weeks.

cc: Marcia Hale

(HHS) regarding an interpretation of the Multi-Ethnic Placement Act of 1994 (MEPA). Recent negotiations between MN and HHS have failed to resolve HHS's assertion that MN is not in compliance with MEPA and that Federal funds would be terminated under Title VI. During the coming week, the Civil Rights Division hopes to meet with HHS and the Office of Legal Counsel to discuss the matter.

- **Government will Refrain from filing Civil Forfeiture Actions Against Tribes Involved in New Mexico Gaming:** In *Pueblo of Santa Ana v. Kelly*, the parties signed a stipulation setting aside a hearing on a motion for preliminary injunction. The Tribes will withdraw their mandamus and injunctive relief motions. In exchange, the government agreed to refrain from filing civil forfeiture actions during the pendency of the action. The Tribes have also agreed not to block highways, and to voluntarily close down their operations if the judge ultimately finds that the gaming is unlawful.
- **Solicitor General To Defend Constitutionality of Statute Concerning Indecent Cable Programming:** On or before January 29, DOJ will file a brief on the merits in the Supreme Court in *Denver Area Educational, Inc. v. FCC*. The government is defending the constitutionality of Section 10 of the Cable Television Consumer Protection and Competition Act of 1992, which deals with indecent programming on cable television. The provision's constitutionality was upheld by the D.C. Circuit sitting *en banc*.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- **CDC Report on Tobacco Use Released:** On January 25, the CDC released a new report summarizing data on tobacco use in all 50 states and the District of Columbia. This is the first compilation of state-based data on the prevalence of tobacco use, the health impact and costs associated with tobacco use, tobacco control laws, and tobacco use prevention and control programs. According to the CDC report, tobacco use remains the leading preventable cause of death in the United States, causing more than 400,000 deaths each year at an annual cost of more than \$50 billion.

• **New Hampshire Medicaid Waiver:** The *Granite State Partnership for Access and Affordability in Health Care*, a statewide section 1115 demonstration proposal, would expand the cutoff for Medicaid eligibility for pregnant women and children from 170 - 185% of the Federal poverty level, and extend Medicaid coverage to the uninsured up to 155% of the Federal poverty level. The plan would also eliminate categorical and asset requirements, create a public insurance product to provide health care coverage to low income workers, and provide a broader array of community services for the frail elderly and disabled. The State submitted a revised proposal June 20, 1995 and met with the Administrator on June 26 to discuss various options for health reform. Based on these discussions, the State has submitted a new concept paper for reform of its health care system. An issues letter was sent to the State by HCFA on October 20. HCFA is currently awaiting the State's response.

Crawford  
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