

**DISCOVERING LEADERSHIP  
THAT MATTERS**

**Understanding Variations in State  
Medicaid Spending**

**By**

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# **DISCOVERING LEADERSHIP THAT MATTERS**

## **Understanding Variations in State Medicaid Spending**

### **I. INTRODUCTION**

Enacted in 1965, Medicaid is a combined federal and state entitlement program of health and long term care for poor families, and poor elderly, blind and disabled individuals, covering 36 million Americans. At \$157 billion Medicaid has become one of the major components of our country's \$880 billion health care industry.<sup>1</sup> The decisions government officials make about Medicaid affects not only the well-being of those eligible for the program but also influences states' economies through the program's effects on the doctors, hospitals, nursing homes, pharmaceutical companies and other health care providers who participate in the program. In addition, Medicaid has become a major component of state budgets, accounting for 20 percent of all state spending (including the federal share).<sup>2</sup>

This paper focuses on understanding variations in state Medicaid spending with a view towards uncovering stories of public leadership in modifying or reforming state programs. Given the structure and dynamics of the Medicaid program, what capacity do policymakers have to influence the direction of the program and to manage costs? In facing the many factors driving the Medicaid program, why are some policymakers more successful than others in introducing innovations? What accounts for the wide variety in states' approaches to shaping their programs?

To address these questions, the paper is structured as follows: section II briefly describes the dynamics of the federal/ state partnership; section III describes Medicaid spending patterns, beginning with national trends and continuing with state-specific patterns; section IV then describes the levers through which state policymakers may influence their programs and highlights, through eight case studies, how policymakers actually did influence their programs over the past 10 years. Although not a

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<sup>1</sup> As measured by personal health care expenditures which totaled \$879 billion dollars in 1995. Source: Health Care Financing Review, Fall, 1996.

<sup>2</sup> Source: National Association of State Budget Officers.

comprehensive analysis of innovations in all 50 state Medicaid programs, the case studies do show the broad variety of initiatives which state policymakers have successfully implemented.

## **II. A FEDERAL/ STATE PARTNERSHIP**

Medicaid is an illustration of a federally mandated and state designed and administered program, with funding jointly shared by the states and the federal government. From 1980 to 1995 program expenditures grew in nominal dollars from \$25 billion to \$157 billion of which the federal share grew from \$14 billion to \$90 billion. Basically, the federal government establishes the minimum requirements for who is eligible and what services are to be covered in the program. Through the Health Care Finance Administration (HCFA) of the Department of Health and Human Services, the federal government approves the types of health care spending in the states to be covered. Each year the federal government also establishes the formula -- the Federal Medical Assistance Percentage (FMAP), which ranges from fifty to eighty percent -- by which states are partially reimbursed for their approved spending.

At a minimum, the federal government requires that poor families eligible for cash assistance and certain poor elderly, blind and disabled individuals be eligible for Medicaid. In addition certain pregnant women and infants and children are entitled to services as are individuals who become needy by virtue of their own health care costs. Eligible persons are entitled to basic federally mandated services, which may be grouped into acute and long-term care. Acute care services include inpatient and outpatient hospital services, physician services, laboratory and x-ray services, early and periodic screening, diagnostic and treatment (EPSDT) services for individuals under age 21, family planning, rural health clinic and federally qualified health center (FQHC) services and services of nurse-midwives and nurse practitioners. In addition, eligible individuals 21 years or older may receive nursing facility services or long term home health services.

Within these federal guidelines, the states themselves influence their level of spending by (1) establishing their own eligibility standards; (2) determining the type,

amount, duration and scope of medical services offered; (3) establishing the level of reimbursement for the doctors, hospitals and nursing home providers which serve Medicaid patients; and (4) instituting alternative care systems, such as managed care (in place of fee-for-service care) or community and home based care (in place of nursing home care). In the early 1990s states also introduced a fifth lever by which they have increased the level of Medicaid spending in their programs dramatically, without necessarily increasing the amount of health services offered -- (5) states increasingly have used controversial finance mechanisms, such as collecting provider taxes, voluntary contributions or intergovernmental transfers and making supplemental payments to hospitals serving a disproportionate share of low-income patients, to leverage more federal reimbursements. States have varied in how freely they have used these mechanisms and how closely they have linked them to more health services.

These factors result in a wide variation of spending across states. To illustrate, in its Medicaid program in 1995 a liberal spending state such as Minnesota spent \$7,800 per poor person while Florida averaged only \$3,100 per poor person.<sup>3</sup> Minnesota chooses to cover more of its poor population (115 percent compared to Florida's 97 percent) with more care, offering 32 of the 34 optional services compared to 24 in FL. The concentration of care also substantially differs in the two states. Fifty-four percent of MN's Medicaid spending covered long term care compared to only 28 percent in FL, even though the share of recipients that are elderly or disabled is not very different in the two states (29 percent and 26 percent in MN and FL, respectively).

### **III. SPENDING PATTERNS**

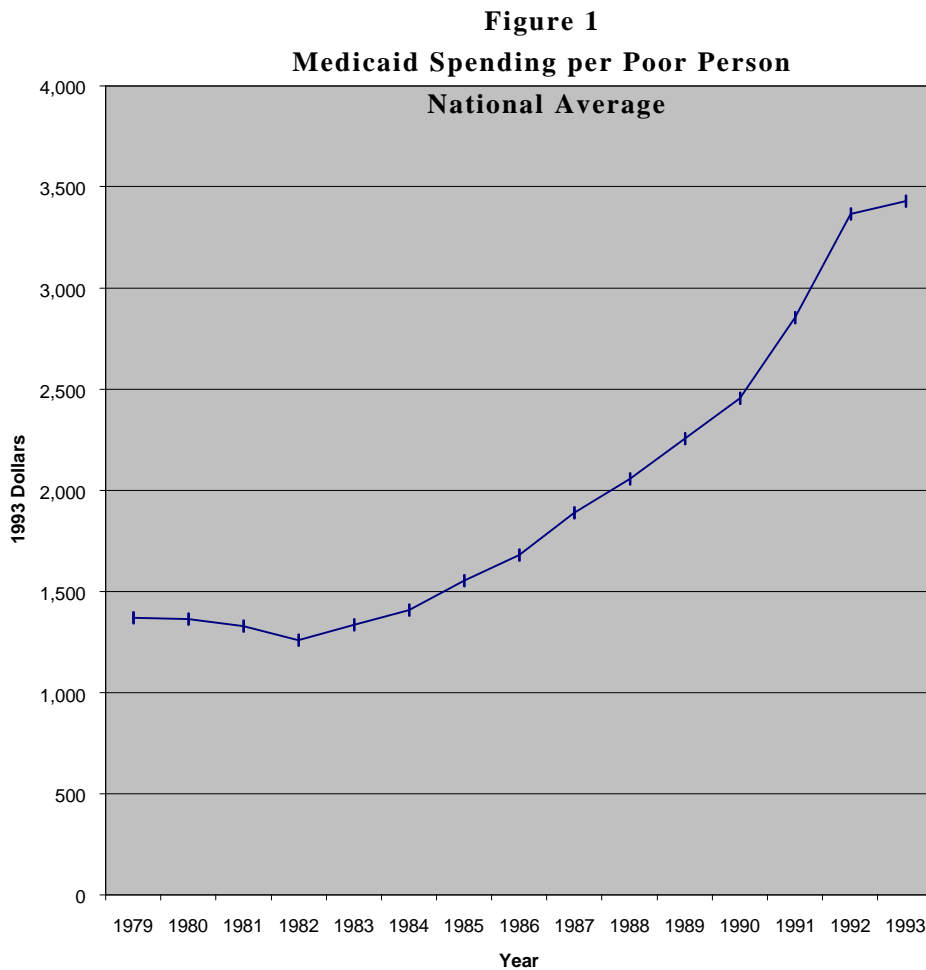
#### **National Trends**

Over our fifteen-year study period, from FY 1979 to FY 1993, the Medicaid program nationwide experienced phenomenal real growth, from \$1,400 per poor person to

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<sup>3</sup> Expenditures are in state cost of living adjusted dollars. In 1995 MN and FL's COL indexes were .94 and .95 respectively.

\$3,400 per poor person.<sup>4</sup> As is shown in Figure 1, the spending pattern over the fifteen years followed four trajectories. First between FY 1979 and 1982 real spending declined slightly, but by the mid- to late 1980s grew consistently, averaging 8.7 percent a year. The years 1991 and 1992 show above average growth (16.2 percent and 18.0 percent, respectively) which then leveled off to 1.8 percent in 1993.



<sup>4</sup> Figures are based on a 48-state average, excluding Arizona and Alaska. AZ has been omitted from our calculations since it does not operate a traditional Medicaid program. Since 1982 it has operated a federally assisted medical assistance program for low-income persons under a demonstration waiver. Because historically it has been an outlier in state finances, AK has also been excluded from our analysis.

These four spending trajectories over the past fifteen years correspond to four federal Medicaid policy waves. A year-by-year list of the federal policy changes are detailed in the Appendix and can be grouped as follows. In the early 1980s the federal government introduced policies which were more likely to reduce or limit state Medicaid costs. Such policies included:

- Restricting eligibility
- Allowing new hospital and nursing home payment systems such as “prospective payment systems” or billing according to “diagnostic related groups;
- Granting waivers which would allow states to introduce alternative delivery systems, such as HMOs or home and community based care; and
- Actively managing costs and services.

Between 1984 and 1991 federal mandates served to increase spending in low spending states. The first series of mandates between 1984 and 1987 expanded coverage to low income children and pregnant women whose incomes met AFDC financial eligibility standards but who for other reasons may have been ineligible for AFDC benefits in individual states. Mandates were then soon instituted which allowed eligibility based on the *poverty* rate versus a state’s AFDC eligibility or SSI determination. By tying Medicaid eligibility to poverty rates versus a state’s AFDC program those predominantly southern states, whose AFDC standards were far below the poverty line, had further to go to meet the new federal criteria. The more expansive federal mandates, which were instituted between 1988 and 1991, also served to increase Medicaid costs in those states with minimal Medicaid programs. The mandates included:

- Instituting nursing home standards
- Mandatory coverage for pregnant women and infants at 100 percent of poverty, then 133 percent of poverty
- Mandatory coverage of all children through age 6 up to 133 percent of poverty
- Mandatory coverage of all children through age 18 in families up to 100 percent of poverty.

In order to pay for the increased costs of expanding coverage and improving standards, states began to more actively use unusual financing techniques to leverage additional federal dollars. The widespread success of states' efforts are reflected in a jump in spending per poor person of 16 percent and 18 percent in 1991 and 1992, respectively.

The federal windfall to states from these flexible finance systems was soon questioned, however. In September 1991, effective FY 1993, the federal government became more restrictive in what would be considered allowable Medicaid reimbursable costs. The data reflect these policy changes with a leveling off of the growth in Medicaid spending per poor person to 1.8 percent in FY 1993.

### **Changes in State Spending Patterns**

Because states face different costs and social-economic circumstances and because they make different choices in providing health care for poor people, their spending on Medicaid varies widely. Even within a state, its costs, fiscal circumstances and values may change over time, resulting in spending changes. Comparing Medicaid spending in a low cost state with few poor children to the national average or to a state facing higher health care costs and with more low-income families may be misleading. In order to better measure real differences in states' priorities towards Medicaid, we developed a methodology to separate out those factors -- like costs or fiscal circumstances -- which may influence spending levels but which a state may not be able to control from those the state can control.

Briefly, our method was as follows.<sup>5</sup> We used HCFA report-64 data on total (federal and state shares combined) Medical Assistance Payments and Administration by state for the fifteen years from 1979 through 1993. We adjusted the expenditures for inflation over time and for differences in the cost of providing health care services in various states, thus producing data on the real level of Medicaid spending over time. A

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<sup>5</sup> For a full treatment of the methods used in this paper, including descriptions of the estimation process and data, see the appendices in Herman B. Leonard, *By Choice or By Chance?* (Boston: Pioneer Institute, 1992.)

state's health care cost index is a weighted average of its cost of living index<sup>6</sup> and a private wage index. To better evaluate the level of effort made by states to address the need for government subsidized health care, we compared spending per poor person rather than spending per Medicaid recipient, since states may spend a lot per person in the system but may choose to make entry into the system difficult. To adjust for the different social and fiscal circumstances facing each state -- such as a state's personal income, the percent of elderly poor or poor children, and the percent of the population in urban and rural areas -- we examined the ways in which the expenditure levels varied across states and over time with these different circumstances. Using standard statistical techniques, we then created a "benchmark" of spending for each state for each year, which is an estimate of how much on average the other states would spend in Medicaid, if they faced the circumstances of that particular state in a given year. We then compared each state's cost-adjusted Medicaid spending to the national average and to its benchmark.

Using Connecticut as an example, in 1993 the state spent \$5,000 per poor person on Medicaid in cost-adjusted dollars compared to a 48-state national average of \$3,430. (See Figure 2A.) Primarily because of the state's high incomes relative to the number of poor people, its estimated benchmark spending was \$3,750, which means that on average other states would spend \$3,750 if they faced the same social-economic circumstances. So Connecticut's spending was 32 percent above its benchmark compared to 44 percent above the national average. In contrast Kentucky spent approximately \$3,000 per poor person in 1993, but because of its low incomes, the state's benchmark was only \$3,100. So the state was spending 3 percent below its benchmark compared to 14 percent below the national average.<sup>7</sup>

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<sup>6</sup> See also Monica E. Friar and Herman B. Leonard, *Variations in Costs of Living Across States*, Taubman Center for State and Local Government, Kennedy School of Government, Harvard University, 1998, for a discussion of creating the cost of living indexes.

<sup>7</sup> Graphs of 48 states' actual and benchmark Medicaid spending compared to the national average may be accessed in the Public Finance section of the Taubman Center web page at [www.ksg.harvard.edu/Taubman/](http://www.ksg.harvard.edu/Taubman/).

Figure 2-A  
 Medicaid Spending per Poor Person  
 Connecticut

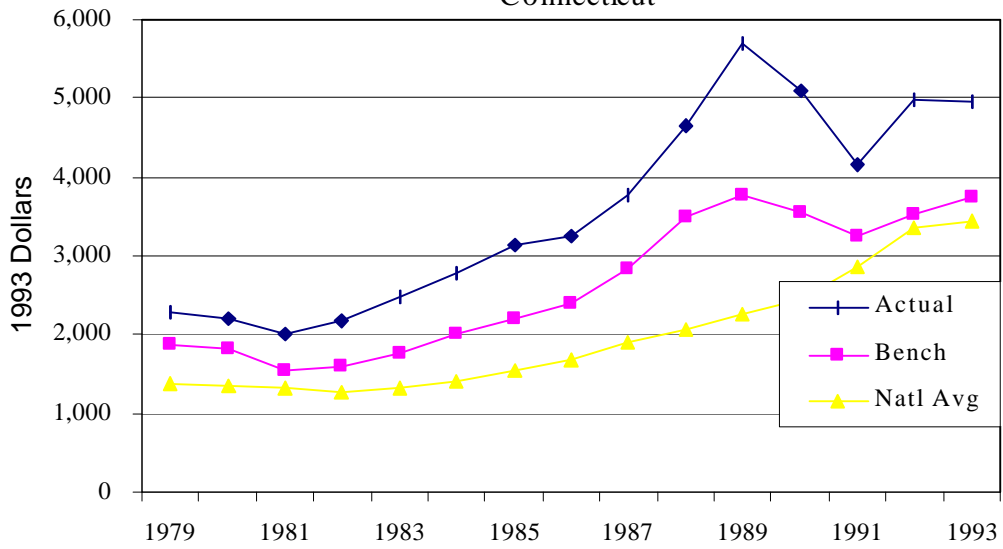
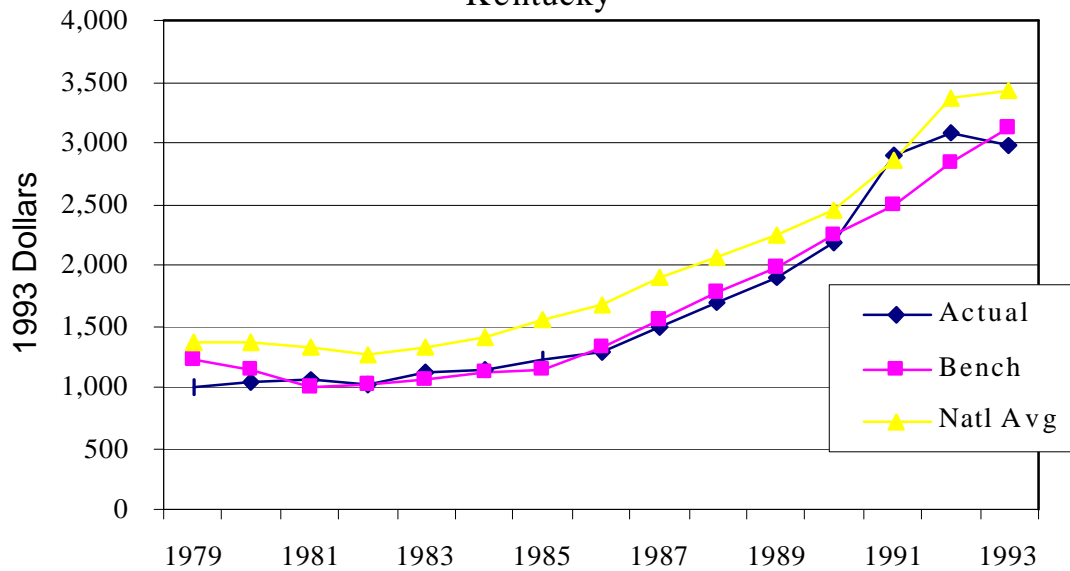


Figure 2-B  
 Medicaid Spending per Poor Person  
 Kentucky

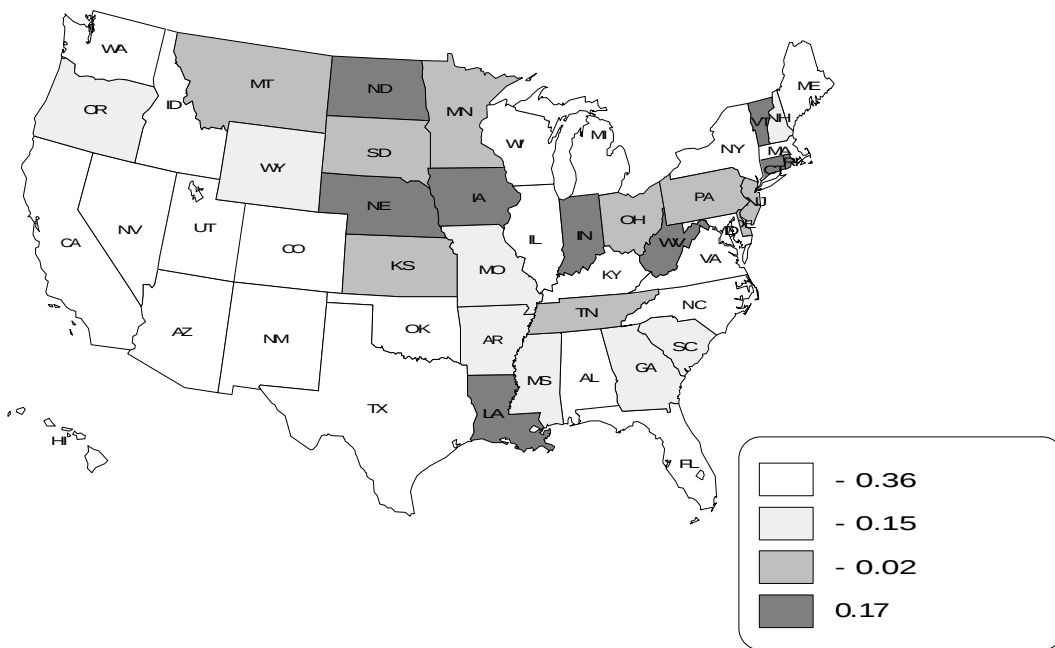


We should emphasize that a state's benchmark is in no sense a "target" or "desirable" level of spending; it is simply an estimate of what other states would spend based on an average of other states' spending decisions. The benchmark merely provides a way of describing how states' spending choices differ by controlling for the different costs and circumstances. In other words, benchmarks cannot indicate when one is spending "enough." However, because it does control for certain fiscal and social circumstances, it is a more reliable measure for comparison than the national average alone.

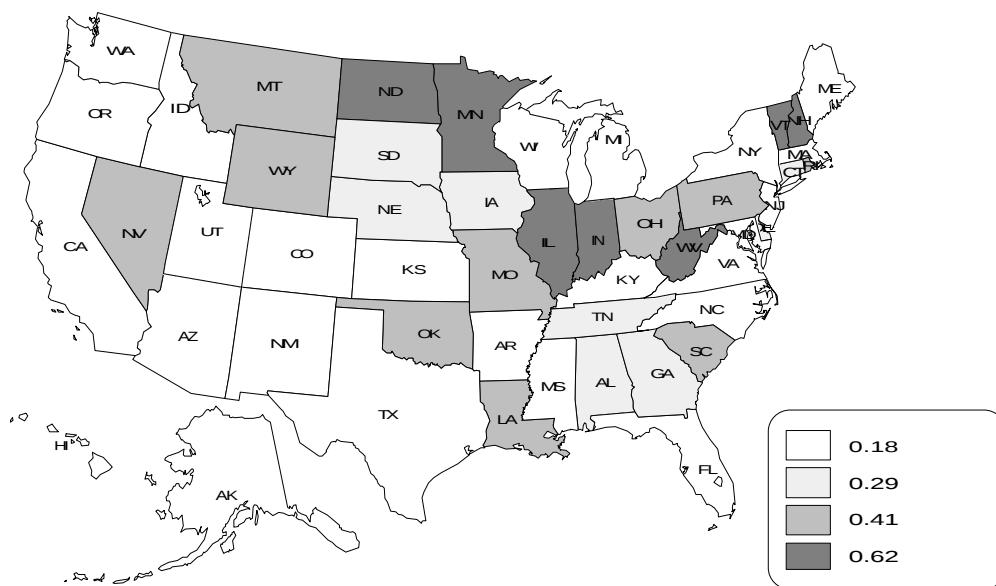
Figure 3-A shows the states divided into quartiles in terms of the percentage difference between their actual and benchmark spending on Medicaid per poor person in 1993. (Table 1 shows the underlying data.) States exhibiting a relatively high spending priority in this area in comparison with other states are shown darkly shaded; states with the lowest relative priority are unshaded.

We also identified those states whose difference from benchmark spending changed the most dramatically over the study period. Figure 3-B shows a map of the states' percent difference from benchmark spending in Medicaid, with those with the largest changes, whether positive or negative, shaded most darkly. The twelve states whose Medicaid spending changed the most substantially over this period are: California, Hawaii, Illinois, Indiana, Massachusetts, Minnesota, New Hampshire, New York, North Dakota, Vermont, West Virginia, and Wisconsin. Of those twelve states only North Dakota, West Virginia and Indiana *increased* their spending relative to their benchmark over the course of the fifteen years. States who have historically been more "liberal" with respect to Medicaid spending -- like California, Hawaii, Massachusetts, Minnesota, New York, Vermont and Wisconsin -- all experienced dramatic declines relative to their own benchmarks over this period.

**Figure 3-A**  
**Medicaid Spending per Poor Person**  
**Percent Difference from Benchmark**  
**1993**



**Figure 3-B**  
**Maximum minus Minimum**  
**1979-1993**



**Table 1**  
**Medicaid Spending per Poor Person**  
**Actual, Benchmark, Difference**

State	Actual	Benchmark	Diff	Percent Diff
AL	2,750	3,290	(540)	-16.4%
AR	3,182	3,264	(82)	-2.5%
CA	2,009	3,017	(1,007)	-33.4%
CO	2,837	3,533	(696)	-19.7%
CT	4,947	3,745	1,202	32.1%
DE	3,709	3,740	(32)	-0.8%
FL	2,421	3,329	(908)	-27.3%
GA	2,931	3,390	(459)	-13.5%
HI	1,996	3,140	(1,143)	-36.4%
ID	2,312	3,256	(944)	-29.0%
IL	2,687	3,340	(653)	-19.6%
IN	4,510	3,465	1,045	30.2%
IA	4,373	3,661	711	19.4%
KS	3,587	3,592	(5)	-0.2%
KY	2,985	3,115	(130)	-4.2%
LA	4,018	3,035	982	32.4%
ME	4,832	3,243	1,589	49.0%
MD	3,683	3,759	(76)	-2.0%
MA	4,460	3,435	1,026	29.9%
MI	3,050	3,328	(278)	-8.3%
MN	4,074	3,532	542	15.4%
MS	2,686	3,113	(427)	-13.7%
MO	3,054	3,355	(301)	-9.0%
MT	3,483	3,238	246	7.6%
NE	4,384	3,745	639	17.1%
NV	2,561	3,388	(827)	-24.4%
NH	3,267	3,554	(287)	-8.1%
NJ	3,773	3,565	208	5.8%
NM	2,050	2,996	(946)	-31.6%
NY	4,665	3,148	1,517	48.2%
NC	3,459	3,463	(4)	-0.1%
ND	4,882	3,474	1,408	40.5%
OH	3,605	3,355	250	7.5%
OK	2,318	3,164	(846)	-26.7%
OR	2,827	3,321	(495)	-14.9%
PA	3,309	3,364	(55)	-1.6%
RI	5,557	3,328	2,229	67.0%
SC	3,112	3,223	(112)	-3.5%
SD	3,789	3,454	336	9.7%
TN	3,386	3,280	106	3.2%
TX	2,586	3,245	(659)	-20.3%
UT	2,997	3,348	(351)	-10.5%
VT	4,363	3,438	925	26.9%
VA	3,024	3,810	(786)	-20.6%
WA	3,557	3,368	189	5.6%
WV	3,604	3,030	574	19.0%
WI	3,851	3,464	386	11.2%
WY	3,068	3,429	(362)	-10.5%

The trends in the national average are telling in explaining why the largest changes have been in those states that have traditionally been liberal. Except for California, these states continue to have higher than average Medicaid spending but because federal mandates expanding eligibility have forced low spending states to expand their programs, the discrepancy is no longer as extreme.

#### **IV. UNDERSTANDING VARIATIONS IN STATE MEDICAID PROGRAMS**

As was discussed above, within the federal structure, states have leeway in controlling their Medicaid spending patterns by manipulating the following five levers:

1. Establishing Medicaid eligibility standards. Historically, eligibility for Medicaid has been tied to eligibility for two cash assistance programs: Aid to Families with Dependent Children (AFDC) for poor families and the Supplementary Security Income program (SSI) for poor elderly and disabled individuals. Recipients of these cash assistance programs were considered categorically eligible. Since states themselves determined eligibility for AFDC they also, in effect, determined eligibility for Medicaid. Because SSI is a federal program, states have had less control determining Medicaid categorical eligibility for the aged and disabled. In addition states may choose to provide Medicaid to the “medically needy,” which are those low income persons who do not qualify for cash assistance but who are determined by the state to be eligible to receive medical assistance.
2. Determining the type, amount, duration and scope of services. In addition to the ten federally mandated basic medical services which all state Medicaid programs must offer, states can decide which of the thirty-four optional services, such as prescription drugs, care in intermediate care facilities for the mentally retarded or dental services, they will provide. States not only decide what services may be offered but also how much of each service it is willing to cover, for example how many doctor visits or how many days in the hospital.
3. Establishing the level of reimbursement for the doctors, hospitals and nursing homes which serve Medicaid patients. Since 1981 states have been free to establish their own reimbursement systems to pay providers for the services rendered to Medicaid patients. States must only ensure that the reimbursements be “reasonable and adequate to meet the

costs which must be incurred by efficiently and economically operated facilities” and be enough to ensure that poor people have reasonable access to care.

4. Using unusual finance mechanisms such as collecting provider taxes or voluntary contributions and making disproportionate share hospital (DSH) payments to leverage more federal reimbursements. In the late 1980s states began to take advantage of the federal regulations which permitted them to receive donations or taxes from private medical care providers, such as hospitals and nursing homes. Federal law also permits states to make higher than average reimbursements to hospitals serving a “disproportionate share” of low-income people. States counted the provider revenues as part of their state-share of funds for Medicaid, which then leveraged additional federal matching funds. Using the federal reimbursements and the flexibility of DSH payments, states could ensure that hospitals received back at least what they contributed through donations or taxes. Until 1993, when the federal restrictions on the use of provider donations and taxes became effective, many states financed large expansions in their Medicaid program with these controversial mechanisms.
5. Instituting alternative care systems such as managed care or community and home based care. Motivated to contain costs in their fast-growing Medicaid programs and to improve the quality of care available, states have been looking for alternatives in the way they provide acute and long-term care services to those eligible for Medicaid. As a substitute to fee-for-service care, states are seeking to enroll their Medicaid population in managed care systems. By providing more home and community-based care, states also hope to keep more of their elderly and disabled out of expensive and impersonal nursing homes. HCFA is increasingly granting waivers to states to enable them to experiment with these health care alternatives.

State Medicaid policy is a complicated interplay of these five levers. As a result of a budget surplus or a governor’s campaign promises a state may change the scope of services offered to specific populations. Health and human services’ officials may be forced to renegotiate reimbursement rates to doctors, hospitals or nursing homes as a result of lawsuits. By observing the successes or failures in neighboring states, policymakers may decide to introduce alternative care systems or alternative finance mechanisms. The impact on spending of these different

factors may not be immediately evident nor are they easily quantifiable, however, we identify and examine illustrative indicators in the hopes of understanding patterns in selected states' Medicaid spending.

### **Lever 1: Establishing Eligibility**

Medicaid covers two broad categories of people -- poor families with children and poor individuals who are aged, blind or disabled. Until the Welfare Reform Act of 1996, families that were eligible for Aid to Families with Dependent Children (AFDC) were automatically eligible for Medicaid. Since states themselves determined eligibility for AFDC, they also controlled Medicaid eligibility for poor families. With the 1996 replacement of the AFDC cash assistance program with the time-limited welfare reform block grant program called Temporary Assistance to Needy Families (TANF), eligibility for Medicaid has become more complicated. For the most part, families who would have met the state's AFDC eligibility criteria prior to welfare reform are still eligible for Medicaid – even if they are not currently eligible for cash assistance under the state's TANF program. However, states are finding that with the separation of Medicaid eligibility from cash assistance many low-income families are not accessing the public funded health care to which they are entitled.

Poor elderly, blind and disabled individuals who are eligible for the Supplementary Security Income (SSI) program are also categorically eligible for Medicaid. Since SSI is predominantly a federal program, states have less control in determining eligibility for this group of people -- with some exceptions,<sup>8</sup> a person eligible for SSI (and thus Medicaid) in one state is eligible in any state.

States also have the option of providing Medicaid to the “medically needy,” that is those individuals who may have incomes too high to become eligible for Medicaid under AFDC or SSI but whose high medical costs may make them needy. As of 1995 thirty-seven states provided some services for medically needy individuals. The medically needy program does not have to be

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<sup>8</sup> The federal SSI program replaced the joint federal/state Aid to the Aged, Blind and Disabled (AABD) program for which states determined eligibility. With the passage of the SSI program states had the option of keeping their own more restrictive AABD criteria to determine Medicaid eligibility for SSI recipients rather than replacing it with federal eligibility criteria. Twelve states (referred to as 209(b) states) chose to do so.

as extensive as the categorically needy program. However, if a state elects to have any medically needy program certain groups and certain services must be included.

Because of their intensive use of acute and long term care services, the elderly, blind and disabled, whether eligible through SSI or by virtue of medical need, accounted for 60 percent of Medicaid spending in 1995, even though they made up less than 30 percent of the caseload. Interestingly, while adults and children in low-income families make up nearly three-fourths of beneficiaries, they accounted for only 28 percent of Medicaid spending in 1995. Supplements to hospitals which serve a higher than average caseload of uninsured patients in the form of disproportionate share hospital payments made up the remaining 12 percent of Medicaid funding.<sup>9</sup>

#### **Wisconsin Manages Eligibility**

While the state of Wisconsin is known for being liberal with respect to Medicaid, it is also illustrative of managing state Medicaid spending by managing eligibility. Even prior to the state's recent welfare reform initiative, which introduced time limits statewide to AFDC relief, caseloads were dropping significantly. During the 1980s the state received several federal waivers to introduce welfare reform programs such as "Learnfare," a program that required all teens aged 13-19 without high-school diplomas or equivalents to be enrolled in school or face sanctions. More recently its "Parental and Family Responsibility Demonstration Project" of 1994 put in place a family cap, among other welfare changes. In 1995 the state also implemented a pilot work program for AFDC recipients in Fond du Lac and Pierre counties called "Work Not Welfare" which limited cash assistance payments to AFDC recipients to 24 months. At the same time Wisconsin was reducing AFDC-based eligibility for Medicaid, it was expanding eligibility based on the poverty rate by enrolling low income people into managed care programs. Between 1991 and 1995 the number of AFDC children and adults enrolled in Medicaid dropped by 91,000 people while those enrolled on other bases grew by 84,000 people.

With its most recent welfare reform initiative "Wisconsin Works (W-2)" coupled with an expanded health care system under "Badger Care," the state continues to separate eligibility for Medicaid from eligibility for cash assistance and to expand health care coverage to low income families. Since families not traditionally within the welfare safety net system will now become eligible for health care, the state plans to do more outreach to poor families to enroll them in Medicaid.

### **Lever 2: Scope of Services**

<sup>9</sup> Table 47: Medicaid Beneficiaries by Group and Table 48: Medicaid Expenditures by Group, *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends: 1990-1995*, The Kaiser Commission on the Future of Medicaid, November 1997.

The second lever by which states control their Medicaid program is to determine the type, amount, duration, and scope of services. In addition to the 10 required medical services, states have the option of providing another 34 services -- such as prescribed drugs, clinic services, prosthetic devices, nursing facility services for those under 21 and intermediate care services for the mentally retarded -- for which they receive federal reimbursement. States range from offering a low of 15 optional services (in Alabama and Alaska) to a high of 33 (Wisconsin excluded only coverage of Christian Science nurses). Among those states with the largest increase in the number of optional services offered between 1981 and 1995 are Vermont, Mississippi, Wyoming, Florida, Idaho and Texas adding between 9 and 17 optional services to their Medicaid program. Illinois was unusual in reducing the number of optional services covered from 26 in 1993 to 16 in 1995 and then again increasing them to 20 in 1996.

States also control program spending and quality of care by controlling the amount and duration of services offered. For example, states may limit the number of hospital days or hospital visits their Medicaid program will cover or they may limit the amount of physician services or long term health services they will provide. However, these restrictions must meet the following criteria: “(1) the limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.”<sup>10</sup>

#### **Illinois Controls Spending by Cutting Medicaid Services**

Beginning in 1992 and continuing through the mid 1990s Illinois entered a multi-year recession. Like other states, Illinois was also facing double-digit medical inflation and demand pressures on its Medicaid program from a larger population made eligible by federal mandates, court orders and successful lobbying from advocacy groups. Among its strategies to deal with its budget problems, the Republican administration delayed reimbursements to providers, allowing a backlog of \$1.5 billion (of its \$4.5 billion Medicaid program) to develop. The Medicaid debt was one of the factors resulting in the downgrading of the state's bond rating. To remedy its deepening fiscal woes, the state chose to raise taxes and to cut the number of optional Medicaid services offered. Between 1993 and 1995 the state cut, among others, podiatry services, optometrist services, chiropractors, dental services and personal care services -- in all cutting 10 of the 26 optional services covered in 1993. A year later, facing an improved fiscal situation, the state had restored 4 of the optional services cut, including emergency hospital services, case management services and hospice care services.

<sup>10</sup> *Overview of Medicaid*, “Amount and Duration of Services.” Health Care Financing Administration web page: <http://www.hcfa.gov/medicare/ormedmed.html>.

### **Lever 3: Establishing Reimbursement Rates to Providers**

Prior to 1980 states were required to follow federal Medicare cost-based systems for reimbursing hospitals, doctors and nursing homes under Medicaid. Until 1983, Medicare used a retrospective payment system in which accounting records were reviewed to determine allowable per diem rates for rooms and other services. With the enactment of the Boren Amendment to OBRA 1980, states were authorized as of 1981 to establish their own reimbursement systems to nursing homes as long as rates were “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.” A year later the Boren Amendment was extended to hospital reimbursements as well. Because providers voluntarily choose to participate in the Medicaid program and low reimbursement rates could affect provider participation, the Boren Amendment also stipulated that Medicaid must pay enough to ensure that poor people have reasonable access to care.

Since 1981 states have thus varied in the way they reimburse hospitals and nursing homes for Medicaid costs. For institutional services, such as inpatient hospital and nursing facility (NF) services, most states use “prospective” payment systems, under which the amount of payment for a defined unit of service (such as a day of care in an NF or full treatment of an inpatient hospital case) is established in advance. In some prospective reimbursement systems hospitals are paid a fixed fee for admissions in one of several hundred categories known as diagnostic related groups (DRGs). Other prospective systems used by states are reviewing hospital budgets and then reimbursing based on trends in their costs. California, which has had a waiver from the Boren Amendment since 1982, contracts with certain hospitals to provide Medicaid services at specific inpatient rates and then restricts Medicaid patients to one of these hospitals.

Many of the new reimbursement systems instituted under the Boren Amendment reduced payments to below what providers claimed were the costs of treating the Medicaid patient. As a result hospitals and nursing homes have taken their states to court to sue for higher reimbursements. In 1990 the Supreme Court affirmed that institutions could sue under the “reasonable and adequate reimbursement ” requirement of the Boren Amendment. Since then many states have been required, either through court orders or through settlements, to increase reimbursements.

**Negotiating Hospital Reimbursement Rates  
The California Medical Assistance Commission**

In 1982, responding to spiraling Medicaid costs and federal legislation allowing states more flexibility in defining eligibility, scope of benefits, and reimbursement standards, the California Legislature passed AB 799 reforming health care in the state. One of the reforms was to create the California Medical Assistance Commission (CMAC), which would negotiate reimbursement rates with hospitals wishing to participate in the state's Medicaid program, known as Medi-Cal.

Under CMAC, the state first determines the number of hospital beds needed for each of 7 basic service types – general medical, surgical, obstetrics, intensive care, neonatal, rehabilitation and pediatrics – within each of its 68 Health Facility Planning Areas. Hospitals then bid against each other to provide those services at certain rates. CMAC contracts with the lowest bidders within each HFPA, assuring that the projected needs of Medi-Cal patients are met.

This approach allows the state to use its purchasing power in regions of the state where there is significant competition. In regions where there is little competition, hospitals may choose not to negotiate contracts with CMAC and may instead receive cost-based reimbursement directly from the Medi-Cal program, a form of payment which generally results in higher reimbursement levels.

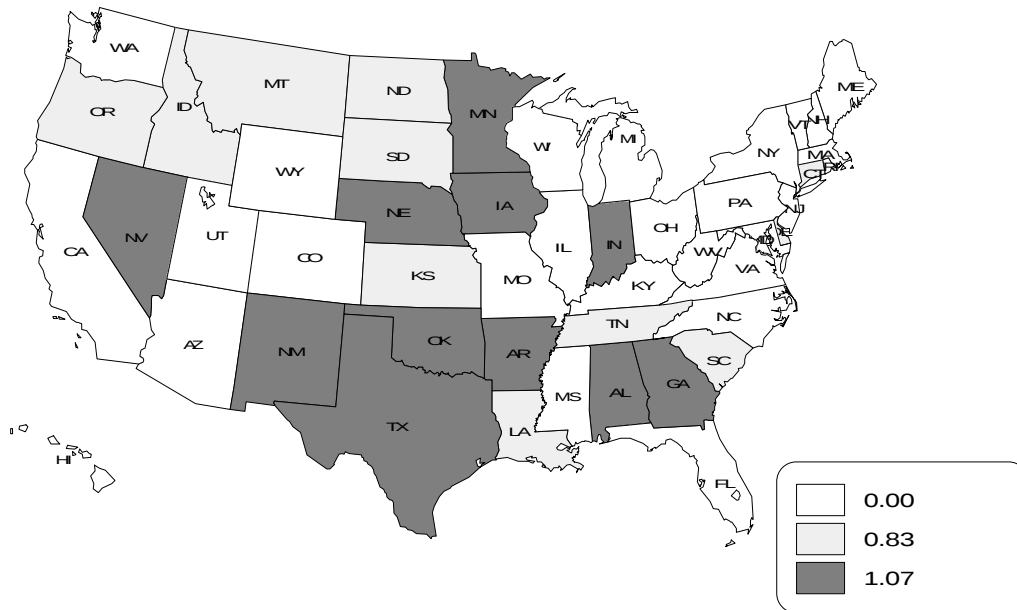
CMAC estimated that in its first year of operation it saved the state \$100 million in reimbursements, increasing to \$400 million by 1991. To institute the hospital reimbursement plan under CMAC the state needed a waiver from the Boren Amendment, which it received and has had since 1982. California remains the only state to have such a waiver.

As a result of the different reimbursement systems, Medicaid rates vary substantially across states. In its annual report *Across the States, Profiles of Long Term Care Systems*, the American Association of Retired Persons publishes comparative Medicaid per diem reimbursements for nursing homes from a survey done by scholars at University of California, San Francisco and Wichita State University. Even when adjusted by states' costs of living, average nursing home reimbursements varied widely across states, ranging from a low of \$54 per day in Oklahoma to \$122 per day in New York. Figure 4 shows a definite geographic pattern to nursing home reimbursement rates. States with high nursing home per diems are found in the Northeast plus Minnesota, Florida, Washington, North Carolina and Hawaii. The lowest rates are in states clustered in the Central region, both north and south. Whether higher per diems reflect better quality nursing home care, more expensive labor costs, higher occupancy rates, or effective lobbying by providers is difficult to determine.



Review Commission (PPRC) and the National Governors Association,<sup>12</sup> is almost the reverse of Figure 4. Except in Massachusetts, reimbursements to physicians treating Medicaid patients in the Northeast are far below average, while Southeastern and South Central states reimburse doctors at much higher rates.

**Figure 5**  
**Medicaid Physician Reimbursement Rate Index**



See Table 2-13: Index of Relative Medicaid Fees by State, *Physician Payment Under Medicaid*, Physician Payment Review Commission, July, 1991, p. 33. The index was constructed as follows -- Eighteen surveyed fees were grouped into nine service types: office visits, hospital visits, emergency room visits, X-ray services, EKGs, psychiatric services, obstetrical services, and surgical and other procedures. Fees for total obstetrical care for both vaginal deliveries and cesarean sections were not used in the fee indexes because many states could not report fees for these services. Fees for each service type were then combined in proportion to their Medicaid utilization to create a typical Medicaid fee for each state. The index value is each state's typical fee divided by the nationwide average. Footnote 14, p. 28.

Dr. Philip R. Lee, who chaired the commission conducting the study while he was director of the Institute for Health Policy Studies at the University of California at San Francisco, proposed that states trade off liberal benefits with lower physician reimbursements and vice versa. When interviewed for the New York Times upon the release of the PPRC report, he said: “while Medicaid payments to doctors are relatively low in New York, the state’s program has liberal eligibility rules, offers a wide range of optional benefits and pays for large amounts of long term care. By contrast, the Indiana Medicaid program pays higher fees to doctors, but eligibility for benefits is stricter.” Dr. Lee goes on to say that “poor people have limited access to private physicians in New York City because Medicaid payments are often less than what it costs the physician to provide the service, but New York City has a well-developed system of public hospitals and outpatient clinics that assure access to health care for Medicaid beneficiaries and other poor people.”<sup>13</sup>

#### **Lever 4: Alternative Finance Mechanisms<sup>14</sup>**

When the Medicaid program was established in 1965 states were required to follow Medicare principles for reimbursing the doctors, hospitals and nursing homes which provided care. With the Boren Amendment to the Omnibus Reconciliation Acts of 1980 and 1981, Congress separated Medicaid reimbursement rates from Medicare, saying simply that payments to nursing homes and hospitals must be “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.” In addition, to assist hospitals that incurred a high rate of uncompensated expenses by serving large numbers of uninsured poor people, the Boren Amendment required that state Medicaid programs pay special subsidies to hospitals handling “disproportionate shares of low-income people with special needs.” This minor provision of OBRA 1981 grew to a multibillion dollar federal subsidy to state Medicaid programs as states learned to use the disproportionate share hospital (DSH) payments to leverage additional federal reimbursements.

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<sup>13</sup>Robert Pear, “Low Medicaid Fees Seen as Depriving Poor of Care,” New York Times, April 2, 1991.

<sup>14</sup> For a detailed discussion of the evolution of these finance mechanisms see the Urban Institute paper “The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues” by Teresa A. Coughlin and David Liska, part of the New Federalism Series A, No. A-14, October 1997.

States began to collect taxes or voluntary donations from hospitals, count these contributions as part of the state's Medicaid funding which leveraged from \$1 to \$4 of federal matching money for every dollar paid by the hospitals and then reimburse hospitals the amount of the original contribution or more. Under the term "intergovernmental transfers," city or county hospitals or governments were also contributing to states' Medicaid programs and triggering a federal match. It should be noted that states actually had to spend on Medicaid the taxes or donations raised before they could earn the federal match, since federal Medicaid matching payments are based on expenditures not revenues.

Although DSH payments were originally authorized in 1981, it was only in 1985 that HCFA issued a rule allowing states to receive donations from private medical care providers and in 1986 that Congress passed legislation prohibiting the Secretary of Health and Human Services from limiting DSH payments, thus putting into place the pieces necessary for states to more fully benefit from the new finance mechanism. States themselves may have had little incentive to change their reimbursement methodologies until the latter 1980s when they were forced to comply with the federal mandates expanding Medicaid coverage and requiring additional state spending. Facing the federal mandates and lower state revenues due to recessions in the late 1980s, many states began to utilize the revenue bonanza offered by combining provider donations with DSH payments matched by federal reimbursements.

Because DSH payments are not specifically tied to a particular service and until 1993 had no limits, hospitals were often willing participants in these finance arrangements. Since states had broad discretion in distributing DSH payments, they were able to guarantee that hospitals would be reimbursed amounts equal to or greater than their contributions. Depending on their federal matching percentage, states could receive up to four federal dollars for every \$1 raised locally and, after reimbursing the hospitals, use the extra to expand their Medicaid programs or supplement other budget priorities.

The following example taken from a 1995 Congressional Research Service report illustrates how a state might take advantage of the program. "A state with a 60% federal matching rate might pay a hospital \$100 and claim \$60 in federal matching funds. It would then tax the hospital \$40 (or the hospital would agree to donate \$40 to the state). The hospital would still be \$60 ahead, the federal government would have spent \$60, and the state would actually

have spent no state funds. Some states achieved the same effect through intergovernmental transfers. A state might make Medicaid payments to a state or local facility (such as a state mental hospital), claim federal matching on the payments, and then transfer the funds back from the facility to the state general fund.”<sup>15</sup>

Table 2 shows the states’ shares of Medicaid spending in DSH payments sorted from highest to lowest in 1992, the peak year for DSH payments as a percent of Medicaid expenditures. New Hampshire and New Jersey are among the predominantly southern states which relied extensively on DSH payments in the early 1990s.

**Table 2**  
**DSH Payments as a Percent of Medicaid Expenditures**

	1990	1991	1992	1993	1994	1995
<b>United States</b>	<b>1.9%</b>	<b>5.6%</b>	<b>14.7%</b>	<b>13.0%</b>	<b>11.8%</b>	<b>11.9%</b>
New Hampshire	0.0%	12.7%	50.7%	49.5%	39.2%	38.4%
Louisiana	8.2%	7.9%	36.0%	30.7%	31.1%	30.1%
Missouri	4.3%	29.3%	31.0%	30.5%	27.4%	25.7%
South Carolina	7.0%	16.5%	28.3%	25.7%	25.0%	21.4%
Alabama	23.5%	14.0%	27.1%	25.1%	23.0%	21.1%
Texas	0.1%	5.1%	24.0%	20.7%	17.8%	16.7%
New Jersey	1.5%	6.7%	23.6%	21.7%	21.1%	23.1%
Kansas	6.3%	7.6%	20.1%	16.7%	16.3%	7.6%
Nevada	0.1%	0.3%	19.5%	19.9%	18.4%	15.6%
Maine	0.4%	7.6%	18.5%	19.3%	17.6%	17.2%
Tennessee	6.5%	10.6%	17.9%	15.8%	3.9%	0.0%
California	0.1%	1.1%	17.8%	17.2%	12.5%	16.0%
Connecticut	0.1%	0.0%	17.2%	20.3%	17.0%	17.5%
New York	3.3%	4.6%	16.1%	13.8%	11.3%	11.7%
Pennsylvania	0.2%	9.8%	15.2%	12.1%	11.4%	10.3%
Kentucky	0.0%	11.9%	14.2%	7.3%	3.6%	10.1%
Mississippi	0.4%	2.9%	13.9%	12.6%	11.8%	11.6%
Michigan	2.0%	7.9%	13.6%	11.9%	11.8%	8.1%
North Carolina	4.2%	7.1%	13.2%	11.8%	12.1%	10.7%
Georgia	0.1%	2.5%	11.8%	10.8%	10.7%	11.3%
Colorado	0.7%	6.7%	11.8%	10.0%	9.2%	22.6%

<sup>15</sup> Merlis, Mark, “Medicaid: Program Description and Recent Trends,” Congressional Research Service Report for Congress, July, 27, 1995, p. 5.

Hawaii	0.0%	0.7%	11.2%	10.9%	6.2%	0.1%
Massachusetts	0.0%	23.7%	11.0%	12.1%	12.3%	11.9%
Washington	2.2%	1.5%	10.9%	10.7%	11.3%	11.4%
Rhode Island	0.0%	11.1%	10.3%	11.6%	11.6%	16.8%
Indiana	0.3%	1.1%	9.4%	1.2%	11.7%	18.7%
Ohio	2.0%	1.7%	9.2%	8.4%	8.8%	9.8%
Virginia	0.6%	1.0%	8.9%	7.0%	7.2%	6.8%
West Virginia	0.0%	0.0%	8.8%	8.6%	8.1%	1.9%
Vermont	0.0%	0.7%	8.7%	6.7%	6.1%	10.4%
Illinois	2.5%	3.0%	7.1%	4.6%	5.5%	6.6%
Maryland	0.0%	0.0%	5.6%	3.8%	6.4%	6.3%
Florida	1.7%	1.1%	4.5%	4.8%	5.3%	5.4%
New Mexico	0.3%	0.0%	2.2%	1.4%	1.1%	0.8%
Minnesota	0.6%	0.6%	2.1%	1.4%	1.7%	0.8%
Oklahoma	0.4%	1.3%	2.0%	2.0%	2.1%	1.5%
Oregon	0.7%	1.0%	2.0%	2.0%	1.8%	1.8%
Utah	0.3%	0.7%	1.0%	0.9%	0.9%	0.6%
Nebraska	0.3%	0.2%	0.6%	0.6%	1.4%	1.3%
Iowa	0.3%	0.3%	0.5%	0.4%	0.6%	0.4%
Idaho	0.0%	0.0%	0.5%	0.3%	0.1%	1.1%
Wisconsin	0.1%	0.2%	0.4%	0.4%	0.5%	0.5%
Arkansas	0.2%	0.2%	0.3%	0.2%	0.3%	0.3%
Wyoming	0.0%	0.1%	0.1%	0.1%	0.0%	0.0%
Montana	0.1%	0.1%	0.0%	0.2%	0.1%	0.1%
South Dakota	0.0%	0.0%	0.0%	0.0%	0.1%	0.3%
North Dakota	0.0%	0.0%	0.0%	0.0%	0.4%	0.4%
Delaware	0.0%	0.0%	0.0%	2.0%	2.0%	2.0%
Arizona	0.0%	0.0%	0.0%	5.8%	5.2%	7.2%
Alaska	0.0%	0.0%	0.0%	4.4%	5.7%	5.4%

Source: Tables 80 and 64, *Medicaid Expenditures and Beneficiaries, National and State Profiles and Trends, 1990-1995*, Urban Institute and the Kaiser Commission on the Future of Medicaid, November, 1997.

Interestingly, the size of the federal match is not the only factor determining which states rely more heavily on DSH payments and which do not. Some states like New York, with a federal matching percent of 50 percent, chose to finance up to 16 percent of their Medicaid spending with DSH payments while others like Wisconsin, with an FMAP of 60 percent, chose not to rely on this funding. Policymakers in New York argue that these unusual financing techniques are a way to redress the imbalance in their overall flow of funds with the federal government and the fact that the federal reimbursement for Medicaid expenses is based only on a

state's per capita income and not its level of poverty nor cost of living.<sup>16</sup> In contrast policymakers in Wisconsin say they used provider taxes later and less extensively than other states because they did not want to “game” the system. Wisconsin also chooses to finance its DSH payments primarily with state general fund dollars rather than provider taxes. Although initially hesitant to use provider taxes coupled with DSH payments, Missouri officials finally acquiesced under the rationale that they were merely making the federal government pay for the unfunded mandates it was imposing on the states.

In response to sky-rocketing DSH payments, which in many states were questionably tied to increased medical services for poor people, Congress passed the Medicaid Voluntary Contribution and Provider Specific Tax Amendment effective in FY 1993 restricting the use of these special financing arrangements. Primary among those restrictions were:

- Provider donations are banned for most reasons.
- Provider taxes are capped and not to exceed 25 percent of the state's share of Medicaid expenditures. They must also be broad-based and applied uniformly across an entire class of providers, such as acute care hospitals or nursing homes.
- HCFA is permitted to set state caps for DSH payments, roughly at their 1992 levels. State spending for DSH payments was limited to 12 percent of the state's total Medicaid spending in any given year, with the 12 percent limit being phased in over time.
- In general, explicit hold harmless arrangements are disallowed. States are prohibited from guaranteeing that a provider's DSH payments would equal or exceed its tax payments.

With the new provisions, DSH payments have declined as a share of total Medicaid spending to 11.9 percent in 1995, after peaking at 14.7 percent in 1992. Nevertheless, they remain a substantial source of Medicaid financing and state policymakers continue to lobby the Health Care Financing Administration to preserve their payments.

Different Uses of Provider Taxes and DSH Payments – Two States' Stories

### **The Massachusetts Uncompensated Care Pool**

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<sup>16</sup> Senator Daniel Patrick Moynihan eloquently makes the New York case in his introduction to *The Federal Budget and the States Report, FY 1996*, Taubman Center for State and Local Government, Harvard University.

In 1991 part-time state employee Kathleen Betts of the Massachusetts Department of Public Welfare received a special citation from then Governor William Weld for proposing a fiscal arrangement whereby the state could realize an additional \$513 million in federal funds for its Medicaid program. For six years the state had been operating a hospital Uncompensated Care Pool totaling approximately \$300 million and administered by the Division of Health Care Finance and Policy. HCFP would collect a fee from hospitals based on their private sector charges and redistribute it to them based on the amount of their uncompensated care. What Ms. Betts along with General Counsel Jean Sullivan and other state Medicaid officials recognized was that these redistributed funds met the criteria for federal reimbursement under Medicaid DSH legislation that had been amended in November, 1990.

HCFP structured a program in which it continued to collect the \$300 million dollars from hospitals for the uncompensated care but now was federally reimbursed for half of that. Of the \$150 million received from the federal government, an additional \$30 million was added to the Pool and the \$120 million remainder went into the state's General Fund. The \$513 million that the state realized included an additional three years' worth of retroactive federal reimbursements, which were used to balance the state's budget in 1991.

Although it received a large federal lump sum reimbursement in 1991, Massachusetts was actually restrained compared to other states in leveraging federal dollars using provider taxes and DSH payments. The state primarily incorporated the DSH payments into an existing finance mechanism – the Uncompensated Care Pool – without expanding the pool substantially, increasing reimbursements to hospitals nor increasing the Medicaid program in other areas. Of the \$300 million raised from the Uncompensated Care Pool provider tax, the state asked for a federal reimbursement of only \$150 million, most of which went into the state's General Fund. Missouri, on the other hand, illustrates a much more aggressive leveraging of federal dollars, which it then used to increase reimbursement rates to hospitals and physicians and to expand its Medicaid program through managed care.

**Missouri's Voluntary Contribution Program and Federal Reimbursement Allowance Program<sup>17</sup>**

In 1990, facing a Medicaid budget shortfall due to a state recession, Gary Stangler, Director of the Department of Social Services (DSS), approached the Missouri Hospital Association (MHA) to discuss collecting voluntary contributions from hospitals to be used to leverage federal matching funds. In exchange DSS would increase the disproportionate

<sup>17</sup> For a more detailed discussion of Missouri's Voluntary Contribution and Federal Reimbursement Allowance Programs, see the Kennedy School of Government case, *Financing the Expansion of Missouri's Medicaid Program: 1987-1992*, number CR14-99-1489.

share hospital payments to eligible hospitals to more than offset the donated funds. Since according to DSS officials most of the cuts would have occurred in the hospital appropriation, the MHA recognized that it would be in the hospitals' interest to participate in the donation program. Since the donations would be targeted to those receiving the increased reimbursements, the MHA stated, "under the Voluntary Contribution Program, there were no losers. All hospitals received payments in excess of their contribution."

The program lasted from March, 1991 through September, 1992 until federal legislation prohibiting the use of provider donations went into effect. To comply with the new federal regulations, Missouri enacted the Federal Reimbursement Allowance Program, which assessed a broad-based hospital tax and made disproportionate share hospital payments to all hospitals, based on the hospital's Medicaid and Medicare contractual adjustments.

In 1996 under Missouri's Federal Reimbursement Allowance program the state collected \$326 million from the hospital tax, which it used to leverage \$489 million dollars in federal funds based on its federal matching percent of 60 percent. The state then spent the total \$815 million on its Medicaid program – allocating \$529 million back to the hospitals in DSH payments and for hospital care, \$232 million for premiums for its newly established managed care program, \$33 million for emergency care and \$21 million to physicians.

Because Missouri had further to go than Massachusetts to meet the federal mandates expanding eligibility and services, the state may have had more incentive to aggressively use the DSH program to leverage federal funds. Massachusetts already had more liberal eligibility and a more expansive program, spending \$4,190 per poor person in 1990 compared to Missouri's \$1,795 (in 1995 state cost of living adjusted dollars). Due in large part to its Federal Reimbursement Allowance program, Missouri made substantial progress in closing its Medicaid spending gap with Massachusetts, spending \$4,655 per poor person in 1995 compared to Massachusetts' \$5,990.

### **Lever 5: Providing Alternative Health Care Systems -- Managed Care and Home and Community-Based Systems**

Under the broad umbrella of Medicaid, two very different types of services are offered: acute care services – serving primarily poor children and adults and the blind and disabled – and long term care services or nursing home care – serving the elderly and the blind and disabled. In 1995 acute care accounted for 52 percent of total Medicaid spending compared to 35 percent for long term care and 12 percent for disproportionate share hospital payments. With average annual growth rates of 16.7 percent and 10.8 percent for providing acute and long-term care, respectively, states are facing increasing pressure to institute alternative health care delivery

systems. Motivated to contain costs, to promote more preventive care and to improve the quality of health care, states have focused on two types of alternative Medicaid systems: establishing managed care organizations (MCOs) as an alternative to fee-for-service care and providing home and community based services as an alternative to institutional long term care.

### **Managed Care**

Between 1991 and 1996 the proportion of Medicaid beneficiaries enrolled in managed care programs quadrupled, growing from 10 percent in 1991 to 40 percent in 1996. And the proportion keeps on growing. All fifty states now have some sort of managed care program for their Medicaid populations and twenty states have enrolled more than 50 percent of their beneficiaries in MCOs.

The Kaiser Commission on the Future of Medicaid describes the major Medicaid managed care models as follows:

- *Full-Risk Plans (HMOs or HIOs)*: Under a fully capitated plan, a health plan is paid a fixed monthly fee per enrollee and assumes full-risk for the delivery of a comprehensive range of services. The major types of full-risk plans are Health Maintenance Organizations (HMOs), in which the contracting entity and the providers are integrated into one plan, and Health Insuring Organizations (HIOs), which operate as fiscal intermediaries.
- *Limited Risk Prepaid Health Plans (PHPs)*: A PHP is an entity, usually a clinic or a large group practice, that either contracts on a non-risk basis or a prepaid, capitated-risk basis to provide services that are not comprehensive (often ambulatory care only).
- *Fee-for-Service Primary Case Management (PCCM)*: In a PCCM, a specific provider, usually the patient's primary care physician, is responsible for acting as a "gatekeeper" to approve and monitor the provision of covered services to beneficiaries. These gatekeepers contract directly with state Medicaid agencies, and

are paid a per-patient monthly case management fee, as well as fee-for-service payment for medical care.<sup>18</sup>

According to the federal Health Care Finance Administration (HCFA), as of June 30, 1995 26 states were using HMOs, 17 states had some sort of prepaid health plans and 33 states had instituted primary care case management systems for their Medicaid recipients.

Instituting managed care systems to contain costs is not without controversy. While some argue that enrolling poor people in managed care systems will encourage more preventive medical care than a fee-for-service model and may even improve the quality of their care, others are more skeptical that MCOs will actually improve health care for the poor or change their health care behavior. While some argue that using fixed, capitated systems will save states money, others believe that using intermediaries like HMOs is unnecessary since the state's financial risks are small enough to be manageable. They argue that when you have as large a share of the health care market as Medicaid, states can buy health care directly and still manage costs. There are those who also believe that managed care is not necessarily good for providers such as community based hospitals. They fear that under managed care private organizations will selectively serve healthier Medicaid patients and the public hospitals will continue to serve the sickest, most expensive patients and yet will be reimbursed at the same fixed fee.

Interestingly, while managed care systems are being instituted with the intent of containing state Medicaid costs, for the most part they have been targeted to the least expensive group – poor children and families, who averaged only \$1,570 per beneficiary for acute care -- rather than the more expensive elderly and disabled, who averaged \$4,050 per beneficiary. Nevertheless, like the health care system at large, the move to managed care in Medicaid has become widespread.

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<sup>18</sup> Appendix A: Medicaid Fact Sheets, "Medicaid and Managed Care," *Medicaid Expenditures and Beneficiaries, National and State Profile and Trends, 1990-1995*, The Urban Institute and The Kaiser Commission on the Future of Medicaid, November, 1997.

### **Tennessee's Statewide Waiver for Managed Care – TennCare<sup>19</sup>**

Tennessee celebrated the 1994 New Year by becoming the first state in the nation to replace its fee-for-service Medicaid program with a statewide managed health care program called TennCare. Under the leadership of Democratic Governor Ned McWherter, Commissioner of Finance and Administration David Manning and the State Medicaid Director Manuel (Manny) Martins, and with the support of consumer and social service advocacy groups, 800,000 Tennessee Medicaid recipients and 400,000 uninsured became eligible to receive acute care health coverage under TennCare. Over the course of several years, all Medicaid recipients and certain working poor have been enrolled in health maintenance organizations (HMOs).

In 1992, facing a serious budget crisis, observing that the federal reimbursements to the states for Medicaid were being restricted, and drawing on his expertise moving state employees into managed care, Manning concluded that the state needed a drastic long-term solution to the Medicaid fee-for-service system. A statewide managed-care program for Medicaid beneficiaries was his proposed solution. Observing that the state was paying twice as much for health care for its Medicaid recipients than it was for its state employees, he reasoned that if the state could get its payments per Medicaid recipient down, then not only would it take pressure off the state budget but Tennessee's large uninsured population might also be able to receive health care.

Under previous administrations, Tennessee's Medicaid program had always considered provider interests paramount, as represented by the Hospital Corporation of America, large nonprofit hospitals, pharmaceutical companies and an organized medical community. McWherter, Manning and Martins realized that their TennCare proposal was sure to alienate this constituency. Recognizing that doctors and hospitals could mount powerful political opposition to their proposal, they approached consumer groups and human service advocates for their support. Initially skeptical to the initiative, advocacy groups eventually supported what they labeled a "labor/ management" deal with state administrators because of the goodwill generated with the state's earlier use of provider taxes and DSH payments to expand the Medicaid program and their recognition that more poor families could be given health insurance under managed care.

Every other Friday for 4 hours, over the course of several months, Manning and Martins met in the state capitol to discuss the TennCare proposal with anyone who wanted to attend. Meanwhile McWherter was laying out the Medicaid options to the State Legislature: either (1) raise taxes, which was politically unpopular, (2) slash the program dramatically, or (3) consider a fundamental change in the way Tennessee purchased health care – TennCare. The Legislature agreed to the managed care experiment in Spring, 1993. With state authorization in hand, McWherter, Manning and Martins then began to relentlessly lobby Washington for the HCFA waiver necessary to implement the program. In the words of David Manning, "Governor McWherter took the new President (his friend and former fellow Governor, Bill Clinton) at his word when he vowed to give the states flexibility in managing their Medicaid programs by granting waivers to states that wished to try a new approach." In November, 1993, HCFA granted Tennessee a waiver to run TennCare.

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<sup>19</sup> For a more detailed discussion of Tennessee's managed care program see the Kennedy School of Government case, *Tennessee's Medicaid Revolution: TennCare*, number CR14-99-1490.

TennCare was scheduled to be implemented January 1, 1994. Consumer groups asked Manning to delay the start of the program until more of the bugs had been worked out, but Manning declined for two reasons. First, the 1993-94 state budget had been front-loaded to pay for the new program and a delay in implementation would wreak havoc on the state's finances. In addition, if they were to wait, lobbyists against the program would surely kill it once the Legislature was back in session January 15. From Manning's point of view an imperfect program was better than no program.

According to Gordon Bonnyman of the Tennessee Justice Center, "TennCare has changed the psychology of health care in the state. Manning took a program that was of, by and for providers and flipped it. Now even the Republican Governor Don Sundquist cannot eliminate TennCare." Nor does he want to. The Governor has said that he wants Tennessee to be the first state to have universal health insurance for children. According to a recent study by the Urban Institute, he may have his way. Tennessee has the lowest percentage of uninsured people in the country.

### **Home and Community Based Services**

At \$7,822 per elderly beneficiary and \$3,696 per blind or disabled beneficiary, providing long term care services is one of the most expensive of Medicaid services. As our elderly population continues to grow, it will increasingly become one of the most important of Medicaid services. Medicaid currently pays for nearly half of all nursing facility or home health services used in this country and an even larger percent for those who need more than four months of care. While nursing home care for individuals aged 21 and older is a mandatory Medicaid benefit and intermediate care for the mentally retarded is an optional service now offered by all states, states vary widely in their long term care spending due to several factors:

- 1) How expensive the nursing home care is in the state – for example, reimbursement rates to nursing homes ranged from \$54 per day in Oklahoma to \$122 per day in New York.
- 2) Whether the state allows individuals to “spend down” their assets in order to become eligible for Medicaid long term care;
- 3) The demographics in the state;
- 4) How extensively institutional care is used in the state.

The eleven states whose long term spending exceeded 45 percent of their total Medicaid spending in 1994 included North Dakota, Minnesota, South Dakota, Connecticut, Wisconsin, Wyoming, Arkansas, Pennsylvania, Montana, Nebraska, and New York. Running the two largest Medicaid programs, New York and California provide interesting contrasts in the priority given to long

term care. With nearly half of its spending in long term care, New York dwarfs California's share of only 23 percent, which places it last among the states.

Both to improve the quality of life of those unable to function independently and to reduce costs, states are increasingly turning to providing long term care in home and community-based settings rather than in institutions. States who have led the way in turning to home health care are Oregon, Wyoming, Vermont, Colorado, New York, New Hampshire, Maryland and West Virginia, with more than 25 percent of their long term health expenditures provided by home and community based health care.

**Wisconsin's Home and Community-Based Care Program -- The Community Opportunity Program (COP)**

In 1982 with the highest number of nursing home beds per elderly person in the country and continually rising nursing home costs, officials in the state of Wisconsin concluded that they needed to actively manage their long term care costs. State officials were also interested in maintaining or improving the quality of care offered. Providing home and community based services to the elderly and disabled who may otherwise have need nursing home care and instituting a moratorium on licensing new nursing home beds were the state's solutions.

Under the program, which came to be known as the Community Opportunity Program (COP), a county caseworker serves as a gatekeeper to those potentially needing nursing home care. Understanding the difficulty of reversing the emotionally-charged decision to place a family member in a nursing home, the caseworker contacts patients before they are discharged from the hospital to determine the various services needed that might keep them from entering the nursing home in the first place.

When it was first established in 1982, the COP program was completely funded by state General Purpose Revenues (GPR). In 1986 state officials decided to apply for a waiver from the Health Care Finance Administration (HCFA) to extend the COP program to Medicaid-eligible people and thus leverage federal matching funds. In order to receive the waiver states have to demonstrate that caring for individuals in the community rather than an institution would save Medicaid dollars or, at a minimum, be cost neutral. In addition the state must design a program in which individuals who are eligible to receive nursing home care under Medicaid are informed of the availability of the waiver services but are not required to participate in the waiver program. Wisconsin successfully demonstrated these conditions and was granted a waiver in 1987. In calendar year 1995 7,608 persons received services supported by COP-waiver funds at a cost of \$45.6 million dollars, including \$18.1 million GPR. With the implementation of the COP program, the state now ranks tenth in the number of nursing home beds per elderly resident.

Since then the state has also received federal waivers for Medicaid-eligible developmentally disabled individuals to receive community-based care as an alternative to placement in either private or state-run Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

## **Conclusion**

States are fashioning very different Medicaid programs within the same federal framework as a result of their manipulation of the five levers. Whether a state focuses on changing eligibility standards, expanding or limiting the scope of benefits, renegotiating reimbursement rates to providers, structuring unusual finance mechanisms, or experimenting with alternative delivery systems will depend on a variety of factors. Its political culture, its economic base, problems in its current program, the priorities of policymakers, the institutional capacity in place, the ability of elected officials to manage the politics of change and the creativity of those with a stake in the program will all influence the shape of a state's health care system for the poor. While not exhaustive, the examples of California, Illinois, Massachusetts, Missouri, Tennessee and Wisconsin are illustrative of the innovations that states are capable of making in their Medicaid programs. In the context of a changing health care environment, states will continue to be challenged to fashion programs that are responsive yet efficient in providing care.

**APPENDIX  
FEDERAL MEDICAID POLICY CHANGES**

1965 Medicaid Program enacted – program began Jan.1, 1966

1976 Health Maintenance Organization Amendments enacted

- established federal requirements for Medicaid contracts with HMOs

1980 OBRA 1980

Boren Amendment

- Repealed requirement that states follow Medicare principles in reimbursing nursing facilities and ICFs/MR. Substituted language that said payments to nursing homes must be “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities,” but not necessarily tied to actual costs.
- Also Medicaid must pay enough to ensure that poor people have “reasonable access” to hospital care

1981 OBRA 1981: Cost Containment Measures (Reagan Era)

- 3 year reduction in Federal reimbursements
- Reduced eligibility for welfare benefits
- Established Freedom of Choice, 1915 (b) waivers: States can require recipients to obtain services from certain providers. Waiver is needed to enroll recipients in HMOs or to use primary care case management systems.
- Home and Community Based Care, 1915 (c) waivers: States can provide wide range of home and community-based care (including homemaker, personal care and case management) to elderly, mentally retarded and other chronically ill populations who might otherwise be institutionalized. States must demonstrate that average expenditures for a person receiving waiver services would not exceed expenditures for that person in the absence of a waiver.
- Expanded Boren Amendment to hospital reimbursements. Repealed requirement that states follow Medicare “reasonable cost” reimbursements for hospital inpatient services, but required that states take account the situation of hospitals with “disproportionate shares of low-income patients with special needs.

1982 Tax Equity and Fiscal Responsibility Act of 1982

1983 Allow states to extend Medicaid eligibility to certain disabled children living at home who would be eligible for SSI if they were institutionalized

- Permits states to require cost sharing (copayments, deductibles) for nearly all mandated or optional services provided to both the categorically and medically needy

1983 (phased in over 1983-84): Prospective Payment System (adopted with Medicare first)

- pay hospitals based on Diagnostic Related Groups (DRGs), ie. System sorts admissions into one of 600-700 categories then pays hospital a fixed fee for each admission in that category (based on labor costs in region)
- prior to DRGs hospital payments are based on costs

1984: 1<sup>st</sup> Provider tax levied – in Florida on physicians

DEFRA (Deficit Reduction Act) 1984

- Requires coverage of all children born after 9/30/83 meeting state AFDC income and resource standard regardless of family structure.
- Requires coverage of pregnant women if they would qualify for AFDC or AFDC-UP once child was born even if state didn't have AFDC-UP program.
- Requires automatic coverage for 1 year after birth if mother is already receiving Medicaid and remains eligible.

OBRA 1985

- Additional coverage for pregnant and postpartum women with income below state AFDC levels.
- Requires coverage for adoptive and foster children.
- Established optional hospice and case management benefits

HCFA Rule in 1985

- States are allowed to receive donations from private medical care providers.

OBRA 1986 (Switching to optional eligibility based on poverty rate versus AFDC or SSI levels)

- Established option for states to extend Medicaid coverage to all pregnant women, infants up to age 1, and children up to age 5 with family incomes up to 100 percent of the poverty level.
- Established option for state to extend Medicaid coverage to all elderly and disabled with incomes up to 100 percent of poverty and meeting SSI asset test.
- Required states to continue Medicaid coverage for disabled individuals with severe impairments who lose eligibility for SSI as a result of earnings from work.

1986: Provider Taxes and Donations and Intergovernmental Transfer Programs

- With OBRA 1981 Medicaid programs were allowed to make DSH payments. Now Congress taking limits off those payments. Payments to hospitals and mental health facilities that serve disproportionately high level of low-income patients can now be higher than Medicare payments.
- West Virginia one of first to seek permission to use donations from hospitals and to increase payments to hospitals through DSH program

- Big growth in hospital inpatient spending in 1990 and continuing through 1992

#### OBRA 1987: Nursing Home Reforms

- Nursing home services made mandatory
- Specified standards for scope of services to be provided, levels and qualifications of staff, assessment of each resident's functional capacity and sanctions.

Also:

- Options to extend coverage to pregnant women and infants up to 185 percent of the poverty level;
- Established a new home and community-based waiver authority for persons over 65.

#### 1988: Medicare Catastrophic Cost Act (MCCA)

- States required to extend eligibility to pregnant women and children with incomes up to 75 percent of poverty by July 1, 1989 and 100 percent of poverty by July 1, 1990.
- Increased the amount of income and assets a non-institutionalized spouse of a Medicaid recipient receiving nursing home services may retain
- Imposed a new national "transfer of assets" policy for institutionalized Medicaid recipients.
- States required to pay Medicare premiums, deductibles and coinsurance for low-income aged and disabled Medicare beneficiaries

#### Family Support Act of 1988

- Requires states to continue Medicaid coverage for 12 months to working poor families who leave cash assistance due to earnings
- Requires states to provide full Medicaid coverage to all members of two-parent families on AFDC-UP even in months when cash assistance is not being paid.

#### OBRA 1989

- Required states to raise Medicaid eligibility for pregnant women and children and infants to 133 percent of poverty
- Required states to cover children through age 6 up to 100 percent of poverty, and to pay for all "medically necessary" services for problems identified during regular Medicaid-covered checkups.

#### 1990: Supreme Court permits Boren Amendment Lawsuits by Medicaid providers

- Reduced states' abilities to modify hospital and nursing home payment rates
- 21 States were being sued for hospital reimbursements
- 20 states for nursing home reimbursements

#### OBRA 1990

- Taxes imposed by the state solely on hospitals, nursing facilities or ICF/MRs were not a reimbursable Medicaid cost
- Required states to phase in coverage of children through age 18 in families at or below 100 percent of poverty
- Requires continuous coverage of 60 days post-partum for pregnant women and 1 year for infants. Requires states to conduct outreach.
- Authorizes programs within Medicaid for home and community-based care for frail or immobile elderly and developmentally disabled.

September, 1991 effective FY 1993: Amendments to Medicaid Voluntary Contributions and Provider Specific Taxes

- Bans provider donation for most reasons
- Requires that provider taxes be “broad-based” taxes across an entire class of providers such as acute care hospitals, nursing homes
- Prohibits states from guaranteeing that DSH payments will exceed tax payment for each hospital
- Permits HCFA to set state caps for DSH payments
- Repealed provision that provider taxes are not reimbursable Medicaid costs. Allows them to be reimbursed.
- States using provider taxes included Alabama, Arkansas, Illinois, Indiana, Kentucky, Massachusetts, Maine, Minnesota, Montana, New Hampshire, New Jersey, Nevada, New York, Ohio, South Carolina, Tennessee, Vermont, Washington, Wisconsin
- States using voluntary contributions included California, Georgia, Michigan, Missouri, North Carolina, Pennsylvania, South Carolina and Utah
- States using both – Florida, Maryland, and Mississippi

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Kelly Carter, Special Assistant to the Administrator, Illinois Department of Public Aid, (November, 1998).

William G. Hall, Director, Economic and Fiscal Commission, (November, 1998).

### MASSACHUSETTS

Alan Levitis, former Assistant Budget Director, Division of Medical Assistance, Executive Office of Health and Human Services, (October, 1998).

Jean Sullivan, General Counsel, Division of Medical Assistance, Executive Office of Health and Human Services, (October, 1998).

### MISSOURI

Donna Checkett, former Director, Division of Medical Services, Missouri Department of Social Services, now with the HMO Missouri Care, (May, 1998).

Dwight Fine, Vice President for Legislation, Missouri Hospital Association, (May and August, 1998).

Ned Holland, Health Care Attorney, former Chairman of the Board, Truman Medical Center, (June and November, 1998).

Dr. James Mongan, former Executive Director, Truman Medical Center, now CEO of Mass General Hospital, (June, 1998).

Brent Schondelmeyer, former reporter Kansas City Business Journal, now on the Local Investment Commission (LINC), Family Investment Group, (April, 1998).

Gary Stangler, Director Missouri Department of Social Services, (May, 1998).

Greg Vadner, Director, Division of Medical Services, Missouri Department of Social Services, (April, 1998).

## TENNESSEE

Gordon Bonnyman, Attorney, Tennessee Justice Center, (April, 1998 and November, 1998).

Karen Franklin, Council of Community Services, (April, 1998).

Tony Garr, Executive Director, Tennessee Health Care Campaign, (April, 1998).

David Manning, former Tennessee Commissioner of Finance and Administration, now a consultant to America's Health Network, (September, 1998 and November, 1998).

Manuel Martins, former Medicaid Director, Tennessee Department of Health, now a Health Care Consultant, (October, 1998).

Ned McWherter, former Governor of Tennessee, (October, 1998).

## WISCONSIN

Tom Frazier, Executive Director, Coalition of Wisconsin Aging Groups, (September, 1997).

Judy Fryback, Director, Bureau of Quality Assurance, Department of Health and Family Services, (November, 1997).

Tom Kaplan, Professor, Institute for Research on Poverty, University of Wisconsin, (November, 1997).

Gene Kussart, former Executive Assistant to Gerry Whitburn, Department of Health and Human Services, now at Department of Transportation, (September, 1997).

David Lund, Chief, Nursing Home Reimbursement Section, Bureau of Health Care Finance, Department of Health and Family Services, (November, 1997).

Richard Megna, Analyst, Legislative Fiscal Bureau, (October, 1997).

Gerry Whitburn, former Secretary of Wisconsin's Department of Health and Family Services, (September, 1997).

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