The Medicaid Reform Debate in 1997

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Assessing the New Federalism
An Urban Institute Program to Assess Changing Social Policies

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Assessing the New Federalism

Assessing the New Federalism is a multi-year Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income, security, job training, and social services. Researchers monitor program changes and fiscal developments, and changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in thirteen states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site. This paper is one in a series of occasional papers analyzing information from these and other sources.

The Medicaid Reform Debate in 1997

On May 2, 1997, President Clinton and the Republican congressional leadership reached agreement on a broad outline for a five-year plan to balance the federal budget. As part of the plan, they agreed to Medicaid savings of approximately $16 billion. In addition, the president and the congressional leadership agreed not to impose caps on the increase in average federal Medicaid expenditures per enrollee, as originally proposed in the president's budget. Instead, although not specified in the agreement, savings are expected to be generated from increased state flexibility and limitations on disproportionate share hospital (DSH) payments. Budget negotiators also agreed to a variety of proposals that would restore Medicaid benefits to some people who would have lost them as a result of welfare and immigration reforms enacted in 1996.

The budget agreement grows out of the Medicaid proposals contained in the president's fiscal year 1998 budget. The four components of the president's Medicaid proposals were (1) imposition of limits on the growth in average expenditures per enrollee, termed "per capita caps"; (2) reduction in DSH payments, which are payments that states make to hospitals that serve a large number or percentage of Medicaid and uninsured patients; (3) expansion of state flexibility in managing the Medicaid program; and (4) use of some of the savings to encourage states to expand health insurance coverage for children. With the exception of the proposals related to children, these proposals are virtually the same as those made by the president in 1995.

The per capita cap proposed by the Clinton administration would have established a limit on the growth in average federal spending per enrollee. The

federal government would have provided matching payments on state expenditures only up to the cap. Under the president's proposal, the per capita cap would have generated $6 billion in savings from 1998 to 2002, approximately 0.7 percent of Medicaid spending during that period.[1] The second proposal would reduce DSH payments by about 20 percent by freezing them at 1995 levels and then reducing them by 15 percent in 1999 and by 25 percent in 2000. These reductions are relative to 1995 levels; the reductions are larger relative to what DSH expenditures would be under current law. Over $16 billion would be saved from the president's proposal from 1998 to 2002.

Third, the president proposed giving states substantially increased flexibility in a number of areas, including repeal of the Boren amendment, which establishes federal rules on reimbursement to hospitals and nursing homes, eliminating the need to obtain federal waivers for mandatory enrollment in managed care plans and for use of plans with more than 75 percent Medicaid and Medicare enrollment and permitting states to implement a broad range of home and community-based services to persons at risk of institutionalization without federal waivers. The administration would retain current eligibility rules; federal quality standards for nursing homes; rules on amount, duration, and scope of benefits; and requirements for early and periodic screening, diagnosis, and treatment (EPSDT). The plan would retain all provisions affecting provider taxes and donations enacted in 1991 and the per-hospital limits on DSH payments enacted in 1993.

The Clinton budget also proposed giving states the authority to expand eligibility to individuals with incomes up to 150 percent of the federal poverty level without a federal waiver. In the original Clinton proposal, federal matching would have an aggregate limit based on the number of traditional enrollees multiplied by the per capita spending cap; if the states could serve additional populations without exceeding this cap, they would be allowed to do so. This provision will need to be restructured in the absence of the per capita cap.

This report provides an overview and analysis of the key components of the president's Medicaid proposals as a starting point for discussions surrounding the budget agreement and the legislative changes likely to result. The notable exception is the per capita cap, which is not part of the budget agreement. It is, however, reviewed here as background to this year's budget debate and some of the issues that eliminated its consideration as part of the budget agreement. Also, we do not analyze the provisions affecting coverage of children, because we believe these should be considered separately with other children's health insurance proposals.

Disproportionate Share Hospital Payments

When they were enacted in 1981, the legislative intent of DSH payments was to provide financial relief to hospitals that serve a large number of low-income patients. The rationale was that such hospitals often lost money as a result of uncompensated care and low Medicaid reimbursement rates. Furthermore, hospitals that provide care to a "disproportionate share" of low-income patients frequently had low private caseloads and were less able to shift the costs of

uncompensated care to privately insured patients. However, many states have used the program to generate federal funds for the state rather than to help solve the problems of these hospitals.

Disproportionate share payments are an obvious target for federal spending reductions because a substantial portion of DSH expenditures have not been used as intended. These arrangements brought a large number of federal dollars to many states, typically by using provider taxes or transfers from local governments to finance the state share. DSH payments accounted for about $400 million in 1988 and grew to more than $17 billion by 1992. DSH expenditures remained at roughly this level thereafter and were an estimated $19.0 billion in 1995, with the federal share approximately $10.8 billion.

A typical arrangement is that hospitals pay taxes to states, and states then make DSH payments to the same providers. The DSH payments would return much, if not all, of the hospital's tax payments along with federal matching funds. In other states, federal funds substitute for expenditures states would have made otherwise, leaving total expenditures for health care more or less the same. The real beneficiary is the state treasury.

Two examples illustrate how states exploit DSH payments, effectively reducing state matching contributions to the program. If the state imposes a tax of $100 million on hospitals and then makes DSH payments of $200 million to the same hospitals, with a 50 percent federal match rate, these DSH payments include $100 million of federal matching funds. The hospitals have gained $100 million at no net cost to the state. At the other extreme, a public hospital can make an intergovernmental transfer (a transfer between local and state government or between one state government agency and another) to the Medicaid program of $150 million. The state makes a DSH payment of $200 million to the public hospital, of which $150 million is a return of the intergovernmental transfer and $50 million is a federal matching payment. The state collects $100 million in federal matching payments, keeps $50 million in the state treasury, and sends $50 million to the public hospital. In this example, the state "makes money" on DSH payments, effectively reducing state matching contributions to the program.

In the past few years, intergovernmental transfer payments have become prominent because of federal limitations on provider taxes and donations. In 1991 federal legislation banned provider donations and severely restricted the kinds of provider taxes the states could employ. In effect, states could no longer guarantee that a hospital could be fully compensated for donations or tax payments through reciprocal DSH payments. The 1991 legislation also capped DSH payments at 12 percent of Medicaid program expenditures. Any state whose DSH payment exceeded that level was frozen at 1993 levels until DSH payments accounted for 12 percent of overall Medicaid expenditures. Those states whose DSH payments were below 12 percent of total expenditures were allowed to grow at the same rate as program spending on benefits.

Since the restrictions on provider donations and taxes were enacted, states have increasingly used intergovernmental transfers to bring in more federal matching dollars. In 1993, additional legislation restricted the level of DSH payments to specific hospitals. States could no longer pay a hospital more than it was losing through low Medicaid reimbursement rates or uncompensated care.

This change restricted the states' ability to pay large amounts of money to specific hospitals and reduced Medicaid expenditures in some states.

Because of these practices, DSH has become a focus of administration and congressional efforts to reduce federal Medicaid spending. To achieve most of its budget savings, the Clinton administration proposed to reduce DSH payments by about $16 billion, assuming that the DSH cuts were implemented along with a per capita cap. With a per capita cap, states would be discouraged from increasing regular hospital payments to make up for the loss of DSH payments. However, without a cap, states could increase hospital reimbursement rates and, if they chose, finance the state share with intergovernmental transfers. To the extent that states increase hospital reimbursement rates, federal savings may be smaller than anticipated. To the extent that states do not increase reimbursement rates, "safety net" hospitals may suffer and states may become more vulnerable to lawsuits related to the adequacy of their reimbursement rates (unless the Boren amendment is repealed).

The administration's proposal would have two components. For states with DSH spending greater than 12 percent of total Medicaid expenditures, it would grandfather all DSH spending above the 12 percent level. These expenditures are now "frozen" (i.e., not permitted to grow) and would remain so. For the remainder of DSH expenditures, both high-DSH states (those with DSH spending in excess of 12 percent of program expenditures) and low-DSH states would be frozen at 1995 levels and then reduced by 15 percent in 1999 and by 25 percent in 2000. Since low-DSH states are now allowed to increase DSH spending at the same rate as program expenditures, only low-DSH states are affected before 1999. The reductions in DSH spending are therefore greater relative to baseline spending each year into the future.

In its budget proposal in 1996, the administration also proposed to both reduce and redistribute DSH payments. The redistribution proposal was to phase out the existing DSH program and replace it with one that would allocate DSH payments among states on the basis of their share of low-income patient days provided by safety net providers. The state would receive an allotment reflecting a reduced level of total federal DSH payments, which would be based on its share of low-income patient days relative to the total for the nation. The redistribution aspect of the 1996 program was not included as part of the administration's proposal in 1997.

In addition to the manipulation of federal funds, there are several other problems with the current disproportionate payment system. There is currently no rational basis for the distribution of DSH dollars to states. Distribution is simply based on how aggressively states used this mechanism before the 1991 legislation became effective. While Congress has taken strong steps to reduce the use of provider donations and taxes and limit DSH payments, it has not been willing to penalize the high-DSH states beyond freezing their existing level of DSH payments. As a result, 13 states accounted for over 75 percent of all federal DSH expenditures in 1994. As shown in table 1, there are wide discrepancies among states in DSH spending per low-income person and per uninsured person.

Moreover, not all federal funds are used as intended, to support safety net hospitals. As shown by Ku and Coughlin, states have distributed roughly two-

Table 1 *Federal Disproportionate Share Hospital Payments per Low-Income and per Uninsured Person, 1994*

	Total Expenditures (millions)	Per Low-income Person[1]	Per Uninsured Person
United States	$9722.4	$251.4	$252.4
Alabama	297.3	306.7	414.1
Alaska	8.7	126.2	95.3
Arizona[2]	69.7	93.0	90.3
Arkansas	2.3	3.5	4.7
California	1004.4	210.8	172.8
Colorado	57.8	152.2	118.0
Connecticut	204.5	822.4	678.6
Delaware	3.0	39.0	30.3
District of Columbia	26.7	238.5	230.4
Florida	156.0	65.3	59.9
Georgia	222.1	194.0	193.4
Hawaii	14.8	115.2	127.0
Idaho	0.3	1.5	1.7
Illinois	150.2	110.3	104.8
Indiana	187.2	218.7	244.8
Iowa	3.8	10.3	17.0
Kansas	98.3	302.6	320.6
Kentucky	47.8	57.0	99.2
Louisiana	974.8	846.0	978.6
Maine	102.4	477.0	677.3
Maryland	75.3	149.3	112.8
Massachusetts	270.6	490.4	385.4
Michigan	346.9	280.0	304.2
Minnesota	23.9	49.8	47.4
Mississippi	124.9	157.6	277.6
Missouri	432.4	474.2	698.8
Montana	0.2	1.1	1.4
Nebraska	5.4	28.0	26.9
Nevada	37.0	231.9	134.7
New Hampshire	190.1	2048.0	1403.3
New Jersey	516.8	702.2	464.8
New Mexico	5.9	14.8	17.5
New York	1253.3	524.7	480.7
North Carolina	253.8	217.0	298.6
North Dakota	0.8	8.4	10.3
Ohio	302.8	196.8	241.8
Oklahoma	16.6	21.9	22.4
Oregon	13.3	29.6	30.6
Pennsylvania	445.9	316.9	335.2
Rhode Island	51.0	489.7	560.5
South Carolina	342.2	408.4	551.6
South Dakota	0.2	1.4	2.0
Tennessee[2]	72.3	70.0	107.5
Texas	971.2	272.6	257.4
Utah	3.6	12.2	17.4
Vermont	11.2	162.1	144.9
Virginia	69.8	114.6	89.2
Washington	167.5	314.4	282.8
West Virginia	78.3	166.2	291.9
Wisconsin	7.1	11.0	16.9
Wyoming[3]	0.0	0.0	0.0

Source: Urban Institute calculations based on HCFA 64 data and projections from the March 1994 Current Population Survey.

Note: Does not include administrative costs, accounting adjustments, or the U.S. territories. Totals may not add because of rounding.

[1] "Low-income" defined as under 150 percent of the federal poverty guideline, which was $12,320 for a family of three in 1994.

[2] For Arizona and Tennessee, expenditure and beneficiary data are based on figures reported directly by the state; adjustments were made to categorize these numbers in the same manner as other states' reports to the HCFA.

[3] No DSH payments reported in 1994.

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thirds of federal DSH payments to hospitals.[2] Approximately one-third has been returned to state treasuries. Third, the proportion of DSH dollars going to hospitals versus the state treasury varies greatly by state. Ku and Coughlin found that states such as New York, Texas, and California return large proportions to hospitals. On the other hand, states such as Alabama, South Carolina, and Kansas return large proportions to the state treasury. Thus, federal DSH payments under current policy are not well targeted to hospitals serving low-income people.

Yet there is a strong justification for a rational DSH program, because there are over 35 million uninsured Americans and their care is often concentrated in a small number of hospitals. Public hospitals play a major role in care of the uninsured, though many nonprofit and for-profit hospitals also provide a large amount of uncompensated care. Hospitals providing significant amounts of uncompensated care are undergoing increasing financial stress as Medicaid programs move rapidly toward managed care and HMOs control costs by avoiding higher-cost inner-city public and nonprofit hospitals and moving patients to less expensive facilities. The revenues that these hospitals have counted on to support the uninsured are falling.

Many of these hospitals also are likely to see cuts in Medicare payment levels, including reductions in the basic reimbursement amounts, DSH payments, and teaching adjustments. Finally, these hospitals are also facing a difficult struggle in competing for private patients. Because of their uncompensated care loads, they have more expenses, all else being equal; many also have a broad array of unprofitable services such as burn and trauma units. In the absence of universal coverage, it may be necessary to directly support many of the hospitals that provide care to low-income individuals as well as other community benefits (such as trauma care and other public goods) but that do not have large numbers of patients with third-party coverage.

These considerations would argue for a DSH program that targets federal dollars more fairly, both in the distribution across states and in the distribution within states. However, the administration's proposal would neither expand nor redistribute DSH. It would grandfather in place DSH payments above 12 percent while prohibiting DSH payments in the low-spending states from increasing. Between 1998 and 2002, low-DSH states would have greater percentage reductions than high-DSH states. Table 2 shows that under the administration's proposal, low-DSH states such as Delaware, Iowa, Minnesota, New Mexico, and Utah would have reductions of more than 50 percent, while high-DSH states such as Alabama, Louisiana, Missouri, New Jersey, and South Carolina would have reductions of 10 percent or less.

The administration's proposal to increase participation of eligible children in Medicaid by giving states grants to develop programs for covering uninsured children and providing short-term assistance to unemployed families would, in effect, redistribute some current DSH expenditures. But it is difficult to know how these funds would be distributed, whether they would be effective in reducing the number of uninsured, or whether they would displace current state expenditures for children. Meanwhile, states would still be left with many uninsured adults, and the need for some kind of DSH policy would remain.

There are a number of ways the distributional issues could be addressed. One alternative would be to establish DSH payments as a block grant, with a

Table 2 *Estimates of the Impact of the Administration's Disproportionate Share Hospital Reform Proposal*

State	1995 DSH as a Percent of Total Spending	DSH 1998–2002				2002 Capped DSH as a Percent of Total Spending
		Baseline (millions)	Capped (millions)	Difference MIllions)	Percent	
Total	12.5%	$78,003	$61,451	($16,552)	–21.2%	6.1%
Alabama	21.4%	1,470	1,320	(150)	–10.2%	11.6%
Alaska	6.1%	65	38	(27)	–41.9%	2.9%
Arizona	7.9%	813	333	(481)	–59.1%	3.5%
Arkansas	0.3%	24	10	(15)	–59.9%	0.1%
California	19.3%	5,479	4,655	(824)	–15.0%	9.4%
Colorado	23.3%	782	714	(69)	–8.8%	11.5%
Connecticut	15.9%	1,073	868	(205)	–19.1%	7.5%
Delaware	2.1%	39	14	(25)	–63.2%	1.0%
District of Columbia	6.3%	162	95	(67)	–41.4%	3.0%
Florida	5.4%	1,882	770	(1,112)	–59.1%	2.2%
Georgia	11.4%	1,899	1,042	(858)	–45.1%	5.1%
Hawaii	0.1%	—	2	2	—	0.0%
Idaho	1.2%	15	6	(9)	–60.5%	0.3%
Illinois	6.9%	1,096	845	(252)	–22.9%	3.3%
Indiana	15.8%	888	739	(149)	–16.7%	6.2%
Iowa	0.4%	64	12	(52)	–81.8%	0.2%
Kansas	7.8%	533	178	(356)	–66.7%	3.7%
Kentucky	10.2%	972	626	(346)	–35.6%	4.7%
Louisiana	30.7%	4,423	4,097	(326)	–7.4%	16.7%
Maine	17.4%	523	458	(65)	–12.5%	10.0%
Maryland	6.5%	639	293	(347)	–54.2%	2.9%
Massachusetts	10.9%	2,120	1,177	(943)	–44.5%	5.3%
Michigan	8.6%	1,732	1,019	(713)	–41.2%	4.3%
Minnesota	0.8%	174	54	(121)	–69.1%	0.4%
Mississippi	12.0%	1,053	587	(466)	–44.2%	5.4%
Missouri	26.4%	2,190	2,002	(188)	–8.6%	16.3%
Montana	0.0%	2	0	(0)	–55.1%	0.0%
Nebraska	1.4%	16	22	6	35.3%	0.7%
Nevada	15.9%	192	159	(33)	–17.4%	7.7%
New Hampshire	38.7%	980	775	(205)	–20.9%	25.4%
New Jersey	23.9%	2,735	2,442	(294)	–10.7%	12.8%
New Mexico	0.9%	85	20	(64)	–76.1%	0.4%
New York	12.4%	8,559	6,010	(2,549)	–29.8%	6.8%
North Carolina	11.0%	2,208	1,137	(1,071)	–48.5%	4.5%
North Dakota	0.4%	5	3	(2)	–34.4%	0.2%
Ohio	10.3%	2,984	1,564	(1,420)	–47.6%	5.0%
Oklahoma	1.6%	110	53	(58)	–52.3%	0.9%
Oregon	2.0%	159	72	(87)	–54.9%	0.9%
Pennsylvania	11.4%	2,740	1,759	(980)	–35.8%	6.0%
Rhode Island	17.2%	—	252	252	—	6.1%
South Carolina	21.8%	1,555	1,399	(155)	–10.0%	11.5%
South Dakota	0.3%	6	3	(3)	–52.1%	0.2%
Tennessee	0.0%	—	—	—	—	0.0%
Texas	17.4%	4,865	4,189	(675)	–13.9%	8.4%
Utah	0.6%	37	10	(27)	–73.0%	0.3%
Vermont	11.1%	150	72	(77)	–51.7%	4.4%
Virginia	7.1%	642	297	(345)	–53.7%	3.5%
Washington	12.3%	1,187	716	(471)	–39.7%	5.8%
West Virginia	2.0%	177	76	(101)	–57.1%	0.9%
Wisconsin	0.5%	57	28	(29)	–50.2%	0.3%
Wyoming	0.0%	—	—	—	—	0.0%

Source: Urban Institute calculations based on HCFA 64 data.
Note: Calculations are affected by rounding.

phasing-out of current distributions and a phasing-in of a new system. Unlike overall Medicaid service benefits, the states' matching shares of DSH payments are often only "on paper" because the taxes or intergovernmental transfers are returned to the hospital or local government. Therefore, federal DSH payments can likely be decoupled from a state matching requirement without substantial adverse effects on hospitals. One difficulty, however, is that in some states, like Tennessee, DSH payments are now integrated into the overall financing for their research and demonstration programs.

Under this approach, the current allocation of DSH payments could be phased out over, say, a five-year period and replaced by allotments that are distributed across states on the basis of each state's share of the low-income population or uninsured population. The advantage of distributing DSH payments on the basis of the number of uninsured is that it would be related to the number of people that hospitals are expected to serve, but this type of system penalizes states with generous Medicaid eligibility standards and rewards states with low eligibility thresholds. Assuming this policy had been implemented in 1994, gains and losses to states are shown in columns 3 through 5 of table 3. California and Florida would be the largest gainers, and Louisiana and New York the biggest losers.

Another alternative to the administration's policy is to reduce payments to high-DSH states while continuing to allow low-DSH states to grow at the same rate as their program expenditures (i.e., continue the current limits on low-DSH states). For example, DSH payments in high-DSH states could be reduced to 8 percent of program expenditures over a five-year period. The results shown in table 4 indicate that the savings to the federal government would be about the same as in the administration's proposal. The distribution of the DSH reductions across states, however, would be much different from that in the administration's proposal and the resulting allocation of DSH spending across states much fairer.

A targeted DSH policy would also require that all federal spending for DSH go to hospitals or other community providers, with none of the federal DSH payments returned to the state treasury. To implement such a policy, the federal government would have to establish criteria for DSH payments (e.g., DSH payments could only go to hospitals serving more than 20 percent Medicaid or uninsured patients) and maintain current limits on use of taxes and donations.

Greater State Flexibility

Perceptions of how much freedom states currently have to design and operate their Medicaid programs vary greatly. Federal policy makers believe that Medicaid is essentially a federal program over which they have little control because of the enormous amount of state flexibility. On the other hand, state policy makers believe that Medicaid is fundamentally a state program over which they have little control because of extensive federal requirements. Whatever the actual balance, there is now a growing consensus that states ought to be given more latitude to run the Medicaid program, although there is not much agreement on which federal requirements should be repealed and which should be retained.

Table 3 *Redistributing Disproportionate Share Hospital Payments, 1994*

	Current (millions)	Redistribution (millions)	Per Uninsured Person[1]	Increase (Decrease)
United States	$9,722.4	$9,722.4	$252.4	$0.0
Alabama	297.3	181.4	252.4	(115.9)
Alaska	8.7	23.1	252.4	14.4
Arizona[2]	69.7	195.0	252.4	125.3
Arkansas	2.3	123.7	252.4	121.4
California	1,004.4	1,468.8	252.4	464.4
Colorado	57.8	123.8	252.4	66.0
Connecticut	204.5	76.2	252.4	(128.3)
Delaware	3.0	25.0	252.4	22.0
District of Columbia	26.7	29.3	252.4	2.6
Florida	156.0	658.1	252.4	502.1
Georgia	222.1	290.2	252.4	68.1
Hawaii	14.8	29.4	252.4	14.6
Idaho	0.3	44.6	252.4	44.3
Illinois	150.2	362.2	252.4	212.0
Indiana	187.2	193.2	252.4	6.0
Iowa	3.8	56.5	252.4	52.7
Kansas	98.3	77.5	252.4	(20.8)
Kentucky	47.8	121.8	252.4	74.0
Louisiana	974.8	251.7	252.4	(723.1)
Maine	102.4	38.2	252.4	(64.2)
Maryland	75.3	168.7	252.4	93.4
Massachusetts	270.6	177.4	252.4	(93.2)
Michigan	346.9	288.2	252.4	(58.7)
Minnesota	23.9	127.4	252.4	103.5
Mississippi	124.9	113.7	252.4	(11.2)
Missouri	432.4	156.4	252.4	(276.0)
Montana	0.2	36.1	252.4	35.9
Nebraska	5.4	50.7	252.4	45.3
Nevada	37.0	69.4	252.4	32.4
New Hampshire	190.1	34.2	252.4	(155.9)
New Jersey	516.8	281.0	252.4	(235.8)
New Mexico	5.9	85.2	252.4	79.3
New York	1,253.3	658.8	252.4	(594.5)
North Carolina	253.8	214.8	252.4	(39.0)
North Dakota	0.8	19.6	252.4	18.8
Ohio	302.8	316.4	252.4	13.6
Oklahoma	16.6	187.3	252.4	170.7
Oregon	13.3	109.8	252.4	96.5
Pennsylvania	445.9	336.1	252.4	(109.8)
Rhode Island	51.0	23.0	252.4	(28.0)
South Carolina	342.2	156.8	252.4	(185.4)
South Dakota	0.2	25.3	252.4	25.1
Tennessee[2]	72.3	170.0	252.4	97.7
Texas	971.2	953.4	252.4	(17.8)
Utah	3.6	52.3	252.4	48.7
Vermont	11.2	19.5	252.4	8.3
Virginia	69.8	197.7	252.4	127.9
Washington	167.5	149.7	252.4	(17.8)
West Virginia	78.3	67.8	252.4	(10.5)
Wisconsin	7.1	106.2	252.4	99.1
Wyoming[3]	0.0	14.2	252.4	14.2

Source: Urban Institute calculations based on HCFA 64 data and projections from the March 1994 Current Population Survey.

Note: Does not include administrative costs, accounting adjustments, or the U.S. territories. Totals may not add because of rounding.

[1] "Low-income" defined as under 150 percent of the federal poverty guideline, which was $12,320 for a family of three in 1994.

[2] For Arizona and Tennessee, expenditure and beneficiary data are based on figures reported directly by the state; adjustments were made to categorize these numbers in the same manner as other states' reports to the HCFA.

[3] No DSH payments reported in 1994.

Table 4 *Estimates of the Impact of an Alternative Disproportionate Share Hospital Policy*

State	1995 DSH as a Percent of Total Spending	DSH 1998–2002				2002 Capped DSH as a Percent of Total Spending
		Baseline (millions)	Capped (millions)	Difference MIllions)	Percent	
Total	12.5%	$59,563	$43,421	($16,142)	–27.1%	7.0%
Alabama	21.4%	1,470	978	(493)	–33.5%	8.0%
Alaska	6.1%	65	65	—	0.0%	7.8%
Arizona	7.9%	813	610	(203)	–25.0%	8.0%
Arkansas	0.3%	24	24	—	0.0%	0.5%
California	19.3%	5,479	3,955	(1,524)	–27.8%	8.0%
Colorado	23.3%	782	533	(250)	–31.9%	8.0%
Connecticut	15.9%	1,073	837	(235)	–21.9%	8.0%
Delaware	2.1%	39	39	—	0.0%	4.1%
District of Columbia	6.3%	162	162	—	–0.0%	7.8%
Florida	5.4%	1,882	1,855	(27)	–1.4%	8.0%
Georgia	11.4%	1,899	1,341	(558)	–29.4%	8.0%
Hawaii	0.1%	—	—	—	—	0.0%
Idaho	1.2%	15	15	—	–0.0%	1.1%
Illinois	6.9%	1,096	1,096	—	0.0%	6.6%
Indiana	15.8%	888	808	(80)	–9.0%	8.0%
Iowa	0.4%	64	64	—	–0.0%	1.7%
Kansas	7.8%	533	313	(220)	–41.2%	8.0%
Kentucky	10.2%	972	862	(111)	–11.4%	8.0%
Louisiana	30.7%	4,423	2,539	(1,884)	–42.6%	8.0%
Maine	17.4%	523	370	(154)	–29.4%	8.0%
Maryland	6.5%	639	601	(38)	–6.0%	8.0%
Massachusetts	10.9%	2,120	1,487	(633)	–29.9%	8.0%
Michigan	8.6%	1,732	1,507	(225)	–13.0%	8.0%
Minnesota	0.8%	174	174	—	–0.0%	2.0%
Mississippi	12.0%	1,053	724	(329)	–31.2%	8.0%
Missouri	26.4%	2,190	1,259	(931)	–42.5%	8.0%
Montana	0.0%	2	2	—	–0.0%	0.1%
Nebraska	1.4%	16	16	—	–0.0%	0.8%
Nevada	15.9%	192	149	(43)	–22.4%	8.0%
New Hampshire	38.7%	980	423	(557)	–56.8%	8.0%
New Jersey	23.9%	2,735	1,723	(1,012)	–37.0%	8.0%
New Mexico	0.9%	85	85	—	–0.0%	2.5%
New York	12.4%	8,559	6,225	(2,334)	–27.3%	8.0%
North Carolina	11.0%	2,208	1,618	(591)	–26.7%	8.0%
North Dakota	0.4%	5	5	—	0.0%	0.5%
Ohio	10.3%	2,984	2,046	(938)	–31.4%	8.0%
Oklahoma	1.6%	110	110	—	0.0%	2.8%
Oregon	2.0%	159	159	—	0.0%	3.1%
Pennsylvania	11.4%	2,740	1,998	(742)	–27.1%	8.0%
Rhode Island	17.2%	—	110	110	—	0.0%
South Carolina	21.8%	1,555	1,038	(517)	–33.3%	8.0%
South Dakota	0.3%	6	6	—	0.0%	0.5%
Tennessee	0.0%	—	—	—	—	0.0%
Texas	17.4%	4,865	3,745	(1,120)	–23.0%	8.0%
Utah	0.6%	37	37	—	–0.0%	1.5%
Vermont	11.1%	150	106	(43)	–28.9%	8.0%
Virginia	7.1%	642	540	(102)	–15.9%	8.0%
Washington	12.3%	1,187	828	(359)	–30.3%	8.0%
West Virginia	2.0%	177	177	—	–0.0%	3.2%
Wisconsin	0.5%	57	57	—	0.0%	0.8%
Wyoming	0.0%	—	—	—	—	0.0%

Source: Urban Institute calculations based on HCFA 64 data.

Note: DSH policy assumes that DSH expenditures in all states are reduced to 8 percent of program expenditures by 2002; low-DSH states are permitted to grow as under current law, up to a maximum of 8 percent of program expenditures. Calculations are affected by rounding.

In the context of the budget and the per capita cap proposal, the Clinton administration proposed giving the states additional flexibility in several areas. Specifically, states could initiate three types of activities as state plan amendments rather than having to obtain a federal waiver: requiring mandatory enrollment in managed care organizations, providing a broad range of home and community-based services to people at high risk of institutionalization, and covering any person whose income is less than 150 percent of the federal poverty line without regard to traditional eligibility categories so long as total Medicaid expenditures do not exceed certain limits. States also would be permitted to contract with Medicaid-only managed care organizations instead of having to contract with only mainstream HMOs. Finally, the Boren amendment and a variety of other rules governing the reimbursement of providers would be repealed.

Philosophically, the administration appears prepared to offer flexibility in how states organize care and reimburse services, but not in which groups or services must be covered.[3] Under the block grant legislation passed by Congress in 1995 and 1996 but not enacted, states would have been given substantially more flexibility than suggested by President Clinton. The Clinton list of additional flexibility items is not as broad as that put forth by the National Governors' Association (NGA) in 1997 but includes most of its high-priority requests.[4]

Beyond the details of the proposals is the more general policy question of what elements of the Medicaid program should be uniform (or at least meet minimum standards) throughout the country and which should be allowed to vary by state. Those who favor reduced federal regulation point out that restrictive and uniform national rules do not work well, given the wide variation in economic circumstances and voter preferences across states, and place federal lawmakers or regulators in the position of micromanaging the Medicaid program. Governors and state legislators often view federal regulations as unwarranted interference in "their" programs and as "unfunded mandates."

Opponents of devolution believe that since Washington provides the lion's share of funds, it is only reasonable to expect federal legislators and administrators to retain a major voice in how Medicaid is run, since they are responsible for raising the revenue to support the program from taxpayers throughout the country. For example, with its 78.9 percent federal matching rate, the vast majority of Mississippi's program is financed by funds from out of state. It is only fair and reasonable for the one who pays the piper to call the tune. If federal oversight were scaled back, Congress and the president may see less reason to support the program financially. Although it would be nearly impossible for states to do so, in theory states that do not want to meet the federal requirements can refuse the federal funds.

Another important argument made in favor of at least some minimum national standards is the notion that we are a nation and not just a collection of states. Because we are a nation, citizens in Connecticut, for example, have an legitimate interest in making sure that poor children in Texas receive adequate medical care. The federal government can limit the "race to the bottom" and reduce interstate competition by establishing minimum national standards for receiving federal aid. States are not required to participate in the Medicaid

program, but those that do must meet federal standards, including the provision of Medicaid to children under age six and pregnant women with incomes below 133 percent of the federal poverty line. States cannot reduce Medicaid spending (and therefore their tax burdens) by not providing coverage. National minimum standards also represent a national agreement (as evidenced by their passage by Congress and signing by the president) that all Americans who meet specified criteria should have access to certain Medicaid benefits. Given differences in political will and culture, some states would never agree to those standards unless required to do so, while other states go beyond the required minimum coverage.

Since states will be allowed but not required to do some things differently under the new flexibility, it is difficult to assess what the cost implications of these changes will be. Some of the proposed changes—such as those proposed for home and community-based waivers—would change how quickly states could implement certain initiatives but would not change the initiatives themselves. Other changes—such as repealing the requirements for nursing home and hospital reimbursement—could result in substantial savings, but only if states overcame strong internal political opposition. Still other changes—such as allowing states to cover more people with incomes below 150 percent of the federal poverty line—might actually result in increased federal costs, depending on how tightly the federal government implemented and monitored the provision.

The Boren Amendment: Hospital and Nursing Home Reimbursement Rate Standards

Under current law, states may set Medicaid payment rates at whatever level they choose for most services, but they must meet a minimum standard for nursing home and hospital reimbursement. This standard is prescribed by the Boren amendment, which requires that providers be reimbursed at rates that the state "finds and makes assurances satisfactory to the Secretary [of the Department of Health and Human Services] are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards" (Section 1902(a)(13) of the Social Security Act). Within this standard, states may use a wide variety of reimbursement methodologies. Although this law was designed to relax previous requirements, many states have had difficulty meeting this standard. As a result, repeal of the Boren amendment has been long sought by the governors, and its elimination is included in the president's proposal.

Although initially important for both hospitals and nursing homes, the Boren amendment has declined in importance for hospitals. First, the explosion in DSH payments in the late 1980s means that hospitals receive only part of their Medicaid revenues through regular per diem or per-admission payments that are governed by the Boren amendment. Second, as more and more Medicaid beneficiaries are enrolled in health maintenance organizations, hospital reimbursement levels are increasingly being set through negotiations between hospitals and managed care entities without the involvement of the

Medicaid agency. The Boren amendment has been interpreted by the Health Care Financing Administration (HCFA) to apply only to payment rates set by the state, not by managed care organizations. However, despite the growth in managed care, most dollars spent for Medicaid hospital payments are still made through the fee-for-service system for the elderly and disabled. If large cuts are made in DSH payments as proposed by the administration, hospitals might be more likely to sue under the Boren amendment.

By comparison, with 69 percent of nursing home residents dependent on Medicaid to help pay for their care, federal reimbursement rules play an extremely critical role for nursing homes.[5] It is not surprising, then, that as of 1993 nursing home reimbursement lawsuits had been filed against states for violation of the Boren amendment's substantive or procedural standards.[6] If states reduced Medicaid nursing home payment rates by 5 percent, then total Medicaid spending would decline by about 1 percent.[7]

Although the Boren standards would appear to be minimal, states contend that they have been nearly impossible to operationalize and that the courts have been unreasonable in their interpretation. Moreover, Boren's procedural requirements, such as making a "finding" that the methodology meets the substantive standard, compound the difficulty of defending the state's methodology in court. Medicaid officials often believe that the lawyers representing the state are inadequate compared with the "high-priced" attorneys hired by nursing home providers. Because of their poor prospects of winning in court, the threat of a lawsuit is nearly as important as an actual lawsuit in affecting state payment policy. Furthermore, many state officials believe that it is unfair that they are forced to give rate increases to nursing homes but not to home and community-based care and other providers. The net result is that states feel that they are forced to spend too much on nursing homes and go far beyond the minimalist standard embodied in the plain language of the statute. Advocates of repeal of the Boren amendment contend that Medicaid payment rates will be reduced but will not fall drastically, because nursing home associations are extremely powerful at the state level and will succeed in maintaining adequate levels of reimbursement.

The problem with repealing the reimbursement standards is that Medicaid nursing home payment rates are already fairly low, especially in comparison with Medicare and private-pay rates. In 1993, average Medicaid nursing home payment rates were $82 per day, while average Medicare payment rates were $170 per day.[8] In addition, although there is great variation across facilities and states, private-pay charges tend to be substantially higher than Medicaid rates.[9] Indeed, some states have an implicit policy of having private-pay residents subsidize the care of Medicaid beneficiaries. Not surprisingly, nursing homes prefer private-pay to Medicaid patients, and Medicaid beneficiaries often have difficulty gaining access to nursing homes.[10] To the extent that states cut reimbursement rates and the payment differential between private-pay and Medicaid residents widens, access problems may worsen.

In addition, while there is little evidence of a simple relationship between cost and quality, there is probably some threshold level of reimbursement below which it is impossible to provide adequate quality of care. While the quality of care in nursing homes has improved over the past twenty years, advo-

cates for nursing home residents remain extremely concerned about the quality of care provided in many facilities.[11] Repeal of the Boren amendment without any substitute would eliminate the quality safeguard that Medicaid payment levels will not go below that minimum threshold.

Community/Migrant Health Centers, Rural Health Clinics, and Reasonable Cost Reimbursement

Community and migrant health centers and rural health clinics (RHCs) are important providers of primary health care to the Medicaid and uninsured populations. The 1977 Rural Health Clinics Act encourages the use of mid-level health care providers (such as nurse practitioners) in underserved rural areas and requires state Medicaid programs to pay for rural health clinic services on a reasonable-cost basis. In 1995, the U.S. Department of Health and Human Services provided community health, homeless, and migrant health center funds to 634 grantees, which served almost seven million individuals. Approximately 80 percent of health center patients are on Medicaid or uninsured. In response to concerns that Medicaid payments were below cost and, as a result, were reducing health centers' ability to serve the uninsured population, the Omnibus Reconciliation Act of 1989 required Medicaid programs to reimburse so-called federally qualified health centers (FQHCs) and FQHC look-alikes on a reasonable-cost basis.[12]

President Clinton's Medicaid proposal would eliminate the requirement for cost-based reimbursement for FQHCs and RHCs beginning in 1999; a temporary, capped funding pool would be established to help these facilities during the transition. Since expenditures for FQHCs and RHCs constitute only about 0.7 percent of Medicaid expenditures, even if states cut reimbursement by a quarter, total Medicaid expenditures would decline by less than 0.2 percent. If Medicaid patients substituted emergency room care for health centers, total expenditures could actually increase. In addition, the proposed transition fund would further reduce net savings.

Advocates for greater state flexibility contend that cost-based reimbursement is an archaic and undesirable methodology in a world of managed care, diagnosis-related groups, and resource-based relative value scales. Cost-based reimbursement, they argue, is inherently inflationary because it fails to provide incentives for efficiency. In addition, with the anticipated repeal of the Boren amendment, FQHCs and RHCs would be virtually the only service providers with detailed federal rules on how they should be reimbursed under Medicaid and the only providers for which states have no payment leverage.

On the other hand, supporters of FQHCs and RHCs argue that the important role that clinics play in providing health care to the uninsured and Medicaid beneficiaries warrants special protections. They note that clinic and physician reimbursement rates under Medicaid are often low and that they fail to recognize the additional services provided by community health centers, such as health education, social services, and outreach, or to compensate for the inability of centers to shift costs to private patients, as do providers with large numbers of privately insured patients. The reason for the original legislation—low reimbursement rates—has not disappeared. If the states reduce

Medicaid reimbursement, then clinics will have to use federal funds to subsidize the care of Medicaid enrollees as well as the uninsured, which is an inefficient use of limited grant money. If their Medicaid reimbursement is cut back, some clinics may not be able to survive financially or at least may not be able to serve as many uninsured.

Managed Care and Freedom of Choice Waivers

Almost all states are moving to enroll more of their Medicaid beneficiaries in managed care organizations. Reflecting the original goal of the Medicaid program, integrating beneficiaries into mainstream medicine, current law generally requires that beneficiaries be given freedom of choice of providers and that enrollment in managed care organizations be voluntary. However, since the Omnibus Budget Reconciliation Act of 1981, states have had the option of requesting so-called freedom of choice waivers that allow the states to require enrollment in managed care organizations, but states can only contract with managed care organizations in which at least 25 percent of enrollees are not Medicare or Medicaid beneficiaries (Section 1903(m)(2)(A)(ii) of the Social Security Act). This 75–25 mix rule is based on the theory that HMOs that have to compete for the privately insured population will have a higher quality of care and greater financial solvency than those that provide services only to public beneficiaries.

President Clinton proposes to allow states to require mandatory enrollment in managed care without a waiver and to allow use of Medicaid-only managed care organizations. In its place would be as yet undefined requirements for quality monitoring, which would be more outcome-oriented than the 75–25 mix standard. Since states are already enrolling large numbers of Medicaid beneficiaries in managed care, and many have already waived the 75–25 mix requirement in their research and demonstration programs, it is doubtful that this provision would generate large additional savings.[13]

Advocates of greater flexibility for the states argue that managed care is the primary mechanism for states to reform the financing and delivery system and to obtain savings without adversely affecting beneficiaries.[14] Indeed, by providing a "medical home" to beneficiaries who otherwise do not have a primary care physician responsible for their care, managed care can improve access to and quality of care. The current requirement for waivers, they argue, imposes needless paperwork and slows down the process. Moreover, the prohibition on the use of Medicaid-only managed care organizations prevents states from contracting with entities organized by public hospitals and community health centers and is not a good proxy for quality of care.

Opponents of greater flexibility for the states contend that inherent difficulties with Medicaid managed care warrant substantial federal oversight. While there is a risk of overutilization in a fee-for-service system because providers are paid for each service they provide, there is a risk of underservice in managed care systems. Since HMOs and other managed care entities receive a fixed payment per person, the fewer services they provide, the more money they make, potentially putting beneficiaries at risk of inadequate care. This is particularly a risk where there is mandatory enrollment and limited opportu-

nity to change providers. In more than a few instances, states that have been granted waivers to expand their use of managed care have run into problems, especially when they have tried to expand quickly to meet self-imposed budget targets.[15] In some cases, the access to and quality of services have been compromised. If anything, slowing down the process and requiring periodic review may be a positive factor in ensuring that states do not proceed more quickly than their capabilities allow.

Moreover, state Medicaid staffs, data, and technology are largely unequipped to measure quality of care and access to services in managed care organizations. Even the process of writing contracts with managed care organizations requires a whole new approach to Medicaid that few states have mastered.[16] The quality-monitoring system that the Clinton administration envisions is not yet in place. Given this situation, opponents argue that the federal government should retain substantial oversight responsibilities in order to ensure that an acceptable quality of care is provided.

Optional Eligibility Expansion for Persons with Incomes up to 150 Percent of Poverty Line

Medicaid currently provides coverage for only about half of the population below the poverty line. Eligibility levels for AFDC/TANF adults are usually well below the federal poverty line, and Medicaid only covers certain categories of low-income individuals—children, parents of AFDC/TANF children, people with disabilities, and older persons.[17] Under the regular program, childless, nondisabled, nonelderly men and women are not covered, regardless of their medical expenses or income. In response to the growing number of uninsured, some states have developed research and demonstration projects to expand Medicaid eligibility to this uninsured population.

As a way of facilitating these efforts, President Clinton proposed to allow states to expand coverage to individuals—including those in categories not currently covered, such as single adults—with incomes up to 150 percent of the federal poverty line, as long as aggregate expenditures stay below the levels established by the per capita caps for those eligible under current law. The decision by President Clinton and congressional negotiators not to include a per capita cap in the budget agreement makes it unclear how federal spending would be limited if this provision were enacted.

Advocates for this provision note that health care for the uninsured is a growing problem. Because of constraints of current law, states attempting to address this problem are required to apply for Medicaid research and demonstration waivers. Some of these applications have little merit from a "research and demonstration" perspective but are reasonable efforts to provide health care to the uninsured. In addition, the requirement that research and demonstration waiver programs be budget neutral has resulted in contortions of budget projections that strain credulity and may be ineffective in protecting the federal purse.[18] This proposal will establish much clearer and simpler, albeit less generous, rules for determining budget neutrality. Under this option, states will not have to pretend that their plans are research projects, nor will they be as tempted to manipulate their proposals to meet a strained definition of budget neutrality.

On the other hand, opponents of this provision worry that states will find ways to use the new eligibility flexibility to substitute federal funds for existing state, county, and municipal spending on health care. Thus, the end result may be not any improvement in access to health care for the uninsured, but substantial additional federal spending. Moreover, to avoid increased federal spending, a per capita cap would have to be established for each state; however, agreement on doing that would seem unlikely, since no consensus could be reached on a per capita cap for the program as a whole. In the absence of a per capita cap, it is hard to see how this option could be implemented.

Home and Community-Based Waivers

Increasingly, states are attempting to reform their long-term care delivery system by providing a wide range of home and community-based services. States hope both to create a more balanced delivery system and to save money.[19] In the traditional Medicaid program, personal care is virtually the only nonmedical long-term care service that can be provided, and states are at risk of unanticipated high expenditures because services must be provided as an entitlement.

Since the Omnibus Budget Reconciliation Act of 1981, states have been able to apply for Medicaid waivers (Section 1915(c) of the Social Security Act) to expand home and community-based long-term care services. Under the waivers, states must target people at high risk of institutionalization (e.g., nursing home care or intermediate care facilities for the mentally retarded) and assure the HCFA that, on average, the cost of providing services with the waiver will not exceed the cost without the waiver. Because of this cost-effectiveness requirement, states may provide these services only to a preapproved number of people, limiting their potential financial liability. States may cover a very broad range of nonmedical long-term care services, including case management, home health aide services, personal care services, adult day care, rehabilitation, and respite care. After a reasonably slow start in the early 1980s, home and community-based waiver expenditures have grown extremely rapidly in recent years, increasing from $0.7 billion in 1988 to $4.6 billion in 1995. President Clinton's Medicaid proposal would allow states to implement these programs on a budget-neutral basis without having to obtain a federal waiver. While there may be some reduction in administrative burden, it is doubtful that additional savings would be generated by ending the requirement for a waiver.

Advocates of increased state flexibility argue that states have substantial experience with long-term care services and that many of the waiver requirements are for needless documentation that does not ensure quality of care. Moreover, although conflict between the federal government and the states over approval of waivers was substantial and bitter during the Reagan and Bush administrations, regulatory changes implemented by the Clinton administration have made obtaining waivers fairly routine in recent years. Thus there are limitations to what can be gained by eliminating the requirement that states go through the waiver process.

Opponents of greater state flexibility argue that the current ease of obtaining waivers is precisely the problem with the current system. In this

view, the HCFA has not been tough enough in requiring that waivers be cost-effective. Because of lax standards, services are often provided to people—especially the elderly—who are not at a high risk of institutionalization, and the net result is an inappropriate increase in federal Medicaid spending. Particularly for persons with mental retardation or developmental disabilities, the increased expenditures for Medicaid home and community-based waiver services represent refinancing of existing state programs rather than spending on new services.[20] Allowing states to implement such programs without extensive federal review is an invitation for more cost shifting from the states to the federal government.

Comparability of Amount, Duration, and Scope

The NGA has requested that states be given the flexibility to design benefit packages that would vary by eligibility category for the optional eligibility groups.[21] While the Clinton administration has proposed allowing greater state flexibility in many areas of the Medicaid program, it has not supported changes that could negatively affect eligibility or covered services. Thus eligibility rules and benefit package configuration are not included in the proposed flexibility list.

Current law requires "comparability" of "amount, duration, and scope" of benefits to all Medicaid beneficiaries, except where that is specifically waived (e.g., home and community-based and freedom of choice waivers). This requirement means that all categories of beneficiaries must be eligible for the same set of benefits. For example, a state cannot provide physical therapy to the elderly without also providing it to children. Finally, covered services must be the same in all parts of the state (this requirement is often referred to as "statewideness").

Advocates of greater state flexibility argue that states should be allowed to stretch limited Medicaid dollars by providing a smaller package of benefits to a larger number of people. The mandatory Medicaid benefit package is very comprehensive, especially when compared with the commercial insurance packages that many working poor receive.[22] A more limited set of benefits would lower costs and could enable states to establish wider eligibility for the optional groups. In addition, since, by definition, states are not required to cover optional groups, the states should have more flexibility in what services they provide to optional groups. Supporters of this position also note that comparability has already been broken, because almost all elderly poor have Medicare and states are required to pay the cost sharing associated with that program. Thus the elderly are already eligible for benefits that differ greatly from those of the rest of the Medicaid population.

Proponents of a strong federal role worry that elimination of the comparability requirement will adversely affect children and nondisabled adults. The concern is that states may want to reduce benefits to these beneficiaries but are currently unwilling to do so because they would also have to reduce benefits to the elderly and people with disabilities, who are more politically favored. Given freedom to alter the benefit package, states may reduce benefits but not use the savings to expand eligibility. Similarly, there is a concern that some

states may politically favor certain geographic areas at the expense of others if they are not required to provide benefits on a statewide basis. In addition, they note that the additional services covered by Medicaid that make the benefit package comprehensive do not add much to overall costs.[23]

The Road Not Taken: Per Capita Caps

The Clinton budget proposal included imposition of a per capita cap on Medicaid spending per beneficiary, but this approach was not included in the budget agreement. This section reviews the Clinton proposal and the issues it raised.

Under the per capita cap proposed by the Clinton administration, each state's base-year average expenditure per enrollee would have been allowed to grow by a federally specified index. States would have received federal matching payments equal to the lesser of their actual spending or the cap. There would have been separate caps for the elderly, the blind and disabled, adults, and children. The proposal included administrative costs but would have excluded from the cap DSH payments, Medicare premiums and cost sharing for dual eligibles and qualified Medicare beneficiaries (QMBs), and Indian Health Service expenditures. The allowed growth rate in spending per enrollee was to be tied to a five-year average of historical growth in nominal gross domestic product (GDP) per capita plus 2 percentage points in 1998 and 1 percentage point thereafter. Over the budget period, the growth per enrollee would have been about 5 percent per year. If state spending for one population group exceeded the cap, the excess could have been offset by a shortfall for another group.

The major rationale for the per capita cap policy as an alternative to block grants was that it would save money by giving states strong incentives to limit spending growth by means other than reducing enrollment. In the President's fiscal year 1998 proposal, the rationale was less to provide an alternative to block grants than to prevent future unexpected spending growth. The savings objectives were modest, and the proposal seemed primarily intended to control future Medicaid spending by providing strong incentives for the states to manage efficiently and to reduce the federal government's risk if spending turns out to be higher than currently projected.

A number of important advocacy groups strongly opposed the president's proposal for per capita caps. These groups included Families USA, the Children's Defense Fund, the American Health Care Association, and the National Association of Public Hospitals and Health Systems. While some congressional Democrats supported the cap, most opposed it because of concern about its potential impact on access to and quality of care. Most Republicans had little enthusiasm for the policy because it retained the Medicaid entitlement and did not devolve financial and administrative authority to the states. Finally, the NGA strongly opposed Medicaid per capita caps because governors were concerned that they would not have the flexibility to restructure their programs so that spending would be under the cap. They feared that federal Medicaid spending would be reduced by shifting costs to the states. In the end,

the administration did not fight to include the caps in the budget agreement because savings from the caps were small and, therefore, not essential to the administration's budget-balancing plan.

The Argument for Per Capita Caps

The administration's main argument in support of a per capita cap was that it would provide some, but not rigid, control over the growth in federal expenditures. We estimate that the administration would have saved $6.3 billion between 1998 and 2002, or about 0.7 percent relative to the Congressional Budget Office (CBO) baseline. (Results of our simulation of the policy are shown in the appendix.) Caps at these levels would not have imposed large burdens on states. The federal government would be protected against states' failure to control prices and utilization, but not against unexpected growth in enrollment. In addition, by reducing Medicaid expenditure growth and lowering the federal budget deficit, a per capita cap policy would weaken momentum for more significant program changes, such as a block grant.

Compared with a block grant, a per capita cap would maintain the entitlement for current Medicaid eligibles, giving states no incentives to reduce eligibility and protecting states against recessions by allowing them to receive federal matching payments for additional Medicaid enrollees if enrollment grew because of job loss. The incentives to expand coverage of traditional groups would remain the same as under current law as long as rate of growth allowances for enrollee spending were consistent with increases in the costs of health services. If states could control Medicaid spending growth at rates of increase below that in the specified caps, then they could expand coverage to nontraditional enrollment groups.

A per capita cap policy would encourage states to manage their programs efficiently. While states cannot control the impact of the economy on enrollment or overall inflation in health care costs, decisions on the use of managed care and provider payment rates are within their control. The enhanced flexibility proposed by the administration would further aid them in controlling Medicaid expenditures.

Finally, a per capita cap would discourage efforts by states to bring a wide range of services wholly funded by states and localities into the Medicaid program to obtain federal matching payments, a practice known as "Medicaid maximization." While exact figures are not available, states, counties, and cities currently spend billions of dollars on health and quasi-health programs that are not currently billed to the Medicaid program. Shifting some of these services into Medicaid and using intergovernmental transfers to finance the state share of the cost increases federal spending at little or no new cost to the state. Such efforts benefit state treasuries but increase federal expenditures without necessarily improving access to services for low-income beneficiaries, and they often lead to the perception that Medicaid spending is "out of control." With per capita caps, the advantages of Medicaid maximization are lost because expenditures above the cap would not receive federal matching payments. In sum, the per capita cap offered a way to limit future federal spending for Medicaid and gave states incentives to moderate spending per beneficiary and disincentives to refinance existing state services through Medicaid.

The Arguments against Per Capita Caps

While there are arguments for imposing per capita caps in Medicaid, there are a variety of difficulties, including problems of equity and implementation, that others cite in opposition.[24] The basic equity issue is that each state's per capita cap would have been based on historical expenditure levels, permanently locking in large interstate differences in spending per enrollee. For example, as shown in table 5, total Medicaid spending on children in 1994 varied by a factor of three across states, ranging from $2,290 in Massachusetts to $633 in Idaho.[25] Spending on the disabled varied from $17,603 in Connecticut to $3,920 in Tennessee. Under a per capita cap, low-spending states would be unable to catch up to the average state, let alone the high-spending states; conversely, high-spending states would continue to receive high levels of federal spending.

To make federal spending limits more equitable, growth rates would have to vary across states, with lower growth rates in high-spending states and higher growth rates in low-spending states. Even with such adjustments to growth rates, it would take a very long time to produce equity because the differences are large and there are practical limits to allowable differences in growth rates.

Implementation Issues

There are a number of problems surrounding implementation of per capita caps. Each of these issues—determining growth rates, applying caps to beneficiary groups, rebasing, and data quality—would need to be addressed before a proposal for a per capita cap could move forward.

The Growth Allowance

The first issue is how the allowed rate of growth should be determined. Should the growth in spending per enrollee be tied to the rate of growth in general inflation, medical care inflation, GDP, or an alternative? The argument for a general inflation index is that it reflects increases in prices in the economy as a whole. It is expected that medical care prices would grow at least slightly faster than general inflation. An index tied to inflation plus 2 or 3 percentage points would be historically consistent with the growth in health care costs. But more recently medical care inflation seems to have risen more slowly, perhaps less than the rate of general inflation.

An alternative would be to tie the rate of growth directly to the rate of increase in medical care costs. There has been considerable criticism in recent years of the medical care component of the Consumer Price Index (CPI), as with the index as a whole. The basic criticism is that the medical care component of the CPI is an index of list prices, not transaction prices, and a large number of private and public payers are obtaining substantial discounts from the list prices. Because it is believed to be a poor measure of price change and is in a state of flux, the medical care CPI probably would not be a useful basis for a Medicaid expenditure growth limit.

The administration chose to use a five-year average of the growth in nominal GDP per capita, which would include both inflation and the real growth in the economy. It does not reflect the costs of health services; rather, it reflects the ability of the economy to devote resources to the program. In general, nominal

Table 5 *Total Medicaid Spending per Enrollee, 1995*

	Aged	Blind/ Disabled	Adults	Children	Total
United States	$8,966	$7,691	$1,740	$1,198	$3,090
Alabama	5,660	4,144	1,918	744	2,351
Alaska	9,712	11,324	2,425	1,813	3,284
Arizona	551	1,003	3,196	2,077	2,137
Arkansas	6,365	5,672	1,344	1,184	3,096
California	4,277	4,945	1,216	789	1,723
Colorado	8,111	7,325	1,814	1,247	3,113
Connecticut	18,428	17,603	1,942	1,264	5,768
Delaware	11,935	10,623	2,014	1,337	3,732
District of Columbia	20,922	14,967	2,731	2,394	6,224
Florida	6,830	5,415	1,250	1,360	2,532
Georgia	5,495	6,148	2,380	960	2,483
Hawaii	9,635	12,732	2,208	1,025	2,824
Idaho	8,517	7,871	1,450	633	2,497
Illinois	7,977	8,618	1,454	1,101	2,810
Indiana	10,688	10,402	1,675	1,080	3,273
Iowa	7,599	8,646	1,651	1,485	3,343
Kansas	8,099	8,160	1,572	933	2,964
Kentucky	6,606	4,994	2,013	907	2,680
Louisiana	6,971	7,705	2,367	1,295	3,456
Maine	11,971	7,638	1,597	1,217	3,808
Maryland	10,819	8,630	2,054	1,628	3,695
Massachusetts	15,501	12,238	2,442	2,290	6,070
Michigan	11,575	7,691	1,744	1,366	3,228
Minnesota	17,654	15,688	2,010	1,750	5,255
Mississippi	5,075	3,932	1,758	869	2,229
Missouri	7,593	6,315	1,040	821	2,390
Montana	14,299	8,386	1,318	838	3,328
Nebraska	10,347	8,899	1,486	1,188	3,369
Nevada	6,013	8,164	1,785	1,269	2,704
New Hampshire	12,501	13,837	1,705	1,309	4,579
New Jersey	13,178	11,578	2,604	1,156	4,574
New Mexico	6,076	7,160	1,686	896	2,167
New York	17,936	14,947	2,705	1,967	6,138
North Carolina	6,149	7,192	2,324	1,209	2,952
North Dakota	11,062	12,559	1,405	968	4,272
Ohio	11,973	8,579	1,450	1,120	3,374
Oklahoma	6,146	6,287	1,132	999	2,316
Oregon	5,981	9,065	1,745	1,873	2,862
Pennsylvania	12,495	6,223	1,223	1,294	3,394
Rhode Island	12,843	13,585	2,011	1,724	5,791
South Carolina	5,265	6,656	1,746	1,045	2,811
South Dakota	11,148	9,587	1,598	896	3,669
Tennessee	4,941	3,920	1,785	1,086	2,201
Texas	6,074	7,099	2,109	949	2,386
Utah	8,757	8,840	2,153	1,204	2,616
Vermont	8,488	8,193	1,316	869	2,770
Virginia	6,706	6,109	1,516	920	2,552
Washington	10,182	8,399	1,606	1,213	2,885
West Virginia	8,333	6,083	1,421	979	2,602
Wisconsin	12,931	7,382	1,245	1,328	3,560
Wyoming	7,434	9,487	2,254	888	2,940

Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data.
Note: Spending does not include administrative costs, adjustments, disproportionate share hospital, or payments to Medicare.

GDP per capita would increase faster than the general inflation rate and, in recent years, the increases in medical care prices. Nominal GDP per capita over the 1998–2002 period would grow about 4 percent per year. Nominal GDP growth plus 1 percentage point would be slightly faster than the CBO prediction for growth in private sector health spending per capita (5.0 percent versus 4.7 percent between 1998 and 2002).

The potential problem with a cap tied to GDP growth is the impact of recessions. Growth in nominal GDP declines or becomes negative in a recession, and its use as an index would cause major problems for Medicaid. A five-year rolling average of GDP per capita growth would weaken the impact of a recession on the growth rate, but a prolonged recession could still be problematic. Moreover, a sharp increase in inflation, particularly in medical care prices, would adversely affect states because the index could not adjust quickly to changes in the cost of health care. A final issue is that, once the link between expenditures and federal reimbursement is broken, an index tied to GDP per capita growth plus an adjustment factor could be ratcheted down in the future to obtain greater budget savings.

Choosing Beneficiary Groups

A second set of implementation issues relates to the population groups to which limits would be applied. A single aggregate cap would create incentives to add low-cost enrollees such as children. Without establishing relatively homogeneous groups—groups that are similar with respect to health care expenditures—there are incentives for states to reduce optional benefits used most heavily by the more expensive groups or cut coverage for groups entirely, in the case of optional categories.

The administration proposed that per capita caps be applied to four groups: the elderly, the disabled, adults, and children. The problem is that there are still major differences in spending on different groups within each of these categories. For example, spending on the cash-assistance elderly population, primarily users of acute care and community-based services, is substantially lower than spending on the noncash-assistance group, which contains much greater users of institutional long-term care services (table 6). There are only relatively small differences between adult and child cash and noncash beneficiaries, but pregnant women are far more expensive than other adults, and very young children are more expensive than older children.

Rebasing

A third major implementation issue is whether there should be rebasing, i.e., whether the base to which the growth rate is applied is the actual or the capped level of expenditures. That is, if actual spending per enrollee for a particular group exceeds the cap, should that higher level be the base for spending caps in subsequent years? For example, if 1998 expenditure targets are based on 1996 expenditures per enrollee multiplied by the allowed growth rate, and the state's actual 1998 spending exceeds the 1998 cap, should the higher level of actual 1998 spending be the basis for the 2000 cap? Or should it be the 1998 capped spending level multiplied by a growth index? If actual spending is used (i.e., rebasing), any excess spending would be built into a subsequent-year cap.

Table 6 *Total Medicaid Spending per Enrollee, 1995*

	Aged	Blind/ Disabled	Adults	Children
Total	$8,966	$7,691	$1,740	$1,198
Cash	4,123	6,452	1,670	1,231
Noncash	12,697	12,015	1,835	1,162

Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data.
Note: Spending does not include administrative costs, adjustments, or disproportionate share hospital payments.

Rebasing would weaken incentives for efficiency. For example, if states spent less than the expenditure targets in a given year and the lower level was used as the base, states would gain only in the first year for efficiently operating their programs and could not extend those gains into the future.

The major advantage of rebasing is that it allows the federal government to adjust for case-mix or benefit-package changes made by states. For example, if states exceed spending targets because their patient mix has become more complex, they would not be penalized beyond the first year or two. Similarly, if they enrolled less expensive populations or reduced optional benefits, they would not be rewarded beyond the first year or two after they adopted such policies.

Data Quality

A fourth issue is data quality. A cap on spending per enrollee assumes that we have good data on the growth in spending and enrollment. State reporting of expenditures has been the basis of federal matching payments for over 30 years, but states have not been required to provide enrollment data. Only in 1997 has CBO begun to make projections of enrollees as opposed to those beneficiaries who are users of services. If data are of low quality in many states, there will be serious problems in the implementation of per capita caps. The federal government would have to begin with currently available data and, presumably, give states an opportunity to revise or "correct" those numbers. There would be an incentive for states to understate base enrollment. If enrollment is understated, then spending per enrollee would be overstated, making it easier to keep spending within a cap.

The Future

There are at least two reasons to believe that a per capita cap will be considered again. First, under a balanced-budget regime, efforts to expand coverage must be explicitly paid for, and a cap would probably be viewed as a politically easier source of revenue than a tax increase. Second, Medicaid spending growth is at least partially under the control of states. States have shifted state-funded services into Medicaid, increasing federal spending with no increase in state outlays. If Medicaid maximization leads to growth above rates currently forecast by CBO, there will be renewed calls for controls on the program's expenditures.

Any future per capita cap proposal should be designed to control expenditures without forcing states to reduce access to and quality of care. Several

critical issues must be confronted. First, a per capita cap must address the enormous differences in spending across states. Exempting low-spending states from the cap as long as spending is below an established threshold would be more equitable but would reduce the savings to the federal government.

Second, tying the growth allowance to the change in private sector health spending per capita would help ensure that Medicaid can keep pace with private spending, which is currently projected by CBO to increase by 4.7 percent a year between 1998 and 2002. The rationale is that Medicaid programs would have a harder time controlling expenditures if private health care spending increased more rapidly. An index tied to the growth in private sector health spending per capita would also be less susceptible to arbitrary reductions.

Third, policy makers need to conduct more serious analysis of the groups to which caps should be applied. The administration proposed to apply caps to the elderly, the disabled, adults, and children, but there are still major variations in the amount of spending within each of these categories, particularly for the elderly and the disabled. The risk is that a per capita cap could create incentives to reduce optional benefits used most heavily by the more expensive groups or to reduce eligibility for optional categories. One alternative might be to treat long-term care beneficiaries separately.

Fourth, any per capita policy would need to rebase (periodically change the base to which the growth rate is applied). This is necessary because of patient-mix and benefit-package changes that would be made by states in the early years of implementation of a per capita cap policy. The objective is to create greater incentives for efficiency and not to encourage gaming; rebasing would reduce the gains or losses from case-mix or benefit changes. Finally, the quality of Medicaid data, particularly on enrollment, needs to be significantly improved.

Conclusions

In this report we have examined a number of issues related to the Medicaid policy debate on per capita caps, disproportionate share payments, and increased state flexibility. The May budget agreement explicitly rejected the limit on average spending per enrollee proposed by the Clinton administration. Under the agreement $16 billion in savings would be obtained, mostly by reducing DSH payments and by providing states with greater flexibility in how they manage the Medicaid program.

The proposed reductions in DSH payments can be justified by the inequitable distribution of these funds among states and the way they have been distributed within states. While the payments are no doubt an attractive target for budget cutting, the policy ignores the need to assist many of the hospitals with large uncompensated care burdens and protects the very states that manipulated the system the most. In the absence of a per capita cap, states affected by DSH cuts may be more likely to seek other avenues for Medicaid maximization, such as increasing hospital reimbursement and financing the state share with intergovernmental transfers.

To provide more options for states to manage their Medicaid programs, the Clinton administration proposes to give the states additional discretion in several areas, none of which are likely to result in very large savings. The proposed

additional flexibility could help control the rate of growth in Medicaid spending, but there is less certainty that federal savings will be obtained without the imposition of a per capita cap.

Although there is general agreement that states should have more flexibility in running their Medicaid programs, the current requirements were put in place to solve problems that have not gone away. In some cases, such as requiring that all Medicaid beneficiaries have access to the same benefit package, the federal rules are designed to protect less favored classes of eligibles. The Boren amendment is clearly not working—it was originally intended to give states considerable freedom in setting nursing home and hospital rates—and lawsuits have constrained state flexibility. However, completely eliminating these standards raises concerns about the impact of potentially large reimbursement rate cuts on access to services by Medicaid beneficiaries and on quality of care. The current requirement for cost-based reimbursement for FQHCs and RHCs seems to be a throwback to a long-gone era in health care, but without generous reimbursement these facilities will almost certainly have to use scarce federal grant dollars to subsidize Medicaid patients and will have to reduce services to the uninsured. Allowing states to mandate enrollment in managed care without a waiver will clearly speed up its use, but the incentives for underservice in HMOs and the problems of implementation are sufficiently large that federal procedural oversight may be warranted.

Moreover, some federal rules are designed to protect the federal purse, and eliminating them in the absence of a per capita cap or some other budget constraint may result in increased federal expenditures. For example, the current rules that limit the categories of people Medicaid can cover mean that large numbers of people remain uninsured, but eliminating the rules could shift to Medicaid costs for public hospitals and health departments that are now borne by state and local governments. Similarly, requiring that states submit a home and community-based waiver in order to cover a broad range of long-term care services under Medicaid does impose an administrative burden (although a relatively small one), but totally eliminating the federal review may encourage states to refinance existing state long-term care programs that would not meet the budget-neutrality requirements of the current law.

Finally, the per capita cap proposed by the Clinton administration was dropped from the budget agreement. The cap would have provided additional control over the growth in federal Medicaid spending and prevented another round of Medicaid maximization by the states, which might shift billions of dollars in state and local spending to the Medicaid program. On the other hand, a per capita cap as proposed by the administration would have been extremely inequitable, locking in large variations in spending per enrollee across states. Moreover, if the growth allowance did not appropriately adjust for factors driving spending increases that were beyond the control of states, the Medicaid cuts required could have been large. Finally, implementation of the per capita caps would be difficult because of the lack of reliable data. If per capita caps reemerge as a policy option, serious consideration needs to be given to the issues of equity, growth allowances, grouping of enrollees, rebasing, and data quality.

Appendix

The Clinton administration's per capita cap proposal was designed so that the per capita growth rates would result in only small savings relative to the CBO baseline. Using the Urban Institute Medicaid simulation model, we estimate baseline spending growth by state and then model the potential impact of a per capita cap. The model's projections are calibrated to the CBO's national level but incorporate adjustments to make state-specific projections. The model allows for faster growth in states that had higher growth rates in recent years (1990 to 1995) and slower growth in states that have experienced lower growth in recent years. Differences between state-specific growth rates and the national projected growth rate are phased out over time, and by 2000 all states are assumed to grow at the same rate.

We simulated a policy like that proposed by the Clinton administration: a per capita cap applied to four groups, allowed to grow by a five-year historical average of GDP plus 2 percentage points in 1997 and 1998 and GDP plus 1 percentage point thereafter. The policy we simulated would yield $6.3 billion in federal savings over five years, roughly the amount envisioned by the Clinton administration. The results shown in table 7, columns 3 and 4, indicate that the per capita cap results in reducing federal payments to states relative to the simulated baseline by 0.7 percent from 1998 to 2002. The reductions vary by state, from 0.3 percent for Missouri and Wisconsin to 1.0 percent or more for Louisiana, South Carolina, Alabama, and Mississippi.

The impact is extremely small relative to projected spending decreases under the 1995 and 1996 block grant proposals, reflecting the recent slowdown in Medicaid spending growth. The reductions tend to be slightly greater in states where acute care accounts for a high percentage of state spending. This includes Alabama, Florida, Georgia, Louisiana, Mississippi, New Mexico, South Carolina, and Texas. In contrast, states where long-term care makes up a high percentage of state spending (Connecticut, Indiana, Iowa, Nebraska, Pennsylvania, Vermont, and Wisconsin) would experience smaller reductions because long-term care spending per enrollee has been growing more slowly than acute care spending.

Because the growth in spending per enrollee is more controllable by states than growth in enrollment, predicting the future course of spending per enrollee is more difficult. We therefore show projections of the impact of a per capita cap that assume all states grow at the same rate. The results are shown in columns 5 and 6 of table 7. The impact of the per capita cap, not surprisingly, is virtually the same in every state. The results also show that there is very little difference in the impact of the per capita cap under two sets of assumptions about state growth rates, primarily because the proposed reductions are so small.

Table 7 *Simulation of Hypothetical Per Capita Cap on Medicaid Expenditures, 1998–2002*

	1998–2002 (Urban Baseline)				1998–2002 (Uniform Growth Rates)	
	Millions of Dollars ($)					
	Baseline	Per Capita Cap	Difference	Percent Change	Difference (millions)	Percent Change
Total	$884,947	$878,684	($6,263)	–0.7%	$(5,934)	–0.7%
Alabama	10,997	10,857	(139.9)	–1.3%	(72.4)	–0.7%
Alaska	1,901	1,889	(11.6)	–0.6%	(13.5)	–0.7%
Arizona	10,170	10,088	(81.6)	–0.8%	(74.9)	–0.7%
Arkansas	8,214	8,134	(80.6)	–1.0%	(56.5)	–0.7%
California	68,481	68,165	(315.9)	–0.5%	(471.1)	–0.7%
Colorado	8,209	8,157	(52.3)	–0.6%	(55.6)	–0.7%
Connecticut	15,783	15,719	(64.6)	–0.4%	(92.1)	–0.6%
Delaware	2,249	2,232	(17.4)	–0.8%	(16.5)	–0.7%
District of Columbia	4,744	4,701	(43.2)	–0.9%	(35.3)	–0.7%
Florida	42,932	42,497	(435.3)	–1.0%	(286.0)	–0.7%
Georgia	23,134	22,886	(248.1)	–1.1%	(165.9)	–0.7%
Hawaii	5,648	5,611	(36.9)	–0.7%	(32.9)	–0.6%
Idaho	2,375	2,364	(11.1)	–0.5%	(17.1)	–0.7%
Illinois	37,417	37,187	(230.1)	–0.6%	(286.2)	–0.8%
Indiana	13,543	13,490	(53.1)	–0.4%	(83.0)	–0.6%
Iowa	6,970	6,943	(26.9)	–0.4%	(48.6)	–0.7%
Kansas	5,790	5,760	(29.7)	–0.5%	(40.5)	–0.7%
Kentucky	13,559	13,437	(121.9)	–0.9%	(95.7)	–0.7%
Louisiana	22,041	21,658	(382.8)	–1.7%	(155.9)	–0.7%
Maine	4,915	4,887	(27.6)	–0.6%	(31.6)	–0.6%
Maryland	14,984	14,861	(122.9)	–0.8%	(110.8)	–0.7%
Massachusetts	32,330	32,120	(210.1)	–0.6%	(217.0)	–0.7%
Michigan	30,413	30,199	(214.1)	–0.7%	(217.7)	–0.7%
Minnesota	19,829	19,708	(120.9)	–0.6%	(127.6)	–0.6%
Mississippi	9,499	9,379	(120.4)	–1.3%	(66.1)	–0.7%
Missouri	12,565	12,533	(32.0)	–0.3%	(75.5)	–0.6%
Montana	2,447	2,437	(10.8)	–0.4%	(14.8)	–0.6%
Nebraska	3,899	3,884	(15.0)	–0.4%	(25.1)	–0.6%
Nevada	2,850	2,828	(21.9)	–0.8%	(21.3)	–0.7%
New Hampshire	3,678	3,658	(20.5)	–0.6%	(20.4)	–0.6%
New Jersey	26,702	26,502	(199.7)	–0.7%	(175.6)	–0.7%
New Mexico	5,449	5,383	(65.3)	–1.2%	(42.0)	–0.8%
New York	131,050	130,350	(699.7)	–0.5%	(877.4)	–0.7%
North Carolina	27,361	27,159	(201.9)	–0.7%	(175.7)	–0.6%
North Dakota	1,852	1,841	(10.5)	–0.6%	(10.8)	–0.6%
Ohio	37,256	37,017	(238.6)	–0.6%	(224.8)	–0.6%
Oklahoma	6,428	6,390	(37.7)	–0.6%	(42.8)	–0.7%
Oregon	9,752	9,705	(47.7)	–0.5%	(64.2)	–0.7%
Pennsylvania	39,179	39,019	(159.6)	–0.4%	(235.7)	–0.6%
Rhode Island	5,382	5,338	(43.2)	–0.8%	(34.7)	–0.6%
South Carolina	11,858	11,712	(146.7)	–1.2%	(83.0)	–0.7%
South Dakota	2,005	1,991	(14.0)	–0.7%	(13.7)	–0.7%
Tennessee	25,093	24,969	(124.6)	–0.5%	(183.6)	–0.7%
Texas	54,936	54,308	(627.6)	–1.1%	(347.8)	–0.6%
Utah	3,922	3,894	(28.1)	–0.7%	(28.6)	–0.7%
Vermont	1,946	1,938	(7.9)	–0.4%	(13.6)	–0.7%
Virginia	12,281	12,201	(79.5)	–0.6%	(78.5)	–0.6%
Washington	17,085	16,982	(103.3)	–0.6%	(121.4)	–0.7%
West Virginia	8,765	8,684	(80.1)	–0.9%	(61.0)	–0.7%
Wisconsin	13,867	13,825	(42.2)	–0.3%	(83.3)	–0.6%
Wyoming	1,210	1,204	(5.7)	–0.5%	(8.0)	–0.7%

Source: Urban Institute Medicaid Expenditure and Beneficiary Baseline, 1997.

Note: Spending does not include administrative costs, adjustments, disproportionate share hospital (DSH), or payments to Medicare. Per capita cap growth rate assumes no cap in 1996 and 1997, 5-year rolling-average GDP + 2 percent for 1998 and 5-year rolling-average GDP + 1 percent for 1999–2002. Five year rolling-average GDP estimates are OMB estimates. Per capita cap was calculated separately by enrollment group (aged, blind/disabled, adult, child); "savings" from one enrollment group where baseline spending growth was less than the cap rate was applied to "losses" from other groups with baseline growth above the cap rate.

Notes

1. Urban Institute estimates.
2. Leighton Ku and Teresa A. Coughlin, "Medicaid Disproportionate Share and Other Special Financing Programs," *Health Care Financing Review,* vol. 16, no. 3 (Spring 1995), pp. 27–54.
3. States are actually provided with some additional options to expand eligibility to children, legal immigrants, and the working disabled, but none that would allow states to reduce eligibility.
4. Examples of flexibilities requested by the NGA but not included in the president's proposal include the ability to limit services provided to children under the EPSDT program, reconsideration of the nursing home quality standards, freedom to vary the Medicaid benefit package by category of eligibility and geographic area of the state, and the ability to replicate any research and demonstration waiver granted to another state. National Governors' Association, "Medicaid," NGA Policy EC-8 (Washington, DC: National Governors' Association, 1997).
5. American Health Care Association, *Nursing Facility Fact Book, 1996* (Washington, DC: American Health Care Association, 1996).
6. Charlene Harrington, Joanna Weinberg, Kay Strawder, and Richard DuNah Jr., "Nursing Home Litigation under the Boren Amendment: Case Studies" (San Francisco, CA: Institute for Health and Aging, University of California, November 1993).
7. John Holahan et al., *Cutting Medicaid Spending in Response to Budget Caps* (Washington, DC: Kaiser Commission on the Future of Medicaid, 1995).
8. American Health Care Association, *Facts and Trends: The Nursing Facility, 1995* (Washington, DC: American Health Care Association, 1995). Since not all Medicaid providers participate in Medicare, and vice versa, these two figures are not the average of exactly the same facilities. In addition, more expensive hospital-based nursing facilities participate more actively in the Medicare program. There are also case-mix differences between Medicare and Medicaid nursing home residents that account for some of the rate disparity. Avi Dor, "The Costs of Medicare Patients in Nursing Homes in the United States," *Journal of Health Economics,* vol. 8 (1989), pp. 253–70.
9. In the 1980s, private reimbursement rates tended to be 18 to 30 percent higher than Medicaid reimbursement rates. Authors' estimates based on the 1985 National Nursing Home Survey; Congressional Research Service, *Medicaid Source Book: Background Data and Analysis (A 1993 Update),* prepared for the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce, Committee Print, 103 Cong., 1 sess. (January 1993); Robert J. Buchanan, R. Peter Madel, and Dan Persons, "Medicaid Payment Policies for Nursing Home Care: A National Survey," *Health Care Financing Review,* vol. 13 (Fall 1991); and Institute of Medicine, *Improving the Quality of Care in Nursing Homes* (Washington, DC: National Academy Press, 1986).
10. John A. Nyman, "Excess Demand, the Percentage of Medicaid Patients, and the Quality of Nursing Home Care," *Journal of Human Resources,* vol. 23 (Winter 1988), pp. 76–92; John A. Nyman, "The Effect of Competition on Nursing Home Expenditures under Prospective Reimbursement," *Health Services Research,* vol. 23 (October 1988), pp. 555–74; John A. Nyman, Samuel Levey, and James E. Rohrer, "RUGS and Equity to Access to Nursing Home Care," *Medical Care,* vol. 25 (May 1987), pp. 363–74; Charlene Harrington and James H. Swan, "The Impact of State Medicaid Nursing Home Policies on Utilization and Expenditures," *Inquiry,* vol. 24 (Summer 1987), pp. 157–71; and William J. Scanlon, "A Theory of the Nursing Home Market," *Inquiry,* vol. 17 (Spring 1980), pp. 25–41.
11. Marylou Tousignant and Patricia Davis, "Nursing Homes in Area, Nationwide Plagued by Reports of Abuse," *Washington Post,* October 13, 1996, pp. B1, B6.
12. FQHCs are health centers that receive grants under Sections 329, 330, and 340 of the Public Health Service Act. FQHC look-alikes are centers that do not receive federal funds but could meet the requirements for such grants.

13. Holahan et al., op. cit. (1995), estimated that moving Medicaid adults and children into managed care could save 0.8 to 1.6 percent of total program expenditures. Doing away with the waiver requirement could speed up enrollment in managed care slightly, but it is unclear that Medicaid-only managed care organizations would be less expensive than conventional managed care organizations.

14. Most research suggests that managed care for the nonelderly, nondisabled Medicaid population can save between 5 and 10 percent of expenditures compared with the fee-for-service system. Diane Rowland, Sara Rosenbaum, Lois Simon, and Elizabeth Chait, *Medicaid and Managed Care: Lessons from the Literature* (Washington, DC: Kaiser Commission on the Future of Medicaid, 1995). The potential savings from enrolling the elderly and people with disabilities into managed care and from integrating acute and long-term care are less clear because there is much less experience.

15. Michael Sparer, Marsha Gold, and Lois Simon, "Managed Care and Low-Income Populations: A Case Study of Managed Care in California" (Menlo Park, CA: Henry J. Kaiser Family Foundation, 1996), and Marsha Gold, Hilary Frazer, and Cathy Schoen, "Managed Care and Low-Income Populations: A Case Study of Managed Care in Tennessee" (Menlo Park, CA: Henry J. Kaiser Family Foundation, 1995).

16. Sara Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, Volume I* (Washington, DC: George Washington University Medical Center, 1997).

17. TANF refers to Temporary Assistance to Needy Families; it is the replacement for the Aid to Families with Dependent Children (AFDC) program.

18. U.S. General Accounting Office, *Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs,* GAO/HEHS-96-44 (Washington, DC: U.S. General Accounting Office, November 1995).

19. Review of the research literature casts doubt on the notion that expanding home and community-based services for the elderly can reduce expenditures. This is because large increases in home-care use more than offset the relatively small reductions in nursing home use. See, for example, Joshua M. Wiener and Raymond J. Hanley, "Caring for the Disabled Elderly: There's No Place like Home," *Improving Health Policy and Management: Nine Critical Research Issues for the 1990s,* edited by Stephen M. Shortell and Uwe E. Reinhardt (Ann Arbor, MI: Health Administration Press, 1992), pp. 75–110. More recent but less rigorous research suggests that states may be doing a better job of making home care more cost-effective: Lisa Maria B. Alecxih, Steven Lutzky, John Corea, and Barbara Coleman, *Estimated Cost Savings from the Use of Home and Community-Based Service Alternatives to Nursing Facility Care in Three States* (Washington, DC: American Association of Retired Persons, 1996).

20. Gary A. Smith and Robert M. Gettings, "The Medicaid Home and Community-Based Waiver Program: Recent and Emerging Trends in Serving People with Developmental Disabilities" (Alexandria, VA: National Association of State Directors of Developmental Disabilities Services, 1996).

21. National Governors' Association, op. cit.

22. Although the mandatory Medicaid benefit package is very comprehensive in most ways, it does not cover prescription drugs.

23. Probably the most contentious part of the current benefit package is the requirement that states cover all medically necessary services found to be required for treatment as a result of EPSDT examinations, even if the state does not normally cover those services. No data are available on how large the expenditures are for these normally uncovered services, but they are likely to be small in the aggregate (although possibly large in individual cases).

24. For a thorough discussion of many of these problems, see Linda Bilheimer, "Medicaid Per Capita Cap Proposals," internal Congressional Budget Office memorandum, December 1995.

25. David Liska, Karen Obermaier Marlo, Anuj Shah, and Alina Salganicoff, *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends, 1988–1994, Second Edition* (Washington, DC: Kaiser Commission on the Future of Medicaid, 1996).