GEORGETOWN UNIVERSITY

Health Policy Institute

Financing Under Federal Medicaid Section 1115 Waivers: Federal Policy and Implications for New Hampshire

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Introduction

New Hampshire is considering a major initiative to restructure its Medicaid program through a "Section 1115" waiver. Waivers allow states to use federal Medicaid funds in ways that do not conform to federal standards regarding matters such as eligibility and enrollment, benefits, and beneficiary costs. The restructuring initiative raises many important questions, including questions about whether and to what extent a Section 1115 waiver would change the way in which the federal government shares Medicaid costs.

This report examines federal policy and practice with respect to Medicaid Section 1115 waiver financing. It is intended to help inform policymakers, stakeholders, and the general public about this particularly opaque area of federal policy for the purpose of promoting thoughtful consideration of the potential implications of restructuring Medicaid through this type of waiver.

I. New Hampshire's Medicaid Program: A Brief Overview

Medicaid plays a significant role in New Hampshire as it does in all other states. Nationwide, Medicaid is now the single largest health insurer in the nation; it is larger than Medicare both in terms of dollars spent and numbers of people served.[1]

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Federal Standards and State Flexibility

It is often said that if you have seen one Medicaid program you have seen one Medicaid program. The diversity reflects Medicaid's unique brand of federalism. Medicaid is jointly financed and administered by the states and the federal government. In exchange for federal financial support (the federal government pays half of all Medicaid costs in New Hampshire)[2] federal Medicaid law sets certain standards and guidelines regarding who can be covered and what services they receive. For example, states that choose to participate in Medicaid (all states do) must cover all poor children and certain groups of people who are disabled or age 65 and older. States also must cover a specified set of medical services and maintain affordability by keeping beneficiary costs below certain levels.

The federal government pays half of all Medicaid costs in New Hampshire.

These standards give the program its basic shape, but the rules also leave states broad discretion to cover additional groups and additional benefits and to impose some limits on the benefits they cover. States have even broader authority under federal law to design their service delivery systems and to set the rates they pay to the health care providers who participate in the program.

Although states have considerate flexibility to design their programs, over the years, states have also relied on waivers to help shape their programs and services. As explained in Figure 1, there are different types of Medicaid waivers, and states have used waivers in many different ways. "Home and Community Based Service" waivers authorized under section 1915 of the Medicaid law, for example, have allowed states to provide long term care services for people outside of

institutional settings. (New Hampshire has four of these types of waivers.) This report focuses on the broad, more comprehensive waivers available under "Section 1115" of the Social Security Act. (Figure 1)

Figure 1

Not All Waivers Are Alike: Two Types of Medicaid Waivers

There are two types of Medicaid waivers: targeted waivers that operate under limited federal statutory authority (Section 1915 of the Medicaid law) and relate to specific aspects of the Medicaid program, and "Section 1115" waivers, which can be much broader in scope and which apply to a number of federal programs, including Medicaid and the State Children's Health Insurance Program (SCHIP). (They are called "Section 1115" waivers or demonstration projects because they are authorized by Section 1115 of the Social Security Act. Title XIX, which establishes the Medicaid program, is part of the Social Security Act.) Under federal law, Section 1115 waivers are intended to be for "research and demonstration projects" that "further the objectives" of the program. The Secretary of the U.S. Department of Health and Human Services (HHS) is charged with the responsibility for reviewing and approving or denying these waivers.

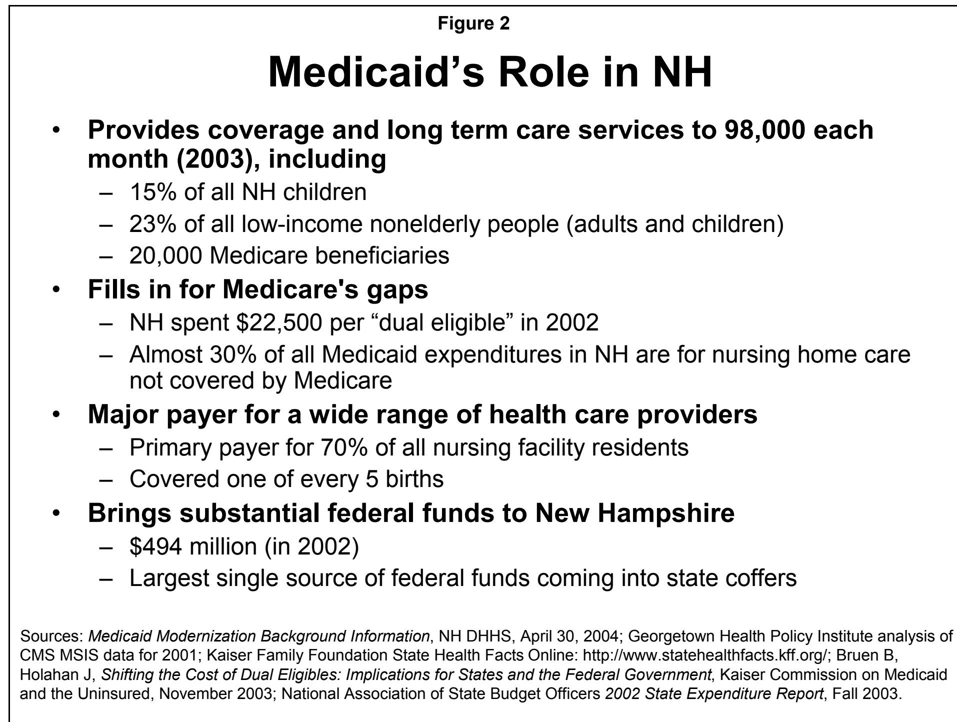
According to CMS, New Hampshire has four targeted ("Section 1915(c)") waivers. These waivers have helped the state provide home and community-based services to children with developmental disabilities, people with mental retardation and developmental disabilities, people with acquired brain disorder, and other elderly and disabled people.

New Hampshire does not have any Section 1115 waivers, the type of waiver that it is likely to need if it chooses to restructure Medicaid in significant ways.

Source: CMS waiver website, www.cms.hhs.gov/medicaid/waivers/nhwaiver.asp and conversations with CMS central office staff.

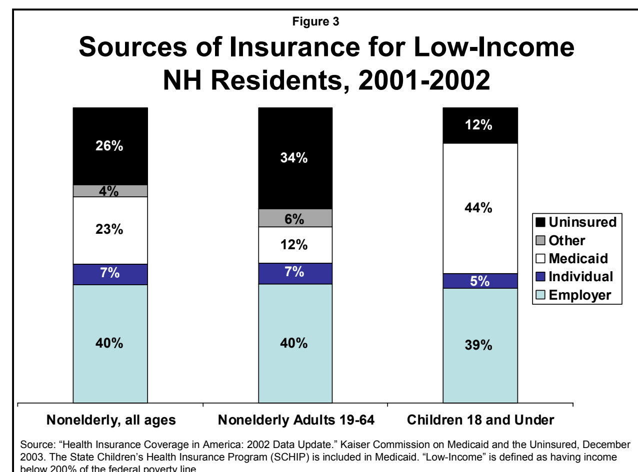
Medicaid's Many Roles

Medicaid has multiple roles. (Figure 2) Its role providing health insurance to families, the elderly, and people with disabilities, is most prominent. In state fiscal year 2003, New Hampshire's program covered about 98,000 people each month.[3]



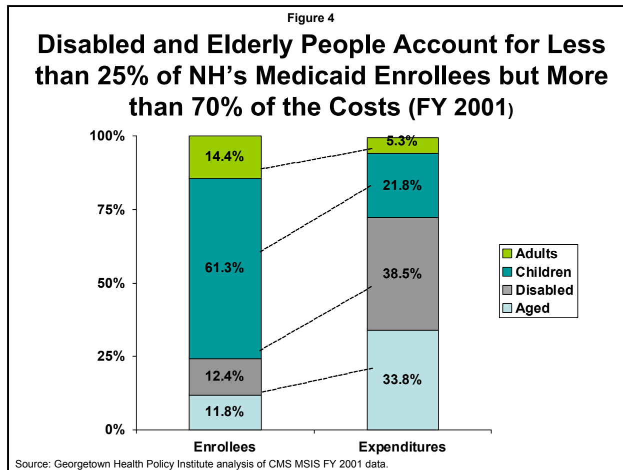
Sources: *Medicaid Modernization Background Information*, NH DHHS, April 30, 2004; Georgetown Health Policy Institute analysis of CMS MSIS data for 2001; Kaiser Family Foundation State Health Facts Online: http://www.statehealthfacts.kff.org/; Bruen B, Holahan J, *Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government*, Kaiser Commission on Medicaid and the Uninsured, November 2003; National Association of State Budget Officers *2002 State Expenditure Report*, Fall 2003.

Coverage for Children and Low-Income Families. In 2001-2002, nearly one quarter (23 percent) of all low-income nonelderly New Hampshire residents relied on Medicaid for their health insurance coverage. (Figure 3) This includes 12 percent of all low-income adults under age 65 and 44 percent of New Hampshire's low-income children. (For this purpose, "low-income" is defined as having income below 200 percent of the federal poverty line; in 2004 this equates to a $2,612 in gross monthly income for a family of three). Children's coverage is through Medicaid or through the State Children's Health Insurance Program (SCHIP), which in New Hampshire are called Healthy Kids Gold and Silver, respectively. Medicaid and SCHIP's penetration among children is much greater than for their parents because New Hampshire's Medicaid and SCHIP income eligibility levels are much higher for children than for parents.



Source: "Health Insurance Coverage in America: 2002 Data Update." Kaiser Commission on Medicaid and the Uninsured, December 2003. The State Children's Health Insurance Program (SCHIP) is included in Medicaid. "Low-Income" is defined as having income below 200% of the federal poverty line.

Coverage and Long Term Care Services for the Elderly and People with Disabilities. Although Medicaid is perhaps best known for its coverage of low-income children and their families, it is a critical source of financing for coverage and long-term-care services provided for people with disabilities and the elderly. In New Hampshire, and in all other states, Medicaid spending on disabled and elderly people far exceeds spending on children and their parents, even though many fewer disabled and elderly people are enrolled in the program. (Figure 4) The high cost of serving the elderly and people with disabilities is due to their need for medical care and long term care services. Most of the people in these two groups are also eligible for Medicare, but Medicare does not pay for most long term care services and will not begin to pay for pharmacy services until 2006 (under the new Medicare drug law). Medicaid has filled these critical gaps.[4]



Support for Health Care Providers and an Economic Engine in Many Communities. Medicaid's contribution to the state extends beyond its basic coverage role. Because it brings the state at least one federal dollar for every state dollar spent in the program[5], Medicaid provides federal financial support for coverage and services that New Hampshire or its counties, cities and towns might have provided with state and local dollars. These funds account for a substantial source of revenues for hospitals, clinics, county nursing homes, the state mental hospital, community mental health centers, and other health care providers, and this flow of funds, in turn, stimulates other economic activity.[6]

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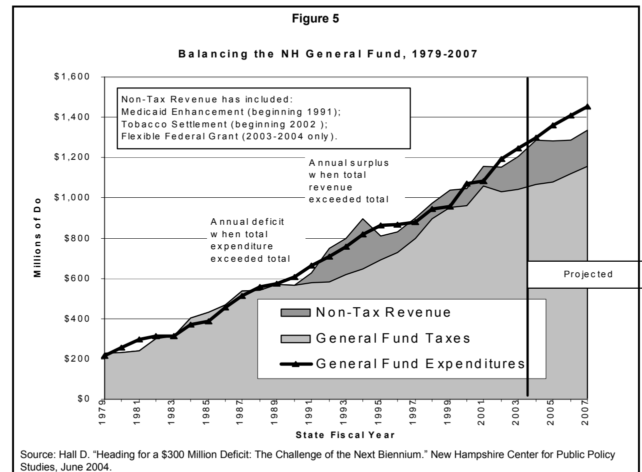
Funds Other State Priorities. Perhaps more controversial is New Hampshire's long history of bringing in additional federal dollars, known in New Hampshire as "enhancement revenues." It has done this through a combination of so-called Disproportionate Hospital Share (DSH) payments, intergovernmental transfers, and health care provider taxes. The original purpose of Medicaid DSH was to allow states to give additional support to hospitals that provided a large amount of care to uninsured and Medicaid patients. Over the years, a number of states found ways (generally involving intergovernmental transfers and health care provider taxes) to draw down federal DSH funds and use those funds for other purposes.[7] New Hampshire has a rich history of engaging in such arrangements.

To give a sense of the scope of these practices relative to other states, in 2002, New Hampshire ranked first among all 50 states and the District of Columbia when DSH payments are measured against total Medicaid expenditures (17.7%).[8] In that year, New Hampshire's DSH payments amounted to $144.24 for every state resident (ranking 3rd among states) and $821.89 for every low-income state resident (ranking 1st among states).[9]

It is important to note that while New Hampshire claims these federal payments through the Medicaid program, it transfers these payments—the so-called Medicaid enhancement revenues – to its General Fund. Since 1991, when these payments first began, they have been used to balance the overall state budget, not to pay for Medicaid program costs.[10] (Figure 5)

Figure 5



Source: Hall D. "Heading for a $300 Million Deficit: The Challenge of the Next Biennium." New Hampshire Center for Public Policy Studies, June 2004.

These types of financing practices have been scrutinized and modified by Congress and federal Medicaid administrators over the years. Recently, the Center for Medicare and Medicaid Services (CMS), the federal agency within HHS that oversees Medicaid, has increased federal oversight of state financing practices, and the President proposed changes in intergovernmental transfer payment rules that would have the affect of reducing federal payments to states by close to $24 billion over ten years.[11] It is unclear at this point whether or how these initiatives will affect New Hampshire's federal payments.

In a separate action, however, CMS has required New Hampshire to change its method for calculating New Hampshire's hospital provider tax. This change will result in the loss of a projected $100 million in so-called Medicaid enhancement revenues over the biennium beginning in July 1, 2005. The loss of these funds – funds that have never been used to finance Medicaid – has been a major factor cited by Commissioner Stephen and others as prompting the current Medicaid restructuring initiative.[12]

II. Medicaid and Section 1115 Waiver Financing Compared

While fiscal concerns stemming from the potential loss of "enhancement revenues" underlie much of the pressure to restructure Medicaid, an even more fundamental change in Medicaid financing could result if New Hampshire restructures its Medicaid program through a Section 1115 waiver. The question of how New Hampshire's federal Medicaid funding may change under a Section 1115 waiver is a matter of central importance to the state, the counties, health care providers, and the citizens of New Hampshire. In 2002, federal Medicaid payments accounted for 44.7% of all federal funds received by state government. (Figure 6) Medicaid is, by far, the largest source of federal funds coming into New Hampshire's coffers. Any change in the basic flow of these funds could have a major impact on New Hampshire's ability to finance health care services and on its overall fiscal condition.

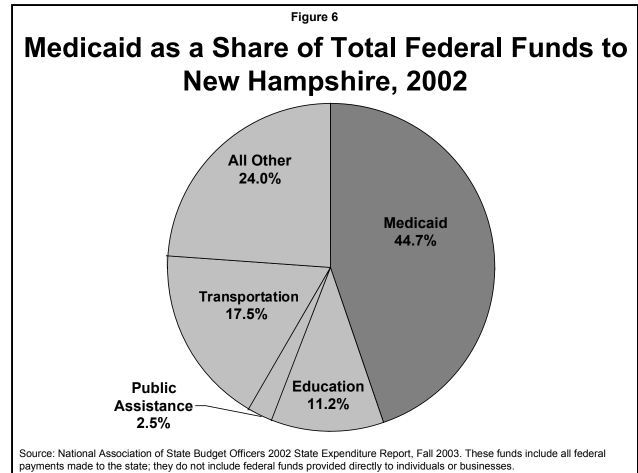


Figure 6

Medicaid as a Share of Total Federal Funds to New Hampshire, 2002

Source: National Association of State Budget Officers 2002 State Expenditure Report, Fall 2003. These funds include all federal payments made to the state; they do not include federal funds provided directly to individuals or businesses.

Under Regular Medicaid Financing, the Federal Government Shares All Costs

Under regular Medicaid financing rules, the federal government is obligated to share a state's Medicaid costs, at the prescribed matching rate, whatever those costs turn out to be. There is no cap or ceiling on the amount of federal funding that states can claim, as long as the claims are for legitimate Medicaid expenditures. If costs rise for any reason – an aging population, a natural disaster, a new cancer drug, a plant closing or a broader downturn in the economy – federal funding levels automatically respond. (Figure 7)

Financing under Section 1115 waivers is quite different. Under longstanding federal policy, Section 1115 Medicaid waivers must be "budget neutral" for the federal government. This means that the Secretary of HHS, usually in conjunction with the White House Office of Management and Budget (OMB), must determine that the waiver will not cost the federal government more than it would have spent without the waiver.

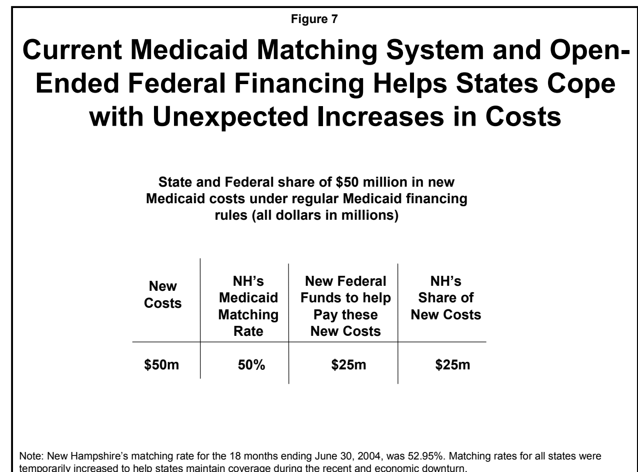


Figure 7

Current Medicaid Matching System and Open-Ended Federal Financing Helps States Cope with Unexpected Increases in Costs

State and Federal share of $50 million in new Medicaid costs under regular Medicaid financing rules (all dollars in millions)

New Costs	NH's Medicaid Matching Rate	New Federal Funds to help Pay these New Costs	NH's Share of New Costs
$50m	50%	$25m	$25m

Note: New Hampshire's matching rate for the 18 months ending June 30, 2004, was 52.95%. Matching rates for all states were temporarily increased to help states maintain coverage during the recent and economic downturn.

Waivers May Not Result In New Federal Costs

When a state applies for a Section 1115 waiver, CMS creates something akin to a ledger sheet. It projects federal costs with and without the waiver for the period covered by the proposed waiver (usually five years). Under federal budget neutrality policy, these costs must balance out. Thus, if a state is planning to use a waiver to implement an expansion or improvement that it could not have accomplished without a waiver – such as covering nondisabled adults who are not living with children-- it will need to identify offsetting federal savings.[13]

In the past, states that have expanded coverage through Section 1115 waivers have generally found these savings in one of two ways: They have redirected federal DSH payments toward coverage or they have expanded coverage at the same time they have implemented mandatory managed care (applying the anticipated savings from managed care to the new coverage costs). A new option suggested by HHS's Health Insurance Flexibility and Accountability (HIFA) waiver guidelines, issued in August 2001, is for states to find savings by reducing benefits or increasing cost sharing for people eligible for Medicaid prior to the waiver.[14] A few states have now used this approach to "pay for" limited, waiver-based coverage expansions.[15]

Some states also have redirected unspent federal SCHIP funds to pay for new coverage expansions. These are SCHIP Section 1115 waivers, not Medicaid waivers, but the same concept of budget neutrality applies. Unexpended SCHIP funds allocated to the state are used to offset any new federal cost involved in the proposed coverage expansion. [16]

All Section 1115 waivers Include A Cap To Enforce Federal Budget Neutrality

Whether or not a state is planning an expansion or other improvements under its waiver, the federal government has required states to accept a cap on the amount of federal funds that will be paid to the state for all waiver-related expenditures. These caps assure that the federal government's costs under a waiver will not exceed the costs it projects it would incur without the waiver. They turn the spending projections developed for budget neutrality purposes into federal payment limits. Even when a state is planning to use a waiver to *reduce* spending the federal government insists on a cap. For example, Washington State recently sought a waiver to impose premiums on children. The waiver would, by definition, reduce costs and, therefore, the state sought a waiver with no budget neutrality cap.[17] A cap was ultimately imposed, however.[18]

Whether or not a state is planning an expansion or other improvements under its waiver, the federal government has required states to accept a cap on the amount of federal funds that will be paid to the state for all waiver-related expenditures.

Budget neutrality caps imposed in Medicaid Section 1115 waivers have generally come in two forms: "per capita" caps and "global" caps. [19] Both types of caps are described below.

Per Capita Caps. In most Section 1115 Medicaid waivers, the federal government has relied on "per capita" caps to enforce its budget neutrality policy. The cap is set based on the state's historical cost of serving the category or categories of people covered under the waiver. That per-person base amount is then adjusted upward each year by a pre-set amount written into the

waiver agreement. The adjustment is intended to account for projected health care inflation and in general is based on the lesser of a state's historic growth rates or projected U.S. Medicaid spending growth rates.[20]

Once a waiver with this type of cap is implemented, the state submits its claims for federal matching payments as it normally does, but over the time period covered by the waiver the state's federal payments for all waiver-related expenditures cannot exceed the cap. In the case of a per-capita waiver cap, the state cannot claim more than the per-person amount (the base payment, as adjusted under the formula) times the number of (non-expansion) [21] people enrolled under the waiver. If actual per-person costs are greater than the projections allowed for, the state must either take action to reduce costs or pay for those added costs with state General Funds.

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Global Caps. Recently, in the context of a new type of Section 1115 waiver, known as "Pharmacy Plus," HHS relied on "global caps" to enforce its budget neutrality policies. A global cap sets an overall limit on the federal funds that will be spent on the coverage and services financed through the waiver. Like a per capita cap, it shifts the risk of higher-than-projected per person costs on to the state. But under a global cap, the state also assumes the risk of higher-than-projected enrollment. If the cost of serving people *or* the number of people served exceeds the pre-set limit on federal payments, the state must either cut back on coverage or absorb the added cost with state-only dollars. (Figure 8) A global cap is similar to the block grant or "capped allotment" Medicaid proposal that the President included in his FY2003 budget.[22]

Like a per capita cap, a global cap shifts the risk of higher-than-projected per person costs on to the state. But under a global cap, the state also assumes the risk of higher-than-projected enrollment.

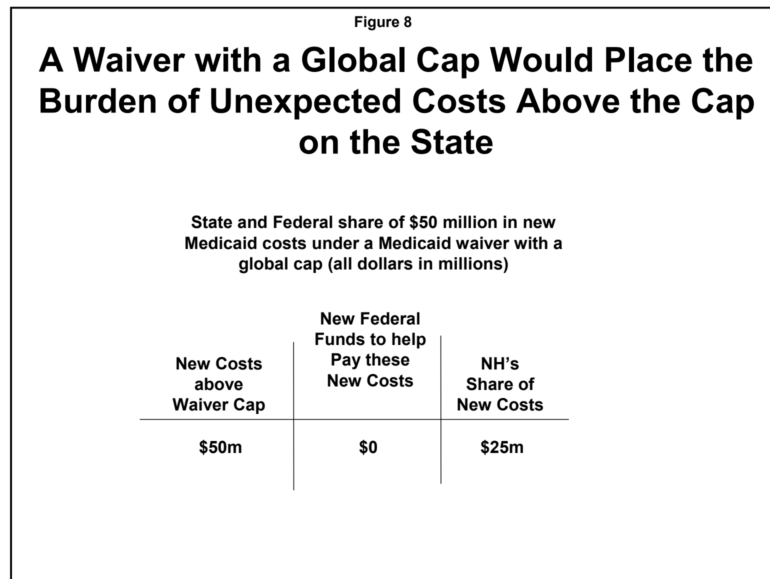


Figure 8

A Waiver with a Global Cap Would Place the Burden of Unexpected Costs Above the Cap on the State

State and Federal share of $50 million in new Medicaid costs under a Medicaid waiver with a global cap (all dollars in millions)

New Costs above Waiver Cap	New Federal Funds to help Pay these New Costs	NH's Share of New Costs
$50m	$0	$25m

Under a waiver with a global cap, a base amount is set with reference to historical spending in the state for the beneficiaries and services that will be covered under the waiver. This amount is adjusted annually by pre-set rate. The cap on federal payments would not vary based on the actual cost of services or the actual number of people served under the program. (Figure 9)

Federal payments under the cap would not vary based on the actual cost of services or the actual number of people served under the program.

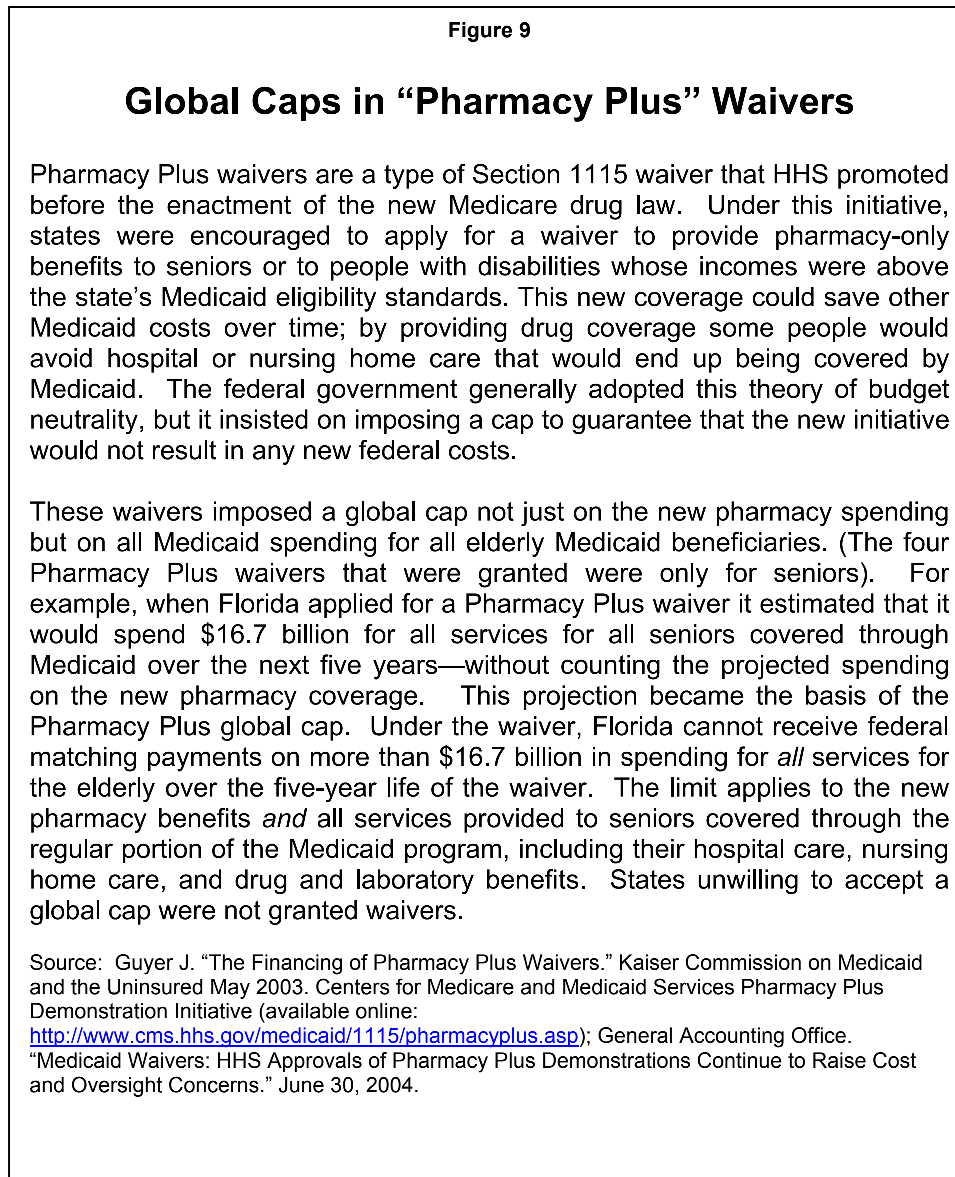


Figure 9

Global Caps in "Pharmacy Plus" Waivers

Pharmacy Plus waivers are a type of Section 1115 waiver that HHS promoted before the enactment of the new Medicare drug law. Under this initiative, states were encouraged to apply for a waiver to provide pharmacy-only benefits to seniors or to people with disabilities whose incomes were above the state's Medicaid eligibility standards. This new coverage could save other Medicaid costs over time; by providing drug coverage some people would avoid hospital or nursing home care that would end up being covered by Medicaid. The federal government generally adopted this theory of budget neutrality, but it insisted on imposing a cap to guarantee that the new initiative would not result in any new federal costs.

These waivers imposed a global cap not just on the new pharmacy spending but on all Medicaid spending for all elderly Medicaid beneficiaries. (The four Pharmacy Plus waivers that were granted were only for seniors). For example, when Florida applied for a Pharmacy Plus waiver it estimated that it would spend $16.7 billion for all services for all seniors covered through Medicaid over the next five years—without counting the projected spending on the new pharmacy coverage. This projection became the basis of the Pharmacy Plus global cap. Under the waiver, Florida cannot receive federal matching payments on more than $16.7 billion in spending for *all* services for the elderly over the five-year life of the waiver. The limit applies to the new pharmacy benefits *and* all services provided to seniors covered through the regular portion of the Medicaid program, including their hospital care, nursing home care, and drug and laboratory benefits. States unwilling to accept a global cap were not granted waivers.

Source: Guyer J. "The Financing of Pharmacy Plus Waivers." Kaiser Commission on Medicaid and the Uninsured May 2003. Centers for Medicare and Medicaid Services Pharmacy Plus Demonstration Initiative (available online: http://www.cms.hhs.gov/medicaid/1115/pharmacyplus.asp); General Accounting Office. "Medicaid Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns." June 30, 2004.

Once a Section 1115 waiver with a global cap is in place, a state would claim federal matching payments on all expenditures under the waiver, up to but no more than the capped level of federal funding. If costs rose above the caps, the state could either reduce the scope of the program (relying on traditional options available under Medicaid rules or the new flexibility permitted through the waiver) or bear the additional costs with state funds.

III. How Might Waiver Financing Affect New Hampshire?

Ultimately the fiscal impact of a major new waiver will depend on many factors, including the breadth of the waiver (i.e., how much of New Hampshire's program would be subject to waiver financing), the type of waiver cap imposed, as well as factors specific to New Hampshire's Medicaid program and its demographics. Any type of budget neutrality cap would limit the amount of federal Medicaid payments the state would receive over the life of the waiver and could shift major new costs onto the state, counties and health care providers -- or force program changes that the state does not now anticipate. The dimensions of this cost-shift and potential program reductions are illustrated below.

Any type of budget neutrality cap would limit the amount of federal Medicaid payments the state would receive over the life of the waiver and could shift major new costs onto the state, counties and health care providers -- or force program changes that the state does not now anticipate.

Potential Impact of a Waiver with a Global Cap

To illustrate the potential impact of a Section 1115 waiver with a global cap (a so-called "block grant" waiver), the federal government's share of additional costs that might result from higher-than-projected enrollment or health care costs has been calculated under three different, illustrative scenarios. The cap modeled here is designed like the caps imposed in the Pharmacy Plus waivers, except the cap would cover the full program rather than just the payments relating to care for the elderly. In these scenerios, the base payment for the cap is set by reference to the total amount of New Hampshire's federal Medicaid payments in 2001 and that base amount is adjusted annually by 7.2 percent, the adjuster used in the recent Washington state waiver.[23]

Table 1 illustrates what might happen over five years if enrollment rose at an average annual rate of two percent and per person healthcare costs grew at 7.2 percent (the level assumed in the cap). Under these circumstances, the state would face $276 million in additional costs over the five-year period. New Hampshire would receive $138 million in additional federal payments to help pay these costs under regular Medicaid financing rules. By contrast, under a Section 1115 waiver with a global cap, it would have to bear the full cost without new federal funds; the state could lose $138 million in federal funds compared to regular Medicaid financing. (Table 1, scenario 1).

If enrollment were flat, but per person costs rose by eight percent (instead of the projected 7.2 percent), the new costs would be $101 million, and state could lose $50.6 million in federal funds. (Table 2, scenario 2) And if enrollment *and* per person costs rose at higher-than projected levels (two percent enrollment growth and an eight percent cost increase), the five-year federal funding shortfall could grow to $192.6 million under a broad-based waiver with a global cap. (Table 1, scenario 3)

Table 1
State and Federal Spending under Alternate Global Cap Scenarios

	Program Dynamics		Regular Financing Rules	Waiver Financing: Global Cap
1st Scenario	2% enrollment growth 7.2% growth in per-person costs	Additional Program Costs	$276.1 million	$276.1 million
		Additional Federal Payments to Meet New Costs	$138.1 million	$0
2nd Scenario	Flat enrollment 8% growth in per-person costs	Additional Program Costs	$101.3 million	$101.3 million
		Additional Federal Payments to Meet New Costs	$50.6 million	$0
3rd Scenario	2% enrollment growth 8% growth in per-person costs	Additional Program Costs	$385.3 million	$385.3 million
		Additional Federal Payments to Meet New Costs	$192.6 million	$0

Potential Impact of a Waiver with a Per Capita Cap

Perhaps a more likely set of scenarios, given Commissioner Stephen's public statements rejecting a "block grant" waiver, would involve a cap that limits the amount of federal payments received on a per-person basis. The potential impact of a program wide Section 1115 waiver with a per capita cap that grows at an annual rate of 7.2 percent each year is shown in Table 2.[24] Under this type of a waiver cap, if enrollment rose at an average annual rate of two percent over the five years, but per-person costs stayed below 7.2 percent, New Hampshire could receive the same amount of federal funds under the waiver to help pay these added costs as it would under regular Medicaid financing rules. This is because the federal government would continue to share the risk of higher-than-projected enrollment. (Table 2, scenario 1)

However, if enrollment remained flat, but costs rose for other reasons—for example, due to higher drug costs—New Hampshire could experience a shortfall in federal funds under a per capita budget neutrality cap. The new drug costs would shift to the state. For example, if health care costs rose by eight percent (instead of the 7.2 percent built into the waiver), the state could receive $50.6 million less in federal payments than under regular Medicaid financing rules. (Table 2, scenario 2)

Under a per capita waiver cap, if enrollment remained flat, but costs rose for other reasons—for example, due to higher drug costs—New Hampshire could experience a shortfall in federal funds under a per capita budget neutrality cap. A higher portion of the new drug costs would shift to the state.

Table 2
State and Federal Spending under Alternate Per Capita Cap Scenarios

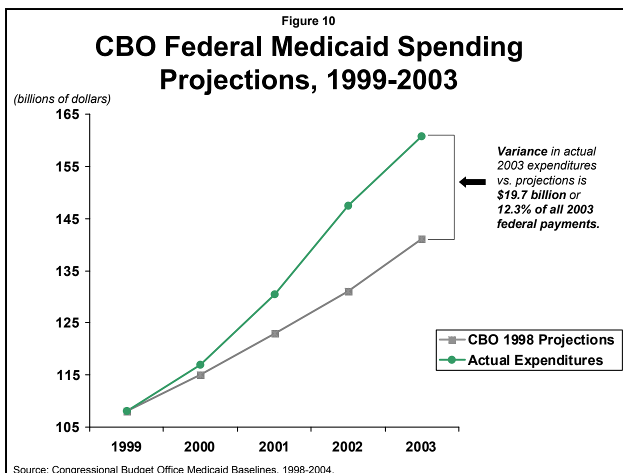
	Program Dynamics		Regular Financing Rules	Waiver Financing: Per-Capita Cap
1st Scenario	2% enrollment growth 7.2% growth in per-person costs	Additional Program Costs	$276.1 million	$276.1 million
		Additional Federal Payments to Meet New Costs	$138.1 million	$138.1 million
2nd Scenario	Flat enrollment 8% growth in per-person costs	Additional Program Costs	$101.3 million	$101.3 million
		Additional Federal Payments to Meet New Costs	$50.6 million	$0

The Risk Of Higher Costs Is Substantial Given How Difficult It Is To Predict Or Fully Control Health Care Spending.

If New Hampshire proceeds with a waiver that encompasses a portion of the program, rather than the full program, the potential impact of the cap might not be as great as shown in these illustrations. The variations in health care inflation or enrollment assumed in these illustrations, however, are modest considering how volatile health care spending has been in recent years. (For example, according to an analysis prepared by the National Conference of State Legislators, New Hampshire's state employee health care costs for family coverage rose at an average annual rate of 21.4 percent between 1999 and 2004.[25]) Sharper jumps in costs than those assumed in these illustrations would result in even greater losses of federal funds—and potentially a larger hole in the state budget, greater unanticipated reductions in program coverage and services, and/or cost-shifting onto counties and health care providers.

Health care spending is notoriously difficult to predict.

Health care spending is notoriously difficult to predict. In 1999, the Congressional Budget Office predicted federal Medicaid spending for 2003, but it turned out that actual spending in that year was 12.3 percent above CBO's projections. (Figure 10)



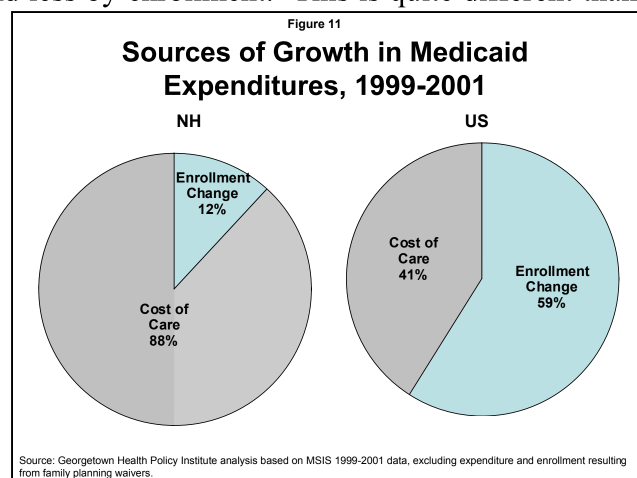
The variability in Medicaid growth rates and sources of the growth can be seen by comparing New Hampshire to some of its neighboring states and to the U.S. Table 3 shows New Hampshire's average annual change in enrollment, expenditures and per capita costs for the four major Medicaid beneficiary groups compared to other New England states (except Maine) between 1999

and 2001. [26] Even among five New England states, there is considerable variation. Each state's numbers are affected by a host of factors, including differences in demographics, policies, economic circumstances, and their health care marketplace; moreover, the factors that can affect health care and Medicaid costs in any given state can change quickly and often in unpredictable ways.

Table 3
Average Annual Growth in Medicaid in New England, FY 1999-2001

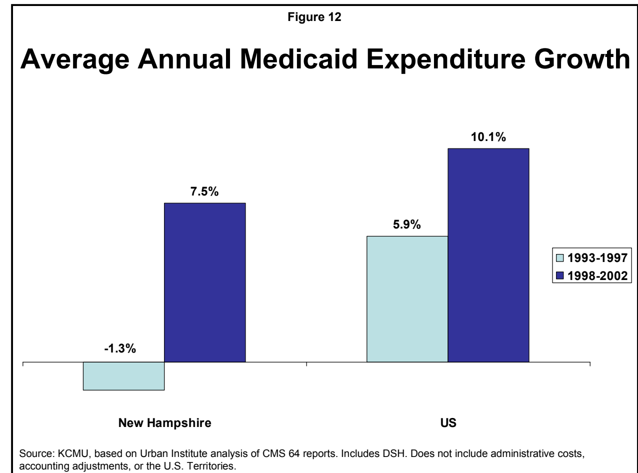
	CT	RI	MA	NH	VT	US
Enrollment						
Disabled	2.7%	7.7%	3.5%	1.2%	2.4%	3.4%
Children	3.7%	13.1%	2.8%	2.4%	6.4%	5.7%
Adults	7.8%	17.5%	6.3%	-2.1%	4.8%	9.6%
Elderly	4.3%	4.5%	2.4%	1.5%	7.1%	1.4%
Total	4.4%	12.1%	3.9%	1.5%	5.5%	5.7%
Expenditures						
Disabled	5.9%	11.2%	9.6%	10.9%	12.6%	10.8%
Children	-10.7%	31.6%	8.2%	12.9%	19.9%	12.8%
Adults	-11.6%	17.8%	9.6%	8.8%	13.3%	11.9%
Elderly	5.1%	3.7%	4.2%	22.0%	9.3%	6.5%
Total	5.3%	11.5%	7.9%	14.5%	13.4%	10.2%
Per-Capita Expenditures						
Disabled	3.2%	3.3%	5.9%	9.6%	9.9%	7.1%
Children	-13.9%	16.4%	5.3%	10.2%	12.7%	6.7%
Adults	-18.0%	0.3%	3.1%	11.2%	8.2%	2.2%
Elderly	.7%	-0.8%	1.7%	20.2%	2.0%	5.0%
Total	.9%	-0.5%	3.9%	12.9%	7.5%	4.3%

During this period, New Hampshire's Medicaid costs were driven largely by an increase in the per-person cost of covering its beneficiaries, and less by enrollment. This is quite different than the dynamics for the U.S. generally, as shown in Figure 11. If this pattern continues, New Hampshire could be substantially disadvantaged by a per-capita waiver cap.



Variability is also evident when looking at New Hampshire's Medicaid spending growth rates over time. Figure 12 shows the growth rates for the two five-year periods between 1993 and 2002 (the most recent ten-year period for which data are available).[27] According to these data, total Medicaid spending actually declined during the first five years but grew by an average rate of 7.53 percent in the second five-year period.

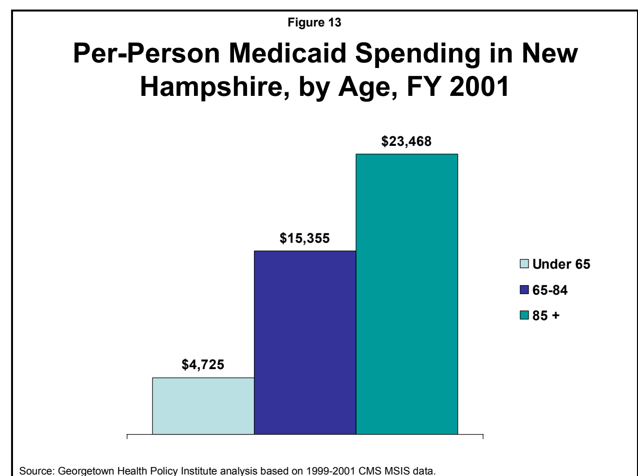
These variations (within the state over time and across states) underscore just how difficult it is to predict Medicaid costs because so many forces – many well beyond the state's control – drive these costs. This unpredictability is hard for states to manage, but the challenges presented by volatile health care costs could be much greater if New Hampshire's federal Medicaid payments were constrained under a waiver cap by predictions that proved to be inaccurate as time went on.



How Will Waiver Financing Affect New Hampshire's Ability To Care For Its Growing Elderly Population?

The aging of the baby boomers is a well known phenomenon, but it will affect some states more than others. U.S. Census Bureau projections suggest that New Hampshire will be hard hit by the aging of the population, a fact often cited by the Commissioner in his Medicaid restructuring presentations. In 1993, New Hampshire ranked 47th among states in terms of the percent of its population that was age 65 or older. By 2002, its ranking had jumped to 33rd. Between 2004 and 2013, the number of people age 65 and older in New Hampshire is projected to grow by an average annual rate of 2.4 percent. By 2013, the elderly will account for 13.4 percent of New Hampshire residents compared to 11.8 percent in 2003.[28]

As the Commissioner appropriately points out, the problem is exacerbated by growth among the group of people age 85 or older.[29] Between 2000 and 2005, the 85 + group is projected to grow by 29 percent. Growth in the elderly population, and particularly among the very old, will have a direct and substantial affect on New Hampshire's health care costs. New Hampshire's average annual cost for serving its oldest Medicaid beneficiaries was $23,568 in 2001, compared to $15,355 for people between 65 and 85 and $4,725 for those under 65. (Figure 13)



A waiver cap (global or per capita) would be particularly challenging for a state with an aging population. Over time, the shift in demographics will necessarily result in higher overall Medicaid costs, which would generally not be adequately reflected in either the waiver base payment (which is set based on historical spending and therefore historical demographics) or the inflation adjustor (which is typically based either on state historical spending growth or projected U.S. Medicaid spending growth). A per capita waiver cap could result in somewhat less harm

than a global cap, but still would shift risk onto the state. If the per-capita cap were set by beneficiary group (as is often done), then higher enrollment of the elderly would be accounted for, but only to the degree that the capped per person payment reflected actual costs. The costs associated with serving the elderly and people with disabilities have driven the growth in Medicaid spending in New Hampshire and elsewhere in recent years. New Hampshire's state budget problems would be much worse than they are today if the federal share of these rising costs had been subject to a pre-set cap.

Figure 14

The New Medicare Drug Law Creates Additional Uncertainties for New Hampshire

Currently, and up until January 2006 when the new Medicare drug benefit is implemented, New Hampshire's Medicaid program pays for drug coverage for low-income Medicare beneficiaries (so-called "dual eligibles"). Beginning in 2006, people who are dual eligibles will receive their drug coverage through Medicare instead of Medicaid. States will realize considerable saving from not having to provide drug coverage, but the new law recaptures most of the savings through a "clawback" provision that requires states to pay the federal government for most of the cost of the new drug benefit.[30] (The new law also imposes other costs onto states.) Questions surrounding the new law and how it will be implemented have important implications for New Hampshire and its waiver initiative. For example:

- *How will the federal government compute the portion of the waiver cap corresponding to this group of beneficiaries?* Historical spending would include drug coverage, but the federal government is not likely to let a state keep that spending in its waiver base beginning in 2006 since that would violate budget neutrality (i.e., the federal government would be incurring more costs than it would without the waiver) and undermine the intent underlying the clawback provision. Would New Hampshire have drug expenditure data for its population of dual eligibles that the federal government will rely on? Without such data, how will the federal government adjust the base for purposes of calculating the Section 1115 waiver cap?

- *Will the new Medicare drug benefit be adequate for New Hampshire's elderly and disabled residents?* If not, New Hampshire could supplement the benefit but with state-only dollars. How will this affect New Hampshire's health care costs over time?

These could be significant issues for New Hampshire. Most of the elderly and disabled people enrolled in New Hampshire's Medicaid program are "dual eligibles."[31] (In most states, including New Hampshire, most of a state's elderly Medicaid beneficiaries are also enrolled in Medicare. New Hampshire stands out among states, however, because a particularly large portion of its disabled Medicaid beneficiaries are dually eligible.)

IV. How Will These Important Issues Be Resolved And Who Will Be Part Of The Debate And The Decision-Making Process?

The Section 1115 waiver process varies from waiver to waiver, but generally, it involves closed door negotiations between the state (usually led by the Medicaid agency) and CMS. The Secretary of HHS ultimately makes the decision, in consultation with OMB, and sometimes after intervention by the governor, members of the state's Congressional delegation, and the White House. Following is a brief description of the steps in the waiver process:

- *Pre-application discussions.* Discussions between a state and the federal government typically begin before a formal waiver application has been submitted.[32] These pre-application conversations help states learn more about what the federal government may be willing to consider, and they give CMS some early indications of what it can expect from the state's waiver submission.

- *The waiver application.* If the state decides to pursue a waiver it will submit a formal waiver application, which is then posted on the CMS website.[33] (As of September 9, 2004, New Hampshire had not submitted its waiver application to CMS.) Some state waiver applications are quite detailed while others have been more general. Often there is little or no discussion of the financing terms in a state's waiver application; alternatively, the application includes the state's initial financing proposal, which often is quite different from the final waiver terms. The real negotiations over financing are typically left to the end of the process.[34]

- *Negotiations.* Once a Section 1115 waiver application is submitted, the state and the federal government begin formal negotiations. In general, the negotiating team is led at the federal level by CMS staff, joined by people from HHS and the OMB. OMB often takes the lead once the negotiations get to the issue of financing. These are all "closed door" negotiations, although a state's governor or members of its Congressional delegation will sometimes intervene with CMS or directly with the Secretary.

- *Public Input.* CMS policy requires states to have some public input *at the state level* with respect to the development of the initial waiver application, but there is no formal process for HHS or CMS to receive and consider public input *at the federal level* once the waiver has been submitted.[35] Stakeholders (e.g., health care provider associations, county associations, and beneficiary groups) sometimes do submit comments and occasionally meet with CMS staff, however. Federal policy or practice does not establish any mechanism for public accounting of the negotiations between the state and federal agency staff, nor does it require state legislative approval before a waiver can be submitted or approved. States may decide on their own to open up the process.

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- *Decision by federal HHS.* Ultimately, the Secretary of HHS either denies or approves the waiver, which may, in the end, look quite different from the original waiver submission. Approval comes in the form of a letter from the Secretary and "terms and conditions" which lay out some of the specifics of the waiver. [36] The appendices to the terms and conditions typically provide the waiver financing provisions. Usually this is the first time the financing terms are shared with the public.

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- *Post waiver oversight and implementation.* Once the waiver is approved, the state does not have to implement the waiver or, unless state law provides otherwise, it can decide to implement only part of the waiver. (If it implements only part of the waiver, it may have to renegotiate the financing terms.) In recent situations where Section 1115 waivers have included coverage expansions and coverage reductions, the reductions, but not all of the expansions have been implemented due to state fiscal pressures.[37] If the state does implement its waiver, it must submit periodic reports to CMS. These include financial reports showing whether the state is keeping its expenditures within the budget neutrality limits.

It comes as no surprise, given the lack of clear guidelines or open process with respect to waiver negotiations, that variations in waiver financing arrangements can be seen from state to state and from one federal administration to another. The imposition of a budget neutrality cap, however, is a constant feature of all Section 1115 waivers, dating back to the Carter Administration. While every state attempts to negotiate financing terms that are as favorable as possible, states often have little leverage in this aspect of the negotiations, and, given the clear federal interest in constraining federal Medicaid spending, this is not a particularly favorable time to be negotiating Section 1115 waiver terms. Moreover, as states push to get the best deal possible, they may be torn between achieving short term advantages versus longer term fiscal protections, and their financial interests are not always aligned with local jurisdictions and other stakeholders who might ultimately bear some of the costs shifted from the federal government.

Notwithstanding variations from waiver to waiver, the imposition of a budget neutrality cap is a constant feature of all Section 1115 waivers, dating back to the Carter Administration.

Conclusion

Much is at stake in the Medicaid restructuring debate. Financing is just one issue, but one that is driving the debate and is likely to affect all other issues. And yet, financing is typically the least understood and least open part of the waiver process. Waivers are negotiated behind closed doors, and the financing terms are typically not disclosed until after the waiver agreement has been announced. In the states with Pharmacy Plus Section 1115 waivers, state legislators and health care providers were largely

Much is at stake in the Medicaid restructuring debate. Financing is just one issue, but one that is driving the debate and is likely to affect all other issues.

unaware of the global cap imposed by those waivers until after the waiver terms and conditions were settled and publicly announced.

New Hampshire faces considerable challenges given the anticipated loss of federal revenues to the state's General Fund, along with a number of budget difficulties compounded by an aging population. In light of these challenges and the health care needs of New Hampshire residents, it is appropriate for the state to consider whether Medicaid program changes are needed. Waivers have a place in Medicaid, and, in some circumstances, they can help states maximize federal funding, target limited resources more effectively, and improve the system for delivering care. A new, broad Section 1115 waiver, however, could shift considerable financial risk onto the state in ways that could trigger unanticipated cutbacks in coverage and harm to state and county finances. As such, it will be important to consider the options, proposals, and ultimately the terms of any proposed waiver agreement carefully with the benefit of data, analysis, and robust public debate.

1 Nationwide, Medicaid covers more than 50 million people and expenditures are projected to reach $305 billion (federal and state dollars) in 2004, compared to Medicare's 41 million beneficiaries and $278 billion expenditures. Congressional Budget Office, Baseline for Medicaid and the State Children's Health Insurance Program, and Medicare, March 2004; total spending for Medicaid is computed off the CBO baseline (which reports federal spending only) by using CBO estimates that nationwide 57 percent of total Medicaid spending is financed with federal funds.

2 Federal matching rates are reported at http://aspe.hhs.gov/search/health/fmap.htm. Some costs are matched at a higher rate. To help states manage higher enrollment during the economic downturn, Congress increased federal Medicaid matching rates by 2.95percent for 18 months under the Tax Equity Act. These higher rates expired at the end of June, 2004.

3 New Hampshire Department of Health and Human Services, Medicaid Modernization Background Information, April 30, 2004.

4 As discussed later in this report, even after the new federal Medicare drug law is implemented, New Hampshire will have to continue to pay for a large share of the cost of providing drug coverage to low-income Medicare beneficiaries as a result of the "clawback" provision written into the new law. A.Schneider, *The "Clawback": State Financing of Medicare Drug Coverage*, Kaiser Commission on Medicaid and the Uninsured, June 2004.

5 As noted above, the basic matching rate in New Hampshire is 50 percent, but some services and activities are matched at higher rates. New Hampshire's matching rate under the State Children's Health Insurance Program is 65 percent. In addition, Medicaid enhancement measures may have reduced the nominal 50 percent matching rate to a lower effective rate.

6 Several studies have estimated the extent to which federal and state spending in Medicaid contributes to state and local economies. Seventeen of these studies are identified and summarized in The Role of Medicaid in State Economies: A Look at the Research, Kaiser Commission on Medicaid and the Uninsured, April 2003.

7 For a discussion of these practices, see, D. Rousseau and A. Schneider, *Current Issues in Medicaid Financing—An Overview of IGTs, UPLs, and DSH*, Kaiser Commission on Medicaid and the Uninsured, April 2004; T. Coughlin, B. Bruen and J. King*, States' Use of Medicaid UPL and DSH Financing Mechanisms in 2001*, Urban Institute, January 2003.

8 Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of CMS-64 data. 2002 is the most recent year for which DSH data for all states is available.

9 Georgetown Health Policy Institute analysis based on March 2003 Current Population Survey, and KCMU and Urban Institute analysis of CMS-64 data.

10 See, Doug Hall, *The NH Budget: Trends through 2003*, New Hampshire Center for Public Policy Studies, February 2003.

11 Testimony of Dennis Smith, Director of the Center of Medicaid and State Operations at the Center for Medicare and Medicaid Services, *Congressional Hearting: Inter-governmental Transfers: Violations of the Federal-State Medicaid Partnership or Legitimate State Budget Tool?*, April, 1 2004, transcript of the proceedings available online: http://www.kaisernetwork.org/health_cast/uploaded_files/040104_houseec_medicaid.pdf.

12 John A. Stephen, Commissioner, *Medicaid Modernization: May-August 2004 Draft Working Plan*, NH Department of Health and Human Ser ices, June 11, 2004; Daniel Barrick, "Medicaid to be reformed. Health commissioner orders a review to correct shortfall," *Concord Monitor*, May 5, 2004; Daniel Barrick, "Stephen faces doubts on Medicaid. Residents concerned change would hurt quality of care," *Concord Monitor*, June 4, 2004; David Irwin, "Medicaid's irreconcilable dispute," *Concord Monitor*, June 13, 2004; Garry Rayno, "Stephen: HHS, Medicaid must change," *Manchester Union Leader*, July 1, 2004.

13 Expansions for groups that could be covered under Medicaid without a waiver do not need an offset. These are considered "pass through" populations since they can result in costs to the federal government without a waiver.

14 CMS, *Guidelines for States Interested in Applying for a HIFA Demonstration*, available online: http://www.cms.hhs.gov/hifa/hifagde.asp.

15 C. Mann, S. Artiga, J. Guyer, *Assessing the Role of Recent Waivers in Providing New Coverage*, Kaiser Commission on Medicaid and the Uninsured, December 2003.

16 CMS, *Guidelines for States Interested in Applying for a HIFA Demonstration*, available online: http://www.cms.hhs.gov/hifa/hifagde.asp; CMS, *Guidance on Proposed (SCHIP) Demonstration Projects Under Section 1115 Authority*, available online: http://www.cms.hhs.gov/schip/sho-letters/ch73100.asp Use of SCHIP funds to cover the cost of childless adults, permitted under the HIFA guidelines, has been questioned by some

members of Congress and the General Accountability Office, *SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals*, January 5, 2004.
17 State of Washington, Section 1115 Application, July 21, 2003;
http://www.cms.hhs.gov/medicaid/1115/wawppprop.pdf.
18 Approval letter to Secretary Dennis Braddock, from Dennis Smith, Acting Administrator for CMS, Special Terms and Conditions.
19 States that solely use DSH funds to finance waiver changes have waiver caps that are set by reference to their available federal DSH funds. See, for example, section 22 of *Special Terms and Conditions, MaineCare for Childless Adults*, available at http://www.cms.hhs.gov/hifa/mecaretc.pdf.
20 CMS, Guidelines for States Interested in Applying for a HIFA Demonstration, available at http://www.cms.hhs.gov/hifa/hifagde.asp.
21 In the case of a waiver that expands coverage to a group of people that the state could not otherwise cover under Medicaid, such as childless adults, the cap is determined without consideration of claims relating to this group of people. For example, if a waiver covers one million parents (who can be covered under the program without a waiver) and 500,000 childless adults, the state can submit claims relating to the expenses of both groups of adults, but overall it cannot claim more federal funds than an amount determined by multiplying the per person cap times the number of parents enrolled. To ensure "budget neutrality," the so-called "expansion group" has to be financed within the funds allocated just for the parent group.
22 J. Guyer, *Bush Administration Medicaid/SCHIP Proposal*, Kaiser Commission on Medicaid and the Uninsured, May 2003; C. Mann, M. Nathanson, E. Park, *Administration's Medicaid Proposal Would Shift Fiscal Risks to States*, Center on Budget and Policy Priorities and Georgetown University Health Policy Institute, April 2003. The National Governors Association did not end up endorsing the proposal, but the Administration has continued to press this approach to Medicaid reform, *Budget of the US Government, Fiscal Year 2005*, Office of Management and Budget, p. 148-149.
23 2001 CMS MSIS data for New Hampshire.
24 For these calculations, the same set of assumptions and data relied on for the calculations of the potential impact of a global cap were used; per person amounts were calculated based the number of beneficiaries served in New Hampshire's program on New Hampshire 2001 MSIS data.
25 D. Cauchi, *State Employee Health Benefits - Monthly Premium Costs*, National Conference of State Legislators, June 2004. Available online: http://64.82.65.67/health/StateEmpl-healthpremiums04.xls.
26 Georgetown Health Policy Institute analysis based on CMS MSIS 2001 data for 48 states plus the District of Columbia. Excludes Hawaii and Washington, who have not submitted data to CMS. Also excludes enrollment and expenditure data for Family Planning waivers. The MSIS data for Maine has an unexplained and very sharp jump in enrollment for the elderly which may not accurately reflect actual enrollment patterns. The data is not included in this analysis.
27 These calculations are based on MSIS data for 2001, the most recent year for which expenditure and enrollment data are available by group.
28 2003 data from Georgetown University Health Policy Institute analysis based on March 2003 Current Population Survey. 2004-2013 projections from Center on Budget and Policy Priorities analyses of US Census Bureau Detailed State Projections, March 2003
29 John A. Stephen, Commissioner, *Medicaid Modernization May-August 2004 Draft Working Plan*, NH Department of Health and Human Services, June 11, 2004. Data are from New Hampshire Office of State Planning, Population Projections. Available online: http://www.epa.gov/ttn/naaqs/ozone/areas/pop/popp_nh.pdf.
30 A. Schneider, *The "Clawback: State Financing of Medicare Drug Coverage*, Kaiser Commission on Medicaid and the Uninsured, June 2004; Issues Surrounding the Medicare Drug Clawback, Federal Funds Information for States, July 7, 2004.
31 B. Bruen B and J. Holahan, *Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government*, Kaiser Commission on Medicaid and the Uninsured, November 2003. Some 19,000, or 93 percent, of New Hampshire's 20,000 dual eligible beneficiaries are "full duals"—only "full duals" receive drug benefits through Medicaid.
32 See, http://www.cms.hhs.gov/medicaid/1115/gensteps.asp
33 See http://www.cms.hhs.gov/medicaid/waivers/waivermap.asp.
34 Applications and terms and conditions can be reviewed and compared; they are posted on the CMS website; http://www.cms.hhs.gov/medicaid/waivers/waivermap.asp.

35 Dennis Smith letter to State Medicaid Directors. Public Input to Comprehensive 1115 Waivers, Home and Community-Based Service Waivers and Managed Care Waivers Process, Centers for Medicare and Medicaid Services, May 3, 2002.
36 The terms and conditions require the state to submit "Operational Protocols" to set forth more of the details of how the waiver program will operate. These protocols can cover important aspects of the waiver, including the specifics around cost sharing or benefit limitations. In general, a state must submit these protocols 90 days before the waiver is implemented and have to be approved by the federal agency (although sometimes they are not approved before the waiver is implemented). There is no federal requirement that these protocols be submitted to the public for comment before submission to the federal agency or approval by CMS. Terms and conditions and sometimes operational protocols are available on the CMS waiver website.
37 See for example, Cindy Mann and S. Artiga, *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program*, Kaiser Commission on Medicaid and the Uninsured, June 2004.