

medicaid
and the **uninsured**

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**VERMONT'S GLOBAL COMMITMENT WAIVER:
IMPLICATIONS FOR THE MEDICAID PROGRAM**

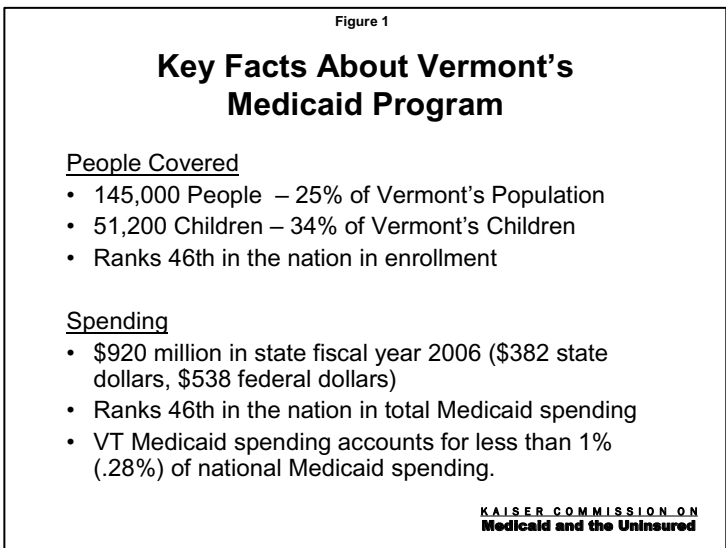
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EXECUTIVE SUMMARY

In the fall of 2005, Vermont secured approval for a Section 1115 Medicaid waiver, known as the “Global Commitment waiver,” that allows it to fundamentally restructure its Medicaid program. The waiver imposes a cap on the amount of federal Medicaid funding available to Vermont to provide acute care services to its Medicaid population. In combination with a second, long-term care waiver, the Global Commitment waiver makes Vermont the only state in the nation facing a fixed dollar limit on the amount of federal funding available for its Medicaid program. In exchange for taking on the risk of operating under a capped funding arrangement, the waiver allows Vermont to use federal Medicaid funds to refinance a broad array of its own, non-Medicaid health programs, creating a fiscal windfall for the state. It also gives Vermont new flexibility to reduce benefits, increase cost sharing, and cap enrollment for many Medicaid beneficiaries.

The state has articulated that the goals of the waiver are to: 1) provide the state with financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services; 2) continue to lead the nation in exploring new ways to reduce the number of uninsured citizens; and 3) foster innovation in health care by focusing on health care outcomes. Governor Douglas also cited state fiscal problems and the desire for more flexibility to change the Medicaid program without federal review.

Despite the small size of Vermont’s Medicaid program (Figure 1), the Global Commitment waiver is being watched by policymakers across the country because it contains some of the key elements of a block grant—capped federal funding and elimination of some federal standards governing benefits, cost sharing, and the entitlement to coverage for many beneficiaries. Due to unique circumstances in Vermont, however, it is not clear that the Global Commitment waiver will provide a useful guide for evaluating the impact of a block grant as an alternative to Medicaid’s current financing structure. Most notably, the funding cap for the Global Commitment waiver is set at a relatively generous level, raising the prospect that the waiver may result in additional costs to the federal government. In contrast, recent proposals to change Medicaid financing to a block grant have been designed to reduce or, at a minimum, hold constant federal Medicaid spending.



Basic Structure of the Waiver

There are four key elements to the Global Commitment waiver. First, the waiver imposes a global cap that limits the state to drawing down federal Medicaid matching funds on no more than a total of \$4.7 billion in Medicaid spending for acute care services over a five-year period. The cap appears to be relatively generous, allowing the state to spend more than the \$4.2 billion it estimates it needs to operate its Medicaid acute care program (hereafter, “the Medicaid program”). If, however, Vermont reaches the \$4.7 billion cap, it will not receive any additional assistance from the federal government for Medicaid costs. This is a marked contrast to the regular Medicaid financing structure, which provides states with guaranteed federal Medicaid matching funds for all Medicaid services provided to Medicaid beneficiaries with no set limits.

Second, the waiver allows the state to establish itself as a managed care company. As such, it will pay itself a premium for each beneficiary that it serves. If the state can deliver care for less than the premium revenue, it can use the “excess” revenue for a broad array of purposes. Within limits, the state controls the amount it pays itself, which means it can ensure that “excess” premium revenue arises by paying (with the assistance of federal matching funds) more than needed to operate its Medicaid program.

Third, the waiver provides Vermont with new flexibility to use federal Medicaid funds for non-Medicaid health programs. Through the “excess” premium revenue, Vermont can replace some of its own spending on various state-funded health care initiatives. The state already has identified 50 different state-funded programs for which it may be able to use the excess premium revenue, including tobacco cessation programs, domestic violence initiatives, and the state’s medical school and public laboratory. According to fall 2005 estimates prepared jointly by the administrative and legislative branches of government in Vermont, the state anticipates being able to secure up to \$335 million in new federal Medicaid matching funds under the waiver that it does not need to provide care to Medicaid beneficiaries. Instead, it can use these “extra” federal funds for fiscal relief or to expand non-Medicaid health initiatives.

Finally, the waiver gives Vermont new flexibility to reduce benefits, increase cost sharing, and limit enrollment or set up waiting lists for most of the “optional” and “expansion” populations in the state (i.e., groups the state covers at its option with the assistance of federal Medicaid funds). These populations include many children and parents in low-income working families and all other adults who are not disabled or elderly covered by the Vermont Medicaid program. Under the Global Commitment waiver, the federal government has given the state significant authority to decide if and when it will impose reductions or cost sharing increases. For example, the state can reduce the benefits of optional and expansion populations by as much as 5 percent over the life of the waiver or impose substantial new cost sharing on them without further CMS review.

Key Implications of the Waiver

- **By capping federal funding, the waiver shifts financial risk to the state.** Even though it appears that the Global Commitment waiver primarily offers fiscal relief to Vermont, it also places the state at fiscal risk for costs in excess of the global cap. If the state were to reach its cap, Vermont would need to choose between cutting back on Medicaid coverage, reducing its use of Medicaid funds for non-Medicaid health initiatives and fiscal relief, or using 100

percent state funds to cover excess costs. Even if Vermont does not reach its cap in the short term, the cap may be binding over a longer time period for which it is even more difficult to predict health care costs or enrollment increases. There also is a risk that federal policymakers will raise questions about CMS allowing the state to use federal Medicaid funds for fiscal relief and other non-Medicaid purposes.

- **The waiver may pose a risk to Medicaid beneficiaries.** In the short-term, the state has no plans to use its new authority to cut back on coverage, nor is the state’s decision to become a managed care organization expected to have a notable impact on the way that care is delivered. If, however, the state reaches its funding cap, it will no longer be able to share the burden of additional costs with the federal government, making it more likely that the state will use its authority to cut back on coverage for beneficiaries. For its optional and expansion beneficiaries, it can establish waiting lists, reduce benefits, or increase cost sharing beyond what is allowed under federal standards. Unlike in a traditional Medicaid program, beneficiaries also may find themselves competing for Medicaid matching funds with broad-based public health initiatives, the state’s medical school, or numerous other stakeholders that could receive Medicaid funds under the Global Commitment waiver.
- **Vermont’s experience may not serve as a useful guide for understanding the implications of capping federal Medicaid funding.** Because of the unique circumstances of Vermont’s waiver, including the expansiveness of its existing Medicaid program, lower uninsured rates, and the apparent generosity of its global funding cap, the state may have different experiences than might emerge in capped federal funding arrangements in other contexts. Other experience with block grants has shown that spending for capped programs can fall short of need and that these financing arrangements are not flexible enough to respond to emergencies or enrollment changes.¹ For example, funding for the AIDS Drug Assistance Partnership (ADAP) program often runs short, causing states to establish waiting lists for low-income HIV or AIDS patients in need of life-saving medications.²
- **The precedents set in the Vermont waiver could pose greater risks if adopted in other states.** As a small state that was willing to set the precedent of accepting an aggregate cap on federal Medicaid funds, Vermont secured a relatively generous financing arrangement and significant fiscal relief. It is unlikely that other states would fare as well given the potential costs to the federal government. For example, if federal Medicaid spending were to grow nationwide at the same rate as allowed in Vermont (instead of at currently projected levels), it would cost the federal government an additional \$105 billion over five years and a third of a trillion dollars over ten years. Also, Vermont already covers close to one in four of its citizens and over a third of its children. As such, it is less likely than other states to take on a major new expansion or to experience a significant jump in enrollment, reducing its risk relative to other states of reaching a global funding cap. If other states were to seek similar waivers, they would likely receive more limited financing, making it more likely that they would fall short of federal funding and face pressure to reduce coverage.

Conclusion

The Vermont Global Commitment waiver will be watched by policymakers around the country who will be interested in the consequences of capping federal Medicaid funding and eliminating some federal standards governing Medicaid coverage. Although the waiver does pose some risk to the State of Vermont and its Medicaid beneficiaries, the state has secured a relatively generous cap that reduces its chances of running out of federal Medicaid funding. Further, it already covers a far greater share of its population than most other states, and a number of its state policymakers have committed to not using the waiver as a means for cutting back on coverage for beneficiaries. These unique circumstances reduce the risk to Vermont of the waiver, but also raise the possibility that Vermont's experiences will create a misleading guide to the implications of capping federal Medicaid funding. If adopted in other states, the concepts in the Global Commitment waiver could pose greater risks, as other states are likely to receive more limited financing arrangements and, thus, may be more likely to face fiscal pressures to reduce coverage.

INTRODUCTION

In the fall of 2005, Vermont secured approval of a waiver from the federal government that allows it to dramatically shift the way it operates its Medicaid program. The Section 1115 Medicaid waiver, known as the “Global Commitment” waiver, imposes a cap on the amount of federal Medicaid funding available to the state to provide acute care services in exchange for providing it with more flexibility over its program. This new flexibility allows Vermont to use some of its federal Medicaid funds for state fiscal relief and a broad array of non-Medicaid health initiatives and gives the state new options to reduce Medicaid benefits, increase cost sharing, and cap enrollment for many beneficiaries. In combination with a second, long-term care waiver, the Global Commitment waiver makes Vermont the only state in the nation operating its Medicaid program under a fixed dollar limit on the amount of federal Medicaid funding available to pay for the health and long-term care services of Medicaid beneficiaries.

This issue brief 1) provides some general background on Vermont’s Medicaid program and the Global Commitment waiver; 2) answers a series of key questions about how it is designed to work; and 3) discusses the potential implications for the state of Vermont, beneficiaries, and the Medicaid program.

BACKGROUND

Vermont’s Medicaid Program

From a national perspective, Vermont’s Medicaid program is small, accounting for less than one percent (.28 percent) of all Medicaid spending nationwide. Nevertheless, it has long been watched by policymakers around the country as a program that sets trends, particularly among states with a strong commitment to providing and expanding health insurance. The state has one of the most expansive programs in the country, covering close to one in four adults and more than one in three of the state’s children.

Even prior to the Global Commitment waiver, the state operated much of its Medicaid program under a Medicaid waiver known as the Vermont Health Access Program (VHAP). VHAP often is described as providing coverage to three different groups:

- **“Mandatory populations,”** which consist of people the state is required to cover under federal law, including children with income below 100 percent of the federal poverty level or “FPL” (below 133 percent FPL if they are under age six);
- **“Optional populations,”** which consist of people who can be covered at state option under federal law; in Vermont, they include children in low-income working families and parents with income above mandatory coverage levels; and an
- **“Expansion population,”** which consists of people for whom federal Medicaid matching funds are not available in the absence of a waiver, primarily non-disabled childless adults under the age of 65 with income below 185 percent of FPL.

The Global Commitment Waiver: An Overview

The “Global Commitment” waiver is a Section 1115 Medicaid waiver that the federal government approved for the State of Vermont on September 27th, 2005 to operate its acute care program. (For the remainder of this brief, the phrases “Medicaid program” and “Medicaid spending” refer to the state’s acute care program unless otherwise noted. Acute care spending accounts for 75 percent of total Medicaid spending in the state.)³ The waiver allows Vermont to deviate from traditional federal Medicaid law and regulations in the following key ways:

- **Imposes a global cap on federal funds.** The waiver includes a global cap that limits the state to drawing down federal Medicaid matching funds on no more than \$4.7 billion in total Medicaid spending over a five-year period. (If Vermont’s matching rate were to average 58 percent over the next 5 years, the amount of federal matching funds available over this period would be \$2.7 billion (\$4.7 billion x 0.58)). The cap appears to be relatively generous, allowing the state to spend more than the \$4.2 billion it estimates it needs to operate its Medicaid program. If, however, the state reaches the cap due to unexpectedly high Medicaid spending or its spending on non-Medicaid activities, it cannot receive any additional assistance from the federal government. This is a marked contrast to the regular Medicaid financing structure, which provides states with guaranteed federal Medicaid matching funds for all Medicaid services provided to Medicaid beneficiaries without limits.
- **Establishes the state as a managed care organization.** The waiver allows the state to establish itself as a managed care organization and to pay itself a premium for each beneficiary that it serves. If the state can deliver care for less than it pays itself in premiums, it can use the “excess” premium revenue for a broad array of non-Medicaid purposes. Within limits, the state controls the amount it pays itself, which means it can ensure that “excess” premium revenue arises by paying itself (with the assistance of federal matching funds) more than it needs to deliver care.
- **Allows the state to use federal Medicaid funds for state fiscal relief and non-Medicaid health programs.** By tapping any “excess” premium revenue that is available, Vermont can use some federal Medicaid funds to replace its own spending on various state-funded health care programs and initiatives, generating fiscal relief for the state. The state has developed a list of 50 state-funded programs for which it may be able to replace some state funds with federal Medicaid matching funds, including tobacco cessation programs, a domestic violence initiative, and the state’s public health laboratory.
- **New flexibility to cut back on coverage.** The waiver gives Vermont new flexibility to reduce benefits; increase cost sharing; and limit enrollment for its optional and expansion populations within some limits. Currently, the state does not have plans to use the new flexibility to reduce coverage, but the financing structure of the waiver may create new fiscal incentives for it to do so in the future.

Purpose of the Global Commitment Waiver

In explaining the reasons for seeking the waiver, Governor Douglas cited state fiscal problems and the desire for more flexibility to change the Medicaid program without federal review. As summarized in the state's fact sheet on the waiver, the goals of the waiver are to: 1) provide the state with financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services; 2) continue to lead the nation in exploring new ways to reduce the number of uninsured citizens; and 3) foster innovation in health care by focusing on health care outcomes.⁴ As explained in more detail later, the waiver also was pursued because the state needed to find a way to sustain federal financing of its existing waiver, the Vermont Health Assistance Plan (VHAP).

From the federal government's perspective, the stated purpose of the waiver is for Vermont to "demonstrate its ability to promote universal access to health care, cost containment, and improved quality of care."⁵ The waiver, however, does not require Vermont to cover new people. By providing the state with authority to limit enrollment of optional and expansion populations into its Medicaid program and capping federal financing, the waiver makes it difficult for the state to use Medicaid as the vehicle for expanding coverage and could contribute to people losing Medicaid coverage. The waiver does create a short-term fiscal windfall for the state which could potentially be used for coverage expansions, but Governor Douglas has argued against a legislative plan to expand coverage using these funds, describing them as "unsustainable."⁶

Debate Over the Global Commitment Waiver

Governor Douglas of Vermont first broadly announced his intention to pursue fundamental changes to the state's Medicaid program in his State of the Union address in January of 2005. Vermont's state legislature was actively involved in reviewing and approving the waiver proposal throughout 2005. As part of its review, the Legislative Joint Fiscal Committee commissioned a report on the waiver from a private consulting firm, Health Management Associates (HMA).⁷ The HMA report concluded that the Global Commitment waiver was likely to provide substantial fiscal relief to the state at relatively little risk. After receiving the report, the Joint Fiscal Committee granted approval for the waiver to begin on October 1, 2005, contingent on additional information and assurances from the state's Medicaid agency and other parties.⁸ The Joint Fiscal Committee eventually gave final approval on December 13, 2005. Two days later, on December 15, 2005, Vermont's Agency of Human Services sent a letter to the federal Department of Health and Human Services formally accepting the terms and conditions of the waiver.

Implementation Plans

Although final, formal notification that Vermont had accepted the terms and conditions of the waiver did not occur until December 15, 2005, the state has been retroactively operating under the Global Commitment financing structure since October 1, 2005. State policymakers pushed for as early an implementation of the financing aspects of the waiver as possible because of the fiscal relief it generates for the state, as much as \$500,000 to \$1 million per week.⁹

The state, however, did not implement any delivery system changes on October 1, 2005. The changes to the Medicaid delivery system under the waiver are modest, making their implementation a relatively minor issue. On implementation dates for delivery system changes, the state has said that it will make changes to ensure that the state meets the standards of a managed care organization on “various dates,” as well as that it will submit an evaluation plan to CMS in early spring of 2006.

Although not designed exclusively for its Medicaid population, the state also is moving forward with a variety of initiatives, such as a population-based chronic care initiative aimed at standardizing the treatment of people with various, serious health conditions, that could affect the cost of providing care to Medicaid beneficiaries.

KEY QUESTIONS AND ANSWERS

1. How does the Global Commitment waiver change Vermont’s system for financing its health care system?

Under regular Medicaid program rules, the states and the federal government share the cost of financing care for Medicaid beneficiaries under an open-ended matching rate system. The federal government reimburses each state a share of any Medicaid costs it incurs based on a statutory formula recalculated each year. This share or “matching rate” currently is 58 percent in Vermont, which means that—in the absence of a waiver—the federal government would pick up 58 percent of the state’s spending on Medicaid-approved services for Medicaid beneficiaries. Under Medicaid rules, there is no upper limit on the amount of Medicaid matching funds that the federal government will provide to a state. The federal government and the states share the cost of any increases in Medicaid spending due to increases in enrollment or the cost of providing care; they also share the fiscal relief if Medicaid spending grows more slowly than expected.¹⁰

Section 1115 Medicaid waivers are intended to allow states to experiment with alternative ways of operating their Medicaid programs by disregarding some of the federal rules that otherwise govern the program. Historically, Section 1115 Medicaid waivers have been used by many states, including Vermont, to expand coverage to groups of people who cannot be covered with federal Medicaid matching funds under “regular” rules, such as adults without children. More recently, they have been used by some states to cut back on the coverage provided to Medicaid beneficiaries.¹¹

Under longstanding practice, the federal government requires all Medicaid 1115 waivers to be “budget neutral,” which means that a waiver is not supposed to cause federal Medicaid spending to increase above what it would be in the absence of the waiver. To enforce budget neutrality in Medicaid 1115 waivers, the federal government uses an array of strategies, most of which entail imposing some kind of cap on the federal Medicaid funding the state can draw down during the course of the waiver. In most cases, it relies on a “per capita cap,” which imposes a limit on the maximum amount of Medicaid spending the federal government will match for each beneficiary on the program. Such caps put states at risk of running out of federal Medicaid matching funds if the per person cost of providing care exceeds expectations, but states can still get additional federal Medicaid funds if they experience an increase in the number of people who are enrolled in Medicaid.

Prior to the Global Commitment waiver, Vermont used a combination of the traditional Medicaid financing structure (i.e., state spending was matched by the federal government as needed) and of waiver financing under its earlier VHAP waiver. VHAP was implemented in 1995 and allowed the state to expand coverage to uninsured adults with incomes below 150 percent of the federal poverty line (later raised to 185 percent). Vermont financed the VHAP expansion with savings generated from implementing Medicaid managed care and agreed to a per capita cap under the waiver.

The Global Commitment waiver fundamentally alters the way that Vermont finances its health care system. It changes both the nature of the federal government’s commitment to financing Medicaid, as well as opens up opportunities for the state to use federal Medicaid funds to pay for non-Medicaid parts of its health care system. The changes include a global cap that places an overall limit on federal funds the state can receive; a premium-based financing structure; and new flexibility to use Medicaid funds for non-Medicaid purposes. Each of these financing elements is discussed in more detail below.

2. What is Vermont’s “global cap”?

The global cap is a limit on the total amount of Medicaid spending for acute care services for which the federal government will provide matching funds to the state of Vermont over the next five years.¹² A second waiver limits the amount of federal funding available for long-term care services (see Appendix A for details on the long-term care waiver). The limit is set at \$4.7 billion in total Medicaid spending for fiscal year 2006 through fiscal year 2010. Unlike under the regular Medicaid financing system, the federal government will not match more than \$4.7 billion in total Medicaid spending on acute care services over the next five years. If the state’s matching rate remains at 58 percent, this means the federal government will provide the state with no more than \$2.7 billion in federal Medicaid funding.

Under budget neutrality requirements, the global cap is supposed to reflect the amount that federal and state officials believe the state of Vermont would have spent on its Medicaid program in the absence of securing a waiver from the federal government. In reality, this amount (often referred to as the “without waiver” baseline) is unknowable. The \$4.7 billion figure reflects the product of closed negotiations between the federal government and the state.

To date, the state of Vermont and the federal government have declined to make public any detailed information about how the \$4.7 billion figure was reached. The state’s Medicaid Director, however, has said in interviews and public presentations that it was generated by taking the state’s fiscal year 2004 spending on services affected by the waiver and trending it forward at a 9 percent annual growth rate to generate an estimate of the total amount that state would spend in federal fiscal years 2006 – 2010 on acute care services for its mandatory and optional Medicaid populations. In addition, the state won the opportunity to increase its overall cap by \$66.6 million to reflect the amount of “surplus” or “unused” federal Medicaid funds that were left over from its earlier VHAP Medicaid 1115 waiver.¹³

The lack of detailed information on how the cap was established means that a number of questions remain unanswered. For example, it is not clear why the Global Commitment cap is

set at \$4.7 billion even though the state’s projections indicate that it needs only \$4.2 billion to operate its current Medicaid program.¹⁴ The \$500 million gap between what current projections suggest is needed versus what the state is allowed to spend raises the question of whether the waiver will be “budget neutral” to the federal government. The state’s view is that the waiver should be considered budget neutral if it ultimately succeeds in holding Vermont’s Medicaid growth rate to the same or lower levels than other states.¹⁵ Its expectation is that Vermont’s investments in population-based efforts to address chronic health care initiatives will allow it to reduce Medicaid spending growth relative to other states even with the state using some federal Medicaid funds for non-Medicaid purposes. Federal policymakers, however, may have a different perspective because even if Vermont holds its Medicaid spending growth to the same level as other states, the federal government may still end up spending more on Medicaid in Vermont than it would have in the absence of the Global Commitment waiver.

3. What happens if Vermont reaches its global funding cap?

Currently, the \$4.7 billion appears to be more than enough for Vermont to continue operating its Medicaid program in its existing form. Nevertheless, Vermont could reach its global funding cap if 1) Medicaid costs are higher than expected due either to enrollment or health care cost pressures; or 2) the use of Medicaid funds for non-Medicaid activities leaves insufficient funds to cover Medicaid costs. If Vermont appears to be reaching its global funding cap, it has the following options:

- **Use state dollars.** The state can use money from its general revenue fund or other sources to finance Medicaid spending in excess of \$4.7 billion. It, however, would need to do so without the benefit of federal Medicaid matching funds.
- **Cut back on Medicaid coverage.** The state can use the flexibility provided to it under the waiver or standard Medicaid rules to cut back on Medicaid spending. For example, it could establish waiting lists or simply shut down enrollment for optional or expansion populations; reduce benefits; increase cost sharing; or reduce provider payments. Vermont law would require the state’s legislature to approve many of these changes.
- **Reduce spending on non-Medicaid activities.** If, as planned, the state has diverted Medicaid funds to non-Medicaid activities, the state could reverse course. In doing so, however, it would need to be willing to forego any fiscal relief it had gained by refinancing existing state-funded programs with federal Medicaid dollars. Or, if it has used the Medicaid funds to expand existing state-funded programs or adopt new ones (instead of solely for fiscal relief), it would need to weigh the relative merits of maintaining Medicaid coverage or the new non-Medicaid activities.

The waiver appears to leave it to the state to decide which of these options to adopt. For example, the waiver terms and conditions do not ban Vermont from diverting federal Medicaid funds to non-Medicaid initiatives even as it effectively cuts back on coverage for Medicaid beneficiaries.¹⁶ (It, however, is possible that Vermont would be limited from doing so by a requirement, discussed in Question 4, that the premiums it pays to itself be “actuarially sound.”)

Vermont officials have argued that in the face of higher-than-expected Medicaid spending, the state would need to cut back on coverage to conserve state funds even in the absence of the funding cap. The cap, however, increases the fiscal pressures that the state may face to cut back on coverage. In the absence of the cap, the state would pay less than half (42 percent) of any unexpectedly high Medicaid expenses. If, however, it reaches its cap, the state must pay 100 percent of any unexpectedly high costs, creating far more powerful fiscal incentives to cut back on coverage.¹⁷

4. What is the premium-based financing structure that Vermont is adopting?

The waiver allows Vermont to use a “premium-based” financing structure for the bulk of its Medicaid program. Under this structure, the state will operate as a public managed care company for delivering services to Medicaid beneficiaries and pay itself premiums for the beneficiaries it serves. Specifically, the Agency of Human Services will pay a lump sum premium to the Office of Vermont Health Access (OVHA) each month to provide acute care to the state’s Medicaid beneficiaries.¹⁸ For federal fiscal year 2006, the size of this monthly lump sum premium payment is set at \$65.4 million. Of this amount, the federal government will reimburse the state for \$37.9 million of this cost (\$65.4 million x .58).

The move to a premium-based financing structure is not expected to have significant implications for the way the state of Vermont delivers care to Medicaid beneficiaries, particularly in the short term. The Medicaid Director has said that people will experience little or no change in the way that they secure care. The state does need to ensure that OVHA meets the requirements for a Medicaid managed care organization, such as requirements governing people’s access to information about their benefits, interpreter services, a single grievance and appeal process, and quality assurance activities.¹⁹ But, the state already operates a primary care case management program for many of its Medicaid beneficiaries and, thus, meets many of these Medicaid managed care requirements.²⁰

The most important implication of Vermont’s decision to move to a premium-based financing structure is the opportunity to use “excess” premium revenue for fiscal relief. To the extent the premiums that OVHA receives are more than the cost of providing care to Medicaid beneficiaries, the state can use the “excess” premium revenue for a broad range of activities. Specifically, the state can use it for:

- (1) reducing the rate of uninsured or underinsured;
- (2) increasing access to quality health care for Medicaid beneficiaries, uninsured, and underinsured;
- (3) providing “public health approaches to improve the health outcomes and quality of life” for Medicaid eligibles, uninsured, and underinsured; or
- (4) encouraging the formation and maintenance of “public-private partnerships in health care.”

The state has identified 50 state programs for which it could potentially use its excess premium revenue to replace existing state spending. These include numerous mental health and substance

abuse programs, community-based treatment for sex offenders, domestic violence programs, tobacco cessation efforts, emergency medical services, newborn screening, funding for school nurses, and funds for Vermont educational institutions, such as the state medical school, that train health care and dental providers.²¹ The decision to allow Vermont to use its excess premium revenue to *replace* existing state spending on non-Medicaid programs is notable. In the past, CMS generally has allowed states to use savings that they generate under Medicaid 1115 waivers to *expand* existing state-funded programs.²² The opportunity to replace existing state spending with federal Medicaid matching funds is the source of the fiscal relief for the state generated by the Global Commitment waiver.

Since the state of Vermont can use “excess” premium revenue for a broad array of state health programs, it has an incentive to “overpay” OVHA to deliver care to Medicaid beneficiaries. The larger the gap between the premium revenue it receives and the actual cost of providing care, the more excess revenue that OVHA accumulates. However, there are some limits on the amount that Vermont can or would overpay:

- **Global funding cap.** The amount by which Vermont can overpay itself is limited by the global cap on federal funding – the cumulative amount that OVHA receives in premium revenue cannot exceed \$4.7 billion over the five-year life of the waiver.
- **Requirement that premium payments be “actuarially sound.”** Medicaid managed care regulations require that premiums paid to managed care organizations annually be certified as “actuarially sound” by an actuary. The original intent of these requirements was to prevent state Medicaid programs from underpaying private managed care companies. In the Vermont, context, however, they potentially could limit the extent to which the state overpays itself. As of yet, it is not clear whether the actuarial soundness requirement will serve this function. In the Health Management Associates report prepared for the Vermont legislature on the Global Commitment waiver, it was noted that Medicaid rules allow actuarially sound rates to include administrative costs and profits that are not applicable to the state of Vermont, creating the opportunity to inflate the rates beyond what Vermont needs to provide care.²³

In the long-run, the actuarially sound requirement could create difficulties for the state’s efforts to use the waiver for fiscal relief. If Vermont reduces benefits or increases cost sharing, the state’s actuary firm presumably would need to lower the acceptable range of premiums that the state can pay to itself in future years, reflecting the narrower scope of coverage that it is providing. However, many details remain unclear about how the “actuarially sound” requirement will work in practice. For example, it is not clear to what extent the actuarial firm will allow Vermont’s rates to stay higher than strictly needed to provide care if the state has operated a chronic care program or other public health initiatives that might have reduced cost growth.²⁴

The state also must come up with the state share of premium payments, which may also serve as a break on the extent to which it can overpay itself. The task, however, is made easier because the state effectively can use its existing spending on many non-Medicaid health activities for state match. Specifically, the state can transfer funds from the 50 existing state programs discussed above to help finance the Agency for Health Services’ initial premium payments to

OVHA. The federal government will “match” these premium payments at a rate of 58 percent. If, as expected, OVHA’s premium revenue exceeds the amount it needs to care for Medicaid beneficiaries, it can use the “excess” to return the transferred funds to the existing state programs, holding them harmless for their initial contributions. It also can provide them with the federal Medicaid matching dollars generated by their initial contributions, allowing the state to reduce their appropriations and generate fiscal relief.²⁵

5. How much additional federal Medicaid funding does Vermont anticipate receiving under the Global Commitment waiver?

During debate over the Global Commitment waiver, state agency staff urged the Legislature to act expeditiously on the grounds that the state lost between \$500,000 and \$1 million each week that it delayed implementing the waiver.²⁶ It is difficult to come by more detailed information, but estimates prepared by the Joint Fiscal Office of the Vermont legislature in the fall of 2005 provide some insight. They indicate that the state has identified some \$255.8 million in projected state spending on non-Medicaid programs that they can use to generate federal Medicaid matching funds under the Global Commitment waiver. Given the state’s Medicaid matching rate of 42 percent, these state funds can be expected to generate as much as \$365.5 million in federal Medicaid funds over the five-year life of the waiver.²⁷ (See Question 4 for a detailed description of the way that existing state spending on non-Medicaid activities can be used to generate fiscal relief.)

To put the \$365.5 million in context, the cost of operating the state’s existing acute care Medicaid program (including the cost of providing coverage to optional and expansion populations) is projected to be \$4.181 billion over the five-year life of the waiver. Of this amount, the federal government would be expected to pay for \$2.5 billion under the regular Medicaid matching rate structure. If the state can, in fact, draw down an additional \$365.5 million in federal Medicaid funds over the five-year life of the waiver, it would represent a 15 percent increase over the \$2.5 billion that the federal government would spend if it simply paid for 58 percent of Vermont’s Medicaid program, as called for under the regular Medicaid financing structure.

6. What new authority does the state have over benefits, cost sharing and enrollment?

The Global Commitment waiver gives the state broad new authority to change the benefits and cost sharing it applies to many of its Medicaid beneficiaries, particularly its “optional” and “expansion” populations. For these groups, the state has the following options:

- **Benefits.** Without CMS review, Vermont can reduce (or increase) the value of the benefits provided to optional and expansion populations by as much as 5 percent over the life of the waver. With CMS review, the state can further reduce or increase benefits.
- **Cost sharing.** Without CMS review, the state can increase premiums or co-payments for optional and expansion populations as long as it ensures beneficiaries’ total charges do not exceed five percent of a family’s gross income.

- **Enrollment.** With CMS approval, the state may eliminate eligibility or cap enrollment for the optional and expansion populations.

For people that must be covered under federal law (i.e., “mandatory populations”), the waiver requires the state to continue their eligibility for coverage and to meet federal cost sharing standards. With CMS approval, however, it can reduce their benefit packages.²⁸

As a result of Vermont policies (as opposed to the federal terms and conditions of the waiver), Vermont’s legislature must approve changes to eligibility or benefits.²⁹

The flexibility provided to Vermont under the Global Commitment waiver goes beyond what Congress recently provided in the Deficit Reduction Act (DRA). Specifically, it allows Vermont to impose cost sharing and benefit cuts on populations that are exempt from such changes under the DRA. For example, the waiver allows Vermont to impose cost sharing set at up to 5 percent of income on optional parents with income below the poverty line (i.e., parents between 72 percent of poverty and 100 percent), a group that is exempt from all but nominal cost sharing under the DRA.³⁰

7. What are the plans to evaluate the waiver?

Section 1115 Medicaid waivers are intended to be research and demonstration programs that are evaluated to provide federal and state policymakers with information on the impact of changes implemented through waivers. Vermont is required to conduct an evaluation of the Global Commitment waiver during the five-year life of the project. CMS and the state, however, did not agree to evaluation plans prior to the approval and implementation of the waiver. Instead, the state of Vermont intends to develop its plans for evaluating the Global Commitment waiver in the early spring of 2006. The state’s Medicaid Director, however, has indicated that this timeframe may slip because the agency has been occupied addressing issues arising as a result of the new Medicare prescription drug benefit.³¹

KEY IMPLICATIONS

The Global Commitment waiver fundamentally alters the financing structure of the program; allows the state to use Medicaid funds for a broad, new range of activities; and gives the state more authority to cut back on coverage. The potential implications of these changes for key stakeholders are discussed below.

For the State of Vermont

In the short-term, the Global Commitment waiver is expected to provide the State of Vermont with additional federal Medicaid funds that it can use for a wide variety of purposes, including fiscal relief. Indeed, the state’s legislature appears to have agreed to the waiver in no small part because it is expected to help alleviate a Medicaid funding shortfall, estimated in January of 2006 at \$60 million in state fiscal year 2007 and at \$370 million over five years. In the long-run, however, the cap on funding may pose a fiscal risk for the state. Even though it now appears unlikely that the state will reach its funding cap during its initial five-year waiver period due to Medicaid costs, the state’s projections could turn out to be erroneous. It also could end up

reaching the cap due to spending on non-Medicaid activities. If it appears close to reaching the cap, the state can cut back on non-Medicaid spending or on Medicaid spending by reducing benefits, increasing cost sharing, and/or capping enrollment.

There also is a risk to the state that its financing arrangement could be disrupted, either because federal policymakers raise questions about the extra federal funds flowing to Vermont under the initial Global Commitment waiver or because the premium rates that it pays itself are eventually deemed excessive by its actuarial firm.

Finally, over the longer term, most states continue demonstration waivers beyond the initial five year period. It is unclear if Vermont would be able to negotiate such a generous federal cap after its Global Commitment waiver ends, creating more pressure on the state to cut eligibility or benefits, or to increase cost sharing.

For Vermont Medicaid Beneficiaries

In the short-term, Vermont apparently has no plans to use its new authority to cut back on coverage, nor is the state's decision to become a managed care organization expected to have a notable impact on the way that care is delivered. If, however, the state begins to reach its funding cap, it will not be able to share the burden of additional costs with the federal government, making it more likely that the state will use its authority to cut back on coverage for beneficiaries. For its optional and expansion beneficiaries, it can establish waiting lists, reduce benefits, or increase cost sharing beyond what is allowed under federal standards. Since the federal government does not require the state to maintain Medicaid coverage before cutting back on spending on non-Medicaid programs, Medicaid beneficiaries could find themselves competing for limited federal Medicaid funds with broad-based public health initiatives, the state's medical school, or numerous other stakeholders that now can receive Medicaid funds because of the Global Commitment waiver.

For the Federal Government

Although capped funding often is put forth by federal policymakers as a solution to concerns about rising federal Medicaid spending, it appears the Global Commitment waiver may actually increase federal costs, at least in the short-term. The waiver, however, does provide the federal government with some certainty as to the maximum amount that it will spend on Medicaid in the state of Vermont over a five-year period (even if this amount may be more than it would have spent under the regular Medicaid financing structure).

It does not appear likely that the waiver will allow the federal government to reach one of its key stated goals, experimenting with promoting "universal access to health care." To the contrary, the waiver precludes Vermont from considering any significant expansions to its Medicaid program. The state's legislature currently is debating legislation to expand coverage, using a variety of revenue sources, including some of the windfall expected from the Global Commitment waiver. Governor Douglas, however, has argued that the windfall (along with other proposed revenue sources) is not a reliable revenue source for a coverage expansion.

For Other States

As a small state that was willing to set the precedent of accepting a Medicaid funding cap, Vermont secured a relatively generous financing arrangement and the possibility of significant savings. Past experience suggests that it is unlikely that other states would fare as well if they sought to follow Vermont's lead. With the Pharmacy Plus Medicaid 1115 waivers of the early 2000s, Illinois, the first state to secure such a waiver received a very generous financing arrangement.³² To varying degrees, the other states that followed suit received more limited financing. To put the Vermont financing arrangement in context, if federal Medicaid spending were to grow nationwide at the same rate as allowed in Vermont (instead of at currently projected levels), it would cost the federal government an additional \$105 billion over five years and a third of a trillion dollars over ten years.³³ Also, Vermont already covers close to one in four of its citizens and over a third of its children. As such, it is less likely than other states to take on a major new expansion or to experience a significant jump in enrollment, reducing its risk relative to other states of reaching a global funding cap due to unexpectedly high Medicaid spending.

If other states were to seek similar waivers, they would likely receive more limited financing, increasing the chances that they would fall short of federal funding and face pressure to reduce coverage. Even if they were able to secure relatively favorable financing arrangements, other states would still be assuming greater risk of running out of federal funding because most states have more limited Medicaid programs than Vermont. Vermont is among a handful of states that already covers a substantial share of its population through Medicaid, making it less likely to experience an unexpected increase in enrollment or to decide to significantly expand its Medicaid program.

CONCLUSION

The Vermont Global Commitment waiver will be watched by policymakers around the country who are interested in the consequences of capping federal Medicaid funding and eliminating some federal standards governing Medicaid coverage. However, the special circumstances of the waiver, including the apparent generosity of the funding cap and Vermont's unique Medicaid program, may limit the relevance of the Global Commitment waiver to other states. Other states can be expected to find it difficult to secure a similarly generous cap and would be at greater risk of unexpectedly high Medicaid spending, creating increased pressure to reduce coverage for beneficiaries.

Even in Vermont, the waiver poses some risks to Medicaid beneficiaries. Although the state currently does not seem interested in cutting back on their coverage, it could face strong fiscal incentives to do so if the global funding cap turns out to not be as generous as expected. The federal government's decision to allow Vermont to use some of its federal Medicaid matching funds to refinance existing state-funded health programs increases the risk that the state will reach its funding cap. If it does, some Medicaid beneficiaries could face waiting lists, benefit cuts, or cost sharing increases.

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Appendix A

Vermont's Long-Term Care Plan Waiver

This waiver is described by CMS as “creating an entitlement to home and community-based services, for a group with the highest needs.”³⁴ Under current law, most Medicaid beneficiaries are entitled to nursing facility services and other mandatory services when medically necessary. Federal Medicaid matching funds for these services are available without limitation.

Beneficiaries have access to home and community-based services (HCBS) only if their States obtain HCBS waivers to offer these services, and only if a “slot” is available. Further, federal Medicaid matching funds are available for HCBS only up to the budget neutrality limits specified in the waiver. (In January 2007, states will have new flexibility to provide HCBS without a waiver under changes allowed by the Deficit Reduction Act of 2005.)

Under the Long-Term Care Plan waiver, some new Medicaid beneficiaries will no longer have an individual entitlement to nursing facility services when needed. Instead, Vermont will be allowed to limit coverage for new applicants in a new “high needs” group to the services covered in an individual’s approved care plan. The State will also be allowed to limit the number of nursing facilities with which it contracts to provide residential LTC services to program beneficiaries. The State must, however, continue to provide both nursing facility and HCBS services to beneficiaries who were receiving these services at the time of initial implementation.

Federal Medicaid matching funds for all long-term care services, including nursing facility and HCBS services are subject to a 5-year aggregate cap. The cap is defined as “total computable expenditures” and set at \$1.236 billion. If Vermont’s matching rate were to average 58 percent over the next 5 years, the total amount of federal matching funds available over this period would be \$717 million ($\$1.236 \text{ billion} \times 0.58$). To draw down those funds, the State will have to satisfy CMS that the sources of its state share are consistent with federal law.

The \$1.236 billion aggregate expenditure cap is based on projections regarding the demand for, and cost of, long-term care services by low-income elderly and disabled Vermonters over the next five years.

If these projections turn out to produce an expenditure cap that is too low, Vermont has a number of policy tools to limit expenditures. Vermont has the flexibility to establish waiting lists for new applicants in the “high needs” group. In addition, neither the waiver nor current law includes any minimum payment requirements for nursing facility services or HCBS services, so Vermont also has the flexibility to freeze or reduce payments to providers of these services for both new applicants and existing beneficiaries.³⁵

Endnotes

¹ For details, see Cindy Mann, *Medicaid and Block Grant Financing Compared*, Kaiser Commission on Medicaid and the Uninsured, January 2004 and Jeanne Lambrew, “Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals,” *The Milbank Quarterly* 83 (1), March 25.

² *The 2005 National ADAP Monitoring Project Report*, Kaiser Family Foundation, April 2005.

³ Data are for state fiscal year 2006 and are based on estimates from the Joint Fiscal Committee of the Vermont Legislature.

⁴ State of Vermont, *Summary Overview, Global Commitment to Health Medicaid 1115 Demonstration Waiver*, November 3, 2005.

⁵ Letter from Mark McClellan to Michael Smith, Secretary, Vermont Agency for Human Services, September 27, 2005.

⁶ See Kevin O’Connor, “Health Care Reform So Close, and Yet So Far,” *Times Argus*, March 12, 2006.

⁷ Health Management Associates, *Vermont Global Commitment: Independent Review and Risk Analysis*, September 2005, prepared for the Joint Fiscal Office of the Vermont State Legislature. The report was available on Vermont’s Medicaid agency’s web site in the fall of 2005, but no longer appeared in April of 2006.

⁸ When it approved the waiver to begin on October 1, 2005, the Joint Fiscal Committee made the approval contingent on the following being provided by November 17, 2005: 1) a more thorough explanation of the waiver provisions; 2) final information about premium rates and methodologies; and 3) a list of criteria and MCO targeted health care investments; and 4) review by the Attorney General. Due to a delay in receiving a report from the state’s actuarial firm on premium rates, the committee ultimately did not finalize approval until mid-December.

⁹ HMA report, see endnote 4.

¹⁰ The implications of the open-ended entitlement to federal Medicaid funding are discussed in detail in Mann and Rudowitz, *Financing Health Insurance Coverage: The State Children’s Health Insurance Program Experience*, Kaiser Commission on Medicaid and the Uninsured, 2005.

¹¹ Cindy Mann, *New Developments in Medicaid Waiver Design: Who Bears Financial Risk and Responsibility?*, Kaiser Commission on Medicaid and the Uninsured, forthcoming.

¹² Excluded from the cap are SCHIP funds, DSH payments, and the administrative cost of making major changes to the state’s computer systems.

¹³ OVHA PowerPoint Presentation, *State of Vermont Global Commitment to Health Waiver: Program Summary*, January 2006. Both the State of Vermont and CMS declined to provide detailed information on how the cap was established, leaving a number of questions unanswered. For example, it is not clear to what extent the projections used to set the \$4.7 billion cap included administrative costs or the cost of covering childless adults.

¹⁴ One partial explanation may be that CMS and the state used state fiscal year 2004 as the base year for future projections of Medicaid spending, assuming it would grow 9 percent a year. The state’s Medicaid director, however, has indicated that 2004 was a “high” year in Medicaid spending growth. If spending actually grew less than 9 percent after 2004, it creates an artificial bump in spending projections for subsequent years.

¹⁵ Author’s e-mail correspondence with Joshua Slen, Director of OVHA, April 4, 2006.

¹⁶ In similar situations in the past, CMS has set priorities for the activities that should be funded if federal dollars fall short of what is needed to finance all of the activities allowed under a waiver. For example, see the Arizona SCHIP waiver which requires the state to cut back on coverage of childless adults and parents before eliminating coverage for children if it begins to run out of SCHIP funds.

¹⁷ To some extent, Vermont would have been be at risk for higher than expected per capita spending even if the Global Commitment waiver had not been enacted because its earlier VHAP waiver operated as a per capita cap. In practice, however, it appears that the per capita amounts used in the VHAP waiver were relatively generous, including enough of a gap between the per capita limit and actual per person spending on regular Medicaid beneficiaries to finance the state’s expansion to childless adults. According to state presentations, the size of the excess was shrinking, but the state nevertheless was able to fold \$66 million of excess VHAP funds into its \$4.7 billion funding cap for the Global Commitment waiver.

¹⁸ The terms and conditions of the waiver indicate that Vermont can pay itself a premium for each Medicaid beneficiary to whom it provides care. However, the use of a monthly lump sum premium payment set at \$65.4 million for all of federal fiscal year 2006 raises the question of whether the state is instead receiving an amount that is “pre-set” regardless of actual Medicaid enrollment.

¹⁹ The Medicaid managed care organization requirements are contained at Part 438 of Title 42 of the Code of Federal Regulations.

²⁰ State of Vermont: *Global Commitment to Health Waiver, Program Summary*, January 2006, presentation available on the OVHA web site at www.ahs.state.vt.us/OVHA.

²¹ See Appendix 2, OVHA Budget Document for State Fiscal Year 2007, available at http://www.ahs.state.vt.us/OVHA/docs/2006-02-09-Budget_Book_SF_Y_2007.pdf.

²² In its report to the Joint Legislative Fiscal Committee, Health Management Associates notes that this policy of allowing the state to use federal Medicaid funds to replace existing state spending is “in marked contrast” to other recently approved waivers. See also the CMS guidelines developed for Health Insurance Flexibility and Accountability waivers, which

explains that for such waivers “states will not be permitted to receive additional federal match for previously state-only health service programs under a waiver” (http://www.cms.hhs.gov/HIFA/02_Guidelines.asp).

²³ According to the HMA report, “actuarially sound premiums can be generous enough to allow MCOs to build reserves and make reasonable profits, as well as including an administrative component (8 - 10%) that is higher than the typical administrative load of a state Medicaid agency (3 – 5%).” HMA notes that Vermont will be allowed to use this same methodology for determining actuarially sound premiums, without adjustments reflecting that OVHA is a public entity that does not need to make profits and that has lower administrative costs than a private plan. The actuarial firm that developed the acceptable range of rates for Vermont did not respond to inquiries for more information. However, its final actuarial analysis built into the rates an assumption that the state would need 7 percent of premiums to cover administrative costs and an additional 2 percent for “contingencies.” Its analysis also allowed Vermont to pay itself the premium rate it had pre-selected prior to asking the firm to certify a range of actuarially sound rates. The full report is available at http://www.ahs.state.vt.us/OVHA/docs/Final_actuary_report.pdf.

²⁴ In its formal acceptance of the Global Commitment waiver, the state included numerous “clarifications,” including a statement that “it is permissible for the actuary to make adjustments [to rates] based on plan specific encounter and financial data to ensure that an efficiently run managed care plan is not penalized for its efficiencies.” It is not clear whether this clarification is binding, nor whether it prevents the actuarial firm from adjusting the acceptable range of premiums downwards to reflect lower-than-expected costs.

²⁵ CMS has clarified that the state cannot use the federal funds flowing into the state as a result of the excess premium revenue opportunity to turn around and generate even more federal Medicaid funding for Vermont.

²⁶ HMA report, page 9.

²⁷ Specifically, if all of the \$255.8 million in existing state spending on non-Medicaid health programs can be used to generate federal Medicaid matching funds, it can support total computable spending of \$621.3 million ($.42 * \$621.3 \text{ million} = \255.8 million). The federal share of \$621.3 million equals \$365.5 million ($.58 * \$621.3 \text{ million} = \365.5 million). The state presumably would “return” the \$255.8 million to the programs who originally contributed it, potentially along with a share of the \$365.5 million in federal Medicaid matching funds that it generates. It is not yet clear whether the state will be able to take full advantage of the opportunity to secure federal Medicaid matching funds for the \$255.8 million in existing state spending. It will depend on whether there is room under the \$4.7 billion aggregate cap and sufficient “excess” premium revenue to allow for \$621.3 million in spending on state-funded programs.

²⁸ There has been some controversy as to whether the terms and conditions of the waiver allow the state to reduce benefits for mandatory populations, including EPSDT services for mandatory children. Item 6 of the terms and conditions says that for mandatory populations, Vermont must comply with federal rules governing eligibility and cost sharing. In contrast, it indicates that reductions in benefits for mandatory populations must be approved by CMS, suggesting that such reductions might be allowed. In any event, the state has said that it does not intend to reduce mandatory benefits, including EPSDT, for mandatory populations.

²⁹ See letter from Michael Smith to Secretary Leavitt, December 15, 2005. The letter specifies that the legislature must approve changes to eligibility or benefits, but does not address whether cost sharing or premium increases are subject to legislative approval.

³⁰ Although a drafting error has called into question the federal standards required for most adults below poverty, it is clear that Congress intended to limit cost sharing for this population to nominal levels indexed by medical CPI. See letter from Senator Grassley and Representative Barton to Secretary Leavitt, March 29, 2006.

³¹ Phone presentation by Joshua Slen, Director, OVHA, February 16, 2006.

³² See Guyer, *Financing of Pharmacy Plus Waivers: Implications for Seniors on Medicaid of Global Funding Caps* (May 2003),

³³ This calculation assumes that federal Medicaid spending would be allowed to grow at a 9 percent rate between 2004 and 2015. It then compares the level of spending allowed under such a growth rate to the Congressional Budget Office’s projections from January 2006 of federal Medicaid spending for 2006 – 2010 (for the five-year estimate) and 2006 – 2015 (for the 10-year number).

³⁴ Letter from Mark McClellan, M.D., Ph.D., Administrator, CMS, to Michael Smith, Secretary, Vermont Agency of Human Services, June 13, 2005.

³⁵ These same policy tools are also available to the State should it not be able to generate the state funds needed to draw down the federal matching payments. The waiver requires only that the State maintain the level of expenditures and the number of eligibles covered during SFY 2003.

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