kaiser commission on medicaid and the uninsured

Federal Medicaid Waiver Financing: Issues for California

Prepared by
Cindy Mann and Joan Alker

July 2004

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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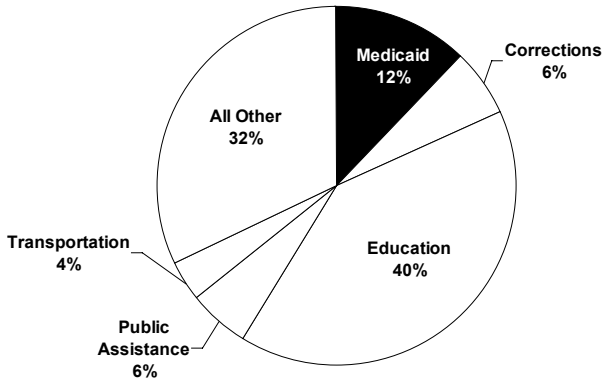
Executive Summary

Governor Schwarzenegger's budget for fiscal year 2004-05 proposes to restructure the Medi-Cal program by obtaining a Medicaid Demonstration Waiver (often referred to as a "Section 1115 waiver") from the federal government. The Medi-Cal redesign process has been prompted by state budget pressures. Medi-Cal necessarily looms large in state budget discussions because of its role in California's health care system. It is the single largest source of health care coverage for people in California, accounting for one out of six dollars spent in the state on health care and a little more than 12 percent of all state expenditures (Figure 1).

Figure 1

State Medicaid Spending as a Percent of Total California State Expenditures, 2002



Note: Expenditures include State General Fund spending and Other State Fund spending. These calculations do not consider federal Medicaid payments. Source: National Association of State Budget Officers 2002 State Expenditure Report, Fall 2003.

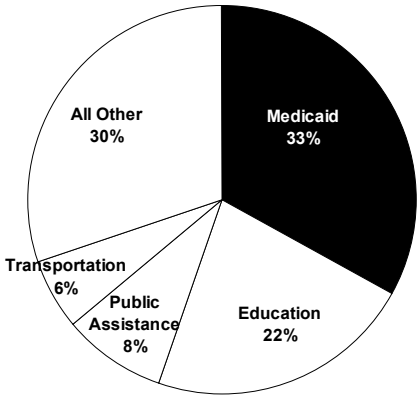
Rising health care costs across California (in private insurance and publicly-funded programs), along with growing enrollment in Medi-Cal prompted by the downturn in the economy, have added to the stress. California's budget problems are particularly severe, but California is not alone in trying to develop initiatives to rein in health care costs generally and Medicaid costs in particular.

A section 1115 Medicaid waiver, however, can create additional challenges, in part, because a waiver would change the way in which the federal government shares Medi-Cal costs with California. Currently, the federal government pays half of all Medicaid costs and federal Medi-Cal payments are the single largest source of federal funds for the state (Figure 2). The issue of

how a new waiver might affect California's federal Medicaid payments is, therefore, a matter of considerable importance.

Figure 2

Federal Medicaid Payments as a Share of Total Federal Funds to California, 2002



Source: National Association of State Budget Officers 2002 State Expenditure Report, Fall 2003.

This issue brief focuses on the potential fiscal implications of section 1115 waivers. The fundamental difference between how Medi-Cal is financed now and how it would be financed under a waiver has to do with who bears the risk of unanticipated costs—California or the federal government. Under regular program rules, all costs are fully shared. If costs rise for any reason, the federal government and California share the added costs. By contrast, under a section 1115 waiver, the federal government limits the amount of funds it will provide as a way to protect itself from incurring additional costs as a result of the waiver (this policy is referred to as "budget neutrality").

Every waiver has some kind of cap or limit on the amount of federal funds that will be paid over the course of the waiver. In general, these budget neutrality caps are set either on a per person ("per capita") basis or on an overall ("global") basis. California—not the federal government—would be responsible for costs above the capped levels of payment. It is not clear at this point which kind of cap might be used to enforce federal budget neutrality in a Medi-Cal redesign waiver, but all section 1115 waivers have a budget neutrality cap of one kind or another.

What are some of the issues that waiver financing could raise for California?

- *Waivers with per capita budget neutrality caps shift the risk of higher per person costs onto the state.* With this type of waiver financing, the federal government would no longer share the cost of unpredicted jumps in health care costs. Costs associated with a new cancer drug, a new protocol for treating patients with heart disease, or increases in prescription drug costs, for example, may have to be managed without the benefit of additional federal funds.

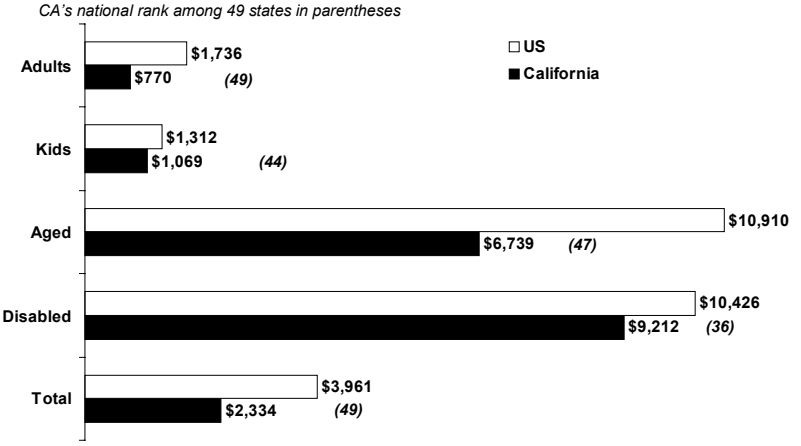
- *A waiver with a global cap also shifts the risk of higher-than-projected enrollment onto the state.* If the federal government imposes a global cap on Medi-Cal payments covered by the

waiver, unanticipated increases in enrollment, as well as unanticipated cost increases that exceed the cap, would be borne by the state. A flood or fire that puts people out of work, an outbreak of a new disease, or another downturn in the economy could result in billions of dollars in new Medi-Cal costs that might not be shared with the federal government. California's experience with AIDS shows how difficult it is to predict health care costs and how important it is to have the federal government automatically share all Medi-Cal costs.

- *Under either type of budget neutrality cap, the cap would be based on historic federal payments to California, and California's Medi-Cal spending per beneficiary is the lowest in the nation.* Under a waiver (either one that relies on a per person cap or a global cap), California's very low (relative to the nation) per person spending levels would be used to set the budget neutrality cap (Figure 3). With such a tight basis for the cap, if costs began to rise, California would likely have little room to achieve savings without having to turn to measures that cut back on eligibility, benefits, and access to care or that withdraw support from safety net institutions. The State may not be planning to adopt these kinds of measures, but, over time, its options could be circumscribed by the financing constraints set by the waiver and its relatively low base payment levels.

Figure 3

California's Medicaid Expenditures Per Beneficiary, by Category, 2001



Source: Georgetown Health Policy Institute analysis based on CMS MSIS 2001 data for 48 states plus the District of Columbia. Excludes Hawaii and Washington, neither of which have submitted their data to CMS.

The impact that waiver financing might have on California, the counties, Medi-Cal beneficiaries and the state's health care system will depend, in part, on the breadth of the waiver, whether it subsumes existing waivers (such as the hospital selective contracting waiver), and the kind of budget neutrality cap that is established through negotiations with the federal government. Financing is typically the least transparent part of an opaque waiver process. The terms relating to financing are usually settled at the very end of the negotiations and generally are not made public until after the waver agreement has been announced. The state will no doubt seek the best deal possible, but it will have to balance competing goals (for example, between achieving short term financing gains versus longer term fiscal protections) and tensions (for example, among state, county and health care provider interests). In any event, states often have little leverage in this part of the negotiations. Over the past year, the federal government has been particularly aggressive in dealing with states on a wide range of financing issues. With so much at stake, it will be important for waiver financing issues to be considered fully and publicly throughout the waiver development and negotiation process.

I. Introduction

Current efforts to redesign Medi-Cal have been triggered by California's particularly severe budget problems. It is not surprising that sharp and persistent revenue shortfalls have focused policymakers' attention on Medi-Cal—it is a large and diverse program serving 6.4 million Californians (Figure 4). In 2002 (the most recent year for which data for all states are available), Medi-Cal accounted for 12.1 percent of all state expenditures (12.7% of general fund expenditures). The percent of state funds spent on Medi-Cal is lower than average for the U.S., but still represents a substantial investment (Figure 5).

Figure 4

Medi-Cal's Role

- Provides coverage and long term care services to 6.4 million people (as of June 2003), including
  - One in six Californians under age 65
  - Nearly 1 in 4 children
  - Most people living with AIDS
  - 42% of all births (in 2000)
- Fills in for Medicare's gaps
  - Provides assistance to 40,000 Medicare beneficiaries
  - California spent $8.3 billion on dual eligibles in 2002, second highest in the nation
- Major payer for a wide range of health care providers
  - Finances $1 of every $6 in health care spending in California
  - Accounts for two-thirds of public hospital revenues and 42% of community health center revenues
  - Pays for two-thirds of all nursing home days
- Brings substantial federal funds ($17 billion in 2003) into California
  - Largest single source of federal funds coming into the state

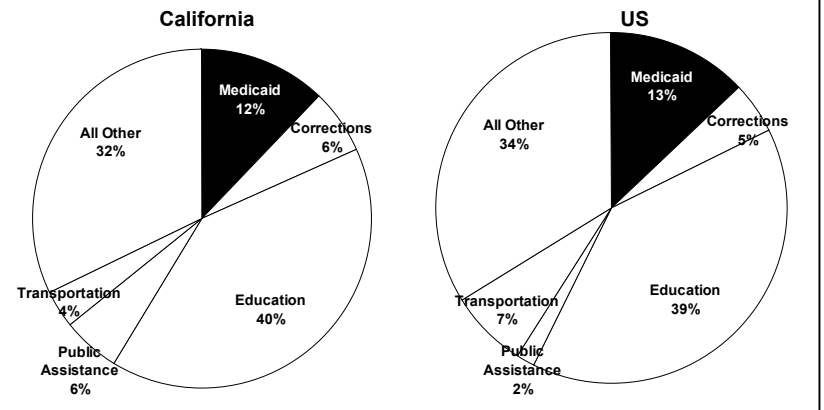
Source: "Medi-Cal Facts and Figures: A Look at California's Medicaid Program", California HealthCare Foundation, January 2004 (based on data from the Department of Health Services). Bruen B, Holahan J. "Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government." Kaiser Commission on Medicaid and the Uninsured, November 2003.

This Issue Brief considers waiver financing—just one of many issues that arise in the context of Medi-Cal redesign, but one that potentially overshadows all others. It explains federal policies and recent practices relating to waiver financing and looks at some of the implications waiver financing may have.

Although California's budget problems have been more severe than those of most other states, all states have seen their revenues fall during this recent downturn, and virtually all states have looked for ways to contain Medicaid spending. Most states have reduced or frozen provider payments and adopted pharmacy cost containment strategies. Many have also curtailed optional benefits, and some have rolled back eligibility. States have considerable authority to take these kinds of actions without a waiver, subject to federal minimum standards. A number of states have considered using Medicaid waivers as a way to make changes that go beyond what the standards allow. Through a

Figure 5

State Medicaid Spending as a Percent of Total State Expenditures, 2002



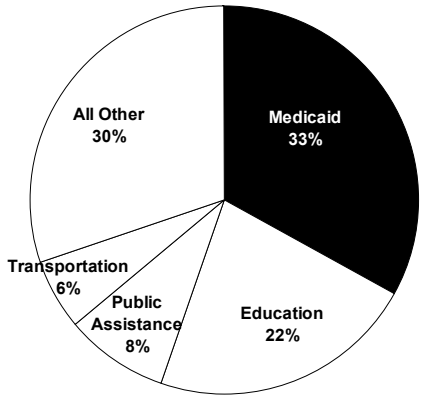
Note: Expenditures include State General Fund spending and Other State Fund spending. Federal expenditures are not included.
Source: National Association of State Budget Officers 2002 State Expenditure Report, Fall 2003.

section 1115 "demonstration," (the formal name for waivers) the Secretary of the U.S. Department of Health and Human Services (HHS) can "waive" certain federal standards and offer states additional avenues for reshaping aspects of their programs. In recent years, the Bush Administration has granted waivers that have allowed states to cap enrollment, narrow the benefit package below minimum standards and increase beneficiary out-of-pocket costs above what is otherwise allowed under federal rules.

Any effort to reduce state Medi-Cal spending at a time when overall health care costs (not just Medi-Cal costs) are rising at a double digit pace and more people are turning to Medi-Cal due to their age, their disabilities, and the decline in job-based coverage necessarily raises issues for beneficiaries, health care providers, and counties. Waivers have sometimes helped states work through these challenges by giving them the opportunity to try new delivery systems, refinance state- or locally-funded programs with federal dollars, or redirect federal dollars to promote and expand coverage. On the other hand, waivers can also bring new issues into play both because waivers can allow the elimination of key program standards and because section 1115 waivers change the way the federal government shares Medi-Cal costs. This is no small matter: In 2002, federal Medicaid funds were the largest single source of federal revenues for California, accounting for one-third of all federal funds received by the state (Figure 6). If a new waiver results in restrictions on the amount of federal Medicaid payments the state will receive over the course of the waiver, the waiver could add to rather than lessen state fiscal pressures.

Figure 6

Federal Medicaid Payments as a Share of Total Federal Funds to California, 2002



Source: National Association of State Budget Officers 2002 State Expenditure Report, Fall 2003.

II. What is a Waiver?

Waivers permit states to use federal funds in ways that do not conform to federal program standards; they do not provide states with any additional federal funds. There are two types of Medicaid waivers: waivers that operate under limited federal statutory authority and relate to specific aspects of the Medicaid program (such as managed care or home and community based care) 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).[1] Under federal law, these waivers are intended to be for research and demonstration projects that "further the objectives" of the program. The Secretary of the U.S.

[1] These waivers are called "section 1115" waivers or demonstration projects because they are authorized by section 1115 of the Social Security Act (SSA). Title XIX, which establishes the Medicaid program, is part of the SSA.

Department of Health and Human Services is charged with the responsibility for reviewing and approving or denying these waivers requests. As explained below, longstanding federal waiver policy requires that any new waiver not cause federal spending to increase. Thus, section 1115 waivers approved by HHS must be found to be "budget neutral" to the federal government.

California already has both types of waivers. It has several targeted waivers, including waivers to implement managed care in some parts of the state, to allow selective contracting with hospitals, and to provide home and community-based services to certain groups of people who need long-term care. It also has three approved section 1115 waivers: the Los Angeles county waiver, the family planning waiver, and the parent coverage SCHIP waiver (the parent waiver has not been implemented). See Appendix A for a list of California's current Medicaid and SCHIP waivers.

The Medi-Cal redesign initiative anticipates a new section 1115 waiver for California, which may subsume some or all of California's existing waivers. Section 1115 waivers can be used either to change discrete aspects of Medicaid or SCHIP or to accomplish more sweeping changes. Waivers are not new to Medicaid, but section 1115 waiver activity has grown recently. Since August 2001, the Bush Administration has released guidelines promoting three different waiver initiatives—the "Health Insurance Flexibility and Accountability" (HIFA) initiative to promote coverage expansions within existing resources; the "Pharmacy Plus" initiative to allow states to use federal Medicaid funds to provide pharmacy benefits to seniors and people with disabilities whose incomes are above regular Medicaid levels; and "Independence Plus" to promote certain types of consumer-based long term care initiatives.[2] More recently, the Administration has been reported to be consulting with some states about so-called "mega-waivers" that would allow states to substantially restructure Medicaid, possibly with an overall cap on federal Medicaid payments.[3]

States have had their different reasons for pursuing waivers. In the past, states used waivers to require beneficiaries to enroll in managed care and, in some cases, to expand coverage. Waivers, however, do not offer states new federal funds for coverage so their use as a vehicle for expansions has limitations.[4] More recently, state budget pressures have prompted some states to look to waivers as a way to address state budget shortfalls. States have considered different approaches to achieve savings, but, by and large, waivers have achieved savings principally by reducing coverage.[5] This reflects the fact that there is considerable flexibility in the program to adopt other types of cost-containment measures without a waiver (e.g., changes in provider

[2] See http://www.cms.hhs.gov/medicaid/waivers/default.asp

[3] Caputo M. "Medicaid Proposals Criticized." The Miami Herald, April 25, 2004; Ulferts A. "Doctors Resist Bush's Plan to Cap Medicaid Spending." St. Petersburg Times, May 17, 2004;Waldman H. "State Might Try Medicaid Cost-Cutting Plan." Hartford Courant, May 1, 2004; Barrick D. "Health Chief Weighs Cap on Medicaid: Possible Limit on Federal Money Worries Health Care Community." Concord Monitor, April 16, 2004.

[4] Given state fiscal pressures and the fact that waivers do not offer states access to additional federal funds, it is not surprising that recent waiver activity has not resulted in much new coverage. Mann C, Artiga S, Guyer J. "Assessing the Role of Recent Waivers in Providing New Coverage." Kaiser Commission on Medicaid and the Uninsured, December 2003.

[5] Mann C, Guyer J, Gill S. "Section 1115 Medicaid and SCHIP Waivers: Policy Implications of Recent Activities." Kaiser Commission on Medicaid and the Uninsured, June 2003. Mann C, Artiga S. "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.

payment rates, greater case management of high-cost cases, prescription drug pricing and utilization review). It also reflects the fact that there is little "fat" in the Medicaid program; states have a difficult time identifying a significant amount of savings that can be realized over a relatively short period of time except by changing eligibility rules and costs imposed on beneficiaries or by reducing benefits below federally required minimum standards.

III. How are Waivers Financed?

Any time a state is considering a major restructuring of a program as substantial as Medi-Cal, attention necessarily focuses on the potential programmatic changes. The financing changes that would accompany a major new section 1115 waiver, however, also could be significant. Waivers change the way in which states receive their federal Medicaid payments.

Under regular Medicaid financing rules, the federal government is obligated to pay its share of all Medi-Cal costs, whatever those costs turn out to be. Because Medicaid is an open-ended entitlement, there is no cap on federal payments to states. If costs rise due to the outbreak of a disease, a natural disaster, a new medical treatment, or a break-through drug, or because more people turn to Medi-Cal as a result of a plant closing or broader economic downturn, the federal government shares those additional costs. In California, federal payments finance half of all Medi-Cal costs with no upper limit.[6]

By contrast, waivers have financing caps. All section 1115 Medicaid or SCHIP waivers include some kind of a cap that sets a limit on the amount of federal funds a state will receive under the waiver. The extent to which a waiver cap will impact program operations and financing depends on a number of factors, including the scope of the waiver (i.e., how much of the program is subject to the cap), the design of the cap, and the particular financing terms. In all cases, however, a cap shifts financing risks onto the state that, under normal rules, are shared with the federal government.

Waiver caps are imposed as part of the federal government's policy that section 1115 waivers be "budget neutral" for the federal government. That is, over the course of the waiver, the federal costs for the state must be the same as what they would have been absent waiver changes. There are two aspects of the federal budget neutrality rules:[7]

[6] The rate at which the federal government shares costs is set each year in accordance with the "federal matching assistance payment" or "FMAP." California's FMAP for almost all expenditures is set at 50%. In 2003-2004, all states received an enhanced federal match rate to help them maintain coverage during the economic downturn. California's enhanced match rate, which expired on June 30, 2004, was 54.4% in the 2003 quarters and 53% in the 2004 quarters during which the enhanced rate was in effect.

[7] These rules are not set in statute or regulation but can be gleaned from years of practice and from sub-regulatory policy guidance. See for example, the discussion of budget neutrality in the HIFA waiver guidelines, Centers for Medicare and Medicaid Services. "Guidelines for States Interested in Applying for a HIFA Demonstration." Available online: http://www.cms.hhs.gov/hifa/hifagde.asp. See also, Shirk C. "HIFA: Finding the Flexibility." National Governor's Association, October 24, 2001.

A. Waivers are designed to ensure that the federal government incurs no new costs; any new federal costs resulting from waiver changes must therefore be "offset" with federal savings.

When a waiver is negotiated, a type of ledger sheet is developed. The federal government estimates what costs it would have incurred without the waiver and what costs it will incur with the waiver. These costs must balance out in order for a section 1115 waiver to be approved. This concept is referred to as "budget neutrality."

Under this policy, if a state is planning to use a waiver to implement an expansion or improvement that it could not have been accomplished without a waiver, it will need to identify offsetting federal savings.[8] In the past, states have found these savings in one of two ways: they have redirected federal Disproportionate Share Hospital (DSH) payments to cover the new waiver costs or they have offset new costs by achieving savings through managed care. More recently, the Bush Administration's Health Insurance Flexibility and Accountability (HIFA) waiver initiative advised states that they could offset new waiver costs by reducing benefits, limiting eligibility, or increasing out-of-pocket costs for people eligible for Medicaid before the waiver.[9] A few states have used this approach to keep their waiver-based coverage expansions from resulting in any new federal costs.[10]

Some states have also used unspent federal SCHIP funds to pay for new coverage expansions. These are SCHIP waivers, not Medicaid waivers, but the same concept of budget neutrality applies. Unexpended SCHIP funds allocated to the state for children's coverage are redirected under the waiver and used to offset the federal cost of an expansion.[11] California's parent coverage waiver authorizes the state to use unexpended SCHIP funds to cover low-income parents.[12] Due to state budget problems, the waiver has not been implemented.

B. All section 1115 waivers include a cap on federal payments to allow the federal government to monitor and enforce federal budget neutrality.

All section 1115 Medicaid (or SCHIP) waivers, whether or not they involve a coverage expansion, include a cap on federal funds. These caps provide the federal government a way to assure that, over the course of the waiver, federal costs do not exceed the costs projected to be incurred without the waiver. Even when a state is planning to use a waiver to *reduce* spending,

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[8] 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.
[9] Centers for Medicare and Medicaid Services. "Guidelines for States Interested in Applying for a HIFA Demonstration." Available online: http://www.cms.hhs.gov/hifa/hifagde.asp
[10] Mann C, Artiga S, Guyer J. "Assessing the Role of Recent Waivers in Providing New Coverage." Kaiser Commission on Medicaid and the Uninsured, December 2003.
[11] Centers for Medicare and Medicaid Services. "Guidelines for States Interested in Applying for a HIFA Demonstration." Available online: http://www.cms.hhs.gov/hifa/hifagde.asp; Centers for Medicare and Medicaid Services. "Guidance on Proposed (SCHIP) Demonstration Projects Under Section 1115 Authority." Available online: http://www.cms.hhs.gov/schip/sho-letters/ch73100.asp
[12] Approval letter to Secretary Grantland Johnson, March 18, 2002 from Thomas A. Scully, Administrator for CMS, Special Terms and Conditions Attachment A. In contrast to Medicaid, SCHIP is a capped program; each state receives up to but no more than a capped allocation of federal funds.

the federal government insists on a cap (see text box, next page). Budget neutrality caps imposed in Medicaid Section 1115 waivers have generally come in two forms:[13]

1. Per Capita Caps limit federal Medicaid spending on a per-person basis

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. (This can be newly covered people, previously covered people, or both.) That per-person base amount is then adjusted upward each year by a pre-set rate written into the waiver agreement. The adjuster is intended to account for projected health care inflation. The rate is subject to negotiation, but, in general, it is based on the lesser of a state's historic growth rates or projected U.S. Medicaid spending growth rates.[14]

Once a waiver with this type of cap is implemented, the state submits its claims for federal matching payments as it normally does, and the state receives its regular matching payment (based on the appropriate federal matching rate) on qualified expenditures. Over the time period covered by the waiver (usually five years), however, the state's federal payments for all waiver-related expenditures will be subject to the cap. Under a per capita budget neutrality 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)[15] people enrolled under the waiver. If actual per-person costs are greater than the cap allowed for, the state must either take action to reduce costs or cover the added costs entirely out of state funds; no additional federal matching payments would be available.

[13] States with waivers financed with DSH funds have spending caps that are set by reference to their available federal DSH funds. See, for example, Centers for Medicare and Medicaid Services Special Terms and Conditions, Maine Care for Childless Adults, Section 22. Available at http://www.cms.hhs.gov/hifa/mecaretc.pdf. Similarly, as noted above, SCHIP waivers assure budget neutrality by limiting the expenditures under the waiver to the state's available SCHIP funds, which themselves are subject to a cap.

[14] Centers for Medicare and Medicaid Services. "Guidelines for States Interested in Applying for a HIFA Demonstration." Available online: http://www.cms.hhs.gov/hifa/hifagde.asp.

[15] 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 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 (for the parents) 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.

Budget Neutrality Caps Imposed in "Reduction" Waivers
Washington State: A Recent State Example

In its 2003 waiver application, Washington State attempted to make the case that it should not be subject to a waiver cap. The state argued that it could assure the federal government that its proposed waiver would not increase federal costs because the only change it was proposing was to charge premiums for children, a change that would invariably reduce federal and state costs. The federal government did not dispute this characterization but still insisted, consistent with long standing federal policy, on placing a limit on the amount of federal dollars that will be paid to Washington State for providing health care to a large number of low-income children over the life of the waiver.

The waiver permits the state to impose premiums on most so-called "optional" children; that is, all children who the state is not required to cover under Medicaid. The caps were set by reference to the historical cost in Washington of covering this group of children, which was $117.40 per child per month. This amount was then adjusted on an annual basis by 7.2% to account for projected health care inflation.

Over the course of the five years, Washington can submit its claims for federal matching funds for all expenses relating to this group of children. However, the state's total claims cannot exceed the amount of these caps multiplied by the number of children covered. If costs actually rise by 7.9% rather than the projected 7.2% each year (for example, because the new premiums prompt healthier children to drop coverage) the state would not receive federal funds for these higher costs. (Note that after approval of the waiver, the Governor decided not to implement the new premiums at this time.)

Source: Approval letter to Secretary Dennis Braddock, from Dennis Smith, Acting Administrator for CMS, Special Terms and Conditions.

2. Global caps limit total federal spending for coverage and services under the waiver

Recently, in the context of "Pharmacy Plus" waivers, an initiative of the Bush Administration designed to allow states to use federal Medicaid funds to provide elderly and disabled people with pharmacy benefits, the Administration relied on a different type of cap to enforce its budget neutrality policies. It used a "global cap," which limits the total amount of federal funds that will be paid to the state (see text box, next page). Like a per capita cap, a global cap shifts the risk of higher-than-projected per person costs onto 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 results in costs that exceed the pre-set limit on federal payments, the state must either cut back on coverage or take other steps to contain costs, or absorb the added cost with state-only dollars.

These global cap arrangements provide a precedent for constructing a waiver in which all or most federal Medicaid payments to a state would be subject to an overall ceiling, similar to the design of the Administration's 2003 "block grant" or "capped allotment" legislative proposal for Medicaid.[16] Following the Pharmacy Plus model, under such a waiver, a state

[16] Under the Bush Administration's proposal, states could receive a capped amount of federal funds based on past spending and adjusted annually based on a pre-determined inflation adjuster exchange for broad new flexibility to set program rules governing eligibility, benefits and beneficiary costs. Guyer J. "Bush Administration Medicaid/SCHIP Proposal." Kaiser Commission on Medicaid and the Uninsured May 2003. The proposal was not actively considered by Congress and was not embraced by the National Governors Association, but the Administration continues to promote it. "Budget of the US Government, Fiscal Year 2005." Office of Management and Budget, p. 148-149.

would claim federal payments for all expenditures under the waiver based on the appropriate federal matching rate, but, over the course of the waiver, those payments could not exceed the pre-set level of federal funding. If costs began to rise at a faster rate for whatever reason, including higher health care costs, rising enrollment driven by a weak economy, or unanticipated public health needs like HIV, the state could either reduce the scope of the program or shoulder the additional costs with state funds. Although the financing under this type of waiver is similar to the Administration's block grant proposal, the Pharmacy Plus waivers show that these kinds of caps have been imposed in the waiver context even where a state was not seeking the kind of very broad authority to revise their programs as might have been permitted under a block grant.

Global Caps in Pharmacy Plus Waivers—Recent State Examples

Pharmacy Plus waivers are a type of section 1115 waiver that the Bush Administration promoted before the enactment of the new Medicare drug bill. 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, people would stay healthier and many would avoid hospital or nursing home care that would end up being covered by Medicaid after they incurred very high health expenses that made them eligible for Medicaid (i.e., avoiding eligibility through the Medically Needy "Spend Down" or "Share of Cost" Program). The federal government generally adopted the theory but insisted on imposing a overall cap on federal payments to guarantee that the new initiative would not result in any new federal costs.

Pharmacy Plus waivers impose a global cap not just on the new pharmacy spending but *on all Medicaid spending for the elderly*. (The only Pharmacy Plus waivers that were granted were 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. 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.

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)

IV. What are the Financing Issues in California's Medi-Cal Redesign Waiver?

Over the past several months, the California Health and Human Services Agency (CHHSA) and the Department of Health Services (DHS) have been engaged in a process to develop a section 1115 waiver proposal that could make significant programmatic changes in the Medi-Cal program. Details of the proposal are expected to be released in early August. Through the stakeholder process, DHS and CHHSA have indicated that a wide range of substantial program changes are under consideration. These include new cost sharing requirements, a tiered benefit structure in which some groups of beneficiaries would receive a more restrictive benefit package, new managed care arrangements, and changes in the enrollment and renewal process. In

addition, the waiver could change the way in which Medi-Cal pays hospitals and other safety net providers.[17]

Questions about whether budget neutrality would be effectuated by a per capita or a global cap, as well as how budget neutrality will be calculated are very unclear. Little has been said by state administrators about financing under the redesign initiative, except that the waiver will seek to stabilize financing for safety net institutions and try to avoid the difficulties many states are encountering as a result of steps the federal government has taken to limit certain state Medicaid financing arrangements.[18]

There is, in fact, little the state can say now about financing because the financing aspect of section 1115 waivers is largely driven by the federal government over the course of the waiver negotiations. States that sought Pharmacy Plus waivers, for example, did not ask for a global cap on their federal payments; a cap was imposed by federal negotiators as the quid pro quo for letting the states use federal Medicaid funds to provide pharmacy benefits to certain elderly residents. States that wanted to extend drug benefits to the elderly but believed that a global cap on all expenditures for all elderly beneficiaries was not in their interest were not able to get their Pharmacy Plus waivers approved.

Financing is typically the least transparent part of an opaque waiver process. Waivers are negotiated behind closed doors, with the White House Office of Management and Budget typically playing a major role in the financing discussions. The financing terms are generally not disclosed until *after* the waiver agreement has been announced. In the states with waivers that included global caps, state legislators and providers affected by the cap were largely unaware of the cap until after the waiver terms and conditions were settled.

Inevitably, if California moves forward to negotiate a section 1115 redesign waiver it will attempt to reach the best deal possible with the federal government, but states often have limited leverage. The "best deal" possible, moreover, may depend on what and whose interests are seen as paramount. There is often a tension between achieving short term advantages and long term fiscal protections and inevitably, the state, the counties, providers will have somewhat different interests with respect to certain financing issues.

Ultimately, the fiscal impact of a redesign waiver will depend on how certain key questions are resolved.

- ***What will be the scope of the redesign waiver?***

  The extent to which a federal budget neutrality cap (either a per capita cap or a global cap) will have a major impact on state and county financing and California's health care system will depend, in part, on the scope of the waiver. If California's redesign waiver puts all or most of the current Medi-Cal program under waiver authority, the budget neutrality rules will

[17] Documents, a record of proceedings, and the schedule of events relating to the Medi-Cal Redesign process are available at http://www.medi-calredesign.org.
[18] See "The Administration's May 2004 Update on Medi-Cal Redesign." May 13, 2004. Available online: http://www.medi-calredesign.org/pdf/May_13_Redesign_Update.doc

end up shifting a substantial degree of new risk onto the state and place a very large amount of federal funds (and a substantial portion of California's revenues) under a waiver cap. In 2003, federal Medicaid payments amounted to $16.6 billion, one-third of all federal funds received by the state.[19] By contrast, the largest section 1115 waiver now in place in California involves $159 million.[20]

To date, only a few states have very broad section 1115 waivers that govern most or all aspects of their Medicaid programs. None of them was negotiated in the first instance with the current Administration, which has been clear about its interest in limiting federal Medicaid spending.[21]

- ***What kind of cap will be imposed?***

  Any type of cap on California's federal Medicaid payments could have a significant impact on state and county finances and on California's health care system. This impact will be significant even if the cap applies to only part of the Medi-Cal program; it will be far greater if a large segment of the program is moved under the new waiver.

  Table 1 (next page) illustrates the potential impact of a waiver with a per capita cap—a cap that limits the amount of federal payments received on a per-person basis. These calculations show that even a relatively modest increase in per-person costs above the levels contemplated in the cap could result in a significant loss of federal Medicaid payments as compared to the payments California would receive under regular Medicaid financing rules.

  Under a waiver with a per capita 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, California would receive the same amount of federal funds under the waiver as it would under current rules. This is because the federal government would continue to share the risk of higher-than-projected enrollment (Table 1, scenario 1). If, on the other hand, enrollment remained flat, but costs rose for other reasons—for example, due to higher drug costs—California could experience a significant shortfall in federal funds under a per capita budget neutrality cap. Assuming most of the program was moved into the waiver, if health care costs rose by eight

[19] "Medi-Cal Facts and Figures: A Look at California's Medicaid Program." The California Healthcare Foundation, January 2004.
[20] California Family Planning, Access, Care and Treatment (PACT) Estimated expenditures for 2004, from "Budget of the US Government, Analytical Perspectives, Fiscal Year 2005." Office of Management and Budget, page 364.
[21] Arizona, Delaware, Hawaii, Massachusetts, Minnesota, Oregon, Tennessee, and Vermont have relatively broad section 1115 waivers. In general, these states, except Arizona which came into the Medicaid program through a section 1115 waiver in order to implement managed care, sought these waivers to expand coverage. Generally, the waivers did not alter key elements of the program for their pre-waiver beneficiaries or, in most cases, for their expansion group. Some of these states (e.g., Massachusetts, Oregon and Tennessee) have recently scaled back their waiver-based coverage expansions.

percent, for example, the state could receive $2.1 billion less in federal payments than under regular Medicaid financing rules (Table 1, scenario 2).[22]

Table 1: State and Federal Spending under Alternate Per Capita Cap Scenarios

	Program Dynamics		Regular Financing Rules	Waiver Financing: Per-Capita Cap
Scenario 1	2% enrollment growth 7.2% growth in per-person costs	Additional Program Costs: Additional Federal Payments to Meet New Costs:	$11.5 billion $5.7 billion	$11.5 billion $5.7 billion
Scenario 2	Flat enrollment 8% growth in per-person costs	Additional Program Costs: Additional Federal Payments to Meet New Costs:	$4.2 billion $2.1 billion	$4.2 billion $0

Notes: These illustrations are based on 5-year projections. Scenarios assume a waiver that encompasses all spending and beneficiaries. Calculations were based on California expenditure and enrollment data from in "Medi-Cal Facts and Figures: A Look at California's Medicaid Program." California HealthCare Foundation, January 2004 (based on data from the Department of Health Services). The per-beneficiary cost (total) was $4,484 and this amount is used as the base amount for purposes of calculating the per-capita cap.

Table 2 (next page) illustrates what might happen (using the same set of assumptions) if the waiver has a global cap. The fiscal impact of a global cap almost certainly would be harsher than a per capita cap, because a global cap shifts the risk of higher per-person costs *and* higher enrollment onto the state. If enrollment rose at an average annual rate of two percent over five years and per person costs grew at 7.2 percent (the level assumed in the cap), the state would lose $5.7 billion in federal funds compared to what the state would have received without the waiver cap (Table 2, scenario 1). If enrollment were flat, but per person costs rose by eight percent (instead of the projected 7.2 percent), the state would lose $2.1 billion (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 shortfall would grow to $8 billion under a broad-based waiver with a global cap (Table 2, scenario 3).

[22] For purposes of these illustrations, we assume that Medi-Cal is converted to a waiver program and that the caps are based on 2003 federal spending adjusted annually at a rate of 7.2 percent (the same inflator that was used in the recent Washington state waiver).. We rely on 2003 DHS data showing 6.4 million beneficiaries and total federal payments of $16.6 billion. Medi-Cal Facts and Figures: A Look at California's Medicaid Program," The California Healthcare Foundation, January 2004.

Table 2: State and Federal Spending under Alternate Global Cap Scenarios

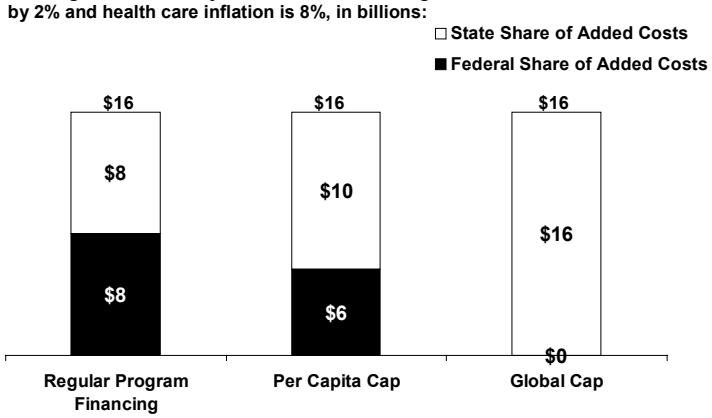
	Program Dynamics		Regular Financing Rules	Waiver Financing: Global Cap
Scenario 1	2% enrollment growth 7.2% growth in per-person costs	Additional Program Costs: Additional Federal Payments to Meet New Costs:	$11.5 billion $5.7 billion	$11.5 billion $0
Scenario 2	Flat enrollment 8% growth in per-person costs	Additional Program Costs: Additional Federal Payments to Meet New Costs:	$4.2 billion $2.1 billion	$4.2 billion $0
Scenario 3	2% enrollment growth 8% growth in per-person costs	Additional Program Costs Additional Federal Payments to Meet New Costs	$16.0 billion $8.0 billion	$16.0 billion $0

Notes: These illustrations are based on 5-year projections. Scenarios assume a waiver that encompasses all spending and beneficiaries. Calculations were based on California expenditure and enrollment data from in "Medi-Cal Facts and Figures: A Look at California's Medicaid Program." California HealthCare Foundation, January 2004 (based on data from the Department of Health Services). Total federal Medicaid payments were projected to be $14,350,000,000 and this amount is used as the base amount for purposes of calculating the global cap.

The variations in health care inflation or enrollment assumed in these examples are relatively modest considering how volatile health care spending has been in recent years. Yet, even these variations could result in a significant loss of federal funds for California (Figure 7). Sharper jumps in costs due either to more people needing coverage, new medical advances, or higher health care costs would result in even greater losses of federal funds—and either a larger hole in the state budget, or more reductions in program coverage and services and potential cost-shifting onto counties and safety net providers.

Figure 7

Federal Share of Added Costs Under Regular Financing Versus Waiver Caps



Source: Georgetown University Health Policy Institute analysis. For details on the calculations, see footnote 23.

Health care spending is inherently difficult to predict. Medi-Cal costs depend on a myriad of factors, many of which are well beyond the state's control. Growing drug costs, new medical technologies, an outbreak of a disease, a downturn in the economy, a drop in employer-based coverage, a natural disaster, and changes in the health care marketplace can all affect Medicaid spending. The AIDS epidemic is just one illustration of how health care costs generally, and Medi-Cal costs specifically, can grow sharply and with little warning (see text box, next page).

The HIV/AIDS Crises—A Case in Point

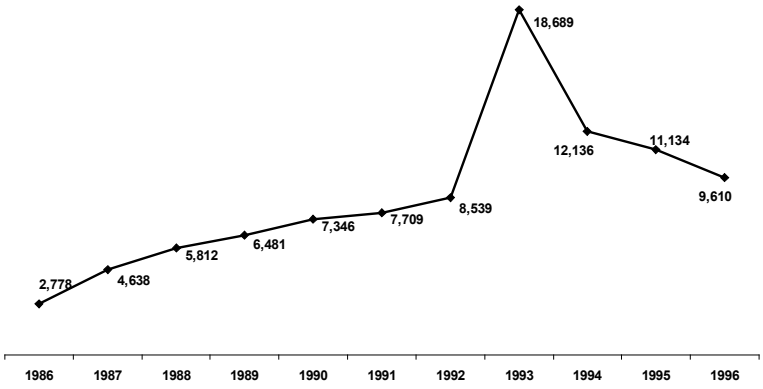
Medicaid is by far the largest single source of federal financing for HIV/AIDS care. In fiscal year 2004 *federal* Medicaid matching funds alone for HIV/AIDS are expected to reach $5.4 billion nationwide.[23] Medicaid's current open-ended funding structure assured that federal payments to states were immediately and automatically available in response to the unpredicted costs states incurred when they responded to the HIV/AIDS epidemic.

California was one of the states hardest hit by HIV/AIDS. The incidence of AIDS in California increased dramatically over a ten-year period (Figure 8). Consequently, spending for treatments and services needed by people with HIV/AIDS has also grown substantially over time. If California had had a waiver with a global cap in 1986, before the full extent and nature of the AIDS epidemic was understood, the state's federal funding would not have increased in each of the ensuing years to accommodate the sharply rising costs of providing life-sustaining medications and services to people with HIV and AIDS. The state might have had to bear the full cost with no federal financial participation.

Figure 8

AIDS Incidence in California Grew Rapidly Once the Epidemic Hit

(1986-1996)



Source: CDC HIV/AIDS Annual Surveillance Reports, 1986-1996. Persons included with vital status "alive" reported; excludes persons whose vital status is unknown. Data from December of each year.

- ***How would the redesign waiver affect existing California waivers?***

  As discussed above, California has a number of current Medicaid waivers, each of which has been designed to address a particular problem or set of issues. The redesign waiver could leave these waivers in place (some are up for renewal this year; see Appendix A) or roll them into the new waiver. If the new waiver subsumes these smaller initiatives, the state could potentially gain new authority over these funding streams and service delivery systems. This could give the state greater flexibility to redesign the program, but it could also disrupt current financing and care arrangements and leave providers who rely on these funding streams less secure. A large portion of the state's Medi-Cal payments to hospitals are financed through California's selective contracting waiver.

[23] Summers T. and Kates J. "Trends in U.S. Government Funding for HIV/AIDS." Kaiser Commission on Medicaid and the Uninsured, March 2004.

V. What are the Particular Challenges for California?

Waiver financing can create challenges for any state with a relatively broad waiver, particularly if that waiver has a global cap. But three factors could make waiver financing particularly challenging for California.

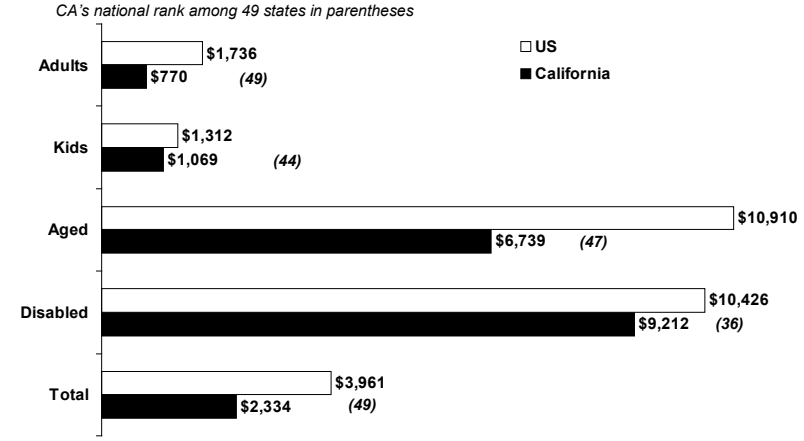
- ***A waiver cap would be based on its historic federal payments and California's Medi-Cal payments per beneficiary are among the lowest in the country.***

  Waiver financing could be particularly challenging for California because of its relatively low per-person Medi-Cal spending. Under a waiver with *either* a per capita or a global budget neutrality cap, the cap would be calculated based on the levels of federal payments California received in the past. States that generally do the best under waiver financing are those who have a higher-than-average spending base from which to calculate the cap.

  California's per person spending base is among the lowest in the country (Figure 9).[24] Its per beneficiary spending in 2002 was $2,334 compared to $3,961 for the U.S. as a whole and $7,749 for New York, the state with the highest spending per beneficiary. California's spending per elderly beneficiary – the most costly group to serve because of their high health and long term care needs – ranks 47th nationwide. California is currently spending 62 percent of the national average for elderly beneficiaries.

Figure 9

California's Medicaid Expenditures Per Beneficiary, by Category, 2001



Source: Georgetown Health Policy Institute analysis based on CMS MSIS 2001 data for 48 states plus the District of Columbia. Excludes Hawaii and Washington, neither of which have submitted their data to CMS.

A waiver would lock these comparatively low spending levels into place. If, over time, California needed to reduce spending, it would have little room to maneuver because its costs

[24] Georgetown Health Policy Institute analysis based on MSIS 2001 data. Data are available at http://www.cms.hhs.gov/medicaid/msis/msis99sr.asp. More precisely, California has the lowest among the 49 states for which comparable data are available; Hawaii and Washington have not yet reported their 2001 data. Note that MSIS data includes enrollment and expenditures relating to family planning waivers including California's Family Planning, Access, Care and Treatment (PACT) waiver. These waivers have low per-person spending and California's family waiver is the largest in the country. When these family planning enrollment numbers are excluded from the calculations (for California and the other states with similar waivers), California's ranking among states with respect to spending per beneficiary (without regard to beneficiary category) changes only slightly, rising from 49th, to 48th at $2,696 per beneficiary.

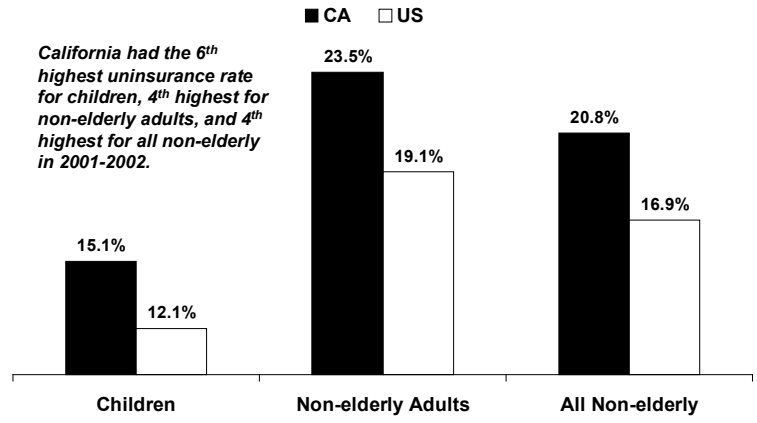
are already among the lowest in the country. Deep cuts in services or coverage would likely be necessary to achieve savings needed either to live within the caps or to cover the cost of any improvements the state might want to consider once the economy improved.

- ***With one of the highest uninsured rates in the country, a waiver could make it much more difficult for California to address its uninsured problem.***

Under regular Medicaid financing rules, if California decides to cover a new group of uninsured people through Medi-Cal, the federal government shares half the cost for the eligible population.[25] A waiver, that is not originally designed to expand coverage (as many of the broad based waivers were), however, potentially closes off the option to claim additional federal funding for program improvements. If this occurred, California would be foregoing any realistic opportunity to address one of the most significant problems facing the state—the large number of people who currently lack insurance. In 2001-2002, more than one-fifth of all Californians lacked health insurance. Only three states (Louisiana, New Mexico, and Texas) had higher uninsured rates for their nonelderly population (Figure 10).

Figure 10

California and US Uninsurance Rates Compared, 2001-2002



Source: "Health Insurance Coverage in America: 2002 Data Update." Kaiser Commission on Medicaid and the Uninsured, December 2003.

Waivers sometimes have been useful tools to expand coverage, particularly when states have used them to redirect federal dollars (such as DSH or SCHIP funds) that were allocated to the state but that were not being used for coverage. In a few cases, waivers have helped states expand coverage by allowing the state to refinance a state-funded program (thus freeing up state dollars to expand coverage). In general, however, because waivers do not put any new federal dollars on the table, their value with respect to coverage expansions is quite limited. A study of all section 1115 waivers approved between January 2001 and September 2003 showed that only about 200,000 people gained new coverage as a result of these waivers (mostly in New York State).[26] These were all waivers that in one way or another were designed to expand coverage; if California were to agree to a broad-based waiver that was not designed to expand coverage but rather to constrain spending, the possibilities for coverage expansions in the future, when the economy improved, might be even more

[25] Under current rules, states can cover most groups of low-income people through Medicaid; however, they cannot cover adults without dependent children who are not pregnant, elderly, or disabled, unless they obtain a waiver.
[26] Mann C, Artiga S, Guyer J. "Assessing the Role of Recent Waivers in Providing New Coverage." Kaiser Commission on Medicaid and the Uninsured, December 2003.

constrained. Depending on how the waiver is designed, the state might be foreclosed from drawing down additional federal dollars for new coverage and therefore would have to finance any new coverage within the limits of the budget neutrality cap or solely with state funds.

- ***The federal government is taking a number of steps to limit federal spending and increase its oversight of state Medicaid financing.***

  It is important to consider potential waiver financing terms in the context of broader federal budget constraints and recent federal actions aimed at tightening federal oversight of Medicaid spending. For a number of reasons, this is not a favorable time to be negotiating Medicaid financing terms with the federal government

  The Bush Administration is aggressively looking for ways to contain and, in some cases reduce, federal Medicaid spending. In addition to its capped allotment proposal, in its FY05 Budget, the Bush Administration proposed that Congress enact legislation to reduce federal Medicaid spending by nearly $24 billion over the next ten years.[27] Administratively, CMS has recently stepped up its scrutiny of state Medicaid spending. For example, the federal agency now closely examines state Medicaid financing arrangements whenever a state submits a Medicaid state plan amendment or a waiver request, regardless of whether that amendment or request is related to the financing practice under review. In some cases, CMS is re-examining state Medicaid financing arrangements that it had already approved.[28] California is being questioned about federal payments received between 1998 and 2002 under the selective contracting waiver. An audit by the HHS Office of Inspector General released in May 2004, challenged California's method for computing savings and costs under this waiver.[29] These findings could lead to the state having to repay federal funds received under that waiver.

  It is possible that California may be counting on getting some sort of special financing arrangement with the federal government. This is possible, but, once approved, California's waiver terms will be examined closely by other states, members of Congress who have questioned aspects of the recent waiver activity, and the General Accounting Office, which has been reviewing waiver financing. [30] Under this kind of spotlight, it will not be easy for

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[27] 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. http://www.kaisernetwork.org/health_cast/uploaded_files/040104_houseec_medicaid.pdf

[28] Testimony of Dennis Smith, Director of the Center of Medicaid and State Operations at the Center for Medicare and Medicaid Services, and testimony of Barbara Edwards, Deputy Director of the Office of Medicaid for the State of Ohio, Congressional Hearting: Inter-governmental Transfers: Violations of the Federal-State Medicaid Partnership or Legitimate State Budget Tool?, April, 1 2004, transcript of the proceedings. http://www.kaisernetwork.org/health_cast/uploaded_files/040104_houseec_medicaid.pdf

[29] Department of Health and Human Services, Office of Inspector General, "Audit of California's Medicaid Selective Provider Contracting Program, July 1, 1998 through June 30, 2002," May 2004. Audit No. A-09-02-00082.

[30] "Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns," General Accounting Office, July 12, 2002; "SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with

HHS to grant California a significantly better deal than it is willing to give to other states. It is important, moreover, to consider not just how financing arrangements might look now but also how the state might fare when the waiver comes up for renewal. At that point, federal budget problems could be significantly worse than they are now.

VI. Conclusion

It comes as no surprise, given the lack of clear guidelines or open process with respect to waiver negotiations, that some variations in waiver financing arrangements can be seen from state to state and from one administration to another. The imposition of a budget neutrality cap, however, is a constant feature of all section 1115 waivers. While California would no doubt attempt to negotiate financing terms that are as favorable as possible, a formula-based cap on payments carries inherent risks as compared to the open-ended financing system that operates under regular program rules.

Health care costs are notoriously difficult to predict. Whatever inflation adjuster might be agreed to in the context of waiver financing does not change the fact that in one way or another waiver financing shifts risks onto the state and ultimately to counties, providers and the uninsured. For California, which has a very low per-person spending base, where so many people's coverage and so much of the state's health care spending would potentially be put under a waiver, where natural disasters are common, where the economy experiences extreme highs and lows, and where the rate of uninsurance is particularly high, the challenges presented by waiver financing could be particularly great.

Waivers have a place in the Medicaid program, and, in some circumstances, they have been used by states, including California, to maximize federal funding, expand coverage, and improve the system for delivering care. Depending on design and scope, a new waiver could, however, circumscribe California's financing flexibility and over time lead to unanticipated cutbacks in coverage and harm to state and county finances and to California's already fragile health care system.

This background paper was prepared by Cindy Mann and Joan Alker of the Georgetown University Health Policy Institute.

Program Goals," General Accounting Office, January 5, 2004; Letter from Senators Grassley and Baucus to CMS Administrator Mark McClellan, June 16, 2004.

Appendix A:
Section 1115 and Targeted Medicaid Waivers in California as of July 2004

Waiver Names	Original Approval Date	Status	Annual Expenditures
Section 1115 Waivers			
California Parental Coverage Expansion	1/25/02	Not Implemented	$466 million (2004), $487 million (2005), $337 million (2006)
Medicaid Demonstration Project for Los Angeles County	4/15/96	Approved through 6/30/05	$123 million (2004), $65 million (2005)
Family Planning, Access, Care and Treatment (PACT)	12/1/99	Approved through 11/30/04	$159 million (2004), $27 million (2005)
California Targeted Medicaid Waivers			
General Managed Care and Selective Contracting Waivers Under 1915(b) Authority			
Selective Provider Contracting	9/21/82	Approved through 12/31/04	Not Reported*
Santa Barbara Health Initiative	1/1/87	Approved through 1/11/05	Not Reported*
Health Plan of San Mateo	11/30/87	Approved through 8/26/04; renewal under CMS review	Not Reported*
Solano Partnership Health Plan	5/1/94	Approved through 2/10/05	Not Reported*
HIO of California	7/10/03	Approved through 7/10/05	Not Reported*
CCS Dental	8/13/03	Approved through 8/12/05	Not Reported*
Specialty Service and Population Waivers Under 1915(b) Authority			
Hudman Waiver	4/24/92	Approved through 12/14/05	Not Reported*
Intermediate Care Facilities for Persons with Developmental Disabilities-Continuous Nursing (ICF/DD-CN)	8/17/01	Approved through 9/30/05	Not Reported*
Medi-Cal Mental Health Care Field Test (San Mateo County) Program	7/23/01	Approved through 7/25/05	Not Reported*
Medi-Cal Specialty Mental Health Services Consolidation Program	11/16/00	Approved through 4/27/05	Not Reported*
Home and Community Based Services (HCBS) Waivers Under 1915(c) Authority			
Inpatient Nursing Facility (0139)	2/28/02	Not Reported*	Not Reported*
Disabled Frail Elderly (0141)	3/24/00	Not Reported*	Not Reported*
HIV/AIDS (0183)	3/15/02	Not Reported*	Not Reported*
MR/DD (0336)	9/28/01	Not Reported*	Not Reported*
Disabled Individuals (0348)	6/28/00	Not Reported*	Not Reported*
Physically Disabled (0384)	2/28/02	Not Reported*	Not Reported*

*Data reported here are from federal sources; annual expenditure data for targeted Medicaid waivers and status information for HCBS waivers were not available through these sources.
Source: CMS Website: http://www.cms.hhs.gov/medicaid/waivers/cawaiver.asp, updated through conversations with CMS project officers. Annual expenditures for Section 1115 waivers from "Budget of the US Government, Analytical Perspectives, Fiscal Year 2005." Office of Management and Budget, page 364.

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